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Meeting the Need for Long-Term Care: Strengthening the Nursing Assistant Occupation

As our nation's population becomes older and lives longer, the demands on the health care system will increase, especially in the area of long-term care. The responsibilities for providing care will be up to the facilities and health care professionals, especially direct-care workers or, as they are also called, Certified Nursing Assistants (CNAs).

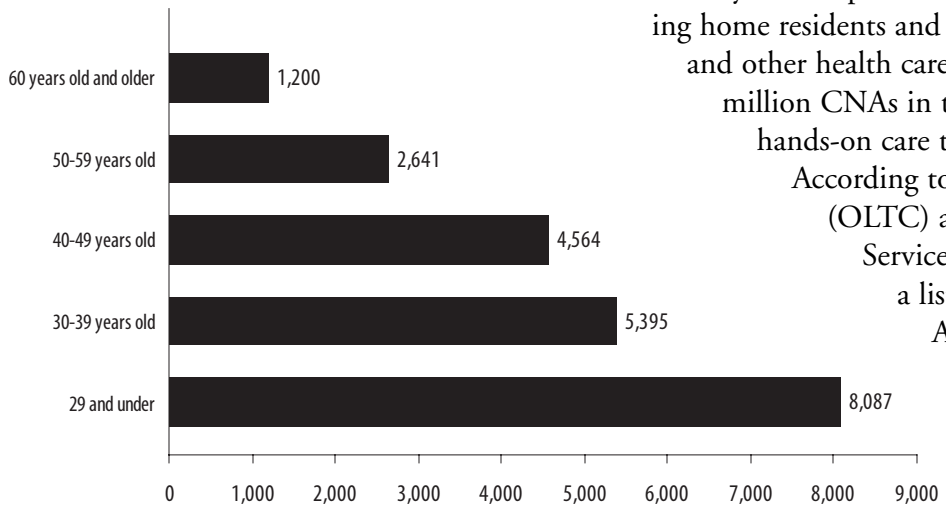
A recently released report by the Department of Health and Human Services (HHS) and the Department of Labor (DOL) found that our long-term care workforce is facing a shortage, and by the year 2050, we will need three times as many, or an additional 1.9 million long-term care professionals to meet the needs of the Baby Boom generation. [1] Included in those long-term care professionals are CNAs. While these professionals work under several different professional titles—direct care workers, nursing assistants, and home health aides—they play a critical role in the health care system. This issue of Policy Points will explore the CNA profession in Arkansas, including the challenges that CNAs confront, the critical shortage the workforce is facing, and policy recommendations for strengthening and improving this occupation, which is vital to the quality of care provided by the health care system.

Role of CNAs in Our Health Care System

Today, CNAs along with orderlies and attendants are the second largest health occupation, which represents over ten percent of our health care workers. [2] CNAs are responsible for providing basic health and personal care to persons with chronic illnesses, the disabled, and the elderly. Their responsibilities include feeding, bathing, dressing, grooming, and assisting patients in walking and standing, as well as changing linens and many times being the link between residents, other health care professionals, and family members. While many work in long-term care facilities, many are employed in home health facilities and in hospitals. All of their work is done under the supervision and direction of nursing professionals.

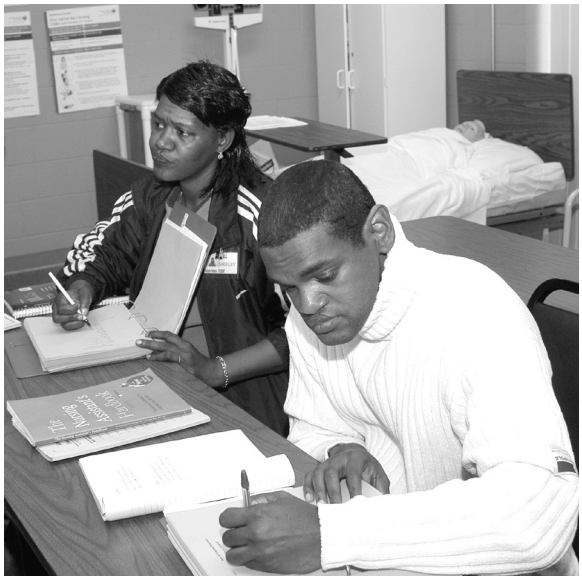
Certified Nursing Assistants in Arkansas

Active CNAs in Arkansas by Age



Nationally, CNAs provide eight out of ten hours of care to nursing home residents and are often the link between the patient and other health care staff. [3] There are approximately two million CNAs in the United States that provide the daily hands-on care that is required by the residents. [4] According to the Office of Long Term Care (OLTC) at the Arkansas Department of Human Services, which is responsible for maintaining a list of both active and inactive CNAs in Arkansas, as of February 2004, there were over 63,000 CNAs, of which 21,888 were active. As the chart indicates, of these active CNAs, 8,087 are 29 years old and

younger, 5,395 are between the ages of 30-39, 4,564 are between the ages of 40-49, 2,641 are between the ages of 50-59, and over 1,200 are over the age of 60.



Required Training: To become a CNA, an individual must complete a minimum of 75 hours of CNA training; this is both a federal and state requirement. They must also pass a competency test. In Arkansas training consists of a combination of classroom and clinical instruction. A minimum of 16 hours is spent in classroom instruction, and the remaining 59 hours are spent in the classroom, lab, or clinical setting.

Where They Work: While there is very limited Arkansas data on where CNAs are currently employed, most work in nursing homes, assisted living facilities, adult care homes, hospitals, or home health settings. It is estimated that of the 21,888 active CNAs, most find employment in one of Arkansas' nursing home facilities or hospitals, where they may face patients who are impaired, have many limitations, and may be suffering from Dementia or Alzheimer's. Nationally, it is estimated that two in five CNAs work in nursing care facilities, and about one-fourth are employed in hospitals. [5] As the residents and patients of these facilities become older, their situations and medical needs increase.

Demographics: The General Accounting Office (GAO) estimates that 90 percent of those in the profession are women, compared to the entire U.S. workforce, which is 47 percent female. [6] Those within the profession are also disproportionately women of color, and almost one quarter of all CNAs are unmarried, living with and caring for children.

Shortage: As the population being served by CNAs continues to increase, the workforce is facing severe shortages. According to the American Health Care Association, 52,000 CNA positions are vacant nationwide, with an annual turnover rate exceeding 60 percent in 32 states. [7] According to the U.S. Bureau of Labor Statistics, by 2010 more than 780,000 additional aides must be found to fill long-term care direct-care positions, an increase of 39 percent over the year 2000. However, during the same 10-year period, the "traditional" source of such new long-term care workers-women aged 25 to 44 participating in the civilian workforce-is projected to grow by just 1.25 percent, an increase of only 400,000 workers. [8]

Challenges Faced by CNAs

Vacancies and a high rate of turnover noted above present some substantial challenges to the profession. Foremost, when there are vacancies or significant turnover within a facility, the present workforce must take on additional responsibility and thus may not give significant time and attention to patients. A report at the request of Representative Vic Snyder, done by the Special Investigations Division, Committee on Government Reform, examined the 245 nursing homes in Arkansas that accept residents covered by Medicaid and Medicare and found that 92 percent or 224 of the 244 facilities for which staffing data was available did not meet the required staffing levels.[9] This not only includes CNAs, but all levels of staffing. When there are not enough supervisors, orderlies, or other professionals, all staff must take on additional responsibilities, which could have a negative impact on care and residents. Little or no consistency with care can possibly lead to an increased risk that medical needs will go undetected because caregivers may be unfamiliar with an individual's needs, and they have less time to spend with a patient. There are several factors that explain the shortages and vacancy rates in the profession: the demanding work, the negative view that many hold of the profession, the poor pay and little or no benefits, and the lack of training and opportunities for advancement.

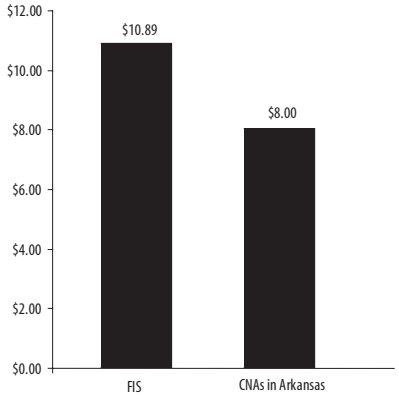
As the report released by HHS and DOL indicates, the need for qualified health care professionals is increasing at an alarming rate. The population who are 80 years old and older will increase by 14.3 percent by 2005, but the CNA workforce is projected to shrink by 2.5 percent. [10]

Physically Demanding Work: CNAs are responsible for much of the physically demanding work that is associated with patient care. This includes turning and lifting patients and physically supporting them as they walk, use the facilities, or bathe. Between 1993 and 1999, a report found that CNAs ranked third, behind truck drivers and laborers, as having the largest number of work-related injuries and illnesses resulting in time away from work. These injuries range from back strain due to supporting patients, lifting patients because of a lack of equipment, and the overall burn-out associated with physically draining work. [11]

Negative View of Role: Many people have a negative view of the work that CNAs provide. Their work is perceived to be unskilled and unpleasant, and many view the care as something that only low-income, mostly women, with little opportunity or ability to do anything else, will do. Within a health care setting, CNAs usually have all of their work delegated to them by a supervisor and rarely have input into the care that is delivered, even though they provide most of the hands-on care to their patients. Unfortunately, there are those that view the work of direct care professionals as an extension of the housekeeping staff and do not see them as providers of health care services. One of the reasons for this is that direct care workers are responsible for some of the unpleasant or unpopular care activities, such as emptying bedpans, changing soiled linens, and feeding patients

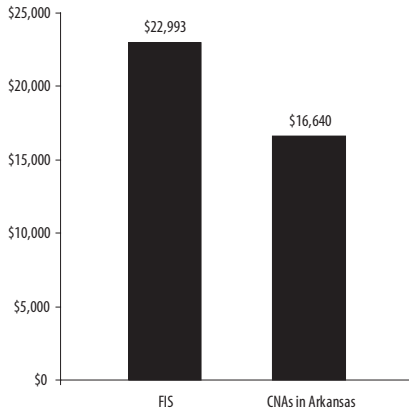
Low pay and little or no benefits: Low wages and few or no benefits are two of the biggest challenges facing CNAs and a reason why there is a shortage within the profession. While wages vary across the country, one undisputed fact is that the profession is one of the worst paid in the service sector. [12] Hourly wages for CNAs average between $6.00 and $8.50 an hour. According to a report conducted by the GAO in 2001, 36 percent of CNAs reported family incomes below $20,000, and it was reported that 18 percent of CNAs who work in nursing homes and 19 percent working in home health care have incomes below the poverty level. [13] According to the Arkansas Healthcare Association, in 2003 the average wage for a CNA in Arkansas was $8.30 an hour, and in 2002 the average hourly wage was $8.00. It is estimated that in some places such as central and northern Arkansas, CNAs can earn slightly more an hour, while in other areas of Arkansas such as in the Arkansas Delta, CNAs earn just above minimum wage.

2002 Hourly Wage Comparison



In August 2003, Arkansas Advocates for Children and Families (AACF) published the report, "The Arkansas Family Income Standard, How Much Does it Really Cost to Raise a Family?" In this report, AACF looks at the Family Income Standard (FIS) compared to the federal poverty level. The FIS is the amount of money that a working family in Arkansas truly needs to earn to meet all of its daily living needs without assistance from the government or private organizations. In 2002, the FIS for an Arkansan with one child was $22,993 or an hourly wage of $10.89. The FIS includes the basic living expenses such as food, housing, utilities, health care, transportation, childcare, taxes, clothing, personal care, and household items. [14] As the charts indicate, what the average CNA earns on an hourly basis will not cover their basic expenses and most are not able to work 40 hours a week.

2002 Annual Wage Comparison



In addition to the low-wages, many CNAs lack access to basic benefits. One of the biggest ironies about the profession is that according to an article in the American Journal of Public Health, 1.36 million health care workers provide care that they and their children cannot expect to receive. According to a report conducted by the GAO, approximately one-fourth of aides in nursing homes and one-third in home care have no health insurance. While there is no specific Arkansas data to document how many CNAs have health care insurance or even the option for insurance, it can be assumed that Arkansas follows national trends. There are four main reasons why direct-care workers do not have health insurance. First, many employers do not offer health

insurance to their employees. Over the past few years, employees have either dropped or cut back on benefits due to increased costs. Secondly, many workers do not have access to employer health plans because they work for temporary agencies. It is estimated that one in five home health aides and one in ten nursing aides work for such agencies. Third, not all direct-care workers are eligible for health insurance because they work part-time. It is estimated that 30 percent of the CNAs who work in nursing home facilities are not able to work full time, but only part time and thus are ineligible for their employee health insurance. And the last reason why most direct-care workers do not have health insurance is because they cannot afford it. They cannot afford the premiums, which can be a significant portion of their paycheck, or the co-pays. [15]

Minimum training requirements: Currently, federal law requires that CNAs who are Medicare-funded must receive 75 hours of training and pass a certification exam. This is followed by 12 hours of in-service education a year. States are allowed to add to the certification requirements, and about half do require more training hours, but Arkansas does not. [16] As of now, Arkansas requires only 75 hours of training for a person to become a CNA followed by the successful completion of a certification exam and 12 hours of in-service training a year.

Many argue that 75 hours is not adequate to property train individuals to do all of the work that they are required and want to do. As noted above, as the population becomes older and those that need services become sicker, the need for a highly qualified workforce with numerous skills will be imperative. The limited training to CNAs limits opportunities for advancement, either financially or within the profession, especially since the next steps in the career ladder, are becoming a LPN or RN and this requires more extensive training, up to two years. Most LPNs need a technical certificate, which is a one-year program, and RNs need an Associate's degree although there are certificate programs too. As a result of low training, those that are already in the workforce often see their situation as a dead-end job, and those that are looking to join see little to no opportunities.

Policy Recommendations

There are several recommendations that policymakers should consider if they want to 1) ensure that direct-care workers stay in and move up within the profession 2) attract more people into the workforce, and 3) ensure that patients are provided with quality and adequate staff to meet the current and future needs of our health care system.

Increase pay and benefits: As described above, pay for nursing assistants is not high enough to cover the basic needs of their families. While the term, "working poor" is often cited, few understand what this term means. These are people, who have a job, are part of a workforce that is responsible for providing quality and often life-sustaining care to individuals. Yet, these are the same people that are so poorly compensated for their work that they are twice as likely to receive government benefits than workers in other job categories because their wages are so low. [17] These are the same professionals who are working, yet not earning enough to be self-sufficient and provide for themselves and their families.

When an employee has the resources for their basic needs—food, housing, childcare, and reliable transportation—their stability in the profession increases. They are less likely to miss work, thus creating a shortage in the workplace, or leave the profession all together.

If we want direct-care workers to provide the type of quality care that meets the needs of patients, then we need to guarantee that these professionals have their basic needs met as well. This includes a wage that covers their basic needs and affordable health care for themselves and their children. The work that is demanded is hard and yet

very rewarding, but we need to make sure that when care is being delivered, those CNAs do not have to worry about how they are going to put food on the table or afford to take their child to the doctor. The CNAs need to give their complete attention and time to their patients and not worry about how to meet their own basic needs.

Develop career ladders for direct care workers: With a shortage within the profession and the demand for the skills and expertise of CNAs in great demand, we must ensure that our direct-care workforce is adequately trained to meet the future needs of consumers and that options are available for those who want to further their career. Creating opportunities for advancement for those already in and those new to the workforce would help decrease the shortage of workers, improve job satisfaction, make the job more attractive, and increase diversity.[18]

A good example of creating advancement opportunities is already happening in Massachusetts. In 2000, Massachusetts introduced the Extended Care Career Ladder Initiative (ECCLI), which was created to address the shortage within the CNA profession, increase the skills and pay for employees, and improve the quality of care for clients.

During its first year, ECCLI involved over 50 nursing homes throughout the state. Each of the nursing homes received funding from the ECCLI program to initiate and implement new career ladder programs in their facilities, in collaborations with community-based organizations, Workforce Investment Boards, community colleges, workforce development organization, and training providers. Each of the collaborative partners helped with the development of a training curriculum, career counseling and assessment, and program coordination. The ECCLI model is a sequence of career steps. These serve as a guide to the employer and CNA in determining the skills, credentials, and competencies necessary to advance from lower to higher career steps. Accomplishments of these steps are tied to job titles, descriptions, and higher wages. [19]

New York, Pennsylvania, and Illinois have initiated their own career ladder program for CNAs. These states see and value the relationship between an increase in skills and an increase in care and worker retention. It is a win-win situation for the CNA, the patient, the provider and the profession.

Offer educational opportunities: One way to facilitate career advancement is to finance education for CNAs to advance their training and education. Arkansas should create a scholarship program specifically for those CNAs who want to move up the health care career ladder to become a nurse or other health professional. Priority should be given to those students that demonstrate a financial need and have been a CNA for a specific period of time. In 2003, Arkansas created the Nursing Student Loan Revolving Fund, which provides loan forgiveness and financial aid to nursing students. To be eligible for a loan, a student must be enrolled in or accepted in an approved school of nursing program to become a RN or LPN, have unmet financial need, and intend to practice nursing within the state. This program is a good first step, but it needs more financing. Additional opportunities such as continuing education courses, beyond the 12-hour per year in-service requirement, should be provided to CNAs. These courses would serve as another opportunity than what is currently required and should be created for those who seek to improve their care skills, career, and options. CNAs should be encouraged and opportunities should be made through leave with pay or scholarships, to attend conferences and seminars such as those sponsored by the Direct-Care Alliance (DCA) or Paraprofessional Healthcare Institute.

View the work as a respected and valued profession: It must be recognized and acknowledged that those in the profession are critical to the quality of care that is given. On paper this looks like an easy recommendation to implement but may be one of the most difficult to achieve. It involves changing people's perception and an understanding of the profession and teaching them about the work that is required.

Some proposals that could be advanced are the identification of constituencies with which direct care workers can work and from which they can build respect. These should include family support groups and members, providers, consumers, and advocacy groups. Another opportunity to gain support and respect is with the supervisors of direct care workers. When the Direct-Care Alliance asked their members to identify factors that contributed to good working conditions, supervision that was fair, consistent, and knowledgeable was most often cited. Direct-care workers prefer a supervisor who treats her staff as members of the team and who mentors and encourages them. Supervisors are traditionally nurses who received training in the clinical part of the job but who received little or no supervisory skills training. Supervisors must be offered training on how to manage and empower staff to ensure retention and quality care.

One example of how an agency is ensuring quality care and valuing their employees is the Home Care Association (HCA), in Philadelphia. HCA believes that if the employees are to provide quality care they need to have quality jobs that are valued and respected. When a direct-care worker is hired, they are not just offered health care benefits, transportation passes, and time-off, such as vacation and sick leave, they are also encouraged to provide input and discuss their problems or concerns with the organization. This helps everyone in understanding each other's work and responsibilities, thus creating an atmosphere of respect and encouragement.

Training: When a person enters the profession she must be given all of the tools to do her job and provide the care that consumers need and demand. There is the question of whether or not 75 hours of training is adequate to prepare CNAs for the challenges that they will face. Nail technicians and school crossing guards in many states are required to complete more than 75 hours of training. As the population becomes older and lives longer, a higher set of training standards will be needed to meet these increasing challenges.

The training requirements need to be reexamined and reworked so that they prepare students for the stresses, both mentally and physically, of the job. Training needs to better reflect the needs of the patients; for example, students need more training on how to deal with Dementia and Alzheimer's and how to effectively deal with the stress of the job. Workers want to provide the best care that they can deliver, but it is difficult to do so if they are not given the tools and resources to provide the best care.

One example of a good training program is the program offered by the Good Faith Fund in Helena and Pine Bluff. Since 1997, over 500 nursing assistants have graduated from the program. In 2003, the job placement rate was 81 percent and the job retention rate was 78 percent. The training program that is offered is unlike any nursing assistant training program in Arkansas. Students must complete 260 hours of training, compared to the 75 required by the state. About 120 hours are spent in the classroom, another 120 hours are spent in clinical settings, including both hospitals and nursing homes, and the remainder of the time is spent on life and employability skills.

Conclusion

Patients, family members, and consumers consistently cite the quality of care as the primary factor in the care they receive. All want a stable, qualified, and consistent workforce with whom they can develop relationships and from whom they can receive care that is dignified, professional, and high quality. In order for a stable, qualified, and consistent potential CNA to be attracted to the workforce and for those who are already in it to stay, we need to ensure that their basic needs are met through family-sustaining wages and that they have access to affordable health care. It is vital that those who take on the responsibility of this demanding and rewarding profession are recognized for their contributions. No one wants to work in a profession, in which they are not respected and treated as a professional. These current and future workers need be properly trained with the latest and most up-to-date information in order to provide quality care for our growing and older population. If we do not make changes within the profession, we will continue to experience a shortage within the workforce, with few new prospects entering. If this were to continue, who will take care of us, as we get older?

Notes

[1] U.S. Department of Health and Human Services. "State-Based Initiatives to Improve the Recruitment and Retention of the Paraprofessional Long-Term Care Workforce." June 2003.

[2] Salsberg, Edward. "Making Sense of the System: How States Can Use Health Workforce Policies to Increase Access and Improve Quality of Care." Milbank Memorial Fund, September 2003.

[3] Institute for the Future of Aging Services. "Why Workforce Development Should be a Part of the Long-Term Care Quality Debate." October 2003.

[4] U.S. Department of Health and Human Services, www.aspe.hhs.gov/daltcp/reports/pltcwf.htm.

[5] U.S. Department of Labor, Bureau of Labor Statistics, www.bls.gov/oco/ocos154.htm.

[6] U.S. General Accounting Office, "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Problem." Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions, May 2001.

[7] American Health Care Association. "Results of the 2002 AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes." February 2003. www.ahca.org/research/rpt_vts2002_final.pdf.

[8] Citizens for Long Term Care. "Long-Term Care Financing and the Long-Term Care Workforce Crisis: Causes and Solutions." January 2003.

[9] Special Investigations Division, Committee on Government Reform. "Nursing Home Conditions in Arkansas: Many Nursing Homes Fail to Meet Federal Standards for Adequate Care." November 2003.

[10] U.S. Department of Health and Human Services, "The Future Supply of Long-term Care Workers in relation to the Baby Boom Generation." A Report to Congress, May 2003.

[11] U.S. Department of Labor, Bureau of Labor Statistics, "Lost-Work Time Injuries and Illnesses: Characteristics and Resulting Time Away from Work in 1999." Press Release, March 28, 2001.

[12] Stone, Robyn. "Long-term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-first Century." Milbank Memorial Fund, 2000. www.milbank.org/0008stone/#workforce

[13] GAO Report. "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is A Growing Concern." May 2001.

[14] Arkansas Advocates for Children and Families. "The New and Improved Arkansas Family Income Standard: How Much Does it Really Cost to Raise a Family?" August 2003.

[15] Institute for the Future of Aging Services. "Health Insurance Coverage for Direct-Care Workers: Riding Out the Storm." March 2004.

[16] GAO Report. "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is A Growing Concern." May 2001.

[17] Citizens for Long Term Care. "Long-Term Care Financing and the Long-Term Care Workforce Crisis: Causes and Solutions." January 2003.

[18] Salsberg, Edward. "Making Sense of the System: How States Can Use Health Workforce Policies to Increase Access and Improve Quality of Care." Milbank Memorial Fund, September 2003.

[19] Boston Workforce Development Coalition. "Career Ladders in Boston: A Summary of Recent Progress." August 2002.

Prepared by Stephanie Sikora
Senior Policy Analyst for the
Public Policy Program of
Good Faith Fund
1123 S. University, Suite 1018
Little Rock, AR 72204
501.661.0322

e-mail: ssikora@ehbt.com
www.goodfaithfund.org

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2304 W. 29th Avenue
Pine Bluff, AR 71603