



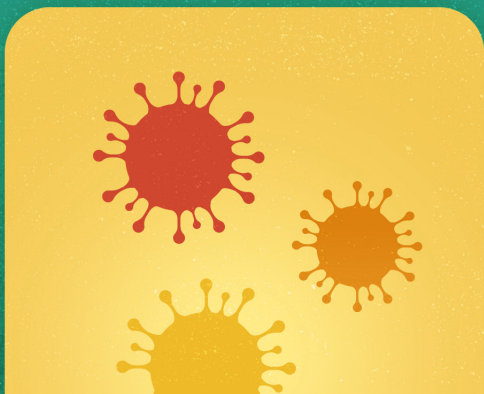
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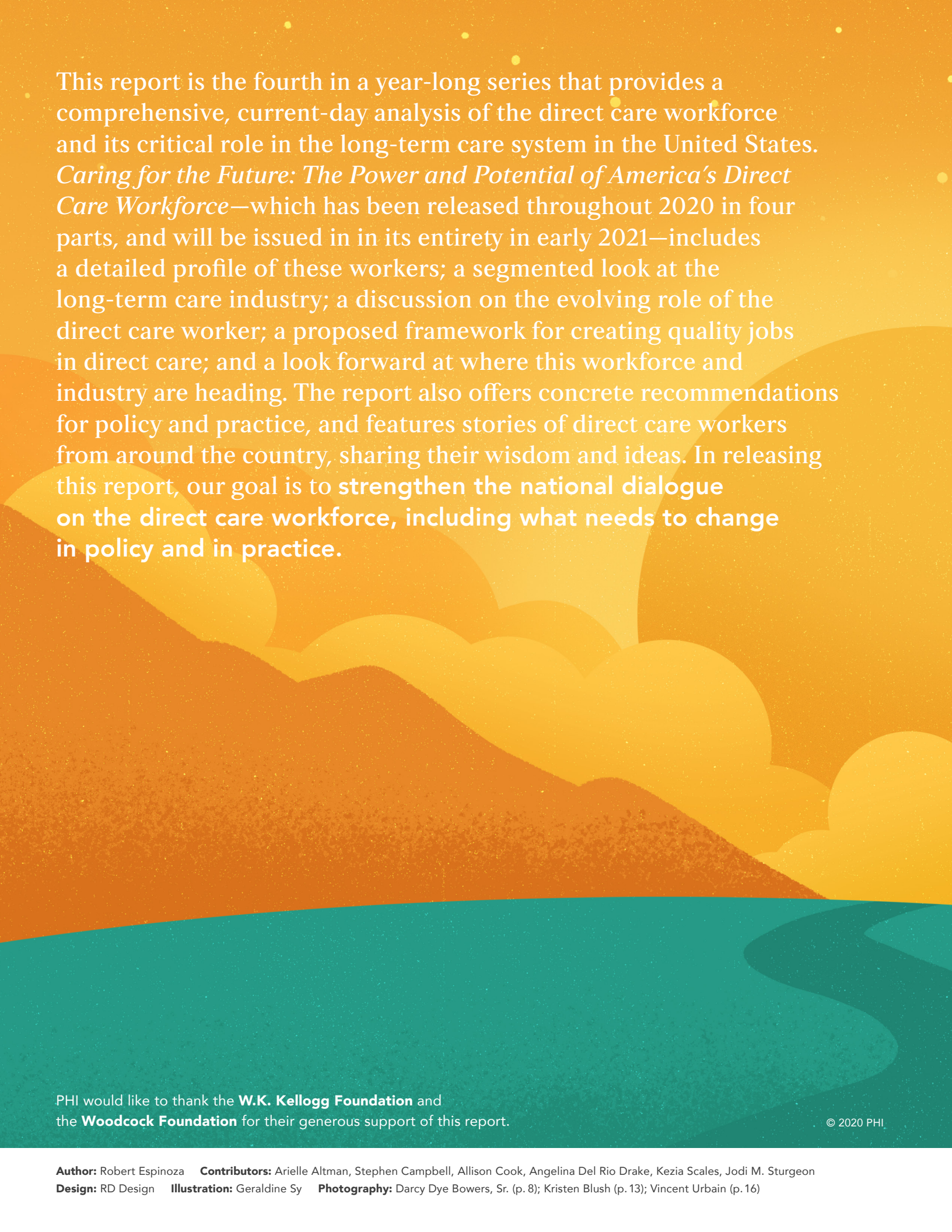
QUALITY CARE
THROUGH
QUALITY JOBS



WOULD YOU STAY?

Rethinking Direct Care Job Quality





This report is the fourth in a year-long series that provides a comprehensive, current-day analysis of the direct care workforce and its critical role in the long-term care system in the United States. *Caring for the Future: The Power and Potential of America's Direct Care Workforce*—which has been released throughout 2020 in four parts, and will be issued in its entirety in early 2021—includes 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 policy and practice, 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.**

PHI would like to thank the **W.K. Kellogg Foundation** and the **Woodcock Foundation** for their generous support of this report.

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Executive Summary

PHI's 'Caring for the Future' Timeline

Part 1 - January 2020
Part 2 - Spring 2020
Part 3 - Summer 2020
Part 4 - Fall 2020

Full report with policy and practice recommendations - January 2021

The typical direct care worker in the United States is a woman, most likely a woman of color, and increasingly an immigrant. She earns a poverty-level wage and struggles to cover her daily expenses. Despite her skilled and demanding role, she has likely not received high-quality, competency-based training—and she has limited career advancement opportunities. Despite the rich insights she can offer about the people she supports, her voice has probably not been properly integrated into the interdisciplinary care team. She remains underutilized in health care delivery and culturally devalued, and she has likely faced discrimination throughout her life because of her gender, race/ethnicity, and/or immigration status. As COVID-19 rages, she is deemed “essential” and “heroic” yet denied basic job supports and protections. Faced with so many employment challenges, she leaves her job and the sector, likely within the first 90 days of employment.

If you were in her place, would you stay?

This report is the fourth in a year-long series—culminating in a comprehensive final report in January 2021—that examines the importance and impact of the direct care workforce. Each report in the series provides original data, in-depth analyses, and policy and practice recommendations, as well as featuring individual direct care workers from around the country. The final report will compile all four individual reports, synthesize the key issues, articulate future challenges and opportunities, and provide a full set of policy and practice recommendations.

This report, *Would You Stay? Rethinking Direct Care Job Quality*, begins by describing how poor job quality defines today's direct care job. As illustrated by the typical worker's story above, the quality of direct care jobs has remained weak for decades, too often shaped by low compensation, inadequate training, limited career advancement opportunities and gender and racial inequalities that harm a mostly female, people of color workforce. As a result, many job seekers

are discouraged from considering careers in direct care, and existing direct care workers leave their jobs for roles in other industries that offer marginally better pay, more stable schedules, and/or less demanding workloads. The poor quality of direct care jobs has become acutely obvious in 2020, as COVID-19 has ravaged long-term care settings—with direct care workers on the frontlines of the crisis, struggling to remain in their jobs and provide quality care without sufficient training, support, protection, or compensation.

The core of this report is a new framework for direct care job quality. Job quality frameworks help promote better jobs across industries and assess whether a specific job meets the values and standards defined by workforce experts. PHI's new framework for quality jobs in direct care spans five pillars: quality training, fair compensation, quality supervision and support, respect and recognition, and real opportunity. This framework includes a rationale for each of these domains and discusses various strategies that will help transform these jobs for this critical workforce.

This fourth installment in the *Caring for the Future: The Power and Potential of America's Direct Care Workforce* series concludes with two immediate opportunities for improving direct care job quality. The first relates to improving data collection on the direct care workforce to better understand its volume, stability, compensation, training/credentials, and overall level of job quality—at any level of geographic analysis. The second is to strengthen the social safety net for low-wage workers, ensuring that direct care workers have access to paid sick days, paid family and medical leave, free or low-cost childcare, and affordable long-term services and supports. Together, these improvements represent a meaningful step toward achieving the vision for direct care job quality outlined throughout this report and strengthening the capacity of the long-term care sector to successfully overcome long-standing challenges and respond to immediate crises.

Terminology

ACTIVITIES OF DAILY LIVING (ADLS)

Essential activities performed every day, including bathing, dressing, eating, toilet care, and transferring/mobility.

CENTERS FOR MEDICARE AND 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 a client or resident.

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.

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.

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.



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.

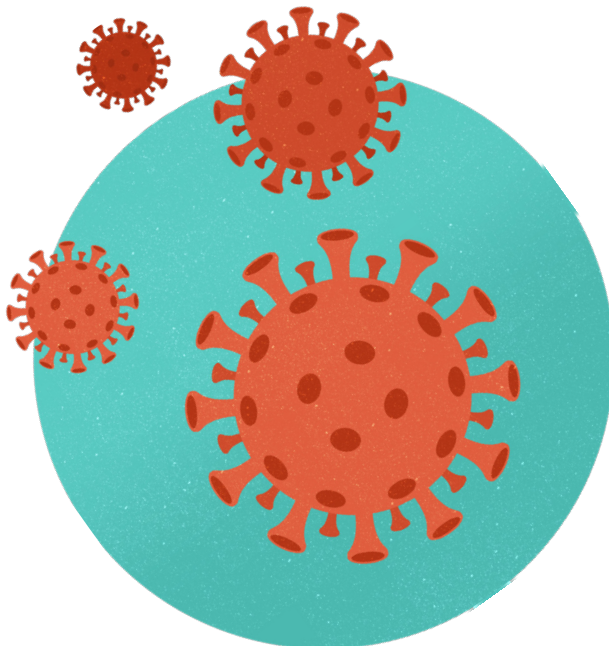
While this health crisis has raised the visibility of direct care workers, notably through in-depth news coverage in the first few months of the pandemic, less attention has been drawn to the longstanding challenges they face. Nevertheless, tragedies can raise the collective consciousness, and in this 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 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.¹ 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 in this report, a focus on job quality allows employers and policymakers to create jobs that satisfy workers, support employers and consumers, and build our economy.

This report 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, the report reviews the profound and devastating impact of COVID-19 on the direct care workforce, their employers, and the individuals they serve. Finally, the report proposes a newly updated framework for job quality in direct care comprising five key pillars and 28 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 reviews 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 installment of this report series, *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

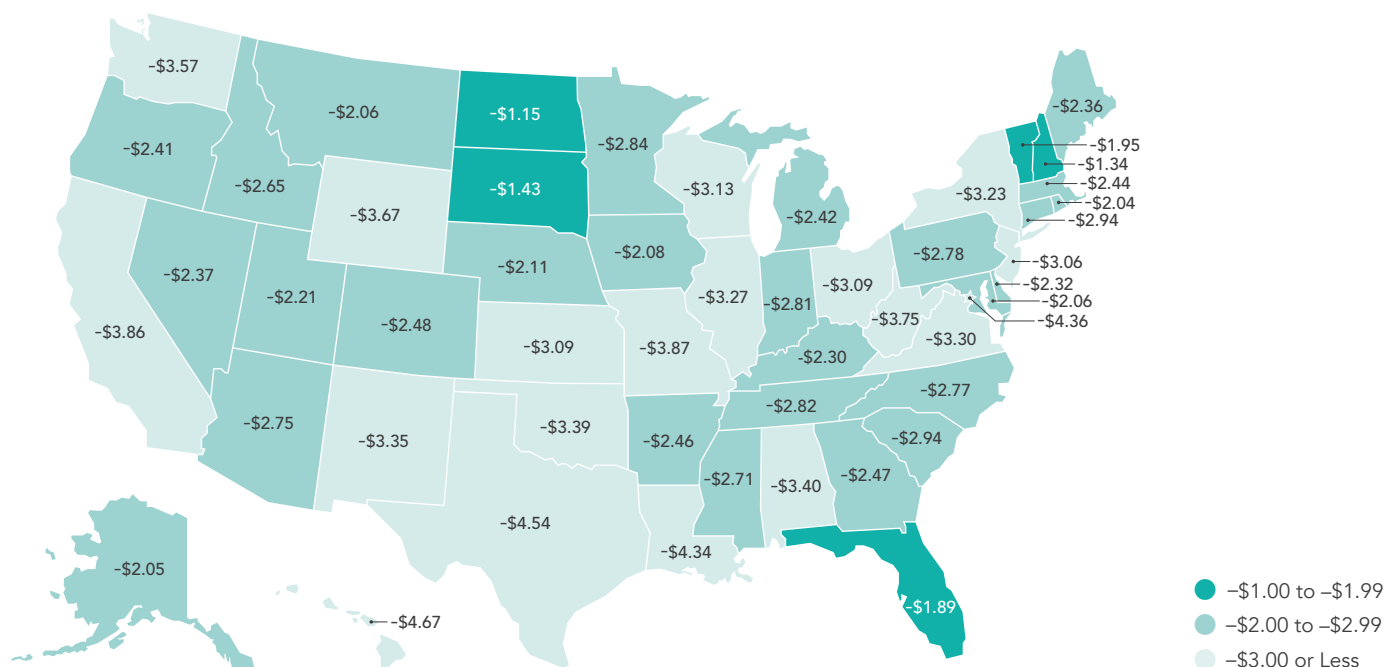
amount that has improved only modestly in the last decade (from \$12.61 in 2009).²

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.³ 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

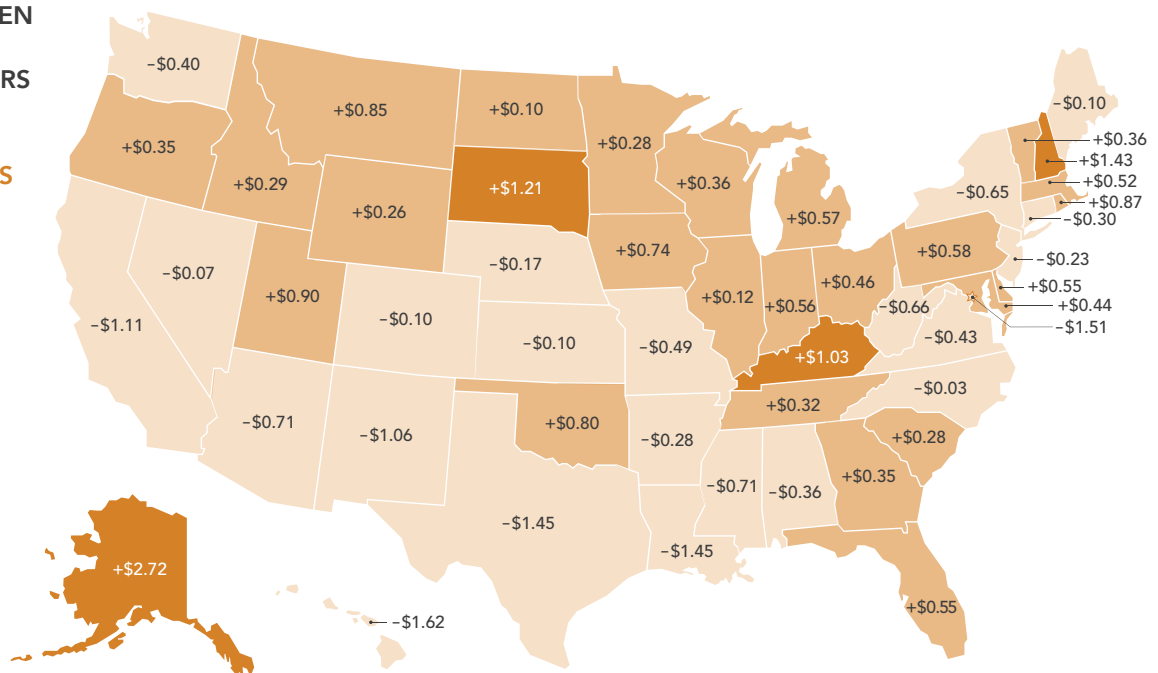
Growth in median hourly wage for direct care workers between 2009 (\$12.61) and 2019 (\$12.80), adjusted for inflation

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

- \$1.00 and Over
- \$0.00 to \$0.99
- Less than \$0.00



Source: 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/oesrci.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 \$20,300.⁴ 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.⁵

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 installment of this report series, *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 report, 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.⁶

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.”⁷ 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.⁸ 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.⁹ 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.¹⁰ 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.¹¹ 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."

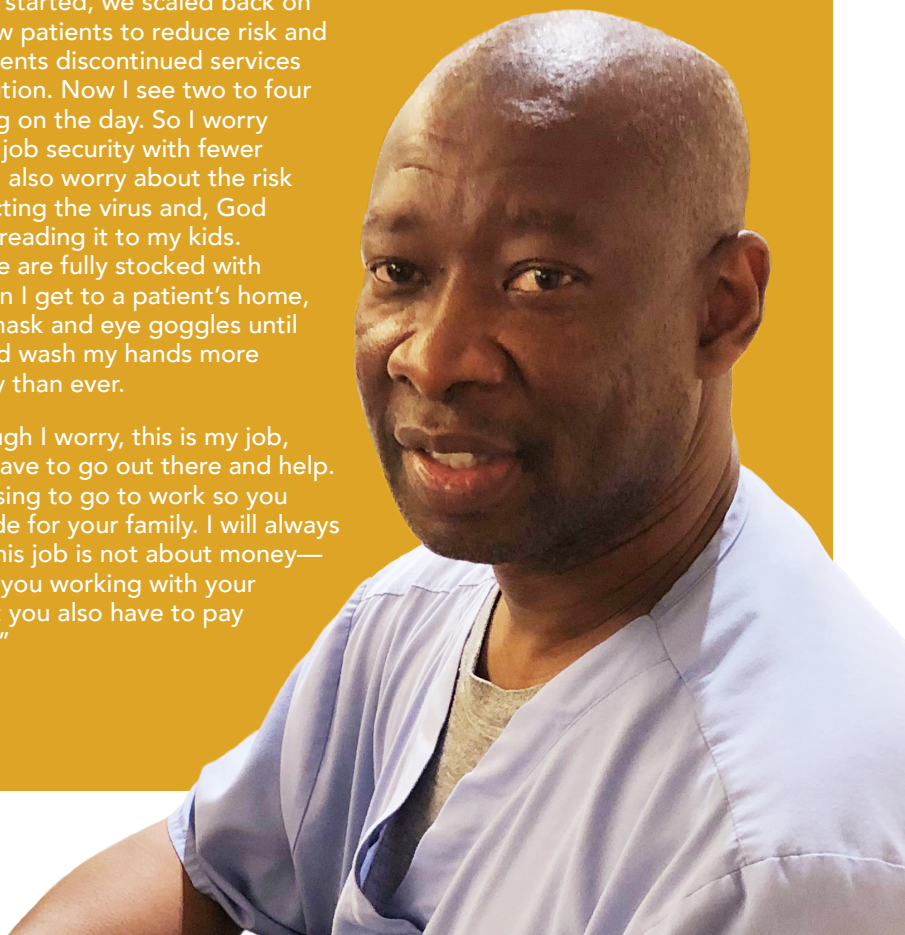
ON THE IMPACT OF COVID-19:

"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.¹²)


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.¹³ 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.¹⁴ 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.¹⁵ 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. In the next section, this report 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 of
September 20, 2020,
about

377,100

nursing home residents
have contracted
COVID-19 and

57,000

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.¹⁶ (Globally, these figures jump to more than 34 million cases and more than 1 million deaths, according to *The New York Times*.)¹⁷ 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.¹⁸ 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).¹⁹ 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-19.²⁰ 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).²¹ 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.²²

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.²³ 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 of September 20, 2020, about 377,100 nursing home residents have contracted COVID-19 and 57,000 have died from the virus. Additionally, 318,100 nursing home staff have had suspected or diagnosed cases of COVID-19 and approximately 900 have died.²⁴ 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.²⁵ 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.²⁶ 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.²⁷

It is clear that our flawed long-term care system—as described in the second report in this series, *We Can Do Better: How Our Broken Long-Term Care System Undermines Care*—has hindered long-term care leaders from quickly distributing implementing a standardized, nationwide response to this crisis.²⁸ 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.²⁹ 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.³⁰ PHI carefully selected 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.³¹ 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 gaps:** 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.³² 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 than 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.)³³ 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 not 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.³⁴

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 installment of this report series, 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-racking, 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.³⁵ 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.³⁶ 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.³⁷

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 installment of this report series, 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.³⁸

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.³⁹ 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.⁴⁰ 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 2020.⁴¹ 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.⁴²

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.⁴³ 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.

The next section of this report details PHI’s new direct care job quality framework, which comprises five pillars and 28 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 report in this series will provide 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.⁴⁴ **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.⁴⁵

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.⁴⁶ 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.⁴⁷

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 installment of this report series. 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.⁴⁸ 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.⁴⁹ 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.⁵⁰ 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."⁵¹

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.⁵² 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.⁵³ For consumers, more consistent schedules for workers can improve care outcomes for consumers.⁵⁴ 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.⁵⁵

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.⁵⁶ 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.⁵⁷

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.⁵⁸ 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 like 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.⁵⁹

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.⁶⁰

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.⁶¹

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.⁶²



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.⁶³ Research also shows that diverse and equitable organizations experience improvements in recruitment, retention, employee job satisfaction, innovation, reputation, and financial performance, among other benefits.⁶⁴

Consistent feedback is given on work performance and retention is celebrated

As described in the previous installment of this report series, 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.⁶⁵ Companies with “recognition-rich” cultures experience 31 percent lower turnover than their peers—an example of how formal recognition approaches benefit the entire organization.⁶⁶

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.⁶⁷ 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.⁶⁸

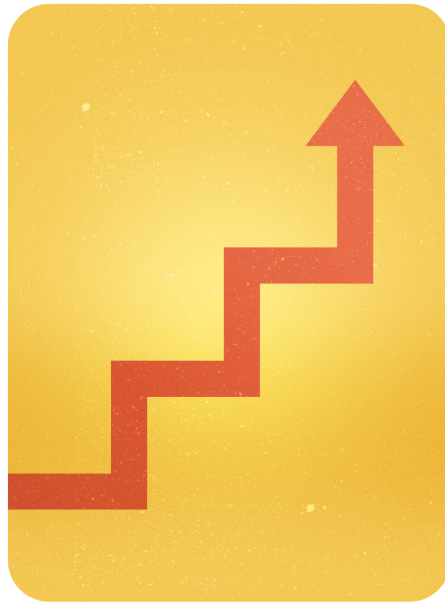
Other staff trained to value direct care workers' input and skills

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.⁶⁹ 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.⁷⁰ 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.⁷¹

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.

Discussion and Conclusion

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.⁷² 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.⁷³



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.⁷⁴ 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).⁷⁵ 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.⁷⁶

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.⁷⁷ 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 and full report in this series, *Caring for the Future: The Power and Potential of America's Direct Care Workforce*, will include an expansive collection of action-oriented policy and practice recommendations that span the topics covered in the first four installments.

Notes

1. PHI. "Workforce Data Center." Last modified September 2020. <https://phinational.org/policy-research/workforce-data-center/>.
2. PHI. "Workforce Data Center."
3. This analysis is 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* in the O*NET database, while jobs with lower entry-level requirements are captured in *Job Zone One: Little or No Preparation Needed*. Wages for occupations for similar or lower entry-level requirements were calculated as a weighted average 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/oesrci.htm>; analysis by PHI (September 2020).
4. PHI. "Workforce Data Center."
5. Cook, Allison. 2018. *Paid Family and Medical Leave: How States Should Support Direct Care Workers*. Bronx, NY: PHI. <https://phinational.org/resource/paid-family-medical-leave-states-support-direct-care-workers/>.
6. Vasey. 2007. "Job Perceptions and Intent to Leave among Direct Care Workers: Evidence from the Better Jobs Better Care Demonstrations." *The Gerontologist* 47(6):820-29. doi.org/10.1093/geront/47.6.820.
7. Kemper, Peter, Brigitt Heier, Teta Barry, Diane Brannon, Joe Angelelli, Joe Vasey, and Mindy Anderson-Knott. 2008. "What Do Direct Care Workers Say Would Improve Their Jobs? Differences across Settings." *The Gerontologist* 48(suppl1):17-25. doi:10.1093/geront/48.Supplement_1.17.
8. Ejaz, Farida K., Linda S. Noelker, Heather L. Menne, and Joshua G. Bagaka's. 2008. The Impact of Stress and Support on Direct Care Workers' Job Satisfaction. *The Gerontologist* 48(suppl_1): 60-70. doi.org/10.1093/geront/48.Supplement_1.60.
9. Espinoza, Robert and Jean C. Accius. 2020. "The Case for Racial Equity in Aging Has Never Been Stronger." *American Society on Aging Blog*. <https://www.asaging.org/blog/case-racial-equity-aging-has-never-been-stronger>.
10. Migdal, Ariela. 2015. "Home Health Care Workers Aren't Guaranteed Minimum Wage or Overtime, and the Legacies of Slavery and Jim Crow Are the Reason Why." *ACLU Blog*, May 6. <https://www.aclu.org/blog/womens-rights/womens-rights-workplace/home-health-care-workers-arent-guaranteed-minimum-wage-or>.
11. Luniewski, Paul. 2020. "A Two-Part Presentation: COVID Surveys and Direct Care Worker Wage Increases." Virtual presentation for PHI Staff, July 24, 2020.
12. PHI. "Understanding the Direct Care Workforce." <https://phinational.org/policy-research/key-facts-faq/>.
13. Scales, Kezia. 2020. *From Crisis to Emergency: 8.2 Million Direct Care Job Openings Expected by 2028*. Bronx, NY: PHI. <https://phinational.org/resource/from-crisis-to-emergency-8-2-million-direct-care-job-openings-expected-by-2028/>.
14. Office of the Assistant Secretary for Planning and Evaluation. *Predictors of Job Satisfaction among Home Health Workers: An Analysis of the Home Health Aide National Survey*. Washington, DC: HHS. <https://aspe.hhs.gov/report/predictors-job-satisfaction-and-intent-leave-among-home-health-workers-analysis-national-home-health-aide-survey/overview-job-satisfaction-and-turnover-research>.
15. PHI. "Understanding the Direct Care Workforce." <https://phinational.org/policy-research/key-facts-faq/>.
16. *The New York Times*. "Covid in the U.S.: Latest Map and Case Count." https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?action=click&pgtype=article&state=default®ion=TOP_BANNER&context=storylines_menu.
17. *The New York Times*. "Covid World Map: Tracking the Global Outbreak." <https://www.nytimes.com/interactive/2020/world/coronavirus-maps.html>.
18. Cohen, Patricia, and Tiffany Hsu. 2020. "'Rolling Shock' as Job Losses Mount Even With Reopenings." *The New York Times*, May 14. <https://www.nytimes.com/2020/05/14/business/economy/coronavirus-unemployment-claims.html>.
19. Johns Hopkins University. 2020. "COVID-19 Poses Unique Challenges for People with Disabilities." <https://hub.jhu.edu/2020/04/23/how-covid-19-affects-people-with-disabilities/>.
20. PHI. 2020. *Direct Care Workers in the United States: Key Facts*. PHI: Bronx, NY. <https://phinational.org/resource/direct-care-workers-in-the-united-states-key-facts/>; National Center for Health Statistics. 2019. *Long-Term Care Providers and Services Users in the United States, 2015–2016: Analytical and Epidemiological Studies*. U.S. Department of Health and Human Services: Washington, DC. https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf.
21. Espinoza, Robert and Jean C. Accius. 2020.
22. Oppel Jr., Richard A., Robert Gebeloff, K.K. Rebecca Lai, Will Wright and Mitch Smith. 2020. "The Fullest Look Yet at the Racial Inequity of Coronavirus." *The New York Times*, July 5. <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latino-african-americans-cdc-data.html>.
23. Booker, Brakton. 2020. "Seattle-Area Nursing Home Linked to Dozens Of Coronavirus Deaths Faces \$600,000 Fine." *NPR*, April 2. <https://www.npr.org/sections/coronavirus-live-updates/2020/04/02/826360394/seattle-area-nursing-home-linked-to-dozens-of-coronavirus-deaths-faces-600-000-f>.
24. Centers for Medicaid and Medicare Services (CMS). 2020b. *COVID-19 Nursing Home Dataset*. <https://data.cms.gov/Special-Programs-Initiatives-COVID-19-Nursing-Home/COVID-19-Nursing-Home-Dataset/s2uc-8wxp>].
25. Gebeloff, Robert, Danielle Ivory, Matt Richtel, Mitch Smith, Karen Yourish, Scott Dance, Jackie Fortier, Elly Yu, Molly Parker. "The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes." 2020. *The New York Times*, May 21. <https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html>.
26. Laise, Eleanor. 2020. "What It's Like to Be a Health Worker During the Coronavirus Crisis." *Barron's*, April 3. <https://www.barrons.com/articles/for-care-workers-coronavirus-is-a-war-on-multiple-fronts-51585742400>; Blaud, Reuven. 2020. "Lysol the Doorbell: Home Health Aides Take No Chances." *The City*, March 30. <https://www.thecity.nyc/health/2020/3/30/21210387/lysolving-the-doorbell-home-health-aides-take-no-chances>.
27. Weller, Christian. 2020. "Home Care Aides Keep Working Amid Massive Health Risks." *Forbes*, July 15. <https://www.forbes.com/sites/christianweller/2020/07/15/home-care-aides-keep-working-amid-massive-health-risks/#10a4cac93641>.
28. Campbell, Stephen. 2020. *We Can Do Better: How Our Broken Long-Term Care System Undermines Care*. Bronx, NY: PHI. <https://phinational.org/resource/we-can-do-better-how-our-broken-long-term-care-system-undermines-care/>.
29. Campbell, Stephen. 2020.
30. Luniewski, Paul. 2020. "A Two-Part Presentation: COVID Surveys and Direct Care Worker Wage Increases." Virtual presentation for PHI Staff, July 24, 2020.
31. Scales, Kezia. 2019. "Leveraging Technology to Support—Not Supplant—the Home Care Workforce." *Health Affairs Blog*, August 7, 2019. <https://www.healthaffairs.org/do/10.1377/hblog20190805.54553/full/>.
32. Propper, David. 2020. "Coronavirus: New York School Districts Must Quickly Set up Daycare for Kids of Essential Workers." *Lohud / USA Today*, March 18. <https://www.lohud.com/story/news/education/2020/03/18/school-districts-must-set-up-child-care-sites-children-essential-workers/2867317001/>.
33. Anthony, Cara. 2020. "'Staying Away From Grandma' Isn't An Option In Multigenerational Homes." *Kaiser Health News*, April 6. <https://khn.org/news/multigenerational-households-social-distancing-at-home-coronavirus/>.
34. Sterling, Madeline R., Emily Tseng, Anthony Poon, Jacklyn Cho, Ariel C. Avgar, Lisa M. Kern, Claire K. Ankuda, Nicola Dell. 2020. "Experiences of Home Health Care Workers in New York City During the Coronavirus Disease 2019 Pandemic: A Qualitative Analysis." *JAMA Intern Med*. doi:10.1001/jamainternmed.2020.3930.
35. "Michigan Direct Care Home Workers to Receive Temporary Raise." 2020. *The Detroit News*, April 23. <https://www.detroitnews.com/story/news/local/michigan/2020/04/23/michigan-direct-care-home-workers-receive-temporary-raise/3017409001/>; Rosbrow-Telem, Laura. 2020. "NH First State to Offer COVID Stipend to Long-term Care Workers." *Public News Service-NH*, April 17. <https://www.publicnewsservice.org/2020-04-17/senior-issues/nh-first-state-to-offer-covid-stipend-to-long-term-care-workers/a69879-1>.

36. Arkansas Governor. 2020. "Governor Hutchinson Announces CMS Approval of Additional Pay For Eligible LTSS Direct Care Workers Due to COVID-19 Emergency." News release, April 15. <https://governor.arkansas.gov/news-media/press-releases/governor-hutchinson-announces-cms-approval-of-additional-pay-for-eligible-ltss-direct-care-workers-due-to-covid-19-emergency>.
37. Propper, David. 2020.
38. Rau, Jordan and Elizabeth Lucas. 2020. "How Well Does Your Nursing Home Fight Infections? Look It Up Here." *Kaiser Health News*, March 13. <https://khn.org/news/how-well-does-your-nursing-home-fight-infections-look-it-up-here/>.
39. Scales, Kezia. 2019.
40. Centers for Medicare & Medicaid Services (CMS). 2020. *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*. <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.
41. Roubain, Rachel. 2020. "Trump Administration Renews Public Health Emergency after Urging from States." *POLITICO*, July 23. <https://www.politico.com/news/2020/07/23/trump-coronavirus-public-health-emergency-380799>.
42. Scales, Kezia. 2020. "Nursing Assistants Have Training Standards for a Reason." *PHI Blog*, June 2, 2020. <https://phinational.org/nursing-assistants-have-training-standards-for-a-reason/>.
43. Stone, Robyn I. and Steven L. Dawson. 2008. "The Origins of Better Jobs Better Care." *The Gerontologist* 48(Issue suppl_1): 5-13. doi.org/10.1093/geront/48.Supplement_1.5.
44. The Aspen Institute. "Section 1: Understanding Job Quality." <https://www.aspeninstitute.org/longform/job-quality-tools-library/section-1-understanding-job-quality/#definitions-frameworks>.
45. Ton, Zeynep. 2017. "The Case for Good Jobs." *Harvard Business Review*, November 2017. <https://hbr.org/cover-story/2017/11/the-case-for-good-jobs>.
46. Campbell, Stephen. 2017. *Training Standards for Personal Care Aides: Spotlight on Washington*. Bronx, NY: PHI. <https://phinational.org/resource/training-standards-for-personal-care-aides-spotlight-on-washington/>.
47. SEIU 77 Benefits Group. "About Us." <https://www.myseiubenefits.org/about/>.
48. Campbell, Stephen. 2018. *The Part-Time Dilemma for Direct Care Workers*. Bronx, NY: PHI. <https://phinational.org/resource/part-time-dilemma-direct-care-workers/>.
49. Drake, Angelina. 2020. *Direct Care Work is Real Work: Elevating the Role of the Direct Care Worker*. Bronx, NY: PHI. <https://phinational.org/resource/direct-care-work-is-real-work-elevating-the-role-of-the-direct-care-worker/>.
50. Scales, Kezia. 2019. *Envisioning the Future of Home Care: Trends and Opportunities in Workforce Policy and Practice*. Bronx, NY: PHI. <https://phinational.org/resource/envisioning-the-future-of-home-care-trends-and-opportunities-in-workforce-policy-and-practice/>.
51. Campbell, Stephen. 2017. *Training Methods Matter: Results of a Personal Care Aide Training Program in Chicago*. PHI: Bronx, NY. https://phinational.org/wp-content/uploads/2017/07/training_methods_matter_-_phi_-_july_2017.pdf.
52. Scales, Kezia. 2019.
53. Golden, Lonnie. 2015. *Irregular Work Scheduling and Its Consequences*. Washington, DC: Economic Policy Institute. <https://www.epi.org/publication/irregular-work-scheduling-and-its-consequences/>.
54. Koren, Mary Jane. 2010. "Predictable Scheduling." *Modern Healthcare*, August 16. <https://www.modernhealthcare.com/article/20100816/MAGAZINE/308169998/predictable-scheduling>.
55. Scales, Kezia. 2019.
56. Joseph, Chris. 2014. "The Advantages of Employer-Provided Health-Care Coverage." *Houston Chronicle*. <https://smallbusiness.chron.com/advantages-employerprovided-healthcare-coverage-21114.html>.
57. PHI. "Workforce Data Center."
58. Cook, Allison. 2018. *Paid Family and Medical Leave: How States Should Support Direct Care Workers*. Bronx, NY: PHI. <https://phinational.org/resource/paid-family-medical-leave-states-support-direct-care-workers/>.
59. Brown, Christopher and Lisa Robinson. 2016. *Breaking the Cycle: From Poverty to Financial Security for All*. Oakland, CA: PolicyLink. https://www.policylink.org/sites/default/files/BreakingTheCycle_0.pdf.
60. PHI. 2011. *PHI Coaching Approach Demonstration Yields Positive Outcomes for Employers*. Bronx, NY: PHI. <https://phinational.org/resource/phi-coaching-approach-demonstration-yields-positive-outcomes-for-employers-2/>.
61. Escadón, Ines and Marcia Mayfield. 2010. *The Business of Caregiving: Loretto's PACE Central New York Proactively Tackling Retention*. Bronx, NY: PHI. <https://gcgj.mit.edu/sites/default/files/imce/resourceuploads/Loretto.pdf>.
62. Zimmerman, Sheryl, Barbara J. Bowers, Lauren W. Cohen, David C. Grabowski, Susan D. Horn, and Peter Kemper, for the THRIVE Research Collaborative. 2016. "New Evidence on the Green House Model of Nursing Home Care: Synthesis of Findings and Implications for Policy, Practice, and Research." *Health Services Research* 51(Suppl 1): 475-496. doi: 10.1111/1475-6773.12430.
63. PHI. 2018. "PHI Releases Research Series on Racial Disparities in Direct Care." News release, February 6. <https://phinational.org/news/phi-releases-research-series-racial-disparities-direct-care/>.
64. Catalyst. 2020. "Why Diversity and Inclusion Matter: Quick Take." <https://www.catalyst.org/research/why-diversity-and-inclusion-matter/>.
65. Scales, Kezia. 2018. *Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employers*. Bronx, NY: PHI. <https://phinational.org/resource/growing-strong-direct-care-workforce-recruitment-retention-guide-employers/>.
66. Achievers. 2017. *The Ultimate Guide to Employee Recognition: Engage, Align, and Recognize Your Employees to Inspire Success*. Toronto, ON: Achievers Solutions Inc. <https://www.achievers.com/resources/ebooks/ultimate-guide-to-employee-recognition/>.
67. Scales, Kezia. 2019.
68. Drake, Angelina. 2020.
69. Drake, Angelina. 2019. "How 'Upskilling' Can Maximize Home Care Workers' Contributions And Improve Serious Illness Care." *Health Affairs Blog*, March 4, 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20190227.420595/full/>.
70. Drake, Angelina. 2020.
71. Greenwood, Beth. "The Advantages of Promotion from Within." *Houston Chronicle*. <https://work.chron.com/advantages-promotion-within-6320.html>.
72. National Direct Service Workforce Resource Center. 2009. *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection*. Woodlawn, MD: CMS. <https://www.medicare.gov/medicaid/ltss/downloads/workforce/monitoring-dsw.pdf>.
73. Cook, Allison. 2019. "State Workgroups Confront the Direct Care Workforce Crisis." *PHI Blog*, October 29. <https://phinational.org/news/state-workgroups-confront-the-direct-care-workforce-crisis/>.
74. ZERO TO THREE and National Partnership for Women & Families. 2018. *The Child Development Case for a National Paid Family and Medical Leave Program*. Washington, DC: ZERO TO THREE and National Partnership for Women & Families. <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/the-child-development-case-for-a-national-paid-family-and-medical-leave-insurance-program.pdf>.
75. Saad-Lessler, Joelle and Kate Bahn. 2017. *The Importance of Paid Leave for Caregivers*. Washington, DC: Center for American Progress. <https://www.americanprogress.org/issues/women/reports/2017/09/27/439684/importance-paid-leave-caregivers/>.
76. The Women's Initiative. 2017. *Paid Family and Medical Leave: By the Numbers*. Washington, DC: Center for American Progress. <https://www.americanprogress.org/issues/women/reports/2017/09/27/439527/paid-family-medical-leave-numbers/>.
77. Veghte, Benjamin W., Alexandra L. Bradley, Marc Cohen, and Heidi Hartmann. 2019. *Designing Universal Family Care: State-Based Social Insurance Programs for Early Child Care and Education, Paid Family and Medical Leave, and Long-Term Services and Supports*. Washington, DC: National Academy of Social Insurance. <https://www.nasi.org/research/2019/designing-universal-family-care-state-based-social-insurance>.

Appendix 1: Data Sources and Methods

The direct care workforce comprises three occupations as defined by the Standard Occupational Classification system developed by the Bureau of Labor Statistics at the U.S. Department of Labor: nursing assistants, home health aides, and personal care aides.⁹³ 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. “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.

Appendix 2: 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

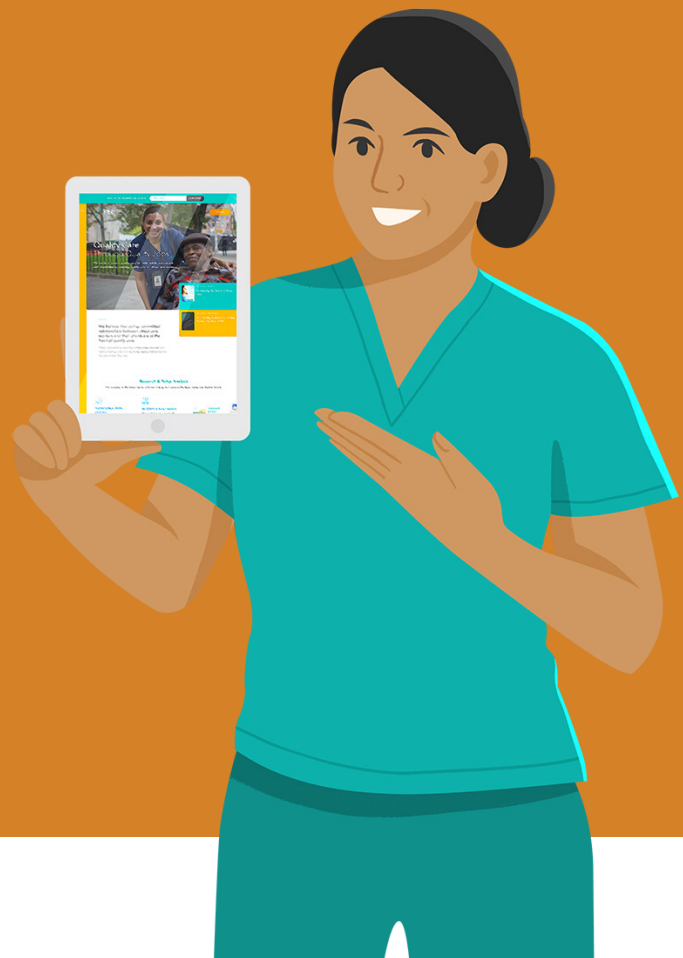
Source: These analyses are based on *Job Zones*, as defined in the O*NET database. Occupations with similar entry-level requirements to direct care jobs are categorized in *Job Zone Two: Some Preparation Needed*, whereas jobs with lower entry-level requirements are captured in *Job Zone One: Little or 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/oesrsci.htm>; analysis by PHI (September 2020).

About PHI

PHI works to transform eldercare and disability services. We foster dignity, respect, and independence for all who receive care, and all who provide it. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.

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