

Characteristics of Multiple Job Holders in Long-term Care

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Executive Summary

Introduction/Background

The primary reason for individuals holding multiple jobs is concern for one's financial security, resulting from low wages, inconsistent or insufficient hours, a lack of benefits, or some combination of these factors. The fact that the long-term care (LTC) workforce is affected by all of them, it is not surprising that second job holding rates in the LTC workforce are higher by comparison with the workforce overall. Moreover, the COVID-19 pandemic has created a new source of concern with regard to multiple job holding in the LTC workforce. COVID-19 is an especially serious threat to the frail residents in LTC facilities and nosocomial infections are an important driver of COVID-19 outbreaks in LTC settings. The potential for LTC staff to be a primary route of virus transmission is high.

This data brief examines rates of multiple job holding by the LTC workforce. It uses estimates from the Current Population Survey to describe the characteristics of individuals providing direct patient care in LTC settings, with a focus on identifying differences between single and multiple job holders. The data reveal important factors that contribute to multiple job holding and point to opportunities to improve employment practices to better support the LTC workforce and protect the population they serve.

Data Source

We pooled 10 years of basic monthly data files from the Current Population Survey (CPS) covering the period 2010 to 2019 to ensure a sufficient number of sample observations. The data were restricted to individuals whose reported employment status was either "employed-at work" or "employed-but absent" (from work). Health care workers providing direct patient care were defined to include registered nurses (RNs), licensed practical and vocational nurses (LPNs), nursing aides, home health aides, and personal care aides (PCAs). LTC employment settings were defined to include home health care, skilled nursing facilities, residential care, individual and family services, and private households.

Despite using a pooled dataset, it was necessary to combine RNs and LPNs into a single occupational group (and to combine some racial and ethnic categories), when examining differences between single and multiple job holders. The CPS itself uses the Census Occupation Code classification system to identify an individual's occupation, which combines nursing aides and home health aides into a single group (and also includes psychiatric aides)

Methods

Descriptive methods were used to identify differences in the characteristics of single versus multiple job holders across occupational groups and LTC employment settings. Results were presented as proportions or means. Logistic regression and predicted marginal probabilities were estimated to test for statistically significant differences in proportions.

Results

The rate of multiple job holding in LTC was 6% or greater for all occupation groups. In comparison, the rate of multiple job holding in non-LTC employment was only 4.4%. Multiple job holding was more common among PCAs (7.1%) and RNs/LPNs (6.8%) than for nursing, psychiatric, and home health aides (6%). The median age of multiple job holders was lower for nursing, psychiatric, and home health aides and PCAs in comparison to single job holders but was slightly higher among RN/LPNs. Female RN/LPNs and female nursing, psychiatric, and home health aides were less likely to hold second jobs compared with men. The percentage of second job holding male

RN/LPNs was twice as large as single job holding male RN/LPNs. Among all three occupation groups, Black or African American workers accounted for a larger percentage of second job holders in comparison to single job holders. Among RN/LPNs, White workers represented a larger percentage of single job holders relative to second job holders but a comparatively larger percentage of second job holders among PCAs. The percentage of foreign-born RN/LPNs who were second job holders (25.5%) was much larger compared with single job holders (15.9%).

RN/LPNs who had multiple jobs averaged 2.4 hours per week less in their primary jobs than RN/LPNs who held only one job. Second job holding nursing, psychiatric, and home health aides averaged one hour per week less in their primary job than single job holders. Across all three occupation groups, health workers who had multiple jobs were less likely to work full-time in their primary job. Analysis of earnings data did not indicate substantial differences in the hourly wage earned by single job holders versus second job holders. It did, however, demonstrate that nursing, psychiatric, and home health aides and PCAs earned considerably less than RN/LPNs. Moreover, these data underscored that healthcare workers employed in LTC earned less by comparison with workers employed in other settings. Finally, nearly one-third of RN/LPNs and nursing, psychiatric, and home health aides holding multiple jobs reported secondary employment in the same occupation and in a LTC setting; among PCAs the percentage was smaller (26.5%). Secondary employment in LTC generally (whether in the same or a different occupation) ranged from 45% to 53% across the occupational groups.

Conclusions

Multiple job holders differed from single job holders in terms of age, gender, race/ethnicity, and foreign-born status, although not always consistently across all occupation groups. LTC employment paid considerably less than other healthcare settings, particularly for RNs and LPNs. However, we found no meaningful difference for any occupation group in the estimated median hourly wage for single versus multiple job holders' primary jobs. Our analysis also showed that a near majority of multiple job holding RN/LPNs and PCAs, and an actual majority of nursing, psychiatric, and home health aides, were also employed in a LTC setting for their second jobs (whether in the same or in a different occupation). Moreover, approximately two-thirds of multiple job holding RN/LPNs and nursing, psychiatric, and home health aides reported secondary employment in healthcare (in any occupation, whether in LTC or another healthcare setting).

Multiple job holding is a difficult phenomenon to measure. It is plausible that patient care workers employed in LTC settings are more likely than average to engage in alternative work arrangements such as informal home health care services providers. The number of patient care providers in LTC settings who hold multiple jobs may be higher than official estimates. The urgency of the threat posed by COVID-19 to the LTC patient population has diminished with the widespread availability of effective vaccines. Beyond the challenges posed by a viral pandemic, employment in LTC remains at a competitive disadvantage with other healthcare settings and many other sectors of employment generally. Among policy reforms recommended to better support the LTC workforce, reforming how LTC is financed is critical, as it is the most likely pathway to higher wages and more generous benefits across the LTC workforce. These changes could have the effect of lowering the rate of multiple job holding, which would further reduce stress for LTC workers and mitigate the infection risk posed by individuals employed across multiple care settings.

Introduction/Background

Research indicates that individuals holding multiple jobs are motivated by three principal factors: financial need, professional development, and psychological fulfillment.^{1,2} A second job can be a source of skill development for those seeking professional advancement in their chosen career, or to shift into a new career. It may be a way to turn a “passion project” into a source of financial gain. These motivations may overlap. Multiple studies, however, point to concern for one’s financial state as the main driver of working more than one job.^{1,2} This concern may result from insufficient wages, inconsistent hours, a lack of benefits, or the inability to work more paid hours (e.g., salaried employees who cannot earn more for additional hours worked).

Low wages, poor benefits, unpredictable schedules, high rates of turnover, and staff shortages are workforce issues in long-term care (LTC) that policy makers and other stakeholders have sought to address to improve employment conditions and care quality.^{3,4} Given these factors, it is not surprising that second job holding rates in the LTC workforce are higher by comparison with the workforce overall.^{5,6,7,8}

The COVID-19 pandemic has created a new source of concern for the LTC workforce. COVID-19 is an especially serious threat to the frail residents in LTC facilities; researchers have estimated that somewhere between 30% and 40% of all COVID-19-related deaths in the United States have occurred in LTC facilities. Nosocomial infections are an important driver of COVID-19 outbreaks in LTC settings,⁹ and the potential for staff to be a primary route of virus transmission is high. This has raised concern about the extent to which staff in LTC settings hold more than one job (or work at multiple sites for a single organization),⁸ given the potential for an infected worker to transmit the virus across more than one care setting.¹⁰

This data brief examines rates of multiple job holding by the LTC workforce. It uses estimates from the Current Population Survey to describe the characteristics of individuals providing direct patient care in LTC settings, with a focus on identifying differences between single and multiple job holders. The data reveal important factors that contribute to multiple job holding and point to opportunities to improve employment practices to better support the LTC workforce and protect the population they serve.

Data Source

We constructed our dataset by pooling 10 years of Current Population Survey (CPS) basic monthly files covering the period from 2010 to 2019. The individual monthly data files were downloaded from the public use data archive of the National Bureau of Economic Research.¹¹ Pooling the data was necessary to ensure a sufficient number of observations of individuals providing direct patient care in LTC settings. Individual sample weights were adjusted to account for the pooled samples, and test estimates were generated and benchmarked against published estimates available from the Bureau of Labor Statistics to calibrate accuracy. The dataset was restricted to include only cases where employment status was coded as “employed-at work” or “employed-but absent” (from work). To avoid duplicate observations of the same individual, only cases in month four of the rotation through the CPS panel were included.

Health care workers providing direct patient care were defined to include registered nurses (RNs), licensed practical and vocational nurses (LPNs), nursing aides, home health aides, and personal care aides. Despite pooling a decade of data to mitigate issues related to sample size, it was necessary to combine RNs and LPNs into a single occupational group (and to combine some racial and ethnic categories), when examining differences between single and multiple job holders. The CPS itself uses the Census Occupation Code to identify an individual’s occupation, a scheme that combines nursing aides and home health aides into a single group (and also includes psychiatric aides).

LTC employment settings were defined to include home health care, skilled nursing facilities, residential care, individual and family services, and private households. Earnings were presented as inflation-adjusted hourly wages in 2019 dollars. For persons identified as being paid on an hourly basis, we used the reported hourly wage. If the individual was identified as being paid on a non-hourly basis, we computed the hourly wage as *reported earnings per week / usual hours worked per week*. The weekly earnings variable was top-coded at \$2,884.61, and data were not adjusted to account for any potential bias this might introduce. Sample cases where the reported or computed hourly wage was less than the federal minimum wage were excluded.

Methods

Descriptive methods were used to identify differences in the characteristics of single versus multiple job holders across occupational groups and LTC employment settings. Results were presented as proportions or means. The Wilcoxon rank-sum test was performed to test for statistically significant differences in median values; independent t-tests with unequal variance were performed to test for statistically significant differences in mean values. Logistic regression and predicted marginal probabilities were estimated to test for statistically significant differences in proportions. This method of using predicted probabilities produced a p-value for each estimated proportion and allowed us to evaluate the probability that an obtained value occurred by chance alone. However, it is important to acknowledge that statistical significance does not equal importance. Many of the differences presented here are quite small, and while they may be statistically significant, they may not have practical importance.

The results of this analysis are a series of descriptive tables. Each table presents estimates of employment by occupation group or by LTC employment setting, and by single versus second job holding status, for selected characteristics. The following abbreviations are used throughout the tables:

- RN/LPN denotes persons employed as registered nurses or licensed practical/vocational nurses.
- NPHH denotes persons employed as nursing aides, psychiatric aides, or home health aides.
- PCA denotes persons employed as personal care aides.

Results

Table 1 presents data on total employment of the patient care occupations in each of the LTC sectors. The total employment of RN/LPNs, NPHHs, and PCAs was largest in nursing care/skilled nursing facilities, at 221,461, and smallest for private households, at 92,896. The second column of Table 1 presents the percentage of total employment in each LTC setting composed of RN/LPNs, NPHHs and PCAs. These occupations accounted for more than 80% of total employment in home health settings and approximately 60% of total employment in nursing care/skilled nursing facility settings, while accounting for much smaller percentages of total employment in residential care, individual and family services, and private household settings.

Table 1. Total Employment in LTC, by LTC Setting

LTC Setting	Total employment	Combined RN/LPN, NPHH, & PCA employment as percentage of total employment
Home Health	162,493	81.2%
Nursing Care/Skilled Nursing Facilities	221,461	59.7%
Residential Care	101,099	33.3%
Individual & Family Services	191,040	25.1%
Private Households	92,896	16.1%

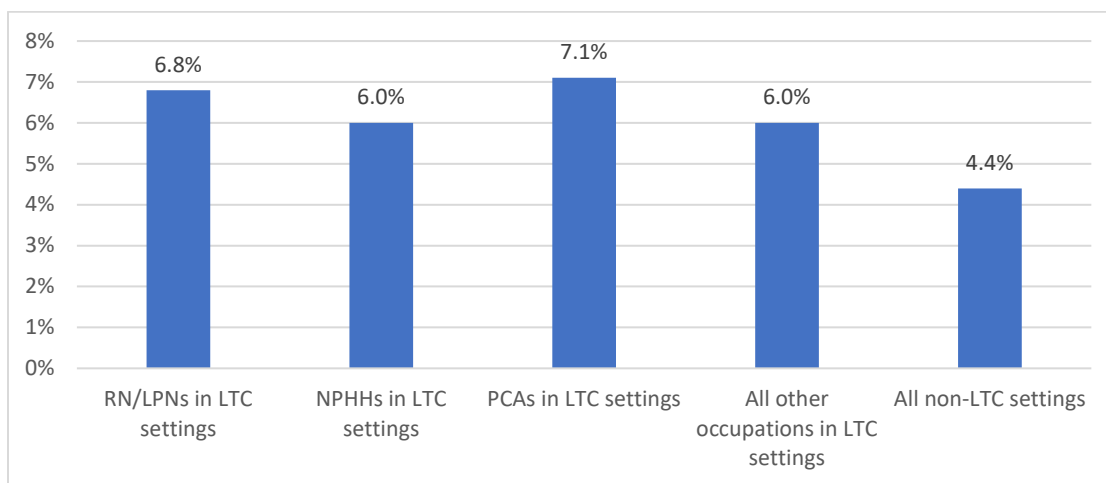
Table 2 presents the distribution of primary employment for each occupation across the different LTC settings. Approximately 90% of RN/LPNs and NPHHs who worked in LTC were employed in either a home health or nursing care/skilled nursing facility setting. In contrast, employment for PCAs was not concentrated in any one setting.

Table 2. Estimated Percentage of Employment in Primary Job, by LTC Setting and Occupation

LTC Setting	RN/LPN	NPHH	PCA
Home Health	31.1%	40.5%	35.0%
Nursing Care/Skilled Nursing Facilities	59.5%	48.0%	6.9%
Residential Care	5.6%	6.1%	16.0%
Individual & Family Services	3.4%	4.9%	30.8%
Private Households	0.5%	0.5%	11.4%
Total employment	77,572	161,618	121,274

Figure 1 shows the percentage of employed persons identified as holding more than one job. The figure presents estimates for each LTC occupations of interest, as well as for all other persons employed in LTC and all other persons employed outside of LTC. The rate of multiple job holding in LTC was 6% or greater for all occupation groups, which was higher by comparison with non-LTC employment. The average rate of multiple job holding across all employment settings outside of LTC was only 4.4%. Multiple job holding was more common among PCAs (7.1%) and RNs/LPNs (6.8%) than for NPHHs (6%).

Figure 1. Percentage of Workers Holding More Than One Job, by Occupation



Note: Differences between percentages are statistically significant ($p < .01$).

As seen in Table 3, the median age of multiple job holders was lower for NPHHs and PCAs in comparison to single job holders but was slightly higher among RN/LPNs.

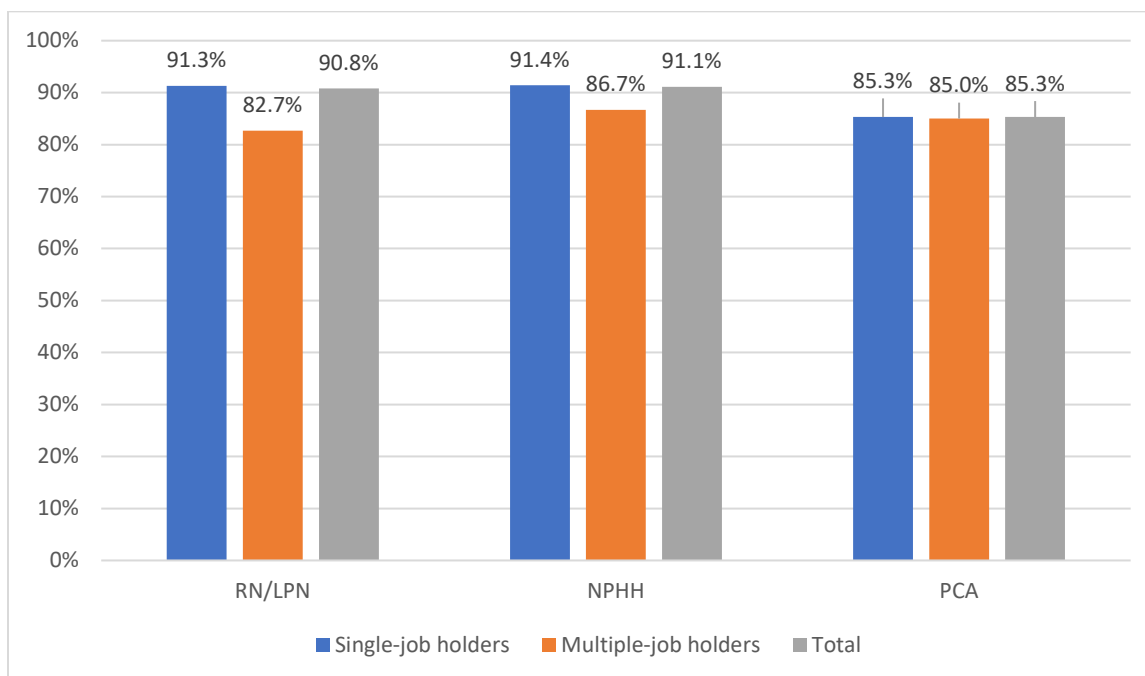
Table 3. Median Age by Occupation and by Second Job Holding Status, LTC Employment Settings

	Median age, single job	Median age, more than one job
RN/LPN	44	45
NPHH	41	39
PCA	45	42

Note: Differences in the median age of single vs. multiple job holders were statistically significant ($p < .01$) for NPHHs and PCAs; difference among RN/LPNs was not statistically significant.

Health care workers employed in LTC settings were predominantly female: 91% of NPHHs and RN/LPNs, and 85% of PCAs. However, as seen in Figure 2, female RN/LPNs and NPHHs were less likely to hold second jobs compared with men. The percentage of second job holding male RN/LPNs (17.3%) was twice as large as single job holding male RN/LPNs (8.7%). There was a similar 4.5 percentage point difference among NPHHs.

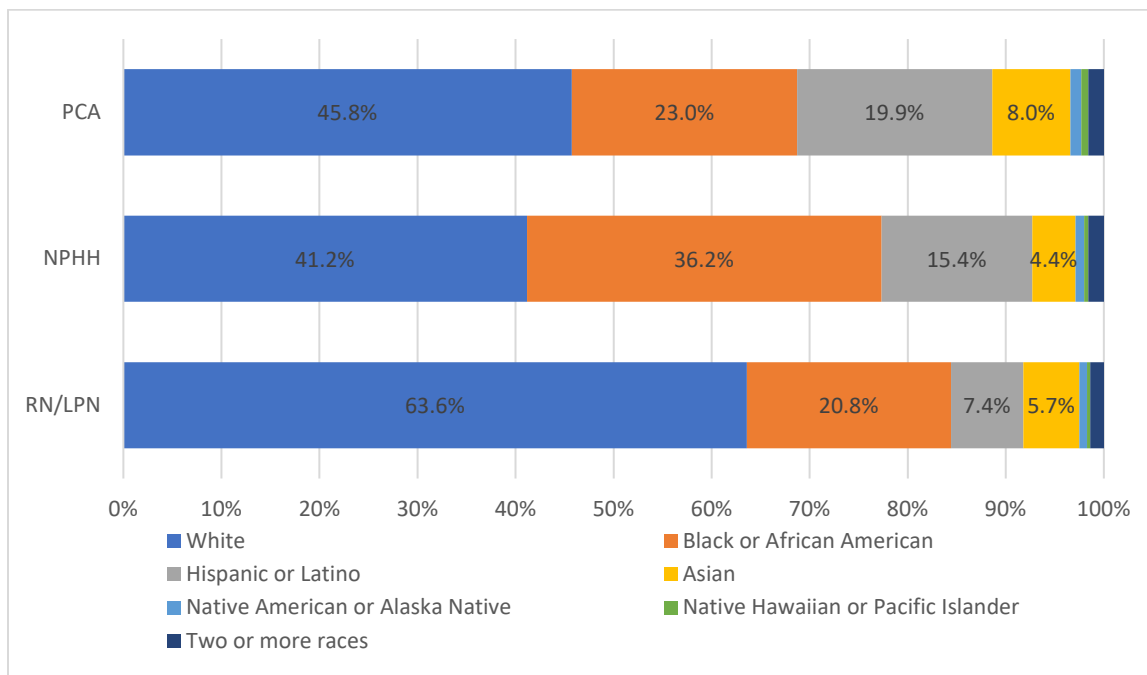
Figure 2. Percent of Workers Who are Female, by Occupation and by Second Job Holding Status, LTC Employment Settings



Note: Differences in the gender composition of single vs. multiple job holders were statistically significant ($p < .01$) for RN/LPNs and for NPHHs; difference among PCAs was not statistically significant.

Figure 3 describes the racial/ethnic composition for each of the occupation groups regardless of second job holding status. The percentage of White NPHHs (41%) and PCAs (46%) was substantially smaller in comparison with RN/LPNs (64%). Black or African American workers accounted for a much larger percentage of NPHHs (36%) relative to the other occupation groups (21% of RN/LPNs and 23% of PCAs); Hispanic or Latino workers accounted for a much larger percentage of both NPHHs (15%) and PCAs (20%) relative to RN/LPNs (7%).

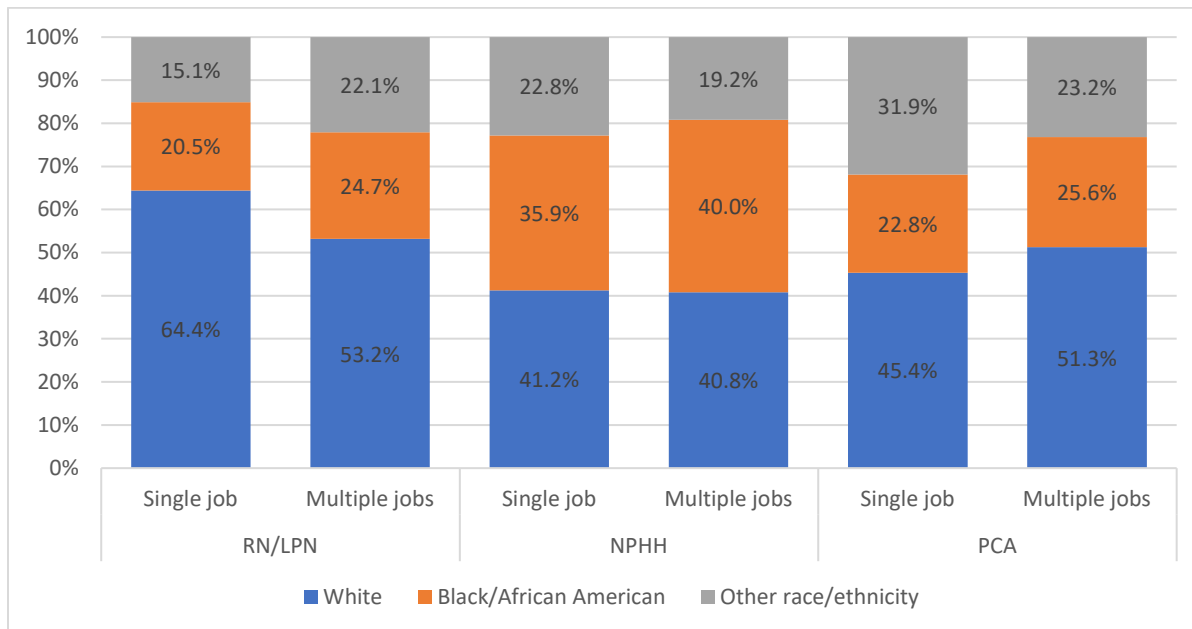
Figure 3. Racial/Ethnic Composition by Occupational Group, LTC Employment Settings



Note: Differences in the racial/ethnic composition within each occupation group were statistically significant ($p < .01$).

Because of the small number of sample observations, we collapsed race/ethnicity into three categories: White, Black or African American, and all other racial and ethnic groups. There were notable differences in racial/ethnic composition based on second job holding status, as seen in Figure 4. For all three occupation groups, Black or African American workers accounted for a larger percentage of second job holders in comparison to single job holders. Among RN/LPNs, White workers represented a larger of percentage of single job holders relative to second job holders but a comparatively larger percentage of second job holders among PCAs. Persons representing other racial and ethnic groups formed a larger percentage of second job holders among RN/LPNs and NPHHs but a smaller percentage among PCAs.

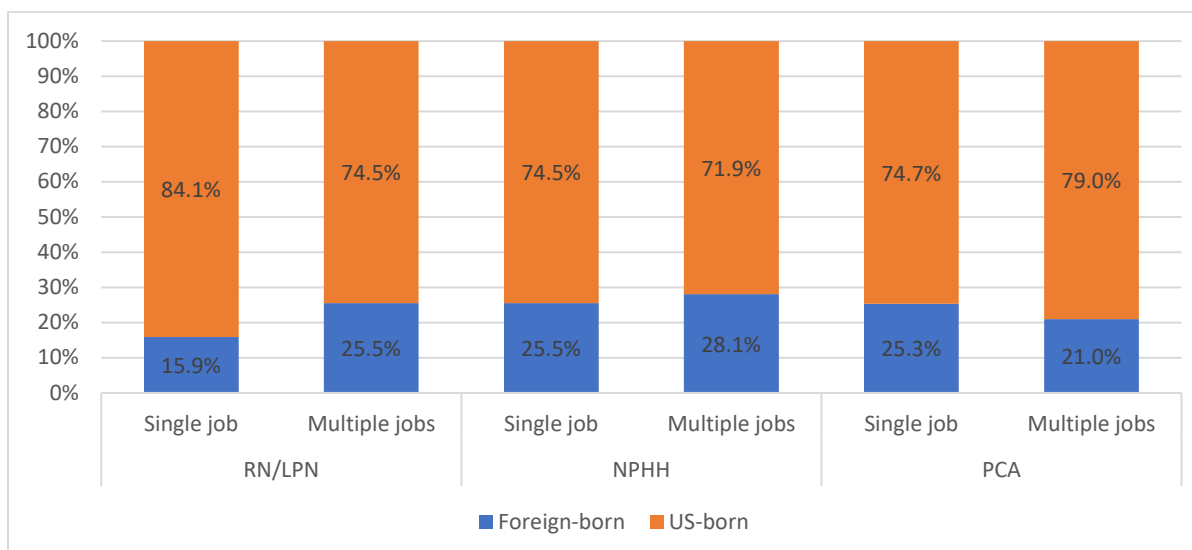
Figure 4. Racial/Ethnic Composition by Occupational Group and Second Job Holding Status, LTC Employment Settings



Note: Differences in the racial/ethnic composition of single vs. multiple-job holders within each occupation group were statistically significant ($p < .01$).

As seen in Figure 5, foreign-born persons accounted for a much larger percentage of NPHHs and PCAs employed in LTC settings compared with RN/LPNs. Figure 5 also shows a substantial difference in the percentage of foreign-born RN/LPNs who were second job holders (25.5%) compared with single job holders (15.9%).

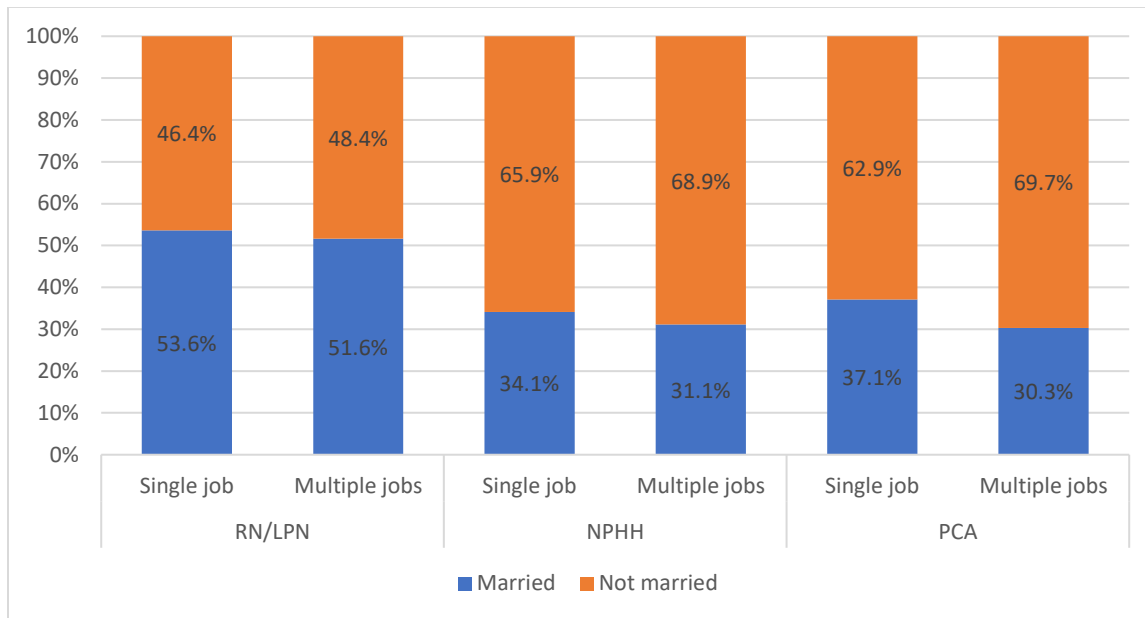
Figure 5. Foreign-Born Status by Occupation and Second Job Holding Status, LTC Employment Settings



Note: Differences in the foreign-born vs. native-born composition of single vs. multiple job holders within each occupation group were statistically significant ($p < .01$).

Figure 6 shows that second job holders working in LTC settings were more frequently unmarried by comparison with single job holders across all three occupation groups.

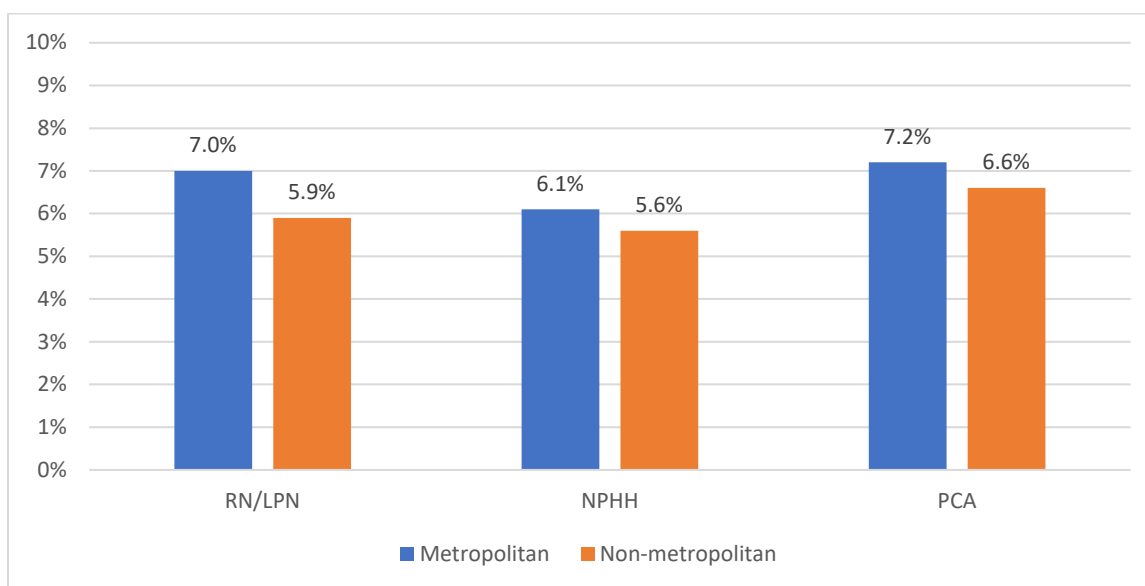
Figure 6. Marital Status by Occupation and Second Job Holding Status, LTC Employment Settings



Note: Differences in the marital status of single vs. multiple job holders within each occupation group were statistically significant ($p < .01$).

As seen in Figure 7, second job holding rates were slightly lower for workers residing in non-metropolitan areas compared to workers living in metropolitan areas for all occupation groups.

Figure 7. Percentage of Workers with More than One Job, by Occupation and Metropolitan Versus Non-Metropolitan Place of Residence, LTC Employment Settings



Note: Differences in the metropolitan/non-metropolitan composition of single vs. multiple-job holders within each occupation group were statistically significant ($p < .01$).

Table 4 compares the average number of usual hours worked per week for single job holders and multiple job holders in their primary job. RN/LPNs who had multiple jobs averaged 2.4 hours per week less in their primary jobs than RN/LPNs who held only one job. Second job holding NPHHs averaged one hour per week less in their primary job than single job holders.

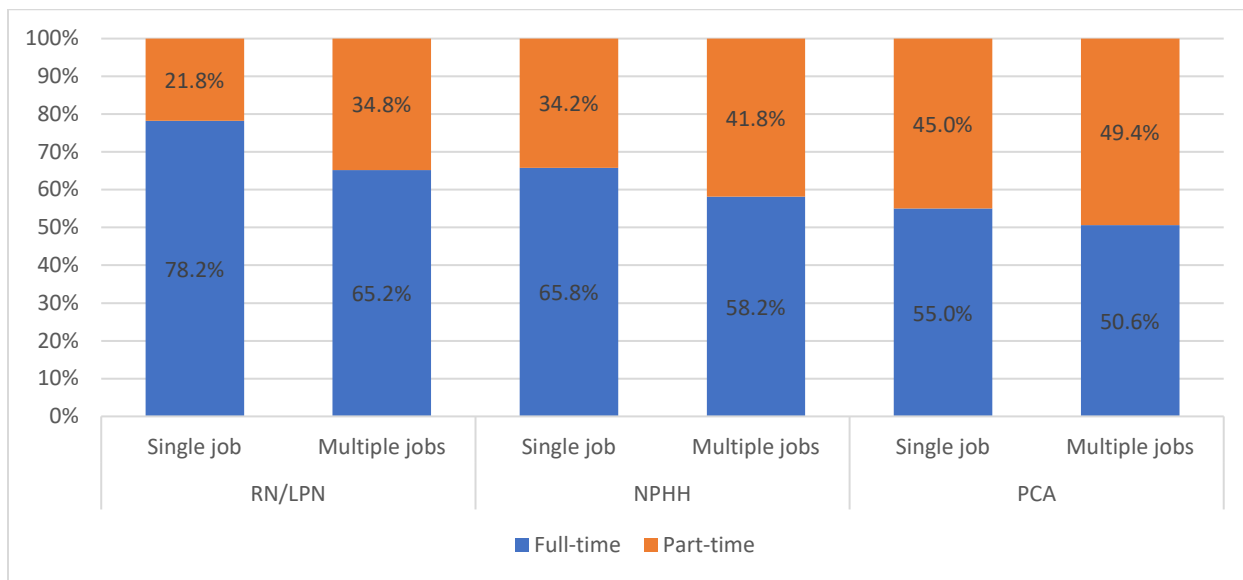
Table 4. Average Number of Usual Hours Worked per Week in Primary Job, by Occupation and Second Job Holding Status, LTC Employment Settings

	Average hours worked per week, single job	Average hours worked per week, more than one job
RN/LPN	37.1	34.7
NPHH	34.5	33.5
PCA	33.3	33.0

Note: Differences in the average number of hours worked per week (primary job) by single vs. multiple job holders within each occupation group were statistically significant ($p < .01$).

Figure 8 shows that for all three occupation groups, health workers who had multiple jobs were less likely to work full time in their primary job. The difference was largest for RN/LPNs, where 78.2% of single job holders were working full time in their primary nursing position, compared to just 65.2% of second job holders. The Current Population Survey considers full-time employment to be 35 or more hours worked per week.

Figure 8. Full-Time Versus Part-Time Status in Primary Job, by Occupation and Second Job Holding Status, LTC Employment Settings



Note: Differences in the full-time vs. part-time employment status of single vs. multiple job holders within each occupation group were statistically significant ($p < .01$).

Table 5 presents the median hourly wage earned for each occupation group in their primary job. These estimates did not indicate substantial differences in the hourly wage earned by single job holders versus second job holders. They did, however, demonstrate that NPHHs and PCAs earned considerably less than RN/LPNs. These data also underscored that healthcare workers employed in LTC earned less by comparison with workers employed in other settings; the median hourly wage earned by RN/LPNs in their primary job in healthcare settings outside of LTC was \$30, and for NPHHs it was \$13.39. There was no difference in the median hourly wage earned by PCAs working in healthcare settings outside of LTC as compared with LTC jobs; this may be attributable to the fact that

comparatively few PCAs worked in non-LTC healthcare settings (less than 8% of the PCA workforce identified in the sample used for this analysis).

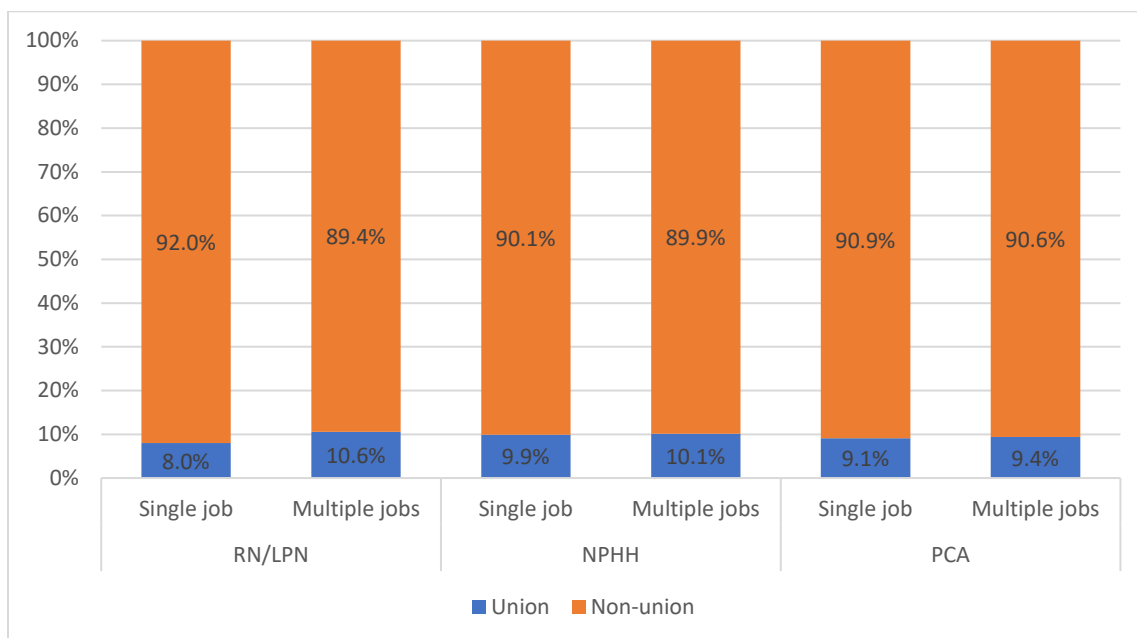
Table 5. Median Hourly Wage in Primary Job, by Occupation and Second Job Holding Status, LTC Employment Settings

	Median hourly wage, single job	Median hourly wage, more than one job
RN/LPN	\$23.44	\$23.05
NPHH	\$11.82	\$12.09
PCA	\$11.33	\$11.44

Note: Differences in the median hourly wage of single vs. multiple job holders were statistically significant ($p < .01$) for RN/LPNs and NPHHs; the difference among PCAs was not statistically significant.

Figure 9 presents the extent to which workers reported being members of a labor union, an employee association similar to a union, or being otherwise covered by a union or employee association contract in their primary job. The data indicate that union coverage for RN/LPNs and NPHHs employed in LTC was low in comparison with other healthcare settings; approximately 20% of RN/LPNs and 14% of NPHHs employed in non-LTC settings reported union coverage in their primary job. For PCAs there was no difference, with approximately 9% of those employed in non-LTC settings reporting union coverage. Union coverage for second job holding RN/LPNs was slightly higher in comparison with single job holders, but there was no real difference among either NPHHs or PCAs. These estimates suggest that union coverage may not be an important factor with respect to whether someone holds a second job.

Figure 9. Union Membership/Coverage in Primary Job, by Occupation and Second Job Holding Status, LTC Employment Settings



Note: Differences in the union membership status of single vs. multiple job holders was statistically significant ($p < .01$) for RN/LPNs; differences among NPHHs and PCAs were not statistically significant.

Table 6 describes multiple job holding RN/LPNs, NPHHs, and PCAs by whether their secondary employment was in the same occupation within a LTC setting, a different occupation within a LTC setting, a non-LTC healthcare setting, or outside of healthcare. Nearly one-third of RN/LPNs and NPHHs holding multiple jobs reported secondary employment in the same occupation and in a LTC setting; the percentage was smaller for PCAs (26.5%). Between 15% and 19% of each occupation group reported secondary employment in a LTC setting but in a different occupation. Secondary employment in a non-LTC healthcare setting (in any occupation) ranged from approximately 8% of PCAs holding multiple jobs to nearly 21% of RN/LPNs. Approximately one-third of RN/LPNs, 37% of NPHHs, and nearly 47% of PCAs who are multiple job holders reported secondary employment outside of healthcare.

Table 6. Second Job Holders in LTC, by Occupation and Employment Setting of Second Job

	Employed in LTC, same occupation	Employed in LTC, different occupation	Employed in non-LTC healthcare setting, any occupation	Employed outside healthcare
RN/LPN	32.0%	15.2%	20.7%	32.2%
NPHH	32.8%	19.1%	10.7%	37.4%
PCA	26.5%	18.6%	8.2%	46.7%

Conclusions

This data brief describes the prevalence of multiple job holding among occupations that provide elder care in LTC settings and explores selected characteristics of multiple job holders. We found that multiple job holding rates for all selected occupations, and for LTC settings generally, were higher than average, and that within LTC, PCAs and RN/LPNs had the highest rates.

Multiple job holders differed from single job holders in terms of age, gender, race/ethnicity, and foreign-born status, although not always consistently across all occupation groups. Multiple job holding NPHHs and PCAs were younger on average, but there was no statistically significant difference in the median age of single versus second job holding RN/LPNs. Males accounted for a substantially larger percentage of RN/LPNs and NPHHs holding multiple jobs, but there was no difference in gender composition among PCAs. Overall, the NPHH and PCA workforce was more racially and ethnically diverse compared to the RN/LPN workforce. Across all three occupation groups, a larger percentage of the multiple job holding workforce was Black or African American. The percentage of White RN/LPNs that held multiple jobs was 10 percentage points smaller than single job holders. Single and multiple job holding RN/LPNs also differed substantially in their composition by foreign-born status; the percentage of RN/LPNs holding multiple jobs who identified as foreign-born was 10 percentage points larger.

LTC employment paid considerably less than other healthcare settings, particularly for RNs and LPNs. However, we found no meaningful difference for any occupation group in the estimated median hourly wage for single versus multiple job holders' primary jobs. We found that compared to single job holders, a smaller share of multiple job holding RN/LPNs and NPHHs reported full-time employment in their primary position; this was likely to be one of the most important factors in the decision to seek secondary employment. Overall, union membership among RN/LPNs and NPHHs employed in LTC settings was lower in comparison with non-LTC healthcare settings. We found a small increase in the percentage of multiple job holding RN/LPNs reporting union membership in their primary job, but it is difficult to draw any conclusions about why this would be the case. Finally, our analysis showed that a near majority of multiple job holding RN/LPNs and PCAs, and an actual majority of NPHHs, were also employed in a LTC setting for their second jobs (whether in the same or in a

different occupation). Moreover, approximately two-thirds of multiple job holding RN/LPNs and NPHHs reported secondary employment in healthcare (in any occupation, whether in LTC or another healthcare setting).

Multiple job holding is a difficult phenomenon to measure. Recent estimates of the percentage of workers holding more than one job in the U.S. labor force range from 5%¹² to as much as 13%.¹³ These percentages are likely to undercount rates of multiple job holding, as available data sources do not provide details about self-employment or about informal or unpaid work. It is plausible that patient care workers employed in LTC settings are more likely than average to engage in alternative work arrangements such as informal home health care services providers. The number of patient care providers in LTC settings who hold multiple jobs may be higher than official estimates.

The urgency of the threat posed by COVID-19 to the LTC patient population has diminished with the widespread availability of effective vaccines. However, there is some evidence of vaccine hesitancy among frontline health workers,¹⁴ creating a possibility that vaccination mandates in healthcare facilities may exacerbate existing staffing shortages¹⁵ in LTC settings. Beyond the challenges posed by a viral pandemic, employment in LTC remains at a competitive disadvantage with other healthcare settings and many other sectors of employment generally. The work is difficult, emotionally draining, and workers earn lower wages relative to their peers who work in inpatient hospital settings or ambulatory care settings.^{16,17} Among policy reforms recommended to better support the LTC workforce, reimagining how LTC is financed is at the top of the list.¹⁸ New modes of financing are needed to support higher wages and more generous benefits across the LTC workforce, likely reducing turnover and staff shortages, as well as improving worker morale. These changes could have the effect of lowering the rate of multiple job holding, which would further reduce stress for LTC workers and mitigate the infection risk posed by individuals employed across multiple care settings.

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