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Certified Senior Care Assistants: A Non-Clinical Workforce Model to Mitigate Nursing Shortages in Long-Term Care

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ABSTRACT: Nursing homes and other long-term care (LTC) facilities across the U.S. are facing serious staff shortages. Nurses and certified nursing assistants (CNAs) often spend at least 25% of their time on non-clinical tasks, contributing to burnout and reduced care quality. Certified Senior Care Assistants (CSCAs) are trained workers who handle non-clinical tasks, allowing nurses and CNAs more time for medical responsibilities. The goal is to improve staff efficiency, boost resident and family satisfaction, and create a clear pathway for new individuals to enter healthcare careers. We reviewed sources like the Bureau of Labor Statistics and the American Health Care Association, and examined volunteer models from providers such as Sunrise and Duke Health. These informed a 33-hour CSCA training program combining online, lab, and on-site components. CSCAs can reduce non-clinical workloads by 20–30%, saving 7–10 hours weekly per staff member. The CSCA model as a workforce pipeline offers a cost-effective, scalable solution to LTC staffing gaps. Pilot testing is recommended to evaluate the impact and inform certification policies.

KEYWORDS: Biomedicals and Health Sciences Other (Public Health), Non-Clinical Workforce, Long-Term Care (LTC), Certified Senior Care Assistants (CSCAs).

Introduction

The U.S. healthcare system is currently facing a significant challenge in staffing long-term care (LTC) facilities. As the population ages, the demand for nurses and certified nursing assistants (CNAs) continues to rise.[1] However, even today, many facilities are already experiencing workforce shortages that negatively impact the quality of care and increase burnout among existing staff.[2] For instance, a 2023 survey by AMN Healthcare found that 68% of nurses reported feeling burned out most days.[3] A major contributor to staff burnout is the inefficient use of clinical personnel for non-clinical tasks. Nurses, for example, spend roughly 17–41% of their time on documentation and administrative duties.[4] CNAs dedicate at least 25% of their work hours to responsibilities like providing companionship, assisting with meals, and transporting residents.[5] While these tasks are vital to resident well-being, they do not require clinical expertise and ultimately reduce the time available for direct medical care.

Staffing levels in many LTC facilities are insufficient to deliver even the minimum required care. Moreover, the pathway to becoming a nurse or CNA often involves significant financial and time commitments, making these roles less accessible—particularly in communities with limited access to education and training.[6] Scope-of-practice regulations further compound the problem. Clinical professionals are often required to perform tasks outside their medical focus, contributing to inefficient care delivery. Although minimum nurse-to-patient ratios are mandated in some states, many LTC facilities, particularly those in rural or underfunded regions, struggle to meet these requirements due to workforce shortages.[2]

To help address these critical issues, this paper introduces the Certified Senior Care Assistant (CSCA) model. CSCAs are non-clinical staff trained to support LTC residents by providing companionship, mobility support, basic observation, and assistance with daily routines. By delegating appropriate non-clinical tasks to CSCAs, clinical staff can focus more on patient care. Additionally, the CSCA role serves as a practical entry point into the healthcare field, making it easier for new workers—especially students, career switchers, and community volunteers—to contribute to and grow within the healthcare workforce. This paper presents the rationale for the CSCA model, outlines a proposed training framework, and evaluates its potential impact on staff efficiency, burnout reduction, and long-term workforce sustainability in LTC settings.

Methods

Study Design and Comparative Analysis:

To design an effective CSCA model, we first examined existing eldercare support programs. By analyzing their strengths and limitations, we sought to identify best practices while addressing critical gaps in service delivery and workforce development. Although limited publicly available data prevented a full comparative analysis of training formats and outcome metrics, several well-documented volunteer programs offered valuable qualitative insights.

Table 1 summarizes five volunteer initiatives from prominent long-term care and healthcare providers, highlighting their approaches across key areas.[7-11] While these programs positively impact resident well-being through emotional support and engagement, they tend to be informal, offering minimal

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training, limited task scopes, and few structured pathways into healthcare careers. These limitations underscore the need for a more formalized and scalable approach—such as the CSCA model—which bridges the gap between casual volunteerism and clinical support roles by providing comprehensive training, structured supervision, and clear opportunities for career advancement.

Table 1: Overview of five popular volunteer programs that support eldercare and patient engagement. The table highlights key characteristics, including training, scope of tasks, supervision, career pathway, and credentialing.

Program	Training	Scope of Tasks	Supervision	Career Pathway	Credentialing
Sunrise Senior Living	Basic orientation; may vary by location	Social activities, art workshops, companionship	On-site staff or activity coordinator	Informal; no direct clinical pathway	None (volunteer - based)
Brookdale Senior Living	Introductory training and orientation	Group events, one-on-one visits, lifestyle program support	Activity directors or volunteer coordinators	Informal; community service	None
Elderwood	Informal orientation	Social visits, recreational activities, flexible engagement	Recreational staff or volunteer managers	Informal experience only	None
UNC Health Rex	Formal application, health clearance, orientation	Elder service support, patient care areas (non-clinical)	Departmental supervision	Good exposure to clinical settings	None
Duke Health	Structured onboarding, possibly background check	Patient engagement, admin support, compassionate presence	Volunteer services department	Insight into healthcare roles	None

This initial comparative review focused on regional and national U.S.-based programs due to accessibility of documentation and relevance to the U.S. LTC context. However, future program development and pilot testing will benefit from a broader analysis that includes international eldercare volunteer models—such as those implemented in Canada, the UK, or Japan—which may offer valuable frameworks for training, supervision, and integration into clinical settings.

CSCA Training Framework:

To contextualize the CSCA training structure, we compared it to traditional CNA programs. CNA training typically ranges from 75 to 120 hours, depending on state regulations, and includes three main components: (1) approximately 50 hours of classroom instruction covering topics such as anatomy, infection control, and patient care fundamentals; (2) at least 30 hours of supervised clinical practice; and (3) successful completion of a state-approved program followed by passing a licensure examination.[6]

In contrast, the CSCA program is shorter and specifically designed for non-clinical support roles in long-term care settings (Table 2). CSCAs are trained to perform non-clinical support tasks that do not require licensure but still significantly contribute to resident well-being and staff efficiency. Key responsibilities include companionship and social engagement, meal assistance (e.g., preparing trays, feeding support with supervision), resident escorting (e.g., walking residents to appointments or group activities), observational reporting (e.g., documenting notable changes in mood, hygiene, appetite, or safety concerns, and promptly notifying licensed staff), and assistance with select Activities of Daily Living (e.g., dressing and grooming only when approved by supervising clinical staff and not involving high-risk tasks like toileting, bathing, or lifting, which remain under CNA/RN supervision). Its week-by-week structure gradually builds knowledge, practical skills, and confidence (Table 3). Unlike informal volunteer programs, the CSCA model offers formalized training, structured integration with clinical teams, measurable outcomes, and defined pathways for career advancement. The competency-based format also adds flexibility—participants with prior training or certifications (e.g., CPR or First Aid) can test out of applicable modules. This accessible approach makes the CSCA program appealing to a wide range of applicants, including students, retirees, and entry-level job seekers.

Proposed Evaluation Metrics for Future Pilot Testing:

To evaluate the feasibility and effectiveness of the CSCA model in real-world care settings, future pilot programs should measure staff burnout reduction through validated surveys,[13] assess resident and family satisfaction using standard tools commonly implemented in LTC facilities, and track non-clinical task reallocation through detailed time-use audits.[5] These metrics will help determine the feasibility, impact, and scalability of the CSCA model in real-world healthcare settings.

Table 2: Comparison of CNAs vs. CSCAs in terms of the scope of practice, training hours, certification, supervision, and cost. The CSCA offers a clear pathway for career advancement, requiring only 33 hours of training.

Category	Certified Nursing Assistants (CNAs)	Certified Senior Care Assistants (CSCAs)
Scope of Practice	Clinical + basic care: bathing/toileting, vital signs, repositioning, medication support (varies by state)	Non-clinical support: companionship and social engagement, meal assistance, resident escorting, observational reporting, and assistance with select Activities of Daily Living
Training Hours	75–120 hours (varies by state): 50 classroom, 30+ clinical rotations, final skills exam	~33 hours (standardized hybrid model): 10 online, 12 lab, 8 shadowing, 3 assessment
Format	In-person classroom & clinical rotations	Hybrid: online modules, in-person labs, on-site shadowing
Instructional Modules	Anatomy, infection control, hygiene, patient rights, clinical skills	Elder care communication, dementia basics, safety, companionship roles
Labs	30–40 hours of in-facility training on hygiene, mobility, feeding, toileting, vital signs	12 hours focused on supervised practice in mobility support, tray set-up, feeding assistance, fall prevention, emergency response simulation
Shadowing	Supervised clinical rotations with real patient care	8 hours of shadowing CNAs or nurses in LTC performing non-clinical support duties
Final Assessment	Written exam + hands-on clinical exam, state certification required	3-hour final competency exam: scenario-based role play, written multiple choice, and safety protocol simulation
Certification	Mandatory, state-approved licensure and registry listing	Optional, employer- or program-issued (no state licensure)
Supervision	Supervised by RNs or LPNs; often works more independently	Supervised by RNs or LPNs with task-specific oversight
Cost	~$1,200–$2,000 (tuition plus exams); ~$3,000–$6,000 including onboarding[12]	~$500 (stipend or subsidized volunteer model)
Career Pathway	Entry-level role, leads to LPN or RN education	Gateway to CNA or healthcare support careers, especially for students, retirees, and volunteers

Table 3: The CSCA training framework consists of online modules, in-person labs, on-site shadowing, and a final assessment, totaling 33 hours. This structured format ensures efficient yet comprehensive skill development.

Week	Format	Content	Hours
1	Online Modules	Basics of elder care, communication, dementia awareness	10
2	In-Person Labs	Mobility assistance, hygiene support, meal preparation	12
3	On-Site Shadowing	Supervised experience in LTC facility	8
4	Final Assessment	Competency exam (written and practical)	3

Results and Discussion

Task Reallocation Potential:

Preliminary findings suggest that CSCAs can substantially alleviate the non-clinical workload of licensed nurses and CNAs in LTC facilities, with early estimates indicating a potential reduction of 20–30% of their current burden. According to national staffing data compiled by PHI International and other studies, CNAs spend a significant portion of their time on supportive tasks such as social engagement, meal assistance, and resident transport.[12-14] For example, companionship and social interaction typically require 6–10 hours per week per resident, which CSCAs could cover up to 75%, reducing about 7 hours of weekly staff workload. Similarly, tasks related to meal assistance—including tray preparation, feeding support, and intake monitoring—consume 4–6 hours weekly, of which CSCAs could handle 50–70%, saving an additional 3–5 hours. Accompanying residents to activities and appointments takes another 2–4 hours, and CSCAs could manage 80–90% of these responsibilities. Though they do not conduct clinical assessments, CSCAs can perform basic observation and flag behavioral or safety concerns, offering an estimated 1–2 hours of weekly support. It is worth noting that these projections represent averaged estimates from staffing audits and observational studies.[12-14] Actual time may vary depending on facility size, resident acuity, and staffing models. Nonetheless, the CSCA model shows promise in improving efficiency and easing staff burden in LTC environments.

Workforce Impact:

The CSCA model is designed to offer both short-term relief and long-term workforce development. Training a CSCA is significantly less expensive (approximately $500) compared to CNA training ($1,500–$2,000), and substantially less than the full replacement cost of a CNA ($3,000–$6,000) when accounting for recruitment and onboarding.[6,12] The accessible training format appeals to high school students, second-career adults, and retirees—especially in communities underserved by traditional healthcare education. In addition, CSCAs offer a low-barrier entry point into the healthcare field, allowing participants to gain exposure to elder care before committing to longer certification programs. The program is also ideal for rural and resource-limited regions where CNA training may be unavailable or impractical, helping close critical care access gaps. By creating a scalable, cost-effective support model, CSCAs have the potential to ease current staffing shortages while cultivating a more resilient, well-distributed healthcare workforce.

Discussion

Key Benefits and Pilot Evaluation:

To determine the effectiveness of the CSCA program, pilot implementations should focus on three primary outcomes: (1) reduction in staff burnout, (2) the extent of non-clinical task delegation to CSCAs, and (3) improvements in resident satisfaction. These indicators will help assess whether the program is scalable, sustainable, and impactful over time.

1. Reduced Staff Burnout and Improved Retention: Burnout is a major contributor to high turnover in long-term care settings. A 2020 study by Dall'Ora *et al*. found that over 34% of LTC nurses reported high emotional exhaustion.[13] Delegating non-clinical tasks such as companionship, meal support, and activity escorting to CSCAs can allow licensed staff to concentrate on direct medical care, improving their job satisfaction and retention.

2. Cost Efficiency: Training a CSCA is estimated to cost approximately $500 per participant, which includes online platform fees, instructor time, printed materials, and practical training resources. In contrast, CNA programs typically cost between $1,500–$2,000, with added recruitment and onboarding costs pushing the total CNA hire cost to $3,000–$6,000.[12] If a facility trains 10 CSCAs for a total of $5,000, and each CSCA frees up 7–10 hours of clinical staff time per week, the cost-per-hour saved becomes highly competitive. For example, assuming a nurse's time is valued at $40/hour, offloading 10 hours weekly saves $400/week—or $20,800/year per CSCA in staffing value. Even accounting for supervision time, the net benefit is significant. Over time, CSCAs can help reduce reliance on costly agency staff while also serving as a pipeline for future CNA roles.

3. Workforce Development: The CSCA program offers a structured, low-barrier entry point into the healthcare workforce. Designed to alleviate non-clinical workload from nursing staff, it also provides participants with a pathway to transition smoothly into certified nursing assistant (CNA) roles, supporting broader workforce development goals.

4. Broadened Participation: With its flexible, shorter training schedule, the CSCA model attracts a more diverse applicant pool—including students, career switchers, and residents of underserved communities—who may otherwise lack access to formal healthcare training.

5. Enhanced Resident Outcomes: CSCAs provide reliable companionship and assistance with daily activities, which can increase resident satisfaction, improve emotional well-being, and reduce unnecessary hospitalizations.

Comparison with Alternative Solutions:

Various strategies have been proposed to address staffing shortages in long-term care, including increased funding for nursing education, adoption of technology-based solutions, and efforts to retain existing staff. However, each of these approaches faces notable limitations. While expanding nursing program funding is beneficial, growth is constrained by limited clinical placements and a nationwide shortage of qualified educators—factors that led to over 65,000 qualified applicants being turned away from nursing programs in 2023.[15] Similarly, technologies such as electronic health records (EHRs) and telehealth platforms can enhance efficiency but cannot replace the hands-on, interpersonal support that many seniors require. EHR implementation has sometimes been linked to increased documentation burdens for healthcare providers.[4] Staff retention strategies—such as offering financial incentives or improving work conditions—are valuable but may not adequately relieve the immediate workload pressures on nurses

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and CNAs. In contrast, the CSCA model offers a practical, short-term solution by directly addressing non-clinical tasks. Its hybrid training structure enables rapid deployment, with benefits such as workload redistribution and staff relief that can be quickly realized in practice.

Implementation Challenges:

Despite its potential, the CSCA model faces several challenges. Involving non-clinical personnel in mobility or routine care raises safety concerns, which can be addressed through structured training, competency-based assessments, and continuous supervision. Additionally, misunderstanding the CSCA's scope may lead to misassigned responsibilities or inefficiencies. Clear job descriptions and interdisciplinary staff training are critical to ensuring smooth integration.

Policy Recommendations:

To facilitate adoption and ensure the CSCA program's long-term success, states should establish standardized training, credentialing, and job descriptions for CSCAs to legitimize the role within healthcare systems. Simultaneously, partnerships between nursing schools and LTC facilities should be encouraged to pilot and refine the CSCA model. These pilots will help generate reliable outcome data related to program effectiveness, which can inform broader policy development. Implementing these recommendations will embed the CSCA model into long-term care systems, thereby addressing workforce shortages and enhancing care delivery in a sustainable and measurable way.

■ Conclusion

The CSCA model offers a structured and practical response to the growing staffing crisis in LTC facilities. By training non-clinical personnel to handle essential support tasks—such as meal assistance, resident escorting, and companionship—CSCAs can take on approximately 20–30% of duties currently performed by licensed nurses and CNAs. This targeted task reallocation enables clinical staff to focus on direct patient care, enhancing both the quality of care and staff well-being.

In addition to addressing immediate staffing challenges, the CSCA model also promotes long-term workforce development. Structured entry-level roles like CSCA can serve as effective pipelines into clinical positions. Its streamlined, competency-based training is designed to be accessible and flexible, attracting a diverse applicant pool that includes high school students, career changers, and individuals from underserved communities.

Next Steps: To validate its effectiveness, we recommend launching CSCA pilot programs in partnership with LTC facilities and educational institutions. These pilots should collect data on staff burnout reduction, resident satisfaction, and the scope of non-clinical workload transferred to CSCAs. If the outcomes are positive, the next phase would involve developing a standardized certification pathway and supporting policy infrastructure at the state level. Broad adoption of the CSCA model has the potential to transform how LTC facilities address workforce shortages, making eldercare more sustainable and patient-centered.

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