

# Caregivers on the Front Line: Building a Better Direct-Care Workforce

Employers and state and federal governments must work to ensure we develop a stable, competent, direct-care workforce that can meet the demands of our growing elder population.

Many eras of American economic history have been defined and shaped by a particular workforce. During their ascendancy, many of these workforces—textile workers, miners, railroad laborers, steel and automotive workers—gained recognition and fairer treatment. Today's society is being shaped by the aging of our population—a transformation recasting many aspects of our economic, social, and cultural life. The workforce destined to undergird this aging transformation era is the direct-care workforce—a rapidly expanding workforce of more than 3 million personal-care aides, home health aides, and nursing and psychiatric aides.

The historic stature of the direct-care workforce as reflected in its capacity and growth is unquestionable. From 1998 to 2008, direct-care jobs accounted for 11 percent of the 10.4 million new jobs produced by economic growth. By 2018,

there are expected to be more direct-care workers in America (4.3 million) than K-12 teachers (3.9 million), all law enforcement and public safety workers (3.7 million), or registered nurses (3.2 million).

Explored here are the basic parameters of this historically unprecedented workforce and why it is important. This article also examines the opportunities state and federal policy makers and employer-providers have to make workforce improvements that promote the quality of care for older Americans and improve the efficiency of our service delivery systems for long-term services and supports.

## The Parameters of the Direct-Care Workforce

The direct-care workforce is now statutorily defined by the 2010 Affordable Care Act (ACA) as encompassing four

Standard Occupational Classifications: Home Health Aides [31-1011], Psychiatric Aides [31-1013], Nursing Assistants [31-1014], and Personal Care Aides [39-9021] (Patient Protection and Affordable Care Act, 2010). These workers provide essential daily supports and services to millions of Americans living with functional limitations and needs

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due to aging-related impairments, chronic disease, and other disabilities.

Much of direct-care work is difficult, physically taxing, and requires ongoing responsibility and judgment as well as emotional commitment and flexibility. Direct-care workers provide

## Types of Long-Term Services and Supports

- Self-care assistance, otherwise known as activities of daily living (ADLs), includes assistance with personal activities such as bathing, dressing, toileting, eating, and ambulating. These tasks are related to the care of the consumer's body.
- Everyday tasks, or instrumental activities of daily living (IADLs), are activities necessary for an individual to live a healthy and productive life integrated in the community. Direct-care workers provide assistance with activities such as shopping, laundry, and meal preparation.
- Social supports are services that enable the consumer to take an active part in his or her family or community, or ensure that the consumer's cognitive state does not deteriorate due to social isolation. Social supports also consist of supervision and assistance provided to persons with cognitive impairments, including persons with mental illness or an intellectual disability, as well as persons who have Alzheimer's Disease and other forms of dementia.
- Paramedical tasks are usually performed by home health aides under the direction of a nurse or therapist, and can include limited clinical duties such as taking blood pressure, assisting with range-of-motion exercises, ostomy and catheter hygiene, and wound care.

various kinds of long-term services and support in a wide range of settings (see “Types of Long-Term Services and Social Supports”), and patients often need a repertoire of services.

Over the past twenty-five years, significant shifts have occurred in three interrelated dimensions of the workforce: where direct-care workers work, the tasks they perform, and who employs them. Whereas the majority of direct-care workers historically have been employed in traditional nursing-care facilities and hospitals, these workers are now more likely to work in home- and community-based settings. National industry employment projections indicate that by 2018, home- and community-based direct-care workers will outnumber facility workers by nearly two

to one (PHI, 2010a). Several states already exceed these proportions. For example, approximately three-quarters of California's direct-care workforce is employed in home- and community-based settings (PHI, 2010c).

The shift toward home-based settings means direct-care work now requires more autonomy, responsibility, and skill. Caregiving skills must be practiced with far less direct supervision and access to onsite consultation from professionals. Additionally, direct-care workers face greater challenges associated with the higher levels of acuity of many nursing home-eligible consumers receiving services at home.

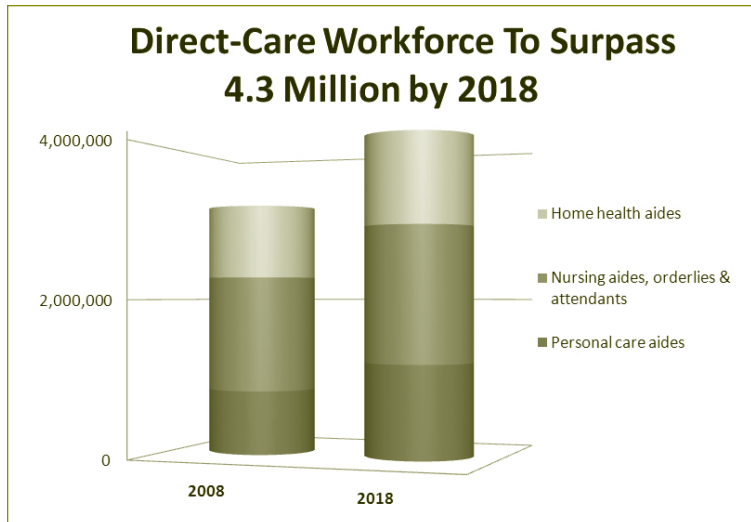
Two decades ago, the dominant employers of direct-care workers were nursing homes and nonprofit home

healthcare agencies. Today, many more direct-care workers work for homecare or private-duty companies specializing in providing non-medical homecare. A sizeable proportion of these agencies are now for-profit. Workers are also more likely to be employed directly by private households. These are either households with members who participate in public programs that allow them to hire their own direct-care worker (known as consumer- or participant-directed programs), or households that hire their own aides under private arrangements.

### Employment Levels: Past, Present, and Future

The latest figures from the Bureau of Labor Statistics indicate direct-care workers number more than 3.2 million

**Figure 1.**



Source: PHI. 2011

(PHI, 2011a). Adding in the significant number of direct-care workers who are uncounted arguably brings the true size of this workforce closer to 4 million. One million new workers joined the direct-care workforce between 1998 and 2008; a 52 percent increase at more than seven times the rate of overall new job growth (7 percent).

Nurse aide employment leveled off over the last decade, increasing by only 7.5 percent, whereas employment growth for personal-care aides and home health aides expanded rapidly, increasing by 133 percent. Around 2005, the number of personal-care aides surpassed the number of nursing aides, orderlies, and attendants.

Over the next ten years, demand for another 1.1 million positions in this workforce is

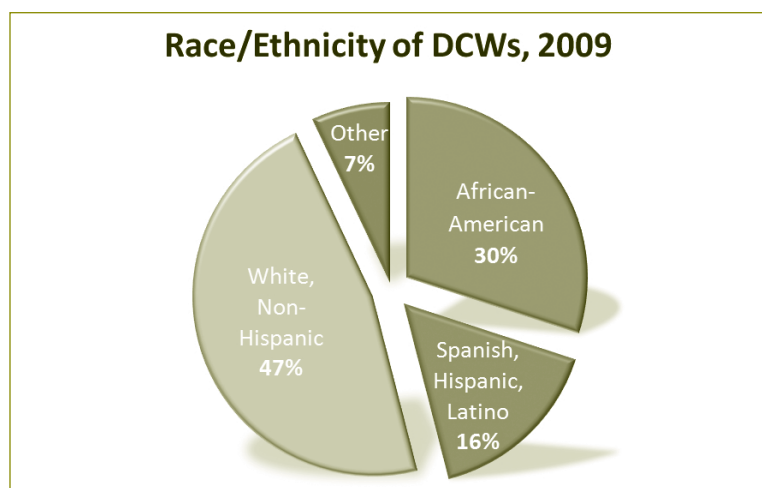
expected, fueled by a general increase in longevity, the aging of the baby boom generation, and an increasingly overburdened family caregiver system. During this period, home health aides and personal-care aides are projected to be the third- and fourth-fastest growing occupations in the

country, increasing by 50 percent and 46 percent, respectively (PHI, 2010a). Figure 1 shows the expected trajectory of the direct-care workforce from 2008 to 2018.

### Demographics

Direct-care workers are overwhelmingly female (89 percent) with men constituting a steady 10 to 12 percent of the workforce for the past five years. The average age of direct-care workers is 42, and the workforce as a whole is aging. Women ages 55 and older constitute an increasing share of these workers, and by 2018 about a third of this frontline workforce can be expected to be ages 55 and older, up from 22 percent in 2008 (PHI, 2011b). The direct-care workforce is disproportionately minority: nationally, 47 percent are white, 30 percent are African American, 16 percent are

**Figure 2.**



Source: PHI. 2011

Hispanic, and 7 percent are other races or ethnicities (see Figure 2 on page 29). Twenty-three percent of the workforce is foreign born. Fifty-five percent have a high school diploma or less (PHI, 2011a).

Elements of this national workforce profile vary markedly by region and state. For example, in California and New York, up to half of the workforce is foreign born. And much higher proportions of these workers are non-white (roughly 70 percent in both California and New York) (PHI, 2010c). These numbers are quite different in parts of the Midwest, where direct-care workers are 75 percent white and only 7 percent are foreign born.

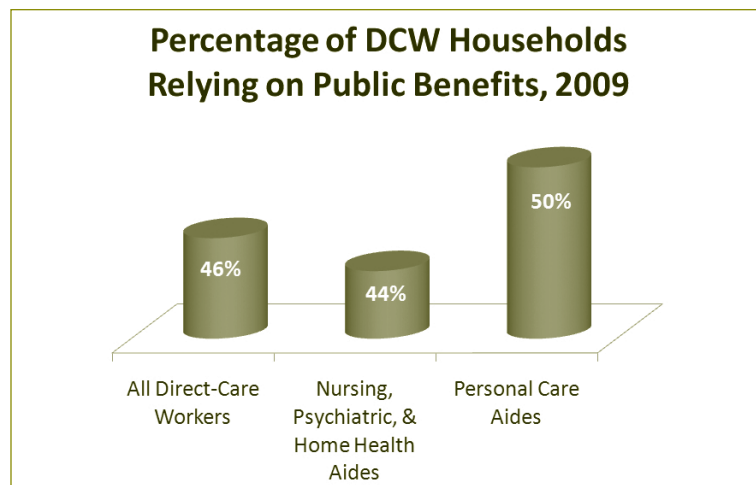
### Job Quality for Direct-Care Workers

The quality of direct-care jobs is relatively poor. Direct-care workers typically receive low wages and few benefits, and work under high levels of physical and emotional stress. In general, formal training requirements and initial training delivered for these occupations are quite limited.

#### Uncompetitive wages, unpredictable hours

In 2009, the median hourly wage for all direct-care workers was just \$10.58—significantly less than the median wage of \$15.95 per hour for all U.S. workers. Nursing aides, orderlies, and attendants

**Figure 3.**



Source: PHI, 2011.

earned \$11.56, while personal-care and home health aides earned less than \$10 per hour (\$9.46 and \$9.85, respectively). Psychiatric aides fared better with a median hourly wage of \$12.33 (PHI, 2011a).

In 70 percent of states (36 states), average hourly wages for personal-care aides in 2009 were below 200 percent of the federal poverty level wage (\$10.42) for individuals in one-person households working full time. More disconcerting, from 2008 to 2009, the number of states paying these low wages for personal-care aides increased from thirty-two to thirty-six (PHI, 2010b).

Agency staffing and scheduling practices have a dramatic effect on the job and income stability of direct-care workers. Homecare workers in particular have trouble amassing full-time hours on a regular basis. Unreliable schedules and

irregular hours also correlate with lower rates of job satisfaction and higher rates of intent to leave (Morris, 2009). In 2009, for example, more than half of personal-care aides (58 percent) worked part-time or full-time for only part of the year (PHI, 2011a).

Part-time hours reduce overall earnings; thus, in 2009, median annual earnings for direct-care workers averaged just \$16,800. Due to their low earnings, nearly half (46 percent) of direct-care workers lived in households that received one or more public benefits such as food stamps, Medicaid, housing, childcare, or energy assistance (PHI, 2011a).

#### Few benefits, many hazards, little formal training

Despite serving the health-care system, an estimated 900,000 direct-care workers

did not have health coverage in 2009 (PHI, 2011a). One in every four nursing home workers, and more than a third of aides working in agency-based homecare lacked health coverage. While 67 percent of adult civilian workers in America received health coverage through an employer, less than half of direct-care workers (47 percent) had such employer-based coverage.

Direct-care workers are charged with supporting the well-being of others, yet they face significant on-the-job risks to their own personal safety and health. In fact, the umbrella occupation encompassing nursing aides, orderlies, and attendants is one of the top four most dangerous jobs in the country, when it comes to both number and incidence of

the actual incidence of injuries for these workers (Friedman and Forst, 2007; Newcomer and Scherzer, 2006). This underreporting notwithstanding, in 2009 personal and homecare aides faced an incidence rate for injuries and illnesses that was more than double the rate for all occupations taken together, placing this job among the country's thirty riskiest occupations (Bureau of Labor Statistics, 2009). Homecare workers often lack appropriate assistive devices for lifting, carrying, and supporting clients. In addition, studies also show that lack of training, support, and supervision increases the likelihood of injury among direct-care workers (Alamgir et al., 2008; McCaughey et al., 2010).

Research also indicates that the work of homecare and

these hourly training requirements have not changed in more than twenty years. While most states have requirements exceeding the federal minimum, twenty states still require only seventy-five hours. Furthermore, only fourteen states meet or exceed the 120-hour training requirement recommended recently by the Institute of Medicine (Institute of Medicine, 2008).

With respect to personal-care aides, there are no federal requirements. However, some states have instituted limited training standards for at least some groups of these aides, but within a given state, these standards can vary widely across different programs.

### **Leveraging the Unique Potential of the Direct-Care Workforce**

The unique position of today's direct-care workforce stems from its enormous size, combined with its strategic location at the intersection of two critical socioeconomic issues: improving our eldercare and disability systems and improving jobs for low-income workers.

From the vantage point of eldercare and disability services, direct-care workers are vital to two key policy goals. First, they are critical to the goal of expanding state-based delivery systems for long-term services and supports in home- and community-based

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injuries and illnesses involving days away from work (Bureau of Labor Statistics, 2009). A recent study using two nationally representative surveys showed 35 percent of nursing aides reported injuries in the prior month due to physical aggression by nursing home residents (Tak et al., 2010).

Official injury statistics for homecare workers are thought to significantly underestimate

nursing care can be accompanied by high levels of job stress (Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2010; Substance Abuse and Mental Health Services Administration, 2007).

Federal law requires only seventy-five hours of training for certified nurse assistants and home health aides, and

settings—the settings of choice for growing numbers of consumers and their families. The expansion of in-home services is predicated on the availability of an adequate, stable direct-care workforce. However, most states have yet to develop workforce development policies commensurate with their rebalancing goals, much less policies aligned with new federal incentives for expanded home- and community-based services found in the Patient Protection and Affordable Care Act.

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Second, the direct-care workforce is key to our capacity to design new care models for older adults (Institute of Medicine, 2008), and more efficient and effective service delivery systems for long-term services and supports. Because these paid caregivers are uniquely embedded in the lives of their clients—providing 70 to 80 percent of all paid care—they are well-situated for observing and reporting changes in their clients' conditions. With expanded and new roles, direct-care workers could assist with transitions from one care setting to another, prevent hospital readmissions, participate in team approaches to chronic

disease management, and provide support and information to family caregivers.

More fundamentally, a better trained and supported, and thus more valuable and valued, frontline workforce is central to efforts to recast traditional, medically oriented organizational cultures found in hospitals, nursing homes, assisted living facilities, and homecare agencies alike. New skills in communication and problem-solving are needed throughout organizations in order to foster “relationship-centered” caregiving, where both workers and consumers are central and honored.

The direct-care workforce is also positioned to play a pivotal role in workforce development for low-income workers. The industries in which direct-care workers are employed form the employment core of one of the most powerful “job creation machines” in the American economy—the eldercare-disabilities sector. Jobs in this sector have been growing at four times the rate of jobs in the economy overall, even in the midst of a recession. Furthermore, from 2008 to 2018, this sector is expected to generate roughly four out of every ten new jobs in the healthcare and health-assistance sector. This translates into 1.6 million jobs in the eldercare-disabilities sector out of the 3.7 million

new jobs projected for the overall healthcare and health-assistance sector (PHI, 2008).

Since most of these new caregiving jobs pay wages within the bottom quartile of all U.S. occupations, the importance of this workforce to employment within low-income communities cannot be overstated. One out of every twelve low-wage workers in the United States is a direct-care worker; in New York City, one out of every seven low-wage workers is a homecare worker.

For communities, the value of direct-care jobs is immense. These jobs are plentiful and are among the fastest growing at a time when states are grappling with high unemployment rates and the need to move unemployed individuals into economic sectors with strong job growth potential. In addition, they are relatively recession-proof and can't be outsourced.

### **Key Policy and Practice Opportunities**

Changes in both public policy and employer practices are needed to leverage the potential of the direct-care workforce to improve care for elders, rein in healthcare costs within the eldercare- and disability-services sectors, and bolster job growth.

#### **Federal and state policy**

Probably the most singular deterrent to the development of



the direct-care workforce has been the calculation that direct-care jobs constitute a poor investment for workforce development and training dollars because they are, by and large, low-quality and dead-end. But the changing fundamentals described previously are reconfiguring the value proposition of direct-care jobs—to the healthcare system, to communities, and to workers. Consequently, there is an unprecedented opening for federal and state policy strategies that enhance the quality of direct-care jobs and unlock the full potential of this valuable, but underutilized, workforce. Chief among these policy strategies are the following:

- Implementing effective payment and procurement policies that encourage family-sustaining compensation standards for direct-care jobs, and create financial incentives for adopting human resource practices consistent with high-quality service delivery.
- Modernizing our country's approach to direct-care worker training. This requires efforts on several fronts. The content of entry-level and advanced training needs to be enhanced using competency-based curricula, and consistent standards need to be set across occupations requiring similar skills. Federal hourly training standards need to be extended and both state and federal requirements will need revising to align with competency-based approaches to training. Finally, state infrastructure for training direct-care workers needs to be improved by fostering an array of training entities and aligning government payment policies to create parity for reimbursing training costs across all types of direct-care workers. (Currently, the Centers for Medicare and Medicaid Services [CMS] only authorizes federal reimbursement of Certified Nurse Assistant (CNA) training delivered through a nursing home, or for a person who paid for their CNA training and who then goes to work in a nursing home.)
- Creating new care models that expand the roles of direct-care workers who care for older adults. This will require direct-care workers to receive training and support to assume greater levels of responsibility that add genuine value to the emerging health reform constructs of “care coordination,” “care transitions,” “accountable care,” and “person-directed services.”
- Broadening quality assurance mechanisms to encompass basic workforce measures that relate to adequate and safe staffing. This includes incorporating job quality and workforce indicators into national and state provider

quality standards, and making workforce an explicit part of the review of Medicaid-related long-term-care programs conducted by CMS.

### Employer practices

The prevailing business model in long-term-care organizations is predicated on low investment in staff, leading to high turnover viewed as an unavoidable cost of doing business. A vicious cycle is created whereby low retention and high turnover create strong disincentives for providers to invest in staff training, as well as retention-oriented supervisory practices and career advancement programs. Workforce “churning” in turn contributes to service delivery failure and disrupts critical caregiving relationships, leading to lower quality of care.

A structural “supply-side” change is underway because of decreasing numbers of working age females entering the labor force compared to previous eras. This change, combined with rapidly increasing demand for services, and labor competition across different eldercare and disability industries, is shifting the workforce calculus to a focus on retention and a consideration of the costs of turnover attributable to replacement, additional training, lost productivity, and lost revenues (Seavey, 2004).

Over the course of the last decade, evidence-based

interventions have convincingly demonstrated decreased staff turnover and improved retention, and shown positive connections to improved client or resident satisfaction and care quality (Dawson, 2007; Morris, 2009; Seavey and Salter, 2006). These interventions include:

- Competitive wages and benefits that reward tenure and skill enhancement, and that reinvest savings from lower turnover in direct-care worker compensation.
- Scheduling and staffing practices that support stable hours and income for home-care workers.
- Improved orientation and training based on core competencies and using an adult-learner-centered education approach.
- Retention-oriented supervisory practices such as a coaching style of supervision.
- Enhancing and deepening direct-care worker roles and responsibilities by creating opportunities for advancement and job enrichment.


Central to a wider adoption of these evidence-based practices is acceptance of the evidence that expending precious resources in these ways is not an expense, but rather an investment with the potential to generate a net financial benefit.

## Conclusion

Ironically, what is probably the largest workforce ever produced by our economy, and currently the fastest growing one, is a workforce charged with providing basic hands-on, caregiving services to millions of elders and persons with disabilities needing assistance with basic daily activities and tasks.

Today's direct-care workforce is preeminent in its size and enormous in its employment impact in an otherwise slow-growth economy. It offers tremendous value as an underused asset of our healthcare infrastructure that can be leveraged toward the reform goals of improving access,

promoting quality, increasing efficiency, and controlling costs.

But this historic workforce has only begun to come into its own in terms of receiving the policy and practice attention that will allow it to realize its potential value for the health-care system, for communities, and for workers. Concerted and timely investments by employers and state and federal governments can play a huge role in ensuring the development of a stable, competent direct-care workforce adequate to meet the growing demand for services, particularly in home and community settings. On the line is nothing less than the social fabric in place to support both the older Americans and others who need assistance, and those who care about them. 

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