



PHI QUALITY CARE
THROUGH
QUALITY JOBS

IT'S TIME TO CARE

A Detailed Profile of America's
Direct Care Workforce



This report is the first 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 will be released throughout 2020 in four parts, and 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.**



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

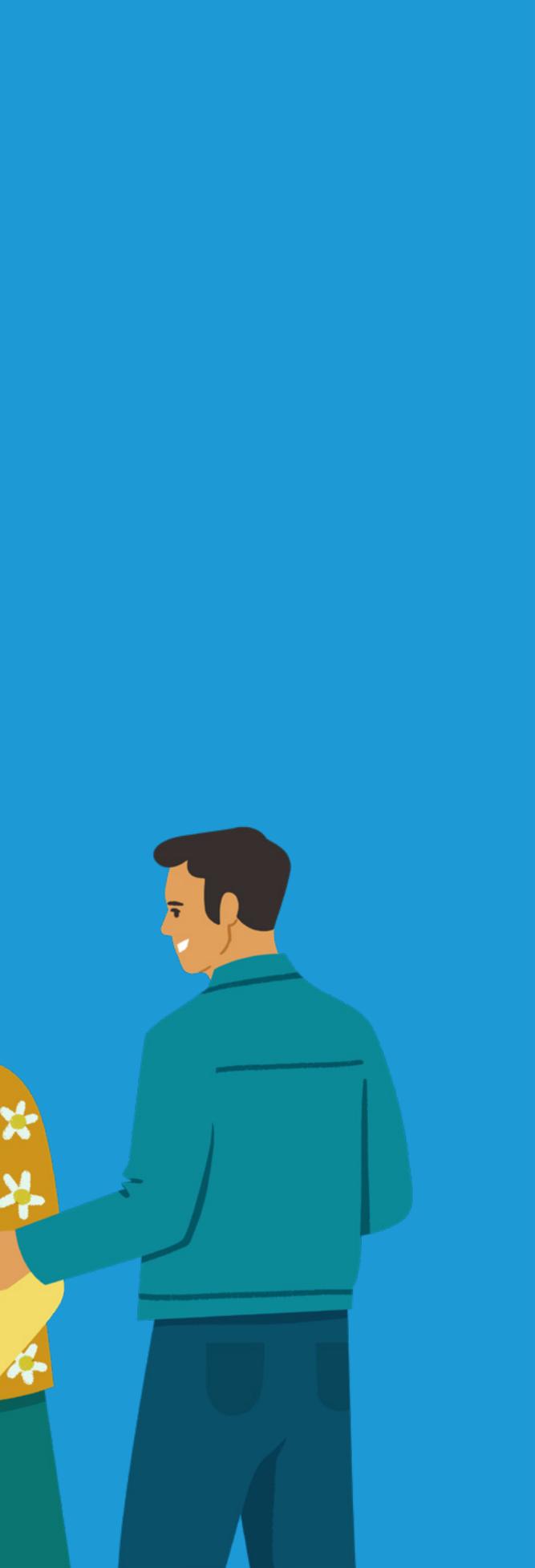


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Executive Summary

PHI's 'Caring for the Future' Timeline

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

Full report with policy and practice recommendations - January 2021

Every day, nearly 4.5 million direct care workers support older adults and people with disabilities across the United States. Their role is invaluable to the individuals they support, their families, and the long-term care system—and to our economy and society. Yet direct care workers are often overlooked, their contribution unrecognized, and their efforts undercompensated.

It's time to care about direct care workers.

This report is the first in a year-long series—culminating in a comprehensive final report in January 2021—that will examine the importance and impact of the direct care workforce. Each report in the series will provide original data, in-depth analyses, and policy and practice recommendations, as well as feature individual direct care workers from around the country—because it's critical that we include workers' voices, and their experiences and insight, in efforts to shape and improve this sector.

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 begins by defining the direct care workforce—the personal care aides, home health aides, and nursing assistants who provide assistance with daily activities in private homes, communities, nursing homes, and other formal settings. The next section of the report describes how the direct care role is evolving in response to changes in the health and long-term care system and among consumers. In short, direct care workers are supporting individuals with more complex needs in every setting, particularly in private homes and communities, and these workers require more technical, interpersonal, and linguistic and cultural competencies than ever before.

Despite the changes in their roles and responsibilities, compensation for direct care workers—who are primarily

women, particularly women of color and immigrant women—remains notoriously low, leading to high rates of poverty in the workforce. And the data reveal further disparities in wages and annual earnings *within* the direct workforce, according to gender, race and ethnicity, and other demographic characteristics.

This paradox—between the changing profile of direct care and the persistent marginalization of direct care workers—cannot be sustained in the face of growing demand, as described in the next section of the report. From 2018 to 2028, the workforce is expected to add 1.3 million jobs, and an additional 6.9 million jobs will become vacant as existing workers leave the field or exit the labor force. These figures indicate the pressing need to improve direct care jobs—because without broad and targeted efforts, we will experience an escalating national crisis of unmet need for long-term services and supports.

This first installment in the *Caring for the Future: The Power and Potential of America's Direct Care Workforce* series concludes with two immediate opportunities to recruit and retain a strong direct care workforce. The first is to improve hourly wages and annual earnings to ensure that workers are fairly compensated for the value of their contribution. The second is to build the workforce pipeline, including by targeting new populations of potential workers and by addressing the harmful effects of recent immigration policies on workforce recruitment and retention. These are just two aspects of a comprehensive solution to the long-term care crisis, however. Other essential strategies include remedying the inadequacy of the financing system, improving training and career development for direct care workers, ensuring that direct care workers are well-supported on the job, and more. These strategies will all be explored in the upcoming reports in this series and translated into recommendations for action in the comprehensive final report in January 2021.

Terminology

ACTIVITIES OF DAILY LIVING (ADLS)

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

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

A federal agency within the U.S. Department of Health and Human Services that administers Medicare and partners with state governments to administer Medicaid, among other responsibilities.

CONSUMER

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

CONSUMER-DIRECTED SERVICES

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

DIRECT CARE WORKER

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

DIRECT SUPPORT PROFESSIONAL

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

FAIR LABOR STANDARDS ACT (FLSA)

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

HOME AND COMMUNITY-BASED SERVICES (HCBS)

LTSS that are delivered in private homes and community settings, including assisted living and adult day services.

HOME CARE WORKERS

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

HOME HEALTH AIDE

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

INDEPENDENT PROVIDER

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

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)

Tasks associated with living independently, such as preparing meals, shopping, housekeeping, managing medications, and attending appointments.

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*.

NURSING ASSISTANT

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

PERSONAL CARE AIDE

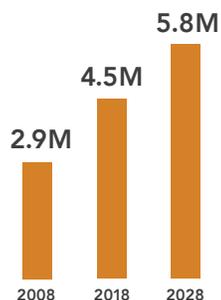
Direct care worker who assists individuals with ADLs and/or IADLs in their homes and communities, and who may also support individuals with employment and other forms of community engagement.

RESIDENTIAL CARE AIDE

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



Introduction



The workforce has already nearly doubled within a decade, from 2.9 million workers in 2008 to almost 4.5 million in 2018. Looking ahead, the long-term care sector is expected to add a further 1.3 million direct care jobs, primarily personal care aide positions, from 2018 to 2028—more new jobs than any other occupation in the U.S. economy.

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

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

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

The direct care workforce, which is already sizable, is expanding rapidly as our population grows older, as people live longer with disabilities and chronic conditions, and as the supply of potential family caregivers dwindles. The workforce has already nearly doubled within a decade, from 2.9 million workers in 2008 to almost 4.5 million in 2018.³ Looking ahead, the long-term care sector is expected to add a further 1.3 million direct care jobs, primarily personal care aide positions, from 2018 to 2028—more new jobs than any other occupation in the U.S. economy.⁴

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

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

Ricardo Araujo

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

ON WHY HE DECIDED TO BECOME A HOME HEALTH AIDE:

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

ON WHAT HE FINDS MOST CHALLENGING IN HIS ROLE:

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

ON WHAT IT TAKES TO SUCCEED IN HIS JOB:

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

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



Dessaline Watkins

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

ON WHY SHE DECIDED TO BECOME A DIRECT SUPPORT PROFESSIONAL:

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

ON WHAT SHE ENJOYS MOST ABOUT HER JOB:

"I enjoy giving my time and working directly with residents to help them be the best version of themselves. I have eight children, including two sets of twins.

I am very caring and feel that my job as a DSP is an extension of my life as a mother. Both roles require empathy, patience, and communication skills. I have a big family at home and a big family at Misericordia."

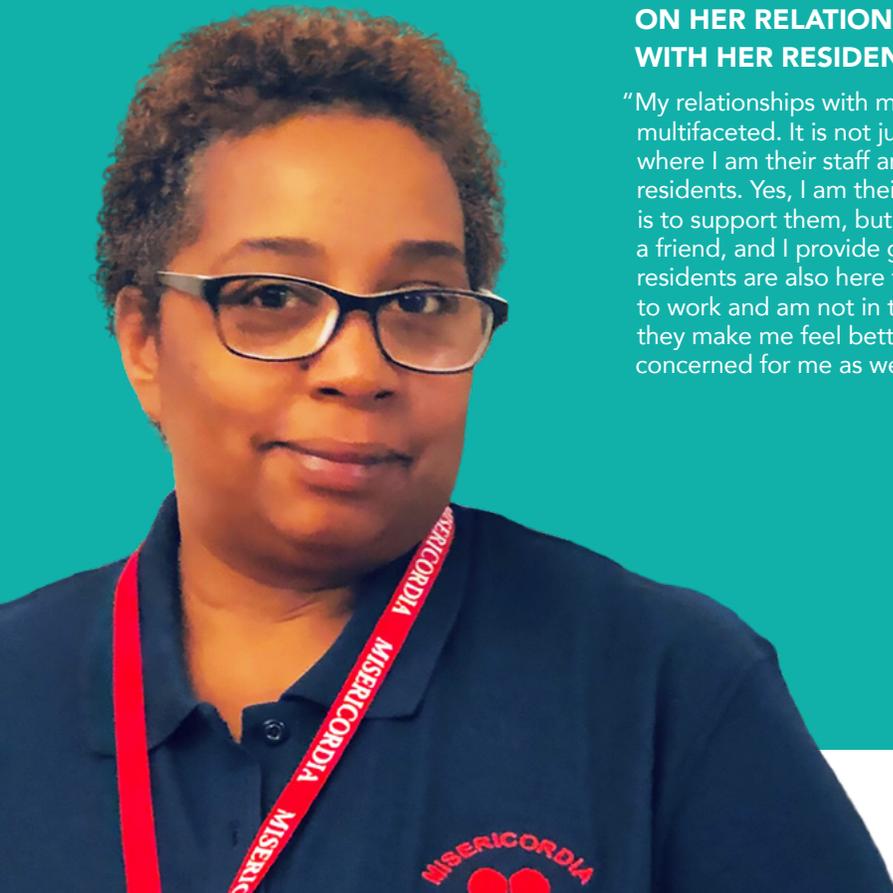
ON WHAT SHE FINDS MOST CHALLENGING IN HER ROLE:

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

ON HER RELATIONSHIP WITH HER RESIDENTS:

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

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



Defining the Direct Care Workforce

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

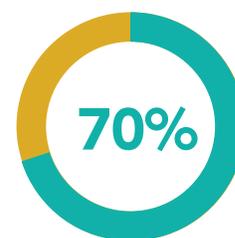
The direct care workforce comprises three main occupations as defined by the Bureau of Labor Statistics's Standard Occupational Classification (SOC) system: personal care aides, home health aides, and nursing assistants.⁵ According to this classification system, *personal care aides* (SOC 39-9021) assist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

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

Within the home care workforce is a distinct group of workers, known as *independent providers*, who are employed directly by consumers through publicly funded consumer-direction programs or individual private-pay arrangements. Independent providers are more likely than agency-employed home care workers to have a prior relationship with the individuals they support—up to 70 percent of independent providers in consumer-direction programs are family members or friends⁷—and tend to be exempt from training requirements, nurse delegation rules, and certain other regulations that apply to agency-employed home care workers. When hired privately by consumers through the so-called “grey market,” these workers are often excluded from employment protections as well.

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

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



70%
of independent providers in consumer-direction programs are family members or friends—and tend to be exempt from training requirements, nurse delegation rules, and certain other regulations that apply to agency-employed home care workers.

The Evolving Direct Care Role

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

THE SHIFTING PROVISION OF LTSS

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

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

Importantly, Medicaid was originally designed to provide LTSS for individuals with chronic conditions or disabilities in institutions only, not in private homes or community settings. Although persistent, this institutional bias has gradually eroded over the years. Home health care became a mandatory Medicaid benefit in 1970 and personal care became a state plan option in 1975. In 1981, the Omnibus Budget Reconciliation Act created Section 1915(c) waivers, enabling states to provide home and community-based services (HCBS) for individuals who would otherwise require an institutional level of care. Several other policy decisions and court cases followed. Particularly influential were the Americans with Disabilities Act of 1990 and the 1999 U.S. Supreme Court ruling

in *Olmstead v. L.C.*, which affirmed the civil right of individuals with disabilities to live in their homes and communities—and placed responsibility on public programs, including Medicaid, to uphold this right (within budget parameters).¹⁰

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

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

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



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

Culix Wibonele

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

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

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

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

ON WHAT SHE FINDS MOST CHALLENGING IN HER ROLE:

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

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

ON HER RELATIONSHIP WITH HER CLIENTS:

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

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

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

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



THE CHANGING FACE OF CONSUMERS

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

The number of individuals with Alzheimer’s disease and other forms of dementia—75 percent of whom require personal assistance¹⁹—is also rising rapidly. There are currently 5.8 million Americans with Alzheimer’s disease, the most common form of dementia, and that figure is expected to increase to nearly 14 million by 2050, barring major medical advances.²⁰

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

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

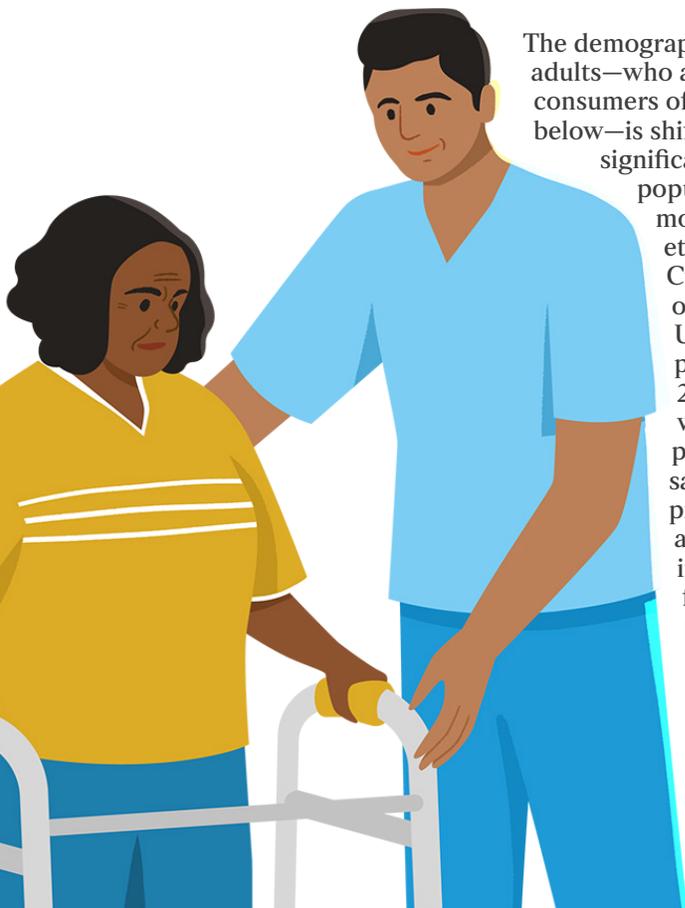
Older people of color, particularly those from immigrant communities, may also be more likely to receive support outside the formal LTSS system, due to cultural values, historical mistrust of medical professionals, and cultural, linguistic, and economic access barriers.²³ Within the formal LTSS system, older people of color are more likely to receive care in nursing homes than HCBS, an imbalance that appears to be caused by inequitable access to community-based care—which is the preferred setting for the majority of adults, regardless of race or ethnicity²⁴—rather than by demographic factors alone.²⁵

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

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



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



Profile of the Direct Care Workforce

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

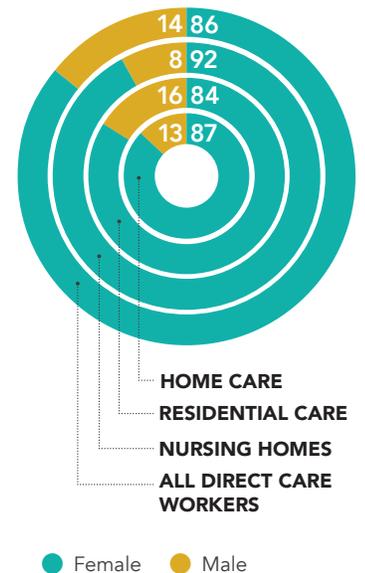
DEMOGRAPHIC PROFILE

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

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

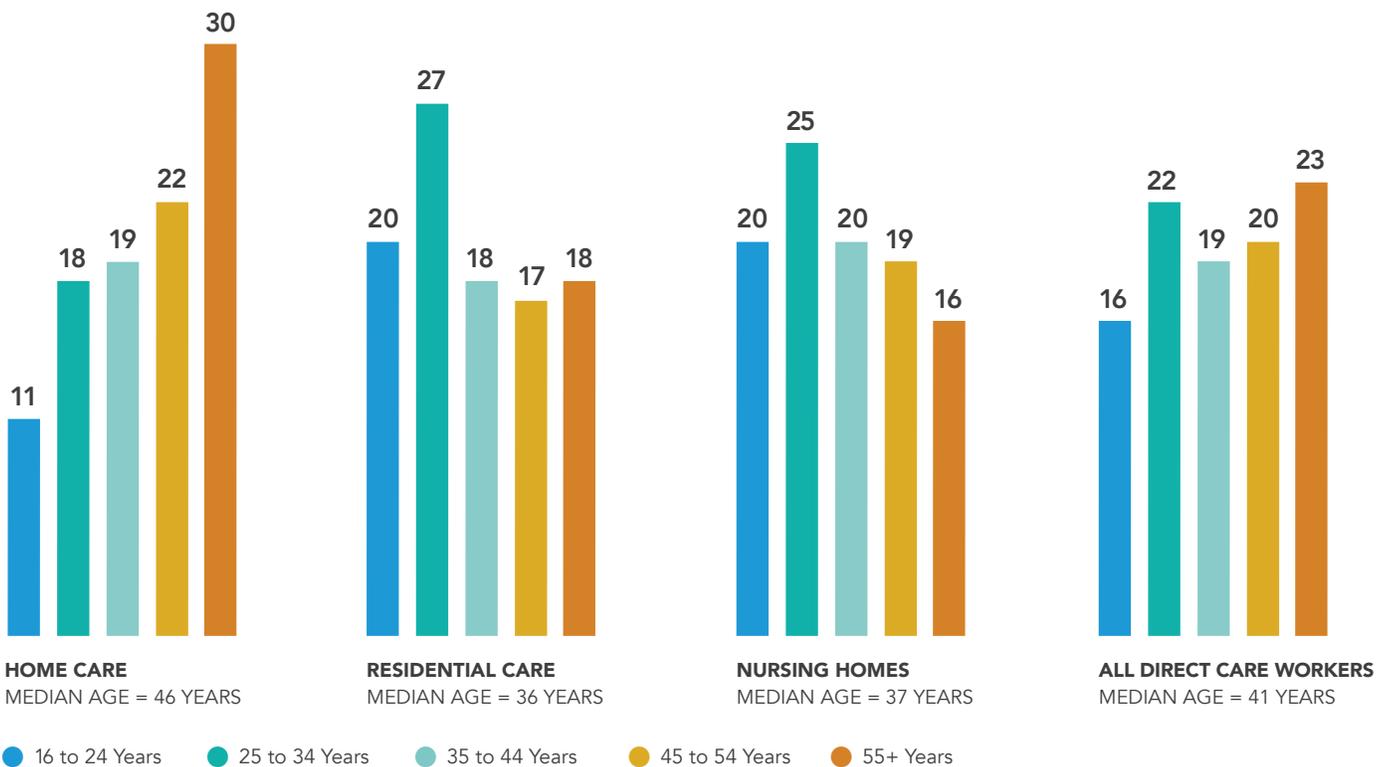
DIRECT CARE WORKERS BY GENDER ACROSS SETTINGS, 2017

(In Percentages)



DIRECT CARE WORKERS BY AGE ACROSS SETTINGS, 2017

(In Percentages)

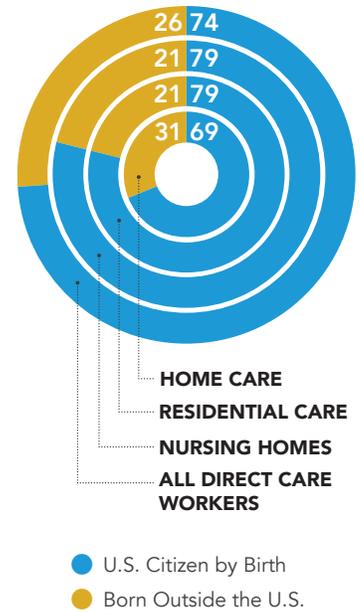


Source: Ruggles, Steven, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. 2019. *IPUMS USA: Version 9.0*. Minneapolis, MN: IPUMS, University of Minnesota. <https://doi.org/10.18128/D010.V9.0>; analysis by PHI (July 8, 2019).

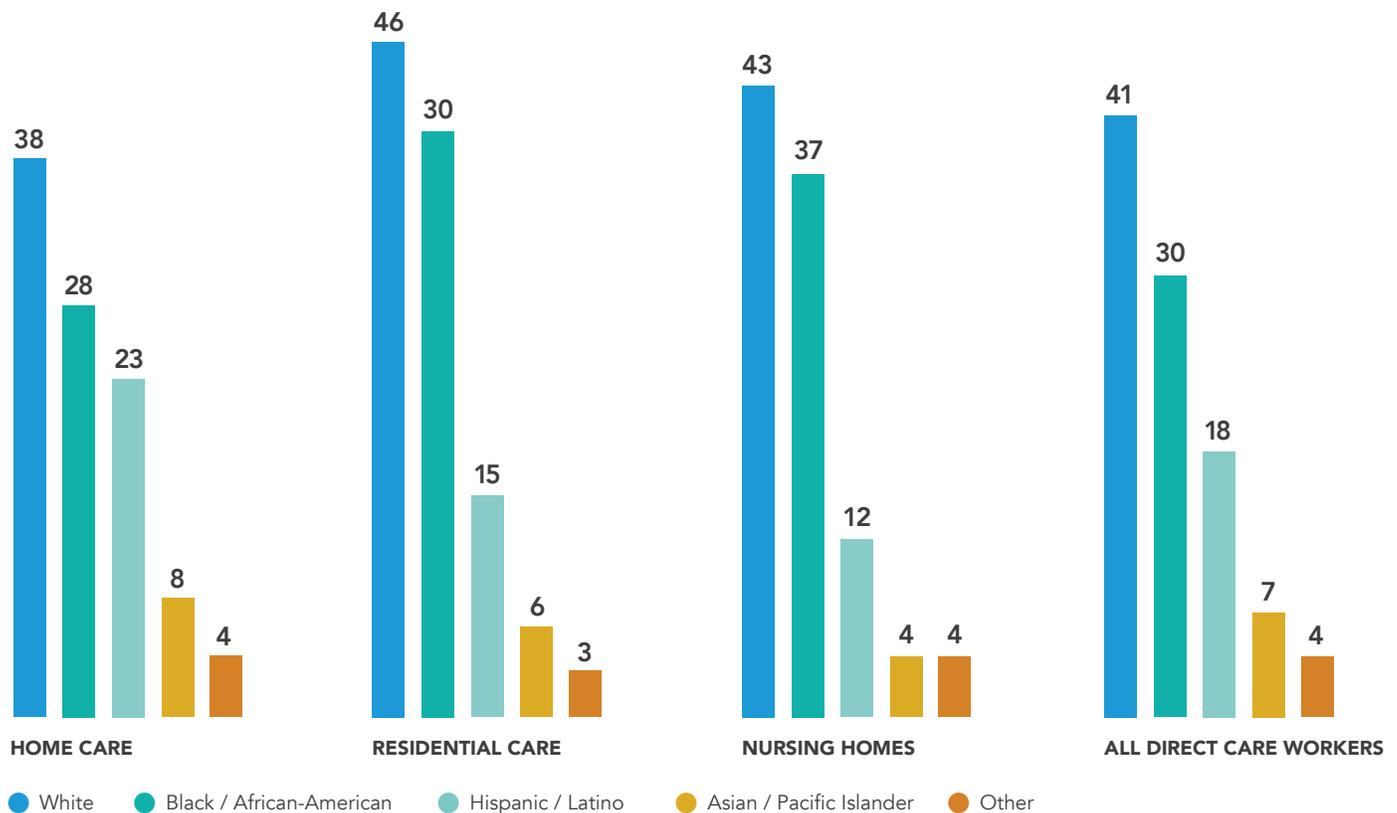
The majority of direct care workers (59 percent) are people of color, including 30 percent who are Black/African-American, 18 percent who are Hispanic/Latino (of any race), 7 percent who are Asian or Pacific-Islanders, and 4 percent who identify as other races or ethnicities. This diversity is reflected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

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

DIRECT CARE WORKERS BY NATIVITY ACROSS SETTINGS, 2017
(In Percentages)



DIRECT CARE WORKERS BY RACE AND ETHNICITY ACROSS SETTINGS, 2017
(In Percentages)



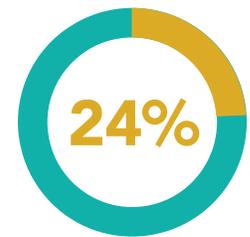
Note: Hispanic/Latino includes people of any race who identify as Hispanic or Latino; these individuals are not included in any of the other race/ethnicity categories.

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

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

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

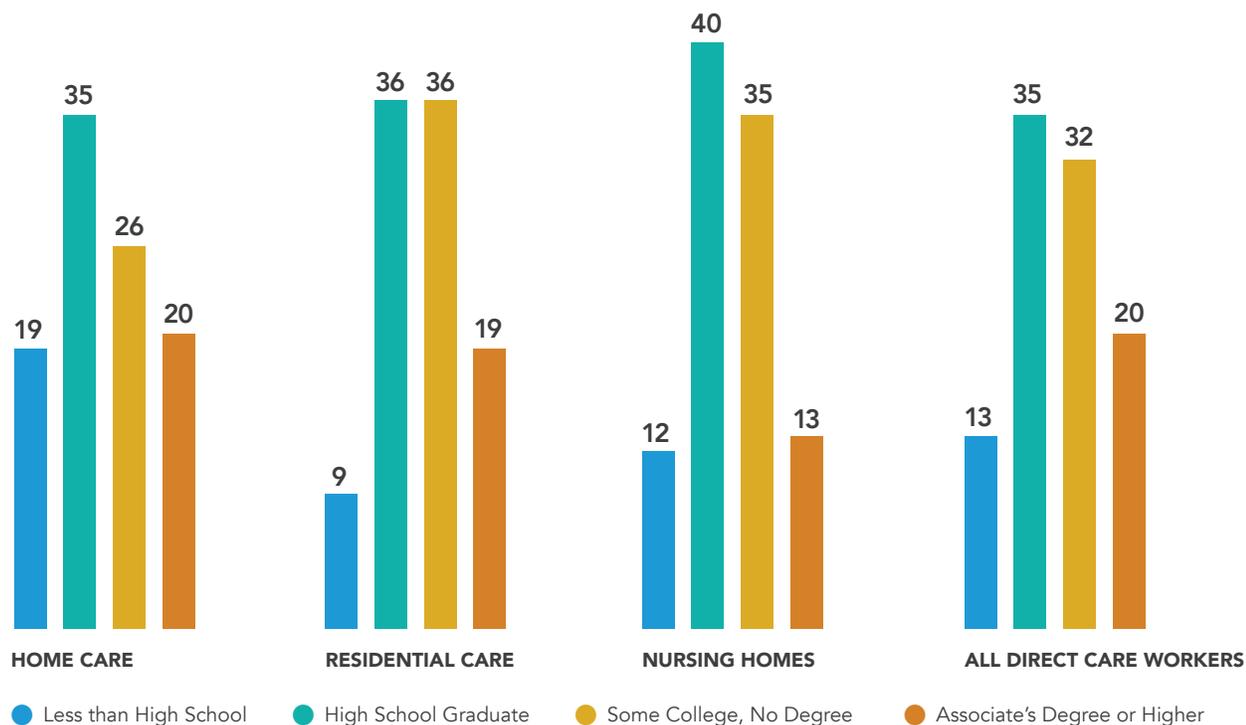
But the workforce is also changing. The proportion of men in the workforce increased from 12 percent in 2007 to 14 percent in 2017—a modest but auspicious change for this historically female workforce. Furthermore, while the median age of direct care workers remained the same, the age distribution of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



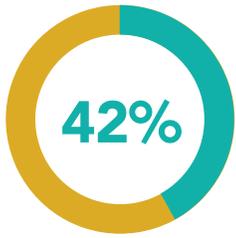
of all direct care workers are aged 55 and above, compared to 19 percent a decade ago.

DIRECT CARE WORKERS BY EDUCATION LEVEL ACROSS SETTINGS, 2017

(In Percentages)



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



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

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

SOCIOECONOMIC PROFILE

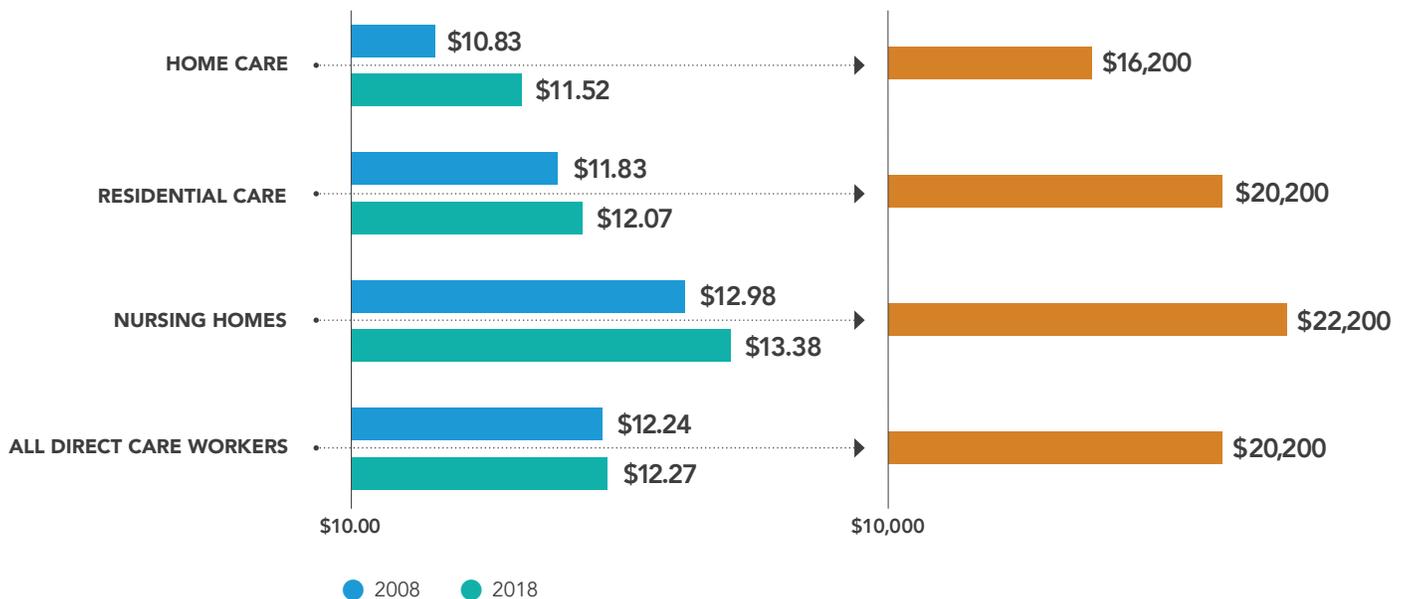
Wages and earnings are persistently and notoriously low for the direct care workforce. According to the most recent data from the Bureau of Labor Statistics, the median wage for all direct care workers is \$12.27 per hour and—due to high rates of part-time employment as well as low wages—median annual earnings are just \$20,200. Hourly wages have not kept pace with the increasing demand for workers over the past decade: from 2008 to 2018, even as the direct care workforce doubled, wages increased by only three cents (adjusting for inflation).

Among direct care workers, home care workers earn the least, at \$11.52 per hour and \$16,200 per year, while residential care aides earn \$12.07 per hour and \$20,200 annually and nursing assistants in nursing homes earn \$13.38 per hour and \$22,200 annually.

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

MEDIAN HOURLY WAGES ACROSS SETTINGS, 2008-2018

MEDIAN ANNUAL EARNINGS ACROSS SETTINGS, 2017



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

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

Even at this low end of the scale, there are further disparities in wages and earnings *within* the direct workforce—according to gender, race and ethnicity, and other personal characteristics. For example, women and people of color tend to earn less per hour than white male direct care workers (with some variation between settings). Among home care workers, the largest segment of the workforce, median wages are \$11.13 for women of color and \$11.50 for white women, compared to

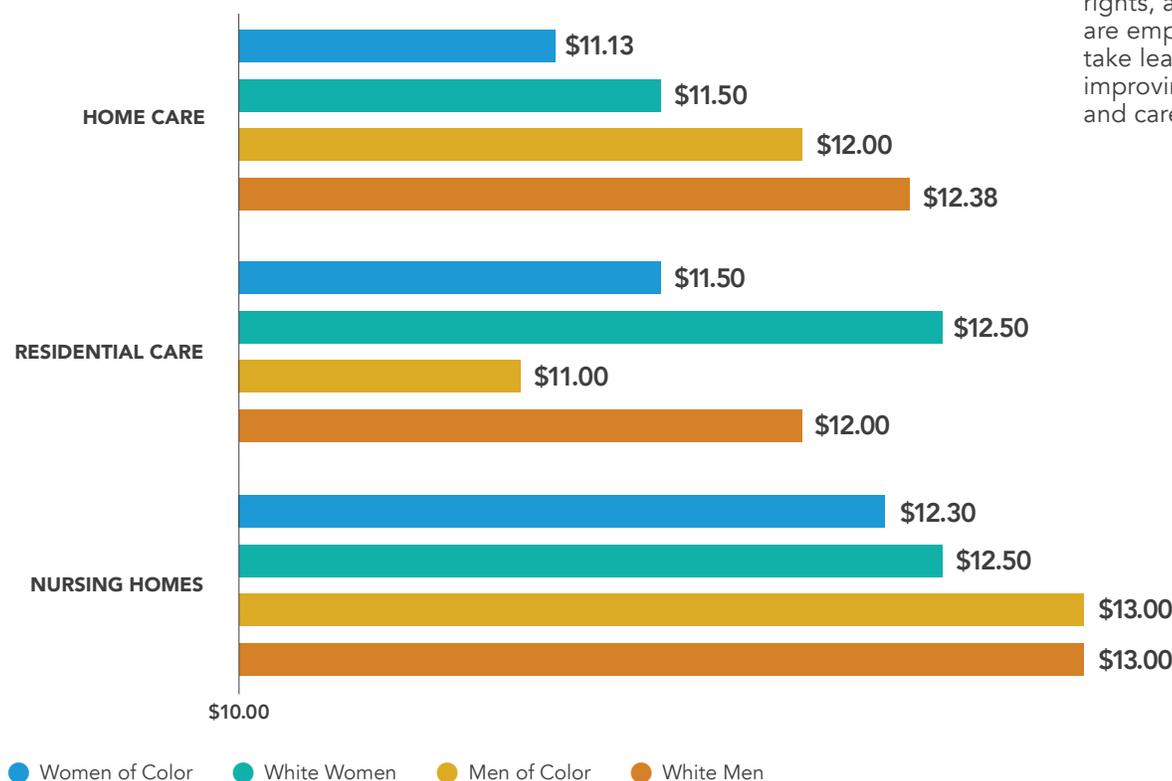
\$12.00 for men of color and \$12.38 for white men. In residential care, men of color earn a dollar less than white men (\$11.00 versus \$12.00), and women of color earn a dollar less than white women (\$11.50 versus \$12.50). In nursing homes, median wages are higher for all men (\$13.00 per hour) than for white women (\$12.50) or women of color (\$12.30). Across the board, women of color in the direct care workforce are also more likely to live in poverty or low-income households and to require public assistance than white women or men.

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

Industry Feature

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

HOURLY WAGES BY RACE AND GENDER ACROSS SETTINGS, 2017



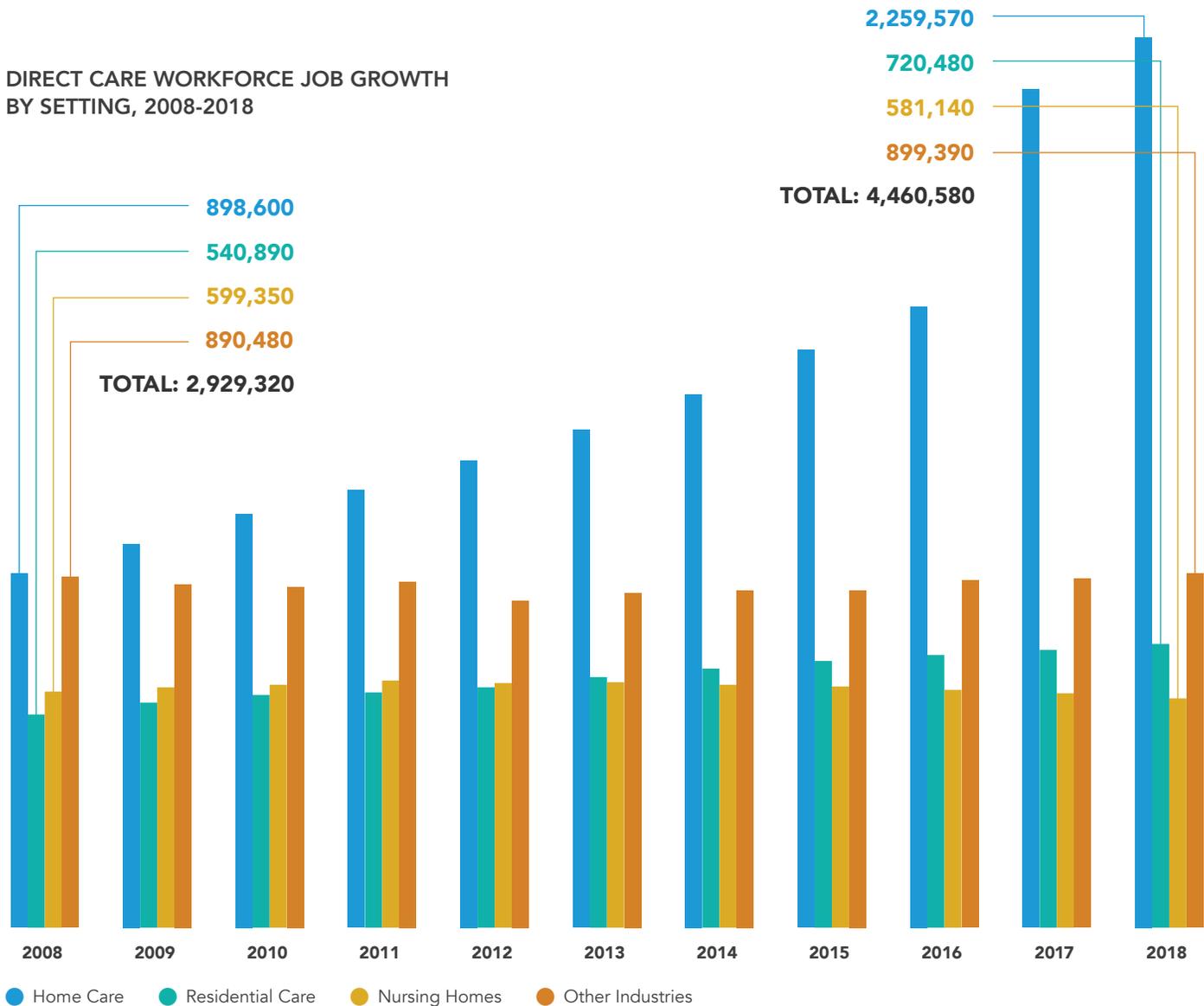
Source: Flood, Sarah, Miriam King, Renae Rodgers, Steven Ruggles and J. Robert Warren. 2019. *IPUMS, Current Population Survey: Version 6.0*. Minneapolis, MN: IPUMS, University of Minnesota. <https://doi.org/10.18128/D010.V9.0>; analysis by PHI (October 10, 2019).

A Rapidly Growing Workforce

The direct care workforce nearly doubled in the past decade, from 2.9 million workers in 2008 to almost 4.5 workers in 2018,³¹ and it is expected to add an additional 1.3 million new positions within the next 10 years (by 2028).³² Reflecting the trends described above, the majority of job growth will be in home care, which is projected to add just over a million new jobs (46 percent growth).³³ That means

more new jobs in home care than in the second and third U.S. occupations with the most job growth *combined* (namely, food services and registered nursing). The residential care sector will also grow substantively, adding 168,400 new jobs (23 percent growth), while nursing homes are projected to contract by 3 percent (losing 19,300 jobs).

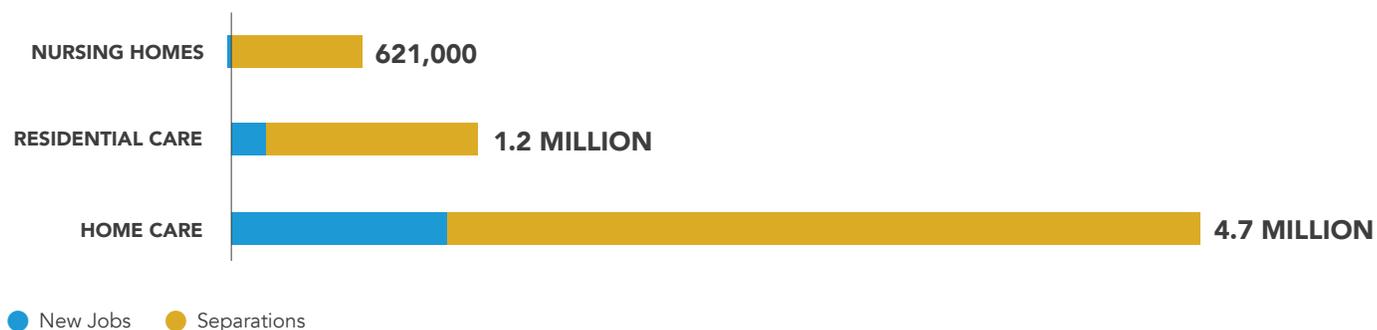
DIRECT CARE WORKFORCE JOB GROWTH BY SETTING, 2008-2018



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

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

PROJECTED JOB OPENINGS IN DIRECT CARE, 2018-2028



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

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

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

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

Neither do the employment projections account for turnover *within* each segment of the direct care workforce, which is strikingly high. Although there is no reliable national figure on turnover in the direct care workforce, turnover has

generally been reported at 40 to 60 percent or higher³⁶—and the most recent annual survey of private-duty home care agencies found that turnover reached a historic peak of 82 percent in 2018, a 15 percent increase over the previous year.³⁷ As a proxy indicator of turnover, results from national workforce surveys indicate that 1 in 4 nursing assistants in nursing homes and 1 in 5 home health aides are currently looking for another job.³⁸ Forty-five percent and 35 percent of these workers, respectively, report that they are somewhat or very likely to leave their current job within the next year.

DRIVERS OF WORKFORCE DEMAND

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

State Policy Spotlight

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

A Closer Look at Data Collection

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

Population aging is significant because personal assistance needs and formal LTSS use increase with age. More than 21 percent of adults in the community who are aged 85 years and above require assistance with ADLs, compared to 8 percent of those 75 to 84, just under 4 percent of those 65 to 74, and just 3 percent of those 18 to 64.⁴⁰ Across LTSS settings, the majority of consumers are aged 65 and over, including 93 percent of residential care residents, 83 percent of nursing home residents, and 82 percent of home health patients.⁴¹ Moreover, as life expectancy for individuals with disabilities continues to improve due to advances in health care and medical technology, a larger number of younger people with disabilities today can be expected to require LTSS in the future.⁴² These figures indicate that demand for LTSS will increase precipitously in the years ahead. At the same time, the caregiver support ratio—meaning the ratio of those aged 18 to 64 years old, who are most likely to provide care, to those aged 85 and above, who are most likely to need care—will shrink dramatically. The caregiver support ratio is projected to fall from 31 to 1 in 2016 to only 12 to 1 by 2060.⁴³

Population aging will not occur uniformly, however—with implications for LTSS service delivery and workforce supply. In particular, rural areas are expected to age more quickly than urban and suburban areas.

According to PHI's analysis of data from the Urban Institute's Mapping America's Futures project, the population of rural-dwelling adults aged 65 and older will grow by 984,000 (64 percent) from 2010 to 2030, while the population of rural residents aged 20 to 64 will fall by 638,000 (12 percent).⁴⁴ This means that by 2030, adults aged 65 and older will constitute more than a quarter (28 percent) of the rural population, compared to one-fifth (20 percent) of the urban and suburban population.

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



Conclusion and Implications

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

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

IMPROVE COMPENSATION

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

Two recent policy developments are helping move the needle on direct care workers' compensation, but with significant caveats. The first is the trend toward increasing the minimum wage across states, which helps raise the wage floor for all low-income workers. (Although the federal minimum wage has held steady at \$7.25 since 2009, 29 states and DC have raised their minimum wage above that rate, along with more than 40 cities and counties since 2012.⁴⁸)

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

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

In Focus: PHI's Policy Approach

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



State Policy Spotlight

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

Second, wage increases must be implemented with attention to the impact on benefit eligibility for direct care workers—so that increased wages do not, paradoxically, lead to *lower* (or unchanged) total compensation, due to a corollary loss of benefits.⁵¹ Finally, policies that lift all boats, such as minimum wage increases, must be accompanied by redoubled recruitment and retention efforts, to ensure that workers are not lost to other sectors that offer a similar wage but more hours, preferable schedules, or other advantages.

BUILD THE WORKFORCE PIPELINE

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

Recruitment efforts can be targeted at other segments of the labor force as well. As noted, older workers already make a substantive contribution to the direct care workforce—nearly one in four are aged 55 and above—but may be recruited in larger numbers through existing initiatives, such as the Senior Community Service Employment Program (SCSEP). SCSEP is a federal workforce development program that has been used successfully to recruit direct care workers in past pilot projects.⁵² Certain aspects of the direct care role, such as flexible schedules and

part-time hours, may be more amenable to individuals seeking an “*encore*” career, as compared to younger workers with more pressing financial responsibilities.

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

The second strategy for building the workforce pipeline, on a different order of magnitude, is to stem the tide of hostile immigration policymaking. Recent policies affecting direct care workers—just over a quarter of whom were born outside the United States—include the travel ban, the elimination of temporary protected status, and the new public charge rule. The travel ban, introduced in 2016 and upheld by the Supreme Court in 2018, indefinitely suspends the issuance of visas to applicants from Libya, Iran, North Korea, Somalia, Syria, Venezuela, and Yemen. The proposed termination of temporary protected status, currently subject to legal challenge, may affect immigrants from El Salvador, Haiti, Honduras, Nepal, Nicaragua, and Sudan. Together, these policies directly implicate nearly 70,000 direct care workers,

In Focus: PHI's Workforce Innovations

For decades, PHI has worked with Cooperative Home Care Associates (CHCA) to develop best practices for strengthening the direct care workforce, which we share with LTSS providers nationwide. Our **young adult training and employment program** is a key example. In this program, young adults enjoy all the advantages of the CHCA model (see page 15), but they are additionally supported by a Young Adult Case Manager who provides individualized case management and connects them with peer mentors and targeted employment supports. In 2018, the retention rate for young adults at CHCA was 77 percent after three months on the job, far above the industry standard for new hires.

including 16,300 workers from countries affected by the travel ban and nearly 53,400 non-U.S. citizens from countries that may lose temporary protective status.⁵⁴

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

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



CONCLUSION

Nearly 4.5 million direct care workers provide essential daily support to older adults and individuals with disabilities across LTSS and other settings in the United States. The need for their assistance is increasing precipitously as our population grows older and the supply of family caregivers diminishes. At the same time, the direct care role is evolving, as service provision shifts to the community and consumers require assistance with more complex conditions, among other changes. As a result, direct care workers across all long-term care settings require a range of new technical and interpersonal competencies.

The obvious response to these trends is to invest more energy and resources into direct care jobs—to build career pathways into direct care, create jobs that are financially sustainable and intrinsically rewarding, and ensure that the workforce is prepared to provide the services and supports that consumers need. To that end, this report has identified two primary opportunities to invest in the direct care workforce: first, increase compensation for direct care workers (to rectify their historical devaluation and bring economic self-sufficiency into reach); and second, build the pipeline of new workers into direct care, including through targeted outreach and supportive rather than punitive immigration policies.

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

Industry Feature

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

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Appendix 1: Data Sources and Methods

The direct care workforce comprises personal care aides, home health aides, and nursing assistants. Direct care worker occupational categories are defined by the Standard Occupational Classification (SOC) system developed by the Bureau of Labor Statistics (BLS) at the U.S. Department of Labor (DOL).⁵⁸ Workers are classified based on their on-the-job responsibilities, skills, education, and training.

The industries that are described in this report are defined by the North American Industry Classification System (NAICS).⁵⁹ “Home Care” includes two industries: (1) Services for the Elderly and Persons with Disabilities and (2) Home Health Care Services. “Residential Care Homes” also comprise two industries: (1) Residential Intellectual and Developmental Disability Facilities and (2) Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly. “Nursing Homes” refers to the Nursing Care Facilities (Skilled Nursing Homes) industry. “Total” includes all industries where direct care workers are employed.

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

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

Appendix 2: Direct Care Workforce Characteristics by Setting

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

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

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

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

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

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

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

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

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

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

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

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

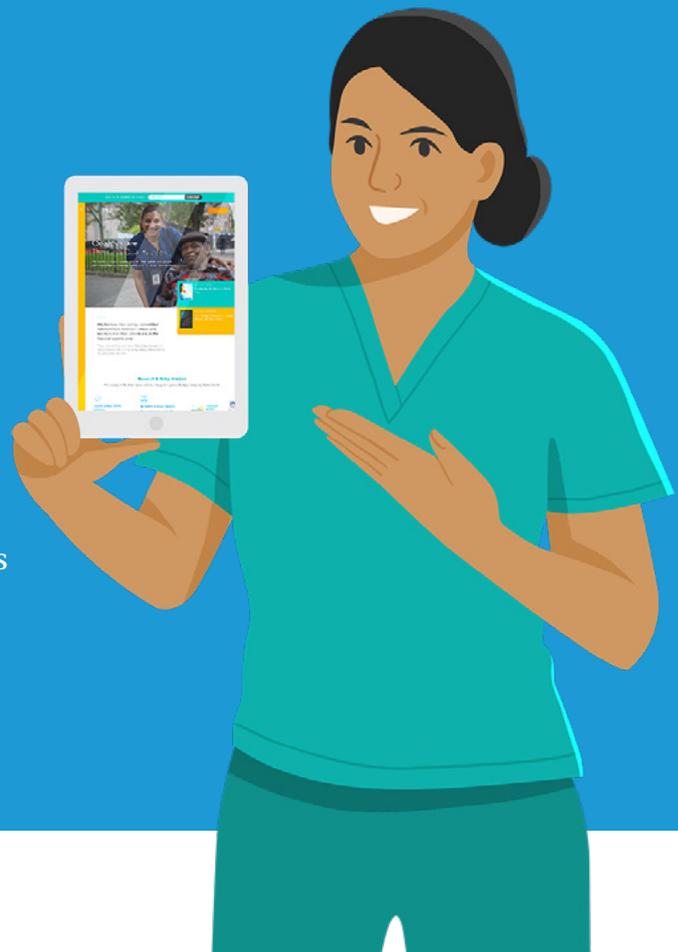
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