Pathways to Living-Wage Jobs in Health Care

Health care is seemingly an ideal sector to pursue a career-ladder strategy. It has lots of entry-level and paraprofessional positions, and demand will continue to grow with the aging of the population, the growth of nursing home and community-based care, and the reorganization of hospital care. But are there really career ladders for, say, dietary aides or certified nursing assistants (CNAs) and others on the lowest rungs? It depends. The challenge of creating career opportunities along the broad spectrum of health care occupations goes beyond merely educating more people. The wages of many entry-level workers in health care are determined by government reimbursement. Without increasing government funding to a level that allows offering decent pay raises for increased skills, career ladder training programs are not pathways out of poverty. We cannot address the skills and labor shortage without paying higher wages.

Care Career Ladders in Nursing

There are a number of programs across the nation that have had some success in helping home health aides and certified nursing assistants advance into LPN and RN positions. Going to scale requires more than identifying the features of best practice programs, however. To assess the potential for advancement in nursing one has to understand broader contextual factors such as what type of facilities employ nurses, what career progressions exist, and the pay structure for nurses and nurse educators.

Many health care career ladder programs focus on the certified nursing assistant (CNA). Long-term care facilities and nursing homes rely on CNAs for most of the day-to-day care of patients. The licensed practical nurse (in some states licensed vocational nurse) takes on the role of the registered nurse (RN) charge nurse in these settings. In long-term and nursing home care the career ladders have been creating higher levels of training and a career ladder within the nursing home setting and creating a career ladder between CNA and LPN. Hospitals employ fewer CNAs, so the career ladders for entry-level workers in hospitals tend to be into allied health and administrative and clerical occupations.

In my 2006 book, *Moving Up in the New Economy*, I examined numerous health career ladder programs throughout the country.[1] They were led by community colleges, community organizations, unions, employers, and every possible combination of these organizations. I identified two career-ladder strategies: 1) creating tiers within occupations; and 2) career ladder programs.

For a CNA, moving up just one rung to LPN is a long pathway. Pursued as a full-time program, a high school graduate can earn this credential in one year. Pursuing it part-time is a much longer path because many CNAs have to start by taking remedial courses before completing a part-time program (few of which exist) while working (often more than one job) and raising a family. If the CNA quits the program at any time short of

[1] Fitzgerald, Joan. 2006. Moving Up in the New Economy. Thousand Oaks, Ca.: Sage.

earning the LPN degree, she gains nothing for whatever skills she has acquired along the way. Recognizing this, several programs have attempted to create tiers within the CNA occupation to recognize higher level skills and knowledge.

Perhaps the best known of these programs is the Extended Care Career Ladder Initiative program in Massachusetts.[2] Several participating facilities created tiers within the CNA occupation and developed training programs for workers. The programs created in 8 nursing homes and 3 home health agencies provided very modest pay raises, improvements in morale, job performance, and reduction of turnover. I identify similar programs in other parts of the country in the book, but conclude that even in the most successful programs, a key problem is that the new job titles (e.g. CNA I, II, III) are recognized only by the employer offering them, and thus do not provide a portable credential. Thus, new occupational categories need to be created and endorsed by professional organizations at the state level for these programs to succeed. Most problematic is that the programs do not lift workers out of poverty wages. Because wages in long-term care are based on federal reimbursements, we need to increase reimbursements and earmark them for wages to motivate CNAs to stay on the job and to become more skilled at what they do.

In theory, the nursing career pathway is as follows: CNA→LPN→RN (assoc. degree)→BSN (bachelor's degree)→MSN/ Nurse Practitioner→Ph.D.[3] In practice, the most likely career ladder for long-term care workers is CNA to LPN.[4] And this pathway offers the biggest jump in pay and benefits for the amount of time invested. Of the numerous programs I examined across the country, by far the most effective were those led by unions. And of these, the 1199C Training and Upgrading Fund stands out as the nation's best CNA to LPN program.

In Philadelphia, the American Federation of State, County and Municipal Employees (AFSCME) District 1199C Training and Upgrading Fund has been operating for 35 years. The fund is a trust negotiated between the union local and the hospitals and nursing homes and other health care facilities, to which management contributes 1.5 percent of gross payroll. It serves over 10,000 workers annually through various training programs, counseling, placement, certification testing, and workshops. The fund opened a school of practical nursing that is approved by the Pennsylvania Board of Nursing and is the only union-run LPN school in the country. Because the union receives grants from the Department of Labor and other government funding sources and foundations, it can make

[2] ECCLI is part of the Massachusetts Nursing Home Quality Initiative, which started in 2000.

[3] I should note that many in the nursing profession advocate for the entry-level certification for a registered nurse being a bachelor's degree. This argument is based on considerable research on quality of care, particularly that of Dr. Linda Aiken. Those arguing this position would argue that the CNA or LPN is no more a rung on the nursing career ladder than a physician's assistant is to a doctor or a paralegal is to a lawyer.

[4] Some small percentage of LPNs advance to RN, and mostly move into a hospital setting. Practices vary considerably geographically, as hospitals in some cities, such as Boston, hire only bachelor's degree nurses.

the program available to community residents as well as union members. As local hospitals have cut their programs due to high costs, the 1199C program is now the only LPN program in the Philadelphia area.

The first LPN class of 31 students started in 2001. The program extends the full-time, year-long course to 18 months because it is offered on evenings and weekends to accommodate work schedules. Students who want to advance, but don't have the math or English skills, have several options. The union fund offers two levels of pre-nursing prep that combine English, math, and anatomy and tie these topics to health care. These courses have been an important vehicle for recruiting people who may not qualify initially. About half of the students have to take at least one of the basic education or pre-nursing courses. According to Cheryl Feldman, executive director of the fund, the Philadelphia area has a shortage of LPNs, so graduates are practically guaranteed a job. Union CNAs make $13 an hour in hospitals and $8-10 in nursing homes. Working as LPNs, they would make over $20 an hour.

The elements of the program that contribute to its effectiveness include the experiential remedial work, tuition support, using instructors who themselves advanced from entry-level positions, and creating a sense of community and support. Although 1199C has worked successfully with non-union facilities, Feldman explains that the union difference is that the labor-management trust created by giving workers a strong voice in the program means that workers who advance are likely to stay on the job. The program is a true labor-management partnership.

Assistance in paying tuition is essential to career ladder programs. For all of 1199C's programs, union members may apply for tuition reimbursement, leaves of absence with stipends, and other forms of assistance. Employers pay for half of the workers' time while they are in training, making both workers and employers feel they have a stake in the program's success. In the past scholarships have been available to RN and LPN students through a U.S. Department of Labor H1-B grant and employer matches.

An unusual feature of the 1199C training fund is that residents in the nearby communities in welfare-to-work programs are eligible for scholarships. Funding from federal, state and foundation sources have made this possible. As foundation support dries up in the current economy, continued federal support will be essential to 1199C and other training programs to assisting unemployed and displaced workers move into health care occupations.

One barrier facing 1199C and other nursing career ladder programs is the shortage of nursing faculty (and although not the topic of my testimony, the shortage of RNs persists).[5] In recent years, anywhere between 80,000 and 150,000 qualified applicants

[5] With an average salary of $56,888, registered nursing should be an attractive occupation. But the United States had about 126,000 nursing vacancies last year. And the U.S. Bureau of Labor Statistics predicts that the shortfall could go as high as 800,000 by 2020. The U.S. Department of Health and Human Services predicts that by 2020 at least 36 percent of RN positions will be vacant ((see Health Resources and Services Administration. 2004. What is Behind HRSA/s Projected Supply, Demand and Shortage of Registered

have been turned down by U.S. schools of nursing (both associate and baccalaureate degrees) due to insufficient faculty and classroom or lab space, or lack of clinical sites. There are two underlying reasons. The first is that nursing programs are often money losers for community colleges and universities because of the low student to faculty ratio required for clinical education. The second is the unattractiveness of teaching careers for nurses due to low pay and long working hours. Master's level faculty average $66,588 annually -- about the same as an associate degree RN in clinical practice and substantially less than a nurse-practitioner with a master's degree who makes $81,517 a year. Beginning assistant professors at universities (with Ph.Ds in nursing) typically make about $72,000 annually and work long hours to balance the teaching, research, and service components of their positions.

Investing in career ladder programs for those at the bottom of the nursing career ladder has to be done in parallel with programs to address the faculty shortage problem. Many universities are developing creative programs to increase faculty capacity and deliver curricula in nursing programs. These initiatives have received federal, state, foundation, and industry funding.[6]

At the state level, the Oregon Nursing Leadership Council, a consortium of state nursing and credentialing organizations, community colleges, and university deans, developed a statewide strategic plan for addressing all aspects of the nursing shortage problem. This initiative has increased the state's nursing graduation rate by 11 percent per year since 2001 by having nursing schools share some clinical facilities and maximizing use of faculty by developing a shared curriculum and simulation education. The Oregon Council for Nursing also created a software program to coordinate clinical placements regionally. Typically hospitals have affiliations with schools with an agreed upon number of clinical placements. Sometimes scheduling is such that a school can't fill its allotted slots, so they go unused. Now, all hospitals and schools in the Portland region pool their unused slots so that none are wasted. Potential students, particularly minorities at the high school level, are being recruited into nursing through several creative programs. Hospitals are offering scholarships to nursing students who agree to work at the hospital for at least three years after graduation. Several universities are developing new graduate nursing programs and there is a statewide partnership between eight community colleges and the public university to create a shared, competency-based curriculum. Once in place schools will have the same prerequisites, with one application and dual enrollment so students

---

Nurses? ftp://ftp.hrsa.gov/bhpr/workforce/behindshortage.pdf). Meanwhile, 500,000 RNs have left the profession and are working in other jobs. The reasons for the shortage are complex, but boil down to nurses leaving the profession and fewer people are entering because of education bottlenecks. Both reflect massive failures of national policy. And instead of making it possible for more Americans to take these good jobs, policy is luring immigrant nurses from poor countries. The current economy seems to be easing the shortage—now, as in past periods of high unemployment, former nurses are returning to work to supplement family income. But in the long-term, the lack of new recruits will create severe shortages (See Allan, Janet D. and Jillian Aldebron. 2008. A Systematic Assessment of Strategies to Address the Nursing Faculty Shortage, U.S. *Nursing Outlook*. 56: 286-297).

[6] See Allan and Aldebron, 2008 and Fitzgerald, Joan. 2006. Getting Serious About Good Jobs. *The American Prospect.* (October).

and their financial aid can move between programs. Although the initial goal of doubling nursing program enrollments by 2004 wasn't reached, the council is well on the way to achieving its 2010 goals of increasing retention of nurses in the first three years of practice and increasing the state's nursing faculty by 65 instructors.[7]

This foundation-funded initiative demonstrates that improving the work culture and coordinating state resources and strategies can reduce quit rates and attract new people to the profession, yet the problem of nurse overwork and underfunded nurse training calls for national policy.

While more support is needed for programs like Oregon's, the problem will not be solved without addressing the wage gap. The only federal program proposed to address the wage gap was the Nurse Education, Expansion, and Development Act, introduced in 2005. The legislation never made it out of committee. Referred to as the NEED act, the bill has been reintroduced by Senator Richard Durbin (D IL) in February of this year. Our national policy has been more focused on outsourcing nursing education than investing in expanding it in the U.S.[8]

Advancement in Allied Health Occupations

Kaiser-Permanente, the nation's largest managed care organization, supports several education and training upgrading programs in partnership with the 27 unions that represent its hospital and other workers. Its programs borrow heavily from 1199C, but are applied to allied health and clerical workers in addition to those in nursing occupations.

Kaiser-Permanente is one of 25 employers participating in the SEIU United Health Workers West & Joint Employer Education Fund. The fund was started in the late 1990s and replicates many of the Philadelphia 1199C offerings. It serves 70,000 health care workers in California, Colorado, Oregon, and Washington. The program offers bridge programs in anatomy, chemistry, microbiology, and nursing to prepare for college-level courses in these subjects needed in nursing and other allied health occupations. In career upgrading, SEIU has recently added a program for licensed vocational nurses to obtain the RN degree at City College of San Francisco.

---

[7] Oregon Nursing Leadership Council Strategic Plan, 2005-2008. http://www.oregoncenterfornursing.org/documents/ONLC%20strategic%20plan%20final%205-15-06.pdf

[8] Instead of investing in nurse education and creating good jobs for Americans, we are importing immigrant nurses from the Philippines, India, Nigeria, and elsewhere. The U.S. invests token amounts for educating U.S. nurses while removing caps on hiring foreign nurses. For example, the Nurse Education Loan Repayment Program (NELRP) repays 60 percent to 85 percent of student loans for nurses who agree to practice two years in a facility experiencing a critical staff shortage. The Nursing Scholarship Program provides scholarships and stipends to students in exchange for the same two-year commitment. In fiscal year 2008, the NELRP received 6,078 eligible applications and made 232 2-year awards and 203 3-year awards. Only 172 of the 4,894 eligible scholarship applications were funded. Due to insufficient federal funding, the vast majority of applicants are denied.

In addition to participating in the SEIU fund, in 2007 Kaiser Permanente and its other unions created the Ben Hudnall Memorial Trust for education and training to open education and skills upgrading possibilities to all employees. Like 1199C, project managers work with employees and managers in developing programs and evaluating outcomes. The Fund and Trust provide remedial courses, counseling, and other employment-related services and community and four-year colleges offer the certificate and degree programs, most of which are customized for Kaiser Permanente employees. The trust has sponsored an orthopedic technolgist[9] and other technician programs for hospital workers.

Program completion rate is one of the key indicators of success. The Kaiser Permanente programs have an average 98 percent completion rate. Community college administrators involved in the program note that the Kaiser Permanente student completion rate is more than twice that of other students. A key difference is that the Kaiser Permanente employees are guaranteed a job at end of training. And because of the customization of the program for Kaiser Permanente employees, they start their new jobs without needing to retrain for using various computerized systems. Kaiser-Permanente management is also pleased with the retention rates of employees who advanced through the career ladder program. Eighteen months after training an astounding 89 percent are still in their new jobs. The high retention is saving Kaiser Permanente a considerable amount of money—employers spend about 1 and a half times a position's salary to fill it and provide "onboarding" training.

To date, about 400 employees have been upgraded through the career ladder programs. Because funded with project managers, involvement with employer and union. We had a 98 percent success rate in our programs. Because we had federal and state grants had to do retention.

Federal Policy Needed to Support Advancement of Entry-Level Health Care Workers

In *Moving Up in the New Economy* I conclude that government policy is both the key problem and the potential solution to the crisis in nursing care. This is best stated by Steve Dawson, founder of the Paraprofessional Healthcare Institute:

> As the single largest funder of health care, the federal government has in essence created an entire labor market of paraprofessional health care workers—a labor market that would not exist without its funding, a labor market that keeps low-income women in the ranks of the working poor.

[9] Orthopedic technologists fit and adjust canes, crutches and walkers, and provide patient instruction on their use; apply simple braces, prosthetics; perform minor adjustments and repairs to prosthetic and other equipment; fabricate splints and apply plaster and synthetic casts under the direction of an orthopedic surgeon.

> And yet our government has yet to accept responsibility for creating and maintaining literally thousands of poverty-level jobs.[10]

A few special federal training funds have been allocated to improving the quality of nursing home care, but federal policy is contradictory here too. On the one hand, the "cost-containment" guideline of Medicare and Medicaid is responsible for low wages in the health care industry, which in turn reduces the quality of care and is partly responsible for the shortage of direct care providers. On the other hand, the U.S. Department of Labor creates special pools of funds to improve worker training. These demonstration projects, however, cannot compensate for the overall low levels of funding for training and wages.

At least 21 states have adopted what is called a "wage pass through," which requires that a specific amount or percentage of any increase in state Medicaid payments to long-term care providers must be spent on increasing the wages and/or benefits of paraprofessional healthcare workers. The results in terms of reducing shortages and turnover have been mixed at best.[11] States cannot solve nursing home and home health care problems on their own, and they have even less influence over hospitals.

The bottom line is that the nation's investment in upgrading the training of health care workers remains grossly inadequate, and state and federal health care funding is still not enough to create anything approaching self-sufficiency wages.

If public policy were adequate to the challenge, it would set as a national goal not just the expansion of various small programs, but the ideal that all positions in the health care field pay at least the salary of a good paraprofessional. This would require additional public funds, not just for higher pay, but for a coordinated strategy of training, placement, and the subsidy of living expenses so that people could afford to train.

---

[10] Dawson, Steven L. and Rick Surpin. 2001. Direct-Care Healthcare Workers: You Get What You Pay For. *Workforce Issues in a Changing Society*. Washington, D.C.: Aspen Institute.

[11] U.S. Department of Health and Human Services (Institute for the Future of Aging Services). 2002. State Wage Pass-Through Legislation: An Analysis. WORKFORCE ISSUES: No. 1**.** **http://aspe.hhs.gov/daltcp/reports/wagepass.htm.**