

CHAPTER 8

THE LONG-TERM CARE WORKFORCE: FROM ACCIDENTAL TO VALUED PROFESSION

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As millions of baby boomers march inexorably toward older ages, there are increasing concerns about the capacity of the caregiving workforce to meet the demand for long-term care. Much long-term care, in contrast to more medically oriented services, is unpaid assistance provided by family and friends (Spillman and Black 2005; Gonyea 2009). There are uncertainties, however, about the extent to which family members will be willing and available to continue to play their pivotal role in caring for disabled older adults in the future. In addition, many long-term care policy officials, providers, worker and consumer organizations and researchers agree that the formal long-term care workforce is already in crisis (Harahan and Stone 2009). The crisis is reflected in labor shortages, rapid staff turnover among administrators, clinicians and direct care workers, the inability of many consumers to find willing providers outside their families, and grave concerns about the quality of the workforce and how that translates into quality of care (IOM 2008). Many people enter the field “accidentally,” often moving into long-term care positions from other parts of the health care sector or other fields. They lack the understanding, education and training that is needed to work in this complex and rapidly changing environment.

This chapter provides an overview of the formal, paid long-term care workforce including the direct care workers that deliver the bulk of formal services and the professional staff who oversees, manages and delivers agency- and facility-based long-term care to older adults. This is followed by a discussion of the current workforce challenges, the factors contributing to this crisis and the reasons why this issue must be addressed. The chapter concludes with recommendations on short and longer-term solutions to the workforce crisis and some brief comments on implications for the future.

It is important to note that approximately 49 percent of the population needing long-term care is under age 65 (Kaye, Harrington and LaPlante 2010). Since younger people with disabilities differ with respect to needs, preferences and goals—particularly in the areas of school participation and employment—the workforce providing services to the under age 65 population warrants separate consideration beyond the scope of this chapter. Many of the concerns about and solutions to the

elder care workforce crisis pertain to those caring for younger disabled populations as well.

The Formal Providers of Long-Term Care

The paid (“formal”) long-term care workforce serving America’s elderly population is made up of licensed professionals and unlicensed direct care workers who manage and deliver services in nursing homes, assisted living facilities, other residential and community-based care settings and private residences.

Direct Care Workers

Direct care workers are the core of the long-term care system, responsible for helping frail and disabled older adults carry out the most intimate and basic activities of daily life such as eating, bathing, dressing and toileting. They represent the largest component of the long-term care workforce, have the most frequent contact with care recipients and are most likely to directly influence the quality of care and quality of life provided to elderly consumers. In 2006 an estimated 2.3 million direct care workers—certified nursing assistants, home health care aides, and home care/personal care workers—were providing care to older adults in the United States (BLS 2010). This figure greatly underestimates the actual size of the direct care worker population because it does not capture many workers hired privately by elderly consumers and their families.

To become certified as a nurse aide, federal law requires less than two weeks of training or passing a certification exam although most states add on to these requirements. Home health aides must pass a federally mandated competency exam for their employers to receive reimbursement from Medicare. Federal continuing education requirements for home health aides and nurse aides are minimal and content is left to states and providers. The regulation of other direct care workers, including those who work in assisted living, and personal care and home care agencies is determined by the states. Typically staff in these settings receives little or no training (Seavey 2007).

Registered Nurses

Registered nurses are responsible for ensuring the quality of clinical care, developing clients’ treatment plans, delivering certain types of care, supervising licensed practical nurses in various settings and direct care workers in the home health sector, and instructing patients and their families in self-care. Federal law requires that the director of nursing in a skilled nursing facility be a registered nurse; there are no federal requirements for other settings. In 2006 approximately 312,000 registered

nurses were employed in long-term care settings serving elderly populations (BLS 2010). By 2020, an estimated 287,300 registered nurses will be needed to work in nursing homes, an increase of 66 percent from 2000. The comparable estimate for home health nurses is 275,600, an increase of 109 percent from 2000 (HRSA 2004).

Licensed Practical/Vocational Nurses

Licensed practical/vocational nurses (LPNs) provide direct patient care, including the taking of vital signs and administering medications. Approximately 26 percent of all LPNs work in nursing homes; there are no comparable estimates for the percentage employed in other long-term care settings (BLS 2007). Although their scope of practice is more limited than that of registered nurses, a survey conducted by the National Council of State Boards of Nursing (Smith and Crawford 2003) indicates that more than 60 percent act as charge nurses or team leaders with responsibility for supervising and directing the care provided by nursing assistants and other direct care workers. In 2006, an estimated 297,000 licensed practical nurses were employed in a range of long-term care settings (BLS 2010). Anecdotal evidence suggests that because of the difficulty in recruiting RNs in many states, it is not unusual for LPNs to be the only category of nursing professional—other than the director of nursing who is required, by regulation, to be an RN—employed by the nursing home (Harahan and Stone 2009).

Mental Health Clinicians

Mental health professionals in long-term care settings include social workers and clinicians trained in psychiatry, psychology and nursing. Several studies (President's New Freedom Commission on Mental Health 2003; Bartels, Moak, and Dums 2002) show there is a severe shortage of practitioners in the mental health workforce who can provide mental health services to older adults regardless of setting. A majority of older adults in residential care are reported to have a significant mental health disorder and are in need of mental health services. A review of medical records by the Office of the Inspector General (OIG 2003) in a sample of skilled nursing facilities showed that 95 percent of the residents who received a psychosocial assessment had at least one psychosocial service need. However, 39 percent did not have a care plan indicating how these services were to be delivered.

The only published data on mental health clinicians in long-term care focus on social workers. In 2006, approximately 36,100-44,200 licensed social workers were employed in long-term care (ASPE 2006). Licensed social workers are hired to address the psychosocial needs of elderly residents/clients and family caregivers across the full range of long-term care settings. Many are involved in the admissions

process to a nursing home or assisted living facility. A subset of individuals trained as social workers provide care management services to community-dwelling elderly individuals. A 2004 national survey of licensed social workers found that social workers in long-term care report facing greater challenges than their peers in other care sectors. These challenges include lower pay, higher caseloads, a greater proportion of tasks below their skill levels, and a lack of peer networks and agency support. All of these factors tend to compromise job satisfaction and continued participation in the field.

Licensed Therapists

Physical therapists provide services that help restore functioning and improve mobility for people who need rehabilitation following a hospital discharge. These services also help maintain functioning or prevent further deterioration for those with chronic physical and cognitive disabilities. Occupational therapists also help residents/clients to improve or restore functions related to activities of daily living such as dressing, bathing and eating. Approximately 40 percent of the 173,000 physical therapists in 2006 were employed in some type of long-term care setting (BLS 2010). No comparable data exist for occupational therapists.

Physician Medical Directors

A physician medical director, responsible for overseeing residents' medical care and participating in care planning, is required at each nursing home reimbursed by Medicare or Medicaid. In 2004, over two thirds of all nursing homes had a medical director who spent four or fewer days per month in the facility; only 14 percent had a medical director who spent 11 or more days in the facility (Resnick et al. 2009). Assisted living and home health agencies are not required to have a medical director, but home health agency care plans must be approved by a physician. Coordination and communication between physicians and home health agencies has long been regarded as inadequate (Markeley and Winberry 2008).

Consultant Pharmacists

The role of the pharmacist in the interdisciplinary care of older adults was reinforced in 1974 when Medicare first mandated drug regimen reviews in nursing homes by consultant pharmacists (Levenson and Saffel 2007). The consultant pharmacist's role includes the provision of information and recommendations to physicians regarding medications, identification of improper use of medications or the prescription of incompatible medications, and collaboration with the medical director and other staff to develop proper protocols for response to adverse events. This role has become more

important as the number of medications administered to chronically ill and disabled elderly patients/residents has increased.

Administrators

Nursing home, assisted living and home health administrators are responsible for staff supervision and management and for compliance with federal and state regulations. The federal government requires states to license nursing home administrators, although there are no national standards. The credentialing of administrators of other settings is at the state's discretion.

States' nursing home administrator licensing requirements vary greatly; some require only a high school diploma and passing an exam. The number of people who take such exams has declined by 40 percent since 1998, and pass rates have fallen. Barriers to recruitment and retention include a lack of reciprocity in states with more rigorous requirements to honor licenses issued in other states, inadequate job preparation, the requirement in most states that candidates for nursing home administrator jobs serve an unpaid "preceptorship," dissatisfaction with pay and co-workers and work overload, and the burden of being responsible for federal regulatory requirements (Lindner 2007).

The Workforce Challenges

Numerous federal agencies (the U.S Department of Health and Human Services, U.S. Department of Labor, the Institute of Medicine), more than 35 state commissions and task forces, and many privately sponsored employer, union and consumer groups (including the National Eldercare Workforce Alliance) have identified the development and sustainability of a quality long-term care workforce as a serious challenge in the 21st century (Kovner, Mezey, and Harrington 2007; IOM 2008; Stone and Harahan 2010). There is a widespread consensus that there are insufficient numbers of competent licensed and direct care staff to manage, supervise and deliver services to the elderly population and younger people with disabilities (Harahan and Stone 2009; IOM 2008).

Long-term care providers and consumers face a double-edged sword. It is difficult to recruit staff—from physicians and nurses to direct care workers. Once hired, staff turnover is rapid, leaving large numbers of positions vacant, putting heavy burdens on the remaining workforce and creating further barriers to attracting and retaining a quality workforce. The most recent national data on turnover and vacancies from AHCA's 2007 nursing home staffing survey showed an annual turnover rate among certified nurse aides of 66 percent and a vacancy rate of 9.5 percent, a shortfall of about 60,300 workers (AHCA 2008). In 29 states, the average turnover was above the

66 percent figure. Freestanding rural facilities had the highest turnover rates for direct care workers. In 2007, furthermore, the perceived difficulty in recruiting nursing assistants was greater than the perceptions about problems with recruitment of RNs and LPNs.

Comparable national estimates of turnover are not available for home care and other community-based settings. A recent state study of the homecare and hospice markets in North Carolina, however, found a 60 percent turnover rate among homecare agencies and a 30 percent turnover rate among hospice providers (Dill and Cagle 2010).

A confluence of factors—including a negative industry image, noncompetitive wages and benefits, a challenging work environment and inadequate education and training--makes it very difficult to recruit professional clinical and administrative staff and direct care workers (Stone and Dawson 2008; Stone and Harahan 2010).

Negative Image

Negative stereotyping of long-term care environments and workers discourages new job entrants. Ageism in the broader culture, the sensationalizing of nursing home and assisted living problems in the media and negative attitudes of educators and leaders in professional schools and associations conspire to reinforce the image of long-term care as a poor career choice (Kaiser Family Foundation 2007). Among high school students considering a nursing career, for example, almost half have no interest in specializing in geriatrics, whereas 87 percent report having an interest in pediatric nursing (Evercare 2007).

Noncompetitive Compensation and Benefits

Compensation and benefits for all staff categories are not competitive. For instance, compared with nurses in hospital settings, RNs who work in nursing homes or other extended-care facilities receive lower annual earnings on average, even though they work more hours per week, incur more hours of overtime, and have a larger percentage of overtime hours that are mandatory (BHP 2006). Stakeholders in some states have observed that acute care hospitals are able to draw staff away from long-term care employers by offering higher salaries and /or better benefits (Center for Health Workforce Studies 2005).

In 2007, Forbes magazine profiled personal and home care aide jobs as one of the top 25 worst-paying occupations in America (Maidment 2007). In 2005, the average annual earnings of female direct care workers were significantly lower than the average annual earnings of female workers in general (\$17,228 versus \$30,441), and

19 percent of female direct care workers had incomes below the poverty level; versus eight percent of female workers in general (Smith and Baughman 2007). Employers, furthermore, have a diminished capacity to increase wages because more than 70 percent of their financing comes from Medicaid and Medicare, which seek to limit costs regardless of labor market conditions.

Direct care workers also have limited access to employee benefits, including health insurance coverage, sick leave and retirement benefits (Smith and Baughman 2007; Stone and Dawson 2008). Often these workers are unable to afford their share of health insurance premiums or they are ineligible for coverage because they work part time or they work independently of an agency.

Challenging Work Environment

Workforce environments typically do not support front-line supervisors and direct care workers, starting with a hierarchical chain of command structure that discourages involvement of lower-level staff in care planning and ongoing decision making. Not surprisingly, LPNs, nursing assistants and home health/home care aides do not feel that their jobs are respected, a perception that contributes to job dissatisfaction and high turnover rates (Bishop et al. 2008; Bowers, Esmond and Jacobson 2003; Wiener et al. 2009). Other workforce challenges include inflexible work flow and job design, ethnic and racial tensions due to cultural diversity of staff and consumers in long-term care settings, and a paucity of career advancement opportunities (Wiener et al. 2009; Castle and Engberg 2006).

Caring for older adults can be physically taxing. Direct care staff in nursing homes has one of the highest rates of workplace injury among all occupations. In 2006, the rate of non-fatal occupational injury and illness involving days away from work was 526 incidents per 10,000 workers among nursing aides, orderlies and attendants (BLS 2007). This was four times the average rate among all occupations and was a higher rate than found among either construction workers or truck drivers. Nursing aides, orderlies and attendants also had the highest rate of musculoskeletal disorders among all occupations examined.

Inadequate Education and Training

The preparation of potential candidates for long-term care positions is out of sync with the realities of the long-term care demand and practice. Medical, nursing and social work students have little exposure to long-term care in their curricula or clinical placements (Harahan and Stone 2009). Only a fraction of these students receive training in geriatrics, and even then, the focus is primarily on acute and primary care (IOM 2008; Stone and Harahan 2010). Administrators, nurses and medical directors

are poorly prepared for the management and supervisory roles with which they are charged in long-term care settings, and there are few in-service training programs to help those who are already employed in these positions (Bowers, Edmonds and Jacobson 2003; IOM 2008; Resnick et al. 2009).

The strategies employed by regulators and educators to prepare and license or certify the workforce and to assure that personnel are able to keep pace with changes in the clinical knowledge base and new technologies are not effective. There are relatively few standards or competencies that are specific to long-term care. There is, furthermore, a huge shortfall of personnel who are competent and committed to educating and preparing both professional and direct care workers for long-term care careers. This translates into a dearth of people—both current and in the pipeline—who are adequately trained and educated to assume increasingly complex jobs across the long-term care settings.

This inadequacy of investment in education and training is compounded by the need for better knowledge and skills to respond to new philosophies and models of care. Emerging philosophies such as person-centered care and culture change in nursing homes, have catalyzed the design of service delivery models that emphasize the role of the consumer and family members in decision making and that empower lower-level staff to be more involved in the management of the workplace and resident/client decisions (Hamilton and Tesh 2002; Kane et al. 2007). The growth in publicly-funded consumer-directed programs that give the consumer the resources and the authority to hire and fire their workers—including their own family members—raises serious workforce issues. These include the magnitude and scope of training that should be required, and the roles and responsibilities that consumers can or must assume when they become employers (Foster et al. 2003).

With the expansion of home and community-based services, many states have changed their nurse practice laws to allow nurses to delegate tasks to direct care workers under their supervision (Reinhard et al. 2003). The implications of delegation for training and oversight in such areas as medication management and wound care are significant, leading the National Council of State Boards of Nursing and the American Nurses Association to call for the development of competencies and training programs for supervisory nurses to facilitate safe empowerment of direct care workers (Harvath et al. 2008).

The increasingly complex health and functional needs of the elderly long-term care population also present training and education challenges. The presence of multiple chronic conditions and dementia in long-term care recipients exacerbates the already difficult problem of effectively coordinating and managing transitions back and forth

across settings: hospitals, nursing homes, assisted living and home care (Coleman and Berenson 2003). It is difficult to see how the new chronic care management and transitional care demonstrations funded by the Patient Protection and Affordable Care Act of 2010 (PPACA) can be successfully implemented in light of the lack of trained, competent professional and direct care staff to carry out the required roles and responsibilities. The growth in hospice programs in long-term care settings and the proliferation of palliative care approaches to end-of-life services delivery (Huskamp et al. 2010) underscore the need for better formal and in-service training for all licensed and direct care staff.

The trend toward the use of more sophisticated information technology in care planning and coordination within and between care settings highlights another gap in the education and training of long-term care staff. The success of health information technology in improving efficiency and quality is dependent on a competent, knowledgeable staff that understands how to operate the system and use the data. Most professional and direct care staff is currently not trained in how to use these data tools and systems.

Why Workforce Matters

Workforce shortages, instability and inadequate preparation contribute to 1) significant access problems for many consumers; 2) extreme workload burdens and stress on the existing workforce; 3) unnecessary costs for employers resulting from the need to continuously recruit and train new staff; and 4) a seriously compromised quality of care for many long-term care recipients.

A 2001 Institute of Medicine (IOM) report on quality in long-term care identified workforce development as one of its nine guiding principles and acknowledged that quality of care depends largely on the performance of the caregiving workforce (Wunderlich and Kohler 2001). Until recently, most of the discussion of workforce issues has focused on achieving minimum staffing levels for nurses and direct care workers in nursing homes. However, the landmark 2008 IOM report—*Retooling for an Aging America*--made it clear that enhanced training and education—both formal and ongoing in-service—for clinical staff, managers and direct care workers—are essential to improve the quality, not just the quantity, of the workforce.

A growing body of empirical evidence supports the relationship between the quality of the workforce—particularly direct care workers—and quality of care/quality of life outcomes for elderly residents/clients. In one of the early studies examining this relationship, Eaton (2001) documented reductions in mortality and pharmaceutical use and increases in resident functioning after the introduction of innovative

organizational programs that improved the work environment of nursing home aides. These programs included the development of self-managed work teams, improved information-sharing between nurses and direct-care staff, and enhanced responsibilities for the direct care workers themselves. In their evaluation of the Wellspring nursing home quality improvement program, Stone and colleagues (2002) found that the empowerment of the direct care workers, including their significant participation in care planning and care plan implementation, was associated with reduced turnover, a reduction in health deficiency citations from state surveyors and a decrease in incontinence rates. Bostick and colleagues (2006) found that lower nursing assistant turnover rates (a measure of job satisfaction and a quality work environment) were associated with improved quality outcomes including reduced use of physical restraints, catheters and psychotropic drugs, fewer contractures and pressure ulcers and fewer quality-of-care state survey deficiencies.

The literature underscores the critical role licensed nurses play—particularly in nursing home settings—in improving the quality of care (Harrington et al. 2000; Rantz 2003; Reinhard and Reinhard 2006; Bostick et al. 2006). One recent longitudinal analysis of California state survey data on nursing home quality from 1999 to 2003 found that registered nurse staffing levels were negatively associated with the number of quality of care deficiencies (Kim et al. 2009). Several studies have shown that nurse practitioners can have a positive effect on nursing home residents' care outcomes (Garrard et al. 1990; Rosenfeld et al. 2004).

There is a paucity of studies on the role that other professionals play in determining the quality of care for long-term care consumers. One recent study did find a positive relationship between having a certified medical director on staff (an individual with additional education tied specifically to the medical director role) and nursing home quality outcomes (Rowland et al. 2009). Analyzing nursing home deficiency data from the Centers for Medicare and Medicaid Online Survey Certification and Reporting database, the research team found that the standardized quality score of facilities with certified medical directors were higher than the scores of facilities lacking a medical director with a special certification.

The shortage of direct care workers in the home care industry has a direct impact on consumer access to services. Evaluation results from the Cash and Counseling demonstration program found that participants who relied on the traditional agency-based service system were often not able to obtain the services because of worker shortages (Dale and Brown 2007). In their analysis of five years of data from the National Long-Term Care Survey, Spillman and Black (2005) found that the proportion of community-dwelling elderly care recipients who relied on formal care

dropped from 43 percent in 1994 to 34 percent in 1999, while the proportion who relied entirely on informal care increased from 57 percent to almost 66 percent. While some of this reduction may have resulted from federal budget cuts in the Medicare program, the authors also attributed this reduction, in part, to a shortfall of paid home care/personal care workers.

While there are no published studies examining the effects of nurse or home health aide turnover on patient quality of care, studies have highlighted the important role that a positive relationship between the patient and the aide plays in both quality of life outcomes (Eustis and Fischer 1991; Rodat 2010). Frequent turnover of aides, where clients are constantly faced with establishing new relationships, is likely to negatively affect quality of care and quality of life.

High staff turnover and vacancies are expensive. Seavey (2004) conducted a meta-analysis of the literature and concluded that a minimum direct cost of frontline turnover per worker is at least \$2,500. Most of the studies she reviewed estimated the costs of separation and vacancy, hiring, training, and increased worker injuries. Seavey noted, however, that the indirect costs of turnover (lost productivity until the replacement is trained, reduced service quality, lost clients to other organizations, deterioration in the organizational culture and employee morale) may be substantial and tend to be overlooked because they are less visible and hard to measure. This estimate, furthermore, does not include the costs of managerial and licensed clinical staff turnover—including administrators and directors of nursing.

Solutions to the Workforce Crisis

To meet the current and future long-term care demands of an aging society, policymakers, providers, educators and other stakeholders must take action in a number of key areas.

Expand the Supply

Explicit policies must be developed to expand the supply of personnel entering the field. Today's developers of advanced training programs in geriatrics for professionals other than physicians must look to private foundations for support, or else it falls on the individual students to pay for the programs. For example, in 2007 the John A. Hartford Foundation awarded a \$5 million grant to the Gerontological Society of America for the purpose of preparing doctoral students in geriatric social work. This program and others funded by the private sector, however, do not focus specifically on building the long-term care workforce. A number of public policy strategies have been identified to help attract individuals into administrative and clinical professions in the long-term care sector (IOM 2008; Harahan and Stone 2009). These include the

creation of financial incentives such as grant programs to foster greater interest among people considering the long-term care field; scholarships, federal traineeships and residency programs for people preparing for advanced degrees in long-term care; matching grants to fund administrator-in-training programs for people interested in management positions; and loan forgiveness programs for people who commit to long-term care careers.

The PPACA established a 15-member national commission to review projected workforce needs and recommend ways to align federal healthcare workforce resources to meet them. Grants would be available for states to do comprehensive workforce planning and development. The health care reform law also increases the loan amounts in the nursing student loan program and specifically identifies long-term care as one of the priority areas.

The U.S. Department of Labor's Long-Term Care Regional Apprenticeship program illustrates how targeted programs can be used as public policy tools to expand the supply of direct care workers. Currently available in 20 states and in the process of being evaluated, this program combines classroom and on-the-job training with career advancement opportunities to expand the pool of nursing assistants and home care aides (Anderson et al. 2010; Kuehn et al. 2011). The public authority model--established in certain states (California, Washington) and localities (many counties in California) to support independently hired personal care workers—could be used more extensively to recruit individuals into these direct care jobs.

Older workers also provide a potentially rich pool of direct care workers (Hwalek, Straub and Kosniewski 2008). Research findings indicate that both older adults and long-term care providers are interested in exploring the potential of older workers and retirees to fill some of the current and future workforce gaps. Accordingly, several grantees of the Senior Community Service Employment Program, administered by the U.S. Department of Labor, have developed initiatives to train and employ lower-income older adults as direct care workers.

Another potential pool of long-term care workers is the TANF recipient population. Recognizing this opportunity, in 2010 the U.S. Department of Health and Human Services' Administration for Children and Families announced a \$51 million Health Profession Opportunity Grants program that will fund up to 17 five-year projects that provide training for and support educational paths to careers in health professions for TANF recipients and other low-income individuals (ACF 2010). Long-term care professions—including nursing assistants, home care aides and registered nurses—are specifically identified in the call for proposals. Projects must integrate the education

and training with supportive services (e.g., transportation, dependent care, temporary housing) and must result in an employer- or industry-recognized certificate or degree.

A number of long-term care providers have also partnered with local high schools to develop on-site training and internship programs for students, to attract them to careers in this field. These programs combine didactic, classroom education with on-the-job training, support from mentors, opportunities for communication with and shadowing of various long-term care staff, and the offer of jobs upon successful completion of the program.

Another important source of professional and frontline staff to strengthen the pipeline is the immigrant population. A recent study of the role of migrant workers in caring for the elderly reported that approximately one out of seven professional staff working in long-term care is foreign born; the comparable estimate for direct care workers is one in five (Martin et al. 2009). Although immigrants are viewed by many employers as a valuable resource, there are a number of impediments to this strategy as a solution to the pipeline problem. Immigrants may only come into the United States with a temporary or permanent visa. Visas for all temporary and permanent less-skilled workers are capped at 5,000 per year, making it almost impossible for long-term care employers to draw on them to recruit new personnel. Limits for higher-skilled personnel such as nurses and physicians are less restrictive (Leutz 2007). The future of immigration remains unknown but it is clear that the decisions made will have significant implications for the development of the long-term care workforce.

Invest in Workforce Education and Training

A high quality workforce depends, in large part, on the investments that society makes in education and ongoing training of new and experienced personnel. The formal system of education, both initial and continuing, of long-term care managers, licensed professionals and direct care staff must undergo significant reform. Policymakers at the state and federal levels, educators, employers, workforce developers and organizations representing the various occupational categories should jointly assess the adequacy of current educational efforts, including the extent to which these efforts specifically address the developmental needs of the long-term care workforce.

The research literature provides little insight into the similarity between the geriatric competencies needed by health and social work professionals and those needed to effectively perform in long-term care settings (Harahan and Stone 2009). Utley-Smith (2004) compared the perceptions of hospital administrators, nursing home administrators and home health administrators in three states regarding the importance of selected competencies of recent baccalaureate-level nursing students. Competencies

were categorized as health promotion, supervision, interpersonal communication, direct care, computer use and case management. The administrators from the three settings gave similar mean importance ratings to interpersonal communication and direct care competence. Home health agency respondents gave the highest rating to health promotion competence. Nursing home administrators differed strongly from their peers in the other settings in the importance they attached to supervision competence—a finding that reinforces the need to address the deficiencies in the preparation of nurses to supervise other staff and/or delegate or monitor the work of others in the nursing home and other residential care settings.

Policymakers and other stakeholders should also evaluate the effectiveness of professional schools, community colleges and other vendors in providing the education. Based on these assessments, they should determine the curricula and the competencies that are necessary to strengthen and expand the long-term care workforce—with a particular focus on how care should be delivered in emerging home and community-based care settings and through new service delivery approaches (e.g., transitional care, integrated care, consumer direction). Financial incentives should be made available to recruit and develop qualified faculty who have the skills and knowledge and are committed to educating and preparing long-term care managers and clinicians for work in the long-term care sector.

Educational policies need to ensure that students in professional schools are required to take courses and have clinical site placements that provide knowledge and skills tailored for long-term care service delivery. The nursing field appears to have taken the lead in this arena. The University of Minnesota's School of Nursing is an example of a professional school that requires all students to take a course that introduces them to the roles, necessary skills and contributions of nurses in a range of long-term care settings. The course integrates curriculum models with on-site assignment to a nursing home. As part of the course, students must complete a clinical practicum in a long-term care facility and are assigned to specific residents.

Other schools of nursing are beginning to tackle gaps in the preparation and ongoing training of nursing home nurses as a result of funding from the John A. Hartford Foundation and the Atlantic Philanthropies. These foundations have established a partnership between the Hartford Centers of Geriatric Nursing Excellence at the Universities of Arkansas, California at San Francisco, Iowa, and Pennsylvania and the Oregon Health and Sciences University, nursing home providers, regulators and advocacy and payer groups. The goal is to increase the expertise, authority and accountability of RNs through the development of a long-term care nurse practice model that promotes the acquisition of geriatric nursing competencies and the special

management skills needed in long-term care (Bourbonniere and Strumpf 2008; Beck 2008).

In 2006, the Visiting Nurse Service of New York (VNSNY) and the Hartford Institute for Geriatric Nursing at the NYU College of Nursing (with funding from the NY City Department for the Aging and the Fan Fox and Leslie R. Samuels Foundation) began to collaborate on a pilot project to assure that home health care nurses were prepared for geriatrics, with an emphasis on assessment and management of geriatric conditions and syndromes (CNYGEC 2010). The program provides both traditional face-to-face synchronous training and asynchronous internet training to VNSNY nurses using nationally recognized evidence-based best practices training materials. As of spring 2010, the goals of this program have been to prepare 40 nurses in best practices in care for older adults. RNs completing the educational module will sit for the American Nursing Credentialing Center's Gerontological Certification Exam, and participants completing the 40 hours of the educational program receive Certificates of Completion from the Consortium of New York Geriatric Education Centers. This program is currently being evaluated.

Other incentives, such as matching workforce development grants to long-term care providers, are needed to motivate existing professionals and direct care staff to obtain training in geriatrics, management, and cultural competency. Research on the content of continuing education for long-term care professionals is weak (Harahan and Stone 2009). Most studies address the relative effectiveness of various formats for delivering training to practicing professionals but not the content that is provided (Bourbonniere and Strumpf 2008). This knowledge gap is particularly problematic for the vast majority of nursing home and assisted living facility RNs who only have an associate degree or nursing diploma. They are, therefore, dependent largely on in-service opportunities to improve their clinical competence in areas such as geriatrics, supervision and leadership.

Both the initial training and the continuing education of direct care workers appear to be inadequate (Menne et al. 2007; IOM 2008). There are concerns about inadequate number of hours and the content of the educational offerings. The IOM (2008) recommended that the state and the federal governments increase minimum training standards for all direct care workers. Federal requirements for minimum training of certified nursing assistants and home health aides should be raised to at least 120 hours and should include demonstration of competence in the care of older adults as a criterion for certification. States should also establish minimum training requirements for personal care/home care aides.

One area seriously lacking in the current educational content for direct care workers is geriatric competency (IOM 2008). This includes a better understanding and ability to address the needs of elderly residents/clients with multiple chronic problems, dementia and those at the end of life. There is also a dearth of initial and in-service training programs that help direct care workers to improve their teamwork and problem solving knowledge and skills. A number of programs have begun to address this gap, including the initiatives developed by PHI, the largest training and advocacy organization focused on the direct care worker in long-term care. The SCAN Foundation recently supported five California-based projects that are designing and testing in-service training programs that incorporate various elements of geriatrics. The ultimate goal of this initiative is to infuse the curricula into California's basic in-service requirements for nursing assistants and home health aides. The SEIU in the state of Washington has developed a new training program with expanded geriatric content for home care aides and independent personal care workers that will be rolled out over a three-year period

The PPACA included some provisions in health care reform that specifically address the inadequacy of training and education of the long-term care workforce. It authorizes three years of funding for new training opportunities for direct care workers. The act also authorizes funds for geriatric education centers for training in geriatrics, chronic care management and long-term care for faculty in health professions schools and for family caregivers. Another provision expands geriatric care awards to advanced practice nurses, clinical social workers, pharmacists and psychologists and establishes traineeships for individuals preparing for advanced degrees in geriatric nursing, including those who are interested in the long-term care sector.

Make Jobs More Competitive

Federal, state and local workforce policymakers should use multiple policy levers to make the long-term care professional and direct care jobs competitive in the broader health care market as well as with other sectors. Potential approaches include raising the wages for long-term care workers so that they are at least in line with their peers in hospitals. Communities can also raise wages for the direct care workers by passing living wage ordinances.

A number of states have used Medicaid "wage pass through" strategies, in which states allocate extra funds to nursing home or home health agency reimbursement rates with the proviso that these dollars will be used specifically by the providers to increase the wages of the direct care work force (IOM 2008). This approach has had limited success, has been difficult to enforce, and is not likely to be considered when

states are experiencing significant budgetary problems. Given the major role that Medicaid plays in paying for long-term care, such a strategy needs to be improved and reconsidered in the future.

Long-term care staff—particularly direct care workers—must have access to affordable health insurance coverage. Currently, more than one in four—26 percent—of all direct care workers are uninsured. Twenty-two percent of those working in nursing homes and one-third of those employed in home and community-based settings lack coverage (PHI 2010). The PPACA has the potential to ameliorate the lack of coverage for many direct care workers, but the implementation will take time and the outcomes are uncertain. Policymakers also need to explore mechanisms through Medicare and Medicaid to increase compensation for medical directors and directors of nursing, who assume federally mandated responsibilities in nursing homes and home health agencies.

Another approach is to institute payment reform that ties Medicaid rate increases to the success of long-term care employers who demonstrate a significant reduction in turnover, increased staff retention, and better quality outcomes through workplace redesign and continuous quality improvement (Stone and Harahan 2010). Several state Medicaid agencies (Colorado, Georgia, Iowa, Kansas, Oklahoma, Utah and Vermont) have begun including select workforce measures in their pay-for-performance schemes for nursing homes (Bryant, Stone and Barbarotta 2009; Konetzka and Werner 2010), but there has been no evaluation of the effectiveness or consequences of these programs.

Implications for the Future

After 20 years of debate about how to reform long-term care, the development of its workforce is finally beginning to receive attention from policymakers, providers, professional and worker associations, consumers and researchers. The 2008 Institute of Medicine report on retooling the health care workforce for an aging society explicitly acknowledged the need to strengthen and expand this workforce at all occupational levels. Several provisions in the PPACA are designed to enhance the recruitment of individuals into the long-term care sector. The Department of Labor has also developed a number of initiatives specifically targeted to the expansion of direct care workers—particularly in home care and personal care. A number of national and state-level foundations have also identified the long-term care workforce as a priority funding area.

Several trends underscore the immediacy of this issue and the need to address the workforce challenge sooner than later. The oft-cited aging of the baby boomers

ensures that there will be an increased demand for a trained, competent workforce to deliver and manage the services. At the same time that demand is increasing, the labor pool that has historically provided caregiving services to the long-term care population is shrinking. Baby boomers had a smaller than average number of children than their parents, raising uncertainties about the future availability of family caregivers to provide unpaid services. The native-born population aged 25-44, from which both paid and informal long-term care providers largely come, is not projected to increase over the next decade, and the availability of immigrants to fill this gap is uncertain in light of a lack of a defined national immigration policy. In addition, aging nurses are retiring and there is a serious shortage of young nurses to replace those leaving the field. Those entering the field, furthermore, are much more likely to be employed in the acute care sector than to seek a job in the long-term care sector. As a consequence, long-term care employers cannot rely on traditional sources of labor.

Assistive technologies such as canes and walkers, and housing adaptations such as ramps, wheelchair-accessible showers and toilets and grab bars help disabled older adults reduce or even eliminate the need for human assistance in carrying out routine activities. Other technologies such as sensors that help prevent falls or medication reminders that help older adults comply with their medication regimens may also reduce the need for hands-on or even supervisory assistance (Center for Technology and Aging 2009). Telehealth strategies, particularly in rural areas, have the potential to create the efficiencies that can help to reduce the demand for human labor. Questions remain, however, about the extent to which technological advances will replace the long-term care workforce. It is more likely that these mechanisms will complement the professional and direct care workforce. Either way, the expansion of technology will require additional educational efforts to ensure that the staff is adequately trained to use the technologies appropriately and efficiently.

The development of this workforce needs to be viewed as an opportunity as well as a challenge. The long-term care sector—and home care in particular—is one of the fastest growing occupational areas in the country today (CNYGEC 2010). So it is important that we recognize the pivotal role that investment in this workforce can play in driving economic development as well as achieving better quality of care and quality of life for those receiving the services. To achieve this goal, we must shift the perception of work in long-term care as an accidental occupation to one which is attractive, rewarding and valued by society.

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