

Essential Long-Term Care Workers Commonly Hold Second Jobs and Double- or Triple-Duty Caregiving Roles

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OBJECTIVES: Long-term care (LTC) facilities are particularly dangerous places for the spread of COVID-19 given that they house vulnerable high-risk populations. Transmission-based precautions to protect residents, employees, and families alike must account for potential risks posed by LTC workers' second jobs and unpaid care work. This observational study describes the prevalence of their (1) second jobs, and (2) unpaid care work for dependent children and/or adult relatives (double- and triple-duty caregiving) overall and by occupational group (registered nurses [RNs], licensed practical nurses [LPNs], or certified nursing assistants [CNAs]).

DESIGN: A descriptive secondary analysis of data collected as part of the final wave of the Work, Family and Health Study.

SETTING: Thirty nursing home facilities located throughout the northeastern United States.

PARTICIPANTS: A subset of 958 essential facility-based LTC workers involved in direct patient care.

MEASUREMENTS: We present information on LTC workers' demographic characteristics, health, features of their LTC occupation, additional paid work, wages, and double- or triple-duty caregiving roles.

RESULTS: Most LTC workers were CNAs, followed by LPNs and RNs. Overall, more than 70% of these workers agreed or strongly agreed with this statement: "When you

are sick, you still feel obligated to come into work." One-sixth had a second job, where they worked an average of 20 hours per week, and more than 60% held double- or triple-duty caregiving roles. Additional paid work and unpaid care work characteristics did not significantly differ by occupational group, although the prevalence of second jobs was highest and accompanying work hours were longest among CNAs.

CONCLUSION: LTC workers commonly hold second jobs along with double- and triple-duty caregiving roles. To slow the spread of COVID-19, both the paid and unpaid activities of these employees warrant consideration in the identification of appropriate clinical, policy, and informal supports. *J Am Geriatr Soc* 00:1-4, 2020.

Keywords: long-term care workers; nursing home; second jobs; double- and triple-duty caregiving; COVID-19 pandemic

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Long-term care (LTC) facilities are particularly dangerous places for the spread of COVID-19 as the country first learned with the outbreak in Kirkland, Washington's Life Care Center in early March 2020.¹ This means that the more than 3.6 million people who receive support from an LTC facility in the United States are at heightened risk of infection.² As of April 1, 2020, 400 nursing homes nationally reported COVID-19 cases.³ By April 7, 187 homes reported cases in New Jersey alone,⁴ and by April 16, outbreaks had been reported in 3,466 LTC facilities in 39 states,⁵ representing more than 5,500 nursing home resident deaths due to COVID-19.⁶

Nursing homes employ more than 940,000 full-time equivalent nursing staff.⁷ Before the COVID-19 pandemic, low wages and limited benefits meant that many facility-based LTC workers (hereafter LTC workers) held multiple jobs. As essential workers, they continue to face exposure risks and are part of multiple transmission risk pathways.

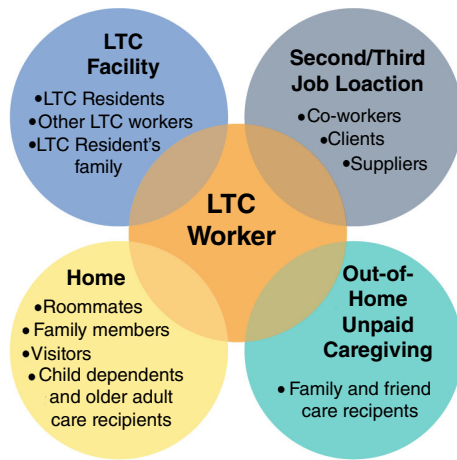


Figure 1 Distinct contact locations of long-term care (LTC) workers.

Not only do we need to consider transmission risk between facility residents to and from LTC workers and between LTC workers to and from their own household members (Figure 1), but additional risks are posed by their second jobs and their unpaid care work in other settings. This article describes the paid and unpaid work of LTC workers to illuminate a potentially potent pathway of COVID-19 transmission risk that should be addressed.

We used data from the final wave of the Work, Family and Health Study (WFHS) to describe the prevalence of (1) second jobs, and (2) unpaid care work for dependent children and/or adult relatives (ie, double- and triple-duty caregiving) among LTC workers.⁸ These data are from 2012, but there is little evidence to indicate the situation has changed for LTC worker since then. The LTC sector was essentially left out of healthcare reform (the Affordable Care Act in 2010), and, as such, financing and public reimbursement for nursing homes have not changed.⁹ Given

Table 1 Characteristics of Long-Term Care Workers

Characteristics	Overall N = 958	RN n = 101 (10%)	LPN n = 191 (20%)	CNA n = 666 (70%)	P
Demographics					
Age, y	40.6 (12.2)	43.7 (12.0)	42.9 (11.8)	39.5 (12.3)	<.001
Female	890 (93%)	95 (94%)	181 (95%)	614 (92%)	.42
White	676 (71%)	77 (76%)	152 (80%)	447 (67%)	<.01
Hispanic	138 (14%)	4 (4%)	8 (4%)	126 (19%)	<.001
Foreign born	275 (29%)	23 (23%)	39 (20%)	213 (32%)	<.01
Married/Living with partner	580 (61%)	77 (76%)	131 (69%)	372 (56%)	<.001
Spouse/Partner has full-time/Part-time job	466 (80%)	67 (87%)	108 (82%)	291 (78%)	.17
Some college or more	595 (62%)	101 (100%)	180 (94%)	314 (47%)	<.001
Total household size	3.1 (1.6)	3.24 (1.8)	3.1 (1.4)	3.1 (1.6)	.70
Health					
At least one chronic condition	342 (36%)	38 (38%)	79 (41%)	225 (34%)	.14
LTC work role					
Hours worked per week at primary job	36.3 (7.6)	37.1 (8.5)	37.1 (6.6)	36.0 (7.6)	.11
Company tenure, y	8.9 (7.1)	8.8 (8.0)	9.6 (7.2)	8.7 (6.9)	.32
Feel obligated to work while sick (agree or strongly agree)	669 (70%)	71 (70%)	135 (71%)	463 (70%)	.38
Additional paid work					
Has second job	167 (17%)	13 (13%)	31 (16%)	123 (19%)	.34
Hours worked per week at second job	19.7 (12.8)	14.7 (15.3)	16.5 (11.4)	21.1 (12.6)	.07
Wages					
Gross annual personal income (range = 1-13)	7.5 (2.9)	11.2 (1.8)	10.5 (2.1)	6.1 (2.0)	<.001
Gross annual household income (range = 1-13)	9.7 (3.2)	12.4 (1.4)	12.1 (1.7)	8.7 (3.1)	<.001
Perceived adequacy of total household income					<.001
We cannot make ends meet	72 (7%)	4 (4%)	12 (6%)	56 (8%)	
We have just enough, no more	294 (31%)	15 (5%)	47 (25%)	232 (35%)	
We have enough, with a little extra sometimes	467 (49%)	67 (66%)	98 (51%)	302 (45%)	
We always have money left over	124 (13%)	15 (15%)	34 (18%)	75 (11%)	
Unpaid care work					
Double- or triple-duty care	582 (61%)	61 (60%)	119 (62%)	402 (61%)	.90

Note: Higher values indicate greater levels of the variable being examined. Chronic conditions included stroke, cancer, high blood pressure, coronary heart disease, and diabetes. Gross annual personal and household income were each measured on a 13-point ordinal scale from 1 = less than \$4,999 to 13 = more than \$60,000. Double- or triple-duty caregivers lived with at least one child aged 18 years or younger for 4 or more days per week and/or provided unpaid care to at least one adult relative for 3 or more hours per week in the past 6 months regardless of residential proximity.

Abbreviations: CNA, certified nursing assistant; LPN, licensed practical nurse; LTC, long-term care; RN, registered nurse.

that labor is the biggest share of the costs of nursing home operations and Medicaid reimbursement rates remain low, LTC worker wages have increased on average 1% in real terms over the past 10 years.¹⁰ In tandem, beyond possibly gaining their own health insurance coverage through healthcare reform, there is no evidence that LTC worker conditions have changed in the past decade. The workforce remains predominantly female and is ethnically and racially diverse. Injuries remain high compared with other occupations,¹¹ wages remain extremely low, and fringe benefits are minimal.¹² Therefore, this unique data source from 2012 can illuminate behaviors of today's LTC workforce.

METHODS

The WFHS was designed to examine the work, family, and health of employees working in 30 nursing home facilities throughout New England.¹³ The most recent and final wave of data collection was completed in December 2012 (N = 1,007). We focused on the subset of study participants providing direct patient care including registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) (n = 958). We present descriptive data on secondary jobs and double- or triple-duty caregiving roles by all LTC workers and by occupational groups. Specifically, we estimate means and standard deviations for continuous variables and for distributions and frequencies for categorical variables. The *P* values for differences among the three occupational groups were obtained from the analysis of variance method for continuous variables and χ^2 tests for categorical variables. Duke University deemed this study as exempt (00105391).

RESULTS

Overall, the mean age of LTC workers was 41 years (Table 1). Most LTC workers were female, white, married or living with a partner, and had some college or more education. A minority were Hispanic and foreign born, and more than one-third reported a chronic condition. The average total household size was three. Of those with a spouse or partner, 80% were dual-earner couples. The LTC work role was a full-time position held on average for nearly 10 years. More than 70% agreed or strongly agreed with this statement: "When you are sick, you still feel obligated to come into work."¹⁴ One-sixth of LTC workers had a second job, where they worked an average of 20 hours per week. The mean annual gross personal and household income brackets were \$30,000 to \$34,999 and \$40,000 to \$44,999, respectively. When asked which of four statements best described their ability to get along on their household income,¹⁵ most (51%) LTC workers chose, "We have enough, with a little extra sometimes." Most LTC workers held double- or triple-duty caregiving roles (61%).

Among the three occupational groups, CNAs significantly differed from RNs and LPNs on several demographic characteristics. CNAs were younger, more often Hispanic, less often married or living with a partner, and proportionately fewer had obtained some college or more education. Additionally, a significantly lower proportion of CNAs were white and US born compared with LPNs. CNAs also significantly differed from their counterparts with respect to

wages. CNAs reported lower gross annual personal and household incomes than both RNs and LPNs. Further, LPNs had a lower gross annual personal income relative to RNs. Perceived adequacy of household income significantly differed by occupational group; RNs more frequently endorsed the statement "We have enough, with a little extra sometimes" (66%) compared with both LPNs (51%) and CNAs (45%). All occupational groups were similar in characteristics pertaining to health, the LTC work role, additional paid work, and unpaid work. Descriptively, the prevalence of second jobs was highest and accompanying work hours were longest among CNAs. At least 60% of LTC workers across all occupations held double- or triple-duty caregiving roles.

DISCUSSION

This analysis is descriptive and provides no causal explanation behind holding second jobs and multiple caregiving roles. In addition to these data dated from 2012, the WFHS represents LTC workers from one region of the United States. And yet we are encouraged that the wages, sex, and foreign-born profiles in the WFHS mirror those seen in LTC workers nationally.¹⁶ Given its regional focus, the WFHS workers may not represent the countries of origin of workers in other regions. Overall, however, this is a unique data set with high relevance to the COVID-19 pandemic today, and the findings lead us to several immediate policy recommendations.

To minimize spread of COVID-19, we need to consider the lives of LTC workers such as those described here. First, the high proportion holding a second job means that risk of spread is higher to and from multiple locations (eg, Figure 1). Their own preexisting health conditions make many LTC workers high risk on their own. They commonly also live with other household members, so their own risks could endanger their own families. A high percentage of their partners are working, and depending on their careers, they may or may not be able to shelter at home.

Facilities could institute policies to help mitigate disease transmission risk. Changing the culture to decrease the obligation to work when sick would be a start. Also called presenteeism, being at work when sick puts everyone at risk: colleagues, residents, and visitors alike. Providing sick leave and benefits would reduce this obligation. These benefits could especially help the lowest wage workers such as CNAs, who are most likely to work a second job. Similarly, increasing wages so that workers can work just one job could mitigate risk to the LTC worker, the LTC residents, and to families by limiting the potential for cross-contamination. To protect their residents from COVID-19, high-end independent living facilities are instituting a rule whereby shifts are only given to workers who do not have a second job. However, without wage or hour increases, this policy will financially penalize the 17% of LTC workers who also work part time elsewhere.

States and the federal government could also mitigate disease transmission risk. Immediately increasing Medicaid and Medicare reimbursement rates during the COVID-19 pandemic could allow firms to increase pay to their direct care workers. These firms do not have high profit margins, and they are also likely to be suffering economic losses due

to fewer non-COVID-19 post-acute care patients during the pandemic; increasing wages is unlikely to be a unilateral move from private firms. Framing increased reimbursement as supporting extending hazard pay to workers could frame the move as temporary to meet the needs of the COVID-19 pandemic.

Finally, informal support for LTC workers, especially those who are double- or triple-duty caregivers, is urgently needed if they are to remain healthy and continue to be effective in their vital roles in and beyond the LTC setting. A temporary shift of unpaid care work to capable nonessential employees or other members of LTC workers' social networks, for example, may help these essential workers self-isolate and decrease opportunities for transmission. Undoubtedly, a shift in primary responsibility for unpaid care to secondary or new family caregivers throws many into uncharted territory; such changes to decrease transmission risk could be facilitated through extending state and federal resources and guidance for caregiving to families.

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