Caring About Caregivers

Reducing Turnover of Frontline Health Care Workers in South Central Wisconsin

October 2003

Jobs With a Future Partnerships

Center on Wisconsin Strategy
University of Wisconsin-Madison
1180 Observatory Drive
Room 7122
Madison, WI 53706

TEL: 608.263.3889
FAX: 608.262.9046
E-MAIL: cows-info@cows.org
WEBSITE: www.cows.org or
www.jobswithafuture.org

The Center on Wisconsin Strategy

Acknowledgements

This report was written by Erin Hatton and Laura Dresser of the Center on Wisconsin Strategy (COWS), for the Jobs with a Future (JWF) Health Care Partnership.

The JWF Health Care Partnership and COWS wish to express appreciation to the State of Wisconsin, Department of Health and Family Services, Division of Supportive Living, Bureau of Quality Assurance for data and technical assistance. We also acknowledge the generosity of the health care partners that completed the turnover surveys and provided job shadow opportunities for our researchers. Without this information, we could not have provided the first-hand accounts and daily challenges of frontline caregivers in our region. Finally, we wish to acknowledge the support of the Joyce Foundation and the Workforce Development Board of South Central Wisconsin.

COWS is a research and policy center dedicated to improving economic performance and living standards in Wisconsin. Based at the University of Wisconsin-Madison with an office in Milwaukee, COWS promotes "high-road" strategies that support living wages, environmental sustainability, strong communities, and public accountability.

The JWF Health Care Partnership is a project of COWS. It brings together regional long-term care facilities, home health agencies, hospitals, and clinics to share information and develop joint strategies for improving workforce training, job quality, and quality of care.

Executive Summary

Caring About Caregivers focuses on frontline caregivers in nursing homes in the South Central Wisconsin region. This report is a follow-up to our 1999 report, *Improving Retention of Frontline Caregivers in Dane County*, extending the earlier investigation to a six-county area that includes Columbia, Dane, Dodge, Jefferson, Marquette, and Sauk Counties.

South Central Wisconsin is home to more than 10,000 frontline caregivers in nursing homes, home health agencies, and other sectors of the region's diverse and dynamic health care industry. In this report, we rely on data for the region's nursing homes to investigate the challenges and correlates of turnover among frontline caregivers.

The Local Turnover Crisis

Turnover of frontline caregivers is commonly identified as a crisis by the region's nursing homes. Our analysis of data for nursing homes in the region from the Wisconsin Department of Health and Family Services (DHFS) shows the significance of the problem. Of the 34 homes in our sample, fully 18 have turnover of frontline caregivers exceeding 60 percent annually. Many homes have turnover of over 100 percent, and a few facilities actually post turnover of over 200 percent. Turnover at these extreme levels is a crisis. The workers who stay on the job are challenged by short staffing, and lack of knowledge among co-workers who enter the endlessly revolving door. Facilities are strapped just trying to keep the door revolving. And, most important, clients face the bewildering experience of constantly changing caregivers. Turnover is a problem that touches the entire industry.

It is important to note that, while turnover is high in the region, in some homes it is quite a bit lower than in others. Obviously, turnover is not simply a fact of life. Some facilities are finding ways to keep staff.

Frontline Caregiver Turnover, Wages, RN Turnover, and Quality of Care in South Central Wisconsin Nursing Homes, Fiscal Year 2000

Frontline Caregiver Turnover Rate	Average Hourly Frontline Caregiver Wage	Average Turnover of Full-Time RNs	Average Number of Complaints	Average Number of Violations	Average Number of Deficiencies
High ($60%)	$10.86	42%	3.5	1.7	20.8
Low (0-59%)	$11.80	23%	2.4	0.2	9.4

Turnover's Relationship to Wages, Work Environment, and Quality of Care

Our analysis investigates correlates of turnover (see table). We find that:

1. *Low-turnover nursing homes provide frontline caregivers with higher wages.*

   The average wage of frontline caregivers in the region's low-turnover nursing homes is about $1 per hour higher than the average wage in the region's high-turnover homes. While we know that wages do not entirely determine turnover (there are exceptions on both sides), it is an important correlate.

2. *High frontline turnover nursing homes have higher turnover of RN staff.*

   Facilities that have high turnover of frontline caregivers also have high turnover among their RN staff. This is unsurprising, perhaps, but important. Volatility in caregiving staff is stressful at all levels of the organization. High turnover of RNs disturbs and disrupts frontline staff routines. Volatility of frontline caregiving staff makes RN work more difficult. Very likely, these tend to be reinforcing problems within organizations.

3. *High-turnover nursing nomes post a lower quality of care.*

   This result is perhaps most important and dramatically demonstrates what many in the industry already believe. Frontline caregivers are the eyes and ears of health care organizations. High turnover disrupts the ability of frontline caregivers to provide and promote quality care. High-turnover facilities in the region post lower quality care as measured by complaints, violations, and deficiencies documented by the DHFS Bureau of Quality Assurance.

High-Road Strategies for Retention

If we want to build strong quality of care in the region, we should begin to pay attention to methods for improving the quality of jobs for the region's caregivers. Below are some retention strategies highlighted in the report:

- *Increase wages.* Link compensation to knowledge and experience.
- *Improve benefits.* Provide affordable health insurance.
- *Increase training.* Provide adequate orientation for new staff and support ongoing training for long-term staff.
- *Ensure safety and reliable schedules.* Provide balanced and safe workloads that offer full-time employment while not overworking employees.
- *Create career ladders.* Provide frontline caregivers with opportunities for career growth within the organization as well as across the continuum of long-term care services.
- *Enhance support networks.* Improve RN supervision and encourage two-way communication at staff meetings.
- *Give greater respect and recognition.* Establish company-wide recognition programs that reward frontline caregivers for dedication and high quality of care.

Caring About Caregivers: Reducing Turnover of Frontline Health Care Workers in South Central Wisconsin *was prepared by Jobs With a Future Partnerships (JWF), a project of the Center on Wisconsin Strategy (COWS). It was funded by the Workforce Development Board of South Central Wisconsin and the Joyce Foundation.*

For more information, contact JWF Director Tracey Meek at (608) 265-9667 or tmeek@cows.org.

Introduction

Dee is, in essence, the eyes and ears of the home health agency.

She spends at least an hour with each client 12 out of every 14 days, while the head nurse sees each client only once every six months.

Dee is acutely aware of any minor changes in each patient's condition, both physical and psychological.

"I miss you on your weekends off," lamented an elderly patient, Mary,[1] to Dee, the home health aide who comes to her house every weekday and every other weekend.

Mary is a very lucid 95-year-old woman who lives alone but is far from isolated. Her nephew travels from several states away to stay with her for four days every month; her niece, living in the next state over, visits even more frequently. She works closely with her friend and landscaper to plant flowers for her hobby, making flower arrangements, and the home health aide, Dee, visits on an almost daily basis. Mary invests in the stock market and reads the *Wall Street Journal* every day. In fact, she has earned enough money from her investments to put several young adults through college. She is active and engaged in life, but she is also dependent on the care of Dee.

When Dee arrives every morning, she helps Mary out of bed and to the bathroom. Having broken her hip several months ago, Mary is now dependent on a walker and must be very careful getting around. Dee helps her to the toilet and then to the shower, where she helps Mary bathe. Altogether, this takes at least half an hour. After bathing, Dee massages and wraps Mary's legs carefully, in order to help ease the discomfort of severe varicose veins.

After getting dressed, they move into the kitchen, where Dee prepares a full breakfast — eggs, toast, grapefruit, yogurt, coffee, and juice — while Mary reads the paper. Mary loves fresh ginger and Dee, because she does all of her grocery shopping, is always on the lookout for a ginger treat for Mary. Today it's ginger cookies. Dee reminds Mary to take her medication and calls the doctor's office to see when Mary's next appointment is. Then she must hurry across town to her next client.

Dee is like thousands of other frontline caregivers in South Central Wisconsin who work in a variety of health care settings, including nursing homes, home health agencies, facilities for the developmentally disabled, and a range of other health care facilities. Providing 90 percent of the hands-on care in the nation's nursing homes (Eaton 2002), frontline caregivers help patients with daily personal tasks, as well as perform some very minor medical tasks.

1. All names have been changed to protect the identity of clients and workers.

The U.S. Bureau of Labor Statistics (BLS) has three occupational categories that describe frontline caregivers like Dee: nursing aides, orderlies, and attendants; home health aides; and personal and home care aides. According to the BLS, nursing aides, orderlies, and attendants "provide basic patient care under direction of nursing staff" and "perform duties, such as feed, bathe, dress, groom, or move patients, or change linens" (BLS 2001). Home health aides "provide routine, personal healthcare, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the home of patients or in a residential care facility" (BLS 2001). And personal and home care aides "perform a variety of tasks at places of residence"; their duties include "keeping house and advising families having problems with such things as nutrition, cleanliness, and household utilities" (BLS 2001).

Frontline caregivers like Dee will become even more important as baby boomers reach retirement. According to the BLS, non-health care employment is expected to grow at a rate of 14 percent over the period 2000-2010, while health care — with an expected growth rate of 29 percent — is projected to grow more than twice as fast. The BLS also predicts dramatic growth for all of the key frontline caregiving occupations within health care during this period: nursing aides, orderlies, and attendants projected to grow at a rate of 24 percent; home health aides up 47 percent; and personal and home care aides projected up 63 percent over the decade (Center for Health Workforce Studies, 2002; BLS 2000). In fact, personal and home health aides rank eighth among *all* jobs in terms of predicted growth rate, and nursing aides rank 12th (AFSCME 2002).

Table 1

Frontline Caregivers at a Glance

	South Central Wisconsin*	Wisconsin	United States
Total Frontline Caregivers	11,018**	51,791	2,281,790
Nursing Aides, Orderlies, & Attendants	NA	38,470	1,307,600
Home Health Aides	NA	11,540	560,190
Personal & Home Care Aides	NA	1,781	414,000
Share of Total Workforce	2.4%	1.8%	1.7%
Median Wage			
Nursing Aides, Orderlies, & Attendants	$8.91	$9.85	$9.27
Home Health Aides	$7.95	$8.90	$8.46
Personal & Home Care Aides	$7.22	NA	NA
Number of Nursing Homes	55	411	18,000
Number of Nursing Home Patients	NA	39,407	1.5 million

* Includes Columbia, Dane, Dodge, Jefferson, Marquette, and Sauk Counties.
** Includes frontline caregivers in all nursing and residential care facilities in South Central Wisconsin.

Note: All data is for the year 2001; sources are listed at the end of the report.

The purpose of this report is to take an in-depth look at the increasingly important work of the growing number of frontline caregivers and the quality of care they provide in South Central Wisconsin. In 2001, there were 38,470 nursing aides, orderlies, and attendants, 1,781 home health aides, and 11,680 personal and home care aides in Wisconsin (BLS 2001). These frontline workers make up the bulk (72 percent) of direct caregivers in Wisconsin's health care facilities (American Health Care Association 2002a).

Caring About Caregivers explores the following questions: What do frontline caregivers like Dee do on a daily basis? What working conditions do they face that make it easier or more difficult to care for their patients? What impact do these working conditions have on turnover among frontline caregivers? How does high turnover affect quality of care? How are different facilities dealing with these issues? And finally, what policies and changes can be implemented in order to improve working conditions and quality of care in the region?

This report is a follow-up to our 1999 report, *Improving Retention of Frontline Caregivers in Dane County*, which found that recruitment and retention of frontline caregivers must be improved in order to sustain a high quality of care among nursing homes and home health agencies in Dane County. The current report has expanded the field of study to include all six counties in the South Central Wisconsin region — Columbia, Dane, Dodge, Jefferson, Marquette, and Sauk. Examining both urban and rural health care facilities and their workers offers even greater insights into the variety of working conditions and strategies to decrease turnover and improve quality of care in the region.

A Note About Sources

The data for this report come from a number of different sources. First, we examined national and state data on nursing home and home health employment, wages, and industry trends over time, largely from the BLS and the Wisconsin Department of Health and Family Services (DHFS).

We then analyzed a wide range of detailed data on employment in nursing homes from the DHFS Bureau of Quality Assurance. These data provide a statistical look at turnover, wages, and quality measures for nursing homes throughout the region. These are the best data available to study the connections between turnover, wages, and quality, but it is important to keep in mind that they represent the reality for only the subset of frontline caregivers who work in nursing homes.

With the hard numbers in hand, we then conducted in-depth interviews with frontline caregivers in both nursing homes and home health agencies, in order to put a human face on the quantitative data.

Working as a Frontline Caregiver

A Day in the Life...

The daily routine for frontline caregivers in nursing homes and home health agencies can differ substantially. At a nursing home, the frontline caregiver often begins her shift by reviewing any changes or developments in the condition of the residents she will care for that day, usually eight to ten people. She is then responsible for making sure that they are awake, dressed, and ready for breakfast, which includes either escorting the patients to the dining room or delivering food trays and feeding each patient in his or her own room. This is no small task, since fully 40 percent of patients are totally dependent on at least one staff member (and often two) in order to bathe, eat, get dressed, use the toilet, and get around, while the other 60 percent are partially dependent on the assistance of one or two staff members in order to accomplish these activities (Center for Statistics Nursing Home Survey 1996).

Soon after breakfast, most patients must be helped to the bathroom. The simultaneity and urgency of the patients' needs makes for a very hectic morning for the frontline caregivers, who run from room to room trying to answer the loud buzzing alarms from many rooms at once. And with only two frontline caregivers on each floor, it can be especially difficult to help those residents who require the help of more than one person to get to the toilet.

For example, at one nursing home we visited, it was Lucy's day for a bath. But her scheduled bath time was after breakfast, when all the residents needed help getting to and from the toilet. Lucy, very frail with bandaged arms and legs and unable to move around on her own, required the help of two aides to go to the toilet and to bathe. Trying to get both nursing aides together in Lucy's room at the same time seemed an impossible task; each was hurrying from room to room trying to attend to the rest of the residents on the floor.

As it turned out, both caregivers were finally able to help Lucy to the toilet — a long 15 minutes after she originally rang the bell — but then had to leave her on the toilet for another half an hour until the bathing attendant could come to give her a bath. Diane, the caregiver assigned to Lucy, clearly felt frustrated by not being able to attend to Lucy's needs with the level of immediacy and dignity she would have liked, but it was also clear that she knew she was doing the best that she could under the circumstances.

Moreover, there is no downtime for frontline caregivers like Diane in nursing homes. If there is extra time while some of the residents eat or nap, frontline caregivers must chart the condition of their residents, recording eating habits, bowel movements, and changes in health or disposition.

Working in home health is very different from working in a nursing home, even though the tasks performed by home health aides are quite similar. The home health aide is still responsible for helping clients with eating, dressing, toileting, bathing, moving around, and other personal care, but she also helps out with other things that the clients need, such as light housework and grocery shopping. The primary difference, however, is that home health aides are able to focus on one client at a time and are allowed much more time per person: the average in Wisconsin is 1.8 hours per client per day (Home Health Summary Book 1995).

This does not mean that home health aides do not have hectic schedules, however. Dee, for example, had to hurry in order to get Mary bathed and fed in order to rush off to her next client. Her daily schedule is planned to the minute, and there's little time to waste. But home health aides tend to have a stronger sense of and ability to control the pace of their days, as only one client requires attention at any time.

Because home health aides travel to and from patients' homes on their own most of the day, they have more autonomy and independence than do frontline caregivers in nursing homes. This autonomy comes at a cost, however, as home health aides can feel isolated and unsupported. Dee said, for example, that she would prefer to work in a hospital setting so that she did not have to drive from place to place alone all day.

Not all frontline caregivers are certified as Certified Nursing Assistants, or CNAs. Dee, for example, worked at the home health agency for three and a half years before obtaining her CNA certification. She has been working to get her CNA certification in addition to doing her jobs (and unbeknownst to the home health agency that employs her) and has just finished her coursework. Doing so has made her schedule very hectic in the past several months. Between classes, out-of-town clinical work, her full-time job as a home health aide, her second job as a jewelry appraiser, and being a wife and mother of two teenagers, Dee is exhausted but continues to be energetic and positive with her clients.

Lots of Work, Little Reward

The work of frontline caregivers like Dee is crucial, but it is also extremely difficult, stressful, injurious, and often unpleasant, with low pay, few benefits, and little recognition. As Dr. Robyn I. Stone, executive director of the Institute for the Future of Aging Services, writes: "Ironically, while these [frontline] workers are delivering essential care to some of the most vulnerable segments of our population, their peers 'flipping burgers at McDonalds' make more, have much more financial security, and are treated with much more respect" (Stone 2001).

First and foremost, the job of frontline caregiver is poorly paid. Across the nation, frontline caregivers earn significantly lower wages and receive fewer benefits than workers in general, particularly those working in nursing homes and home health care (GAO 2001). In 2000, frontline caregivers in Wisconsin earned an average of $9.63 at nursing homes and $8.68 at home health care agencies, slightly higher than the national average at nursing homes ($9.18) and about the same as home health agencies nationwide ($8.71), but still not enough to support a family (BLS 2001). In 2000, the national poverty level for a family of four was $16,700, while the median annual income of nursing home aides was $13,287 and, for home care aides, $12,265 (PHI 2003). It's important to note, however, that one in three frontline caregivers in nursing homes — the *higher* paid of the two workplaces — earned *less* than $10,000 a year, and a full 36 percent reported annual family incomes below $20,000 (GAO 2001).

It's not surprising, then, that frontline caregivers are more than twice as likely as workers in general to rely on public assistance — such as cash assistance and Food Stamps — because their wages are simply not enough to keep them out of poverty (GAO 2001). According to Steven Dawson and Rick Surpin, presidents of the Paraprofessional Healthcare Institute and the Independence Care System, respectively, the intermingling of welfare and health care employment has long provided a hidden subsidy to the health care system, whereby health care providers have been able to "offer artificially low wages and no benefits, forcing their workers to rely, at least in part, on public assistance programs for the necessities of food, housing, and health insurance" (Dawson and Surpin 2001b).

The widespread lack of benefits among frontline caregivers is also a critical issue, and sometimes even more important than wages to many workers (Eaton 2002; see also Himmelstein et al. 1996; Crown et al. 1995; and Wilner and Wyatt 1998). In fact, fully one-third of frontline caregivers in nursing homes and one-quarter of their counterparts in home health agencies do not have health insurance, compared to 16 percent of all workers (GAO 2001).

The job of a frontline caregiver is demanding both physically and emotionally. It requires heavy lifting in precarious positions, often in a rushed manner because understaffing is a chronic problem in the industry. As the Career Nursing Assistant Program, an advocacy organization for frontline caregivers, notes:

> The norm in many nursing homes is "working short." Even with an anticipated workload of 12-15 residents, a single nursing assistant is hard pressed to provide bathing, dressing, toileting, mobility, and feeding to each of these people who need and deserve this care. In fact, if each of these five common tasks takes at least 10 minutes, the nursing assistant who provides these few procedures to 12 residents in a single shift has provided 500 minutes of care or 10 hours of care services in an 8 hour day. This does not include time to coach the slow eater, provide additional fluids, look for washcloths, report, lift and transfer, or the many other tasks that are performed each day (DCA 2002b).

Not surprisingly, sometimes being a frontline caregiver is downright dangerous. Lifting patients in and out of bed, to and from the toilet, and in and out of the bathtub — often without the much-needed help of another staff member due to short-staffing — makes caregiving one of the most injurious jobs in the nation. Nationally, frontline caregivers in nursing homes report 18.2 injuries per 100 workers, which is significantly higher than "high-risk" occupations such as coal mining (6.2 injuries per 100 workers), construction (10.6), and warehousing/trucking (13.8) (SEIU 1997; see also Wise 1996).

Little supportive supervision and almost no training from the health care organization only exacerbate the difficult working conditions of frontline caregivers (see Dawson and Surpin 2001a). When Dee started working for the home health agency four years ago, for example, she had no experience in this field. She attended a couple of seminars the agency provided, but her primary training was on the job. She saw her first clients with nothing but a care plan, which outlined only the basic necessities of each client. If she had questions, hopefully the clients were lucid enough to answer them. If not, she would have to improvise.

In order to become a CNA, the State of Wisconsin requires 75 hours of training, including 16 hours of clinical experience. Although the federal Omnibus Budget Act of 1987 raised the training requirements of frontline caregivers in nursing homes and home health agencies, federal regulations for caregiver training still fall short, according to the Direct Care Alliance (DCA 2002c). In fact, federally mandated training hours for school crossing guards, cosmetologists and even dog groomers are greater than those required for entry-level CNAs and home health aides (DCA 2002c).

Who is taking on these difficult and low-paid jobs? The typical frontline caregiver in the United States is a native-born white woman in her late 30s with a high school degree and at least one child under 18 years old. Compared to the workforce in general, however, frontline caregivers are more likely to be non-native born, nonwhite, unmarried, and with children at home. The vast majority (about 90 percent) of frontline caregivers are women; this extremely high percentage is in stark contrast to all U.S. workers, of whom only about half are women. Most caregivers are in their late 30s, as are service workers nationwide, but the majority of all workers across the nation are over 55 years of age.

While almost a quarter of frontline caregivers in both nursing homes and home health care have less than a high school degree, an even higher percentage have some college experience, indicating that this is not an uneducated workforce as a whole. Additionally, it is important to note that almost a third of all frontline caregivers in nursing homes (and a quarter of those in home health care) are not married but have children, meaning that they are the household's primary breadwinners even though they don't earn family-supporting wages.

The Challenge of Measuring Turnover

Most health care facilities do not track the costs of turnover, because turnover itself, as well as its associated costs, can be difficult to measure. Turnover rates can be deceiving and deserve some clarification. Even a single rate of "100 percent" turnover can mean quite different things.

For example, imagine a facility with 50 workers. If each staff member stayed exactly one year, no more and no less, and then was replaced, the agency would make 50 hires in the year, and post a turnover rate of 100 percent. Now, suppose that, at a different facility with 50 staff, 49 stayed on the job year after year. But in the final position, the agency could never hire anyone who stayed more than a week. This facility would post an annual turnover rate in excess of 100 percent (because it would hire 52 new people each year), but it would have a much more stable employee base than the first agency.

(Most organizations fall somewhere between these two extremes, experiencing the majority of employee turnover in the first three months of employment while maintaining some share of long-term employees.)

In spite of these limitations, turnover rates remain an important and meaningful measure, and provide an important lens on job quality and workforce instability in nursing homes.

The Revolving Door

Given the difficulty of Dee's job, it's not surprising that many workers — unlike Dee — don't last very long under such conditions. They leave for another low-paid job that's less demanding. Or they leave for a similar job that offers health benefits or a few cents more per hour. High turnover among frontline caregivers, like Dee, means that a client like Mary cannot develop a long-term relationship with her caregiver — something that is so obviously important to her mental well-being. Moreover, high turnover among frontline caregivers means that there is no continuity of care for Mary — which is essential to Mary's physical well-being (see Harrington 1996).

Most health care agencies would say that turnover among frontline caregivers like Dee is a major challenge for the organization. In fact, many agencies report that turnover among frontline caregivers has reached crisis levels. The General Accounting Office, in its May 2001 report to the U.S. Senate, asserted: "Retention of nurse aides is a significant problem for many providers, with some studies reporting annual turnover rates for aides working in nursing homes approaching 100 percent" (US GAO 2001). In South Central Wisconsin, over half of nursing homes face turnover of over 60 percent among frontline caregivers.

High turnover is costly to all health care facilities. The most obvious costs associated with turnover are dollars spent on recruiting and training replacements and dollars paid to hire expensive "subs" from temporary help agencies to fill in when facilities are short-staffed. Less easy to calculate, but no less important, are productivity losses that result from reduced morale and increased stress among the current workforce and the decline in the quality of care due to less continuity of care. The cost of recruiting and training a frontline caregiver in a nursing home has been estimated at four times the employee's monthly salary, or $4,000 (Hoffman 2001; see also Pillemer 1996 and Zarht 1992). This cost estimate, moreover, does not include costs associated with lost productivity (Atchley 1996) or the costs of the attrition that occurs between interviewing, hiring, training, and long-term retention (White 1994).

There are more hidden costs associated with turnover as well. If an organization did not have to spend considerable time and money finding replacement workers, for example, it could devote resources and energy in new directions. This hidden cost of turnover is one that often goes overlooked when considering strategies to reduce turnover. If less time were spent dealing with turnover, organizations could actually focus on increasing productivity and improving customer satisfaction. The result? Higher long-term profitability and improved quality of care.

Turnover is an imperfect measure (see box, "The Challenge of Measuring Turnover"). However, given its correlation with a wide variety of workplace and quality of care issues, it is still an important one for looking at stability of jobs and care in the health care industry. And turnover among frontline caregivers continues to be a common and useful benchmark for assessing the quality of employment in health care agencies.

Correlates of Frontline Caregiver Turnover in Nursing Homes

This analysis relies on turnover data from 34 federally certified skilled nursing homes in South Central Wisconsin, provided by the DHFS Bureau of Quality Assurance for fiscal year 2000.[2] For each of the 34 nursing homes, the DHFS data include location, size, and ownership of the homes, as well as CNA turnover rates, wages, benefit costs, and turnover rates of RNs. The data also include measures of quality — such as numbers of complaints, violations, and deficiencies — that are generated by the Bureau of Quality Assurance in its monitoring and inspections of nursing homes in the region.

The first thing that these data make clear is the diversity of experience in turnover at the region's nursing homes. Turnover among frontline caregivers in South Central Wisconsin nursing homes ranges from zero to 275 percent, with a median turnover rate of 64 percent. Two nursing homes report no turnover among frontline caregivers, and 12 homes have less than 50 percent turnover among frontline caregivers. Ten nursing homes have from 50 to less than 100 percent turnover, and eight homes report turnover rates between 100 and 200 percent. Two nursing homes report turnover above 200 percent, both with turnover rates substantially higher than all other nursing homes in the region.

The dramatic range of turnover proves that, while many facilities in the region are truly dealing with turnover crises, some are not. This suggests that there is a range of strategies and approaches to turnover that can be applied to improve retention in the region.

A Note About Data

The data in the report on wages, complaints, violations, and deficiencies are for state fiscal year 2000 (July 1, 1999 to June 30, 2000), while the data on staffing levels are "point-in-time" data as of December 31, 1999. Average wages and turnover rates are weighted averages based on the number of frontline caregivers at each nursing home. Reported numbers of complaints, violations, and deficiencies are weighted averages based on the number of beds at each nursing home. Weighting averages in this manner ensures that nursing homes contribute to regional averages on the basis of their size.

2. Although there is a total of 55 nursing homes in the region, we do not have data for facilities for the developmentally disabled, facilities that are certified only at the state level, or home health agencies.

Privately Owned Nursing Homes Have Higher Turnover

The ownership structure of facilities appears to be meaningfully correlated with frontline caregiver turnover rates. In Wisconsin, of the 422 skilled nursing facilities in the state, only 14.7 percent are public (or government-owned), while about 48 percent are private, for-profit facilities, and 37 percent are private, non-profit facilities (AHCA 2002b). In South Central Wisconsin, 18 percent of the nursing homes are public, while 56 percent are private, for-profit homes, and 26 percent are private, non-profit nursing homes.

Public nursing homes reported the remarkably low turnover rate among frontline caregivers of 18 percent, while private nursing homes — both for-profit and non-profit — posted the much higher turnover rates of 90 and 89 percent, respectively. (See Table 2.) These turnover differences may be explained in part by the fact that public nursing homes tend to be better staffed and provide higher wages, benefits, and stronger worker protections to the more often unionized workforce.

Table 2

Ownership Structure and Average Turnover Rates of Frontline Caregivers in South Central Wisconsin Nursing Homes, Fiscal Year 2000

Ownership Structure	Number of Nursing Homes	Average Turnover Rate
Private, For-Profit	19	90%
Private, Non-Profit	9	89%
Public	6	18%

Source: DHFS Bureau of Quality Assurance.

Geography Matters

To make it easier to identify the factors that correlate with high and low turnover, we divided the 34 nursing homes we studied into two groups: those with turnover rates of frontline caregivers *at or above* 60 percent, and those with turnover rates *below* 60 percent. As Table 3 shows, there are 18 "high-turnover" homes and 16 "low-turnover" homes. The table also shows stark differences between these two groups: the average turnover rate among frontline caregivers in the high-turnover group is 119 percent, while the average turnover rate in the low-turnover group is a much lower 26 percent.

It is important to note, however, that serious problems with turnover are not evenly distributed throughout the six counties in South Central Wisconsin. Rural counties in the region tend to post lower turnover. Perhaps most remarkably, Sauk County nursing homes — two of which had zero percent turnover — post a very low average rate of 12 percent turnover among frontline caregivers. In the middle range, Dodge County nursing homes report an average of 47 percent turnover, and Columbia County nursing homes report an average of 59 percent.

On the high end, Jefferson County nursing homes had an average of 73 percent turnover among frontline caregivers. The region's most urban and densely populated county, Dane, posted an average of 84 percent turnover among frontline caregivers. (The single Marquette County nursing home for which we have data posted 86 percent turnover, which is certainly high for a rural county in the region.)

The challenge of high frontline caregiver turnover is most pronounced in Dane County. Table 3 makes the point obvious. Throughout South Central Wisconsin, facilities are split roughly evenly between high and low turnover. In Dane County, however, 10 homes fall into the high-turnover group, while just three fall into the low-turnover group. Dane County nursing homes are *twice* as likely to have high turnover as their counterparts in the surrounding counties.

Table 3

Average Turnover Rates of Frontline Caregivers in "High" and "Low" Turnover Nursing Homes in South Central Wisconsin, Dane County, and Rural South Central Wisconsin Counties, Fiscal Year 2000

	Number of South Central Wisconsin Nursing Homes	Average Turnover Rate	Number of Dane County Nursing Homes	Number of Rural South Central Wisconsin Nursing Homes
High-Turnover Nursing Homes (Frontline Caregiver Turnover Rates At Or Above 60%)	18	119%	10	8
Low-Turnover Nursing Homes (Frontline Caregiver Turnover Rates 0-59%)	16	26%	3	13

Source: DHFS Bureau of Quality Assurance.

There could be a variety of explanations for this discrepancy in turnover rates between Dane County and the rest of the counties in the region. For example, it is likely that workers have fewer external job opportunities in the more rural counties relative to Dane County, making the low-paying and difficult work of the frontline caregiver simply a necessity for some rural workers. In contrast, Dane County workers may be able to leave the job more easily for something less difficult or higher paying. Whatever the explanation, it is clear that the problem of turnover is much more extreme in Dane County than in the rest of the region.

Lower Pay and Benefits Mean Higher Turnover

National research shows that low wages are correlated with high turnover among frontline caregivers (see DCA 2002a; Massachusetts Health Policy Forum 2000; and Dawson and Surpin 2001a) and that, in some cases, benefits are even more important than wages in affecting turnover (Brown 2002). Our data on turnover among frontline caregivers in South Central Wisconsin nursing homes provide further evidence for this point.

Table 4

Wages, Benefits, and RN Turnover Rates in South Central Wisconsin, Dane County, and Rural South Central Wisconsin Nursing Homes, Fiscal Year 2000

	Number of Nursing Homes	Average Wage	Average Wage Plus Benefits	RN Turnover Rate
Entire South Central WI Region				
High-Turnover Nursing Homes (Frontline Caregiver Turnover Rates At Or Above 60%)	18	$ 10.86	$ 12.75	44%
Low-Turnover Nursing Homes (Frontline Caregiver Turnover Rates 0-59%)	16	$ 11.80	$ 15.58	23%
Dane County Only				
High-Turnover Nursing Homes (Frontline Caregiver Turnover Rates At Or Above 100%)	7	$ 10.89	$ 12.85	50%
Low-Turnover Nursing Homes (Frontline Caregiver Turnover Rates 0-99%)	6	$ 13.70	$ 16.96	24%
Rural South Central WI				
High-Turnover Nursing Homes (Frontline Caregiver Turnover Rates At Or Above 50%)	10	$ 10.11	$ 12.16	46%
Low-Turnover Nursing Homes (Frontline Caregiver Turnover Rates 0-49%)	11	$ 11.03	$ 14.89	31%

Source: DHFS Bureau of Quality Assurance.

Taking the South Central region as a whole, frontline caregivers earn $10.86 an hour in high-turnover nursing homes, while they earn significantly more, $11.80 an hour, in low-turnover nursing homes. The difference in hourly pay rates jumps from $1 to almost $3 when the dollar value of benefits is included with the wage, as frontline caregivers in high-turnover nursing homes earn $12.75 per hour including benefits while their counterparts in low-turnover nursing homes earn, on average, $15.58 including benefits. (See Table 4.) These numbers also suggest that higher wage nursing homes tend to offer more valuable benefits: the benefit load for low-turnover nursing homes — 32 percent of the wage — is substantially higher than the 17 percent benefit bill carried by high-turnover nursing homes.

To correct for the geographic variation within the region that we discussed earlier, and for the fact that the cost of living (and thus pay) is often higher in Dane County, we offer in Table 4 a geographic breakdown of the wage and benefit data. We split Dane County nursing homes into two groups: high-turnover nursing homes with turnover rates of frontline caregivers at or above 100 percent (seven nursing homes), and low-turnover homes with turnover rates below 100 percent (six nursing homes). For the other five counties in South Central Wisconsin, we identified turnover at 50 percent as the relevant dividing line for high- and low-turnover nursing homes: 10 rural South Central Wisconsin nursing homes had turnover at or above 50 percent, and 11 had turnover below 50 percent.

The connection between turnover and wages is most evident when considering Dane County nursing homes. Table 4 shows that Dane County's seven low-turnover homes paid, on average, $2.81 more per hour (that's more than $5,000 annually for full-time workers) than did the county's six high-turnover homes. The earnings advantage in low-turnover homes is even greater when the value of benefits is included. In the other South Central Wisconsin counties, the connection between wages and turnover is slightly less dramatic: frontline caregivers earn about $1 more an hour (and close to $3 more including benefits) in low-turnover nursing homes than in high-turnover homes.

Because of the growing understanding of the causal relationship between low wages and high turnover among frontline caregivers, 21 states across the nation have sought to raise the wages of frontline caregivers by passing "wage pass-through" programs, which entail an additional allocation of funds provided through Medicaid reimbursement for the express purpose of increasing compensation for frontline caregivers (PHI 2003). In 1999, in fact, Wisconsin was one of seven states to grant wage increases for some frontline caregivers.

But evaluations of these programs have shown ambiguous results in improving recruitment and retention of frontline caregivers. Some argue that these programs are too limited in scope and that, without adequate monitoring and evaluation, the money doesn't get to the workers. There may be a variety of reasons that the efficacy of wage pass-through programs is in question, including the timing of legislative efforts, the lack of a common methodology for measuring recruitment and retention, and the sheer difficulty of isolating the effect of wage pass-through programs from other recruitment and retention initiatives (PHI 2003).

Nonetheless, many legislators are embracing these wage pass-through programs, viewing them as, according to Senator Mark Montigny, Chair of the Senate Ways and Means Committee for the Massachusetts Legislature, a "down payment" — a first step in a more comprehensive and long-term plan to improve retention and skill among frontline caregivers (PHI 2003).

Frontline and RN Turnover are Linked

While wages are important, research on frontline caregivers has consistently shown that a number of factors relating to the work environment are critical to retention and turnover as well. The data available from the State of Wisconsin offer a limited view of the work environment by providing data on the turnover of RNs in nursing homes. Clearly, high turnover among RNs can create difficulties and inconsistency for the frontline caregiving staff.

Not surprisingly, we find that high turnover among frontline caregivers is correlated with high turnover among RNs. Among nursing homes in South Central Wisconsin, as well as in Dane County alone, high frontline turnover homes had almost *twice* the RN turnover rate as low frontline turnover homes. In rural South Central Wisconsin the correlation was slightly lower, with high frontline turnover nursing homes reporting 50 percent higher turnover rates among RNs than low-turnover homes. (See Table 4.)

It is not possible with these data to determine whether RN turnover causes frontline turnover or if it is frontline turnover that causes RN turnover. In truth, the problems are most likely reinforcing: high turnover among frontline caregivers makes the RNs' supervisory work that much more difficult, and high turnover among RNs worsens working conditions for frontline caregivers. The data make clear that organizations are likely to have both problems at once.

This provides a glimpse (if an imperfect one) of the effect of the work environment on frontline caregiver turnover. Regardless of the level of turnover of RNs, their ability to communicate with and work directly with frontline staff is a key component of the work environment of frontline caregivers. In interviews with caregivers in the region, we have consistently found that caregivers want to feel respected and valued by their supervisors and RN colleagues. When they feel that they are replaceable, or that their knowledge and relationships with clients are not valued, they are more likely to leave the job. Wages matter, but respect and communication are critical aspects of the work environment as well.

High Turnover Compromises Quality of Care

High turnover is not simply a problem for the managers who recruit and hire frontline caregivers. High turnover has been found to compromise the quality of care that patients receive. Research suggests that quality of care is compromised by high turnover in at least three ways (Dawson and Surpin 2001a; see also Wunderlich et al. 1996; Harrington 1996; and Burger et al. 2000):

1. High turnover means that relatively inexperienced staff members, and fewer of them, are required to take care of more patients in a "rushed or unsafe manner — unsafe to both client and worker — cleaning only 'face, hands, and butts' (in the vernacular of direct-care staff), or transferring a client from bed to wheelchair alone (when two or more staff are required)" (Dawson and Surpin 2001a).
2. High turnover precludes the development of relationships that are critical to both the client and caregiver, creating "needless opportunities for mistakes and [removing] from the client a sense of dignity and control over herself and her environment" (Dawson and Surpin 2001a).

Table 5

Quality of Care in South Central Wisconsin, Dane County, and Rural South Central Wisconsin Nursing Homes, Fiscal Year 2000

	Number of Nursing Homes	Average Number of Complaints*	Average Number of Violations*	Average Number of Deficiencies*
Entire South Central WI Region				
High-Turnover Nursing Homes				
(Frontline Caregiver Turnover Rates At Or Above 60%)	18	3.5	1.7	20.8
Low-Turnover Nursing Homes				
(Frontline Caregiver Turnover Rates 0-59%)	16	2.4	0.2	9.4
Dane County Only				
High-Turnover Nursing Homes				
(Frontline Caregiver Turnover Rates At Or Above 100%)	7	5.5	3.0	28.4
Low-Turnover Nursing Homes				
(Frontline Caregiver Turnover Rates 0-99%)	6	1.8	0.0	7.6
Rural South Central WI				
High-Turnover Nursing Homes				
(Frontline Caregiver Turnover Rates At Or Above 50%)	10	2.1	0.8	13.3
Low-Turnover Nursing Homes				
(Frontline Caregiver Turnover Rates 0-49%)	11	2.4	0.2	11.3

Source: DHFS Bureau of Quality Assurance.
***Note:** Weighted average based on the number of beds at each nursing home.

3. High turnover sometimes means that potential clients are simply turned away, or that those clients who are admitted do not receive essential care from overworked staff (Dawson and Surpin 2001a). In short, high turnover rates "produce the antithesis to consumer-defined quality" (Turnham and Dawson 2003).

Low quality care is a chronic problem in this industry. Nationwide, a full 40 percent of nursing homes certified by the Centers for Medicare and Medicaid Services (formerly the U.S. Health Care Financing Administration) repeatedly failed basic health and safety standards over the last four annual inspection surveys, and many more showed serious patient care deficiencies on at least one survey (Eaton 2002; see also Lieberman 1995). The high turnover numbers, accounts of short-handed staff, and subsequent poor care raise important questions. Just how much do these outcomes cost the health care industry? If residents suffer from additional injuries or illnesses because of low quality care, wouldn't their medical attention cost more than wage increases or improvements in benefits for front-line caregivers?

The negative effect of turnover on quality of care has not gone unnoticed by national organizations in the industry. For example, Elma Holder, founder of the National Citizens' Coalition for Nursing Home Reform, cited staffing issues as the key focus of the Coalition's 1998 annual meeting: "Short staffing affects the welfare of every resident in nursing homes, and in some cases even endangers the lives of residents" (Dawson and Surpin 2001a). The Commonwealth Fund found that high turnover among nurse's aides is a key cause of malnutrition and dehydration, which affects an estimated one third of the nation's nursing home residents (Burger et al. 2000).

Our data from the State of Wisconsin allow us to investigate the connection between turnover and quality of care, as measured by the numbers of complaints, violations, and deficiencies in nursing homes in South Central Wisconsin. "Complaints" are simply the total number of complaints lodged against the region's nursing homes (as opposed to substantiated complaints). For "violations," we counted all violations of rules relating to the operation and maintenance of a nursing home that could threaten the health, safety, and welfare of the nursing home residents as identified in the inspection of the facility. For example, a Bureau of Quality Assurance (BQA) engineer might cite a nursing home for not maintaining a hazard-free environment for residents. Finally, we looked at the total number of "deficiencies" identified during inspection. Deficiencies, as determined by BQA nurses and social workers, include, for example, not preventing and adequately treating pressure sores and not developing a comprehensive care plan for each nursing home resident. While our data on violations and deficiencies are drawn from original surveys and do not reflect those violations or deficiencies that were withdrawn from the official record due to the appeals process, we believe they paint an important picture of quality in the region.

In South Central Wisconsin, turnover is strongly correlated with the quality of care that clients receive. For the region as a whole, high-turnover homes receive more complaints and are cited for many more violations and deficiencies than are low-turnover homes. High-turnover homes received 3.5 complaints on average during state fiscal year 2000, while low-turnover facilities got an average of 2.4 complaints during this same time period. Differences in violations were even more significant: high-turnover homes were cited for nearly two violations (1.7) on average, while low-turnover homes were unlikely to be cited for violations at all (with an average of 0.2 violations for low-turnover homes). Further, high-turnover homes averaged twice as many deficiencies (20.8 per home) as low-turnover homes (9.4). (See Table 5.)

When we break down the data geographically within the region, it is clear that the most striking differences in quality on the basis of turnover are found in Dane County, where the turnover problem is also the most significant. Looking at Dane County's seven homes with high turnover among frontline caregivers (rates at or above 100 percent), we see a quality scorecard that is dramatically worse than that posted by the County's six low-turnover homes. Dane County's high-turnover nursing homes received an average of more than five complaints and were cited with an average of three violations and 28.4 deficiencies, as compared with 1.8 complaints, zero violations, and 7.6 deficiencies on average for the County's low-turnover homes. In the region's more rural counties, the connection between turnover and quality is more muted, though still apparent. (See Table 5.)

While the correlation between turnover and quality of care is clear, it is important to note that there may be other factors that also have an impact on the observed differences in the number of complaints, violations, and deficiencies. For example, insufficient staffing — which is not necessarily the result of high turnover, but often is related to it — may be an important factor in some cases.

Toward Lower Turnover and Higher Quality Care

As we noted earlier, the wide range of turnover rates among frontline caregivers in South Central Wisconsin nursing homes — from zero to 275 percent — indicates that not all nursing homes are dealing with the challenges of retaining frontline caregivers in the same way. Some nursing homes have clearly been more successful than others.

High turnover of frontline caregivers is not inevitable; rather, it can be traced, in part, 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" (Massachusetts Health Policy Forum 2000).

According to recent anecdotes, some health care providers are frustrated enough that they have given up the search for quality employees in order to find anybody, or "warm bodies," to fill the positions (Rimer 2000; also see Stone and Wiener 2001). On the other hand, some health care agencies — understanding the direct correlation between job quality, turnover, and quality of care — have made critical decisions to decrease turnover rates among frontline caregivers. In doing so, they have increased productivity and quality of care in their facilities.

In our own region, employers and workforce leaders have come together to talk about how to improve job quality for frontline caregivers. This work has generated the following suggestions for improving retention:

Strategies for Improving Retention of Frontline Caregivers

- *Increase wages.*

  First and foremost, successful strategies to reduce turnover include increasing the wages of frontline caregivers. Simply put, higher paid frontline caregivers are less likely to leave than their lower paid counterparts. Linking compensation to knowledge and experience will also encourage caregivers to obtain education and training that will improve their skills. Higher paid frontline caregivers are likely to invest more in their jobs — in terms of time, dedication, and initiative — likely providing a better quality of care as a result.

Of course, we are aware that a number of constraints — particularly low Medicare and Medicaid reimbursement rates — limit employers' ability to raise wages. However, given the significant variation in the wage rates among the nursing homes we examined, it's clear that health care facilities do have some control over wages.

- *Improve benefits.*

  The lack of affordable health insurance and other benefits makes it difficult for frontline caregivers to stay in their jobs. Making these benefits available will increase the chances that dedicated staff will be able to continue working in the field.

- *Increase training.*

  When health care facilities don't invest money and time to train their employees, they send the message that the workers are not valued and are dispensable. Agencies should provide adequate orientation for new staff and support ongoing training for long-term staff. Better training will also enhance the quality of care.

- *Ensure safety and reliable schedules.*

  Frontline caregivers will benefit from balanced and safe workloads that offer full-time employment — without resulting in overwork.

- *Create career ladders.*

  When organizations don't create career ladders for committed and experienced workers, employees believe that their hard work and experience is worthless. Frontline caregivers — and their employers — will gain from opportunities for career growth and advancement within the organization as well as across the continuum of long-term care services.

- *Enhance support networks.*

  When facilities don't allow workers to have input into how work is organized, they send the message that employees' opinions simply don't matter. To ensure that frontline caregivers have a greater voice in the workplace, agencies can improve RN supervision and encourage two-way communication at staff meetings.

- *Give greater respect and recognition.*

  When frontline caregivers talk about feeling unsupported on the job, they often cite the lack of respect and recognition for the difficult work they do on a daily basis. Health care agencies should establish formal company-wide recognition programs that reward workers for dedication and high quality of care.

A High-Road Model: Jobs With a Future

Given the multiple and complex causes of turnover in health care facilities, long-term improvements will require the development of an ongoing strategy to deal directly with both the immediate and underlying sources of high turnover among frontline caregivers. Such a strategy is not out of reach. By following the high-road strategies for retention outlined above, health care facilities will be able to provide a higher quality of care while expending less money and time on endless recruitment and training of a constant stream of new workers.

Jobs with a Future Partnerships (JWF), a sectoral initiative based in South Central Wisconsin, offers an important model for helping build a high road for the region's health care industry. JWF brings together business, labor, and public-sector institutions to address skilled labor shortages and promote the creation of family-supporting jobs. Participants in JWF's Health Care Partnership — hospitals, nursing homes, clinics, and home health care agencies — have formed a joint training program in phlebotomy, worked actively to develop career ladders for CNAs, and developed recruitment and retention strategies for frontline caregivers.

Initially based in Dane County, these programs and partnerships are now being expanded throughout the six-county region covered in this report. The health care partners are actively cooperating to review industry "best practices" that can be shared among employers and implemented here in the region, and to develop new training curricula for entry-level health care workers. The partners believe that, by working together, they can achieve desired results and meet the needs of patients and their families.

Conclusion

While most health care facilities realize that their existence depends on the critical work of frontline caregivers, they have little time or resources to invest in higher wages, training, career ladders, and input and recognition programs for employees. This must be changed, however, if employers want to reverse the costly and damaging effects of high turnover among frontline caregivers on productivity and quality of care.

As this report shows, improving job quality for frontline caregivers is an important step toward reducing staff turnover and improving the care that patients receive. Moreover, when employers care about their caregivers, they get real rewards, including increased productivity and a skilled and dedicated workforce. In light of rapidly growing demand for capable caregivers in the near future, we as a society cannot afford to do anything less.

Sources

Regional data on employment among frontline caregivers: the Wisconsin Department of Workforce Development (DWD), 2001. http://www.dwd.state.wi.us/lmi/cew_naics.htm.

State and national data on employment among frontline caregivers (minus Wisconsin personal and home care workers): Bureau of Labor Statistics (BLS), Occupational Employment Statistics, 2001.

State data on Wisconsin's personal and home care workers: the Wisconsin Department of Health and Family Services (DHFS), Division of Health Care Financing, *Wisconsin Annual Survey of Home Health Agencies, 2000: Health Counts in Wisconsin: New Findings from the Bureau of Health Information.*

Frontline caregivers as share of total regional workforce: DWD, 2001. http://www.dwd.state.wi.us/lmi/pdf/wo4qtr/sc0112.pdf.

Frontline caregivers as share of total state workforce: BLS, Statewide and Area Employment, Hours, and Earnings, 2000. http://data.bls.gov/cgi-bin/dsrv

Frontline caregivers as share of total U.S. workforce: BLS, Current Population Statistics, Employment Situation Summary, 2000. ftp://ftp.bls.gov/pub/news.release/History/empsit.01052001.news.

Wage data on frontline caregivers in South Central Wisconsin: DWD, 2001 (based on 1998 Occupational Employment Statistics Wage Data). http://www.dwd.state.wi.us/lmi/WDA/wda_indemand/demwda10.pdf.

Wage data on frontline caregivers in Wisconsin and the United States: BLS, Occupational and Employment Statistics, 2001. http://stats.bls.gov/oes/2001/oes_wi.htm#b31-0000; http://stats.bls.gov/oes/2001/oes_31he.htm.

Number of nursing homes in South Central Wisconsin: DHFS. http://www.dhfs.state.wi.us/provider/nh_FDDsDir01.htm.

Number of nursing homes in Wisconsin: DHFS. http://www.dhfs.state.wi.us/provider/pdf/01nhhc.pdf.

Number of nursing homes in the United States: National Center for Health Statistics. http://www.cdc.gov/nchs/fastats/nursingh.htm.

Number of nursing home patients in Wisconsin and the United States: American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook.* 2001. http://www.ahca.org/research/nfbook.htm.

References

Aaronson, W.E., J.S. Zinn, and M.D. Rosko. 1994. "Do For-Profit and Not-For-Profit Nursing Homes Behave Differently?" *Gerontologist*. 34: 775-786.

American Federation of State, County, and Municipal Employees (AFSCME). 2002. "Cheating Dignity: Who Cares? Worker Supply and Demand." http://www.afscme.org/pol-leg/cd04.htm.

American Health Care Association (AHCA). 2002. "Average Full-Time Equivalent Direct-Care Staff Per Facility by State." CMS OSCAR Data Current Surveys. http://www.ahca.org/research/oscar/rpt_staff1_dec02.pdf.

_____. 2002b. *Facts and Trends: The Nursing Facility Sourcebook, 2001*. "Nursing Facility Ownership, 1999-2000." http://www.ahca.org/research/nfbook.htm.

Atchley, R.C. 1996. *Frontline Workers in LTC Recruitment, Retention and Turnover: Issues in an Era of Rapid Growth.* Oxford, OH: Scripps Gerontology Center.

Brown, Nell Porter. 2002. "A Crisis in Caregiving." *Harvard Magazine*. January-February. http://www.harvard-magazine.com/on-line/010214.html.

Bureau of Labor Statistics (BLS). 2000. Occupational Employment Projections to 2010.

_____. 2001 Occupational Employment Statistics. State Occupational Employment and Wage Estimates for Wisconsin. http://www.bls.gov/oes/2001/oes_wi.htm#b31-0000

http://www.bls.gov/oes/2001/oes311012.htm

Burger, Sarah Greene, Jeanie Kayser-Jones, and Julie Prince Bell. 2000. "Malnutrition and Dehydration in Nursing Homes: Key Issues in Prevention and Treatment." National Citizens' Coalition for Nursing Home Reform. The Commonwealth Fund. www.cmwf.org/programs/el.

Center for Health Workforce Studies. 2002. "Health Care Employment Projections: An Analysis of Bureau of Labor Statistics Occupational Projections, 2000-2010." Albany, NY: School of Public Health, University at Albany. http://chws.albany.edu.

Center for Statistics Nursing Home Survey. 1996.

Crown, W.H, D.A. Ahlburg, and M. MacAdam. 1995. "The Demographic, Employment Characteristics of Home Care Aides and Other Workers." *The Gerontologist.* 35, no. 2: 162-70.

Dawson, Steven, and Rick Surpin. 2001a. "Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care." A report submitted to the Domestic Strategy Group of the Aspen Institute by the Paraprofessional Healthcare Institute.

_____. 2001b. "Direct-Care Healthcare Workers: You Get What You Pay For." Workforce Issues in a Changing Society. *Generations*. www.paraprofessional.org.

Direct Care Alliance (DCA). 2000. National Survey On State Initiatives To Improve Paraprofessional Health Care Employment. October 2000 Results On Nursing Home Staffing. http://www.directcarealliance.org/sections/pubs/st_staffing_survey/national_survey_on_state_initiat.htm.

_____. 2002a. "Issue Brief 1: Inadequate Wages and Benefits." http://www.directcarealliance.org/sections/pubs/IssueBrief1.htm

_____. 2002b. "Issue Brief 2: Unreasonable Workloads." http://www.directcarealliance.org/sections/pubs/IssueBrief2.htm

_____. 2002c. "Issue Brief 3: A Poorly Trained Paraprofessional Workforce." http://www.directcarealliance.org/sections/pubs/IssueBrief3.htm

Eaton, Susan C. 2002. "Beyond 'Unloving Care': Linking Human Resource Management and Patient Care Quality in Nursing Homes." *International Journal of Human Resource Management*. June. http://www.ksg.harvard.edu/socpol/eatonpaper.htm.

Elwell, F. 1984. "The Effects of Ownership on Institutional Services." *Gerontologist*. 24: 77-83.

General Accounting Office (GAO). 2001. "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern." Statement of William J. Scanlon, Director, Health Care Issues. Testimony before the Committee on Health, Education, Labor and Pensions, U.S. Senate. May 17.

Harrington, C.A. 1996. "Nursing Facility Quality, Staffing, and Economic Issues." In Wunderlich, G.S., F.A. Sloan, and C.K. Davis. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Institute of Medicine: Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes. Washington, D.C.: National Academy Press.

Harrington, Charlene, Steffie Woolhandler, Joseph Mullan, Helen Carrillo, and David Himmelstein. 2001. "Does Investor Ownership of Nursing Homes Compromise the Quality of Care?" *American Journal of Public Health*. 91, no. 9: 1452-1455. http://www.ajph.org/cgi/content/full/91/9/1452

Himmelstein, D.U., J.P. Lewontin, and S. Woolhandler. 1996. "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*. 86, no. 4 (April).

Hoffman, Richard. 2001. "Lessons Learned In Creating a Successful CNA Retention Campaign." *Nursing Homes Magazine*. April. http://www.frontlinepub.com/fln_article_lessonlearned.html.

Home Health Summary Book 1995.

Lieberman, T. 1995. "Nursing Homes: When a Loved One Needs Care." *Consumer Reports*. 60, no. 8: 516.

Massachusetts Health Policy Forum. 2000. *Health Care Workforce Issues in Massachusetts*. Issue brief prepared by Barbara Frank and Steven Dawson of the Paraprofessional Healthcare Institute. http://www.forumsinstitute.org/publs/mass/GT-MHPF_workforce_issue_brief.pdf.

Nyman, J.A. 1988. "Improving the Quality of Nursing Home Outcomes: Are Adequacy- or Incentive-Oriented Policies More Effective?" *Med Care*. 26: 1158-1171.

Paraprofessional Healthcare Institute (PHI). 2003. "State Wage Pass-Through Legislation: An Analysis." *Workforce Strategies*. No. 1. www.paraprofessional.org.

Pillemer, K. 1996. *Solving the Frontline Crisis in Long-Term Care*. Cambridge, MA: Frontline Publishing Co.

Rimer, S. 2000. "Home Care Aides for the Frail Elderly in Shorter Supply." *New York Times*. January 3: 1A.

Service Employees International Union (SEIU). 1997. "Caring 'Til it Hurts: How Nursing Home Work is Becoming the Most Dangerous Job in America." Washington, D.C.

Stone, Robyn I. 2001. "Research on Frontline Workers in Long-Term Care." *Generations*. Spring.

Stone, Robyn I., and Joshua M. Wiener. 2001. "Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis." The Urban Institute and the American Association of Homes and Services for the Aging.

Turnham, Hollis, and Steven Dawson. 2003. "Michigan's Care Gap: Our Emerging Direct-Care Workforce Crisis." Paraprofessional Healthcare Institute. www.paraprofessional.org.

White, M. 1994. "Homecare Consortium Addresses Frontline Worker Issues." *Generations.* 18, no. 3: 54-56.

Wilner, M.A., and A. Wyatt. 1998. *Paraprofessionals on the Front Lines: Improving Their Jobs — Improving the Quality of Long-Term Care*. The Fifth Quality of LTC Conference. Background paper prepared for the AARP LTC Initiative. Washington, D.C.: American Association of Retired Persons.

Wise, D. 1996. "An OSHA You Could Love." *Business and Health*. October: 28-30.

Wunderlich, G.S., F. Sloan, and C.K. Davis, eds. 1996. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Institute of Medicine: Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes. Washington, D.C.: National Academy Press.

Zarht, L.M. 1992. "The Cost of Turnover in a Home Care Agency." *Caring.* 11, no. 4: 60-66.