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# Supporting Those Who Support Our Elders

Understanding and Assisting the Direct Care Workforce  
in the Richmond Region

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## INTRODUCTION

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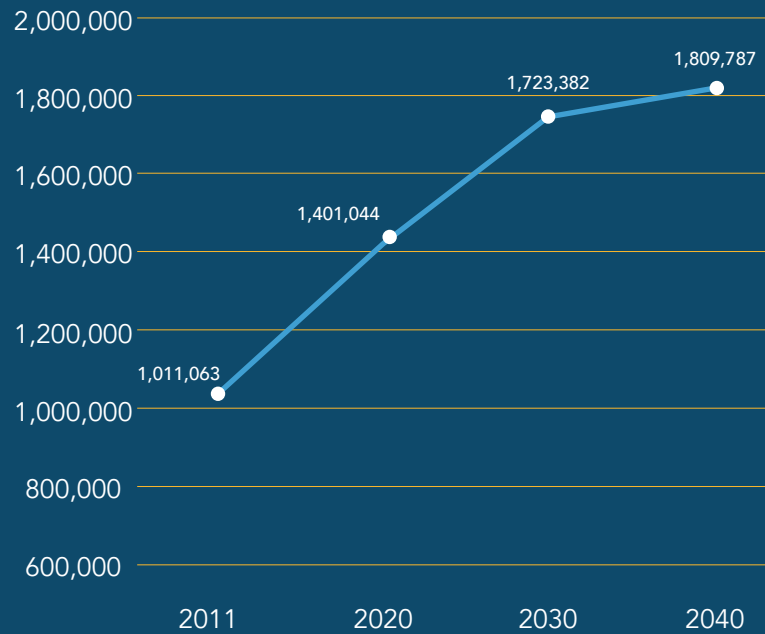
We are facing a crisis of care. As more of us live longer, the amount of care we need will continue to grow. But the number of caregivers is not keeping pace. Between 2018 and 2028 the Virginia home health and personal care workforce will have 94,900 projected job openings created by job growth and separations caused by workers moving into other occupations and leaving the labor force.<sup>1</sup>

Direct care workers—particularly home and personal care aides—are considered “the linchpin of the formal health care delivery system for older adults.”<sup>2</sup> Despite their importance to the system, their status and value remain low, frustrating efforts to recruit and retain new workers.

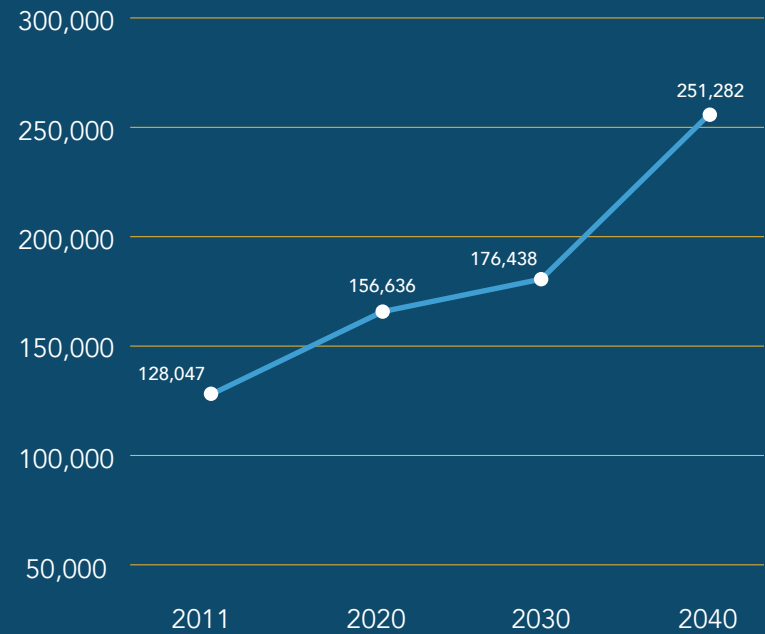
Today, the direct care workforce is composed primarily of low-paid women of color, many of them immigrants with low levels of education. Their limited resources put them at a disadvantage when it comes to advocating for better working conditions, making it easier for their needs to be ignored or dismissed.

Across the country, organizations, institutions and communities are seeking to address this challenge through programs, regulations and public policy. This report looks at the specifics of the direct care workforce challenge in Virginia and the current thinking around effective interventions.

**FIGURE 1. VIRGINIANS AGE 65 AND OLDER (ACTUAL AND PROJECTED)**



**FIGURE 2. VIRGINIANS AGE 85 AND OLDER (ACTUAL AND PROJECTED)**



Source for all data: The University of Virginia Weldon Cooper Center







## THE DEMOGRAPHIC BULGE AND ITS CONSEQUENCES

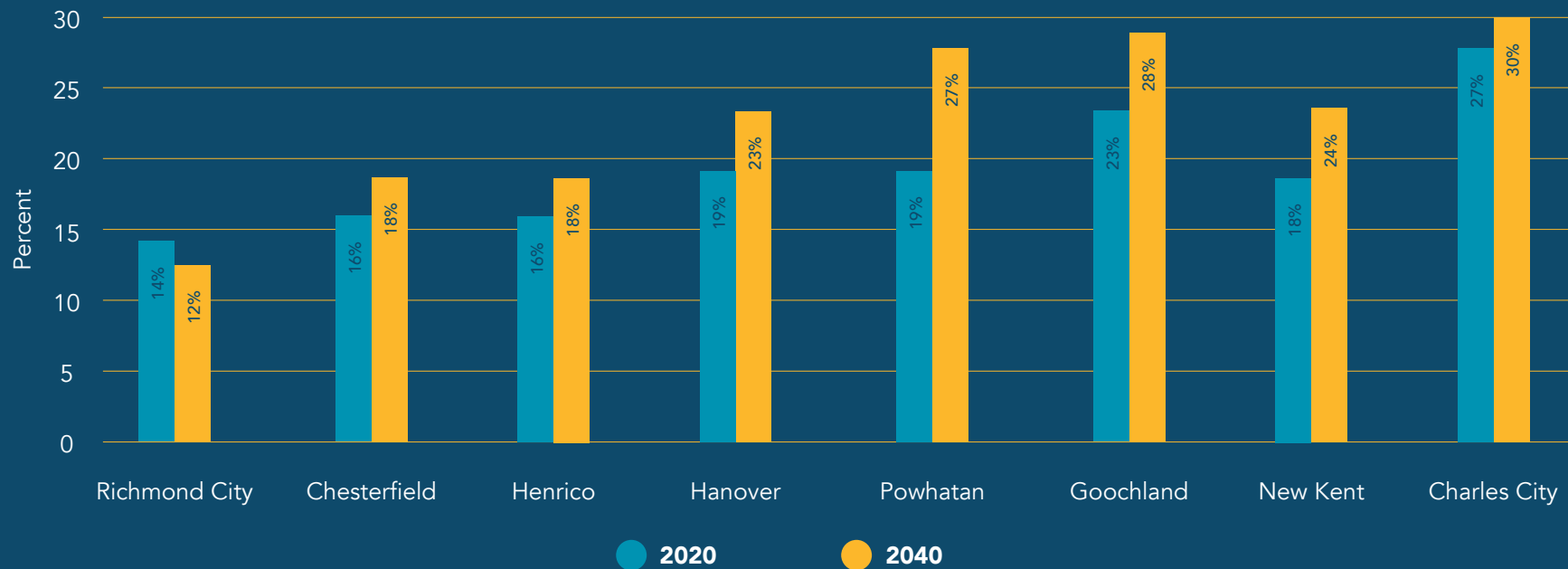
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Across Virginia, there are about 1.4 million older people (2020)—39% more than in 2011.<sup>3</sup> The share of Virginians who are age 65 and older has increased from 12% to 16% (2010-2020) and is expected to increase to 18% by 2030.<sup>4</sup>

The Richmond region has seen an even steeper growth in the number of seniors—over more than 50% in a decade; with another 30% increase expected by 2040. Here, too, elders have gone from comprising 12% of the population to 16%.<sup>5,6</sup>

While the City of Richmond, Chesterfield and Henrico Counties are home to the largest number of seniors in Planning District 15, their seniors comprise a smaller percentage of the total population than in other areas in the Planning District. Looking out over the next two decades, the share of seniors is expected to increase most in the outlying counties, while the number of seniors will remain highest in Chesterfield and Henrico counties.<sup>7</sup>

**FIGURE 3. SENIOR POPULATION, CURRENT AND PROJECTED  
(PERCENT OF POPULATION AGED 65 AND OVER)**



City/County	Senior Population 2020	Projected Senior Population 2040
Richmond City	32,809	30,649
Chesterfield	56,749	77,053
Henrico	54,871	71,976
Hanover	20,287	29,635

City/County	Senior Population 2020	Projected Senior Population 2040
Powhatan	5,858	9,770
Goochland	5,675	8,186
New Kent	4,355	7,586
Charles City	1,810	2,066

Source: The data are from the University of Virginia Weldon Cooper Center and VPAP, "The Graying of Virginia."



These demographic trends in Virginia are not dissimilar to national trends, and they trigger concerns that are common across communities.

Elders are living longer due, in large part, to improved health care as well as improved health behaviors (smoking cessation, for example). But this longer lifespan is not without need for increased support: 80% of those age 65 or older have at least one chronic condition; and nearly 70% have two or more.<sup>8</sup>

Those living longer increasingly require assistance to manage their chronic health conditions, as well as the financial and daily living challenges caused by their health status.

Most seniors who require assistance live in the community, (only 4.5% of older adults nationally live in nursing homes and another 2% live in assisted living facilities<sup>9</sup>) which means the assistance generally must come to them, either in the form of friends, neighbors and family, or paid help. The paid paraprofessionals— nurse aides, home health aides and personal care aides—are collectively referred to as “direct care workers” and are “the primary providers of paid hands-on care, supervision and emotional support for older adults in the United States.”<sup>10</sup>



But low hourly wages combined with a high rate of part-time work result in national median annual earnings for home care workers of \$19,100.<sup>11</sup> Nationally, home care workers are predominantly female (86%), people of color (63%) and immigrants (31%). Half of these workers have no more than a high school education.<sup>12</sup>



**The workforce shortage is not a new crisis. It's been decades in the making."**

For this workforce, low pay, limited benefits, high stress, physically demanding work (nursing assistants face one of the highest rates of injury, at 337 injuries per 10,000 workers<sup>13</sup>) and lack of professional training and career

development result in high turnover and make recruiting difficult.

While these challenges have been recognized for decades, they were brought to the fore during the recent COVID-19 pandemic, as demand for care escalated and fear of infection and lack of care for children no longer in school or daycare put many direct care workers on the sidelines. "The workforce shortage is not a new crisis. It's been decades in the making," said David Totaro, chief government affairs officer of the New Jersey-based Bayada Home Health Care, the nation's largest nonprofit provider. "However, from the beginning of the pandemic until now, Bayada has seen an unprecedented increase in the caregiver staffing shortage in New Jersey."<sup>14</sup>







## A WORD ABOUT VOLUNTARY CAREGIVERS

Without question, voluntary caregivers—family members, friends and neighbors—comprise the largest cohort of caregivers for elders. There are an estimated 43 million voluntary caregivers in the United States whose economic contribution through caregiving is valued at \$470 billion.<sup>15</sup>

While these workers are unpaid, and thus not addressed in this discussion of the elder care workforce, there are important overlaps. When voluntary caregivers need additional support or specialized assistance, they turn to the direct care workforce for help. And, most importantly, when these voluntary caregivers need much deserved respite from caregiving, direct care workers are called upon to fill in the gaps.



# THE DIRECT CARE WORKFORCE IN VIRGINIA AND THE NATION

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Direct care workers are those paraprofessionals who provide care—long-term or short-term—to people in homes, in nursing homes and in residential care facilities. They are frequently divided into three groups—nursing aides, home health aides and personal care aides. Only the former—nursing aides—typically provide services that must be reimbursed by Medicaid; reimbursement for the services of home health and personal care aides is generally at the discretion of the states. These two groups predominantly provide care in a home or community-based setting (adult day care, for example).

Direct care workers care for many types of patients, not just older people. They may care for a teen with disabilities, a young adult with traumatic brain injury, or a middle-aged parent with a chronic disease.

The data below references home care and personal care workers, regardless of the age of the patient that they serve.



## FIGURE 4. THE DIRECT CARE WORKFORCE IN VIRGINIA AND THE NATION

### HOW MANY HOME/PERSONAL CARE WORKERS?

	2011	2021	Percent Change
<b>Virginia</b>	34,990	55,150	+58%
<b>U.S.</b>	1,110,440	2,605,370	+135%

Between 2018-2028, Virginia is projected to need 16,770 new home health and personal care workers, the vast majority of them personal care aides. At the same time, it is estimated that 78,130 home health/personal care aides will leave their jobs, resulting in 94,900 total job openings in that 10-year period.

### WHAT DO THEY EARN?

In Virginia, median annual earnings for home/personal care workers are \$18,400 (2020). Low earnings reflect both a low hourly wage and the lack of full-time work. In Virginia, only 69% of home health/personal care aides work full-time, slightly higher than in the U.S. (63%)

	2011 Hourly Wage	2021 Hourly Wage	Change Adjusted for Inflation	Percent Change Adjusted for Inflation
<b>Virginia</b>	\$10.55	\$11.06	+ \$0.51	+5%
<b>U.S.</b>	\$11.43	\$14.09	+ \$2.67	+23%

### WHO ARE THESE WORKERS?

	Virginia	U.S.
<b>They are predominantly female</b>	88%	85%
<b>They are middle-aged (median age)</b>	47	48
<b>While most are U.S. citizens, a good number were born outside of the U.S. (Not U.S. born)</b>	19%	31%
<b>Few have more than a high school degree (Education: high school degree or less)</b>	52%	52%
<b>A minority are parents of young children – fewer than 30% in Virginia or the U.S. have children under age 18.</b>	28%	29%
<b>They are primarily people of color</b>		
White	36%	37%
Black or African American	50%	27%
Hispanic or Latino (any race)	5%	23%
Asian/Pacific Islander	7%	9%
Other	2%	5%

The direct care workforce is disproportionately composed of women of color. Many see this as the legacy of social structures that historically defined “care work” as “women’s work” and, moreover, as the work of those who face discrimination for race, ethnicity or other factors.

“The undervaluation of caregiving is rooted in a patriarchal system that expects women to be physiologically predisposed to be caregivers centered on the home. Historically, when women—especially Black and immigrant women—were permitted to work outside the home, they were often limited to domestic or caregiving roles, which were viewed as an extension of their natural abilities and kept them from competing with men,” reports the Asset Funders Network in its report “Why Care About Care?”<sup>16</sup>

“Because women’s wages were not believed to be essential to family economic security, caregiving and other professions with a high concentration of women were historically undervalued. This undervaluation persists, even though more than 55 percent of women are in the labor force working for pay, and 64 percent of mothers are considered the breadwinner or co-breadwinner for their families.”<sup>17</sup>



**The undervaluation of caregiving is rooted in a patriarchal system...”**





“The undervaluation of caregiving is also rooted in the system of brutal racial and ethnic discrimination that provided the foundation for the United States: chattel slavery. Black women served as domestic workers, forced to nurse and care for the children of White landowners and the landowners themselves. Once slavery formally ended, the system evolved to limit Black and immigrant women to working as caregivers and domestics and pay them as little as possible to do so while denying them basic workplace protections. While our labor laws have changed, the undervaluation, undercompensation, and underprotection of professions with high concentrations of women of color—like caregiving—persists today.”<sup>18</sup>



**The undervaluation of caregiving is also rooted in the system of brutal racial and ethnic discrimination that provided the foundation for the United States: chattel slavery.”**

Just as the recent pandemic heightened awareness of the critical importance of the direct care workforce, the simultaneous national reckoning on racial injustice sparked by the death of George Floyd and other tragedies forced attention on the gender and racial inequities of that workforce.<sup>19</sup>

“The persistent challenges associated with insufficient reimbursement rates under Medicaid, which make it impossible for employers to invest in the workforce [are combined with] the dogged and widespread gender and racial inequalities within and beyond long-term care, which threaten more marginalized workers and consumers,” notes Jodi Sturgeon, president of PHI, a national advocacy and research firm focused on direct care workers.<sup>20</sup>





## UNDERSTANDING THE MECHANICS OF HOME CARE WORKERS' PAY

In Virginia, the median hourly wage for home health and personal care aides is \$11.06.<sup>21</sup> That translates to an annual salary of \$23,005—assuming the employee works 40 hours per week—barely above the federal poverty level for a family of three in Virginia, which is \$21,960.<sup>22</sup> Between 2011 and 2021, the Virginia home

health/personal care worker's hourly wage increased a total of 51 cents, adjusted for inflation.<sup>23</sup>

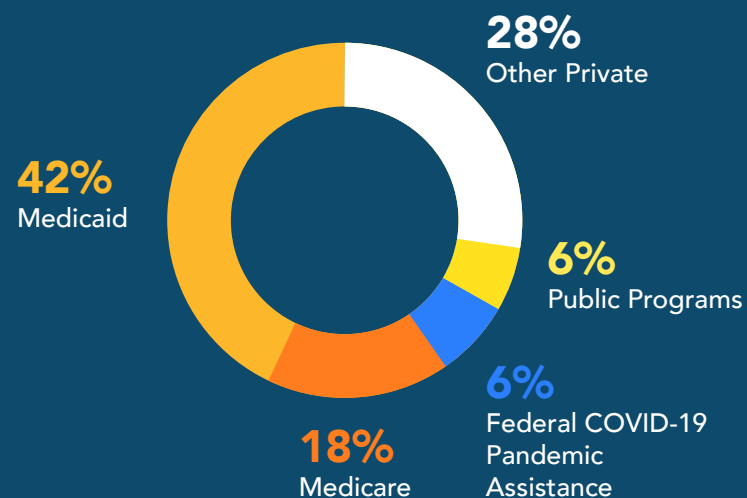
In most states, the key to increasing wages for direct care workers is increasing the Medicaid reimbursement rates for their services.



In the context of this discussion, direct care workers provide Long Term Supports and Services (LTSS) to seniors who have limited ability to perform the activities of daily living such as feeding, bathing or dressing themselves, or taking their medication and managing their health care.

Medicaid, the publicly financed health insurance program for low-income Americans of all ages, is the primary payer for LTSS. In 2022, Medicaid covered 42% of all LTSS expenses. Medicare, by contrast, covered just 18%. Federal COVID-19 Pandemic Assistance covered 6% and other public programs (such as the Veterans Health Administration) covered about 6%. (Only about 28% of LTSS costs are covered by private funds.)<sup>24</sup>

**FIGURE 5. WHO PAYS FOR LTSS?  
(2020 DATA)**





Whether the agency employing the direct care worker is a for-profit business or a nonprofit organization, it likely is highly dependent upon Medicaid reimbursement funds as a revenue stream. (Some sources estimate that as much as two-thirds of all home-care industry revenue comes from public programs.)

Medicaid, unlike Medicare, is a federal program that is administered by the states using federal and state funds. The federal government establishes some minimum services that states must cover but considers many other services “optional”—to be covered at the state’s discretion. States have discretion over which services to cover, and the reimbursement rates for those services.

In 2021, Virginia approved a temporary 12.5% increase in the Medicaid reimbursement rate for certain services, including home health services. The increase expired June 30, 2022. As of July 1, 2022, the rates for home health providers were increased to reflect a 5.4% inflation adjustment.<sup>25</sup>

In recent years, many states have adopted “wage pass through” measures, which require that providers use new or additional Medicaid payments to increase staff wages, rather than support other costs. Wage pass throughs were popular in some states during the pandemic, used as a tool to increase pay for front line workers during the crisis. But wage pass throughs are temporary, and observers are waiting to see what happens to wages when these measures expire.



## WHAT IS THE RIGHT LEVEL OF COMPENSATION?

The Economic Policy Institute examined the pay levels for home care workers and suggested what appropriate levels might be based on a variety of benchmarks.<sup>26</sup>

In EPI's analysis, the current average wage for home health care workers was \$13.81.

**Benchmark #1** – Pay workers the minimum wage = \$15 per hour.

**Benchmark #2** – Pay workers enough to support the worker and one young child in the lowest-cost metro area in the U.S. = \$21.11 per hour.

**Benchmark #3** – Adopt the European Union standard = \$21.85 per hour.<sup>27</sup>

LeadingAge<sup>28</sup> reported that raising the pay of direct care workers to the living wage in their respective state (\$20.28 for a two-adult household in Richmond<sup>29</sup>) would yield an impressive return: fewer staffing shortages, lower turnover, higher productivity, robust economic growth and financial well-being for the workers. Local economies would expand as direct care workers increased their spending and depended less on government assistance to make ends meet.<sup>30</sup>







## HOW INSTITUTIONS, ORGANIZATIONS AND COMMUNITIES HAVE RESPONDED

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For more than two decades, various organizations have grappled with the challenge of addressing the needs of the direct care workforce.

In 2006, the Robert Wood Johnson Foundation partnered with the Hitachi Foundation and the U.S. Department of Labor to invest \$15.8 million over five years in 17 sites nationwide with the goal of establishing work-based

learning opportunities for home care aides and other front-line, direct care health workers. While the target audience of Jobs To Careers was broader than just home care workers, the concerns then were similar to those today: a workforce that is primarily poorly-paid women of color and lacks the training and learning opportunities to advance and improve status.

Jobs To Careers, and other initiatives like it, employed strategies familiar to workforce development efforts:

- **Advanced Roles/Career Ladders** – Helping workers gain skills and move up to better jobs
- **Upskilling** – Helping workers add skills that may not lead to advancement but make them more valuable and marketable
- **Peer Coaching** – Connecting new or younger employees with more seasoned employees for mentoring, coaching and support
- **Soft Skills Coaching** – Preparing entry level, and pre-entry level workers for the workplace

Many of the programs have evaluations that show increases in retention rates, improved job satisfaction and advancement to better positions. In virtually all of these programs, there is evidence that the participants benefited—at the very least they learned more and were exposed to new ideas. And, it can be argued that as the participants learned more, their patients/clients likely benefitted as well.





But there is little to no evidence that these programs created systemic change for the direct care workforce—specifically that the workers as a group in community or beyond saw their value increase to the extent that employers/payers as a group were willing to pay them more. In fact, none of these programs addressed the issue of wages head-on. Attention was focused on activities, which may (or may not) lead to higher wages for some.

The pandemic, however, brought into high relief the concerns around the direct care workforce, particularly as it relates to elders. And that appears to have refreshed interest in strategies to move the workforce forward.

For stakeholders, funders and communities seeking to improve circumstances for direct care workers, the focus today is on the dual challenge: improve both job quality and job compensation. While low pay and thin benefits are deterrents, so are the lack of professionalism surrounding direct care work. By improving both pay and professionalism, stakeholders are better positioned to link the quality of direct care work with the cost efficiencies of the health care system, which is the ultimate prize in today's health care marketplace.



Still, there are significant structural challenges that make change in the direct care workforce difficult.

**Fragmentation and decentralization** – There are tens of thousands of direct-care establishments nationwide, and their number continues to grow. PHI estimates that more than 22,000 new home care establishments were formed between 2007-2017, and that most are small businesses, employing fewer than 50 people.<sup>31</sup> (A quick scan of the Richmond market identified more than a dozen for-profit care providers.) They are predominantly for-profit enterprises (76%), whose growth is being driven by franchising and private equity investment. This complex and diverse web of providers lacks any centralized organizing entity, making it difficult to implement change across organizations.

**Inconsistencies in regulation** – Each state has its own rules and procedures for licensure and certification of direct care workers. Virginia, for example, has among the most rigorous training requirements for nursing assistants among the states, while also having among the least rigorous requirements for home health aides.<sup>32</sup> (LeadingAge credited Virginia for creating a 40-hour

training program for home care aides in 2002, but noted that the training could not be applied to requirements for other direct-care occupations such as a home health aide or certified nursing assistant (CNA).<sup>33</sup> This variation makes national-level advocacy difficult.

**Underfunded and inadequate payment systems** – Medicaid, the primary payer for LTSS, is funded through general tax revenues, not universal payroll contributions, as is Medicare. So, Medicaid funding at the state level must compete with other funding needs (transportation and education, for example).<sup>34</sup> Private payers constitute a minority of the payment sources for LTSS; private insurance is expensive, and few individuals can afford to pay the costs for home or institutional care out of pocket.

**Weak quality measurement** – The quality measurement and management system in home care is underdeveloped. A 2016 study found 261 different quality measures for Home and Community-Based Services (HCBS) “reflecting a lack of consensus on the most important aspects of quality in the field.”<sup>35</sup> Weak quality measures make it difficult to link performance to patient outcomes and system effectiveness.



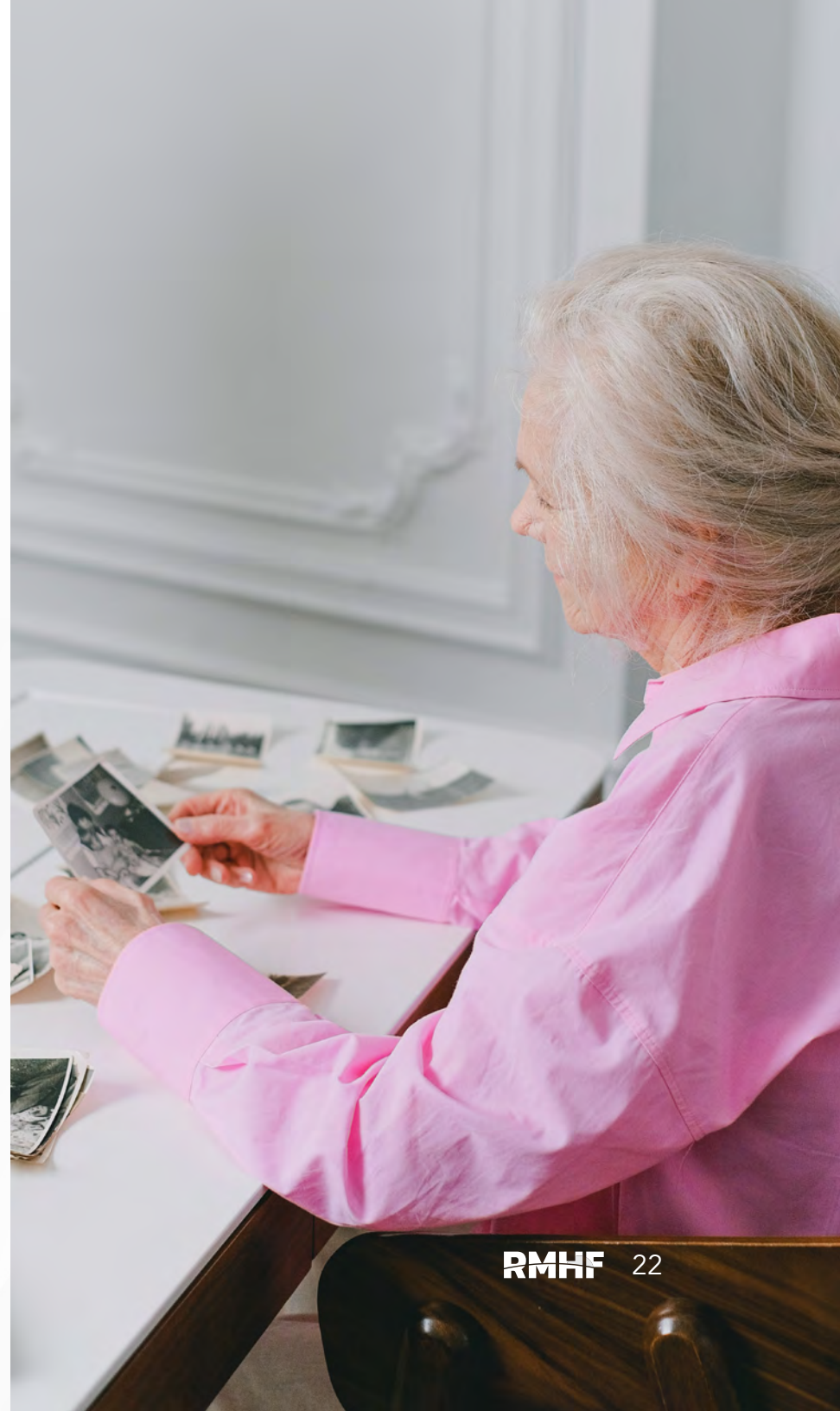
Given these challenges, advocates offer a host of recommendations. But among the thought leaders in the field, there are several recommendations held in common.

**Increase compensation for direct care workers** – While this recommendation is often tied with increasing the professionalism of the workforce, advocates note that it is important for workers to earn a living wage and to have financial security. These factors not only stabilize the worker, but stabilize the employers as well, deterring turnover and enhancing recruitment.<sup>36</sup>

**Enhance and strengthen training** – The field needs consistent identification of required competencies and standards for delivering training and monitoring for competencies.<sup>37</sup>

**Expand the caregiver pipeline** – Adopting recruiting strategies and addressing barriers such as immigration restrictions can attract needed workers to the field.<sup>38</sup>

**Reform long-term care financing** – Medicaid reimbursement, while an important immediate solution, is not a long-term solution. The time has come to seriously explore social insurance solutions. For example, Washington State is in the process of implementing its new state social insurance program that is funded through a small tax on the earnings of each working person<sup>39</sup>





## IMPLICATIONS FOR PHILANTHROPY

In 2021, Asset Funders Network and Economic Opportunity Funders, prompted by the effects of the pandemic, collaborated on a report on the “care economy.”



**Building a robust care infrastructure will support economic recovery, growth, and prosperity; racial and gender equity; and family economic well-being.”**

The report noted that, “Building a robust care infrastructure—a publicly funded system that recognizes care as both an individual and social responsibility, values and better compensates care workers, and supports family members to both care and provide financially for each other—will support economic recovery, growth, and prosperity and support racial and gender equity and family well-being.”<sup>40</sup>



Their suggestions for philanthropy, along with those of others, notably the National Governors Association, PHI and LeadingAge, include:

**Provide opportunities for people to come together** –

Whether across disciplines, across sectors or across enterprises, it is important to share experiences, learn from one another and build common understanding.

**Support research and data collection** – Having good local/regional data is important. Equally important is having a sophisticated understanding of the industry and systems, challenges and trends.

**Fund advocacy and public policy efforts** – Supporting the work of policy and advocacy is essential to fostering long-term change.

**Support “culture change strategies”** – These activities reinforce or follow policy change efforts, helping stakeholders and others embrace change.<sup>41</sup>

Local experts acknowledge that the key players often lack opportunities to come together and share information, enabling them to forge the bonds that can lead to effective advocacy and public education. And evidence suggests that knowledge and understanding of the specifics of Medicaid reimbursement, training and credentialing requirements and other state policies is uneven.

By bringing stakeholders together and providing them with a rich, accurate and consistent body of knowledge around the challenges facing the workforce and intervention/change opportunities, the community can build a strong voice that can speak with authority on behalf of and with direct care workers and press for the potentially difficult actions that are needed.





## WHAT OTHERS ARE DOING

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This section highlights a variety of efforts under way (and completed) in other communities to support the direct care workforce. Many are led by government or public funding

initiatives; others are led by private entities. While this list is far from all-inclusive, it reflects the current state of the industry and the ongoing work.



## COMMUNITY INITIATIVES

### **Baltimore Alliance for Careers In Healthcare**

Baltimore      Ongoing

The Baltimore Alliance for Careers In Healthcare (BACH) uses multiple approaches to maintain a robust pipeline of health care workers for the Baltimore community. The Alliance began in 2002 when representatives of the Baltimore Mayor's Office, Johns Hopkins Health System and philanthropic organizations decided to work together to tackle two challenges: meeting health care employers' needs for staff and creating employment opportunities for lower-skilled residents. Today BACH provides entry level jobs, apprenticeships, skills training, and fellowships for high school students. The initiative is supported by city and state government, a host of philanthropic partners, virtually every health care institution in the region, and numerous community-based organizations. Since 2005, 88% of enrollees completed training, and 73% of completers got jobs at an average at-hire wage of \$16.50 per hour.

### **Cooperative Home Care Associates**

New York      Ongoing

Based in New York City, Cooperative Home Care Associates (CHCA) is the largest worker-owned home care agency in the nation. Established in 1985, it began with a dual mission to provide quality care for patients and quality jobs for its employees in the Bronx. Today, CHCA employs 2,000 staff and provides free training for 600 low-income and unemployed women. It supports its employees with mentoring, training and other supports as well as full-time hours. CHCA employees are invited to purchase a stake in the company through a weekly payroll deduction of \$3.65, which entitles them to annual dividends, a vote on company leadership and the opportunity to run for a seat on the board.

In 1991, CHCA founded PHI, a nonprofit that provides training and advocates for direct care workers and is among the primary sources of research and data on the direct care workforce in America. PHI also works with other organizations, communities and programs, advising them on best strategies and research and data.



## STATE AND PUBLIC AGENCY INITIATIVES

### **Building Training...Building Quality**

Michigan 2011-2013

This program was among six demonstration projects authorized under the Affordable Care Act as part of the Personal and Home Care Aide State Training (PHCAST) program. It targeted personal care aides providing LTSS to older adults and people with disabilities, providing a 77-hour core curriculum training. Partners included the Michigan Office of Services to the Aging (grantee), Michigan State University College of Human Medicine (research and evaluation) and various regional area agencies on aging and similar entities (training delivery). While most of the program goals and evaluation were related to the process of developing and providing the training, the evaluation did note the following:

- The unemployment rate among participants dropped from 58% to 36% at 3 months post-training
- 13% of program graduates said BTBQ helped them get a job
- 38% said it helped them become a better PCA
- 10% said they had advanced to a better job because of BTBQ
- 77% said job satisfaction improved

### **Family Member CNA Program**

State of New Jersey 2021 - Ongoing

In June 2021, New Jersey established a program allowing a family member of an enrollee in Medicaid or NJ FamilyCare, or a third-party individual approved by the parent or guardian of that enrollee, to be certified as a CNA and, under the direction of a registered nurse, provide CNA services to the enrollee through a private duty nursing agency under the reimbursement rates established by the state. The family member or third-party individual must complete all relevant training, testing and other certification steps.

### **Improve Wages and Accountability [for] Home Care Workers**

State of Colorado 2019 – Ongoing

The State of Colorado-passed legislation implements a minimum wage of \$12.41 for direct care workers; calls for an 8.1% increase in federal government reimbursements for Medicaid services under HCBS (Home- and Community-Based Services) waivers, and sets up a process for reviewing and enforcing training for personal care services.



## STATE AND PUBLIC AGENCY INITIATIVES (CONTINUED)

### **Integrated Career Lattice Training Program**

*State of North Carolina*

*Ongoing*

This program also was among six demonstration projects authorized under the Affordable Care Act as part of the Personal and Home Care Aide State Training (PHCAST) program. The goal is to help personal and home care aides move more easily between care settings during their careers. The program establishes a four-phase training program:

- Phase 1: 16-hour module teaches basic job readiness skills and provides a realistic preview of a PHCA's job
- Phase 2: Direct Care Basics, a 60-hour training, covers the personal care tasks needed to work in home care or assisted living, and it also includes soft skill development component
- Phase 3: Nurse Aide I, 120-hour nurse-aide training program in an adult-learning design
- Phase 4: Home Care Nurse Aide Specialty, 100-hour training for home care nurse aides that includes clinical and soft skills

Students can begin training with Phase 1, 2 or 3. Three months post completion, 56.3% of participants had enrolled in additional trainings and 37.9% had applied, or planned to apply, for a new direct care job.

### **Kenosha Long Term Care Workforce Alliance**

*Kenosha County, Wisconsin*

*2019*

A county-level direct care work group, the Kenosha Long Term Care Workforce Alliance is a coalition of public and private organizations that helps "recruit, recognize, and retain [direct care workers]" in Kenosha County, Wisconsin. The Alliance focuses on raising awareness about direct care workers' contributions and developing local and state solutions to the direct care workforce shortage. Activities include quarterly member meetings, educational opportunities for members and direct care workers, an annual Caregiver Recognition Luncheon, and legislative advocacy.

## STATE AND PUBLIC AGENCY INITIATIVES (CONTINUED)

### **QUILTSS**

*State of Tennessee      Ongoing*

Tennessee's Quality Improvement in Long Term Services and Supports (QuILTSS) program establishes a value-based payment program in multiple areas, including HCBS. In addition, the state is redesigning its training infrastructure for direct care to create greater consistency, portability, and stack ability across direct care occupations. QuILTSS includes competency-based training with required competency demonstrations, as well as micro-credentials and mentorship to support trainees' progress. Credentials earned through the program are logged in a state registry to foster their portability across LTSS settings. The program also aims to give trainees opportunities to earn college credits and connect to career pathways. (According to PHI, efforts to introduce the value-based payment program in HCBS was stymied by severe workforce challenges. Providers could not improve workforce recruitment and retention to meet consumer satisfaction targets without some up-front assistance from the state. To address these challenges and enable home care providers to participate in value-based payment arrangements, the state has developed a new workforce training program, and has made direct grants to providers to improve data collection and strengthen recruitment and retention.)

### **Supportive Home Care Aides**

*State of Massachusetts      Ongoing*

Massachusetts created an advanced position—Supportive Home Care Aide—for aides who specialize in mental health or Alzheimer's disease. In addition to the 75 hours of required training for home health aides, Supportive Home Care Aides complete 12 hours of training on their specialty topic and 12 hours of in-service training per year. The aides receive weekly support training and in-services, attend team meetings and interdisciplinary case conferences, have weekly contact with supervisors, and supervision once every three months. The supervisors receive three hours of supervisory training to develop the complementary competencies.

### **Washington State Long-Term Care Trust**

*State of Washington      Ongoing*

In 2019, the State of Washington adopted the Long Term Supports and Services Trust Act, requiring all employees in Washington State to pay \$0.58 per \$100 of earnings into a state trust fund that will provide up to \$36,500 in LTSS during an eligible worker's lifetime. Employees began paying into the fund in January 2022 and benefits will be available beginning January 2025. The fund will support home or institutional care, care coordination, home improvements and caregiver respite.



## PRIVATE INITIATIVES AND PROGRAMS

### **CARE Fund (Care for All with Respect and Equity)**

New York      Ongoing

A coalition of major philanthropies including the Ford Foundation, Open Society Foundations, Robert Wood Johnson Foundation and W.K. Kellogg Foundation, the CARE Fund plans to invest \$50 million over five years “in movement building for a universal publicly supported care infrastructure that will fuel the economy, improve outcomes for kids, promote equity and enable people with disabilities and older adults to live independently with safety and dignity.” After making some rapid response grants in 2021, the Fund has not yet announced its 2022 grants.

### **Iowa CareGivers**

Iowa      Ongoing

Iowa CareGivers is a nonprofit that supports the earning capacity, educational opportunities and overall status of the state’s direct care workforce. In 2019, it distributed a Direct Care Worker Wage and Benefit survey to a sample of direct care workers, in partnership with the Iowa Workforce Development Agency. This survey was mailed to CNAs on the Iowa Direct Care Worker Registry and distributed to local public health agencies under contract with the Iowa Department of Public Health. Iowa CareGivers hosted a forum in partnership with the state and invited state government stakeholders, community colleges, consumers, direct care workers, employers and others to review findings from the survey and make recommendations regarding the direct care workforce.

### **“Man Enough To Care”**

National      Ongoing

Caring Cross Generations, a nonprofit working to transform the care economy, partnered with Wayfair Studios to produce “Man Enough to Care,” a six-part series highlighting male caregivers in the United States. Actor Justin Baldoni is featured in a series of videos where male caregivers share their stories and experiences. The series also features former NFL player Devon Still, actor Nathan Kress, comedian and writer Zach Anner, Robert Espinoza (advocate and expert on care), and Caring Across Generations co-director, Ai-jen Poo.

### **Mercy Care Workforce Development**

State of Arizona      Ongoing

In Arizona, managed long-term care plans must assist providers with direct care workforce development. Mercy Care, the nonprofit, Aetna-affiliated Medicaid health plan serving Arizona, committed to invest \$2 million from 2018 to 2022 to strengthen the workforce. Supported activities include a marketing campaign, free training for workers and an innovation fund that providers can access to launch recruitment and retention projects. Sarah Hauck, Workforce Development Administrator for Mercy Care, said Mercy Care implemented seven Workforce Training and Development pilot initiatives to support the creation of 6,000-10,000 new attendant worker positions in long-term care, as well as enhance recruitment, retention and training of contracted providers in their network.

## PRIVATE INITIATIVES AND PROGRAMS (CONTINUED)

### **Peer Mentor Home Health Aide Program**

Jewish Home Lifecare, Home Assistance Personnel Inc. (HAPI)  
New York      2008-2011      Private funding

At Jewish Home Lifecare, peer mentor home health aides mentored newly hired home health aides within the agency. This career path led to higher paying work that allowed for growth of the workforce for the identified growing care need and positively impacted HHA retention. Mentors received 14 hours of training to become peer mentors; the mentor-mentee relationships lasted up to one year with monthly interactions. Mentees worked an average of 40 hours a week, compared with 28 hours per week for non-mentees; the retention rate for mentees was 87% compared with 49% or 57% in years prior to the program.

### **SEIU 775 BENEFITS GROUP**

State of Washington      Ongoing

To help implement a 2007 Washington State law and 2012 ballot initiative designed to improve the training landscape for direct care workers, SEIU (Service Employees International Union) 775 Benefits Group (a labor-management partnership between the state and SEIU 775) leads a training program for the state's home care workers. This state-wide program includes both entry-level training and continuing education courses. According to SEIU 775 Benefits Group, this training program has provided more than six million hours of essential home care training since 2010. SEIU 775 Benefits Group also offers its members medical, prescription, vision, hearing, emotional wellness and dental plans, a secure retirement plan option for home care workers, and job matching services. SEIU 775 represents more than 45,000 long-term care workers in Washington and Montana. It is currently campaigning for a starting wage of \$20 per hour. (According to PHI, home health and personal care aides in Washington earned \$17.45 per hour in 2021.)

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