COMMENTARY

Who Do We Want to Care for our Mothers?

Defining and Reinforcing the Direct Care Workforce

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The profile of the direct care workforce in North Carolina and the nation provided by Susan Harmuth in this issue of the *Journal* highlights a number of facts about this workforce that have not received sufficient attention. From this article we learn that people in the long-term care workforce are underpaid, overworked, and under-appreciated by the public at large despite the important work they do on a daily basis.

The workforce itself is not well defined, and the diversity of work settings and employment arrangements contributes to this lack of visibility. Despite the similarity of the actual work done by these frontline caregivers, the sites where they provide care and the structures regulating their employment vary substantially. Some workers in residential settings are governed by a medical care model (nursing homes); others by a social care model (adult care homes and assisted living facilities). Some travel to their clients' homes where they may work under the formal—but distant—supervision of physicians or nurses (i.e., as home health care agency employees). Others work directly for clients or families. Further, a substantial portion of direct care workers hold down two or more jobs; of those who do so, many work in another long-term care setting. This suggests that these workers seek out this type of work in part because it appeals to their caring selves. Indeed, the high level of intrinsic motivation and dedication of a large portion of these long-term care workers remains a source of inspiration and hope to all of us as citizens, but especially to those of us who have family members in their care or who can more easily envision ourselves in such care arrangements.

We also learn from this article that a substantial portion of the employers of this workforce receive funding from public sources such as Medicaid and Medicare, while a significant minority of this workforce also receive public funds directly. Many direct care workers live below the poverty line and must rely in part on subsidies to make ends meet. All of these sources of funding are currently under intense pressure to constrict. Hence, those who govern these programs are challenged to maintain or improve the quality of care provided to North Carolina's impaired and elderly citizens in a climate of severe fiscal austerity and resistance to increased taxes. The issue of availability of qualified and motivated workers in the long-term care sector cannot be separated from the issue of aggregate social and economic investment in the entire activity of long-term care service provision and the higher visibility this issue deserves in the health and public policy arena.

What is unclear is how public policy initiatives can most effectively leverage increased compensation and improved working conditions for this workforce in a fair and rational way. Recruitment bonuses are temporary and may disproportionately attract those interested in short-term rewards; retention bonuses may be effective in keeping people on the job, but do not necessarily reward better quality performance. Participation in integrated systems of care within the same community may provide opportunities for career ladders and cross-subsidizing employment benefits. Moving from being a nurse aide in home health or nursing home setting to an affiliated hospital with a pay increase may be an attractive motivator for some individuals, but this mobility itself creates more vacancies in the less rewarded employment situation. However, development of continuing care retirement communities, or closer affiliations between home health and skilled nursing facilities, not only may provide better coordination of care for clients but might also encourage continuity between individual caregivers and recipients in the context of a single employer with a common human resource administration and benefits.

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Legislated increases in minimum staffing requirements do not increase the aggregate amount of resources going into the sector and may not stimulate the desired internal reallocation of funding from the boardrooms to the residents' rooms. Raising the Medicaid rate while stipulating that there be direct "pass-through" or "labor enhancement" is relatively easy to implement and politically attractive, but poses accounting challenges. More importantly, labor enhancements may not selectively reward the kinds of culture change that might be required at the organizational level, or selectively reward better performance at the individual level. Promising experiments in "culture change" under way across the nation suggest that improvements in care and improvements in the workplace are synergistic, but that both require resource increases.

North Carolina's home-grown, ongoing workforce experiment, the "Win a Step Up" program, has seen some success in retaining qualified and motivated caregivers and in increasing their job satisfaction through linking compensation, education, and commitment to the job. This effort has resulted in documented increases in job satisfaction and reductions in turnover of participants when compared to workers in similar settings. (See the results of this project at the University of North Carolina Institute on Aging website: http://www.aging.unc.edu/research/winastepup/index.html) This pilot program is modeled on North Carolina's highly successful, decade-old TEACH Early Childhood® Project. Common to the two North Carolina programs is a focus on providing incentives and education directly to individual caregivers rather than indirectly through their employers, expecting that their enhanced value to employers and increased job skills will lead to increased recognition and rewards. However, it is important to acknowledge that, in comparison to workers in child day care, the long-term care workforce faces different challenges. These include less public recognition, higher levels of turnover, more diverse work settings and hours, and distinctive regulatory requirements.

More importantly, whatever public and private investments have been made in the early childhood workforce have been justified by well-conducted studies linking education and continuity of caregivers to short- and long-term impacts on a broad variety of children's educational and developmental outcomes. Further, such outcomes can be translated into easily understood cost-benefit terms. Although everyone wants to reduce long-term care workers' turnover and increase their skill base, definitive research documenting links between worker continuity, worker education, and quality of care is lacking. In part this is so because it is difficult to find facilities where turnover is low, but also because care outcomes are inherently difficult to measure among older and more impaired patients. This is clearly a situation where well-planned, large-scale demonstrations with major federal and foundation support could have an important and synergistic effect on the quality of care for recipients and the quality of work for caregivers.

In the meantime, concrete solutions to the problem of the long-term care workforce in North Carolina are likely to be diverse, eclectic, and incremental. Clearly, clinical leadership from organized medicine, nursing, and other health professions will be required to strengthen and transform the culture of long-term care organizations so that the vital work of direct caregivers as members of a healthcare team is recognized. However, in order for practitioners to move in the right direction, it is important that policymakers, educators, and those in government have a vision of that direction that is collaborative, that transcends artificial boundaries of departments and agencies, and that is sustained. Fortunately, we are overcoming the past situation in which different segments of the workforce are related exclusively to different professional bodies, state agencies, or regulatory bodies, making it difficult to establish coherent and consistent policy across the various segments of this workforce.

The late John Eisenberg, MD, who headed the federal Agency for Healthcare Research and Quality (AHRQ), often stressed to clinical and health policy researchers that they should subject their work to the "mom test." By that he meant, if we can't explain clearly to our own mothers the actual impact of what we are doing, then we might want to rethink what we are doing. As physicians, nurses, and health care and public policy makers, when we consider the training, working conditions, and compensation of direct caregivers, we need to apply an expanded version of Dr. Eisenberg's "mom test." We need to ask, *What kind of a person do we want to be taking care of our own mom? What skills, motivation, and resources do we want that person to bring to that job?* If stakeholders and purse holders can come to a consensus honestly on the answer to that question, we will be on our way.