



RAISE Act State Policy Roadmap for Family Caregivers: The Direct Care Workforce

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Section 3B: The Direct Care Workforce

Rationale for Strengthening the Paid Direct Care Workforce

Nearly 20 million adults in the United States need assistance with self-care and other daily tasks, including about 17 million individuals living in the community, with family caregivers serving as the primary source of care and support for many. Over the remainder of their lifetime, individuals turning 65 today will need an average of 1.1 years of paid care, in addition to the care provided by family and other informal caregivers.

According to the U.S. Bureau of Labor Statistics, between 2019 and 2029 the demand for home health and personal care aides is expected to grow by 33.7 percent; during that same period, the demand for nursing assistants will grow 7.6 percent. With demand increasing, the country’s aging population will narrow the ratio of working-age adults to retirement-age adults from 4 to 1 to 3 to 1 during roughly that same time period. State Medicaid-funded long-term services and supports (LTSS) systems are not well-positioned to compete for this shrinking pool of workers.

In all 50 states, the median wage for the direct care worker is lower than the median wage for other occupations with similar entry-level requirements (including janitors, retail salespersons, and customer service representatives). Moreover, 85 percent of direct care workers are below 200 percent of poverty; 45 percent access public assistance.



Direct Care Worker Categories

Three primary categories of direct care workers serve older adults and adults with disabilities:

Personal Care Aides (PCAs). PCAs provide personal assistance with self-care activities, such as bathing, toileting, and dressing. PCAs may also provide assistance with light housework, laundry, meal preparation, and similar tasks. Services may be provided in a variety of home or community settings. PCA qualifications, responsibilities, and training are determined at the state level and can vary widely.

Nursing Assistants. Typically, nursing assistants also provide personal assistance with self-care activities. Nursing assistants may perform some delegated nursing tasks under clinical supervision. Nursing assistants may provide services in a nursing facility, a residential care facility, or other long-term services and supports (LTSS) settings. A certified nurse assistant (CNA) is qualified to work in a Medicare-certified nursing facility.

Home Health Aides. Home health aides (HHAs) also provide personal assistance with self-care activities and health-related tasks, such as changing bandages or administering medications. HHAs perform their work under clinical supervision. A Medicare-certified HHA is qualified to provide services through a Medicare-certified home health agency.

Note: This is a non-exhaustive list, as paid caregivers can be known by a broad range of service titles. For purposes of consistency, this report will utilize the term “direct care worker” to describe paid individuals providing skilled and/or social services and supports for older adults and adults with disabilities.

The shortage of direct care workers undermines a state’s ability to serve people with disabilities in the most integrated setting appropriate to a person’s needs and preferences. The COVID-19 pandemic has worsened these burdens, with the increased shortage of workers underscoring the critical role direct care workers play for the people they serve, as well as family caregivers. [Responsible for 43 percent of all LTSS expenditures](#), state Medicaid programs have a major role to play in responding to this crisis.

State Challenges

In addition to the demographic and economic challenges that hamper growth within the LTSS workforce, states that want to improve the quality and supply of the direct care workforce face a number of challenges:

- **Competing priorities for state leaders:** Compounded by the COVID-19 crisis, state leaders have multiple urgent priorities that compete with state action to bolster the LTSS workforce. Family caregivers often serve as care of last resort for older adults, obscuring the scope of the crisis.



Equity and the Direct Care Workforce

Nearly 90 percent of direct care workers are [women](#). Over 60 percent are members of a [racial or ethnic minority](#). Twenty-seven percent of all direct care workers are [immigrants](#). As states move forward on goals to improve the direct care field, it can be critical to identify and address the impact of systemic barriers and discriminatory practices that have contributed to low wages, lack of benefits, and little job mobility for this workforce. [Research from PHI](#) on racial disparities in this workforce notes the following strategies:

- Expand opportunities for advancement in direct care.
- Collect race-related outcomes data.
- Set hiring and retention goals to diversify the long-term care field.
- Provide comprehensive supports to workers.
- Draw on the vast and diverse leadership of people of color workforce experts.

For additional resources, see NASHP's catalog of [Resources for States to Address Health Equity and Disparities](#).

- **Diverse and siloed resources that support labor and workforce development:** Many of the resources and policy levers that could be used to improve the quality and supply of direct care workers are dispersed across multiple state agencies, including educational, economic and workforce development, public health and health resources, licensing and certification, human services, Medicaid, and state agencies that develop policy and operate public LTSS programs. This section of the roadmap highlights some of the policy levers that have been used.
- **Complex and often duplicative systems for training, certification, and career growth:** Many states have a patchwork of direct care job titles created for different programs, each with similar but different qualifications, training programs, and responsibilities. In many cases, workers cannot transfer their skills, knowledge, and experience across job titles without completing duplicative training. Even within the same job title, worker credentials might not be portable if a state does not have the infrastructure in place to certify and track the training a worker has completed.

Recommendations and State Strategies

As part of its recommendations for reform, the RAISE Family Caregiving Advisory Council identified the need to increase and strengthen the paid LTSS and direct care workforce.

State leaders recognize that strengthening the direct care workforce is a challenging but urgent priority, particularly in the wake of the disruption caused by the COVID-19 pandemic. Numerous states have also proposed using American Rescue Plan Act (ARPA) to invest in the direct care workforce.

Prioritize a Reform Agenda

States often convene stakeholder groups to develop consensus around a reform agenda that can then be used to inform legislation or policy. The governor, the legislature, or other leaders or policymakers within the state form these groups. In addition to developing a reform agenda, stakeholder groups can also help to lead reform.

- Master Plans on Aging:** In California, the [governor formed](#) the California Master Plan for Aging Stakeholder Advisory Committee via executive order in 2019. The advisory committee was charged with developing a comprehensive blueprint for state and local governments, private sector, and philanthropy for promoting healthy aging and preparing for California's changing demographics. The [Master Plan for Aging](#), issued in 2021, included [key recommendations relating to caregiving](#), including a recommendation to form a Direct Care Workforce Solutions Table to address workforce supply challenges, expand training opportunities, and diversify the pipeline for direct care workers. The Master Plan also shaped California's proposed [ARPA HCBS spending plan](#), which includes incentive payments for specialized training for consumer-directed direct care workers to serve people with complex needs, including people with behavioral health needs or Alzheimer's disease.
- Legislative Initiatives:** In 2019, the [Maine Legislature formed](#) the Commission to Study Long-term Care Workforce Issues to develop recommendations to improve the supply and quality of the direct care workforce. The Commission's 2020 [report](#) included recommendations to increase reimbursement, promote recruitment and retention, develop educational and training programs, provide loan repayment, expand consumer-directed options, and develop a matching registry. Maine's proposed [ARPA HCBS spending plan](#) proposes to implement a number of the Commission's recommendations, including the development of a matching registry, recruitment and retention bonuses, and expansion of consumer direction.
- Within Medicaid:** Following an intensive internal stakeholder process, Colorado's Medicaid agency, the Department of Health Care Policy and Financing, formed a stakeholder-led [Direct Care Workforce Collaborative](#) to develop a reform agenda. This group is developing recommendations about compensation and benefits, training and career advancement, and public awareness of the importance of direct care. Colorado sees the collaborative as having an ongoing advocacy role and is actively working to increase the number of direct care workers serving as members.



The American Rescue Plan Act and the Paid LTSS Direct Care Workforce

The [American Rescue Plan Act of 2021 \(ARPA\)](#) temporarily increases by 10 percent the amount Centers for Medicare and Medicaid Services (CMS) contributes toward certain Medicaid expenditures for home and community-based services (HCBS). [States can use these additional resources to enhance, expand, or strengthen Medicaid-funded HCBS](#). These funds must be spent before March 31, 2024. States have submitted their [draft ARPA spending plans](#) to CMS for approval. While subject to change, these draft plans reflect state priorities for enhancing HCBS.

See NASHP's [overview of key workforce development strategies proposed in states' draft ARPA spending plans](#).

Coordinate Workforce Policy and Resources across Agencies

By aligning workforce development, education, and other state resources, states have an opportunity to optimize existing programs to support entry and advancement within the direct care field. By improving coordination, states can more effectively target common barriers to employment (e.g., the lack of transportation or child care), increase access to training by leveraging vocational rehabilitation or other employment services, or make entry into the direct care field more appealing by creating career pathways in coordination with secondary and post-secondary educational systems.

- Partner with Departments of Labor:** The [Michigan Career and Technical Institute](#) (MCTI), within the Michigan Department of Labor and Economic Opportunity, conducts vocational and technical training programs and provides supportive services to Michigan citizens with disabilities. At the request of the Michigan Department of Health and Human Services (DHHS), MCTI [adapted its campus-based CNA training program to make it more accessible to individuals with disabilities who are receiving TANF](#). The training program aligns services from multiple state agencies, including Michigan's one-stop employment centers, while DHHS pays for the training. The community expansion program has graduated 347 CNAs, 89 percent of whom passed the certification exam and 75 percent of whom obtained jobs. MCTI plans to expand this community-based training program.
- Partner with Community College Systems:** Tennessee's Medicaid agency, TennCare, worked with Tennessee's [Quality Improvement in Long Term Services and Supports \(QILTSS\) Institute](#) to develop a career and education pathway for direct care workers that allows workers to "learn and earn," while acquiring credentials with value in the labor market. TennCare and the QILTSS Institute leadership worked closely with the state Department of Education's board of regents to craft a curriculum that met accreditation standards for Tennessee's community college system. Students taking these courses earn credits and can access Department of Education funds through Tennessee PROMISE, a scholarship program for high school students, and RECONNECT, a grant program for adults returning to school. While this coursework is voluntary for direct care staff, employees will receive wage increases upon completion of these courses. Tennessee is planning on [using ARPA funding to cover the cost of wage incentives](#).



The Workforce Innovation and Opportunity Act

The Workforce Innovation and Opportunity Act (WIOA), passed in 2014, provides states with an important vehicle for coordinating employment and educational programs with a state's workforce development needs. Under WIOA, states are required to align policy and resources across six core programs, including vocational rehabilitation, adult education and literacy, and those providing assistance to job seekers, youth, dislocated workers, and individuals with barriers to employment.

States may also choose to submit a combined plan that aligns WIOA core programs with other federally funded programs, including career and technical education programs, Temporary Assistance for Needy Families (TANF), the Senior Community Service Employment Program, the Supplemental Nutrition Assistance Program, and Community Development Block Grants.

Develop Career Pathways

Direct care can serve as an entry point into health care and other professions, and policymakers can streamline that progression by promoting the development of [career pathways](#) that connect progressive levels of education, training, support services, and credentials. [Career pathways](#) can start at the high school level or in adult education programs and can be built around a single occupation or a cluster of occupations. The ideal trajectory allows participants to enter and exit the pathway at each level, so they can earn a credential, work, and then return for more education to advance further along the career path.

- **Create a Clear Progression:** Colorado has built a [career pathway](#) for nursing that identifies the progression in education and credentials that can lead from entry level (home health aide, personal care aide, CNA, orderly, and licensed practical nurse) to mid-level (registered nurse, operating room nurse, and critical care nurse) and advanced (nurse practitioner and nursing instructor or teacher) occupations. Colorado would like to expand these options to include allied health professions and other occupations. The state has also developed an online platform, [My Colorado Journey](#), that provides students, professionals, and jobseekers with tools for exploring these and other career pathways.
- **Engage Workforce Early:** Massachusetts developed a framework for teaching “health assisting” at the high school level. The [health assisting framework](#) defines the technical knowledge and skills required for health-related careers. High school students in the health assisting program acquire CPR and first-aid certification and complete a certification or specialty program meeting state or national standards (280-hour minimum). All high schools with approved vocational programs are part of an [agreement](#) with 15 Massachusetts community colleges that governs the college credits earned by students who complete the health assisting program and obtain CNA certification. Adoption of the health assisting framework is determined by local school districts and higher education and employer partners.



Consumer Direction

Given the workforce shortages, the Medicaid consumer-directed option is another useful tool to expand workforce capacity. Consumer direction (sometimes called self-direction) is an alternative [opportunity](#) that provides greater choice and control for care recipients to choose who provides their care, such as a family member.

As direct care providers, family caregivers can be paid and trained through Medicaid. Consumer direction can expand the pool of people who provide care so more individuals can receive services in home and community-based settings with less reliance on stretched-thin service agencies.

A NASHP report, [Paying Family Caregivers through Medicaid Consumer-Directed Programs: State Opportunities and Innovations](#), provides more information for state policymakers on best practices.

Improve Training

In addition to improving the quality of the direct care services provided, robust training programs can improve job quality for direct care workers and lay the foundation for professional growth. With increased use of HCBS for those who might otherwise be served in a nursing facility, direct care workers are assuming increasingly complex responsibilities, often without on-site supervision. Training for direct care workers must address this increasing complexity.

Raise Minimum Standards: Aides employed by Medicare-certified nursing facilities or home health agencies must be trained and evaluated through state-approved training programs that meet minimum standards, including a requirement that the training be at least 75 hours. The Institute of Medicine (IOM) has recommended that the minimum number of hours be increased to 120 hours to account for the increased complexity of direct care. Currently, 13 states and Washington, DC, meet the IOM's suggested standard of 120 hours of [training for CNAs](#), while six states and DC meet that standard for [training home health aides](#).

While there is no national standard for PCA training, through the National Direct Service Workforce Resource Center, CMS has developed a [set of core competencies](#) for direct care workers. However, states vary widely in how they approach direct care training requirements. Some regulate PCA training, while others have different standards depending on the program. [Fourteen states](#) have consistent training requirements for all agency-employed PCAs.

Leverage Medicaid Managed Care Contracting: Medicaid managed LTSS plans in Pennsylvania's [Community HealthChoices](#) program are required to demonstrate workforce innovation initiatives that promote recruitment and retention of long term care workforce. Specifically called out are initiatives that provide:

- Training programs that exceed Department of Health and Department of Human Services requirements for direct care worker qualifications.
- Pre-service orientation.
- Promotion of direct care worker organizations and associations.
- Professional support, certifications, and career ladder opportunities.
- Care team integration that engages front-line workers.



Use Existing Workforce Effectively: Nurse Delegation

Registered nurses may delegate certain tasks to direct care workers — allowing direct care workers to provide a broader scope of care to people living at home and in the community and reducing the burden on families who might otherwise need to perform these tasks themselves or find nurse services to fill the gap. [AARP's 2020 LTSS State Scorecard](#) identifies state policy governing nurse delegation with a range of health maintenance tasks as an indicator of a state's support for family caregivers.

State policy varies widely: While 18 states allow delegation of all 16 tasks, four states do not allow delegation of any. The National Council of State Boards of Nursing and the American Nurses Association have issued [guidelines for nurse delegation decisions](#) that are driven by the LTSS provider's policies and procedures, the patient's condition, and whether the direct care worker has the appropriate skills. Under these guidelines, the nurse remains responsible for appropriately communicating what tasks are being delegated, monitoring the delegated activity, and being ready to intervene as necessary.

[State regulation](#) can promote delegation by developing guidance, training, and competency testing for nurse-delegated tasks. For example, [Washington](#) state has developed nurse delegation training modules to ensure that direct care workers have the appropriate skills needed for nurse-delegated tasks.

Note: As identified in [AARP's 2020 LTSS State Scorecard](#), the 16 health maintenance tasks for nurse delegation include: (1) administer oral medications, (2) administer medication on an as needed basis, (3) administer medication via pre-filled insulin or insulin pen, (4) draw up insulin for dosage measurement, (5) administer intramuscular injection medications, (6) administer glucometer test, (7) administer medication through tubes, (8) insert suppository, (9) administer eye/ear drops, (10) gastrostomy tube feeding, (11) administer enema, (12) perform intermittent catheterization, (13) perform ostomy care including skin care and changing appliance, (14) perform nebulizer treatment, (15) administer oxygen therapy, and (16) perform ventilator respiratory care.

Streamline Training

While direct care can look very different depending on the needs of the individuals being served, common skills, knowledge, and abilities are required across LTSS settings, job titles, and providers. States can use these core competencies as both a benchmark for quality and as a strategy for developing streamlined training programs. By building specialized modules around a core curriculum, states can use their training resources more efficiently and offer workers opportunities for growth, specialization, and movement within the direct care field.

Across Settings: Washington state has developed a 75-hour training program that serves as the core curriculum for direct care workers in multiple settings, including adult family care homes, assisted living facilities, and homes. Washington has also developed specialty modules for residential settings providing services to people with dementia, mental illness, or developmental disabilities; nurse delegation modules; and continuing education curricula.

LTC Worker Training	Required Training by Setting			
	Home Care	Adult Family Home	Assisted Living Facility	Enhanced Services Facility
State Developed or Approved Curricula				
Orientation (2 hours)	✓	✓	✓	✓
Safety (3 hours)	✓	✓	✓	✓
Fundamentals of Care (70 hours)	✓	✓	✓	✓
Dementia Specialty (8 hours)		✓*	✓*	✓*
Mental Health Specialty (8 hours)		✓*	✓*	✓*
Develop. Disabilities Specialty (16 hours)		✓*	✓*	✓*
Nurse Delegation Core	✓**	✓**	✓**	✓**
Nurse Delegation — Focus on Diabetes	✓**	✓**	✓**	✓**
Continuing Education	✓***	✓***	✓***	✓***
Other curricula				
First Aid and CPR		✓	✓	✓
Orientation to Facility		✓	✓	✓

Sources: Washington State Department of Social and Health Services [Available Curriculum](#); [75-Hour Training and Home Care Aide Certification Overview](#); [Adult Family Homes Training Requirements](#); [Assisted Living Training Requirements](#); and Washington Statute, [Chapter 388-112A WAC](#).

* Specialty training required for workers serving in an adult family care home, assisted living facility, or enhanced services facility that serves people with specialized needs. Specialized training may be applied toward the population-specific training required under fundamentals of care, if completed timely. Specialty training may also be used to meet the population-specific training requirement for home care aides.

** Nurse delegation training and certification as a nursing assistant or home care aide, or as a nursing assistant registered, is required before a nurse-delegated task may be performed.

***Continuing education required for all certified home care aides.

Across Job Titles: Iowa’s [Prepare to Care](#) program [streamlines training requirements](#) across three direct care certificate programs. The core training module builds competency in person-centered care, communications and interpersonal skills, infection control, and other foundational competencies for direct care. In addition to the core module, Prepare to Care has [five advanced modules](#): home and community living, instrumental activities of community living, personal support, personal activities of daily living, and health monitoring and maintenance. An individual who completes the core training and one of three different combinations of advanced modules is eligible to take an exam to qualify for one of three different direct care certifications. The curriculum for the health support professional meets federal requirements as an option for home health aide and hospice aide training.

Iowa’s Prepare to Care Program Advanced Training Modules Required for Direct Care Certificates			
Advanced Training Certificates	✓		
Home and Community Living	✓	✓	
Instrumental Activities of Daily Living	✓	✓	
Personal Support		✓	
Personal Activities of Daily Living			✓
Health Monitoring and Maintenance			✓

Note: Certificates are awarded with completion of the core training, the required advanced training modules, and successful completion of the state exam.

Improve Working Conditions

[Direct care workers](#) often need multiple jobs to pay their bills, and many do not have access to health insurance, paid vacation, or sick leave. Moreover, when a client dies or moves to another care setting, direct care workers can lose their job or experience a reduction in hours. For independent workers, unemployment insurance is not an option.

Increasingly, states have [implemented wage increases](#). To ensure that provider reimbursement increases translate into higher wages for the worker, many states enact [wage pass-through](#) provisions in their Medicaid programs so the additional funding is channeled directly to compensation for direct care workers. In 2019, Colorado passed [legislation](#) enacting a rate increase for direct care services, along with a pass-through provision requiring home care agencies to pass 100 percent of the rate increase on to the direct care workers. Signaling workforce as a significant priority, ARPA plans for [29 states](#) address reimbursement for the direct care workforce.



ARPA plans for [29 states](#) address reimbursement for the direct care workforce, including:

- Bonuses to workers who provided care during the COVID-19 pandemic.
- Temporary increases to HCBS provider reimbursement to help stabilize the direct care workforce.
- Rate studies to better understand the cost of direct care.

Positive Work Environment

Workplace culture is well-recognized as important to recruiting and retaining direct care workers, with supervisors and managers having a key role in shaping that culture. [Research focused on LTSS settings](#) found that a lack of respect and poor management and supervision led workers to leave a job, while a commitment to the work, the clients, and co-workers were factors in staying.

- **Payment Incentives for Providers:** As the primary purchaser of LTSS, some state Medicaid programs are using their purchasing power to improve conditions for the direct care workforce. For example, Tennessee's QullLTSS program [conditions a portion of a nursing facility's reimbursement](#) on its [performance on key measures](#), including workforce measures relating to employee satisfaction, staffing levels, consistency of staff assignments for residents, staff retention, and staff training. Tennessee is planning on [using ARPA to fund quality incentive payments to HCBS providers](#) for workforce training and other activities focused on improving workforce capacity.
- **Licensing Designation:** North Carolina has used a different incentive system for improving workplace culture. With support from the Robert Wood Johnson Foundation, North Carolina developed a special license designation for home care agencies, adult care homes, and nursing facilities that have implemented a set of defined workplace interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff and the care provided. The [provider manual](#) for this program identifies numerous elements of a supportive work environment for direct care workers.

Create Systems to Support Direct Care Workers

States can invest in systems and infrastructure that facilitate professional development and employment for direct care workers.

- **Credential portability:** When a worker has successfully completed an approved training program, or obtained a certification or other type of credential, both the worker and the LTSS system benefit when those credentials can be used to meet job qualifications in another job or setting, to earn college credit on a career pathway, or as a step toward a higher tier of specialization within the direct care field. Portable credentials require administrative infrastructure, including defined minimum standards for the curriculum and evaluation criteria, as well as a system for maintaining and making available a record of worker credentials. For example, in Washington, a home care aide's certification can be confirmed through the [Department of Health's Provider Credential Search](#) portal. In Oregon, the [Oregon Home Care Commission](#) operates a statewide [registry and referral system](#), which combines a registry of worker credentials with a portal for matching direct care workers with people in need of direct care.

- **Matching Registries:** Matching registries provide a platform for workers to find people in need of their services and people in need of services to find workers. As discussed above, the [Oregon Home Care Commission](#) operates a statewide [registry and referral system](#) matching people in need of direct care to those who provide direct care. A person who wants to hire a direct care worker (the employer) submits a profile that allows them to identify their preferences (e.g., for a non-smoker or a worker of a specific gender), any special conditions required (e.g., the ability to work for someone with a pet), preferred training, the types of personal care needed, and the type of schedule required. The worker provides information on the geographical areas where they can work, their credentials, limits on what conditions they will accept, the types of personal care and household tasks they are willing to provide and the types they have experience providing, the type of schedule they will consider (e.g., full time, part time, working as a live-in), and their preferred schedule. The registry also collects data on training, history of investigations for abuse and criminal background checks.

According to PHI, there are [15 matching registries in 10 states](#). These registries vary in several ways, including whether they are operated by the state or a nonprofit agency.

Enhance Data Collection

The National Direct Service Workforce Resource Center has identified [three categories of data elements](#) that states need for understanding the direct care workforce, including workforce volume (i.e., the number of direct care workers currently employed by setting); workforce stability (i.e., separations, turnover, and vacancies); and workforce compensation (i.e., wages and benefits by setting and job title). Ideally, this information would be collected for independent providers as well as workers employed by agencies.

States can also conduct staff stability surveys. To support states' efforts to improve the direct care workforce for individuals with developmental disabilities, the National Core Indicators program has developed a [Staff Stability Survey](#) to collect information about turnover rates, tenure, full-time/part-time status, vacancy rates, hourly wages, benefits, and recruitment and retention.

Surveying direct care workers and employers can provide insight into the reasons workers keep or leave their jobs, what would improve job quality, and other factors that can inform workforce policy. For example, Arizona recently completed a [survey of the state's paid caregivers](#) that collected information on worker demographic and socioeconomic characteristics, the type of work they do, the number of hours they work, and other data elements. [Survey instruments for worker and employer surveys](#) developed under the National Balancing Indicators Project are available through the U.S. Office of Management and Budget.



Arizona's Workforce Development Alliance

Arizona has used its purchasing power to require its Medicaid managed care organizations (MCOs) to focus on workforce development and collaborate in improving the direct care workforce. MCOs must establish a [Workforce Development Operation \(WFDO\)](#) and participate in a [Workforce Alliance](#), which includes a [Workforce Development Alliance for the Arizona LTSS System](#). The WFDO administrator for each MCO participates in the Alliance. Although still a relatively young initiative, the Alliance has successfully conducted a direct care survey and developed a portal for collecting workforce data.

In [Arizona](#), Medicaid MCOs are also required to collect workforce data, including the number of licensed and unlicensed direct service personnel, the age of the workforce, the retention rate (as a measure of workforce stability), the turnover rate (as a measure of workforce volatility), difficulty in filling positions, and the time it takes to fill them. Arizona has developed and piloted a portal for collecting the data and imposed a standard way of calculating retention and turnover. Arizona will expand data collection requirements going forward.

Lessons Learned

- The urgency created by direct care worker shortages, exacerbated by the pandemic and coinciding with the potential offered by ARPA funding, have brought focus and momentum to improving the direct care workforce.
- With leadership and in collaboration with stakeholders, states can use multiple policy levers for improving direct care, including those within Medicaid, labor, education, licensure and certification, human services, and LTSS.
- With these policy levers, states can shape direct care worker training, compensation, career pathways, portable credentialing, payment incentives, supervision, and data collection.

About This Roadmap

The purpose of this roadmap is to support states that are interested in developing and expanding supports for family caregivers of older adults by offering practical resources on identifying and implementing innovative and emerging strategies. Although families care for people across the lifespan, the focus of this roadmap is on policies, programs, and funding for family caregivers of older adults.

NASHP created this roadmap with guidance from policymakers and leaders from across state government, using the RAISE Act goals and recommendations as a framework. Congress enacted the [Recognize, Assist, Include, Support, and Engage \(RAISE\) Family Caregivers Act](#) in 2018, which created an advisory council to develop the country’s first national Family Caregiver Strategy. With support from The John A. Hartford Foundation and in coordination with the [U.S. Administration for Community Living](#), NASHP’s aims to support states as they develop policies to address family caregivers.

The RAISE Family Caregiving Advisory Council published its [five goals and 26 recommendations](#) that highlight ways that states can better support family caregivers. In alignment with the Council’s work, the roadmap is organized into the following sections as a series:

- Section 1: Public Awareness and Outreach to Family Caregivers
- Section 2: Engagement of Family Caregivers in Health Care Services and Systems
- Section 3: Services and Supports
 - Services and Supports for Family Caregivers
 - The Direct Care Workforce (this section of the roadmap)
- Section 4: Financial and Workplace Security for Employed Family Caregivers
- Section 5: Research, Data, and Evidence-Informed Practices

This section — The Direct Care Workforce — is the third publication in this series.

The federal government alone cannot implement the RAISE Act Family Caregiving Advisory Council recommendations; it will need to work in partnership with state and local governments and the private sector. The goal is for state officials to be able to use the roadmap to better understand the state policy landscape for supporting family caregivers of older adults and to identify opportunities for innovation in their own states.

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