ISSUE BRIEF
The Massachusetts Health Policy Forum

Health Care Workforce Issues in Massachusetts

Thursday, June 22, 2000
8:30 to 9:00 – Breakfast
9:00 to 11:00 – Discussion
Omni Parker House Hotel
School and Tremont Streets
Boston

A Discussion Featuring:

Barbara Frank
Paraprofessional Healthcare Institute
Boston, MA

Susan C. Eaton
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Cambridge, MA

Andrew L. Harris
Benjamin Health Care Center
Boston, MA

Charisse DuBois
Women's Educational and Industrial Union
Boston, MA

Moderated by: Representative Harriette Chandler
Chair, Joint Committee on Health Care
Massachusetts House of Representatives

Registration: Please call Sue Thomson at 617-338-2726 as soon as possible.

NO. 9

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Executive Summary

The Massachusetts health care system is experiencing an unprecedented labor crisis. High vacancy and turnover rates among direct care workers[a] are generating a downward spiral within the state's health care labor force—creating an instability that threatens the quality and availability of health care services for thousands of people who are ill, elderly or living with disabilities.[b] Unfortunately, the present foreshadows an even larger and deeper crisis as "baby boomers" begin to face long-term care needs—first for their parents, and then for themselves.

The hot economy contributes to the crisis, but is not its sole cause. Now, and throughout the next 30 years, demand for care will outpace the overall supply of workers. In response, to retain and attract quality direct care workers, the health care system must compete effectively against other Massachusetts employers by offering comparatively high-quality jobs. *The emerging labor crisis requires both **immediate action** to stem the current downward spiral, and then a **comprehensive, far-reaching response** to address its complex and structural causes.*

Dynamics of the Health Care Labor Market

The Massachusetts health care labor market faces a fundamental, systemic challenge:

- *The **demand** for direct care services already exceeds the supply of direct care workers and is growing geometrically*—particularly as the population ages.

- *The **supply** of potential direct care workers cannot keep pace*—due to slow growth in the labor force and the shrinking number of women aged 25-54, who are the "traditional" providers of direct care.

- *A combination of third-party payment policies and industry practices restricts the ability and/or willingness of health care employers to increase substantially their labor **"price"***—wages, benefits and working conditions—thereby rendering health care jobs relatively unattractive compared to employment options in other industries. The exception is those few health care providers who offer better quality jobs, and thus experience lower rates of turnover and fewer staff vacancies.

Deteriorating Job Quality and Care Quality

The health care system is neither retaining experienced nurses and paraprofessionals nor attracting sufficient numbers of new care-giving staff due to:

- *Insufficient and Declining Wages*—especially for paraprofessionals who are paid such low wages that they must work multiple jobs to provide for their families;

- *Lack of Health Insurance*—particularly when jobs are only part-time, or employers' health plan premiums are too high;

- *Insufficient Training and Career Advancement*—both for nurses who shoulder increased managerial responsibilities, and for paraprofessionals who receive little entry-level training and few opportunities for skill-building or promotion;

- *Dangerous Workloads*—for both nurses and paraprofessionals, who are regularly hurt on the job, and are now required to provide more care within shorter time periods, bearing legal responsibility should neglect result; and

- *Poor Management and Supervision Practices*—that render nurses and paraprofessionals unappreciated, overworked, and poorly utilized.

These trends have placed enormous burdens not only on direct care workers, but also on the hundreds of thousands receiving care who must endure:

- *Rushed or Delayed Care*—Exhausted workers do not have enough time with people to take care of them, and are sometimes forced to ignore even the most basic needs;

[a] Direct-care workers include professionals (nurses) and paraprofessionals (certified nursing assistants, home health aides, homemakers, and personal care attendants).

[b] Statewide, at least 8500 direct-care positions currently lay vacant.

- *Loss of Continuity*—With high worker turnover, people receive care from a parade of new caregivers unfamiliar with their individual needs;
- *Higher Risk of Injury*—Rushed, understaffed care results in falls and other injuries;
- *Loss of Experienced Caregivers*—Health care is losing too many experienced workers, no longer available to guide and mentor others.

Recommendations for State Action

Neither significant slowing in the demand for care nor increases in the overall supply of workers are likely. Therefore, both immediate and longer-term actions are needed by third party payers and health care providers to correct prevailing policies and practices that have contributed to the sector's deepening failure to retain and attract workers. Recommendations within health care and labor/workforce policy and practice include:

- ***Document the Health Care Labor Market***—estimate current and project future health care consumption and workforce needs; survey the direct care workforce to determine its status and needs; and issue job quality report cards;
- ***Invest in the Expansion of the Qualified Labor Pool***—position health care as a gateway to employment for new workers, providing targeted public supports for recent immigrants, for people transitioning from welfare to work, and for other low-income individuals who need assistance to succeed in direct care occupations;
- ***Improve the "Price" Offered to Direct Care Workers***—increase nurse and paraprofessional wage and benefit levels through public policies and provider practices; improve training and opportunities for advancement; establish staffing levels that ensure safe workloads; and promote innovations in supervision and management that maximize the value of direct care workers; and
- ***Establish a Health Care Workforce Commission***—forge a Legislature-sponsored, multi-stakeholder taskforce to monitor health care consumption and worker availability, develop strategies to implement immediate reforms, and recommend changes over time to address long-term health care workforce needs.

Introduction

Across Massachusetts, health care providers are reporting unprecedented labor vacancies—particularly for those paraprofessionals and nursing staff who provide "hands-on" direct care services. For example, nursing home providers report an 11 percent vacancy rate in their paraprofessional positions and 12 percent in their professional nursing positions. Even acute-care hospitals, which typically pay relatively high salaries, report vacancies in nursing staff positions exceeding 5 percent.

These vacancies are spreading across a health care delivery system already plagued by high rates of direct care staff turnover. Long-term care providers, for example, report annual losses of 40 to 60 percent among paraprofessionals in home care agencies, and 70 to 100 percent turnover among paraprofessionals working in nursing homes.

This combination of high turnover and system-wide vacancies suggests a critical deterioration in the quality of jobs within our health care system. Consumers consistently identify a kind caring connection with care-givers as the key factor for their quality of care. Researchers have identified such a significant relationship between the quality of direct care jobs and quality of care that it is likely this deteriorating cycle of job quality will profoundly de-stabilize the ability of the Commonwealth's health care system to ensure quality care for its residents.

Such high vacancy and turnover rates are the result of massive forces at work throughout the State—with an increase in demand for health care services colliding against rigid cost constraints for the funding of those services. Pinned between are health care providers and their direct care staff who must deliver more care with relatively fewer resources. When employers turn to look for additional workers, they find that a red-hot Massachusetts economy has driven unemployment rates to historic lows, creating unprecedented competition for employees. Unfortunately, within this heated competition for labor, our health care system now offers relatively unattractive jobs.

Yet these vacancies and turnover rates are not a matter of public policy alone; cause can also be traced to a pattern of decisions made by health care providers themselves. This is particularly true concerning paraprofessionals—certified nursing assistants (CNAs), home health aides, homemakers, and personal care attendants—within the long-term care system. To fill these jobs, the long-term care industry has long structured itself on the assumption of an endless supply of low-income,

contingent workers, and typically offered only low wages, few benefits, and very poor working conditions.

Unfortunately, the future offers even greater reason for concern: The availability of caregivers relative to the number of health care consumers will likely worsen dramatically in the coming decades. For example, the elderly in Massachusetts—who have relatively greater health needs than the general population—are predicted to **increase** by 48 percent during the next 25 years. *Yet during that same period, the numbers of women aged 25 through 54—who make up the vast majority of "traditional" direct care workers—are projected to* ***decrease*** *by 7 percent.*

Clearly, our health care system is now captive within an increasingly competitive labor market. To break the negative spiral, policy makers and industry leaders must work with consumers and their families, workers, and the public, to stabilize and then rebuild the Commonwealth's health care employment structure—crafting public policies and industry practices that will both attract, and retain, direct care workers. Failure to respond will simply drive more workers away from the health care workforce, disrupt provider services, and most importantly, compromise the quality of care available to our families and ourselves.

In Section I of this paper, we define the dimensions of the Commonwealth's emerging health care workforce crisis. Section II describes current health care employment practices and their impact on quality care. In Section III, we recommend immediate and long-range action by policy makers and health care leaders.

Section I: Overview of the Massachusetts Health Care Workforce

Depiction of the Emerging Crisis[1]

Although reports of staff vacancies now echo throughout the health care system, this Issue Brief focuses explicitly on "direct care" workers—those who provide health and personal care in acute and long-term care settings. We include within the definition of "direct care" staff both professionals (Registered Nurses and Licensed Practical Nurses) and paraprofessionals (home health aides, certified nursing assistants, homemakers, and personal care attendants). While professional nurses and paraprofessional health care workers have very different roles and responsibilities, together they form much of the health care "delivery system"—they are the face, hands and voice of health care for hundreds of thousands of ill, elderly and disabled persons.

Vacancy and turnover rates of direct care staff are at historic highs. This turmoil is not only destabilizing providers, it has two other profound impacts: For *health care workers*, low staffing undermines those who remain on the job: forced to "work short" and therefore "speed up," workers must care for more people with relatively less time. Direct care staff face higher levels of stress, a greater likelihood of injury, and deep frustration when they are unable to provide the care consumers deserve, and which they are legally responsible to provide.

Yet for *health care consumers*, the impact of understaffing is even more direct: Care that is rushed, care that is delayed, and in some cases, care that is entirely forgone — a home care client not visited; a person with disabilities left in bed all weekend, or whose family cannot work because help is not available; a hospital patient whose medication is forgotten; a nursing home resident who sits alone, hungry and dehydrated.

Using a "labor-market paradigm," this section analyzes the forces within and external to the health care system causing this disruption among direct care staff—forces that foreshadow a system-wide health care crisis across the Commonwealth. Part 1 provides an overview of health care employment in Massachusetts. It describes the health care labor market, the scale of current vacancies and turnover rates, and projections of future employment. Part 2 analyzes the dynamics of the health care labor market, and examines factors that affect the demand for care, the supply of labor, and the price third-party payers and health care employers pay for labor.

Part 1 - Scale of Massachusetts Health Care Employment[c]

Direct care staff are employed within a range of formal, "reported" employment relationships—as direct

[c] An analysis that relied solely on existing, published data to describe key factors in the health care labor market—such as total employment, hours, wages and benefits—would be both inadequate and misleading. Figures are outdated before they are published, and data collection is not well structured for monitoring basic workforce and occupational trends. This Issue Brief draws its analysis as much from interviews with industry participants and observers as from published data. Indeed, the absence of useful data is so alarming—particularly for a labor force paid substantially with public tax dollars—that structuring, collection and analysis of sophisticated labor market information is a major recommendation of this report.

employees of hospitals, nursing homes, or home health and home care providers; as agency workers subcontracted to the site of a contracting provider; or as independent workers contracting directly with consumers.

The health care system provides 13 percent of all reported employment in Massachusetts—approximately 365,000 jobs[2] —making health care a more important employer in the state than nationwide, where health care totals only 9 percent of reported employment.[3] Formal employment is augmented considerably by unreported, "gray market" employment within paraprofessional "in-home" services.[d] Difficult to quantify, gray market employment nonetheless adds substantially to the health care labor market.[4]

Employment by Provider Group and Position

Hospitals, nursing homes and home health/home care agencies account for nearly three quarters of total reported health care employment. Figures for 1996/1997 suggest that, of total health care employment, the approximate shares by setting were as follows:[5]

Hospitals (private and public)	41-42%
Nursing and personal care facilities	21-22%
Home health care services	10-14%
Other	22-28%

Over the course of the 1990s, the composition of industry employment in the health care sector began to shift away from hospitals and toward long term care.[e] The Massachusetts Division of Employment and training predicts that hospital employment will fall to about a third of all health care employment by 2006 (34 percent), and long-term care will increase to over 40 percent of total health care employment in 2006.[6]

Occupational Employment Statistics data for 1998 from the Bureau of Labor Statistics indicate that Massachusetts employed over 60,000 paraprofessional and roughly 89,000 professional direct care workers. Table 1 gives the breakdown, as reported, by occupation[7] (again, unreported caregivers would increase the paraprofessional count significantly).

Union Role in Workforce

Unionization of Registered Nurses in Massachusetts stands at slightly more than 20 percent; unionization of Licensed Practical Nurses and paraprofessionals is not documented, but is reported by union officials to be quite low. The Service Employees International Union reports 5 percent of nursing homes and 2 percent of home health care agencies are organized in the state. This degree of unionization is relatively modest—for example, nearly 13 percent of all nursing homes nationwide are organized.

Scale of Vacancies and Turnover

All three of the key stakeholders in the Massachusetts health care system—providers, consumers, and workers—report both significant vacancies and high turnover rates among direct care health workers. These

Table 1: Number of Direct care Staff by Occupation in Massachusetts, 1997- 1998

Occupation	1997	1998
Personal and home care aides*	3,310	3,010
Home health aides	21,810	18,720
Nursing aides, orderlies, and attendants	38,810	38,620
Licensed practical nurses	17,460	17,000
Registered nurses	68,990	72,050

Source: U.S. Bureau of Labor Statistics, Occupational Employment Statistics "Occupational Employment and Wage Estimates" (http//:stats.bls.gov/oes/oes_data.htm)

*Contrary to OES data, the disability community reports approximately 8,000–10,000 personal care attendants provided independently contracted assistance to people with disabilities during that time.

[d] In addition to unreported paid employment, a significant underground workforce exists among undocumented workers, who are legally unavailable for hire by health care provider agencies but who provide personal and supportive services to consumers.

[e] Private hospital employment declined from nearly half of private health sector employment in 1990 to 40 % in 1998, while long-term care employment expanded from 25 % in 1990 to 28 % by 1998. Yet within these broader industry trends, contrary occupational shifts often occur. In 1998 hospitals began to increase nursing employment after several years of decline, while home health care reduced paraprofessional positions significantly in 1998 after several years of rapid expansion, according to Medicaid cost reports.

exist in all portions of the health care sector, both long-term and acute care, and at both the nursing and paraprofessional levels. Long-term care providers, consumers and unions representing long-term care workers concur that these vacancies levels are now compromising quality care.[8]

Nursing homes report an 11 percent vacancy rate in paraprofessional positions and a 12 percent vacancy rate in nursing positions.[9] Hospitals report a 5.1 percent vacancy rate for nursing positions.[f,10] In-home providers also report increased difficulty in hiring staff; unfortunately, the home health care industry does not document staff vacancies.

Furthermore, representatives of the long-term care industry agree that Massachusetts experiences rates of turnover similar to the rest of the nation, which have consistently been reported at 40 percent to 60 percent within the home health industry, and between 70 percent and 100 percent within the nursing home industry.

One-third of nursing homes responding to a survey by their trade association, the Massachusetts Extended Care Federation, reported that they have restricted client admissions, or expect to restrict admissions, due to "dangerously" low staffing. Nursing homes across the state report they increasingly rely upon staffing agency "pools" for temporary help to fill vacant positions at high per-hour costs. Facilities report that, in particular, second shift positions—from 3:00 PM to 11:00 PM—are the hardest to fill.

Using a conservative estimate of a 7 percent vacancy rate across all providers, and an assumption that 80 percent of all professional and 95 percent of all paraprofessional positions are direct care, *then direct care vacancies currently total at least 8500 throughout the Commonwealth.*

Projection of Future Employment Trends

Health care employment in Massachusetts is projected to grow to more than 400,000 positions by 2006, with little hospital employment growth, 15 percent growth in nursing home jobs, and expansion of in-home care jobs by 42 percent. Since these predictions were made prior to the spike in labor competition—and before recent reversals in Medicare funding—their precision is subject to question. Nonetheless, industry observers predict continued expansion in demand for direct care services, especially in home and community-based settings, for the next six years and beyond (see "Factors of Labor Demand," below).

Part 2 - Dynamics of the Health Care Labor Market

As is true for every sector of the economy, health care employers compete for workers within a dynamic labor market. However, if the Massachusetts health care labor market were functioning "perfectly," direct care vacancies should not continue for long. That is, the supply of workers would expand to meet demand, as employers adjusted their "price" (wages, benefits *and* working conditions) upward to attract and retain more workers. Unfortunately, several factors prevent our health care system from achieving rapid labor-market "equilibrium" to fill all available positions. These factors include:

- *Continually expanding* pressures on the demand for health care services;
- Limitations on the supply of additional workers who might enter the formal health care labor market; and
- Restrictions on the ability and/or willingness of employers to increase their labor "price" sufficiently to attract an adequate supply of workers.

To understand labor dynamics of demand, supply and price in context, it is necessary to draw an approximation of this "imperfectly" functioning labor market:

1] Factors of Labor Demand

Geometric Expansion of Service Need

Demand for health care workers is "pushed" by: the aggregate number of consumers, the illness acuity[g] levels of those consumers, and technology.

One proxy for increased demand is the rise in the number of elderly, who require greater health services relative to the general population.[h] Although the elderly in Massachusetts are projected to decrease slightly during the next five years (from 842,500 in 2000 to 826,400

[f] Despite vacancies, the Massachusetts Nurses Association reports that hospitals often do not hire available new nurse graduates who require clinical preceptor experience before they can take on a full level of responsibilities.

[g] "Acuity" is a term used in health care to quantify a patient's level of illness and intensity of need.

[h] An estimated one-fourth of all elderly required assistance with one or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) in 1994, according to the Department of Labor's Women's Bureau (http://www.dol.gov/dol/wb/public/wb_pubs/elderc.htm).

in 2005), this age group is projected to increase very rapidly thereafter—17 percent by 2015, and another 30 percent by 2025.[11]

Similarly, the acuity of patients has steadily risen: The statewide inpatient case-mix index[i] for all inpatients of acute hospitals climbed more than 10 percent from 1993 through 1999,[12] and is projected to continue to increase.

Finally, in the health care sector, many technological advances help individuals manage their illnesses and disabilities outside of hospital-based settings. This ironically *increases* demand for hands-on care-giving staff in post-acute settings.

In sum, growing numbers of consumers, with higher acuity rates, who are served in increasingly labor-intensive settings, will place geometric pressures on the need for health care services. Fully-staffing the health care system will thus be increasingly difficult—especially as elderly population growth begins to accelerate in 2005.

"Effective Demand" vs. "Need"

While the factors noted above "push" the "need" for more labor, other attributes of the health care labor market may suppress, or at least distort, the "effective demand" for labor (defined as the level of services that payers are willing to fund). Since health care is funded largely by public and private third-party payers who have strong financial incentives to limit their costs, "effective demand" as determined by third-party payers will likely always be less than the "need" as perceived by direct consumers or their providers of health services.

Federal and state public payers are influenced by the broader political process of apportioning tax dollars to an array of public services—health care being only one among many. Similarly, private insurers,[13] accountable to purchasers and shareholders who drive prices down, have created capitation arrangements, utilization reviews, and a rigorous definition of what constitutes health care (as distinct from social services) in order to control costs. Irrespective of increased requests for service, third-party payers may choose to constrict, or perhaps even *reduce*, "effective service demand," which in turn suppresses effective demand for labor.

System-wide, the health care labor market can best be understood as driven by massive demographic forces that push to "accelerate" aggregate demand for services, while simultaneously, powerful third-party payers (both public and private) attempt to "brake" that demand through regulatory constraints and cost containment.[j]

Therefore, while official predictions of health care employment may well be overstated, industry observers agree that aggregate effective demand for direct care workers will continue to expand into the foreseeable future. However, such expansion will be irregular and "balky," depending on political and financial—not simply health-related—considerations.

2] Factors of Labor Supply

General Trends

During the 1990s, Massachusetts experienced remarkably slow growth both in its general population and its labor force.[14] From 1990 to 1997, the resident population grew by only 1.7 percent, compared to a national population growth rate of 7.3 percent. The labor force over this period expanded by only 1 percent from 1990 to 1997, compared to an 8 percent increase for the U.S. as a whole. *All* of the net labor force growth in Massachusetts during the past decade can be attributed to immigration.[k] Direct care positions are already employ a disproportionately composed of international immigrants.

Both the general population and the labor force in Massachusetts are predicted to grow very slowly through the year 2006 and beyond. Therefore—short of a major expansion of already high international immigration rates—the State's health care system cannot presume a significantly larger "general" pool of potential workers to draw upon for decades to come.

[i] "Case-mix index" provides a measure of the level of illness and need of the overall patient population by grouping patients and classifying them according to various "acuity" measures.

[j] This reality makes official predictions of the resulting labor demand difficult to rely upon: For example, despite an absolute decline in home health aides nationwide during 1999 due to major cuts in Medicare funding, the Bureau of Labor Statistics still predicts that home health aides and personal aides will increase 58 percent nationwide between 1998 and 2008—supposedly still the seventh fastest growing occupation in the nation.

[k] During the period 1990 through 1997, net domestic migration was dramatically negative in Massachusetts, falling by more than 220,000. Net international migration added 112,237 persons to the state's population. – See analysis in Andrew M. Sum, et. al. (1998) *The Road Ahead: Emerging Threats to Workers, Families & the Massachusetts Economy* (Boston: The Massachusetts Institute for a New Commonwealth) on the Internet at http://www.massinc.org/pages/Reports/RoadAhead/The_Road_Ahead.htm.

The "Caregiving" Workforce

While the State's general pool of workers is unlikely to grow, the future supply of "traditional" health care workers—women between the ages of 25 and 54—is cause for even greater concern.

Nationwide, women hold 78 percent of all health care positions, and women are even more disproportionately represented in direct care positions.[15] Ninety-three percent of paraprofessionals are women; 89 percent are under 55 years of age.[16] Women also account for 95 percent of a rapidly aging professional nursing staff. The number of women in Massachusetts between the ages of 25 and 54 is projected to decrease during the next 25 years, down from 1,415,000 to 1,311,000 (a 7 percent loss).[1,17]

Figure 1 juxtaposes the likely increase in demand for services (proxied by the growing number of elderly) against the shrinking number of "traditional" caregivers, suggesting a worsening, long-term staffing challenge to the health care system over time.

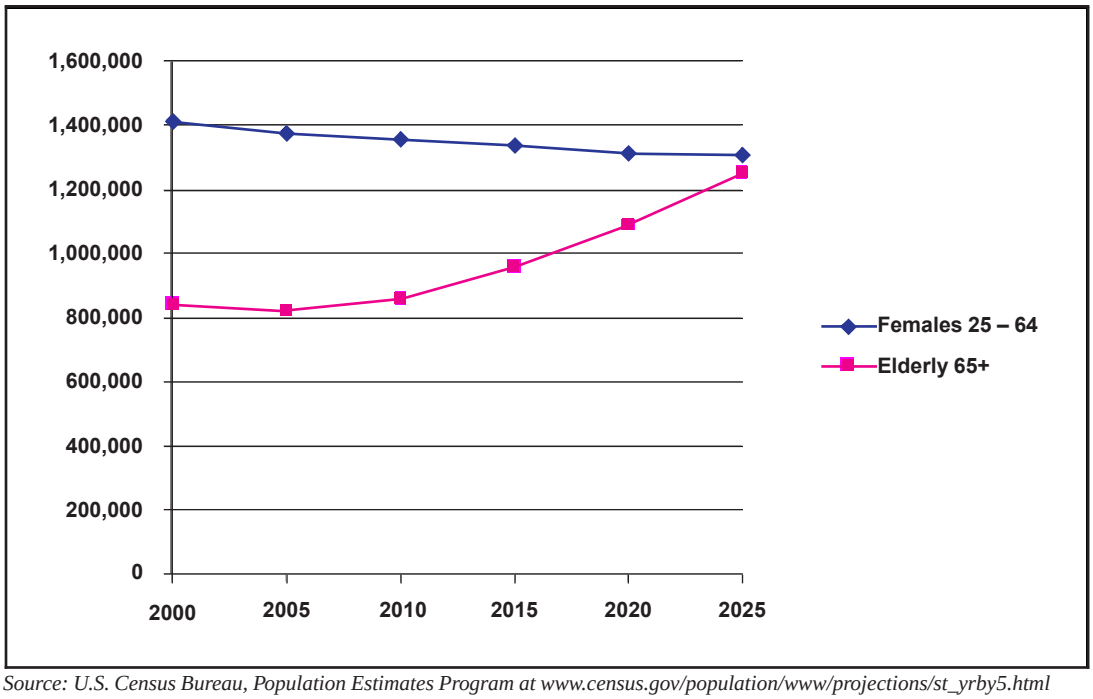
Furthermore, since women in this age group also make up the vast majority of family caregivers, their shrinkage will likely place even greater demand onto the "formal," paid health care system.[18]

This relationship between the elderly and their paid and unpaid caregivers can also be understood by creating a "caregiver ratio"—that is, the number of elderly compared to the number of females aged 25 to 54 who might be available for their care. The ratio of elderly to females 25-54 in Massachusetts is projected to worsen significantly over the next 25 years—*from 60 elderly per 100 caregiving-aged females in 2000, to 95 elderly per 100 caregiving-aged females in 2025—nearly a one-to-one correspondence.*

The Impact of Education on Professional Positions

Educational standards pose one factor that sharply divides the paraprofessional from the professional care-

Figure 1: Elderly and Women of Caregiving Age in MA, 2000-2025*
(Individuals 65 and older; females aged 25-54)



Source: U.S. Census Bureau, Population Estimates Program at www.census.gov/population/www/projections/st_yrby5.html

*This "demand curve" proxy only accounts for the number of elderly, not the multiplier effects of increased acuity or technology.

[1] Although presuming that women should remain the primary source of caregivers may be gender-biased, looking to men as a potential source of health care labor provides little relief: Men of the same age group are also projected to decrease 7 percent over the same 25-year period.

givers. For paraprofessional workers, most all positions require no more than two weeks of training, and many do not require a high school diploma or G.E.D. Therefore, entry into the workforce is nearly instantaneous. However, the nursing profession requires between two and four years of college education.

Over the past five years nursing school enrollments nationally have declined by 15 percent; in Massachusetts they have declined by 25 percent.[19] As the nursing workforce ages—nationally, the average age increased from 40.3 years in 1980 to 44.3 years in 1996[20]—more nurses will be retiring. Since education creates a "lag time" of several years before new nurses can be admitted into the workforce, Massachusetts will face a shrinking supply of new nurse professionals for the next several years, even if the college enrollment trends reverse immediately.

One mitigating factor for the supply of professionals is the large number of those who *currently* hold nursing licenses, but are not practicing. In Massachusetts, 17 percent of licensed nurses remain outside the profession— a pool of approximately 17,000 trained nurses who might be recruited back into the health care labor market[21] with improvements in wages, benefits, and working conditions.

The Unemployed and Individuals Receiving Public Assistance

The official unemployment rate in Massachusetts is now at historic lows. With one-third of employers reporting plans to hire, a softening of unemployment in the near future seems unlikely.[22] With very low population and labor force growth, even a "normal" business cycle recession will likely yield only a modest increase in the number of unemployed.[23] Therefore, those "officially" unemployed (actively seeking work) do not offer a large untapped pool of potential health care workers.

One other source of potential workers is the pool of individuals transitioning from welfare to work. However, since the number of individuals receiving public assistance in Massachusetts has dropped by 57 percent since 1995,[24] a substantial portion of that potential source of workers has already been absorbed into the worker-hungry economy.

Furthermore, those who remain on public assistance are now more likely to have multiple barriers to employment—e.g., substance abuse, physical or mental disabilities, or other barriers such as limited transportation resources. Unfortunately, the more barriers that potential employees face, the more costly it will be for the public and for employers to assist these individuals as they move into stable employment.

Therefore, although public assistance recipients will remain a source of direct care health workers, particularly for paraprofessional positions, it is unlikely that they represent a large *additional* pool of potential workers.

Private Pay and "Gray-Market" Influence

Higher-income consumers often pay privately for in-home services provided by agencies that target the private-pay market, or by caregivers who work directly for in-home consumers (often within unreported "gray market" arrangements in which payroll taxes are not withheld). A significant underground labor market exists among "undocumented" workers, who are legally unavailable to health care providers. During this current period of high labor competition, private-pay and gray market arrangements are draining workers away from the larger, publicly-funded portion of the health care system, by offering relatively higher "take home pay" (see below).

3] "Price" Inflexibility in the Health Care Labor Market

Given that options for identifying new sources to expand the general labor pool are likely to remain very limited—and that the numbers of "traditional" caregivers are actually shrinking—one other path remains for policy makers and providers: competing successfully against other employers for workers. Put bluntly, only by improving the relative quality of direct care positions can health care employers successfully recruit workers from other parts of the labor market, and retain those workers once they are employed.

This strategy requires improving the "price" of health care jobs—wages, benefits *and* working conditions. However, two core factors inherent in the health care labor market must be addressed: third-party payers and provider employment practices.

Third-Party Payer Distortion

As noted earlier, a "perfect" health care labor market would respond to the system's current mismatch between supply and demand by improving wages, benefits and working conditions. However, the health care system is funded largely by public and private third-

party payers who play a primary role in determining "effective demand."

Third-party payers influence the price of labor—by determining the amount they will pay per person, per illness/episode, or per visit. While providers have some flexibility in setting wages and benefits (see below), that flexibility is limited by this third-party payer constraint. In periods of high labor competition—if payment rates fail to keep up with the "true" cost of providing services—agencies have correspondingly less flexibility to "meet the market."

Within the Commonwealth's highly competitive labor market, this "third-party payer" dynamic has played a significant role in keeping wages and benefits artificially below the levels necessary to attract and retain quality staff.

The Influence of Provider Employment Practices

Although third-party payers constrain provider flexibility, providers nonetheless retain a degree of discretion over how total payments are allocated among the full range of costs and profitability—after all, direct care wages and benefits do vary from employer to employer even within the same industry.

Furthermore, although wages and benefits are an essential part of "pricing" for labor, working conditions are equally important. Working conditions include a broad array of factors, from the tangible (part-time employment or unsafe workloads) to the intangible (feeling "respected") and much in between (good training or opportunities to advance). In recent discussions, direct care workers in New England reported multiple examples of insulting and sometimes dangerous working conditions;[25] they also reported that working conditions were of *equal importance* to wages and benefits in their decisions to remain employed within health care.[26,27]

Providers retain significant control over working conditions within the "labor price"—for example, improving the quality of supervision—and significant improvements here can often be implemented at relatively limited expense.

Finally, costs associated with improving the price of labor should be at least partially offset by savings from reduced turnover:[28] Several studies suggest that staff "replacement costs" in the health care industry—recruitment and training costs, increased management expenses and lost productivity—are between $3,500 and $5,000 per direct care worker. Additionally, working conditions, quality of care, and turnover rates are closely related.[29] Consumers cite stable, caring relationships with staff as the most critical ingredient for quality care.[30]

Summary

Staff vacancies and turnover in direct care exist within a highly competitive labor market, where options for expanding the pool of *new* workers are severely limited. Some efforts to increase the supply of potential labor—through a limited increase in immigration, or greater facilitation of people currently on public assistance into health care jobs—are worthy of careful examination. Yet the primary response that remains within the control of the health care system is to examine ways in which health care employers can *compete more successfully* for labor against other Massachusetts employers.

Successful competition essentially requires improving the "price" of labor—examining ways to increase wages, benefits and working conditions *in order to attract and retain a higher percentage of the existing Massachusetts labor supply*. Failure to do so is a choice, allowing a deteriorating cycle of poor quality jobs to endanger all Massachusetts residents, including its most vulnerable—our ill, elderly and disabled.

Section II
Paying the Price for Quality Health Care Workers: Current Practices and Their Impact on Care

Introduction

Many health care jobs in Massachusetts provide low wages, few benefits, limited opportunities for advancement, and poor overall working conditions. Within the current "full employment economy," few new workers are attracted into direct care employment, and many experienced workers are leaving. Unfortunately, those workers who remain face worsening conditions: Forced to "work short," they are unable to provide the time and caring that makes the job worthwhile, and then they too are more likely to leave.[31]

Unfortunately, Massachusetts is not alone: Forty-two of the 48 states responding to a 1999 survey by the North Carolina Division of Facility Services reported recruitment and retention problems among their paraprofessional health care workforce.[32]

As a direct consequence to high vacancy and turnover rates of direct care workers, Massachusetts consumers report deterioration in access to and quality of long term care services.[33] Elders, people with disabilities, and their families report lack of access to in-home services, because agencies do not have enough workers to meet client requests.[34,35] Many nursing homes have reported that they are refusing new admissions because they lack sufficient staff to care for additional residents.[36] The Long Term Care Ombudsman Program documented an increase in care-related complaints in the last year.[37]

This section describes current health care employment practices and their impact on caregiving. Part 1 presents the current state of caregiving employment. Part 2 describes how health care and workforce policies contribute to the poor quality of direct care jobs. Part 3 discusses the consequences of poor quality jobs for health care consumers and workers.

Table 2: 1999 Average Hourly Wages*

	Home Health Agencies+	Home Care Agencies‡	Nursing Homes§	General Hospitals
Nurses	$21.84	N/A	$19.00	$23.00
Paraprofessionals	$9.93	$8.77	$9.74	Not available
Newly hired paraprofessionals**	$8.25	$8.00 - $8.50++	$8.50	Not available

* Wages are based on industry reported compensation rates, which include 15-20 percent for benefits. Information provided by Home and Health Care Association of Massachusetts, Massachusetts Extended Care Federation, Massachusetts Council of Home Care Aide Services, and Massachusetts Nurses Association, February, 2000. Regarding nursing home wage information, MECF notes that "a change in the 1999 survey methodology for calculating hourly wages that directed respondents not to include overtime, shift differentials, or pay in lieu of benefits precludes a valid comparison between median wages of that year with wages from prior years' surveys." Home care average hourly employee compensation includes wages and fringe benefits (includes only non-statutory employee benefits). Executive Office of Elder Affairs RFA (Request for Approval) Provider review application form FY 2000 defines hourly employee compensation as "base wages, travel pay, holiday pay, sick pay, personal days pay, vacation pay, health insurance, training wages, transportation stipends, bereavement pay, annuity pension, and other."

+ Home and Health Care Association of Massachusetts wage survey, 1999.

‡ Massachusetts Council of Home Care Aide Services, 1999.

§ Massachusetts Extended Care Federation member employment survey, 1999.

** A disproportionate number of paraprofessionals make entry-level wages because of high turnover.

++ Lower range applies to homemakers, higher range applies to home health aides through EOEA funded Home Care programs. There are regional variations in starting wages. Homemakers in Worcester begin at $7.00; in Boston they begin at $8.50. Personal care-homemakers in Worcester begin at $7.50; in Boston they begin at $8.75. Home health aides in Worcester begin at $8.00 and in Boston they begin at $9.25. Data provided by the Massachusetts Council of Home Care Aide Services based on regional meetings March 2000.

1] The Current State of Caregiving Employment

➢ ***Insufficient Wages*** **(See Table 2)**

Poverty wages: Full-time paraprofessional workers earned $16,000 - $18,000 in 1999 – just more than half of the state's per-capita income of $31,200.[38] In-home providers cannot guarantee full time work for paraprofessionals who therefore have even lower earnings. Forty-one percent of home care workers surveyed in 1998 had family incomes between 100 and 200 percent of poverty.[39] Working part-time affects life-time earnings and ultimately social security benefits.

Lack of family-sustaining wages: The Self-Sufficiency Standard for Massachusetts, released in 1998 by the Massachusetts Family Economic Self-Sufficiency (MassFESS) Project,[40] finds that a single adult with a preschooler in Boston needs an hourly self-sufficiency wage of $15.28 per hour to cover the basic costs of housing, child care, food, transportation, health care, miscellaneous expenses, and taxes. (See Appendix 2.)

Wages are not competitive in this labor market: Many paraprofessionals work at least two jobs, yet a recent North Carolina study found that many of those who had left health care increased their incomes enough that they no longer needed to work two jobs.[41]

Lack of parity across the sector: Wage increases in one part of the health care sector draw workers away from other health care employers, destabilizing the workforce, rather than increasing health care's relative competitiveness with other sectors.

➢ ***Lack of Health Insurance Coverage***

Part-time workers: Thirty-four percent of home care workers surveyed in 1998 had no health insurance.[42] Only half of nursing homes responding to a 1999 employment survey offered health insurance to their part-time workers,[43] however worker participation rates are not known. No insurance program is available for the 8,000–10,000 Personal Care Attendants who serve 5,000 people with disabilities in Massachusetts.[44]

Premiums are too high: Many workers cannot afford health care premiums. Thirty-five percent of nursing homes pay less than half of their employees' individual premiums and 56 percent pay less than half the cost of family health insurance.[45] One worker's family health insurance costs $102 per week while he earns $9.24 per hour.[46]

Ineligible for Medicaid: Paraprofessionals often earn too much for Medicaid, yet too little to afford private insurance premiums.

➢ ***Insufficient Training; Lack of Advancement Opportunities***

Nurses are not prepared to supervise: Nurses are not trained sufficiently in supervision and management—let alone in cultural competencies needed to manage and support the Commonwealth's increasingly diverse direct care staff.[47]

Curriculum inadequate: Prospective direct care workers receive limited training in basic clinical skills, inter-personal communication and problem-solving skills,[48] and have little opportunity to apply skills in real care settings.[m] Training curricula do not prepare paraprofessionals for the increasingly complex care that is required.

Training does not support the new workforce: Many trainees have limited English language capabilities, or lack literacy or numeracy skills. They require teaching methods and curriculum emphasis geared to adult learners, yet few health care trainers know how to develop or deliver curricula to meet these educational needs.

Lack of Career Ladders: Few opportunities exist for ongoing skill building that would provide access to better-paying jobs along a direct care career ladder. Talented caregivers leave "dead end" direct care jobs. Housekeeping and kitchen staff lack opportunities to move up the job ladder into caregiving positions.[49]

➢ ***Dangerous Workloads***

Stretched thin: Nurses and paraprofessionals are asked to provide more care in less time —a situation that puts clients and workers at greater risk of neglect and injury.[50,51]

Higher acuity in hospitals: Patient acuity has increased by 10 percent since 1993.[52] Nurses report that they are regularly "asked" to work overtime or pull double-shifts when the patient census changes, patient complications develop, or a colleague calls in sick.[53]

[m] Currently, Massachusetts requires 75 hours of training for certified nursing assistants, 40 hours for homemakers, 60 hours for personal care-homemakers, and 75 hours for home health aides.

Higher acuity in long-term care: As hospitals discharge patients "quicker and sicker," nursing homes and home health agencies report that their residents and clients have more complex needs, requiring more staff time.[54]

Nursing home staffing inadequate: State regulations have, at least since 1965, required 2.4 hrs of nursing staff per resident day.[55] Massachusetts nursing homes average closer to 3.4 hours per resident day, a level consumers, providers, and workers agree is inadequate.[n,56]

Shortened in-home visits: Since recent federal Medicare cuts, Massachusetts' home health aides and visiting nurses must provide the same services to clients as before, but in shorter visits.[57] Rushing between short-hour cases forces home health aides to spend far more time (often unpaid) traveling, exacerbating caregiver exhaustion and stress. Shorter visits also result in fewer paid hours for paraprofessionals, and thus greater difficulty in creating full-time jobs.

➢ ***Poor Management and Supervision: Negative Work Culture***

Lack of employee involvement: Many nurses and paraprofessionals report that they do not feel valued in daily practice or in the overall "culture" of their health care organization. Both report a lack of participation in decision-making in their work settings or in care delivery and lack of opportunities to discuss work with peers or other members of the care-giving team.[58]

Untrained, overworked supervisors: Supervisors do not have time or expertise to mentor and "coach" new paraprofessionals or deal with the off-the-job, poverty-associated employment barriers workers face.[59]

Lack of cultural competencies: Serious barriers exist between supervisors and paraprofessionals, including language, culture, class, ethnicity, and training.[o]

Poor management practices: Team building, permanent assignments, clustering—all successful managerial approaches—are still rare within the health care system.

2] How Public Policy Contributes To Poor Quality Jobs

All the factors reviewed above – insufficient wages; lack of health insurance; insufficient training and lack of career advancement opportunities; dangerous workloads; part-time employment; and poor quality management and supervision – contribute to the poor quality of direct care jobs. Combined they make health care jobs increasingly unattractive to current and potential workers. Yet, while these problems are a direct result of industry practice, public policies create much of the context within which these practices occur. While public payment policies have not provided adequate funds for care or direction for their use, public quality assurance mechanisms have been unable to prevent deterioration in care.[60]

➢ ***Health Care Payment Policies:***

Poor wages beget poor wages: To calculate payment rates for long-term care providers, public agencies analyze the costs of providing care. Fifty to seventy percent of the payment rate typically goes to labor costs (calculated as the amount of staff time required to meet care needs at estimated wage rates).[61] Wages are calculated based on previous provider practices, in the aggregate, with regional variations. Prevailing wages become a primary basis for future payment rates, thus inhibiting wage progression and failing to cover fully labor costs.[p]

Out of sync with labor market: Inflation adjustors recalculate rates from previous years based on current economic indicators. Medicaid has relied on the consumer price index to "update" labor costs, instead of a measure that reflects actual wages in Massachusetts. This makes reimbursement structurally resistant to labor market pressures, diminishing providers' ability to attract and retain workers under rapidly changing labor market conditions. According to Christine Bishop, a leading health care economist, "The result of continuously underestimating wage costs is that nursing facili-

[n] Numerous studies document the correlation between staffing levels and quality care (including a study by Charlene Harrington, using national survey data, see note 69). Researcher Jeanie Kayser-Jones documented significant dehydration and malnutrition in California nursing homes in two separate studies. She and her team directly observed residents over a prolonged period of time, noting their intake of food, in the first study, and fluids, in the second study. In each study, they observed residents with dangerously low levels of basic fluids and nutrients. The most frequent cause of this lack of intake was understaffing.

[o] The majority of paraprofessionals are women of color, and 91 percent of nurse supervisors are white.

[p] This is despite state Medicaid law which requires that payment be "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities."

ties [and home health providers] will be unable to purchase the labor inputs they need to take care of patients…especially in the highest-labor-demand areas of the State."[62]

No more margin: Prior to the rate increase in FY 2000, home health agencies had only had one rate increase, of 2.11 percent, in seven years. Prior to 1999, Personal Care Attendants serving people with disabilities had had no increase since 1990. Nursing home payment increases, from 2.5 percent to 3.5 percent per year since 1994, have not kept pace with rising costs.[63] For years, health care providers relied on Medicare and private payment to make up for Medicaid shortfalls. Medicare cuts through the Balanced Budget Act of 1997 and, shifts of long-term care private pay resources to assisted living, have eliminated these counterbalances. Now, 15 percent of Massachusetts' nursing homes are in some form of bankruptcy and 26 home health agencies closed their doors over the last two years.

➢ ***Workforce Development and Welfare Policy***

Almost all Massachusetts paraprofessionals are "low-wage workers", and are affected by policies relevant to low income families.[q]

Inadequate public supports drive workers from health care: Waiting lists for sliding scale, income-eligible child care have lengthened as more low-income workers need child care services than the system can accommodate. Confusion after welfare reform regarding eligibility for Medicaid/food stamps programs has impeded access to these programs. Limits on access to pre-employment training have made it more difficult for people transitioning from welfare to receive the education that would enable them to develop the skills needed for advancement out of poverty. As these supports decrease and health care wages remain low, many workers must leave direct care in order to provide for their families.

Absence of supports for low-income job-holders: The full-employment economy has provided work for many who transitioned from welfare. Those still receiving welfare benefits are predominantly long-term recipients[64] who have "multiple barriers to work" and require tangible assistance with childcare, transportation, and training—in clinical and other skills to help them prepare for the world of work, or to compensate for a lack of basic education or English-language skills. Health care providers are not currently able to support these needs. Many, due to fiscal constraints, have eliminated middle management positions that would provide this support.[65]

3] Consequences: Downward Spiral for Workers and Consumers

The current state of caregiving employment has caused higher rates of turnover and understaffing, diminishing job quality and quality of care.

➢ ***Impact on Care and the Work Environment:***

High Turnover: Annual turnover rates of 40 - 60 percent in home care and 70 - 100 percent[66] in nursing homes disrupt continuity of the caregiving relationship that consumers define as the foundation of quality care.[67]

Spreading Caregivers Too Thin: Remaining workers carry a heavier care-giving load, and cannot give the time and attention they know is needed.[68] Experienced caregivers spend time orienting new and temporary workers while also attending to their own assignments.

Quality of Care Suffers: When staffing levels are inadequate, consumers are likely to suffer discomforts, indignities, pain, and declines in their condition.[69] In some instances there is no care, when a PCA or home care aide is not available, or a nursing assistant does not have enough time to respond to residents' needs.

Quality of Life Suffers: Stretched thin, workers have limited, if any, time for conversation or to attend to social and emotional needs. Nursing home residents spend less than 3 percent of their time interacting. Isolation, loneliness, and depression contribute significantly to deterioration in individuals' physical and mental condition.

High Replacement Costs: High turnover means high replacement costs, $3500 - $5000 per staff turnover in long-term care, for repeated recruitment and training of new staff.[70]

Reliance on Costly Temporary Workers: Temp staff cannot deliver individualized care or step in with

[q] Many have relied on public assistance programs—welfare cash assistance, food stamps, public housing, Mass Health —to compensate for the inadequate wages and benefits. Many workers originally entered direct-care through publicly-funded training programs—such as CNA or home health aide certification programs funded under the Job Training Partnership Act (JTPA) overseen by Regional Employment Boards, or the Mass Jobs program run by the state's Department of Transitional Assistance.

the same level of productivity and teamwork as full-time employees.

Higher Rates of Injuries to Workers and Clients: Understaffing often causes injuries among workers and consumers. Direct care-giving work has the highest rates of injury of any job,[71] leading to increased hospitalizations, workers' compensation, and lost time.

Loss of Experienced Problem-Solvers: Fewer experienced nurses and paraprofessionals are available to mentor and guide new workers.[72]

Exacerbating Vacancies and Poor Job Conditions – The Downward Spiral: The Harvard Nurses Study of 125,000 nurses from 1992-1996 has found that these difficult working conditions have contributed to a decline in nurses' personal health and well-being, as well as a decline in their job satisfaction.[73] Paraprofessionals, similarly report increased stress and a decline in job satisfaction.[74] While workers say that wages are important, it is working conditions that more often drive them to leave.[75]

By contrast, a high-quality job can attract and retain competent, compassionate direct care workers and counteract these negative effects on quality care. The essential elements of a high-quality job are listed in Appendix 1.

Section III: Recommendations for Action[r]

This section recommends responses to the current and emerging health care workforce crisis. These recommendations are not mutually exclusive. The crisis is so complex in origin that no one action alone can sufficiently resolve it. Immediate responses can help to stabilize the downward spiral in the direct care workforce, and provide the time to develop and implement longer-term, more comprehensive strategies.[s]

Massachusetts has a history of consensus in developing policy through participation among key stakeholders. For an effective immediate response, the state must convene all key stakeholders—particularly providers, consumers and labor—to develop proposals for wages, health insurance, workloads, and training. This will then allow time to address systemically longer-term responses under the umbrella of a Health Care Workforce Commission.

Recommendations

Recommendation # 1: Data Collection, Analysis, and Public Disclosure

Rationale: Information about health care consumption and the supply of workers is scattered among a dozen state agencies with jurisdiction over health care, welfare, labor and workforce development.[t] Informa-

Recommendation # 1: **Data Collection**	Structured collection, analysis and dissemination of labor market and health care utilization information.
Recommendation # 2: **Gateway to Employment**	Targeted support to recent immigrants and individuals transitioning from welfare to work; improved access to nursing education.
Recommendation # 3 & 4: **Improve the Price Paid for Labor—Public Policy and Private Practice**	Public policies and private practices to improve wages, benefits, training, workloads, opportunities for advancement and overall working conditions.
Recommendation # 5: **Restructure the Health Care System's Workforce Policies and Practices**	Health Care Workforce Commission: A participatory, Legislature-sponsored process to plan, monitor, and fundamentally adjust the Commonwealth's evolving health care workforce needs.

[r] The recommendations do not contain specific cost estimates. Accurate data is not available for precise estimates and costs vary among the many options presented within each issue area.

[s] For example, increasing wages is an immediate step to counteract the current flight from health care. Permanently recalibrating wages to compete for qualified workers may take more time and deliberation to accomplish, but will have a more long-lasting impact.

[t] Agencies use different definitions, time periods, and sources, making it difficult to assemble definitive information about health care consumers or the workforce. The disarray reflects the "silos" that maintain separate information on health care consumption by payer and by provider, and therefore do not capture information about consumers and workers, who move regularly throughout the health care system.

tion is not collected on a systematic basis; some essential information is not collected at all. Although health care and labor systems intersect around health care employment, no crossroad exists among these systems' data collection efforts.[u] Policy-makers need a coordinated, inter-agency system of data collection and analysis to document current conditions; provide public information to consumers; assist agencies to monitor current and evolving conditions; and provide the basis for longer-term planning and evaluation.

Proposed Action:

A. **Bi-annual report to the Legislature on current and projected health care consumption and workforce needs:** Include information from state agencies overseeing health care service delivery[v] and the workforce[w] about: (a) current and projected use of health and long-term care services, including demographics, acuity levels, treatment protocols, outcomes, and resources needed; and (b) projected need for and availability of paraprofessionals and nurses. Through the Board of Nursing, survey nurses at license-renewal to determine their work status, setting, longevity, hours, and earnings; survey nursing schools about enrollment trends; survey health care employers about projected needs.

B. **Issue "Job Quality Report Cards":** Require health care providers to report on Job Quality Data—turnover, absenteeism, and injury rates; wages and benefits; health insurance provided; on-site education and opportunities for wage progression; workloads; current and projected direct care vacancies; and the percentage of overall expenditures on staffing. Publish annual Job Quality Report cards, including comparative and individual provider information, to assist consumers in exercising choice. Require providers to post Job Quality Report Cards.

C. **Survey the direct care workforce:** Profile the direct care workforce through regular sample surveys including: worker demographics; household make-up; status and type of health insurance coverage; eligibility for and use of public benefits; educational level; and factors on and off the job that affect employee retention (e.g., job quality and job satisfaction data; their needs as low-wage earners in low-income families).

D. **Evaluate regularly the ability of the health care sector to attract and retain qualified workers:** Compare vacancy rates, turnover rates, and earning levels in direct care positions with rates and earnings in other comparable jobs, using quarterly wage reports to provide longitudinal information about comparative wages.

Issues to Consider:

Public agencies may have to change their data collection systems to coordinate reporting, analysis and planning across agencies. Where needed information is not now available, agencies may have to create new means of collection (e.g., employer surveys) and crossover processes from existing data sources (e.g., payroll information).

Recommendation # 2: Make Long-term Care the Gateway for Employment

Rationale: Many people now transitioning from welfare to work require substantial assistance as they enter the world of work. Many have few workplace skills, several barriers to employment, and limited resources. Many immigrants also face these and additional language and cultural obstacles. With supports from the welfare and workforce systems, long-term care can be a gateway to successful employment for new workers.

Proposed Action:

Create a welfare and workforce development fund for health care workers—provide targeted funding to: assist individuals who face employment barriers, support pre- and post-employment education, and promote health sector analysis.

[u] Health care and labor agencies do not coordinate their data analysis, delaying policy adjustments. For example, the impact of the 1997 Balanced Budget Amendment on home health care employment is not yet reflected in the Department of Employment and Training's employment projections. And, while unemployment rates declined throughout the late 1990s, only recently have the agencies that fund health care services begun to look at the worsening employment crisis.

[v] The Department of Public Health, the Division of Health Care Finance and Policy, the Division of Medical Assistance, and the Executive Office of Elder Affairs.

[w] Division of Employment and Training, the Department of Labor and Workforce Development, and the Corporation for Business, Work, and Learning.

A) Assistance overcoming barriers to work:

- Pilot programs for welfare recipients to work in long-term care and develop workplace skills while still receiving health insurance and income supplements.
- Use Transitional Assistance to Needy Families (TANF) funds to provide low-wage health care workers with expanded access to childcare and transportation. Use TANF and welfare-to-work funds for post-employment counseling and retention assistance.
- Use TANF for health care workers' access to childcare: (1) Raise income eligibility levels and lower sliding scale fees for subsidized childcare; (2) provide resources to create childcare centers in health care settings; and (3) provide incentives for childcare centers to expand hours of operation to cover evenings and weekends.

B) Education:

- Provide high-quality, pre-employment training to prepare new direct care workers for the demands of hands-on caregiving. Develop the clinical and problem-solving skills new workers need to provide quality care.
- Give health care employers who maintain quality work environments priority access to workplace training funds.[x] Use funds to facilitate partnerships between health care employers and community-based educators. Conduct worker needs assessments and provide education to build the skills and earning potential of incumbent workers, and implement career ladders within health care settings.
- Target training and education resources to programs that connect recent immigrants to direct care employment, including worksite based ESOL (English-for-Speakers-of-Other Languages) training.
- Fund loan forgiveness and low-interest loan programs, scholarships and fellowships to increase nursing school enrollment.[y]

C) Sectoral Analysis and Action:

- Produce studies of health and long-term care through the Massachusetts Occupational Information and Coordinating Committee (MOICC) to assist Workforce Investment Boards (WIBs) to target workforce development and training funds to health care.
- Encourage health care participation on local WIBs and the state workforce board.
- Evaluate current and projected earnings for paraprofessional health care workers in relation to the Self-Sufficiency Standards for Massachusetts[76] released by the Massachusetts Family Economic Self-Sufficiency Project (MassFESS).[z]

Issues to Consider:

The welfare system can provide at least limited assistance to compensate for relatively low health care wages. In addition, health care providers can contribute resources to workforce development efforts, for example through paid release time for workers engaged in educational programs. Demonstrations in the health sector can provide information about the efficacy of these initiatives for other low-wage workers. Packaging tuition assistance or long-term care employment with welfare benefits can help individuals use their time receiving public assistance to maximize their preparation for successful employment and increased earning potential.

Recommendation # 3: Improve the "Pricing" (Quality) of Jobs – Public Policy

Rationale: Improving the price of labor—better wages, benefits, training and staffing/workload levels for all direct care staff—can stabilize the workforce and make direct care jobs more competitive in the labor market.

Proposed Action:

A. WAGES:

- **Wage pass-through:** Implement an increase that is solely dedicated to wages and/or benefits as an add-on to payment rates.[77]

[x] These include funds from the Department of Labor, the Department of Education, the Department of Transitional Assistance, and the Workforce Training Fund of the Unemployment Compensation Fund.

[y] According to the Boston College School of Nursing and the University of Massachusetts at Amherst School of Nursing, undergraduate training typically takes between two and four years at an average cost of $9,000/ year for tuition, room, board and books, in-state, and $18,000/year, out-of-state, in public school, and $30,000/year in private school.

[z] The Self-Sufficiency Standard can help determine whether wages support self-sufficiency and can guide workforce development funding to support job retention, employment-based training and wage progression.

- **Make targeted wage increases:** Fully reimburse providers who pay higher wages for afternoons and evenings, weekends and holidays, travel time for home health workers, step increases for job tenure, and for career ladders (see Recommendation 4-B).
- **Raise direct care wages to a higher earnings bracket in a stepped fashion,** over a period of time and index wages to labor market indicators rather than the consumer price index to ensure that health care wages are competitive in the labor market.[78]
- **Public oversight of wage rates:** Convene key stakeholders to review adequacy of wages based on: vacancies, turnover, overtime, temporary pool use, analysis of wages for comparable jobs, and levels needed for economic self-sufficiency.

Issues to Consider:

Though wage increases are costly,[79] they can produce some savings from reduced turnover and vacancies. Wage pass-throughs provide a temporary boost to wages but are subject to competing economic considerations, budgetary availability, and the political process. Targeted increases for longevity or shift differentials can be administratively cumbersome, especially as payment systems move toward capitated rates.

B. HEALTH INSURANCE:

- **Medicaid buy-in through expansion of CommonHealth:**[aa] Medicaid could allow paraprofessionals to buy into MassHealth on a sliding scale, as adults and children with disabilities who are over-income for MassHealth now do. Medicaid buy-in would require a statutory change and an amendment to the Section 1115 Medicaid waiver.[80]
- **Collective purchasing pool:** The State could help health care employers leverage their collective purchasing power (and broaden their risk pool) with private insurers.[81] Private insurance could have sliding scale premiums through state subsidy.[bb]
- **Use the uncompensated care pool to fund coverage:** Acute hospitals use their free care funds to provide a broad array of services, including primary care, to residents who are eligible for free care and do not qualify for other programs, such as MassHealth. A few hospitals, such as Boston Medical Center and Brigham and Women's Hospital, operate outpatient pharmacies and thus are able also to provide free care for outpatient prescription drugs.

  A program for health care workers could be initiated by using free care demonstration project funds and/or combining current pool funds with employer and employee contributions to cover a broader array of services than traditionally are reimbursed by the pool as is being done under the Fishing Partnership Health Plan.*
- **Expand the Insurance Partnership Program (IPP):** IPP gives premium assistance to employers with less than 50 workers and to workers earning below 200 percent of FPL.[cc] Eliminate the 50-worker limit for health care employers and raise eligibility to 250 percent of FPL.
- **Pass-through health insurance coverage costs:** Reimburse health care providers for 100 percent of their health insurance premiums for low-wage workers. The Medical Security Trust Fund, created to preserve health care access for unemployed workers, is one possible revenue source.[dd]
- **Maximize the Children's Health Insurance Program (CHIP):** Work with health care employers to ensure that eligible employees have enrolled their children in public health insurance programs.

Issues to Consider:

Most health care employers do offer health insurance now, but workers (especially part-time) can't afford the premiums. A program that expands health insurance without assisting with premiums will not have a significant impact on access.

Options could diminish employer-provided health insurance, and interfere with or crowd out the private insurance market. Guidelines are needed to ensure that providers are prudent buyers of health insurance.

C. EDUCATION:

- Update and expand initial and on-going curriculum to reflect clinical realities and adult life-long learning techniques (e.g. problem-solving, communication skills);

[aa] Rhode Island expanded Medicaid to include childcare workers whose wages are constrained by public reimbursement. The same logic extends to health care workers. Medicaid expansion could be phased-in starting with the lowest wage workers, such as part-time home care workers.

[bb] The Massachusetts Fishermen's Fund provides health insurance on a sliding scale to fishermen, whose income has been limited by government environmental controls on fishing. They have access to a private health insurance plan which offers sliding scale premiums, subsidized through funding from the state's Uncompensated Care Pool and the US Department of Commerce.

[cc] Premiums are $25 per month for individuals and $30 per month for families.

[dd] If this fund is used, it will be important to preserve a significant balance in the Medical Security Trust Fund to cushion negative cash flow in recessions. The balance of funds should remain available for the Fund's original purpose – health insurance for unemployed workers.

* Emended 8/22/00

- Lengthen pre-service training and add a transition period from classroom to hands-on caregiving;[ee]
- Provide courses in specific care areas (e.g. Alzheimer's, rehabilitation, depression);
- Create curriculum and competency evaluations for career ladders;
- Coordinate entry-level training for home health and nursing facility positions to allow easier crossover among long-term care settings; and
- Strengthen linkages between paraprofessional training and the community college and state university systems to maximize potential for workers to continue their education.

Issues to Consider:

Despite some differences across care settings, the basic elements of paraprofessional work are similar. A core paraprofessional curriculum provides portability for workers.

Health care policies require training before workers provide hands-on care. Yet, welfare policies favor post-employment training limiting funding for pre-service training.

D. WORKLOADS:

- **Increase nursing home staffing ratio:**[ff] Increase ratios to a minimum of 4.13 hours of direct care per resident day, adjusted upward for acuity, as recommended by NCCNHR and other national experts.[gg]
- **Develop a hospital staffing ratio:** Establish safe nurse staffing standards for hospitals.[hh]
- **Create a commission to establish safe staffing levels:** A standing commission, comprised of consumer, provider, and health care union representatives and expert researchers, would review data on acuity and outcomes, surveys and complaints, and from consumer, family, and worker focus groups. It would set minimum staffing levels and recommend staffing-related improvements in wages, training, supervision, and management.

Issues to Consider:

Establishing staffing standards and an on-going oversight commission creates a counterforce to fiscal pressures that drive staffing below levels needed for quality care. An oversight commission can provide for changes over time, as care needs change. The commission would need information and technical assistance from relevant state agencies to aid in its deliberations, though not all data is readily available.

Recommendation # 4: Improve the "Price" (Quality) of Jobs – Industry Practice

Rationale: Improvements in provider management affect retention. When providers invest in their workforce, workers feel a reciprocal investment. Many inexpensive, cost-effective management approaches provide better care and create a better work culture.

Proposed Action:

A. QUALITY MANAGEMENT AND SUPERVISION:

- **Train supervisors:** Develop a core curriculum for supervisors on: fostering a team approach; utilizing quality management; and developing critical thinking and problem solving skills. The curriculum would include the use of adult learning techniques, emphasize competencies in supervising workers from multiple cultures, and provide information about how to access public supports available to low-income workers.

[ee] Training requirements are currently 40 hrs. for homemakers, 60 hrs. for personal care/homemakers, 75 hrs. for home health aides/ CNAs.

[ff] Some have proposed use of "single-task" workers at mealtimes. While malnutrition and dehydration in nursing homes is a serious problem, a single-task worker approach could further degrade both the quality of the job and the quality of care. Residents who cannot feed themselves generally have physical or cognitive problems and require trained assistance. Paraprofessional jobs need to be upgraded, not made piecemeal.

[gg] The National Citizens' Coalition for Nursing Home Reform (NCCNHR) endorsed this staffing ratio based on the experiences of residents, families, nursing home staff, and developed by professional experts convened by The John A. Hartford Institute for Geriatric Nursing at New York University in April 1998 at a one-day conference funded by the Agency for Health Care Policy and Research. Conferees reviewed: (1) studies on staffing and quality; (2) federal survey data; (3) federal time management studies from 1995-97; and (4) NCCNHR's preliminary 1995 staffing standard. The conferees' work is described in the February 2000 issue of The Gerontologist. A bill to apply the NCCNHR staffing standard to Massachusetts nursing homes, and establish an on-going Commission to review the adequacy of staffing, was acted on favorably by the Joint Health Care Committee and is pending before the Legislature. It will require funding to be implemented.

[hh] The Massachusetts Nurses Association has advocated legislation for safe staffing ratios in hospitals.

- **Promote pioneering approaches to culture change:**[82] A few high-quality practitioners have pioneered transformative work to change the nursing home culture for those who live and work there. They provide individualized, resident-centered, community-oriented care. Trade associations can promote these practices and provide educational support and other technical assistance to individual providers.

- **Use inclusive, supportive management practices in the health care workplace:**

  - Develop teamwork and permanent assignments in nursing homes; clustered staffing and supervision in home health care.

  - Maximize direct care workers' knowledge and experience in planning care.

  - Provide support groups and team meetings for direct care workers.

  - Develop culturally competent supervision and management.

  - Coach and problem-solve to help workers overcome barriers on and off the job.

  - Create "family-friendly" workplaces. For example, provide family and medical leave and flexible scheduling to accommodate workers' family responsibilities.

  - Package full-time work for those who want it.[ii]

- **Support provider consortia:** Develop consortia of providers who, by joining together, can create an expanded pool of employees, offer better benefits through pooled employee assistance programs, create full-time work, develop career ladders, and offer joint training.

- **Support caregiver associations:** Support development of paraprofessional caregiver associations to provide peer support, to create learning opportunities, and to advance workers' interests.

- **Fund demonstration projects:** Fund individual employers and consortia who provide quality work environments to establish projects that support good management practices. Facilitate partnerships among local health care employers and community-based organizations that assist low-income workers. Develop cooperative employee recruitment, training, assistance, and career advancement opportunities. Fund programs with Civil Monetary Penalty (CMP) funds[jj] and Workforce Investment Act (WIA) funds,[kk] and the Workforce Training Fund. The Corporation for Business, Work, and Learning could coordinate these demonstrations and provide for statewide dissemination.

Issues to Consider:

Demonstration projects should meet local needs, resources and realities, and be shared and coordinated among health care providers statewide. Where relevant, resources and expertise developed for health care workers should be shared with other employers of low-wage workers. Projects should have input from consumers, health care employers and workforce training providers, labor unions, caregiver associations and other workers.

B. OPPORTUNITIES FOR ADVANCEMENT:

Proposal: Create career ladders for paraprofessional workers within long-term care. Within individual employment settings, provide a formal pathway for advancement. Conduct worker assessments and develop plans to attain career advancement. Develop curricula and wages to support increased duties. A career path could take non-certified workers into certified work and provide certified workers with a specialty-training track. State reimbursement could provide for wage progression for workers who complete a recognized course of training and competency evaluation, and are assigned duties commensurate with the training.[ll] Public resources for workplace education could support adult

[ii] Guarantee enough hours of work for a 35-hour work week and pay travel, meal, and learning time. See *Better Jobs, Better Care: Building the Home Care Work Force* by Surpin, Haslanger, and Dawson, United Hospital Fund, NY 1994.

[jj] CMP funds are to be spent to improve quality care for nursing home residents.

[kk] Workforce Investment Act (WIA) funds support job placement, retention and progression for low-wage workers. Local Workforce Investment Boards (WIBs) could target funds to health care employers for training and demonstration projects in quality improvements to support and retain a high-quality workforce. Many of the people WIA targets, who are transitioning from welfare to work, go into service-related jobs, specifically in health care.

[ll] Massachusetts currently recognizes the senior aide curriculum in EOEA-funded home care.

basic education and incumbent worker skills upgrades.[mm]

Issues to Consider:

Steps in the career ladder should include training, pay, and assignments for new levels of competency. Health care employers should not just use career ladders to save money by replacing more skilled workers with lesser trained ones.[nn] Individual employers can create their own career ladders but collaboration with other providers can create more job opportunities for workers, and make the long-term care sector, as a whole, more competitive with other employment sectors. For formal recognition and reimbursement, the State would have to develop criteria for training, competency evaluation, assignments and wages. The Corporation for Business, Work, and Learning, which will be certifying training vendors under the Workforce Investment Act (WIA), should work with the Department of Public Health's content and certification requirements in approving WIA-funded aide-training.

Recommendation # 5: Health Care Workforce Commission

Rationale: The current workforce crisis merely foreshadows a larger impending one. The problems that underlie the workforce crisis require comprehensive longer-term solutions that cut across policy sectors. An oversight commission is needed to plan, guide, monitor and evaluate policy options as they are considered and implemented.

Proposal: The Massachusetts Legislature should form a Commission whose primary functions would be to: (a) track and analyze changes in health care needs, clinical protocols and workforce dynamics; (b) project workforce needs; and (c) develop Five-Year Plans for the Health Care Workforce, over the period from 2005 through 2030. It would plan, monitor and evaluate whether training, compensation, workload, and quality management initiatives provide a stable, qualified workforce in sufficient numbers to meet health care needs. In particular, the Commission would be empowered to assess and make recommendations on: (a) rationalizing the multiple funding "silos" that fragment not only health care services, but the health care labor market as well, and (b) coordinating the Commonwealth's health care policy functions with its workforce and welfare policy functions.

The Commission would have representation from appropriate state agencies, stakeholders (health care consumers; providers; unions; and welfare, workforce and training interests), and researchers with expertise in health care and in low-wage employment. It would coordinate with the Five-Year Planning process under the Workforce Investment Act.

Issues to Consider:

The Commission would require resources and access to relevant data. The Commission would need to have a reporting authority that would make its work relevant. The Commission could report to the State Legislature, the Governor, all relevant Boards and agencies, and the public, on action needed to meet consumer needs and workforce goals.

The magnitude of the emerging crisis in our health care workforce leaves Massachusetts with little choice: we must first stabilize, and then rebuild our health care system's approach to its workforce. To do so will require a fundamental review of how the state structures and pays for the workforce component of health care services, and a profound challenge to how health care providers recruit, train, reward and supervise their direct care staff.

Without a public commitment to stabilize the Commonwealth's health care workforce, there will simply be too few people willing to be direct care workers

[mm] A number of grants have been awarded to health care employers to enhance skills and develop career ladders for current workers. The Department of Labor funded a project through the Boston PIC in which Benjamin Health Care Facility in Jamaica Plain has developed a career ladder curriculum, now available for replication in 10 nursing homes across the state. The Alliance for Home Care in Jamaica Plain received funding from the Workforce Training Fund to design modules in Alzheimer's and End-of-Life Care for workers in long-term care settings from adult day care to skilled nursing care. The Department of Education funds a partnership between the Service Employees International Union Local 285's Workforce Training Partnership and the Women's Educational and Industrial Union to provide adult basic education for home care workers. The Corporation for Business, Work, and Learning's tactical training initiative for incumbent worker training could also support career ladders.

[nn] Professional nurses have raised concerns about the use of unlicensed assistive personnel in hospitals as a decision driven by fiscal considerations that can compromise care. Consumers have voiced concerns about the use of lesser-skilled workers for hands-on care-giving such as providing assistance at meals. Assignments must not exceed clinical training and capabilities, and must not compromise the quality of care.

under current conditions. However, a well-planned investment in the quality of jobs for health care workers —by both public policymakers and industry practitioners, in partnership with consumers and workers—will generate countless dividends in the quality of care for health care consumers.

Acknowledgements

Thanks to the following individuals for assisting in the development of this paper:

Christine Bishop, Schneider Institute for Health Policy, Heller School, Brandeis University; Susan Eaton, Kennedy School of Government; Rachel Pohl, Cox Charitable Trust; Deborah Thomson, Alzheimer's Association, Massachusetts Chapter; Rosemary Sullivan, American Red Cross; Barbara Munro, Boston College School of Nursing; Rebeka Lashman, Boston Private Industry Council; Claudia Green and Sarah Griffen, Boston Workforce Development Coalition Career Ladders Committee; Bill Henning, Cape Organization for Rights of the Disabled; Dan Manning, Monica Halas, and Melanie Malherbe, Greater Boston Legal Services; Peter Buerhaus, Harvard Nursing Research Institute, Harvard School of Public Health; Michael Miller and Marcia Hams, Health Care For All; David Keepnews, Heller School, Brandeis University; Tim Burgers and Julie Deschenes, Home and Health Care Association of Massachusetts; Elizabeth Ganz and Carla Cicerchia, staff of Joint Legislative Health Care Committee; Harneen Chernow, Massachusetts Chapter of AFL-CIO; Peggy Munro, Massachusetts Council of Home Care Aide Services; Carolyn Blanks, Tara Gregoria, and Scott Plumb, Massachusetts Extended Care Federation; Leslie Kirle, Massachusetts Hospital Association; Stacey Ober and Gloria Craven, Massachusetts Nurses Association; Linda Lutey and Mary Ann Mulligan, Massachusetts Organization of Nurse Executives; Merlin Southwick, Mt. Pleasant Home; Mary McKenna, State Long Term Care Ombudsman, Executive Office of Elder Affairs; Tom Higgins, Service Employees' International Union, Local 285; Robert Shafner, Worcester Center for Health Professions; Janet McGill and Laura Russell, Women's Educational and Industrial Union.

Appendix 1

Elements of a Quality Job

Stable quality jobs require a mutually committed high-investment employment relationship with appropriate compensation, workloads, education, opportunities for advancement, and inclusive, supportive management and supervisory practices.

Compensation and Workload:

- Vacation pay, sick pay, paid holidays, individual and family health insurance, retirement benefits, and family medical leave;
- Rewarding longevity with step increases in pay, and providing a pathway for advancement to senior aides, mentors, and care specialties;
- For in-home care, structuring assignments so that paraprofessional workers who want full-time employment can find it within one agency; providing a salary base for a 35-hour work week that pays for travel time, mealtime, and learning time; and allowing flexibility in scheduling client cases and other care responsibilities to package full-time work;*
- In nursing homes, a minimum staffing level of 4.13 hours of nursing staff time per resident per day is needed to meet consumers' medical and psychosocial needs.**

Education and Opportunities for Advancement:

- Update and expand initial and on-going educational curriculum to reflect current care needs, clinical realities, and adult life-long learning techniques;
- Cultivate problem-solving skills, interpersonal and communication skills;
- Provide concentrated learning opportunities in the specific care needs (e.g. Alzheimer's, rehabilitation, depression, etc.);
- Develop a career ladder for non-certified and certified staff and incorporate into the wage scale a schedule of increases, commensurate with increased learning, that supports a pathway of economic advancement.

Inclusive, supportive management and supervisory practices:

- Foster teamwork, use permanent assignments and clustering approaches to staffing and supervisory patterns;
- Utilize nursing and paraprofessional workers' information and expertise in decisions about care and operations;
- Provide support groups and team meetings for direct care workers;
- Enhance the skills of supervisors so that they are culturally competent and able to take a coaching and problem solving approach to workers who face on and off the job barriers to successful employment;
- Build flexibility into scheduling and provide full-time work for those who want it; and
- Maximize workers' access to public support available to low-wage workers and low-income families.

* Surpin, R, Haslanger, K., and Dawson, S. Better Jobs, *Better Care: Building the Home Care Work Force*. Bronx, NY; United Hospital Fund; 1994.
** As recommended by the National Citizens' Coalition for Nursing Home Reform, Washington, DC.

Appendix 2

Women's Educational and Industrial Union
The Self-Sufficiency Standard for Massachusetts

The Self-Sufficiency Standard measures the amount of money families need in Massachusetts to meet their basic needs for housing, food, transportation, child care, health care, miscellaneous expenses, and taxes - in today's market without public or private subsidies. The Standard was developed by Dr. Diana Pearce of the University of Washington at Seattle, former director of the Women and Poverty Program at Wider Opportunities for Women. The Standards are calculated for 40 different areas in Massachusetts, and for many different family types based on the number of adults, and number and ages of children. Some examples follow (see also Tables 1 and 2 below).

Self-Sufficiency Standard (Per Month)

	One Adult	One Adult + One Preschooler	One Adult + Preschooler + School Age
City of Boston	**$1,324**	**$2,690**	**$3,263**
Worcester Area	**$1,271**	**$2,492**	**$2,955**
Rural Berkshires	**$1,085**	**$2,056**	**$2,460**

Findings from The Self-Sufficiency Standard: Where Massachusetts Families Stand:

- Forty-six cities and towns in Massachusetts have over 30% of families with incomes below the Standard, e.g. Boston 34%, Worcester 35%, Lowell 37%, Springfield 38%, Lynn 39%, Fall River and New Bedford 42%, Lawrence 48%.
- The Self-Sufficiency Standard is a better benchmark of family well-being than the federal poverty level. *At $17,050 for a family of four in 2000, the federal poverty level provides just $3.89 per person, per day for food, and only $7.79 per person, per day for all other expenses - not reality-based.*
- The percentage of households with incomes below the Self-Sufficiency Standard is 3 times the percentage of people with incomes below the poverty level: 27% vs. 9%.
- Many families are caught *above poverty but below self-sufficiency*; they earn *too much* to qualify for many types of assistance, but *too little* to really make ends meet.
- Single parents face the greatest challenges in reaching self-sufficiency. All communities face challenges for at least some of their residents.

The Massachusetts Family Economic Self-Sufficiency (MassFESS) Project is a growing statewide coalition of organizations working to help all families thrive. Copies of the reports, *The Self-Sufficiency Standard for Massachusetts*, September 1998, and *The Self-Sufficiency Standard for Massachusetts: Where Massachusetts Families Stand*, January 2000, are available for $5.00 each from MassFESS at the Women's Educational and Industrial Union, 617.536.5651 ext.140; or email ckavanah@weiu.org.

Table 1
The Self-Sufficiency Standard for Boston, MA-NH-PMSA
Suffolk County, 1997 - City of Boston *

Selected Family Types

Monthly Costs	One Adult	One Adult + preschooler	One Adult + preschooler + schoolage	Two Adults + preschooler + schoolage
Housing	$669	$839	$839	$839
Child Care	$0	$669	$985	$985
Food	$157	$239	$355	$488
Transportation	$46	$46	$46	$92
Health Care	$89	$163	$183	$235
Miscellaneous	$96	$196	$241	$264
Taxes	$267	$578	$694	$724
Earned Income Tax Credit (-)	$0	$0	$0	$0
Child Care Tax Credit (-)	$0	($40)	($80)	($80)
Self-Sufficiency Standard per Month	$1,324	$2,690	$3,263	$3,547
Self-Sufficiency Wage per Hour **	$7.52	$15.28	$18.54	$10.08 per adult

Source: Wider Opportunities for Women

Table 2
The Self-Sufficiency Standard for Berkshire County, MA
Western Massachusetts, 1997 - Rural Berkshire County *

Selected Family Types

Monthly Costs	One Adult	One Adult + preschooler	One Adult + preschooler + schoolage	Two Adults + preschooler + schoolage
Housing	$446	$526	$526	$526
Child Care	$0	$520	$707	$707
Food	$157	$239	$355	$488
Transportation	$113	$117	$117	$227
Health Care	$89	$163	$183	$235
Miscellaneous	$81	$156	$189	$218
Taxes	$199	$395	$463	$523
Earned Income Tax Credit (-)	$0	($16)	$0	$0
Child Care Tax Credit (-)	$0	($44)	($80)	($80)
Self-Sufficiency Standard per Month	$1,085	$2,056	$2,460	$2,845
Self-Sufficiency Wage per Hour **	$6.16	$11.68	$13.98	$8.08 per adult

Source: Wider Opportunities for Women

* The Standard is calculated by adding expenses and taxes and subtracting tax credits.
** The hourly wage is calculated by dividing the monthly wage by 176 hours (8 hours per day times 22 days per month).

Notes

[1] The authors are indebted in this section to the analysis of Dr. Lynn C. Burbridge found in *The Labor Market for Home Care Workers: Demand, Supply and Institutional Barriers*, The Gerontologist, Vol. 33, No. 1, 1993 and to the analysis of Dr. Dorie Seavey found in *An Industry Study of Services for People with Mental Retardation and Severe Mental Illness in Massachusetts: The Client/Consumers, the Workforce, the Providers, and the State*, Special Report CRW21, Wellesley, MA: Center for Research on Women, Wellesley College, March 1999.

[2] U.S. Census Bureau, "County Business Patterns" on the Internet at http://www.census.gov/epcd/cbp/view/cbpview.html

[3] U.S. Census Bureau, "County Business Patterns" on the Internet at http://www.census.gov/epcd/cbp/view/cbpview.html

[4] At discussions on workforce issues sponsored by the Massachusetts Council of Home Care Aides Services throughout the state in March 2000, home care providers noted that a substantial amount of home care services are provided in informal arrangements, and that workers providing these services are, therefore, not countable.

[5] U.S. Census Bureau, "County Business Patterns" on the Internet at http://www.census.gov/epcd/cbp/view/cbpview.html and Division of Employment and Training (DETMA), Commonwealth of Massachusetts (1998) *The Massachusetts Job Outlook through 2006*, Table B, on the Internet at http://www.detma.org/pdf/2059N_1298.pdf

[6] Division of Employment and Training, Commonwealth of Massachusetts (1998) *The Massachusetts Job Outlook through 2006*, Table B, on the Internet at <http://www.detma.org/pdf/2059N_1298.pdf > SIC-3 industry figures were supplied upon request by DETMA from the MA Occupational Employment, Wages and Training Database, 1996-2006.

[7] U.S. Bureau of Labor Statistics, Occupational Employment Statistics, “Occupational Employment and Wage Estimates” on the Internet at http//stats.bls.gov/oes/oes_data.htm. Not all direct-care workers are employed in the health services sector, as it is traditionally defined. For example, about 5 percent of registered nurses work in government (excluding education and hospital positions), and 2 to 3 percent work in business services and educational services, respectively. About 9 percent of LPNs work in government (again excluding education and hospitals). Roughly 20 percent of home health aides work in both the social services sector and the business services sector.

[8] Testimony by numerous witnesses at hearings of the Massachusetts Division of Health Care Finance and Policy on November 29, 1999 and the Massachusetts Joint Committee on Health Care, June 1, 1999 and February 17, 2000.

[9] Massachusetts Extended Care Federation. *1999 Employment Trends in Massachusetts Nursing Facilities*. January 2000. (Newton Lower Falls, MA: Massachusetts Extended Care Federation; 2000.)

[10] Massachusetts Hospital Association. *Nursing Survey 1999*. (Burlington, MA.)

[11] Calculated from database available at U.S. Census Bureau, Population Projections Program, "State Population Projections: Every Fifth Year" on the Internet at http://www.census.gov/population/www/projections/st_yrby5.html

[12] The Massachusetts Division of Health Care Finance and Policy has been collecting and measuring hospital inpatient acuity since 1993. Using FY 93 as the base year with a measure of 1.0000, the FY 99 data shows a rise in patient acuity to 1.1013.

[13] The line between public and private third-party payment systems has blurred in recent years with the trend toward public payers funding commercial managed care programs—e.g., Medicaid managed care programs for recipients of Transitional Assistance for Needy Families, and Medicare managed care programs for the elderly—in which public tax dollars fund private insurers to pay health insurance premiums for public beneficiaries.

[14] Sum AM, et. al. (1998) *The Road Ahead: Emerging Threats to Workers, Families & the Massachusetts Economy* (Boston: The Massachusetts Institute for a New Commonwealth) on the Internet at http://www.massinc.org/pages/Reports/RoadAhead/The_Road_Ahead.htm

[15] Himmelstein DU, Lewontin JP, and Woolhandler S. Medical Care Employment in the United States, 1968 to 1993: The Importance of Health Sector Jobs for African Americans and Women, *American Journal of Public Health* 1996; 86(4):525–528.

[16] Wilner MA and Wyatt A. *Paraprofessionals on the Front Lines: Improving Their Jobs – Improving the Quality of Long-term Care* – 1998. Conference Background Paper for the AARP Long-term Care Initiative and the Paraprofessional Healthcare Institute. (Bronx, NY)

[17] Calculated from database available at U.S. Census Bureau, Population Projections Program, "State Population Projections: Every Fifth Year" on the Internet at http://www.census.gov/population/www/projections/st_yrby5.html

[18] According to the U.S. Department of Labor's Women's Bureau, labor force participation rates for women were at 60% nationally in 1997. At the same time, nearly one in four households provide family care-giving to elders, typically by middle-aged employed women who spend approximately 18 hours per week caring for a nearby parent over an average duration of 4.5 years, at a net cost in lost productivity to U.S. businesses of at least $11.4 billion per year.

[19] Enrollment data available from the American Association of Colleges of Nursing, Washington, DC.

[20] *The Registered Nurse Population, March 1996 Findings from The National Sample Survey of Registered Nurses*, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing.

[21] *The Registered Nurse Population, March 1996, Findings from the National Sample Survey of Registered Nurses*, US Dept of HHS, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, Tables 38 and 39.

[22] Across Massachusetts' 21 Labor Market Areas, annual average unemployment rates for 1999 were either the same or below their 1998 levels with the exception of Fitchburg-Leominster (4.0 to 4.1 percent). Four of the LMAs had rates below 3 percent, including Boston (2.7 percent), the state's largest labor market area. The Nantucket (1.7 percent), Great Barrington (2.5 percent), and Greenfield (2.8 percent) areas also averaged below 3 percent for the year and nine other labor market areas recorded rates under 4 percent. Source: MA Division of Employment and Training, "Unemployment rates down from one year ago in most areas; Annual average rates also show decline," Press Release, 3/1/2000.

[23] Dr. Richard Judy, Director of the Hudson Center for Workforce Development, suggests that the United States over the next 20 years can expect unemployment rates to vary only within the narrow range of a low of 3.5 percent to a high of 6.5 percent. Since Massachusetts population growth is projected to be far below the rest of the nation, the State's unemployment rate will likely continue to trend toward the lower end of this range. Testimony of Richard W. Judy, Director of the Center for Workforce Development, Hudson Institute, to the Subcommittee on Oversight and Investigation, Committee on Education and the Workforce, U.S. House of Representatives, February 17, 2000. Hudson Institute, Indianapolis, Indiana. www.hudson.org

[24] Department of Transitional Assistance, Commonwealth of Massachusetts, "Welfare Reform--Chapter 5: Where we've been & where we're headed" on the Internet at http://www.magnet.state.ma.us/dta/dtatoday/reform/WelfareReform_Chapter5.htm

[25] Author interviews with providers and professional and paraprofessional direct care workers, 2000.

[26] Four focus groups totalling 38 current and former paraprofessional health care workers across New Hampshire, conducted by the New Hampshire Community Loan Fund, Concord, N.H. January and February 2000.

[27] Certified Nursing Assistants Panel. Conference on Recruitment and Retention, October 13, 1999. Sponsored by the Massachusetts Extended Care Association, Newton Lower Falls, MA.

[28] Lower turnover exists in unionized nursing homes in Massachusetts that have improved their price for labor. Larry Hunter PhD Diss 1996 MIT.

[29] Eaton SC. *Pennsylvania's Nursing Homes: Promoting Quality Care and Quality Jobs*. April 1997. Harrisburg, Pa: Keystone Research Center.

[30] *Consumer Perspective on Quality Care: The Residents' Point of View*. (Washington, DC: National Citizens' Coalition for Nursing Home Reform;1985).

[31] Author interviews with workers, focus groups of workers through the New Hampshire Community Loan Fund, 2000 (See note 26 above.) Testimony of workers before Joint Committee on Health Care, June 1, 1999 and February 17, 2000.

[32] North Carolina Division of Facility Services. *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aides and Other Paraprofessional Aide Workers* – 1999.

[33] Testimony of a number of witnesses, including consumers, workers, and providers, before the Joint Committee on Health Care, June 1, 1999 and February 17, 2000, and the Division of Health Care Finance and Policy on the home health Medicaid rate, November 29, 1999.

[34] MassHealth Access Program, a collaboration of the University of Massachusetts Medical School and the Division of Medical Assistance. *Optimizing the Homemaker Service Plan*. April 2000. Available through the Senior Care Options and Senior Care Plan of the Massachusetts Division of Medical Assistance.

[35] Home and Health Care Association of Massachusetts, and Cape Organization for Rights of the Disabled. Testimony before the Division of Health Care Finance and Policy on the Medicaid home health rate, November 29, 1999.

[36] Information provided by the Massachusetts Extended Care Federation, January 2000.

[37] Interview with the State Long Term Care Ombudsman, Executive Office of Elder Affairs, March 2000.

[38] North Carolina Division of Facility Services. *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aides and Other Paraprofessional Aide Workers* – 1999.

[39] Health Care For All. *Health Survey of Massachusetts Home Care Workers. Final Report* (Boston, MA; April 1998).

[40] Pearce D, Brooks J, Russell L. *The Self-Sufficiency Standard for Massachusetts* – 1998. Wider Opportunities for Women and Women's Educational and Industrial Union.

[41] Konrad T. Institute on Aging, UNC Chapel Hill, Presentation to the Legislative Study Commission on Aging, March 1, 2000.

[42] Health Care For All. *Health Survey of Massachusetts Home Care Workers. Final Report* (Boston, MA; April 1998).

[43] Massachusetts Extended Care Federation. *1999 Employment Trends in Massachusetts Nursing Facilities*. (Newton Lower Falls, MA; January 2000).

[44] As reported by Bill Henning, Cape Organization for Rights of the Disabled, Hyannis, MA.

[45] Massachusetts Extended Care Federation. *1999 Employment Trends in Massachusetts Nursing Facilities*. (Newton Lower Falls, MA; January 2000).

[46] Testimony of Tom Higgins, Service Employees International Union Local 285. Hearing of the Joint Committee on Health Care, February 17, 2000.

[47] Author interviews with providers and with professional and paraprofessional direct care workers.

[48] Workshop on CNA training at the National Citizens' Coalition for Nursing Home Reform Annual Meeting, October 31, 1999. Certified Nursing Assistant Leadership Training Conference held in Washington, DC, October 30, 1999.

[49] Author interviews with providers, 1999.

[50] Institute of Medicine. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* (National Academy Press, Washington, DC: 1996).

[51] Buerhaus, P, Director of the Harvard Nursing Research Institute, Harvard School of Public Health, *The Nursing Workforce - Trouble Ahead* – January 26, 2000 State House Briefing sponsored by the Massachusetts Organization of Nurse Executives

[52] Massachusetts Division of Health Care Finance and Policy hospital patient acuity data from 1993 through 1999 (See also note 12 above).

[53] Author interview with professional nursing representatives, 2000.

[54] Testimony provided by a number of witnesses, including consumers, workers, and providers before the Joint Committee on Health Care, June 1, 1999 and February 17, 2000.

[55] The state's regulations allow staff who do not provide direct hands-on care to be included in this count.

[56] Testimony provided by a number of witnesses, including consumers, workers, and providers, before the Joint Committee on Health Care, June 1, 1999 and February 17, 2000.

[57] Testimony provided by a number of witnesses, including consumers and providers at Division of Health Care Finance and Quality hearing on Medicaid home health rate, November 29, 1999, and author conversations with home health care providers, workers and consumers.

[58] Interviews with Massachusetts Nurses Association, 1999; Paraprofessional Health Care Assembly, Sponsored by the Paraprofessional Healthcare Institute, NY, April 1999; CNA Leadership Institute in Washington, DC at the meeting of the National Citizens' Coalition for Nursing Home Reform, October 1999; CNA panel at Massachusetts Extended Care Federation conference, October 1999.

[59] Discussion sponsored by the Boston Workforce Development Coalition with long term care provider associations, 1999–2000.

[60] 1998-99 studies by the General Accounting Office (GAO), and hearings by the U.S. Senate Special Committee on Aging have documented the failure of the federal and state nursing home enforcement systems. GAO studies include *California Nursing Homes: Care problems persist despite federal and state oversight* (HEHS-98-202), *and Nursing Homes: Additional steps needed to strengthen enforcement of federal quality standards* (HEHS-99-46).

[61] As reported by the Home and Health Care Association of Massachusetts and Massachusetts Extended Care Federation – 1999.

[62] Bishop C. Statements presented at Public Hearings for Division of Health Care Finance and Policy, Dec. 29, 1998 and November 29, 1999, on Medicaid nursing home and home health rates, respectively.

[63] As reported by the Home and Health Care Association of Massachusetts and Massachusetts Extended Care Federation – 1999.

[64] According to figures provided by the Department of Transitional Assistance to the Boston Private Industry Council, 62 % of Boston's welfare recipients as of January, 2000 had been receiving welfare benefits for 30 months or longer, suggesting that they have significant barriers to work. Two-thirds of those individuals are not eligible for waivers and will likely lose their benefits once they reach the time-limit on assistance.

[65] Boston Workforce Development Coalition focus group discussions with long-term care providers, 1999.

[66] Normal employment turnover is 10% or less, according to labor market studies. (Susan Eaton, PhD Dissertation, Massachusetts Institute of Technology 2000.)

[67] Wilner, MA and Wyatt, A. *Paraprofessionals on the Front Lines: Improving Their Jobs – Improving the Quality of Long-term Care* – 1998. Conference Background Paper for the AARP Long-term Care Initiative and the Paraprofessional Health care Institute, Bronx, NY.

[68] Testimony of nursing home and home health workers at Joint Committee on Health Care hearing on June 1, 1999 and before the Massachusetts Division of Health Care Policy and Finance on November 29, 1999.

[69] Institute of Medicine. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* (National Academy Press, Washington, DC: 1996). Harrington C, Kovner C, Mezey M, et al. Experts recommend minimum nurse staffing standards for nursing facilities in the United States. The Gerontologist 2000;40(1):5-16. Kayser-Jones J, Schell ES, Porter C, Barbaccia JC, Shaw H. J Am Geriatr Soc 1999;47:1187-1194. Kayser-Jones J. Reflections on a Mother's Death. Geriatric Nursing 1999; 20(2):83. Kayser-Jones J. Mealtime in nursing homes: the importance of individualized care. Journal of Gerontological Nursing 1996;22(3):26-31.

[70] Wilner, MA and Wyatt, A. *Paraprofessionals on the Front Lines: Improving Their Jobs – Improving the Quality of Long-term Care* – 1998. Conference Background Paper for the AARP Long-term Care Initiative and the Paraprofessional Health care Institute, Bronx, NY.

[71] According to the U.S. Bureau of Labor Statistics (BLS), working in a nursing or personal care facility has the highest national injury rate of any overall industry and the highest incidence rate of lost workday cases. This is also true for Massachusetts where home health care services is also among the top five industries with the highest injury rates and lost workday cases. (Note: At the SIC-4 industry level, several manufacturing and transport subindustries have higher injury rates than home health, nursing, and personal care but their industry averages (SIC-3) are lower.) For U.S. data see BLS, Safety and Health Statistics, Injury and illness data from the Survey of Occupational Injuries and Illnesses, "Table 1 - Incidence rates - detailed industry level, 1998" on the Internet at http://www.bls.gov/special.requests/ocwc/oshwc/osh/os/ostb0759.pdf. For MA data, see http://www.bls.gov/special.requests/ocwc/oshwc/osh/os/pr986ma.pdf

[72] See note 25 above.

[73] Buerhaus, P, Director of the Harvard Nursing Research Institute, Harvard School of Public Health, *The Nursing Workforce - Trouble Ahead* – January 26, 2000 State House Briefing sponsored by the Massachusetts Organization of Nurse Executives

[74] Testimony provided by a number of witnesses, including consumers and providers before the Joint Committee on Health Care, June 1, 1999 and February 17, 2000.

[75] Four focus groups totalling 38 current and former paraprofessional health care workers across New Hampshire, conducted by the New Hampshire Community Loan Fund, Concord, N.H. January and February, 2000.

[76] Dr. Diana Pearce and Jennifer Brooks with Laura Henze Russell, *The Self-Sufficiency Standard For Massachusetts* (Washington, DC: Wider Opportunities for Women, 1998). This report was prepared for and released by the Massachusetts Family Economic Self-Sufficiency Project (MassFESS), a statewide coalition of organizations convened by the Women's Educational and Industrial Union (WEIU). It calculated market-based cost of living budgets for different sizes and compositions of families in different areas of the state using 1997 costs. The WEIU and MassFESS plan to update the Self-Sufficiency Standard for Massachusetts using 2000 costs.

[77] According to the North Carolina Division of Facility Services report, *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers*. September 1999, "The majority of states who have a wage pass through in place stated that monitoring providers' compliance with the wage and bene-

fits requirement has not been, or is not expected to be, an undue burden for their agencies. Some states have required/will require providers to submit an initial plan describing usage of the additional funds, and then confirm compliance when the state audits providers. Other states provide additional funding to providers without an initial plan but ensure compliance by reviewing fund usage during annual audits. For some states, implementing a wage pass through system is still very new and they have not yet determined the most effective, low-cost way to monitor providers and ensure compliance."

[78] Testimony by Christine Bishop before the Division of Health Care Finance and Policy on Medicaid rates for home health agencies, November 29, 1999.

[79] A 4.5% increase for nursing assistants in the FY 2000 budget is priced at $20 million. The Medicaid home health aide wage increase of $0.90 per hour for FY 2000 will cost approximately $1.54 million Estimate based on 1.6 million hours of Medicaid funded home health aide hours in FY 1997.

[80] Health Care For All. *Health Survey of Massachusetts Home Care Workers. Final Report*. Boston, MA; April 1998.

[81] North Carolina Division of Facility Services. *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers*. September 1999.

[82] Fagan, R.M., Williams, C.C., Burger, S.G. *Meeting of Pioneers in Nursing Home Culture Change*. LIFESPAN; Rochester, NY; 1997.