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Transforming Direct Care Jobs, Reimagining Long-Term Services and Supports

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A B S T R A C T

The diverse array of individuals who receive long-term services and supports share one common experience, which is the need for assistance with personal care and/or other daily activities. The direct care workers (including nursing assistants, home health aides, and personal care aides) who provide this assistance play a critical role in keeping individuals safe, supporting their health and well-being, and helping prevent adverse outcomes. Yet despite decades of research, advocacy, and incremental policy and practice reform, direct care workers remain inadequately compensated, supported, and respected. Long-standing direct care job quality concerns are linked to high turnover and job vacancy rates in this workforce, which in turn compromise the availability and quality of essential care for older adults and people with disabilities—which has never been more evident than during the COVID-19 pandemic. This special article makes the case for transforming direct care jobs and stabilizing this workforce as a centerpiece of efforts to reimagine long-term services and supports system in the United States, as a public health priority, and as a social justice imperative. Drawing on research evidence and examples from the field, the article demonstrates that a strong, stable direct care workforce requires: a competitive wage and adequate employment benefits for direct care workers; updated training standards and delivery systems that prepare these workers to meet increasingly complex care needs across settings, while also enhancing career mobility and workforce flexibility; investment in well-trained frontline supervisors and peer mentors to help direct care workers navigate their challenging roles; and an elevated position for direct care workers in relation to the interdisciplinary care team. The article concludes by highlighting federal and state policy opportunities to achieve direct care job transformation, as well as discussing research and practice implications.

The long-term services and supports (LTSS) system in the United States is a labyrinthine, fragmented, evolving system comprising different payers and payment streams, regulations and requirements, settings and service models, tools and technologies, and occupational roles. Individual LTSS users' trajectories and experiences also vary widely by need, geographic location, entry point, demographic characteristics, and many other factors. Nonetheless, the majority of LTSS users share a common experience, which is the need for assistance with personal care and/or other daily activities. The direct care workers who provide this assistance play a critical role in keeping individuals safe, supporting their optimal health and well-being, and helping prevent adverse outcomes—yet they remain inadequately compensated, supported, and respected. This special article makes the case for transforming direct care jobs and stabilizing this workforce as a centerpiece of efforts to reimagine LTSS access, quality, and outcomes. The ideas presented here build on decades of direct care workforce research, advocacy, and incremental policy and practice reform[1]—but they are newly energized by the urgency of the workforce crisis; animated by the unprecedented public and political attention on LTSS and direct care jobs; characterized by a coherent perspective on this workforce across occupational roles and settings; and distinguished by an explicit commitment to promoting equity and social justice for all those who receive and provide LTSS.

Profile of the Direct Care Workforce

The direct care workforce comprises 4.6 million personal care aides, home health aides, and nursing assistants who provide essential daily care and support to older adults and people with disabilities across settings.[2] All direct care workers provide assistance with activities of daily living (ADLs) and/or instrumental ADLs, while home

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health aides and nursing assistants may also perform certain clinical tasks under the supervision of licensed professionals.

As a whole, the direct care workforce outnumbers every other occupational group in the United States, and this workforce is growing rapidly—primarily because of rising demand for LTSS (also known as long-term care).[3] From 2009 to 2019, the direct care workforce increased by 52%, and nearly 1.3 million new direct care jobs will be added from 2019 to 2029.[1] This growth will predominantly occur in home and community-based services (HCBS), while nursing homes are expected to lose about 10,000 nursing assistant positions.

Reflecting the complexity of the LTSS landscape overall, the direct care workforce is highly differentiated. Direct care workers may be hired directly by consumers or employed by home care agencies, assisted living communities, nursing homes, or other providers; their services may be covered by private funds or reimbursed with public dollars through various programs and payment mechanisms; the majority of direct care workers provide LTSS, but many also or alternatively provide post-acute and other types of care; they support older adults, individuals with physical disabilities or intellectual and developmental disabilities, medically fragile children, and/or other populations; and they are subject to different regulations and requirements depending on state and locality, among other factors.

Nonetheless, long-standing recruitment and retention challenges rooted in poor job quality extend across the full direct care workforce, especially in LTSS.[4–7] These challenges have only intensified during the COVID-19 pandemic, as workers have left their jobs because of illness, fear, family responsibilities, economic conditions, and other reasons.[8,9] High turnover[10,11] and job vacancies[12,13] in turn compromise the availability and quality of care for the millions of older adults and people with disabilities who require LTSS[14–16]—rendering direct care workforce improvement an urgent public health issue.[17] Therefore, while recognizing that there are significant variations across the direct care workforce—requiring a range of tailored policy and practice solutions—this article also calls for a coordinated approach (as far as possible) to overcome historic siloes, garner broad-based support, and truly transform direct care jobs. Guided by the conceptual framework in Figure 1, the article focuses on 4 priorities: compensation; training and advancement; supervision and support; and empowerment and inclusion.

Improve Compensation

The direct care workforce predominantly comprises women (87%), people of color (59%), and immigrants (26%).[18] This demographic profile intersects with the historic undervaluing of caregiving labor, ongoing occupational segregation by sex and race/ethnicity, and persistently inadequate investment in LTSS to produce direct care jobs that are egregiously underpaid.[19]

The national median wage for all direct care workers is $13.34 per hour and—because of unstable and/or part-time schedules as well as low wages—median annual earnings are just $20,200.[16] Although direct care wages are relatively low across every state,[20] these national figures nonetheless mask considerable variations among states and between direct care occupations that are driven by payment policies and reimbursement rates (especially in Medicaid, which is the largest single payer of LTSS[21]), minimum wage and other employment laws, and other factors. Further disparities are found within this marginalized workforce by race and sex[22]; notably, women of color in direct care earn the lowest wages and are most likely to live in poverty and require public assistance than white

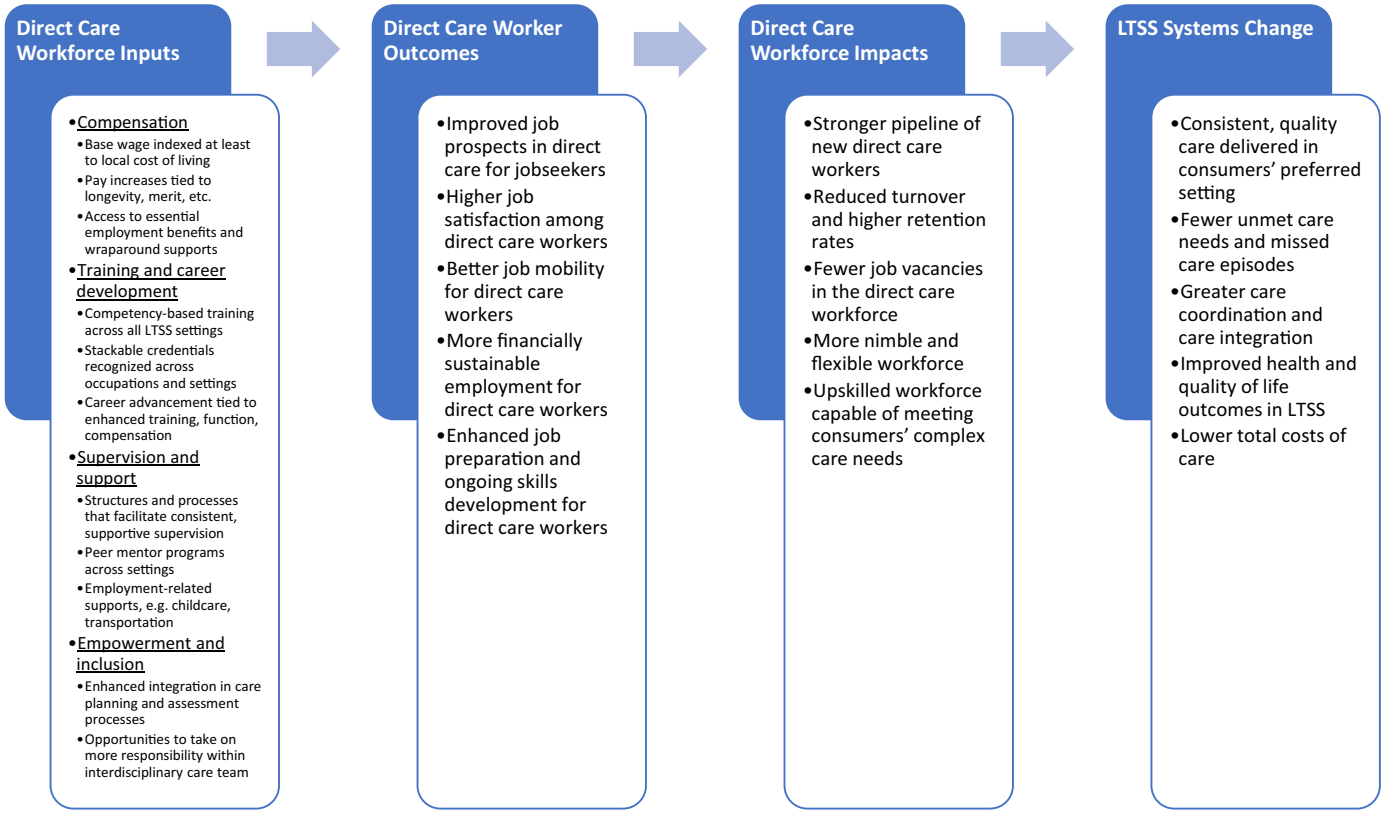

Fig. 1. Direct care workforce transformation in LTSS*. *Adapted from PHI. The 5 Pillars of Job Quality. https://phinational.org/resource/the-5-pillars-of-direct-care-job-quality/. Accessed July 22, 2021.

women or men of any race.[19] People of color are also most likely to work in under-resourced LTSS settings and have been disproportionately impacted by the pandemic.[23]

Inadequate or unstable income makes it difficult for workers to meet basic household needs, achieve secure housing, arrange childcare, and maintain their physical and emotional health, all of which can compromise their employment performance.[24] Moreover, minor fluctuations in hours or wages can threaten eligibility for public assistance, causing further economic instability.[25] Overall, poor compensation perpetuates structural, intergenerational inequities that impact the women and people of color comprising this workforce.

Low wages also undermine the competitiveness of direct care jobs. Analysis of 2019 data shows that median wages for direct care were lower than median wages for every other occupation with similar entry-level requirements.[26] Competition for workers has been accentuated by the COVID-19 pandemic, as employers across sectors are now struggling to fill job openings.[27] LTSS providers and individual consumers who rely on Medicaid have less latitude to offer higher wages or other financial incentives compared to employers in retail, food services, and other competing sectors[19]—and most private-pay consumers already struggle to cover the costs of care, in many cases facing financial hardship over time and eventually spending down to Medicaid eligibility levels.[28] These financial constraints are not universally distributed across LTSS, however. Medicaid reimbursement rates vary significantly between states,[29] which differentially impacts providers' ability to raise wages; nursing homes that serve a higher share of post-acute patients operate on larger margins than those primarily serving long-stay residents,[30] though their profits may be reaped by owners or shareholders rather than reinvested in the workforce and resident care[31]; and many assisted living communities and home care agencies (among other providers) do not rely on public reimbursement,[19] but their workforce investments may still be defined by industry standards and individuals' ability to pay.

Notwithstanding these fiscal constraints, it is clear from the evidence that raising wages (eg, by increasing Medicaid rates with a wage pass-through)[32] would not only improve recruitment and retention[33,34] but also care outcomes. One analysis using quality data from the Centers for Medicare and Medicaid Services (CMS) found that higher wages for nursing assistants in nursing homes were associated with increased income and retention, fewer inspection violations, and lower rates of preventable health outcomes and mortality among residents.[35] Higher wages could also benefit the wider economy: one model found that raising direct care workers' wages to a living wage in 2022 would benefit three-quarters of this workforce, with the cost offset by lower turnover, reduced expenditure on public assistance, increased consumer spending, and higher productivity.[36]

Enhance Training and Career Advancement

Direct care workers support individuals with complex care needs across settings, since the rebalancing of Medicaid-funded services has raised acuity levels in home and community-based settings, while nursing homes have continued to support those with high post-acute and long-term care needs.[19] New payment and service-delivery models designed to improve efficiency and outcomes—including managed care, value-based payment, care coordination and integration programs, and more—have elevated the importance of direct care workers, as they are ideally positioned to monitor individuals' health status, identify changes of condition, trigger clinical interventions, and help avert adverse outcomes.[37]

Yet training standards and practices for direct care workers remain inconsistent and, for the most part, inadequate. The federal entry-level training minimum for nursing assistants and home health aides employed by CMS-certified providers is just 75 hours, although over one-half the states have set higher requirements for nursing assistants at the state level and about one-third have done the same for home health aides (ranging from 80 to 180 hours in each case).[19] (To note, the federal training and certification requirement for nursing assistants in nursing homes has been waived by CMS during the COVID-19 public health emergency.[38]) There is no federal benchmark for personal care aide or residential care aide training, which also leads to wide variation across states. As examples: only 17 states and DC require a minimum number of entry-level training hours for assisted living aides (ranging from 1 to 90 hours); only 14 states have established consistent training standards for all home care agency-employed aides; and 7 states do not regulate personal care aide training at all.[19] Entry-level training programs do not tend to cover the full range of core competencies required for direct care, meaning that "upskilling" interventions are needed to meet contemporary LTSS consumers' needs; additional training is needed, for example, on condition-specific care, infection prevention, emergency management, and cultural and linguistic competence, among other topics.[19] Finally, there is insufficient emphasis in policy and practice on appropriate teaching methods and environments, which undermines training effectiveness and knowledge uptake.[39]

Better training can improve job quality and satisfaction[40–42] and care outcomes[43,44] and, when offered within a formal credentialing framework, can also facilitate career mobility and workforce flexibility.[45] Relatedly, there is also a need for advanced roles in direct care—tied to a recognized credential and higher wage—to retain experienced workers and maximize this workforce within a reimagined LTSS system. Examples include: condition-specific specialist roles, such as diabetes and dementia specialists; care integration or care transition aides, to bridge the gaps between services and settings; and peer mentors and trainers. Although the evidence base on advanced roles in direct care is limited, pilot projects from both HCBS[46] and nursing homes[47] have shown promising outcomes, including higher wages and job satisfaction, reduced emergency department and rehospitalization rates, and lower family caregiver strain. Although many upskilling and career advancement interventions can be implemented within existing nurse delegation rules,[48] updating and aligning these rules across states is another necessary step toward overcoming inequities for direct care workers and LTSS consumers.[49,50]

Further, career advancement opportunities within direct care must be complemented by accessible career pathways from direct care to other health care occupations.[45] The most well-known pathway is from direct care to licensed practical nurse to registered nurse, but this option may not be viable for many direct care workers due to the educational prerequisites, training time, and costs involved.[19] Work-based learning, up-front tuition assistance, micro-credentialing, wraparound supports (to address childcare, transportation, and other needs), and other strategies and approaches are needed to expand opportunities for direct care workers to progress into nursing, therapy, administrative, and other roles.

Strengthen Supervision and Support

Direct care workers, like other health care workers, have been under intense pressure during the COVID-19 pandemic. Along with managing the immediate risks of transmission and infection, they have struggled with increased or inconsistent workloads, inadequate access to personal protective equipment (PPE), limited training and guidelines, and heightened anxiety and grief,[51,52] along with financial hardship, childcare and transportation challenges, family separation, and other personal life stressors.[53] These stressors have exacerbated existing risks for direct care workers,[54,55] which are

disproportionately experienced by workers of color[56]—underscoring the importance of addressing workforce challenges as a matter of social justice.

Combined with the increased job demands and training limitations described above, these challenges indicate the need for better support on the job, with supervision a key mechanism. Evidence from across occupations shows that effective supervisory relationships help mediate job stress and improve job satisfaction,[57] and supervision in LTSS has been identified as a primary driver of job satisfaction, intent to leave, actual turnover, and more.[33,58–62] For example, one study of home health aides found that organizational and supervisory support positively impacted job satisfaction and weakened the negative relationship between job-related stressors and job satisfaction.[63]

Nonetheless, there has been limited research on training and support interventions for LTSS supervisors. As one example from the field, a coaching supervision model that was implemented across 17 nursing homes and home care agencies showed statistically significant improvements in job satisfaction and satisfaction with supervision among nearly 1500 participating direct care staff, as well as garnering an estimated $6000 in cost savings per supervisor (among those reporting efficiencies because of the supervision training).[64]

Peer mentorship programs also show promise as a method for supporting direct care workers while also providing a career advancement opportunity for experienced workers and fostering a collaborative organizational culture. Although more research is needed on peer mentorship programs in LTSS, small studies have shown a promising impact on retention among nursing assistants in nursing homes[65] and among home care workers.[66]

Promote Empowerment and Inclusion

The value of interdisciplinary approaches to caring for those with serious illness across settings is now well-recognized.[67] However, direct care workers have not historically been included in care planning and assessment processes[68,69] and often report that their contributions are overlooked or unrecognized.[70,71] Federal regulations now require nursing assistants' inclusion in the interdisciplinary care team in nursing homes,[72] but implementation of this requirement is hindered by a lack of clear guidelines and accountability.[73] Home health agencies registered with CMS are also required by the federal conditions of participation to include home health aides in the interdisciplinary care team,[74] but their involvement in person-centered care planning is not explicitly named, and there are no similar federal requirements for other segments of the direct care workforce.

Nonetheless, innovative efforts to empower and integrate direct care workers exist. For example, the nursing home culture change movement has produced several team-based models that elevate nursing assistants' status. The Green House homes model, as one example, aims to empower nursing assistants in their direct care role and in relation to clinical partners,[75] which has been shown to create opportunities for more appropriate and timely resident care, depending upon implementation.[76] (To note, there is mixed evidence about whether the "universal worker" approach in Green House homes and other culture change models empowers direct care workers vs increasing their workloads and actually undermining the provision of person-centered care.[69,77]) Evidence from the Nursing Home Culture Change Survey shows a link between nursing assistant empowerment and retention; nursing homes with medium and high levels of empowerment (based on a 7-item scale) had a 44% and 64% greater likelihood of having high retention, respectively, compared with those in the low-empowerment category.[78] The introduction of culture change—including staff empowerment—was also associated in the survey data with significant improvements in key care processes and outcomes among "high practice adopters" and fewer survey deficiencies among other adopters, indicating the implications of staff empowerment for quality improvement as well.[79]

Although more limited, the evidence from HCBS also suggests that empowerment and integration interventions are well-received by participants and are associated with improved wages, confidence, team communication, and care outcomes.[80–82] For example, a pilot program designed to improve care integration and outcomes for home care clients by upskilling direct care workers and enhancing their role on the care team showed promising impacts on medication adherence, emergency department and hospitalization rates, health-related quality of life, and satisfaction with care.[83]

Implications for Research, Policy, and Practice

Reimagining LTSS requires a broad-based commitment to improving the quality of direct care jobs. This commitment must be matched by strategies that span across direct care occupations and LTSS settings to the extent possible—to achieve a strong, stable workforce that is well-prepared to provide competent care where and when needed.

The policy window is now open, given the unprecedented attention on LTSS and the direct care workforce at the federal and state levels. As of late 2021, states are preparing to implement their *American Rescue Plan Act* HCBS spending plans, many of which include investments in direct care workers' compensation, training, career development, and more.[84] Also at the time of writing, Congress is debating the *Build Back Better* reconciliation budget bill,[85] which includes $150 billion to strengthen states' HCBS infrastructure, plus additional funding to improve direct care training and workforce development overall and to secure essential benefits for all workers, including paid leave, affordable childcare, and universal preschool.[86] Although it falls short of President Biden's original "caregiving economy" campaign promise,[87] this bill heralds significant progress toward improving direct care job quality and enhancing LTSS access. In parallel, nursing home policy reform efforts are also underway, with direct implications for nursing assistant jobs; as one key example, the bicameral *Nursing Home Improvement and Accountability Act* introduced in Congress in September 2021 proposes to improve compensation for nursing home staff and set minimum staffing levels, among other provisions.[88]

Consistent with the enhanced federal attention on and investment in LTSS, now is the time for a national direct care workforce strategy. To that end, the US Department of Health and Human Services could convene an advisory council comprising representatives from relevant federal agencies and departments as well as LTSS payers, providers, workforce development experts, worker advocates, consumers and family members, and direct care workers themselves. Among its efforts, the council could develop recommendations for improving direct care workers' compensation; raising competency-based training standards across settings and occupations; establishing recognized career pathways; strengthening supervision in LTSS; enhancing care team integration, including by addressing nurse delegation barriers; and overcoming the substantial gaps in direct care workforce data collection.[89]

These recommendations could be judiciously built into federal funding and accountability mechanisms (eg, as seen in the *Better Care Better Jobs* draft legislation[90]) to promote equity across the country without undermining states' role as the primary locus of LTSS policy and innovation. In parallel, multi-stakeholder workgroups[91] could fulfill a complementary remit at the state level: eg, identifying state-specific workforce priorities, developing strategies and solutions aligned with federal guidance and/or requirements, and monitoring progress over time.

These policy reforms are necessary but far from sufficient for improving direct care jobs and stabilizing the workforce. Because Medicaid is the primary public payer for LTSS, Medicaid policy changes have outsize significance; but changes within Medicare are also required to support the provision of post-acute care across settings, and changes in state licensure and other regulations are needed to address assisted living and other settings and services that fall largely outside the public payment system. In the longer view, a fully reimagined LTSS system will require a transformative financing approach that ensures coverage for eligible individuals (without impoverishing them), builds in job quality for direct care workers, and enhances equity and social justice.[92,93]

In the research arena, the evidence base on the links between direct care workforce interventions, workforce outcomes, and care outcomes must be strengthened. Evidence is especially needed on the impact of wage increases (to identify the wage threshold for recruiting and retaining a sufficient direct care workforce); on the implementation, replication, and scale-up of training, upskilling and advanced role interventions; and on different models of supervision and peer mentorship, with attention to both implementation and impact.

In practice, LTSS providers need more tools and guidance on how to improve direct care job quality and better leverage the skills and expertise of direct care workers to the extent possible within financing and regulatory parameters. Key opportunities include upskilling workers with more condition-specific knowledge and the skills to observe, record, and report changes of condition that may require clinical attention; building structured communication protocols to ensure effective two-way knowledge exchange between frontline caregivers and other clinical providers; creating meaningful opportunities for direct care workers to participate in interdisciplinary care planning and assessment processes; developing internal career pathways for direct care workers; and providing training and ongoing support for supervisors and peer mentors. Finally, employers would benefit from guidance on how to develop partnerships and networks with community-based organizations and public agencies to assist direct care workers in securing affordable childcare, transportation, housing, health care, immigration services, and other essential wraparound supports.

Across all efforts to transform direct care jobs, it is imperative to include direct care workers themselves—centering their experiences and leveraging their insights about how to reimagine this system of care and support.

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