PHI
QUALITY CARE THROUGH QUALITY JOBS

CARING FOR THE FUTURE

The Power and Potential of America's Direct Care Workforce

This report is the culmination of a year-long series of reports (released throughout 2020) providing a comprehensive, current-day analysis of the direct care workforce and its critical role in the long-term care system in the United States. By bringing these reports together, this final report provides: a detailed profile of these workers; a segmented look at the long-term care industry; a discussion on the evolving role of the direct care worker; a proposed framework for creating quality jobs in direct care; and a look forward at where this workforce and industry are heading. The report also offers concrete recommendations for policymakers, employers, advocates, and other long-term care leaders, and features stories of direct care workers from around the country, sharing their wisdom and ideas. **In releasing this report, our goal is to strengthen the national dialogue on the direct care workforce, including what needs to change in policy and in practice.**

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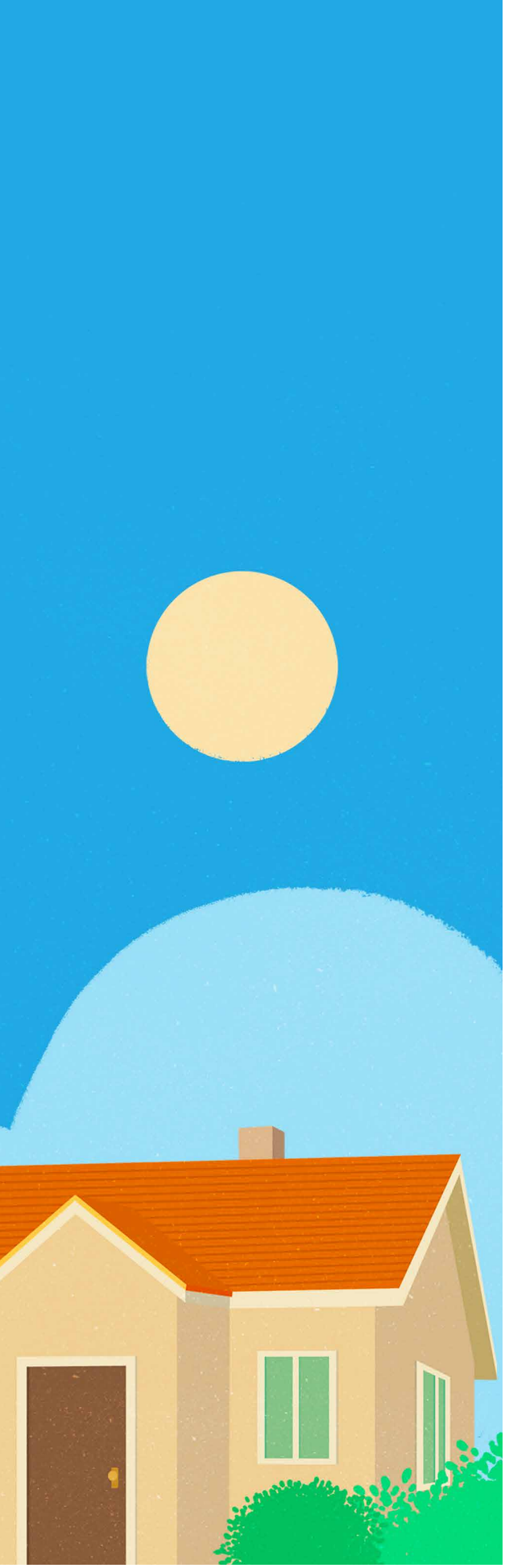
Caring for the Future: The Power and Potential of America's Direct Care Workforce was made possible by generous funding from the **W.K. Kellogg Foundation**, the **Woodcock Foundation**, and **The John A. Hartford Foundation**.



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Introduction

Every day around the country, direct care workers leave their homes to ensure that older adults and people with disabilities have the care and support they need to be safe and to fully participate in their communities. These 4.6 million workers are the paid frontline of support for consumers and their families, growing as a workforce annually as people live longer and demand surges. They work in private homes, nursing homes, and residential care settings, such as assisted living. They are unquestionably essential. They are predominantly women, people of color, and immigrants—diverse and consistently marginalized workers. These workers are not valued, compensated, or supported at the level they deserve. This report—*Caring for the Future: The Power and Potential of America's Direct Care Workforce*—explains why these and other challenges to ensuring a quality direct care job exist and offers a clear and achievable path forward.

Last year brought to the forefront two significant, large-scale challenges for this essential workforce. COVID-19 emerged as an unprecedented crisis, infecting 16.6 million people and claiming 302,314 lives in the U.S. (as of mid-December, according to *The New York Times*). The pandemic further strained the chronically under-funded, siloed, and otherwise dysfunctional long-term care system. As a result, direct care workers and their employers have lacked sufficient resources to deliver quality care through this crisis, which has disproportionately impacted the populations that make up most of their clients and residents: older adults (specifically those with certain underlying conditions), people with disabilities, and people of color. The impact of COVID-19 and an under-resourced system continues today as providers struggle to not only provide quality care, but to adequately protect and support their workforce.

At the same time, George Floyd's May 2020 murder at the hands of police officers helped spark an uprising and compelled a national reckoning on racial injustice nationwide. As a workforce comprised primarily of women and people of color, direct care workers are disproportionately impacted by race and gender inequalities and the systemic racism deeply embedded in our long-term care system. PHI has pledged an ongoing commitment to gender and racial justice for the direct care workforce. *Caring for the Future* explicitly speaks to both the importance of effectively navigating COVID-19 and addressing the consequences of gender and racial injustice on direct care workers.

This report also acknowledges the extraordinary policy window that has been opened in this moment. The long-term work and persistence of direct care workforce advocates has generated an ever-growing level of awareness and support for these workers among policymakers, practitioners, and the general public. In the last few years alone, state and federal leaders have moved a range of policy proposals to strengthen this job sector, news outlets have broadened the media coverage on the many challenges facing direct care workers, and workforce development innovators have designed responsive interventions to improve these jobs and deliver quality care to consumers. Moreover, while PHI has worked successfully on bipartisan initiatives for decades, we also recognize that the recent election of President Joe Biden offers a powerful opportunity to shine the national spotlight on these essential workers and the federal policies that are needed to support them. Never has there been such a clear opportunity to transform these jobs once and for all.

It is remarkable how much has changed in long-term care and the direct care workforce since I joined PHI almost 16 years ago—much of which is detailed in *Caring for the Future*. We have seen several developments in the system, including: the significant growth of long-term services and supports (LTSS) and the direct care workforce, spurred largely by the increase in older adults; the gradual shift to Medicaid managed care models, which have added new incentives and complexities to LTSS delivery and direct care job quality; the expansion of home and community-based services as states have rebalanced their Medicaid spending on LTSS, which has boosted demand for home care workers; and the sweeping impact of the Affordable Care Act, which decreased the uninsured rate among direct care workers by 26 percent from 2010 to 2014. It is equally remarkable what has not changed in that time: the persistent challenges associated with insufficient reimbursement rates under Medicaid, which make it impossible for employers to invest in the workforce; and the dogged and widespread gender and racial inequalities within and beyond long-term care, which threaten more marginalized workers and consumers.

During this time, I have been proud to work alongside a growing ecosystem of advocates in the workforce, aging, and long-term care sectors to respond to these developments in long-term care and achieve remarkable wins for direct care workers. As one notable example at the national level, in 2015, I celebrated PHI's years of hard work and collaboration with these leaders when the U.S. Department of Labor's final home care rule went into effect, extending wage and overtime protections under the Fair Labor Standards Act to more than two million home care workers nationwide. I have also been encouraged to see more leaders enter and expand this field in the last decade, a growing evidence base of workforce interventions and demonstration projects in direct care, deeper news coverage on the multiple challenges facing direct care workers, and a positive shift in public and political support for these workers. All these developments attest to our collective power as a sector and the urgency with which we must continue to strengthen these jobs. And yet, we still have much work ahead of us to create a stable, well-prepared, and economically secure workforce.

Caring for the Future: The Power and Potential of America's Direct Care Workforce offers a comprehensive, current-day analysis of the direct care workforce and its critical role in the long-term care system. The first section describes in detail the direct care workforce, including an analysis of how the direct care role has changed over time and a statistical overview of key demographics, socio-economic characteristics, and employment projections. The next section broadens the report's focus to the long-term care system, including its financing shortfalls, its seismic shifts over the years, its fragmentation and inconsistent oversight, and its many dispersed stakeholders—all of which coalesce to reinforce poor job quality in direct care.

Section three examines the training landscape for direct care workers; the defining aspects of direct care that are often unseen or underestimated (such as its physical demands, social and emotional complexity, and growing contributions to consumers' health management); and the promise of upskilling, care integration, and advanced roles. Section four takes a closer look at job quality for the direct care workforce, including how poor-quality jobs affect the entire sector and the impact of COVID-19 on workers and employers. This section also delineates PHI's new and current framework for job quality, which includes 29 elements across five pillars: quality training, fair compensation, quality supervision and support, respect and recognition, and real opportunity. *Caring for the Future* concludes with a detailed slate of concrete recommendations for policymakers, employers, and other stakeholders to strengthen this workforce across eight core areas. We hope they inspire and guide leaders across the field to design policies and practices that holistically improve direct care jobs nationwide.

In time, 2021 could be remembered as the tipping point for a direct care workforce national movement. But it will take concerted efforts across sectors and a significant public-private investment to achieve the recommendations outlined in *Caring for the Future.*

Direct care workers deserve this transformation—and without it, we will never achieve the consistent quality of care we all deserve.

Jodi M. Sturgeon, President, PHI

Terminology

ACTIVITIES OF DAILY LIVING (ADLS)
Essential activities performed every day, including bathing, dressing, eating, toilet care, and transferring/mobility.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare and partners with state governments to administer Medicaid, among other responsibilities.

CONSUMER
An individual who receives paid LTSS due to physical, cognitive, developmental, and/or behavioral conditions. Also referred to as *client.*

CONSUMER-DIRECTED SERVICES
Publicly funded service delivery model that enables consumers to manage their own LTSS, including by hiring, scheduling, supervising, and dismissing their own workers. Also known as *participant-directed* or *self-directed services.*

CORE COMPETENCIES
A set of competencies—broadly, the knowledge, skills, and abilities applied to complete one's role—that are considered foundational to successful performance of an occupation or set of occupations. Other components of workforce preparation, such as training design, delivery, and assessment, can be developed from a set of core competencies.

DIRECT CARE WORKER
Assists older adults and people with disabilities with daily tasks and activities across LTSS settings (and in hospitals and other settings, though these other settings are not the focus of this report). Direct care workers are formally classified as personal care aides, home health aides, and nursing assistants, but their specific job titles vary according to where they work and the populations they serve.

DIRECT SUPPORT PROFESSIONAL
Direct care worker who assists individuals with intellectual and developmental disabilities across a range of settings.

FAIR LABOR STANDARDS ACT (FLSA)
U.S. labor law establishing federal regulation of wages and work hours. Passed in 1938, FLSA did not cover home care workers until a final U.S. Department of Labor rule came into force in 2015.

FEE-FOR-SERVICE
A payment system where providers receive payments directly from public payers based on the amount of service that they provide.

HOME AND COMMUNITY-BASED SERVICES (HCBS)
LTSS that are delivered in private homes and community settings, including assisted living and adult day services.

HOME CARE WORKERS
An aggregate term for direct care workers—primarily personal care aides and home health aides—who provide assistance to individuals in their own homes.

HOME HEALTH AIDE
Direct care worker who provides ADL and IADL assistance to individuals in the community and who may also perform certain clinical tasks under the supervision of a licensed professional.

INDEPENDENT PROVIDER
Direct care worker who is employed directly by consumers through publicly funded consumer-direction programs or private-pay arrangements.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)
Tasks associated with living independently, such as preparing meals, shopping, housekeeping, managing medications, and attending appointments.

JOB QUALITY
Refers to the range of job attributes that shape workers' experiences and ultimately their health, economic security, and quality of life.

LONG-TERM SERVICES AND SUPPORTS (LTSS)
A range of health and social services provided to individuals who require assistance with ADLs and IADLs. Also described as *long-term care.*

MANAGED LONG-TERM SERVICES AND SUPPORTS
An alternative Medicaid payment model whereby private health insurance plans manage care services using monthly, per-capita payments from states.

MATCHING SERVICE REGISTRIES
Online job boards that 1) enable consumers to contact potential workers based on their needs and preferences and potential workers' availability and 2) help home care workers find clients and build sustainable work schedules.

NURSING ASSISTANT
Direct care worker who provides ADL and IADL assistance, as well as completing certain clinical tasks, for individuals living in skilled nursing homes.

PERSONAL CARE AIDE
Direct care worker who assists individuals with ADLs and/or IADLs in their homes and communities, and who may also support individuals with employment and other forms of community engagement.

PORTABILITY
The degree to which a training experience, credential, or certification in one occupation or role, care setting, or geographic region can be applied toward qualification and employment in the same role in another care setting or geographic region.

RESIDENTIAL CARE AIDE
Direct care worker who assists individuals living in adult family homes, assisted living communities, and other community-based residential care settings.

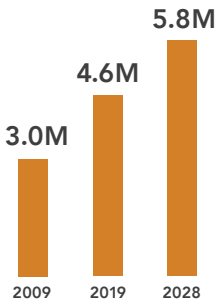
STACKABILITY
The degree to which a training experience, credential, or certification in one occupation or role can be applied toward training requirements, qualification, and employment in a different—typically higher-level—occupation or role.

TRAINING REQUIREMENT
A set of regulations that specifies training content and/or duration mandated for certification or employment in a specified occupation. In addition to content and duration, requirements may include instructor qualifications, competency assessment, portability of credentials, continuing education, and additional elements.

IT'S TIME TO CARE

A Detailed Profile of America's Direct Care Workforce

Introduction



The workforce already grew by half within a decade, from 3 million workers in 2009 to almost 4.6 million in 2019. Looking ahead, the long-term care sector is expected to add a further 1.3 million direct care jobs, primarily personal care aide positions, from 2018 to 2028—more new jobs than any other occupation in the U.S. economy.

Nearly 20 million adults in the United States require assistance completing self-care and other daily tasks due to physical, cognitive, developmental, and/or behavioral conditions.[1] This number includes about 17 million individuals living in the community, 1.5 million residing in nursing homes, and nearly one million in residential care.

Individuals with personal assistance needs rely first and foremost on family members, friends, and neighbors—a cadre of more than 43 million caregivers whose economic contribution is valued at $470 billion.[2] But for those with limited local caregiving networks, or with more complex needs, paid direct care workers are a lifeline.

Direct care workers—formally classified as personal care aides, home health aides, and nursing assistants, but known in the field by a much broader array of job titles—provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) across care settings. Their role requires considerable technical skill, especially as consumers' acuity increases, but also an extensive set of interpersonal skills. These skills are essential for building relationships with individuals and their families; communicating effectively with other members of the care team; managing conflicts and crises; and more.

The direct care workforce, which is already sizable, is expanding rapidly as our population grows older, as people live longer with disabilities and chronic conditions, and as the supply of potential family caregivers dwindles. The workforce already grew by half within a decade, from 3 million workers in 2009 to almost 4.6 million in 2019.[3] Looking ahead, the long-term care sector is expected to add a further 1.3 million direct care jobs, primarily personal care aide positions, from 2018 to 2028—more new jobs than any other occupation in the U.S. economy.[4]

Despite this staggering need and the importance of their contribution, direct care workers continue to struggle for recognition. Historically (and erroneously) defined as low-skill work and persistently undervalued in policy and practice, direct care continues to be provided predominantly by women, people of color, and immigrants—and poorly compensated.

In this section of the report, we look closely at this paradox—describing a critically needed but persistently marginalized workforce—and explore key opportunities to strengthen and stabilize the direct care workforce.

Ricardo Araujo

HOME HEALTH AIDE AT COOPERATIVE HOME CARE ASSOCIATES IN THE BRONX, NY
2.5 YEARS AS A DIRECT CARE WORKER

ON WHY HE DECIDED TO BECOME A HOME HEALTH AIDE:

"I love helping people. I used to work as a security guard and was looking for a new job. Now working as a home health aide, my job is about more than just getting a paycheck every week. My sister uses a wheelchair, so I had experience helping her get around to meet her needs. I came to CHCA knowing how to take care of others, but now I have also learned how to help people outside my family, especially people who live without family members. It is work, but I get to do something I enjoy."

ON WHAT HE FINDS MOST CHALLENGING IN HIS ROLE:

"I have a client who was used to being cared for by females and did not want a male home health aide. He had a hard time with me in the beginning, with a man he didn't know coming into his home. I needed to win him over, or I was going to be replaced. That was a challenge at first, but thankfully I was able to make him comfortable with me. I would tell him, 'Yes, sir, anything you need, I will be right here and can do it for you.' It was an adjustment for him, but now he trusts me. He just needed a chance to get to know me better."

ON WHAT IT TAKES TO SUCCEED IN HIS JOB:

"You need a whole lot of patience to do this job. You don't know what kind of day your clients are going to have, or what you are going to be dealing with. All clients are different. You could get willing, welcoming clients, or ones that will just close the door to you. Whatever comes up, no matter how you feel in that moment, you can't take anything personally. Sometimes my clients can be grumpy, but I'm pretty sure I would act the same way if I had to stay in bed and needed help moving. I just remember to do my job and to always be patient and understanding. I am there to care for my clients and that is the most important thing."

With a passion for helping others, Ricardo's caring nature and patient demeanor make him a natural fit for supporting older adults in their homes in the Bronx.

Dessaline Watkins

DIRECT SUPPORT PROFESSIONAL AT MISERICORDIA IN CHICAGO, IL
4 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A DIRECT SUPPORT PROFESSIONAL:

"I have a niece with developmental disabilities who I was very involved in raising, and Misericordia was one of the organizations I was introduced to while working with her. I was really impressed with the level of care and support I saw the workers giving to residents and thought, 'Wow, this is a job I would love to do.' I saw firsthand how the support my niece received growing up allowed her to blossom and enjoy a full life. Now I work with Misericordia to do the same for others."

ON WHAT SHE ENJOYS MOST ABOUT HER JOB:

"I enjoy giving my time and working directly with residents to help them be the best version of themselves. I have eight children, including two sets of twins. I am very caring and feel that my job as a DSP is an extension of my life as a mother. Both roles require empathy, patience, and communication skills. I have a big family at home and a big family at Misericordia."

ON WHAT SHE FINDS MOST CHALLENGING IN HER ROLE:

"Learning how to decompress and separate the stress of the job from the rest of my life can be difficult. When you deal with people you care about on a daily basis, you tend to bring those cares home with you. It is very stressful being directly responsible for a person's well-being. Keeping residents safe is a huge responsibility that families give us, and I take that very seriously. I am the type of person who is always trying to figure out better ways to do my job and to solve problems. I often leave work thinking, 'How can I reach my residents in a better way?' and that can be hard to turn off when I get home."

ON HER RELATIONSHIP WITH HER RESIDENTS:

"My relationships with my residents are multifaceted. It is not just black and white, where I am their staff and they are my residents. Yes, I am their staff and my job is to support them, but I am also a mentor, a friend, and I provide guidance. The residents are also here for us. If I come to work and am not in the best mood, they make me feel better and are concerned for me as well."

Supporting individuals with developmental disabilities at a residential group home, Dessaline recognizes that a supportive work environment is essential to her ability to provide her residents with the highest quality care.

Defining the Direct Care Workforce

Direct care workers provide daily assistance to older adults and individuals with disabilities across a range of long-term services and supports (LTSS) settings, including private homes; community settings, such as adult day services and activity centers; residential settings, such as adult family homes and assisted living communities; and skilled nursing homes. Direct care workers are also employed in hospitals and other settings of care, but this report focuses on the largest segment of the workforce, namely direct care workers in LTSS.

The direct care workforce comprises three main occupations as defined by the Bureau of Labor Statistics's Standard Occupational Classification (SOC) system: personal care aides, home health aides, and nursing assistants.[5] According to this classification system, *personal care aides* (SOC 39-9021) assist individuals with ADLs and often also provide support with IADLs and a range of community engagement activities. *Home health aides* (SOC 31-1011) and *nursing assistants* (SOC 31-1014) perform similar duties but may also conduct certain clinical tasks under the supervision of a licensed professional, such as monitoring vital signs, performing range-of-motion exercises, or administering medication, among others. The extent of home health aides' and nursing assistants' clinical responsibilities varies by state and setting, according to nurse delegation rules, provider policies, and norms of practice.

There is both overlap and diversity within the direct care workforce, however, that is not captured by this tripartite occupational classification. First, in practice, personal care aides and home health aides (and in some cases, nursing assistants) fulfill very similar roles in the home care setting. Collectively, these *home care workers* comprise the largest segment of the direct care workforce, at almost 2.3 million workers.[6] *Residential care aides* (720,500 workers) constitute another distinct group of direct care workers who are employed in residential settings. Residential care aides may be personal care aides, home health aides, or nursing assistants, depending on state-level regulations and local hiring practices.

Within the home care workforce is a distinct group of workers, known as *independent providers*, who are employed directly by consumers through publicly funded consumer-direction programs or individual private-pay arrangements. Independent providers are more likely than agency-employed home care workers to have a prior relationship with the individuals they support—up to 70 percent of independent providers in consumer-direction programs are family members or friends[7]—and tend to be exempt from training requirements, nurse delegation rules, and certain other regulations that apply to agency-employed home care workers. When hired privately by consumers through the so-called "grey market," these workers are often excluded from employment protections as well.

It is very difficult to accurately estimate the number of independent providers in the United States, given the wide variation in methods used to quantify this workforce across states and underreporting of their employment in the grey market. We can assume that at least a million independent providers are employed through consumer-direction programs, however, based on the most recent data on enrollment in these programs.[8] Specific considerations for this segment of the workforce will be raised throughout this series of reports.

Another distinct group of direct care workers are *direct support professionals*, who support individuals with intellectual and developmental disabilities across a range of settings, including private homes, group homes, vocational and day training programs, and others. Although there is not a separate occupational code for direct support professionals, these workers' on-the-job responsibilities tend to differ significantly from those of direct care workers who serve older adults or individuals with physical disabilities. For example, direct support professionals often coach their clients and assist them with finding and maintaining employment, which are not typical duties for other direct care workers. There were an estimated 1.3 million direct support professionals in 2013, according to the most recent data available.[9]

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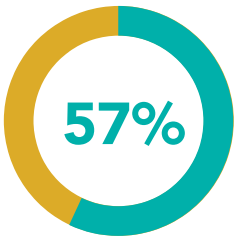
The Evolving Direct Care Role



In every year since 2013, HCBS have represented the majority of Medicaid LTSS spending. By 2016, the most recent year available, 57 percent of the $167 billion spent on Medicaid LTSS went to HCBS.

Although ADL and IADL assistance remain the central components of direct care, the direct care role—and its required competencies—has evolved over time in line with changes in the LTSS industry and consumer population.

THE SHIFTING PROVISION OF LTSS

Today's LTSS system originates in the Social Security Act of 1935, which formally placed long-term care (among other programs) under the auspices of government funding and oversight—and more specifically in the Act's 1965 amendments, which created Medicare and Medicaid.

When these programs were designed, LTSS was included under Medicaid, a *means-tested* public assistance program funded jointly by states and the federal government (and administered at the state level). In contrast, Medicare, which was designed to cover primary, acute, and post-acute health care, became a federally funded *universal* benefit. Thus the publicly supported LTSS system has, from its inception, focused only on those who are poor or who become impoverished—with adverse implications for funding levels and access to LTSS for the wider population. This issue will be explored further in the financing portion of the next section of this report.

Importantly, Medicaid was originally designed to provide LTSS for individuals with chronic conditions or disabilities in institutions only, not in private homes or community settings. Although persistent, this institutional bias has gradually eroded over the years. Home health care became a mandatory Medicaid benefit in 1970 and personal care became a state plan option in 1975. In 1981, the Omnibus Budget Reconciliation Act created Section 1915(c) waivers, enabling states to provide home and community-based services (HCBS) for individuals who would otherwise require an institutional level of care. Several other policy decisions and court cases followed. Particularly influential were the Americans with Disabilities Act of 1990 and the 1999 U.S. Supreme Court ruling in *Olmstead v. L.C*, which affirmed the civil right of individuals with disabilities to live in their homes and communities—and placed responsibility on public programs, including Medicaid, to uphold this right (within budget parameters).[10]

Cumulatively, these legal and policy decisions have pushed the balance of LTSS from nursing homes to the community. In the early 1980s, HCBS accounted for less than 10 percent of all Medicaid spending on LTSS.[11] By the late 1990s, that proportion had crept up to 25 percent—and in every year since 2013, HCBS have represented the majority of Medicaid LTSS spending.[12] By 2016, the most recent year available, 57 percent of the $167 billion spent on Medicaid LTSS went to HCBS.[13]

In parallel with the expansion of HCBS, and in response to other developments in health care financing and service delivery, the skilled nursing home sector has contracted somewhat in recent years, but also changed significantly. Nursing homes have taken on a much higher volume of post-acute care patients, who are primarily funded by Medicare for ever-shorter lengths of stay.[14] (In 2014, just over $29 billion Medicare dollars were spent on post-acute care in nursing homes, which was the highest proportion of Medicare's total post-acute care spending.[15]) As post-acute care provision also increasingly shifts to the community, however, nursing homes are now diversifying to serve new populations, such as those with behavioral health treatment needs.[16] At the same time, nursing homes continue to play a critical role in supporting consumers with the most extensive post-acute and long-term care needs.

These LTSS industry trends—rebalancing to the community matched by more post-acute and complex long-term care in nursing homes—have resulted in higher acuity among consumers in all settings. In turn, direct care workers carry new responsibilities and require additional technical and interpersonal competencies, relative to previous generations of the workforce.

Culix Wibonele

CARE PARTNER AT PARK SPRINGS IN STONE MOUNTAIN, GA
6 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A CERTIFIED NURSING ASSISTANT (CNA):

"I followed in the footsteps of my mom, who is a CNA. I grew up in Kenya where we did not have senior living homes. When our relatives get older there, they move in with us or we stay with them. Coming here, it is such a different culture to take your loved ones somewhere to get taken care of until they pass. So when I would hear about my mom's job, it was a little bit strange to me, but intriguing, too. I thought, 'This is like being home, but you get paid for giving care.' It felt natural.

I used to work as a salesperson and a cashier. From there, I went to school to become a dental assistant. That job was good, but something was still missing. I'm a hands-on person and I wanted something where I would be engaging people and helping them. So I decided to become a CNA. I feel like this is my calling. I am joyful when I go to work in the morning now. With Park Springs, it feels like I am going to my second home."

ON WHAT SHE FINDS MOST CHALLENGING IN HER ROLE:

"Many CNAs do not get paid enough. You have a lot of responsibility taking care of members. You are giving medication. You are doing laundry. You are feeding them. You are giving them a shower. You are making sure they don't fall. You are also taking care of their family members and answering all their questions about their loved ones.

We are the eyes and ears for these members, and we know what is going on with them 24/7 more than anybody else. This job can be stressful, and when you are not earning enough money to make ends meet, many people leave to find better pay."

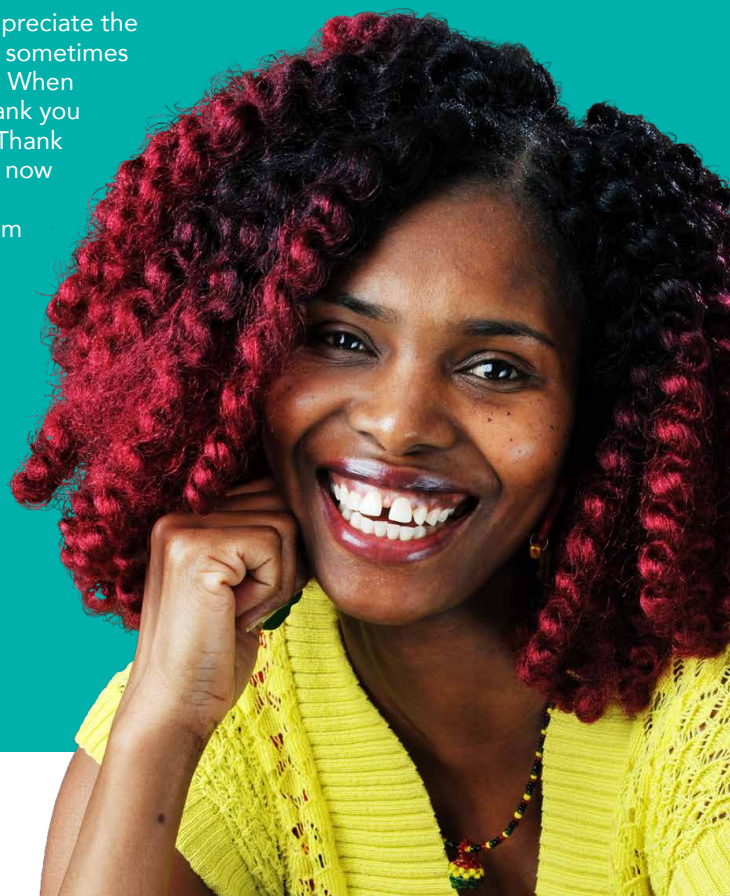
ON HER RELATIONSHIP WITH HER CLIENTS:

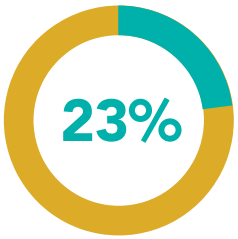
"Instead of calling them residents or patients, we use the word 'member' at Park Springs because they are members of our family.

We talk to them, we hold hands, we do activities, we sit and have a meal with them. We also give them options about their day. For example, if they are not ready to get up in the morning, we give them more time to sleep because that is their right. When they get up when they are ready, they are not cranky. They are not sleepy. They are alive. They are happy.

Our members appreciate the simple things we sometimes take for granted. When they tell me, 'Thank you for the hug,' or 'Thank you for smiling,' I now I did something right to make them happy and that makes my day."

Working in the Park Springs Memory Care Unit, Culix's enthusiastic, person-centered approach brings joy to the members she supports.



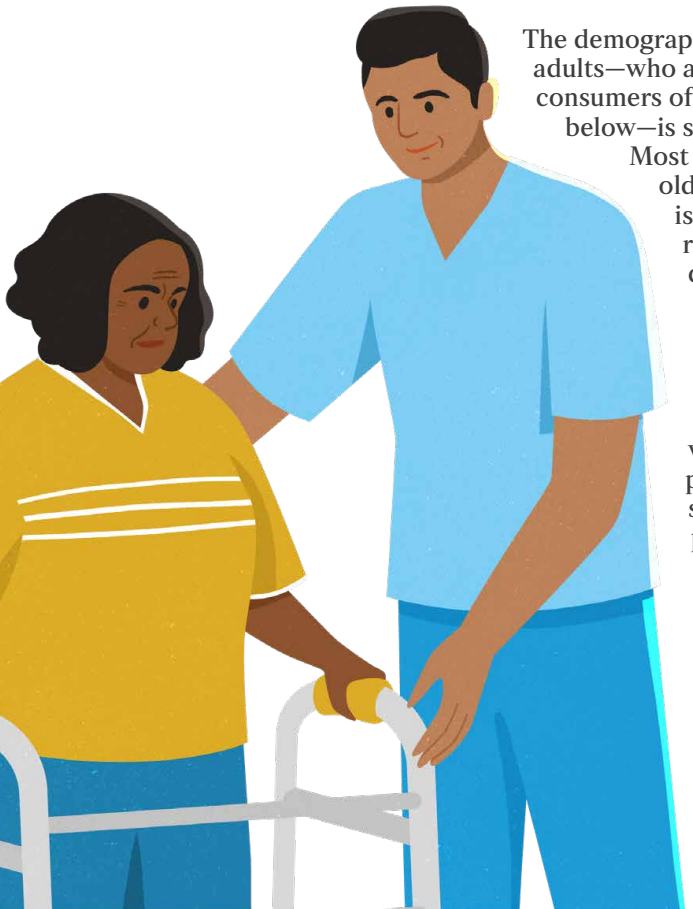


of older adults are people of color. By 2060, that proportion will increase to 45 percent.

THE CHANGING FACE OF CONSUMERS

Changes in population health and demographics are also re-shaping the direct care role. First, the growing number of individuals living with chronic conditions—and related functional impairment—is driving up demand for LTSS overall, as well as generating the need for new, condition-specific competencies among direct care workers. According to recent estimates, 60 percent of Americans now have at least one chronic condition, such as obesity and hypertension, while just over 40 percent of Americans have multiple conditions.[17] Chronic conditions are even more prevalent among older adults: approximately 80 percent of those aged 65 and above have at least one chronic condition, and nearly 70 percent have two or more.[18]

The number of individuals with Alzheimer's disease and other forms of dementia—75 percent of whom require personal assistance[19]—is also rising rapidly. There are currently 5.8 million Americans with Alzheimer's disease, the most common form of dementia, and that figure is expected to increase to nearly 14 million by 2050, barring major medical advances.[20]



The demographic profile of older adults—who are the primary consumers of LTSS, as described below—is shifting as well. Most significantly, the older adult population is becoming more racially and ethnically diverse. Currently, 23 percent of older adults in the United States are people of color, but by 2060, that proportion will increase to 45 percent.[21] Over the same period, the proportion of older adults who are immigrants will grow from 14 percent to 23 percent.

Personal assistance needs, family caregiving patterns, and formal service utilization all vary by race and ethnicity. For example, due to a range of health and socioeconomic factors, older adults of color are more likely to require ADL assistance than white older adults: in 2018, nearly 12 percent of Hispanic/Latino and 11 percent of Black/African-American older adults had ADL needs, compared to 6 percent of white older adults.[22]

Older people of color, particularly those from immigrant communities, may also be more likely to receive support outside the formal LTSS system, due to cultural values, historical mistrust of medical professionals, and cultural, linguistic, and economic access barriers.[23] Within the formal LTSS system, older people of color are more likely to receive care in nursing homes than HCBS, an imbalance that appears to be caused by inequitable access to community-based care—which is the preferred setting for the majority of adults, regardless of race or ethnicity[24]—rather than by demographic factors alone.[25]

There are also approximately 2.4 million adults aged 65 and over in the United States who identify as lesbian, gay, bisexual, and/or transgender (LGBT), a number that will continue to increase in line with the overall expansion of the older adult population.[26] LGBT older adults have historically concealed their identities in LTSS settings due to fears of neglect, abuse, or refusal of care. Even though these concerns persist,[27] older adults are now more likely to openly identify as LGBT in LTSS settings—and as systemic bias and discrimination are addressed, may be more likely to seek and access services in the years ahead.

These combined demographic characteristics and trends are likely to compound future demand for LTSS and impact the distribution of services (depending how caregiving patterns evolve and HCBS access barriers are addressed). Without doubt, they are driving up the need for cultural and linguistic competency in the direct care role, along with other interpersonal and technical competencies. The third section of this report will examine the evolution and expansion of direct care competencies in more detail.

Profile of the Direct Care Workforce

The direct care workforce is primarily composed of low-income women and people of color, many of whom face barriers to education and work in other settings. This section describes the demographic and socioeconomic characteristics of the direct care workforce as a whole, as well as drawing out distinctions between three main segments of the workforce (home care workers, nursing assistants in nursing homes, and residential care aides) and identifying changes over time. These statistics derive from PHI's analyses of the Bureau of Labor Statistics's Occupational Employment Statistics program, and the American Community Survey and Current Population Survey from the U.S. Census Bureau.[28]

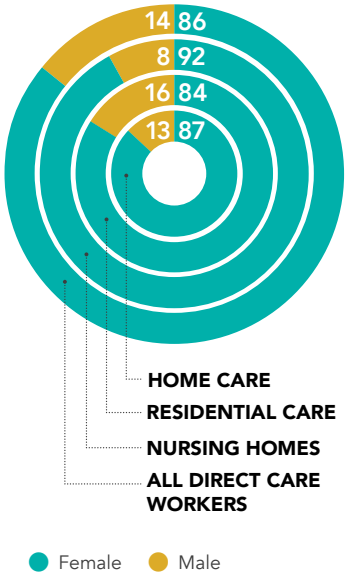
DEMOGRAPHIC PROFILE

The direct care workforce is predominantly female (86 percent), with some variation by setting: 92 percent of nursing assistants in nursing homes are female, compared to 87 percent of home care workers and 84 percent of residential care aides.

The median age of direct care workers is 41, but the age distribution of the workforce varies considerably. In home care, the median age is 46, and the workforce is older overall: 30 percent of home care workers are aged 55 and over (compared to just 11 percent who are 16 to 24 years old, the youngest age cohort). The other two segments of the workforce are younger: the median age is 37 for nursing assistants in nursing homes and 36 for residential care aides, and one in five of these workers are 24 years old or younger. Only 16 percent of nursing assistants and 18 percent of residential care aides are aged 55 and above.

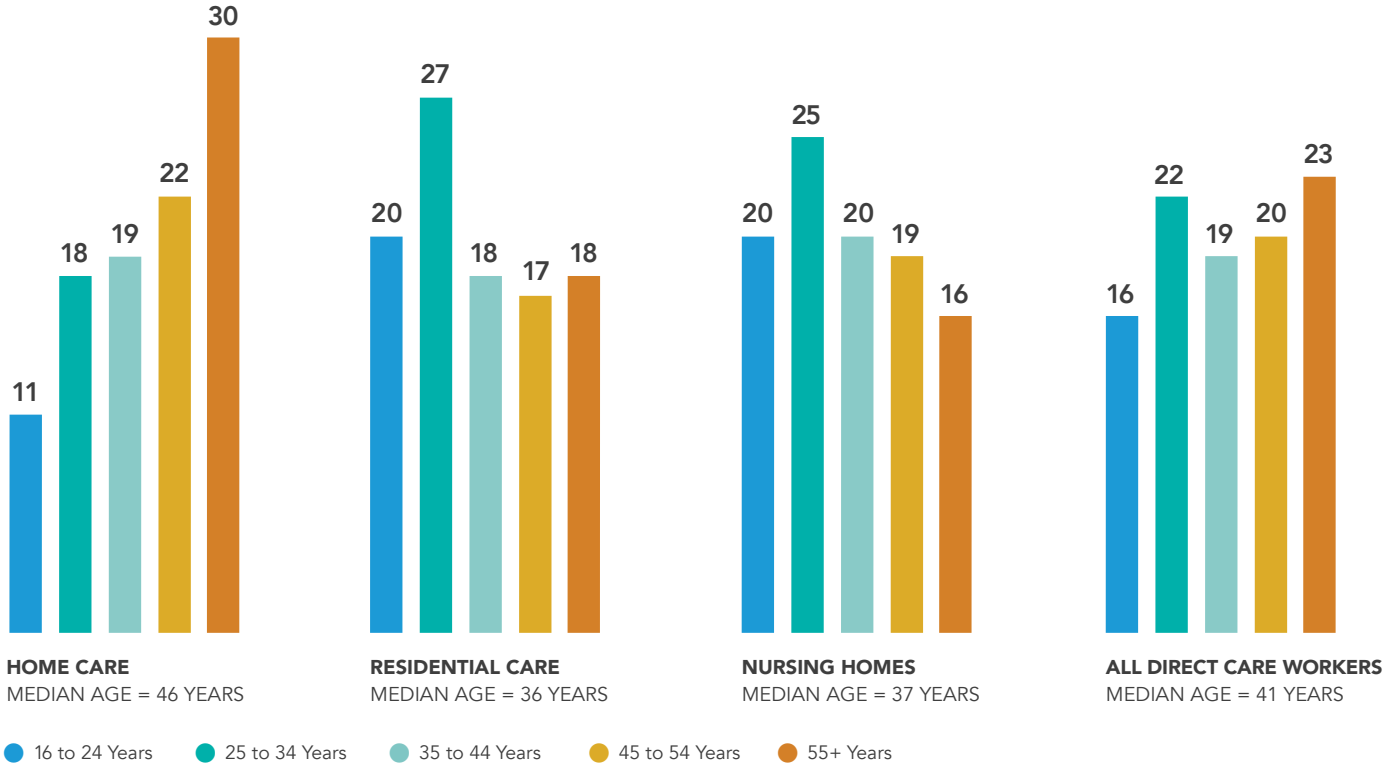
DIRECT CARE WORKERS BY GENDER ACROSS SETTINGS, 2017

(In Percentages)



DIRECT CARE WORKERS BY AGE ACROSS SETTINGS, 2017

(In Percentages)



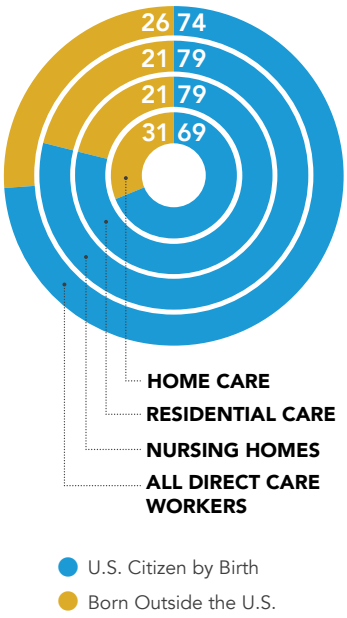
Source: Ruggles, Steven, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. 2019. *IPUMS USA: Version 9.0*. Minneapolis, MN: IPUMS, University of Minnesota. https://doi.org/10.18128/D010.V9.0; analysis by PHI (July 8, 2019).

The majority of direct care workers (59 percent) are people of color, including 30 percent who are Black/African-American, 18 percent who are Hispanic/Latino (of any race), 7 percent who are Asian or Pacific-Islanders, and 4 percent who identify as other races or ethnicities. This diversity is reflected across all segments of the workforce, with slight variations: home care has the highest proportion of workers of color overall (62 percent) and Hispanic/Latino workers (23 percent), for example, while a larger share of the nursing assistant workforce is Black/African-American (37 percent).

The direct care workforce also relies heavily on immigrant workers. Approximately one in four direct care workers (26 percent) was born outside the United States, with a range from 21 percent of nursing assistants and residential care aides to 31 percent of home care workers.

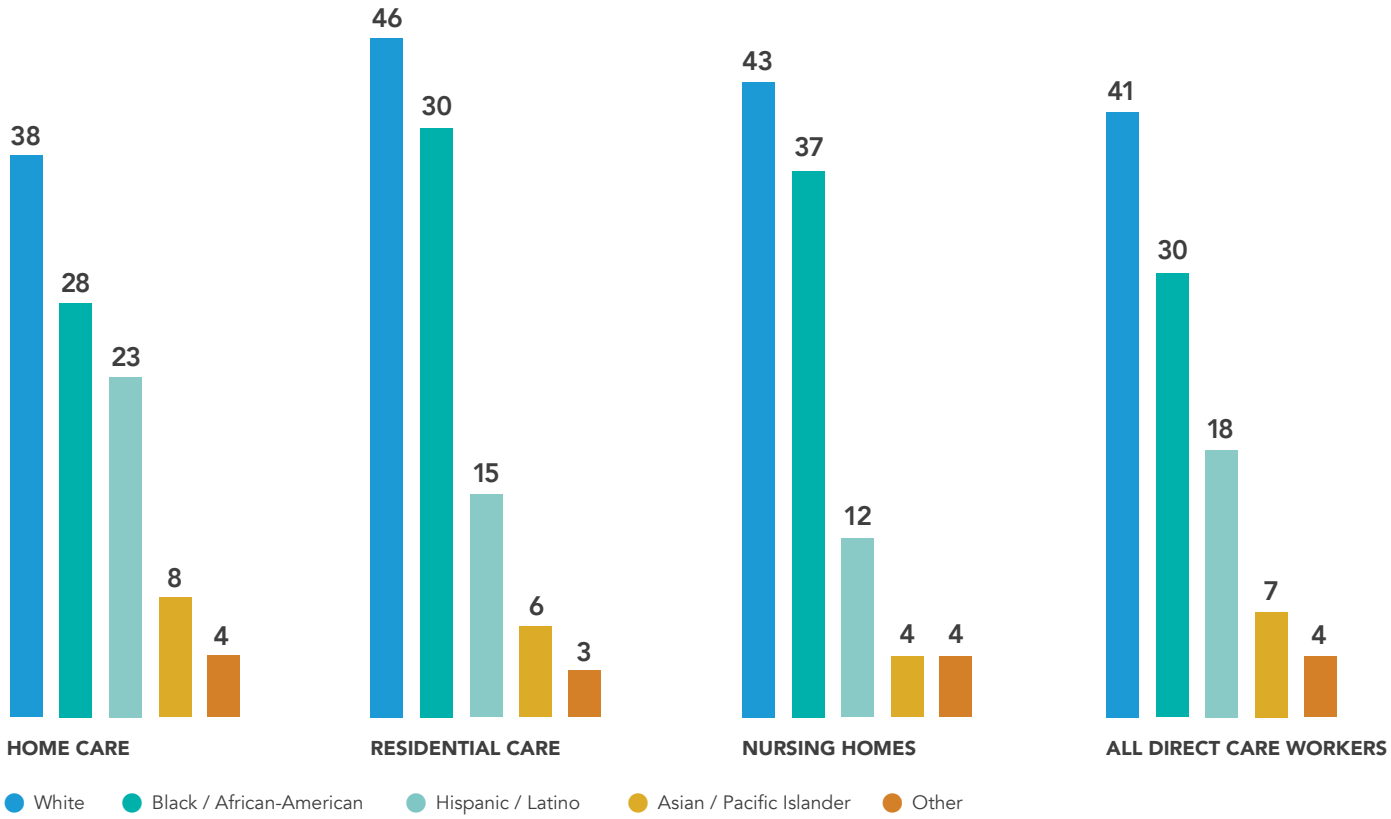
DIRECT CARE WORKERS BY NATIVITY ACROSS SETTINGS, 2017

(In Percentages)



DIRECT CARE WORKERS BY RACE AND ETHNICITY ACROSS SETTINGS, 2017

(In Percentages)



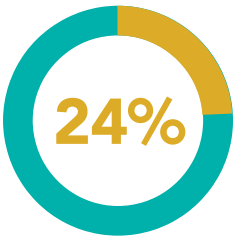
Note: Hispanic/Latino includes people of any race who identify as Hispanic or Latino; these individuals are not included in any of the other race/ethnicity categories.

Source: Ruggles, Steven, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. 2019. *IPUMS USA: Version 9.0.* Minneapolis, MN: IPUMS, University of Minnesota. https://doi.org/10.18128/D010.V9.0; analysis by PHI (July 8, 2019).

Finally, educational attainment is a defining characteristic of the direct care workforce. Overall, just under half (49 percent) of all direct care workers have a high school education or less, while 32 percent have some college and 20 percent have an Associate's degree or higher. Educational levels are highest among residential care aides (where 55 percent have some college or a college degree) and lowest among home care workers (where this proportion drops to 46 percent). Educational levels in the direct care workforce vary by demographic characteristics as well, including gender, age, race and ethnicity, and immigration status, among others. For example, men in direct care tend to have higher educational attainment: 53 percent of male home care workers, 67 percent of male residential care aides, and 54 percent of male nursing assistants in nursing homes have some college or a college degree, versus 45 percent, 53 percent, and 47 percent of female workers in each setting.[29]

In some ways, the traditional demographic profile of the direct care workforce has become increasingly entrenched in recent years. For example, the proportion of people of color in the workforce grew from 51 percent in 2007 to 59 percent in 2017, and women of color in particular increased from 45 percent to 51 percent. The share of immigrants in the workforce also increased from 22 percent in 2007 to 26 percent in 2017.

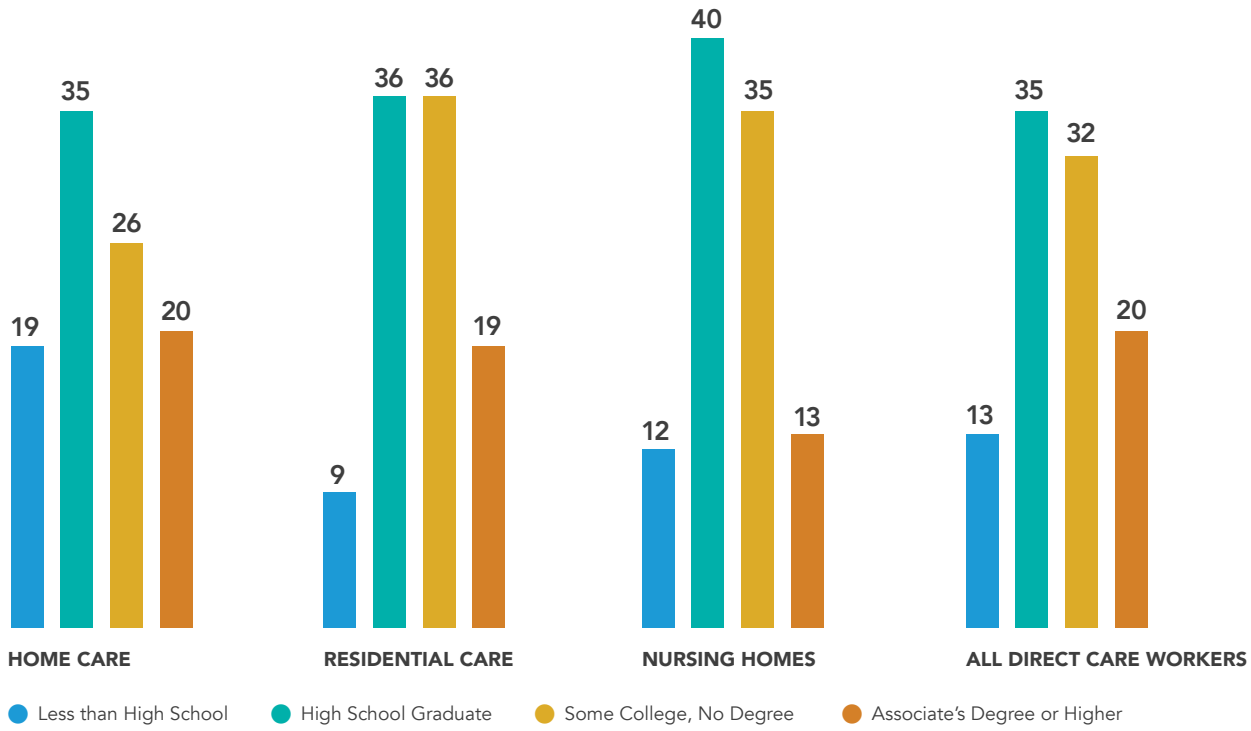
But the workforce is also changing. The proportion of men in the workforce increased from 12 percent in 2007 to 14 percent in 2017—a modest but auspicious change for this historically female workforce. Furthermore, while the median age of direct care workers remained the same, the age distribution of the workforce shifted noticeably from 2007 to 2017. The proportion of workers aged 55 and above increased from 19 to 24 percent within the decade, and those aged 16 to 34 also increased slightly, from 37 to 38 percent.



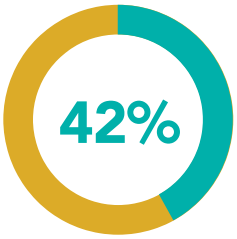
of all direct care workers are aged 55 and above, compared to 19 percent a decade ago.

DIRECT CARE WORKERS BY EDUCATION LEVEL ACROSS SETTINGS, 2017

(In Percentages)



Source: Ruggles, Steven, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. 2019. *IPUMS USA: Version 9.0.* Minneapolis, MN: IPUMS, University of Minnesota. https://doi.org/10.18128/D010.V9.0; analysis by PHI (July 8, 2019).



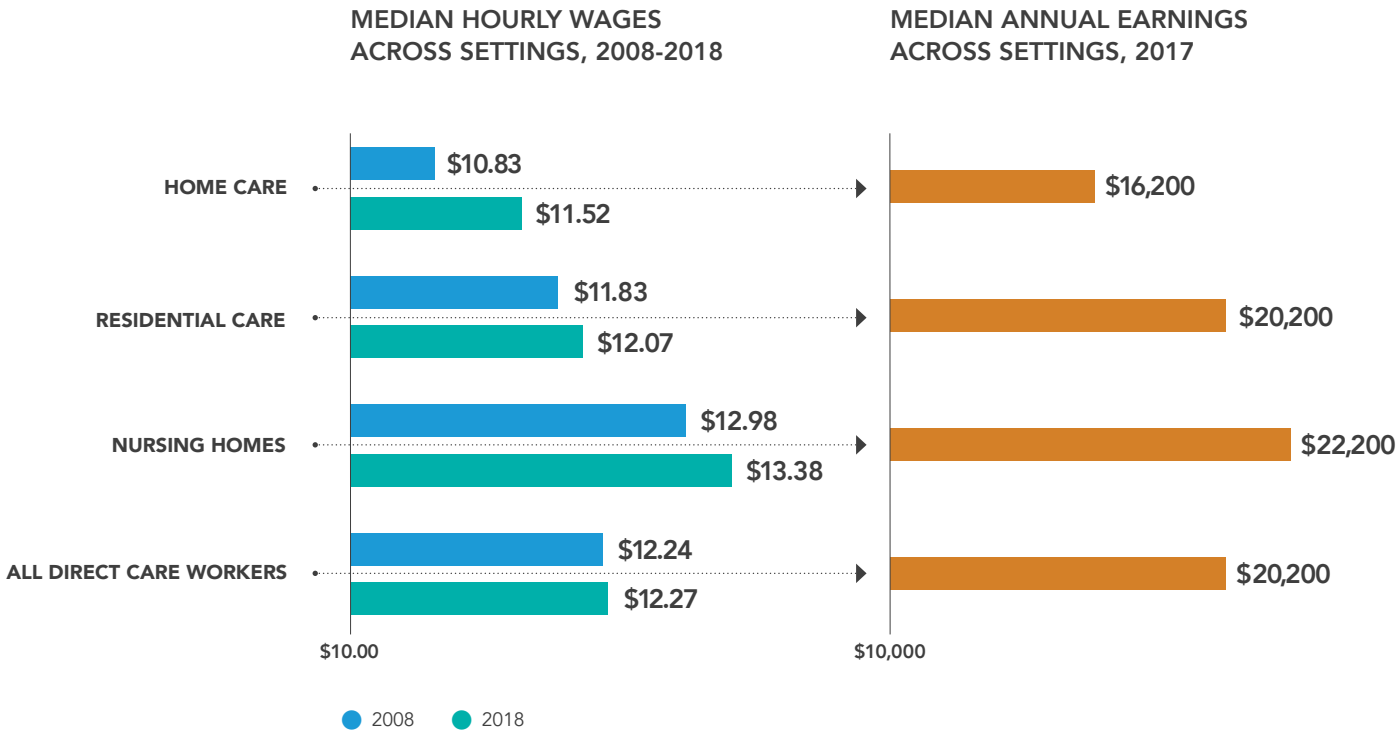
of direct care workers require some form of public assistance due to low earnings and high rates of poverty.

During the same period, the proportion of workers in their middle years (35 to 54) declined considerably, from 44 percent to 39 percent. Educational levels also rose among direct care workers in the past decade: the percentage of those with some college or a college degree grew by nearly 10 percentage points, from 42 percent to 51 percent.

SOCIOECONOMIC PROFILE

Wages and earnings are persistently and notoriously low for the direct care workforce. According to the most recent data from the Bureau of Labor Statistics, the median wage for all direct care workers is $12.27 per hour and—due to high rates of part-time employment as well as low wages—median annual earnings are just $20,200. Hourly wages have not kept pace with the increasing demand for workers over the past decade: from 2008 to 2018, even as the direct care workforce grew substantially, wages increased by only three cents (adjusting for inflation). Among direct care workers, home care workers earn the least, at $11.52 per hour and $16,200 per year, while residential care aides earn $12.07 per hour and $20,200 annually and nursing assistants in nursing homes earn $13.38 per hour and $22,200 annually.

Low wages and annual earnings are associated with high levels of poverty within the direct care workforce. Altogether, 15 percent of direct care workers live in poverty, which is defined as living below 100 percent of the federal poverty level, while 44 percent live in low-income households, meaning below 200 percent of the poverty line. (In 2017, the year from which these data derive, the federal poverty level was set at $12,060 for an individual and $24,600 for a family of four.[30]) Among all direct care workers, home care workers are most likely to live in poverty (18 percent), and close to half (48 percent) of both home care workers and residential care aides are low-income.



Sources: U.S. Bureau of Labor Statistics (BLS), Division of Occupational Employment Statistics (OES). 2019. *May 2008 to May 2018 National Industry-Specific Occupational Employment and Wage Estimates.* https://www.bls.gov/oes/current/oessrci.htm; Ruggles, Steven, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas, and Matthew Sobek. 2019. *IPUMS USA: Version 9.0.* Minneapolis, MN: IPUMS, University of Minnesota. https://doi.org/10.18128/D010.V9.0; analysis by PHI (July 8, 2019).

Further, more than two in five direct care workers (42 percent) require some form of public assistance, including Medicaid (26 percent), food and nutrition assistance (24 percent), and cash assistance (2 percent). As with the findings on income and poverty, home care workers are the most likely to require assistance (53 percent), compared to nursing assistants in nursing homes (36 percent) and residential care aides (38 percent).

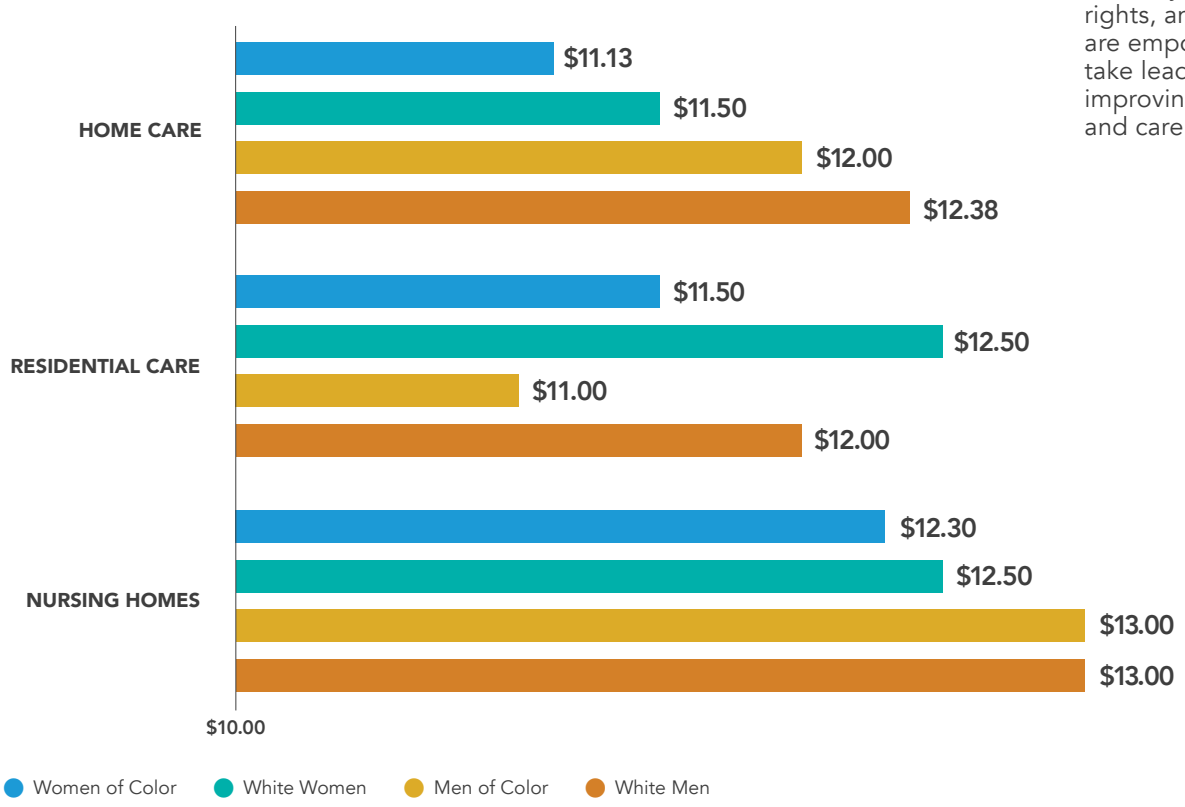
Even at this low end of the scale, there are further disparities in wages and earnings *within* the direct workforce—according to gender, race and ethnicity, and other personal characteristics. For example, women and people of color tend to earn less per hour than white male direct care workers (with some variation between settings). Among home care workers, the largest segment of the workforce, median wages are $11.13 for women of color and $11.50 for white women, compared to $12.00 for men of color and $12.38 for white men. In residential care, men of color earn a dollar less than white men ($11.00 versus $12.00), and women of color earn a dollar less than white women ($11.50 versus $12.50). In nursing homes, median wages are higher for all men ($13.00 per hour) than for white women ($12.50) or women of color ($12.30). Across the board, women of color in the direct care workforce are also more likely to live in poverty or low-income households and to require public assistance than white women or men.

Taken together, these data reveal a workforce that is collectively marginalized in the labor market while also internally divided by the same gendered and racial inequalities that characterize society overall. Further disparities in the direct care workforce related to compensation and other aspects of job quality will be examined in the fourth section of this report.

Industry Feature

Cooperative Home Care Associates (CHCA) leads the industry in promoting high-quality jobs for direct care workers. Established in the Bronx in 1985, CHCA is the country's largest worker-owned company, with over 2,000 employees. In collaboration with PHI, CHCA provides a robust training program with guaranteed employment, and offers its workers full-time hours, health and dental benefits, paid time-off, a range of employment supports, opportunities for advancement, and more. Worker-owners enjoy additional advantages, including annual dividends and majority voting rights, and all workers are empowered to take leadership roles in improving home care jobs and care quality.

HOURLY WAGES BY RACE AND GENDER ACROSS SETTINGS, 2017

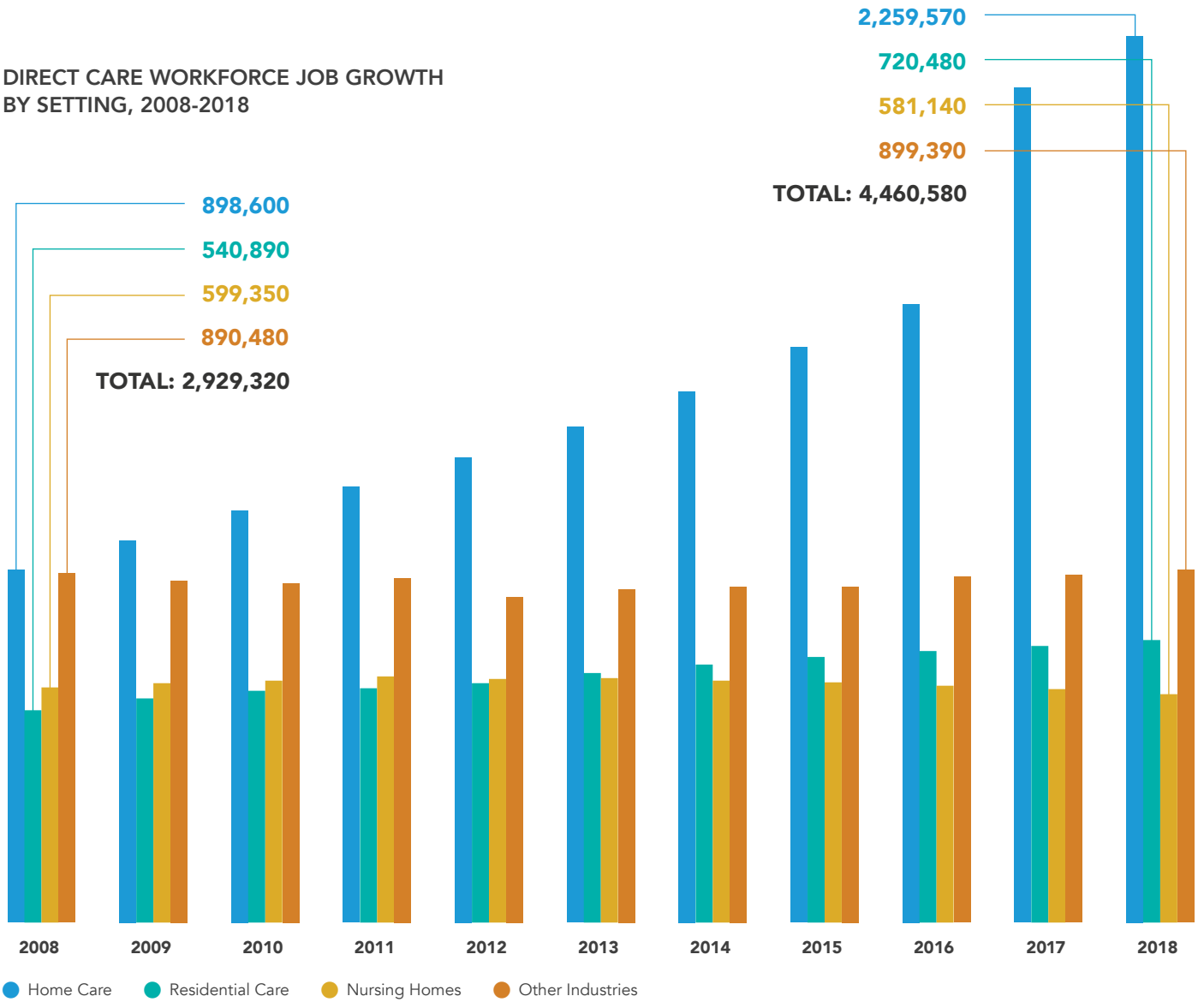


Source: Flood, Sarah, Miriam King, Renae Rodgers, Steven Ruggles and J. Robert Warren. 2019. *IPUMS, Current Population Survey: Version 6.0*. Minneapolis, MN: IPUMS, University of Minnesota. https://doi.org/10.18128/D010.V9.0; analysis by PHI (October 10, 2019).

A Rapidly Growing Workforce

The direct care workforce grew by 52 percent within a decade, from 3 million workers in 2009 to almost 4.6 million in 2019,[31] and it is expected to add an additional 1.3 million new positions within the next 10 years (by 2028).[32] Reflecting the trends described above, the majority of job growth will be in home care, which is projected to add just over a million new jobs (46 percent growth).[33] That means more new jobs in home care than in the second and third U.S. occupations with the most job growth *combined* (namely, food services and registered nursing). The residential care sector will also grow substantively, adding 168,400 new jobs (23 percent growth), while nursing homes are projected to contract by 3 percent (losing 19,300 jobs).

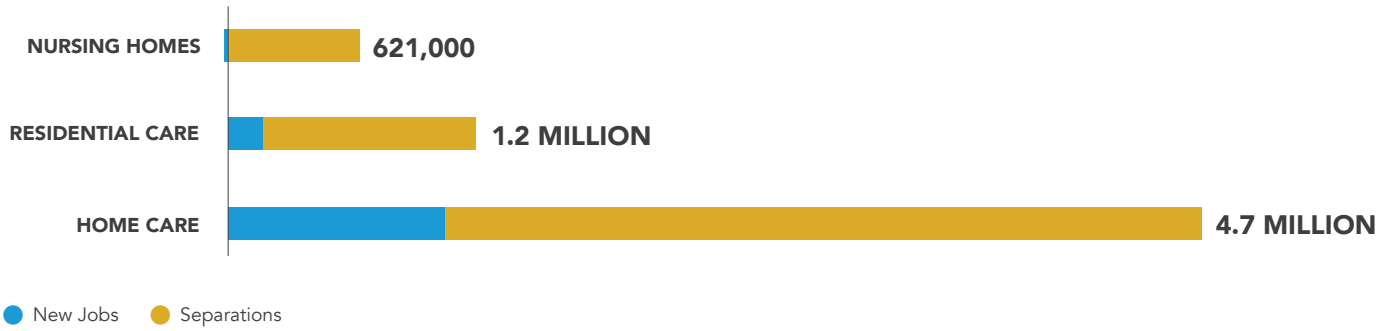
DIRECT CARE WORKFORCE JOB GROWTH BY SETTING, 2008-2018



Note: "Other industries" includes all other settings where direct care workers are employed (not including home care, residential settings, and nursing homes).

Sources: U.S. Bureau of Labor Statistics (BLS), Division of Occupational Employment Statistics (OES). 2019. *May 2008 to May 2018 National Industry-Specific Occupational Employment* and Wage Estimates. https://www.bls.gov/oes/current/oessrci.htm; BLS OES. 2019. *May 2008 to May 2018 National Occupational Employment and Wage Estimates.* https://www.bls.gov/oes/current/oessrci.htm; analysis by PHI (July 2, 2019).

PROJECTED JOB OPENINGS IN DIRECT CARE, 2018-2028



Note: "Separations" include job openings caused when workers leave the labor force (due to retirement, disability, or other reasons) or move into other occupations; these separation estimates do not include turnover within direct care occupations (e.g., movement from one nursing assistant job to another).

Sources: U.S. Bureau of Labor Statistics (BLS), *Employment Projections Program (EPP). 2019. Employment Projections*: 2018–28, National Employment Matrix – Occupation. https://www.bls.gov/emp/; BLS EPP. 2019. *Occupational Projections Data*. https://www.bls.gov/emp/; analysis by PHI (September 17, 2019).

What's more, the direct care workforce will need to fill 6.9 million additional job openings over the next decade as existing workers leave the field or exit the labor force altogether.[34] When combined with growth, this means that nearly 8.2 million total direct care job openings are anticipated from 2018 to 2028. The home care workforce will have 4.7 million job openings; residential care will have 1.2 million job openings; and nursing homes will need to fill approximately 621,000 nursing assistant jobs.[35]

As startling as these projections are, they do not tell the full story. First, the projections are necessarily based on the assumption that base year employment meets demand—failing to account for existing job vacancies, which are poorly measured but widely experienced in the field. Further, the projections do not account for anticipated or unexpected shifts in population health, family caregiving, the organization and delivery of health care and LTSS, and other factors.

Neither do the employment projections account for turnover *within* each segment of the direct care workforce, which is strikingly high. Although there is no reliable national figure on turnover in the direct care workforce, turnover has generally been reported at 40 to 60 percent or higher[36]—and the most recent annual survey of private-duty home care agencies found that turnover reached a historic peak of 82 percent in 2018, a 15 percent increase over the previous year.[37] As a proxy indicator of turnover, results from national workforce surveys indicate that 1 in 4 nursing assistants in nursing homes and 1 in 5 home health aides are currently looking for another job.[38] Forty-five percent and 35 percent of these workers, respectively, report that they are somewhat or very likely to leave their current job within the next year.

DRIVERS OF WORKFORCE DEMAND

Direct care job growth is driven primarily by population aging and the changing supply of family caregivers. (Turnover, in contrast, is largely a job-quality issue.) From 2016 to 2060, the number of adults in the United States aged 65 and over will nearly double, from 49.2 million to 94.7 million, and the number of those aged 85 and over will triple, from 6.4 million to 19 million.[39] During the same period, the number of adults aged 18 to 64 is projected to increase by only 15 percent.

State Policy Spotlight

Long-term care leaders in **Wisconsin** have taken action to raise the profile of nursing assistants and address the growing workforce shortage in nursing homes. WisCaregiver Careers is a statewide workforce development program that aimed to train 3,000 new nursing assistants within two years and place them in stable jobs. To publicize the program, the state launched a multi-media campaign in 2018 that showcased the diversity of the workforce and promoted its value. A partnership between state agencies and nursing home providers, the WisCaregiver Careers program was supported by a Civil Monetary Penalty grant and other funds.

A Closer Look at Data Collection

Overall, the LTSS field lacks sufficient data on the direct care workforce at the state and national levels. Essential data include: workforce **volume** (namely the number of full-time and part-time workers across programs and settings), workforce **stability** (specifically, turnover and vacancy rates), workforce **credentials** (such as training and certification rates), and workforce **compensation** (including wages, annual earnings, and access to benefits). These data are critically needed to measure workforce capacity, develop recruitment and retention goals, inform policy changes, evaluate progress, and compare results across states and over time.

Population aging is significant because personal assistance needs and formal LTSS use increase with age. More than 21 percent of adults in the community who are aged 85 years and above require assistance with ADLs, compared to 8 percent of those 75 to 84, just under 4 percent of those 65 to 74, and just 3 percent of those 18 to 64.[40] Across LTSS settings, the majority of consumers are aged 65 and over, including 93 percent of residential care residents, 83 percent of nursing home residents, and 82 percent of home health patients.[41] Moreover, as life expectancy for individuals with disabilities continues to improve due to advances in health care and medical technology, a larger number of younger people with disabilities today can be expected to require LTSS in the future.[42] These figures indicate that demand for LTSS will increase precipitously in the years ahead. At the same time, the caregiver support ratio—meaning the ratio of those aged 18 to 64 years old, who are most likely to provide care, to those aged 85 and above, who are most likely to need care—will shrink dramatically. The caregiver support ratio is projected to fall from 31 to 1 in 2016 to only 12 to 1 by 2060.[43]

Population aging will not occur uniformly, however—with implications for LTSS service delivery and workforce supply. In particular, rural areas are expected to age more quickly than urban and suburban areas. According to PHI's analysis of data from the Urban Institute's Mapping America's Futures project, the population of rural-dwelling adults aged 65 and older will grow by 984,000 (64 percent) from 2010 to 2030, while the population of rural residents aged 20 to 64 will fall by 638,000 (12 percent).[44] This means that by 2030, adults aged 65 and older will constitute more than a quarter (28 percent) of the rural population, compared to one-fifth (20 percent) of the urban and suburban population.

Aside from population aging, other socioeconomic and demographic shifts are diminishing the supply of potential family caregivers, leading to higher demand for direct care workers.[45] There are more women in the labor market than in previous generations, meaning fewer full-time caregivers at home. Families are smaller and more geographically dispersed. Divorce rates are increasing among older people. Adult children may already be juggling caregiving responsibilities with paid employment, and/or may have their own age-related or other health concerns. Because of these and many other factors, individuals who develop personal assistance needs may not have a spouse, adult child, or other family member nearby or available to provide support. Where they are available to help, family members are taking on increasingly complex and challenging care tasks, such as medication management, incontinence care, wound care, and more—incurring physical, emotional, and financial stress that can lead to burnout.[46] Although these and other trends will continue evolving over time, there is no doubt that they are already generating an urgent need for formal LTSS and a robust, stable direct care workforce.

Conclusion and Implications

Collectively, the factors described in this section of the report have produced a crisis in the direct care workforce. Long-term care employers are struggling to recruit and retain enough workers to fill vacant positions, while existing workers are shouldering the burden of growing demand without enough resources or support. Consumers are struggling to access the care they need—piecing together support from family and friends; waiting months or even years to receive formal services;[47] moving into nursing homes sooner than necessary; or simply going without.

Based on the findings presented in this section, we conclude with two immediate opportunities to recruit and retain a workforce that will be sufficient to meet demand in the years ahead. The next three sections of this report will explore in further detail the policy and practice factors that define the current direct care workforce crisis and propose additional levers for resolving it, while the final section will present specific recommendations for action.

IMPROVE COMPENSATION

There are numerous ways to improve job quality and thereby build the direct care workforce—but the bottom line is that workers must be better compensated, in line with the value of their contribution. Otherwise, the LTSS sector will continue struggling to recruit and retain a strong workforce, especially given the fierce competition for entry-level workers across the labor market.

Two recent policy developments are helping move the needle on direct care workers' compensation, but with significant caveats. The first is the trend toward increasing the minimum wage across states, which helps raise the wage floor for all low-income workers. (Although the federal minimum wage has held steady at $7.25 since 2009, 29 states and DC have raised their minimum wage above that rate, along with more than 40 cities and counties since 2012.[48])

The second is the recent revision of the companionship exemption under the Fair Labor Standards Act (FLSA). Since it was passed in 1938, FLSA had categorically excluded domestic workers, including home care workers. FLSA was amended in 1974 to include domestic workers, but even then, so-called "companionship services"—whether provided by independent providers or through a home care agency—were explicitly exempted. It was not until 2015—after numerous court cases and a lengthy rule-making process—that a final rule that substantively narrows the companionship exemption came into force. As a result, with limited exceptions, home care workers must now be paid at least the federal or state minimum wage, whichever is higher, for the first 40 hours of the work week; must be paid overtime; and must be paid for travel time between clients that are assigned by a single employer.[49]

In Focus: PHI's Policy Approach

For nearly a decade, PHI produced research and policy analysis in support of extending federal labor protections to home care workers, who had long been excluded from the **Fair Labor Standards Act (FLSA)**. In 2011, when the U.S. Department of Labor (DOL) announced the intent to correct this injustice—extensively citing PHI's research—we joined forces with other organizations to advocate for a successful outcome. In 2013, the DOL issued the final rule, which then came into force in 2015—a landmark victory for home care workers and their advocates.

State Policy Spotlight

In 2011, **New York** passed the Home Care Worker Wage Parity Law, resolving a long-standing imbalance in wages for personal care versus home health aides in New York City and surrounding counties. Part of the state's Medicaid Redesign efforts, the law set a broad precedent by creating a wage floor to ensure that all Medicaid-funded home care workers in the region receive a living wage. In 2017, wage parity was extended to independent providers in the Consumer Directed Personal Assistance Program as well.

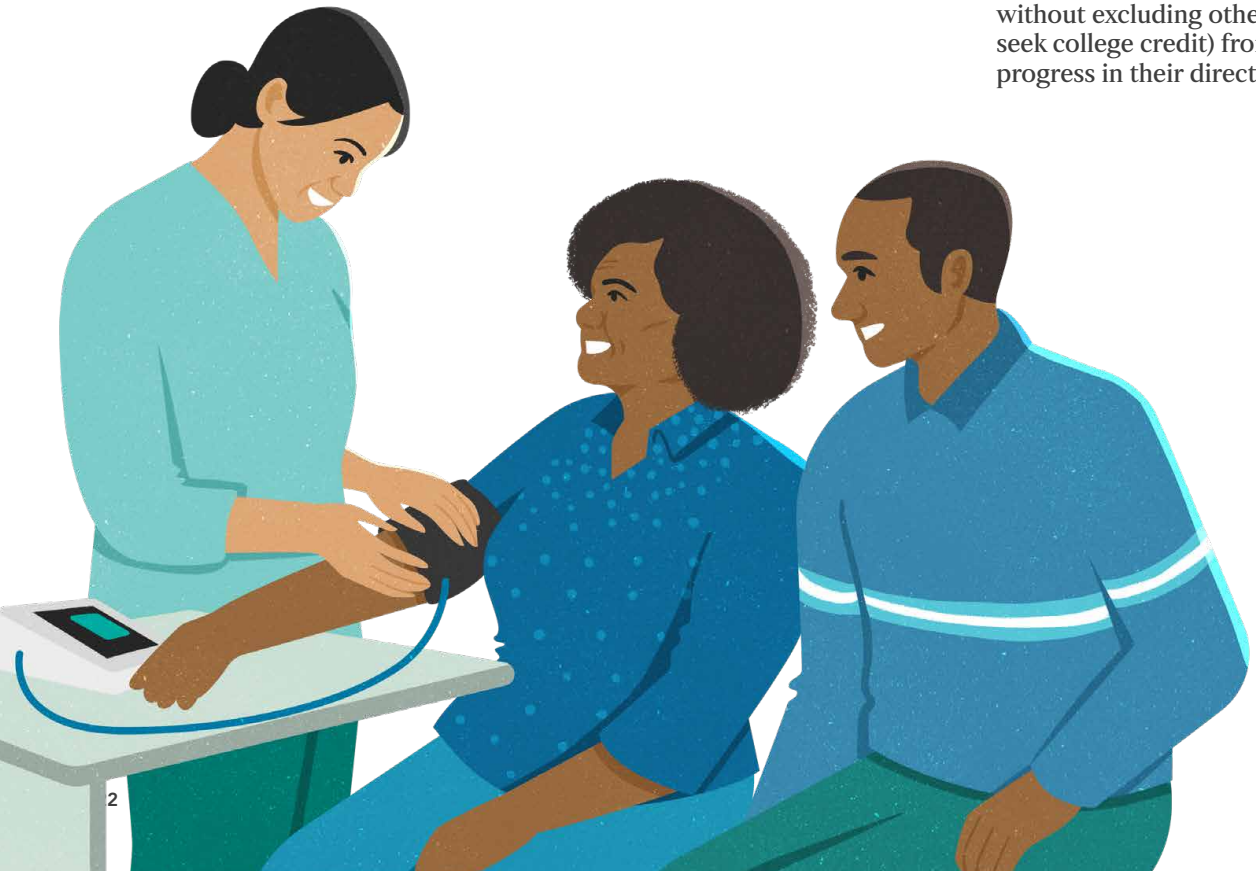
While immensely positive, these policy developments require additional action to ensure that they translate into improved compensation for direct care workers. First, they must be matched by reimbursement rate increases from Medicaid (the largest payer for LTSS), with requirements for passing the increase directly to workers; otherwise, Medicaid-funded employers struggle to cover new wage mandates, and workers do not necessarily experience the benefits. A number of states have implemented "wage pass-throughs" over the years, as one way to ensure improved compensation for workers. Most recently, 15 states reported implementing wage increases for Medicaid-funded direct care workers in 2018, while 24 states reported implementing wage increases in 2019 (with 14 states reporting increases across both years).[50]

Second, wage increases must be implemented with attention to the impact on benefit eligibility for direct care workers—so that increased wages do not, paradoxically, lead to *lower* (or unchanged) total compensation, due to a corollary loss of benefits.[51]

Finally, policies that lift all boats, such as minimum wage increases, must be accompanied by redoubled recruitment and retention efforts, to ensure that workers are not lost to other sectors that offer a similar wage but more hours, preferable schedules, or other advantages.

BUILD THE WORKFORCE PIPELINE

Considering the demographic profile of the direct care workforce presented above, two clear recruitment strategies emerge. The first strategy is to target recruitment efforts at specific types of workers. For example, the direct care workforce (particularly in home care) tends to be older—but has gained a greater proportion of younger workers in recent years. A well-articulated workforce development program focusing on younger jobseekers could capitalize on this trend. A gold standard program would provide a pathway for high school students to complete direct care training while earning their high school diploma, then move directly into a job after graduation. Further along the pathway could be opportunities to earn post-secondary educational credit by completing additional training modules, benefitting direct care workers of all ages who seek to advance their education—without excluding others (who do *not* seek college credit) from opportunities to progress in their direct care careers.



Recruitment efforts can be targeted at other segments of the labor force as well. As noted, older workers already make a substantive contribution to the direct care workforce—nearly one in four are aged 55 and above—but may be recruited in larger numbers through existing initiatives, such as the Senior Community Service Employment Program (SCSEP). SCSEP is a federal workforce development program that has been used successfully to recruit direct care workers in past pilot projects.[52] Certain aspects of the direct care role, such as flexible schedules and part-time hours, may be more amenable to individuals seeking an "encore" career, as compared to younger workers with more pressing financial responsibilities.

Finally, there is a clear imperative to recruit more men to the direct care workforce, building on the modest growth trend described above. One option is to recruit men who already have experience as family caregivers, considering that 40 percent of all family caregivers (and 47 percent of Millennial family caregivers) are men.[53]

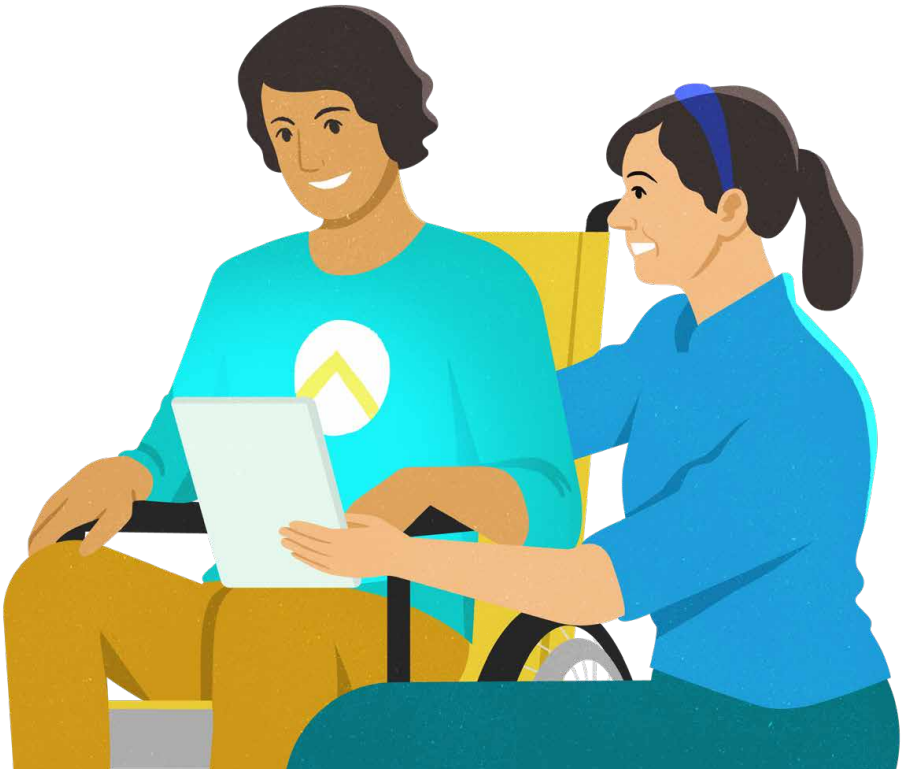
The second strategy for building the workforce pipeline, on a different order of magnitude, is to stem the tide of hostile immigration policymaking. Recent policies affecting direct care workers—just over a quarter of whom were born outside the United States—include the travel ban, the elimination of temporary protected status, and the new public charge rule. The travel ban, introduced in 2016 and upheld by the Supreme Court in 2018, indefinitely suspends the issuance of visas to applicants from Libya, Iran, North Korea, Somalia, Syria, Venezuela, and Yemen. The proposed termination of temporary protected status, currently subject to legal challenge, may affect immigrants from El Salvador, Haiti, Honduras, Nepal, Nicaragua, and Sudan.

Together, these policies directly implicate nearly 70,000 direct care workers, including 16,300 workers from countries affected by the travel ban and nearly 53,400 non-U.S. citizens from countries that may lose temporary protective status.[54]

The new public charge rule, the most recent affront to immigrant workers, considerably broadens the range of programs that are included when determining whether a visa or residency applicant is or will become a "public charge" (i.e., a cost to the state).[55] The rule adds Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and several housing programs to the determination equation; adjusts the income standard down to 125 percent of the federal poverty level; and defines subsidized marketplace coverage less favorably than private health insurance, among other changes.[56] Considering the income, poverty, and public assistance statistics presented above, this rule will directly impact many direct care workers and their families, and—like other policies targeted at the most vulnerable immigrant groups—will create fear and uncertainty among countless others.[57] As of the writing of this report, the rule has been temporarily blocked from implementation due to legal challenges.

In Focus: PHI's Workforce Innovations

For decades, PHI has worked with Cooperative Home Care Associates (CHCA) to develop best practices for strengthening the direct care workforce, which we share with LTSS providers nationwide. Our **young adult training and employment program** is a key example. In this program, young adults enjoy all the advantages of the CHCA model (see page 17), but they are additionally supported by a Young Adult Case Manager who provides individualized case management and connects them with peer mentors and targeted employment supports. In 2018, the retention rate for young adults at CHCA was 77 percent after three months on the job, far above the industry standard for new hires.



Industry Feature

In 2015, an Albuquerque-based nonprofit organization called **Encuentro** created a new home health aide training program specifically for Latino immigrants. The innovative 15-week program is conducted in Spanish, and scholarships are available to cover the costs of tuition and childcare. Encuentro also launched a matching service registry, EnCasa Care Connections, to help consumers and workers find each other. With their comprehensive, culturally and linguistically competent approach, Encuentro is helping to improve both jobs and access to care for Latino immigrants in New Mexico.

Altogether, these aggressive immigration policies threaten the future pipeline of immigrant workers into direct care jobs, while also driving existing workers into the grey market or out of the workforce altogether. On the other hand, supportive immigration policies and pathways will help build and strengthen this essential segment of the workforce.

CONCLUSION

Nearly 4.6 million direct care workers provide essential daily support to older adults and individuals with disabilities across LTSS and other settings in the United States. The need for their assistance is increasing precipitously as our population grows older and the supply of family caregivers diminishes. At the same time, the direct care role is evolving, as service provision shifts to the community and consumers require assistance with more complex conditions, among other changes. As a result, direct care workers across all long-term care settings require a range of new technical and interpersonal competencies.

The obvious response to these trends is to invest more energy and resources into direct care jobs—to build career pathways into direct care, create jobs that are financially sustainable and intrinsically rewarding, and ensure that the workforce is prepared to provide the services and supports that consumers need.

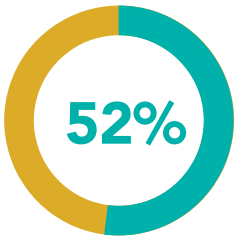
To that end, this report section has identified two primary opportunities to invest in the direct care workforce: first, increase compensation for direct care workers (to rectify their historical devaluation and bring economic self-sufficiency into reach); and second, build the pipeline of new workers into direct care, including through targeted outreach and supportive rather than punitive immigration policies.

These investments are necessary but not sufficient to strengthen direct care jobs and address the growing care gap in long-term care—a comprehensive solution will require remedying the inadequacy of the LTSS financing system, improving training and career development for direct care workers, ensuring that direct care workers are well-supported on the job, and more. These strategies will all be explored in the upcoming sections of the report.

WE CAN DO BETTER

How Our Broken Long-Term Care System Undermines Care

Introduction



of all revenue for long-term services and supports is provided by Medicaid.

In the previous section of this report *(It's Time to Care: A Detailed Profile of America's Direct Care Workforce)*, we discussed a paradox in the long-term care field: direct care workers are in extremely high demand, but their job quality is poor. They are often overlooked, underutilized, and poorly compensated—and as a result, the field struggles to meet the growing need for their services. We suggested that this status quo could be disrupted through significant and immediate investments in two areas (among others): improving compensation and building career pipelines into direct care jobs.

But where do we start? A bewildering array of systemic barriers stand in the way of transforming job quality for direct care workers. First, long-term services and supports (LTSS) are expensive—typically ranging from $50,000 to $90,000 per year[58]—but consumers have limited options to cover these costs. Because many consumers impoverish themselves paying for long-term care, Medicaid has become the primary payer for these services—accounting for 52 percent of all LTSS revenue[59]—but Medicaid programs are often underfunded and fragmented by various regulations and eligibility requirements.

"Fragmented" also aptly describes the expanding and evolving landscape of long-term care industries. Most notably, from 2007 to 2017, the home care industry added over 22,000 new establishments to meet rising demand.[60] Compared to nursing homes, home care establishments employ fewer workers, are less likely to be part of chains, and are rarely licensed by states.[61] This decentralization makes it very difficult to effect widespread improvements in job quality.

Given these systemic challenges, successful direct care workforce development efforts will require concerted effort by a range of stakeholders in the field. For example, at the highest level, state and federal governments can take steps to improve job quality through legislation and regulations. Individual consumers and businesses (whether small and local or large and national) that directly employ direct care workers can also play a role in empowering and supporting workers.

In this section of the report, we examine the structural drivers of direct care job quality from three vantage points: financing, the business landscape, and the key actors that shape long-term care. By providing this macro-level analysis of our industry, we provide critical context for the subsequent sections of this report, which will address job quality factors on the ground.

Venecia Bradley

CARE PARTNER AT VILLAS OF KILLEARN LAKES (THE VILLAS) IN TALLAHASSEE, FL
6 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A RESIDENTIAL CARE AIDE:

"I do this work because of the love that I have for the Elders (residents of the Villas). My mom, who always taught me to respect my elders, actually got me started working in this field. She has done this work for years, and sometimes I would go with her to help out with her clients, and I just grew to love it. So I can't stop doing it. I won't stop doing it. I want to go further in this career because I have a lot of love for my Elders."

ON WHAT SHE FINDS MOST CHALLENGING IN HER ROLE:

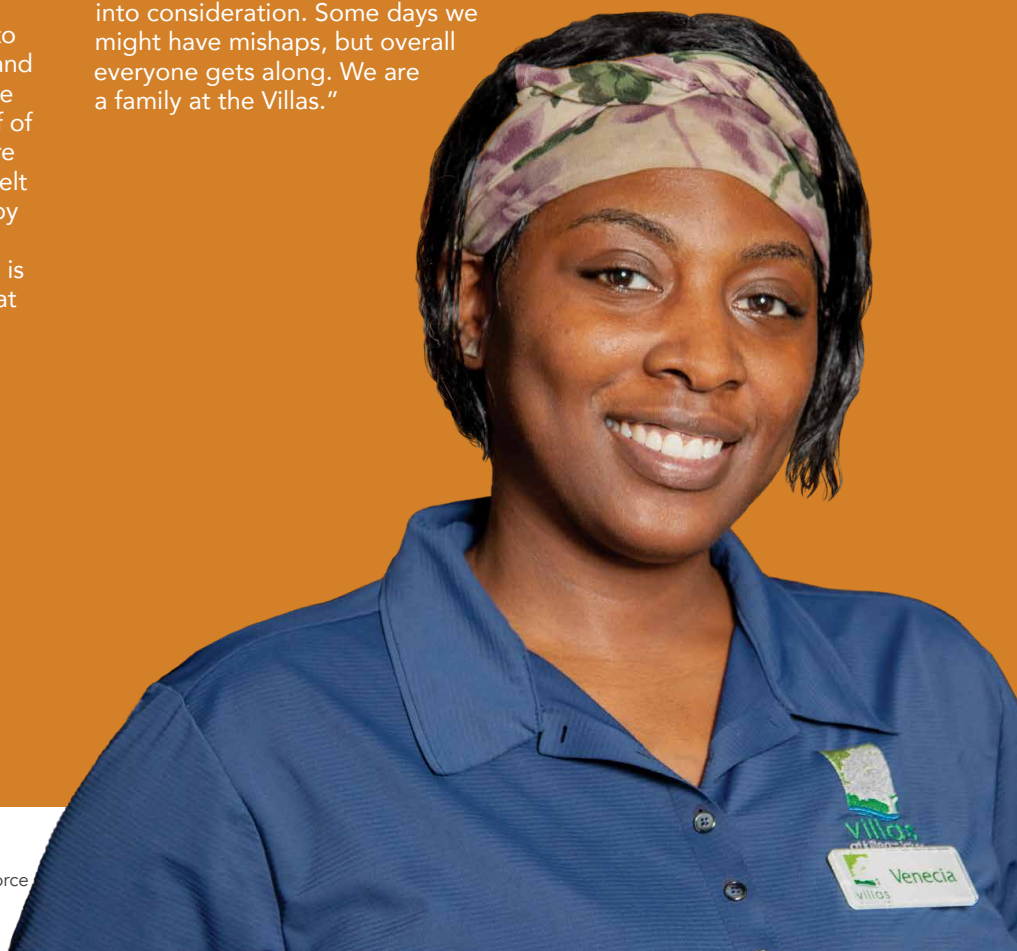
"I enjoy my job, but some days the work can be very difficult. For example, bathing Elders is a challenge. Some Elders, the first thing they will do is tense up or even attack you. It can be hard, but you just have to know how to redirect them and help them understand that they are okay. You also need to be confident, because the Elders read off of you and if you're not okay, then they're not going to be okay either. Before I felt comfortable giving a bath or shower by myself, I would ask someone to assist me because the most important thing is to make sure there are no falls and that everyone stays safe."

ON WHAT SHE ENJOYS MOST ABOUT HER JOB:

"Caregiving in general is a lovely thing. Caring for somebody feels amazing, and helping people really is the best way of giving back. I actually love showing up to work just to interact with my Elders and talk about the simple things: hearing about their lives, their likes and dislikes, and what their favorite colors are. We have freedom to engage with them, and every day is something new here.

At the Villas, we don't have supervisors; we have coaches. Coaches are there for us if we need any assistance or help with certain Elders. They listen and encourage us and give support. Even our head boss, he shows a lot of respect for us. Our opinions matter. I had literally never worked at a job before where our bosses are so understanding or take how we feel into consideration. Some days we might have mishaps, but overall everyone gets along. We are a family at the Villas."

A residential care aide who found her calling caring for older adults, Venecia's favorite part of working in a "small house" and neighborhood setting is forming bonds with residents and giving them the freedom to make choices about their days.*



*The Villas refers to residential care aides as "Care Partners" and residents as "Elders." In this interview, "Elders" and "older adults" are used interchangeably.

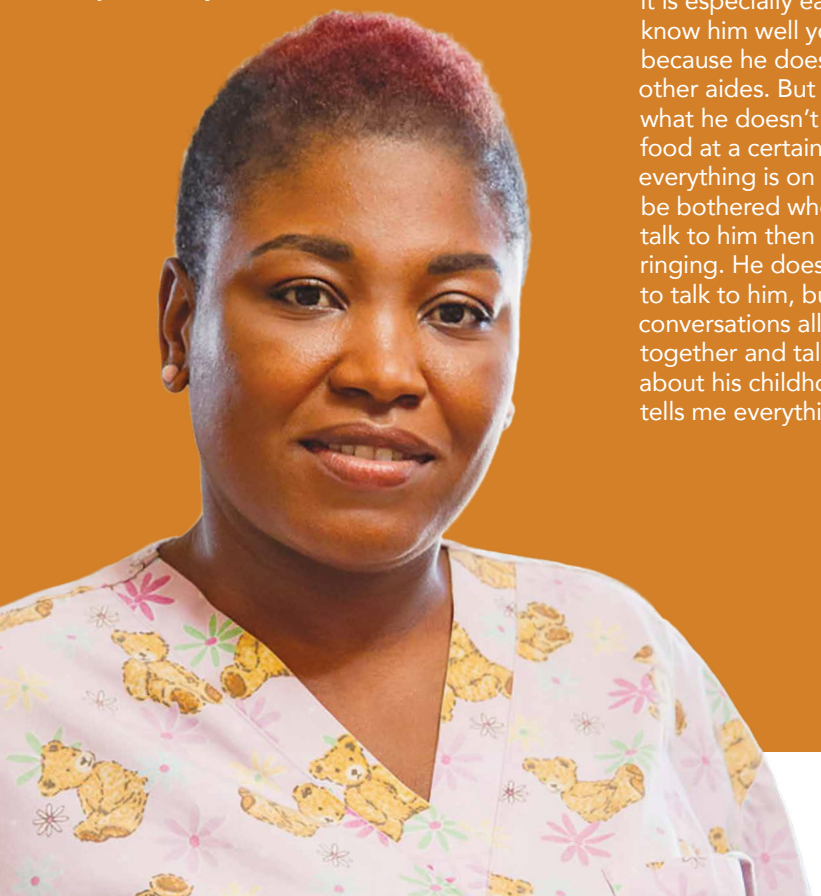
Farah Germain

HOME HEALTH AIDE AT JASA IN BROOKLYN, NY
15 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A HOME HEALTH AIDE:

"I grew up taking care of sick family members. First my aunt, who was very sick when I came to this country from Haiti. Then it was my grandmother, and then my dad. I really like taking care of people.

When I first finished up school, I got a job in a clothing store, but it wasn't me. So I took a class to become a home health aide and started doing this work in 2005, and right away I loved it. But then, about five years ago, I decided to go to school for hotel management and was working as a housekeeping manager at a hotel. The job was good and the pay was okay, but I didn't like it. It just didn't feel like me. Everybody said I was crazy to throw away a job that paid twenty-something dollars an hour and make half as much money going back to home care. I told them, 'Yeah, I know, but they say don't do a job because of the money, do it because you love it.' You really have to have the heart for this job to stay in it."



ON WHAT SHE FINDS MOST CHALLENGING IN HER ROLE:

"I'm a single parent working six days a week, and I don't spend enough time with my kid. As home health aides, we work too hard, we're dealing with too much stress with the client, and we also have to deal with family members, and we're not getting paid for how hard we work. That's the problem. You have to pay your bills. You have to take care of your family. And if you are working hard six to seven days a week and you still can't cover your bills, then why are you working?"

ON HER RELATIONSHIP WITH HER CLIENTS:

"Some clients will make you hate this job, but others will make you love it because they appreciate you helping them. I've never had a problem with clients. I'm with my current client six days a week and have been with him for almost three years now. I'm a very caring and patient person, but it is especially easy with him. If you don't know him well you might not expect that, because he doesn't always get along with other aides. But I know what he likes and what he doesn't like. He likes to get his food at a certain time, and to make sure everything is on time. He doesn't like to be bothered when it's nap time, so I don't talk to him then or tell him if the phone is ringing. He doesn't like for a lot of people to talk to him, but me and him, we have conversations all the time. We watch TV together and talk about it, and he tells me about his childhood when he was a kid. He tells me everything."

With the natural inclination to care for and connect with others, Farah remains committed to supporting older adults as a home health aide, a job she loves despite the long hours and limited wages that can put a strain on her family.

Shortfalls in Long-Term Care Financing

The long-term services and supports (LTSS) financing system in the United States is overcomplicated and inadequate. Median annual costs for LTSS range from about $50,000 for home care services and residential care to over $90,000 dollars for nursing home care[61]—yet the average household only has around $9,000 in savings,[63] and more than half of Americans aged 18 to 64 have nothing saved for retirement.[64] Further, only 11 percent of adults aged 65 and older hold private long-term care insurance policies (according to 2014 data), which carry high premiums and often limit or deny coverage for those with pre-existing conditions.[65] Due to high costs, limited savings, and few private insurance options, the path to poverty is short for many LTSS consumers.

Thus, the bulk of LTSS financing falls on Medicaid—a state and federal social assistance program for people who live in poverty. In 2015, the most recent year of data available, Medicaid payments constituted 52 percent of all long-term care spending.[66] No other payer came close: out-of-pocket payments accounted for 16 percent, private insurance was just 11 percent, and the remaining 20 percent came from a variety of other public sources. This final category includes the Department of Veterans Affairs, the Older Americans Act, other non-Medicaid state programs, and Medicare Advantage plans. Traditional Medicare does not cover long-term care, although it does cover short-term, post-acute services that are often provided in nursing homes or home and community-based settings.

Notably, the balance of Medicaid spending on LTSS varies across settings. Upwards of 80 percent of non-medical home care revenue comes from Medicaid,[67] while at the other end of the spectrum, assisted living and continuing care retirement communities receive just nine percent of their revenue from Medicaid (and 49 percent through out-of-pocket payments from consumers).[68] In between these two endpoints, Medicaid payments constitute 41 percent of nursing home revenue and 18 percent of home health care revenue. These two industries balance their revenue somewhat by billing Medicare and private insurers for short-term, post-acute care services.

UNDERSTANDING MEDICAID LTSS PROGRAMS

While Medicaid is the largest payer of LTSS overall, there is considerable variation and complexity in Medicaid-funded LTSS programs across the country. In this section, we describe this complexity before drawing out the main implications for consumers and direct care workers.

While state Medicaid programs look very different (as discussed below), federal regulations require that all Medicaid programs share some common characteristics. According to the Centers for Medicare & Medicaid Services (CMS), states must cover a range of acute and post-acute care benefits for all Medicaid-eligible individuals. Covered services and eligibility requirements must be laid out in a "state plan" that CMS approves. Importantly, nursing home care is one of the services that must be included in state plans, but home care is not.

Despite this inbuilt "institutional bias" in federal Medicaid regulations—as described in the previous section of the report—states have gradually shifted the balance of Medicaid spending for LTSS to home and community-based settings in recent decades. Consumers overwhelmingly prefer to receive services at home, a preference that has been supported by decades of disability rights advocacy, court decisions, and policy changes.[69] Also, since home care is less expensive in most cases, states can save money by helping consumers delay or avoid nursing home admission.

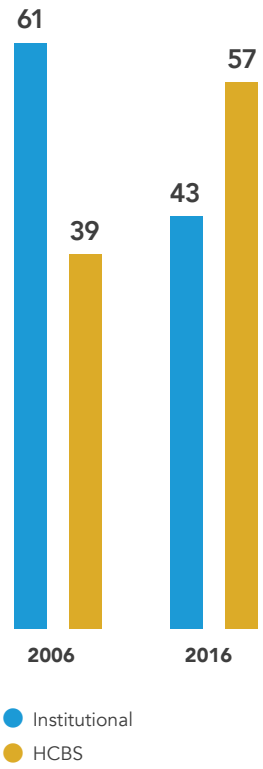
LTSS SPENDING BY PAYER, 2018

- Medicaid 52%
- Other Public and Private 20%
- Out of Pocket 16%
- Private Insurance 11%

Source: Musumeci, MaryBeth, Priya Chidambaram, and Molly O'Malley Watts. 2019. *Medicaid Home and Community-Based Services Enrollment and Spending.* Washington, D.C.: Kaiser Family Foundation. https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/.

MEDICAID HCBS AND INSTITUTIONAL LTSS EXPENDITURES AS A PERCENTAGE OF TOTAL MEDICAID LTSS EXPENDITURES, 2006 TO 2016

(In Percentages)



The majority of Medicaid funding for home and community-based services (HCBS) comes through 1915(c) waiver programs (which are authorized by section 1915(c) of the Social Security Act of 1935).[70] In nearly every state (except Arizona, Rhode Island, and Vermont), these waiver programs serve people in the community who require an institutional level of care—meaning they meet eligibility criteria for the costlier mandatory nursing home care benefit. Even though they are the primary vehicle for funding HCBS, many 1915(c) waiver programs still have long waiting lists (because waivers allow states to cap enrollment for otherwise eligible consumers). In 2017, 707,000 people were on waiting lists for 1915(c) waiver services in 40 states, up from 332,000 in 2007.[71]

As well as 1915(c) waivers, states may also choose from a wide range of other program options—each with their own stipulations for consumers and the workforce. Thirty-five states offer personal care to certain consumers through amendments to their state plans—the same plans that cover mandatory acute and post-acute care services.[72] Among these 35 states, 17 have caps on services—which means that the level of services provided might not be sufficient, especially for people with more severe needs. States may also choose the 1915(i) authority under the Social Security Act to tailor state-plan personal care benefits *only* to a population with specific conditions or care needs. Finally, another option is the 1915(k) authority, which allows states to introduce a self-directed option for consumers under their state plans (a model that we discuss later in this section of the report). Often, regulations under these programs overlap or conflict, adding to the complexity in Medicaid home and community-based services—and complicating workforce development efforts.

PAYMENT MODELS IN MEDICAID

In addition to variation in service design and eligibility requirements, Medicaid programs vary across and within states by payment model. In the past, all states reimbursed LTSS providers through fee-for-service arrangements, whereby providers received direct payments for each hour of service for consumers. In recent years, however, states have adopted alternative payment models with the goal of making LTSS more efficient and effective.

Most notably, 24 states have shifted from a fee-for-service model to a managed long-term services and supports (MLTSS) model.[73] MLTSS programs are authorized under four authorities (namely, sections 1932(a), 1915(a), 1915(b), and 1115 of the Social Security Act), each with its own goals, structure, and eligibility requirements. Under MLTSS, private insurance companies, called managed long-term care plans, receive monthly, per-capita payments that they use to coordinate services for their members. These programs are intended to financially motivate plans to meet consumers' needs and improve care outcomes at a lower cost. Proponents of MLTSS argue that these goals are not necessarily aligned in fee-for-service systems.

Another payment trend in Medicaid-funded LTSS is value-based payment, whereby payers deliver financial rewards or impose penalties based on outcomes related to cost and care quality. These arrangements are more common in acute care settings and nursing homes than in home care.[74] This is partly because quality measurement in home care is underdeveloped—a 2016 study from the National Quality Forum (NQF), a nonprofit organization focused on health care improvement, uncovered 261 different quality measures for HCBS, reflecting a lack of consensus on the most important aspects of quality in this field.[75]

Sources: Wenzlow, Audra, Steve Eiken, and Kate Sredl. 2016. *Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS)*, FY 1981-2014. Washington, D.C.: Centers for Medicare and Medicaid Services (CMS). https://www.medicaid.gov/sites/default/files/2019-12/evolution-ltss-expenditures.pdf; Eiken, Steve, Kate Sredl, Brian Burwell, and Angie Amos. 2018. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016*. Washington, D.C.: CMS. https://www.medicaid.gov/sites/default/files/2019-12/ltssexpenditures2016.pdf.

Camran Hayes

HOME CARE SPECIALIST AND PERSONAL CARE WORKER AT COMMUNITY LIVING ALLIANCE IN MADISON, WI
1.5 YEARS AS A DIRECT CARE WORKER

ON WHY HE DECIDED TO BECOME A HOME CARE WORKER:

"When I was a teenager, my first job was at a nursing home as a dietary aide. I would pass out the milk, coffee, and food. And I was always so intrigued by the CNAs (certified nursing assistants) and the nurses. People would tell me, 'You should become a caregiver. You have that type of personality.' Never would I have ever thought that I could actually do this job. But then I guess I've always loved working with people.

My family is Iranian, and Persians take care of their elders. So I had some experience helping out with my grandparents, but nothing to the extent of nurse-delegated tasks. I never had any experience with that. Originally, I planned for this to be a 10 hours-a-week gig while I went to school and then maybe even worked another part-time job. But then I just started getting more clients, and they were giving good feedback, and eventually I started working full time. And then I just kept at it. I fell in love with it. I'm constantly growing and feeling challenged. Nothing feels more natural."

ON WHAT HE FINDS MOST CHALLENGING IN HIS ROLE:

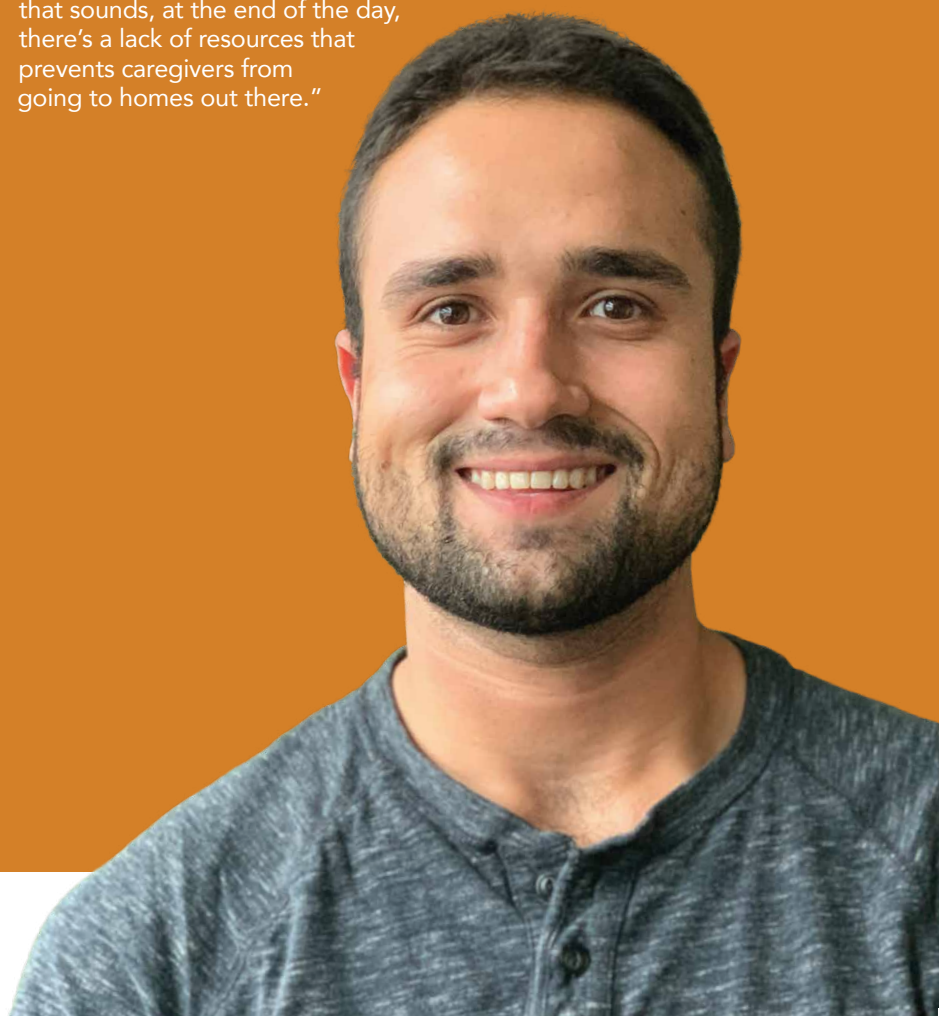
"Many CNAs do not get paid enough. With home care, you don't have co-workers. When I first got this job, I kind of felt like I was on my own for the longest time. I felt so lost and scared. And all the time I would think, 'Oh man, did I do something wrong?' When I started working on-call, the person who trained me became a caregiver role model for me, and that's when I started feeling more supported.

There's too much work to get done and not enough people doing the work. And I know that a lot of that has to do with pay. You could probably make more money working at QuikTrip, to be honest. And then you also have to take care of people's bodies and do toilet care. You have to be a certain kind of person to be able to do that kind of work."

ON SERVING RURAL AREAS:

"Transportation can definitely be an issue for caregivers. A lot of people at Community Living Alliance use the bus route to get to their clients' homes. I have a car so I can go anywhere in the Dane County area, but a lot of people just can't travel out to the outskirts or more rural areas. As upsetting as that sounds, at the end of the day, there's a lack of resources that prevents caregivers from going to homes out there."

Providing care to older adults and people with disabilities in their homes, Camran helps his clients live independently, a job he says gives his life a deeper purpose.



State Policy Spotlight

Tennessee has a well-established value-based payment program in nursing homes, but recent efforts to introduce a similar approach in HCBS were stymied by severe workforce challenges. Providers could not improve workforce recruitment and retention to meet consumer satisfaction targets without some up-front assistance from the state. To address these challenges and enable home care providers to participate in value-based payment arrangements, the state has developed a new workforce training program, and has made direct grants to providers to improve data collection and strengthen recruitment and retention.

Also, many existing measures have been carried over from acute and skilled nursing care settings and miss elements of home care quality that matter most to consumers, like quality of life and community integration, as two examples. Based on its research, NQF developed recommendations for assessing quality, but some are not yet tested and the field still lacks a robust, standardized home care quality framework. In short, before payers can reward quality in home care on a widespread basis, further work is needed to effectively measure quality.

MLTSS and value-based payment arrangements come with costs and benefits. On one hand, these payment systems present new opportunities for states, plans, providers, and other key stakeholders to collaborate in efforts to improve job quality and care quality. However, as noted above, introducing private payers and intricate payment incentives into public service delivery creates new complexity in an already fractured system.

MEDICAID IS NOT THE ANSWER

Various Medicaid program options have made HCBS services widely available and, in many states, have led to the successful diversion of consumers away from nursing homes.[76] However, there are three major drawbacks to relying on Medicaid as the primary mechanism for financing LTSS overall.

First, because it is only a safety net program, Medicaid requires consumers to fall far into poverty before it catches them—and even as a safety net, it does not always offer a sufficient level of support for eligible consumers. Many Medicaid-eligible consumers still fall through the gaps because they are placed on a waiting list, because their needs exceed service limits, or because they do not meet the specific eligibility requirements for waiver programs.

The second, and closely related, problem is that Medicaid systematically underfunds long-term care. Wage trends in recent years illustrate this point. In the previous section of this report, we showed that wages for direct care workers have hardly changed in the past decade—from $12.24 in 2008 to $12.27 in 2018—leaving direct care workers facing persistent economic instability.[77] By comparison, over the same period employers in other industries, like fast food and retail, have raised wages to stay competitive. Even in the face of close competition for workers—and rising demand for LTSS—only about half of states committed to increasing direct care worker wages in 2019 and 2020 through Medicaid reimbursement rate changes.[78] Also, among those states that did raise reimbursement rates, the increases tended to be marginal and some did not keep up with inflation year to year. This limited investment in workers' wages, as an indicator of inadequate financing for Medicaid-funded LTSS, has been a key contributor to direct care workforce shortages nationwide.

Why this systematic underfunding? One of the main reasons is that, as a means-tested social assistance program, Medicaid is funded through general tax revenues rather than through universal payroll contributions. Therefore, Medicaid programs must always compete with other state budget items, like transportation and education—leaving far too many consumers without enough support and hindering vital job quality improvements.

The third challenge with relying on Medicaid as the primary payer of LTSS pertains directly to workforce development. Most states offer a multitude of LTSS programs targeting certain populations with specific services, and each program is often regulated separately—including with regards to workforce requirements. As a result, workforce development efforts often necessarily focus on a specific segment of the workforce, such as direct care workers in a particular Medicaid program, without addressing the big-picture challenges that are endemic in the field.

For these reasons, efforts to improve our long-term care financing system—and direct care jobs—will likely need to extend well beyond Medicaid.

THE FUTURE OF LTSS FINANCING

In fact, policymakers have recently begun to develop proposals for radically transforming the publicly financed LTSS system in the United States, in order to overcome the challenges described above and bring our nation in line with much of the industrialized world.[79]

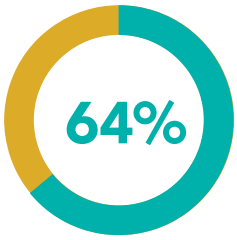
A key step toward reform came when the federal government attempted to create a new long-term care benefit through the Community Living Assistance Services and Supports (CLASS) Plan. Passed as part of the Affordable Care Act, the program would have provided a $50 daily benefit to people in need of long-term care. However, the program was repealed before it was implemented due to concerns around financial sustainability.[80]

Despite this setback at the federal level, innovative ideas have continued percolating in individual states. As a leading example, Washington State has established a Long-Term Care Trust that, beginning in 2025 will provide a daily benefit of $100 (up to a lifetime benefit of $36,500) to people who require assistance with three or more activities of daily living.[81] Although many consumers will have lifetime expenditures that exceed this amount, this program will be the nation's first universal long-term care benefit and could mark a significant turning point in LTSS financing.

Other states might soon follow the lead of Washington State. Stakeholders in Maine put forward a ballot initiative that would have established a universal long-term care benefit, and this new system would have funded direct care workforce development.[82] Other states have also begun legislatively exploring long-term care social insurance program options. Michigan, for example, recently commissioned a study to explore the feasibility of a universal long-term care insurance program, including workforce considerations.[83] These cases illustrate the growing recognition that our current Medicaid-centric system cannot be sustained.

Medicaid programs must always compete with other state budget items, like transportation and education—leaving far too many consumers without enough support and hindering vital job quality improvements.

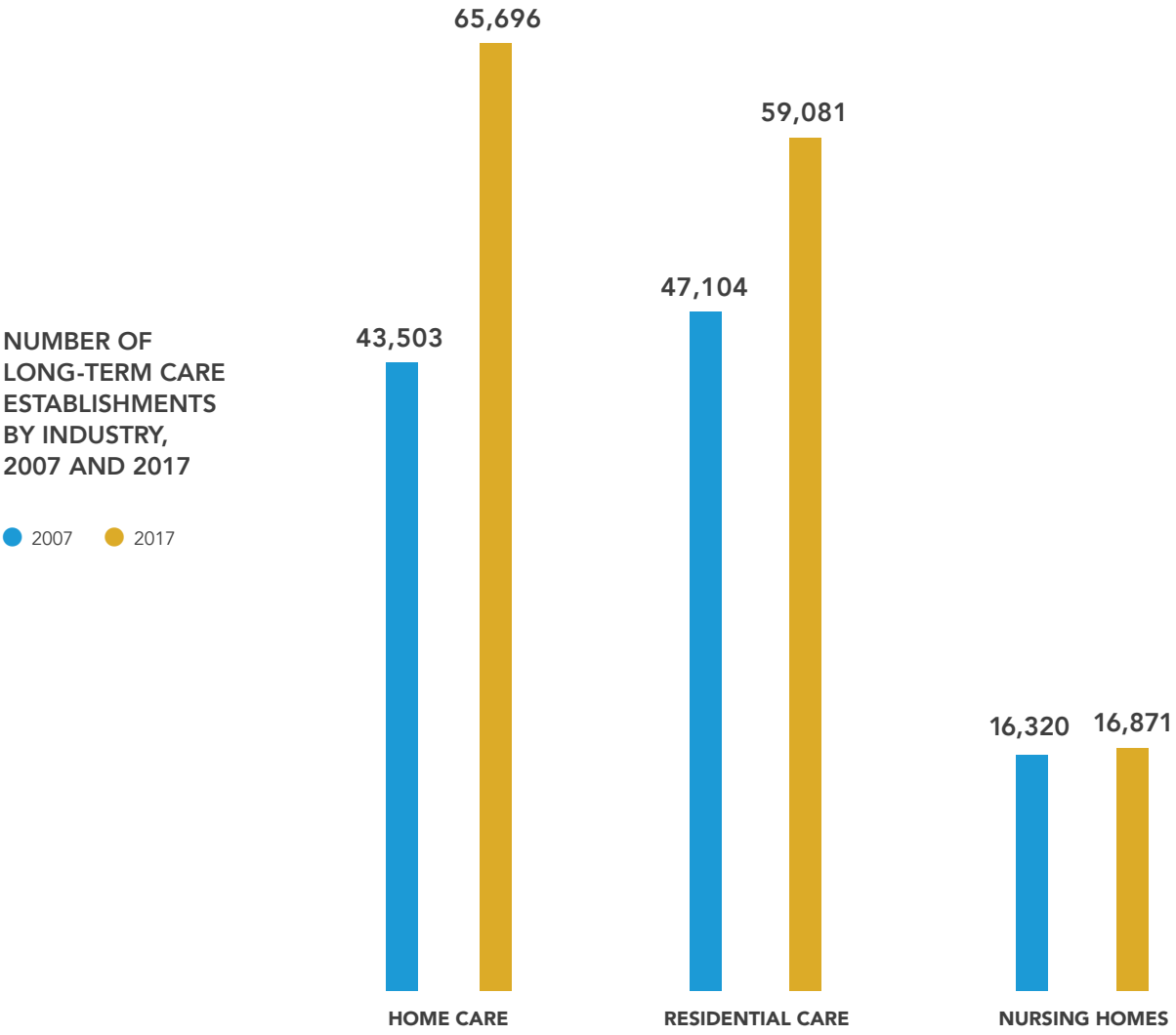
The Shifting Long-Term Care Landscape



Most new LTSS establishments (22,200, or 64 percent) have been in home care.

Notwithstanding the financing challenges discussed above, the LTSS industry continues to expand rapidly to meet growing demand for services. According to PHI's analysis of Economic Census data, long-term care added 34,700 new establishments from 2007 to 2017.[84] (Establishments are individual business units that may be sole proprietorships, franchise members, or branches of a corporate chain.) Most of those new establishments (22,200, or 64 percent) were in home care. Residential care added 12,000 new establishments—including 7,600 new communities for people with intellectual and developmental disabilities and 4,700 new assisted living communities. (The residential care industry also lost 400 continuing care retirement communities.) Nursing homes added just 600 establishments.

NUMBER OF LONG-TERM CARE ESTABLISHMENTS BY INDUSTRY, 2007 AND 2017

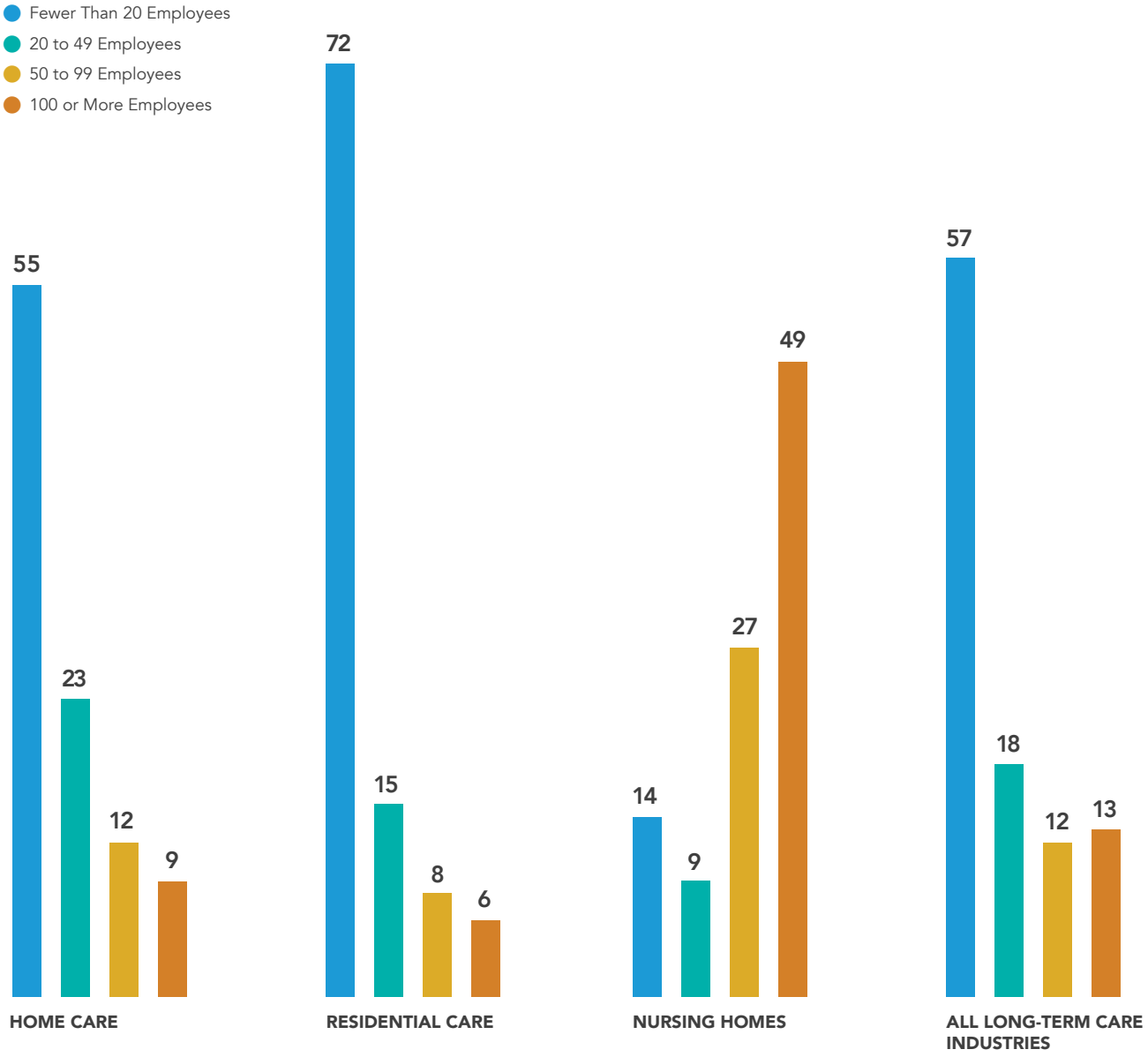


Sources: U.S. Census Bureau. 2010. *Health Care and Social Assistance: Geographic Area Series: Summary Statistics: 2007*. https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2007_US/62A1/0100000US; Economic Census of the United States U.S. Census Bureau. 2020. *Health Care and Social Assistance: Summary Statistics for the U.S., States, and Selected Geographies: 2017*. https://www.census.gov/data/tables/2017/econ/economic-census/naics-sector-62.html; analysis by PHI (December 2019).

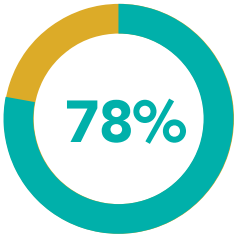
While the home care industry (and to a lesser extent, residential care) is growing much more rapidly than the nursing home industry, rate of growth is not the only distinguishing factor among long-term care providers. There are also systematic differences in employment patterns, chain ownership, and concentration of ownership across the home care, residential care, and nursing home industries. To explore these differences, we rely on data from the 2012 Economic Census. (While dated, this survey provides the most robust picture of each industry.)

EMPLOYMENT LEVELS IN LONG-TERM CARE ESTABLISHMENTS BY INDUSTRY, 2012

(In Percentages)



Source: U.S. Census Bureau. 2016. *Health Care and Social Assistance: Subject Series - Estab & Firm Size: Employment Size of Establishments for the U.S.: 2012.* https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ2/0100000US; analysis by PHI (December 11, 2019).



of home care providers employ fewer than 50 employees.

According to our analysis:

- Over three quarters of home care establishments employ fewer than 50 total employees (including direct care workers, licensed professionals, and other staff), whereas only one quarter of nursing homes have fewer than 50 employees.[85] Of note, 87 percent of residential care providers also employ fewer than 50 employees.
- Thirty-three percent of home care providers are owned by chains, compared to 57 percent of nursing homes and 63 percent of residential care providers.[86]
- The 50 largest firms in the home care industry control just 26 percent of total industry revenue, versus 31 percent in nursing homes and 33 percent in residential care.[87]

Taken together, these data demonstrate that the home care industry—while growing quickly—is also particularly fragmented and decentralized.

NEW PLAYERS IN THE HOME CARE INDUSTRY

The home care industry is becoming more like the nursing home sector in at least one area: for-profit ownership. From 2007 to 2017, the proportion of for-profit home care agencies increased from 67 percent to 76 percent.[88] The greatest change was among non-medical home care providers (a subset of the home care industry), where for-profit ownership jumped from 45 percent to 60 percent.

CHAIN OWNERSHIP
BY LONG-TERM CARE INDUSTRY, 2012

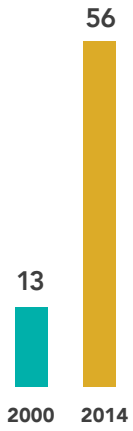
INDUSTRY REVENUE CONCENTRATED AMONG THE 50 LARGEST FIRMS
BY LONG-TERM CARE INDUSTRY, 2012

Sources: U.S. Census Bureau. 2016. *Health Care and Social Assistance: Subject Series: Estab & Firm Size: Summary Statistics for Single Unit and Multiunit Firms for the U.S.: 2012.* https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ3/0100000US; U.S. Census Bureau. 2016. *Health Care and Social Assistance: Subject Series: Estab & Firm Size: Summary Statistics by Concentration of Largest Firms for the U.S.: 2012.* https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ6/0100000US; analysis by PHI (December 11, 2019).

For-profit ownership is on the rise in home care for at least three reasons. First, the home care industry is increasingly attracting new franchise brands and aspiring franchise owners. From 2000 to 2014, the number of home care franchise brands jumped from 13 to 56,[89] and in 2019, like previous years, three home care brands topped the Forbes list of "Best Franchises to Buy."[90] Franchising is an attractive option because it offers a high growth opportunity paired with a low initial investment—but it presents both opportunities and risks for the sector. On one hand, franchising might allow small home care businesses to access the benefits of a larger organization, such as training curricula, marketing materials, and operational supports. On the other hand, franchisees might enter the market seeking a lucrative investment without a firm understanding of the industry's complexity—a naiveté that could put consumers and workers at risk.

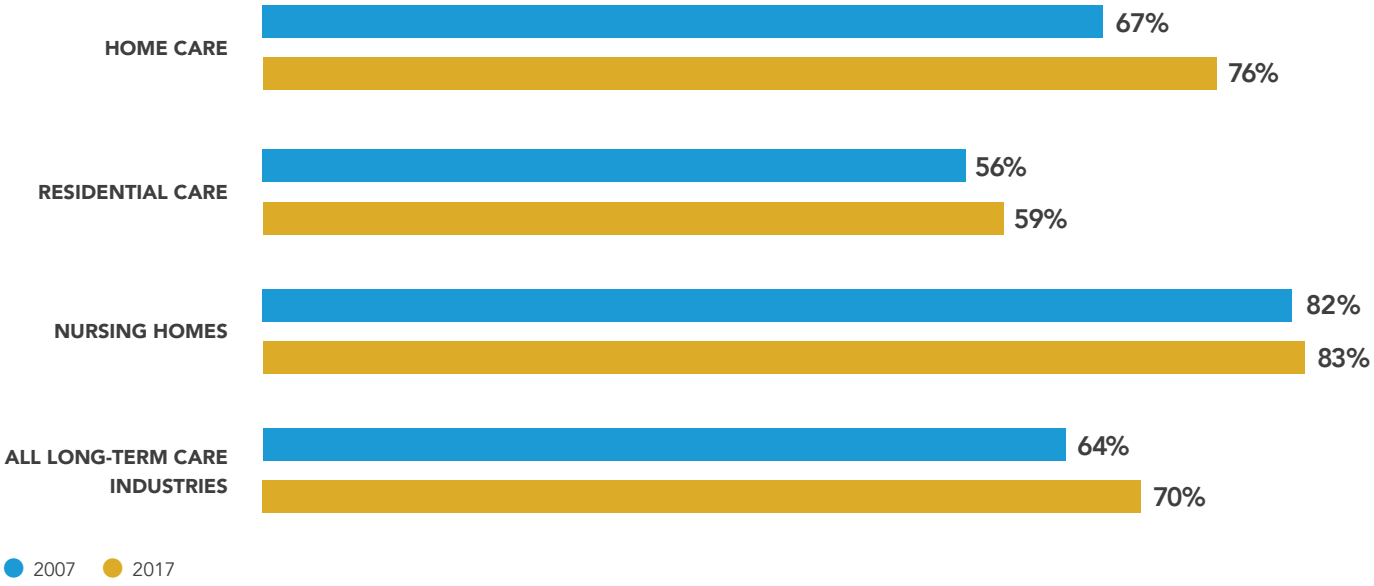
Like franchise owners, private equity investors are also seeing an opportunity to invest in the home care industry.[91] (Private equity investors directly invest in private companies that are not publicly traded.) The boost of capital from these investors can help home care agencies build the infrastructure that they need to grow and thrive in a competitive market, including marketing programs and customer relationship managements systems, among other infrastructure elements. At the same time, the investors' expectations of financial return might lead providers to cut corners in pursuit of profit, again to the detriment of care quality or job quality.

Finally, venture capital investors are interested in home care, too. Unlike private equity investors—who aim to shore up the existing home care industry—venture capital investors seek to disrupt the home care sector, primarily by investing in innovative start-up companies.[92] In home care, most venture capital funds support start-ups that compete directly with existing home care agencies using technology-driven platforms. However, recent moves by three major home care start-ups indicate that these companies have reassessed their initial assumptions about the home care industry.



The number of franchise brands in home care increased in recent years.

FOR-PROFIT OWNERSHIP BY LONG-TERM CARE INDUSTRY, 2007 AND 2017



Sources: U.S. Census Bureau. 2010. *Health Care and Social Assistance: Geographic Area Series: Summary Statistics: 2007*. https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2007_US/62A1/0100000US; Economic Census of the United States U.S. Census Bureau. 2020. *Health Care and Social Assistance: Summary Statistics for the U.S., States, and Selected Geographies: 2017*. https://www.census.gov/data/tables/2017/econ/economic-census/naics-sector-62.html; analysis by PHI (December 2019).

A Closer Look at Data Collection

The true size of the home care workforce—including workers hired directly by consumers—is difficult to count. First, states may include Medicaid-funded consumer-directed home care workers in their labor market data, but they are not required to do so (and it is difficult to ascertain which ones do). Moreover, workers employed through the gray market are almost impossible to identify because they are often paid off the books by consumers. Even though gathering data from individual households requires a significant investment, this may be what is needed to obtain a more **accurate estimate** of workforce volume, and to gain a better understanding of the role and impact of this workforce.

- Honor (with $115 million in venture capital funds) began by offering services through an entirely online platform.[93] However, the company recently changed course and launched a partnership program, where they provide their services through existing agencies.[94]

- Vesta Healthcare (with over $40 million in venture capital funds) recently shifted its focus away from tech-enabled home care services toward Medicaid care management.[95]

- Finally, HomeHero (which received $23 million in venture capital funds) ceased operations because, according to founder and CEO Kyle Hill, they had begun with unrealistic assumptions about the industry, including an underestimation of the technological expertise of existing home care agencies.[96]

It is not yet clear how these different types of for-profit companies will change the home care sector in the long term. While added capital and better infrastructure may improve access to care and job quality, investors and franchisees may also negatively impact the field—if they prioritize profits over care quality for consumers and job quality for workers.

CONSUMERS AS EMPLOYERS IN HOME CARE

Another key feature of the shifting landscape of LTSS is the growing role of consumer direction in home care. Under the traditional agency-based model, consumers access the services they need through home care agencies, which handle all aspects of employment for home care workers. In contrast, the consumer-directed model positions consumers as the locus of control over their services, with responsibility over most aspects of home care worker employment. Every state and the District of Columbia offers Medicaid-funded consumer-directed options and, as of 2016, over one million consumers directed their own services under these public programs.[97] (The total number of consumers who direct their care is actually much larger, given that many consumers privately hire and pay their own workers through the "gray market.")

There are two types of publicly funded consumer-directed programs.[98] Under the "budget authority" model, consumers receive a flexible budget from the state to purchase the goods and services that they need. Under the "employer authority" model, consumers do not control their own budgets, but they still manage most aspects of the employment process, including recruiting, hiring, training, supervising, and firing workers. All states offer the employer authority option in at least one program and 33 grant consumers more control over their individual budgets.[99]

Between the agency-based and consumer-directed models, there is a third model known as "agency with choice." In this model, the home care agency and the consumer share employer responsibilities: the consumer maintains nearly the same level of control as in a consumer-directed model, but the agency is the employer for tax purposes.[100] Also, unlike in the consumer-direction model, both consumers and workers can turn to the agency for additional support, such as for training and continuing education.

To note, although this section has focused on consumer direction in home care, principles of choice and autonomy can be integrated into residential settings as well. Since the 1980s, proponents of "culture change" have advocated for a more person-centered approach in nursing homes and residential care communities—prioritizing individual choice and preference over standardized care.[101] Within the culture change movement, providers strive to create more home-like environments in which residents are encouraged to determine their own daily lives, maintain their independence, and retain their individuality. In these homes and communities, direct care workers often have an elevated role, working in partnership with residents, nurses, and other members of the care team to deliver person-centered care. The culture change model has been shown to improve resident satisfaction and outcomes, and components of culture change have been codified in regulation.[121] For example, a recent CMS rule requires nursing assistants to be directly involved in the care-planning process, recognizing their unique understanding of residents' needs and preferences.[103]

Who Shapes Direct Care Job Quality?

To this point, we have discussed the LTSS system in terms of financing mechanisms and industry characteristics. We now turn to the stakeholders within the system who shape direct care job quality. Our purpose is to identify the various levers that are available to improve these jobs, as well as to underline the importance of strong collaboration and commitment to job quality at every level.

Starting at the highest tier, the federal government plays a role in shaping direct care jobs through Medicare policy and regulations. The federal government has used this role to mandate minimum training requirements for home health aides and nursing assistants who work for Medicare-certified home health and nursing home providers (which constitute the majority of those providers). Since these workers likely also assist consumers who are enrolled in Medicaid and/or other public programs, such federal training requirements have an impact far beyond Medicare.

The federal government also has a role in directing Medicaid policy. While states have broad discretion over Medicaid program design, they must follow certain federal rules and guidelines. For example, through CMS, the federal government sets rules for various settings, from home care to nursing homes; approves or denies waiver applications, imposing limits on what states can and cannot do; and establishes regulations for implementing relevant legislation.

Compared to the federal government, however, states hold more power in shaping the direct care workforce. Nearly all nursing homes and many residential care communities are certified or licensed by states,[104] and these requirements often include some stipulations about staff qualifications. In home care, licensure is less common—just 26 states license non-medical home care agencies[105]—but states can still regulate the home care workforce through Medicaid regulations, for example by requiring agencies to meet certain workforce requirements to receive Medicaid dollars. Further, states can improve job quality through Medicaid reimbursement policy by, for example, stipulating a percentage of payments to providers that must be spent on workers' wages and benefits. Also, when states contract with managed care plans, they can set baseline rates that managed care organizations must pay providers (accounting for comprehensive labor costs) or allocate additional funding to plans that contract with high-road employers. To develop these policies, states sometimes gather input from state-sponsored workgroups—advisory bodies comprised of diverse stakeholders who are charged with producing recommendations to improve the direct care workforce.[106]

Finally, given their direct access to long-term care providers, states are well-positioned to improve data collection on the direct care workforce. As noted in the previous section, the data that are most critically needed relate to the size, stability, and compensation of this workforce. States can use these workforce data to inform and evaluate the success (or shortcomings) of policies designed to support and strengthen the workforce.

As noted in the section on LTSS financing, managed long-term care plans also have a role in shaping direct care jobs. First, plans determine their own reimbursement rates for providers (similar to states with fee-for-service systems) and can therefore influence job quality.[109] Second, managed care plans are responsible for ensuring that consumers receive the services to which they are entitled, and an adequate workforce is key to meeting this requirement because workforce shortages can cause service gaps and delays. In certain states (most notably, Arizona and Tennessee), managed care plans have taken innovative steps to strengthen provider networks by partnering with local trainers, improving the workforce pipeline, and offering innovation and capacity grants to providers, among other workforce development efforts.[110]

State Policy Spotlight

The **Texas** Health and Human Services Commission (HHSC) recognized in a 2018 report that the state was unable to adequately measure the scope of direct care workforce challenges without improved data collection.[107] To address this barrier, the HHSC added new questions about worker turnover, retention, and compensation to their existing provider surveys.[108] These insights will help guide Medicaid policymaking and workforce planning in the state.

Industry Feature

Managed long-term care plans in Arizona are required to assist providers in their networks with direct care workforce development.[111] In response to this requirement, **Mercy Care**, a managed long-term care plan in southern Arizona, committed to invest $2,000,000 from 2018 to 2022 to strengthen the workforce. These funds are supporting a range of activities, including a marketing campaign, free training for workers, and an innovation fund that providers can access to launch recruitment and retention projects.

Similar to state and federal policymakers and managed care plans, employers—including organizations and individual consumers—play a direct role in shaping direct care job quality. Indeed, regardless of their state's policies and reimbursement levels, some employers excel in supporting direct care workers while others fall behind.

Home care cooperatives exemplify the important role that employers can play in improving direct care jobs. In the coop model, workers can own a portion of their employing agencies and access a range of benefits, including paid dividends in profitable years. Worker-owners also exercise real power in their workplaces and organizations, including by electing board members and participating in key decisions. This model appears to make a difference: on average, cooperatives pay $.54 more per hour than other home care agencies in their states, and turnover at these organizations is 38 percent (versus 82 percent nationally).[112] Currently, there are just 11 home care cooperatives nationwide that collectively employ 2,470 home care workers, but many elements of their worker-centered approach are transferable to other home care agencies. These cooperatives demonstrate that worker-centered practices can lead to strong outcomes, even in challenging business and policy environments.

Individual consumers shape job quality for workers as well. Under consumer-directed programs, consumers have control over most elements of employment, although they are only able to set workers' wages in the budget authority model.

Also, most states delegate training to individual consumers, meaning workers receive all their training directly from their consumer-employers, and this training is neither standardized nor transferable to other employers. Therefore, the responsibility of ensuring that each worker is equipped with the necessary competencies to succeed in their role falls to each consumer-employer.

Self-directing consumers are often supported by specialized entities, which also therefore play a role in shaping job quality for direct care workers. Under Medicaid consumer-directed programs, fiscal management service (FMS) providers primarily assist with technical aspects of employment, like payroll and tax withholdings. One example of how the responsibilities of FMS providers can be expanded, however, comes from Washington State, which recently contracted with a single agency to serve as the "employer of record" for all 35,000 workers employed under the state's Medicaid consumer-directed programs.[113] Unlike typical FMS providers, this agency will also have important workforce development responsibilities, for example related to recruitment, compensation, supervision, and more. Although still in development, Washington's approach could serve as a model for other states to replicate in their own consumer-directed programs.

Consumer-led nonprofit organizations called Centers for Independent Living (CILs) also support consumers and their workers with employment-related issues. In some cases, CILs also directly recruit workers or operate full home care agencies. Some CILs and state agencies also operate matching service registries—online job boards that help consumers and workers find each other and establish employment relationships. These registries, which are active in 14 states, can also connect workers and consumers with other resources, including training and background checks.[114]

There are also several similar online job boards for consumers and workers in the gray market. As a notable example, Care.com is an international, subscription-based platform that assists consumers with finding care for their loved ones, including older adults. The platform allows consumers to search for workers based on their needs, preferences, and location in the same way as nonprofit matching service registries. Care.com recently received $157 million in venture capital investments to expand their services for individual consumers.[115]

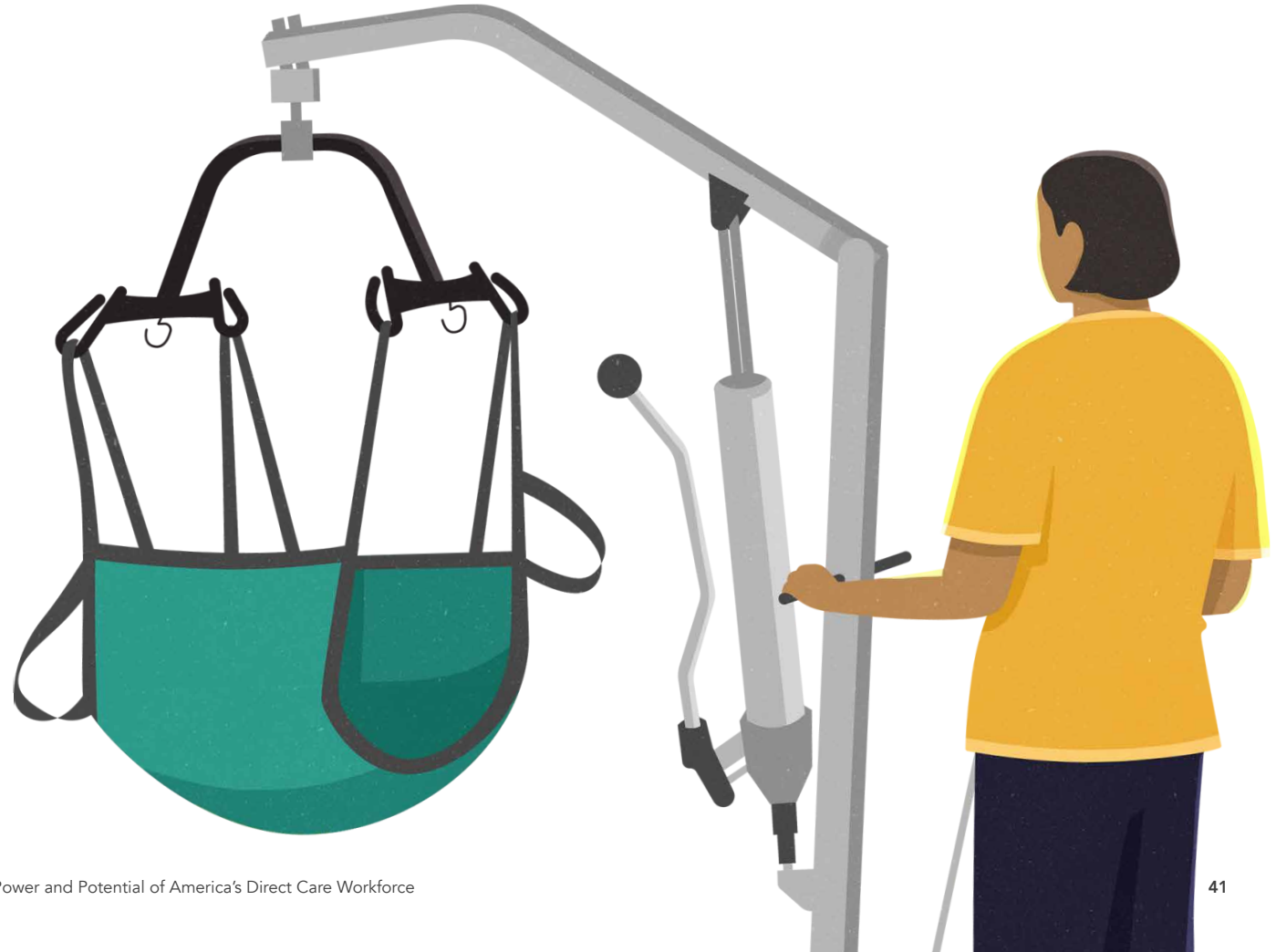
Finally, unions also have a role in shaping job quality in some cases. Unions that represent direct care workers collectively bargain with states around wages, training, and other elements of job quality. According to PHI's analysis of Current Population Survey (CPS) data, unionized direct care workers earn a median wage of $13.00 per hour, compared to $11.66 for non-unionized workers.[116] Unions also connect workers to resources and supports, including affordable union-sponsored health insurance.

Over half (51 percent) of unionized workers have insurance through their employer or union; by comparison, less than a third (31 percent) of non-unionized direct care workers have health insurance through their employers. (The CPS data include consumer-directed workers who report they are employed by government entities but not those who are self-employed. As a result, these data cannot be used to estimate the overall unionization rate in the direct care workforce, and the analyses described here likely underestimate the impact of unionization in long-term care.)

Also, under some collective bargaining agreements, unions serve as the primary trainer for the direct care workforce in their states. The most notable example of this is the SEIU 775 Benefits Group in Washington State, which provides the required 75 hours of training to consumer-directed workers, as well as offering extensive continuing education options for workers.[117]

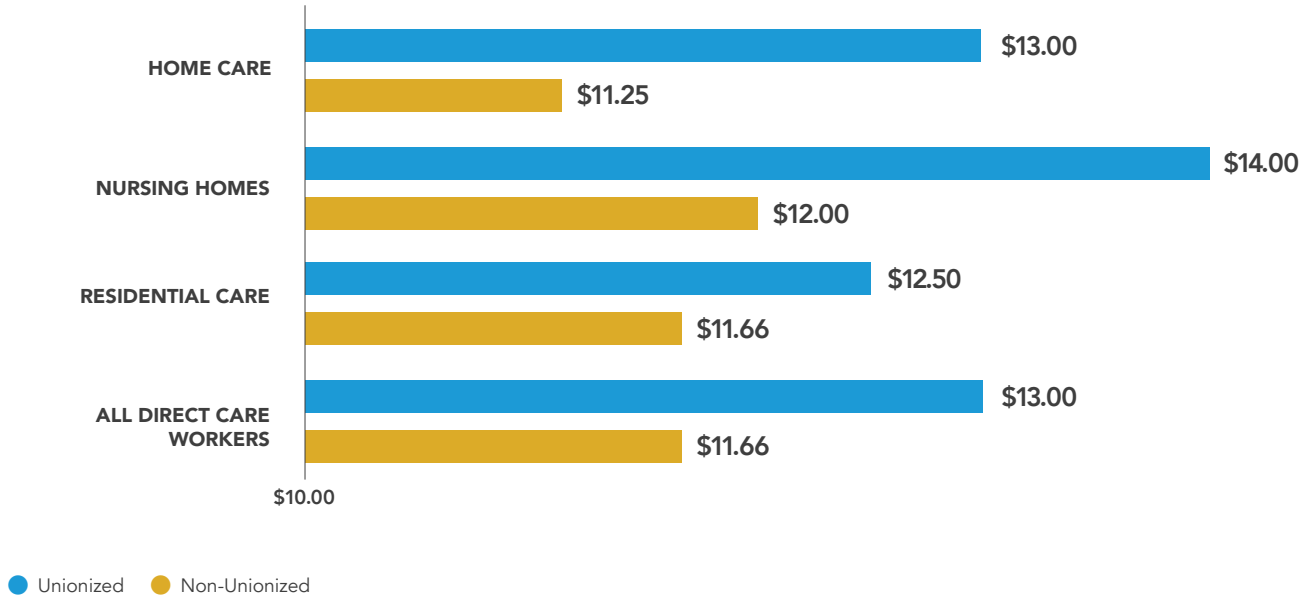
Industry Feature

In California, four Centers for Independent Living (CILs) offer a **QuickMatch** matching service registry. This registry platform includes features for consumers and workers, including the option for workers to record short messages for prospective employers. CIL staff maintain the registries by fielding questions from users, advertising their services, and, in some cases, recruiting workers to use the registries.



Recent court cases and policy changes may weaken the power of unions to collect dues and collectively bargain.[118] First, in Harris v. Quinn, the Supreme Court ruled that consumer-directed home care workers are not fully public employees and therefore, non-union members cannot be compelled to pay union dues, even if they benefit from statewide collective bargaining agreements.[119] Also, the federal government recently prevented Medicaid programs from paying union dues on behalf of workers, making it more difficult for unions to collect dues from their members.[120] To date, these rulings have not fundamentally altered the union landscape—unions report minimal membership losses and stable or rising funding levels—but their long-term impact remains to be seen.[121]

MEDIAN WAGES AMONG UNIONIZED AND NON-UNIONIZED DIRECT CARE WORKERS BY INDUSTRY, 2018



Sources: Flood, Sarah, Miriam King, Renae Rodgers, Steven Ruggles and J. Robert Warren. 2019. *IPUMS, Current Population Survey:* Version 6.0. Minneapolis, MN: IPUMS, University of Minnesota. https://doi.org/10.18128/D010.V9.0; analysis by PHI (February 7, 2020).

Conclusion and Implications

This report section has examined how the LTSS system impacts direct care jobs from three vantage points. First, we have shown how our strained LTSS financing system underinvests in workers' job quality (and in consumers' care). Second, we have discussed how the changing industry landscape (that is characterized by rapid growth in home care and the increased dominance of for-profit companies) presents opportunities and challenges for strengthening the direct care workforce. And third, we have described the various stakeholders who shape direct care jobs, from the federal government to individual employers, and more. Based on these observations, we conclude with two systems-level ideas for strengthening the direct care workforce.

REFORMING LONG-TERM CARE FINANCING

The current approach to long-term care financing falls short. It does not protect consumers from financial ruin, nor does it ensure a living wage for the direct care workforce (or other elements of a quality job). Because few consumers can afford to pay privately for LTSS, Medicaid has taken on a dominant role in long-term care financing, including increasingly in the home care sector. But Medicaid is not a universal benefit—which would be funded through widespread payroll contributions—so it must compete with many other budget priorities in state policymaking. This often leaves the system underfunded. Moreover, Medicaid programs are often developed in a piecemeal fashion and are immensely hard to navigate for consumers. This complexity also leads to fragmented or siloed workforce development efforts.

There is a clear need for a new approach to LTSS financing that addresses the overlapping interests of consumers and workers—with state-based universal LTSS social insurance programs offering the most promise. Such programs could provide consumers with the services they need without impoverishing them, in the same way that Medicare supports older adults in meeting medical costs. New long-term care insurance programs should also consider the needs of workers—including with regards to compensation, training, supervision, and other elements of job quality.

In Focus: PHI's Policy Approach

In 2019, the National Academy of Social Insurance released a report promoting "universal family care," a social insurance model designed to support care needs from early childhood through LTSS. Complementing this publication, PHI partnered with Caring Across Generations to release a report on the **nine key considerations** to strengthen the direct care workforce through LTSS social insurance programs.[122]

In Focus: PHI's Workforce Innovations

In 2015, PHI partnered with a managed care plan and three home care providers to create a salaried advanced role for home care workers—called a **Care Connections Senior Aide.** These workers are trained to provide coaching and support for home care workers and family caregivers and serve as a resource to the interdisciplinary care team, strengthening ongoing knowledge and communication about clients' conditions. Pilot-testing of the new role showed a reduction in caregiver strain and an 8 percent drop in emergency department visits (compared to the previous year).

A more immediate, emergent opportunity to strengthen the direct care workforce and consumers' access to care is through Medicare Advantage. The federal government recently allowed Medicare Advantage plans, which are managed care plans for Medicare enrollees, to cover non-medical home care as an optional benefit, just like dental coverage or gym memberships. This expansion of coverage could be leveraged to support the workforce in a number of ways. For one, under-resourced Medicaid-reliant home care agencies could secure a new revenue stream by providing services to Medicare Advantage enrollees—generating additional funds to invest in the direct care workforce. Relatedly, payers and providers could create new roles for direct care workers that focus on improving consumer outcomes and generating value for Medicare Advantage plans.

As states and the federal government continue to consider new funding mechanisms for long-term care, workforce considerations must be front and center. After all, a key challenge in the current system is that workforce shortages undermine access to care for all consumers, regardless of their method of paying for care.

ORGANIZING LONG-TERM CARE TO IMPROVE JOB QUALITY

The home care industry (and its direct care workforce) is growing rapidly. But home care is more diffuse and less regulated than the nursing home and (to a lesser extent) residential care industries, which makes it difficult to universally enact and enforce workforce policies and protections—or care quality standards. Also, workforce policies and reimbursement rates often vary across and within Medicaid programs.

A good start toward standardizing workforce policy across long-term industries would be to license home care agencies and fill in licensing gaps in residential care. Enacting workforce policy through licensure regulations can create consistency across providers, regardless of whether they are predominately publicly or privately financed. This approach is not only a consumer protection, but a critical lever for improving job quality.

In establishing and revamping licensure requirements, states could work to better align workforce regulations to create a more coherent regulatory framework across payers. For example, establishing portable, stackable training requirements through licensure requirements would allow direct care workers to work across settings without repeating their training. (As we will discuss in the next section of this report, current training requirements in different settings are often duplicative and nontransferable.)

Later sections of this report will explore the job quality improvements that are critically needed to boost recruitment, reduce turnover, and improve consumers' access to services, now and in the future. However, transforming direct care jobs will require restructuring our long-term care financing system and better aligning workforce policies (especially in the home care industry)—to ensure adequate funding and strengthen recruitment and retention across sectors. These goals will only be attained through coordinated and concerted effort among stakeholders at all levels of the long-term care system.


DIRECT CARE WORK IS REAL WORK
Elevating the Role of the Direct Care Worker

Introduction

Systemic under-investment in LTSS and disrespect of its workforce run deep in our society. How can these barriers be overcome?

In the *Caring for the Future* report so far, we've taken an in-depth look at the direct care workforce and the complex, fractured long-term services and supports (LTSS) industry. In the first section (*It's Time to Care: A Detailed Profile of America's Direct Care Workforce*), we described the characteristics of the direct care workforce, underscored the need to bring more workers to this sector to meet escalating demand, and identified opportunities to elevate compensation and develop a more robust recruitment pipeline. In the second section *(We Can Do Better: How Our Broken Long-Term Care System Undermines Care)*, we examined the LTSS financing system and how its fragmented organization and competing priorities often leave both workers and consumers at an economic disadvantage, pointing to the need for systemic reforms.

As we have shown so far, efforts to generate the commitment needed to address workforce shortages and improve jobs for direct care workers confront an array of challenges. Direct care work is less publicly visible than other occupations, taking place primarily in private homes, nursing homes, and residential care communities. The work performed by direct care workers and the regulatory systems that shape it remain poorly understood by most people. Systemic under-investment in LTSS and disrespect of its workforce run deep in our society. How can these barriers be overcome?

We need to better understand the work of delivering LTSS to the 20 million adults in the United States who require assistance carrying out daily activities, engaging with their communities, and managing an increasingly intricate set of health conditions.[123] The demands on nursing assistants and home care workers have evolved significantly in recent decades—and particularly intensified in the midst of the 2020 coronavirus pandemic—but training standards and regulations for these roles have not kept up.

The patchwork nature of the current training infrastructure for direct care occupations undermines both the potential and perceptions of these workers. But improving training and career opportunities in the long-term care sector also holds promise for demonstrating the value of direct care work and driving greater investment in its workforce.

In this section of the report, we survey the regulatory landscape that governs training of direct care workers in the U.S. and compare existing training standards against the challenges workers face on the job. In accounting for the aspects of direct care work that frequently go unrecognized, we argue for a deeper appreciation of the skills needed to deliver quality LTSS. This concept of appreciation directly informs the next section of the report, which will cover strategies for improving job quality for the direct care workforce.

Direct Care Training Regulations

Direct care is the largest job sector in the U.S., with nearly 4.6 million people employed as nursing assistants, home care workers, and residential care aides across care settings. Their work benefits millions more LTSS consumers and family members. But the requirements underlying training for direct care occupations are uneven, with federal mandates applicable only to those providing care in Medicare-certified agencies and state training regulations varying widely across long-term settings and job titles. In this section, we review these regulations and their implications for different segments of the long-term care workforce.

FEDERAL TRAINING REGULATIONS

Federal regulations govern training for two occupations within the direct care workforce. **Nursing assistants** employed in nursing homes that participate in Medicaid and Medicare are federally mandated to complete a state-approved training program and pass a standardized assessment to become certified nursing assistants before beginning work.[124] The rules require that these trainings include at least 75 hours of instruction, including 16 hours of supervised practical training. They further specify which competencies should be covered and under what circumstances training and evaluation can take place. Nursing assistant training topics include assisting residents with activities of daily living (ADLs, like bathing, feeding, and mobility); responding to residents' behavior, which may be affected by physical and/or mental health conditions; and providing social support. They also cover basic nursing tasks like observing and reporting changes in residents' health conditions and recording vital signs. Training may cover other clinical tasks that are specified at the state level and must be conducted under the supervision of a licensed nurse. Some but not all states allow for reciprocity of nursing assistant credentials, meaning workers trained and certified in this occupation in one state can apply for their certifications to be accepted in another state without requiring additional training.

Home health agencies participating in Medicare are also subject to a federal requirement to employ **home health aides** who have completed at least 75 hours of instruction, including 16 hours of supervised practical training, through a state-approved program that follows federal regulations on content, delivery, and evaluation.[125] Topics specified include providing assistance with ADLs, instrumental activities of daily living (IADLs, such as food preparation and maintaining a safe environment), and health-related tasks, such as observing and reporting changes in residents' health conditions and recording vital signs. As with nursing assistant training programs, home health aide training may cover other health-related tasks that are specified at the state level and must be conducted under the supervision of a licensed nurse. These home health aides are also federally mandated to receive 12 hours of in-service training per year.[126] Medicare-funded home health aide services are usually time-limited, for example to periods when Medicare beneficiaries have transitioned home from an acute care setting and require short-term assistance during recovery.

The requirements underlying training for direct care occupations are uneven, with federal mandates applicable only to those providing care in Medicare-certified agencies and state training regulations varying widely across long-term settings and job titles.

Personal care services are not reimbursed by traditional Medicare, and there are no federal training standards for personal care aides.

While federal standards make nursing assistants and home health aides the only segments of the direct care workforce whose training hours are consistently regulated across the U.S., these standards have been criticized as insufficient for preparing workers to meet the needs of long-term care consumers in the current era. In 2008, the National Academy of Medicine recommended that the minimum standards for nursing assistants and home health aides be increased from 75 to 120 hours of instruction, to better prepare workers for the increasingly complex care requirements of an aging population.[127] In the years since, the 120-hour standard has been endorsed by numerous long-term care stakeholder groups but only adopted by a handful of states.[128]

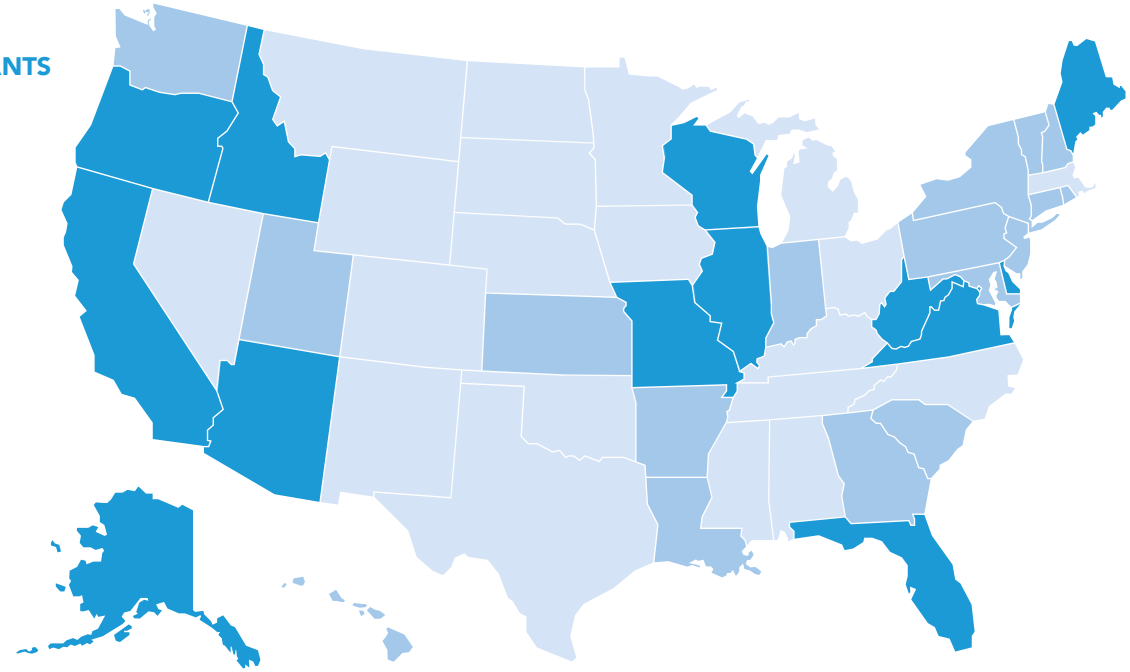
There are no federal requirements for training home care workers employed by agencies that do not participate in Medicare. Personal care services (explored below) are not reimbursed by traditional Medicare, and there are no federal training standards for personal care aides. When personal care services are funded through Medicaid programs, training regulations are decided at the state, program, or payer level.

STATE TRAINING REGULATIONS

Many states have chosen to expand training requirements for direct care workers beyond the federal minimum. Thirty-one states and the District of Columbia require more than 75 hours of training for nursing assistants, and 32 states exceed the 16-hour minimum for supervised practical training. Seventeen states and D.C. require more than 75 hours of training for home health aides, and 11 of these states also require home health aides to first be certified as nursing assistants. The 16-hour minimum for supervised practical training for home health aides has been expanded by 15 states and D.C.[129] Home health aides also care for Medicaid beneficiaries requiring long-term care; as discussed in the second section of this report, such Medicaid funding is primarily disbursed through waiver programs.

TRAINING STANDARDS FOR NURSING ASSISTANTS ACROSS U.S. STATES

- 75 Hours
- 76-119 Hours
- 120+ Hours



Source: PHI. *Nursing Assistant Training Requirements by State*. Bronx, NY: PHI. https://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/

Michelle Godwin

CERTIFIED NURSING ASSISTANT (CNA) AT VILLAS AT KILLEARN LAKES IN TALLAHASSEE, FL
23 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A CNA:

"Ever since I was teenager, I've always loved to be around older adults. I would befriend elderly neighbors, sit with them, and help them with anything they need. We would even sit down and eat dinner together.

After I graduated high school, I went to college for a little bit, but then decided to become a CNA. As soon as I passed my certification, I went right into working in this field. That was more than 20 years ago, and I've been working in it ever since—in nursing homes, hospitals, mental health facilities, home health care, and in a 'small house' neighborhood setting. I just love helping people and am very compassionate for people who can't always help themselves. I also know that one day I will get older and will want to be treated well and have the best care too."

ON HER RELATIONSHIP WITH HER CLIENTS:

"We are very close, and that's what I love most about my job. They see my smiling face, and they can tell through my character and sense of humor that I really care about them. They know that I'm here to do anything to make them feel better. I just enjoy them, and I can tell they enjoy me, too, because we make each other laugh all of the time."

ON WHAT SHE FINDS MOST CHALLENGING IN HER ROLE:

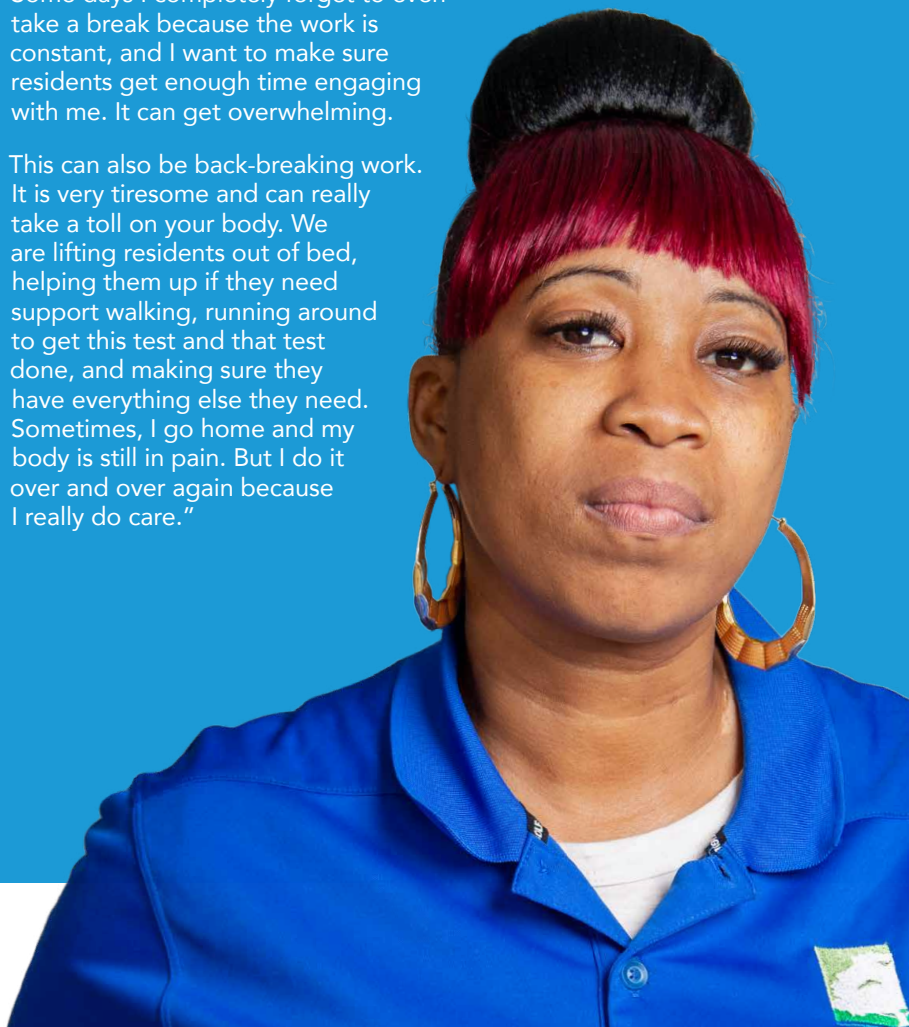
"If you last in this work for more than a year or two, it's because you're not in it for the paycheck—you're in it because you really care. I love what I do, yet I still have bills and responsibilities, and sometimes I don't feel we get paid our worth. That's why I think there is so much turnover in this field. I've worked in nursing homes and other places before where we were really short on help. In some of these places, I was assigned up to 20 residents, and there was no possible way to physically give each of them the care they needed. We are battling to do whatever needs to get done because we care. But if they were paying us more, that high turnover might stop and they'd be more likely to keep staff."

IF SHE COULD CHANGE ANYTHING ABOUT THE FIELD:

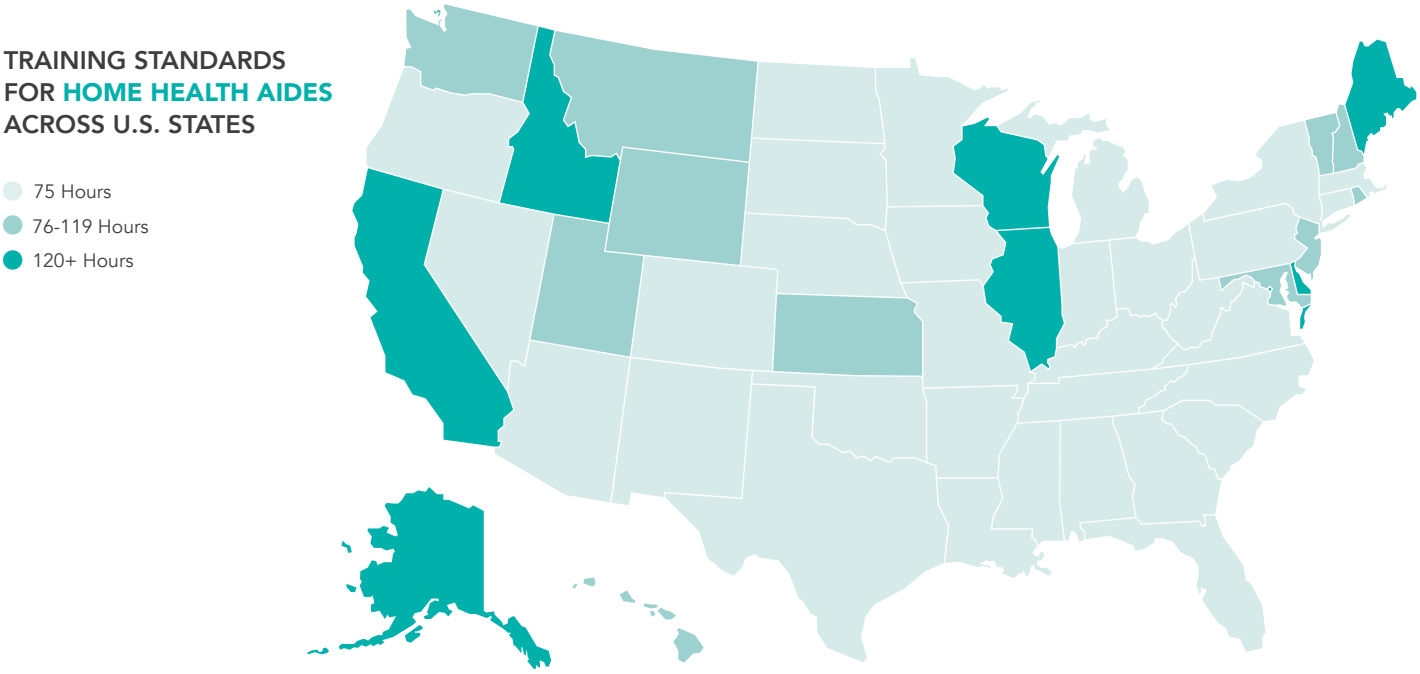
"If I could make a change, it would be for this field to show more appreciation for what we do because we are the main backbone of this work. We're the most hands-on with clients and spend more time with them than anyone else. Some days I completely forget to even take a break because the work is constant, and I want to make sure residents get enough time engaging with me. It can get overwhelming.

This can also be back-breaking work. It is very tiresome and can really take a toll on your body. We are lifting residents out of bed, helping them up if they need support walking, running around to get this test and that test done, and making sure they have everything else they need. Sometimes, I go home and my body is still in pain. But I do it over and over again because I really do care."

A CNA with more than two decades of experience working across a variety of care settings, Michelle's commitment to the wellbeing and happiness of older adults started early in life.



TRAINING STANDARDS FOR HOME HEALTH AIDES ACROSS U.S. STATES



Training requirements for direct care workers in residential care settings vary, as these agencies are licensed and for the most part regulated at the state level. Some states license multiple categories of residential care facilities, each of which may have distinct training requirements. All but three states require some form of entry-level training for **residential care aides** employed in assisted living communities. In most cases, these requirements are limited to an orientation on a uniform set of topics.[130] Only 17 states and D.C. require a minimum number of entry-level training hours for residential care aides in assisted living, ranging from 1 to 90 hours. Thirty-eight states require some form of continuing education for these workers. Direct care workers supporting residents with distinct needs within residential care communities, including those with dementia, are often required to complete additional training, as are workers approved to administer medication in these settings.

State variations in training regulations are most pronounced for home care workers who exclusively provide non-medical personal care services, usually in consumers' own homes and communities. Formally classified as **personal care aides** by the U.S. Bureau of Labor Statistics, these workers are known in the field by a range of job titles that vary by state and program—including *personal care aide, personal care assistant, home attendant,* and *home care aide.* Only 14 states have established consistent training standards for this occupation, meaning that training on a uniform list of topics is required for all personal care aides employed by home care agencies in those states. Standards for personal care aide training differ between payment programs within another 29 states and D.C. Among the 43 states (and D.C.) that have at least one set of training requirements for personal care aides, 27 have established a minimum number of hours for personal care aide training, only 16 of which exceed 40 hours. The remaining seven states do not regulate personal care

Source: PHI. *Home Health Aide Training Requirements by State.* Bronx, NY: PHI. https://phinational.org/advocacy/home-health-aide-training-requirements-state-2016/

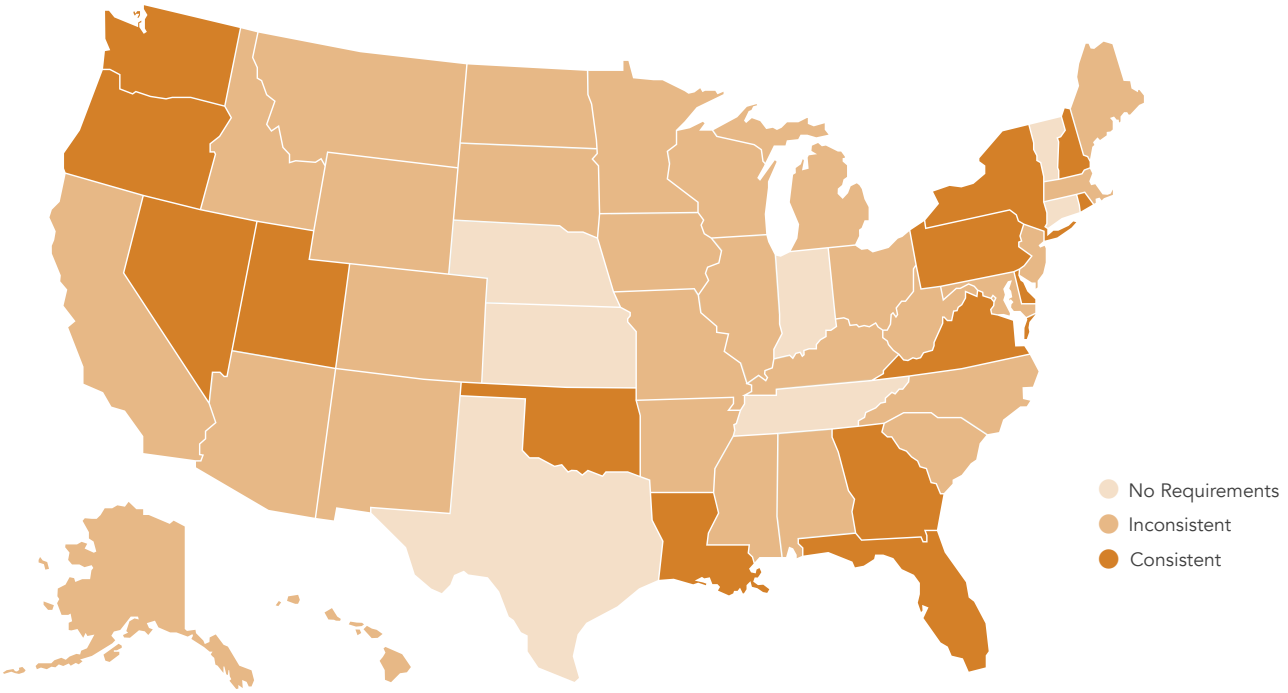
aide training at all.[131] The considerable disparities in whether and how agency-employed personal care aides are trained across states, programs, and job titles suggest that many do their jobs with little formal preparation—with negative implications for variation in the quality of services delivered.[132] Researchers and long-term care stakeholders have for many years called for better training for this segment of the workforce. Along with recommendations for nursing assistants and home health aides, the National Academy of Medicine's 2008 report recommends that all states establish minimum training standards for personal care aides. With demand for this occupation driving the majority of job growth in long-term care, strengthening training standards for personal care aides has been identified as an important factor in meeting consumer need for LTSS in the coming decades.[133]

The considerable differences in training requirements among direct care occupations at the state level make it difficult for workers in this field to translate their experiences across settings. In general, training and credentialing achievements in home care and residential care are not portable: a worker certified in one LTSS setting is rarely eligible for employment in another without additional training, and home care and residential care credentials are not recognized across state lines. Workers must satisfy the unique training requirements of a new setting or state when they switch LTSS fields or move out of state. Further, regulations for direct care titles rarely permit training completed for one role to be applied toward certification in another, whether or not training content overlaps. This inflexibility challenges workforce development in long-term care and has made it more difficult to mobilize direct care workers from one LTSS environment to address workforce shortages or emergency needs in another, such as to stem understaffing in nursing homes during the COVID-19 outbreak.

State Policy Spotlight

Through its **Quality Improvement in LTSS (QuILTSS)** program, Tennessee is redesigning the state's training infrastructure for direct care to create greater consistency, portability, and stackability across direct care occupations.[134] QuILTSS includes competency-based training with required competency demonstrations, as well as micro-credentials and mentorship to support trainees' progress. Credentials earned through the program are logged in a state registry to foster their portability across LTSS settings. The program also aims to give trainees opportunities to earn college credits and connect to career pathways.

TRAINING STANDARDS FOR AGENCY-EMPLOYED PERSONAL CARE AIDES IN THE U.S.



Source: PHI. *Personal Care Aide Training Requirements.* Bronx, NY: PHI. https://phinational.org/advocacy/personal-care-aide-training-requirements/.

A Closer Look at Data Collection

In 2017, Massachusetts passed a law requiring **a public registry for home care workers** in its State Home Care Program.[144] The registry verifies the type of training received and credentials earned by these workers, allowing employers to make hires without duplicating training. Worker registries also offer opportunities for states to assess the size and competency levels of their workforces—addressing a key data gap in long-term care—though few have such databases in place. Advocates have raised concerns that the Massachusetts registry threatens workers' privacy and safety, prompting exemptions for people with heightened safety needs, such as domestic violence survivors.[145] Challenges in the registry's rollout demonstrate the need to incorporate workers' perspectives and privacy into data collection.

REGULATIONS FOR INDEPENDENT PROVIDERS

In consumer-directed models of home care, most or all of the responsibilities for employing a direct care worker, often known as an **independent provider**, are held by the consumer—including training. Among consumer-directed programs that are publicly funded, few require independent providers to receive any standardized training.[135] When consumers directly hire and pay workers privately through what is known as the *gray market*, these workers are not generally subject to any training requirements either.[136]

Allowing consumers to determine whether and how training for their independent providers takes place accords with the principles of autonomy and independent living that helped drive the initial creation and proliferation of consumer-directed LTSS programs.[137] Proponents of these models believe consumers are best able to understand their own needs for in-home LTSS and direct others to deliver them. For many, this appears true: consumer direction has been found effective in supporting consumers' independence, customized needs for support, and satisfaction with care.[138]

The primary training gap identified in consumer-directed programs relates to preparing consumers to understand their respective roles and responsibilities, such as what it means for a consumer to simultaneously occupy the roles of employer, care recipient, and, in many cases, family member or friend.[139] There is little support for establishing training standards for independent providers, as many consumers worry this would affect workers' ability to deliver services that are fully aligned with their preferences.[140] Certain advocates, however, believe that some level of training requirement for consumer-directed workers could help establish greater consistency, safety and quality assurance, and workforce opportunities in these programs.

A NOTE ON TRAINING DELIVERY AND QUALITY

The infrastructure for delivering training for each of the main direct care occupational categories in the U.S.—nursing assistant, home health aide, and personal care aide—is disorganized and underfunded. While some evidence suggests a majority of direct care workers receive training through their employers, not all employers offer this option.[141] Cost is a significant barrier to employer-based training, as entry-level training costs are not generally reimbursable through the Medicare and Medicaid funding many long-term care employers rely on. The availability of direct care training programs varies per region and, in addition to employer sites, may be spread across colleges, proprietary training schools, community-based organizations, vocational high school training programs, and labor organizations.[142] States regulate nursing assistant and home health aide certification programs according to federal standards, and some states regulate aspects of personal care aide training.

Little is known about quality enforcement for these programs overall, but it is likely that the quality of direct care instruction differs significantly across regions and training providers.[143]

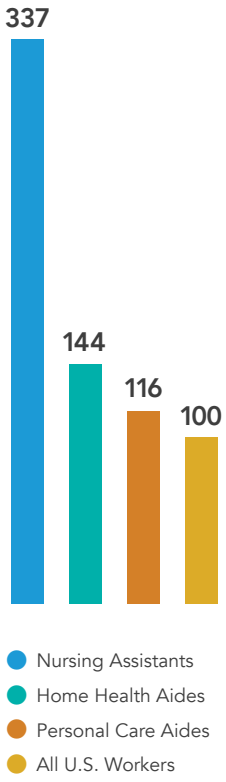
TRAINING STANDARDS FOR DIRECT CARE WORKERS: OCCUPATIONAL CATEGORIES IN SUMMARY

Occupation	Federal Training Standards?	Federal Training Minimum	State Training Requirements		
			75 Hours	76-119 Hours	120+ Hours
NURSING ASSISTANT	✓	**75** hours total, including **16** hours clinical	AL CO IA KY MA MI MN MS MT NE NV NM NC ND OH OK SD TN WY	AR CT GA HI IN KS LA MD NH NJ NY PA RI SC TX UT VT WA	AK AZ CA DE D.C. FL ID IL ME MO OR VA WV WI
HOME HEALTH AIDE	✓	**75** hours total, including **16** hours clinical	AL AZ AR CO CT DE FL GA IN IA KY LA MA MI MN MS MO NE NV NM NY NC ND OH OK OR PA SC SD TN TX VA WV	HI KS MD MT NH NJ RI UT VT WA WY	AK CA D.C. ID IL ME WI
PERSONAL CARE AIDE	✗	None	Requirements exist in 43 states and D.C., varying per job title and program		

Sources: PHI. *Nursing Assistant Training Requirements by State.* Bronx, NY: PHI. https://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/; PHI. *Home Health Aide Training Requirements by State.* Bronx, NY: PHI. https://phinational.org/advocacy/home-health-aide-training-requirements-state-2016/; PHI. *Personal Care Aide Training Requirements.* Bronx, NY: PHI. https://phinational.org/advocacy/personal-care-aide-training-requirements/.

The Real Demands of Direct Care Work

DIRECT CARE WORFORCE INJURIES PER 10,000 WORKERS



Much of the discourse that shapes direct care training policies and delivery systems fails to capture the full complexity and scope of the demands faced by this workforce. Training requirements, curricula and assessments, job descriptions, and care plans that describe expectations for direct care workers' preparation and performance tend to focus on basic tasks associated with assisting consumers with ADLs and IADLs.[146] There is often inadequate attention to the physical demands posed by this work, the significant social and emotional aspects of its delivery, and the extent to which direct care workers, regardless of title, are now assisting consumers in managing complex health conditions.

PHYSICAL STRAIN

Direct care workers provide the majority of paid, hands-on care delivered to long-term care consumers, yet the physical demands of their work are frequently undervalued. Helping people to transfer safely between locations, such as in and out of a bathing chair—manually or using an assistive device like a Hoyer lift—requires technical skill, but also physical strength and stamina. Care tasks that require intimate or weight-bearing assistance can also cause stress, fear, or agitation for consumers, and attending to these emotional needs at the same time can compound direct care workers' strain.[147] The limited practical training hours required for most nursing assistants and home health aides, and the dearth of these requirements in personal care aide training, mean that most direct care workers do not adequately practice a range of physically intensive caregiving tasks before beginning work.

It is unsurprising, then, that the direct care workforce has some of the highest rates of occupational injury and on-the-job violence in the U.S.[148] Nursing assistants face the highest rates of injury, at 337 injuries per 10,000 workers (compared with 100 per 10,000 among U.S. workers overall according to 2016 data). These workers perform the majority of physically demanding tasks in nursing homes, assisting multiple residents each shift. Injuries commonly reported by nursing assistants include back injuries, strained or sore muscles, slips, and skin wounds. Home health aides and personal care aides experience injuries on the job at rates of 144 and 116 per 10,000 workers, respectively. It is expected that the rates among home care workers are lower in part due to under-reporting. While home care workers generally carry out fewer physically demanding maneuvers per shift than nursing assistants, implementing these tasks in isolation has been found to elevate their physical risks.[149] Having less training and experiencing low-quality training are factors that have been associated with a higher likelihood of injury among direct care workers across settings.[150]

Further, because much of the essential support provided by direct care workers requires physical assistance, these workers cannot observe the social distancing practices advised during outbreaks of infectious disease. The 2020 coronavirus pandemic brought new attention to the health risks that direct care workers and consumers face in the delivery of LTSS. In the months following the first COVID-19 outbreak in a U.S. nursing home in Kirkland, Washington, direct care employers across the country struggled to provide personal protective equipment and clear guidance on managing infection risk to their workers. The in-person nature of direct care work—in addition to the precarity created by its low wages, lack of paid leave, and limited training—placed personal care aides, home health aides, and nursing assistants among the workforces facing the highest risk due to the coronavirus.[151]

SOCIAL AND EMOTIONAL LABOR

While much of the training and regulation of direct care focuses on visible, measurable tasks, a significant component of what direct care workers do remains

invisible. Developing relationships with consumers to support their emotional wellbeing has been identified as an instrumental component of quality care.[152] Strong caregiving relationships can also facilitate the successful delivery of other, more technical or health-related direct care services.[153] To develop these relationships, direct care workers draw on a range of relational skills. The ability to listen and communicate effectively allows workers to understand consumers' conditions and better fulfill their needs and preferences. Perceiving and interpreting consumers' verbal and nonverbal communication is particularly critical to the delivery of quality care for individuals with speech impairments, behavioral health conditions, and dementias.

Direct care workers must also frequently manage relationships with clients' family members, which adds to their relational workload. In both home and facility-based care settings, family members can misunderstand the role of the direct care worker and place additional demands on workers' time.[154] Leveraging communication skills when managing these dynamics can engender trust and reduce opportunities for miscommunication and conflict. Additionally, as described in the first section of this report, the population of adults over 65 in the U.S. is becoming more racially and ethnically diverse, with a growing number of individuals in this population identifying as lesbian, gay, bisexual, and/or transgender, driving demand for more culturally and linguistically competent care. Yet despite the importance of communication and cultural sensitivity to the delivery of LTSS, such competencies are rarely included in training standards for direct care workers.

Coping with high levels of job-related stress is another under-recognized requirement of direct care work. Caring for individuals experiencing functional disabilities or serious physical and mental health conditions requires sustained emotional engagement, especially when care recipients are experiencing negative emotions such as anger, fear, paranoia, or depression. Placing consumers' emotional needs before one's own is fundamental to the delivery of LTSS. Doing so effectively requires the exertion of emotional labor, such as maintaining sensitivity to others' emotions, suppressing emotions that are not appropriate to the workplace, and adopting or performing emotions that provide comfort or reassurance.[155] These activities can be highly rewarding for direct care workers, who often cite their abilities to express compassion and observe its impact as key drivers of job satisfaction. However, this emotional labor is psychologically taxing and over time can contribute to stress and burnout among direct care workers.[156]

The general lack of attention to relational and self-management skills in direct care training programs—combined with the low-levels of compensation and professional recognition afforded to this workforce—suggests that much of these workers' social and emotional labor goes unseen.

MANAGING COMPLEX HEALTH CONDITIONS

As discussed earlier in this report, adults in the U.S. now experience a higher prevalence of chronic conditions and functional disability than previous generations. These trends are exacerbated among older adults. Further, in recent decades health care policies have increasingly shifted the provision of post-acute care and LTSS to home and community-based settings. Together, these factors have heightened the complexity of service delivery in long-term care, where the work of supporting individuals in managing chronic and serious health conditions primarily falls to direct care workers.

Yet, the training most direct care workers receive fails to cover the range of topics and skills needed to meet consumers' evolving needs. Consistent among the gaps identified in direct care worker training is in-depth education on complex health conditions commonly presented by long-term care clients. These include Alzheimer's disease and other forms of dementia, which are becoming more prevalent among older adults and require knowledge about disease progression and communication strategies to manage

The general lack of attention to relational and self-management skills in direct care training programs—combined with the low-levels of compensation and professional recognition afforded to this workforce—suggests that much of these workers' social and emotional labor goes unseen.

Industry Feature

In 2017, physician-researcher Madeline Sterling, MD led a first-of-its-kind study into the perspectives of **home care workers caring for consumers with heart failure**, one of the leading causes of hospitalization for adults over 65.[166] Through focus groups with 46 home care workers from 1199SEIU in New York, Sterling and her team found that home care workers are regularly involved in their clients' self-care surrounding heart failure, even though most have not received training in the condition. Workers also reported feeling overworked and left out of care team communication. Still, they expressed passion for their jobs and interest in additional training on heart failure.

effectively.[157] Other chronic diseases needing special instruction include diabetes, heart failure, chronic obstructive pulmonary disease, and asthma. General skill areas that are critical to supporting health maintenance among long-term care clients, but have been flagged as receiving too little attention in training programs, include cultural competence, geriatric care, behavioral health, use of assistive and medical devices, and infection prevention and control—the latter topic has taken on added urgency due to the coronavirus pandemic.[158]

Another barrier to direct care workers' ability to support consumers with complex care needs pertains to the restricted rules on task delegation affecting this workforce. The range of activities that direct care workers are allowed to perform varies by state, LTSS program, and direct care title. For example, some states allow direct care workers to carry out nurse-delegated tasks, like administering specific medications or performing catheterization. A recent analysis showed that 28 states allow nurse delegation of at least 14 out of 16 named health-related tasks to agency-employed home health aides or personal care aides, whereas four states do not allow delegation of any of those 16 tasks.[159] The degree to which home care workers perform activities that are outside their allowable scope or otherwise considered medical in nature is largely unknown.[160] Home care workers employed in consumer-directed programs do not for the most part face restrictions on the health-related services they can provide their consumers.

Regardless of delegation rules, direct care workers perform a wide range of tasks that support consumers' health and prevent declines in serious conditions. These tasks include observing changes in consumers' health and reporting them to ensure the consumer's timely access to primary or acute care as needed. Those serving individuals with chronic conditions provide them with encouragement and assistance in engaging in health-supporting behaviors such as healthy eating, physical activity, and adherence to condition-specific lifestyle guidance or treatments.[161]

In home care settings, direct care workers may also conduct activities like tracking consumers' medical appointments and supporting appointment attendance.

A Note on Skill Level Classifications

Inconsistent attention to the real work involved in direct care has contributed to poor understanding of direct care workers' roles among the public and even among health care officials whose decisions affect this field.[162] These jobs are often erroneously termed as "unskilled" or "low-skilled," which may contribute to the limited enforcement and expansion of training standards in direct care.

Most classification systems that determine whether and to what extent an occupation is "skilled" are based not on the amount of skill required to perform a given job but on the training and formal education required to begin employment. Poor training standards, then, reinforce beliefs that direct care work is not skilled work.

Occupational skill-level categorizations have also been criticized as proxies for wage levels, contributing to the incorrect perception that low-paying work requires little or no skill.[163] The low wages afforded to direct care are fundamentally tied to systems of discrimination that have assigned low value to work traditionally performed by women, people of color, and immigrants—who still today comprise the majority of the direct care workforce.[164] Policy decisions to repeatedly exclude home care workers in particular from pay and labor protections in the U.S. date back to efforts to maintain domestic work arrangements that originated in slavery. The intersection of sexism, racism, and xenophobia compounds the overall underestimation of the demands, and value, of direct care work.

As this report section has examined, delivering LTSS to consumers in nursing home, home care, and residential care settings is complex. It is work that requires skills extending far beyond what the field's training standards provide—and is worth far more than its workers are paid.[165]

Janet Folsom

HOME HEALTH AIDE, CERTIFIED NURSING ASSISTANT (CNA), AND PEER MENTOR AT KNUTE NELSON IN ALEXANDRIA, MN
5 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A HOME HEALTH AIDE:

"I decided to go back to school to become a CNA at the age of 50 and am going on five years as a home health aide. Before that, I worked at a day care for 20 years and then spent a little time working at a high school. Direct care work was always something that I wanted to do in my younger years—to work with older people and take care of people that needed help. Even though I took a big pay cut, I absolutely love my job. I know I'm making a difference in the lives of the people I am helping, and that means a lot to me."

ON HER RELATIONSHIP WITH HER CLIENTS:

"I've created quite a bond with each and every one of my clients. We talk, I listen to them, and I pay attention to their wants and needs so they feel safe and can trust me. When I can walk into a home and make somebody happy, that means more to me than anything. And I can usually take a person who is pretty down in the dumps and end up having them smile and laugh. So it can be a very rewarding job."

ON WHAT IT TAKES TO SUCCEED IN HER JOB:

"Caregiving in general is a lovely thing. You need to be a person who has patience and a kind, caring heart. I always think: how would I want to be approached? Or: how would I want somebody approaching my parents or my loved ones? And you need to understand that being a home health aide is work. It's a challenging job, both physically and mentally."

ON TAKING ON AN ADVANCED ROLE IN HOME CARE:

"As a peer mentor, I train new home health aides and make myself available to support a group of five aides. They can come to me with any questions or concerns they have, or to simply talk about their day. When the position was posted, I was encouraged to apply by my coworkers. I felt very honored knowing that they see me as a role model and proudly accepted. I really enjoy connecting with new staff. In my role, I help them feel comfortable and confident when they go out into the field on their own, and I get to share some of my experiences with them."

ON THE IMPACT OF COVID-19:

"Since the start of the coronavirus, my job is more mentally and physically draining than before. Knute Nelson continuously informs us of guidelines from the health department on how to stay safe, and we have access to all the protective gear we need. So we've been very fortunate. But it's really hard for everyone. My clients are scared, and they're getting depressed and lonely. I try and switch off the news if they've been watching 24/7 and to pick them back up and get them to a better mental place, which can be emotionally draining.

Working in the field, we are exposing ourselves to so much risk. We are wearing masks 99.9 percent of our day. We're sanitizing equipment and taking so many precautions. I just wish we had more acknowledgement, or some kind of extra incentive, to help keep us going on the really tough days so we know we're not forgotten."

After a career in childcare and education, Janet became a direct care worker. She enjoys seeing the impact of her work as a CNA and home health aide in the lives of those she serves. Janet also supports other aides in the field in her advanced role as a peer mentor.

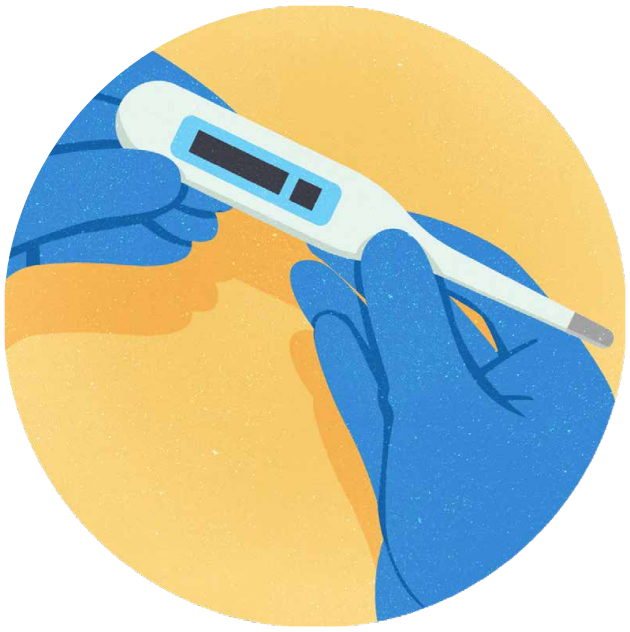
Opportunities for Improving Direct Care Training

While the need for improved training requirements is most evident among personal care aides, experts believe all direct care workers could benefit from the development of core competencies and elevated standards for their enforcement.

Improving standards for training will be a key step toward building the workforce needed to care for our future. Better training not only supports the delivery of high-quality LTSS, it offers professional recognition to direct care work and can help attract more people to this field.

CORE COMPETENCIES FOR ALL DIRECT CARE WORKERS

Recognizing that much of the knowledge and skill applied by direct care workers is transferrable across occupational categories and care settings, several competency sets have been developed to guide training in long-term care. A competency-based approach prioritizes trainees' successful demonstration of competencies as the key indicator of program completion, rather than the number of hours spent receiving instruction. While the need for improved training requirements is most evident among personal care aides, experts believe all direct care workers could benefit from the development of core competencies and elevated standards for their enforcement.[167]



The existing competency sets for direct care workers emphasize interpersonal competencies that are limited in formal training standards, such as communication and relationship development, alongside the ADL assistance traditionally included in training. Several sets include person-centered care practices—like consumer empowerment, advocacy, and direction—along with support for consumers' engagement in the community through social, educational, and professional activities. Some include infection control and supports for consumer wellness, but there is less attention to condition management and other topics that could be considered health-related. Only a few competency sets include a self-care competency area for workers, which speaks to skills like managing stress on the job. (See Appendix 4 for a summary of existing LTSS core competency sets.)

In this section, we review a selection of programs that have developed and implemented core competency standards for various segments of the direct care workforce, distilling lessons learned for future model development.

Personal and Home Care Aide State Training Demonstration Program (PHCAST)

As part of the 2010 Patient Protection and Affordable Care Act, PHCAST supported six states in adapting and scaling a competency-based personal care aide training. The curricula used in this program were based on PHI's 10-part Competencies for Direct Care Workers, from which the participating states—California, Iowa, Maine, Massachusetts, Michigan, and North Carolina—developed training programs ranging from 50 to 120 hours in length.[168] The curricula were designed to be applicable across LTSS settings, not just in home care. More than 4,500 new and incumbent direct care workers were trained through PHCAST over a three-year period. Though evaluation methods differed among the states, trainees overall reported high levels of satisfaction with the program and increased knowledge as a result of the training.

While training infrastructure varied across states prior to the program's implementation, each state reported that PHCAST strengthened their training capacity in some way, including by developing a cadre of trainers, centralizing information about training, and prompting the development of career ladders. These outcomes suggest that a standardized core competency model holds promise for use across multiple states. That knowledge gains were reported among PHCAST participants regardless of job tenure or credentials also indicates the applicability of core competency training across the direct care workforce.[169]

Washington State's Training Model

In 2012, Washington State began implementing Ballot Initiative 1163, which mandates that all long-term care workers providing personal care services to adults in the state complete a 75-hour, competency-based training to achieve certification as a home care aide, along with 12 hours of continuing education annually—more than doubling the prior standard. Notably, this mandate includes the independent provider population (home care workers hired directly by consumers). Curriculum topics include responsibilities within the home care environment, working on a care team, infection control, stress management and other aspects of self-care, as well as specific competencies for dementia care and supporting people with disabilities. The Washington State curriculum is designed to be transferrable across care settings, and its program has also established infrastructure to support stackability, meaning that trainees can leverage their existing training toward additional certifications, such as becoming a nursing assistant.

Trainees have reported high satisfaction with Washington State's training model.[170] The program has also experienced challenges, including: barriers to access for some trainees; a relatively low certification rate of approximately 60 percent, leading to concerns about workforce supply; and difficulties in preparing home care aides to balance the mandated training content with individual consumers' needs and preferences, which has drawn concern among members of the consumer-directed community. The program's continued evolution will help inform future efforts to mandate cross-setting training standards for direct care workers.

National Alliance for Direct Support Professionals (NADSP) Direct Support Professionals Competencies

For more than a decade, the national nonprofit advocacy group NADSP has promoted a set of core competencies for direct support professionals, a subset of the personal care aide workforce that supports people with intellectual and developmental disabilities. Each of the 15 NADSP Competency Areas is associated with three or more skill statements that must be satisfied to demonstrate competency.[171] The competencies focus on direct support professionals' abilities to empower and develop strong relationships with consumers, including assessing their needs and preferences in a given context; supporting their participation in professional, social, and personal activities; and completing tasks in service of consumers' goals. The NADSP competencies form the basis for the organization's voluntary credentialing programs for direct support professionals, which span multiple career ladder tiers, as well as for certification programs in several states and a national apprenticeship program administered by the U.S. Department of Labor.[172] Training and certification for NADSP credentials is now offered through e-learning methods.

BETTER TRAINING METHODS AND DELIVERY

In addition to updated and expanded curricula, programs seeking to improve training for direct care workers have implemented best practices in training methods and program delivery to maximize trainees' access and engagement. Traditional didactic education methods, which are found in many direct care training programs, may be less effective for adult learners, particularly those with limited formal or recent education experience or whose classroom experiences have been negative. In contrast, other direct care training programs implement adult

Industry Feature

The San Francisco-based nonprofit home care agency, **Homebridge**, runs an award-winning adult learner-centered training program for independent providers in California's consumer-directed In-Home Supportive Services program. The 48-hour entry-level training covers the essentials of personal care, including general safety, recognizing abuse and neglect, and caring for people with dementias or other cognitive disorders.[173] Homebridge also offers shorter, specialized trainings in 24 physical and social determinants of health topics. Caregivers at the agency receive full benefits and have opportunities, through its STEPS Program, to move up through an internal career ladder, with additional training and compensation associated with each new role.

In Focus: PHI's Workforce Innovations

In 2013, PHI launched the **Homecare Aide Workforce Initiative (HAWI)** with the UJA Federation of New York, which piloted a 120-hour, adult learner-centered home health aide training curriculum with 531 trainees across three home care agencies in New York City, along with other workforce interventions. Specialty training programs were also conducted at additional employer sites. The home health aide certification curriculum included core competencies for home care delivery including communication, patient-centered care, and cultural competence. An independent evaluation found that 90 percent of participants completed the course and HAWI trainees were more than twice as likely to be on the job at three months—and 64 percent more likely to be on the job at six months—compared to home health aides hired before the project.[180]

learner-centered training principles, utilizing a range of dynamic training methods to promote participation and accommodate multiple learning styles.[174] These methods include group demonstrations, paired work, call-and-response, and role play activities. Adult learner-centered training methods are also designed to break down traditional hierarchical classroom dynamics by centering trainees' expertise and building on the life experiences they bring to the classroom.

Including or strengthening hands-on learning activities, job previews, and field practice in entry-level direct care training is associated with higher levels of satisfaction with training and, in some cases, better outcomes for consumers.[175] These practical learning methods are particularly important for home care workers, whose isolated work structure provides few additional opportunities for on-the-job demonstration. Experts also recommend that direct care training assessments accommodate different test-taking styles, with options to self-pace during examination and demonstrate competency through written, spoken, or performative means.[176]

Training providers should also consider whether their programs are accessible to individuals seeking jobs in direct care. Most prospective and active direct care workers are low-income, and some may be working multiple jobs. Further, workers in this sector are likely to have their own family care commitments. Both the PHCAST demonstrations and Washington State's expanded competency programs faced accessibility challenges because trainings were initially scheduled during weekday working hours when many trainees had competing job commitments they could not afford to break. The PHCAST programs also experienced trainee attrition because training sites were difficult or expensive to access. Acknowledging these challenges, PHCAST organizers retooled their training structures, implementing more flexible make-up policies, moving training to locations that were easily accessible by public transit or subsidizing workers' transportation costs, and offering food, and in some cases, training stipends. These efforts were considered a success; at the end of the program, PHCAST attrition rates were lower than most job training programs, ranging from 1 to 12 percent across sites.[177] Washington State has also addressed its training barriers by boosting the number of home care aide training sites, implementing more flexible training schedules, and offering training in multiple languages.[178]

In-person training remains the best practice and industry standard for direct care occupations. The intensely interpersonal nature of this work and high level of hands-on activities it requires are well-served by in-person training formats. Use of online, asynchronous e-learning technologies to train direct care workers is often posited as a solution for the workforce shortages in this field. E-learning has also been identified as a solution for disseminating training to address emergent needs in direct care, such as recommendations for preventing and treating infections of the novel coronavirus. However, there is limited research on the effectiveness of virtual training methods for this workforce, and field experts have raised concerns about the accessibility and adoptability of such technology. Low-income trainees may lack access to the personal computers and Internet/data plans that make e-learning programs effective and/or may have limited comfort or familiarity with online learning. Blended or hybrid training models, which augment engaging in-person instruction and hands-on learning opportunities with classroom-based technologies, are considered preferable to fully online learning methods for direct care training programs.[179]

Maximizing the Direct Care Role

In addition to being underprepared by most entry-level training programs, direct care workers are underutilized in the delivery of LTSS. These workers have limited opportunities to access quality, condition-specific training as they progress in their jobs. Staff development initiatives are most likely to exist in nursing homes, though studies show they are rarely sustained over time.[181] The isolated and mobile nature of home care work makes it more difficult for direct care workers in these settings to receive formalized on-the-job training, such as orientation and on-site supervision, than for those working in nursing homes or residential care.[182] Many learn from experience, figuring out how to best navigate new challenges in the moment.[183]

While direct care workers' close relationships and sustained contact with consumers can provide an intimate understanding of their health conditions, this workforce is rarely guided to communicate what they know to other members of consumers' health care and social service teams.[184] Interventions that upskill existing direct care workers, particularly those that develop workers' health-related knowledge and team-based communication skills, could significantly augment these workers' contributions to quality care.

UPSKILLING

Upskilling recognizes that the minimum standards of training for most direct care workers are insufficient. Through additional training, upskilling is intended to bridge the gap between workers' entry-level preparation and the competencies required to meet the complex needs of today's long-term care consumers. Upskilling typically focuses on bolstering training in topics within direct care workers' existing scope of responsibilities and is not necessarily associated with pay increases or title promotions. However, many advocates see these training upgrades as key to demonstrating direct care workers' real value: data that links upskilling to improvements in consumer health outcomes and health care spending can be leveraged to bolster the business case for investing more in direct care workers' training and compensation.

Home care and nursing home workers consistently report interest in continuing to develop their skills and contributing more to their consumers' health outcomes.[185] Skill enhancement can elevate workers' job satisfaction and also confer benefits to long-term care employers in the form of increased commitment and performance.[186] Beginning in 2012, an upskilling program through the Schmieding Center for Senior Health and Education trained 3,447 home care workers across four states to better support consumer health maintenance and outcomes. Results from the program showed significant improvements in workers' reported satisfaction, caregiving knowledge, earnings, and retention.[187]

Opportunities for upskilling include a focus on enhancing skills around conditions that are widespread among long-term care consumers, including asthma and dementia, and on providing unbiased, culturally relevant care to specific communities. The 2020 coronavirus pandemic offers an example of an emergent upskilling need: while additional training in infection control procedures had previously been called for among direct care workers, the rapid escalation of the COVID-19 crisis created an urgent need to build infection control skills among this workforce that were contextualized to the pathology of a novel and rapidly spreading virus.[188]

To drive the investment needed to improve direct care training, stakeholders will need to make the case that better training for this workforce contributes to cost savings and quality care outcomes. This can be achieved by designing upskilling demonstrations that speak to the benefits of additional worker training for long-term care payers, which include managed care plans, private insurance providers, health systems, and public payers.[189] Calls to strengthen the direct care workforce increasingly focus on maximizing these workers' contributions to care coordination and the prevention

Data that links upskilling to improvements in consumer health outcomes and health care spending can be leveraged to bolster the business case for investing more in direct care workers' training and compensation.

Opportunities for upskilling include a focus on enhancing skills around conditions that are widespread among long-term care consumers, including asthma and dementia, and on providing unbiased, culturally relevant care to specific communities.

of avoidable, costly health outcomes among LTSS consumers—which have become key priorities in the era of value-based purchasing and payment.[190]

As one example of upskilling training that aligned the interests of workforce development with its impact on consumer health outcomes, in 2014, the New York home care agency Partners in Care implemented a one-week intensive training program on health coaching skills for home health aides. Topics included how to identify symptoms of a deteriorating health condition, promote consumers' medication adherence, and adopt health-supporting behaviors. Consumers served by participating workers showed improvement in self-care maintenance practices, and high-risk heart failure patients who had transitioned home from the hospital experienced improved health-related quality of life.[191]

COMBINING UPSKILLING WITH CARE TEAM INTEGRATION

Through upskilling, direct care workers can cultivate a deeper understanding of their consumers' health and how to manage it in a long-term care environment. But the utility of that information is limited if it is not shared with, and valued, by other members of the consumer's care team.[192]

In some long-term care settings, interdisciplinary care teams already include direct care workers, to varying extents. Several decades ago, nursing homes began adopting models of self-directed care teams that embodied the nonhierarchical tenets of the organizational culture change movement. These teams represent a cross-section of staff and intentionally include nursing assistants. Members receive training on collaborative problem-solving and developing shared accountability for resident outcomes. These team-based care models have been associated with higher job satisfaction and self-esteem for all workers, the development of new skills among nursing assistants, and improved efficiency and turnover overall.[193] In part due to the success of such programs, federal regulations for nursing homes now require nursing assistants to be included in comprehensive person-centered care planning processes.[194] In nursing homes, the "small home" model of custom-built residences designed to provide a home-like experience—most often identified with the Green House Project—centers its care team on the role of the direct care worker, known as a Shahbaz, who receives more training and exercises more autonomy than a traditional nursing assistant. Models for Programs of All-Inclusive Care for the Elderly (PACE), which centralize the coordination of a range of services for older adults, have also included direct care workers on interdisciplinary care teams.[195]

A growing body of research supports the formal inclusion of home care workers in care teams, so that they can both share observations from consumers' home environments to inform decisions about care and transmit relevant information back to consumers and family members.[196] Successful integration into the care team requires enhanced training for home care workers on observing, recording, and reporting changes in consumers' physical and environmental health conditions, as well as training on team-based problem-solving. Advocates note that other members of the care team, such as nurses and social workers, will also benefit from training on how to listen to home care workers' observations and understand their contributions to consumer health.[197]

Research on care team integration in home care is limited, but the success of several pilot demonstrations suggests that training and supporting home care workers to contribute to care coordination can produce valuable health outcomes. Between 2012 and 2015, the California Long-Term Care Education Center implemented a 60-hour competency-based training for 6,375 home care workers in the state's consumer-directed In-Home Supportive Services (IHSS) program and supported these workers' integration into care teams. The project showed improved recruitment and retention among home care workers, a 41 percent decline in the average rate of repeat emergency department visits among consumers, a 43 percent decline in the average rate of rehospitalization, and cost savings of as much as $12,000 per trainee.[198]

Another intervention with IHSS consumers from the St. John's Well Child and Family Center in 2012 provided six weeks of upskilling training, covering health-supporting and disease management competencies, to 97 home care workers and integrated them into care teams. The intervention generated improvements in consumers' health-related quality of life (67 percent), satisfaction with care (13 percent), and medication adherence (40 percent), as well as reductions in monthly rates of admission to hospitals (-53 percent) and emergency room visits (-54 percent).[199]

BUILDING THE DIRECT CARE CAREER LADDER

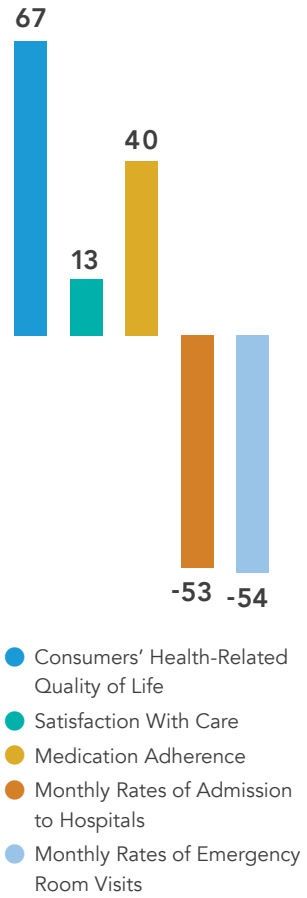
The failure to understand direct care workers' value and integrate their work with other segments of LTSS and health care delivery has hindered the development of a meaningful career ladder for this workforce. In most settings, the next formally recognized health care title above home health aide and nursing assistant positions is a licensed practical nurse (LPN). But while the former certifications can be obtained in a matter of weeks or months with few educational prerequisites, LPN credentials require a year or more of training in addition to a high school diploma or equivalency. The time, financial resources, and educational experience required to pursue an LPN career are out of reach for many direct care workers, particularly those balancing multiple jobs and family caregiving responsibilities. Further, while these workers consistently express interest in acquiring new skills and fairer rates of pay, many also see the work they do at the direct care level as a career and are not interested in leaving the field.

And yet, a lack of career growth opportunities contributes to poor job quality in direct care. It has been identified as a barrier to attracting new workers and to retaining workers over time. There is a significant need to develop rungs in the career ladder that are accessible to direct care workers and that build from their existing experience. Meaningful advancement for this workforce should represent an elevation in title, function, and compensation. Advanced roles for direct care workers have also shown promise for increasing the quality and efficiency of care delivered to consumers.

A number of long-term care employers have recognized the potential for their direct care workers to do more within their existing scopes of work and have created customized advanced roles. The following subsections review the types of advanced roles that have been developed and piloted for direct care workers across the country, with specific examples.

RESULTS OF CARE TEAM INTERVENTION WITH IHSS CONSUMERS FROM THE ST. JOHN'S WELL CHILD AND FAMILY CENTER

(In Percentages of Change)



There is a significant need to develop rungs in the career ladder that are accessible to direct care workers and that build from their existing experience.

Peer Mentors

Retention among direct care workers, particularly in their first months in the field, is a persistent challenge in long-term care.[200] The peer mentorship model trains experienced direct care workers in coaching and problem-solving competencies so they can serve as Peer Mentors who support new workers, helping them navigate caregiving challenges and other issues that arise during the transition into direct care work. Peer Mentors may even go into the field to support their mentees on the job. In some programs, workers serve as Peer Mentors full time, and in others they blend hours worked in this advanced role with their existing work as home care workers or nursing assistants.[201] In the late 2000s, an initiative to improve retention at the long-term care organization Loretto's Program of All-inclusive Care for the Elderly in Central New York centered on the creation of Peer Mentor roles to support home health aides. The project was associated with annual retention rates between 84 and 90 percent among Loretto's home care workforce, compared to a rate of 52 percent before the program.[202]

Care Coordination Roles

The integration of direct care workers into consumer care teams and as key players in care coordination, as described above, also presents opportunities to create advanced positions.

In 2015, PHI created the Care Connections Senior Aide role. Following 240 hours of training in chronic disease knowledge; communication skills; enhanced observe, record, and report skills; and care team participation, eight home health aides were elevated to salaried Care Connections Senior Aide roles. These Senior Aides made home visits to support the upskilling of hundreds of entry-level home care workers. They also helped improve care transitions, solved caregiving challenges in the home, and served as members of consumers' care teams. Outcomes from the initial 18-month demonstration project included an 8 percent reduction in the rate of emergency room admission among the 1,400 consumers impacted, reduced caregiving strain among family members, and improved job satisfaction among home care workers.[203] Following the demonstration period, a majority of the Care Connections Senior Aide roles were sustained at the participating home care agencies.

As another example, PHI has supported the design and development of a Transition Specialist role at Trinity Senior Health Communities in Michigan, applying learnings from the Care Connections Project to nursing homes. Nursing assistants promoted to Transition Specialists are trained in common chronic conditions and how to observe, record, and report changes in their residents' health. The role, which is currently being pilot tested, is structured to improve residents' transitions from acute care settings to the home or nursing home and to prevent avoidable hospital readmissions.[204]

Other Advancement Opportunities

Employers may also promote direct care workers to internal, administrative positions based on their experience in the field. The home care agency Cooperative Home Care Associates (CHCA) in New York estimates that as much as 40 percent of its administrative staff has been recruited from the agency's home care workforce. In addition to a robust Peer Mentor program, CHCA regularly promotes home health aides into positions including Assistant Trainer and Clinical Coordinator. As another example, Community Living Alliance in Wisconsin offers additional training and compensation to prepare experienced home care workers to serve as on-call aides for a range of clients when their regular workers are not available.[205]

Although documented examples are rare, there are also opportunities for employers to promote direct care workers to condition-specific specialty roles, like Dementia Care Specialist or Diabetes Specialist.

Marisol Rivera

CARE COORDINATOR AT COOPERATIVE HOME CARE ASSOCIATES (CHCA) IN THE BRONX, NY
22 YEARS AS A DIRECT CARE WORKER

ON ADVANCING TO NEW ROLES IN HOME CARE:

"I trained to become a Care Connections Senior Aide over three months, which was wonderful. This role built on what I had been doing every day for years.

In the beginning, I was nervous because aides saw me as a supervisor. I would assure them, 'I am a home health aide just like you, but because I've been in the field so long, I'm here to give you support.' As time went on, I felt more comfortable. Now as Care Coordinator, I help triage clients and assist workers over the phone. It's all about delivering better services to clients and keeping them home in the community where they want to stay."

ON WHY ADDITIONAL SUPPORT HELPS WORKERS DELIVER QUALITY CARE:

"I know from my years as a home health aide how difficult that job can be, and I don't think that's something anyone who hasn't been in the field can fully understand. For example, a lot of workers get their initial training in how to use one type of Hoyer lift, but when they get to the home and see a lift they haven't worked with, they worry they might be judged if they call for assistance. But the moment aides heard I was there to provide support and additional training, I could see their tension fade. I'd always speak calmly and tell them, 'It's okay. We'll do this together.'

I know how overwhelmed workers can feel when they're on their own, but when they know they have someone to support them, it helps them to do their job and follow up on client issues. I think every agency should have these roles. They will prevent a lot of hospitalizations."

IF SHE COULD CHANGE ANYTHING ABOUT THE FIELD:

"I think the role of the home health aide should be considered just as important as any other health care role. When an aide reports something, it should be listened to and not disregarded because of her title. Sometimes the aide knows more about the client's health than a physician or family member. We know that we are not a doctor or a nurse, but the home care role can be just as important in supporting the client.

One of the main challenges in a client's home is that family members can misunderstand the home health aide's role. Some people think we are a maid or that we have to care for everyone in the home. During my visits as a Senior Aide, I'd show the client and family the plan of care and what responsibilities it specified. This would help reduce complaints and keep aides with clients longer. Yes, an aide may help clean the client's environment and help them with toileting, but they're also there taking care of your loved one in ways that relieve some caregiving stress otherwise placed on the family."

WHAT HER CAREER PATH HAS MEANT TO HER:

"Working in these advanced roles has given me a lot of confidence in what I do. I feel good about being able to help more clients, more workers, and more family members. I continue to learn, which is also good for me. And I am proud of the example I have set for my daughters.

When home health aides ask me how I got this role, I tell them my story and to look for openings. I tell them, 'You're qualified, so apply for it!'"

With a desire to help others in her community and gain steady employment while she raised children, Marisol was drawn to home care. After 16 years as a home health aide, she trained for an advanced role coaching aides and helping reduce hospitalizations for high-risk consumers. She was later promoted again.

Washington State operates an Advanced Home Care Aide Specialist program that offers additional training to home care workers to support consumers with complex care needs.

Some states have also taken steps to formalize advanced roles for direct care workers. Since 1995, Massachusetts has offered additional training to home health aides to obtain a Supportive Home Care Aide (SHCA) title specializing in care for individuals with either mental health conditions or Alzheimer's disease and other forms of dementia. The program also integrates SHCAs into care teams and provides them with additional supervision.[206] Washington State operates an Advanced Home Care Aide Specialist program that offers additional training to home care workers to support consumers with complex care needs. Workers promoted to the Advanced Home Care Aide Specialist role make an additional $0.75 per hour.[207] In 2016, the New York legislature passed a bill to create an advanced role known as the Advanced Home Health Aide (AHHA), which would permit home health aides with this title to administer certain pre-measured or pre-filled medications, such as insulin. Other advanced tasks, as well as employment and compensation structures for this role, are still being defined. The state has not allocated funding to the implementation of the AHHA, which has stalled its rollout.[208]

Considerations for Nurse Delegation

Many efforts to maximize the role of direct care workers through upskilling and advanced role development cover topics and functions that fall within workers' state-specific job descriptions. However, in some cases, as with New York's AHHA program, amendments to nurse practice acts are required to allow advanced aides to complete previously restricted tasks through nurse delegation. These amendments can be challenging to pass given concerns among certain stakeholders about changes in direct care workers' roles impacting nurses' scopes of practice or consumers' quality of care. Studies on the impact of expanded nurse delegation are rare, but a pilot in New Jersey in which home health aides received enhanced delegation to administer medication found no adverse outcomes and documented a range of positive impacts on consumers and workers.[209] Advocates of expanding nurse delegation to direct care workers argue that if these changes are implemented thoughtfully with appropriate training and supervision, they can safely address unmet care needs and help maximize nursing assistants' and home care workers' contributions to care quality outcomes.[210]

Conclusion and Implications

In reviewing the current regulations and infrastructure for direct care training programs in the U.S., this report finds the landscape for training nursing assistants, home health aides, and personal care aides to be irregular and under-resourced. There is a need to understand the considerable skill level required of direct care workers and the value their work offers to consumers, employers, and society at large. The gap between existing training regulations and programs and the demands workers face on the job is significant. It is in all stakeholders' best interests to address this gap and elevate minimum standards for direct care training across care settings and geographies. A stronger training system will both improve quality of care for people receiving LTSS and afford overdue recognition to the important role of direct care workers. Drawing on lessons learned from programs that have elevated training quality and infrastructure, we conclude with two opportunities to strengthen training in long-term care.

Invest in and Enforce Competency-Based Training

The most widely proposed recommendation for transforming direct care training in the U.S. is to establish a set of core competencies for the delivery of LTSS and require its adoption across states, drawing on existing competency models and involving diverse stakeholders in a consensus process.[211] Numerous groups have defined the core competencies that are needed to prepare direct care workers to be effective in their jobs supporting LTSS consumers. However, the recommendation of these competencies alone has not been enough to spur their widespread adoption. With adults receiving long-term care presenting increasingly complex health and social conditions, we need a workforce that is better prepared and empowered to provide high-quality services.

Building on the input of consumers, workers, and public health professionals, long-term care authorities should establish a standard for direct care competencies at the national level that draws from core competency sets that have already been developed. Ideally, these core competencies should apply to all direct care workers, regardless of payment source, with opportunities for workers to attain additional competency-based credentials to fulfill setting- and consumer population-specific direct care roles, such as home health aide or nursing aide certifications. Further, the core competencies should be accompanied by regulation that mandates their adoption by states—allowing states to then tailor their training programs, based on these universal competency standards, to meet state-specific requirements and regulations. To better serve the career development of direct care workers, states should also receive guidance on how to recognize the core competencies across care settings and integrate them with credentialing programs so that they can be applied toward other health care training.

Evaluate the Impact of Upskilling, Advanced Roles, and Care Team Integration Interventions

Efforts to increase training and compensation for this essential workforce will require better valuing the real work of direct care—and the people who provide it. Greater research attention to what direct care workers can do will help to show the complex system of LTSS payers that investing in these jobs yields a meaningful return. Upskilling, advanced roles, and care team integration are key to this aim. The failure to appropriately recognize direct care work has been aided by a lack of research on the impact of the direct care workforce on the outcomes frequently sought by LTSS payers—primarily positive client health outcomes and reductions in health care spending.[212]

State Policy Spotlight

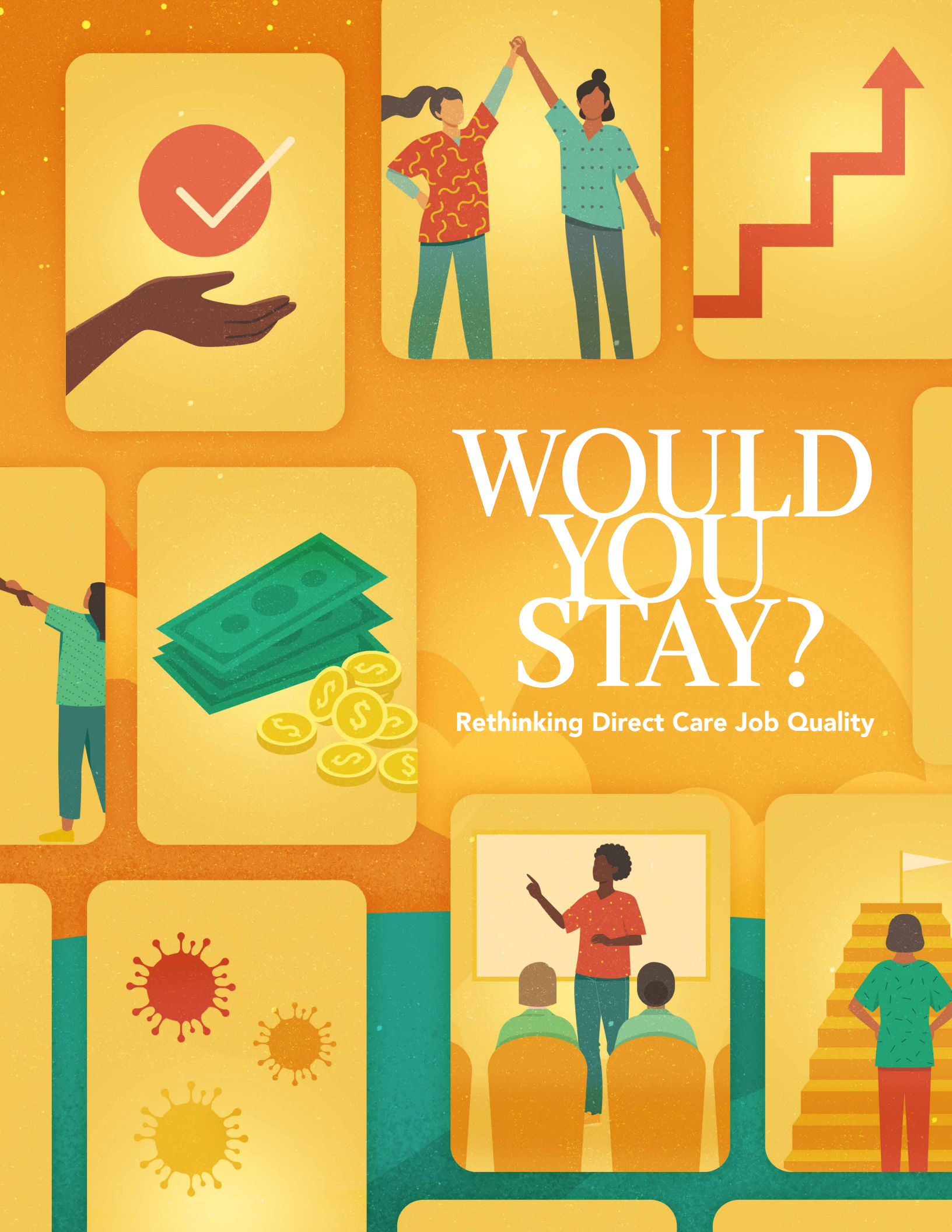
In 2005, public and nonprofit agencies in Alaska launched a program to strengthen training for the state's direct care workforce. Through a consensus process led by 27 stakeholders from across the state, the initiative established the **Alaskan Core Competencies for Direct Care Workers in Health and Human Services** in 2010 and developed a cohort of trainers using a train-the-trainer model.[213] The competencies are designed to meet Alaska's unique needs for delivering individualized direct care across LTSS settings in frontier areas. However, regulatory requirements and funding at the state level are still needed to spur widespread implementation of the Core Competencies.

Highlighting training and workflow interventions that have multiple layers of benefit (for consumers, families, workers, employers, and health systems) is important for driving needed social and economic investment in the direct care workforce.

Making this case must start with demonstrations that elevate the role of the direct care worker within health care and social service delivery. We know that direct care workers can with training contribute more meaningfully to the management of chronic and serious conditions, reductions in adverse health outcomes, and improvement in consumers' social determinants of health—in most cases while staying within states' nurse delegation rules.[214] But quality studies on such upskilling interventions are lacking, especially beyond the pilot-testing phase. With research attention and investment from public and private funders, more promising models can be developed, evaluated, and potentially scaled for greater impact.

Understanding the power of direct care work—emboldened with data from upskilling, advanced role, and care team integration demonstrations—can help change the conversation about direct care to be one of opportunity, rather than one of low-quality jobs and intractable challenges.

Highlighting training and workflow interventions that have multiple layers of benefit (for consumers, families, workers, employers, and health systems) is important for driving needed social and economic investment in the direct care workforce. Training and career pathways, however, are only part of what constitutes a quality direct care job. The next section of this report will examine all aspects of the jobs held by nursing assistants, home health aides, and personal care aides and bring attention to strategies that have been successful in improving job quality.



WOULD YOU STAY?

Rethinking Direct Care Job Quality

Introduction

Now is the time to improve direct care job quality—and direct care workers deserve this transformation.

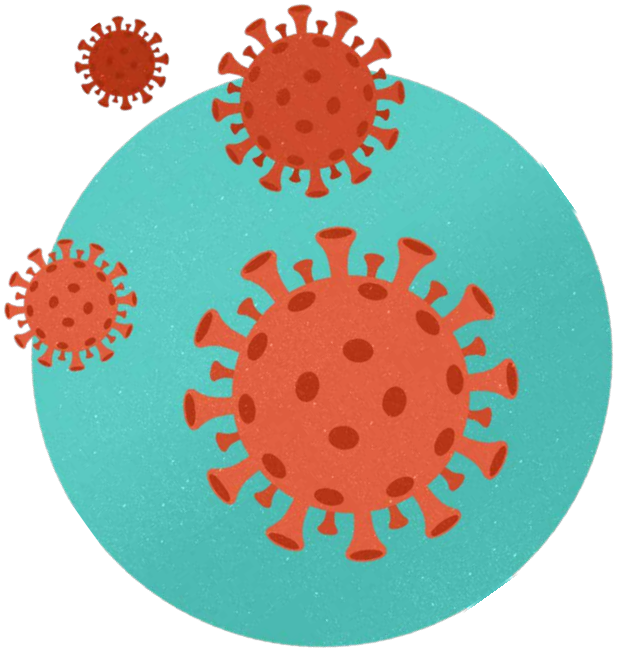
No single recent event has impacted the direct care workforce and upended the long-term care sector more than COVID-19. In its first few months, the novel coronavirus overwhelmed nursing homes, home and community-based services, and residential care settings across the country, tragically claiming thousands of lives. Direct care workers have been on the frontlines of this crisis since the beginning, at considerable risk and often without sufficient protection or support. Many workers have left the long-term care sector altogether, compounding a direct care workforce shortage that has been worsening for years.

While this health crisis has raised the visibility of direct care workers, notably through in-depth news coverage in the first few months of the pandemic, less attention has been drawn to the longstanding challenges they face. Nevertheless, tragedies can raise the collective consciousness, and in this spirit, COVID-19 offers an entry-point for systemically improving the quality of direct care jobs. About 4.6 million home care workers, residential care aides, and nursing assistants around the country provide critical daily support to older adults and people with disabilities nationwide, yet as this section of the report describes, these jobs do not pay enough, nor do they offer the training, career advancement, and other types of support to make them tenable in the long term.[215] As a result, turnover remains alarmingly high.

Now is the time to improve direct care job quality—and direct care workers deserve this transformation. As explained here, a focus on job quality allows employers and policymakers to create jobs that satisfy workers, support employers and consumers, and build our economy.

This section also explains why job quality matters for the direct care workforce and the long-term care sector. It then examines the consequences of poor direct care job quality on workers, employers, consumers and their families, and the economy. Next, this section reviews the profound and devastating impact of COVID-19 on the direct care workforce, their employers, and the individuals they serve. Finally, we propose a newly updated framework for job quality in direct care comprising five key pillars and 29 elements before concluding with two immediate opportunities for action.

The coronavirus painfully brought to light the critical value of these workers, the profound barriers they experience, and the sweeping transformations that are needed to stabilize this workforce and strengthen long-term care. This report aims to guide our country in that direction.



Direct Care Job Quality Matters

Many individuals are drawn to direct care jobs by the desire to care for others and to make a positive contribution to their communities. But these strong intrinsic motivations are often overshadowed by the extrinsic rewards of the job, like compensation, training, career advancement opportunities, support, and recognition, as well as by gender and racial inequalities. As a result, the sector struggles to recruit and retain enough workers, despite the significant demand for these jobs. This section begins by reviewing these challenges and lays the foundation for PHI's new job quality framework, presented later in the report.

LOW COMPENSATION

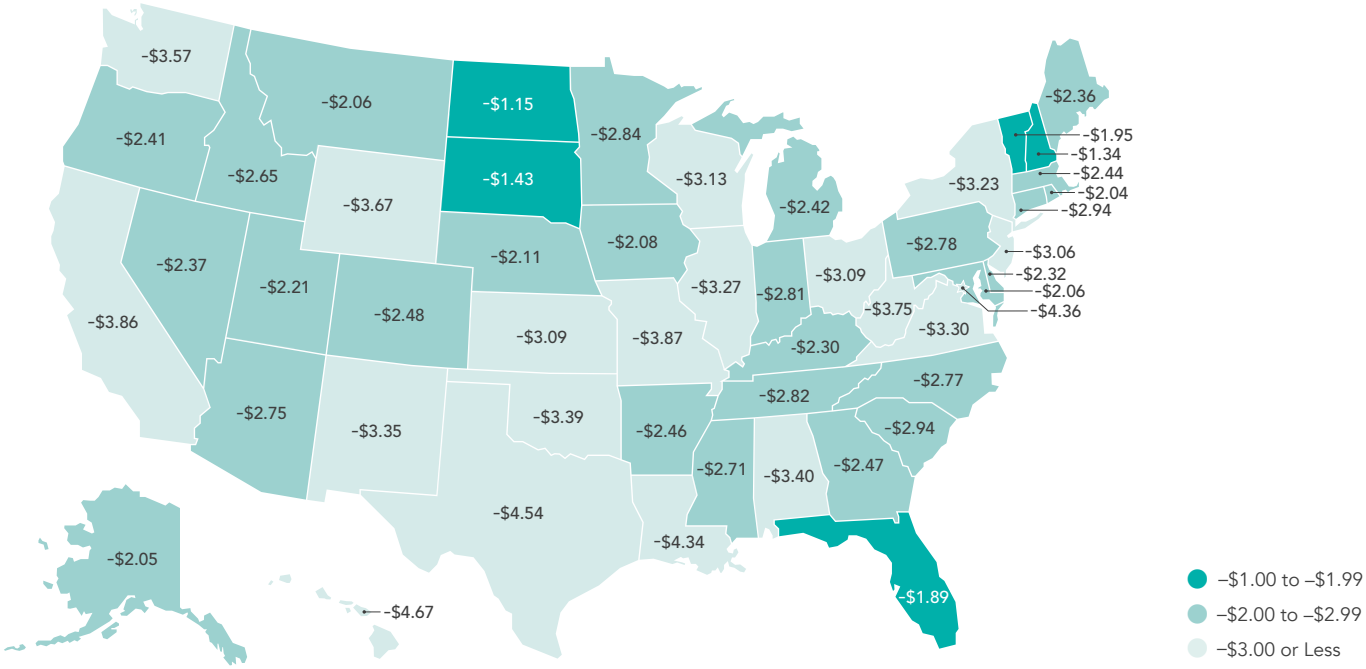
As described in the first section of this report *(It's Time to Care: A Detailed Profile of America's Direct Care Workforce)*, a preeminent characteristic of poor job quality for direct care workers is low compensation. Direct care workers earned a median hourly wage of $12.80 in 2019, an amount that has improved only modestly in the last decade (from $12.61 in 2009).[216]

As illustrated in the figures below, these low wages are not competitive with many occupations at a similar level, which makes it difficult for employers to recruit and retain enough workers. In all 50 states and the District of Columbia, the direct care worker median wage is lower than the median wage for other occupations with similar entry-level requirements, such as janitors, retail salespersons, and customer service representatives.[217] Also, in 46 states and the District of Columbia, the direct care worker median wage is less than a dollar higher than the median wage for occupations with lower entry-level requirements (like housekeepers, groundskeepers, and food preparation workers). This figure includes 23 states and the District of Columbia where direct care worker wages are lower than wages for occupations with the most minimal entry-level requirements. These findings are more egregious when one considers that the level of skill needed for

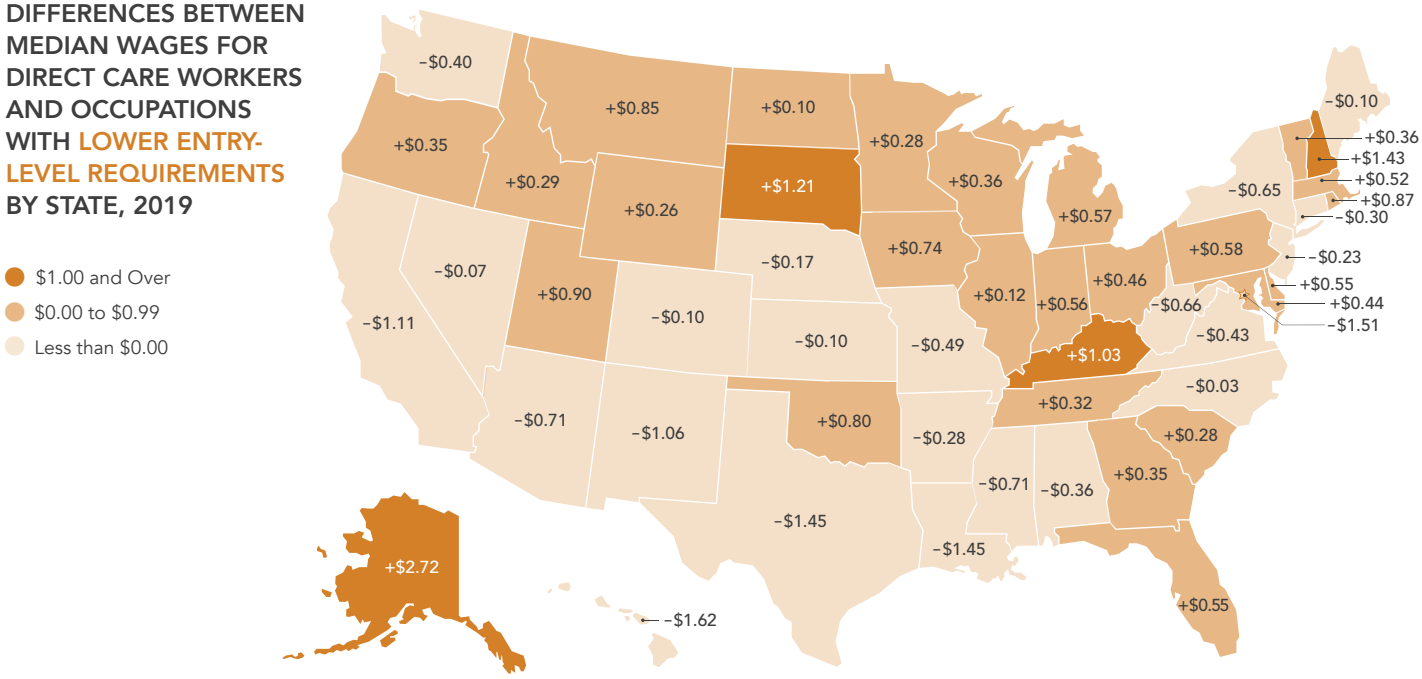
$0.19

Growth in median hourly wage for direct care workers between 2009 ($12.61) and 2019 ($12.80), adjusted for inflation

DIFFERENCES BETWEEN MEDIAN WAGES FOR DIRECT CARE WORKERS AND OCCUPATIONS WITH SIMILAR ENTRY-LEVEL REQUIREMENTS BY STATE, 2019



DIFFERENCES BETWEEN MEDIAN WAGES FOR DIRECT CARE WORKERS AND OCCUPATIONS WITH LOWER ENTRY-LEVEL REQUIREMENTS BY STATE, 2019



Sources: O*NET Resource Center. 2020. *Job Zones.* https://www.onetcenter.org/dictionary/25.0/excel/job_zones.html; U.S. Bureau of Labor Statistics (BLS), Division of Occupational Employment Statistics. 2020. *May 2009 to May 2019 National Industry-Specific Occupational Employment and Wage Estimates.* https://www.bls.gov/oes/current/oessrci.htm; analysis by PHI (September 2020).

direct care merits more robust training requirements than these occupations. (One important consideration regarding wages: in long-term care, which is primarily covered by Medicaid, low wages are often shaped by inadequate funding for the entire system and low reimbursement rates under Medicaid and other public payers that limit providers from raising wages and implementing job improvements.)

Because many direct care workers are relegated to part-time and irregular schedules by their employers or the structure of long-term care (e.g., short-term cases, financing), median annual earnings for this workforce are $20,300.[218] As a result, 45 percent of direct care workers live in or near poverty and 47 percent of workers access public assistance such as Medicaid, food and nutrition support, and cash assistance. Additionally, many of these workers lack other forms of support, such as paid sick days and paid family and medical leave. For example, a relatively recent study found that among direct care workers who took time off for family care or medical reasons between 2012 to 2017, only about one in three (or 35 percent) were able to take paid leave.[219]

INADEQUATE TRAINING AND LIMITED CAREER PATHS

The training landscape for direct care workers (i.e., training requirements, delivery systems, content, and methods) leaves many of them without the skills, knowledge, and confidence to succeed in their roles. As described in the third section of this report *(Direct Care Work Is Real Work: Elevating the Role of the Direct Care Worker)*, direct care training requirements vary significantly by state, program, and occupational role; personal care aides, for example, lack any federal requirements, and state laws for this segment of the workforce are thin and inconsistent. Furthermore, many training programs in this sector are topic-based and duration-based, instead of taking a competency-based approach that emphasizes workers' acquisition of the right knowledge, skills, and abilities. These programs are also rarely rooted in adult learner-centered instruction, which works best in the direct care context, where many workers have limited formal education. Further, as described later in this section, best practice in direct care training—which focuses on core competencies, incorporates the (informal) learning experiences of participants, and

assumes active not passive (or didactic) learning and skills demonstration—is unfortunately not the norm in this field.

Additionally, career advancement opportunities are sparse for direct care workers, and their roles are rarely maximized in the delivery of care. The lack of career pathways within direct care jobs—and from direct care into other fields—prevents direct care workers from assuming new roles with elevated titles and higher compensation. This scarcity of career paths also affects retention; a study published in 2007 of more than 3,000 direct care workers found that a lack of advancement opportunities increased intent to leave among workers within the next year.[220]

LIMITED SUPPORT, RESPECT, AND RECOGNITION

Many direct care workers function without a clear understanding from their employers about their job requirements, responsibilities, workflows, or reporting structures; this problem creates inefficiencies and misunderstandings at best, and compels mistakes and accidents at worst. Because training and support programs for supervisors in this sector are inadequate, and many supervisors enter these roles without management experience, direct care workers must often contend with supervisors who are inconsistent, inaccessible, or unsupportive. Additionally, direct care workers have limited access to supplies that promote safety for workers and consumers (such as personal protective equipment, as emphasized during COVID-19), formal peer support on the job, and assistance from their employers in accessing community-based resources, such as transportation, childcare, and eldercare supports, to name a few.

A respectful and empowering job culture is atypical in many direct care workplaces, despite research showing that these factors shape job satisfaction in direct care. Studies on direct care workers have found that workers—when asked about the "single most important thing" an employer can do to improve their jobs—cite work relationships rooted in listening, appreciating, and respecting them as workers, along with "improved communication, better supervision, and more teamwork."[221] Additionally, many employers have not integrated these workers into their guiding documents, such as their organizational missions, values, and business plans. Direct care workers also routinely work for employers without diversity, equity, and inclusion plans and practices, which can harm more marginalized workers who are dealing with the compounding effects of discrimination on the job and in their lives. In this regard, research on workforce support and job satisfaction among direct care workers has found that when negative interactions and racism on the job decrease, job satisfaction among direct care workers increases.[222] Employers might also lack protocols for rewarding retention and performance on the job, an important element of supporting workers. Finally, direct care workers are often shut out of organizational decisions and new developments within the organization. They are rarely included in consumer care teams, and other health and social care staff have rarely been trained to value direct care workers' contributions and experience.

GENDER AND RACIAL INEQUALITIES

Systemic racism and a lifetime of discrimination (across education, employment, health care, housing, and more) have concentrated people of color in low-wage sectors without adequate protection and support, resulting in severe health disparities and pronounced economic insecurity across the lifespan and from one generation to another.[223] These trends are acutely evident in the direct care sector, where the workforce is comprised primarily of women, people of color, and immigrants. Gender and racial inequalities therefore disproportionately affect large segments of this workforce, and racist and sexist assumptions have long been evoked to devalue direct care workers, denying them basic protections and transformative job improvements that would help counteract generations of discrimination.[224] Poor job quality in direct care is both shaped and magnified by these inequalities, creating harsher outcomes for more marginalized members of the direct care workforce.

State Policy Spotlight

PHI recently examined **state-level policy measures that increased wages for direct care workers across 11 states** to understand what these policies entailed, and how they were funded, distributed, and enforced.[225] This research showed that these wage increases varied in a number of ways, including with regards to: whether they aligned with a corresponding increase in reimbursement rates (under Medicaid, largely) for employers; whether they led to wages that were higher than those offered in retail and fast food, which compete with the long-term care sector for job candidates; and whether they benefitted direct care workers or a broader category of domestic workers, including housekeepers, childcare workers, etc. **We also found that enforcement for these measures was often unfunded and inconsistent across states**; few states funded the administrative costs associated with wage increases; and states with a strong union presence showed higher wage increases. These findings illustrate the importance of accounting for various contextual factors and implementation issues when designing wage policies that could truly benefit direct care workers' earnings.

Musa Manneh

CERTIFIED NURSING ASSISTANT (CNA) AT TRANSITIONS LIFECARE IN RALEIGH, NC
18 YEARS AS A DIRECT CARE WORKER

ON WHY HE DECIDED TO BECOME A CNA:

"I used to work in management for retail and restaurants. After leaving one job, I helped my friend as his private caregiver while he was traveling. When we returned from travel, management at his facility encouraged me to go into caregiving. They supported me as I became a CNA, and I worked there for five years on the floor as a CNA and Med Tech. Then I met someone from hospice who recommended that I move to that field, and I have been working for hospice ever since. It is a totally different experience going into homes to help terminally ill people. I thought it was going to be hard for me at first, but as time went on, I felt more comfortable and enjoyed being able to help in this way."

ON HIS RELATIONSHIP WITH HIS PATIENTS AND THEIR FAMILIES:

"Working in hospice, I have direct communication with both the patients and their families, and I enjoy providing support for both. I feel privileged to get to know a lot of families and help them. Sometimes families get completely agitated when a loved one is terminally ill, and sometimes they get so confused. My presence there brings them comfort. You teach them how to care for a dying loved one. You become bonded with the family. I know how much of a difference I am making. But emotionally, it is very challenging. Some months I've had three patients that pass. You just want to help them to be comfortable through this journey. But the grief takes a toll on you."

HOW CULTURALLY COMPETENT PROVIDERS ADDRESS DIVERSE CLIENT NEEDS:

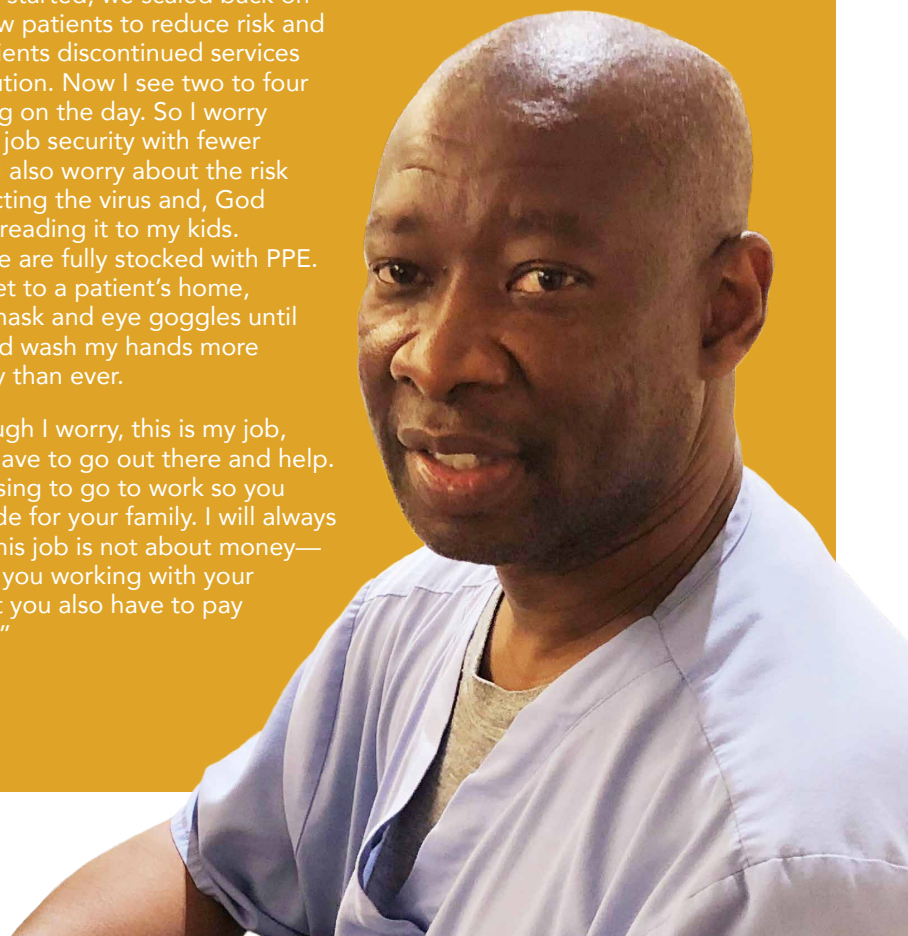
"Every month, Transitions LifeCare conducts in-service trainings for us on different topics, and they provide a very good multi-cultural conference each year. In hospice, we see patients from many different cultures, and this training helps staff learn about and become sensitive to other cultures so they can have a better understanding when providing care. For example, I am Muslim and from West Africa, so I participate on a panel and present on my culture so aides can learn what to expect if they happen to have a Muslim patient. This has proven to be very successful and makes a big difference."

ON THE IMPACT OF COVID-19:

"Prior to the pandemic, we were seeing about six patients a day. After the lockdown started, we scaled back on taking new patients to reduce risk and some patients discontinued services out of caution. Now I see two to four depending on the day. So I worry about my job security with fewer patients. I also worry about the risk of contracting the virus and, God forbid, spreading it to my kids. Luckily, we are fully stocked with PPE. When I get to a patient's home, I wear a mask and eye goggles until I leave and wash my hands more frequently than ever.

Even though I worry, this is my job, and you have to go out there and help. It's a blessing to go to work so you can provide for your family. I will always say that this job is not about money—it's about you working with your heart. But you also have to pay your bills."

A CNA who provides hospice patients and their families with a positive presence even in the midst of the pandemic, Musa views his job in end-of-life care as a blessing.*



* Individuals receiving hospice care are generally referred to as "patients" rather than "clients" or "consumers."

The Impact of Poor Job Quality in Direct Care

While direct care workers carry the brunt of the challenges created by poor job quality, the long-term care sector and the economy are also deeply impacted.

First, long-term care providers—home care agencies, nursing homes, and a range of residential care providers—also deal with the consequences of poor direct care job quality. As a result of the challenges described above, many job seekers choose not to pursue direct care careers, while existing direct care workers leave this sector for jobs in other industries that pay more and offer more stable schedules. (In the absence of strong data, researchers estimate that turnover in direct care hovers around 40 to 60 percent, a challenge that exacerbates the growing workforce shortage in direct care.[226])

The challenge of recruiting and retaining direct care workers will only magnify in the years ahead. Between 2018 and 2028, the long-term care sector will need to fill about 8.2 million job openings in direct care, including 1.3 million new jobs and an additional 6.9 million jobs that will become vacant when workers leave the field or exit the labor force altogether.[227] However, long-term care providers will fall short of meeting this demand unless job quality in direct care dramatically improves.

Long-term care consumers, who include older adults and people with disabilities, live with the negative impacts of poor-quality jobs in direct care. For example, when direct care workers have not been properly trained, consumers and their family caregivers cannot be assured their workers have the necessary skills to deliver quality care. Further, when direct care workers are not integrated into interdisciplinary care teams, their valuable insights are unlikely to be optimized—and consumers suffer.

High turnover among these workers also harms continuity of care for consumers; valuable information on their health, needs, and preferences can get lost in the constant transition from one worker to another.[228] Because direct care workers address social and emotional as well as physical and medical needs, losing a trustworthy and familiar worker can be emotionally devastating to a consumer.

Poor quality jobs also hurt the economy. As the country's largest-growing job sector, direct care will create more new jobs than any other occupation in the decade ahead.[229] However, because these jobs are poor in quality, they create other costs for the system. For example, when Medicaid reimbursement rates (and, by extension, direct care wages) are kept low to save money, these "savings" are offset by increased use of public assistance and reduced consumer spending among direct care workers. In contrast, high-quality jobs can save costs, increase consumer spending, and boost the economy, as workers put their additional income back into our financial system. Robust training approaches in direct care can also prevent costly injuries, accidents, and malpractice suits—and advanced roles in direct care can improve care quality and prevent unnecessary emergency department visits, hospital admissions, and other costly health outcomes.

All the challenges outlined in this section compound during a crisis, as the COVID-19 pandemic has demonstrated. This section examines how this coronavirus has impacted the direct care workforce and its employers, and how poor job quality (among other systemic factors) has hindered an effective response to protect workers and consumers.

As the country's largest-growing job sector, direct care will create more new jobs than any other occupation in the years ahead. However, because these jobs are poor in quality, they create other costs for the system.

COVID-19 Strikes Long-Term Care

As of the week ending December 6, 2020, nearly

410,000

nursing home residents have contracted COVID-19 and

81,790

have died from the virus.

Few people could have precisely imagined how ferociously a virus like COVID-19 would overwhelm this country and our world. According to *The New York Times*, as of October 1, 2020, more than 7.2 million COVID-19 cases had been reported in the U.S. and more than 207,000 people had died.[230] (Globally, these figures jump to more than 34 million cases and more than 1 million deaths, according to *The New York Times*.)[231] Initially, the novel coronavirus forced countries worldwide to shut down and economies to plunge; in the U.S., it sparked a recession and generated more than 36 million unemployment claims within the first two months alone.[232] As the coronavirus has continued to surge—with no end in sight—governments have been routinely rethinking how to operate a safe and productive economy.

Questions about how to move forward safely as a country are perhaps most salient in the long-term care sector. Since its onset, COVID-19 has disproportionately impacted long-term care settings and the lives of those who live and work in these environments. The populations served by direct care workers have been at greatest risk of COVID-19 complications, including older adults, who have generally weaker immune systems and are more likely to live with chronic conditions; and people with disabilities, who struggle with obtaining accessible information, adopting social distancing and handwashing protocols, and accessing COVID-19 health care and reliable long-term care (a problem rooted in disability biases and the workforce challenges described in this report).[233] People of color—who make up about 25 percent of long-term services and supports consumers and 59 percent of direct care workers—have also faced the disproportionate impact of COVID-19.[234] People of color are at higher risk of COVID-19 infections and deaths because they are more likely to be exposed (as essential workers) to the virus and have worse health outcomes rooted in a long history of structural racism, such as limited access to health care and health care coverage, discrimination in health insurance, and environmental racism (i.e., living in communities with toxic health hazards).[235] The brutal evidence of this racism can be found in the COVID-19 death toll; despite the limited reliability of race and ethnicity data on COVID-19 cases and deaths, researchers have found that in the first few months of the coronavirus, Black people have accounted for one in four U.S. deaths (or more than 24,000 people), a rate twice their population share.[236]

The earliest major outbreak of the coronavirus in the U.S. occurred in a Seattle-area nursing home, where more than three dozen residents died in a matter of weeks.[237] Though this tragedy helped spark a national nursing home lockdown—and soon after, state-by-state shelter-in-place orders—nursing homes were nevertheless devastated by the coronavirus in the months that followed—and continue to be one of the highest-risk settings. As of the week ending December 6, 2020, nearly 410,000 nursing home residents have contracted COVID-19 and 81,790 have died from the virus. Additionally, approximately 350,700 nursing home staff have had suspected or diagnosed cases of COVID-19 and 1,216 have died.[238] Nursing homes are at particular risk of COVID-19 infection and death for a variety of reasons: workers and residents are in close regular contact, nursing homes lack sufficient personal protective equipment and staff to prevent infection, and nursing home residents typically live with many of the conditions that enable COVID-19's worst outcomes—among other factors. Moreover, early data has shown that nursing homes that were primarily Black and Latino were hit twice as hard as homes that were primarily White—another stark example of how systemic racism places people of color in more danger during these moments.[239] The home and community-based services sector has also struggled to consistently provide services and protect clients during this time, but the scattered, fragmented nature of this sector and its weak data collection systems have prevented an accurate measure of COVID-19 infection and fatality rates. Nevertheless, journalists have captured numerous harrowing experiences of direct care workers being asked to work without adequate protection and forced to take desperate measures to

avoid infection, including wearing gowns made from garbage bags and spraying themselves with Lysol before and after job shifts.[240] As a result, the direct care workforce has contracted since the pandemic began; a recent study estimated that the number of direct care workers dropped by 280,000 during the first three months of COVID-19—from March to May 2020. Home care workers accounted for 232,000 of those losses, and direct care workers employed in nursing homes and assisted living settings accounted for 50,000 departures.[241]

It is clear that our flawed long-term care system—as described in the second section of this report *(We Can Do Better: How Our Broken Long-Term Care System Undermines Care)*—has hindered long-term care leaders from quickly distribute implementing a standardized, nationwide response to this crisis.[242] For example, even a strong, coordinated federal response would have struggled to quickly best practices, personal protective equipment, and other supplies to all long-term care establishments in the country, given their volume and dispersal and the lack of consistent oversight across all segments of the industry.[243] Likewise, rapidly creating and disseminating standardized COVID-19 training across nursing homes, home care agencies, and residential care settings has remained nearly impossible, given their different guiding frameworks, regulatory requirements, and conflicting interests. Finally, the chronic underfunding of long-term care, paired with the partisan resistance to increasing Medicaid funding, has meant that long-term care employers across the spectrum have lacked the resources to purchase personal protective equipment, supplies, and tests, and they have not been able to improve these jobs through hazard pay measures, paid leave, or new training approaches, including training specific to COVID-19, among other necessities. Instead, what has emerged is a perfect storm of long-term care dysfunction that has been brewing for decades—exposed and amplified by COVID-19—and direct care workers have been at its center, in harm's way.

ESSENTIAL YET UNDERVALUED

In the earliest stage of the pandemic, most states deemed direct care workers as "essential." Their clients and residents—older adults and people with disabilities in a variety of long-term care settings—relied heavily on their support and were among the groups at highest risk of COVID-19 complications.

What Early Research on COVID-19 Reveals

When COVID-19 erupted, various long-term care providers, organizations, and news sites issued surveys to understand how the crisis was affecting this sector.[244] PHI carefully reviewed 16 of these surveys (issued between March and June 2020) and found that:

- Overall, respondents expressed high levels of distress about the individual and systemic impact of COVID-19 across long-term care settings;
- Respondents expressed significant concerns about shortages in personal protective equipment;
- Most staff reported receiving training on COVID-19 (mainly through virtual platforms), though this training tended to focus narrowly on safety measures rather than on broader issues related to COVID-19 care; and
- Even as staffing shortages in long-term care settings worsened during this time, incentives to recruit and retain workers remained marginal.

More research is needed to understand how long-term care leaders have managed the crisis, including by surveying direct care workers to directly capture their thoughts and experiences in the field.

Further, two of the most important measures for stemming the spread of the coronavirus—social distancing and remote work—have not applied to direct care workers, since direct care requires a range of in-person tasks that cannot take place remotely. While technology has made modest progress in strengthening home care delivery by training workers, facilitating communication across the care team, and augmenting in-home supports to consumers, direct care workers remain as the primary support in home and community-based services.[245] As millions of people around the country have sheltered at home, direct care workers have risked their lives every day.

A Closer Look at Data Collection

The COVID-19 crisis vividly illustrates **the lack of systematic data on the direct care workforce**, and how this limitation has prevented state leaders from identifying and resolving workforce shortages when coronavirus "hot spots" have emerged in certain geographic areas. Across the board, states lack strong data systems that can measure and report figures on workforce volume, stability, and compensation, among other variables. **But this pandemic has also revealed other urgent data gap**s: real-time survey data from workers on their needs and experiences in the field; data on workers' access to paid leave, childcare, personal protective equipment, and other supports and supplies; information on training and skill levels across different topics; disaggregated data by gender, race/ethnicity, and other demographic characteristics that would provide a clearer picture on disparities in this sector—and much more. Robust data on this workforce will keep workers and consumers safe and strong as this country navigates COVID-19 and beyond.

Unfortunately, the "essential" designation has not translated into significant boosts in government funding for long-term care employers.[246] The various federal relief bills on COVID-19 have largely left out direct care workers and provided insufficient funding to home care agencies, nursing homes, and residential care settings. As a result, many providers in this sector have scrambled to protect both workers and consumers, while denouncing the lack of sufficient personal protective equipment, supplies, and support. They have expressed concerns that they remain lower in the distribution chain than hospitals and emergency care clinics, despite protecting some of COVID-19's most at-risk populations.

In March of this year, PHI surveyed its network of providers and workers (among others) to understand how they were managing this pandemic and what they needed. The survey showed a sector in crisis. One employer wrote: "Our staff is extremely stressed about dealing with the pandemic. They are concerned not only for the safety of themselves and their families but for their consumers as well. These are dedicated individuals who work hard every day. This has made their job especially difficult and for less pay then they deserve." With little government support for their employers, direct care workers have been navigating their high-risk jobs with constant anxiety since the pandemic began, and many workers have been opting not to work or to leave these jobs altogether. As low-wage earners, many direct care workers live in multigenerational households out of economic necessity, which multiplies both the risk of COVID-19 transmission and their fears about passing on the virus to their families and consumers. (Nationwide, one in five Americans, totaling 64 million people, live in multigenerational households.)[247] A qualitative study of 33 New York City home care workers supporting consumers during COVID-19 found that workers felt invisible, despite being on the frontline of this crisis; were deeply concerned about contracting and transmitting the virus to consumers; and had different and often inadequate levels of support from their employers, including information, personal protective equipment, and training. These workers also sought information and support from sources outside their agencies (e.g., news outlets, websites, and peers), and were forced to make difficult choices, such as working and risking exposure or nor working and risking a financial hit. Additionally, 12 percent of these workers believe they contracted COVID-19 (during the study period) and took time off to recover.[248]

Echoing the results of this study, PHI's March survey (described above) also captured workers' fears and anxieties as the pandemic spread with alarming speed. One direct care worker wrote: "I am a direct care worker with young children. I am working seven days a week with no extra pay, no assistance, and no health coverage. I have no childcare, and I may have to leave my job to care for my family. But then I don't know how I will pay my bills, and I am just making it through now with the pay I get." Another worker feared for their family members and was outraged by the invisibility of direct care workers in the public response: "We are also very concerned with being exposed from other caregivers and taking it home to our families. We also have been forgotten when it comes to hazard pay or any incentive to continue to risk our lives to be called essential." And another worker captured the desperation and fatigue of the moment: "I am tired, exhausted, and worry every day about contracting COVID or any (of the other) things going around. My immune system is low due to the stress of these things every day. We are the ones in the homes making sure client needs are met, we get mentally drained."

Ricardo Araujo, a Home Health Aide at Cooperative Home Care Associates in the Bronx, NY who was featured in the first section of this report, perhaps captures best the essence of this frightening time: "I live with my sister and my nephews. They are staying home now while I have to leave for work, and I'm scared to bring anything home from the streets that could harm them. Even if I wash my hands all the time, what about the clothes I'm wearing? What about my coat? I'm still touching my uniform and getting stuff out of my pockets during the day. I wish I knew more about those things. But the only thing that I can do is try my best to be safe out there."

Zulma Torres

HOME HEALTH AIDE AT COOPERATIVE HOME CARE ASSOCIATES (CHCA), BRONX, NY
23 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A HOME HEALTH AIDE:

"Back in 1997, I found myself in a bind. My youngest daughter was two years old, my son was in the hospital, and we were living with my mother in the Bronx. I needed a job.

My sister-in-law was taking a training nearby with Cooperative Home Care Associates (CHCA) and suggested I do the same so I could get a job as a home health aide. I didn't have any experience, but I took a chance. There were so many things I wanted for my family, but I needed a job before any of them could be possible. So I took the training and passed my tests, and CHCA put me to work. It was really hard in the beginning. But with time, I found that this is my purpose and where I belong."

ON THE IMPACT OF COVID-19 ON HER CLIENTS:

"We aren't hearing as much about home health aides in the news, but we are dealing with our own crises during this coronavirus pandemic. It's a scary time right now for us, as well as for our clients and their families. Some clients don't want anyone in their homes, and we are scared when we get to their homes. Even though they need our services, some of them don't want them now. But what happens to them if we don't go in? Who will take care of them?

One of my clients watches the news 24/7 and constantly hearing about the virus can really get to you mentally. I don't blame her for worrying because we are all at risk, so I am understanding and I listen. But in my case, I do my best to be careful and then leave the rest to God."

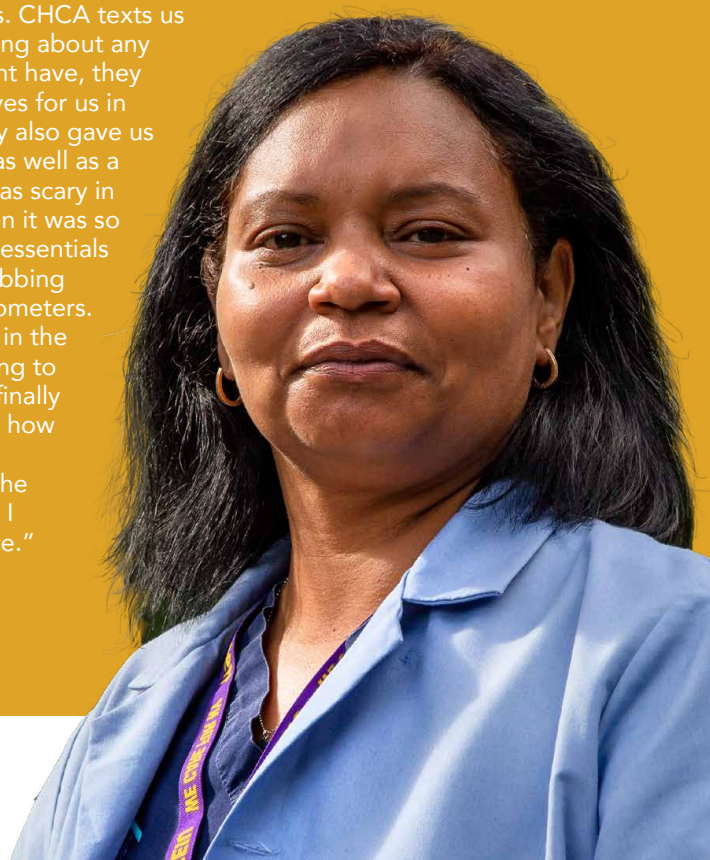
ON HER RESPONSE TO THE RISKS OF INFECTION:

"I live in Connecticut now and take three trains to get to New York for my night shift. I take the same Metro North train line that had one of the earliest coronavirus cases, so it was extremely scary. For the first couple weeks, I would try to disinfect my area the best I could and would always wear my gloves and mask. During those nerve-wracking, three-hour train rides to work, I would pray. Since then, my son-in-law started driving me because my family was so worried about me taking public transportation. I'm grateful for his help, but even without it nothing would stop me from showing up for my client because I know she needs me."

ON THE TYPES OF SUPPORT SHE HAS NEEDED DURING THE COVID-19 CRISIS:

"CHCA has done a great job giving us guidance throughout the pandemic, and I know what I need to do to prevent spreading the virus. CHCA texts us every morning asking about any symptoms we might have, they have boxes of gloves for us in the office, and they also gave us disposable masks as well as a washable one. It was scary in the beginning when it was so hard to get all the essentials we needed, like rubbing alcohol and thermometers. I went everywhere in the Bronx one day trying to find Lysol. When I finally found it, you know how much it cost? $15. I couldn't believe the price gouging, but I didn't have a choice."

With more than two decades of experience as a home health aide, Zulma finds deep purpose in caring for her clients and believes that the COVID-19 crisis in New York City has only underscored how critical direct care workers are to families.



The constant tension between short-term emergency measures and long-term job improvements for this chronically underfunded sector only affirms the importance of transforming it once and for all.

Recognizing that inadequate compensation drives many direct care workers out of these jobs and turns away potential new job candidates, several states and many providers have been increasing wages in the short term for direct care workers. In April, for example, Michigan increased pay temporarily for home care workers employed by Medicaid-funded agencies, offering a $2-an-hour raise, while New Hampshire provided a $300 weekly increase to all Medicaid-funded direct care workers.[249] Likewise, that month, Arkansas announced a pay increase for all direct care workers employed by Medicaid-funded providers, boosting their base pay with an additional $125 to $500 a week, depending on hours worked and the acuity of beneficiaries.[250] These hazard pay measures have expired, though new waves of the virus might require states to issue new increases. The constant tension between short-term emergency measures and long-term job improvements for this chronically underfunded sector only affirms the importance of transforming it once and for all.

A BROKEN SAFETY NET, LIMITED EMPLOYMENT SUPPORTS

As with many other U.S. workers, direct care workers struggle with the consequences of our country's broken social safety net and a lack of employment benefits and supports to help them through this moment. Limited access to paid sick leave has prevented many direct care workers who become infected with the coronavirus from taking paid time off to recover. In this context, a number of states have instituted mandatory pay for workers who take time off to recover from COVID-19 without providing employers additional reimbursement funding to cover these costs. Restrictions on paid family and medical leave has also limited the support that direct care workers can offer to family members. Additionally, while the Affordable Care Act has greatly expanded health coverage for direct care workers, about one in 10 of these workers still goes without health insurance and therefore faces financial catastrophe in the event of a health crisis.

Finally, as schools have closed fully or partially to contain the coronavirus, essential workers with children, including direct care workers, have been burdened with finding affordable childcare options, since targeted financial assistance has only been provided by some states, such as New York.[251]

Because of their low pay, direct care workers have been forced to choose between going to work and possibly contracting the virus—with no safety net to allow them to recover—or staying home and being unable to pay for necessary costs such as food, electricity, and rent. As a result, direct care workers and their employers have been even more strained to deliver quality care.

TRAINING AND RECRUITMENT IN A CRISIS

As described in the previous section of this report, training standards for direct care workers vary across states, programs, and occupational roles, which leaves many workers without the preparation and skills to deliver quality care. Inadequate training in this workforce contributes to poor job quality in this sector—and has been exacerbated during the COVID-19 crisis.

The COVID-19 pandemic has surfaced three distinct concerns related to training direct care workers: inadequate training for these workers related to both COVID-19 and infection control and prevention; the possibilities and limitations of virtual training in strengthening the direct care job pipeline during this high-demand moment; and the inherent challenges of a new federal measure that has allowed nursing assistant candidates to bypass federal training requirements to take on these roles.

The COVID-19 crisis has called into question the preparedness of workers and their employers to manage this virus and infection control and prevention. A variety of COVID-19 training modules have emerged from employers and other leaders in the industry. However, the broad heterogeneity of these modules suggests that the content and quality vary by program, and this sector's fragmented training infrastructure likely means that

large pockets of this workforce might not be trained on the specifics of this virus. Nursing homes are routinely cited for infection control and prevention violations despite having more robust training standards than other segments of long-term care, which raises questions about this sector's ability to keep workers and residents safe.[252]

COVID-19 has raised another training challenge for the home care sector: how to train new home care workers effectively within the existing (mostly in-person) training system, especially in a time of urgent demand. In response to this barrier, many training providers and employers have been exploring ways to move training content online, at least in the short term. However, a new, entry-level virtual training program for home care workers will require revising training regulations to sanction this new approach, a complicated and time-consuming process. Also, sector-wide acceptance of virtual training could be elusive given concerns about the efficacy of virtual training in the home care sector.[253] Such an approach would also require significant funding for creating and evaluating these virtual training programs (in light of the significant gap in training infrastructure in this sector), quickly adapted curricula, and the implementation of new technologies. Many low-wage workers also face various technology-related barriers that would prevent them from participating in virtual training, including limited access to high-speed internet and adequate data plans and devices. To date, there are no concrete plans for any virtual, state-approved, entry-level home care training program.

Finally, a new federal rule regarding training requirements for nursing assistants has highlighted the tension between short-term emergency responses and long-term consequences. In the first few months of the coronavirus, the federal government made it easier to become a nursing assistant in order to ease the sector's staffing crisis.[254] The Centers for Medicare and Medicaid Services issued a temporary waiver that allowed nursing homes to bypass the typical 75-hour training requirement and testing rules for nursing assistants, as long as these new workers could "demonstrate competency in skills and techniques necessary to care for residents' needs." Advocates have questioned the implications of this change: suspending training and certification requirements would likely mean that many workers would enter the field without the complex array of skills required to deliver quality care and protect themselves and their residents, especially in a high-stress COVID-19 environment. This waiver will likely expire at the end of the federal public health emergency order, which has currently been extended to October 2020.[255] In the long term, if this rule remains in place beyond the end of the emergency order, it could bring into the sector a population of less-qualified nursing assistants—unless stronger competency testing standards are implemented to assess these new workers.[256]

Additionally, by not providing these temporary workers a pathway to becoming certified nursing assistants at the end of this emergency period, this federal approach would contribute to the systemic recruitment and job quality challenges facing this workforce and the many job quality concerns outlined in this report. As one solution to this problem, robust bridging programs could allow nursing assistants employed under the temporary waiver to receive full training and certification.

The COVID-19 crisis has called into question the preparedness of workers and their employers to manage COVID-19 and infection control and prevention.

Erika Honan

HOME CARE PROVIDER AND CAREGIVER EMERGENCY RESPONSE TEAM (CERT) PROVIDER AT HOMEBRIDGE IN SAN FRANCISCO, CA
1.5 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A CAREGIVER:

"I became a Home Care Provider at Homebridge in June 2019 after I completed a recovery program for alcoholism. Most of my career before that point had been in the restaurant industry or taking care of animals. But when I went back into the workforce after my program, I knew I wanted to give back to the community in a more significant way, and I found in-home support service care. My work feels very meaningful now. Rather than just going to work to make money, I'm working to make sure people get the attention they need so they can be okay. It can get pretty intense at times, but the care is really important to the clients and that gives me motivation. I am very passionate about helping people, and I recently just went back to school part time to earn my master's degree in social work."

ON HER RELATIONSHIP WITH HER CLIENTS:

"I make sure to always remember that my job is to honor and respect my clients and help them keep their dignity. I help them change their clothes, bathe, keep their environment clean, and get the food they like to eat. A lot of them want to maintain their independence, so rather than just doing things for them, I start by asking them how they like things done. To me, that is their basic right as a human and that's how I establish trust with them.

Before COVID-19, I had six to eight clients I would see regularly. We were close, and I know they looked forward to seeing me. For some people, I was really the only person they would ever see regularly. As part of Homebridge's Caregiver Emergency Response Team (CERT), I'm mostly seeing clients who are sheltering in place at hotels because they are homeless. Similar to many of the regular clients I used to see, they are also living in poverty and rely on government support, have disabilities or are older adults, and several face issues with drugs or alcohol. With CERT, I am seeing up to 25 clients now at times."

ON THE IMPACT OF COVID-19:

"I was really scared at the beginning of the pandemic. Nobody knew what we were walking into. But our training prepared us for how to protect ourselves. We have all the protective equipment we need and systems in place to change into PPE before and after seeing clients. But I'm still terrified of getting somebody else sick. That's my biggest fear, and because of that I don't really spend time with anyone other than my clients. My mom has cancer and my best friend has a pre-existing condition. My boyfriend and I used to spend every weekend hiking together, but we basically don't see each other anymore so he won't get exposed. Outside of work, I'm by myself all the time now. That part has really affected me. I think isolation in general is a challenge for caregivers, but with the risk of COVID added, it has really been very taxing. I'd say that's the hardest part of the job for me."

Less than a year after becoming a home care provider, Erika joined CERT to support clients infected by or exposed to COVID-19. In addition to caring for clients in their homes, she also serves homeless clients who are living in hotels during the pandemic.

PHI's Five Pillars of Direct Care Job Quality

Poor job quality has persisted in the direct care workforce for decades, yet this workforce has not received a commensurate level of attention in the job quality discourse and literature—with one exception. As part of the 2002 to 2006 "Better Jobs Better Care (BJBC)" initiative that tested and demonstrated the correlation between quality direct care jobs and quality care, PHI and LeadingAge (then the American Association of Homes and Services for the Aging) developed a framework for job quality in this workforce.[257] This framework, "The Nine Elements of a Quality Job for Caregivers," was organized across three dimensions—compensation, opportunity, and supports—and delineated nine areas of job quality for this workforce including: (1) family-sustaining wages; (2) family-supportive benefits; (3) full-time hours, a stable schedule, and no mandatory overtime; (4) excellent training; (5) participation in decision making; (6) career advancement; (7) resources to resolve barriers to work; (8) supportive supervisors; and (9) owners who lead quality improvement efforts. This seminal framework informed the BJBC initiative and has guided PHI's workforce interventions, policy advocacy, and research and analysis over the years.

Yet the direct care sector has evolved considerably since that time. Over the last two decades, leaders in this field have developed new workforce interventions, expanded the research literature, and introduced an array of public policies that have modestly improved the quality of these jobs while emphasizing how much work remains to be done. A new, more modern job quality framework is urgently needed for this workforce.

This section of the report details PHI's new direct care job quality framework, which comprises five pillars and 29 elements, each with its own rationale and key strategies. While many of the elements are framed through an employer lens, the solutions for this job transformation will also require systemic policy and industry reforms. The final section of this report provides a wide-ranging slate of policy and practice recommendations for actualizing these job improvements.

QUALITY TRAINING

A quality direct care job should ensure that all workers acquire the skills, knowledge, and confidence to succeed in their complex roles.

Training is accessible, affordable, and relevant to the job

In a quality job, direct care workers have access to training that is relevant to their roles and responsibilities. Training should be easily accessible to workers—including people with disabilities and people with different learning styles—and not require workers to travel long distances. If the training is virtual, workers should be supported in having the right hardware, high-speed internet, and tech support to complete the training program. Training should also be free or low cost, and workers should ideally be paid for time spent while completing the training. Furthermore, programs should meet relevant training requirements and exceed them where possible to ensure workers have the full range of skills and knowledge they need to perform their jobs successfully.

A Note on Job Quality Frameworks

Though definitions and frameworks vary across sectors, job quality generally refers to the range of job attributes that shape workers' experiences and ultimately their health, economic security, and quality of life. Many of these frameworks include elements such as wages, benefits, scheduling, training, and career advancement, as well as elements that support personal growth and opportunity, such as belonging and recognition.[258] **Overall, quality job frameworks help employers, workforce development professionals, and policymakers assess and create jobs** that lead to multiple positive outcomes—from improved job satisfaction, economic security, and career mobility for workers to reduced turnover, higher productivity, and cost savings for employers and the economy. High-quality jobs also strengthen the economy as workers earn and spend more, and their reliance on public benefits decreases.[259]

Industry Feature

Training programs that are high-quality, entry level, and continuous are essential to job quality in direct care. To help implement a 2007 Washington State law and 2012 ballot initiative designed to improve the training landscape for direct care workers, **SEIU 775 Benefits Group** (a labor-management partnership between the state and SEIU 775) leads a training program for the state's home care workers. This state-wide program includes both entry-level training and continuing education courses.[260] According to SEIU 775 Benefits Group's website, this training program represents "Washington's second-largest educational institution, providing more than 6 million hours of essential home care training since 2010." Demonstrating the importance of a multi-faceted approach to improving job quality for direct care workers, SEIU 775 Benefits Group also offers "affordable, high-quality medical, prescription, vision, hearing, emotional wellness and dental plans," a secure retirement plan option for home care workers, and job matching.[261]

Content covers a range of relational and technical skills associated with quality care

A quality direct care job should train workers on the range of skills required in direct care, which are delineated in the previous section of this report. Direct care workers should receive training on supporting individuals with activities of daily living (bathing, dressing, eating, toilet care, and mobility) and instrumental activities of daily living (preparing meals, shopping, housekeeping, managing medications, and attending appointments). In addition, training should be offered on how best to navigate the physical, social, and emotional demands of direct care and on health-related topics and best practices for supporting individuals with complex conditions and care needs—a growing population.[262] A direct care worker should feel confident in delivering care no matter who they are supporting or what challenges may arise.

Competency-based, adult learner-centered instruction with opportunities for hands-on learning

Quality direct care training should be competency-based (i.e., focused on acquiring the specific knowledge, skills, and abilities required for the job) rather than the current norm in which training programs focus on vaguely-defined topics or time spent receiving instruction, regardless of what's learned. Various direct care competency sets are in circulation in the field, commonly covering areas such as communication, infection control and prevention, safety and emergencies, person-centered practices, and more.[263] Quality direct care training should also be adult learner-centered, a type of instruction that has been shown to work best in direct care, leading to high satisfaction among trainees.[264] As described in a previous PHI report "The adult-learning classroom is oriented around the students' learning process—not the teacher or trainer's expertise—with an emphasis on inquiry, interaction, application, and reflection."[265]

Programs account for cultural, linguistic, and learning differences

Quality direct care training should account for the full diversity of direct care workers. First, given the significant presence of people of color and immigrants in direct care, training approaches should be responsive to the multicultural norms and practices of each local community and assessed for implicit bias and disparities in learning outcomes and access. Training should also be provided in multiple languages when necessary, based on local trainees' linguistic needs. Finally, because trainees have various learning styles and differences, training programs should be as engaging and accessible as possible.

Documentation and verification of program completion and/or certification, with connections to employment

When direct care workers complete a training program and/or become certified, this information should be centrally documented so that workers can share their training credentials and certifications when job hunting, and employers can verify job candidates' qualifications. This systematized approach can also prevent certain workers from undergoing unnecessary additional and costly training when transferring to a new job—recognizing that moving from one long-term care setting to another requires additional training, and workers cannot move from state to state without meeting the new state's training requirements. For independent providers (i.e., direct care workers who are employed directly by consumers), a matching service registry—an online job board where consumers and workers find each other based on needs, preferences, and availability—can provide a useful platform for this type of documentation.

FAIR COMPENSATION

A quality direct care job should enable workers to achieve economic stability, safeguard their health, and plan for the future.

Living wage as a base wage

A quality job for direct care workers requires a living wage that accounts for the local and regional cost of living (a formula based on common expenses such as housing, food, clothing, transportation, and more). This living wage should be set as a base wage, with benefits, raises, bonuses, and other job supports layered on top. As noted earlier, direct care workers earn a median hourly wage of about $12, which has remained virtually stagnant over the last decade, and this substandard wage drives many of these workers into poverty or out of this sector. Establishing a base wage for direct care that is aligned with the cost of living makes it affordable for workers to pursue these jobs.

Access to full-time hours

Direct care workers should have access to full-time hours that increase their earnings, promote economic stability, and decrease the need to obtain multiple jobs to make ends meet. Of note, 31 percent of direct care workers work part time, including 26 percent who work part time due to family or personal obligations and five percent who work part time because of economic conditions in their employer or the economy.[266] As well as ensuring access to full-time hours for workers who desire them, these figures show the importance of providing additional supports such as childcare and eldercare—described in the next element—that would allow workers to meet their personal and family needs, take on additional hours, and thereby boost their incomes.

Consistent scheduling and notice of scheduling changes

As an essential aspect of direct care job quality, consistent scheduling (including notifying workers about schedule shifts) promotes job stability and reduces stress for workers, ensuring they can plan their lives outside of work. Research shows promotes irregular or unpredictable scheduling among low-wage workers can contribute to work-family conflict, work-related stress, and income instability.[267] For consumers, more consistent schedules for workers can improve care outcomes for consumers.[268] To ensure consistent scheduling, employers need reliable systems and processes that track their staff, including schedules, hours worked, worker and consumer preferences, and more—a need that technology could help fulfill.[269]

Access to employment-based health insurance

Access to employer-sponsored coverage (or plans offered through unions, where applicable) is crucial for direct care workers to manage their health and remain productive. When these entities provide health coverage, workers avoid the stress of finding health plans on their own or financial catastrophe when illness or injury strikes. Business leaders have also observed that employer-sponsored plans can improve job satisfaction and promote recruitment and retention.[270] Nationwide, while 52 percent of direct care workers have health coverage through their employer or union, 13 percent lack any form of health insurance, including public coverage or an individually purchased plan.[271]

In Focus: PHI's Workforce Interventions

Home care delivery in rural areas poses unique challenges for both workers and consumers. Since 2017, PHI has collaborated with providers in Minnesota and Wisconsin to transform the quality of home care jobs in rural areas of these states. Central to this initiative are strategies that train and support home care workers to have more expansive roles in this sector, **elevating their role in health care delivery**. PHI is also working with these providers to develop a replicable entry-level training and employment model for rural communities, implement a slate of recruitment and retention strategies, and build awareness through social media of the key challenges facing home care workers and consumers in these states. The results from this initiative will help guide direct care workforce interventions in other rural regions around the country.

A quality direct care job should offer additional levels of compensation—beyond the base wage—to recognize workers' contributions and commitment, as well as to support their economic well-being and promote recruitment and retention.

Paid sick days and paid family and medical leave

Paid sick days allow workers to take time off to recover from an illness, while paid family and medical leave supports workers to manage care for themselves or a family member through a severe medical challenge or to bond with a new child. Unfortunately, many employers do not offer these benefits, and federal and (most) state policy options are limited in scope.[272] Offering these benefits would also improve recruitment and retention for employers by making the job more attractive to workers.

Grief support and bereavement leave

Direct care work is emotionally demanding, especially when a worker loses a client or resident (a pronounced reality in a COVID-19 era, given the staggering mortality rates across long-term care settings). Likewise, direct care workers experience deaths in their own lives, as family members and friends pass away, which can affect their emotional presence on the job. A quality direct care job includes access to grief support programs and paid bereavement leave, both of which can help workers cope with loss and manage their mental and emotional health over time.

Financial support and asset development programs

Direct care workers, like other low-wage workers, may not have had the opportunity to access financial products or to develop financial literacy skills that can help maximize their economic stability, build their assets, weather short-term economic challenges, and plan for the future. A quality job in direct care can overcome this barrier by connecting workers to financial support and asset development programs. These programs typically assist workers in opening checking and savings accounts, obtaining tax credits (such as the Earned Income Tax Credit), and managing financial matters slate budgeting, building credit, debt management, savings plans, and more. Empowering workers with financial supports can also reduce poverty for generations and improve their overall health.[273]

Access to merit, longevity, and other base pay increases

Many direct care jobs offer the same wage regardless of a worker's training, skills, experience, or performance. A quality direct care job should offer additional levels of compensation—beyond the base wage—to recognize workers' contributions and commitment, as well as to support their economic well-being and promote recruitment and retention. Merit pay rewards direct care workers for their success on the job, while longevity pay honors the long-term contributions of employees; both offerings encourage high performance and help reduce turnover. Workers could also receive other types of additional pay, such as bonuses tied to a company's year-end performance or a holiday, which would promote job satisfaction and longevity on the job.

QUALITY SUPERVISION AND SUPPORT

A quality direct care job should offer workers the support and supervision they need to work safely and effectively.

Clear presentation of job requirements, responsibilities, workflows, and reporting structures

In a quality direct care job, a worker clearly understands their job requirements and responsibilities, as well as their employers' workflows and reporting structures. A fuller picture of the job—ideally introduced during the onboarding process and then reinforced over time—helps workers deliver better care and contribute to the organization's success. On the other hand, a lack of understanding about the job can lead to mistakes, accidents, and other negative outcomes for workers and consumers.

Consistent, accessible, and supportive supervision

Poor supervision in many industries, including long-term care, drives workers away and contributes to costly turnover rates. A quality job in direct care must provide consistent, accessible, and supportive supervision that helps workers succeed. Unfortunately, these workers are often unaware of who their supervisors are or have more than one, which can create confusion—and many supervisors are promoted into their roles without proper training or support. To be successful, a supervisor must be accessible to their reports, engage in clear and consistent communication, and encourage supportive problem solving that helps resolve daily challenges and empowers workers to flourish in their roles.[274]

Access to personal protective equipment and other supplies to ensure worker and client safety

Safety must be guaranteed in a quality direct care job. As COVID-19 demonstrates, a lack of safety measures for direct care workers places them and consumers in peril. Direct care workers should have sufficient access to personal protective equipment such as gloves, masks or face shields, gowns, and hand sanitizer. Workers should also be trained and educated in infection control and prevention practices. Moreover, especially during a crisis, workers should be privy to the latest developments in preventing and containing the spread of infectious disease. When workers are safe and feel protected, their health and productivity remain strong.

Connection to peer mentors and peer support networks

Given the numerous and complex demands that direct care workers face on the job, peer support can be profoundly beneficial. Especially during their first few months of employment, direct care workers can turn to peer mentors to help answer their questions, address their concerns, understand their new roles, and develop their knowledge and skills. Over time, peer mentors and peer support networks can continue offering their fellow workers regular support and guidance, contributing to a culture of belonging and high retention.[275]

Connection to community-based organizations to address employment-related barriers

A quality job in direct care should connect direct care workers to community-based organizations that address employment-related barriers. As a result of the legacy of low wages in this field, to succeed on the job, direct care workers might need support with other aspects of their lives, such as housing, transportation, childcare, family caregiving, immigration-related issues, and more. While no single employer can address all these needs, they can play an important role in developing relationships with community-based organizations and providing referrals for their employees. Employers can also institutionalize this referral practice by designating its responsibility to a single staff member.

A quality job in direct care must provide consistent, accessible, and supportive supervision that helps workers succeed.

Industry Feature

Developed and championed by The Green House® Project, the Green House model has been adopted by hundreds of nursing home and residential care leaders since its creation in the early 2000s. The model relies on a few key concepts, including providing a **real home** for residents, with typically no more than 12 residents per home; ensuring a **meaningful life** for residents where they direct their eating times, sleeping patterns, social activities, and more; and designing self-managed teams of **empowered staff**, primarily comprised of nursing assistants fulfilling a **universal worker** role. The growing evidence on this model suggests that it can improve care quality outcomes, reduce costs, and decrease turnover among direct care staff.[276]

RESPECT AND RECOGNITION

A quality direct care job should honor the expertise, contributions, and diverse life experience of workers.

Direct care workers reflected in organizational mission, values, and business plans

In a quality direct care job, an organization centers direct care workers in all the documents that shape its direction and communicate its core values, such as its mission statement and business plans. As one example, Cooperative Home Care Associates, a worker-owned home care agency in the Bronx, includes in its mission statement a central role for workers: "to give workers opportunities to learn and grow as members of a health care team." Organizations should also incorporate these worker-centered ideals in its values and daily practices.

Diversity, equity, and inclusion formalized in organizational practices

Given the diverse demographics of this workforce and the historical impact of social injustice on this sector, an intentional approach to diversity, equity, and inclusion is central to direct care job quality. As described in PHI's research series on racial disparities in the direct care workforce, employers should implement race-explicit workforce interventions that collect race-related outcomes data and set hiring and retention goals to diversify their workplaces, among other strategies.[277] Research also shows that diverse and equitable organizations experience improvements in recruitment, retention, employee job satisfaction, innovation, reputation, and financial performance, among other benefits.[278]

Consistent feedback is given on work performance and retention is celebrated

As described in the previous section of this report, direct care workers' contributions often remain invisible and, in turn, unrecognized by employers. Direct care workers should be recognized for their strong performance and for their commitment to the job. This recognition works best when it honors workers for specific outcomes (communicating precisely why a worker is being recognized), and when employers develop formal recognition programs so that less visible employees are not left out (which may happen when recognition is provided only on an informal or ad hoc basis). Further, employers can create methods for employees to honor each other, such as through bulletin boards in public spaces. Moreover, they should share recognition widely—through newsletters and social media, for example.[279] Companies with "recognition-rich" cultures experience 31 percent lower turnover than their peers—an example of how formal recognition approaches benefit the entire organization.[280]

Opportunities for direct care workers to influence organizational decisions

Given their unique knowledge and insights, direct care workers should be integrated into an organization's decision-making processes. Whether through advisory bodies, workgroups, topic-focused committees, or other mechanisms, workers should be able to bring their unique wisdom from the field to an organization's operations and business strategies, particularly operations matters that directly impact their work and job quality, such as communication workflows. Less formal approaches to engaging workers can also be effective, as long as they include clear structures for ensuring that workers' voices are heard. Ultimately, empowering direct care workers benefits the entire organization—from workers to consumers to the overall business.

Clear communication about changes affecting workers, with opportunities for feedback

A quality direct care job acknowledges that workers should be informed of changes that affect them and their employers, while also being afforded the opportunity to offer feedback on those developments. Long-term care organizations must regularly adapt to changes in the landscape, including new laws and regulations, economic shifts and additional pressures, and changes in priorities or direction. All these changes impact workers, and they should be updated and allowed to respond along the way. From our experience in the field, the COVID-19 crisis has shown that providers who have kept their workers in the loop when new developments have emerged—to avoid confusion, gather input, and foster solidarity across the organization—have been more successful in weathering the moment and maintaining quality care.

Direct care workers empowered to participate in care planning and coordination

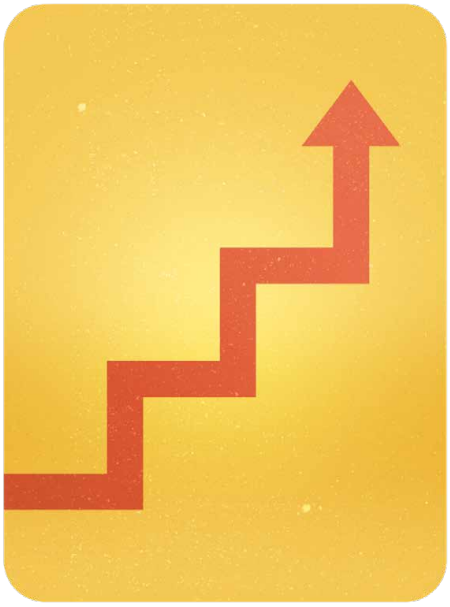
A quality job in direct care empowers workers to participate in care planning and coordination, maximizing their roles and delivering better care to consumers. Regardless of the long-term care setting, workers should be trained and supported to observe and record changes in clients' health and wellbeing—and successfully report that information to the full care team.[281] Integrating direct care workers in care planning and coordination can improve worker retention, optimize health outcomes for consumers, and lead to cost savings for the health system.[282]

Other staff trained to value direct care workers' input and skills

To ensure a quality job for direct care workers, staff across the organization should be trained to value these workers' ideas and skills. As already stated, direct care workers should be trained, supported, and integrated into the care team to deliver optimal care. But if other staff in the organization do not recognize these workers' insights and experiences, workers feel devalued and care quality is compromised. As a best practice, employers should adopt an organization-wide approach to valuing workers that includes training for all staff members and the creation of cross-functional teams that foster a culture of respect for all employees' strengths and experiences.

To ensure a quality job for direct care workers, staff across the organization should be trained to value these workers' ideas and skills.

When workers trust that their employers are looking out for their career growth—by providing clear pathways for advancement and looking internally first for strong job candidates—their job satisfaction will improve, and they will be less likely to leave their jobs in search of better opportunities.



REAL OPPORTUNITY

A quality direct care job should invest in workers' learning, development, and career advancement.

Employer-sponsored continuous learning available to build core and specialized direct care skills

Entry-level training is essential, but a quality direct care job should also provide continuous learning opportunities to workers. Ongoing training reinforces and enhances workers' core competencies in direct care, while also boosting their capacity to care for an increasingly complex and diverse range of long-term care consumers. Employers should also be responsive to what workers identify as their learning needs.

Opportunities for promotion into advanced direct care roles with wage and title increases

The opportunity to move into advanced roles—with increased training, responsibilities, and compensation—is a critical element of job quality in direct care. Career advancement opportunities can improve job satisfaction, recruitment and retention, and care for consumers.[283] Examples of advanced roles include (among others): peer mentors, where workers support both new and incumbent direct care workers; care coordination roles, where workers are integrated into care teams and help with upskilling workers, care transitions, and interdisciplinary team communication; and specialty roles, where workers provide condition-specific care, for example, care for individuals living with Alzheimer's disease or other forms of dementia.[284] These roles can be created at the employer or health system-level and customized per setting.

Organizational commitment to cross-training workers and promoting from within

Quality jobs for direct care workers also depend on their employers' commitment to cross-training and hiring from within. For example, current employees should be considered first when recruiting for administrative positions, assistant trainers, or any of the positions noted above. When workers trust that their employers are looking out for their career growth—by providing clear pathways for advancement and looking internally first for strong job candidates—their job satisfaction will improve, and they will be less likely to leave their jobs in search of better opportunities.[285]

Connections to external training and job development programs for other health care and social service careers

Direct care workers may also be interested in pursuing other health care and social services careers. To facilitate these goals, employers should develop formal relationships with external training and workforce development providers that open the door for career advancement beyond direct care (into licensed nursing roles, for example). Workers should also have easy access to information about these programs; one option is to designate an employee in-house who can be trained and charged with managing these inquiries and making referrals when requested.

Conclusion and Implications

While the COVID-19 has raised the visibility of direct care workers, it has not led to a substantive discussion on job quality in this workforce and solutions for improving workers' jobs and lives. However, with significant investment, employers, industry leaders, and policymakers can transform these jobs for the better—and PHI's new framework for quality jobs in direct care provides a detailed and practical roadmap. As a result of these job improvements, workers will be more financially secure, employers will reduce turnover costs and improve operational stability and care quality, consumers will receive better care, and the overall economy will experience a boost as workers earn and spend more. Based on this report's lessons, here are two meaningful steps for improving direct care job quality.

IMPROVE DATA COLLECTION ON DIRECT CARE WORKERS AND JOB QUALITY

The first immediate opportunity relates to strengthening the data and evidence base on direct care workers. For years, states have suffered from a lack of systematic data on the direct care workforce, which prevents state leaders from understanding the key challenges facing workers and identifying where workers are needed most in their states, among other issues.[286] During a health crisis like COVID-19, state policymakers have struggled to discern where direct care workforce capacity is strained within the state, which would allow them to identify surges in cases and efficiently deploy workers to those regions.

State governments can lead the way in improving data on the direct care workforce. They can create the infrastructure to systematically collect, analyze, and report data on these workers. These systems could (at a minimum) collect data on workforce volume, stability, compensation, training/credentials, and other measures of job quality in direct care outlined in this report. By identifying and collecting data on these key indicators, government agencies and providers could track the quality of jobs over time and use that evidence to design policy reforms and workforce interventions. States could also fund new studies on this workforce and robust evaluations of workforce interventions in direct care. Moreover, states could invest in rigorous surveys of direct care workers that explore their needs, aspirations, and experiences on the job to help inform related public policies and industry practices. Researchers could draw on all these data sources to evaluate the impact of reforms and interventions and to launch new workforce studies, building the evidence base on job quality in this critical sector.

State Policy Spotlight

Around the country, workgroups are forming at the state level to tackle the workforce shortage in direct care and strengthen this essential workforce. PHI took a closer look at 16 of these state-level workgroups and found remarkable similarities in their final policy recommendations. The five most common policy goals across the workgroups were: **increasing compensation, improving training, boosting public awareness, developing career advancement opportunities, and establishing workforce data systems**. A critical strategy for these workgroups' success was to bring together stakeholders of all types—workforce and consumer advocates, private sector leaders, unions, community-based organizations, and more—to identify common concerns and advocate together in unity.[287]

In Focus: PHI's Policy Approach

States continue to advance direct care worker policy change—and many leaders across the country are seeking guidance and collaboration from PHI on these issues. In our state advocacy program, **PHI partners with stakeholders of various types** to advocate for policy reforms that improve jobs for direct care workers within specific states. In New York, home to PHI's headquarters for nearly 30 years, we have led successful advocacy efforts to establish wage parity for home care workers, enact an advanced aide occupation, and elevate the value of this workforce in health and long-term care delivery and public policy. In early 2020, thanks to support from the W. K. Kellogg Foundation (one of the lead funders of this report), PHI launched a **three-year, multi-state advocacy initiative** in Michigan, New Mexico, and North Carolina to increase compensation, invest in workforce innovations, and improve data on direct care workers.

STRENGTHEN THE SAFETY NET FOR LOW-WAGE WORKERS

As low-wage workers, direct care workers also need a stronger public safety net that includes paid sick days, comprehensive paid family and medical leave, and affordable childcare and long-term care support. In the absence of federal legislation, workers' access to these benefits is restricted to a limited number of cities and states that have enacted such laws. Yet as the coronavirus has emphasized, lacking these supports puts workers' lives in danger and prevents them from delivering quality care.

These types of public policies also have multiple benefits, as a growing body of research demonstrates. Paid family leave that allows working parents to bond with a new child supports the long-term health and development of children, positively impacts the health of mothers, and promotes financial stability across the entire family.[288] Paid family and medical leave laws can also increase labor force participation. An analysis of California's paid family and medical leave program shows that it has had a positive effect on labor force participation, specifically on unpaid family caregivers who were employed (supporting them in managing their jobs and their caregiving responsibilities) and on family caregivers who were not working (enabling them to re-enter the labor market).[289] This same state program has also been popular among the business community; a large majority of employers report positive results on productivity, performance, profitability, turnover, morale, and cost savings.[290]

Advocates have proposed various approaches for extending paid sick days, comprehensive paid family and medical leave, and affordable childcare and long-term care support to low-wage workers. Depending on the policy, these options can be enacted at the federal, state, and/or local levels. They can be adopted as stand-alone policies or under a "universal family care" framework that encompasses all of them.[291] Together, these benefits would ensure that direct care workers have affordable access to critical supports across the lifespan, improving their abilities to live financially secure lives and contribute to the delivery of quality care.

Creating quality direct care jobs must be the future of this workforce—but how do we get there? The final section of this report presents an expansive collection of action-oriented policy and practice recommendations that span the topics covered in the first four sections.

RECOMMENDATIONS

Caring for the Future describes the many profound challenges that have long faced this country's direct care workforce, including low compensation, inadequate training, limited career advancement opportunities, and deep-rooted gender and racial inequalities. To our collective detriment, direct care workers remain undervalued and underutilized in the long-term care sector—and their work is often unseen or underestimated, including its physical demands and its social and emotional complexity. At the core of these challenges is a chronically underfunded, fractured, and dispersed long-term care system that has failed to improve job quality for these workers and ensure that consumers receive the services and supports they deserve.

More than ever, this workforce merits attention and investment. As described in the previous section of this report, to navigate the COVID-19 crisis direct care workers need regular and improved access to PPE, supplies, testing, and—as they become more widely available—treatment and vaccines, as well as hazard pay, emergency leave, affordable childcare, and other job supports. The entire long-term care sector needs more relief funding and a federal analysis of what transpired and what can be improved to prevent future calamities. Yet what direct care workers need most—for this pandemic and the future—are a range of policy and practice interventions that transform their jobs for the better. High-quality jobs are the best defense for any future crisis.

The recommendations presented here, then, span an expansive scope of challenges and solutions facing the direct care workforce. They are aimed at policymakers, employers, industry leaders, advocates, and other stakeholders invested in transforming the direct care workforce. Further, they are rooted in the belief that improving direct care jobs requires a comprehensive, national strategy that guides national, state, and local leaders across the public and private sectors—and that all relevant stakeholders should be engaged and held accountable when implementing this strategy.

It's time to move this sector forward.

1 REFORM LONG-TERM CARE FINANCING TO STRENGTHEN DIRECT CARE JOBS

To ensure that long-term care financing programs address the profound needs of consumers and workers

• Protect and strengthen Medicaid to cover more individuals and improve direct care jobs.

Medicaid plays a significant role in the long-term care sector, providing health coverage to many direct care workers, supporting low-income people with long-term services and supports (LTSS), and funding providers to deliver care and support their workforces. Despite its large-scale benefits, Medicaid remains politically contested and underfunded, leading to prohibitive eligibility requirements, long waiting lists, and service caps for consumers—and financially straining providers, which prevents them from creating high-quality direct care jobs. Federal and state policymakers should protect and strengthen Medicaid while integrating direct care workforce measures into its funding and delivery systems.

• Increase reimbursement rates to bolster job quality in direct care.

Inadequate reimbursement rates under Medicaid (and other public payers) prevent many long-term care employers, including self-directing consumers, from offering competitive wages and investing in direct care job quality. These public reimbursement rates should be increased—with requirements that employers spend a meaningful percentage of their reimbursements on improving wages, benefits, training, and other pillars of job quality. Similarly, managed care plans should be required to provide a minimum base rate to employers that covers these vital workforce investments. To ensure adequate and accurate reimbursement rates, policymakers should follow a rigorous and transparent rate-setting methodology, drawing from cost reports and other input from stakeholders.

• Create a stronger public financing approach for long-term care and the direct care workforce.

New social insurance programs should be created to make long-term care affordable to all older adults and people with disabilities, regardless of their income and assets. These programs should also be designed to proactively strengthen the direct care workforce. Long-term care leaders should convene work groups and commission new studies to inform the design and development of new long-term care programs, with explicit attention to direct care workforce concerns.

Job Quality in Direct Care Matters

A focus on job quality ensures that policymakers, employers, and other relevant leaders create high-quality jobs comprised of multiple dimensions. In October 2020, PHI introduced its new framework, *The 5 Pillars of Direct Care Job Quality*, which identifies 29 specific job quality elements across five categories (see the previous section of this report). This comprehensive framework should guide and thread through the implementation of the recommendations outlined in this section. Additionally, well-defined, standardized measures of direct care job quality should be used to track progress over time toward fulfilling these recommendations in policy and practice.

2 INCREASE COMPENSATION FOR DIRECT CARE WORKERS

To improve economic security for direct care workers and ensure that direct care jobs are competitive with other occupations

• Pay direct care workers a living wage.

Providing a living wage to direct care workers would support their economic security, decrease turnover, improve care, and boost the economy (through increased consumer spending and a reduced reliance on public benefits). Policymakers should establish wage floors for these workers that are aligned with their skills and experience and tied to the cost of living in their geographic areas. To prevent cuts in LTSS, these wage measures must be accompanied by increased public reimbursement rates.

• Improve access to full-time schedules for direct care workers.

One in four part-time direct care workers reports being unable to find full-time work with their employer or on the wider labor market, while others work part time because they are raising children, helping other family members, or in school. Providers should be adequately financed to provide full-time hours to every worker who wants them. Policymakers should also study the scheduling barriers that long-term care employers and direct care workers face, and invest in evidence-based technology solutions that help align employers' scheduling requirements with workers' availability, offer workers more control over their schedules, and streamline the connection between self-directing consumers and potential workers.

- **Strengthen the social safety net and improve access to workplace benefits for direct care workers.**

Affordable health insurance, free or low-cost childcare, paid sick leave, paid family and medical leave, and retirement savings options are critical elements of economic security, among others. Policymakers should strengthen the social safety net by extending these benefits to all low-wage workers, including direct care workers. In the meantime, long-term care reimbursement rates should be structured to account for the cost of providing these benefits to direct care workers through their jobs.

- **Evaluate the unintended impact of wage increase measures on direct care workers, their employers, and consumers.**

While essential to direct care workers' economic well-being, policies that increase wages can have unintended consequences. For example, unless paired with an increase in Medicaid funding and reimbursement rates, new wage requirements can force long-term care employers, including self-directing consumers, to cut service hours or reduce staffing levels. Additionally, because of benefit cliffs and plateaus, low-wage workers might see their total compensation remain the same or even drop when their wages increase because of a corresponding decrease in public benefits. Policymakers should evaluate the impact of policies that increase wages on direct care workers' total compensation, the financial stability of employers, and consumers' service hours—and devise strategies to address any unintended negative effects.

3 STRENGTHEN TRAINING STANDARDS AND DELIVERY SYSTEMS FOR DIRECT CARE WORKERS

To prepare workers with the depth of knowledge and skills required to meet the needs of today's long-term care consumers

- **Establish a national standard for direct care competencies.**

Training standards for direct care workers, where they exist, vary widely across geographic locations, care settings, and job titles. Most training standards are not competency-based and many are inadequate for delivering quality care. There should be a national standard for the core competencies required to deliver LTSS that are relevant to all direct care workers, regardless of payment source or setting—recognizing the physical demands, social and emotional complexity, and health-related support activities involved in direct care—and that are transferrable across state lines. To be effective, states should then mandate the implementation, enforcement, and evaluation of this minimum standard. States and employers could build from the national standard to provide training programs that are setting- or population-specific, that are tailored to independent providers in consumer-directed programs, and/or that lead to higher-level or advanced direct care roles.

- **Overhaul direct care worker training curricula to reflect the full set of skills needed for this work.**

Most training standards and curricula for direct care workers focus on basic tasks and many have not been meaningfully updated in decades, despite considerable changes in LTSS consumers' needs and the long-term care system. Long-term care leaders and direct care workforce development experts should draw directly on workers' experiences to understand the range of challenges they face on the job, as well as incorporating consumers' perspectives where appropriate and other evidence and expertise. Training curricula should address these challenges and upskill the direct care workforce by covering areas like communication, condition-specific care, and reporting, among others.

- **Strengthen training infrastructure to support adult learner-centered training and the attainment of meaningful direct care credentials.**

To improve direct care training quality, states should incentivize training providers to offer in-person and blended training programs that incorporate best practices for adult learners. Given the growing interest in e-learning and online training for this workforce, training programs using these modalities should be properly evaluated for accessibility and effectiveness before being brought to scale. States should also track and report direct care training and certification data, to improve efficiency and accountability within the sector. If their training information is recorded and made available to training providers and employers, for example, trainees can easily evidence and build on existing competencies to earn higher-level or more specialized direct care titles.

- **Increase funding for direct care training delivery and training standard enforcement.**

The costs associated with training entry-level direct care workers are not generally reimbursable through Medicaid or Medicare, which places the funding burden on individual workers, employers, or third-party training entities. This funding barrier can undermine access to training programs and/or compromise their quality. Public funding sources should account for training-related costs in reimbursement rates for LTSS, with specific funding marked for training delivery, enforcement, and evaluation. States can also create innovation funds to support employers and other training providers in creating quality training programs, among other innovations.

4 FUND, IMPLEMENT, AND EVALUATE DIRECT CARE WORKFORCE INTERVENTIONS

To strengthen and leverage the direct care workforce while building the evidence base for future investments in this workforce

- **Strengthen the workforce pipeline in direct care.**

Demographic shifts and persistently poor job quality have created significant workforce shortages in long-term care. To ensure there are enough qualified direct care workers to meet consumer demand, targeted efforts are needed to attract more candidates to these jobs. Recruitment strategies and training programs should be designed to meet the unique demographic, cultural, linguistic, learning, transportation, and care needs of a particular region. Programs should also be designed to recruit new populations for direct care jobs, such as men and workers displaced by COVID-19, as two examples. States should support such efforts, including efforts specifically aimed at independent providers in consumer-directed programs, and ensure that publicly funded job placement services are prepared to connect jobseekers with free direct care training and employment programs.

- **Integrate direct care workers onto the care team.**

Though direct care workers spend more time with consumers than any other paid provider, they are rarely consulted by—or trained to communicate with—members of the consumer's interdisciplinary care team. Research shows, however, that bringing direct care workers' observations about consumers to care teams—either through direct communication pathways between entry-level workers and other care team members, or via advanced direct care workers serving as intermediaries—can maximize the direct care workforce in care coordination and improve consumer outcomes and cost savings. The public and private sectors should invest in implementing, evaluating and scaling-up care team integration initiatives, with attention to the different approaches required for different LTSS service-delivery models and settings.

- **Develop rungs in the career ladder that are accessible to direct care workers and that build on their experience.**

Today's direct care workers have few options for advancement within direct care; for example, pursuing the next formally recognized rung on the career ladder, licensed practical nurse (LPN), requires time, resources, and educational credentials that are often inaccessible to direct care workers. With support, employers can take a leadership role in creating and evaluating advanced roles for direct care workers that represent an elevation in title, function, and compensation. States should also establish and fund advanced direct care roles that meet the needs of employers and consumers, such as those specializing in care coordination, worker retention, condition-specific care, and more.

5 IMPROVE DIRECT CARE WORKFORCE DATA COLLECTION AND MONITORING

To better understand direct care workforce capacity and develop tailored solutions to pressing workforce challenges

- **Create robust workforce data collection systems.**

While workforce shortages are widely reported in the field, their scope, severity, and root causes are not fully understood. New data collection systems should be established to regularly measure workforce size, stability, credentials, and compensation. These data would help policymakers strengthen the direct care workforce—notably by quantifying workforce needs and evaluating the impact of policies and programs on workforce supply and job quality.

- **Update federal industry and occupational classification codes to understand the direct care workforce more fully.**

Existing public data on direct care workers combine diverse industries and occupations, obscuring critical differences within the workforce and limiting employment projections and other calculations. For example, the current industry classification "Services for the Elderly and Persons with Disabilities" elides non-medical home care providers, adult day care centers, and other dissimilar services. Also, direct support professionals who care for people with intellectual and developmental disabilities are combined with other direct care workers, which creates significant gaps in knowledge about this critical workforce, and independent providers employed directly by consumers are also difficult to quantify. Federal leaders should re-assess how best to code data on this sector to allow for more precise analysis of long-term care occupations and industries.

- **Strengthen and integrate direct care workforce quality measures into research, practice, and policy.**

High-quality jobs in direct care—along with strong relationships between direct care workers and consumers—are essential to care quality. Federal and state policymakers should integrate direct care job quality measures into the laws, policies, and payment mechanisms that shape long-term care, to ensure that job quality is prioritized and evaluated over time.

6 CENTER DIRECT CARE WORKERS IN LEADERSHIP ROLES AND PUBLIC POLICY

To ensure that direct care workers' voices are heard and that their concerns are directly addressed in policy and practice

• Establish a statewide workgroup to create recommendations for advancing policies that improve direct care jobs.

For many states, the growing workforce shortage in direct care can seem insurmountable, given the entrenched challenges facing this job sector and the unique—and sometimes conflicting—interests of stakeholders. States should form and properly resource state-level workgroups comprised of leaders from different sectors to identify and promote an expansive set of policy recommendations that strengthen this critical workforce.

• Create a division of paid care that supports direct care workers with accessing their employment rights and resources.

Many direct care workers navigate their jobs without a strong understanding of their legal rights or the job-related resources that are available in their communities. States and localities should create paid care divisions to assist all types of direct care workers (as well as childcare workers and housekeepers) with legal and employment concerns while monitoring relevant workforce-related trends.

• Integrate direct care workers into key advisory roles and leadership positions throughout the public and private spheres.

For too long, direct care workers have been virtually shut out of these spheres of influence, despite their experiences and profound insights on this field.

Who's Affected by Systemic Inequality?

Because women, people of color, and immigrants make up the majority of direct care workers, addressing these populations' needs will require policies and interventions that foreground the distinct and interrelated structural barriers they face. As well as directly addressing gender, race, and immigration, the strategies outlined below can also respond to other aspects of workers' identities, including sexual orientation, gender identity, age, disability status, religion, and more.

Actualizing the recommendations outlined in this section will require that direct care workers be centered as experts across organizations, long-term care businesses, government bodies, and the advocacy space. These workers must be empowered to help define the policies and programs that impact their jobs and lives.

7 RECTIFY STRUCTURAL GENDER AND RACIAL INEQUITIES FOR DIRECT CARE WORKERS

To address the structural inequities that harm the lives and employment experiences of direct care workers who are women, people of color, and/or immigrants

• Develop strategies to address systemic barriers and strengthen diversity, equity, and inclusion within this job sector.

To ensure that women, people of color, and immigrants (among other marginalized groups) can succeed in these roles, employers must design interventions that explicitly target the systemic barriers these workers experience. A critical step is to collect gender and race-related outcomes data across various job quality indicators in order to identify and address disparities in recruitment, hiring, retention, and other workforce outcomes.

• Build the evidence base on equitable direct care workforce interventions.

Interventions focused explicitly on supporting marginalized segments of the direct care workforce should be adequately funded and evaluated to help build the evidence base on equity in this job sector. Further, as workforce development leaders and other innovators design and test new interventions for direct care workers (related to training, advanced roles, and more), they must evaluate whether women, people of color, and immigrants benefit equally from these approaches—in the short and long-term.

• Bolster supports for immigrant direct care workers.

Immigrants are a significant part of the direct care workforce, and they need targeted supports to make it easier to fulfill their roles. These workers would benefit from more research to understand their unique challenges, public policies that address their recruitment and employment needs, culturally and linguistically competent workforce supports (especially for workers with limited-English proficiency), stronger access to community-based resources (legal and housing assistance, etc.), and a pathway to citizenship.

8 SHIFT THE PUBLIC NARRATIVE ON DIRECT CARE WORKERS

To enable advocates to communicate effectively about direct care workforce issues and build broader awareness and support for this workforce

- **Fund public education campaigns that improve the general public's understanding of the direct care workforce.**

Workforce, aging, and long-term care advocates have successfully designed public education campaigns in recent years to raise the visibility of challenges facing direct care workers and the value of these workers. Additional campaigns should be produced and well-funded across the country to build awareness and support for these workers, as well as to spark policy and practice improvements that transform the quality of their jobs.

- **Build communications capacity to effectively advocate for direct care workforce policy solutions.**

The long-term care sector could benefit from an investment in market research, framing strategies, and message-testing related to the direct care workforce, to support leaders in better communicating the challenges facing this workforce to different audiences (according to their roles, values, demographics, and more). In addition, the communications capacity of advocates should be bolstered to ensure they have the staffing, knowledge, and tools to advocate effectively for direct care workers.

- **Support storytelling projects that empower direct care workers to tell their stories in their own words.**

As the paid frontline of care for older adults and people with disabilities, direct care workers have a lot to say about their jobs, long-term care delivery, and the entire sector. Storytelling projects should be designed and well-funded to capture workers' unique insights using various multi-media formats and storytelling approaches, and widely propagated across digital media and other outlets. These projects should be participatory, collaborative, and democratic, allowing a diverse cross-section of workers to tell their own stories.

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Appendix 1: Data Sources and Methods

The direct care workforce comprises personal care aides, home health aides, and nursing assistants. Direct care worker occupational categories are defined by the Standard Occupational Classification (SOC) system developed by the Bureau of Labor Statistics (BLS) at the U.S. Department of Labor (DOL).[292] Workers are classified based on their on-the-job responsibilities, skills, education, and training.

The industries that are described in this report are defined by the North American Industry Classification System (NAICS).[293] "Home Care" includes two industries: (1) Services for the Elderly and Persons with Disabilities and (2) Home Health Care Services. "Residential Care Homes" also comprise two industries: (1) Residential Intellectual and Developmental Disability Facilities and (2) Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly. "Nursing Homes" refers to the Nursing Care Facilities (Skilled Nursing Homes) industry. "Total" includes all industries where direct care workers are employed.

Direct care worker demographics, annual earnings, poverty status, and use of public assistance were sourced from the U.S. Census Bureau's American Community Survey (ACS). For the home care industry analyses, since the ACS does not provide data at the level of the Services for the Elderly and Persons with Disabilities industry, the parent industry (Individual and Family Services) was used instead. The comparative data on wages for direct care workers by demographic characteristics were drawn from the U.S. Census Bureau's Current Population Survey.

Wage and employment trends were sourced from the Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) program, and employment projections were sourced from the BLS Employment Projections program. Wages were calculated as a weighted average of median hourly wages for each occupation in each industry. In this context, median wages are preferable to mean wages, which are skewed by a small proportion of atypically highly paid workers. The Consumer Price Index for All Urban Consumers (Current Series) was used to adjust wages for inflation to 2018 dollars.

Appendix 2: Direct Care Workforce Characteristics by Setting

Table 1: **Direct Care Workforce Employment by Setting, 2008 to 2018**

Setting	2008	2018	Change	Percent Change
Home Care	898,600	2,259,570	1,360,970	151%
Personal Care Aides	452,460	1,548,670	1,096,210	242%
Home Health Aides / Nursing Assistants	446,140	710,900	264,760	59%
Residential Care	540,890	720,480	179,590	33%
Nursing Homes	599,350	581,140	-18,210	-3%
All Direct Care Workers	**2,929,320**	**4,460,580**	**1,531,260**	**52%**

Sources: U.S. Bureau of Labor Statistics (BLS), Division of Occupational Employment Statistics (OES). 2019. *May 2008 to May 2018 National Industry-Specific Occupational Employment and Wage Estimates.* https://www.bls.gov/oes/current/ oessrci.htm; BLS OES. 2019. *May 2008 to May 2018 National Occupational Employment and Wage Estimates.* https://www.bls.gov/oes/current/oessrci.htm; analysis by PHI (July 2, 2019).

Table 2: **Direct Care Workforce Employment Projections, 2018 to 2028**

Setting	Growth	Percent Growth	Separations	Total Job Opening
Home Care	1,054,400	46%	3,684,200	4,738,600
Personal Care Aides	736,700	47%	2,697,800	3,434,500
Home Health Aides / Nursing Assistants	317,700	44%	986,400	1,304,100
Residential Care	168,400	23%	1,035,500	1,203,900
Nursing Homes	-19,300	-3%	639,900	620,600
All Direct Care Workers	**1,321,100**	**28%**	**6,863,000**	**8,184,100**

Sources: Bureau of Labor Statistics (BLS), *Employment Projections Program (EPP). 2019. Employment Projections: 2018–28, National Employment Matrix – Occupation.* https://www.bls.gov/emp/; BLS EPP. 2019. *Occupational Projections Data.* https://www.bls.gov/emp/; analysis by PHI (September 17, 2019).

Table 3: **Direct Care Workforce Wages by Setting, 2008 to 2018**

Setting	2008	2018	Change	Percent Change
Home Care	$10.83	$11.52	$0.69	6%
Personal Care Aides	$10.33	$11.40	$1.07	10%
Home Health Aides / Nursing Assistants	$11.34	$11.77	$0.43	4%
Residential Care	$11.83	$12.07	$0.24	2%
Nursing Homes	$12.98	$13.38	$0.40	3%
All Direct Care Workers	**$12.24**	**$12.27**	**$0.03**	**0%**

Sources: BLS OES. 2019. *May 2008 to May 2018 National Industry-Specific Occupational Employment and Wage Estimates.* https://www.bls.gov/oes/current/ oessrci.htm; BLS OES. 2019. *May 2008 to May 2018 National Occupational Employment and Wage Estimates.* https://www.bls.gov/oes/current/ oessrci.htm; analysis by PHI (July 2, 2019).

Table 4: **Direct Care Workforce Demographic and Job Quality Data by Setting, 2017**

Setting	Home Care	Residential Care	Nursing Homes	All Direct Care Workers
Gender				
Female	87%	84%	92%	86%
Male	13%	16%	8%	14%
Age				
16-24	11%	20%	20%	16%
25-34	18%	27%	25%	22%
35-44	19%	18%	20%	19%
45-54	22%	17%	19%	20%
55-64	21%	14%	13%	17%
65+	9%	4%	3%	6%
Median Age	46	36	37	41
Race and Ethnicity				
White	38%	46%	43%	41%
Black or African American	28%	30%	37%	30%
Hispanic or Latino (Any Race)	23%	15%	12%	18%
Asian or Pacific Islander	8%	6%	4%	7%
Other	4%	3%	4%	4%
Citizenship Status				
U.S. Citizen by Birth	69%	79%	79%	74%
U.S. Citizen by Naturalization	16%	12%	13%	15%
Not a Citizen of the U.S.	14%	9%	8%	11%
Educational Attainment				
Less than High School	19%	9%	12%	13%
High School Graduate	35%	36%	40%	35%
Some College, No Degree	26%	36%	35%	32%
Associate's Degree or Higher	20%	19%	13%	20%

Source: Ruggles, Steven, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. 2019. *IPUMS USA: Version 9.0.* Minneapolis, MN: IPUMS, University of Minnesota. https://doi.org/10.18128/D010.V9.0; analysis by PHI (July 8, 2019).

Appendix 3: Long-Term Care Industries by the Numbers

Setting	Home Care	Residential Care	Nursing Homes	All Long-Term Care Industries
Industry Trends				
Establishments in 2007	43,503	47,104	16,320	106,927
Establishments in 2017	65,696	59,081	16,871	141,648
Numeric Change	22,193	11,977	551	34,721
Percent Change	51%	25%	3%	32%
Trends in For-Profit Ownership				
Proportion of For-Profit Establishments in 2007	67%	56%	82%	64%
Proportion of For-Profit Establishments in 2017	76%	59%	83%	70%
Percentage Point Change	9%	4%	2%	5%
Percent Change	13%	7%	2%	9%
Chain Ownership and Franchise Establishments				
Chain Ownership	33%	63%	57%	48%
Chains with fewer than 5 establishments	11%	9%	11%	10%
Chains with 5 to 9 or more establishments	6%	6%	6%	6%
Chains with 10 or more establishments	15%	48%	40%	32%
Franchise Establishments	7%	–	–	–
Long-Term Care Establishment Employment Size				
Fewer than 20 employees	55%	72%	14%	57%
20 to 49 employees	23%	15%	9%	18%
50 to 99 employees	12%	8%	27%	12%
100 or more employees	9%	6%	49%	13%
Share of Revenue Controlled by Largest Firms				
4 largest firms	7%	13%	11%	10%
8 largest firms	12%	18%	16%	15%
20 largest firms	19%	25%	22%	21%
50 largest firms	26%	33%	31%	30%

Sources: U.S. Census Bureau. 2010. *Health Care and Social Assistance: Geographic Area Series: Summary Statistics: 2007.* https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2007_US/62A1/0100000US; Economic Census of the United States U.S. Census Bureau. 2020. Health Care and Social Assistance: Summary Statistics for the U.S., States, and Selected Geographies: 2017. https://www.census.gov/data/tables/2017/econ/economic-census/naics-sector-62.html; U.S. Census Bureau. 2016. *Health Care and Social Assistance: Subject Series: Estab & Firm Size: Summary Statistics by Concentration of Largest Firms for the U.S.: 2012.* https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ6/0100000US; analysis by PHI (December 11, 2019).

Appendix 4: Training Requirements for Direct Care Workers

Table 1: Nursing Assistant Training Requirements

	Minimum Total Training Hours	Minimum Clinical Training Hours
120+ Hours (13 States + D.C.)		
Maine	180	70
Missouri	175	100
Oregon	155	75
California	150	100
Delaware	150	75
Alaska	140	80
District of Columbia (D.C.)	120	75
West Virginia	120	55
Arizona	120	40
Florida	120	40
Illinois	120	40
Virginia	120	40
Idaho	120	32
Wisconsin	120	32
76 – 119 Hours (18 States)		
Indiana	105	75
Hawaii	100	70
New Hampshire	100	60
Connecticut	100	50
Maryland	100	40
South Carolina	100	40
Texas	100	40
New York	100	30
Utah	100	24
Rhode Island	100	20
Kansas	90	45
New Jersey	90	40
Arkansas	90	16
Washington	85	50

Table 1: **Nursing Assistant Training Requirements** (Cont.)

	Minimum Total Training Hours	Minimum Clinical Training Hours
Georgia	85	24
Louisiana	80	40
Pennsylvania	80	37.5
Vermont	80	30
75 Hours (19 States)		
Iowa	75	30
Montana	75	25
Alabama	75	16
Colorado	75	16
Kentucky	75	16
Massachusetts	75	16
Michigan	75	16
Minnesota	75	16
Mississippi	75	16
Nebraska	75	16
Nevada	75	16
New Mexico	75	16
North Carolina	75	16
North Dakota	75	16
Ohio	75	16
Oklahoma	75	16
South Dakota	75	16
Tennessee	75	16
Wyoming	75	16

Source: PHI. *Nursing Assistant Training Requirements by State*. Bronx, NY: PHI. https://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/. Accessed April 3, 2020.

Table 2: **Home Health Aide Training Requirements**

	Minimum Total Training Hours	Minimum Clinical Training Hours
120+ Hours (6 States + D.C.)		
Maine*	180	70
Alaska*	140	80
District of Columbia (D.C.)	125	40
California**	120	20
Idaho*	120	40
Illinois	120	40
Wisconsin*	120	32
76 – 119 Hours (11 States)		
Kansas**	110	45
Utah*	100	24
Rhode Island*	100	20
New Hampshire*	100	60
Hawaii*	100	70
Maryland*	100	40
Montana**	91	25
Wyoming**	91	16
Washington*	85	50
Vermont*	80	30
New Jersey	76	16
75 Hours (33 States)		
Alabama	75	16
Arizona	75	16
Arkansas***	75	16
Connecticut	75	16
Colorado	75	16
Delaware	75	16
Florida	75	16
Georgia	75	16
Iowa	75	16
Indiana	75	16
Kentucky	75	16

Table 2: **Home Health Aide Training Requirements** (Cont.)

	Minimum Total Training Hours	Minimum Clinical Training Hours
Louisiana	75	16
Massachusetts	75	16
Michigan	75	16
Minnesota	75	16
Mississippi	75	16
Missouri	75	16
Nebraska	75	16
Nevada	75	16
New Mexico	75	16
New York	75	16
North Carolina*	75	16
North Dakota	75	16
Ohio	75	16
Oklahoma	75	16
Oregon	75	16
Pennsylvania	75	16
South Carolina	75	16
South Dakota	75	16
Tennessee	75	16
Texas	75	16
Virginia	75	16
West Virginia	75	16

* State requires that home health aides be certified as nursing assistants

** State allows certified nursing assistants to be dual certified as home health aides with additional training

*** State allows home health aides to become certified nursing assistants with no additional training provided through successful completion of the nursing assistant competency evaluation

Source: PHI. *Home Health Aide Training Requirements by State*. Bronx, NY: PHI. https://phinational.org/advocacy/home-health-aide-training-requirements-state-2016. Accessed April 3, 2020.

Table 3: **Training Requirements For Agency-Employed Personal Care Aides**

State	Training Requirement Consistency	Any Training Hours	Any Competency Assessment	Instructor Requirements	Portable Credentials
Alabama	Inconsistent	No	No	No	No
Alaska	Inconsistent	Yes	Yes	Yes	Yes
Arizona	Inconsistent	No	Yes	Yes	Yes
Arkansas	Inconsistent	Yes	Yes	Yes	Yes
California	Inconsistent	Yes	No	No	No
Colorado	Inconsistent	Yes	No	No	No
Connecticut	No Requirements	No	No	No	No
Delaware	Consistent	No	Yes	No	No
District of Columbia (D.C.)	Inconsistent	Yes	Yes	Yes	Yes
Florida	Consistent	Yes	Yes	Yes	Yes
Georgia	Consistent	Yes	No	Yes	No
Hawaii	Inconsistent	Yes	Yes	Yes	Yes
Idaho	Inconsistent	No	Yes	Yes	No
Illinois	Inconsistent	Yes	Yes	No	Yes
Indiana	No Requirements	No	No	No	No
Iowa	Inconsistent	Yes	Yes	No	No
Kansas	No Requirements	No	No	No	No
Kentucky	Inconsistent	No	Yes	No	No
Louisiana	Consistent	Yes	Yes	No	Yes
Maine	Inconsistent	Yes	Yes	No	Yes
Maryland	Inconsistent	No	No	No	Yes
Massachusetts	Inconsistent	Yes	Yes	No	Yes
Michigan	Inconsistent	No	No	No	No
Minnesota	Inconsistent	No	Yes	No	Yes
Mississippi	Inconsistent	Yes	Yes	Yes	No
Missouri	Inconsistent	Yes	Yes	Yes	Yes
Montana	Inconsistent	Yes	Yes	Yes	Yes
Nebraska	No Requirements	No	No	No	No
Nevada	Consistent	Yes	Yes	No	No
New Hampshire	Consistent	No	No	No	No
New Jersey	Inconsistent	Yes	Yes	Yes	Yes

Table 3: **Training Requirements For Agency-Employed Personal Care Aides** (Cont.)

State	Training Requirement Consistency	Any Training Hours	Any Competency Assessment	Instructor Requirements	Portable Credentials
New Mexico	Inconsistent	Yes	Yes	No	Yes
New York	Consistent	Yes	Yes	Yes	*Yes*
North Carolina	Inconsistent	No	Yes	Yes	*Yes*
North Dakota	Inconsistent	No	Yes	No	*Yes*
Ohio	Inconsistent	Yes	Yes	Yes	*Yes*
Oklahoma	Consistent	No	Yes	Yes	*Yes*
Oregon	Consistent	No	Yes	No	*No*
Pennsylvania	Consistent	No	Yes	No	*Yes*
Rhode Island	Consistent	Yes	Yes	Yes	*Yes*
South Carolina	Inconsistent	No	Yes	Yes	*Yes*
South Dakota	Inconsistent	No	No	No	*No*
Tennessee	No Requirements	No	No	No	*No*
Texas	No Requirements	No	No	No	*No*
Utah	Consistent	No	Yes	No	*No*
Vermont	No Requirements	No	No	No	*No*
Virginia	Consistent	Yes	Yes	Yes	*Yes*
Washington	Consistent	Yes	Yes	Yes	*Yes*
West Virginia	Inconsistent	No	No	Yes	*No*
Wisconsin	Inconsistent	No	Yes	Yes	*No*
Wyoming	Inconsistent	Yes	Yes	Yes	*Yes*

Note: Categories refer to at least one set of training requirements per state

Source: PHI. *Personal Care Aide Training Requirements.* Bronx, NY: PHI. https://phinational.org/advocacy/personal-care-aide-training-requirements. Accessed April 3, 2020.

Appendix 5: Competency Sets for Direct Care Workers in LTSS

Table 1: **Competency Sets for Direct Care Workers in LTSS, by Date of Publication**

Competency Set	Description	Core Competencies
Community Support Skill Standards (CSSS): Tools for Managing Change and Achieving Outcomes[294]	The CSSS represent practice standards for direct service workers in a wide variety of human service program settings, regardless of specific job title or population served. Development and validation of the CSSS, which involved a national coalition of key stakeholders, was led by the Human Services Research Institute with support from the Departments of Labor and Education.	1. Participant Empowerment 2. Communication 3. Assessment 4. Community and Service Networking 5. Facilitation of Services 6. Community Living Skills and Support 7. Education, Training, and Self-Development 8. Advocacy 9. Vocational, Educational, and Career Support 10. Crisis Intervention 11. Organizational Participation 12. Documentation
PHI Competencies for Direct Care Workers	PHI's Competencies for Direct Care Workers, which apply to personal care aides, home health aides, and nursing assistants, are the basis of the organization's flagship entry-level training programs. This competency set was included in the development of the Department of Labor's Long-Term Care and Supports Competency Model and has informed numerous other training models and curricula, including the curricula that were implemented in the PHCAST program.	1. Role of the Direct Care Worker 2. Consumer Rights, Ethics, and Confidentiality 3. Communication, Problem-Solving, and Relationship Skills 4. Personal Care Skills 5. Health Care Support 6. In-Home and Nutritional Support 7. Infection Control 8. Safety and Emergencies 9. Apply Knowledge to Needs of Specific Consumers 10. Self-Care
National Alliance for Direct Support Professionals' (NADSP) Direct Support Professionals Competencies[295]	This set of 15 competencies, which is based on the CSSS, underpins the NADSP voluntary credentialing program for direct support professionals (DSPs) working in community human services. There are four levels of the credentialing program: • DSP-Registered (DSP-R) • DSP-Certified (DSP-C) • DSP-Specialist (DSP-S) • Frontline Supervisor (FLS) The NADSP competency set is used in a number of competency-based training programs and statewide certification programs, including in Georgia, Ohio, New Jersey, and Indiana, and is the basis of the national DSP Apprenticeship Program through the Department of Labor.	1. Participant Empowerment 2. Communication 3. Assessment 4. Community and Service Networking 5. Facilitation of Services 6. Community Living Skills and Supports 7. Education, Training, and Self-Development 8. Advocacy 9. Vocational, Educational, and Career Support 10. Crisis Prevention and Intervention 11. Organizational Participation 12. Documentation 13. Building and Maintaining Friendships and Relationships 14. Provide Person-Centered Supports 15. Supporting Health and Wellness

Table 1: **Competency Sets for Direct Care Workers in LTSS, by Date of Publication** (Cont.)

Competency Set	Description	Core Competencies
Department of Labor Employment and Training Administration's Long-Term Care, Supports, and Services Competency Model[296]	The Employment and Training Administration worked with technical and subject matter experts from education, business, and industry to develop this competency model for LTSS. The model is designed as a resource for workforce development activities such as writing job descriptions and developing curricula. Presented as a pyramid (with competencies within each tier), the model depicts the increasing specialization and specificity in the application of skills as workers progress in their roles.	1. Personal Effectiveness Competencies *e.g., interpersonal skills, dependability* 2. Academic Competencies *e.g., reading, writing, critical and analytical thinking, communication* 3. Workplace Competencies *e.g., teamwork, problem-solving* 4. Industry-Wide Technical Competencies *e.g., supporting daily living, documentation* 5. Industry-Sector Technical Competencies *NADSP competency areas* 6. Management Competencies/Occupation-Specific Competence *No competencies specified*
Alaskan Core Competencies for Direct Care Workers in Health and Human Services[297]	The Alaskan Core Competencies were developed by a consensus group of long-term care stakeholders from different regions of the state. The set draws from pre-existing, nationally recognized competency models, whose components were reviewed and modified for practice in Alaska's unique needs, which include delivering LTSS in frontier areas to a diverse consumer population. The Alaskan model is designed to be "skill oriented" and includes metrics to assess performance of its competencies.	1. Working with Others 2. Assessing Strengths and Needs 3. Planning Services 4. Providing Services 5. Linking to Resources 6. Advocating 7. Individualizing Care 8. Documenting 9. Behaving Professionally and Ethically 10. Developing Professionally
Administration for Community Living's (ACL) Long-Term Services and Supports Workforce Competency Model[298]	The ACL developed the Long-Term Services and Supports Workforce Competency Model from the Department of Labor model described above. In the ACL model, the first through fourth foundational tiers apply to the full long-term care workforce, including direct care workers but also care managers, counselors, administrators, directors, etc. The fifth tier encompasses competencies required for the specific setting, such as a home health agency or Area Agency on Aging, and the top tier covers occupation-specific competencies.	1. Personal Effectiveness Competencies *e.g., interpersonal skills, dependability* 2. Basic Education Competencies *e.g., reading, writing, critical and analytical thinking, communication* 3. Workplace Competencies *e.g., teamwork, problem-solving, and decision making* 4. Industry-Wide Technical Competencies *e.g., supporting daily living, documentation* 5. Industry-Sector Technical Competencies *No competencies specified* 6. Occupation-Specific Requirements *No competencies specified*

Table 1: **Competency Sets for Direct Care Workers in LTSS, by Date of Publication** (Cont.)

Competency Set	Description	Core Competencies
Centers for Medicare and Medicaid Services Direct Service Workforce Core Competencies[299]	Led by the National Direct Service Workforce Resource Center, the Direct Service Workforce Core Competencies were developed through a rigorous process involving a literature review and content analysis with expert input. With applicability across community-based LTSS settings, the competency set is designed to serve as resource for training development and performance improvement and to serve as foundation for career ladders and lattices.	1. Communication 2. Person-Centered Practice 3. Evaluation and Observation 4. Crisis Prevention and Intervention 5. Safety 6. Professionalism and Ethics 7. Empowerment and Advocacy 8. Health and Wellness 9. Community Living Skills and Supports 10. Community Inclusion and Networking 11. Cultural Competency 12. Education, Training, and Self-Development
LeadingAge's Personal Care Attendant Competency Model[300]	LeadingAge's Personal Care Attendant Competency Model is designed to specify the skills, knowledge, and behaviors that will help personal care aides deliver effective supports and services across a variety of positions and LTSS settings, including HCBS, residential, and institutional settings. The model is built around four broad competency areas.	1. Technical Skills *e.g., ADL and IADL care, infection control, role of the direct care worker* 2. Applied Understanding *e.g., dementia, end-of-life care, professionalism and ethics* 3. Interpersonal Skills *e.g., relationship skills, teamwork, communication, accountability* 4. Self-Directed Care *e.g., cultural competency, individualizing care*

Note: This table was originally published in 2019 within PHI's *Envisioning the Future of Home Care: Trends and Opportunities in Workforce Policy and Practice* report authored by PHI Director of Policy Research Kezia Scales. It has been adapted for this report

Appendix 6: Differences Between Median Wages for Direct Care Workers and Occupations with Similar or Lower Entry-Level Requirements by State, 2019

Area	Direct Care Worker Median Wage	Direct Care Worker Median Wage Compared to Median Wage for Occupations with Similar Entry-Level Requirements	Direct Care Worker Median Wage Compared to Median Wage for Occupations with Lower Entry-Level Requirements
Alabama	$10.39	-$3.40	-$0.36
Alaska	$16.88	-$2.05	+$2.72
Arizona	$12.63	-$2.75	-$0.71
Arkansas	$11.30	-$2.46	-$0.28
California	$13.18	-$3.86	-$1.11
Colorado	$13.93	-$2.48	-$0.10
Connecticut	$14.12	-$2.94	-$0.30
Delaware	$12.89	-$2.32	+$0.55
District of Columbia	$14.92	-$4.36	-$1.51
Florida	$12.19	-$1.89	+$0.55
Georgia	$11.57	-$2.47	+$0.35
Hawaii	$14.46	-$4.67	-$1.62
Idaho	$11.92	-$2.65	+$0.29
Illinois	$12.90	-$3.27	+$0.12
Indiana	$12.29	-$2.81	+$0.56
Iowa	$13.41	-$2.08	+$0.74
Kansas	$11.84	-$3.09	-$0.10
Kentucky	$12.23	-$2.30	+$1.03
Louisiana	$9.70	-$4.34	-$1.45
Maine	$13.33	-$2.36	-$0.10
Maryland	$13.90	-$2.06	+$0.44
Massachusetts	$15.34	-$2.44	+$0.52
Michigan	$12.95	-$2.42	+$0.57
Minnesota	$14.24	-$2.84	+$0.28
Mississippi	$10.39	-$2.71	-$0.71
Missouri	$11.38	-$3.87	-$0.49
Montana	$13.19	-$2.06	+$0.85

Area	Direct Care Worker Median Wage	Direct Care Worker Median Wage Compared to Median Wage for Occupations with Similar Entry-Level Requirements	Direct Care Worker Median Wage Compared to Median Wage for Occupations with Lower Entry-Level Requirements
Nebraska	$13.23	-$2.11	-$0.17
Nevada	$13.02	-$2.37	-$0.07
New Hampshire	$14.32	-$1.34	+$1.43
New Jersey	$13.36	-$3.06	-$0.23
New Mexico	$10.89	-$3.35	-$1.06
New York	$14.24	-$3.23	-$0.65
North Carolina	$11.44	-$2.77	-$0.03
North Dakota	$16.24	-$1.15	+$0.10
Ohio	$12.10	-$3.09	+$0.46
Oklahoma	$10.89	-$3.39	-$0.80
Oregon	$14.32	-$2.41	+$0.35
Pennsylvania	$12.86	-$2.78	+$0.58
Rhode Island	$14.65	-$2.04	+$0.87
South Carolina	$11.24	-$2.94	+$0.28
South Dakota	$13.06	-$1.43	+$1.21
Tennessee	$11.65	-$2.82	+$0.32
Texas	$10.38	-$4.54	-$1.45
Utah	$12.94	-$2.21	+$0.90
Vermont	$14.51	-$1.95	+$0.36
Virginia	$11.64	-$3.30	-$0.43
Washington	$14.97	-$3.57	-$0.40
West Virginia	$10.65	-$3.75	-$0.66
Wisconsin	$12.73	-$3.13	+$0.36
Wyoming	$13.94	-$3.67	+$0.26

Source: These analyses are based on *Job Zones*, as defined in the O*NET database. Occupations with similar entry-level requirements to direct care jobs are categorized in *Job Zone Two: Some Preparation Needed*, whereas jobs with lower entry-level requirements are captured in *Job Zone One: Little or No Preparation Needed*. Wages for occupations with similar or lower entry-level requirements were calculated as weighted averages of median hourly wages for all occupation in each job zone. O*NET Resource Center. 2020. *Job Zones*. https://www.onetcenter.org/dictionary/25.0/excel/job_zones.html; U.S. Bureau of Labor Statistics (BLS), Division of Occupational Employment Statistics. 2020. *May 2009 to May 2019 National Industry-Specific Occupational Employment and Wage Estimates*. https://www.bls.gov/oes/current/oessrci.htm; analysis by PHI (September 2020).

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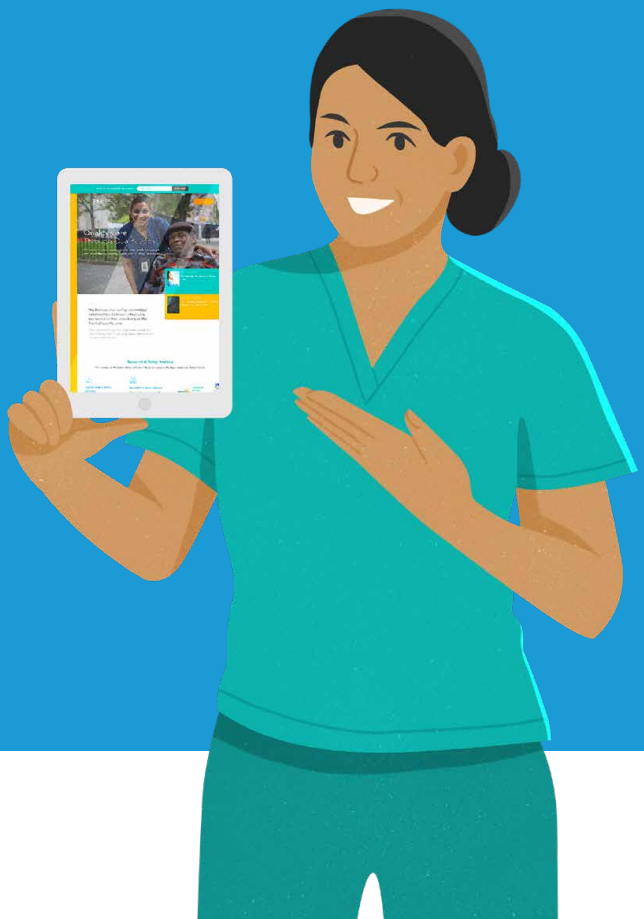

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