

THE WORKING POOR FAMILIES PROJECT

POLICY BRIEF ■ WINTER 2017

IMPROVING JOB QUALITY FOR THE DIRECT CARE WORKFORCE: A REVIEW OF STATE POLICY STRATEGIES

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THE WORKING POOR FAMILIES PROJECT

Strengthening State Policies
for America's Working Poor

Millions of American breadwinners work hard to support their families. But, despite their determination and effort, many are mired in low-wage jobs that provide inadequate benefits and offer few opportunities for advancement. In fact, nearly one in three American working families now earn wages so low that they have difficulty surviving financially.²

Launched in 2002 and currently supported by The Annie E. Casey, Joyce and W. K. Kellogg foundations, the Working Poor Families Project is a national initiative that works to improve these economic conditions. The project partners with state nonprofit organizations and supports their state policy efforts to better prepare America's working families for a more secure economic future.

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INTRODUCTION

Direct care workers—including certified nursing assistants, home health aides, and personal care aides—provide most of the paid, hands-on care received by older adults and people with disabilities who require long-term care. As the demand for long-term care has increased due to the aging of the U.S. population, the direct care workforce has become one of the country's largest occupations.

This substantial workforce is essential to quality of care and life for older people and people with disabilities, yet direct care workers remain undervalued in our long-term care system. Direct care jobs are characterized by low pay, poor benefits, insufficient hours, and minimal training and advancement opportunities. In turn, these workers and their families often struggle to make ends meet.

State policymakers are uniquely positioned to promote quality jobs for the direct care workforce. State-level policy authorities, which reflect state-specific powers affecting wages, labor standards, and worker training as well as state government resources and budgets, have the ability to address the unique needs of these workers. Furthermore, states have wide latitude over the structure and policies of the federally funded Medicaid program and therefore can also affect wages, benefits, and training requirements for such workers.

The Working Poor Families Project, a national initiative that seeks to strengthen state policies on behalf of low-income working families, has commissioned this report to identify state-level policy levers that invest in direct care workers. This brief examines five areas where states are enacting policy reforms for this workforce: (1) wages, benefits, and workforce supports; (2) financing; (3) recruitment, training, and career advancement; (4) workforce data collection and analysis; and (5) stakeholder engagement. This brief concludes with recommendations for state policymakers, including advocates and other policy actors, to support direct care workers in their states.

BACKGROUND

The direct care workforce is comprised of long-term care workers who are paid low wages, offered few opportunities for advancement, and provided limited on-the-job supports. As a result, these workers often sacrifice their financial well-being to care for older adults and people with disabilities. Because they represent one of the largest-growing low-income workforces in the country, interventions that support and improve the job quality of direct care workers significantly helps working poor families across the country.

The Direct Care Workforce

Direct care workers provide a majority of the paid, hands-on care in the long-term care system. They include certified nursing assistants (CNAs, also known as “nursing assistants” or “nursing aides”); home health aides (HHAs); and personal care aides (PCAs, also known as “personal care attendants” or “home attendants”). Home health aides and personal care aides are occasionally referred to collectively as “home care aides” or “home care workers.” Direct care workers help their clients bathe, dress, and negotiate a range of daily tasks.

Table 1: Direct Care Worker Definitions, Training and Care Settings

Worker Type	Definition	Training Requirements	Care Setting(s)
Personal Care Aide (PCA)	<ul style="list-style-type: none"> • Assist with activities of daily living (ADLs)^a • Often help with housekeeping, chores, meal preparation, and medication management • Can also help clients go to work and remain engaged in their community, and advise on nutrition, household maintenance, and other issues 	<ul style="list-style-type: none"> • No federal requirements • 18 states and the District of Columbia have set their own uniform training requirements^b 	<ul style="list-style-type: none"> • Most work in home care • In certain states, some work in assisted living facilities
Home Health Aide (HHA)	<ul style="list-style-type: none"> • Assist with ADLs • May perform certain clinical tasks under supervision of licensed professional 	<ul style="list-style-type: none"> • Federal training requirement of 75 hours • 17 states and the District of Columbia require more than the federal minimum^c 	<ul style="list-style-type: none"> • Most work in home care • In certain states, some work in assisted living facilities
Certified Nursing Assistant (CNA)	<ul style="list-style-type: none"> • Assist with ADLs • May perform certain clinical tasks under supervision of licensed professional 	<ul style="list-style-type: none"> • Federal training requirement of 75 hours • 31 states and the District of Columbia require more than the federal minimum^d 	<ul style="list-style-type: none"> • Most work in nursing homes • In certain states, CNA certification is required to work in home care • In certain states, some some work in assisted living facilities

^a According to the Center for Medicare and Medicaid Services (CMS), activities of daily living are activities related to personal care, including bathing, dressing, walking, getting in and out of bed or a chair, using the bathroom, and eating.

^b PHI. 2016. “Personal Care Aide Training Requirements.”

^c PHI. 2016. “Home Health Aide Training Requirements by State, 2016.”

^d PHI. 2016. “Nurse Assistant Training Requirements by State, 2016.”

In 2016, there were approximately 4.5 million direct care workers, including approximately 2.4 million home care workers and 600,000 nursing assistants employed in nursing homes.³ Meanwhile, approximately 10,000 Americans are turning 65 every day,⁴ with 70 percent expected to need long-term care at some point in their lives.⁵ With this increase in demand, long-term care in this country will need a projected 1.1 million new direct care workers between 2014 and 2024.⁶

A vast majority of these workers are female and over half are people of color.⁷ They are a lifeline for the people they serve, as they help to support health, independence, social engagement, and other elements of their clients' quality of life. Direct care workers can also provide important support for clients' family caregivers, many of whom may struggle to provide this care on their own.

Despite their importance, direct care jobs are not typically high in quality, especially when it comes to compensation. The median wage is \$11.62/hour, and the median annual income is about \$17,000.⁸ Forty-three percent of direct care workers receive some form of public assistance.⁹ A key factor in direct care workers' low income is that 60 percent work part time, most involuntarily.¹⁰

Additionally, direct care worker training standards vary by state and are largely insufficient, and workers rarely have opportunities for career advancement. Federal regulations require that certified nursing assistants and home health aides receive at least 75 hours of training,¹¹ though the National Academy of Medicine (NAM) recommends at least 120 hours of training for these workers.¹² Only 13 states and the District of Columbia have enacted the NAM recommendation for certified nursing assistant training hours,¹³ and only six states and the District of Columbia for home health aides.¹⁴ Meanwhile, there are no federal training standards for personal care attendants, and only 18 states and the District of Columbia have implemented uniform training requirements for this workforce segment.¹⁵

The lack of sufficient training standards is partly because, historically, direct care worker jobs were considered "unskilled." But as people live longer with higher care needs, direct care workers play an increasingly important role in helping manage complex conditions, ensuring

quality and continuity of care, and supporting interdisciplinary teamwork – making their work far from "unskilled."

The Long-Term Care System

Long-term care refers to a range of ongoing services and supports that assist older adults and people with disabilities with daily living. The areas of long-term care that employ most direct care workers include:

- **Home Health Care:** According to the U.S. Department of Health and Human Services, home health care "helps older adults live independently.... [and] may include occupational and physical therapy, speech therapy, and skilled nursing. It may involve helping older adults with activities of daily living, such as bathing, dressing, and eating. It can also include assistance with cooking, cleaning, other housekeeping, and monitoring one's medication regimen."¹⁶ Home care aides are usually employed by a home care agency or directly hired by a client. There were over two million home care workers in 2017, representing more than half of the direct care workforce.¹⁷ This figure is likely an undercount, as it can be difficult to quantify the number of workers who are directly employed by consumers. For example, consumers may not know how to properly report their status as an employer, or may prefer to pay workers "off the books." Most home care workers are home health aides or personal care aides but, in some states, certified nursing assistants also work in home care.
- **Nursing Homes:** According to the U.S. National Library of Medicine, a nursing home is "a place for people who don't need to be in a hospital but can't be cared for at home. Most nursing homes have nursing aides and skilled nurses on hand 24 hours a day."¹⁸ Most of the direct care in nursing homes is delivered by certified nursing assistants.
- **Assisted Living Facilities:** According to the U.S. Department of Health and Human Services, assisted living facilities "offer a housing alternative for older adults who may need help with dressing, bathing, eating, and toileting, but do not require the intensive

medical and nursing care provided in nursing homes.”¹⁹ Depending on a state’s regulations, direct care workers in assisted living facilities may be home health aides, personal care aides, or certified nursing assistants.

Over half of long-term care is funded by Medicaid,²⁰ though Medicare offers limited support (largely for post-acute care). Most people who do not qualify for public funding pay for long-term care out-of-pocket.²¹ Because Medicaid is the largest payer of long-term care and is administered by states, this brief focuses largely on state-level, Medicaid-related strategies for supporting the direct care workforce.

Challenges for the Direct Care Workforce

As work primarily undertaken by women and people of color—two historically marginalized segments of the U.S. workforce and the broader population—direct care has long been undervalued, as evidenced by persistently poor job quality. Existing public funding mechanisms exacerbate the economic challenges for this workforce in three key ways:

- First, the **reimbursement rates** paid to long-term care providers by Medicaid are insufficient, leading to low wages and inadequate benefits for direct care workers.
- Second, **training for direct care workers** is lacking, due in part to insufficient funding from both the public and private sectors, as well as minimal state and federal training requirements, especially for personal care aides.
- Third, there are limited **career advancement opportunities** in direct care; workers often remain in entry-level positions with little increase in compensation and no opportunity for upward mobility.

Poor job quality has led to high turnover in the industry and a growing workforce shortage, as reported by providers and news outlets nationwide.²² And as the economy strengthens, workers have more alternative job opportunities. For example, in some states, workers can earn the same or better wages in the retail or fast food

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industries compared to long-term care. As a result of this competition, long-term care providers struggle to fill direct care jobs, especially in rural areas where the labor supply is smaller.

While demand for long-term care is increasing, the number of workers entering the labor market will remain relatively stable – creating a greater gap between demand for direct care workers and supply.²³ Unfortunately, inadequate data collection on this workforce, especially in the home care sector, makes it difficult to measure or address the workforce shortage. Taken together, these trends affecting the direct care workforce create an impetus for widespread policy reform.

State-Level Policy Advocacy

While direct care workers can benefit from both federal and state reforms, state policymakers are uniquely positioned to support the direct care workforce. State-level policy solutions, which reflect state-specific demographic trends, infrastructure, and budgets, have the potential to address the unique needs of working families in each state. Furthermore, states have wide latitude over the structure of their Medicaid programs and, consequently, authority over wages, benefits, and training requirements for direct care funded through Medicaid – which, as noted above, is the primary funder of long-term care.

POLICY AREAS

This section highlights a range of state and local policies focused on the direct care workforce. While it is not an exhaustive list of state policies, it illustrates the important role that states play in investing in this workforce. The five areas described in this section include: (1) wages, benefits, and workforce supports; (2) financing; (3) recruitment, training, and career advancement; (4) workforce data collection and analysis; and (5) stakeholder engagement. While no single policy will solve the challenges facing the direct care workforce, a combination of policies that address multiple areas can substantially improve job quality.

1) Wages, Benefits, and Workforce Supports

State laws that lift wages and improve benefits can make a meaningful difference in the lives of direct care workers and their families. While many states are passing minimum wage laws or family medical leave programs for all low-wage workers, this section highlights the states that are focusing explicitly on the direct care workforce.

Through Medicaid, states can set minimum standards for direct care wages and benefits in a number of ways. In recent years, some states have increased the wages of direct care workers by allocating additional Medicaid funds specifically

for wage increases (see “Financing”). New York State has taken a slightly different approach through its 2011 “wage parity” law, which requires that Medicaid-funded home health aides in certain counties receive a minimum level of compensation in the form of both wages and benefits (see “Spotlight: Wage Parity in New York”).²⁴

States have also improved compensation and benefits for the direct care workforce through other routes. For example, Wisconsin began offering a \$500 bonus to certified nursing assistants in nursing homes after six months on the job in 2017.²⁵ This policy change both increased compensation for workers and helped consumers by encouraging workers to stay on the job, supporting continuity of care.

Additionally, several states—such as Oregon,²⁶ Illinois,²⁷ and Nevada²⁸—have passed “Domestic Workers’ Bill of Rights” laws over the past three years. Domestic workers generally include people who are providing care in the home, as well as house cleaning, cooking, and other home-based services. These laws typically extend workplace harassment protections to domestic workers (including home care aides), require paid time off, and enhance overtime protections, among other provisions.

Although a local example, New York City has taken an approach that could be replicated at a

Spotlight: Wage Parity in New York

The New York wage parity law sets minimum wage and benefit levels for Medicaid-funded home health aide services. Prior to 2011, when the law was passed, personal care attendants were generally paid a higher wage than home health aides, despite requiring less training. This was because Medicaid personal care attendant services were contracted at the county level, and thus governed by county-based “living wage laws,” whereas home health aide services were aligned with the state minimum wage. As the state moved to Medicaid managed care, personal care attendant services were largely replaced by home health aide services.

To avoid a significant drop in compensation for personal care attendants when they became certified as home health aides, the state created the wage parity law. Each year, the state sets wage parity limits based on a county’s prevailing Medicaid reimbursement rate, living wage, and the minimum wage. The state identifies a portion that must be paid in wages and an additional amount that can either be paid in benefits or wages. Anecdotally, almost all long-term care agencies pay the additional amount in benefits, rather than wages, because it is more cost-effective.

Source: PHI. 2014. [Wage Parity for Home Care Aides](#). Bronx, NY: PHI.

state level. In 2016, the New York City Council created the Division of Paid Care, which provides support for home care and child care workers by educating workers on their rights, facilitating the filing of complaints, connecting workers to low- and no-cost trainings, and referring them to applicable public assistance.²⁹ Importantly, the Division of Paid Care is housed within an agency that has the authority to investigate employers' violations of city laws, which may help ensure that workers receive the benefits to which they are legally entitled, such as paid time off. This system of workforce support and legal enforcement could be replicated at a state level to help ensure that regulatory increases in wages and benefits are actually seen by workers on the ground.

2) *Financing*

A state's long-term care financing system determines the available public funding for long-term services and supports and, in the context of the workforce, shapes what long-term care providers can invest in their employees. When consumers pay privately for long-term care, providers can adjust what they charge consumers.

For long-term care services covered by Medicaid, the government and its contractors determine reimbursement rates, which do not always account for the actual cost of delivering care, much less ensure a living wage for the direct care workforce. Adequate reimbursement rates in Medicaid would allow long-term care providers to invest in the workforce through enhanced training opportunities, higher wages, and expanded benefits. Importantly, investing in better wages for direct care workers may reduce their reliance on Medicaid for health coverage, potentially reducing the net Medicaid expenditure.³⁰

Increases in a state's Medicaid provider reimbursement rates may trickle down to the workers themselves – though this is not guaranteed. In 2016, Maine raised Medicaid reimbursement rates for personal care services after a study determined that the rate should be much higher to adequately reflect costs, including workforce training and compensation costs (see Spotlight: Maine Rate Study).³¹ However, the increased rates were not required to be passed

Spotlight: Maine Rate Study

For years, stakeholders in Maine advocated for higher Medicaid rates for personal care services. In 2014, the Maine Department of Health and Human Services commissioned a study to determine the true cost of providing personal care services in the state. This study determined that home care providers needed \$8 million more than the current rate to make ends meet. Importantly, the rate calculation included workforce costs such as training, health insurance, paid days off, and supervision costs. The study findings were key to stakeholders' success in lobbying the legislature to allocate funds to increase rates in 2016 and 2017.

Sources:

Burns & Associates. 2016. "[Rate Review for Personal Care and Related Services: Final Rate Models](#)" and PHI interviews with Maine stakeholders about the rate review process.

along to the workforce, leaving it up to individual providers to determine how to use the new money.

Other states have earmarked rate increases specifically for investment in direct care workers, known as "wage pass-throughs"—a targeted way to ensure workers see an improvement. For example, through their 2017 budget processes, both Rhode Island³² and Montana³³ implemented rate increases that specifically raised the wages of direct care workers. As another example, since 2015, the District of Columbia has allocated money to long-term care providers that, by regulation, must fund personal care attendant wages to meet the living wage requirement that applies to most Medicaid-funded personal care attendants.³⁴ Relatedly, Minnesota requires that 72.5 percent of Medicaid payments to home care agencies go directly to worker compensation.³⁵ Finally, certain states, such as California,³⁶ have allocated Medicaid funding specifically to cover new minimum wage, overtime, and travel time requirements for direct care workers under the federal Fair Labor Standards Act.³⁷

In addition to wages and benefits, states can invest in training for direct care workers, ideally with coordination between the state's workforce development system and Medicaid program in order to maximize the benefits for direct care workers. For example, for more than 10 years, Nebraska has allotted Medicaid funding to entry-level certified nursing assistant training.³⁸ Wisconsin took similar action early in 2017, obtaining federal approval to invest \$2.3 million to train up to 3,000 nurse aides.³⁹

States also can allocate general fund dollars to finance entry-level training for direct care workers. For example, in 2013, the Wisconsin Department of Workforce Development used the newly enacted Fast Forward state training program in partnership with Wisconsin Technical Colleges to provide additional funds for direct care worker training and reduce training waitlists around the state.⁴⁰ States and local areas can also use federal funding through the Workforce Innovation and Opportunity Act (WIOA) training program.⁴¹ There is some concern that WIOA funding should not cover direct care occupations since they do not pay family-sustaining wages or provide opportunities for advancement. However, training programs that build certifiable skills, especially within a career pathway, provide a good opportunity to link worker competencies to wages, which is a step toward higher compensation (see next section).

Finally, some state policymakers are pushing for a new long-term care financing system. In 2017, Hawaii became the first state to create a public long-term care insurance program for people who do not qualify for Medicaid.⁴² Family

caregivers who also work full-time will receive up to \$70 per day to help cover the cost of long-term care, including hiring home care workers. Although Hawaii's long-term care insurance program does not specifically target direct care job quality, policymakers in other states may include investment in the direct care workforce—such as through higher wages or job quality standards—as a component of similar initiatives designed to expand access to long-term services and supports.

3) Recruitment, Training, and Career Advancement

Training and career advancement opportunities are important elements of a quality job. Research and experience show that direct care workers succeed when they can access high-quality entry-level training,⁴³ ongoing training to enhance their skills,⁴⁴ and specialized training that improves care and provides opportunities for advancement.⁴⁵ Strong training requirements and an effective training system are essential to realizing these benefits.

Entry-level training provides the base knowledge and skills a direct care worker needs to provide care, yet many states have insufficient requirements. Realizing the importance of training standards, Arizona⁴⁶ and Washington⁴⁷ (see “Spotlight: Washington State PCA Training Standards”) engaged stakeholders to strengthen training requirements for personal care aides. Through a ballot initiative in 2012, Washington created a new training system for personal care attendants that includes enhanced training content and new certification requirements. That same year, Arizona adopted new personal

Spotlight: Washington State PCA Training Standards

While Washington has had statewide training requirements for personal care aides since 1990, many leaders in the state agreed they were inadequate. A 2007 state law established the Long-Term Care Worker Training Workgroup to determine how to upgrade these training requirements. Based on the workgroup's findings, a successful 2012 ballot initiative implemented enhanced training requirements, including by increasing minimum required training hours to 75 and requiring that personal care attendants pass a certification exam. Once certified, personal care attendants may now complete abbreviated trainings to become a home health aide or certified nursing assistant.

Source: Stephen Campbell. 2017. [Training Standards for Personal Care Aides: Spotlight on Washington](#). Bronx, NY: PHI.

care attendant training standards through administrative changes to Medicaid.

Taking a different approach, the District of Columbia has created a uniform “core curriculum” for direct care workers, with additional training to become certified as a home health aide or certified nursing assistant. Switching from the home health aide to certified nursing assistant role only requires workers to complete 40 more hours of training rather than the full 120-hour certified nursing assistant certification program. This policy may help reduce attrition in the workforce by enabling direct care workers to move more easily between long-term care settings.

Policymakers can also implement improvements in the content and the number of hours required for ongoing training for direct care workers. Ongoing training, which primarily refers to in-service training provided to workers by their employers, can help direct care workers enhance their skills and prepare them to better support their clients—leading to higher job satisfaction for workers and improved care for consumers.⁴⁸ Federal requirements stipulate that certified nursing assistants and home health aides must receive a minimum of 12 hours of in-service training annually.^{49,50} Some states, such as Iowa⁵¹ and Illinois,⁵² have created additional in-service requirements for personal care attendants. Other states, such as Arkansas and California,⁵³ have enhanced requirements for direct care workers by requiring in-service trainings to address specific topics, such as dementia or communication skills.

Career advancement opportunities also enhance job quality for direct care workers by enabling workers to increase their skills and compensation. In contrast, a lack of advancement opportunities increases a worker’s intent to leave the profession.⁵⁴ (To note, requiring additional training without offering opportunities for advancement and increased wages can also cause workers to leave the profession.⁵⁵) Ahead of the curve, Indiana provides one example of a career pathway for direct care workers that was established in 1977: certified nursing assistants who complete additional training and pass a competency exam are able to administer medications and typically receive a higher wage.⁵⁶ Additionally, New York

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State passed a law in 2016 establishing an advanced home health aide occupation, which allows these aides to perform certain clinical tasks under supervision.⁵⁷ These models help ensure that consumers receive the care they need while providing direct care workers with an opportunity for advancement.

Some states are addressing the recruitment and training needs of the direct care workforce through other means. For example, Arkansas created the Division for Provider Services and Quality Assurance in 2017, which aims to develop a plan to create a pipeline of home care workers.⁵⁸ Similarly, New York recently established the Workforce Investment Program that will fund designated training centers to provide entry-level and advanced training to Medicaid-funded direct care workers.⁵⁹

4) Workforce Data Collection and Analysis

Ongoing data collection and analysis enable states to identify and describe the existing workforce and estimate future demand, which are critical steps toward designing appropriate solutions to the growing workforce shortage in long-term care. PHI, a national organization that specializes in the direct care workforce, has identified three key areas for direct care workforce data collection: workforce volume, workforce stability, and worker compensation.⁶⁰

Workforce volume includes “the number of full-time and part-time workers” and “the distribution of workers across settings and programs,” and

can be used to prioritize resource allocation. Workforce stability includes “turnover rates and vacancy rates,” and can be used to assess “whether investments in the workforce reduce turnover and improve retention.” Worker compensation, which can be used to assess whether direct care jobs are “competitively attractive with other occupations,” includes “average hourly wages, annual income, and benefits such as health insurance and paid time-off.” By collecting data in these three areas, state agencies can help inform policy reforms.

Current state-level efforts to build a strong direct care workforce data system are limited. States require licensed long-term care providers, including nursing homes and home care agencies, to report extensive data on their services, but this data does not often include workforce measures. One modest exception is Iowa, which requires the state’s Department of Human Services to issue an annual report on staff turnover in nursing homes to its governor and other legislators.⁶¹

Another possible data collection tool is a direct care worker registry. States use two types of registries: training or certification registries and matching services registries. Training or certification registries, such as those in Washington,⁶² Arizona,⁶³ and New York,⁶⁴ are used primarily by employers to verify that employees have met state training and certification requirements. Matching services registries gather information about workers and consumers who direct their own long-term care in order to “match,” or connect, the two parties. Twenty-three states have a matching services registry, 19 of which are statewide.⁶⁵ Information about workers typically includes certifications, availability, and preferences, among other areas. Some states use matching services registries to provide additional services; for example, Oregon’s registry connects workers to training opportunities.⁶⁶ Additionally, a new union-sponsored registry in Washington provides workers with the opportunity to list their full range of skills and trainings, which can potentially connect them to more work.⁶⁷

Although registries are not typically used for systematic data analysis and reporting, they represent a valuable opportunity to track the supply of workers in different areas of a state in order to identify regional workforce needs.

5) Stakeholder Engagement

States are also recognizing the importance of engaging stakeholders on issues related to the direct care workforce. Stakeholders can offer context for data collected by the state and help identify challenges in the field where data is limited or non-existent.

One form of stakeholder engagement is a legislative hearing. A February 2017 hearing in New York State invited stakeholders to testify about the challenges facing the home care workforce.⁶⁸ Stakeholders shared stories about how the workforce shortage has caused consumers to remain institutionalized rather than receiving care in their communities, and identified reasons behind the shortage, including low wages and inadequate workforce investment. Such testimonies can help raise awareness among legislators and fuel efforts to address these workforce challenges through legislative action.

In July 2016, Minnesota’s Department of Human Services took a different approach to stakeholder engagement by convening a “Direct Care/Support Workforce Summit.” Participants identified five key workforce goals that should inform future policy decisions: increase compensation, grow the worker pool, enhance training, improve job satisfaction, and increase public awareness.⁶⁹

Taking a third approach, some states have convened workgroups to focus on the direct care workforce, usually with the intent to develop policy recommendations. Over the past few years, workgroups to address direct care workforce challenges have been convened in New Mexico,⁷⁰ Iowa,⁷¹ Maine,⁷² California,⁷³ and Michigan.⁷⁴ Specifically, New Mexico’s workgroup issued recommendations in 2017 on how to implement the new minimum wage and overtime provisions of the federal Fair Labor Standards Act, and will issue additional recommendations in 2018 on how to stabilize the direct care workforce (See “Spotlight: New Mexico’s Direct Care Worker Task Force”).

These different approaches to stakeholder engagement can help identify direct care workforce challenges, develop possible solutions, and generate momentum that may lead to legislative or regulatory changes.

Spotlight: New Mexico's Direct Care Worker Task Force

In early 2017, the New Mexico State Legislature passed a law that established a task force on the direct care workforce. This task force was required to issue recommendations (released in October 2017) on the implementation of wage and overtime protections for home care workers under the federal Fair Labor Standards Act, as well as broader recommendations on stabilizing the direct care workforce (scheduled for release in October 2018). The task force includes a wide group of stakeholders, including government representatives, consumer advocates, workforce advocates, workforce development professionals, and long-term care providers. The first set of recommendations includes implementing the Fair Labor Standards Act in compliance with the Americans with Disabilities Act, establishing an ombudsman to address implementation challenges, and distributing written guidance to providers and consumers. The state legislature will now determine whether those recommendations will become law.

Source: Senate Joint Memorial 6 Task Force. 2017. "[Phase 1 Report: Recommendations on New Mexico Medicaid Programs Related to Fair Labor Standards Act "Home Care Rule" of 2015.](#)"

RECOMMENDATIONS

The Working Poor Families Project (WFPF) offers five recommendations for strengthening state investments that can improve the job quality of direct care workers. WFPF is mindful of the complexity of the direct care system, especially the federal-state Medicaid program, and the challenges of addressing job quality issues within such a system. As such, WFPF state partners are encouraged to develop a solid understanding of the needs and opportunities for change, to focus attention in specific areas that provide entry points for substantive discussions and actions, and to build sufficient knowledge to understand the nuances of the specific policies and procedures being addressed.

The following recommendations can ensure direct care workers have access to the compensation, training, career advancement opportunities, and other supports necessary to improve care and support in their communities. Although the challenges facing long-term care extend across the nation, particular factors affecting the direct care workforce vary from state to state. Therefore, these recommendations must be considered with attention to each state's unique needs and opportunities, taking into account state-specific demographic and workforce trends, the specifics of existing systems and policies, and budgetary constraints.

1. ***Strengthen and stabilize the direct care workforce through policies that improve wages, benefits, and workforce supports.***

Increasing wages and benefits helps direct care workers and their families make ends meet, reduces turnover, and stabilizes care for consumers. **State policymakers should increase Medicaid-funded wages and benefits for direct care workers through legislated wage floors or increased reimbursement rates earmarked for worker compensation. Policymakers should also guarantee that worker protections, including from harassment and discrimination, are legislatively mandated through laws such as the "Domestic Workers' Bill of Rights."**

Importantly, state policymakers should ensure that these increases in wages, benefits, and other worker protections are properly enforced.

2. ***Strengthen the financing systems for long-term care to ensure adequate investment in the direct care workforce.***

Because a state's financing system determines what long-term care providers can invest in their workers, increased funding can improve training, wages, benefits, and career advancement opportunities. **State policymakers should assess how Medicaid**

and other funding sources in their states can better invest in compensation, training, and career advancement for the direct care workforce.

3. *Advocate for innovative training and advancement programs that help recruit and retain direct care workers.*

Training and career advancement opportunities are critical aspects of job quality for direct care workers. Entry-level and ongoing training ensure that workers are prepared for their jobs, while career advancement opportunities help workers enhance their skills, deliver optimal care, and increase their compensation. **State policymakers should improve direct care worker training requirements in their states and create career advancement opportunities.**

4. *Establish consistent, systematic data collection on the direct care workforce to identify challenges facing the direct care workforce.*

Improving data collection will help states identify the workforce, determine trends, and project future demand. **State policymakers should create and implement long-term care workforce data systems that measure workforce volume, stability, and compensation.** To promote transparency, states should also regularly report these data.

5. *Create approaches to stakeholder engagement in order to identify and address challenges facing the entire long-term care system, including the direct care workforce.*

Stakeholders can provide context for data on long-term care services and the workforce, as well as generate strategies for investing in the direct care workforce. Importantly, stakeholders can also identify trends and challenges when there is a lack of data. **State policymakers should establish public engagement opportunities, such as workgroups and legislative hearings, where state residents, employers, and advocates can identify challenges and generate solutions.**

RECOMMENDATIONS

1. Increase wages, benefits, and other workforce protections for direct care workers.
2. Assess how funding sources can better invest in the direct care workforce.
3. Improve direct care worker training requirements and career advancement opportunities.
4. Establish data systems that track and identify direct care workforce challenges.
5. Create stakeholder engagement opportunities in order to provide context to data, identify direct care workforce challenges, and determine solutions.

CONCLUSION

Direct care workers are a critical part of long-term care in this country—and many states are taking steps to enact policy reforms that strengthen this workforce. Policies that increase wages and benefits, improve training, and create career advancement opportunities ensure that direct care workers can support their families as well as deliver better care. Additionally, a strong data system at the state level, coupled with opportunities to inform new policies through workgroups and hearings, will help states continually identify and address the needs of this sector.

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ENDNOTES

¹ Allison Cook is the New York Policy Manager at PHI. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care. The author would like to acknowledge the following individuals for their expertise and assistance in reviewing this paper: Kezia Scales, Stephen Campbell, and Robert Espinoza, PHI; Ceri Jenkins and Brandon Roberts, Working Poor Families Project; Abby Marquand, New York Alliance for Careers in Healthcare; Laura J. Dresser, COWS; Judy Berman, DC Appleseed Center for Law and Justice; and Christian Gonzalez-Rivera, New York Center for an Urban Future.

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