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# FEELING VALUED BECAUSE THEY **ARE VALUED**

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A Vision for Professionalizing the Caregiving Workforce  
in the Field of Long-Term Services and Supports

*By Robyn I. Stone and Natasha Bryant*



## **ABOUT THIS WHITE PAPER**

LeadingAge would like to thank researchers at the LeadingAge LTSS Center @UMass Boston for developing this white paper. This paper provides a long-range vision for reimagining the professional direct care workforce across long-term care settings. LeadingAge maintains a short- and mid-range federal policy and advocacy agenda that is detailed in our [2021 Policy Priorities](#) under Workforce.

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## **ABOUT LEADINGAGE**

LeadingAge represents more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information visit [leadingage.org](https://www.leadingage.org).

## **ABOUT THE LTSS CENTER**

The LeadingAge LTSS Center @UMass Boston conducts research to help our nation address the challenges and seize the opportunities associated with a growing older population. LeadingAge and the University of Massachusetts Boston established the LTSS Center in 2017. We strive to conduct studies and evaluations that will serve as a foundation for government and provider action to improve quality of care and quality of life for the most vulnerable older Americans. The LTSS Center maintains offices in Washington DC and Boston, MA. For more information, visit [LTSSCenter.org](https://www.LTSSCenter.org).

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# TABLE OF CONTENTS

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<b>Introduction</b> .....	1
<b>Profile of Professional Caregivers</b> .....	4
<b>Six Strategies for Professionalizing the LTSS Workforce</b> .....	8
<b>STRATEGY 1: Expand the Caregiver Pipeline</b> .....	8
<b>STRATEGY 2: Enhance Training and Education</b> .....	9
<b>STRATEGY 3: Facilitate Career Advancement</b> .....	11
<b>STRATEGY 4: Increase Compensation</b> .....	15
<b>STRATEGY 5: Prepare Universal Workers</b> .....	18
<b>STRATEGY 6: Reform the LTSS Financing System</b> .....	18
<b>Conclusion</b> .....	19
<b>References</b> .....	20

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*This paper breaks with common practice by renaming what is commonly referred to as the “direct care worker.” Throughout this paper, we refer to these individuals as “professional caregivers” or “direct care professionals” to emphasize their rightful status in our field and the dedication and skills they demonstrate as they care for the most vulnerable among us.*

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# INTRODUCTION

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The coronavirus pandemic shed new—and much-needed—light on the valuable work that nursing assistants, personal care aides, and home health aides carry out each day as they provide life-sustaining services and supports to older adults who are particularly susceptible to COVID-19.

These professional caregivers—often referred to as direct care workers—have always played an important role in the field of long-term services and supports (LTSS). But the pandemic exacerbated and highlighted the challenges they experience on the job each day. The health crisis also raised awareness of how much consumers and aging services organizations depend on them to provide care, and exposed deficiencies in the LTSS system that are likely to challenge this workforce far into the future.

For example, staffing shortages, already an issue in the LTSS sector, became widespread during the pandemic. From March to May 2020, the number of direct care professionals dropped by 280,000, with the majority of workforce reductions occurring among personal care aides (PHI, 2020b).

Since March 2020, COVID-19 outbreaks in residential care settings placed additional burdens on direct care staff, and ongoing virus outbreaks made it difficult for care settings to attract caregivers and fill vacancies (Barnett and Grabowski, 2020). In addition to the challenges associated with caring for infected residents, staff members ran the very real risk of being exposed to the deadly virus. Their need to quarantine after COVID-19 exposure exacerbated workforce shortages even further.

A 2020 study by the LeadingAge LTSS Center @UMass Boston found that direct care professionals in assisted living, nursing home, and home and community-based settings experienced a variety of challenges during COVID-19, including increased workload demands, increased risk of virus transmission to and from residents/clients, and understaffing. Caregivers also reported personal challenges associated with being separated from family members, managing the personal needs and demands of family, and experiencing financial hardships (Cimarolli and Bryant, 2021).

Not all of these challenges will disappear once we are able to stop the spread of the coronavirus. Instead, the LTSS workforce will face long-term challenges that were exposed by the pandemic and must be addressed immediately so we can continue providing high-quality services and supports to a rapidly growing older population in the years to come.

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*Despite the valuable work they do, direct care professionals are not valued by our society or its health care system.*

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The coronavirus pandemic also gave new relevance to LeadingAge's long-standing efforts to encourage all Americans, including policymakers and consumers, to reexamine how they view direct care professionals and the work they do, and to reimagine the role these caregivers can play within our health and LTSS systems.

**Why is it necessary to reimagine the direct care workforce?** Despite the valuable work they do, direct care professionals are not valued by our society or its health care system. Too many of these caregivers earn low wages, receive inadequate benefits, and endure poor working conditions while carrying out an extremely labor-intensive job. Given these conditions, inevitable staffing shortages and workforce instability will lead to lower-quality care, lower-quality of life for consumers and their families, and unmet needs among care recipients (Ruffini, 2020).

**What would a reimagined direct care workforce look like?** LeadingAge envisions a direct care workforce that is a professionalized workforce. Just like professionals in other fields, direct care professionals would:

- Receive high-quality, competency-based training.
- Earn a living wage and meaningful benefits commensurate with their competency levels.
- Enjoy good working conditions and skilled supervision.
- Have access to a variety of career advancement opportunities.
- Be respected and appreciated by their employers, care recipients, and the general public.

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**How do we get there?** This white paper proposes six strategies for professionalizing the direct care workforce so caregivers *feel* valued because they *are* valued. The strategies outlined below will improve recruitment of new caregivers, reduce turnover among current caregivers, and ensure that a stable, high-quality workforce will be available to care for older adults with LTSS needs. The strategies include:

- 1. Expand the pipeline of potential caregivers** by recruiting nontraditional workers to the LTSS field and changing immigration policy so more caregivers will seek out jobs in the LTSS field.
- 2. Enhance education and training**, both initial and ongoing, so professional caregivers will feel well-prepared to carry out increasingly complex care tasks, and so nursing homes, assisted living communities, home care organizations, consumers, and their families will have confidence in those caregivers. States should identify competencies that direct care professionals must demonstrate, support the development of training that addresses those competencies, and establish public/private partnerships to invest in relevant, high-quality training and education.
- 3. Facilitate career advancement** so caregivers can grow into meaningful LTSS careers that offer them a variety of opportunities, including career pathways that allow them to become condition-specific specialists, take on advanced caregiving roles, be accepted as valued members of integrated care teams, or perform a full range of health maintenance tasks under the supervision of a registered nurse. Direct care professionals should also have access to career ladders that offer opportunities beyond the traditional nursing path, including careers in social work, therapy, and management positions that use their relationship skills.
- 4. Increase compensation** so direct care professionals can earn at least a living wage. This level of compensation would provide caregivers with enhanced financial security while also reducing turnover and staffing shortages at aging services organizations, boosting productivity, enhancing quality of care, and increasing overall economic growth in communities where direct care professionals live.
- 5. Prepare universal workers** who could become direct care professionals in nursing homes, assisted living communities, and home and community-based settings. This would involve identifying a core set of competencies at the federal level that aides, regardless of setting, could master and demonstrate. These “universal workers” would then have the flexibility to work across settings and even across state boundaries.
- 6. Reform the LTSS financing system** by using insurance-based dollars to provide additional and more consistent funding for LTSS and to help ensure that the LTSS workforce receives adequate compensation.

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# PROFILE OF PROFESSIONAL CAREGIVERS

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Professional caregivers—classified as nursing assistants, personal care aides, and home health aides—provide the majority of hands-on care to older adults and younger people with disabilities who receive LTSS in nursing homes, assisted living communities, other residential and community-based settings, and private homes (U.S. Bureau of Labor Statistics, 2020). The work these professionals carry out is essential to ensure the health and well-being of their care recipients and the overall functioning of the LTSS and health care systems.

Professional caregivers provide support to 20 million older adults who require assistance completing self-care and other daily tasks due to physical, cognitive, developmental, and/or behavioral conditions (PHI, 2020b). In 2019, this caregiving workforce consisted of:

- 2.4 million personal care aides and home health aides.
- 735,000 aides working in residential care settings.
- 566,000 nursing assistants working in nursing homes (PHI, 2020a).

While the number of professional caregivers in the U.S. may seem impressive, these numbers don't give a full picture of the ability of direct care professionals to meet the growing need for their services. A more complete picture comes from the caregiver support ratio, which predicts the ratio of potential caregivers—working-age adults aged 18 to 64 years old—to people aged 85 and older who are most likely to need care.

The caregiver support ratio in the United States is expected to decline between 2016 and 2060. In 2016, there were 31 people of working age for every older adult 85 and older. We expect there will only be 12 people of working age for every older care recipient in 2060 (PHI, 2020b). The ratio's current trajectory predicts an increasing demand for—and shortage of—aides in the coming decades.

The field of professional caregiving is projected to add a total of 8.2 million jobs between 2018 and 2028. This number includes 1.3 million new caregiving jobs—a 28% increase—and 6.9 million job openings that will occur when professional caregivers leave their existing jobs (PHI, 2020b) Our ability to fill these openings with qualified caregivers depends on our ability to professionalize the caregiver workforce.

## WORKFORCE DEMOGRAPHICS

The professional caregiver workforce is composed primarily of women and people of color. The median age of a direct care professional is 43, and 87% of these caregivers are female. More than half of professional caregivers are people of color (59%), including caregivers who are:

- Black (31%).
- Hispanic/Latino (18%).
- Asian or Pacific-Islander (7%).
- Those who identify with other races or ethnicities (3%) (PHI, September 2020).

## IMMIGRATION STATUS

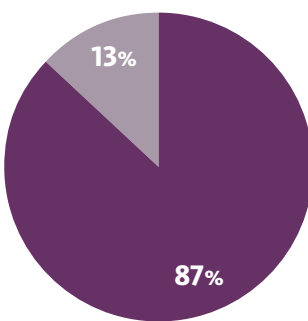
A large portion of the professional caregiver workforce consists of immigrants, with approximately one in four (27%) direct care professionals born outside the United States. Immigrant caregivers are more prevalent in home care (31%) than in nursing home settings (20%) (PHI, September 2020).

## EDUCATION

More than half (53%) of professional caregivers have a high school education or less, while 29% have some college, and 18% have an associate degree or higher (PHI, September 2020).

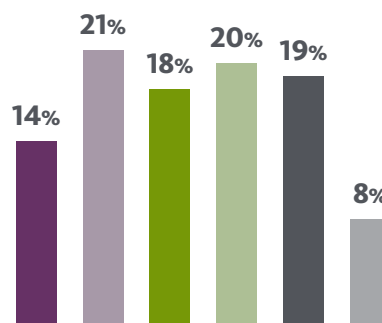
### WORKFORCE DEMOGRAPHICS BY

#### GENDER



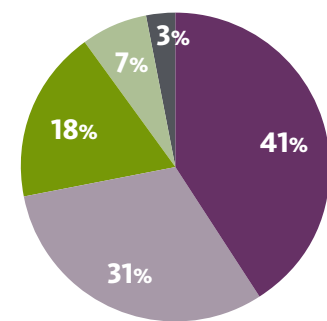
- Female
- Male

#### AGE



- 16-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

#### RACE & ETHNICITY



- White
- Black/African American
- Hispanic/Latino
- Asian/Pacific Islander
- Other



# CHALLENGES FACED BY PROFESSIONAL CAREGIVERS

A plethora of issues at the societal, policy, and practice levels make it difficult to recruit and retain a high-quality, committed direct care workforce.

## OVERLOOKED VALUE

Direct care jobs are perceived as “low wage” and “low skill.” These perceptions underscore the degree to which this workforce is undervalued by the general public, policymakers, providers, and consumers and their families (Spetz et al., 2019).

All of these groups lack awareness of the complex nature of professional caregiving jobs, and the significant technical and interpersonal competencies these caregivers bring to their work, which involves providing personal care and emotional support to individuals living with serious and chronic conditions and physical and cognitive impairments.

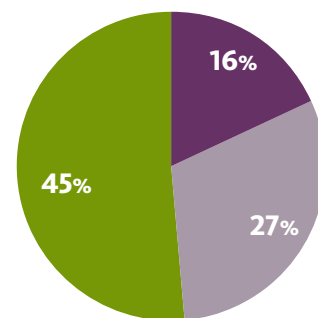
## LOW PAY AND FEW BENEFITS

The underappreciation of professional caregivers translates into low pay, few benefits, and a marginalized status for caregivers, and a labor market that makes it difficult to attract new caregivers and retain current ones. Consider:

- The median hourly wage for professional caregivers is \$12.80, with wages ranging from \$12.12 per hour for home care aides to \$13.90 per hour for nursing assistants. Hourly wages in the professional caregiving field have increased by only 19 cents over the last decade.
- Median annual earnings for professional caregivers are \$20,300, due to a combination of high rates of part-time employment and low wages.
- Fifteen percent of professional caregivers do not have health insurance, while 36% of caregivers receive health insurance through Medicaid, Medicare, or other public coverage.

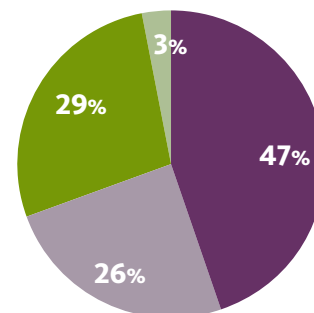
Low wages and inadequate benefits create financial instability for the professional caregiving workforce. Forty-five percent of caregiver households live below 200% of the federal poverty level and 47% rely on some form of public assistance to make ends meet. One-third of these caregivers (36%) lacks affordable housing (PHI, September 2020).

## POVERTY LEVEL



● < 100%   ● < 138%   ● < 200%

## PUBLIC ASSISTANCE



● Any Public Assistance  
● Food & Nutrition  
● Medicaid   ● Cash

## INADEQUATE TRAINING AND LITTLE STANDARDIZATION

The preparation of potential candidates for professional caregiving positions, and ongoing training for those working in the field, do not align with the demand for LTSS services and the current state of practice in the field. Inadequate investment in the education and training of the workforce (Stone and Bryant, 2012) means that professional caregivers across the spectrum of LTSS settings are often ill-prepared to assume their hands-on responsibilities for the daily care of nursing home residents, assisted living residents, and home care clients.

Federal law requires that certified nursing assistants and home health aides receive 75 hours of training. Thirty-one states and the District of Columbia require more than 75 hours of training for certified nursing assistants. Seventeen states and the District of Columbia require more than 75 hours of training for home health aides (PHI, 2020b).

On the other hand, federal training standards and requirements do not exist for personal care aides. Because Medicaid is the major public funder for home care services, each state sets its own standards and training requirements (Marquand and Chapman, 2014). Forty-three states and the District of Columbia have at least one set of training requirements for personal care aides, and seven states do not regulate personal care aide training at all (PHI, 2020b).

The availability of required training programs varies by region. Training can be offered through community colleges, employer sites, vocational tech schools, vocational high school training programs, and proprietary training schools. Training programs are hampered by a significant shortage of faculty who are competent and committed to educating and preparing professional caregivers for LTSS careers (Stone, 2017). In addition, training curricula often fail to cover the range of skills, knowledge, and competencies that professional caregivers need to support consumers with complex chronic or serious health conditions and functional impairments.

## LIMITED OPPORTUNITIES FOR CAREER MOBILITY

The organizational structures of aging services organizations are relatively flat and offer professional caregivers few opportunities for advancement. Currently, there are three main opportunities for caregivers to take on more expansive and satisfying roles, but not all caregivers have access to these opportunities. They include:

- **Career Ladders:** A career ladder is a formal process within an organization that allows employees to advance in their careers to higher levels of salary, responsibility, or authority.
- **Career Lattices:** A career lattice allows professional caregivers to explore and grow their careers by moving across organizations into varied roles, including medication management, behavioral health, or dementia care specialists.
- **Apprenticeship Programs:** Apprenticeship programs offer direct care professionals the opportunity to receive didactic and on-the-job training and career advancement opportunities.

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# SIX STRATEGIES FOR PROFESSIONALIZING THE LTSS WORKFORCE

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This white paper proposes six strategies for professionalizing the direct care workforce so caregivers *feel* valued because they *are* valued. These strategies provide a framework for a broad action plan that would improve the recruitment and retention of direct care professionals—and strengthen the direct care workforce—by expanding the pipeline of caregivers, enhancing education and training, facilitating career advancement, increasing compensation, preparing universal workers, and reforming the LTSS financing system.

## STRATEGY 1

### EXPAND THE CAREGIVER PIPELINE

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The LTSS field is experiencing a workforce crisis. There are simply not enough professional caregivers to provide high-quality support to older adults and younger people with disabilities. This crisis calls for new and concerted efforts to target recruitment to new groups of workers, including nontraditional workers and foreign-born workers.

#### NONTRADITIONAL WORKERS

Nontraditional workers—individuals not usually attracted to or sought after for LTSS caregiving jobs—may hold the key to expanding the pool of professional caregivers in the LTSS field. These workers may include high school students, displaced workers, and older people who want or need to work past retirement age.

LTSS providers can tap into these nontraditional worker groups by building partnerships with high school programs, colleges, workforce development programs, and government or community agencies to create awareness about LTSS jobs and bring new caregivers into the field.

#### FOREIGN-BORN WORKERS

Providers of aging services often have difficulty attracting and retaining native-born workers to meet the demand for LTSS (Stone and Bryant, 2018-2019).

Negative attitudes toward immigration, and the recent focus on deportation of undocumented individuals, created a culture of fear among foreign-born individuals who might be interested in pursuing professional caregiving jobs. This anti-immigration climate has been a barrier to recruitment

for hard-to-fill LTSS positions. However, the new federal administration may be more open to changes in immigration policy that increase the number of foreign-born workers available in the United States and expand the potential labor pool for LTSS jobs.

LeadingAge has proposed a workforce initiative called International Migration of Aging and Geriatric Workers in Response to the Needs of Elders (IMAGINE). IMAGINE features a targeted set of policy recommendations aimed at engaging foreign-born workers to meet the growing care needs of a rapidly aging America. Several IMAGINE proposals could help expand the professional caregiving workforce:

- Create an “H2Age” guest worker program modeled on current guest worker authorities for agriculture and hospitality workers. The H2Age program would allow employers to hire qualified foreign-born individuals for a fixed amount of time after demonstrating that there are no native-born workers available to fill the positions.
- Expand the cultural exchange (J-1) visa to allow “au pairs” to work in homes with individuals over age 65 who need assistance. Au pairs are now limited to working in homes with children under age 18.
- Expand and modify the EB-3 visa program to allow more foreign-born professional caregivers to enter the U.S., and to increase the number of visas available to address LTSS needs (LeadingAge, 2019).

## STRATEGY 2

### ENHANCE TRAINING AND EDUCATION

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The LTSS field depends on direct care professionals to help it meet two important goals:

- To deliver high-quality LTSS across a variety of settings.
- To help implement delivery and payment reforms that focus on care coordination and integration across LTSS, primary care, and acute care settings.

In order to attain these goals, it is critical for the LTSS field to identify the competencies that will help direct care professionals address the complex service needs of residents and clients and implement new care practices. Then, we must develop robust curricula that address these competencies during initial and ongoing training.

### COMPETENCIES

Basic and ongoing training and education should ensure that professional caregivers know how to:

- Support individuals as they carry out activities of daily living and instrumental activities of daily living.
- Navigate the physical, social, and emotional demands of direct care.
- Demonstrate cultural competency.
- Deliver person-centered care.
- Support individuals with complex conditions and care needs.
- Help care recipients manage chronic diseases (PHI, 2020b).

The [Personal and Home Care Aide State Training \(PHCAST\) program](#) could form the foundation for a national set of training standards for personal care aide education. During FY 2010, this national demonstration allowed six states to develop, implement, and evaluate training models based on nine core competency areas.

Other existing competency models, including the [Direct Service Workforce Core Competencies](#) developed by the Centers for Medicare & Medicaid Services (CMS), and the [Personal Care Attendant Competency Model](#) developed by LeadingAge, could also inform a more standardized approach to establishing competencies.

## TRAINING

For many years, researchers have supported increasing the 75-hour federal training requirement for certified nursing assistants and home health aides (Institute of Medicine, 2008; Spetz et al., 2019). Specifying a minimum number of required training hours is important. However, such requirements are no substitute for taking deliberate steps to ensure that the training taking place during required hours provides trainees with the skills they need to provide high-quality care.

It is especially important that direct care professionals receive their training in a “real world” environment and that the skills they learn can be sustained over time. The number of required training hours should be based on the competencies defined for a particular group of professional caregivers and the time needed to train these caregivers in the knowledge and skills required to demonstrate each competency.

The curriculum for Arizona’s state-sponsored personal care aide training program is one example of this approach. The program covers the core fundamental skills for personal care aides and has population-specific modules. The effectiveness of the training is demonstrated through standardized assessments and test results, rather than a prescribed number of minimum training hours. The curriculum’s learning objectives focus on knowledge attainment and demonstration of technical skills (LeadingAge LTSS Center @UMass Boston, not published).

Another exemplary example of this approach is a competency-based curriculum for personal care aides in Massachusetts. The curriculum is divided into 13 modules that each include skills-based learning objectives and incorporate adult learner-centered principles. This interactive, case-based educational method allows learners to build on their existing knowledge and fit learning into real-life practice. The training also provides guidance to help trainers use a combination of observation and testing to assess trainees’ knowledge, skills, and attitudes (LeadingAge LTSS Center @UMass Boston, not published).

## INVESTING IN EDUCATION AND TRAINING

Federal and state agencies could develop partnerships with the private sector to invest in the education and training of the professional caregiver workforce at the entry level and at more specialized levels. Specialized training can create opportunities for career advancement of direct care professionals in nursing, social work, human resources management, and other clinical and management fields.

## STRATEGY 3

# FACILITATE CAREER ADVANCEMENT

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### CAREER LATTICES

State and federal policymakers could work with providers of aging services to create meaningful career lattices for direct care professionals, so they can aspire to:

- Become condition-specific specialists in dementia care, chronic condition management, behavioral health, and medication and pain management.
- Take on advanced roles as integral members of care transition teams or as peer mentors.

Creating meaningful career lattices requires that employers develop competency-based job descriptions for these roles and that educational institutions create appropriate training programs and match that training to the skill sets of the employee.

There are a number of promising career lattice programs around the country, including the following:

**Expanding Aide Responsibilities:** In 2012, St. John's Well Child and Family Center, an independent network of federally qualified health centers in Los Angeles, developed and tested a one-year pilot to integrate clinic-based and home-based services for older adults and people with disabilities who qualify for Medicaid. Ninety-seven pairs of clinic aides and patients participated in the pilot program.

Aides received 25 hours of training to expand their health-related knowledge and skills and prepare them to perform supplemental tasks related to chronic care management. They were integrated into patients' medical and social care teams and included in care planning, ongoing communication, and service coordination.

An evaluation of the pilot results showed that:

- Patient satisfaction with care increased by an average of 13.4%.
- Medication compliance among patients improved by 40%.
- Patients' unhealthy days decreased from 25.3 to 15.6 per month (St. John's Well Child and Family Center, ULTCW SEIU, and United Long-Term Care Workers, 2014).

**Peer Mentoring:** The New Jewish Home in New York sponsors a peer mentor program through which experienced home health aides support newly hired home health aides or aides who need special assistance or have received disciplinary action (Kreiser, Adamski, and Gallagher, 2010). The peer mentor provides the mentee with support on client care issues and ensures that the mentee understands the organization's policies and procedures.

Experienced aides in the program attend two days of training, during which they learn about peer mentoring, communication, cultural diversity, servicing the private-pay population, psychiatric and mental health disorders, palliative care, and telehealth. After completing the training and passing a competency test, these aides receive a certification that qualifies them as peer mentors and makes them eligible for an hourly pay increase.

A limited evaluation showed promise for the peer mentor program. Peer mentor aides worked an average of 40 hours a week, compared to 28 hours a week for other aides. They also had an 87% retention rate, compared to retention rates of 49% (in 2007) and 57% (in 2008) for all the organization's aides. (Kreiser, Adamski, and Gallagher, 2010).

Pilot programs to create career lattice opportunities, particularly for home health and personal care aides, have shown preliminary positive outcomes. These programs should be rigorously evaluated to determine their impact on professional caregivers and clients, and the potential cost savings. Successful programs should be disseminated and scaled to support wider adoption and help create an evidence-based case for sustained investment.

## ADVANCED ROLES AND INTEGRATION INTO TEAM-BASED CARE

Nursing assistants, personal care aides, and home health aides are the eyes and ears of the health system. Based on their often long-standing relationships with care recipients, these caregivers are able to observe subtle changes in a care recipient's condition. Information about these changes can help inform clinical decision-making and therapeutic interventions by the care team.

For this reason, professional caregivers should be encouraged to take on advanced roles like participating in emerging team-based care approaches. However, employers must acknowledge that these roles belong in a different job category with different functions and responsibilities, and increased pay.

In addition, direct care professionals seeking to take on this advanced role must receive training in the skills they need to:

- Observe the care recipient.
- Document the person's health status and the care furnished to that person.
- Communicate effectively with other members of the care team.

CMS could foster the development of this advanced role by supporting demonstration programs exploring opportunities for aides to become essential members of team-based care models in post-acute home health care, transitional care from hospital to skilled nursing settings, home care, and home-based primary care. Health care team members may also need to be educated on the role aides can play on the care team and the value they can bring to the team. This education would result in more successful integration and use of aides' knowledge and skills by the care team.

Several promising programs include aides in team-based care models:

**Care Connections Senior Aide:** PHI, a training advocacy organization for direct care professionals, and Independent Care System, a Medicaid managed care plan in New York City, worked in partnership to create an advanced personal care aide role called the care connections senior aide (CCSA) (Misiorski, 2018). The CCSA program was designed with the goal of reducing emergency department (ED) use and preventing rehospitalization.

CCSAs coached and supported entry-level personal care aides, helped improve care transitions, solved caregiving challenges in the home, and served on an interdisciplinary home-based care team. CCSAs received 240 hours of in-classroom and on-the-job training that was designed to:

- Strengthen the aides' observation, documentation, and reporting skills.
- Prepare aides to educate and mentor other personal care aides.
- Deepen aides' knowledge of the chronic conditions most likely to lead to a preventable hospitalization.

An internal evaluation of the CCSA program found an 8% reduction in ED visits among 1,400 clients, and reduced levels of strain among family members. CCSAs received several benefits from the program:

- A 60% wage increase.
- Improvements in job satisfaction.
- Greater inclusion in care team activities.
- Better relationships with families and clients.
- Improved communication with clinical managers.

**Care Team Integration of the Home-Based Workforce:** Personal care aides in the California's consumer-directed In-Home Supportive Services (IHSS) program were integrated into clients' care teams (Coffman and Chapman, 2012; California Long-Term Care Education Center, 2016). The pilot, developed by the California Long-Term Care Education Center, featured a 17-module, 75-hour program that trained IHSS aides to monitor clients' health conditions and medication adherence, communicate with clients and team members, navigate the health system, and coach clients. Program staff also educated participating health plans and medical groups about the training program and its goals.

An evaluation of the program found:

- Trainees reported increased knowledge and skills, increased confidence, and improved communication with clients and primary care physicians.
- ED visits and rehospitalizations declined among clients..
- Cost savings of \$12,000 per trainee were recorded due to these declines.



## APPRENTICESHIPS

Apprenticeship programs allow individuals to learn occupational competencies both in formal classroom settings and while working at a job that directly applies and reinforces those competencies. Structuring training in this way provides apprentices with an income during the training and helps ensure that the skills they learn are useful to employers.

Apprenticeship programs have not been particularly successful in helping to create career advancement opportunities in the professional caregiving field



because these caregiving jobs are viewed as entry-level and low-skilled positions and not worth the investment that an apprenticeship program requires. However, these programs still hold great potential for strengthening the professional caregiving field.

To help boost the role that apprenticeships can play in helping direct care professionals advance in their careers, the U.S. Department of Labor and its state counterparts could work with providers and educational institutions to develop comprehensive apprenticeship programs that provide didactic and on-the-job training and career advancement opportunities for direct care professionals. These programs could attract veterans, high school students interested in LTSS careers, or the large number of retail, hospitality, and other service workers who were displaced from their jobs during the COVID-19 pandemic.

## CAREER LADDERS

Typically, the only career ladder available to direct care professionals is a career in nursing. However, aides who want to move up the career ladder may not necessarily want to be nurses and may be interested in positions beyond nursing.

Employers could offer direct care professionals career ladders that provide alternatives to the traditional nursing path. For example, professional caregivers could be encouraged to explore career opportunities that tap into the relationship skills they developed as direct care professionals. These opportunities might lead professional caregivers into careers in social work, therapy, and management.

## NURSE DELEGATION

Every state has its own Nurse Practice Act, which designates the nursing services that can only be performed by or under the direct supervision of a licensed nurse (Reinhard, 2010). The acts also designate the nursing services that can be delegated to aides.

In some states, the tasks that can be delegated to an aide are wide-ranging and may include medication administration, caring for wounds, assisting with insulin pumps, changing catheters, and other nursing-related tasks (Stone and Weiner, 2001). Other states prohibit aides from performing services such as placing pills in a care recipient's mouth or administering over-the-counter eye drops. Agency-employed personal care aides are subject to delegation rules contained in their states' nurse practice acts, while family caregivers and independent providers are often exempt from these acts.

A study by Reinhard and colleagues (2020) found that in 2019, 18 states allowed registered nurses to delegate to personal care aides a full range of health maintenance tasks included in a sample set of 16 tasks. Among those delegated tasks were medication administration, blood glucose monitoring, and wound care. At the other end of the spectrum, 12 states permitted delegation of three or fewer tasks to aides. Florida, Indiana, Pennsylvania, and Rhode Island did not permit delegation of any of the sample set of health maintenance tasks.



States can support career development by revising nurse delegation regulations to expand the specific roles that direct care professionals can carry out under those regulations. Delegated roles could even expand beyond personal care tasks to include formal documentation of a care recipient's condition, medication assistance, and health coaching.

State experience with nurse practice acts shows that expanding nursing delegation:

- Contributes to increased staff retention.
- Saves money for public payers because they are able to rely on less-expensive labor to carry out some caregiving tasks.
- Requires a concomitant focus on appropriate nurse supervision, and the need to allocate resources to support nurse training and ongoing support.
- Requires adequate Medicaid reimbursement to cover increased wages for aides who pursue more specialized positions.

## STRATEGY 4

### INCREASE COMPENSATION

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Professionalizing the direct care workforce can improve the recruitment and retention of caregivers (Weller et al., 2020a). One step in that process calls for increasing the pay of direct care professionals to a living wage in their states of residence. A recent LeadingAge study—[Making Care Work Pay: How a Living Wage Benefits Us All](#)—found that raising the pay of direct care professionals to a living wage in 2022 would translate into an average pay increase of 15.5% and would benefit 75.3% of direct care professionals (Weller et al., 2020b).

The LeadingAge study showed that a meaningful pay raise would provide professional caregivers with enhanced financial security, while also:

- Reducing turnover and staffing shortages at aging services organizations.
- Boosting caregiver productivity.
- Enhancing quality of care.
- Increasing overall economic growth in communities where direct care professionals live.

Several states implemented temporary measures to raise the compensation of direct care professionals during the pandemic. Some states began offering hazard pay to aides who put themselves at risk by coming to work each day. As of November 2020, 36 states had facilitated those pay hikes by temporarily increasing provider payment rates through their 1915(c) home and community-based services waivers (Kaiser Family Foundation, July 2020). Eighteen of these states have increased reimbursement for both nursing home and home care (Musumeci, Dolan, and Guth, 2020).

While these funding changes were designed as temporary measures to help providers of aging services stabilize their workforces during the pandemic, permanent changes to compensation for direct care professionals is desperately needed. In addition to a base rate that guarantees a living wage, these caregivers need benefits, merit and longevity pay, bonuses, and other job supports like childcare and transportation.

## PROVIDING SUSTAINABLE FINANCIAL SUPPORT FOR A LIVING WAGE

Providing a living wage to direct care professionals is an important first step in elevating the value of this workforce. Several actions can help move this agenda forward, including increasing Medicaid reimbursement rates, targeting Medicaid reimbursement rates to wages, and improving how Medicaid funds might support professional caregivers.

**Increase Medicaid Reimbursement Rates.** Providers of aging services want to raise worker wages, but they must be reassured that their wage-related costs will be covered over the short term while they await the longer-term financial and quality benefits that research shows will ultimately result from wage increases (Weller et al., 2020a). That’s why the Medicaid program—the largest [public payer](#) of LTSS—must reimburse providers at a level that allows them to pay professional caregivers a living wage.

**Target Medicaid Reimbursement to Wages.** Only about [half the states](#) made a commitment to increasing aide wages through Medicaid rate changes in 2019 and 2020, despite the close competition for direct care professionals and rising demand for LTSS. Among states that raised reimbursement rates, the increases tended to be marginal and some increases did not keep up with inflation year-to-year. This limited investment in wages has been a [key contributor](#) to direct care workforce shortages nationwide. The next four approaches could improve the situation.

**Ensure Reimbursement Increases Are Passed On.** Since 2009, the federal minimum wage has held steady at \$7.25. As of 2019, 18 states required that, each year, employers increase the minimum wage they pay employees. This mandate should have been a positive development for direct care professionals. Unfortunately, these mandated increases were not paired with adequate Medicaid reimbursement rate increases or with requirements that providers pass reimbursement increases directly to professional caregivers. As a result, Medicaid-funded providers continue struggling to cover new wage mandates, and direct care professionals do not necessarily experience the benefits of a higher minimum wage.

To remedy this situation, several states have adopted “wage pass-through” measures requiring providers to use any new Medicaid payments to increase staff wages. These [approaches](#) are not as effective as they could be because they have limited time frames, have not been sustained, and have been difficult to implement when consumers hire aides directly, rather than through an agency. As an alternative, we recommend that state policymakers:

- Build a living wage for direct care professionals into Medicaid payment rates on an ongoing basis.
- Ensure that the appropriate percentage of provider reimbursement goes directly to pay direct care professionals.
- Require periodic audits to oversee the process.

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*President Biden’s \$400 billion plan to bolster the health care workforce is a critical step toward improving direct care jobs.*

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**Work With Managed Care.** Some states have [passed legislation](#) to support improved benefits and worker protections for aides hired through managed care contracts. Several states are setting an example for how this might work:

- Wisconsin’s 2017 appropriations bill increased the portion of funds in managed care contracts that go toward aide wages, bonuses, time off, and benefits (Bradford, 2019).
- Tennessee pays managed care organizations a nursing home rate based on quality performance: 25% of the score focuses on staffing and staff competency measures, such as retention, training, and consistent assignment. This approach should be expanded to home and community-based services so agencies demonstrating better quality outcomes can receive higher reimbursement rates (Twomey, 2019).

**Bolster Home and Community-Based Care.** President Biden’s \$400 billion plan to bolster the health care workforce is a critical step toward improving direct care jobs. The plan proposes the expansion of home and community-based services (HCBS) by eliminating the current waiting list for Medicaid-funded HCBS and providing a higher federal Medicaid match for states that offer these services through their Medicaid state plans. These efforts would increase the demand for personal care aides.

Biden’s plan also recognizes the importance of professionalizing direct care occupations across settings through adequate compensation, improved working conditions, and greater investment in education and training. The Biden plan calls for increasing wages commensurate with the knowledge and skills of the direct care workforce; and ensuring that aides have access to high-quality training and education, affordable health insurance, federally-provided paid sick leave, family and medical leave, and affordable childcare (Biden, 2020).

**Support Families and Professional Caregivers.** Strategies that provide tax credits to family caregivers also show promise in helping to increase pay for the direct care workforce. However, that promise is dependent on ensuring that the value of tax credits is sufficient to help support a living wage for frontline staff.

For example, the Biden plan allows caregivers to earn Social Security credits for the time they are out of the workforce providing care to a family member. These additional Social Security earnings could partially offset the expenses associated with purchasing supplementary services from personal care aides, thus helping middle-class retired care recipients, their retired spouses, or children pay these aides at least a living wage.



## STRATEGY 5

### PREPARE UNIVERSAL WORKERS

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Several states have developed competency-based training standards designed to prepare individuals to work across all LTSS settings as “universal workers.” Such a strategy could help to address long-term workforce shortages in certain markets within the LTSS sector. Under a universal worker approach, for example, home-based aides could easily fill staffing gaps in nursing homes, and vice versa, depending on the demand for their services.

Federal policymakers could help promote the universal worker concept by identifying a core set of competencies at the federal level that aides, regardless of setting, should master and demonstrate. This approach could ensure that each professional caregiver is prepared for jobs in nursing homes, assisted living communities, other residential care settings, and home care. The universal worker approach would also create a “frontline care professional” occupation that would give aides the flexibility to move across settings and even across state boundaries.

Some states are making progress in laying the foundation for a universal worker approach to training standards and implementation. For example, Washington State requires 75 hours of entry-level training and 12 hours of continuing education for personal care aides. This training is comparable to the federal training requirements for certified nursing assistants and home health aides (Dawson, 2016). Once they pass a qualifying exam and are certified, these personal care aides can complete an abbreviated training to become certified as both nursing assistants and home health aides. Washington’s universal worker program could be the basis for further exploration of the advantages and disadvantages of developing a cross-setting professional caregiver occupation.

## STRATEGY 6

### REFORM THE LTSS FINANCING SYSTEM

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Ensuring a living wage for direct care professionals is not sustainable if the primary source of LTSS funding continues to be the Medicaid program, which was under severe budgetary stress even before the pandemic struck. For that reason, a growing number of states are exploring social insurance approaches to financing LTSS.

For example, Washington State is in the process of implementing its new state social insurance program—the [Long-Term Care Trust Act](#)—which is funded through a small tax (.58%) on the earnings of each working person. These new tax revenues will be set aside in a fund that will pay out up to \$36,500 should the person have an LTSS need (Cohen et al., 2020).

The infusion of insurance-based dollars into the LTSS system can provide additional and more consistent financing that, in part, can help ensure more adequate wages for the LTSS workforce. In addition to state exploration, there have also been a number of [bills put forward in Congress](#) designed to move LTSS financing from a Medicaid or social safety-net approach to a social insurance approach.

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# CONCLUSION

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Direct care professionals face many challenges and are not valued for their essential role to care for older adults and people with disabilities. Programs and policies are needed to stabilize and strengthen the quality of the workforce by investing in competency-based training, providing living wages and benefits, and offering career development opportunities. Targeted Medicaid reimbursement increases and reform of the LTSS financing systems are strategies to move this agenda forward.



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