

**Without Care:
Maine's Direct
Care Worker
Shortage**

MBCCEP
Maine
Center for
Economic
Policy

Lisa Pohlmann



MECEP

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Executive Summary

This report examines the shortage of front line, paraprofessional workers in Maine's long-term care system and its impact on service providers, consumers, and the workers themselves. Overall, the critical work of these certified nursing assistants, personal care attendants, and home health aides has relied on entry-level women workers for the last three decades. A combination of factors contributes to the current and growing shortage. The elderly population is growing at a much faster rate than the number of traditional workers to care for them. The jobs are under-compensated, largely as a result of inadequate public funding. The challenging nature of this work, poor compensation with few career advancement opportunities, and the stress of ongoing staff shortages result in high rates of worker burnout and turnover. Finally, a tight labor market has led many direct care workers to choose employment elsewhere.

The report provides an overview of the long-term care provider system in Maine and the public funding streams that support it. It shows that low Medicaid reimbursement rates have inhibited providers from being able to compete for labor. The report examines the demographic "care gap" that will increase over the next 10-20 years. Direct care workers' experiences are indicated from focus group discussions around the country and from surveys of and discussions with Maine workers. A wage analysis shows that direct care workers' wages, like most in the low-wage labor market, have remained relatively flat over the last decade despite the economic boom, making less stressful jobs in other sectors more attractive. Public policy as well as private initiatives to address the worker shortage are highlighted.

Key recommendations of the report include:

- Coordinate state efforts to address the worker shortage through establishment of a Direct Care Workforce Committee.
- Increase public funding to enable employers to provide livable wages, and ensure benefits for all direct care workers.
- Develop a coordinated training system, career pathways, and workplace culture changes.

Introduction

Across Maine, thousands of workers, predominantly women, provide assistance and health care for elders and adults with disabilities. These paraprofessionals include certified nursing assistants (CNAs), personal care attendants (PCAs), and home health aides. They work in hospitals, nursing homes, residential and assisted living facilities, and in people's homes. Together they provide eight out of every ten hours of paid care received by long-term care clients.¹ Their services range from feeding, bathing, dressing, administering medications, and rehabilitation, to helping people with in-home daily living tasks. Equally important, they provide emotional support, companionship, and a lifeline to the outside world for some of our most vulnerable citizens.

In general, the health care system is the fastest growing sector of the Maine economy, yet it still must compete in a very competitive labor market. The Maine Department of Labor estimates that there were over 18,000 direct care workers employed in 2001. However, given the number of self-employed workers in private pay arrangements that are difficult to track, the numbers are likely much higher. As Maine's population ages, the demand for these services will continue to grow, but already, the supply of workers is not keeping up with demand.

Health care providers are reporting unprecedented vacancies in these positions.² The turnover rate in some elder care positions in Maine was more than 56% in 2001.³ Among Maine's hospital-affiliated nursing facilities, unfilled CNA positions rose from 9% in 1999 to a vacancy rate of 13% in 2000, a 45% increase of unfilled positions.⁴ Three quarters of nursing homes report having CNA vacancies. For every ten CNA jobs in a nursing home or boarding home in Maine, there are five departures and new hires every year.⁵ On average, it takes about four weeks to fill a vacant CNA job. Turnover and vacancy costs – including recruitment and training costs, increased management expenses, and lost productivity – range from \$1,400 to \$4,300 per direct care worker.⁶

Providers often resort to hiring contract labor. More than a third of hospital affiliated nursing facilities in Maine has had to use temporary staffing agencies, or travelers, to fill vacant RN and CNA positions. In 2000, the incidence of Maine's contract labor usage among these

facilities was nearly twice the national average for both RNs and CNAs.⁷ The costs for paraprofessional contract labor are high - typically \$20-\$25 per hour – which drives up providers’ costs.⁸ Another recourse is requiring current staff to work overtime or “work short,” which adds to burnout and further turnover. Indirect costs of turnover include an initial reduction in the efficiency of new staff and a decrease in worker morale and group productivity.

Ultimately, long-term care consumers feel the brunt of the staff shortage. Consumers consistently cite stable, caring relationships with staff as the most critical ingredient for quality care.⁹ Without adequate staffing, good care is compromised by hurried workers or no workers at all. In a survey of Maine hospital-affiliated nursing homes in 2001, 15% believed that the direct care worker shortage was connected to admission waiting lists and 10% said it was linked to reduced beds staffed.¹⁰ Maine home care providers indicate that the worker shortage reduces continuity and quality of care, and efficiency and intimacy with patients, and threatens their overall ability to stay in business.¹¹ A Health Care Financing Administration report to Congress found a direct relationship between nurse aide staffing levels and the quality of resident care.¹²

With high worker turnover, those receiving this intimate care must constantly adjust to new faces, voices and hands. A 2002 home care services consumer satisfaction survey in Maine indicated that consumers are well aware of the staffing shortage. Respondents commented about not receiving the hours they were supposed to get, or expressed concern that they will lose their service because of the staffing shortage.¹³ Many respondents indicated how distressing it was to deal with different workers from week to week.¹⁴ Studies have shown that people in residential homes and their families also view staff turnover as their main concern because they fear a higher risk of resident injury.¹⁵ In addition, the inability to provide good quality care because of staff shortages is a source of stress for workers, driving them away from the field.

There aren't enough qualified people. I can't sleep at night worrying about who is going to take care of Mrs. Jones tomorrow.

Owner of a Portland PCA staffing agency

Even Maine businesses will be increasingly impacted by the shortage. The Family Medical Leave Act recognizes the importance of elder care for the workforce and mandates providers to allow workers to take unpaid leave to provide such care. The need for such leave can arise when workers are caught short of formal paid help and need to take extra time off to cover the care of their loved ones. Even if they do not take leave, they may be distracted and less productive on the job because they are worried about gaps in coverage. Workers' absences and lost productivity add to employers' costs.

I have too many workers all the time... It is hard on me because of this and I have no say in the times that they come. Too many different girls.

Respondent to Maine Home Care Consumer Satisfaction Survey

There are several key factors that contribute to the worker shortage. First is demographics: the elderly population in Maine – aged 65 and older - will continue to grow faster than the pool of traditional direct care workers – women aged 25 to 54. Second, the compensation of these direct care jobs does not make them competitive with other service industry jobs, particularly given the difficult nature of the work and the added pressures brought on by understaffing. Third, the combination of third-party payment policies and industry practices limit the ability and/or willingness of long-term care providers to substantially increase these workers' compensation – wages, benefits, and working conditions – in order to make the jobs more attractive and competitive.¹⁶

To address this growing shortage of workers, policy makers, industry leaders, workers, consumers and the public must come together to craft public policies and industry practices that will both attract and retain direct care workers. With new strategies, Maine can turn this crisis around. Failure to respond to all of the elements of this worker shortage will simply drive more workers away from the health care workforce, disrupt provider services, and, most importantly, compromise the quality of care available to our families.

Responding to the crisis involves these objectives:

- Consumers receive consistent assistance from competent caregivers that have adequate time to focus on their needs.
- Provider agencies receive increased public funding to support adequate compensation for their direct care staff so that turnover is significantly reduced and management and financial resources can be fully invested in worker training, support and retention. Provider agencies have quality management structures that integrate direct care workers as respected members of the care team and reward longevity and skill advancement.
- Workers earn a livable wage, have health insurance for themselves and their families, and receive work supports like child care and transportation assistance. They receive up-to-date, realistic, and ongoing training that prepares them for all the aspects of their jobs.

This report is intended to provide an overview of key elements of Maine's direct care worker shortage that will provide the basis for analysis and policy action. These elements include the make-up of the long-term care system and its financing; the demographics of the worker shortage; a profile of direct care workers and issues with their compensation, training and working conditions; efforts in Maine and other states to address recruitment and retention of these workers; and specific recommendations for Maine policymakers and other stakeholders to meet this challenge.

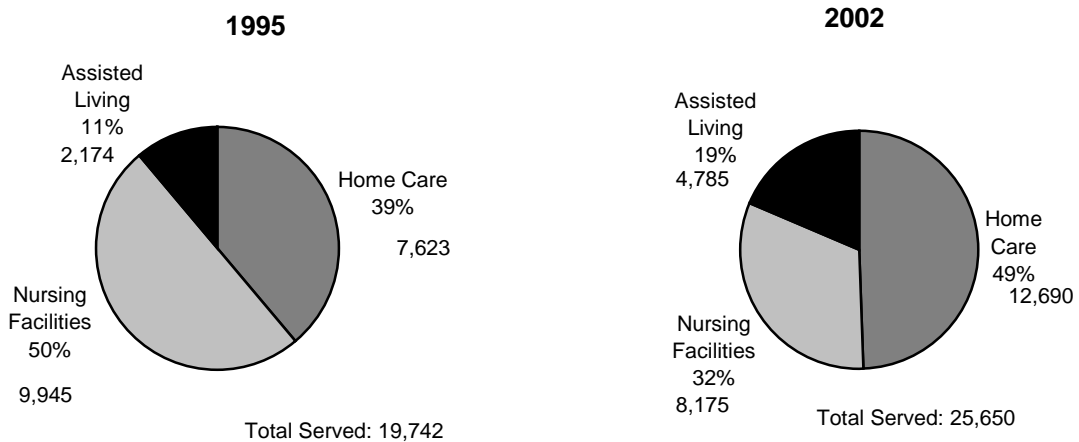
The concerns raised in this report regarding direct care workers apply to all sectors of the long-term care system in Maine, including direct support services provided to children and adults with developmental and behavioral disabilities who receive residential and home care services. While very worthy of similar study, this report does not provide detail on that sector.

I. Maine's Long-Term Care Providers

Maine provides long-term care and assistance to elders and adults with disabilities through various types of facilities and at home. Long-term care services were provided to over 25,500 people in Maine's state fiscal year 2002.

The fiscal crisis of the early 1990s began a period of long-term care reform that shifted caring for people in nursing facilities - the most costly form of care - to caring for people in independent assisted living facilities or in their homes (see Figure 1).

Figure 1: Where are People Receiving Long-Term Care Services in Maine?



Source: Bureau of Elder and Adult Services, 12/4/02

The state established more stringent nursing home admission standards; universal pre-admission screening for nursing home placement; restricted the addition of nursing home beds in facilities; and made greater investments in alternatives. Nursing facility bed capacity has

decreased by approximately 20% - from 10,000 beds prior to 1994 to less than 8,000 beds today. According to data from the federal Centers for Medicare and Medicaid Services, Maine now has the third highest patient acuity¹⁷ index in the nation.

Maine has more, and more kinds of residential alternatives than ever before – over a thousand different settings across the states. They range from private assisted living complexes to small adult family care homes. Many nursing home beds have been converted to residential care beds with less acute care. Table 1 shows Maine’s current long-term care bed count among various types of facilities.

Table 1: Maine Long-Term Care Bed Count, September 30, 2002

Type of Facility	No. Providers	No. Beds
Hospital		
Acute Care	37	3,735
Skilled Nursing Facility	6	89
Skilled Nursing/Nursing Facility	2	102
Swing	11	80
Dual	1	24
Long Term Care		
Free Standing Skilled Nursing Facility	0	0
Skilled Nursing/Nursing Facility	28	2,268
Dually Certified Nursing Facility	86	5,377
Intensive Care Facility/Mental Retardation		
Group	15	100
Nursing	11	158
Combination Group/Nursing	1	7
Mental Health Institutions		
Psychiatric Care	4	414
Residential Care		
Long Term Care Facilities-Level II Beds	60	1,785
Level II Homes (6+beds)	192	5,220
Level I Homes	473	1,711
Adult Family Care Homes	24	139
Adult Day Services Programs	54	739
Congregate Housing	24	1,133

Source: Bureau of Elder and Adult Services

Home care, through a network of more than 200 home health, adult day services, personal care agencies, and independent nurse contractors, is coordinated through Department of Human Services contracts with Elder Independence of Maine, and through the Department of Labor's Bureau of Rehabilitative Services with Alpha One and (see Table 2). Alpha One coordinates home care programs for adults who direct their own care and Elder Independence of Maine manages home care services purchased through agencies and also works with consumers, or their surrogates, who choose to hire their own staff, rather than use an agency.¹⁸

Table 2: State and MaineCare Funded Home Care Programs, 2002

Program by Funding	Administration	No. Served FY02
MaineCare		
MaineCare Home Health	Medicare-certified Home Health Agencies	2,142
Private Duty Nursing/Personal Care Services	Elder Independence of Maine	1,443
Consumer-Directed Attendant Services	Alpha One	326
Adult Day Health	Licensed Providers	169
Waiver: Elders & Adults w/ Disabilities	Elder Independence of Maine	1,535
Waiver: Consumer-directed	Alpha One	361
General Fund		
Home Based Care: Elders & Adults w/Disabilities	Elder Independence of Maine	3,873
Home Based Care: Consumer-directed	Alpha One	216
Homemaker Services	Home Resources of Maine; Aroostook Home Health Svcs.	1,764
Adult Day Services	Adult Day Service Providers	155
Alzheimer's Respite	Area Agencies on Aging	472

Source: Maine Bureau of Elder and Adult Services

II. Maine's Long-Term Care Financing

Public dollars pay for the vast majority of long-term care, through Medicaid and Medicare. The rest is paid privately out-of-pocket or through private long-term care insurance.

Medicare, which is completely funded by the federal government, is the federal health insurance program for people over age 65, and some people under 65 with disabilities. By design, it provides coverage for acute care and assistance for relatively short-term, intensive medical care as well as hospice care for the terminally ill. Medicare support for long-term, chronic conditions is limited.

Medicaid, called MaineCare in this state, is a combined federal/state funded program that provides medical assistance for certain individuals and families with low incomes and assets. Within federal guidelines, each state establishes its own eligibility standards, and determines the type amount, duration and scope of services. Each state also sets the rate of payment for services and administers its own program. If both Medicare and Medicaid cover services, Medicare pays first and Medicaid pays the difference up to the state's payment limit. Medicaid also covers additional services such as skilled nursing care beyond the 100 day Medicare limit, prescription drugs, eyeglasses, and hearing aids.¹⁹ In Maine, Medicaid pays for 72% of the long-term care services in nursing homes and 67% of care in assisted living and residential care facilities (see Figure 2, page 10). Nationally, it is estimated that about 35% of all Medicaid funding goes to long-term care needs.²⁰ In Maine, approximately two-thirds of Medicaid costs support the one-third of beneficiaries who are elderly and disabled for both acute and long-term care.

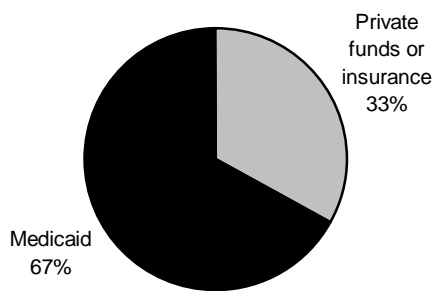
In Maine, nursing home care costs on average about \$4,000 a month, or \$48,000 annually.²¹ Because of these high costs, Medicaid coverage for long-term care provides a safety net for the middle class as well as for low-income families. Approximately one-third of discharged nursing home residents pay privately when admitted and eventually spend down their assets and need Medicaid. In order to be eligible for Medicaid in nursing homes, single individuals must have no more than \$10,000 in nonhousing assets²² and must contribute all of their income toward the cost of their care, except for a small personal needs allowance (\$40 a month). When the institutionalized person is married, the community-based spouse may keep

significantly more in income and assets. In 2000, 68% of nursing home residents nationally were dependent on Medicaid to finance their care.²³

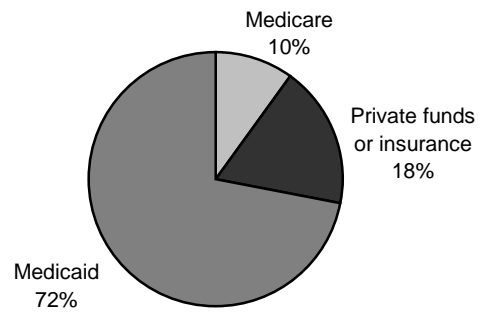
Through a federal Medicaid waiver,²⁴ individuals who require nursing home level care and are financially eligible, but do not want to enter a nursing home, may receive community-based services including home care and other mid-level care paid through the Medicaid program. Maine also provides separate state funds for home care services not available under MaineCare and for individuals who are not MaineCare eligible.²⁵

Figure 2

Who Pays for Care in Assisted Living and Residential Care Facilities?



Who Pays for Nursing Home Care



Source: Maine Health Care Association. 2002. Long-term Care in Crisis.

As indicated above, the long-term care system reforms begun in 1994 shifted more clients away from nursing homes and into less costly settings, and resulted in some initial cost savings. Total state and Medicaid long-term care spending declined 2% between 1995 and 1999. However, costs have now shifted to the alternatives and, due to demand, are rising again. There were significant increased state investments in 1996 in the long-term care system in home care, homemakers respite, adult day services, and the Long-Term Care Ombudsman program.

Overall, per capita spending has declined due to the shift away from nursing facilities. In 1995, Maine was spending \$14,377 per capita on long-term care. In 2001, Maine was spending \$13,026 per capita, a 10% decline even though there was a 29% increase in total numbers served.²⁶ During this same time there was a 64% increase in numbers served in home care and a 17% drop in the number served in nursing facilities. In 1998 Maine allocated 30% of its long-term care budget to home and community care, compared to the national average of 14%.²⁷

Under the MaineCare program in FY02, Maine served 24,284 clients in nursing and residential care facilities, adult day health services, private duty nursing, personal care services, services under waivers for consumer directed care and elders and adults with disabilities and home health care. State-only funded programs served another 7,022 clients in home-based care for elders and adults with disabilities, consumer-directed home-based care, adult day services, congregate housing services and programs, assisted living, Alzheimer's respite care, and homemaker services. While updated numbers are not yet available for additional services provided through the federal Medicare home health program, in 2000 that program served 19,120 persons, through 692,525 total visits.²⁸

Seventy percent of people with Alzheimer's disease are cared for in the home. It's a 24 hour proposition for families. Without enough home care workers, the system breaks down, In fact, it is already breaking down.

Eleanor Goldberg
Maine Alzheimer's Association

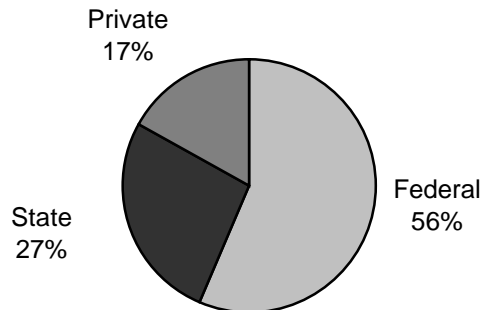
Table 3: Maine Long-Term Care Expenditures, 1995-2002 (in millions)

MaineCare (state and federal)	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
Nursing Facilities	239.6	219.0	202.3	185.6	184.1	200.5	202.7	201.6
Residential Care	16.7	18.7	24.5	40.7	45.7	57.6	61.8	65.6
Home Care	21.2	24.0	29.5	36.7	47.0	46.7	42.5	45.0
Total MaineCare	277.5	261.7	256.3	263.0	276.8	304.8	307.0	312.2
General Fund								
Home Care	7.2	7.7	11.3	12.0	13.9	18.0	18.5	19.2
Assisted Living	n/a	n/a	n/a	.7	.6	1.3	1.8	1.7
Total General Fund	7.2	7.7	11.3	12.7	14.5	19.3	20.3	20.9
Total Expenditures	284.7	264.4	267.6	275.7	291.3	324.1	327.3	333.1

Source: Bureau of Medical Services; Bureau of Elder and Adult Services
Not inflation adjusted

MaineCare funding for long-term care programs in state FY01 was \$307 million (see Table 3). Medicare funding in 2001 totaled \$56.7 million. Other state spending for long-term care in 2001 totaled \$20.3 million. Thus, as shown in Figure 3, federal funding picked up well over half (56%) of the long-term care financing bill in 2001 while state funds paid for just over one-quarter (27%).²⁹

Figure 3: Maine Long-Term Care Funding, 2001



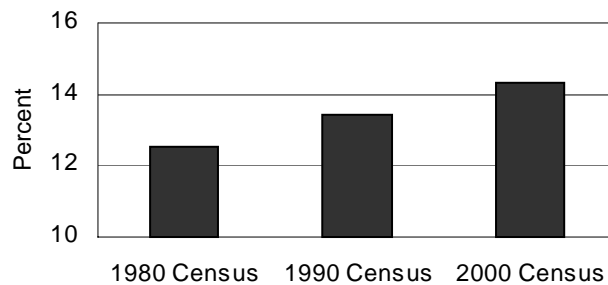
Source: Maine Center for Economic Policy analysis of Maine Bureau of Elder and Adult Services data

III. Demographics of Maine’s Care Gap

All across the U.S. the health care system faces a growing crisis because of our evolving demographics. Medical and technological advancements have enabled longer and more independent lives for both elders and adults with disabilities; however, most still eventually require the help of others to get by. Family members provide much direct care and personal assistance for “free.” It is estimated that the economic value of informal caregiving in Maine as of 1999 was about \$942 million, or three times the amount spent by the state on long-term care.³⁰ But many family members also need help caring for their loved ones while they are still at home, when they need health care, and when they need more supervised assistance in a residential or nursing facility. Direct care jobs cannot be replaced by technology or moved overseas – and the need for these workers is increasing.

As the “baby boom” generation (those born between 1946 and 1964) reaches retirement age, the growth of the elderly population (65 and older) will rapidly increase. Maine’s population is aging even more rapidly than the rest of the nation, and the elderly population is projected to increase 77% from 2000 to 2025.³¹ The proportion of Maine’s elderly relative to the whole population is increasing by the decade (see Figure 4) and is projected to increase from 13.9% in 1995 to 21.4% in 2025.³² The population most likely to require long-term care – those over 85 - will grow 26% from 2000 to 2015.³³

Figure 4: Maine Residents Age 65+ as Percent of Total Maine Population



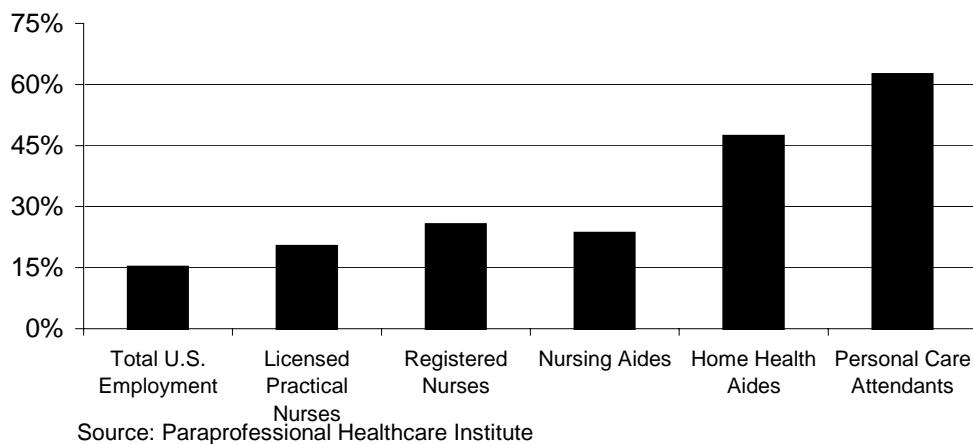
Source: DHS Bureau of Adult and Elder Services

Thus, demand for health care workers is pushed by the aggregate number of consumers living with higher levels of acuity as well as by consumers’ strong preference for receiving

services in their homes. However, other attributes of the health care labor market suppress, or at least distort the “effective demand” for labor. Public and private third-party payers, who largely fund health care, have strong financial incentives to constrain costs. Policymakers are responsible to public taxpayers for allocating revenues between competing needs, and have instituted regulations and cost containment strategies. Insurers are responsible to shareholders and corporate purchasers and have capped payouts and changed definitions of “medically necessary” to lower costs. Thus, the “need” for services perceived by consumers and health service providers is usually greater than the effective demand created by those who pay for the services. This in turn also impacts the effective demand for labor.³⁴

Direct care employment is projected to grow nationally much faster than employment as a whole (see Figure 5). Maine can expect the same. The need for home health aides and PCAs in Maine is expected to increase by 50% from 1998-2008. In fact, home health aides are projected to be the seventh fastest growing job opportunity in Maine during this time period.³⁵

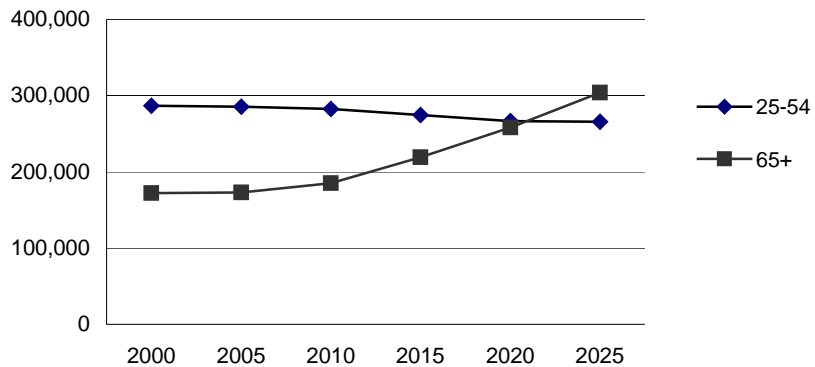
Figure 5
Percent Increase in U.S. Direct Care Employment
2000 to 2010



But where will these workers come from? The long-term care industry has structured itself for many years on a presumed endless supply of traditional long-term caregivers – women aged 25-54. As more women entered the workforce over the past three decades, nearly tripling from 1968 through 1998, this was a reasonable assumption.³⁶ More

recently, welfare-to-work policies have brought a significant number of new workers into the labor force in Maine and many of them have pursued direct care positions. But demographically, the number of women in this age cohort will fall behind the number needing the services over the long-term (see Figure 6).

Figure 6: Women of Caregiving Age and Elderly in Maine - 2000-2025
(Females aged 25-54 and elderly 65 and older)



Source: U.S. Census Bureau Population Projections

Thus, the supply of individuals from which employers can draw new direct care workers will become more limited. This shrinking ratio of support will also place increasing pressure on family caregivers. Women, who provide the bulk of paid and unpaid care, will experience a double-bind when they can no longer care for loved ones themselves, turn to the formal system for assistance, and find that the system cannot provide enough paid staff.³⁷

What is left is to increase the “price” of health care jobs – wages, benefits and working conditions – in order to better compete for workers. But a key factor prevents the health care system from achieving rapid labor market “equilibrium” to fill all available positions. In the private market, when the demand for workers exceeds the supply of workers, businesses can increase wages and benefits to attract more people into their business. They may opt to cover the increased payroll with price increases or by taking a cut in profit. During the recent economic

boom of the late 1990s and the resulting tight labor market, some businesses provided wage increases to attract workers. However, healthcare is not a free market industry. It is difficult to increase the “price” of long-term health care to cover increased wages and benefits when it is primarily paid with public funding controlled by state policymakers.

[My worker] is a very caring person – does all that I need each day – calls for my medications, bath and shampoos. Makes sure I eat properly. Makes sure I take my medication after I eat. When weather is good she takes me for walks. Makes my bed – vacuums when needed and helps me a lot. She is very understanding. She is on time, always neat and walks in with a smile. She knows what to do when I am sick. I’d hate to ever lose her.

Respondent to Maine Home Care Consumer Satisfaction Survey

IV. State Policy Impact on the Worker Shortage

State policy makers decide which citizens will be eligible for MaineCare, what the minimum staffing levels must be in facilities, and how much the reimbursements to providers serving these clients will be. To understand the current cost constraints imposed by the system of long-term care financing and its connection to direct care workers' compensation, it helps to have a few basics about the Medicaid reimbursement procedure³⁸ to long-term care providers.

Nursing and Residential Care Facilities

The payment rate for nursing facilities is based on costs incurred in a specified base year, (currently 1998) and is then adjusted for inflation. Rates are determined prospectively – before costs are incurred. Allowable costs are categorized as direct, routine, and fixed costs³⁹ and there are certain expenditure ceilings per cost category.⁴⁰

The system takes into account that some residents are more costly to care for than others. Reimbursement for direct care costs is based on a classification system that groups residents according to their functional capacity and the resources required to care for them. This is the facility's "case mix."

DHS determines an upper limit cost per day for three "peer groups" of facilities (hospital based facilities, non-hospital based facilities with less than or equal to 60 beds, and non-hospital facilities with greater than 60 beds). The upper limit cost is a percentage (varying by peer group) above the median of the base year mix adjusted cost. Each facility's direct care rate is the lesser

Direct care rates were established at a time when DHS approved every new direct care position and rate of pay, usually not much higher than minimum wage. Now we need to pay people more but the payment rate is still based on these old rates.

John Lacasse
Medical Care Development

of the limit, or the facility's base year adjusted cost per day, all based on case mix. If there are less actual direct care costs at the time of audit, the facility is required to reimburse DHS for the difference.

Residential care facility reimbursement works similarly to nursing facilities as of 2001. Residential care facilities are now based on case mix and a base year (1998). However, residential care's direct component is based on a case mix adjusted price that is not settled at audit. Recently a fourth cost component in residential care – personal care services – was added as a way to capture additional federal matching funds. This will include dietary and housekeeping services, which were previously considered part of routine costs. Inflation adjustments for residential care are not automatic, but rather are determined by DHS.

Home Care Reimbursement

Home care providers are reimbursed under Medicaid and the General Fund on a fee-for-service basis. Table 4 shows the 2002 provider reimbursement rates. Agencies are reimbursed per hour of time in the home, and all administrative and capital costs must be subsumed within that direct care hourly rate, so wage rates are generally much lower than the reimbursement rate. Currently, the rate for PCAs is \$14.20 per hour and \$17.54 for Homemakers. The Homemaker rate is higher because homemaker services include client assessments. In home care, Medicare covered Home Health Aide services are paid as part of an all-inclusive payment that covers a 60-day episode of care. This payment, based upon patient acuity, covers all in home services and medical supplies related to the plan of care.

We all think we are professionals but we don't get looked upon as professionals. It's partly because people don't see the people we're caring for as important.

It would help if we could educate the public and get them to think about what will happen when they are in that position. People tend to push that thought away.

Maine workers at association meeting

Table 4: Home Care Program Reimbursement Hourly Rates, 2002

	Medicaid					General Fund		
	Waiver Elders and Adults	Waiver: Consumer Directed	Private Duty Nursing/ Personal Care Services	Consumer Directed Attendant Services	Home Health	Home Based Care: Elders & Adult	Home Based Care: Consumer Directed	Home maker
PCA	14.20	10.30	14.20	10.45		14.20	10.45	
Home maker	14.52					14.52		17.54
CNA/ Home Health Aide	16.44		16.44		39.84/ visit	16.44		

Source: Bureau of Elder and Adult Services and Home Care Alliance of Maine

Reimbursement Rates Are Too Low

The key problem in the reimbursement procedure for nursing and residential care facilities related to direct care workers' wages is that prevailing wages, already too low, become the primary basis for future payment rates, thus inhibiting wage progression and failing to cover labor costs fully. The regulations do not provide for any mandatory rebasing to adjust the payment rates to reflect changing economic conditions or current operating expenses.

Two-thirds of nursing home costs are labor costs and MaineCare pays for three out of four nursing home patient days in Maine. But because of caps on direct care reimbursement, payments fall far short of the costs of care. In 1999, \$9.3 million of allowable direct care costs for MaineCare patients went unfunded. MaineCare payments continue to erode over time even as direct care costs rise; the average rate of wage inflation for health care facilities was 7.3% in 2000 which outpaces the annual 3% adjustment in the MaineCare budget. This widening shortfall directly restricts wage rates.⁴¹

Administrative officials recently estimated a gap of \$18 million in 2001 between allowable costs under the MaineCare program for nursing facility reimbursement and actual reimbursements. Based on 2000 cost report data for non-hospital based nursing facilities, the average actual cost of operations for nursing facilities was \$166.81 per day, the average allowable MaineCare cost was \$128.80 per day and the average Maine Care reimbursement was \$117 per day. This gap will continue annually until funding is available for DHS to increase reimbursement rates. MaineCare reimbursement for residential facilities was also below costs by \$10 million in 2001.⁴²

Nursing home rates were re-based in 1996 (to base year 1993) and not again until 2000 (to base year 1998). Therefore, many nursing facilities claim that they have been operating in the red and recent increases have not made up for all the ground lost. Kenneth Bowden, President of the Maine Health Care Association Board testified to the Legislature in October 2002:

“From 1994-2002, during a time of state revenue surpluses, total funding to long-term care remained mostly flat at a time when operational costs were rising disproportionately in response to wage pressures, increasing employee benefit costs and rising municipal bills. Today for a large portion of our members, daily wage and benefit costs are far higher than the Medicaid reimbursement designed to pay for them...”⁴³

Bowden noted that, according to state records, 84.3% of all nursing facilities in FY01 failed to have their allowable direct care costs met. If direct costs are not met, providers are unable to compete with other industries for workers because they cannot offer better wages and benefits. Unable to find workers and strained by inadequate funding, nursing homes have been closing. The Maine Health Care Association reports that due to unprecedented closings of nursing homes and receiverships since 2001, some 225 Maine citizens who had been receiving care were displaced, and 325 workers lost their jobs.⁴⁴

Residential care facilities are further constrained by the fact that their inflation adjustments rely on DHS discretion and are not automatic, and they have not received the same worker targeted COLA adjustments that nursing facilities and home care have received in recent

years. Additionally, the liability insurance costs for these facilities have been sharply increasing, further constraining their budgets and ability to improve compensation for workers.⁴⁵

Home care providers are also struggling because of the chronic underfunding of this service. There are home care waiting lists because there are not enough workers. Wages are constrained since all operating costs and worker transportation time and costs must be derived from the hourly rate per visit, which is inadequate. Providers are not able to cover non-billable hours if clients are hospitalized, which often results in losing workers due to work and income reductions. Since home care providers are generally not able to guarantee hours, most are unable to offer benefits such as health insurance and paid time off.

The federal government implemented a 15% cut to Medicare home care in October 2002 as part of the 1997 Balanced Budget Act. Overall Medicare home care reimbursement in the United States has been reduced by \$70 billion since passage of the Balanced Budget Act. In 1999 Maine's Medicaid Home Health Benefit (Section 40) underwent significant rule changes resulting in a reduction of services by \$5 million. There have been steady but small incremental rate increases in state and MaineCare funded home care programs over the last several years. In July 2002, home care reimbursement rates went up 2.5%.

The economic slowdown beginning in 2001 has resulted in layoffs and closings of some businesses in Maine but, unlike many other states, Maine's unemployment rate has been relatively stable in the last 12 months, remaining at 4.3% in November 2001 and November 2002.⁴⁶ According to administrative officials in Maine, there has not been a significant lessening of the direct care worker shortage as a result of the recession so far. At most, there has been a

PCAs are the people who provide the greatest amount of care to elders and people with disabilities in their homes. They bond with them and add quality to their lives. Yet, unlike other direct care workers, they do not have guaranteed hours and therefore, do not have paid time off or access to health insurance.

Susan Rovillard
Home Resources of Maine

slight decrease in the use of temporary staffing agencies by nursing homes. It is important to note, however, that even a rise in unemployment may not impact this problem greatly. Many states that have experienced a rise in unemployment during this recession have not seen a significant lessening of the direct care worker shortage.⁴⁷

The public financing situation is not easy for states to solve, especially in current tight fiscal times. Maine's health care costs are growing at twice the rate of the state's projected revenue growth. Nationally, Medicaid expenditures are projected to more than double in inflation-adjusted dollars between 1993 and 2018 due to the aging of the population and to price increases in excess of general inflation.⁴⁸ Mainers will have to face the fact that quality long-term care for ourselves and our family members requires an adequate number of competent direct care workers, and that is now coming at a higher price than we have been willing to pay so far.

Our program experienced a 10% increase in staffing related complaints from family members and consumers in the first half of 2002. The vast majority of these issues are related to staffing shortages.

Brenda Gallant
Maine Long-term Care
Ombudsman Program

V. Direct Care Workers: Their Work and Their Struggles

Direct care workers, along with nursing staff, provide the face, hands and voice of health care for thousands of elders and people with disabilities in Maine. Doing direct care is rewarding but demanding and difficult work. These workers interact with people who are extremely vulnerable, and they must tend to very intimate needs. They work with people's bodies as well as their emotions and behavior.

When working in homes, they are operating in other people's private spaces, trying to be supportive but not intrusive. They must gracefully set the boundaries around what they are hired to do – such as helping with medications, doing laundry, or taking a pulse – and myriad tasks clients may ask them to do as if they were family members or maids. When working in nursing facilities, direct care workers must negotiate their place in the service spectrum among other professional staff. Some direct care workers are lucky

enough to work in places where they are well supervised and valued, and where the load of work is reasonably shared. But many workers endure a lack of support and respect from the facility hierarchy and its policies.

The daily routine for direct care workers in home settings, residential care settings, and nursing homes differ in many ways.⁴⁹ CNAs begin their day at a nursing home by reviewing reports of any changes in residents they will care for. They then begin to awaken, dress and get ready for breakfast the residents they are assigned to – usually 5 people during the day.⁵⁰ This is a substantial task since about 60% of residents at the skilled nursing level are partially dependent, and the other 40% are totally dependent on the assistance of one or two staff with bathing, eating, dressing, toileting, and ambulating or transporting.⁵¹ After breakfast, CNAs bring

Our work matters. The people we serve have value and they belong in the community. These people deserve respect from the community.

Most people who stay in this field do it because they get personal gratification.

Maine workers at association meeting

residents back to their rooms or to scheduled activities. They then attend to needs such as turning bedridden residents so they avoid bedsores; give baths; and walking residents for exercise. The lunch and dinner routine is similar, getting residents to the dining area and back again. Any time in between is used for charting residents' conditions. However, workers report that the typical day is not orderly and is often rushed. Residents may be uncooperative or ill and require extra time for tasks. Family members may be visiting and have questions. In fact, interruptions, unexpected problems, and crises are the norm rather than the exception.

Home health aides perform many of the same tasks as CNAs in nursing homes but they are able to focus on one client at a time and are allowed more time per person. They also have more independence since they travel from home to home throughout most of their day. The home health aide receives a schedule of clients to see, usually leaves from home, and rarely comes into the home health agency office. There is a health care plan developed by a registered nurse, which the home health aide carries out. The visits can last anywhere from 15 minutes to several hours, but the average visit is about 1.5 hours.

PCAs usually provide assistance with basic living tasks in home settings as well as in residential and assisted living settings. Duties performed at a place of residence may include bathing, dressing, and toileting as well as housekeeping and preparing meals. They may transport clients to appointments. They may supervise activities at non-residential care facilities. They may also advise families and clients on nutrition, cleanliness, and household utilities.

Difficulty Making Ends Meet

Maine's direct care workers are predominantly women from low-income households and over one-third are single parents.⁵² This is similar to the national worker profile.⁵³ In Maine, well over half (59%) of the CNAs work full-time while only 29% of PCAs do. CNAs tend to be younger (58% were under age 35) while PCAs are older (only 18% under age 35).⁵⁴ Over half (59%) of CNAs and two-thirds (67%) of PCAs have household income of less than \$20,000.

With household income at \$20,000 or below, many are eligible for and rely on public assistance to get by including TANF, food stamps, Medicaid, WIC, and subsidized housing.⁵⁵ In fact, CNAs working in home health agencies and nursing homes are twice as likely to receive

public benefits – specifically food stamps and Medicaid – than workers in other job categories.⁵⁶ Many are not offered health insurance by their employer or are not able to afford the co-pays of the employer’s health insurance plan. While some are eligible for MaineCare, others exceed those income guidelines and go uninsured.⁵⁷ This is particularly ironic given that they work in the health care field.

With such low-income, workers are hard pressed to afford child care and maintain transportation, both essential for getting to their jobs. When either falls through, the whole system suffers – providers are short staffed; service is delayed for consumers; other workers must work overtime to fill in; and the workers’ own financial insecurity takes a great toll on their ability to function effectively at home or on the job.

Lack of Adequate Training

Despite the important and difficult nature of their work, relatively little formal training is required for direct care staff. The federal Medicare minimum requirement (and, thus, the norm) for home health aide and nursing home workers is the equivalent of two weeks of training. For personal care attendants who have no “hands-on health care” duties, the federal Medicaid program requires no formal training at all.

States are responsible for approving and overseeing nurse aide training programs and the administration of competency exams. They have considerable freedom in developing the programs within some basic hours requirements. Training programs may take place at facilities or at institutions such as a community college, vocational-technical college, or other school setting. In Maine, CNA training, for example, ranges from \$0-\$900.

My girls are teenagers so I don't need to pay for child care anymore, but it's expensive to keep up a car, which I need for the job. And no way can you get off public assistance on that wage.

CNA from Waldoboro

Maine requires a higher level of training for its direct care staff, including a week for PCAs and four weeks for CNAs (see Table 5).

Table 5: Scope of Duties and Training Required for Unlicensed Direct Care Workers in Long-term Care Settings in Maine

Occupation	LTC Setting	Training Required	Scope of Duties
Personal Care Assistant (PCA)	Home/Assisted Living	40 hours	Personal care*
PCA Consumer-directed	Home	Certified by consumer	Determined by consumer
Certified Nursing Assistant (CNA)	Home/Assisted Living/Nursing Facility	150 hours	Personal care; limited nursing tasks; no medication administration
Certified Residential Medication Aide (CRMA)	Assisted Living	24 hours	Administer medications
Certified Nursing Assistant - Medication	Nursing Facility	CNA+2 years experience+120 hours additional training	Personal care; limited nursing tasks; medication administration
Residential Care Specialist I	Assisted Living	36 hours	Personal care
Home Health Aide – employed by Medicare certified home health agencies	Home	CNA plus competency test	Personal care; limited nursing tasks; no medication administration

Source: Bureau of Elder and Adult Services

*Personal care is assistance with activities of daily living such as bathing, dressing, eating, toileting, locomotion, transfer and bed mobility.

Several worker studies around the country have indicated that there is a lack of adequate training. Worker focus group discussions in Pennsylvania in 2001⁵⁸ indicated that orientation and training had a tremendous impact on employee retention. These workers viewed their experience with training as unrealistic. Due to staff shortages and lack of time, workers simply did not have time to do what they were shown in classroom training session.⁵⁹ Workers across the board

expressed the need for more hands-on training. As one individual said, “Someone is whipping your butt while you’re trying to change them... the dummy you trained on didn’t do that.”⁶⁰ Problems in facility-based training often stem from a lack of time devoted to training once caregivers get on the floor. Co-workers are often little help because they barely have time to do their own jobs, let alone assist others in doing theirs.

Home care workers also felt that they needed more orientation and help during their early visits with clients. One worker revealed that she had not been told what to do if she entered a home and found a consumer deceased or in distress.⁶¹ They felt that orientation should not end when a worker starts their job, but rather should occur any time the workers’ situation or work environment changes. There are many examples of new direct care workers giving up because, due to poor training, the reality of the job was not what they had expected.⁶²

A 2002 national study by the U.S. Department of Health and Human Services⁶³ also indicated that traditional nurse aide training is outdated and has not kept pace with changing care needs. The study found that nurse aides need more skill training on cognitive and behavior disorders, catheter care, colostomy care, lifting, feeding, hydration, and infusion therapies. They also need more training in interpersonal skills, including communication, teamwork, coping with death and dying, time management and new technologies. They found that teaching methods were often ineffective and the clinical exposure was too short. Workers in the study said that the training was taught “over their heads” and involved too much medical jargon. They were taught skills that would not often be used, and limited time was given to practice skills.

The HHS study concluded that earlier clinical exposure would help weed out those who are not interested in doing direct care work, and that federal and state funds are being wasted by

They should have video or at least audio tapes of what is happening on the job as part of your training. I also wish my supervisor would stop in during my shift at some point in case I need something.

CRMA from Rumford

the large number of students who are trained each year and drop out when faced with the realities of the job. Workers in the HHS study suggested using realistic videos, interactive computer programs and games; providing crisis intervention to help deal with emotional aspects of the job; participating in pharmaceutical in-service training so they understand the behavior changes related to the effect of drugs; involving other health care professionals in in-services such as the long-term care ombudsman talking about patient's rights; peer teaching; interacting with family members as part of in-services; and offering in-service training on all shifts to accommodate staff schedules.⁶⁴

They don't have enough money to pay us what we're worth, but they can treat us better in other ways. I'd rather hear, "Hey! Good job!" and get some positive feedback.

Maine worker at association meeting

Lack of Supervision and Integration with Care Team

Direct care workers frequently cite a lack of supervision and support on the job. Focus group discussions among workers in New Hampshire document that supportive supervision at nursing homes is rare and supervision in home care is nearly nonexistent.⁶⁵ They also indicated that working conditions were of equal importance to wages and benefits in their decision to remain employed within health care.

In CNA focus groups in Wisconsin, they emphasized the importance of having nursing staff that did not make a point of setting themselves apart from CNAs and refusing to do work or to help with tasks that were considered "CNA work." They were also acutely aware of the nurses that paid attention to their questions and recommendations. Since CNAs often notice changes in a patient's conditions first, they feel obviously devalued if upper level staff members brush off their observations. They also wanted to hear back whether or not their observation helped improve someone's care.⁶⁶ They reported enjoying their jobs the most when they worked with nurses who emphasized teamwork rather than hierarchies, and that the benefits that accrued from such relationships included better communication, less accidents, more efficiency, and better

care. Organizations that had mechanisms in place to solicit input from CNAs had lower turnover and higher retention.⁶⁷ These included periodic staff meetings and case conferencing.

Workers' loyalty tends to be with the consumer, not the organization or their supervisor. Over two-thirds of the Pennsylvania workers said they imagined they would be in the same profession five years from now, but just over one-third said they'd be with the same employer.⁶⁸ They said that "pats on the back" were too few and far between, and in many cases, non-existent. Sometimes supervisors were an annoyance to be avoided and ignored rather than a supportive, positive part of their job. As one worker said, "Just thank me for pulling a double shift. Instead, I have to go over my paycheck to make sure I got paid for it."⁶⁹

After two years as a PCA in a supported living residence, I left because I couldn't move up. I wasn't respected by my director, the workload was too much, and the turnover tremendous.

Direct support professional from Winthrop now working with people with developmental disabilities

High Injury Rates

Direct care work is often physically demanding, and injuries are common. Such injuries range from back strain due to lifting patients without the proper assistance equipment to assaults from combative patients. The 2000 occupational injury rate for these workers in Maine (at 6.9 incidences per 100 workers) is over twice as high as the rate for all occupations (at 3.0 incidences per hundred workers).⁷⁰ Inadequate training may contribute to higher injury rates.⁷¹

Lack of Career Pathways or Recognition for Longevity

Workers often see this work as "dead end", offering little incentive to stay in the field. There is little in the way of advancement opportunities in direct care work and often very little pay differential for years on the job. In the Pennsylvania discussions, longstanding workers

resented that they did not receive a significant, if any, pay differential from new hires, even though they understood the realities of the workforce shortage and the need to attract new workers.

Stressed About Meeting Consumer Needs

Vacancy and turnover rates impact direct care workers. Without adequate staffing, individual workers are required to work faster and give less attention to individual patients, diminishing the quality of care and also workers' job satisfaction. Workers face a high level of stress when they are unable to provide the kind of care they feel is required and which they are legally responsible to provide.

Many workers are incensed at the significant negative impacts on consumers as a result of the workforce shortage. Pennsylvania workers noted insufficient, and at times, frighteningly unacceptable quality of care such as not having adequate time to thoroughly and safely bathe individuals; having to rush feedings at an uncomfortable pace; not being able to respond to emergency situations quickly; having to be 'short' with individuals because there was not time to explain things; having unqualified individuals mishandling consumers; and not being able to treat consumers respectfully and with dignity.⁷² Many home care workers said they took positions in home care precisely because they felt less pressured and able to take more time with clients.

Workers acknowledge that the impact of a revolving door of workers on consumers was very difficult and that the transitions were rarely made smoothly due to a lack of time, information, and training. They felt that there should be a period for caregivers and consumers to get to know each other, whether a worker was new in their home or new on their floor at a facility. Workers resent the awkward position they are in with consumers when such transitions are not attended to.

Stressed by the System

As noted above, these workers have low incomes and are stretched to keep child care and transportation together. Home care workers in the Pennsylvania discussion noted that there

should be greater reimbursement to help with the high cost of maintaining their vehicles for this work.⁷³ When asked what type of benefit would be most important in recruiting and retaining workers, the overwhelming majority said that it would be child care assistance, either on site or through an allowance.

A Cleveland study of nursing assistants in skilled nursing facilities showed that the most widely reported job-related sources of stress for these workers were scheduling problems such as being asked to come to work early or stay late, feeling unprepared for the job, and complaints about supervisors. Regarding personal sources of stress, over one-third worried about their families while at work, and over half said they could not pay for the medical and dental care they needed.⁷⁴

I challenge anyone to walk into one of these places and see what we see and do what we do for the amount we get paid. They would say, "You can't pay me enough."

PCA from Portland

Increased Isolation and Lack of Support Networks

The shift from caring for people in nursing facilities to residential and home care settings has meant that more workers are on their own each day. There is less opportunity for peer support and collective advocacy for their needs. The rate of unionization is low (less than 10% nationwide).⁷⁵ There are currently ten organized facilities in Maine. These include, for example, Bangor Nursing and Rehab Center (AFT); Winship Green in Bath (IAM); Gorham House (MSEA/SEIU); Atlantic Rehabilitation and Nursing Center in Calais (TEAMSTERS), and Barron Center in Portland (AFSCME).⁷⁶

Not Respected by Society

Workers are not only the hands and faces for consumers, but they are the eyes and ears for consumers needs. Yet, they generally do not feel respected by their organizations, or society

in general, and clearly do not feel they are viewed as professionals. To attract and retain good workers, with a “calling” for this work, there must be a sense of respect for the work and the worker. This cannot be a profession for someone who “just needs a job.” Workers indicate that it takes a “special person” to do direct care work with traits of empathy, compassion, positive attitude, and patience. To this list might be added discretion, bedside manners, a strong back, and a strong stomach, as well as independence, tact and judgment.⁷⁷

While many current workers have been drawn to the field because they have these traits, others are there primarily because they need a job and are likely to go elsewhere when given a better opportunity. In order to ensure a high quality level of care, it is important to find workers who have the calling and then reward them as professionals doing a critical job for society. Workers recognize that the low pay they receive is directly connected to the lack of understanding of what it takes to do the job and a lack of respect for the skills, behaviors and liability required to do the job well.⁷⁸

Leaving for Other Jobs

Many more workers train to be CNAs than are actually currently working in the field. In the last 13 years in Maine, nearly 38,000 CNAs have been certified and actively worked in the field. Within the last two years, at least 13,900 have been re-registered through the state CNA registry, indicating that they were actively employed in the field for at least eight hours under the supervision of a registered nurse.⁷⁹ While this does not necessarily include every active worker, it does indicate both that there are more workers than appear in DOL data, and that there are likely several thousand trained but inactive CNAs who might be recruited back into the health care labor market with improvements in wages, benefits and working conditions.

One quarter of former Maine CNAs and PCAs surveyed indicated that they had left their jobs because they got a better job and one-fifth said they left because working conditions were poor. Of currently working CNAs, only 41% said they would be working as CNAs in five years. Among younger CNAs the proportion was only 25%.⁸⁰

A survey of CNAs in Wyoming who had let their licenses lapse indicated that pay and benefit concerns dominated the reasons for seeking employment elsewhere. Health related

reasons were also offered as motivation to go elsewhere – these were expressed as the desire for less stress, less physical demand, or having taken a different job because of an injury, in some cases related to lifting or staff shortages. When asked why they did not renew their licenses, the most consistent response was that they did not like the working conditions, whereas very few said that they did not like the work itself.⁸¹

The authors of the Pennsylvania worker study summed up the “slippery slope” of the worker shortage in this way:

At this point in time [we are] relying on the “good graces” of direct care workers. The people who do the job well and are willing to “hang in there” and “tough it out” exhibit unparalleled dedication. While this is to be admired, it also creates a precarious situation that is only going to worsen. The impact of a disillusioned or dissatisfied worker, as well as an overall shortage, in the long-term care and services arena is much greater than in other industries and in fact is measured in the well-being and safety of consumers...[W]hen working with a less sophisticated group, a system can actually take advantage of the dedicated and good performers to the extent that a poor situation becomes the norm. At the same time, the individuals who are just in the profession to have a job are allowed to be less than solid performers because the industry to some extent feels “held hostage” by the workforce shortage. This is the current situation and resentment is building. As direct care workers are exposed to more options and, in general, develop a greater overall sophistication, they are becoming more aware than ever that there are a significant number of problems with the current situation. And in no uncertain terms, they want to see change.⁸²

VI. What Are We Willing to Pay Them?

Several sources make it possible to estimate direct care workers' wages. The Maine Department of Labor, in conjunction with the U.S. Bureau of Labor Statistics, conducts a survey of employers each year. Direct care workers are classified under three categories: home health aides; nursing aides, orderlies and attendants; and personal and home care aides.

Table 6 shows median wages from 1996-2001 for direct care workers in Maine. The percent change, inflation adjusted, over this time period reveals that the wages in these low-wage occupations remained relatively flat during this period, despite the economic boom and the tightening labor market. Nursing Aides alone showed modest increases. Studies have shown that the prosperity of the late 1990s did indeed favor upper income earners in most states, including Maine.⁸³ The fact that direct care workers' wages remained flat and/or did not increase faster than other comparable occupations has exacerbated the worker shortage.

Table 6: Median Hourly Wages of Direct Care Workers in Maine 1996-2001

Occupation	Estimated Median Wage		% Change in Real Median Hourly Wage 1996-2001 (inflation adjusted)
	1996	2001	
Direct Care Jobs			
Home Health Aides	7.69	8.43	-3.0%
Nursing Aides, Orderlies, & Attendants	7.29	9.35	13.5%
Personal & Home Care Aides	7.06	8.28	3.8%

Source: Occupational Employment Statistics Program, Maine Department of Labor

Compared to the \$8.69 average hourly wage of all direct care workers in 2001, many positions available to these workers offer far safer, less physically and emotionally demanding, and potentially more stable work at similar or higher pay. Such occupations with their median wages include: retail salesperson (\$8.41), short order cooks (\$8.65), recreation workers (\$9.23); counter and rental clerks (\$8.89); switchboard operators (\$9.82); tellers (\$8.98), receptionists (\$9.43), data entry keyers (\$9.47), electronic equipment assemblers (\$9.68), and file clerks

(\$8.49). Given the very difficult nature of the direct care job, at even comparable wages, other positions remain more attractive.

There are regional variations in wage levels for direct care workers, with median wages tending to be higher in the southern part of the state, and lower in the western, northern and northeastern counties (see Table 7). Labor market pressures have been highest in the southern part of the state, explaining, in part, the higher wages there. Industry officials also note that wages in southern Maine have gone up more because there are a greater proportion of private pay settings there and these agencies are setting a higher competitive wage rate.

Table 7: Median Hourly Wages for Direct Care Workers by Region, 2001

Occupation	Bangor MSA	Lewiston Auburn MSA	Portland MSA	Portsmouth MSA	Northeast Balance	Southwest Balance
Home Health Aides	8.73	9.31	N/A*	9.93	8.32	9.08
Nursing Aides, Orderlies, & Attendants	9.54	9.73	10.18	10.35	8.59	9.12
Personal & Home Care Aides	8.12	8.75	8.69	7.35	7.49	8.36

Source: Occupational Employment Statistics Program, Maine Department of Labor

*N/A indicates data is confidential because only one major employer in the area responded to the survey.

The rebasing of Medicaid reimbursement rates for nursing facilities in 2000 appears to have increased direct care workers' wages. This can be inferred by comparing the General Fund appropriations for nursing facilities in the late 1990s to the rate of wage increase. After appropriation reductions of 29% (inflation adjusted) from 1996 to 1999, there was a 17% increase (inflation adjusted) in nursing facility appropriations from 1999-2000, and another 2% increase (inflation adjusted) from 2000-2001.⁸⁴ From 1999-2001, nursing aides' wages, most of whom work in nursing facilities, increased 7.2%, as compared to the 3.7% increase that occurred from 1996-1998. Since labor accounts for approximately 70% of all operating costs in Maine's long term care facilities, and these facilities are acutely aware of the direct care worker shortage and the need to compete for wages, it makes sense that an increase in their overall funding would

be channeled in part to direct care workers' wages. Administrative data sources also indicate that the median wage for nursing aides in nursing facilities overall is higher than the DOL median for nursing aides.⁸⁵

A 2001 wage study of private duty direct care staff by the Home Care Alliance of Maine indicated that wages for home care workers were actually lower than the DOL data indicated.⁸⁶ This survey also indicated that, at best, less than a tenth (8.5%) of all private duty personnel receive insurance benefits, and only about 5% of private duty staff receive paid time-off.

The wages of direct care workers under the Department of Behavioral and Developmental Services that work with both adults and children with mental retardation and mental illness have been higher on average due to two significant legislative initiatives. In the 1980s, the wages of workers in Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) were tied in rulemaking to the wages of state workers doing similar work (such as Pineland, a state-run facility, now closed). The state system had a career ladder for several steps of workers based on training and experience and this allowed for a career ladder structure for the ICF/MR workers as well.⁸⁷ In 2000, the Legislature appropriated adequate new funding to BDS that allowed for the creation of a wage floor of \$8.15 for all direct support workers working with their clients. Wages for direct care workers in other long-term care settings do not have such a wage floor. Data for 2001 show that wages at the 25th percentile (meaning that 25% of the reported wages were less than this amount) were \$7.60 for home health aides, \$8.14 for nursing aides, and \$7.28 for personal and home health aides, indicating that there are many workers in long-term care settings that are starting out much lower than \$8.15.

Industry officials have noted that direct care workers are often in and out of direct care, doing other self-employment including private direct care as a personal care attendant.⁸⁸ There is an industry of private hires that charge about \$20/hour for workers in private homes, with workers getting about \$12/hour off the books as private contractors. These workers would need to provide for their own social security and taxes as well as health insurance – unlikely even at that wage.

Most of these workers are barely above the federal poverty level, let alone making a livable wage (see Table 8). In 2001, the estimated statewide livable wage in Maine for a family

of two was \$12.86.⁸⁹ In contrast, the statewide average median hourly wage across categories of direct care workers in 2001 at \$8.69 was two-thirds (68%) of a livable wage and about three-quarters (73%) of the overall state median wage of \$11.89. Clearly, these workers are not able to make ends meet on these wages.

Table 8: Comparison of Direct Care Workers' Average Annual Income to the Federal Poverty Level and a Livable Wage Estimate for Maine, 2001

Occupation and Mean Annual Income	Federal Poverty Level Family of 2 (\$11,610)	Federal Poverty Level Family of 3 (\$14,630)	Maine Livable Wage Annual Estimate Family of 2 (\$26,739)	Maine Livable Wage Annual Estimate Family of 3 (\$29,018)
Nursing Aides \$19,480/yr \$9.37/hr	168%	133%	73%	67%
Home Health Aides \$18,590/yr \$8.94/hr	160%	127%	70%	64%
Personal Care Attendants \$17,480/yr \$8.40/hr	151%	120%	65%	60%

Source: Maine Department of Labor, U.S. Health and Human Services, Maine Center for Economic Policy

Such low income often requires these workers to rely on second jobs and/or on public assistance. In fact, the long-term care industry has traditionally relied on the hidden public subsidies of TANF, food stamps, and Medicaid, paid for by public tax dollars, in order to maintain its direct care workforce. While this was never a good strategy to reward a hardworking group of workers providing an essential service to the state, the strategy is now no longer working. If we are to keep the long-term care system afloat and ensure quality care for our family members and ourselves, it is time to develop new strategies at the state and provider level.

VII. State Initiatives to Address Recruitment and Retention

State Government Initiatives

Across the country, states are grappling with the direct care worker shortage. Many have undertaken legislative or administrative initiatives to deal with the problem. These include collaboration among state agencies and other organizations; Department of Labor efforts such as worker training and retraining, organizing job fairs, conducting surveys, and convening stakeholder panels; coordination with state welfare-to-work agencies focused on training, education and job support; support for statewide caregiver associations; evaluation of direct care initiatives; and uniform collection of turnover data and the cost of turnover.⁹⁰

A national survey conducted in 1999 indicated that 42 of 48 states responding were experiencing recruitment and retention problems among their paraprofessional health care workforce.⁹¹ At that time, 33 states were considering or taking actions to address the issue. Maine is definitely among them.

Maine's long-term care administrative officials have been targeting workforce issues for some time. Maine's Long-Term Care Progress Report in Maine in January 2000 to the Joint Standing Committee on Health and Human Services made several recommendations related to the worker shortage. The report recommended appropriation of sufficient funding to provide services for persons on the waiting lists for home care (then about 1,000 and currently around 200), Alzheimer's respite care, homemaker services, and adult day services. DHS was encouraged to propose rule changes and other actions that would "promote the expeditious expansion and career development of the long-term care workforce," and to conduct best practices forums for providers of long-term care.

Maine's State Plan on Aging from 2000-2004 focused attention on the home care workforce, calling for the state to: "Advocate for system changes that will promote a qualified, stable home care workforce. Work with providers and Legislature to address the workforce issues regarding wages and benefits, dignity and respect for the job, and development of career ladders and opportunities for advancement."⁹² The Maine Long-term Care Implementation

Committee recently cited the direct care worker shortage as one of the top six issues to address in Maine’s long-term care system.⁹³

Sixteen states, including Maine, have modestly increased direct care wages and benefits. Some have used a wage “pass through” mechanism that requires provider agencies to direct all or a stated portion of reimbursements to direct care wages and/or benefits. A follow-up survey showed that a third of the 12 states responding that had implemented wage pass throughs reported that it had a positive impact on recruitment, retention and/or had some positive impact.⁹⁴ Recent legislative financing initiatives in Maine related to recruitment and retention of direct care workers are outlined in Table 9.

Table 9: Recent History of Legislative Financing Initiatives in Long-Term Care Related to Direct Care Compensation

Legislative Session Year	Effective Fiscal Year	Initiative	Outcome
1999	FY01	\$.50/hour wage & benefits increase for direct care staff in home care	Passed
1999	FY01	Supplemental payment to nursing homes for recruitment and retention, apportioned by principles of reimbursement	Passed
2000	FY01	Rebased nursing home reimbursement rates; increase not specifically for wages	Passed
2001	FY02-03	3% annual reimbursement increase to nursing homes to raise the average hourly wage and benefits for direct care workers; 2.5% annual reimbursement increase to home care to raise average hourly wages and benefits of direct care workers	Passed
2002	FY02-03	Raise home care reimbursement rates to raise hourly wage and benefits by \$1/hour	Not passed
2002	FY02-03	Raise nursing home reimbursement rates to recognize actually labor inflation – 8% vs. current 3%	Not passed

Additionally, in 2000, as noted in the previous wage analysis, the Legislature appropriated adequate new funding to the Department of Behavioral and Developmental Services that allowed for the creation of a wage floor of \$8.15 for direct support workers that work with their clients.

In 2001, the Maine Legislature gave an annual reimbursement increase, or COLA, of 3% to nursing homes and 2.5% to home care to raise the average hourly wage and benefits for direct care workers. The legislation defined direct care workers as all front-line employees who work in the facility, except the administrator and contract labor. To determine compliance, average wages and benefits from the year prior to enactment are to be compared to average wages and benefits post-enactment.⁹⁵ The legislation does not require providers to give every direct care worker a raise, but rather increase average wages and benefits. In fact, the increase could be taken up by the dramatic rise in health care costs over the last several years.

In the fall 2002, the 120th Legislature passed a supplemental budget that included most of the Governor's recommendations to address the budget shortfall and achieve \$230 million in savings for the current fiscal year. Among them was a 6% nursing home assessment on net operating revenue, or a so-called "tax and match" program. The fee will generate approximately \$22 million to the General Fund, of which \$9.5 million will stay in the General Fund for deficit reduction. The remaining portion of the fee can be matched with federal Medicaid funds to repay nursing homes for the assessment on the MaineCare supported proportion of their revenues and also increase their payments, for a net gain of \$31.5 million.⁹⁶ From this new source of revenue, home care and residential programs will also receive a net increase of approximately \$6.3 million collectively. This will amount to a 5% increase in the hourly rate for home care. Funds for residential care programs will be used to offset increases in liability insurance and other operating costs. Although the rate increases are intended to assist providers to recruit and retain staff, these increases are not specifically targeted to direct care workers' wages.

Maine has also made other investments in this workforce. As noted above, Maine increased the number of training hours required for direct care workers well above the federal requirements. In addition, over the past two years the Maine Bureau of Elder and Adult Services set aside \$47,000 to subsidize PCA training with which it assisted 34 agencies. Also, in 2001 the Bureau spent \$250,000 making one time grants to home care agencies for recruitment and retention of direct care workers. The Board of Nursing is now allowing CNAs to administer

medications in home settings, allowing more flexible use of the existing workforce. There has been development of a common curriculum for PCAs and Residential Care Specialists that will allow these workers more career options. The Bureau has also been working with home care agencies in southern Maine to develop an on-line PCA curriculum to help improve access to the training. There has also been an extension of time allowed for completion of training from three to six months, which gives more flexibility to providers and workers.

The most comprehensive initiative in the U.S. recently occurred in Massachusetts which passed a \$42 million Nursing Home Quality Initiative that includes a \$32 million wage pass-through for CNAs, \$5 million for CNA career ladder grants, \$1 million for a scholarship program for certification of new CNAs, and \$1 million in training and basic education for prospective CNAs. Other examples in New England include Connecticut, which passed legislation in 1999 calling for \$200 million over two years for CNA wages and staffing;⁹⁷ and New York which passed in 2000 the Health Care Reform Act that included health care benefits for home care employees.

Private Initiatives in Maine

Many other important efforts to address the direct care worker shortage have been undertaken in Maine by stakeholder groups, individual providers, and workers. The following examples are meant to be illustrative and by no means inclusive of all the good work being done on this issue.

- A multi-stakeholder Direct Care Worker Coalition, including providers, consumers, and labor began meeting in 2002 to study and initiate policy changes to improve wages and working conditions for direct care workers.
- Coastal Enterprises, Inc. with funding from the U.S. Department of Labor, has awarded demonstration and technical assistance grants to long-term care facilities in Kennebec and Somerset counties to improve direct care worker retention through career path development and workplace culture change.

- The Muskie School of Public Service's Health Policy Institute at the University of Southern Maine has been funded through the Centers for Medicaid and Medicare Services to develop the Maine Personal Assistance Services Association, which had its first meeting in October 2002. Modeled on several worker associations around the U.S., it is intended to involve workers and recognize and advocate for their professional status and support needs.
- Home Resources of Maine maintains a revolving loan fund for up to \$250 to help direct care workers with short-term emergency cash assistance. They also match retirement contributions dollar for dollar up to 3% of the worker's wage.
- The Sarah Fyre Home in Auburn is now offering 100% individual health insurance coverage to all of its staff working over 20 hours per week. Workers commit to the schedule for which they were hired and are responsible for any replacement they may need. In 2001, before the changes, there were 24 new staff members in and out of this agency, with a total staff of 28. In 2002, there were only 6 new staff members. The agency also saved \$25,000 in turnover related costs.
- Sandy River Health System has permitted CNAs to acquire additional training that comes with additional responsibilities and remuneration. They can become an orientation assistant, or mentor, for which they are paid an additional hourly rate even when they are not currently acting as a mentor. They can participate in train-the-trainer programs along with nurses to become peer trainers in areas such as safety management, end of life care, and restorative nursing for which they receive a stipend per training offered. They also recently increased their tuition reimbursement to 75%.

These few examples indicate that many opportunities exist for improving the situation for workers, consumers, and providers by sharing experiences, best practices, and policy ideas in Maine. Additionally, Maine can learn from many groups around the country that are working on this issue.⁹⁸

VIII. Recommendations

To truly address the direct care worker shortage will require a new understanding and appreciation of the work, and new investments in the workers. Maine officials, policymakers, providers, labor representatives and consumer advocates have all taken important steps but more must be done. The following recommendations will help ensure the quality of care and health and safety of long term care consumers through a coordinated long-term care system with well-trained and adequate staffing in all settings.

Coordinate State Efforts to Address the Worker Shortage

Create a Direct Care Workforce Committee with representatives from all relevant state departments; all types of provider agencies; workers; and consumers to help establish the worker shortage as a priority policy issue and monitor the care gap and contributing factors. The Committee will work to:

- ▶ Ensure a comprehensive examination of the direct care, direct support, and personal assistance workforce including workers in consumer-directed models of service:
 - Estimate current and projected long-term care consumption and workforce needs.
 - Collect data on the wage, benefit, and reimbursement structures in each sector of the industry: nursing facilities, residential care, home care.
 - Conduct regular surveys of this workforce to determine its status and needs. In particular, identify how many workers are without health insurance for themselves and/or family members.
 - Establish benchmarks for evaluating employer performance in the areas of turnover; absenteeism; injury rates; wages and benefits; health insurance provided; on-site education and opportunities for wage progression; workloads; current and projected direct care vacancies; and the percentage of overall expenditures on staffing.

- ▶ Coordinate state health, labor, welfare, education and economic development policies as they relate to this workforce:
 - Assess total current public funding flowing to this workforce – including from public assistance programs – in order to rationalize the use of public funds for best effects.
 - Coordinate labor market data collection and analysis across state departments.
 - Coordinate training resources.
 - Coordinate programs to match, train and support transitional and displaced workers for direct care jobs.
 - Implement policies that support employers’ efforts to recruit, train and retain workers.
 - Implement policies to reduce injury rates to protect worker health and stability on the job and to lower providers’ workers compensation costs.

Provide Livable Wages and Benefits for Direct Care Workers

- ▶ Establish a livable wage and benefit scale for this workforce. Increase public funding to allow employers to raise wages on this scale in a stepped up fashion over a ten-year period and then adjust annually.
- ▶ Create wage and benefit parity across the various direct care occupations and settings.
- ▶ Extend Medicaid or other health insurance coverage to all uninsured direct care workers and their families.
- ▶ Support the development of provider consortia to create full employment positions across participating employers in regional areas.
- ▶ Provide workers with child care assistance and adequate transportation reimbursements.
- ▶ Establish employer work support programs to offer employees revolving loan funds, tuition assistance, individual development accounts, and earned time that supports continuing education.

Invest in Training for Direct Care Workers and Their Managers

- ▶ Develop management training that includes communication, coaching, conflict management, rewards and recognition strategies, and team building.
- ▶ Design a coordinated system of learner-centered training based on researched training standards and best practices. Develop a cross training system between direct care occupations and a credentialing system that can be applied to advanced education. Training should include hands-on practice as well as problem solving and communication skills.
- ▶ Implement peer mentoring as part of ongoing orientation and training and financially reward peer mentors.

Develop Career Pathways and Promote Workplace Culture Changes

- ▶ Provide funding for demonstration grants for employers and consortia to establish good management practices and workplace culture changes.
- ▶ Promote quality improvement management structures that promote teamwork, coaching, recognition, evaluation, and respect.
- ▶ Implement career steps for workers with a reimbursement restructure that rewards longevity and increased skill development.
- ▶ Annually award and showcase models of successful long-term care work environments in Maine.

Enhance the Public Image of the Caregiving Profession

- ▶ Designate a Maine Personal Assistance Day to give recognition to exemplary workers across the state.
- ▶ Publicize the existence of career pathways to improve the reputation of direct care jobs.
- ▶ Fund public relations campaigns and other initiatives to market health care career opportunities to students, displaced workers and other individuals considering career changes.

Support Worker Organizations

- ▶ Provide funding for the activities of a professional association of workers to promote a network of information, support, and advocacy.
- ▶ Ensure that efforts at collective bargaining are fully supported according to federal law.

Conclusion

It is time for Maine to come to grips with the direct care worker shortage. We must change our assumptions and strategies and create jobs that will attract workers before the crisis grows even more severe. Maine's vulnerable citizens, and Maine's current and potential caregivers, deserve our full commitment.

I know this is what I want to do
and this is where I want to be.

Maine worker at association
meeting

Endnotes

¹ Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care.

² Nationally, turnover rates have been reported at 40-60% with the home health industry, and between 70-100% within the nursing home industry. Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care. New York. p. 1.

³ American Health Care Association. Employment Survey 2001, cited in Maine Health Care Association. 2002. Long Term Care in Crisis.

⁴ Maine Hospital Association. Maine's Long Term Care Workforce: A Special Report Examining the Implications of a Growing Labor Shortage on Access to Long Term Care. October 2001.

⁵ The Shortage of CNAs and PCAs in Maine: Short and Long Term Solutions. A Report of the Labor Task Force Convened by the Maine Health Care Association. February 1999. p. 1.

⁶ Larson, Sheryl A. K., Charlie Lakin, and Robert H. Bruinlinks. 1998. Staff Recruitment and Retention: Study Results and Intervention Strategies. Washington, DC: American Association on Mental Retardation, as cited in Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care. p. 20.

⁷ Maine Hospital Association. Maine's Long Term Care Workforce: A Special Report Examining the Implications of a Growing Labor Shortage on Access to Long Term Care. October 2001.

⁸ Assisted Home Care II in Lewiston as of November 2002 charged the following hourly rates: CNAs \$22 and weekend/holiday \$25; PCAs: \$20 and weekend/holiday \$23.00.

⁹ A national study of nearly 500 nursing home residents indicated that staff quality was the most important factor in achieving good care: well-trained, efficient staff with positive attitudes. Paraprofessionals on the Front Lines: Improving Their Jobs – Improving the Quality of Long-Term Care. Paraprofessional Healthcare Institute. 1998. See also Consumer Perspective on Quality Care: The Residents' Point of View. 1985. Washington, DC: National Citizens' Coalition for Nursing Home Reform.

¹⁰ Maine Hospital Association. Maine's Long Term Care Workforce: A Special Report Examining the Implications of a Growing Labor Shortage on Access to Long Term Care. October 2001.

¹¹ Private Duty Staff Compensation Survey. Home Care Alliance of Maine. January 2001.

¹² Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides is a Growing Concern. Testimony of William S. Scanlon, Director, Health Care Issues before the Committee on Health, Education, Labor, and Pensions, U.S. Senate. May 17, 2001. GAO-01-750T. p. 14.

¹³ Maine Department of Human Services. Bureau of Elder and Adult Services. Long-Term Care Assessment and Home Care Services. Consumer Satisfaction Surveys. November 2002. pp. 12-15.

¹⁴ Ibid., pp. 12-15.

¹⁵ Bowlby, J. Shortage becoming critical. Wyoming Tribune-Eagle. April 30, 2001; and Cohen-Mansfield, J. 1997. Turnover Among Nursing Home Staff. Nursing Management. Vol 25:5 59-64 as cited in Report of Garry L. KcKee, Director, Wyoming Department of Health, to the Joint Appropriations Committee on Study of Nonprofessional Direct Care Staff Recruitment, Retention and Wages. December 2001.

¹⁶ The Massachusetts Health Policy Forum. 2000. Health Care Workforce Issues in Massachusetts. Issue Brief No. 9. p. 1.

¹⁷ “Acuity” is a term used in health care to quantify the patient’s level of illness and intensity of need. This national rating further indicates the shift away from living in nursing homes in Maine for those who are able, while the percentage of patients with acute needs now in nursing homes is much higher than the national average.

¹⁸ Maine Department of Human Services. Bureau of Elder and Adult Services. www.state.me.us/dhs/beas

¹⁹ Paraprofessional Healthcare Initiative and New Hampshire Community Loan Fund. New Hampshire’s Care Gap: The Healthcare Workforce Shortage. February 2, 2001. p. 6.

²⁰ Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care. p. 2.

²¹ The MaineCare average cost per day for nursing home care currently is \$132 per day according to the Bureau of Elder and Adult Services.

²² Assets include cash and cash equivalents. An automobile is excluded from assets.

²³ American Health Care Association. 2000. Facts and Trends: The Nursing Facility Sourcebook. Washington, D.C.

²⁴ The Medicaid Home and Community-Based Care Waiver for the Elderly and Chronically Ill (HCBC-ECI).

²⁵ Maine Department of Human Services. Bureau of Elder and Adult Services.

²⁶ Interview with Christine Gianopoulos, Director, Bureau of Elder and Adult Services.

²⁷ Maine Department of Human Services. Maine Bureau of Elder and Adult Services.
<http://www.state.me.us/dhs/beas>

²⁸ State of Maine. State and Medicaid Long-Term Care Expenditures. Department of Human Services. Prepared 2002. Number of consumers is not unduplicated. See Appendix C. as reported in State of Maine 120th Legislature. Office of Policy and Legal Analysis. Interim Report of the Blue Ribbon Commission to Address the Financing of Long-term Care. November 6, 2002. p. 2.

²⁹ The federal match for MaineCare is approximately 2:1. To arrive at the percentages, the MaineCare expenditure was divided by one-third for the state MaineCare portion (which was added to the state-only spending) and two-thirds for the federal Medicaid match (which was added to the Medicare spending).

³⁰ Midrange value of informal caregiving excerpted from Arno, Peter S. and Margaret Mennott. Economic Value of Informal Caregiving in United States by State: Methodological Approach and Findings, prepared for the National Alzheimer's Association, March 1999. To determine caregiving prevalence, national data sets were used, including the Survey on Income and Program Participation (SIPP) and the National Survey of Families and Households (NSFH). Based on definitions of caregivers in these two surveys, a ratio of caregivers to the population is derived and a midrange is determined. The estimated caregiving hours per week – 17.9 – are derived from the National Family Caregiving Survey. The replacement wage rate for unpaid family caregiving is derived from the midpoint between the minimum wage and the average rates for home health aides.

³¹ The 2000 Census showed 183,402 persons age 65+ in Maine -- 14.4% of total Maine population.
<http://www.census.gov/population/projections/state/stpjage.txt>. Of those people age 65+ in Maine, 55,483 are living alone. Using data from the 2000 Census and the 1997 Survey of Income and Program Participation, it is estimated that there are 99,954 Mainers 65+ with a disability; 69,143 of those have a severe disability, and 30,628 need assistance. http://www.state.me.us/dhs/beas/data_faq.htm

³² U.S. Bureau of the Census. Population Projections for States.
<http://www.census.gov/population/projections/state/9525rank/meprsrel.txt>

³³ Maine Hospital Association. Maine's Long Term Care Workforce: A Special Report Examining the Implications of a Growing Labor Shortage on Access to Long Term Care. October 2001.

³⁴ Massachusetts Health Policy Forum. 2000. Health Care Workforce Issues in Massachusetts. Issue Brief No. 9. p. 6.

³⁵ Maine Department of Labor. Labor Market Information Services. Hot Jobs in Maine. Projected Job Opportunities in Maine, 1998-2008. <http://www.state.me.us/labor/lmis/pdf/hotjobs00.pdf>

³⁶ Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care. p. 3.

³⁷ Ibid., p. 7.

³⁸ Maine Department of Human Services. MaineCare Benefits Manual. Principles of Medicaid Reimbursement to Nursing Facilities. Chapter 101. Ch. III Section 67. <http://www.state.me.us/sos/cec/rcn/apa/10/ch101.htm>

³⁹ The direct care cost component includes salaries, wages and fringe benefits for registered nurses, licensed practical nurses, nurses aides, patient activities personnel, and ward clerks, as well as contractual labor costs. Also included are medical supplies and medicine. Routine costs include salaries and benefits for personnel in management, dietary, housekeeping, and maintenance as well as all associated costs such as training. Fixed costs include the capital costs of buying and maintaining the facilities.

⁴⁰ Medicaid payments to nursing facilities in the aggregate may not exceed the upper limits of Medicare payments.

⁴¹ Maine Hospital Association. Maine's Long Term Care Workforce: A Special Report Examining the Implications of a Growing Labor Shortage on Access to Long Term Care. October 2001.

⁴² State of Maine 120th Legislature. Office of Policy and Legal Analysis. Interim Report of the Blue Ribbon Commission to Address the Financing of Long-term Care. November 6, 2002. p. 3.

⁴³ Testimony of Kenneth W. Bowden, President of the Board, Maine Health Care Association to the Joint Committee on Appropriations and Financial Services. October 7, 2002.

⁴⁴ Maine Health Care Association. 2002. Long-Term Care in Crisis.

⁴⁵ Robert Chick, Executive Director for the Sarah Frye Home notes that his agency's fire and professional liability insurance costs have risen from \$9,000-\$30,000 in the three year period from 2001-2003.

⁴⁶ Maine Department of Labor. Seasonally-Adjusted Civilian Labor Force Estimates. <http://www.state.me.us/labor/lmis/data/laus/salf.html>

⁴⁷ Paraprofessional Healthcare Institute and the North Carolina Department of Health and Human Services. Results of the 2002 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce. June 2002. p. 5.

⁴⁸ Wiener, Joshua, Laurel Hixon Illston, and Raymond Hanley. 1994. *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance*. Washington, D.C.: The Brookings Institution, cited in Wiener, Joshua M. and David G. Stevenson. *Long Term Care for the Elderly and State Health Policy*. <http://newfederalism.urban.org/html/anf17.html>.

⁴⁹ This description of a typical day for CNAs is derived from Dresser, Laura; Dori Lange; and Alison Sirkus. *Improving Retention of Frontline Caregivers in Dane County*. Madison: Center on Wisconsin Strategy. March 1999. p. 5-6.

⁵⁰ The minimum staffing ratios established by the Maine DHS are one direct care staff person on the day shift to every 5 residents; one direct care staff person on the evening shift to every 10 residents; and one direct care staff person on the night shift for every 15 residents.

⁵¹ Calculated from data collected by Center for Statistics Nursing Home Survey, 1996, as cited in Dresser, Laura, Dori Lange, and Alison Sirkus. *Improving Retention of Frontline Caregivers in Dane County*. Madison: Center on Wisconsin Strategy. March 1999.

⁵² *The Shortage of CNAs and PCAs in Maine: Short and Long Term Solutions*. A Report of the Labor Task Force convened by the Maine Health Care Association. February 1999. p. 6.

⁵³ A 2002 national survey of direct care workers indicated that women represent approximately 90% of the workers; that more than 20% of long-term care workers did not have a high school education; and one quarter of home health aides and nearly one-third of all nursing home workers are single mothers, compared to the entire U.S. workforce in which only 11% are single parents. Paraprofessional Healthcare Institute and the North Carolina Department of Health and Human Services. *Results of the 2002 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce*. June 2002.

⁵⁴ *The Shortage of CNAs and PCAs in Maine: Short and Long Term Solutions*. A Report of the Labor Task Force convened by the Maine Health Care Association. February 1999. p. 6.

⁵⁵ The federal poverty level in 2001 for a family of three was \$14,630. Maine children are eligible for MaineCare if their family income is less than 200% of the federal poverty level (\$29,260 for a family of three); and their parents are eligible for MaineCare if their family income is less than 150% of the federal poverty level (\$21,945 for a family of three). Families qualify for heating assistance in Maine (LIHEAP) if their income is less than 150% of the federal poverty level. The National gross income eligibility test for food stamps is set at 130% of the federal poverty level (\$19,019 for a family of three). Families qualify for WIC (a program providing nutritional supplements for pregnant women, infants and children) if their income is 180% of the federal poverty level.

⁵⁶ More than 13% of all nursing home aides and nearly 15% of all home health care aides receive food stamps, compared to 5.5% of all workers in the U.S. Nearly 10% of all nursing home aides and more than 11% of all home health care aides rely on Medicaid to provide health insurance as compared to 3.9% of all workers in the U.S. GAO Testimony by William Scanlon, Director, Health Care Issues. Long Term Care-Baby Boom Generation Increases Challenge of Financing Needed Services. March 27, 2001, p. 23 as cited in AFSCME. 2001. *Cheating Dignity: The Direct Care Wage Crisis in America*. Washington, DC. p. 18.

⁵⁷ In a 2001 TANF Parents Survey of parents who had been on TANF in early 1997 conducted by the Maine Center for Economic Policy, there were 37 parents who were currently working in direct care as CNAs, PCAs, or CRMAs. Of these, only 14 (38%) had jobs that offered them health insurance and only nine of them were participating in that plan. Eighteen of 36 responding (50%) received MaineCare for themselves.

⁵⁸ *In Their Own Words: Pennsylvania's Frontline Workers in Long Term Care*. A Report to the Pennsylvania Intra-Governmental Council on Long Term Care. February 2001.

⁵⁹ *Ibid.*, p. 4.

⁶⁰ *Ibid.*, p. 22.

⁶¹ *Ibid.*, p. 21.

⁶² *Ibid.*, p. 22.

⁶³ U.S. Department of Health and Human Services. Office of the Inspector General. Nurse Aide Training. November 2002. OEI-05-01-00030.

⁶⁴ *Ibid.*, pp. 15-16.

⁶⁵ Four focus groups totaling 38 current and former paraprofessional health care workers across New Hampshire, conducted by the New Hampshire Community Loan Fund. Concord. MNE. January and February 2000, as cited in Paraprofessional Healthcare Institute. 2000. *Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care*. p. 6.

⁶⁶ Dresser, Laura, Dori Lange, and Alison Sirkus. *Improving Retention of Frontline Caregivers in Dane County*. Madison: Center on Wisconsin Strategy. March 1999. p. 23.

⁶⁷ *In Their Own Words*, op. cit. p. 25.

⁶⁸ Ibid., p. 23.

⁶⁹ Ibid., p. 24.

⁷⁰ Maine Department of Labor. Bureau of Labor Standards. Occupational Injuries and Illnesses in Maine, 2000. Calculated as 1,197 injuries per 17,280 direct care workers = 6.9 incidences per 100 workers, and 17,283 Workers' Compensation injuries and illnesses in 2000 and an estimated 582,870 state, local and private workers in Maine for 3.0 incidences per hundred workers.

⁷¹ As an example of the impact of training, the logging industry had a Lost Workday case rate of 13.0 in the early 1990s so the Certified Logging Professional (CLP) training program was introduced and was so successful that insurers began providing premium incentives to employers who hired workers that went through that training. John Rioux, Maine Bureau of Labor Standards.

⁷² In Their Own Words, op. cit. p. 16.

⁷³ Ibid., p. 20.

⁷⁴ Looman, W. J. et al. Nursing Assistance Caring for Dementia Residents in Nursing Homes: The Family's Perspective on the High Quality of Care. American Journal of Alzheimer's Disease. Sept./Oct.: 221-6 and 1997 Shur, D. et al. 1998. Four Steps to More Committed Nursing Assistant. Balance 2(1): 29-32, as cited in Noelker, Linda S. 2001. The Backbone of the Long-Term Care Workforce. Generations. 25:1, p. 85.

⁷⁵ Paraprofessional Healthcare Institute. 2000. Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care.

⁷⁶ Data from Maine AFL-CIO. Acronyms: American Federation of Teachers (AFT); International Association of Machinists (IAM); Maine Employees Association/Service Employees International Union (MSEA/SEIU); American Federation of State, County and Municipal Employees (AFSCME).

⁷⁷ Dresser, Laura; Dori Lange; and Alison Sirkus. Improving Retention of Frontline Caregivers in Dane County. Madison: Center on Wisconsin Strategy. March 1999. p. 10.

⁷⁸ In Their Own Words, op. cit. p. 18.

⁷⁹ Information as of 1/3/03 from CNA registry within the DHS Bureau of Medical Services, Licensing and Certification.

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- ⁸⁰ The Shortage of CNAs and PCAs in Maine: Short and Long Term Solutions. A Report of the Labor Task Force convened by the Maine Health Care Association. February 1999. p. 8.
- ⁸¹ Report of Garry L. KcKee, Director, Wyoming Department of Health to the Joint Appropriations Committee on Study of Nonprofessional Direct Care Staff Recruitment, Retention and Wages. December 2001.
- ⁸² In Their Own Words. op. cit. p 5-6.
- ⁸³ St. John, Christopher. State of Working Maine 2002. Maine Center for Economic Policy. Choices 8:7.
- ⁸⁴ Maine Center for Economic Policy analysis of Maine State General Fund Appropriations, prepared by the Office of Fiscal and Program Review, updated 10/16/01.
- ⁸⁵ Staffing data from Bureau of Elder and Adult Services. A calculation of CNA hourly wages for fiscal years ending in 2000 showed a range of hourly wages in 122 nursing facilities of \$7.47-\$13.06 with a median of \$9.66 and a mean of \$9.71.
- ⁸⁶ Home Care Alliance of Maine. Private Duty Staff Compensation Survey. January 2001. The survey showed the mean average wage for CNAs was \$8.73 for Home Health Aides; \$7.76 for PCAs; and \$7.24 for Homemakers.
- ⁸⁷ Interview with Charlene Kinnelly, Executive Director, Uplift, Inc.
- ⁸⁸ A person can bill themselves as a PCA in private hire but not a CNA because CNAs work specifically under the direction of a Registered Nurse.
- ⁸⁹ Unpublished data from the Maine Center for Economic Policy, using basic needs budgets as a basis for estimating livable wages.
- ⁹⁰ Results of the 2002 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce. Paraprofessional Healthcare Institute and the North Carolina Department of Health and Human Services Office of Long Term Care. June 2002.
- ⁹¹ North Carolina Division of Facility Services. 1999. Comparing State Efforts to Address the Recruitment and Retention of Nurse Aides and Other Paraprofessional Aide Workers.
- ⁹² Bureau of Elder and Adult Services. State Plan on Aging. October 1, 2000- September 30, 2004. p. 25.
- ⁹³ Report of the Long-Term Care Implementation Committee. Submitted to the Joint Standing Committee for Health and Human Services. December 31, 2002. p. 3.

⁹⁴ The Center for Health Workforce Studies. School of Public Health. University of Albany. Long Term Care Workforce Shortages: A Conceptual Framework for Exploring Potential Solutions. September 2000, as cited in Rhode Island Long Term Care Coordinating Council. Crisis in Care: A Report of the CNA Study Group. March 2001.

⁹⁵ In order to determine compliance with the legislative intent, total wages and benefits for front line employees for fiscal years beginning on or after July 1, 2001 will be divided by total worked hours to determine the average wage and benefit rate per hour. This rate per hour will be compared to the prior year wage and benefit rate per hour to determine a percentage change in the rate per hour. Any nursing facility that does not demonstrate a minimum equal to the COLA increase in the combined wage and benefit rate per hour for front line employees, will have the COLA recouped at the time of audit.

⁹⁶ The federal government has enacted several restrictions to control the misapplication of federal Medicaid dollars, including the prohibition of “hold harmless” provisions; thus, some nursing homes will inevitably lose money with this assessment because they do not have MaineCare patients.

⁹⁷ Rhode Island Long Term Care Coordinating Council. Crisis in Care: A Report of the CNA Study Group. March 2001.

⁹⁸ For an extensive collection of reports related to the direct care worker shortage, see the National Clearinghouse on the Direct Care Workforce, www.directcareclearinghouse.org.