

# Who's Going to Take Care of Me? Our Impending LTC Labor Crisis

A Special Report for the *CSA Journal*

■ There is a growing consensus among experts that America faces a crisis in not having enough skilled health-care workers to provide long-term care for our rapidly aging society. Here is an in-depth report on what is being done to avert this looming crisis, along with practical strategies and resources that CSAs can use to prepare themselves and their businesses. For the complete report, go to [www.csa.us/longtermcarecrisis.pdf](http://www.csa.us/longtermcarecrisis.pdf). BY LISA A. RILL, PH.D.

Perhaps no aspect of long-term care (LTC) is more important than finding qualified, compassionate, and trustworthy caregivers for an aging parent or a loved one. But America's LTC system faces a crisis in its ability to provide sufficient health care to our aging adults. A major concern is the impending disparity between the *increasing* demands of health-care needs and the *decreasing* supply of the LTC workforce. Consider these facts:

- The first of the Baby Boom generation began turning 65 in January 2011 (Stone & Barbarotta, 2011), and the government estimates that the number of persons utilizing paid LTC services will rise from 15 million in 2000 to 27 million in 2050 (Friedland, 2004).
- At the same time, the overall labor force relative to the population size will likely be smaller than it is today, and there will be fewer adult children to provide informal care to their aging parents due to declining fertility rates (Friedland, 2004; Lakdawalla & Philipson, 2002).
- For the LTC workforce to keep pace with the substantial increase in the aging population, it would need to grow, at a minimum, by more than 2 percent each year; however, it is currently expected



to increase by only 0.3 percent per year (Friedland, 2004).

## Why this large gap?

The LTC market is different than the typical competitive labor market because it is influenced by the government, along with other public and private sectors (Burbridge, 1993). The government accounts for the majority of industry revenues, and their payment policies substantially influence the demand for services and the industry's ability to deliver them. In particular, professional training in the health-care field is governed through federal and state statutes and regulations, which restrict

employers' means to increase wages as a way to meet the changing demands (Feldman, 1997).

Factors that affect the *supply* of skilled LTC employees include the following:

- Size and composition of employee pools, wages, and benefits
- Working conditions
- Alternative sources of employment and income

Factors that can increase the *demand* for service and paid labor include the following:

- Number of aging older adults requiring both post-acute and chronic care
- Declining availability of informal caregivers
- Growth of Medicare and Medicaid benefits
- Constraints on hospital inpatient payments and length of stay
- Technological developments that allow more treatments to be provided at home (Feldman, 1997)

The problem is that the current national workforce is unstable for several reasons: the rapid aging population; the Baby Boom generation, a heterogeneous group with different needs; an inadequate workforce due to insufficient training, low wages, poor working conditions, high turnover rates, and lack of value from employees and clients; absence of incentives; and diverse demographic characteristics between direct-care workers and their care recipients, which can lead to miscommunication and conflict. This, in turn, makes it difficult to recruit and retain workers and has negative effects on quality of care.

Experts agree on two important things:

- We must address this shortage of skilled LTC employees by ensuring the availability of a large and competent paid LTC workforce.



- Government must work with the public and private sectors to make certain there will be a skilled LTC workforce in the coming decades to meet the anticipated number of aging adults needing LTC.

### The CSA connection

Many Certified Senior Advisors (CSAs) are on the front lines of this impending crisis—from CSAs who work in skilled health care or provide case management and social services, to those who help seniors find and move to assisted living and nursing homes, to others who help seniors and their families determine how to pay for long-term care. Because of this, it is very likely that, as a CSA, you think things such as, “*Yes, I go through these kinds of LTC staffing problems almost every day in my business,*” or ask, “*How can I help my clients prepare and find solutions—and what can I do for my own situation? I read about these issues and see the crisis coming, but I don’t know what’s being done to solve these problems. The problem is so large, where do I start?*”

CSAs who want to prepare their business, their clients, and their own personal situations for the anticipated shortage of skilled LTC employees will find useful information, strategies, and resources for funding and other support in this report:

- Part 1: News on what is currently being done to recruit, retain, educate, and train LTC workers
- Part 2: Key strategies to prepare you for the anticipated shortage
- Part 3: Resources for financial and other support

Charged by the Institute of Medicine (IOM) to “identify models of care that hold promise to provide high-quality, cost-effective care to older adults, and to analyze the factors that shape the health-care workforce, including education and training as well as recruitment and retention,” the Committee on the Future Health Care Workforce for Older Americans issued its *Retooling for an Aging America: Building the Health Care Workforce* report (IOM, 2008). In the report they propose a three-prong action plan to reduce or prevent the predicted shortage of skilled LTC employees:

1. Enhance the geriatric competence of the entire workforce
2. Increase the recruitment and retention of the workforce
3. Improve the models of care

The following is a summary report of where we as a nation are today in light of these three IOM recommendations. We are making positive strides in some areas, but in others, we have yet to begin to address the issues in a consistent, system-wide, and effective manner. For the complete report, go to [www.csa.us/longtermcarecrisis.pdf](http://www.csa.us/longtermcarecrisis.pdf).

### **Recommendation 1: Enhance geriatric competence**

*According to the IOM, educational and training programs for health-care professionals, direct-care workers, patients, and caregivers should have competencies in geriatrics and geriatric care. This includes all licensure, certification, and recertification requirements. Also, medical residents should be trained in all settings where aging adults receive care, such as assisted living and nursing homes.*

#### **Professionals in the health-care field**

We are making progress in educating health-care professionals. Increasingly,

undergraduate and graduate students in health care must meet minimum competencies in geriatrics, and nursing homes are being used for clinical training of all health-care professionals.

Medical schools and residency programs are required to create individualized courses and clinics in geriatrics to measure a person’s competencies, and licensing and certifying exams such as the United States Medical Licensing Examination and the American Board of Internal Medicine contain geriatric content. Nursing degree programs have also improved geriatric competency at all levels. In 2010, the required set of courses for nurse practitioners was revised and by 2015, two new types of specialists—adult geriatric nurse practitioner and clinical nurse specialist—will be implemented (Mezey et al., 2011).

Also, over the past decade, geriatric content in undergraduate and graduate social work educational programs has increased. In particular, the GeroRich and Gero-Ed initiatives funded by the [John A. Hartford Foundation](http://www.johnhartford.org) provide geriatric material throughout bachelor of social work (BSW) programs and at the master’s level (MSW). In addition, GeroRich and Gero-Ed offer specialized content in mental health and substance abuse to BSW and MSW programs, encourage gerontology-specific minors and certificates, and incorporate geriatric material into accreditation standards and licensing. Furthermore, certification processes are now separated into two new specialties at the BSW level—hospice and palliative social worker and social worker in gerontology—and advanced credentialing





continues in the MSW program (Mezey et al., 2011).

### **Direct-care workers**

*The IOM calls for federal and state governments to increase the minimum training requirements for all direct health-care workers. In particular, the minimum federal training requirements for certified nursing assistants (CNAs) and home health aides should be raised to 120–160 hours, including a demonstration of competence in geriatric care for certification, and states should establish minimum standards for training personal care aides.*

Federal- and state-supported training for direct-care workers is an area where there is still much room for improvement toward a national solution. For instance, the mandatory federal training requirements for direct health-care workers—that is, a minimum of 75 hours—have not changed since 1987. Some states have additional CNA training requirements, but they vary. For instance, 15 states require 76–119 hours and 12 states require 120–175 hours (Sengupta, Harris-Kojetin, & Ejaz, 2010). Similarly, the number of hours required for clinical training ranges from 16–100 hours.

### **Care recipients & informal caregivers**

*The IOM was clear that both care recipients and informal caregivers should be more involved in the health-care team. Care recipients could improve their health by providing their own suggestions for their plan of care, and informal*

*caregivers should receive better training opportunities from organizations in the community.*

We are seeing some change at the state level in this area. Some Medicaid-managed LTC programs emphasize including the care recipient and their caregivers in the decision making for the patient's care. A key component is coordination of care among a team of health professionals that can include a primary care physician, nurses, specialists, and a care manager. The team develops a plan of total care, working together with the senior who needs care (and family members or caregivers). This coordination helps reduce costs and increases the quality of care for seniors by ensuring appropriate services and preventative care. Without this coordination, services would still be available through separate programs; however, it could lead to inefficient services and higher costs (Mitchell, Polivka, Rill, & Stivers, 2011).

### **Recommendation 2: Increase recruitment and retention**

*To improve the desirability of jobs in the field of geriatrics, the IOM recommends that financial incentives—loan forgiveness, scholarships, and increase in payments—should be given to people who become geriatric specialists (both professionals and direct-care workers). Also, for direct-care workers, there needs to be improvements in supervisory relationships, greater opportunity for career growth, and better wages and more benefits provided by state Medicaid programs.*

Nonprofits and government are delivering funding and various new or expanded programs to support individuals in becoming geriatric care specialists and to improve employment conditions for direct-care workers. But here again the need is larger than what current efforts have been able to fill, and collaboration among the government and the public and private sectors is needed to fill the gaps in this and other areas. Here are several

examples of recent government and nonprofit steps to address this problem.

### **Geriatric specialists**

Federal programs under Titles VII and VIII of the Public Health Service Act fund and support educators, nurses, and other workers in geriatrics (see Table 1, below). In 2011, the Eldercare Workforce Alliance (EWA) requested that Congress invest \$71.7 million in geriatric professions and training programs for direct-care workers under Titles VII and VIII (Dawson, Lundebjerg, & Connolly, 2011). The Health Resources and Services Administration (HRSA), which is part of the Affordable Care Act (ACA), expanded additional funding for Title VII and Title VIII programs to increase the capacity of the workforce to care for the aging adult population (Mezey et al., 2011). For example, the Geriatric Career Initiative Awards Program will receive \$10 million over three years, effective 2011–2013, and the Geriatric Education Centers were authorized \$10.8 million in supplemental grants, effective 2011–2014. (The EWA website offers a [complete list](#) of how these funds are allocated.)

In addition, the National Health Service Corps offers a scholarship and loan repayment program to students pursuing a degree in

primary care health professions, including geriatrics (<http://www.usphs.gov/student/NHSC.aspx>). This program offers fully trained health-care professionals \$60,000 to repay student loans in exchange for two years' service in a community-based site in a high-need area.

### **Direct-care workers**

A \$15.5 million five-year national initiative titled “Better Jobs Better Care” (BJBC) was created and funded by the Atlantic Philanthropies and the Robert Wood Johnson Foundation to stimulate changes in policy and practice that lead to improved recruitment and retention of high-quality direct-care workers in nursing homes and home- and community-based settings (Yallowitz & Hofland, 2008). The BJBC is a two-part program—demonstration and applied research.

- The **demonstration** awarded grants to five states to implement “policy changes and practice interventions aimed at attracting and retaining high-quality paraprofessionals.” An evaluation of each state’s plan revealed that there was the ability to successfully build multi-stakeholder coalitions, but that these coalitions struggled to achieve substantive policy changes (North Carolina being the exception). Interventions to support changes in management practices

Table 1: Public Health Service Act

<b>Title VII Geriatrics Health Professions Programs</b>	<b>Title VIII Geriatrics Nursing Workforce Development Programs</b>
<b>Purpose:</b> Increase the number of faculty with geriatrics expertise in a variety of disciplines who provide training in clinical geriatrics.	<b>Purpose:</b> Serve as the primary source of federal funding for advanced nursing education, loan repayment, and scholarships.
<b>Programs:</b> Geriatric Academic Career Awards; Geriatric Education Centers; Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions; Geriatric Career Incentive Awards Program; and others.	<b>Programs:</b> The Comprehensive Geriatric Education Program (CGEP) provides quality geriatric education, continuing education, and training to individuals caring for the aging adult population. The Traineeships for Advanced Practice Nurses is a part of the CGEP that included advanced nurses in the LTC field.

Source: Eldercare Workforce Alliance (2011).

were developed, but only two-fifths of providers fully implemented their planned interventions. And while another one-third made substantial progress, there was no evidence that the implemented practice changes improved direct-care workers' jobs (Robert Wood Johnson Foundation, 2011).

- The **applied research** sent evaluation teams to visit specific sites, review relevant literature, create a direct-care worker database, and survey providers to determine the effects of “studies of workplace innovations and public policy interventions” (Yallowitz & Hofland, 2008). Among other results, the teams found that the factors that improved job satisfaction and retention for direct-care workers were a culturally competent organization, good frontline supervision, flexibility and competitive wages and benefits, ongoing training, and organizations with retention specialists. In addition, team findings were that mature workers (age 55-plus) were interested in training to overcome barriers in providing care; that more outreach is needed to recruit informal caregivers; and that job satisfaction for staff of all levels improved with a 33-hour curriculum focused on clinical and interpersonal skills (for abstracts of all the studies, please refer to [http://gerontologist.oxfordjournals.org/content/48/suppl\\_1.toc](http://gerontologist.oxfordjournals.org/content/48/suppl_1.toc)).

Other than the BJBC program, the most prevalent initiative that focuses on the recruitment and retention of direct-care workers is the state “**wage pass-through**” (WPT). The WPT offers an additional allocation in Medicaid reimbursement funds for the express purpose of increasing compensation for direct-care workers. But the problem is that use by the states is inconsistent because it depends on their budgets. In addition, WPT is not always monitored to ensure the funds are going to the direct-care workers (Bryant & Stone, 2008; Stone, 2004).



The U.S. Department of Labor offers **apprenticeship programs** for all direct-care workers in LTC. For employers, these programs help them recruit and retain skilled workers. Workers receive an opportunity to advance their careers through a structured on-the-job training program, along with an incremental wage increase (<http://www.doleta.gov/OA/>). In terms of health insurance as an incentive for recruiting and retaining direct-care workers, some states attempted to cover uninsured workers through various types of programs; however, many of these states can no longer afford to continue the programs due to state budget crises (Stone, 2004).

Some programs that have successful recruiting and retaining practices for LTC direct-care workers include the Cooperative Home Care Associates in New York, Home Care Associates of Philadelphia, and the George G. Glenner School of Dementia Care in San Diego (Stone, 2004).

### **Recommendation 3: Improve models of care**

*The current health-care system provides insufficient care to the aging adult population. The IOM recommends that for the quality of care to improve, the system needs to be addressed comprehensively, services need to be efficient, and the aging individual should be active in their own plan of care.*

Many innovative models of care have been put into practice, but due to the diversity

of the population, no single model of care is sufficient. Once a model of care has been shown to be effective and efficient, it should be implemented in the appropriate health-care setting.

The Pioneer Network defines organizational culture change as

a transformation anchored in values and beliefs that returns control to elders and those who work closest with them. Its ultimate vision is to create a culture of aging that is life-affirming, satisfying, humane, and meaningful. Culture change can transform a “facility” into a “home,” a “resident” into a “person,” and a “schedule” into a “choice.” (Stone, Bryant, & Barbarotta, 2009, 1)

Over the past 10 years, initiatives to improve organizational culture have become popular in nursing homes across the United States. Select nursing homes have focused on improving quality of care for residents and increasing involvement of direct-care workers in the overall setting (Wiener et al., 2009). Some of the innovative programs include the Eden Alternative, the Wellspring Alliance, and the Pioneer Network (see “New Ways of Caring Are Better for Aging Adults and Their Caregivers,” at right).

Other models of care focus on postponing nursing home placement and keeping aging individuals in the community as long as possible. These programs include the Program of All-inclusive Care for the Elderly (PACE), the Green House homes, the Independence at Home Demonstration, and the Medicaid Health Home state plan option (see “Helping Seniors Age in the Community and in Their Homes,” page 15).

*A final recommendation from the IOM related to improving models of care and system-wide culture change is for federal agencies to provide support for health information technologies (HIT).*

## » New Ways of Caring Are Better for Aging Adults and Their Caregivers

- [Eden Alternative](#) is an international nonprofit organization dedicated to eliminating loneliness, helplessness, and boredom in care environments by transforming them into places that promote quality of life for all involved. Rather than the familiar hierarchy of bureaucracy, it allows for decision making by the aging adults and their care partners. Employees of these homes receive ongoing training while on the job.
- Wellspring Alliance is a group of 11 nonprofit nursing homes in Wisconsin. Its purpose is twofold: (1) to provide high-quality care by improving clinical care to residents, and (2) to improve the working conditions for the employees by providing them with needed skills and the ability to voice their opinions about their work and their relationships with the care recipients (Stone et al., 2002). Wellspring uses team training and cross-level education to create a strong and connected workforce. Team members work together in problem solving and are equally responsible for resident outcomes.
- [Pioneer Network](#) is a nonprofit organization based in Chicago, Illinois. It is committed to creating a culture of aging that is life-affirming, satisfying, humane, and meaningful. The program provides innovative models of care that are consumer-driven and resident-directed for both nursing home residents and community-based care recipients. To reach their goals, the Pioneer Network supports research and policy changes focused on culture change; collects and shares adaptable practices and procedures that put the person before the task; creates networking and learning opportunities; coordinates with state coalitions; and hosts a national conference.

Several health-care practices have implemented electronic referral (e-referral) systems. The e-referral is an email that can include the patient's medical history, physicals, lab results, and radiographic results. This system allows for an increase in communication with other specialists, which can reduce unnecessary face-to-face visits and improve the physician's ability to coordinate care. E-referrals have been successfully implemented in Oregon and San Francisco medical centers and have improved care coordination, reduced waiting times for specialty appointments, and increased response rates between physicians to 24 hours (Bodenheimer, 2008).



### » Helping Seniors Age in the Community and in Their Homes

- Program of All-inclusive Care for the Elderly (PACE) serves individuals who are age 55 or older, need nursing home care, and are able to live safely in the community. For individuals who require nursing home care, PACE pays for it and continues to coordinate the member's care.
- Green House Project is a deinstitutionalization effort. They partner with organizations, advocates, and communities to create small homes with the full range of personal care and clinical services comparable to high-quality nursing homes and provide opportunities for meaningful engagements and relationships. There are more than 100 Green House homes operating in 27 states, and funding from the Robert Wood Johnson Foundation helps organizations replicate this model in even more states (<http://thegreenhouseproject.org/find-a-home/>).
- Independence at Home Demonstration aims to "preserve health and function and to minimize hospital and nursing home use" (Katz & Frank, 2011, 84). Eligible individuals include Medicare beneficiaries with at least two chronic conditions and two functional impairments. Care is received in the individual's home by an interdisciplinary team comprised of a physician, a nurse practitioner, and direct-care workers (Katz & Frank, 2011). The direct-care worker is included in decisions regarding the individual's plan of care and helps maintain the health and functioning of the care recipient (Katz & Frank, 2011).
- The Medicaid Health Home state plan option is a part of the Affordable Care Act. It allows states to provide comprehensive care management, care coordination, transitional care, family support, referrals to support services, and the use of health information technology to individuals with multiple chronic conditions and persistent mental illness (Katz & Frank, 2011). This Medicaid option provides initial planning and start-up grants.



## PART 2: *Prepare now for the future*

Virtually no one will be left unaffected, professionally or personally, by a shortage of skilled LTC workers—doctors, nurses, pharmacists, physical therapists, social workers, psychologists, geriatric care managers, home health-care aides, and others. In addition to the various efforts by the government and nonprofits to address the anticipated LTC labor shortage, the private sector has education and training programs, incentives, and other human resources programs and systems that play an important role in ensuring the availability of skilled LTC employees. Whichever arena CSAs are in, there is ample opportunity to be part of the solution. Here are key strategies that CSAs can use to help prepare for the increasing demand for LTC services.

- Take a step back, look at the bigger picture, and ask yourself, What are the major problems in the long-term care system that lead to poor quality of care? What is being done on the federal and state levels to improve the system? How do I fit into the equation? What can I do to help improve the situation?
- Become familiar with specific regulations and policies in your state.
- Check for any new education, training, and license requirements in your field and make sure you and your employees are up to date with the requirements.
- When hiring employees, look for people who have the required education and training in your field.
- Explore different ways to provide training and incentives for your employees, and seek to build a cross-disciplinary component into your training programs, including both classroom and clinical sites.
- Get involved in programs in your area that provide quality geriatric education, continuing education, and training in the field.
- Research federal programs, such as loan repayment and scholarship options, or apprenticeship programs that apply to your field.
- Work to improve employer/employee relationships by increasing the value of the direct-care worker and by providing greater opportunity for career growth.
- Make sure the model of care that is being used is appropriate for your type of care recipients.
- Include care recipients and informal caregivers in the care plan process.
- Be sensitive to the diverse needs of the care recipients and be mindful of the various backgrounds of the direct-care workers.
- Learn about the current health information technologies available. Where possible, start incorporating these into your business operations and services.
- See if your state offers a youth apprenticeship program for recruiting high school students to health-care jobs through internships and on-site training (for example, see [Wisconsin's Youth Apprenticeship Program](#)).
- Consider recruiting retirees for caregiving work; it can be a good fit for those looking to do meaningful work 20–25 hours a week.
- Educate others on what the impending LTC labor shortage will mean, and encourage them to take whatever actions they deem appropriate.

## PART 3: *Financial and other resources*

The following are various financial and educational online resources that CSAs can explore and use to supplement any existing training, education, and funding that CSAs already have. Organizations and businesses are eligible for some grants—look into what applies to your situation:

### Financial assistance

- John A. Hartford Foundation: Provides information on various grants in health and aging
- National Council on Aging (NCOA): Delivers a wealth of knowledge on aging issues for caregivers, advocates, and professionals, including 12 sources of funding and sustainability for your organization
- National Health Service Corps (NHSC): Offers scholarship program information
- Robert Wood Johnson Foundation: Lists current grants and upcoming calls for proposals

### Training, education, certification, & best practices

- American Geriatrics Society (AGS): Provides information for health-care professionals, advocacy and public policy, and public education
- Assisted Living Administrator Certificate and Certification Programs: Gives certification information
- Bureau of Labor Statistics: Provides information on how to become a certified nursing assistant (CNA)
- Long-Term Care Administration License and Certification: Contains licensure information

- National Council on Aging (NCOA): Includes a wealth of knowledge on aging issues for caregivers, advocates, and professionals, and offers tools and resources for caregivers
- Nursing Home Administrator Training Programs: Lists requirements and recommendations
- Paraprofessional Healthcare Institute (PHI): Helps providers across the long-term care spectrum adapt field-tested practices to fit their workforce and consumer needs, and includes case studies of best practices

### Health-care innovations & information

- Centers for Medicare and Medicaid Services (CMS): Provides information (including regulations and guidance) on Medicare and Medicaid
- Eden Alternative: Contains information on this not-for-profit organization dedicated to transforming care environments into habitats for human beings that promote quality of life for all involved



- Eldercare Workforce Alliance (EWA): Proposes practical solutions to strengthen the eldercare workforce and to improve the quality of care; provides links to the 29 organizations that make up the EWA
- Geriatric Interdisciplinary Team Training (GITT) Program: Offers an interdisciplinary approach to service delivery
- Green House Project: Restores individuals to a home in the community by combining small homes with the full range of personal care and clinical services expected in high-quality nursing homes
- Institute for the Future of Aging Services (IFAS): Aims to bridge research, practice, and policy
- Pioneer Network: Advocates for culture change in eldercare models to create homes that are consumer-driven and resident-directed—from long-term nursing home care to short-term transitional care to community-based care
- Program of All-inclusive Care for the Elderly (PACE): Provides community-based care and services to people who otherwise need a nursing home level of care

## What next?

A consensus is growing that the LTC system will not be able to meet the needs of our rapidly aging society. Developing a sizable and quality LTC workforce and providing a high quality of care for our aging adult population will require the following changes:

- Enhancements in the geriatric competence of the entire health-care workforce
- An increase in the recruitment and retention of the workforce through incentives and benefits
- A redesign of the models of care
- Collaboration and cooperation among the government and the public and private sectors

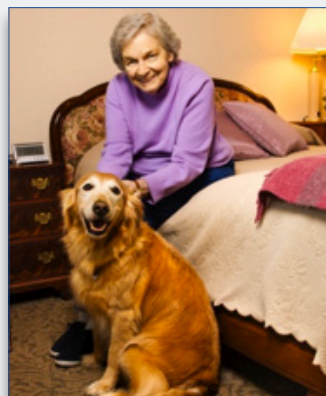
These challenges “must be addressed by both government and private citizens alike if long-term care recipients’ lives are to improve

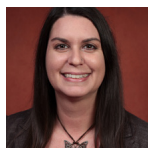
and the increased demand for services is to be met” (Miller, Booth, & Mor, 2008, 450).

Although certain initiatives have been put into place to avoid a critical shortage in qualified professional LTC workers of all types, the challenge for the 21st century workforce continues. ■



Click here for Dr. Lisa Rill’s complete report on the impending LTC labor crisis.





**Lisa A. Rill, Ph.D.**, received her doctorate degree in sociology at Florida State University (FSU). Her specializations are health and aging, with particular interests in the aging process, long-term care, retirement, life course, inequality, social organizations, and social services. Before returning to graduate school, Dr. Rill was a social worker at various nursing homes for five years. During her time in graduate school, she taught classes in sociology and aging, interned at AARP, and received her graduate certificate in Aging Studies from the Pepper Institute on Aging and Public Policy at Florida State University. She also received the FSU Research Grant and the Claude & Mildred Pepper Dissertation Fellowship, which assisted her in completing her dissertation. Her master's thesis focused on bureaucracy in the nursing homes and her dissertation examined the efficacy of senior center participation. Dr. Rill currently works as a research associate at the Claude Pepper Center at FSU, where she conducts research on various aging topics. She can be reached at [drlisarill@gmail.com](mailto:drlisarill@gmail.com).

## References

- Bodenheimer, T. 2008. "Coordinating Care: A Perilous Journey through the Health Care System." *New England Journal of Medicine* 358:1064-1071.
- Bryant, N., and R. Stone. 2008. "The Role of State Policy in Developing the Long-Term Care Workforce." *Generations*, Fall:71-76.
- Burbridge, L. 1993. "The Labor Market for Home Care Workers: Demand, Supply, and Institutional Barriers." *Gerontologist* 33:41-46.
- Dawson, S., N. Lundebjerg, and C. Connolly. 2011. "Federal and State Policy Strategies for Developing a Quality Eldercare Workforce." *Generations* 34:61-67.
- Eldercare Workforce Alliance. 2011. *Title VII and VIII Programs: Preparing the Eldercare Workforce to Care for our Nation's Older Adults* (Issue Brief).
- Feldman, P. 1997. "Labor Market Issues in Home Care." In D. Fox and C. Raphael (Eds.), *Home-Based Care for a New Century*. Malden, MA: Blackwell.
- Friedland, R. 2004. "Caregivers and Long-Term Care Needs in the 21st Century: Will Public Policy Meet the Challenge?" *Georgetown University Long-Term Care Financing Project* (Issue Brief).
- Institute of Medicine. 2008. *Retooling for an Aging America: Building the Health Care Workforce* (Report Brief). Retrieved from [www.iom.edu/agingamerica](http://www.iom.edu/agingamerica).
- Katz, R., and R. Frank. 2011. "A Vision for the Future: New Care Delivery Models Can Play a Vital Role in Building Tomorrow's Eldercare Workforce." *Generations* 34:82-88.
- Lakdawalla, D., and T. Philipson. 2002. "Rise in Old-Age Longevity and the Market for Long-Term Care." *American Economic Review* 92:295-306.

Mezey, M., E. Mitty, T. Cortes, S. Burger, E. Clark, and P. McCallion. 2011. "A Competency-Based Approach to Educating and Training the Eldercare Workforce." *Generations* 34:53-60.

Miller, E., M. Booth, and V. Mor. 2008. "Assessing Experts' Views of the Future of Long-Term Care." *Research on Aging* 30:450-473.

Mitchell, G., L. Polivka, L. Rill, and E. Stivers. 2011. "Medicaid Managed Long-Term Care in Florida: A Roadmap." A White Paper from the [Claude Pepper Data Center](#). Updated version in progress.

Robert Wood Johnson Foundation. 2011, April 27. *Better Jobs Better Care: Building a Strong Long-Term Care Workforce*. Retrieved from <http://www.rwjf.org/files/research/BJC.final.pdf>.

Sengupta, M., L. Harris-Kojetin, and F. Ejaz. 2010. "A National Overview of the Training Received by Certified Nursing Assistants Working in U.S. Nursing Homes." *Gerontology & Geriatrics Education* 31:201-219.

Stone, R. 2004. "The Direct Care Worker: The Third Rail of Home Care Policy." *Annual Review of Public Health* 25:521-537.

Stone, R., and L. Barbarotta. 2011. "Caring for an Aging America in the Twenty-First Century." *Generations* 34:5-10.

Stone, R., N. Bryant, and L. Barbarotta. 2009. *Supporting Culture Change: Working toward Smarter State Nursing Home Regulation* (Commonwealth Fund Issue Brief).

Stone, R., S. Reinhard, B. Bowers, D. Zimmerman, C. Phillips, C. Hawes, J. Fielding, and N. Jacobson. 2002. "[Evaluation of the Wellspring Model for Improving Nursing Home Quality](#)." Institute for the Future of Aging Services, American Association of Homes and Services for the Aging, and the Commonwealth Fund.

Wiener, J., M. Squillace, W. Anderson, and G. Khatutsky. 2009. "Why Do They Stay? Job Tenure among Certified Nursing Assistants in Nursing Homes." *Gerontologist* 49:1-13.

Yallowitz, W., and B. Hofland. 2008. "Better Jobs Better Care: A Foundation Initiative Focusing on Direct Care Workers." *Gerontologist* 48:14-16.