State Policy Resource Guide to the Direct Care Workforce

The Challenge

To adequately support family caregivers in the U.S. requires a robust and informed direct care workforce. This was highlighted by the RAISE Act Family Caregiving Advisory Council and the Advisory Council to Support Grandparents Raising Children, with input from family caregivers and the people they support, released in the 2022 National Strategy to Support Family Caregivers.

This is a resource guide for state policymakers that addresses the recruitment, retention, and training of the direct care workforce

Direct Care Workforce (DCW)

The approximately 4.7 million people in the DCW include personal care aides, home health aides, and nursing assistants. The DCW assists older adults and people with disabilities across settings with daily tasks.

Most direct care workers are women and people of color. Black/African American direct care workers have the lowest family income, and Hispanic/Latino workers have the lowest annual income of any group.

The aging and longevity of the U.S. population increase the demand for long-term care services and supports. At the same time, turnover of vital direct care jobs is excessive, causing chronic shortages across settings. To recruit and retain this workforce, it is essential to find ways to increase the quality of direct care jobs.

The Solutions

Cultivating a Strong DCW to Support Family Caregivers

Increasing Compensation

The median hourly wage for direct care workers was $14.27 in 2021. In addition, the high rate of part-time work makes the median annual earnings $21,700. States have tackled the low compensation in a few different ways: wage reforms, supplemental/hazard pay, and improved benefits.

State Example: Michigan temporarily increased Medicaid wages by $2 an hour for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs) providing care in a long-term care or in-home behavioral health settings during the COVID-19 pandemic. Michigan made permanent a $2.35 per-hour wage increase in the 2022 state budget.

Improving and Streamlining Training

Training requirements of the DCW are uneven and inadequate in siloed delivery systems, and they lack portability across settings, roles, and regions. Developing training standards for the DCW increases quality of care and professionalizes the workforce.

State Example: The DCW in Maine must fulfill the state's Introduction to Health Care and Human Services training curriculum within six months of beginning employment. The training includes 10 of the 12 competency areas from the Centers for Medicare & Medicaid Services Direct Service Workforce Core Competencies and features recommendations for training methods and competency evaluation.

Developing Career Pathways

Gaining the skills and training necessary to move up career pathways in the care workforce is challenging and costly for the DCW, if pathways are available at all. Creating these opportunities to develop new expertise to move into a variety of positions in the care team and at the same time fill necessary roles, such as the care integration senior aide, is vital to professionalizing the DCW. PHI used the principles of care integration models in the development of the senior care integration senior aide to improve the quality of care and provides career pathways for the DCW. This guide provides tools and templates to implement this program.

State Example: Colorado is looking specifically at creating career pathways for several jobs. My Colorado Journey provides an overview of pay, openings and growth rate of priority jobs, as well as potential pathways to higher-paid jobs. The state also prioritizes evaluation of pathways by using state data to track credentials and program completion. While the data-sharing program is relatively new, it will track key outcomes such as salary, exam results, and retention in key health jobs, which will inform future initiatives.

Investing in Research and Data Collection

Policymakers can support research efforts aimed at better understanding the dynamics between direct care workers and family caregivers. This research can inform the development of targeted interventions and policies to improve their relationship.

State Example: Utah used funding from the American Rescue Plan Act's enhanced home and community-based services to "evaluate and recommend ways to address [the] direct services workforce crisis/shortage" and use report recommendations to support one-time projects based on the recommendations resulting from the study. Michigan and Arizona have also recently commissioned and completed statewide DCW research studies.

Collaborations between Providers, Employees, and State Government

These collaborations have been successful at developing training and creating career opportunities for the DCW. By working in partnership, the group creates open communication to address the needs and constraints of each group. This helps establish organized and efficient training as well as incentives to develop policies that help recruit and retain workers.

State Example: The WisCaregiver Careers program, a collaboration between the Wisconsin Department of Health Services, Wisconsin Health Care Association, and LeadingAge Wisconsin, has a streamlined certified nursing assistant (CNA) certification and offers career ladders in health care. Washington state, Colorado, Minnesota, Iowa, and California have collaborated on DCW training and retention efforts as well.

State Example: The DCW often feel their skills are unrecognized, and they don't feel supported or respected. Impart Alliance in Michigan is a coalition that includes direct care workers as well as care recipients, researchers, and agencies. Impart Alliance provides direct care workers with a private forum to connect with other workers, access to training, and ability to join the DCW directory as well as a professional association. Michigan worked with Impart Alliance and its members to increase wages permanently.

Building Connections between Family Caregivers and the Workforce

Strengthening Matching Service Registries

Developing and enhancing platforms that connect paid and unpaid caregivers with each other can facilitate better matches and foster stronger, more productive relationships. Nine states have statewide DCW matching registries where those who need help and their family caregivers can find workers.

State Example: Minnesota's exemplary matching service is available to both Medicaid-funded consumers and those who pay for services out-of-pocket. The service includes workers' background checks, credentials, and continuing education credits in their profiles.

Promoting Care Integration

Policies can encourage the integration of direct care workers and family caregivers into the care team, ensuring their insights and expertise are valued and utilized in care planning and delivery. In an effort to better integrate caregivers in care teams across settings, a National Alliance for Caregivers report shares the importance of caregiver integration and emerging intervention models. For example: Rush University and the Institute for Healthcare Improvement are integrating caregivers into the Age-Friendly Health System. The program RUSH Caring for Caregivers includes caregivers as part of the care team and provides training, guidance, and support for caregivers.

State Example: In California, the Department of Health and Human Services collaborated with managed care plans and SEIU Local 2015's Center for Caregiver Advancement to provide training programs for direct care workers. The Center led a Center for Medicare and Medicaid Innovations pilot project that trained home care workers and consumers as part of an integrated care team in the state's In-Home Supportive Services consumer-direction program. The Center continues to provide quality training in partnership with California as well as leading health plans.

Care Delivery Models that focus on integrated care teams have less turnover and support family caregivers. The Green House model emphasizes resident and staff quality of life in small settings; the model is organized in integrated care teams that results in much lower staff turnover and better care outcomes.

State Example: In Arkansas, the state Medicaid program was able to add a state plan amendment to provide $4 per Medicaid resident per day in additional funding for operators of "home-style" nursing facilities such as Green House.

Program of All-Inclusive Care for the Elderly (PACE) is an innovative model that provides holistically integrated and coordinated care to individuals age 55 and over requiring nursing home-level care to live at home. PACE has demonstrated through the interdisciplinary team framework, which includes direct care workers, that the person enrolled and their family caregivers must be actively involved in the creation, implementation, and execution of care plans. PACE not only has high-quality outcomes but also has reduced family caregiver burden and improve support. Research conducted by the National PACE Association found that 97 percent of family members are satisfied with the support they receive through PACE and that 97.5 percent of family caregivers would recommend PACE to someone in a similar situation.

Because PACE provides both Medicare and Medicaid services, PACE organizations (PO) must develop agreements with the state and federal governments. Some states have developed separate agreements with PO to define state-specific arrangements. The NASHP blog post "State Approaches to Expanding PACE" shares learnings from a convening with the State Pace Action Network regarding ways states can help expand PACE.

Family Caregiver and Workforce Education

Geriatrics Workforce Enhancement Programs (GWEPs) are administered by the Health Resources and Services Administration. GWEPs collaborate with community organizations in 48 locations to educate the broader workforce and family caregivers in the care of older adults. A number of states have leveraged the federal funding to expand these programs in their state. They specifically train people receiving care, family caregivers, direct care workers, health care providers and health professions students, residents, and fellows and faculty on Alzheimer's disease and related dementias.

The Center for Aging and Disability Education and Research at Boston University School of Social Work provides training and initiatives to states for the workforce that provides care to older adults and people with disabilities. One training example, Prevention and Identification of Behavioral Health Issues in Older Adults: Skill Development Among Clergy Members, provided a 19-hour training for faith leaders in Massachusetts to help individuals and their families face mental health problems or traumatic events.

Ongoing Family Caregiver and Direct Care Worker Initiative

The John A. Hartford Foundation is currently funding a project, in coordination with PHI and the National Alliance for Caregiving, to better integrate the DCW and family caregivers. The project will present recommendations for federal and state policymakers.

How Is Your State Doing?

Each state has an opportunity to invest in this workforce to address staffing challenges. PHI provides a snapshot of the DCW in each state in the Direct Care Workforce State Index.

Acknowledgments

The Eldercare Workforce Alliance, a coalition of 35 national organizations, joined together to address the immediate and future workforce challenges in caring for an aging America. In response to the 2008 Institute of Medicine report "Retooling for an Aging America: Building the Health Care Workforce," we formed the national Eldercare Workforce Alliance — representing consumers, family caregivers, the DCW, and health care professionals — to propose practical solutions to strengthen our eldercare workforce and improve the quality of care.

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