Journal of Health Care Law and Policy

Volume 4 | Issue 2 Article 12

The Crisis in the Long-Term Care Workforce

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THE CRISIS IN THE LONG-TERM CARE WORKFORCE

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The concept of a "long-term care workforce" is of relatively recent origin. Throughout much of the history of the United States, only a small proportion of the population was old and infirm.[1] In such cases, dependent aged persons were almost always cared for by family members. Institutional care was virtually unknown, with the exception of almshouses for the truly isolated and destitute.[2] The professional provision of long-term care as we know it today began with the 1935 passage of the Social Security Act and solidified with the advent of Medicare and Medicaid in 1965.[3]

Since that time, the enormous growth in nursing homes, as well as in home care and community-based services, has produced a large number of individuals who care for older persons who are chronically ill and disabled. Unlike acute care, such individuals require care for months or years and are very unlikely to return to totally independent living. Although long-term care workers have become essential to society, developments over the past decade have made work in such settings increasingly challenging. There is now considerable concern, both at the public and at the personal level, about the supply and the caring capacity of long-term care workers.

I. NATIONAL CHALLENGES FACING THE LONG-TERM CARE WORKFORCE

At the beginning of the twenty-first century, recruitment and retention of a committed long-term care workforce has become a serious challenge, and one that is likely to persist for the next several decades. There are a number of reasons for increasing difficulties in this area.

First, the explosive growth in the elderly population has created an enormous need for long-term care workers. The population aged 65 and older will expand by 18 million persons over the next ten

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* The preparation of this paper was supported by the National Institute on Aging, through a Roybal Center on Applied Gerontology grant to the author (1 P50 AG11711-01).

1. *See* LAURA KATZ OLSON, *Long-Term Care in the United States, in* THE GRAYING WORLD: WHO WILL CARE FOR THE ELDERLY? 25 (Laura Katz Olson ed., 1994).

2. *See id.* at 31.

3. *See id.*

years, from 35.7 million to 53.9 million.[4] The number of elderly persons with functional disabilities will also increase in that time by 1.6 million, from 8.8 million to 10.4 million.[5] The growth in the latter group is particularly critical, because it constitutes the demand for long-term care. Much of the anticipated need for additional frontline workers is due to this increase.

Second, the long-term care population is becoming more disabled and complex to care for. The emphasis throughout the 1990s on transferring elderly people from acute to long-term care settings has had a major impact on nursing homes in particular. This trend toward earlier discharge means that more residents have acute illnesses from which they have not completely recovered at the time they are transferred to long-term care facilities.[6] One of the results of this trend is that nursing homes are now using more complicated technologies that were previously used only in hospitals.[7] The burden of care for this increasingly impaired population falls on long-term care workers.

Third, the labor force as a whole is growing at a slower rate than the elderly population that needs care. When one examines the pool of persons most likely to become long-term care workers, there are good reasons to expect a continuing shortfall in the caregiving workforce. Women are the dominant providers in health care, currently representing 78% of health care positions in the U. S. Most critical, 93% of paraprofessionals and 95% of nurses are women.[8] Therefore, a meaningful statistic is the relationship between the size of the elderly population (who are likely to need care), and the number of "traditional" caregivers – that is, working-age women. Nationally, this "caregiver ratio" shows a striking trend. In 2001, census data indicate that the caregiver ratio is 58 elderly persons to every 100 females aged 25-54.[9] In 2025, the ratio will be approximately one-to-one: slightly over 99 elderly persons to 100 females aged 25-54.[10] This is very likely to lead to increased shortages of long-term care workers.

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4. *See* CONGRESSIONAL BUDGET OFFICE, 106TH CONG., PROJECTIONS OF EXPENDITURES FOR LONG-TERM CARE SERVICES FOR THE ELDERLY 6 (1999).

5. *See id.*

6. *See generally* OLSON, *supra* note 1, at 26-28, 31-33.

7. *See id.*; *see also* CELIA S. GABREL, NATIONAL CENTER FOR HEALTH STATISTICS, AN OVERVIEW OF NURSING HOME FACILITIES: DATA FROM THE 1997 NATIONAL NURSING HOME SURVEY, ADVANCE DATA NUMBER 311, at 4 (2000).

8. *See* Symposium, *Health Care Workforce Issues in Massachusetts*, 7 THE MASS. HEALTH CARE POL'Y FORUM (2000).

9. *See* NATIONAL HOUSEHOLDS AND FAMILIES PROJECTIONS, U.S. BUREAU OF THE CENSUS, POPULATION DIVISION (2000).

10. *See id.*

Fourth, restrictive immigration policies reduce the labor pool. New immigrants are relied upon heavily in urban areas to fill frontline long-term care positions. However, employment-based legal immigration is largely limited to skilled workers; it is much more difficult for unskilled workers to obtain work permits.[11] Coupled with the shortage of younger workers, restricted immigration will result in a limited supply of new workers.

II. WHO IS THE LONG-TERM CARE WORKFORCE?

The major job categories in long-term care are as follows:

Certified Nursing Assistant (CNA): Certified nursing assistants work under the supervision of the nursing staff, and provide 60% or more of the direct care to residents.[12] CNAs assist residents with activities of daily living, such as eating, bathing, dressing, and transferring from bed to chair.[13] CNAs may provide skin care, take vital signs, answer residents' call lights, and are expected to monitor residents' well-being and report significant changes to nurses.[14]

Home Health Aides (HHA): Home health aides carry out a number of tasks that are similar to those done by CNAs, but do so in an impaired individual's home, under the supervision of a nurse.[15]

Personal Care Aides (PCA): PCAs are not certified, and provide patients with assistance in activities of daily living in their homes. Major tasks include feeding, dressing, and bathing.[16]

Licensed Practical (or Vocational) Nurses (LPN): Licensed Practical Nurses must be supervised by an RN, and primarily provide direct care after a training program of between 12-18 months.[17] LPNs often have some supervisory responsibility for CNAs in long-term care.[18]

Registered Nurses (RN): RNs can take several types of educational programs that may last different periods of time, but graduates take the same licensing examination.[19] Some RNs focus on direct care of

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11. *See* U.S. State Dep't, *Tips for U.S. Visas: Employment-Based Visas* (visited May 12, 2001) <http://travel.state.gov/visa;employ-based.html>.

12. *See* U.S. BUREAU OF LABOR STATISTICS, OCCUPATIONAL OUTLOOK HANDBOOK 344 (2000).

13. *See id.*

14. *See id.*

15. *See id.* at 352.

16. *See id.*

17. *See id.* at 227.

18. *See id.*

19. *See id.* at 211.

residents, but most have supervisory responsibilities in the long-term care setting.[20]

Because the major actor in the nursing home setting is the CNA, and because workforce problems center around this job category, this entry focuses most heavily on them.

III. CHARACTERISTICS OF THE LONG-TERM CARE WORKFORCE

The National Center for Health Statistics estimated that in 1998, approximately 1,434,000 full-time equivalent employees (FTEs) worked in nursing homes.[21] Of this number, around 950,000 FTEs were made up by nursing staff: registered nurses, licensed practical nurses, and certified nursing assistants.[22] CNAs make up nearly two-thirds of staff who provide nursing services, while RNs account for just 15 percent.[23] This is illustrated as well by the staff-to-bed ratio in nursing homes. CNAs have a staff-to-bed ration of 33.9, followed by LPNs (10.6) and RNs (7.8).[24] Thus, the world of nursing home care is heavily dominated by paraprofessionals. In home health care, there are approximately 368,000 home health aides.[25]

The need for additional paraprofessional workers in long-term care will increase dramatically over the coming decade. Among nursing assistants, a 23.8% increase is anticipated by 2008, and for home health aides, the growth is expected to be fully 74.5%.[26]

Work as a CNA or HHA at the entry level usually does not require a high school education. CNAs must undergo at least 75 hours of training (although individual states have increased this minimum).[27] The training program typically covers basics of geriatric care, such as nutrition, infection control, and body mechanics, as well as the techniques of personal care.[28] Within four months of employment, the

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20. *See id.*

21. *See* CELIA S. GABREL, NAT'L CENTER FOR HEALTH STATISTICS, AN OVERVIEW OF NURSING HOME FACILITIES: DATA FROM THE 1997 NATIONAL NURSING HOME SURVEY, ADVANCE DATA NUMBER 311, at 3 (2000).

22. *See id.*

23. *See id.*

24. *See id.*

25. *See* BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, CAREER GUIDE TO INDUSTRIES 2000-01, EDITION 189 (2000).

26. *See id.*

27. *See* BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, BULLETIN 2520, OCCUPATIONAL OUTLOOK HANDBOOK 2000-01 EDITION 334, 352 (2000). *See also* 42 CFR § 483.152(a)(1) (2000).

28. *See* BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, BULLETIN 2520, OCCUPATIONAL OUTLOOK HANDBOOK 2000-01, EDITION 334 (2000).

nursing assistant must pass a certification examination.[29] Training for home health aides varies from state to state. For those who work in agencies that receive Medicare funding, a competency test is mandated that covers various areas of resident care.[30] Federal law also suggests a 75-hour training program for HHAs.[31]

IV. MOTIVATION FOR LONG-TERM CARE WORK

Studies indicate that long-term care workers frequently derive important satisfaction from their jobs. For example, in a survey of approximately 600 nursing assistants, respondents were asked why they chose nursing home work.[32] They rated twelve possible reasons that have been found to be important to people in selecting jobs.[33] The most frequently chosen reasons were those that related to the intrinsic worth of the job, and the sense that it was socially valuable and personally fulfilling.[34] Three reasons were selected as important by the highest proportions of respondents: provides opportunity to help others (96%), makes respondent feel meaningful (93%), and the job is useful to society (84%).[35] In addition to these "other-centered" reasons, the next most frequent reasons for working as a CNA had to do with rewarding aspects of the job itself.[36] These are that it offers a lot of contact with others (81%), is an interesting job (73%), and that it gives the chance to do responsible tasks (72%).[37]

In addition, frontline jobs in the long-term care field do not require extensive education and training, and are typically available to young people, displaced homemakers, new immigrants, people transitioning from welfare, and other persons with limited work histories. The job offers more varied and meaningful work that many positions in the hospitality, construction, and manufacturing industries (which also compete for these employees). Further, especially in home care, the job offers a greater level of autonomy than other comparable professions.

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29. *See id.*
30. *See id.*
31. *See id.* at 352. *See also* 42 CFR § 483.152(a)(1) (2000).
32. *See* KARL PILLEMER, SOLVING THE FRONTLINE CRISIS IN LONG-TERM CARE 22 (1996).
33. *See id.*
34. *See id.*
35. *See id.*
36. *See id.*
37. *See id.* at 23.

V. PROBLEMS IN LONG-TERM CARE WORK

Although many long-term care workers are highly committed to their work and derive satisfaction from it, research has extensively documented the many difficulties of the job. These factors were found to be related to high rates of perceived job stress and burnout, and lower levels of job satisfaction.[38] In the contemporary tight labor market, these problems lead in turn to high rates of turnover in all positions.

Estimates of turnover of nursing home staff are quite high, with annual CNA turnover at 97%, RN turnover at 52.5%, and overall staff turnover at 69%.[39] Although estimates differ, turnover is also a problem in home care.[40] For this reason, understanding and reducing employee turnover in long-term care settings has become a major undertaking for both researchers and practitioners. As in other health care settings, turnover and short-staffing among long-term care staff has been found to have many negative consequences, including reduced employee efficiency and lower morale among employees who stay on the job.[41] More important, such staffing problems lead to decreased quality of care for residents.[42]

The following are some major causes of stress, burnout, dissatisfaction, and turnover among long-term care workers.

Excessive work pressure. In surveys, many nursing assistants say that they routinely do not have enough time to complete their basic tasks.[43] This sense of time pressure takes the enjoyment out of their work. Nursing assistants report that when time is short, they are not able to do more personal, satisfying tasks, such walking with residents, talking to them, helping with grooming, and so forth.[44] As caregiving work is reduced to the most difficult and least gratifying tasks, and staff feel that they do not have time even to complete these tasks, job stress and burnout increase.[45]

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38. *See id.* at 26.

39. *See* Charlene Harrington et al., *Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States,* 40 THE GERONTOLOGIST 5, 7 (2000).

40. *See* BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, BULLETIN 2520, OCCUPATIONAL OUTLOOK HANDBOOK 2000-01, EDITION 334, 352-53 (2000).

41. *See* Jiska Cohen-Mansfield, *Stress in Nursing Home Staff: A Review and a Theoretical Model,* 14 J. APP. GERONTOLOGY 444, 452 (1995).

42. *See* GOOLOO S. WUNDERLICH ET AL. EDS., NURSING STAFF IN HOSPITALS AND NURSING HOMES, 157-60 (1996).

43. *See* Harrington et al., *supra* note 39, at 7.

44. *See* WUNDERLICH ET AL., *supra* note 42, at 157.

45. *See* Harrington et al., *supra* note 39, at 7.

Understaffing: Work pressure is exacerbated by chronic understaffing in many long-term care facilities.[46] The pressure caused by staff shortages is very severe, and leads to stress and burnout. Conversely, adequate staffing has been found to be a major factor that led to high staff morale. Wilner found that a primary source of dissatisfaction and stress was working with too few other nursing assistants, or with new staff who were not adequately trained.[47] Nursing assistants were especially anxious about injury to themselves, to the new staff member, and to the residents in these situations.[48]

Problems in Supervision: Studies show that problems with supervisors are a major cause of job stress and burnout. Conflicts with supervisors are very stressful to frontline long-term care workers.[49] Helmer and colleagues showed the extent of such dissatisfaction.[50] Their survey of nursing assistants found that 71% wished administrators and nurses would show them more respect, and only 37% felt they received sufficient recognition and appreciation for their work.[51] Further, only 36% felt that management makes them feel "in on things."[52]

Lack of appropriate training: Despite the view that frontline long-term care work is "unskilled labor" the job is in fact both technically and interpersonally complex. As noted earlier, the training given to nursing assistants and home health aides is very limited.[53] Further, it focuses almost exclusively on the technical aspects of care, when there is evidence that difficulties in dealing with the *psychosocial* aspects of nursing home work are causes of stress and burnout.[54]

Wages: Funding for nursing assistants comes primarily from Medicaid and Medicare.[55] In many cases, the wages offered keep some workers near the poverty level. In 1998, the mean hourly wage of

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46. *See* WUNDERLICH ET AL., *supra* note 42, at 252.

47. *See* PILLEMER, *supra* note 32, at 27 (citing MARY ANN WILNER & ANN WYATT, AMERICAN ASSOCIATION OF RETIRED PERSONS, BACKGROUND PAPER FOR CONFERENCE, PARAPROFESSIONALS ON THE FRONT LINES (1998)).

48. *See id.*

49. *See id.* at 28.

50. *See generally* F.T. Helmer et al., *Strategies for Nurse Aide Job Satisfaction*, 21 J. OF LONG-TERM CARE ADMIN. (1993).

51. *See id.* at 12.

52. *See id.*

53. *See* HEALTH SERVICES, BUREAU OF LABOR STATISTICS, BULLETIN 2520, OCCUPATIONAL OUTLOOK HANDBOOK 344 (2000).

54. *See* PILLEMER, *supra* note 32, at 29.

55. *See* Harrington et al., *supra* note 39, at 12.

CNAs was $8.32, and for HHAs $8.17.[56] For the purposes of comparison, in the same year telemarketers earned an average of $9.40 per hour, and elevator operators an average of $14.77.[57] Thus, wages for long-term care workers remain comparatively low, considering the difficult nature of the job. Further, some long-term care providers still do not provide CNAs with health benefits.[58]

Injury: It is acknowledged that CNAs are at high risk of injury. Indeed, rates of injury in nursing and personal care homes exceed that of private industry in total by a significant amount.[59] CNAs are particularly prone to injury from heavy lifting.[60]

VI. RELATIONS WITH FAMILY MEMBERS

An area of significant research interest is the way in which family members of recipients relate to long-term care workers. Clearly, cooperation is essential to optimal resident care. However, research indicates that structural barriers to cooperation between the two groups exist.[61] In the most influential theoretical approach to this problem, Eugene Litwak noted fundamental differences between large-scale formal organizations and primary groups, such as families.[62] In nursing homes, the potential for family conflict with staff is heightened because long-term care facilities represent the classic case of a formal institution seeking to take over primary group tasks, and to fit the performance of such tasks into a bureaucratic, routinized, organizational framework.[63]

Consistent with Litwak's view, one line of research has pointed to discrepancies between staff and family perceptions of appropriate tasks for each group.[64] Although studies vary in their estimates of the extent of such differences, it is clear that ambiguity regarding the divi-

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56. *See* BUREAU OF LABOR STATISTICS, 1998 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATE (last modified Jan. 10, 2001) <http://stats.bls.gov/oes/national/oes_nat.htm>.

57. *See id.*

58. *See* WUNDERLICH ET AL., *supra* note 42, at 156.

59. *See* WUNDERLICH ET AL., *supra* note 42, at 252.

60. *See id.*

61. *See* Marie T. Duncan & David L. Morgan, *Sharing the Caring: Family Caregivers' Views of Their Relationships with Nursing Home Staff*, 34 THE GERONTOLOGIST 235, 242 (1994).

62. *See generally* EUGENE LITWAK, HELPING THE ELDERLY: THE COMPLIMENTARY ROLES OF INFORMAL NETWORKS AND INFORMAL SYSTEMS (1985).

63. *See* Karl Pillemer et al., *Building Bridges Between Families and Nursing Home Staff: The Partners in Caregiving Programs*, 38 THE GERONTOLOGIST 499, 500 (1998).

64. *See* Duncan & Morgan, *supra* note 61, at 242.

sion of labor between staff and relatives exists, particularly in the performance of non-technical tasks, and can lead to conflict.[65]

Even when families relinquish the technical aspects of care to the staff, they nevertheless feel compelled to monitor the quality of service delivery. Mary Ann Parris Stephens and colleagues found that over one-third of relatives reported feeling that they had to remind staff to do things for their resident, and that they needed to tell the staff how to care for the resident.[66]

Research has also identified poor communication between staff and families as an important problem. Many residents, and especially those with cognitive impairments, are unable to give accurate factual information about their experience in the facility. There is often little sharing of detailed information about residents, and families frequently feel that there is no one to whom they can bring their concerns.[67] Further, relatives are sometimes hesitant about offering suggestions and criticism, because of fears that such comments might negatively effect the care provided to the resident.[68] Additional barriers to communication include the fact that staff work under intense time pressure, which limits their availability for conversations with families.[69] Additionally, nursing home staff — and nursing assistants in particular — receive little or no training in communication skills.[70]

As a result of these problems, studies have found that both staff and family members were frequently irritated, and sometimes very angry, during and after interactions with one another.[71] Studies of nursing home staff have shown that problems relating to family members is a major source of stress for staff.[72]

VII. ACUITIZATION OF CARE, STAFFING, AND THE LIABILITY CRISIS

A neglected impact of the long-term care staffing crisis is its role in the increased vulnerability of providers to liability. The spiraling number of lawsuits is in substantial part due to the following fact: many nursing home residents are identical to the patients who would have cared for in the HOSPITAL as a resident a decade ago.[73] They ar-

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65. *See id.*

66. *See* Mary Ann Parris Stephens et al., *Sources of Stress for Family Caregivers of Institutionalized Dementia Patients,* 10 J. OF APPLIED GERENTOLOGY 328, 333 (1991).

67. *See* Pillemer et al., *supra* note 63, at 500.

68. *See id.*

69. *See id.*

70. *See* WUNDERLICH ET AL., *supra* note 42, at 157.

71. *See* Duncan & Morgan, *supra* note 61, at 242.

72. *See generally id.*

73. *See* PILLEMER, *supra* note 32, at 11.

rive with all manner of inpatient technology – intravenous lines, complex surgical wounds, tracheotomies, and mechanical ventilators in some facilities.[74] Often, their discharge from the hospital has been hastened by the DRG reimbursement mechanism for acute care, or by managed care arrangements.[75]

This change in the mixture of nursing home residents — what we would call the "acuitization of long-term care" — can challenge and even overwhelm staff. Over the past decade the prevalence of nursing home residents with several or more impairments in activities of daily living (such as eating, bathing, and dressing) has risen substantially.[76] Further, approximately half of these residents have some degree of cognitive impairment.[77]

The areas of nursing homes that have been dedicated to the care of the residents who need a more acute level of care go by a variety of names: "sub-acute", "post-acute", "transitional", and "rehabilitation" are among the terms most commonly encountered. They are notable not only for the potential innovation they bring to modern medicine, but also because they have evolved insidiously on a national level, driven by prevailing reimbursement strategies and almost completely devoid of physician input.[78] There are a number of causes of this phenomenon, including a reimbursement system that rewards homes for the care of sicker patients, and a managed care industry that has realized the cost savings when such patients are cared for in a nursing home rather than a hospital.[79]

Nowhere is the impact of the more acute status of nursing home residents so clear as in the flood of litigation against providers. We have both served as legal experts in the field of elder abuse and neglect and are sometimes asked to testify in criminal and civil cases of alleged abuse occurring in long-term care facilities. Typically these cases have not involved malevolent elder mistreatment as we would conceptualize it, but rather gaps in care. Furthermore, this substandard care has recently had a recurring and disturbing theme: acute

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74. *See* Steven A. Levenson, *Subacute Settings: Making the Most of a New Model of Care*, 53 GERIATRICS 69, 69-71 (1998).

75. *See* Dulcelina A. Stahl, *New Transfer Rule Encourages Acute Care Partnerships*, NURSING MANAGEMENT, Dec. 1998, at 10, 10-11.

76. *See* OLSON, *supra* note 1, at 26-27.

77. *See* Jay Magaziner et al., *The Prevelance of Dementia in a Statewide Sample of New Nursing Home Admissions Aged 65 and Older: Diagnosis by Expert Panel*, 40 THE GERONTOLOGIST 663, 666 (2000).

78. *See* WUNDERLICH ET AL., *supra* note 42, at 156.

79. *See* Mark S. Lachs & Hirsch S. Ruchlin, *Is Managed Care Good or Bad for Geriatric Medicine?*, 45 GERIATRIC MEDICINE AND MANAGED CARE 1123, 1124-27 (1997).

care patients in the nursing home who manifested a variety of distressing signs and symptoms who did not receive appropriate and/or timely evaluations. We strongly believe that part of the delay involves this new mix of acute care and nursing home cultures.

Three major forces - all economic - have led to the "acuitization" of the nursing home: 1) managed care, 2) the current prevailing mechanism of hospital reimbursement for inpatient care of older persons (diagnosis related groups or DRGs), and 3) reimbursement formulas for nursing homes which favor high acuity patients.

One of the "mantras" of managed care is the notion that the hospital is a "cost center." Under capitated and other managed care arrangements, there is a global fixed budget for the annual care of a "covered life."[80] Expensive interventions rapidly deplete the pool of resources earmarked for the total provision of services that may be used for either an individual or a group of patients for whom a medical group or system has "assumed risk."[81] This situation creates a disincentive to providers for using expensive medical technologies, which has led many to declare that this arrangement is in conflict with the traditional doctor patient relationship.[82] Hospitals are perhaps the most costly intervention and are to be avoided at all costs in this paradigm. For example, in 1994, the average cost of a hospital day in New York City was $1,404, for a New York City nursing home it was $177.[83] Given this differential, it is not surprising that insurers and others "assuming risk" would increasingly turn to nursing homes to care for older adults on the heels of an inpatient stay.

There are system incentives for nursing home acuitization for those older adults who are not enrolled in managed care plans as well. Since 1987, Medicare reimbursement for hospitals has been in the form of diagnosis related groups (DRGs) wherein hospitals are reimbursed for diagnosis and not a per diem rate as had been previously customary.[84] In this strategy, a reimbursement amount based on diagnoses is provided, irrespective of length of stay of inpatient resource utilization.[85] The result was a predictable and dramatic decline in length of stay, with critics arguing the DRG system had caused patients to be discharged "quicker and sicker."[86] Nursing homes represent a

80. *See id.* at 1124.
81. *See id.*
82. *See id.*
83. *See id.* at 1125.
84. *See generally* PHOEBE LINDSEY BARTON, UNDERSTANDING THE U.S. HEALTH SERVICES SYSTEM (1999).
85. *See* Lachs & Ruchlin, *supra* note 79, at 1124-26.
86. *See id.*

logical destination for the hospitalized patient in whom the goal is to reduce length of stay.

Nursing homes are also encouraged to admit these high acuity patients. Prevailing reimbursement strategies for nursing homes reward those facilities that demonstrate high case mix indices (CMI).[87] This can be achieved by preferentially recruiting those patients who have hefty skilled needs: wound care, intravenous antibiotics, tracheotomy care, and even mechanical ventilation.[88] On the other hand, the recently introduced prospective payment system (PPS) for nursing homes has led to dramatic cuts in funding to long term care facilities, though the incentive to admit "sicker" patients remains.[89]

Under intense regulatory pressures in response to cases of elder abuse and neglect that occurred in the 1970's, the long-term care industry became subject to a federally mandated patient evaluation process, which was extremely detailed and algorithmic in its approach, in 1990.[90] The Minimum Data Set (MDS) is intended to ensure that the nursing home resident is comprehensively evaluated with respect to medical, functional, psychosocial, and other domains – perfectly reasonable areas of impairment that require systematic evaluations for "custodial" nursing home residents.[91] It is performed upon admission, quarterly, and with subsequent changes in resident status (such as changes in weight, functional ability, skin care, and dementia related behavioral problems).[92] A completed MDS and associated plan of care must commence within 14 days of nursing home admission.[93] But the patient admitted for "subacute care" has an entirely different set of needs.

To be sure, nursing homes can be excellent places for older adults nearing the end of hospitalization to receive "post acute" services. In that they are focused on the acute causes of hospitalization and reeling from funding and staffing cuts, hospital staff may have little time to focus on such crucial areas for the older patient such as mood disturbance, wound care, nutritional support, and rehabilitation services like basic floor ambulation, swallowing, and recreational therapy.[94] Good long-term care facilities often excel in these areas.

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87. *See* Harrington et al., *supra* note 39, at 12.

88. *See generally* Lachs & Ruchlin, *supra* note 79.

89. *See* Kathleen Vickery, *Surviving PPS*, PROVIDER, 25-39 (Feb. 2000).

90. *See* Marshall J. Graney & Veronica F. Engle, *Stability of Performance of Activities of Daily Living Using the MDS*, 40 THE GERONTOLOGIST 582, 582 (2000)

91. *See* WUNDERLICH ET AL., *supra* note 42, at 135.

92. *See* Carolyn J. Harris, *Self Audits Ensure MDS Accuracy*, PROVIDER 28 (Oct. 2000).

93. *See* WUNDERLICH ET AL., *supra* note 42, at 134.

94. *See id.* at 251.

Indeed, state surveys and the federally mandated MDS focus on such areas as bedsores, restraint use, and interdisciplinary care planning. Rates of restraint use in long-term care facilities, which are associated with a variety of adverse outcomes, have been declining over the past decade.[95] Additionally, skilled nursing facilities may have the time and the multidisciplinary staff to deal with the complex problems of the recently hospitalized older patient.[96] This attentiveness may mean the difference between returning to the community versus having the nursing home as a "last address."

Despite these advantages, as long as there is the mismatch between acute needs of residents and organizations that are primarily staffed to provide long-term custodial care, problems of liability are likely to continue and even expand.

VIII. FUTURE DIRECTIONS

To upgrade the quality of the long-term care workforce, and to solve the problems of recruiting and retaining enough qualified workers, several options have been proposed, including the following:

Increasing Minimum Staffing Requirements: One solution to staffing problems is to increase the number of caregivers in nursing homes. There is considerable consensus among researchers that higher staffing levels are positively associated with better outcomes for nursing home residents.[97] This is particularly the case with RN staffing, but is also applicable to CNAs. Increasing staffing in nursing homes is likely not only to improve the quality of care, but also to benefit staff morale, satisfaction, and retention by reducing the stress of providing care.[98]

Increase and Upgrade Training for Frontline Workers: Although a body of rigorous evaluation research is lacking, there is evidence that training programs of various kinds improves the performance of CNAs and in turn leads to improved outcomes for residents.[99]

Improve Salaries and Benefits: Many nursing homes and home health agencies have very devoted, long-term employees. However, some individuals do not consider long-term care work, or leave it after

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95. *See* Julie Braun and Elizabeth Capezuti, *The Legal and Medical Aspects of Physical Restraints and Bed Siderails and Their Relationship to Falls and Fall-Related Injuries in Nursing Homes*, 4 DEPAUL J. HEALTH CARE L. 1, 60-61 (2000)

96. *See* Vickery, *supra* note 89, at 25.

97. *See* Harrington et al., *supra* note 39, at 5.

98. *See id.*

99. *See id.* at 104. *See also* Nathan Childs, *HCFA Study Ties Increased Staffing to Improved Care*, PROVIDER, 10 (Oct. 2000).

trying it, because the salaries are inadequate. Raising the salaries of workers and improving benefits is now a goal in many states.[100]

Expand the Range of Roles for Frontline Workers: A number of experts suggest re-examining the official role of the frontline worker, and expanding what is now a monolithic job category into a "career ladder" of increasing responsibility.[101] In particular, new job categories can be developed in the nursing home, ranging from an entry-level resident attendant position, to several categories of CNAs.[102] Workers can then advance to new positions of responsibility within the facility.

Aggressively Study Subacute Care: There is a large and critical gap in our knowledge about subacute care. What are the appropriate measures of quality? How does the hospital compare to the nursing home for the same condition with respect to outcomes. What are the appropriate staffing levels in subacute versus traditional long-term care? Nursing assistants often have good clinical judgement in predicting when a resident was becoming ill. How can this valuable team player in the care of the older subacute patient be used and appreciated to maximal potential – especially in the setting of a workforce shortage? Research is greatly needed on this topic.

100. *See* MASS. HEALTH POL'Y FORUM, ISSUE BRIEF, HEALTH CARE WORKFORCE ISSUES IN MASSACHUSETTS, 16 (2000).

101. *See id.* at 19. *See also* Helmer et al., *Strategies for Nurse Aide Job Satisfaction*, J. OF LONG-TERM CARE ADMIN. 10, 14 (Summer 1993).

102. *See* MASS. HEALTH POL'Y FORUM, *supra* note 100, at 19.