



California's Direct Care Workforce: Who They Are, the Work They Do, and Why It Matters

By 2030, one in four Californians will be age 60 or older.¹ The aging population in California will require increasing support from direct care workers to care for their essential needs, yet experts predict a shortage of between 600,000 and 3.2 million direct care workers by 2030.² Fixing the historically fragmented and under-resourced infrastructure supporting this workforce presents urgent challenges that diverse stakeholders must collectively address.³ Bolstering the direct care workforce is a win-win proposition. Not only will investments in this workforce improve the quality of life for older Californians, but they should also improve working conditions for an essential workforce that has been historically marginalized and underpaid.

Who Are California's Direct Care Workers?

Direct care workers are paid to provide essential, hands-on, daily, and long-term assistance to older adults and people with disabilities. They work in a range of settings (from private homes to community to congregate settings), assisting their clients to maximize their quality of life and supporting their clients' ability to remain in their own homes or communities when possible. Many of California's direct care workers come from historically marginalized backgrounds: 80% are women, almost half (47%) are immigrants, and over three-quarters are people of color (38% Latino/x; 24% Asian, Native Hawaiian, and Pacific Islander; 12% Black; 3% other).⁴

Direct Care Worker Job Categories and Responsibilities

The US Bureau of Labor Statistics 2018 Standard Occupational Classification (SOC) System codifies direct care workers into three categories: (1) personal care aides (PCAs), (2) home health aides (HHAs), and (3) nursing assistants, which California calls certified nurse assistants (CNAs) (Table 1).⁵ These occupational categories are not necessarily discrete. Similar job descriptions and overlapping responsibilities blur the boundaries between categories. For instance, direct support professionals (DSPs) and In-Home Supportive Services (IHSS) providers are generally considered subtypes of PCAs, but some of these direct care workers may also have some responsibilities similar to those of HHAs. Moreover, multiple job titles for the same job create confusion. For example, PCAs are also known as personal care attendants, personal assistants, or home care aides.

Direct care workers can be responsible for custodial care, skilled care, or both.

- ▶ **Custodial care** involves assisting clients with non-medical, personal care supports for activities of daily living (ADL) (e.g., eating, dressing, bathing, toileting) or instrumental activities of daily living (IADL) (e.g., housekeeping, chores, meal preparation).
- ▶ **Skilled care** involves managing medical conditions, monitoring health status, or assisting with health-related tasks (e.g., changing bandages, taking blood pressure, assisting with range-of-motion exercises). These services can be provided in the person's residence (e.g., their home, an assisted living facility, or a nursing home).

The care provided varies across direct care worker occupational categories. In general, PCAs provide custodial care, while HHAs and CNAs provide both custodial and limited skilled care. Some PCAs (i.e., IHSS providers) can be delegated to provide paramedical services, which are services ordered by a licensed health care professional who is lawfully authorized to do so, which a person could provide for themselves if they did not have functional limitations (e.g., medication administration, skin and wound care, injections).

Table 1. Direct Care Workers by Occupational Category



OCCUPATIONAL CATEGORY		
PERSONAL CARE AIDES (PCAs)	HOME HEALTH AIDES (HHAs)	CERTIFIED NURSE ASSISTANTS (CNAs)
SOC Code: 31-1122	SOC Code: 31-1121	SOC Code: 31-1131
CARE PROVIDED		
<ul style="list-style-type: none"> ▶ Custodial care 	<ul style="list-style-type: none"> ▶ Custodial care ▶ Limited skilled care 	<ul style="list-style-type: none"> ▶ Custodial care ▶ Limited skilled care
WORK SETTING		
<ul style="list-style-type: none"> ▶ Home ▶ Community* ▶ Residential care facilities† 	<ul style="list-style-type: none"> ▶ Home ▶ Community* ▶ Residential care facilities† 	<ul style="list-style-type: none"> ▶ Community* ▶ Residential care facilities† ▶ Skilled nursing facilities ▶ Hospitals
SUBTYPES WITH SIMILAR RESPONSIBILITIES		
<ul style="list-style-type: none"> ▶ Direct support professionals (DSPs) ▶ In-Home Supportive Services (IHSS) providers‡ 	N/A	N/A

Notes: N/A is not applicable; SOC is Standard Occupational Classification.

* Includes a client’s place of work or leisure (e.g., adult day programs).

† Includes assisted living, board and care, and other residential care facilities.

‡ IHSS workers may be allowed to provide paramedical services in some cases. Paramedical services are services ordered by a licensed health care professional, which a person could provide for themselves, but for their functional limitations. See *Paramedical Services* (PDF), California Department of Social Services, accessed August 29, 2022.

Sources: “2018 Standard Occupational Classification System,” US Bureau of Labor Statistics, last modified April 17, 2020; “CDA’s Direct Care Workforce Initiative” (webinar) California Department of Aging, June 14, 2022; and *Direct Care Workers in the United States: Key Facts*, PHI, September 6, 2022.

- ▶ **Direct support professionals (DSPs)** specifically support people with intellectual or developmental disabilities (I/DD) to live independently and remain integrated in their communities. Some advocates for DSPs aim to establish a specific code from the US Bureau of Labor Statistics for this job category.⁶
- ▶ **In-Home Supportive Services (IHSS)** providers are part of a statewide Medi-Cal benefit that provides long-term services and supports (LTSS) to older adults and people with disabilities who cannot live at home safely without support.⁷
 - ▶ IHSS providers may provide personal care services and/or paramedical services as authorized by the IHSS program.⁸
 - ▶ IHSS clients self-direct their care, which allows them to choose and hire their own provider, including friends and family.
 - ▶ About 70% of IHSS providers are related to their client.⁹

Community Health Workers/Promotores

Generally, community health workers/*promotores* (CHW/Ps) are considered a different type of worker than direct care workers. While the boundaries of these job definitions can blur or overlap at times, generally CHW/Ps provide care navigation to help people get the services they need, while direct care workers provide hands-on care to assist patients with day-to-day activities. For more information on CHW/Ps, see *Advancing California's Community Health Worker & Promotor Workforce in Medi-Cal*, California Health Care Foundation, October 2021.

Number of Direct Care Workers in California

Getting an accurate count of California's direct care workforce is challenging. According to the US Bureau of Labor Statistics (BLS), California had 811,670 direct care workers in 2021, including 717,220 PCAs and HHAs (who were counted as a single category) and 94,450 CNAs.¹⁰ The California Department of Social Services estimated over 550,000 IHSS providers in 2021.¹¹ These numbers may be incomplete and inaccurate for several reasons.¹² First, BLS estimates of PCAs and HHAs include those employed by home health agencies, agencies providing elder care services (e.g., senior centers), and some but likely not all IHSS agencies/employers; these counts may miss PCAs and HHAs who are independent providers, including some IHSS providers.¹³ Second, direct care workers may have multiple jobs in different job categories, which could lead to double-counting. For example, a worker might have a full-time job at a nursing home as a CNA and pick up shifts as a PCA at a second job. Finally, a hidden gray market for direct care workers occurs when consumers hire their own workers outside of a regulated program,¹⁴ making accurate counts of direct care workers even more complicated.

What Do California's Direct Care Workers Do?

The three direct care worker occupational categories (PCA, HHA, and CNA) share many — but not all — job responsibilities. Each faces distinct supervision and training requirements and is overseen by different regulatory entities. See Table 2 for a comparison of direct care worker jobs by category.

Table 2. Comparison of Direct Care Worker Jobs by Occupational Category

OCCUPATIONAL CATEGORY		
PERSONAL CARE AIDES (PCAs)	HOME HEALTH AIDES (HHAs)	CERTIFIED NURSE ASSISTANTS (CNAs)
DUTIES		
<ul style="list-style-type: none"> ▶ Provide custodial care to clients, such as bathing and dressing, and cooking and laundry if care is received at home. 	<ul style="list-style-type: none"> ▶ May monitor and address client’s health-related needs in addition to providing custodial care. ▶ Keep records on clients and report changes to supervisor. 	<ul style="list-style-type: none"> ▶ May monitor and address clients’ health-related needs in addition to providing custodial care. ▶ Provide care that is coordinated with a client’s health care team.* ▶ Are often the principal caregiver to clients in a nursing or residential care facility.
SUPERVISION		
<ul style="list-style-type: none"> ▶ When the worker is hired directly by clients or their family, the client or family assumes responsibility for deciding what the worker needs to know and providing training for those tasks, most often through direct supervision. ▶ Periodic check-ins/visits by supervisor (e.g., client’s family, case managers). 	<ul style="list-style-type: none"> ▶ Supervised by medical practitioners (commonly nurses), with periodic check-ins/visits. ▶ May work with therapists, social workers, case managers, and other medical staff. ▶ The California Health and Safety Code states that HHA services do not include services provided under the IHSS program. 	<ul style="list-style-type: none"> ▶ Supervised by on-site medical practitioners (commonly a registered nurse or licensed practical nurse).
TRAINING		
<ul style="list-style-type: none"> ▶ 0–8 hours, varying by type of worker, agency, or program (e.g., registered/unregistered worker, direct employment by client). ▶ Direct support professionals (DSPs) must complete 70 hours of training (two segments of 35 hours completed in successive years) and must pass a challenge test for each 35-hour training program. ▶ In-Home Supportive Services (IHSS) providers must attend an orientation that reviews program rules given by the county IHSS Office or county IHSS Public Authority. 	<ul style="list-style-type: none"> ▶ 120 hours minimum (4 hours of introduction + 20 hours of clinical training + 70 hours of personal care services + 16 hours of nutrition + 10 hours of cleaning and care tasks in the home). ▶ CNAs can complete an additional 40 hours to also become certified as HHAs (2 hours of introduction + 5 hours of medical and social needs + 20 hours of personal care services + 5 hours of cleaning and care tasks + 8 hours of nutrition). 	<ul style="list-style-type: none"> ▶ 160 hours (60 classroom hours + 100 clinical hours). ▶ Includes facility-based and online training programs.
RESPONSIBLE DEPARTMENT(S)		
<ul style="list-style-type: none"> ▶ California Department of Social Services (CDSS) ▶ California Department of Health Care Services (DHCS) ▶ California Department of Developmental Services (DDS) 	<p>California Department of Public Health (CDPH)</p>	<p>CDPH</p>

* CNAs are often considered part of a client’s health care team of providers, along with physician, nurse, social worker, etc., especially if they work in an institutional setting.

Sources: “**Occupational Outlook Handbook**,” US Bureau of Labor Statistics, last modified September 8, 2022; Joanne Spetz, **Home Health Aides and Personal Care Assistants: Scope of Practice Regulations and Their Impact on Care** (PDF), Healthforce Center at UCSF, July 2019; “**Training Program Review Unit**,” California Department of Public Health, last updated April 25, 2022; “**CDA’s Direct Care Workforce Initiative**” (webinar), California Department of Aging, June 14, 2022; “**Application Submission Requirements (120 hour) Home Health Aide Training Program (HHP)**,” California Department of Public Health, last updated April 14, 2022; “**Nurse Assistant Training Program Applicants: Educational Institution & Agency Application Requirements**,” California Department of Public Health, last updated April 14, 2022; California Department of Public Health, last updated August 23, 2022; “**Home Care Services**,” California Department of Social Services, accessed July 31, 2022; “**1915(c) Home and Community-Based Services Waivers**,” California Department of Health Care Services, last modified July 18, 2022; “**Home Health Aide**,” California Department of Public Health, last updated January 14, 2022; “**Direct Support Professional Training**,” California Department of Developmental Services, last modified April 8, 2021; and “**IHSS Provider Orientation**,” California Department of Social Services, accessed July 31, 2022.

Why Do California's Direct Care Workers Matter?

Over the next decade, demand for direct care workers will outpace supply in California, with an estimated shortage of 600,000 to 3.2 million direct care workers by 2030.¹⁵ Job openings for PCAs are expected to have the largest growth of any occupation in California, with 1.1 million openings between 2018 and 2028 and a total workforce growth of over 30%.¹⁶ Growing demand is driven by an aging and increasingly diverse population, fewer working-aged adults and family caregivers to support this aging population, a growing desire to remain in home and community-based settings, and an increased need for complex care provided in facility-based long-term care settings.

Several factors constrain the supply of direct care workers. Direct care work is physically and emotionally demanding, yet wages for direct care workers remain low, and many direct care workers live in poverty. This contributes to high rates of burnout, turnover, and fewer people willing to perform these jobs.¹⁷ Moreover, direct care workers have been on the front line during the COVID-19 pandemic. Yet they were often rendered invisible despite their essential role, receiving little support, supplies, or resources from their employers.¹⁸

Factors Contributing to an Increased Demand for Direct Care Workers

- ▶ **Aging and diverse population:**¹⁹
 - ▶ All baby boomers (those born between 1946 and 1964) will be age 65+ by 2030.²⁰
 - ▶ One in four Californians will be age 60+ by 2030, representing 10.8 million people.²¹
 - ▶ White, non-Hispanic Californians age 60+ will no longer represent the majority of older adults by 2030.²²
 - ▶ By 2030, the majority of Californians age 60+ will identify as Black; Latino/x; Asian, Native

Hawaiian, or Pacific Islander; American Indian or Alaska Native; or multiracial, necessitating more culturally competent and linguistically appropriate services and providers.²³

- ▶ Over one million older adults in California are projected to have self-care limitations by 2030, which includes a variety of needs like transportation and cleaning services and help with basic tasks such as bathing or eating.
- ▶ **Fewer working-aged adults and family caregivers:**
 - ▶ In coming decades, the ratio of working-age adults (ages 18–64) to older adults age 65+ will shrink significantly: from 4 to 1 in 2020 to 2.4 to 1 in 2040. This will put a strain on the tax base to fund support programs and will drastically shift the balance between the population providing care and the population needing care.²⁵
 - ▶ While society has historically relied on women to provide unpaid caregiving support, women are increasingly entering the paid labor force, so they are often no longer available or amenable to serve in the role of unpaid caregiver.
- ▶ **Increasing need for home and community-based care:**
 - ▶ Older adults and people with disabilities and their families increasingly prefer and/or rely on home care as an alternative to nursing homes or hospitals.
 - ▶ A recent California survey found that among older adults and people with disabilities who need support at home, almost 40% have an unmet need for this type of help. Of those with an unmet need, almost 20% went without groceries because of difficulty shopping.²⁶

► **Growing need for facility-based long-term care:**

- Older adults with chronic, complex, or progressive diseases (e.g., heart disease, dementia, and diabetes) may prefer, or rely on, living in a congregate setting, such as a long-term care or assisted living facility. These facilities rely on direct care workers to provide day-to-day care for these residents.

Factors Contributing to a Constrained Supply of Direct Care Workers

► **Providing care is physically and emotionally demanding work:²⁷**

- CNAs have among the highest rates of injuries and illnesses of all occupations.²⁸
- Direct care workers face risk of injury when helping clients move (such as into or out of bed, or with standing or walking), especially if proper lifting techniques are not used.
- Direct care workers can face difficult or violent behaviors from clients with cognitive impairment or mental health issues, and hazards from infections and exposures to communicable diseases.
- During the COVID-19 pandemic, direct care workers were forced to make impossible choices, such as taking care of a client who had become infected with the virus, which posed risks to themselves and their families, or staying home and seeing their financial situation worsen.²⁹
- Many direct care workers experience burnout and exhaustion from working multiple part-time jobs or working full-time or more, such as by taking shifts at night, on weekends, or over holidays so clients always have a care worker.

► **Low wages contribute to impoverishment of workers:**

- California’s direct care workers earn median wages between \$14.00 and \$18.00 per hour (see Table 3).³⁰
 - California’s minimum wage of \$14.00/hour for employers with 25 or less employees and \$15.00/hour for employers with 26 or more employees is well below the living wage of \$21.82/hour for a single adult with no children in California.³¹
 - Nearly half (47%) of California’s direct care workers receive benefits from public assistance programs.³²
 - Direct care workers who do not have work authorization or documentation are ineligible for certain public assistance programs, putting additional financial strain on them and their families.
- **High turnover:**
- Low and stagnant wages, burnout, lack of advancement opportunities, insufficient training, job-related injuries, concerns about COVID-19 and other infectious diseases, and

Table 3. Wages of California Direct Care Workers by Occupational Category (May 2021)

OCCUPATIONAL CATEGORY		
PERSONAL CARE AIDES (PCAs)	HOME HEALTH AIDES (HHAs)	CERTIFIED NURSE ASSISTANTS (CNAs)
MEDIAN HOURLY WAGE		
	\$14.27	\$18.00
MEAN HOURLY WAGE		
	\$15.26	\$19.12
MEAN ANNUAL WAGE		
	\$31,740	\$39,760

Source: “May 2021 State Occupational Employment and Wage Estimates: California,” US Bureau of Labor Statistics, last modified March 31, 2022.

lack of family leave policies are all factors contributing to high turnover and job vacancies.

- ▶ The estimated cost of turnover per direct care worker is, at minimum, \$2,500 in direct cost (use of temporary staff, training, etc.), plus an indirect cost (loss of productivity, lost clients, etc.) that is harder to measure but could double the estimate.³³
- ▶ California’s IHSS providers have an estimated 33% annual turnover rate, leaving as many as 180,000 clients searching for a new provider to hire and train each year.³⁴

How Do Various Investments Impact California’s Direct Care Workforce?

Solving the direct care workforce shortage requires a multipronged approach.³⁵ Providing a living wage is essential to supporting the direct care workforce. Workers also need career ladders for advancement and career lattices for movement across the continuum of occupational categories that operate in different settings. Training programs are critical but must provide wraparound services to be accessible, including supports like stipends, child care, and transportation.³⁶ Direct care workers, employers, and clients need culturally and linguistically appropriate systems that are easier to navigate. The California Master Plan for Aging begins to address these needs with a goal of creating one million high-quality caregiving jobs by 2030 and several direct care workforce investments are already underway.

California Master Plan for Aging: Direct Care Workforce Goals for 2030

California’s Master Plan for Aging, released in 2021, describes five bold goals. Of those related to the direct care workforce, goal #4 specifies the need to create one million high-quality caregiving jobs by 2030.³⁷ Three sub-initiatives outline solutions for the direct care workforce:

- ▶ Initiative 111: Convene a Direct Care Workforce Solutions Table to address workforce supply challenges and opportunities in skilled nursing facilities (SNFs). (Lead agencies: California Health and Human Services Agency [CalHHS], California Labor & Workforce Development Agency [LWDA].)
- ▶ Initiative 112: Consider expanding online training platforms for direct care workers, including opportunities for dementia training for IHSS family caregivers seeking a career ladder and more. (Lead agencies: CalHHS, LWDA, community colleges.)
- ▶ Initiative 113: Diversify the pipeline for direct care workers in home and community settings by testing and scaling emerging models. (Lead agencies: CalHHS, LWDA, community colleges.)

Investments in the Direct Care Workforce

California is making several investments in the direct care workforce through state and federal funds.³⁸ In fiscal year 2021–2022, California invested \$964.4 million in direct care workers. These included investments in specific direct care worker occupational categories (PCAs, CNAs, HHAs) and investments in specific settings (e.g., home and community-based programs and residential care settings). Initiatives include the following: (1) IHSS Career Pathways Program, (2) California GROWS: Growing a Resilient, Outstanding Workforce in the Home and Community, (3) Direct Support Professional Workforce Training and Development, (4) Home and Community-Based Services Clinical Workforce Program, and (5) Certified Nurse Assistant Workforce Program. Details of these investments are provided in Table 4.

Table 4. Comparison of Direct Care Workforce Programs and Initiatives in California

OCCUPATIONAL CATEGORY					
PERSONAL CARE AIDES (PCAs)			CERTIFIED NURSE ASSISTANTS (CNAs)		
HOME HEALTH AIDES (HHAs)					
PROGRAM					
IHSS Career Pathways Program ³⁹	California GROWs	Direct Support Professional Workforce Training and Development	HCBS Clinical Workforce Program	Certified Nurse Assistant Workforce Program	
RESPONSIBLE DEPARTMENT					
CDSS	▶ CDA ▶ DHCS	DDS	HCAI	HCAI	LWDA
PURPOSE					
To enhance IHSS worker skills with compensation for courses.	To improve job satisfaction, retention, and career advancement through training and stipends.	To foster a more substantial DSP workforce through training and development.	To increase the home and community-based clinical workforce.	To establish new and expand current training opportunities for CNAs.	▶ To expand the CNA apprenticeship program. ▶ To develop a new CNA-to-LVN apprenticeship pathway.
TARGET POPULATION					
IHSS providers	Non-IHSS providers with HCBS programs	DSPs	HHAs and CNAs; LVNs and RNs with HCBS programs	CNAs at skilled nursing facilities (SNFs)	CNAs at SNFs
TOTAL \$ INVESTMENT					
▶ \$295.1M ▶ \$137M for stipends*	▶ \$150M ▶ \$12.5M for stipends†	▶ \$7.9M (FY21–22) ▶ \$23.4M (FY22–23) ▶ \$85M ongoing	\$75M	\$45M	\$14.5M
TIME PERIOD					
Through December 2023	Through December 2023	Ongoing (once implemented)	2 years	6 years	4 years
COMPENSATION					
Hourly wage paid for training, plus incentives	Mirrors IHSS Career Pathways Program compensation	▶ Wage differentials tied to three-tiered training/certification ▶ Bilingual pay differential	Under development	Scholarships, stipends, and grant amounts to be determined	▶ Wraparound services‡ ▶ “Earn and Learn”*** ▶ Wage increases after passing state exam

Notes: CDA is California Department of Aging; CDSS is California Department of Social Services; DDS is Department of Developmental Services; DHCS is Department of Health Care Services; DSP is direct support professional; FY is fiscal year; GROWs is Growing a Resilient and Outstanding Workforce; HCAI is Department of Health Care Access and Information; HCBS is home and community-based services; IHSS is In-Home Supportive Services; LVN is licensed vocational nurse; LWDA is Labor & Workforce Development Agency; M is million; RN is registered nurse.

* Funding from the IHSS HCBS Care Economy Payments.

† Funding from the Non-IHSS Care Economy Payments.

‡ Providing participants with help covering the costs of childcare, groceries, and transportation.

***Participating facilities will be reimbursed for the wages of the participants in CNA training and thus CNAs will continue to earn while they are training.

Sources: “Direct Care Workforce Current Investments” (webinar), California Department of Aging, February 1, 2022; and “CDA’s Direct Care Workforce Initiative” (webinar), California Department of Aging, June 14, 2022.

Conclusion

The need for direct care workers has never been greater. Yet supports and resources for this essential workforce have historically been sorely lacking. Investing in the direct care workforce is a win-win for improving the quality of life of direct care workers and the people for whom they provide care. California is making strides in investing in the direct care workforce, but continued attention, resources, and cross-sector collaboration are needed to ensure we have a fairly compensated and well-trained direct care workforce that can meet the needs of Californians, today and into the future.

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About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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