



A New Commitment to Quality Care

A Report by the Service Employees International Union, Local 4

February 2007

State Falls Short In Providing Quality Care

Illinois provides funding through Medicaid to more than 76,500 nursing home residents in 712 long-term care facilities.ⁱ However, while the state provides Medicaid funding to these facilities through Medicaid reimbursement rates, these rates rank near the bottom of the country's fifty states. These funding levels have contributed to low wages, high staff turnover and low staffing levels in nursing homes, and have created conditions where Illinois nursing home residents are at risk. In recent quality surveys, Illinois nursing homes ranked worse than the national average in 11 quality measures tracked by the Center for Medicare and Medicaid Servicesⁱⁱ, and were more likely than the average nursing home to be cited for causing actual harm to a resident.ⁱⁱⁱ

Experienced Caregivers Provide Quality Care

Conversely, high turnover has a negative impact on nursing homes' ability to recruit and retain experienced staff. Illinois' staggering 75% turnover rate for the nurse aides who care for residents^{iv}, is driven by the state's low reimbursement rate that results in low pay and benefit rates for frontline caregivers.

There is a direct link between quality jobs and quality care: **facilities providing the highest wages for Certified Nurse Aides averaged 30% fewer violations resulting in direct harm to patients than those paying wages and benefits at the low end of the scale.**^v In fact, the average wages for front-line nursing workers is lower than those for restaurant delivery drivers, manicurists and pedicurists, school bus drivers and utilities meter readers.^{vi}

Current Levels Of Support For Quality Care In Illinois Won't Do

Illinois' Medicaid reimbursement rates ranked 46th in the nation according to the most recent available data. The amount of time per day an Illinois direct caregiver can spend with a nursing home resident is 24%^{vii} below the Federal government's recommended standards, and 11% below the national average^{viii}. Numerous academic studies have concluded that higher compensation for direct care workers correlates with lower worker turnover, which may not only create instability in resident care and reduce the experience level of the workforce, but also may cost nursing homes millions that should go to front-line care. Clearly, Illinois has to do more to improve the quality of care for its most vulnerable citizens.

A Prescription For Change

It is clear that Illinois must raise its Medicaid reimbursement rates in order to address this problem. And while these rates have not increased significantly in recent years, facilities have been making money. Between 2004 and 2005, Illinois nursing homes reported a 55% increase in net profits^{ix} while the average wage for nursing aides increased less than 2%.^x In 2005 alone, Illinois nursing home facilities reported over \$81 million in profits.^{xi} Simply raising the rates won't do the job. In Arizona, for example, the state's rates were increased over 40% but wages for their frontline caregiver wages only increased 11%.^{xii} Arizona's experience serves as important reminders that a blank check won't address low caregiver wages and the quality of care issues associated with low wages.

However, at the same time Arizona was struggling to increase caregiver wages, several other states got creative. These states began targeting rate increases toward raising salaries and benefits for frontline caregivers. These targeted increases ensured that funding went to address low wages and high turnover effecting the quality of care provided to their most fragile seniors. From 2000 through 2003, a majority of states implemented some type of wage or benefit pass-through for long-term care workers. To reduce turnover and improve care, Illinois must do the same

Legislation, introduced by Representative Kevin Joyce and Senator Don Harmon, takes Illinois nursing home funding in an important and creative direction and creates a more stable and effective work force caring for Illinois seniors. Their plan, the Senior Care Bill, acknowledges that quality of care can be improved in Illinois by targeting nursing home rate increases directly to improving wage and benefit rates to frontline care givers. When passed, their formula will lead to a much needed improvement in the quality of care Illinois provides nursing home residents.

Illinois pays its nursing homes one of the lowest Medicaid reimbursement rates in the nation. According to an AARP study, Illinois reimbursement rates ranked 46th in the nation as of 2002, the last year for which comparable data for all states are available.^{xiii} Although Illinois' rates have increased twice since that time, from approximately \$90 to an average of \$95 per facility,^{xiv} this increase has not even kept pace with inflation.

Ultimately, nursing home residents are the victims of such low reimbursement. Of the quality measures tracked by the Center for Medicare and Medicaid Services, Illinois homes ranked worse than the national average on 11 and better on only 6.^{xv}

In Illinois,

- 1 in 6 residents are likely to get a pressure sore,
- 1 in 6 residents are more depressed or anxious since the last time they were checked by state surveyors, and
- 1 out of 10 long-stay resident lose too much weight.

The severity and scope of violations of basic patient care standards in Illinois nursing homes is a cause for concern. In 2005, Illinois facilities were 11% more likely than the average U.S. nursing home to be cited for causing actual harm to a resident.^{xvi}

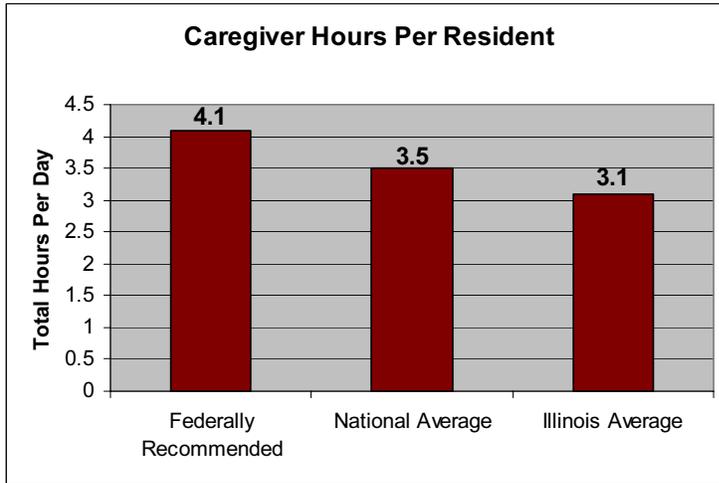
The effects of lapses in care are dramatic, and even horrific. In 2005, these examples included:

- The facility failed to provide adequate staff training on policies and procedures to restrain agitated residents, resulting in an agitated resident being restrained with a “football style tackle” and sustaining a broken leg and torn ACL^{xvii}
- A facility failed to provide wheel chair cushions for 13 residents at risk for developing bed sores and failed to treat or notify physicians when new sores inevitably developed.^{xviii}
- An elderly female resident was hospitalized for heart failure caused by an infection from a septic open lesion.^{xix}
- An elderly resident at risk of falling and becoming injured was left unsupervised and found sitting in their toilet with a 3 ½ inch gapping wound that required 13 sutures.^{xx}
- An elderly woman who required extensive hygiene assistance was sent to an emergency room in a urine-soaked incontinence brief with dried stool caked on her buttocks and legs. The subsequent evaluation by a physician found six areas of skin breakdown and bed sores.^{xxi}

Dedicated nursing home workers are devastated by these examples.

Ultimately, Illinois' low Medicaid reimbursement rate and related cost cutting drives some nursing home owners to staff their facilities at dangerously low levels. Studies have shown that nursing homes with low staffing levels tend to have high worker turnover and provide a lower quality of care.^{xxii} Short-staffing can increase a facilities' reliance on catheters to assist nonambulatory patients.^{xxiii} Short-staffing and staff turnover has also been related to increases in a facilities' number of reported bed sores, urinary tract infections, and deaths.^{xxiv}

The federal government recommends **4.1 hours^{xxv}** of direct caregiver time for each resident day to prevent resident harm such as the violations above. In contrast, the average nursing home resident in Illinois receives just **3.1 hours** of direct care for each day.^{xxvi} This is 11% lower than the **3.5 hours** per day the average U.S. nursing home resident receives.^{xxvii}



“The number of residents in our home has gone up. My patient load has more than doubled. You want to make the residents feel good about themselves by doing little extra things—they deserve that—but you can’t do everything when your workload goes up that much.”
- Dawnalee Bellis, Certified Nursing Assistant, Byron.

Low Caregiver Compensation Leads to Turnover and Decreased Quality of Care

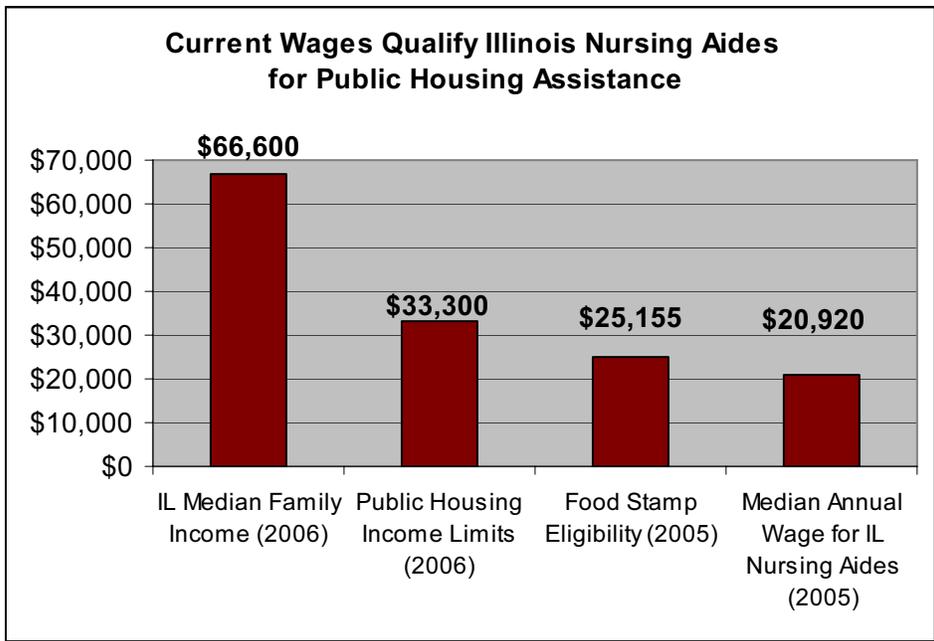
Illinois' nursing home owners further cut costs by paying extremely low wages to their front-line caregivers. Most caregivers' wages are so low they can't afford market rate housing. For example, in Illinois, in order to afford a two-bedroom apartment at \$829/month, a household must earn at least \$15.95/hour.^{xxviii} The following are average wages paid to caregivers in Illinois nursing homes during 2005, the year for which data is most recently available:^{xxix}

- Certified Nurse Aides \$9.73/hr
- Housekeepers \$8.21/hr
- Cooks \$9.61/hr

The average wages provided to Illinois nursing home workers hovers at the federal poverty line for a family of four. At this level, certified nursing aide workers qualify for food stamp assistance.^{xxx}

In comparison, these occupations in Illinois provided the following average wages in 2005^{xxxi}

- Restaurant Delivery Drivers \$9.82
- Manicurist and Pedicurist \$11.93
- School Bus Drivers \$12.00
- Utilities Meter Reader \$14.30



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Academics have frequently argued that higher compensation for direct-care workers is associated with lower worker turnover. In one of the most rigorous studies, a statistical analysis of rising wages for San Francisco’s home care workers over a 52-month period, it was shown that a \$1 increase in wages from \$8 per hour increases the chance of a worker remaining for one year by 17 percentage points.^{xxxiii} The same study concluded that adding health insurance improves worker retention by 21 percent.



“I work as a laundry assistant in a nursing home. When I’m done with my day shift at the nursing home I go to a second full-time job as a home health care worker. My last pay cycle, I worked 87.5 hours in one week at the two jobs. The only way I can make my house payments is to work two full-time jobs. Sometimes, when the census is down in the nursing home, my hours get cut and that really hurts. When that happens, sometimes I can only pay half my bills, and then I catch up later when I can get more hours.”

- Diane Elliott, Laundry Worker, Jacksonville.

In nursing homes, the state of Michigan found that over a 13-year period in which caregiver wages increased by 61%, worker turnover decreased by 21%.^{xxxiv}

Low compensation, and the high turnover it brings, means a less stable, professional workforce is taking care of fragile nursing home residents. In Illinois, lower wages for the direct-care workforce are linked to the most severe care violations, ones in which there is direct harm to patients. Facilities providing the highest wages for Certified Nursing Aides wages averaged 30% fewer violations resulting in direct harm to patients than those facilities providing wages on the lowest end of the pay scale.^{xxxv}

High turnover reduces the experience level of the workforce, creates chronic vacancies, and wastes resources to repeatedly recruit, hire, and train new workers. Frequent staff changes force residents to endure a parade of strangers providing them the most intimate care.

- A report to Congress, focused primarily on nursing home staffing levels, also found a strong, statistically significant relationship between Certified Nurse Aides (CNA) retention and five (of 15) quality measures often used to gauge the quality of care provided in nursing homes. Where CNA retention was low, workers were more likely to suffer sepsis, urinary tract infection, and electrolyte imbalance. They were also more likely to resist care improvement and less likely to improve in their ability to function.^{xxxvi}
- The same report determined that wages would need to be significantly increased at the national level, as much as 22%, in order to achieve staffing improvements also recommended by the study.^{xxxvii}
- The National Academy of Sciences Institute of Medicine found that “high turnover compromises the continuity of care” and “adversely affect[s] residents who do not cope well with frequent changes in staff.”^{xxxviii}
- A study released by the University of Wisconsin-Madison found that high frontline caregiver turnover nursing homes reported a lower quality of care, as measured by care violations, deficiencies and complaints, than homes reporting lower caregiver turnover.^{xxxix}

In the most recent estimates, 75.5% of all Certified Nurse Aides turnover annually in Illinois nursing home facilities..

Given the standard of care in Illinois nursing homes and the low wages currently paid to caregivers, it is time to make a major investment in front-line care. Based on the success other states have had improving care through increased caregiver wages, we recommend:

- \$1 per hour **wage pass-through** for front-line caregivers. Nursing homes will be eligible to receive the reimbursement rate increases necessary to increase the wages of non-managerial employees in nursing homes. The vast majority of employees eligible to receive these increases are Licensed Professional Nurses (LPNs), CNAs, housekeepers, and kitchen assistants.
- \$1 per hour additional increase in compensation for **employee benefits**, such as paid leave, health insurance, disability insurance, and retirement benefits. This would function in the exact same way as the wage pass-through described above.
- A strong **audit process** to ensure that funds allocated are actually used to increase compensation for front-line caregivers. Nursing home owners would be required to submit written documentation of increased wages and benefits. Massachusetts and Wisconsin are among states using an audit processes to create accountability.

States' experiences with across-the-board rate increases paid to long-term care providers also show why targeted funding is good policy. A study of funding increases provided to home care agencies in Arizona determined that rates paid to agencies increased 44% from 2000-2005, yet caregiver wages only rose by 11% over the same 5-year period.^{xi} This wage increase failed to even keep pace with inflation.^{xii} Clearly, this major government investment in long-term care did little to improve the investment in front-line care. Given the close relationship between wages, turnover, and quality of care, it is likely that clients continued to experience high worker turnover as well. For this reason, we recommend a rigorous audit process to accompany the rate increase.

The direct cost of this proposal is approximately \$242 million, of which \$121 would be paid by the state, and the other half through federal matching funds.^{xiii} With over \$28.3 billion in revenues outlined in Governor Blagojevich's proposed 2007 budget, the state share of the Senior Care Bill represents less than 1% of annual revenues.^{xiiii} However, there will also be approximately \$55 million in total cost savings from this proposal that will partly offset this expense.

- **Reduced direct cost of employee turnover.** It is expensive to recruit, hire, and train new employees. An industry-funded study from 2004 estimated that the loss of an employee results in direct costs equal to at least \$2,500.^{xlv} The same study observed that the most substantial cost, inefficient performance of the job by new hires, is actually "hidden" and is almost never accounted for.
- **Cost savings from improved care.** In nursing homes, inexperienced caregivers are more likely to injure themselves or residents, leading to additional costs that are ultimately borne



"There are 53 residents on my floor, and all of them need complete care. But it's hard to do, because there are often only 4 CNAs on my shift, and sometimes only 3 – that's 14 to 18 residents to care for. We have to feed them, clean them, turn them, all of the things you need to do. Almost all the new CNAs are just out of school, just got their certificate – we almost never get experienced workers to apply. This is hard work, and some people just won't stay for the kind of money they start off at now."

- George Buchannan, Certified Nursing Assistant, Chicago.

by Medicaid. By reducing worker turnover, these costs will be reduced, leaving more funds available to spend on direct care. Using the \$2,500 figure provided above, these cost savings could amount to \$55 million annually.

Demonstrated Success: Other States' Improvements

Many other states decided to invest in a stable, professional caregiver workforce. From 2000-2003, a majority of states funded some type of wage or benefit pass-through for direct care workers.^{xlv} Among nearby states implementing such measures for nursing home workers were Michigan, Wisconsin, and Minnesota. Missouri has pursued a wage pass-through for home care workers.

Evaluations of pass-through programs demonstrate that wage pass-throughs can successfully reduce worker turnover when carefully implemented:

- **Michigan** provided wage pass-throughs for nursing home caregivers for over a decade, beginning in 1990. As noted above, the state found that during the 13 years of annual wage pass-throughs to CNAs, wages increased by 61% (before inflation) while turnover decreased by 21%.^{xlvi}
- During the course of **Wyoming's** wage pass-through for direct care workers, full-time staff turnover declined from 52% to 37%. This wage pass-through was for workers providing care to developmentally disabled individuals. Wages increased from \$7.38 in 2001 to \$10.74 in 2004.^{xlvii}
- A **Pennsylvania** survey of nursing homes and other long-term care providers revealed that higher-paying providers were significantly less likely to experience retention and recruitment problems than their lower-paying counterparts.^{xlviii}

In a recently published study, Wyoming's pass-through was cited as a model of success.^{xlix} According to the authors, "Wages and retention for Wyoming direct care professionals working with developmentally disabled individuals were transformed."

Among the factors differentiating this initiative from those in other states was Wyoming's sustained commitment to the direct-care workforce, demonstrated through two follow-up cost of living increases. Also, Wyoming successfully ensured that caregivers would receive intended wage increases through an accountability process. Like the process envisioned for Illinois, Wyoming providers demonstrated through their annual cost reports to the state, that wages had increased. That state even went one step farther by requiring that evidence of reduced worker turnover be provided as part of the same annual cost reports.¹



"The owners at the home where I work hire people above the minimum, and they pay a good shift differential and attendance bonuses, so we don't have the kind of turnover that happens at other places. Most people have been here more than 3 years, and a lot of us have been here a lot longer. I know people, friends and relatives, who work at other homes nearby, and it's crazy where they work – constant turnover, all kinds of turmoil – I couldn't work at those places. You treat people fair, and give them a lot of training like they do here, and people stay."

- Gladys Bell, Certified Nursing Assistant, Chicago.

Training Funds: Creating a More Stable, Professional Workforce

A number of states created training funds to improve caregivers' skills while providing a more clear career path that encourages them to stay in the caregiver workforce. These initiatives are both cost-effective and likely to pay off well into the future.

- **Massachusetts** provided \$5 million in FY 2002 for an Extended Care Career Ladder Initiative, specifically designed to move direct-care workers to higher-skill positions. The state also provided \$1 million for CNA training scholarship funding.ⁱⁱ An evaluation of a career-ladder initiative in Massachusetts found anecdotal evidence that the program was indeed having an impact.ⁱⁱⁱ According to the authors, "each...[nursing home involved in the program had] a story to tell. Most tell of improved skills, lower turnover, better employee attitudes and signs of improved quality of care...employers are also finding it easier to find and keep workers since implementing the program."ⁱⁱⁱ
- **Wyoming** sponsored a training fund for caregivers working with developmentally disabled individuals. This fund was partly credited with contributing to the decline in turnover among these workers.^{iv}
- In May 2002, **California's** Governor announced a \$10.5 million grant fund for the training of direct care workers, with the goal of increasing the size of the workforce by 2,000 within 20 months.^{lv}

Louisiana, Maryland, Minnesota, New York, North Carolina, Pennsylvania, Vermont, and Virginia were among other states that dedicated funds toward some type of training or career ladder initiative for the front-line long-term care workforce.^{lvi}

Conclusion

Wage and benefit pass-throughs are a demonstrated effective way to reduce worker turnover and improve the quality of long-term care. They are especially effective when paired with investments in worker training and rigorous audit and oversight processes. If Illinois chooses to adopt similar policies, the state's nursing homes can expect to see some of the same benefits:

- By improving wages, the funding increase will bring nursing home workers, upon whom fragile nursing home residents rely on intimate personal care, one step closer to being able to provide the quality of life for their families that they strive to provide for their residents.
- By reducing worker turnover, a targeted funding increase will provide a more stable, professional workforce that can improve the quality of care in Illinois' nursing homes
- By improving caregiver skills, a training fund will create a clear career path in long-term care that will keep more workers in the field.

Appendix: Methodology Used to Estimate Cost of Legislative Proposal

SEIU is proposing that the state legislature improve quality care by providing targeted funding for wages, benefits, and training for nursing home workers. The estimated direct cost of this proposal is \$242 million, which was reached by the following method.

In cost reports submitted by all Medicare/Medicaid-certified nursing homes, each home reports the number of beds it has in each of six licensure categories. We have included only those facilities that have SNF-, ICF-, or SNFPED-licensed beds.

On page 20 of these cost reports, each home is required to report the number of actual hours worked, as well as the number of “paid hours” (including sick leave, overtime, etc.). These hours are reported for a variety of job classifications.

To calculate the estimated cost of a \$1/hr. wage increase, this amount was multiplied by the number of paid hours in the following job categories: Licensed Practical Nurses, CNAs and Orderlies, CNA Trainees, Licensed Therapists, Rehab/Therapy Aides, Activity Assistants, Social Service Workers, Dieticians, Habilitation Aides, Cook Assistants, Dishwashers, Maintenance Workers, Housekeepers, Laundry Workers, Clerical Workers, Vocational Instruction Workers, and Medical Records Workers. The \$1/hr. employee benefits improvement was calculated in the exact same way.

Appendix II. Methodology used to compare facility specific Certified Nurse Aide wages and violations of nursing home care standards causing actual harm

In Illinois, lower wages for the direct-care workforce are linked to the most severe care violations found in nursing home facilities. Facilities providing the highest wages for Certified Nursing Aides wages averaged 30% less violations resulting in actual harm to patients than those facilities providing wages on the lowest end of the pay

Each Illinois Medicare/Medicaid-certified nursing homes submits cost reports to the Illinois Department of Healthcare and Family Services. Among various other patient statistics, financial and wage data, these cost reports include information on the total salaries and wages for Certified Nurse Aides (CNA) for each Medicare/Medicaid certified nursing home facility and the total number of paid hours and actual hours worked by CNAs. Facilities are required to calculate an average hourly rate for each job classification in a home by dividing the total number of dollars paid out in a particular job category by the numbers of hours worked by all personnel in that job category. Facilities are not required to report total actual hours by all personal in a particular category and can use a one month sample of the facility’s records to calculate an average wage. Because this data includes the total hours worked by job category, overtime hours are also included in the average wage calculations. The cost reports must be submitted to the Department within 90 days of the end of the facilities’ fiscal year. 2005 is the year for which the most recent data is available.

The federal government compiles data on the performance of every Medicaid and Medicare certified nursing home in the country. This data base, the Online Survey, Certification, and Reporting (OSCAR), includes the nursing home characteristics and health deficiencies issued during the three most recent state inspections and recent complaint investigations. These inspections issue care violations and issue deficiency ratings based on twelve categories representing the combination of the scope and the level of harm. The most severe violations are those causing actual harm to a nursing home resident.

To look at the relationship between wages and the most severe care violations, the six deficiency codes causing actual harm and/or immediate jeopardy to residents were selected from the OSCAR data base

and aggregated for each Illinois facility. The CNA average hourly wage for each Illinois facility was then selected from the cost report data from the Illinois Department of Healthcare and Family Services. Only the severe deficiencies and CNA wages from the 2005 calendar year were selected.

These total numbers of severe deficiencies per facility were then compared to the average wage for Certified Nurse Aides at each facility. The CNA wages were compared to the average number of actual harm and immediate jeopardy deficiencies found at each facility in each quintile. This comparison found that the average number of actual harm deficiencies decreased as the CNA wage per facility increased.

ⁱ Data from 2005 annual cost reports submitted by providers to the Illinois Department of Healthcare and Family Services. The sum of all facilities reporting SNF, ICF, SNFPED resident days was 712. Dividing the sum of SNF ICF, SNFPED resident days in 2005 by 365, the number of days in a year was used to calculate the number of residents in Illinois nursing homes. This calculation resulted in an estimated 76,576 residents in SNF, ICF, and SNFPED facilities.

ⁱⁱ Nursing Home Compare website, <http://www.medicare.gov/nhcompare/home.asp>. Accessed January 5, 2007.

ⁱⁱⁱ Charlene Harrington and James H. Swan, "Nursing Home Staffing, Turnover, and Case Mix," *Medical Research and Review*, September 2003.

^{iv} Results of AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes, Health Services Research and Evaluation, American Health Care Association, February 12, 2003.

^v Data from 2005 annual cost reports submitted by providers to the Illinois Department of Healthcare and Family Services and 2005 Nursing Home Compare Downloadable Database. The average number of violations of nursing home care standards causing actual harm to residents was compared to Certified Nurse Aide wages. This comparison found that the average number of actual harm deficiencies decrease as the CNA wage per facility increased.

^{vi} U.S. Department of Labor, May 2005 State Occupational Employment and Wage Statistics, Accessed 1/26/2007, http://www.bls.gov/oes/current/oes_il.htm#b31-0000

^{vii} U.S. Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc. 2001. *Appropriateness of Minimum Nurse Staffing Ratios In Nursing Homes. Report to Congress: Phase 2 Final*. Volumes I-III. Baltimore, MD: CMS. Accessed on 9/21/2006 at http://www.cms.hhs.gov/CertificationandCompliance/12_NHs.asp

^{viii} Centers for Medicare and Medicaid Services Op. Cit., p. 8-11.

^{ix} Data from 2004 and 2005 annual cost reports submitted by providers to the Illinois Department of Healthcare and Family Services. The net income reported on line 43 page 19 and the salaries paid to related parties of the cost reports were aggregated. Adding this net income (positive and negative) yielded a sum of \$81 million.

^x U.S. Department of Labor, May 2005 State Occupational Employment and Wage Statistics, Accessed 1/26/2007, http://www.bls.gov/oes/current/oes_il.htm#b31-0000 and U.S. Department of Labor, May 2004 State Occupational Employment and Wage Statistics, Accessed 2/8/2007, http://www.bls.gov/oes/2004/may/oes_il.htm#b31-0000

^{xi} Data from 2005 annual cost reports submitted to providers to the Illinois Department of Healthcare and Family Services

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- ^{xii} Dorie Seavey and Vera Salter, "Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants," Paraprofessional Healthcare Institute, October 2006, p. 13.
- ^{xiii} Ari Houser, Wendy Fox-Grage, and Mary Jo Gibson, "Across the States: Profiles of Long Term Care and Independent Living," AARP Public Policy Institute, 2006, pp. 100-105.
- ^{xiv} Medicaid Rate List for Nursing Facilities- Data 06/30/2006, Bureau of Rate Development and Analysis, Illinois Department of Healthcare and Family Services
- ^{xv} Nursing Home Compare website, <http://www.medicare.gov/nhcompare/home.asp>. Accessed January 5, 2007.
- ^{xvi} Charlene Harrington and James H. Swan, "Nursing Home Staffing, Turnover, and Case Mix," *Medical Research and Review*, September 2003.
- ^{xvii} Survey of Deficiencies, Department of Health and Human Services, Center for Medicare and Medicaid Services, Countryside Healthcare Center, 06/23/2005, pp 5-9
- ^{xviii} Survey of Deficiencies, Department of Health and Human Services, Center for Medicare and Medicaid Services, Freeport Rehab and Health Center, 10/13/2005, pp 11-14
- ^{xix} Survey of Deficiencies, Department of Health and Human Services, Center for Medicare and Medicaid Services, Freeport Rehab and Health Center, 01/25/2005, p 12
- ^{xx} Survey of Deficiencies, Department of Health and Human Services, Center for Medicare and Medicaid Services, East Bank Center, LLC, 05/20/2005, pp 22-25
- ^{xxi} Survey of Deficiencies, Department of Health and Human Services, Center for Medicare and Medicaid Services, Freeport Rehab and Health Center, 10/13/2005, p 11
- ^{xxii} Charlene Harrington, Janis O'Meara, and Taewoon Kang, *Snapshot: Staffing and Quality in California Nursing Homes*. Accessed on 9/20/2006 at <http://www.chcf.org/topics/view.cfm?itemID=123317>.
- ^{xxiii} Charlene Harrington, "Nurse Staffing in Nursing Homes in the United States: Part II," in *Journal of Gerontological Nursing*, March 2005, pp. 9-15.
- ^{xxiv} Charlene Harrington, "Nurse Staffing in Nursing Homes in the United States: Part II," in *Journal of Gerontological Nursing*, March 2005, pp. 9-15.
- ^{xxv} U.S. Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc. 2001. *Appropriateness of Minimum Nurse Staffing Ratios In Nursing Homes. Report to Congress: Phase 2 Final*. Volumes I-III. Baltimore, MD: CMS. Accessed on 9/21/2006 at http://www.cms.hhs.gov/CertificationandCompliance/12_NHs.asp
- ^{xxvi} Nursing Home Compare website, Op Cit.
- ^{xxvii} Ibid.
- ^{xxviii} National Low Income Housing Coalition, accessed on 1/26/2007 at, <http://www.nlihc.org/oor/oor2006/data.cfm?getstate=on&state=IL>
- ^{xxix} U.S. Department of Labor, May 2004 State Occupational Employment and Wage Statistics, Accessed 2/8/2007, http://www.bls.gov/oes/2004/may/oes_il.htm#b31-0000.
- ^{xxx} U.S. Department of Health and Human Services, accessed online 1/30/2007 at <http://aspe.hhs.gov/poverty/05poverty.shtml>
- ^{xxxi} U.S. Department of Labor, May 2005 State Occupational Employment and Wage Statistics, Accessed 1/26/2007, http://www.bls.gov/oes/current/oes_il.htm#b31-0000
- ^{xxxii} Illinois Median Family Income, Estimated Median Family Incomes 2006, US Department of Housing and Urban Development. Public Housing Income Limits, based on 50% of Av Median Family Income guidelines, FY 2006 HUD Guidelines, p.5
- ^{xxxiii} Howes, Candace, "Living Wages and Retention of Homecare Workers in San Francisco." *Industrial Relations*, Vol. 44, No. 1, pp. 139-163, January 2005 Available at SSRN: <http://ssrn.com/abstract=639759>
- ^{xxxiv} North Carolina Division of Facility Services, "Results of a Follow-Up Survey to States on Wage Supplements for Medicaid and Other Public Funding To Address Aide Recruitment and Retention In Long-Term Care Settings," November 2000. Also see Health Care Association of Michigan, "Wage and Compensation Report 2004."
- ^{xxxv} Data from 2005 annual cost reports submitted by providers to the Illinois Department of Healthcare and Family Services and 2005 Nursing Home Compare Downloadable Database. The average number of violations of nursing home care standards causing actual harm to residents was compared to Certified Nurse Aide wages. This comparison found that the average number of actual harm deficiencies decrease as the CNA wage per facility increased.

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- ^{xxxvi} Centers for Medicare and Medicaid Services, “Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final,” December 2001, p. 2-19.
- ^{xxxvii} Centers for Medicare and Medicaid Services Op. Cit., p. 8-11.
- ^{xxxviii} “Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?” National Academy of Sciences, Institute of Medicine, 1996.
- ^{xxxix} Jobs With A Future Partnership, Center of Wisconsin Strategy, “Caring for Caregivers: Reducing Turnover of Frontline Health Care Workers in South Central Wisconsin,” University of Wisconsin-Madison, October 2003
- ^{xl} Dorie Seavey and Vera Salter, “Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants,” Paraprofessional Healthcare Institute, October 2006, p. 13.
- ^{xli} Calculated using the Bureau of Labor Statistics Consumer Price Index (CPI) Calculator, accessed online at <http://data.bls.gov/cgi-bin/cpicalc.pl> on January 26, 2007.
- ^{xlii} See Appendix for Methodology used to estimate this cost.
- ^{xliii} Illinois State Budget, Fiscal Year 2007, p 38
- ^{xliv} Dorie Seavey, “The Cost of Frontline Turnover in Long-Term Care,” Better Jobs Better Care, October 2004.
- ^{xlv} Paraprofessional Healthcare Institute and North Carolina Department of Health and Human Services’ Office of Long Term Care, “Results of the 2003 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce,” March 2004.
- ^{xlvi} North Carolina Division of Facility Services, “Results of a Follow-Up Survey to States on Wage Supplements for Medicaid and Other Public Funding To Address Aide Recruitment and Retention In Long-Term Care Settings,” November 2000. Also see Health Care Association of Michigan, “Wage and Compensation Report 2004.”
- ^{xlvii} Paraprofessional Healthcare Institute and North Carolina Department of HHS Office of Long-Term Care, “Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce.” September 2005.
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