United States Government Accountability Office

Report to the Ranking Member, Subcommittee on Health Care, Benefits, and Administrative Rules, Committee on Oversight and Government Reform, House of Representatives

August 2016

LONG-TERM CARE WORKFORCE

Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers

Accessible Version

GAO-16-718

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GAO Highlights

Highlights of GAO-16-718, a report to the Ranking Member, Subcommittee on Health Care, Benefits, and Administrative Rules, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

Millions of elderly individuals and persons with disabling conditions rely on LTSS to help them perform routine daily activities, such as eating and bathing. Direct care workers are among the primary providers of LTSS. Reported difficulties recruiting and retaining direct care workers and the anticipated growth in the elderly population have fueled concerns about the capacity of the paid direct care workforce to meet the demand for LTSS. Despite these concerns, policymakers lack data to help assess the size of the problem.

GAO was asked to provide information on direct care workers who deliver LTSS. This report examines (1) federal and state data available on the paid direct care workforce and (2) actions HRSA has taken to develop information and projections on this workforce. GAO analyzed the most recent data available from the Census Bureau and Bureau of Labor Statistics on paid direct care workers' demographics, compensation, and benefits and reviewed efforts to collect data on direct care workers in four states, selected in part for geographic variation. GAO also reviewed HRSA documents and interviewed agency officials about HRSA's previous, ongoing, and planned efforts to improve data.

What GAO Recommends

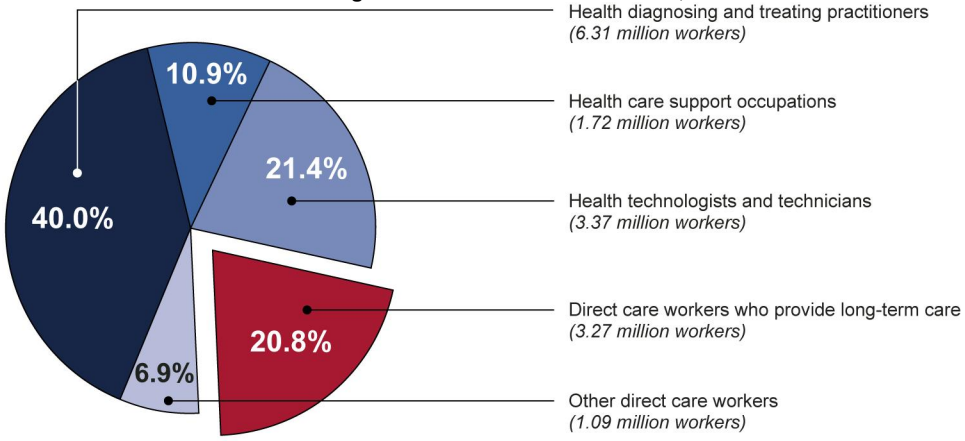
GAO recommends that HRSA take steps to produce projections of direct care workforce supply and demand and develop methods to address data limitations in order to do so. HHS concurred with GAO's recommendation, stating that developing projections for the direct care workforce is timely and important.

View GAO-16-718. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

Federal data sources provide a broad picture of direct care workers—nursing assistants and home health, psychiatric, and personal care aides—who provide long-term services and supports (LTSS), but limitations and gaps affect the data's usefulness for workforce planning. Some states have collected data in areas where federal data are limited, but these have been one-time studies. Federal data show that direct care workers who provide LTSS numbered an estimated 3.27 million in 2014, or 20.8 percent of the nation's health workforce. Federal data show that wages for direct care workers, while differing by occupation, are generally low, averaging between approximately $10 and $13 per hour in 2015. However it is unclear to what extent these wage data include direct care workers employed directly by the individuals for whom they care. The number of these workers, often referred to as independent providers, is believed to be significant and growing. Some states, in coordination with the federal government or on their own, have conducted studies about direct care workers and collected detailed information. These studies showed that a majority of independent providers worked for a family member or someone else they knew.

Direct Care Workers as a Percentage of the Total Health Workforce, 2014



Source: GAO analysis of Census Bureau data. | GAO-16-718

The Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA), which is responsible for monitoring the supply of and demand for health professionals, has developed some information on direct care workers. However, HRSA has not produced projections of this workforce or developed methods to address data limitations, which is in line with one of the goals in its strategic plan. HRSA's actions include sponsoring research and issuing a 2013 report that summarized federal data on different occupations, including direct care workers. While HRSA has recognized the limitations of existing data and cites these as reasons it has not developed projections for this workforce, the agency has not developed methods to address data challenges. Unless HRSA takes steps to overcome data limitations in order to make projections of supply and demand for direct care workers, policymakers will continue to be hampered in their ability to identify workforce trends and develop appropriate strategies to help ensure a sufficient number of qualified direct care workers.

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Abbreviations

ACS	American Community Survey
ADL	activities of daily living
BLS	Bureau of Labor Statistics
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IADL	instrumental activities of daily living
LTSS	long-term services and supports
NAICS	North American Industry Classification System
NBIP	National Balancing Indicators Project

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

August 16, 2016

The Honorable Matt Cartwright
Ranking Member
Subcommittee on Health Care, Benefits, and Administrative Rules
Committee on Oversight and Government Reform
House of Representatives

Dear Mr. Cartwright:

Millions of Americans, including the elderly and people with disabling conditions, rely on long-term services and supports (LTSS) to help them perform routine daily activities, such as eating, dressing, bathing, and making meals. LTSS can be provided in institutional or home- and community-based settings and comprise a broad range of health care, personal care, and supportive services to help individuals with limited ability for self-care maintain their quality of life. Direct care workers—home health aides, psychiatric aides, nursing assistants, and personal care aides—are the primary providers of the paid, hands-on care received by these individuals. High reported attrition rates and persistent challenges recruiting and retaining direct care workers, however, have fueled long-standing concerns by experts and policymakers about the capacity of this workforce to meet LTSS demands. These concerns are heightened by the large increase expected in the number of people ages 65 and older, who are projected to comprise one-fifth of the U.S. population by 2030.

While policymakers and other stakeholders are aware of the challenges in recruiting and retaining direct care workers, their ability to develop relevant, targeted policies addressing these challenges has been hampered by gaps in data. For example, the Congressional Commission on Long-Term Care reported in 2013 that a number of states have experienced shortages and high attrition of direct care workers but lack data to help them assess the size of the problem.[1] The Commission recommended that an appropriate federal agency, such as the Health

[1]Commission on Long-Term Care, *Report to the Congress* (Washington, D.C.: Government Printing Office, Sept. 30, 2013).

Resources and Services Administration (HRSA), initiate a process to collect detailed data about the direct care workforce and launch comprehensive data collection efforts. HRSA, within the Department of Health and Human Services (HHS), is responsible for ensuring that Americans have access to a skilled health workforce.[2] Within HRSA, the National Center for Health Workforce Analysis helps build a body of knowledge about the health workforce by projecting the supply of and demand for U.S. health workers and developing methods to inform health workforce decisions.

Given the concerns about the ability of the direct care workforce to meet current and future demands for LTSS and the reported lack of data needed to estimate the size and characteristics of this workforce, you asked us for current information about direct care workers who provide LTSS, such as their wages, hours, and attrition rates.[3]

This report examines

1. available federal and selected state data about the direct care workforce and
2. actions HRSA has taken to develop information, project supply and demand, and overcome data limitations related to the direct care workforce.

To examine the available federal and selected state data about the direct care workforce, we reviewed data sets collected by the Census Bureau, the Bureau of Labor Statistics (BLS) in the Department of Labor, and selected states. We used the Census Bureau's 2014 American Community Survey (ACS) to estimate the number of direct care workers, their demographics, and hours worked. We used the BLS's 2015 Occupational Employment Statistics and 2015 National Compensation Survey to report data on direct care workers' wages and benefits, respectively. For each source, we used the most recent data available at the time we conducted our work. In addition, while direct care workers are employed in both long-term care settings and acute care settings, such as

[2]Department of Health and Human Services, Health Resources and Services Administration, *Strategic Plan FY 2016-FY 2018*, accessed January 25, 2016, http://www.hrsa.gov/about/strategicplan/strategicplan.pdf.

[3]Loss of staff is referred to as turnover by some researchers, but we use the workforce planning term attrition in this report.

hospitals, we limited our analyses to certain industries in which LTSS are likely provided.[4] (For detailed information on our analysis methods and federal data sources, see app. I.) We assessed the reliability of ACS and BLS data by interviewing knowledgeable officials, reviewing relevant documentation, and comparing the results of our analysis to published data, as appropriate, and determined that these data were sufficiently reliable to inform our objectives. We also gathered information about state efforts to collect data on their direct care workforce by focusing on four states—Arkansas, Maine, Minnesota, and Oregon—that had conducted comprehensive surveys about their direct care workforce since 2012. Three of the states—Arkansas, Maine, and Minnesota—conducted their surveys as part of a multistate study funded by the Centers for Medicare & Medicaid Services (CMS) and were selected because they had achieved the highest survey response rates for their geographic regions. Oregon collected data about direct care workers through its own survey initiative and was selected for geographic variation and its high survey response rate. For each state, we obtained copies of the survey instruments used and documentation of the states' summary survey results to the extent available, and we interviewed state officials about their experiences collecting these data. The survey results for the four states are not generalizable to other states. We did not verify the results of states' data collection efforts but considered them reliable for the purpose of illustrating the range of data these states had collected about direct care workers.

To identify HRSA's efforts to develop information, project supply and demand, and overcome data limitations related to the direct care workforce, we analyzed agency documents that contain details about HRSA's strategic plan, health workforce efforts, assessment of available direct care workforce data, and related workforce data needs. We also interviewed HRSA officials to establish the agency's previous, ongoing,

[4]ACS and BLS data sets use industry codes based upon the Office of Management and Budget's North American Industry Classification System (NAICS), which groups businesses based upon their primary business activity. We considered an industry to provide LTSS if the industry (1) primarily served the elderly or those living with chronic health conditions (i.e., physical, cognitive, or mental disabilities) who need assistance with activities of daily living on an ongoing basis; (2) provided services that help individuals perform everyday activities, including health care, personal care, or supportive services, such as feeding, bathing, administering topical medication, and supported employment; and (3) provided the services and supports in institutions (e.g., nursing homes) or home- and community-based settings. In addition, we included direct care workers employed by private households and the government.

and planned efforts to provide information on the health workforce and to develop and employ approaches to monitor, forecast, and meet health workforce needs.

We conducted this performance audit from April 2015 to August 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Federal census data show that an estimated 12.3 million Americans age 6 years and older needed LTSS in 2010.[5] LTSS are a distinct set of services that are critical elements of support for people with functional limitations due to health conditions. Individuals' needs for LTSS are often measured in terms of their need for assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL). ADLs include bathing, dressing, eating, getting into and out of chairs, walking, and using the toilet; IADLs include using the telephone, doing housework, preparing meals, shopping, and managing money.

LTSS Expenditures

According to the Congressional Research Service, U.S. expenditures for LTSS in 2014 totaled an estimated $337 billion, representing 13 percent of personal health expenditures. Nearly two-thirds of LTSS spending is financed by the federal and state governments, primarily through Medicaid and Medicare. Medicaid is the largest payer of LTSS, accounting for 42 percent of LTSS spending followed by Medicare, which pays an additional 22 percent. Private funding (e.g., out-of-pocket spending and private insurance) accounts for less than one-third of LTSS spending.[6]

[5]Department of Commerce, U.S. Census Bureau, *Americans with Disabilities: 2010* (Washington, D.C.: July 2012).

[6]Congressional Research Service, *Who Pays for Long-Term Services and Supports?* IF10343 (Washington, D.C.: Jan. 5, 2016). These data are from the National Health Expenditure Account. Personal health expenditures are those rendered to treat or prevent a specific disease or condition in a specific person. These include home health care, nursing care facilities, residential care facilities, and other professional and personal care.

Direct Care Workers

A number of job titles are used in the long-term care industry to refer to direct care workers. Often, workers' job titles vary by state or by the setting where they provide care. For example, direct care workers as a group are also referred to as paraprofessional workers, direct support professionals, or direct service workers. Specific job titles for direct care workers include home care aides, personal assistants, home attendants, homemakers, companions, personal care staff, and resident care aides, among others. For this report, we examined data for the four occupations often used to categorize direct care workers:[7]

- Home health aides monitor individuals' health statuses; provide routine individualized health care, such as changing bandages, dressing wounds, and applying topical medications; and assist with ADLs. Home health aides are generally hired through a home health agency and assist individuals in their homes or in residential care facilities.

- Psychiatric aides, under the direction of nursing and medical staff, assist people who are mentally impaired or intellectually and developmentally disabled with ADLs, educational and recreational activities, or accompany them to and from medical examinations and treatments. They may also be referred to as mental health orderlies, psychiatric orderlies, or psychiatric nursing aides. Psychiatric aides in long-term care industries are primarily employed in residential care facilities for the intellectually and developmentally disabled, residential mental health and substance abuse facilities, and state facilities.

- Nursing assistants, also known as nurse aides, provide basic patient care under the direction of nursing staff. They also perform clinical tasks, such as taking blood pressure readings and performing range-of-motion exercises, in addition to assisting with ADLs and IADLs. Nursing assistants work primarily in nursing home and residential care facilities.

[7]Under the Office of Management and Budget's Standard Occupational Classification system, direct care workers are generally captured under four occupations: home health aides, psychiatric aides, nursing assistants and personal care aides. The Standard Occupational Classification system was developed by the Office of Management and Budget for use by federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data.

- Personal care aides assist individuals with ADLs, not including medical care, at a person's home or in a residential care facility. Personal care aides are often employed through an agency or hired directly by an individual to provide assistance with both ADLs and IADLs.

While many direct care workers are employed by traditional business establishments such as nursing homes and home health agencies, some work directly for the individuals they care for or their families under a variety of arrangements. Often referred to as independent providers, these workers are believed to comprise a large and growing portion of the direct care workforce, although their exact numbers are unknown. Independent providers can be employed by individuals under government-funded programs, such as Medicaid, that allow individuals to hire their own workers, including family members; or hired by households under private arrangements; or sometimes hired by both, even for the same client. Most private arrangements are thought to be unreported, constituting what some refer to as a "gray market" of providers.

Federal law requires states to certify nurse aides and home health aides who provide LTSS for nursing home facilities and home health agencies that accept Medicaid and Medicare reimbursement.[8] A state-approved nurse aide or home health aide certification program must require a minimum of 75 hours of training, including at least 16 hours of supervised practical training.[9] While federal law also requires states to maintain a registry of nurse aides who are certified, no such requirement exists for other direct care workers.[10]

Workforce Planning

The goal of workforce planning, the systematic process of identifying and addressing the gaps between the current workforce and the workforce needs of the future, is to ensure that an adequate supply of appropriately trained workers is available to meet demand—either for a particular employer, position, or industry. Workforce analysis requires an

[8]42 U.S.C. §§ 1395i-3(b)(5)(A)(i)(I), 1396r(b)(5)(A)(i)(I), 1395bbb(a)(3)(A)(i). In 2012, BLS began identifying nurse aides as the occupation titled nursing assistants, which we use in this report.

[9]42 C.F.R. §§ 483.152(a), 484.36(a) (2015).

[10]42 U.S.C. §§ 1395i-3(e)(2)(A), 1396r(e)(2)(A).

understanding of the characteristics, capability, and distribution of the current workforce to model the workforce and project how it may change in the future.

In the last 15 years, a number of reports have highlighted the need for direct care workforce planning and called for more data about direct care workers. In addition to the Congressional Commission on Long-Term Care report, HRSA reported in 2004 that informed workforce planning is needed to document the extent of shortages in direct care occupations so that states and institutions can address them and assess the impact of present and future initiatives to balance supply and demand.[11] A 2009 study funded by CMS reported that information about the long-term direct care workforce is essential for understanding workforce issues and developing appropriate policy responses to plan for the future workforce.[12] The study also recommended that states collect a minimum dataset about their direct care workforces that includes three elements: (1) the number of direct care workers; (2) workers' compensation (wages and benefits); and (3) workforce stability measures (attrition and vacancy rates).

One of HRSA's primary goals is strengthening the health workforce. In its fiscal year 2016-2018 Strategic Plan, HRSA specifically aims to strengthen the health workforce by developing and employing approaches to monitor, forecast, and meet long-term health workforce needs as well as providing policymakers, researchers, and the public with information on health workforce trends, supply, demand, and policy issues.[13] Within HRSA, the National Center for Health Workforce Analysis helps build knowledge about the nation's health workforce through data development, projections of supply and demand, and serving as a focal point for health workforce data.

[11]Department of Health and Human Services, Health Resources and Services Administration, *Nursing Aides, Home Health Aides, and Related Health Care Occupations – National and Local Workforce Shortages and Associated Data Needs* (Rockville, Md.: February 2004).

[12]Paraprofessional Healthcare Institute, University of Minnesota Research and Training Center on Community Living, The Lewin Group, and Westchester Consulting, *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection,* a report funded by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (Baltimore, Md.: February 2009).

[13]Health Resources and Services Administration, *Strategic Plan FY 2016-FY 2018*.

Federal Data Provide Broad Picture of the Direct Care Workforce but Contain Limitations and Gaps; Some States Have Collected Data in These Areas

Federal Data on the Number, Characteristics, and Compensation of Direct Care Workers Exist but Have Limitations, and Data about Workforce Stability Are Unavailable

Federal data from the Census Bureau's ACS show that in 2014, the direct care workforce that provided LTSS totaled an estimated 3.27 million workers, about 20 percent of the total U.S. health workforce that year.[14] Personal care aides made up over 46 percent of all direct care workers, and in the last decade their numbers have more than doubled. Over the last decade, the estimated total number of direct care workers increased over 44 percent, in part due to growth in the number of personal care aides. Our analysis of projections from the BLS shows that the number of jobs for direct care workers providing LTSS is expected to increase to 4.56 million in 2024.[15] At the same time, growth in the number of women

[14]Fourteen percent of these individuals had not been employed in the past 12 months but had worked as direct care workers in the past 5 years.

The health workforce includes health care practitioners, such as physicians, pharmacists, nurses, and surgeons; health technologists and technicians, such as pharmacy technicians, sonographers, and paramedics; and health care support workers, such as physical therapy aides, dental assistants, and medical transcriptionists; in addition to direct care workers.

[15]BLS develops its employment projections in a six-step process that examines the size and demographic composition of the labor force, aggregate economic growth, commodity final demand, product input-output, industry output and employment, and occupational employment and openings. See Bureau of Labor Statistics, *Handbook of Methods, Chapter 13: Employment Projections,* accessed February 23, 2016, http://www.bls.gov/opub/hom/pdf/homch13.pdf.

between the ages of 25 and 64, who comprise the vast majority of direct care workers, is expected to remain flat through 2024.[16]

While the ACS provides information on the number and characteristics of direct care workers, these data are subject to limitations, which affect their usefulness for workforce planning. While the ACS separately identifies personal care aides, it combines data for home health aides, psychiatric aides, and nursing assistants into one occupational grouping, so separate estimates for these occupations are unavailable.[17] Another limitation is that the number of these workers employed as independent providers is unclear, because the ACS data do not separately identify independent providers from other direct care workers. In addition, since the ACS inquires only about the job where individuals work the most hours, direct care workers who provided LTSS part-time as a secondary job are not included in these data. The ACS data also include individuals identified as direct care workers who have not been employed in the last 12 months but were employed as direct care workers in the previous 5 years. Finally, the ACS data are self-reported, so individuals choosing not to identify themselves as direct care workers are not picked up in the data.

Federal data from the BLS also provide information on direct care workers' compensation, including wages and benefits. In 2015, direct care workers in long-term care industries received an average hourly wage of $11.21, which is in the bottom quarter of all U.S. wages,

[16]BLS analysis of Census data shows that the number of women aged 25 to 64 in the civilian noninstitutional population will increase 0.2 percent per year between 2014 and 2024. Bureau of Labor Statistics, "Labor Force Projections to 2024: the Labor Force Is Growing, but Slowly," *Monthly Labor Review* (Washington, D.C.: December 2015).

[17]This occupational grouping, titled nursing, psychiatric, and home health aides, also includes orderlies, who are generally not considered direct care workers. May 2014 data from BLS's Occupational Employment Statistics suggest, however, that orderlies make up a small portion of workers in this occupational group.

Another federal data source, BLS's National Employment Matrix, provides separate estimates for each direct care occupation. We chose to report ACS data on the number of direct care workers, in part, because the National Employment Matrix provides counts of jobs, not individual workers, which can affect results when individuals hold more than one job.

according to BLS's Occupational Employment Statistics.[18] The average hourly wage in the United States across all occupations was $23.23, more than double direct care workers' average wage. Personal care aides in long-term care industries had the lowest hourly wage of direct care workers at $10.42, while psychiatric aides had the highest at $12.62. According to data from the ACS, 48.8 percent of personal care workers and 37.6 percent of nursing, psychiatric, and home health aides worked part-time (less than 35 hours per week) in 2014.[19] In addition, data from BLS's National Compensation Survey showed that direct care workers' access to employment benefits varied depending on whether they were employed full-time or part-time. Over 90 percent of full-time direct care workers received paid vacation, paid holidays, and health insurance in 2015; fewer workers were provided paid sick leave, life insurance, and retirement benefits. In contrast, less than half of part-time direct care workers had access to any of these benefits.

BLS data on wages and benefits also have limitations. According to BLS officials, due to the National Compensation Survey's small sample size, benefits data are limited to direct care workers in all industries and cannot be broken down by occupation or specific industry. Also, data on both wages and benefits exclude some direct care workers working as independent providers. Both the Occupational Employment Statistics and the National Compensation Survey collect information from employer-based surveys that do not capture individuals employed by private households, such as independent providers working under private arrangements. The data may include some independent providers funded by government programs, such as Medicaid; however, the extent to which these providers are included in the data depends on their employment relationship with the government program, which can vary. (See app. II for more detailed information about direct care workers' numbers, demographics, wages, and other characteristics.)

[18]BLS's Occupational Employment Statistics measure occupational employment and wage rates for all full- and part-time wage and salary workers in nonfarm industries. The data exclude self-employed workers, owners and partners in unincorporated firms, unpaid family members, workers employed by private households, and government workers in the military and in the legislative and judicial branches.

[19]These estimates exclude those who have not worked in the past 12 months.

The Department of Labor recently made changes to regulations that may affect direct care workers' hours and wages. See GAO, *Fair Labor Standards Act: Extending Protections to Home Care Workers,* GAO-15-12 (Washington, D.C.: Dec. 17, 2014).

We were unable to identify federal data sources on workforce stability measures, which are often used for workforce planning. BLS conducts the Job Openings and Labor Turnover Survey, which provides data on job openings and separations for broad industries, such as all health care and social assistance establishments. However, due to the small sample size, this survey does not determine attrition for specific occupations, such as personal care aides.[20] BLS officials informed us that filling the data gaps of attrition rates at the occupational level would require major changes in their surveys and would be costly to implement.

Some States Have Collected Detailed Data in Areas Where Federal Data Are Lacking

The four states we reviewed (Arkansas, Maine, Minnesota, and Oregon) each conducted one-time studies to obtain more detailed information about direct care workers who provide LTSS in those states. Three of the states (Arkansas, Maine, and Minnesota) collected data on direct care workers in 2012 as part of a CMS initiative called the National Balancing Indicators Project (NBIP). The seven states that participated in the NBIP collected data using two standardized surveys—one for employer organizations and one for independent providers—designed by CMS's National Direct Service Workforce Resource Center, in coordination with the participating states.[21] The surveys were designed to collect data about the number of workers, their hours, worker compensation, and measures of workforce stability. Each survey incorporated these required variables, and states included additional variables at their discretion.[22] See table 1.

[20]The Job Openings and Labor Turnover Survey is a monthly survey conducted by BLS that provides data on job openings, hires, and separations at the industry level.

[21]The seven NBIP states were Arkansas, Florida, Kentucky, Maine, Massachusetts, Michigan, and Minnesota. The National Direct Service Workforce Resource Center was created by CMS in 2006 to respond to the shortage of direct care workers. The Center developed an online database of resources and research related to improving the recruitment and retention of direct care workers and provided technical assistance to selected state Medicaid agencies. According to CMS officials, the Center completed its work in 2015 and is no longer staffed. Key resources from the Center's website have been posted to CMS's Medicaid.gov workforce page: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Workforce/Workforce-initiative.html.

[22]For the NBIP states we reviewed, response rates for the employer organization survey were 38 percent for Arkansas and 54 percent for Maine; Minnesota elected not to field this survey because it had conducted previous surveys of employers. Response rates for the independent provider survey were 51 percent for Arkansas, 46 percent for Maine, and 44 percent for Minnesota.

Table 1: Data Variables Used in the National Balancing Indicators Project Workforce Surveys

Employer organization survey variables	Independent provider survey variables
Required	*Required*
• Populations served	• Populations served
• Type of services provided	• Number of consumers currently serving
• Setting of services provided	• Relationship with consumer
• Number of direct care workers working full time and part time	• Number of hours worked per week
• Number of direct care workers by setting	• Hourly wage rate paid
• Number of consumers by setting	• Health insurance and other benefits
• Average starting wage paid	• Tenure in field
• Average wage paid	• Tenure with current employer
• Benefits provided	• Intent to stay in field
• Turnover rate	
• Vacancy rate	
• Cultural competency policies	
Optional	*Optional*
• Type of organization (e.g., nonprofit)	• Reason for entering field
• Worker demographics	• Training received
• Additional turnover measures	• Training desired
• Training required and provided	• Training recommended
• Recruitment and retention challenges	• Workforce challenges
	• Worker demographics

Source: Centers for Medicare & Medicaid Services. | GAO-16-718

The fourth state we reviewed (Oregon) collected data in 2014 on direct care worker compensation, attrition, and the relationship between workers' wages and Medicaid payment rates over time. Oregon's survey of Medicaid-participating LTSS providers also captured many of the same variables included in NBIP's employer survey.[23] Both NBIP's and Oregon's surveys asked about direct care workers as a group as opposed to asking about each separate direct care worker occupation.

The four states obtained data that federal sources have not, such as information describing the characteristics of independent providers and attrition rates. We obtained summary results from independent provider surveys for Maine and Minnesota, which showed that most responding independent providers worked for a family member, a neighbor, a friend,

[23]Oregon's survey response rate was 81 percent.

or someone else they knew.[24] The data also showed large differences between the two states in the education, income levels, and hourly wages of independent providers. Appendix III provides more detailed information on the NBIP and the survey results for independent providers.

Arkansas, Maine, and Oregon also surveyed employer organizations providing LTSS to calculate attrition.[25] In Arkansas and Maine, the average attrition rate across all employment settings was close to 30 percent, and in Oregon, the rate was about 64 percent, although rates varied widely across settings in all states. The NBIP states and Oregon calculated attrition differently, which could explain in part why Oregon's attrition rate was more than twice the rates of Arkansas and Maine; research on attrition in nursing homes has shown that definitions of attrition can vary substantially, making it difficult to make comparisons across studies.[26]

Officials in all four states said that the data they collected provided helpful information about direct care workers. Despite the usefulness of the survey data, none of these states continued data collection after the study ended; some state officials noted the significant resources required to collect data on this workforce. Each of the three NBIP states received $200,000 to conduct their workforce studies while Oregon spent about $299,800, according to a state official.

Officials from the NBIP states said they appreciated the opportunity to use a standardized survey, emphasizing the value of being able to make cross-state comparisons. The National Direct Service Workforce Resource Center, which carried out the NBIP study, had planned to

[24]Although Arkansas fielded a survey to independent providers, summary results for this survey were unavailable. Oregon did not survey independent providers.

[25]Attrition rates are unavailable for Minnesota, as the state elected not to survey employer organizations for the NBIP study because it had conducted previous surveys of employers.

[26]Attrition rates for the NBIP study were calculated by dividing the number of leavers across all employers in 12 months by the number of positions (current workers + vacancies) at a point in time. According to the contractor for Oregon's study, attrition rates were calculated by taking the total number of direct care workers employed from January 1 to the survey date, adjusting this to a total year estimate, subtracting the number of direct care workers on the survey date, and dividing this by the number of direct care workers on the survey date.

disseminate a data collection toolkit to states for collection of information on direct care workers. The toolkit was to include guidance about data collection methods and versions of the employer and independent provider survey instruments. Although the toolkit was completed by the end of the NBIP contract, CMS's contractor for the study said that the National Direct Service Workforce Resource Center was not funded to disseminate the toolkit or help states use it, and it was not widely disseminated or posted on CMS's website.

HRSA Has Developed Some Information on the Direct Care Workforce but Has Not Projected Supply and Demand or Overcome Data Limitations

HRSA Has Developed Some Information about the Direct Care Workforce

We identified two reports that HRSA issued in the last 12 years that have provided information about the direct care workforce. First, in 2004, HRSA issued a report on workforce shortages of nursing assistants and home health aides and the associated data needs for workforce planning.[27] The report provided a comprehensive assessment of data needed for program and policy development as well as the extent and limitations of available data, including eight federal data sets; 45 state registries of certified nursing assistants; and 4 states' data collection activities. The report concluded that informed workforce planning was needed to document the extent of shortages and to assist states and

[27]Health Resources and Services Administration, *Nursing Aides, Home Health Aides and Related Health Care Occupations*.

other stakeholders in addressing them. The report also included options for making existing data sources more useful, such as expanding state registries of certified nursing assistants to include information on other direct care workers.

Second, in 2013, HRSA's National Center for Health Workforce Analysis issued a chart book summarizing national data on different health occupations.[28] Personal care aides and the occupational grouping titled nursing, psychiatric, and home health aides were among the 35 occupations included in this report.[29] Using data from the ACS for 2008 through 2010, the chart book estimated the number of workers for each occupation and presented figures showing their geographic distribution, workplace settings, and demographic characteristics.

HRSA has also supported academic institutions in conducting research and providing information about health workers, including long-term care workers. HRSA provides funds to seven Health Workforce Research Centers at universities to conduct research and help federal, state, and local decision makers better understand health workforce needs. One of the research centers located at the University of California, San Francisco focuses on the long-term care workforce. This center has examined several topics related to direct care workers, such as training requirements for personal care aides across states; long-term care

[28]Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, *The U.S. Health Workforce Chartbook, Part III: Technologists & Technicians and Aides & Assistants* (Rockville, Md.: November 2013).

[29]The occupational grouping titled nursing, psychiatric, and home health aides also includes orderlies, who are generally not considered direct care workers.

service use trends and workforce demand predictions; and the entry and exit of workers in long-term care.[30]

In addition, HRSA has taken part in the Office of Management and Budget's Standard Occupational Classification Policy Committee, which works to ensure that the occupational classifications used by the government are updated to reflect changes in the economy and nature of work.[31] The Policy Committee, which comprises representatives of several federal agencies, formulates recommendations for revisions to occupational titles and definitions. The Standard Occupational Classification system has been revised several times to reflect changes in the economy and how work is accomplished; the next scheduled revision is 2018. HRSA officials reported that the occupational definitions for home health aides, nursing assistants, and personal care aides are being considered for modification in the 2018 revision to more closely reflect the tasks workers perform.

[30]See for example Abby Marquand and Susan A. Chapman, *The National Landscape of Personal Care Aide Training Standards* (San Francisco, Calif.: University of California, San Francisco Health Workforce Research Center on Long-Term Care, Oct. 31, 2014); Abby Marquand and Susan A. Chapman, *Issue Brief: Leader States in Personal Care Aide Training Standards (*San Francisco, Calif.: University of California, San Francisco Health Workforce Research Center on Long-Term Care, Oct. 31, 2014); Michelle Ko et al., *California's Medicaid Personal Care Assistants: Characteristics and Turnover among Family and Non-Family Caregivers* (San Francisco, Calif.: University of California, San Francisco Health Workforce Research Center on Long-Term Care, July 15, 2015); Joanne Spetz et al., "Future Demand for Long-Term Care Workers Will Be Influenced by Demographic and Utilization Changes," *Health Affairs,* vol. 34, no. 6 (2015): 936-945; and Bianca Frogner and Joanne Spetz, *Entry and Exit of Workers in Long-Term Care* (San Francisco, Calif.: University of California, San Francisco Health Workforce Research Center on Long-Term Care, Jan. 20, 2015).

[31]According to HRSA officials, HRSA, chosen as the HHS representative for the committee in 1994, was not a formal voting member until the 2010 revision was underway.

HRSA Has Not Produced Projections of Supply and Demand for the Direct Care Workforce or Developed Methods to Address Data Limitations

HRSA's strategic plan includes a goal to enhance focus on workforce assessment and policy analysis through developing and employing approaches to monitoring, forecasting, and meeting long-term health workforce needs. According to HRSA's website, the National Center for Health Workforce Analysis conducts projections of the supply of and demand for the U.S. health workforce and works to overcome inherent data challenges in making these projections by improving available data; HRSA has not yet done this for direct care workers.[32] Previously, the National Center for Health Workforce Analysis developed projections of the supply of and demand for workers in a number of other health occupations, including, but not limited to, chiropractors, podiatrists, respiratory therapists, dietitians, pharmacists, and health technicians. Not having such projections for direct care workers is significant because the Center's projections for health professions by discipline help set the national agenda for the health workforce and inform HRSA and HHS programs. According to HRSA officials, HRSA utilizes the information provided in the projection reports to assess changes in the national workforce, and these reports guide the strategic direction of both HRSA and HHS programs. Officials further explained that HRSA sends the workforce projections to HHS agencies to initiate awareness and visibility of workforce issues and to inform budget requests, program planning, and performance management activities. These activities, undertaken as part of the strategic planning and budget development processes, are HHS's main health workforce planning activities.[33]

HRSA officials stated that the agency has not developed projections of the supply of direct care workers, because the available data are insufficient. To project the direct care workforce, HRSA officials stated that they would need basic, uniform, aggregate data that counts the number of workers, but no federal, state, or external body collects data specifically about these workers across all settings. While HRSA considers projecting supply to be problematic, officials told us that projecting demand for direct care workers is possible. However, they have no specific plans to project demand for this workforce, at this time.

[32]Health Resources and Services Administration, *Strategic Plan FY 2016-FY 2018.*

[33]For more information on HHS health workforce planning, see GAO, *Health Care Workforce: Comprehensive Planning by HHS Needed to Meet National Needs,* GAO-16-17 (Washington, D.C.: Dec. 11, 2015).

In spite of finding the data insufficient, HRSA has also not developed methods to overcome data limitations in projecting the direct care workforce. HRSA officials told us that because of its large sample size, the ACS is currently the best source of information about health workers and provides reliable estimates of the direct care workforce, but noted that there are significant limitations. Officials stated that they can use ACS data to estimate the supply of personal care aides, but that it is not possible to develop estimates for the other individual direct care occupations because they are combined into one occupational group—nursing, psychiatric, and home health aides. We asked HRSA officials whether the occupational grouping in the ACS data could be disaggregated to estimate the supply of each direct care occupation separately. Officials responded that when analyzing data, they use the standard data set as supplied by the data sponsor, and they had not asked the Census Bureau whether further disaggregation or special data collection were possible now or in the future. We asked HRSA officials further whether the supply of home health aides, psychiatric aides, and nursing assistants could be estimated from ACS data using data from other sources. For instance, BLS estimates the number of workers in each direct care occupation for its National Employment Matrix by determining the proportion of that occupation that is found in one survey and applying these proportions to data from another survey.[34] When we suggested that similar methods could help develop direct care worker supply estimates from ACS data, HRSA officials responded that they prefer to use direct data rather than making assumptions to derive estimates.

Although HRSA officials said they prefer to use primary data in making projections, the agency has not been proactive in identifying and improving primary data about the direct care workforce. It has been over 10 years since HRSA last produced a comprehensive assessment of the available data on direct care workers, despite the advent of new data sources since that time; some of these new data sources were unknown

[34]BLS uses data from the Current Population Survey on workers employed by all agricultural industries and private households, and those who are self-employed, or are unpaid family workers in its National Employment Matrix to calculate current employment and make projections. To estimate the number of these workers who are home health aides, psychiatric aides, or nursing assistants, BLS calculates the proportion that each occupation is found in the Occupational Employment Statistics and applies these estimates to the Current Population Survey data.

to HRSA officials.[35] For example, at the time we interviewed HRSA officials, they were unaware that CMS planned to begin collecting staffing data from nursing homes that participate in Medicare or Medicaid beginning July 1, 2016, pursuant to a requirement in the Patient Protection and Affordable Care Act.[36] These new data will include information on direct care worker attrition, tenure, and the number of hours of care per resident per day that could potentially fill current data gaps. In addition, HRSA officials were unaware that CMS's NBIP initiative had developed a set of standard survey instruments that were used by seven states to collect direct care workforce data. HRSA officials told us that state-collected data are often not uniform from one state to another and this limits the data's usefulness. However, HRSA noted in its 2004 report that data collected by states could potentially fill existing data gaps and the NBIP initiative represents a significant effort to develop and standardize state data.

Given the limitations with direct care workforce data, new approaches for overcoming these limitations would help improve projections and monitoring of this critical workforce. Developing new approaches would be consistent with HRSA's strategic goal to enhance workforce assessment and analysis. But HRSA has not taken actions to project supply and demand or to overcome the data limitations it cites as challenges to doing so. Without HRSA developing projections of supply and demand, the information on direct care workers will remain limited, and opportunities may be missed to improve the information upon which other HHS agencies and policymakers rely to guide their workforce development efforts.

Conclusions

Direct care workers are responsible for providing the majority of paid hands-on care to millions of elderly and individuals with disabilities needing LTSS. However, reported high attrition rates and problems recruiting and retaining these workers, along with the anticipated rise in

[35]In 2013, HRSA summarized federal data sources that can be used to support health workforce analysis, but this report did not provide an assessment of these data other than noting their relevance for general health workforce analysis. See Department of Health and Human Services, Health Resources and Services Administration, *Compendium of Federal Data Sources to Support Health Workforce Analysis* (Rockville, Md.: April 2013).

[36]GAO, *Nursing Home Quality: CMS Should Continue to Improve Data and Oversight,* GAO-16-33 (Washington, D.C.: Oct. 30, 2015).

the elderly population, have fueled concerns about shortages. The importance of the direct care workforce and the potential for shortages underscores the need for informed workforce planning. The success of such planning will depend in part on having current and reliable estimates of the direct care workforce, and future projections of the supply of and demand for direct care workers. While existing federal data sources provide a broad picture of the direct care workforce, gaps exist, such as the lack of information on independent providers and attrition. Unless HRSA takes actions to overcome data limitations in order to make projections of supply and demand, the ability of policymakers and other stakeholders to develop appropriate workforce strategies to ensure a sufficient number of qualified direct care workers will continue to be hampered.

Recommendation for Executive Action

To improve available data about the direct care workforce, we recommend that the Acting Administrator of the Health Resources and Services Administration

- take steps to produce projections of direct care workforce supply and demand and develop methods to address data limitations in order to do so.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS and the Department of Labor for review and received written comments from HHS, which are reprinted in appendix IV. HHS and the Department of Labor also provided technical comments, which we incorporated as appropriate.

In its comments, HHS concurred with our recommendation that HRSA take steps to develop projections of direct care workforce supply and demand, stating that developing such projections is timely and important. Congruent with the message of our report, HHS stated that given the growth in the aging population and the challenges in recruiting and retaining direct care workers, having clear information on this workforce is critical for workforce planning. To that end, the department stated that HRSA is developing demand projections for certain direct care workforce occupations and will explore ways to develop additional information needed to provide comprehensive workforce trends. Given the challenges with the underlying data on the direct care workforce, HRSA will likely need to develop methods to overcome data limitations to produce this information.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretaries of Health and Human Services and Labor and appropriate congressional committees. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of the report. GAO staff who made key contributions to this report are listed in appendix V.

Sincerely yours,

Kathleen M. King
Director, Health Care

Appendix I: Scope and Methodology

This appendix describes the methods and federal data sources we used to examine the direct care workforce. In total, we analyzed data from three different surveys—one by the Census Bureau and two conducted by the Bureau of Labor Statistics (BLS)—as no one data source contained information about all aspects of the direct care workforce (see table 2). In conducting our analyses, we made some adjustments due to the data sources' differing structures. In addition, to focus our analysis on direct care workers providing long-term services and supports (LTSS) (as opposed to those providing any type of care, including acute care), we used Census Bureau and BLS data to identify the industries and workers most likely providing LTSS. We assessed the reliability of the data by interviewing knowledgeable officials, reviewing relevant documentation, and comparing the results of our analysis to published data, as appropriate, and determined that these data were sufficiently reliable to inform our objectives.

Data Sources

Census Bureau Survey

To report on the number of direct care workers, their demographic characteristics and their hours worked, we used 1-year estimates from the Census Bureau's 2014 American Community Survey (ACS), a monthly household survey that collected data from approximately 3.54 million addresses in 2014, including both housing units and group quarters.[1] The ACS provides broad, comprehensive information on social, economic, and housing data across the United States. We obtained 2014 ACS 1-year estimates using the DataFerrett tool provided by the Census Bureau.[2] We narrowed the data to include only the occupations identified as direct care and industries that provide long-term care. We then selected the demographic variables of interest and downloaded the data.

[1]The ACS combines data from multiple years to produce reliable estimates for small counties, neighborhoods, and other local areas. Currently, the ACS produces 1-year and 5-year estimates. Multiyear estimates are more statistically reliable, in particular for areas with small populations (1-year estimates exclude data for areas with fewer than 65,000 people), but we chose to use 1-year ACS estimates in order to report the most current estimates as the direct care workforce is fast-growing; plus, we report only national-level estimates.

[2]DataFerrett is an online data analysis and extraction tool to customize and access federal, state, and local data. The tool can be accessed at http://dataferrett.census.gov/

For comparison, we also downloaded data using the same demographic variables for all U.S. occupations and industries.

One limitation of the ACS is that it collects information about the job where an individual works the greatest number of hours, or an individual's primary job. This would likely exclude direct care workers who provide LTSS part-time as a secondary job, according to Health Resources and Services Administration (HRSA) officials. While many direct care workers work part-time, we do not know how many do so as a secondary job. Another limitation of the ACS data is that individuals who are currently unemployed are classified into the occupational group in which they were most recently employed, which can be as far back as 5 years. This results in counting approximately 472,000 currently unemployed individuals as direct care workers even though they have not been employed in the past 12 months. The ACS data are also self-reported, so individuals choosing not to identify themselves as direct care workers would not be included in the data.

Bureau of Labor Statistics (BLS) Surveys

To report on direct care workers' wages, we used BLS's May 2015 Occupational Employment Statistics. The Occupational Employment Statistics measure jobs and wage rates by occupation for all full- and part-time wage and salary workers in nonfarm industries. Over a rolling 3-year cycle, BLS gathers semiannual probability samples of approximately 200,000 business establishments for a total of 1.2 million businesses. These establishments are selected from a list of nonfarm establishments that file unemployment insurance reports to state workforce agencies. Self-employed workers, owners and partners in unincorporated firms, household workers, unpaid family workers, and government workers in the military and legislative and judicial branches are excluded. We obtained the data through BLS's online Occupational Employment Statistics database by searching for the direct care occupations of interest and long-term care industries.[3] To calculate the mean hourly wage for an occupation, across all long-term care industries, we multiplied the number

[3]According to BLS officials and documentation for the May 2015 Occupational Employment Statistics data, certain businesses that provide nonmedical home-based services for the elderly and people with disabilities were not included in the survey data used for making estimates. BLS officials explained that in May 2014, there were approximately 490,000 such businesses; it is unknown how many of these employed direct care workers as independent providers. BLS officials also said that these entities are now being classified appropriately and may be included in the 2016 Occupational Employment Statistics.

of workers employed in each industry by the industry's mean hourly wage, summed these numbers, and then divided by the total number of workers.

To report on direct care workers' benefits, we used BLS's National Compensation Survey published in March 2015. The National Compensation Survey collects a range of compensation data along with detailed worker characteristics, such as benefits, union status, and part-time or full-time work schedules. This information is obtained from approximately 10,100 business establishments per year in private industries and state and local governments.[4] The National Compensation Survey excludes workers in federal agencies, quasi-federal agencies, agriculture, and private households as well as military personnel, self-employed workers, unpaid workers and volunteers, individuals receiving long-term disability compensation, and those working overseas. Since National Compensation Survey data on the BLS website is provided by industry sectors, we requested that BLS provide us with data on a range of employment benefits, such as vacation, sick leave, and retirement, specific to direct care occupations for the long-term care industries we identified. Because the National Compensation Survey is administered to a relatively small sample of business establishments, BLS officials stated that they were unable to limit the data to only long-term care industries or provide data for each direct care occupation separately. As a result, the benefit data provided in this report are for all direct care workers in all industries.

One limitation of the BLS surveys we reviewed is that the extent to which they include direct care workers working as independent providers is unclear. According to BLS officials, the Occupational Employment Statistics and National Compensation Survey include some independent providers paid for by government programs, such as Medicaid. Their inclusion in the data, however, depends on their employment arrangement with the government program, which can vary.[5] BLS officials

[4]In each sample area, larger establishments have a greater likelihood of being selected. Approximately 20 percent of private industry establishments are reselected for the sample each year.

[5]For example, in some arrangements, the consumer is considered the employer and handles all employer-related tasks, such as paying required taxes on behalf of the worker, including Social Security and unemployment insurance; in other cases, a designated fiscal agent may manage all employer-related tasks; or in some states, the state or county handles employer-related tasks.

explained that, in contrast, independent providers working under private arrangements are not included in the data because these data sources do not include private household workers and self-employed workers.

Table 2: Comparison of Federal Data Sources Used for This Report

	American Community Survey	Occupational Employment Statistics	National Compensation Survey
Sponsor	Census Bureau	Bureau of Labor Statistics (BLS)	BLS
Sample size	3.54 million addresses annually	400,000 establishments per year x 3 years = 1.2 million establishments	10,100 establishments
Population sampled	All people living in both housing units and group quarters	Wage and salary workers in nonfarm establishments, including the federal executive branch and state and local government	Civilian workers in private industry establishments and state and local governments
Sample excludes	People without addresses	Self-employed people, owners and partners in unincorporated firms, household workers, and unpaid family workers	Workers in federal and quasi-federal agencies, the military, agriculture, private households, and overseas; self-employed people; unpaid workers and volunteers; and individuals receiving long-term disability compensation
Geographic areas surveyed	Areas with populations of 65,000+ for 1-year estimates[a]	National, state, and metropolitan areas	National, state, metropolitan areas, micropolitan areas, and core based statistical areas
Collection method	Mailed questionnaires, telephone interviews, and personal visits	Mail, telephone, internet, and e-mail survey	Personal visits, mail, telephone, and e-mail
Collection frequency	Monthly	Semiannually	Annually
Limitations	Census occupational and industrial groupings are less detailed than surveys, which use the Standard Occupational Classification system and North American Industry Classification System.	Limited to workers whose employers file unemployment insurance	Small sample size limits the granular data available. Direct care workers cannot be identified by specific occupation or industry.[b]
Occupation code system	Census codes	Standard Occupational Classification	Standard Occupational Classification
Industry code system	Census codes	North American Industry Classification System	North American Industry Classification System

Source: GAO analysis of Census Bureau and Bureau of Labor Statistics information. | GAO-16-718

[a]The American Community Survey's 5-year estimates include geographic regions with populations under 65,000.

[b]Since National Compensation Survey data on the BLS website is provided by industry sectors, we requested that BLS provide us with data specific to direct care occupations for the long-term care industries we identified. Because the National Compensation Survey is administered to a relatively small sample of business establishments, BLS officials stated that they were unable to limit the data to only long-term care industries or provide data for each direct care occupation separately.

Occupational Classification

The job titles of direct care worker can vary, but they are often classified into four categories according to the Office of Management and Budget's Standard Occupational Classification system. We selected four Standard Occupational Classification categories equivalent to the direct care occupations: home health aides (code 31-1011), psychiatric aides (31-1013), nursing assistants (31-1014), and personal care aides (39-9021). One difference between BLS and Census Bureau data is that Census Bureau data use fewer detailed occupational codes. Specifically, Census Bureau data classify direct care workers into two groups: personal care aides (occupational code 4610) and one broad grouping that includes nursing, psychiatric, and home health aides (occupational code 3600). The broad occupation referred to as "nursing, psychiatric, and home health aides" also includes orderlies. While orderlies are generally not considered direct care workers, BLS Occupational Employment Statistics data suggest that they comprise a small portion of all workers in this occupational grouping. The ACS uses this grouping that includes orderlies, as shown in table 3.

Table 3: Direct Care Occupations and Related Codes Used for This Report

Occupation	Standard Occupational Classification code	Census code
Nursing, psychiatric, and home health aides[a]	31-1010	3600
Home health aides	31-1011	Not available
Psychiatric aides	31-1013	Not available
Nursing assistants	31-1014	Not available
Personal care aides	39-9021	4610

Source: Census Bureau, 2010; Bureau of Labor Statistics, 2010. | GAO-16-718

[a]This category also includes orderlies. Orderlies are generally not considered direct care workers, but Bureau of Labor Statistics' Occupational Employment Statistics data indicate that orderlies comprise a small portion of all workers in this occupational grouping.

Identifying Long-Term Care Industries

Because direct care workers can also work in non-LTSS settings, such as hospitals, we used the Office of Management and Budget's North American Industry Classification System (NAICS) industry definitions to narrow our scope just to those direct care workers employed in long-term care settings. We considered an industry to provide LTSS if the industry, as defined by NAICS, (1) primarily served the elderly or those living with chronic health conditions (i.e., physical, cognitive, or mental disabilities) who need assistance with activities of daily living on an ongoing basis; (2) provided services that help individuals perform everyday activities,

including health care, personal care, and supportive services, such as feeding, bathing, administering topical medication, and supported employment; and (3) provided the services and supports in institutions (e.g., nursing homes) or home- and community-based settings. In addition, we included direct care workers employed by private households and government. The industries we identified and their associated NAICS and Census codes are shown in table 4.

Table 4: Long-Term Care Industries Used for Report Data

NAICS code[a]	NAICS industry	Census industry	Census code
621600	Home Health Services	Home Health Services	8170
624120	Services for the Elderly and Persons with Disabilities	Individual and Family Services[b]	8370
623100	Nursing Care Facilities (Skilled Nursing Facilities)	Nursing Care Facilities	8270
623210	Residential Intellectual and Developmental Disability Facilities	Residential Care Facilities	8290
623220	Residential Mental Health and Substance Abuse Facilities		
62331	Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly		
623990	Other Residential Care Facilities		
624310	Vocational Rehabilitation Services	Vocational Rehabilitation Services	8390
814110	Private Households	Private Households	9290
999100[c]	Federal Executive Branch	Administration of Human Resource Programs	9480
999200[c]	State Government, excluding Schools and Hospitals		
999300[c]	Local Government, excluding Schools and Hospitals		

Source: Office of Management and Budget, 2012; Census Bureau, 2010 | GAO-16-718

[a]The North American Industry Classification System (NAICS) is the standard used by federal statistical agencies to classify business establishments.

[b]The Census industry codes are broader than NAICS codes. We used the broader industry entitled Individual and Family Services (Census code 8370)–which includes Services for the Elderly and Persons with Disabilities, Child and Youth Services, and Other Individual and Family Services.

[c]This code is used by the Occupational Employment Statistics program and is not an NAICS code. In the Occupational Employment Statistics, the Bureau of Labor Statistics classifies workers employed by the government by the level of government in which they are employed. In the American Community Survey, government employees are not separated by levels of government; instead, they are divided between public administration sectors based upon the work activities, such as the Administration of Human Resource Programs.

In some cases, industries are classified differently between BLS and Census Bureau data, with Census data generally using less specific industry classifications. For example, one of the industries we identified

as long-term care related from BLS data was Services for the Elderly and Persons with Disabilities.[6] The Census Bureau, however, does not use this specific industry and instead utilizes the broader industry Individual and Family Services—the aggregate of Services for the Elderly and Persons with Disabilities and two other industries: Child and Youth Services and Other Individual and Family Services.[7] In addition, BLS data classifies public administration entities into one of three industries based on the level of government—federal, state, and local, whereas Census Bureau data divide government employees among public administration settings based upon work activities. For instance, direct care workers employed by all levels of government are captured in Census data in the industry titled Administration of Human Resource Programs.

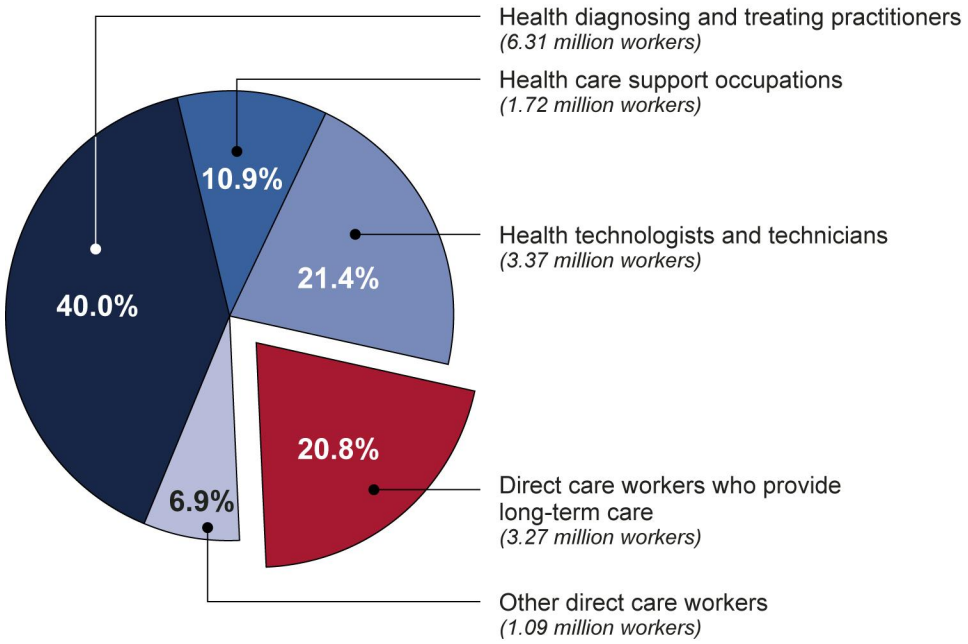
[6]The Services for the Elderly and Persons with Disabilities industry comprises establishments primarily engaged in providing nonresidential social assistance services to improve the quality of life for the elderly, people diagnosed with intellectual and developmental disabilities, or people with disabilities. These establishments provide for the welfare of these individuals in such areas as day care, nonmedical home care or homemaker services, social activities, group support, and companionship.

[7]The industry titled Other Individual and Family Services refers to establishments primarily engaged in providing nonresidential individual and family social assistance services for individuals who are non-elderly adults without disabilities. For example, crisis intervention centers, suicide crisis centers, and family social service agencies are included in Other Individual and Family Services.

Appendix II: Federal Data on the Number of Direct Care Workers and Their Compensation

This appendix contains figures and tables presenting data about direct care workers obtained from federal sources. The data include information on the percentage of direct care workers out of all health workers, and direct care workers' demographics, wages, hours, and benefits.

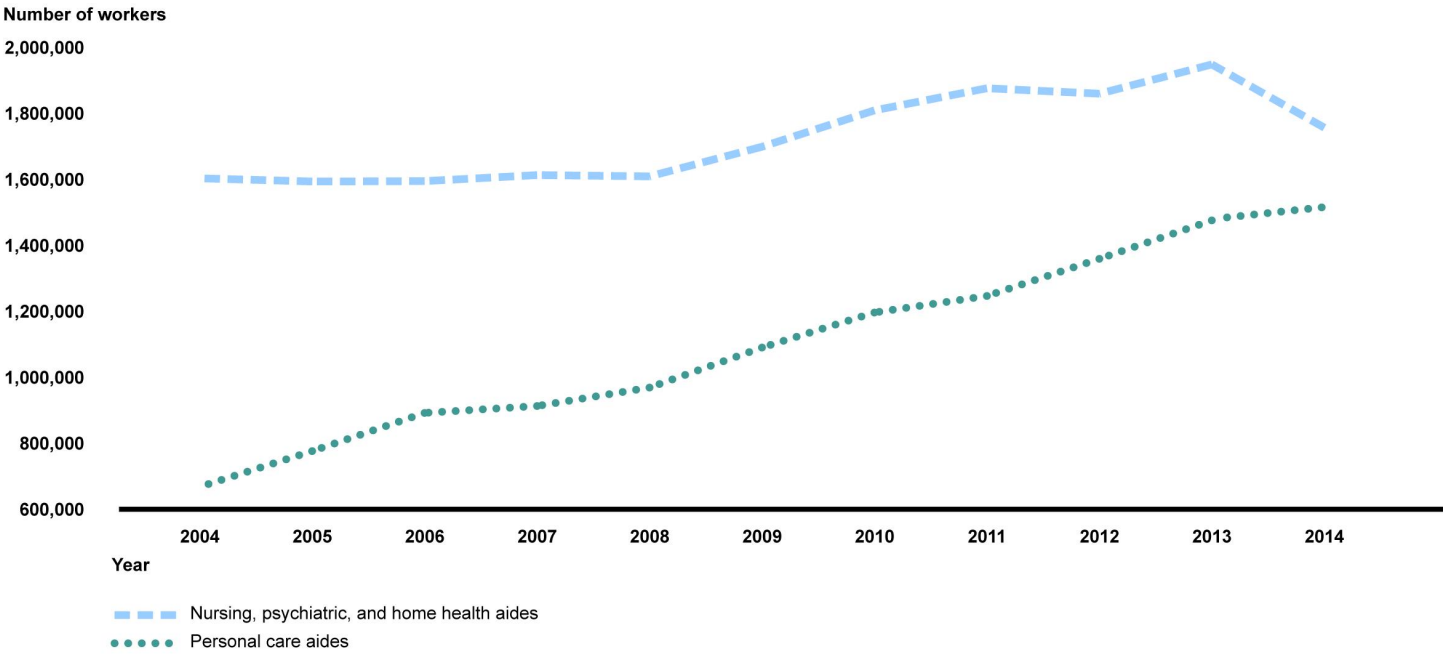
Figure 1: Direct Care Workers as a Percentage of the Total Health Workforce, 2014



Source: GAO analysis of Census Bureau data. | GAO-16-718

Note: The health workforce includes health care practitioners, such as physicians, pharmacists, nurses, and surgeons; health technologists and technicians, such as pharmacy technicians, sonographers, and paramedics; and health care support workers, such as physical therapy aides, dental assistants, and medical transcriptionists. Direct care workers include home health aides, psychiatric aides, nursing assistants, and personal care aides.

Figure 2: Number of Direct Care Jobs by Occupation, 2004-2014



Source: GAO analysis of Census Bureau data. | GAO-16-718

Table 5: Direct Care Worker Demographics, 2014

Characteristic	Component	Nursing, psychiatric, and home health aides[a]	Personal care aides	All U.S. workers
Age (%)	16-18	1.3	0.8	2.5
	19-24	13.5	11.2	12
	25-34	23.7	18.5	22.1
	35-44	19.1	17.5	20.9
	45-54	19.8	20.3	21.6
	55-64	15.8	21.1	16
	65+	7	10.6	4.9
	Mean age (years)	41.6	45	41.3
Gender (%)	Female	91.5	85.1	52.8
	Male	8.5	14.9	47.2
Race & ethnicity (%)	White, non-Hispanic	44.4	48.9	63.8
	Black, non-Hispanic	34.5	21.1	11.8
	Hispanic	13.9	18.5	16.4
	Other races	7.2	11.5	8
Educational attainment (%)	Less than high school	16	17	10.3
	High school diploma or GED	37	35.1	25.4
	Some college, no degree	31.9	28.5	23.9
	Associate's degree	8.1	7.7	8.7
	Bachelor's degree	5.5	9.4	20.2
	Graduate degree	1.4	2.4	11.6
Marital status (%)	Married	36.3	37.5	50.8
	Never married	37	33.3	33.8
	Widowed, divorced, or separated	26.6	29.2	15.4
Immigration (%)	Native-born	77.1	76.1	83.3
	Foreign-born	22.9	23.9	16.7

Source: GAO analysis of Census Bureau data. | GAO-16-718

[a]The occupational group called nursing, psychiatric, and home health aide also includes orderlies. While orderlies are not considered direct care workers, they are included in this occupational title but are relatively small in number, totaling 52,660 out of more than 3.0 million workers.

Table 6: Mean and Median Hourly Wage of Direct Care Workers in May 2015, by Industry and Occupation

	Home health aides		Nursing assistants		Psychiatric aides		Personal care aides		Direct care
Industry	**Mean**	**Median**	**Mean**	**Median**	**Mean**	**Median**	**Mean**	**Median**	**worker mean[a]**
Home Health Care Services	$10.93	$10.44	$11.89	$11.36	$10.18	$9.29	$9.62	$9.20	**$10.50**
Nursing Care Facilities (Skilled Nursing)	11.68	11.03	12.36	11.87	13.80	13.31	10.66	10.33	**12.27**
Residential Intellectual and Developmental Disability Facilities	10.86	10.57	12.22	11.57	10.90	10.35	10.95	10.66	**11.03**
Residential Mental Health and Substance Abuse Facilities	10.95	10.66	12.36	11.85	12.64	12.28	10.81	10.52	**11.23**
Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly	11.06	10.67	12.08	11.64	—	—	10.55	10.30	**11.31**
Other Residential Care Facilities	11.30	10.81	12.04	11.63	11.58	11.10	10.87	10.69	**11.28**
Services for the Elderly and Persons with Disabilities	10.59	10.34	11.35	10.92	11.39	9.39	10.40	10.13	**10.47**
Vocational Rehabilitation Services	10.43	10.22	12.07	11.26	13.30	12.32	10.73	10.39	**10.75**
Federal Executive Branch	—-	—-	17.68	17.40	—	—	—	—	**17.68**
State Government, excluding schools and hospitals	13.49	10.91	14.25	14.17	13.25	12.04	17.35	18.58	**14.68**
Local Government, excluding schools and hospitals	12.00	11.29	13.84	13.58	14.80	14.22	11.21	10.62	**12.94**
All long-term care industries[a]	**$10.94**	**$10.50**	**$12.40**	**$11.93**	**$12.62**	**$11.72**	**$10.42**	**$10.13**	**$11.20**

Source: GAO analysis of Bureau of Labor Statistics data. | GAO-16-718

Note: A dash in an empty cell indicates that data for the occupation in that industry were not released by the Bureau of Labor Statistics in the May 2015 Occupational Employment Statistics.

[a]Means for all direct care workers and for all long-term care industries were calculated as weighted averages. In some cases, data were unavailable for all occupations or industries; in these cases, the means were calculated based upon the data that were available.

Table 7: Mean and Median Hourly Wages of Direct Care Workers in May 2015, by State

	Home health aides		Psychiatric aides		Nursing assistants		Personal care aides	
State	**Mean**	**Median**	**Mean**	**Median**	**Mean**	**Median**	**Mean**	**Median**
Alabama	$9.48	$9.07	$11.70	$11.41	$10.65	$10.37	$8.73	$8.64
Alaska	14.50	14.80	19.95	19.98	17.93	17.70	14.84	15.22
Arizona	11.18	10.70	13.38	13.42	13.89	13.66	10.35	10.19
Arkansas	9.05	8.64	10.81	10.05	10.61	10.41	9.06	8.73
California	13.26	11.42	14.20	13.58	14.96	14.01	11.12	10.47
Colorado	12.59	11.54	13.55	13.33	14.12	13.80	10.63	10.39
Connecticut	12.95	12.90	18.02	17.00	15.33	14.79	12.69	12.24
Delaware	13.90	13.06	14.83	14.01	13.63	13.47	11.17	10.92
District of Columbia	12.55	12.61	13.00	13.23	15.71	15.38	12.01	12.00
Florida	11.02	10.62	12.42	12.09	11.78	11.43	10.46	10.02
Georgia	10.08	9.52	12.64	11.83	10.89	10.61	9.64	9.13
Hawaii	12.70	12.72	17.46	17.46	14.80	14.62	11.53	10.61
Idaho	10.44	9.51	—	—	11.70	11.39	9.73	9.44
Illinois	11.36	10.71	13.06	12.82	12.54	11.76	10.60	10.51
Indiana	10.62	10.51	12.34	11.73	11.70	11.31	9.51	9.39
Iowa	11.50	11.17	15.43	14.93	12.64	12.07	11.05	10.83
Kansas	11.12	10.90	12.98	13.20	11.54	11.21	10.14	10.29
Kentucky	11.36	10.54	12.66	12.35	11.77	11.53	10.29	9.83
Louisiana	9.69	9.02	11.13	10.57	10.05	9.68	8.70	8.63
Maine	11.50	10.99	12.85	11.91	12.12	11.76	10.48	10.37
Maryland	11.67	11.32	14.37	13.79	13.82	13.47	11.56	11.08
Massachusetts	13.78	13.47	13.50	13.08	14.48	14.00	13.05	13.01
Michigan	10.68	10.04	16.34	17.35	13.46	13.38	10.39	9.95
Minnesota	12.22	11.87	—	—	13.79	13.39	11.51	11.15
Mississippi	10.23	10.44	8.97	8.43	10.23	9.64	8.51	8.56
Missouri	10.73	10.82	12.99	12.64	11.48	11.06	9.68	9.33
Montana	10.82	10.72	11.97	12.01	12.12	11.71	10.69	10.57
Nebraska	11.69	11.26	14.70	13.93	12.18	11.60	11.07	10.86
Nevada	12.35	10.98	15.37	14.40	15.73	14.92	10.49	10.53
New Hampshire	12.82	12.61	—	—	14.30	13.96	11.22	11.01
New Jersey	11.07	10.71	16.61	16.18	13.61	13.30	13.50	11.50
New Mexico	11.23	9.97	11.90	11.07	12.86	12.44	9.54	9.17
New York	11.23	10.85	19.64	20.14	16.06	16.20	11.98	11.17
North Carolina	9.46	9.12	13.23	13.34	11.07	10.84	9.79	9.48

	Home health aides		Psychiatric aides		Nursing assistants		Personal care aides	
State	Mean	Median	Mean	Median	Mean	Median	Mean	Median
North Dakota	14.50	14.13	14.12	13.48	14.19	13.98	14.64	14.37
Ohio	10.09	9.83	15.97	16.31	12.09	11.61	10.35	9.71
Oklahoma	11.32	10.61	10.85	10.58	11.01	10.81	9.09	8.85
Oregon	11.33	10.88	16.88	16.60	14.49	14.12	11.30	10.98
Pennsylvania	10.58	10.26	15.66	15.46	13.68	13.46	10.65	10.54
Rhode Island	12.79	11.55	—	—-	13.99	13.60	11.16	10.88
South Carolina	9.75	9.59	10.35	10.39	11.59	10.90	9.22	9.09
South Dakota	12.74	12.60	—	—	11.68	11.21	10.30	10.16
Tennessee	9.35	9.15	10.13	9.90	11.02	10.77	9.13	8.99
Texas	9.59	8.85	11.88	11.31	11.80	11.23	8.65	8.61
Utah	11.76	10.90	11.86	11.34	11.52	11.23	10.52	9.98
Vermont	12.71	12.73	11.60	10.91	13.27	13.13	—	—
Virginia	10.77	10.50	13.06	12.84	12.07	11.75	9.28	8.95
Washington	12.37	11.51	14.30	14.14	14.15	13.68	12.01	11.44
West Virginia	9.19	8.91	9.32	8.96	11.58	11.07	9.10	8.89
Wisconsin	11.67	11.11	15.67	15.16	13.18	12.95	10.29	10.32
Wyoming	12.88	13.18	11.66	11.21	13.47	13.29	10.85	10.64

Source: GAO analysis of Bureau of Labor Statistics data. | GAO-16-718

Notes: These wages reflect direct care workers in all industries and are not exclusive to long-term care industries.

A dash in an empty cell indicates that the data for the occupation in that state were not released by the Bureau of Labor Statistics in the May 2015 Occupational Employment Statistics.

Table 8: Average Hours Worked by Direct Care Workers in the Past 12 Months, 2014

Hours (%)	Nursing, psychiatric, and home health aides[a]	Personal care aides
Part time (<35 hours)	37.6	48.8
Full time (35-40 hours)	51.6	36.6
Overtime (41+ hours)	10.8	14.6
Average hours worked per week	34.9	33.1

Source: GAO analysis of Census Bureau data. | GAO-16-718

Note: These estimates of hours worked do not include individuals who have not been employed as direct care workers in the past 12 months.

[a]In the 2014 American Community Survey, the occupational grouping titled nursing, psychiatric, and home health aides includes orderlies. While orderlies are not considered direct care workers, Bureau of Labor Statistics data suggest that they are relatively small in number. Orderlies total 52,660 workers of the nursing, psychiatric, and home health aide occupation, which is composed of more than 3.0 million workers.

Table 9: Percentage of Direct Care Workers with Access to Employment Benefits, March 2015

	Direct care workers[a]		
Benefit	**Full time**	**Part time**	**Total**
Paid leave	—	—	—
Vacation	96.3	34.4	**67.8**
Holidays	93.5	42.3	**69.9**
Sick leave	84.0	28.4	**58.4**
Life insurance	70.3	15.5	**45.1**
Health insurance	91.0	22.9	**59.6**
Short-term disability	28.3	15.2	**22.3**
Long-term disability	—	—	**18.5**
Retirement	71.4	35.7	**55.0**
Defined contribution	61.4	33.3	**48.5**
Defined benefit	21.1	4.2	**13.3**

Source: Bureau of Labor Statistics. | GAO-16-718

Note: Dashes in empty cells indicate that the sample in the March 2015 National Compensation Survey was too small for an accurate estimate of the benefit.

[a]These data reflect direct care workers—home health aides, psychiatric aides, nursing assistants, and personal care aides—in all industries. Due to the National Compensation Survey's small sample size, this table represents direct care workers in long-term care as well as other industries.

Appendix III: National Balancing Indicators Project and Selected Results from the Study's Surveys to Independent Providers

The Centers for Medicare and Medicaid (CMS) funded the National Balancing Indicators Project (NBIP) from 2010 through 2014 to develop and test the feasibility of implementing a set of national indicators to assess states' efforts toward attaining and maintaining a balanced and person-centered long-term services and supports (LTSS) system. As part of the NBIP, CMS funded seven states (Arkansas, Florida, Kentucky, Maine, Massachusetts, Michigan, and Minnesota) to collect data on direct care workers as a demonstration to see how states could measure the strength and stability of their home- and community-based LTSS workforce. We selected three NBIP states—Arkansas, Maine, and Minnesota—to review because of their geographic diversity and because they had achieved higher response rates in comparison with other states in their geographic region.

CMS's National Direct Service Workforce Resource Center, in coordination with the participating states, designed two surveys to collect uniform minimum data sets from employer organizations and independent providers in each of the states.[1] The survey templates were designed to collect a minimum data set that included measures of workforce volume (the number of full- and part-time workers), workforce stability (attrition and vacancy rates), and worker compensation (average hourly wage and benefits). Each survey incorporated these required questions, and states included additional questions if they wished.

The NBIP states selected which groups of employers participating in their Medicaid home- and community-based services programs to survey. Non-Medicaid participating providers were not included in the NBIP study. Otherwise, states selected which providers to survey, such as providers serving certain populations. Of the states we reviewed, Arkansas and Maine together surveyed 490 employer organizations and obtained response rates of 38 and 54 percent, respectively. Minnesota elected not to survey employer organizations, as the state had conducted previous surveys of these providers. All three NBIP states fielded a survey to independent providers. Working with financial management services

[1]The National Direct Service Workforce Resource Center was created by CMS in 2006 to respond to the shortage of workers who provide direct care to individuals who need LTSS. The resource center developed an online database of resources and research related to improving the recruitment and retention of direct care workers and provided technical assistance to selected state Medicaid agencies. According to CMS officials, the center completed its work in 2015 and is no longer staffed.

vendors or community partners, the states together identified over 11,900 independent providers and achieved response rates ranging from 44 to 51 percent.

The information collected by the NBIP from independent providers was of particular interest, since detailed information on these providers is not available through federal data sources. We obtained summary results from independent provider surveys for two states—Maine and Minnesota.[2] Together these states surveyed a total of 7,209 direct care workers working as independent providers for consumers in Medicaid home- and community-based programs. Overall response rates achieved were 46 and 44 percent for Maine and Minnesota, respectively. The results for these states showed, among other things, that the vast majority of responding independent providers worked for a family member, neighbor, friend, or someone else they knew. The data also showed large differences in the education and income levels between independent providers in the two states. For example, a little over one-third of responding providers in Maine reported having had some college or higher education, compared with over 60 percent in Minnesota, and over half of responding providers in Maine reported having annual household incomes of less than $22,000, while over 40 percent of independent providers in Minnesota reported incomes over $50,001. Wages also differed between the two states, with responding independent providers in Maine reporting an average wage of $9.51 per hour, compared with $15.40 per hour in Minnesota. (See table 10 for selected results for Maine's and Minnesota's surveys to independent providers.)

[2]Although Arkansas fielded a survey to independent providers, summary results for this survey were not available.

Table 10: Selected Results from National Balancing Indicators Surveys of Independent Providers in Maine and Minnesota, 2012

Survey item	Component	Percentage of respondents	
		Maine	Minnesota
Independent provider's relationship to person supported (multiple responses allowed)	Family member	44	68
	Friend, neighbor, or someone provider knew	30	21
	Someone provider didn't know before	31	22
Age of person supported	Birth to 17 years	3	51
	18 to 21 years	2	19
	22 to 64 years	62	23
	65 years or older	33	8
Highest level of education completed by independent provider	Some high school or less	12	9
	High school diploma/GED	32	20
	Vocational diploma/certificate (e.g., certified nursing assistant)	14	14
	Some college	18	22
	Associate's degree	8	11
	Bachelor's degree	7	23
	Master's degree	3	8
	Other	6	6
Annual household income of independent provider	Less than $22,000	51	18
	$22,001 - $30,000	19	17
	$30,001 - $40,000	11	13
	$40,001 - $50,000	11	12
	Over $50,001	9	41
Likelihood of working as a direct care worker a year from now	Very likely	79	79
	Somewhat likely	14	15
	Not likely at all	7	3
	I don't know	0	3

Source: GAO analysis of National Balancing Indicators Project survey results for Maine and Minnesota. | GAO-16-718

Notes: Survey response rates for Maine and Minnesota were 46 percent and 44 percent, respectively. Percentages may not add to 100 due to rounding; in addition, in Minnesota, when survey respondents provided more than one answer to a question, the state included all responses in its analysis.

Appendix IV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUL 27 2016

Kathleen King
Director, Health Care Team
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Long-Term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers*" (GAO-16-718).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED LONG-TERM CARE WORKFORCE: BETTER INFORMATION NEEDED ON NURSING ASSISTANTS, HOME HEALTH AIDES, AND OTHER DIRECT CARE WORKERS (GAO-16-718)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

GAO Recommendation

To improve available data about the direct care workforce, we recommend that the Acting Administrator of the Health Resource and Services Administration (HRSA)

- Take steps to produce projections of direct care workforce supply and demand and develop methods to address data limitations in order to do so.

HHS Response

HRSA concurs with GAO's recommendation and agrees that developing projections for the direct care workforce is timely and important. In light of the expanding aging population, and difficulties in recruitment and retention of direct care workers, clear information on this workforce is critical for workforce planning. To that end, HRSA's National Center for Health Workforce Analysis (NCHWA) is developing a factsheet reporting demand projections for nursing assistants and home health aides. While HRSA recognizes this is only part of the information needed to provide comprehensive workforce trends, we will continue to explore ways to expand information on the long-term care workforce.

HRSA also recognizes the need for robust data on the long-term care workforce. Many entities have a role in this effort, including the federal government and states. As GAO noted, some states have been very successful with their data collection efforts. However, developing comprehensive and longitudinal occupational data on direct care workers—many of whom are unlicensed and independent providers—is resource intensive and requires contributions from various partners to build the necessary data capacity. Given NCHWA's limited funds and mission to develop analysis and resources to inform decision-making on the health care workforce in its entirety, HRSA focuses its strategic planning and budget in areas where it can achieve the most impact within the bounds of its statutory authority and available appropriations.

HRSA believes that for workforce projections to be useful to decision makers, the underlying data need to be accurate and reliable. As indicated by GAO, the labor market conditions for direct care workers are characterized by low barriers to entry and exits, making supply projections particularly problematic. The sources and methods to address this issue suggested by GAO pertain to data related to demand projections. For example, the Centers for Medicare & Medicaid Services' (CMS) staffing data from nursing homes would provide information on staffing levels, tenure, and turnover of direct care workers in nursing homes. Similarly, the Bureau of Labor Statistics' (BLS) method of applying a constant proportion of direct care workers derived from the Occupation and Employment Statistics and Current Population Survey estimations project the employment of (or demand for) direct care workers.

HRSA has been and will continue to work with partners to improve the supply-side information for direct care occupations which is more challenging to collect and project. For example, for

1

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almost two decades, HRSA has worked with the Census Bureau, BLS, and other agencies to improve federal occupational data collection efforts through the Standard Occupational Classification (SOC) Policy Committee. This Committee makes recommendations to the Office of Management and Budget (OMB) regarding the SOC, which makes the final decision on taxonomy revisions. Because the SOC decides how occupational data are classified by federal statistical agencies (e.g., the Census Bureau and BLS), improvements to the SOC can ultimately improve federal data, such as that gathered through the American Community Survey. However, because revisions are made every 10 years, and implementation of changes occurs during the normal cycle of federal surveys and data collection efforts, changes in data are not seen immediately upon SOC revision.

HRSA is planning to collaborate with CMS's Division of Nursing Homes in FY 2017 with regard to the direct care workforce in nursing home settings. This activity will allow HRSA to inform and support CMS's workforce efforts to enhance care and coordination, and improve quality and outcomes. More specifically, the two agencies will work together to develop a framework for nursing home workforce development, assessment, and planning through this partnership.

Finally, HRSA is working to overcome limitations in supply data at the state level to improve primary data collection by supporting the concept of Minimum Data Sets, and assisting states and professional organizations in their data collection and analysis efforts. For example, in addition to funding its Health Workforce Research Center (HWRC) in Long Term Care, HRSA also funds an HWRC at the State University of New York-Albany, whose purpose is to provide technical assistance to state, local, and regional workforce planning entities in their health workforce data collection, analysis, and dissemination.

HRSA will continue to strive to improve the data available on the direct care workforce through various avenues.

Appendix V: Contact and Staff Acknowledgments

GAO Contact:

Kathleen M. King, (202) 512-7114 or kingk@gao.gov

Staff Acknowledgments:

In addition to the contact named above, Christine Brudevold, Assistant Director; Linda McIver, Analyst-in-Charge; Dee Abasute; Elizabeth Morrison; and Lisa Opdycke made key contributions to this report. Also contributing were Vikki Porter, Merrile Sing, and Emily Wilson.

Appendix VI: Accessible Data

Agency Comment Letter

Text of Appendix IV: Comments from the Department of Health and Human Services

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successful with their data collection efforts. However, developing comprehensive and longitudinal occupational data on direct care workers-many of whom are unlicensed and independent providers-is resource intensive and requires contributions from various partners to build the necessary data capacity. Given NCHWA's limited funds and mission to develop analysis and resources to inform decision-making on the health care workforce in its entirety, HRSA focuses its strategic planning and budget in areas where it can achieve the most impact within the bounds of its statutory authority and available appropriations.

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HRSA will continue to strive to improve the data available on the direct care workforce through various avenues.

Data Tables

Data Table for Highlights Figure and Figure 1: Direct Care Workers as a Percentage of the Total Health Workforce, 2014

Occupation	Percent of workers	Number of workers (in millions)
Health diagnosing and treating practitioners	40.0	6.31
Health technologists and technicians	21.4	3.37
Healthcare support occupations	10.9	1.72
Direct care workers who provide long-term care	20.8	3.27
Other direct care workers	6.9	1.09

Data Table for Figure 2: Number of Direct Care Jobs by Occupation, 2004-2014

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nursing, Psychiatric, & Home Health Aides	1,603,270	1,593,557	1,594,752	1,612,966	1,609,135	1,698,879	1,809,244	1,876,231	1,859,725	1,948,449	1,756,792
Personal & Home Care Aides	668,057	776,352	892,121	912,970	968,904	1,090,265	1,196,435	1,246,587	1,359,251	1,475,667	1,515,135

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