

Direct Care Workers in Long-Term Care

Research Report

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Introduction

Direct care workers provide the bulk of paid long-term care. These paraprofessional workers hold a variety of job titles, including personal care assistants, home care aides, home health aides, and certified nursing assistants (CNAs). They work in diverse settings, including private homes, adult day centers, assisted living residences and other residential care settings, and nursing homes. More than a million direct care workers in the U.S. work at jobs that may include:¹

- assisting with personal care activities, such as bathing, dressing, toileting, transferring, and eating;
- providing comfort and companionship;
- observing and reporting changes in a client's condition;
- preparing meals and housekeeping;
- providing oversight for people with cognitive and mental impairments; and
- administering medications and measuring vital signs.

This report examines recently published data that shed light on the characteristics of direct care workers, their working conditions, future demand for their services, and efforts to improve recruitment and retention of these workers.

Characteristics of Direct Care Workers

Compared to the general workforce, direct care workers are more likely to be women, non-white, and unmarried with children (see Table 1).² Over a quarter have completed at least some college. Most intentionally choose direct care work because of a desire to help people and an interest in working in health care.³

Table 1: Characteristics of Direct Care and All Workers

	Nursing home aides	Home health aides	All workers
Female	91%	89%	52%
White, non-Hispanic	57%	49%	74%
Unmarried with children	32%	25%	11%
Mean age	37	41	45
Some college	27%	38%	50%

Source: Scanlon, 2001.

Working Conditions and Turnover

Although the majority of direct care workers find their jobs intrinsically rewarding,⁴ they are often low paid with limited or no benefits, high workloads, unsafe working conditions, inadequate training, a lack of respect from supervisors, lack of control over their jobs, and few opportunities for advancement, all of which contribute to high turnover.⁵

Wages and Benefits

Median hourly wages in 2003 were \$8.05 for personal and home care aides, \$8.75 for home health aides, and \$9.96 for nursing aides, orderlies, and attendants⁶ (see Table 2), compared to \$13.65 for all occupations.⁶ This translates into annual wages for year-round, full-time work of between \$16,750 and \$20,760. However, 30.5% of home care aides and 20.6% of nursing home aides work part time.⁷ Direct care workers in long-term care work an average of about 30 hours per week, thus reducing their annual earnings to less than \$16,000.

Table 2: Wages of Direct Care Workers

Job Category	2003 Median Hourly Wage	Annual Wage, Full-Time Work	Annual Wage, 30 hrs/week
Personal & Home	\$8.05	\$16,750	\$12,558

Care Aides			
Home Health Aides	\$8.75	\$18,200	\$13,650
Nursing Aides, Orderlies, & Attendants	\$9.96	\$20,760	\$15,538

Source: BLS, November 2003 wage data. Note: Annual wages for full-time work were calculated by multiplying median hourly wages times 40 hours a week times 52 weeks a year. Annual wages for 30 hours a week were calculated by multiplying the median hourly wage times 30 hours per week times 52 weeks per year.

From 1997 to 1999, just 45% of nursing home aides and 34% of home health aides had pensions provided by their employers.⁸ Similar proportions (43% of nursing home aides and 30% of home care aides) received health insurance through their employers, and another 18% of nursing home aides and 24% of home care aides were insured through Medicaid or other public programs. The remaining 40% of nursing home aides and 45% of home care aides were uninsured.

Workplace Injuries

Direct care work has one of the highest workplace injury rates of any occupation. In 2003, there were 10.1 workplace injuries or illnesses per 100 full-time workers in nursing and residential care facilities, compared to 6.8 per 100 workers in the construction industry and 5.0 per 100 workers in all private workplaces.⁹

Training

Direct care workers typically receive little or no formal training before starting their jobs. Federal law requires CNAs and home health aides in Medicaid- and Medicare-certified nursing homes and home health agencies to complete a minimum of 75 hours, or about two weeks, of training and pass an exam. Aides may work for up to four months before completing their training. As of 2002, 26 states required more than the minimum federal requirements.¹⁰ Minimum training requirements in these states ranged from 76 hours to 175 hours. In assisted living, training requirements vary by state; the most common amount of required training is between one and 16 hours.¹¹ A few states also have training requirements for other categories of direct care workers.¹²

Vacancies and Turnover

In a 2003 survey of 44 states, respondents from 35 states (80%) said that direct care vacancies were a serious issue in their states.¹³ Eight states did not consider vacancies to be a serious problem, and one state did not answer the question.

Estimates of worker turnover rates vary widely, because various studies use different methodologies for calculating turnover. Annual turnover rates for nursing home workers ranged from 39% to 98% in 2003 in the six states that collected such data.¹⁴

For assisted living, a 2001 national study found average turnover rates of 40% for personal care workers, 39% for CNAs, 30% for universal workers, and 38% for medication aides.¹⁵

Some other studies have found much higher turnover rates. For example, in a 2002 Wisconsin study, turnover among direct care workers ranged from 77% to 164% in assisted living, from 99% to 127% in nursing homes, and from 25% to 50% in home health agencies.¹⁶ In a 2002 North Carolina study, turnover rates were 115% for adult care homes, 95% for nursing homes, and 37% for home care agencies.¹⁷

High turnover rates and high staff vacancy rates have negative consequences for consumers, providers, and workers. For consumers, high turnover and understaffing lead to inadequate and unsafe care, poorer quality of life, and reduced access to services.¹⁸ For providers, the direct cost of turnover (the costs of separation, vacancy, replacement, training, and increased worker injuries) is estimated to be at least \$2,500 per separated employee.¹⁹ Turnover may also entail important indirect costs for providers, such as costs associated with lost productivity, reduced service quality, and deterioration in employee morale. For workers, high turnover rates and high workloads can mean increased risk of on-the-job injuries, more stress and frustration, and less opportunity for training and mentoring, all of which can further increase turnover.²⁰

Future Demand for Direct Care Workers

Between 2002 and 2012, the number of direct care jobs is projected to increase at a much higher rate than employment in the overall labor market (see Table 3).²¹ Demand is expected to be especially high for workers in home and community settings, because of consumer preference for and increased public funding for home- and community-based services,²² as well as favorable socioeconomic and demographic trends that will lead to a more consumer-driven market.²³

Finding workers to fill these job openings will be challenging. Although future demand cannot be predicted with certainty, demographic trends indicate a growing gap between the number of people likely to need care and the number of people who are most likely to provide it.²⁴ Between 2000 and 2030, the U.S. population age 85 and older—those most likely to need personal care services—is projected to more than double, from 4.3 million to 8.9 million.²⁵ Meanwhile, the traditional caregiving population—women age 20-54—is projected to increase by just 9% during this time.

Table 3: Projected Increase in Direct Care and All Jobs, 2002-2012

	# of jobs (1,000s)	% change

	2002	2012	
Home health aides	580	859	48%
Nursing aides, orderlies, & attendants	1,375	1,718	25%
Personal & home care aides	608	854	41%
All direct care jobs	2,563	3,431	34%
All occupations	144,014	165,319	15%

Sources: Hecker, 2004; National Clearinghouse on the Direct Care Workforce, 2004.

Efforts to Recruit and Retain Direct Care Workers

Examples of federal efforts to recruit and retain direct care workers include funding demonstration projects to make health insurance coverage available to direct care workers; funding development of educational materials and training and mentoring programs; creating a pilot "career lattice" apprenticeship program for CNAs; and designing the National Survey of Direct Care Workers.²⁶

State efforts include higher Medicaid reimbursements designated for wages or benefits (wage or benefit "pass-throughs"), home ownership opportunities for workers, enhanced training opportunities, and media campaigns promoting direct care careers.²⁷

Providers have also made a number of efforts to improve staff satisfaction and retention. Examples in nursing homes include mentoring programs, involvement of staff in decision making, and flexible work schedules.²⁸ Managers report that these practices have improved staff satisfaction and retention. In home care, cooperatively owned home care agencies have improved wages, benefits, training, and level of workplace participation.²⁹

Worker associations and public authorities provide outreach, advocacy, support, and training for direct care workers in a variety of settings.³⁰ Public authorities provide an "employer of record" for independent (self-employed) workers, providing them with the right to organize a union. The public authority model was created in California through a 1992 law that established county-level public authorities, and Oregon and Washington recently established statewide public authorities. Examples of worker associations include the Connecticut Association of Personal Assistants, which represents personal care attendants, and the Iowa Caregivers Association, which represents workers in facilities and agencies.

However, models of the various successful programs have not been widely adopted.³¹ Ensuring a stable workforce to meet future long-term care needs will require well-designed evaluations to assess the effectiveness of interventions as well as wider dissemination and implementation of practices that are shown to be effective.³²

Footnotes

* This category consists mainly of CNAs in long-term care settings, although it also includes nursing aides, orderlies, and attendants working in acute care and psychiatric hospitals (National Clearinghouse on the Direct Care Workforce, 2004).

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