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Personal Care Aides in Adult Day Services Centers and Residential Care Communities: United States, 2022

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Abstract

Introduction— Personal care aides (aides) are a key part of the long-term care infrastructure and provide hands-on care and support with essential activities of daily living to older and disabled Americans. This report presents the number of aides employed in adult day services centers (ADSC) and residential care communities (RCC), the hours they spend with their service users, and their training and benefits.

Methods—Data are from the ADSC and RCC provider components of the 2022 National Post-acute and Long-term Care Study, conducted biennially by the National Center for Health Statistics. The study includes several questions on staffing, including about the number of registered nurses (RNs), licensed practical nurses (LPNs) or licensed vocational nurses (LVNs), and aides employed directly by ADSCs and RCCs. Full-time equivalent (FTE) staff is based on the number of full-time and part-time employees. A measure of hours per user (participant or resident) per day was used to compare staffing levels in the two settings relative to the number of users. Responses to questions on number of hours of training required and types of training and benefits offered to aides were used to compare in and across ADSC and RCC settings.

Results—Of the 15,600 nursing (RN, LPN or LVN, and aide) FTEs employed in ADSCs and 452,000 employed in RCCs, the majority were aides (63.2% and 76.0%, respectively). Both settings often employed at least one aide (56.2% and 75.6%). The average total of all nursing staffing hours per participant or resident per day was 1 hour and 34 minutes for ADSCs and 4 hours and 25 minutes for RCCs. A lower percentage of ADSCs than RCCs offered training in dementia care (50.8% and 72.3%) and end-of-life issues (19.7% and 58.4%).

Keywords: assisted living • personal care aides • long-term services and supports • direct care worker training • benefits • National Post-acute and Long-term Care Study

Introduction

Personal care aides (aides) are key workers in the long-term care industry and provide much needed assistance to the older and disabled population (1,2). Working in multiple post-acute and long-term care settings (such as adult day services centers [ADSCs], nursing homes, home health and hospice agencies, residential care communities [RCCs], and private residences), these workers have various job titles, including personal care aides or attendants, home health aides, certified nursing assistants, nursing assistants, direct support professionals, and direct service workers. The National Post-acute and Long-term Care Study (NPALS) includes questions about certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, direct care workers, personal care assistants, and medication technicians or medication aides, subsequently referred to as aides in this report. Aides provide a range of support and caregiving services, such as assisting with activities of daily living (ADLs), preparing meals, helping with medications, getting to planned daily activities, respite care, and other complementary support for family caregivers.

The demand for aides has closely followed the growth of the aging population, increasing from 3.2 million aides in 2012 to 4.8 million in 2022 (1). Earlier studies have found that training and benefits offered to aides vary by setting and state (3–5). Mandatory federal requirements exist for training aides

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working in nursing homes and home health agencies that receive Medicare or Medicaid reimbursement. For example, certified nursing assistants (CNAs) are required to have a minimum of 75 hours of initial training, pass state competency examinations, and complete 12 hours of continuing education every year (6). More recently, several states have increased the initial training requirement for CNAs from slightly more than 75 hours to more than 120 hours (6,7). No federal training mandate exists for aides working in ADSCs and RCCs, and the required number of hours of training (if any) varies by state (8–10). Literature on aides in ADSCs and RCCs and the training and benefits they receive is limited. An earlier study of aides in ADSCs and RCCs showed that hours of training and benefits varied by setting (11). Using nationally representative data from the 2022 NPALS, this report presents national estimates of aides employed in ADSCs and RCCs in the context of all nursing staff employed in these settings, along with the number of hours of training, topics of training, and benefits offered to aides in these settings.

Methods

Data source

Data are from the 2022 NPALS ADSC and RCC surveys conducted by the National Center for Health Statistics (NCHS). NPALS is designed to estimate the supply and use of paid, regulated post-acute and long-term care services in the United States, and policy-relevant characteristics of the providers and service users. For inclusion in NPALS, in addition to being listed in the National Adult Day Services Association's database, ADSCs must:

- Be licensed or certified by the state to specifically provide adult day services, or accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF); or authorized or otherwise set up to participate in Medicaid (Medicaid state plan, Medicaid waiver, or Medicaid managed care) or part of a Program of All-Inclusive Care for the Elderly (PACE)
- Average one or more participants in attendance daily based on a typical week, and
- Have one or more participants enrolled at the center at the location at the time of the survey.

To be eligible for the survey, an RCC must:

- Be regulated by the state to provide room and board with at least two meals a day, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or with health-related services such as medication management
- Have four or more licensed, certified, or registered beds
- Have at least one resident currently living in the community at the time of the survey, and
- Serve a predominantly adult population.

RCCs licensed to exclusively serve people with severe mental illness, intellectual disability, or developmental disability were excluded from the survey.

For the 2022 NPALS, a sample of 1,660 ADSCs was selected from a sampling frame of 5,137 ADSCs, and a sample of 2,088 RCCs was selected from a frame of 46,049 RCCs. In total, 389 ADSCs and 688 RCCs completed the provider questionnaire for a weighted response rate (for differential probabilities of selection, calculated using American Association for Public Opinion Research's response rate 4, see https://aapor.org/wp-content/uploads/2024/03/Standards-Definitions-10th-edition.pdf) of 40% for ADSCs and 34% for RCCs (12). These data represent an estimated 3,082 ADSCs and 32,231 RCCs in the United States in 2022. Additional information on the sampling design and public-use data from the 2022 NPALS is available from: https://www.cdc.gov/nchs/npals/questionnaires/index.html. Restricted data can be accessed through NCHS's Research Data Center (https://www.cdc.gov/rdc/).

Measures

NPALS includes a series of questions about the staffing profiles of ADSCs and RCCs. Information about the number of full-time and part-time staff is provided about RNs, licensed practical nurses (LPNs) or licensed vocational nurses (LVNs), aides, social workers, and activities staff employed directly as well as contract staff who work for these providers. Detailed information about contract staff was not collected in NPALS, so this report does not include that data.

Full-time equivalent (FTE) employees were calculated as a sum of the number of full-time and part-time employees, where a part-time employee was considered to be 0.5 FTE. To measure staffing levels by staff types, hours per user (that is, an ADSC participant or RCC resident) per day were calculated. Hours per participant or resident per day were based on the number of FTEs for each staff type, divided by the current number of participants or residents, and then divided by 5 days for ADSCs and 7 days for RCCs. If hours per participant or resident day were greater than 24, these values were coded as 24.

Additional questions were asked about aide employees. Respondents were asked about the number of hours of training required for aide employees before providing care, as well as ongoing continuing education or annual in-service training. Another question asked how often an ADSC or RCC offered training to prepare aide employees for selected aspects of their jobs, such as:

- Discussing participant or resident care with participants' or residents' families
- Dementia care
- Working with participants or residents who act out or are abusive
- Preventing personal injuries at work, and
- End-of-life issues (advance care planning and helping families cope with grief).

The response categories were:

- Training is always offered
- Training is offered occasionally or as needed
- Training is offered rarely or never, and
- Don't know.

Providers were considered to offer

the training in a specific topic if they selected "training is always offered." "Don't know" responses were coded as missing. A set of binary questions asked respondents if they offered selected benefits to full-time aide employees, including:

- Health insurance for the employee only
- Health insurance that includes family coverage
- Life insurance
- A pension, 401(k), or 403(b)
- Paid personal time off, vacation time, or sick leave; and
- Reimbursement or payment for initial training.

Data analyses

All statements in this report describing differences between estimates indicate that statistical testing was performed. Differences in and between settings were evaluated using *t* tests. All statistical significance tests were two sided using $p < 0.05$ as the significance level. Lack of comment regarding the difference between any two statistics does not necessarily mean that the difference was tested and found not to be statistically significant. Weights were used to adjust for nonresponse, unknown eligibility status of nonresponding ADSCs and RCCs, and complex survey design. The weighted percentage of cases with missing data for all variables in this report ranged from 10.0% for the variable measuring training offered to aide employees relating to end-of-life issues in RCCs to 17.8% for the number of hours of training before providing care to participants in ADSCs. For categorical variables missing more than 10% of cases, the missing cases were included in the denominator for the estimates. For continuous variables based on aggregated counts for each provider, estimates exclude missing cases. To assess the robustness of the findings in light of the values missing from the data set, a sensitivity analysis was conducted. This analysis revealed that, while the overall results remained consistent, certain estimates exhibited variability depending on the approach used to handle the missing data. These results indicate that, despite the presence of missing values, the conclusions drawn from the analysis using the original weights are generally stable and reliable.

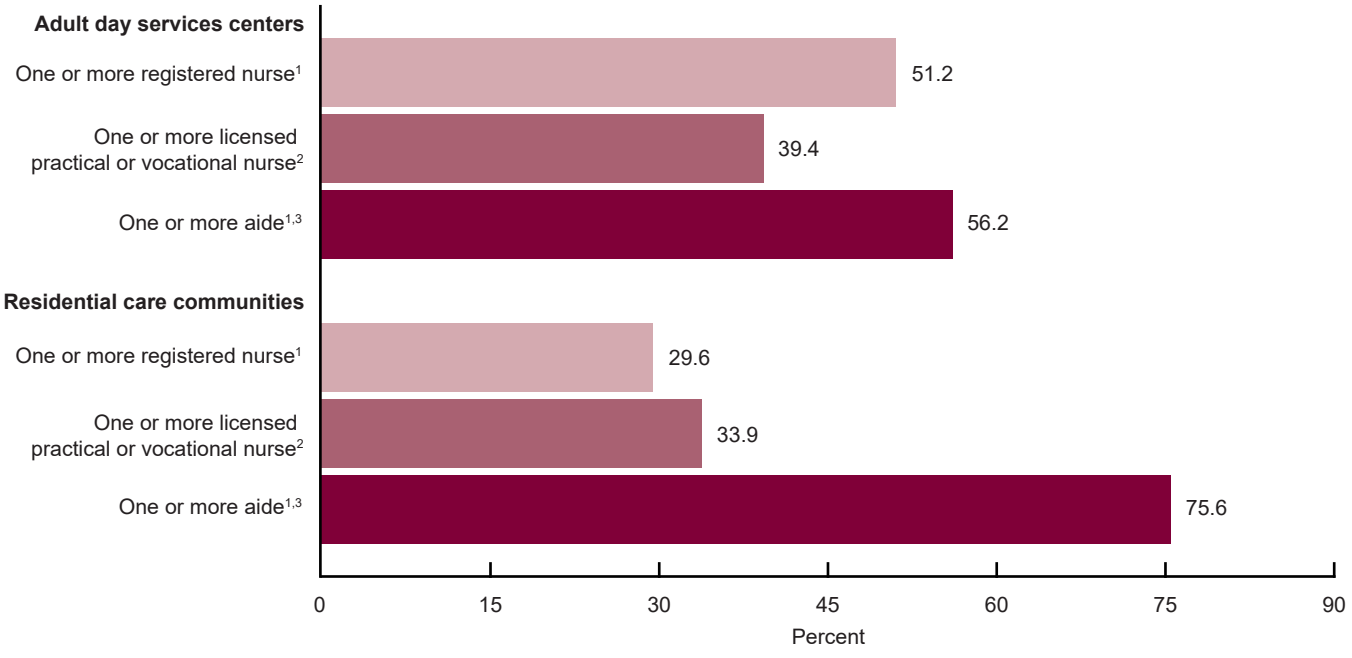
All percentages shown meet NCHS standards for confidentiality and reliability (13). Reliability of estimated means was based on the relative standard error of the estimate and on the number of sampled records on which the estimate is based. SAS-callable SUDAAN (version 11) and Stata/SE (version 17) were used to conduct statistical analyses.

Results

Most ADSCs and RCCs employed at least one aide FTE

- In 2022, a lower percentage of ADSCs employed at least one aide FTE (56.2%) compared with RCCs (75.6%) (Figure 1).
- A higher percentage of ADSCs employed at least one RN (51.2%)

Figure 1. Percentage of adult day services center and residential care communities with one or more full-time equivalent employee of the stated staff type, by setting: United States, 2022



[1]Significant difference between adult day services centers and residential care communities ($p < 0.05$).
[2]Significantly different from other staff types in adult day services centers ($p < 0.05$).
[3]Significantly different from other staff types in residential care communities ($p < 0.05$).
NOTE: Staffing variables were missing for more than 10% of cases, and missing cases were included in the denominator for the estimates.
SOURCE: National Center for Health Statistics, National Post-acute and Long-term Care Study, 2022.

compared with RCCs (29.6%).
- Less than one-half of ADSCs (39.4%) and RCCs (33.9%) employed at least one LPN or LVN.

Among ADSCs and RCCs that employed aides, a majority of employee FTEs were aides

- In 2022, a total of about 15,600 and 452,000 nursing FTEs (a combination of RNs, LPNs or LVNs, and aides) worked in ADSCs and RCCs, respectively (Figure 2).
- The percent distribution of nursing employee FTEs by staff type varied between the two settings. However, most employee FTEs in ADSCs (63.2%) and RCCs (76.0%) were aides.
- A higher percentage of nursing FTEs in ADSCs were RNs (24.4%) compared with RCCs (12.0%), while the percentage of LPNs or LVNs was similar by setting.

Aides spent more hours with ADSC participants and RCC residents per day than other nursing staff

- The average total nursing staff hours (combining RNs, LPNs or LVNs, and aides) per participant or resident per day was 1.57 (1 hour and 34 minutes) for ADSC participants and 4.41 (4 hours and 25 minutes) for RCC residents (Figure 3).
- The average aide hours per participant or resident per day represented the largest share of nursing staff hours for each setting, with aide hours per participant or resident per day being lower in ADSCs (0.91 hours, or 55 minutes) than in RCCs (3.80 hours, or 3 hours and 48 minutes).

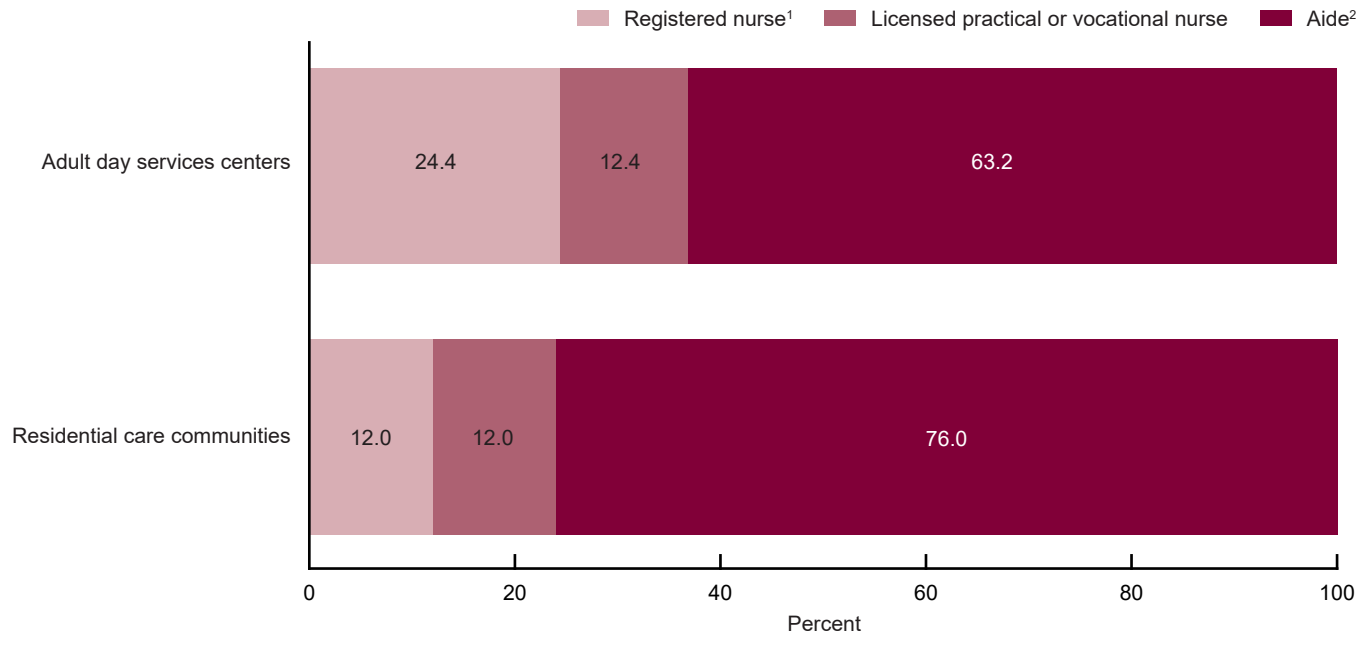
ADSCs required fewer hours of initial training for aides than RCCs

- The average number of hours of required initial training varied by provider setting. On average, ADSCs required fewer hours of training than RCCs for aide employees before providing care to participants or residents: 20.6 hours (20 hours and 36 minutes) in ADSCs and 33.5 hours (33 hours and 30 minutes) in RCCs (Figure 4).
- The average number of hours of ongoing continuing education or annual in-service training were similar among ADSCs (14.2 hours) and RCCs (15.8 hours).

Fewer ADSCs than RCCs offered aides training in dementia care

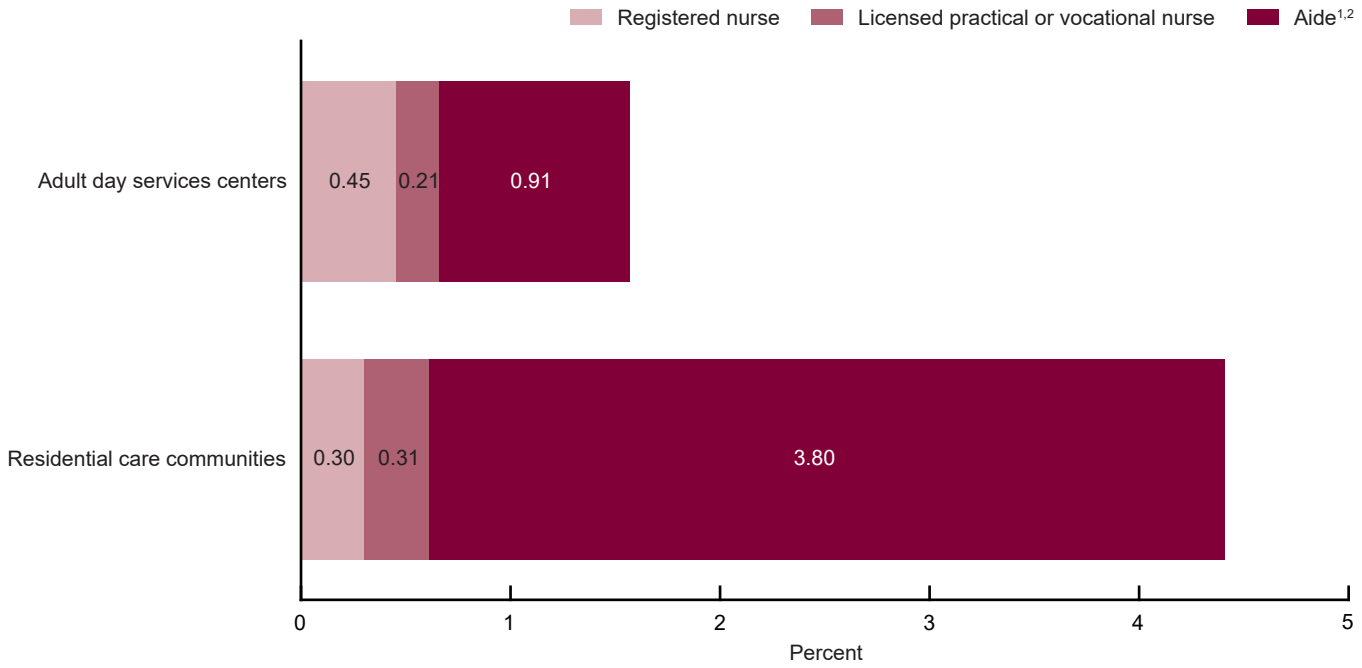
- Fewer ADSCs than RCCs offered training in dementia care (50.8% and 72.3%, respectively) and end-of-life issues (19.7% and 58.4%) (Figure 5).
- ADSCs most commonly offered training in preventing personal injuries at work (64.8%) and less than one-quarter offered training

Figure 2. Percent distribution of nursing and social work full-time equivalent employees, by setting: United States, 2022



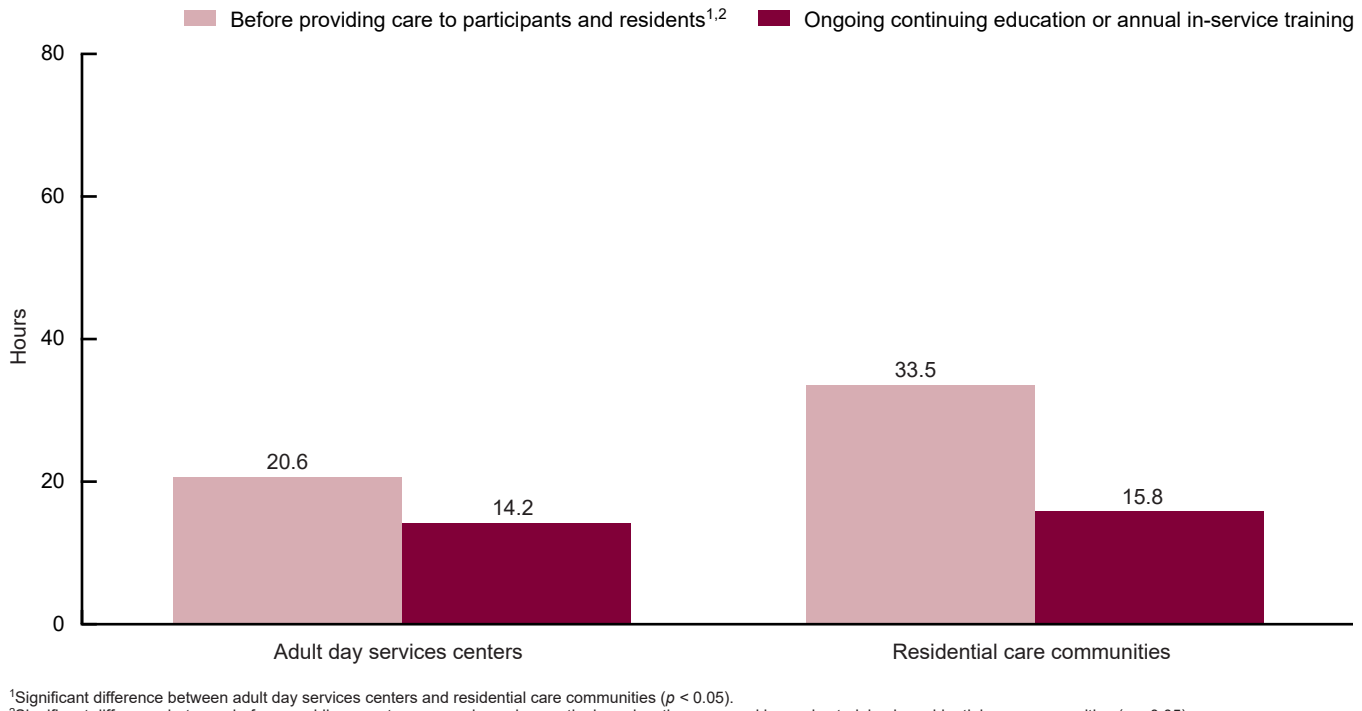
[1]Significant difference between adult day services centers and residential care communities ($p < 0.05$).
[2]Significantly different from other staff types in adult day services centers and residential care communities ($p < 0.05$).
NOTES: Adult day services centers had 15,600 full-time employees (FTEs) and residential care communities had 452,000 FTEs. Staffing variables were missing for more than 10% of cases (11.0% of cases in residential care communities and 14.1% in adult day services centers), but because these variables are based on aggregated counts for each provider, the estimates exclude missing cases.
SOURCE: National Center for Health Statistics, National Post-acute and Long-term Care Study, 2022.

Figure 3. Average staff hours per participant or resident per day, by setting: United States, 2022



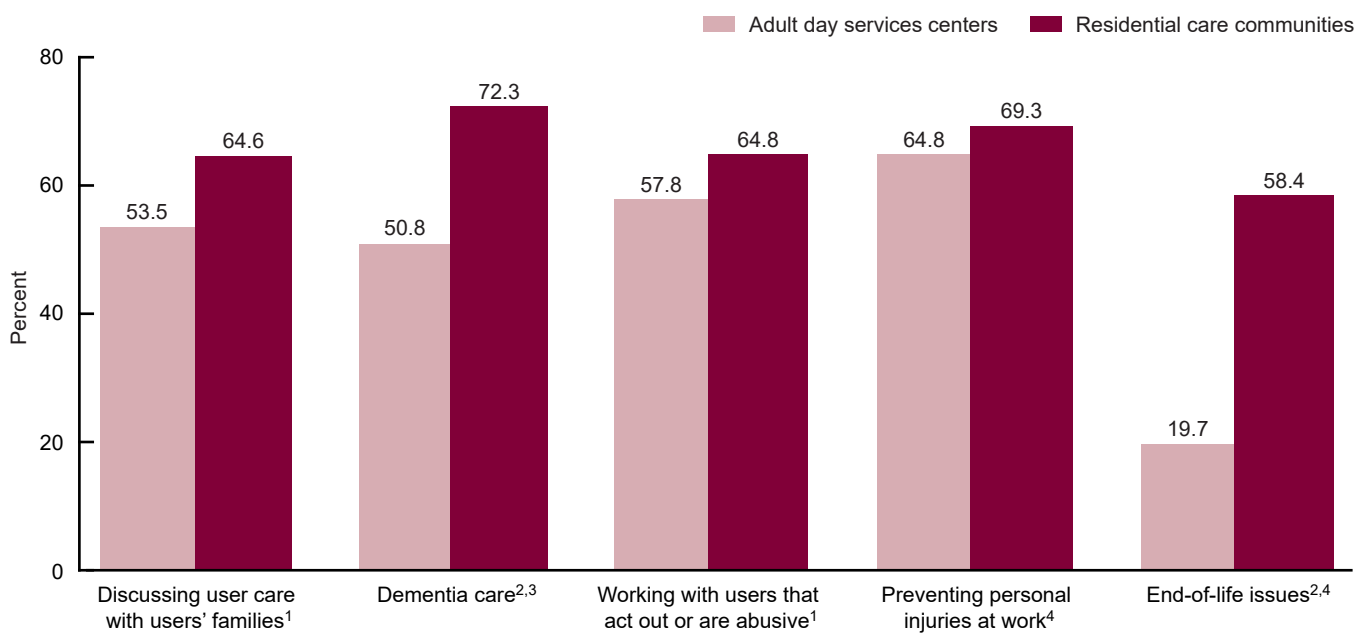
[1]Significant difference between adult day services centers and residential care communities ($p < 0.05$).
[2]Significantly different from other staff types in adult day services centers and residential care communities ($p < 0.05$).
NOTE: Staffing variables were missing for more than 10% of cases, but because these variables are based on aggregated counts for each provider, the estimates exclude missing cases.
SOURCE: National Center for Health Statistics, National Post-acute and Long-term Care Study, 2022.

Figure 4. Average number of hours of training required for aide employees in adult day services centers and residential care communities, by setting: United States, 2022



[1]Significant difference between adult day services centers and residential care communities ($p < 0.05$).
[2]Significant difference between before providing care to users and ongoing continuing education or annual in-service training in residential care communities ($p < 0.05$).
NOTE: Training variables were missing for more than 10% of cases, but because these variables are based on aggregated counts for each provider, the estimates exclude missing cases.
SOURCE: National Center for Health Statistics, National Post-acute and Long-term Care Study, 2022.

Figure 5. Training offered to aide employees in adult day services centers and residential care communities, by training topic: United States, 2022



[1]Significantly different from preventing personal injuries at work and end-of-life issues in adult day services centers ($p < 0.05$).
[2]Significant difference between adult day services centers and residential care communities ($p < 0.05$).
[3]Significantly different from working with users that act out or are abusive, preventing personal injuries at work, and end-of-life issues in adult day services centers ($p < 0.05$).
[4]Significantly different from all other training topics in adult day services centers ($p < 0.05$).
NOTE: All training variables were missing for more than 10% of cases, and missing cases were included in the denominator for the estimates.
SOURCE: National Center for Health Statistics, National Post-acute and Long-term Care Study, 2022.

in end-of-life issues (advance care planning and helping families cope with grief) (19.7%), the least commonly offered training.

- The majority of RCCs offered training in dementia care (72.3%), preventing personal injuries at work (69.3%), working with users that act out or are abusive (64.8%), discussing user care with users' families (64.6%), and end-of-life issues (58.4%).

A majority of ADSCs and RCCs offered paid time off to their aide employees

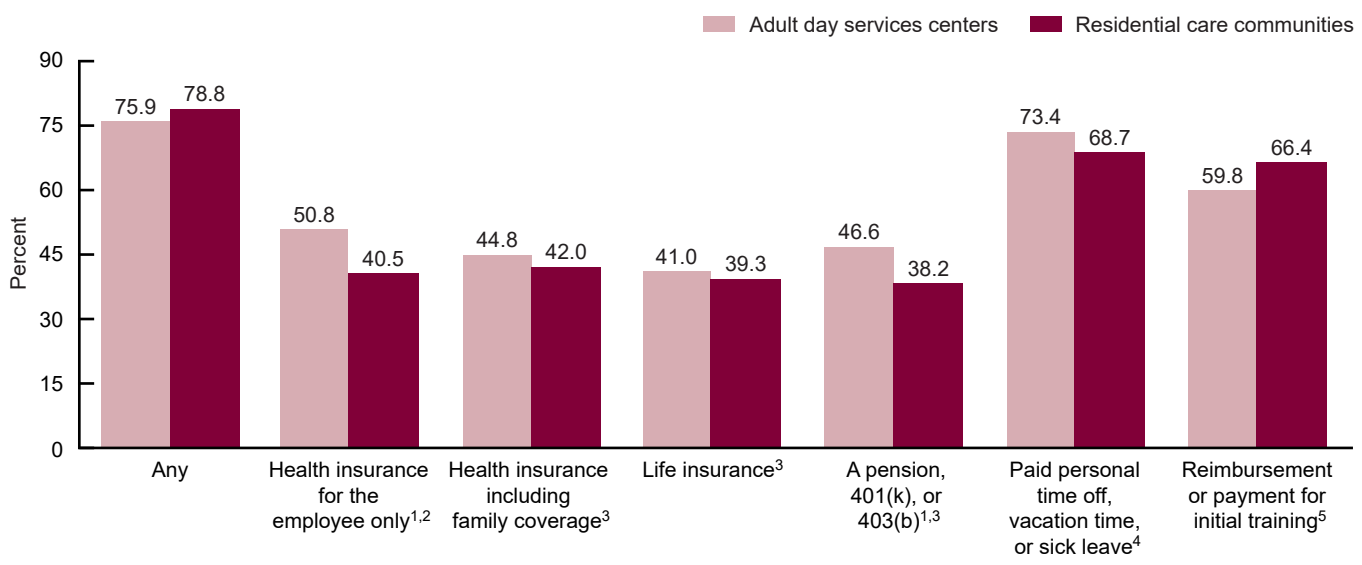
- About three-quarters of ADSCs (75.9%) and RCCs (78.8%) offered at least one of the benefits listed in the questionnaire (Figure 6).
- A higher percentage of ADSCs than RCCs provided health insurance for the employee (50.8% and 40.5%, respectively) and a pension, 401(k), or 403(b) (46.6% and 38.2%).
- The majority of ADSCs offered paid personal time off, vacation time, or sick leave to their aide employees (73.4%). Less than one-half of ADSCs offered life insurance (41.0%), health insurance that included family coverage (44.8%), or a pension, 401(k), or 403(b) (46.6%).
- The majority of RCCs offered paid personal time off, vacation time, or sick leave (68.7%) and reimbursement or payment for initial training (66.4%) to their aide employees. Less than one-half of RCCs offered health insurance that included family coverage (42.0%), health insurance for the employee only (40.5%), life insurance (39.3%), or a pension, 401(k), or 403(b) (38.2%).

Discussion

Using nationally representative data, this report provides estimates of the number of aides employed in ADSCs and RCCs, the number of hours they spend with participants or residents, and the training and benefits offered to them. In 2022, a majority of ADSCs and RCCs employed at least one aide, and a total of about 15,600 and 452,000 nursing FTEs worked in ADSCs and RCCs, respectively. Of these employees, aides made up 6 in 10 and 8 in 10, respectively, of the nursing staff in ADSCs and RCCs that employed aides. Aides also spent more time with participants or residents than any other nursing staff. On average, aides spent 55 minutes per participant per day in ADSCs and 3 hours and 48 minutes per resident per day in RCCs.

The average number of hours of required initial training varied by provider setting, with ADSCs requiring 20.6 hours of training and RCCs requiring 33.5 hours before providing care. The average number of hours of annual in-service training were similar between ADSCs and RCCs. ADSCs and RCCs offered training in many topics. Training in dementia care, preventing personal injuries at work, working with users that act out or are abusive, and discussing user care with users' families were offered by the majority of RCCs. Preventing personal care injuries was the most commonly observed training topic in ADSCs. Less than one-quarter of ADSCs offered training in end-of-life issues. About three-quarters of ADSCs

Figure 6. Benefits offered to full-time aide employees in adult day services centers and residential care communities, by benefit type: United States, 2022



[1]Significant difference between adult day services centers and residential care communities ($p < 0.05$).
[2]Significantly different from life insurance; paid personal time-off, vacation time, or sick leave; and reimbursement or payment for initial training in adult day services centers and paid personal time-off, vacation time, or sick leave and reimbursement or payment for initial training in residential care communities ($p < 0.05$).
[3]Significantly different from paid personal time-off, vacation time, or sick leave and reimbursement or payment for initial training in adult day services centers and residential care communities ($p < 0.05$).
[4]Significantly different from all benefits for adult day services centers and from all benefits except reimbursement or payment for initial training for residential care communities ($p < 0.05$).
[5]Significantly different from all benefits for adult day services centers and from all benefits except paid personal time off, vacation time, or sick leave for residential care communities ($p < 0.05$).
NOTE: Benefits variables were missing for more than 10% of cases, and missing cases were included in the denominator for the estimates.
SOURCE: National Center for Health Statistics, National Post-acute and Long-term Care Study, 2022.

and RCCs offered at least one benefit to the aides they employed. The majority of ADSCs and RCCs offered paid personal time off, vacation time, or sick leave to their aide employees. In addition, reimbursement for initial training was a common benefit for aides employed in RCCs. A higher percentage of ADSCs than RCCs offered health insurance for the employee or a pension, 401(k), or 403(b).

Although this report provides unique findings about training and benefits offered to aides, it has limitations. First, this study excludes contractors and reports only on aides who are employed directly by ADSCs and RCCs. By excluding contractors, this report may underestimate the time aides spend with participants or residents. Second, this study reports on a variety of selected training topics and benefits that are included in NPALS but may exclude other training topics and benefits available in these settings. Finally, the number of aides who received the trainings and benefits is not reported because NPALS did not collect data on training or benefit uptake. Despite these limitations, this report provides a profile of the care provided by aides employed in ADSC and RCC settings, and the ways these providers prepare and compensate them.

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