LTSS STATE SCORECARD

High Performance Revisited: Examining the Direct Care Workforce Supporting Older Adults and Individuals With Physical Disabilities

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About this Paper

High Performance Revisited is meant to inform the LTSS State Scorecard framework in the development of the 2023 edition. The LTSS State Scorecard is a project from AARP Foundation and AARP, funded by The SCAN Foundation, and The John A. Hartford Foundation.

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Introduction

AARP Public Policy Institute (PPI) published the inaugural Long-Term Services and Supports (LTSS) State Scorecard (the Scorecard) in 2011. This first-of-its-kind project measured state LTSS system performance and ranked states in comparison with one another. Building on the work of previous similar projects focused on health care (e.g., the Commonwealth Fund's State Scorecard on Health System Performance), this Scorecard sought to raise the profile of LTSS and drive action both federally and within states. Since then, the Scorecard has helped both to propel and spotlight change in state LTSS systems as well as to improve services and supports that older adults, people with physical disabilities, and family caregivers receive.[1]

The 2023 Scorecard, set for release in September, will be the first since the COVID-19 pandemic began. In light of the impact of COVID-19, the Scorecard team has spent time taking stock of the current LTSS landscape and what has changed. With input from a wide range of advisors and stakeholders, we have revised the framework and it will include more of a focus on

[1] Susan Reinhard et al., *Advancing Action: A State Scorecard on Long-Term Services and Supports for Older Adults, People With Physical Disabilities, and Family Caregivers*, 2020, https://www.longtermscorecard.org/~/media/Microsite/Files/2020/LTSS%202020%20Reference%20Edition%20PDF%20923.pdf.

For the 2023 LTSS State Scorecard, we define LTSS as follows:

Assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) provided to older people and adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period, typically 90 days or more.

LTSS include human assistance; supervision; cueing and standby assistance; assistive technologies/devices and environmental modifications; health maintenance tasks (e.g., medication management); information; and care and service coordination for people who live in their own home, a residential setting, or a nursing facility. LTSS include supports provided to family members and other unpaid caregivers.

Individuals with LTSS needs may also have chronic conditions that require health/medical services. In a high-performing system, LTSS are coordinated with housing, transportation, and health/medical services, especially during periods of transition among acute, postacute, and other settings.

Today, almost half of LTSS spending for older adults and adults with physical disabilities goes to support people in home- and community-based settings rather than to institutional LTSS.

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Source: Brendan Flinn, "High-Performance Revisited: Examining Long-Term Services and Supports System Performance," AARP Public Policy Institute, November 10, 2022, https://www.longtermscorecard.org/publications/promising-practices/high-performance-revisited, and based on the LTSS definition provided in *Raising Expectations*, the 2011 edition of the LTSS State Scorecard.

two issues that have always been important but that emerged as urgent priorities during the COVID-19 pandemic: 1) direct care workforce shortage and stability and 2) equity in terms of access and quality to LTSS across different racial and ethnic groups. This paper lays the groundwork for our approach to addressing state performance in ensuring an adequate direct care workforce. Although direct care workers are typically employed privately by provider agencies, individuals, or families, many of the services these workers provide are paid for through state Medicaid or other public LTSS programs. State agencies have an obligation in their capacity as administrators of these public programs to ensure there are enough workers, competent and prepared, to serve all program enrollees.

Direct service worker is a broad category that encompasses many job titles held by people who provide hands-on services and supports across LTSS systems for all populations. Within this larger group of workers, the term *direct care worker* describes the individuals, with job titles like home care aide and personal care aide, who provide LTSS for older adults and individuals with physical disabilities. They work in multiple settings (e.g., private homes, congregate homes, nursing facilities, assisted living facilities and day programs; see sidebar).[2] With more than 80 percent of adults reporting they would like to live in their homes and communities as they age, rather than in a nursing facility, direct care workers play an important role in helping individuals live where they choose.[3] A high-quality and competent workforce ensures the independence, well-being, and safety of these individuals.

Despite their critical role, direct care workers face multiple challenges including low wages, few employee benefits, and minimal training opportunities. The current workforce supply is not nearly

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[2] Reinhard et al., *Advancing Action*.

[3] Kezia Scales, "It Is Time to Resolve the Direct Care Workforce Crisis in Long-Term Care," *The Gerontologist* 61, no. 4 (2021): 497–504, https://doi.org/10.1093/geront/gnaa116.
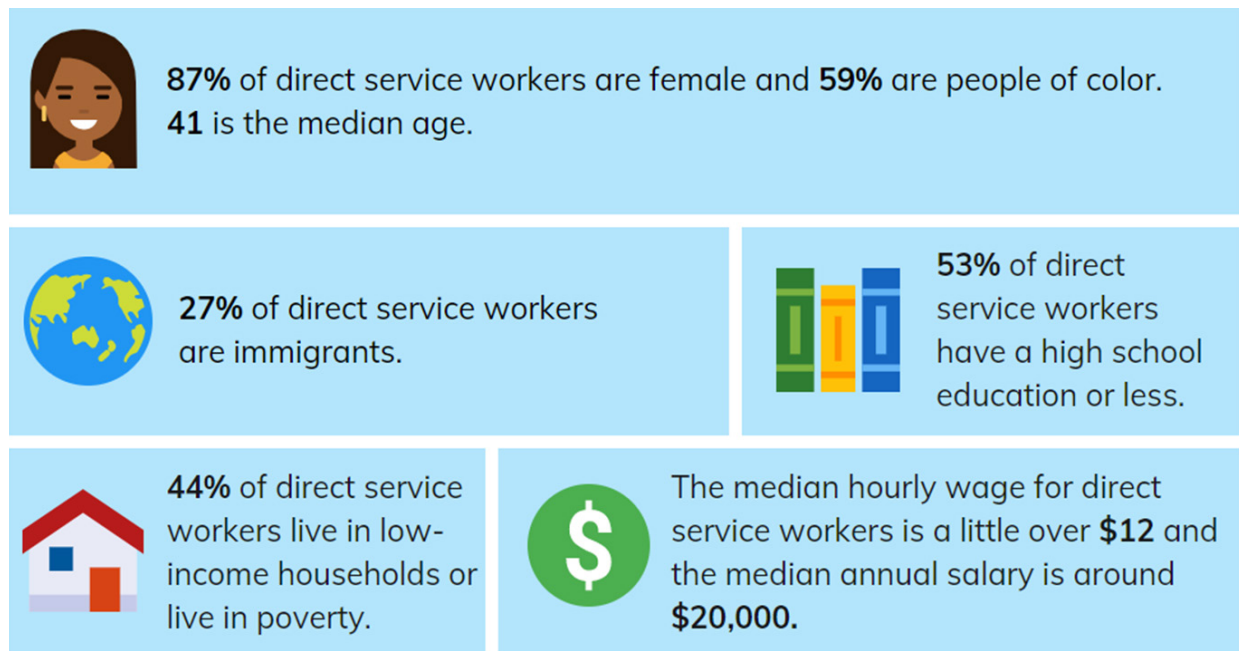
enough to meet an increased demand for supports as individuals live longer and turnover rates are high. Investments in data collection can support quality measurement about the direct care workforce. In turn, quality measurement can inform strategies for enhancing the strength and stability of the workforce, which is essential for the well-being of the individuals who rely on its services.

Demographic Profiles of Direct Service Workers and Recipients

Direct Service Workers

Among the 4.6 million direct service workers in the United States (US),[4] the typical direct service worker is a middle-aged woman of color with a high school education who earns about $20,000 a year *(see Exhibit 1).*

EXHIBIT 1: DIRECT SERVICE WORKFORCE PROFILE*

87% of direct service workers are female and **59%** are people of color. **41** is the median age.

27% of direct service workers are immigrants.

53% of direct service workers have a high school education or less.

44% of direct service workers live in low-income households or live in poverty.

The median hourly wage for direct service workers is a little over **$12** and the median annual salary is around **$20,000.**

* See Scales, "It Is Time," for statistics on gender, race/ethnicity, immigrant status, and education; for statistics on age, poverty, and wages, see Stephen Campbell et al., "Caring for the Future: The Power and Potential of America's Direct Care Workforce," 2021, http://www.phinational.org/caringforthefuture/.

To explore additional data about the direct service workforce, refer to the **American Community Surveys** available through IPUMS, the US Bureau of Labor Statistics' **Occupational Employment Statistics**, or PHI's **Workforce Data Center**.

[4] Scales, "It Is Time."

Recipients of LTSS

Around 12.6 million adults in the US need LTSS.[5] The population of older adults receiving LTSS is becoming more racially and ethnically diverse. By 2060, older adults who are Black, Asian American/Pacific Islander, and/or Hispanic will make up 45 percent of all older adults in the US, and the proportion of older adults who immigrated to the US will grow to 23 percent.[6] Additionally, about 27 percent of adults ages 18 and older with disabilities are Black, Asian American/Pacific Islander, and/or Hispanic.[7] These demographics highlight the need to increase the cultural and linguistic competency of the workforce. Culturally competent services can improve care quality and decrease health inequities.[8]

What Is the Role of a Direct Care Worker?

Although all direct care workers support older adults and/or individuals with physical disabilities with daily tasks (e.g., eating, dressing, and bathing), they can work in a variety of settings and have various job titles. Many employers use the occupational title of *direct service worker,* but positions have different titles including *direct care worker, personal care assistant,* and *home care aide.* Due to the range of job titles, the number of direct care workers may be mis- or undercounted.

There are three main segments of the workforce: home care workers, residential care aides, and nursing assistants.[9]

Home Care Workers	Residential Care Aides	Nursing Assistants
Home care workers and personal care aides assist older adults and individuals with disabilities in their homes with daily tasks. They can also support with household tasks and provide social support.	Residential care aides assist older adults and individuals with disabilities who live in group homes, assisted living and retirement communities, and other community-based care settings.	Nursing assistants support older adults and individuals with disabilities who live in nursing facilities with daily tasks, such as eating, dressing, and taking part in social activities.

Additionally, in some states, direct care workers may perform tasks that would usually be handled by a nurse; registered nurses can delegate care tasks to workers in any setting, such as administering medications, changing dressings, and performing urinary catheterizations.[10] Regardless of setting, direct care workers are vital to ensuring that older adults and individuals with physical disabilities can choose where they live and maintain independence.

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[5] Edem Hado et al., "LTSS Choices: Home and Community-Based Services for Older Adults, AARP Public Policy Institute, November 17, 2021, https://doi.org/10.26419/ppi.00153.001.

[6] Campbell et al., "Caring for the Future."

[7] Nanette Goodman et al., "Financial Inequality: Disability, Race, and Poverty in America," 2019, https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf.

[8] Georgetown University Health Policy Institute, "Cultural Competence in Health Care: Is It Important for People With Chronic Conditions?" https://hpi.georgetown.edu/cultural/.

[9] PHI, "Direct Care Workers in the United States: Key Facts," September 8, 2020, https://phinational.org/resource/direct-care-workers-in-the-united-states-key-facts/.

[10] Heather M. Young et al., "Nurse Delegation in Home Care: Research Guiding Policy Change," *Journal of Gerontological Nursing* 42, no. 9 (2016): 7–15, https://pubmed.ncbi.nlm.nih.gov/27571400/.

What Challenges Do Direct Care Workers Face?

Despite the increased demand for direct care workers as the population continues to age, job quality for all members of the direct service workforce remains low:

- **Low wages and lack of benefits**: The median wage for direct care workers is $12.27 per hour, which is lower than for other occupations with similar entry-level requirements, such as positions in retail and janitors.[11] As a result, 44 percent of direct care workers live in low-income households or in poverty, and 42 percent rely on some form of public assistance due to low earnings. Further, direct care positions often lack health insurance and other benefits (e.g., paid time off, sick leave, retirement contributions).[12]

- **Career development**: Direct care workers often receive minimal or insufficient training and career development opportunities from their employers.[13]

- **Job safety**: Direct care work positions are also physically and emotionally demanding, with high rates of occupational injury.[14]

- **Job environment**: Direct care workers experience high rates of burnout, associated with challenges on the job, low levels of worker empowerment, and the stigma of working what is unfairly considered a low-skill job.[15]

- **Discrimination**: Direct care workers face both racial and gender discrimination that causes, compounds, and/or exacerbates other challenges in their work and personal lives.

All these factors contribute to high turnover rates within this workforce. The average annual turnover for all direct care workers providing HCBS was an estimated at 64 percent in 2021 and for nursing homes, 100 percent in 2017-2018 (before the pandemic).[16] These workers also have low retention rates. About 38 percent of direct service workers leave their positions in less than six months, and approximately 21 percent leave within six to 12 months.[17]

The Impact of COVID-19

COVID-19 disproportionately affected individuals who live and work in long-term care settings. Nursing facilities felt the greatest impact, with COVID-19, killing more than 165,000 residents and staff of nursing facilities.[18] The higher risk for COVID-19 complications and severe illness that older adults and individuals with disabilities' higher risk for COVID-19 complications and severe illness contributed to the high death toll.

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[11] PHI, "Would You Stay? Rethinking Direct Care Job Quality," October 13, 2020, https://phinational.org/resource/would-you-stay-rethinking-direct-care-job-quality/.

[12] Campbell et al., "Caring for the Future."

[13] Campbell et al., "Caring for the Future."

[14] Scales, "It Is Time."

[15] Campbell et al., "Caring for the Future."

[16] PHI, "Understanding the Direct Care Workforce" https://www.phinational.org/policy-research/key-facts-faq/

[17] Hewitt et al., "The Direct Support Workforce Crisis."

[18] AARP, "AARP COVID-19 Nursing Home Dashboard," https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html.

COVID-19 has also affected the workforce by exacerbating existing challenges. People of color have worse health outcomes than their white peers, and COVID-19 disproportionately affected people of color. Kaiser Family Foundation reported that as of mid-2022, "American Indian or Alaskan Native, Hispanic, Native Hawaiian or Pacific Islander, and Black people are about twice as likely to die from COVID-19 as their White counterparts."[19] About 25 percent of individuals who receive LTSS and 61 percent of direct service workers are people of color.[20] Correspondingly, nursing facilities with higher proportions of Black and Latino residents were hit twice as hard as nursing facilities with primarily white residents.[21] More than 60 percent of nursing homes where at least 25 percent of the residents were Black and Latino reported at least one COVID-19 case, a rate double that of nursing facilities with less than 5 percent Black and Latino residents.[22] These statistics highlight how health inequities can affect older adults and the workforce and the need for systematic solutions.

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Targeted Recruitment

Targeted recruitment could help address the workforce shortage, and it could focus on culturally competent and responsive care. Analyzing gaps in the workforce could lead to strategies to recruit from populations not as likely to join the workforce; it could also better match backgrounds of the individuals receiving care with those of their direct service worker. Examples include the following:

- Recruiting older adults from programs such as AmeriCorps Seniors to provide LTSS to other older adults

- Recruiting direct service workers who are bilingual

- Recruiting young people (in high school or college) by using realistic job previews to help individuals make an informed decision on whether direct service work could be the right career for them

- Recruiting family caregivers who might be interested in applying their skills to a direct service work job

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In addition, states have often struggled to collect data about this workforce, and this challenge has continued during the COVID-19 pandemic. Although data were collected on COVID-19 cases and deaths in nursing facilities, relatively few states collected data specifically for Medicaid home and community-based service (HCBS) enrollees.[23] Such inconsistent data collection among states presents an incomplete picture of COVID-19's impact on the long-term care sector.

Lastly, COVID-19 exacerbated the challenges related to low job quality for direct care workers. Direct care workers often do not have sufficient benefits. During COVID-19, many did not have access to health insurance or paid sick leave at a time when they needed them most.[24] It is also very likely that COVID-19 increased turnover. In one study, 62 percent of direct service workers said they know of staff who left

[19] Kaiser Family Foundation, "COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time," August 22, 2022, https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/.

[20] PHI, "Would You Stay?"

[21] PHI, "Would You Stay?"

[22] Priya Chidambiram et al., "Racial and Ethnic Disparities in COVID-19 Cases and Deaths in Nursing Homes," Kaiser Family Foundation, October 7, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/racial-and-ethnic-disparities-in-covid-19-cases-and-deaths-in-nursing-homes/

[23] Molly O'Malley Watts et al., "State Medicaid Home & Community-Based Services (HCBS) Programs Respond to COVID-19: Early Findings From a 50-State Survey," Kaiser Family Foundation, August 10, 2021, https://www.kff.org/coronavirus-covid-19/issue-brief/state-medicaid-home-community-based-services-hcbs-programs-respond-to-covid-19-early-findings-from-a-50-state-survey/.

[24] Beth Almeida et al., "The Demographics and Economics of Direct Care Staff Highlight Their Vulnerabilities Amidst the COVID-19 Pandemic," *Journal f Aging & Social Policy* 32, no. 4–5 (2020): 403–9, https://doi.org/10.1080/08959420.2020.1759757.

their jobs due to the COVID-19 pandemic. Reasons for leaving included caring for a family member with health issues, fear of becoming infected with COVID-19, and childcare issues.[25]

Even with COVID-19 risks, many direct care workers continued to deliver essential care throughout the pandemic. Although challenges existed before the pandemic, COVID-19 has brought heightened attention to this workforce and much greater recognition that we must work harder than ever to improve recruitment, compensation, and job quality.

Responding to Challenges

States and LTSS providers can respond to workforce challenges in a variety of ways. In interviews, national and state provider organizations mentioned the following strategies:

- Increasing wages and offering signing and referral bonuses
- Offering paid sick days
- Creating employee resource networks
- Improving the competencies of supervisors
- Increasing the minimum standard for training hours
- Developing standardized curricula, core competencies, and credentialing strategies[26]

The American Rescue Plan Act

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARPA). Section 9817 assists states with funding for long-term solutions to workforce challenges.[27] The law offers a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS beginning April 1, 2021, and ending March 31, 2022. States have until March 31, 2025, to spend the funding on efforts that enhance HCBS in their states. This increased funding, an estimated $12.7 billion, gives states a rare opportunity to identify and implement changes aimed at addressing existing HCBS workforce and structural issues, expand the capacity of critical services, and meet the needs of individuals on HCBS waitlists and family caregivers.[28]

To be eligible for the increased FMAP funding, states submitted initial plans to the Centers for Medicare & Medicaid Services (CMS) for how they would use the funding. CMS has received HCBS spending plans from 50 states and the District of Columbia. As of June 2022, all states have received at least conditional or partial approval to claim the HCBS FMAP increase retroactively to April 1, 2021, and to

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[25] University of Minnesota Institute of Community Integration & National Alliance for Direct Support Professionals, "Direct Support Workforce and COVID-19 National Report: 12-Month Follow-Up," September 2021, https://publications.ici.umn.edu/community-living/covid19-survey-12-month-followup/main.

[26] Valerie J. Bradley, "Promising Recruitment and Retention Strategies," Human Services Research Institute, Mission Analytics Group, & the Administration for Community Living, September 2021, https://ncapps.acl.gov/docs/Resources/DSP%20Promising%20Recruitment%20and%20Retention%20Strategies.pdf.

[27] American Rescue Plan Act of 2021. Pub L. No. 117-2, 135 Stat. 4. (2021), https://www.congress.gov/bill/117th-congress/house-bill/1319/text.

[28] Centers for Medicare & Medicaid Services, "Strengthening and Investing in Home and Community-Based Services for Medicaid Beneficiaries: American Rescue Plan Act of 2021 Section 9817 Spending Plans and Narratives, https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817-spending-plans-and-narratives/index.html.

begin implementing activities in their spending plans. States will need to continue reporting to CMS and providing information as requested as long as they hold enhanced match dollars.[29]

Within the next couple of years, states can use ARPA funding as a strategic resource to address immediate challenges facing the workforce. Most plans (70 percent) include supplying additional training to direct service workers and around half of the plans include a wage increase, a one-time bonus payment, and/or a retention payment. Additionally, around one-third (35 percent) of plans include creating or improving career ladders for direct service workers. Considerably fewer plans focus on student loan forgiveness (12 percent) or improving benefits for direct service workers (10 percent).[30]

> To explore additional data on the submitted state ARPA spending plans, visit the CMS webpage **here**.

Call to Action: Moving the Direct Care Workforce Forward

States must plan for long-term solutions and think strategically about how to leverage limited resources and initiate strategies to improve the quality of the workforce. As states work toward long-term, sustainable solutions, they must improve data collection processes. Many states do not collect even basic data on workforce volume, stability, compensation, diversity, race, and ethnicity, or they insufficiently or inconsistently collect these data. To measure and improve workforce quality, states must first collect systematic data on the workforce, which can enable leaders to understand the key challenges facing workers.[31]

Once there is sufficient data collection, standard quality measures or indicators can be used to assess states' performance in ensuring a stable and adequate workforce as well as to identify additional areas for improvement. Quality measures can evaluate both the quality of direct service jobs and the quality of services. Ultimately, both types of measures offer insight into the services that individuals receive. Whether a worker has job satisfaction and a responsive and safe job environment can affect the individuals they serve. One study examining nursing facility staff and residents found that a "one-point increase in overall employee satisfaction [supervisor support, respect and caregiving, working conditions, and training] was associated with an increase of 17.4 points (scale of 100) in the satisfaction of residents and family members."[32] Strengthening the workforce is essential to providing older adults and individuals with disabilities with effective supports and services to continue living at home or in the community.

Although existing literature and research focus heavily on the demographics of the workforce and the challenges it faces, limited research addresses measuring the quality of direct service positions, or the quality of services provided by direct service workers. Therefore, it may be necessary to adapt similar existing measures for the workforce. The following table presents examples of existing measures that could be adapted to measure the progress in improving the quality of the workforce. These measures will be explored for potential inclusion in the next Scorecard.

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[29] Centers for Medicare & Medicaid Services, "Strengthening and Investing."

[30] Centers for Medicare and Medicaid Services, "Strengthening and Investing."

[31] Campbell et al., "Caring for the Future."

[32] Bora Plaku-Alakbarova et al., "Nursing Home Employee and Resident Satisfaction and Resident Care Outcomes," *Safety and Health at Work* 9, no. 4 (December 2018): 408–415, https://doi.org/10.1016/j.shaw.2017.12.002.

MEASURING JOB QUALITY AND SATISFACTION

Agency/Instrument	Measure Name	Measure Description	Relevance to Workforce
National Balancing Indicators	Sustainability—Direct Service Workforce: Volume, Compensation, and Stability	"This indicator examines (1) workforce volume (number of workers), (2) worker compensation (average hourly wages, benefits, including health insurance, and paid time off), and (3) workforce stability (turnover rate, vacancy rate)."*	As a method of understanding direct service job quality and satisfaction, states could collect data on and measure workforce volume, compensation, and stability.
The Joint Commission	Voluntary Turnover	"The total number of voluntary uncontrolled separations of nursing staff during the calendar month, stratified by type of staff."[†]	This measure could be adapted for the workforce to measure turnover for staff working in HCBS and nursing facilities. For example, in North Carolina, the Annual Short Turnover Survey by the Department of Health and Human Services is included with the licensure renewal application for long-term care facilities. This survey measures turnover as the total number of staff who leave voluntarily or involuntarily divided by the total number of staff needed for the organization to be fully staffed.[‡]
Bureau of Labor Statistics	Volume, Wages, Training	The total number of individuals holding different job titles, median pay, entry-level education, work experience, on-the-job training[§]	These data could be used to calculate worker volume, compare wages to other fields, and assess worker preparedness.
US Census American Community Survey	Respondents in Relevant Occupations, Annual Income, Hours Worked	Sample of American residents, mandated responses, in every state, DC, and Puerto Rico; includes questions about industry and occupation	The data could be used to estimate size of workforce and income by occupation. Responses are from a sample, and some sample sizes are small.

*Susan Flanagan et al., "The National Balancing Indicators Measures Additions and Refinements Report," Centers for Medicare & Medicaid Services, June 18, 2014, https://www.medicaid.gov/sites/default/files/2019-12/nbip-measure-refinement.pdf.

[†]National Quality Forum, "Quality Positioning System, NQF 0207," https://www.qualityforum.org/qps/.

[‡]Kristen M. Kiefer et al., "Measuring Long-Term Care Work: A Guide to Selected Instruments to Examine Direct Care Worker Experiences and Outcomes," Office of the Assistant Secretary for Planning and Evaluation, March 31, 2005, https://aspe.hhs.gov/reports/measuring-long-term-care-work-guide-selected-instruments-examine-direct-care-worker-experiences-1.

[§]US Bureau of Labor Statistics, "Occupational Outlook," https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htmhttps://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm

MEASURING QUALITY OF CARE AND SERVICES

Agency/Instrument	Measure Name	Measure Description	Relevance to Workforce
National Center on Advancing Person-Centered Practices and Systems (NCAPPS)	Person-Centered Practices Self-Assessment: Workforce Capacity and Capabilities	This section of the self-assessment measures how well employees and workers utilize person-centered practices and the number and quality of opportunities for training on person-centered practices.*	Although this self-assessment is for organizations that serve individuals with developmental disabilities, it could be adapted to measure the quality of care provided by direct service workers supporting older adults and individuals with physical disabilities. This self-assessment is an example of how states or HCBS providers could assess the quality of their person-centered practices as a first step toward improvement.
Nursing Home and HCBS Consumer Assessment of Health Providers and Services (CAHPS®) Surveys	Consumer Experience With LTSS Providers Including Direct Care Workers for Nursing Home Residents and Their Families, and HCBS Recipients	This nationally validated suite of surveys includes questions about how well consumers' needs are met, unmet needs, worker reliability, courtesy, helpfulness, communication, competence, and responsiveness to personal goals and preferences.[†,‡] Several measures from the HCBS CAHPS®are included in CMS's HCBS Quality Measure Set.[‡]	These tools are used on a voluntary basis by some nursing home providers, state agencies, and managed LTSS providers. Data are not publicly available but might be accessed from survey users through data-sharing agreements.
National Core Indicators—Aging and Disabilities Adult Consumer Survey	Consumer Experience and Satisfaction With HCBS workers	This survey assesses experience and satisfaction with support workers among consumers, degree of choice in service planning, satisfaction with their living situation, and a variety of LTSS services as well as quality of life.[§] Several measures from this survey are included in CMS's HCBS Quality Measures compendium.[¶]	This survey is used on a voluntary basis by state agencies and public reports are produced by ADvancing States and HSRI on an annual basis.
Medicare.gov Care Compare	Nursing Home Staff Ratios, Turnover	CMS's Care Compare, the Medicare health care provider rating system, now includes information about staff ratios and turnover rates in nursing homes.	These data could provide a better picture of direct care staffing and stability in nursing facilities, such as certified nursing assistants.

*Mary Lou Bourne, "Person-Centered Practices Self-Assessment," National Center on Advancing Person-Centered Practices and Systems, October 2020, https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf

†CMS, HCBS CAHPS Surveys and Guidance, https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-and-community-based-services-survey/index.html.

‡Agency for Healthcare Research and Quality, "CAHPS Nursing Home Surveys," https://www.ahrq.gov/cahps/surveys-guidance/nh/index.html.

§Daniel Tsai, "Home and Community-Based Services Quality Measure Set," CMS, July 21, 2022, https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf.

ǁNational Core Indicators–Aging and Disabilities, "National Core Indicators–Aging and Disabilities," https://nci-ad.org/

¶Tsai, "Home and Community-Based Quality Measure Set."

Conclusions and Next Steps

The next LTSS Scorecard will be able to make use of some existing workforce data, but large gaps persist in what data are available at the state level, especially in home and community-based service settings. For example, there is no standard source of information that could be used to estimate vacancies and calculate turnover in HCBS settings. Going forward, analyzing existing data sources and developing new measures of workforce strength and stability could be transformative for state LTSS systems. Ultimately, the capacity and quality of the direct service workforce are directly tied to the quality of services provided to older adults and individuals with disabilities. There is a growing list of innovative models and evidence-based solutions that states and employers can use to improve job quality, worker competence, job satisfaction, and retention. The experience of states pursuing workforce initiatives with their ARPA funding will add to that body of knowledge. But systematic improvements to data collection and reporting systems must be made to ensure that state policymakers fully understand the specific challenges that workers face as well as the size, quality, and stability of the direct care workforce available to serve residents with LTSS needs. The ability to track workforce trends will help states take the necessary steps, in partnership with private industry, to recruit and retain workers in these important positions. In preparation for the next Scorecard and in our broader work to monitor and evaluate LTSS system performance overall, AARP will continue to explore data sources and measures about the direct care workforce.

https://doi.org/10.26419/ppi.00196.001