

Direct Care Workforce Policy and Action Guide

Courtney Roman (Center for Health Care Strategies [CHCS]), Clare Luz (IMPART Alliance/Michigan State University), Carrie Graham (CHCS), Nida Joseph (CHCS), and Kate McEvoy (Milbank Memorial Fund)

INTRODUCTION

The Direct Care Workforce Policy and Action Guide examines the challenges direct care workers (DCWs) face and outlines administrative, funding, policy, and regulatory levers that states can use to offer them better support. This Guide is designed to help states understand the complexity of the issues regarding the current direct care workforce shortage, and the role states can play in strengthening and improving this critical workforce. In particular, the Guide offers concrete examples of thoughtful and innovative ways states are working to overcome the challenges that have long plagued the workforce.

The Guide provides:

- An overview of the direct care workforce crisis and the challenges DCWs face;
- The levers state leaders have to strengthen the direct care workforce;
- The actions needed to make meaningful change across sectors;
- Examples of state innovations and strategies to better support the direct care workforce; and
- Steps states are taking to address the long-standing racial and economic disparities that have affected both the direct care workforce as a profession and DCWs themselves.



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TIPS FOR USING THIS GUIDE

Simply making one change to enhance opportunities for DCWs – for example, raising wages or requiring more training hours – is not enough. States should seek to build a statewide, coordinated plan that is tailored to the state’s needs and recognizes the many interrelated factors that contribute to the DCW shortage. A coordinated plan can increase economic security of DCWs, advance sociocultural change and equity, expand the pool of available workers, reduce turnover, and contribute to improved quality of care. When reading this Guide:

Identify opportunities that align with your state’s priorities, recognizing that not all strategies will apply to your state.

Note funding sources to strengthen the direct care workforce, including new opportunities to use American Rescue Plan Act (ARPA) funds.

Look for innovations that could be coupled with your state’s existing efforts to further bolster the workforce.

States understand the importance of meaningfully supporting DCWs but struggle to identify how to tackle the problem in a systematic, effective way. There is significant variance, for example, among states in availability of data on the direct care workforce, mechanisms for consistently engaging stakeholders, wage scales, and the use of collective bargaining. Thus, states vary widely in their levels of capacity and readiness for taking on this issue. This Guide is intentionally meant to meet states wherever they are on the continuum of readiness to strengthen DCW opportunities.

BACKGROUND

The Direct Care Workforce Crisis

DCWs provide care for individuals of all ages, but they most often support older adults and people with physical, cognitive, behavioral health, and intellectual/developmental

disabilities (I/DD). There are roughly 4.5 million DCWs across the United States, in home care, residential care homes, nursing facilities, and other settings such as hospitals.¹ But many more are needed to care for the increasing number of older adults and individuals with disabilities, the majority of whom wish to receive care in their own homes and communities.^{2,3,4}

The national annual turnover rate for all DCWs is estimated to be between 40 and 60 percent, with home care agencies reporting even higher rates, from 65 to 89 percent.^{5,6,7} The combination of increasing need, turnover, and lack of new workers will continue to add to the shortage with some calculations suggesting that the United States will experience a shortage of 151,000 DCWs by 2030 and 355,000 by 2040.⁸ The COVID-19 pandemic only exacerbated this issue with an estimated 420,000 DCWs leaving the nursing home workforce over the last two years.⁹

What Is a Direct Care Worker?

The term direct care workers (DCWs) refers to individuals who provide essential services through behavioral health, community mental health, and long-term care systems to support individuals with physical, cognitive, and intellectual/developmental disabilities and older adults in a range of long-term care settings including their own homes. The term includes, but is not limited to, certified nursing assistants, home health aides, hospice aides, personal care assistants, home care workers, direct support professionals, job coaches, personal care assistants, home care companions, and other workers who support people in self-directing their own care. (This Guide does not address workers who are caring for children.)

The majority of DCWs are paid through Medicaid, but their services may also be covered by private insurance, through Medicare, directly by their clients, or through other sources of funding. Most DCWs have a core set of responsibilities that generally include assisting with hands-on personal care, activities of daily living, instrumental activities of daily living, rehabilitation, and habilitation. DCWs may also engage in vocational assistance, skills development, community integration, crisis prevention and navigation, and other tasks that contribute to an individual’s highest possible level of independence and quality of life.

DCWs Leave the Workforce for Many Reasons

DCWs leave their positions for a variety of reasons. They may move on to jobs with fewer and/or more reliable hours and higher pay in other industries such as retail or fast food.¹⁰ If they choose to stay in health care, they may seek jobs in hospital settings, where they would likely receive both higher pay and some employer-based benefits.¹¹

Additionally, DCWs often feel unprepared for the work due to lack of training.¹² While there are federal training requirements for certified nursing assistants working in nursing homes, and some agencies, employers, and/or states may require a certain number of training hours, most DCWs do not receive the depth of training they feel they need to provide highly specialized care to individuals with complex needs. DCWs also frequently feel unsupported by their agencies and employers when those entities do not provide consistent information about care recipients' backgrounds, preferences and needs, scheduling, and evolving requirements around care.¹³

Finally, the COVID-19 pandemic exacerbated an already precarious situation as DCWs often lacked access to personal protective equipment (PPE), did not feel supported by their employers in infection prevention efforts, and, if they became infected, were pressured to either continue working while sick or take unpaid time off due to a lack of paid sick time.¹⁴ To the extent that these individuals were eligible for federal supports such as the Provider Relief Fund,¹⁵ those processes were hard to navigate and uptake by DCWs was poor. Furthermore, with closures of schools, daycare, and community services for older adults, many DCWs were forced to leave the workforce to provide needed childcare or eldercare at home.¹⁶ As more DCWs left their jobs, the remaining workers had to work longer hours or cover additional shifts, provide care for more residents/care recipients, and experience greater potential exposure to COVID infection.¹⁷

Challenges DCWs Face

Any effort to address the DCW shortage must address the challenges faced by this workforce, including:

Racism and discrimination. DCWs are mostly women, disproportionately women of color, and immigrants.^{18,19} The percentage of DCWs who are women of color increased from 45 to 53 percent between 2009 and 2019 – growing from 1.4 to 2.4 million workers.²⁰ Poor job quality for DCWs both reflects and perpetuates the long-standing societal disadvantages facing women, people of color, and other marginalized populations. For decades, certain government decisions (e.g., anti-immigrant policies, changes to Medicaid, and workforce protections not applying to direct care) have harmed the health and financial security of DCWs of color.²¹

Low wages. Regardless of their sector – but especially in home- and community-based services (HCBS) – DCW wages are extremely low. In 2020, the *median* hourly wage for the direct care workforce was \$13.56.²² Latina DCWs earn the lowest wages of any group of DCWs.²³ In 2019, median annual earnings for white DCWs was \$20,200, while Latina DCWs earned \$18,200.²⁴ It is important to note that these are *median* figures, and thus many DCWs earn significantly less than this.

Lack of benefits. The nature of the work leads DCWs to patch together multiple part-time jobs, working across settings, programs, and payors, both for agencies (home health agencies or nursing homes) and/or directly for consumer employers. When DCWs work part-time, they rarely qualify for employer-based health care or paid sick time, putting them at risk of significant financial hardship in the event of a serious illness or injury.²⁵ DCWs often live at or below the poverty line – 47 percent of DCWs qualify for publicly funded programs such as SNAP and Medicaid.²⁶ Others, however, have income just above the Medicaid eligibility limits and cannot afford the out-of-pocket expenses of exchange-based health insurance.²⁷ Exacerbating their financial struggle, 84 percent of DCWs do not have access to an employer-based retirement benefit.²⁸

Inadequate training. DCWs often perform tasks outside the scope of their limited training, since there are few federal or state training requirements for many categories of DCWs.^{29,30} Furthermore, few states require DCWs to participate in the continuing education that would increase their skill sets over time.³¹

Few opportunities for professional advancement. While most professions have a clear trajectory or career ladder, the direct care workforce does not. Most DCWs do not have official credentials or certifications and report that the experience and training they do earn or complete does not garner higher wages or follow them if they change jobs.³²

Lack of respect and value. The services that DCWs provide to individuals across the country are essential but are generally not valued by society.³³ There is a deeply rooted historical, sociocultural devaluation of domestic work in the United States, which directly relates to institutional sexism and racism, compounded by ageism and ableism.³⁴ For example, during the COVID-19 pandemic, all states immediately identified hospital workers as a priority for the distribution of PPE. However, that designation frequently failed to include DCWs in nursing homes or HCBS settings.³⁵

STATE LEADERSHIP IS ESSENTIAL

State leadership – including state legislators and government agencies from across all sectors working in partnership with DCWs – has a central role to play in strengthening the direct care workforce. The most powerful models of positive change are rooted in state leaders working together, finding common ground, and involving allies at all levels (e.g., DCWs, care recipients, advocacy groups, researchers, universities, and providers) to collaboratively identify mutually agreeable goals and strategies. Examples of state leadership-driven activities to support the direct care workforce include:

- In 2020, the **Michigan** Department of Health and Human Services (MDHHS) established a statewide DCW Advisory Committee with representation from leaders and stakeholders across all care settings, state-funded programs, and populations. Together, these cross-sector partners are working to address the state's DCW shortage and make policy, regulatory, and programmatic recommendations to MDHHS and Michigan legislators. Michigan formed workgroups to address professionalization, training and advocacy, adequate and equitable PPE distribution, and better communications across sectors and with DCWs.³⁶
- In 2018, **New Jersey** created a Caregivers Task Force to research the availability of caregiver support services in the state and provide recommendations for the improvement and expansion of such services. Members of the task force represent DCWs who provide care to individuals with a wide range of needs, including older Americans and those with mental illness, disabilities, chronic health conditions, cognitive or behavioral health challenges, or intellectual and developmental disabilities.³⁷
- Twenty governors mentioned plans to bolster the direct care workforce and tackle shortages in their 2022 State of the State addresses. **Iowa** announced a new apprenticeship program for high school students that would offer them the ability to become certified nursing assistants (CNAs) before graduating high school. Nine governors focused on strategies to retain the existing workforce – particularly individuals who are experiencing exhaustion from the COVID-19 pandemic. **Alabama, Colorado, Maine, New York,** and **Wisconsin** discussed plans to offer increased compensation through pay raises, higher Medicaid reimbursement rates, or bonuses. **Colorado** and **Illinois** mentioned plans to waive licensing fees for health care providers, such as DCWs, in their states.³⁸

The Role of State Leaders

State leaders have significant levers available to develop a coordinated approach to bolstering the direct care workforce, including:

- **Administrative** (e.g., oversight, regulation, and use of executive orders);
- **Funding** (e.g., Medicaid rate setting, use of state general funds, American Rescue Plan Act [ARPA] funds,³⁹ Coronavirus Aid, Relief, and Economic Security [CARES] Act funds,⁴⁰ other one-time federal funds); and
- **Legislative** (i.e., passing laws that value and protect DCWs).

State leaders are positioned to effect change in many key areas to strengthen the direct care workforce. For example, state leaders can:

- **Coordinate and align consistent efforts across sectors and geographies.** The DCW shortage does not exist in a single geographic area, program, setting, or sector. Implementing a piecemeal plan, within one region or sector, will not solve a statewide problem and may further exacerbate challenges. For instance, when wages are raised in one sector such as nursing homes, workers migrate to the higher paying jobs, leaving the lower-paying sectors even more depleted. Regional changes may also motivate DCWs to seek jobs across county lines. Fragmented actions promote more turnover and churn in the workforce. With a statewide coordinated strategy, these unintended consequences can be avoided. State leaders are in a unique position to effect change across all boundaries by directing and encouraging a coordinated strategy to address the DCW shortage.
- **Break down silos within state agencies and branches.** State leaders can break down silos and require coordinated work across state agencies (e.g., Medicaid, Aging Departments, Labor Departments) but also across branches of government (e.g., executive branch and legislators), thus allowing for greater accountability and more integrated activities. For example, executive branches can provide data and offer ideas and experience on potential policy levers, which the legislative branch can then use to enact policy. Both branches can contribute to oversight of performance and revision of strategies over time.
- **Influence and raise wages in standardized and meaningful ways.** Medicaid reimbursement rates, which vary widely across states, are a key driver for DCW wages. Some states may inhibit the ability for Medicaid-funded programs and agencies to increase DCW wages by placing ceilings on the maximum wage that can be paid.⁴¹ Additionally, some states limit workers' total weekly hours to avoid overtime costs.⁴² Efforts to raise Medicaid rates should be paired with activities to ensure that the increases go directly into workers' wages, as opposed to the administrative overhead of employers. ARPA funds offer a unique opportunity to increase wages. For example, 29 states are using ARPA funds to provide bonuses to DCWs specifically for recruitment and retention, and six states will offer higher wages for completing certain classes.⁴³
- **Establish and enhance training and competency requirements.** Because there are few federal training and competency requirements for most DCWs, most are determined at the state level. This leads to disparity in skills among DCWs and a significant amount of variety from one state to another. Without credentials associated with measures of competency and quality standards, the quality of care provided to older adults and persons with disabilities cannot be assured or measured. Thus, state leaders should look for opportunities to set standardized competency standards and then require competency-based trainings or testing at the state level.
- **Avoid unfunded mandates.** If states mandate wage enhancements or increased training for DCWs, a reliable funding stream should be available to adequately sustain such activities. This is especially relevant for providers who rely on Medicaid reimbursement since inadequate funding can make it challenging to support new Medicaid members. To avoid this scenario, state leaders can consider all available options to partially or fully fund wage increases or training and flexible ways to cover these costs. States should also explore opportunities to braid federal, state, and private funding. An example of this is using Medicaid, federal ARPA HCBS funding, and federal and state labor resources.

How States Are Using American Rescue Plan Act Dollars for DCWs

Passed in 2021, the American Rescue Plan Act (ARPA) allows states to use enhanced federal funding to support HCBS. States have proposed using funds for several initiatives intended to strengthen the DCW, including efforts to expand DCW registries ([Iowa](#)); support training and offer training grants ([Colorado](#) and [Wisconsin](#)); increase rates to raise compensation for DCWs ([Washington](#), Michigan, [Connecticut](#), and [New Jersey](#)); establish statewide recruitment campaigns ([Indiana](#)); offer internship and other class opportunities ([Massachusetts](#)); provide sign-on bonuses ([Minnesota](#)); and distribute specialized payments, including hazard pay, overtime pay, and shift differential pay ([Illinois](#)). (Ward, H., Ralls, M., Roman, C., and Crumley, D. Center for Health Care Strategies. "Strengthening the Direct Care Workforce: Scan of State Strategies." December 2021. Available at: <https://www.chcs.org/media/Strengthening-the-Direct-Care-Workforce-Scan-of-State-Strategies.pdf>)

- **Incentivize career pathways.** Providing paths to a professional career can command higher wages and respect, and also support both recruitment and retention. Research has shown doing so could stabilize the workforce, reduce costly turnover, and lead to better client outcomes.^{44,45} State leaders should promote career pathways (e.g., mandate high-quality, buildable trainings tied to wage increases, credentialing systems, education stipends, etc.) and reinforce that doing so will have a significant impact on drawing new DCWs to the field.⁴⁶
- **Improve cost and ownership transparency.** The onus is on the state to ensure that taxpayer dollars paid into the direct care system are used to pay for high-quality care, higher wages, and sufficient staffing for DCWs. State leaders can require increased accountability through cost reporting and other mechanisms, so taxpayer dollars are funneled directly into pathways that support the economic security of DCWs. California demonstrated its commitment to this issue by passing the [Corporate Transparency in Elder Care Act of 2021](#), which requires skilled nursing facilities to provide consolidated financial reports and documentation of the corporate structure to promote both financial and ownership transparency.

Additionally, the Biden-Harris Administration recently announced several efforts to improve [quality and transparency](#) in nursing homes. The reforms will ensure that poorly performing facilities are held accountable, that staffing levels are sufficient, and that the public has the best possible information about facilities so they can make informed decisions. Going forward, states will need to track these reforms as they will likely require specific changes to nursing home policies and procedures.

ACTION AREAS FOR STATES TO STRENGTHEN THE DIRECT CARE WORKFORCE

States can use the above levers in a variety of ways to strengthen and expand the direct care workforce. Below are four key Action Areas to guide states in organizing activities to use the above levers. For a comprehensive approach, we recommend that states choose at least one strategy from each of these four Action Areas:

1. Increase wages/benefits and non-wage benefits/supports;
2. Support professionalization of the workforce;
3. Elevate the social value of DCWs; and
4. Improve data collection, monitoring, and evaluation for the direct care workforce.

Each Action Area below describes proposed strategies, includes examples of state initiatives, and outlines how states can improve equity within the direct care workforce. (See the [Appendix](#) for examples of states that have implemented strategies within each action area.)

ACTION: Increase Wages/Benefits and Non-Wage Benefits/Supports for DCWs

Not surprisingly, solutions for better supporting DCWs usually focus on raising wages. While there are other important factors to consider, offering higher wages is an essential way to draw new workers to the profession, reduce turnover, and improve DCWs' economic security. Policymakers should note that funds used to augment DCWs' low wages could be offset since higher-paid employees could access affordable exchange-based or other health insurance and no longer rely on Medicaid coverage. A recent study in New York demonstrated that raising wages for DCWs (from approximately \$22,000 annually to \$40,000 in New York City, \$35,000 on Long Island and in Westchester County, and \$30,000 for the rest of the state) would significantly reduce Medicaid enrollment. Wage increases, health coverage, and payroll taxes would cost approximately \$4 billion for New York State annually; however, the combined value of new savings, tax revenues, and stronger economic impact due to increased compensation would result in a net gain of \$7.6 billion.⁴⁷ Other studies have shown that raising DCWs' pay by 15 percent in 2022 would cost \$9.4 billion, which reflects a small percentage of the \$366 billion that was spent in the direct care field in total in 2016.⁴⁸ States have several options for raising DCW wages:

- **Set minimum wage requirements.** Several states have set minimum wage requirements for DCWs who are funded through Medicaid, while others have set a minimum wage for entire sectors of the direct care workforce. The latter approach is more effective for ensuring all DCWs receive pay increases, regardless of setting, program, or payor.

EXAMPLES

- In April 2020, DCWs in **Michigan** received a \$2.00 wage increase in the wake of the COVID-19 pandemic, using CARES Act funding. In October 2021, the wage increase was included in Michigan’s state budget with a bump to \$2.35. While the wage increase currently only applies to the governor’s budget for fiscal year 2022, stakeholders and advocates in the state are looking for ways to help the state make the pay increase permanent, either through federal funds such as ARPA, by raising the reimbursement rate, or through other means.⁴⁹
- The **Colorado** Department of Health Care Policy and Finance is using federal COVID-19 recovery funds to raise the amount Medicaid pays for home-based care and requires agencies to use the increase to pay DCWs at least \$15 per hour. The increase will be effective through mid-April 2023, after which the General Assembly will decide whether to pass a permanent rate increase.⁵⁰
- In **New Jersey**, legislation established a minimum wage for nursing facility certified nurse aides that is \$3 higher than the statewide minimum wage (upon reaching \$15/hour in 2024, the statewide minimum wage will be indexed to the Consumer Price Index). In addition, since the minimum wage was increased in 2018, the governor’s budget proposals have included annual rate increases to support competitive wages for direct support professionals, personal care assistants, DCWs in nursing homes, and home health aides, as well as maternity care providers, private duty nurses, community-based mental health and substance use disorder providers, and homeless shelter staff.⁵¹
- **Use wage pass-throughs.** A wage pass-through enables an increase in reimbursement rates to be directly applied to increased compensation for DCWs.⁵² Some states⁵³ have implemented wage pass-through laws that allocate funds to nursing homes and/or home health agencies that must be passed to DCWs through increased compensation (wages or benefits).⁵⁴ Wage pass-throughs are commonly implemented in one of three ways:
 - o A specific dollar amount is added to wages and/or benefits;⁵⁵
 - o A percentage of a Medicaid reimbursement rate increase is added to wages/benefits; or
 - o A trust fund or assessment is used to increase wages/benefits.

To strengthen wage pass-through laws and ensure they are sustainable and applicable to all – including DCWs who work with older adults and individuals with disabilities who hire them directly – advocates suggest building wages for DCWs into Medicaid payment rates and creating a system for periodic audits to oversee the process.⁵⁶

EXAMPLES

- **Arizona** passed its wage pass-through law in 2017, in response to the passage of Proposition 206, a voter-passed law that raised the minimum wage from \$8.35 to \$12.00. The law was created with guidance issued by the Arizona Health Care Cost Containment System (Arizona Medicaid). Arizona’s law designates that a certain percentage of a reimbursement rate increase be used for wages, and it applies to all DCWs, both in facilities and in HCBS.⁵⁷
- In response to the COVID-19 pandemic, **New Jersey** increased state fiscal year 2021 Medicaid nursing facility rates by 10 percent and required that facilities use at least 60 percent of the new revenue to increase direct care staff wages, with the remainder used for infection control preparedness and response. This increase has been retained in subsequent budgets.⁵⁸
- **Leverage collective bargaining relationships.** While not all states will elect to go this route, some states have partnered with organized labor to establish bargaining rights for DCWs.

EXAMPLES

- In **Connecticut**, collective bargaining for personal care assistants (PCAs) was first authorized by gubernatorial executive order,⁵⁹ then implemented through an enabling statute. This action resulted in dramatic increases in wages, paid sick leave, dedicated training funds, and other benefits that are negotiated through a statewide PCA Workforce Council.⁶⁰
- In **Washington**, collective bargaining has allowed for increases in the DCW wage scale overall, leading to more equal and fair wages for all workers. Additionally, collective bargaining has allowed for the offering of a compensation package that includes health care, vision, and dental benefits; paid time off; and retirement savings.
- **Use managed care flexibilities to promote better wages and collaboration.** For states that administer Medicaid and long-term services and supports (LTSS) through managed care organizations (MCOs), state leaders can use contract language to expand and strengthen the direct care workforce. For example, managed care plans can be held accountable for increasing wages and benefits, achieving measurable goals for growing the direct care workforce, and improving the quality of services.⁶¹

EXAMPLES

- **Wisconsin** legislatively increased the amount of funds paid to MCOs that go toward DCW wages, bonuses, time off, and other benefits.⁶²
- **Arizona** requires MCOs to form internal Workforce Development Teams to work closely with providers and DCWs to identify challenges and develop solutions together.⁶³
- **Offer free or reduced-cost health insurance to DCWs.** Some states use federal and state subsidies to reduce costs of exchange-based health insurance coverage. For DCWs who cannot afford private health insurance but are ineligible for Medicaid, having access to exchange-based health insurance coverage is critical. States can look for opportunities to reduce out-of-pocket costs for DCWs who fall into this gap and ensure they have options to cover themselves and their families.

EXAMPLES

- **Massachusetts** offers [ConnectorCare Health Plans](#) through its state health insurance exchange that offers low premiums, no deductibles, and low out-of-pocket costs. The state has a 1115 waiver arrangement under which it claims its state investments for federal Medicaid match in order to offer these plans.
- In one **California** county, the [Medicaid managed care plan](#) offers health insurance to DCWs who provide at least 45 hours of care per month as In Home Support Service providers — a personal care assistance program offered to Medicaid beneficiaries with disabilities.
- **Implement direct care loss ratios.** Some states pass legislation requiring employers to use a certain percentage of their revenue on direct care, to prevent industries from putting it into profits.

EXAMPLE

- **New Jersey** passed a direct care loss ratio bill in 2020, and new Medicaid regulations now require that 90 percent of the Medicaid revenue received by a nursing facility during a fiscal year be expended on the care of residents. Nursing facilities are required to report total revenues collected, along with the amounts expended on staff wages, other staff wages, taxes, administrative costs, and investments in improvements to the facility's equipment and physical space.⁶⁴
- **Provide vouchers for safe and reliable childcare.** Accessing childcare can be challenging for DCWs as they work multiple shifts and hours change. The COVID-19 pandemic created an even more difficult situation with childcare facilities unpredictably closing for exposures. Some states have offered childcare vouchers or subsidies so DCWs are able to consistently access and afford safe and reliable childcare for their children.

EXAMPLES

- In response to statewide childcare facility closures amid the COVID-19 pandemic, **Massachusetts** leaders supported the direct care workforce by providing emergency childcare to those most in need. The state's **Exempt Emergency Child Care Program** offered free backup childcare for parents working in health care, human services, public health, public safety, and law enforcement.
- In response to COVID-19, **New Jersey** offered **Emergency Childcare Assistance to Essential Employees** (including DCWs) through May 2020, during which eligible essential employees were provided subsidies of up to \$450 per week to cover childcare costs. In addition, the state provided various grants and enhanced payments to childcare providers and implemented a temporary program to help families with school-aged children with unanticipated childcare costs due to remote learning.
- **Minnesota's** governor signed an executive order in March 2020 providing free childcare to "emergency workers," which included all DCWs, for all children under 12 years of age.⁶⁵

EQUITY CONSIDERATIONS

Wages and stipends can be structured to improve equity for direct care workers. DCWs are paid low wages and often live in poverty, so any increase in wages can help promote equity both within the direct care workforce and in comparison to other workforce sectors.

EXAMPLE

- In **California**, some agencies offer higher pay for DCWs who are bilingual and those who complete equity training.⁶⁶

ACTION: Support Professionalization of the Direct Care Workforce

In the United States' labor market, educational credentials are often a proxy for which workers are considered "professionals." DCWs are often thought of as "low-skilled" or "unskilled," despite the critical nature of the supports that they provide. For many years, stakeholders and advocates have urged states to help professionalize the direct care workforce as a strategy to meaningfully elevate the role of DCWs. This includes developing the hallmarks of any profession: competency standards, training and skills building, credentials, and career pathways that lead to higher wages and greater respect. In this section, we provide examples of how states are contributing to this effort.

It is important to note that when building training models – or applying or adapting existing models – states should be conscious of features that can either inhibit or facilitate progress. Trainings that are difficult to access, involve out-of-pocket costs, or are only offered in English will likely limit participation by DCWs. By contrast, training models that are affordable to DCWs and employers, offer wage increases or stipends upon completion, include core competencies, are portable and can build on prior training, are available both in-person and online and at a variety of times, and are multilingual are likely to promote uptake and success.

- **Design training and credentialing programs that promote "portability" and "stackability."** A known challenge for DCWs is that their experience and training is not transferable from position to position. This is often referred to as a lack of "portability." Additionally, DCWs may complete dozens of trainings over the course of their career, but they may not "stack" or build on to each other, leading to a higher-level job or role.⁶⁷ Establishing standardized training requirements that cut across programs and settings can offer DCWs flexibilities and help them expand their careers by pursuing opportunities for advancement across settings. Standardized and recognized training encourages current DCWs to stay in the field and may also attract others to join.

- **Use a “core competencies” approach to credentialing.** The term “core competencies” describes the foundational skills DCWs should possess to be successful and thrive in their positions. Examples of core competencies might include patient-centeredness, professionalism and ethics, communication, observation and evaluation, and crisis prevention and intervention.⁶⁸ Many core competencies are translatable from one type of setting or role to another – for example whether someone works in a nursing home, hospital, or home setting. Most states do not use competency-based credentials. Instead, they offer credentials that are siloed within one industry or setting. For example, DCWs in nursing homes have one kind of training/credential. If that worker wants to seek a position in a home care setting, they may have to start from scratch with a new training to obtain a different credential (even though many of the core competencies are similar). This constrains workers to one type of job and prevents portability across sectors. Designing credentialing approaches that use core competencies offers an opportunity for measurable quality standards for DCWs. When states use a competency-based credentialing system, it provides DCWs with a recognized, portable indicator of the breadth and depth of their knowledge, training, and expertise. It also gives employers and care recipients evidence of a DCW’s skill set and instills a measure of personal pride and public value. Ensuring that credentials are portable across care settings will enable capacity and flexibility, especially when systems are strained (e.g., during a pandemic).

EXAMPLES

- **Michigan’s** Professional Direct Care Workers Association developed a set of DCW competencies with the goal of having the competencies administratively adopted by the state.⁶⁹ The premise was that it is essential to start with competency guidelines, and that providers would be more invested in using competency-based training programs if they were endorsed at the state level. These competencies have been vetted and endorsed by the statewide Michigan Department of Health and Human Services DCW Advisory Committee and are now under review by state leadership.
- In 2012, **Arizona** enacted uniform training requirements that ensure a baseline level of skill and credentials for all PCAs, including family caregivers, across all Medicaid long-term care programs. Tiered training requirements align with a state-sponsored curricula and standards, entitled “Principles of Caregiving,” that were developed by a direct care workforce committee. The curriculum includes fundamental skills for all PCAs as well as two specialized training modules: one on caring for older adults and individuals with physical disabilities and one for working with individuals with I/DD.⁷⁰
- **Washington State** mandates that all long-term care workers providing personal care services to adults in the state (with the exception of parents taking care of their adult children or adult children caring for their parents) complete a 75-hour, competency-based training to achieve certification as a home care aide, along with 12 hours of continuing education annually. The mandate also includes independent providers – home care workers hired directly by consumers. Washington State designed its curriculum to be transferable across care settings, and it also includes the infrastructure needed to support stackability, meaning that trainees are able to leverage their existing training toward additional certifications, such as becoming a nursing assistant.⁷¹
- **Create industry incentives to establish advanced DCW roles and career pathways.** States have opportunities to help DCWs deepen and advance their careers. For example, states can offer incentives to providers and agencies to participate in additional training modules (e.g., medication management, patient-centeredness, behavioral health, bilingual competency, or dementia care) that can lead to certifications and increased wages. States can also facilitate career advancement to health specialties outside the DCW scope of work, such as serving as a medical technician, licensed practical nurse, or registered nurse.

EXAMPLES

- The **Alabama** Committee on Credentialing and Career Pathways created a career pathway mapping project that maps in-demand occupations to competencies and assigned credentials, and links them to career clusters and pathways. Direct care work is included because of its projected growth and its capacity to position individuals for higher-wage careers in health care.⁷² The state has also created Mobilizing Alabama Pathways – skills-based workforce training programs that offer short-term credentials that are then transferable to degree programs.⁷³
- **Tennessee** offers a Direct Support Professionals (DSP) Apprenticeship program⁷⁴ through a public-private partnership that includes the state, UnitedHealth Care Community Plan (a Medicaid MCO), and the Quality Improvement in Long Term Services and Supports Institute.⁷⁵ The DSP Apprenticeship Program is a work-based learning model that provides compensation for on-the-job training. Wages increase by \$3.50 or more per hour upon completion of the program, and trainees may earn up to 18 college credits and a post-secondary long-term care certificate.⁷⁶
- **Colorado** has created the My Colorado Journey database,⁷⁷ which offers DCWs an overview of salary scales, job openings, and growth rates of priority jobs, as well as potential pathways to positions with higher pay. The database uses state data to track credentials and an individual's program completion.⁷⁸
- The **Indiana** Governor's Health Workforce Council commissioned a study using state administrative data that examined career pathways for certified nursing assistants (CNAs). By linking social security numbers and state-issued licenses, the state was able to determine how many individuals who previously obtained an Indiana CNA license went on to receive licenses in practical nursing (LPN) or registered nursing (RN). By connecting demographic data to the administrative data, Indiana was then able to identify increased diversity and representation among those nurses (LPN and RN) that previously held a CNA license. This was the silver bullet that led to the development and implementation of a bridge program for CNAs within Indiana's community college network.⁷⁹
- In April 2022, the **Missouri** Department of Mental Health's, Division of Developmental Disabilities launched Missouri Talent Pathways, an apprenticeship program recently approved by the United States Department of Labor's Office of Apprenticeship. The program features a combination of technical instruction and on-the-job mentoring, culminating with participants receiving a Certified Direct Support Professional certificate. In addition to serving as a solution for developing a strong career pathway, the Missouri Talent Pathways apprenticeship also aims to increase competency in national best practices and statewide applicability and portability, improve cost and time efficiencies, and expand talent pipelines.⁸⁰
- **Provide stipends tied to training.** To encourage workers to participate in trainings and reward them for their participation, states can use funds (e.g., ARPA HCBS resources) to offer stipends tied to training. These funds can be used to (1) provide a cash stipend to workers who complete in-service or other trainings; (2) provide stipends to more experienced workers who provide training to new employees; and/or (3) provide stipends, paid time off, or other reimbursement (e.g., textbook funds) for employees who want to become licensed or credentialed at a higher level.



EXAMPLES

- **Rhode Island** College developed a 30-hour Behavioral Health Certificate Training program⁸¹ specifically for DCWs. With federal CARES Act funds, the state offered the training at no cost to DCWs, as well as providing participants with a stipend and a credential, upon completion, to add to their resumes. Up to \$100,000 was distributed by the state to

home health agencies, assisted living residences, adult day care centers, and/or consumer-directed programs to (1) offer each agency payroll supports of \$500 per employee to be paid as compensation to employees who successfully complete the behavioral health certificate training; and (2) provide each agency an additional 15.7 percent of the above payroll supports to cover associated payroll costs and other direct administrative expenses such as recruitment, funds distribution, and reporting of payments and outcomes related to the Behavioral Health Certificate Training program.

As a result of this work, the Rhode Island General Assembly enacted a Behavioral Health Rate Enhancement of \$0.39 per 15-minute unit of service for home care providers with at least 30 percent of their direct care staff (e.g., CNAs and homemakers) behavioral health-certified. The full rate increase must be passed through to behavioral health-certified staff (but is paid to the agency for all units of service, regardless of whether the service is provided by behavioral health-certified staff or not). The Behavioral Health Rate Enhancement is significant because it directly links training and rate increases to wage increases.⁸²

- **California's** Department of Aging has \$150 million from ARPA funds to provide [stipends linked to trainings](#) for direct care workers. The state is currently planning and shaping the program based on the input and recommendations from providers and DCWs.

EQUITY CONSIDERATIONS

An important means of promoting equity for DCWs is through training curricula. Please see examples below.

EXAMPLES

- In **Connecticut**, home health agencies receive an extra 1 percent in reimbursement rate if their staff participate in state classes focused on racial equity training.⁸³
- In **California**, the [Health Careers Pathway](#) (HCP) program focuses on training potential direct care workers who have “addressable barriers,” such as unstable housing, lack of transportation or childcare, etc. The HCP program provides DCW-related skills training, but also includes “soft skills” training including job interview tips, as well as housing placement support, childcare coaching, and assistance for trainees who are struggling with food insecurity. HCP trainers are coached to value and respect trainees and support their skills development. Having this mindset works to shift the view of the profession from the inside out.⁸⁴

ACTION: Elevate the Social Value of DCWs

Increasing the social value associated with being a DCW is critical to elevating this work and addressing workforce shortages and inequity. A concerted cultural shift is needed across the broader health care system and the public in general, so that DCWs are valued for the skilled work they perform as health care professionals. State leaders can do this in specific, concrete ways. In addition to the above economic and advancement supports (e.g., higher wages, training, and building a career pathway), the following are ways that states can help change the perception of DCWs.

- **Shift the public narrative.** States can launch public education campaigns focusing on the critical role of DCWs and the benefits of their work. Drawing on DCWs’ stories and lived experience can be a powerful influence on public opinion and policy.

EXAMPLES

- **Colorado** and **Arizona** are using significant portions of their ARPA funds to invest in public awareness campaigns. These are reframing the DCW position, raising awareness, and communicating the value of the work.⁸⁵
- The **Arizona** Department of Education has implemented 27 home health aide programs in public high schools throughout the state, through which graduating seniors receive training to become DCWs. Providing the

opportunity for young adults to learn about the direct care workforce at a young age and to understand the skills and competencies they will acquire to further their careers helps to shift public perception.⁸⁶

- The **Indiana** Family and Social Services Administration (FSSA) created a Direct Support Workforce Advisory Board, choosing 17 of more than 90 DCW applicants to represent a variety of settings, regions, backgrounds, education, experience, and populations served. Indiana’s DCW board meets once a quarter, but because FSSA is active in the development of its Indiana Direct Support Workforce Plan, the board members are currently meeting more often to contribute ideas and feedback.⁸⁷
- **Prioritize DCWs’ safety, well-being, and health.** State leaders can ensure that DCWs are identified as “essential workers” alongside their peers in hospital and other settings. This will help ensure their eligibility for PPE, sick leave, and paid time off that other health care professionals regularly receive.

EXAMPLES

- **Virginia’s** legislature passed a paid sick leave law at the height of the COVID-19 pandemic that covers DCWs who provide care to individuals who receive consumer-directed services under Medicaid. DCWs who qualify for the benefit may take up to 40 hours of paid sick leave during a calendar year.⁸⁸
- **Michigan’s** DCW Advisory Committee, led by the Michigan Department of Health and Human Services, prioritized DCWs’ need for PPE at the height of the COVID-19 pandemic and created a PPE working group to address these needs. This work elevated DCWs’ level of priority on the state’s priority distribution list.⁸⁹
- **Connecticut’s** Medicaid agency partnered with the Office of the Governor, the National Guard, and a private disability-focused organization to create a system for home delivery of PPE to households self-directing services under Community First Choice. This provided PPE to both employers and their personal care assistants.⁹⁰
- **Invest in new models of care that promote culture change.** Models such as the **Eden Alternative**, **Green House**, or **Small Home** promote “culture change” rooted in the principles of person-centered care. The Eden Alternative places emphasis on treating staff with respect and empowering them to be part of system design, the care team, and decision-making. This model has demonstrated lower staff turnover rates and better care outcomes than traditional nursing home settings.^{91,92} Green House or Small Home nursing homes are also designed to be homelike settings with single rooms, private bathrooms, and kitchen and living space.⁹³ In these models, trained nursing aides (or universal care workers) are empowered with more authority on the care team and provide care dedicated to one cluster or community of about 10-12 residents.⁹⁴ The universal care workers have an expanded scope where they provide personal care to residents, but they also cook with residents, provide light housekeeping, and lead activities with residents as part of a “whole person care” approach. Likely because of this culture shift, research on Green House models has demonstrated greater staff satisfaction and lower rates of staff turnover.⁹⁵ In order to promote these models, state leaders may need to revise building codes, providing up-front capital and additional funding for such needs as single-room occupancy, and invest in the cost of renovations to physical plants.

EXAMPLES

- A 2016 study suggested that residents of Green House models in **Alabama, Arkansas, Kansas, Massachusetts, Michigan, Montana, Nebraska, New York, Pennsylvania, Tennessee,** and **Texas** had lower hospital admission rates and better quality of care, and the models were associated with lower direct care staff turnover.⁹⁶
- A January 2021 study showed that non-traditional small size nursing homes in **Alabama, Arkansas, Colorado, Florida, Illinois, Kansas, Kentucky, Michigan, Minnesota, Missouri, Mississippi, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Wisconsin,** and **Wyoming** had lower rates of COVID-19 infections and deaths.⁹⁷
- **Ensure that DCWs are not forced to work in understaffed environments.** DCWs are often forced to work in environments that are severely understaffed, which is tied to poor quality of care for nursing home residents.⁹⁸ The COVID-19 pandemic exacerbated this issue across all care settings, with providers turning clients away in extreme situations.⁹⁹ Understaffing is dangerous and dehumanizing for DCWs who are forced to take care of too many patients and can be a source of turnover. This has been particularly problematic in nursing homes. In 2001, the Centers for Medicare & Medicaid Services

(CMS) found a clear association between nurse staffing ratios and nursing home quality of care, and endorsed the following minimum staffing standard: 0.75 RN hours per resident day, 0.55 licensed vocational nurse/licensed practical nurse hours per resident day, and 2.8 to 3.0 certified nursing assistant hours per resident day, for a total of 4.1 nursing hours per resident day to prevent harm and jeopardy for long-stay residents.¹⁰⁰ These standards have since been affirmed by other studies¹⁰¹ and have also been endorsed by professional associations and experts.¹⁰²

However, federal law does not currently articulate a specific staffing standard, and CMS does not enforce one.

Acknowledging this, the Biden-Harris Administration recently signaled that it plans to establish a national minimum staffing sufficiency standard.¹⁰³ Pending finalization of that effort, states should consider establishing minimum staffing levels and ratios in support of high standards of care.

EXAMPLE

- **New Jersey** passed a law establishing minimum staff-to-resident ratios in nursing homes in July 2020. The legislation states that there must be one CNA for every eight residents on the day shift, one CNA for every 10 residents on the evening shift, and one CNA for every 16 residents on the night shift.¹⁰⁴
- **Tie rate increases to quality measures, including adequate staffing.** States that increase Medicaid reimbursement rates for providers of direct care have opportunities to link such increases to quality and staffing standards.

EXAMPLE

- In response to legislation, **New Jersey** is currently reviewing Medicaid nursing facility rates, with a particular focus on quality incentives and resident acuity. The study may recommend that increases for nursing facilities be tied to improvements in specific quality and safety metrics. In addition, the state's fiscal year 2023 budget proposal enhances the standards that nursing facilities must meet to earn additional Medicaid payments under the Quality Incentive Payment Program implemented in 2020.¹⁰⁵
- **Offer stipends and bonuses to DCWs.** Some states have begun to provide one-time or recurring cash stipends to DCWs. While one-time payments are not as impactful as permanent wage increases, they signal to a DCW that they are valued by the state and have the potential to improve morale.

EXAMPLES

- **California** provided \$500 to all DCWs during the first year of the COVID-19 pandemic. Later, this policy was embedded in its ARPA spending plan, which provides additional "Care Economy" payments to all DCWs. California also provided hotel room reimbursement for DCWs who wished to protect their families because they were supporting care recipients who had tested positive for COVID.¹⁰⁶
- **Massachusetts** Medicaid provided signing bonuses to residential care facility staff (CNAs, nurses, social workers, and therapists/assistants) who worked 64 hours (at least \$500 bonus) or 128 hours (at least \$1,000 bonus) in the first 15 to 30 days of their employment.^{107,108}
- **North Carolina's** 2022-2023 state budget includes funds to provide one-time bonuses to home- and community-based DCWs who provide care to Medicaid and NC Health Choice beneficiaries. The bonuses will be provided to DCWs working in home- and community-based care settings, intermediate care facilities for individuals with I/DD, nursing homes, assisted living facilities, and all waiver programs. The budget also includes a provision for a wage increase for DCWs working with Medicaid beneficiaries.¹⁰⁹
- **Guarantee sufficient hours or full-time equivalent.** States can explore strategies for ensuring the DCWs have a choice of whether to work part- or full-time, that their hours are stable, that those working part-time have benefit options, and that overtime hours are compensated appropriately. Employers' long-standing reliance on part-time labor has had a significant impact in creating and sustaining the country's labor shortage,¹¹⁰ which includes the direct care workforce.

Many employers continue to offer part-time work to keep labor costs down and avoid paying insurance benefits, despite the fact that DCWs may work several jobs to make ends meet or leave their jobs entirely due to insufficient hours. States can consider mandates that provide full-time and/or guaranteed hours and salaries.

EXAMPLE

- In **Ohio**, Disability Rights Ohio and 10 other groups submitted comments objecting to the state's requirement for a 40-hour-per-week "hard cap" on self-directed workers' hours. Advocacy efforts ultimately helped increase the requirement for self-directed workers to up to 60 hours per week (e.g., 40 regular hours and 20 hours overtime pay).¹¹¹

Equity Considerations

EXAMPLES:

- Advocates in **Pennsylvania** have recommended increasing nursing home staffing ratios to the 4.1 nursing hours per resident day to address the fact that nursing homes with mostly Black or Latinx residents tend to be understaffed, leading to poorer outcomes.¹¹²
- In **California**, an adult day center offers all DCW staff a monthly stipend of \$400 that can be applied toward health insurance, car insurance, or other personal needs. All DCWs receive the same amount regardless of their position or rank, ensuring a fair and equitable benefit for all.¹¹³
- Encuentro **New Mexico**¹¹⁴ offers care recipient- and DCW-focused training that is linguistically and culturally appropriate. To best support the majority female trainees, Encuentro provides free in-house childcare.¹¹⁵

ACTION: Improve Data Collection, Monitoring, and Evaluation for the Direct Care Workforce

States have a major role to play in collecting data, qualitative information on DCW experiences, and other details on their direct care workforces. Ongoing collection of this data can help states identify opportunities for improvement and help guide evidence-based interventions.

- **Track the data and factors involved in the direct care workforce shortage.** While most states understand anecdotally that they have an insufficient supply of direct care workers, tracking those numbers and making those figures public can help state leaders and stakeholders plan effectively for the future, support policy direction, and analyze improvement over time. Some of the biggest gaps in data for the direct care workforce are race, gender, sexual orientation and gender identity, immigration status, and income. By improving collection of these DCW data points, states will be better able to understand the demographics of their direct care workforce.

EXAMPLES

- **California's** Data Dashboard on Aging tracks the number of direct care workers by type and created a visualization that shows licensed workers per 1,000 older adults by county and where to focus their recruitment efforts.¹¹⁶
- The **Texas** Health and Human Services Commission (HHSC) recognized in a 2018 report that the state was unable to adequately measure the scope of direct care workforce challenges without improved data collection. HHSC added new questions about worker turnover, retention, and compensation to its existing provider surveys to help guide Medicaid policymaking and workforce planning in the state.¹¹⁷
- **Colorado's** Department of Health Care Policy (DHCP) convenes a Long-Term Direct Care Workforce Collaborative that is led by the lieutenant governor. Relatedly, DHCP created a shared data analyst position that coordinates activities between the state's higher education agency and its workforce board. The state also established a "data trust" that links several data sources together to enhance sharing.¹¹⁸

- Disparities in staffing and quality deficiencies can be monitored by government agencies using the quarterly Payroll-Based Journal reports that nursing homes are now required to submit to CMS and that are made publicly available on CMS’s website to [compare nursing homes](#)¹¹⁹ and other types of providers.
- **Evaluate existing DCW efforts.** While there are plenty of examples of innovations and strategies, more analysis and evidence are needed to substantiate what strategies are most effective. Many states are currently implementing DCW initiatives using ARPA and other funds, but it is unclear how many states are including evaluation and tracking of the outcomes of these initiatives.

EXAMPLES

- The **New York State** Office for the Aging engaged Cornell University and the City University of New York to examine the economic impact of increasing wages for DCWs on individuals and the community at large and reducing their reliance on public assistance programs, such as Medicaid and SNAP.¹²⁰
- The 2002 **Better Jobs, Better Care** initiative¹²¹ – a workforce demonstration that sought to improve recruitment and retention of direct care workers – required an evaluation of five workforce initiatives (located in Iowa, North Carolina, Oregon, Pennsylvania, and Vermont). These five projects selected provider organizations (including nursing facilities, assisted living facilities, home care agencies, and adult day service providers) to implement changes in management practices designed to improve direct care workers’ jobs. An evaluation analyzed the effects of the management practice interventions on direct care worker turnover, job satisfaction, and other measures of job quality.¹²² Results showed (1) DCW turnover rates were lower at sites that employed a retention specialist trained to systematically address low job satisfaction and turnover; and (2) DCWs who perceive their organization as culturally competent reported higher levels of job satisfaction.¹²³
- **Online data registries can enable employers to connect with potential new recruits and provide valuable data.** Registries can help employers in their efforts to recruit, but also have the added benefit of producing data that states can use to further understand the composition of their direct care workforce and identify gaps. Currently states are capable of tracking and recording the numbers of licensed or certified DCWs but have no way of tracking the “grey market” – individuals who perform direct care jobs but are not certified or licensed. Registries that encourage participation of all types of workers can be an important source of data for a state. Additionally, conducting listening sessions, online surveys, and/or focus groups with current (and former) DCWs can be a rich source of qualitative data about their experiences around recruitment, training, wages, benefits, registries, and work conditions. It is important to enlist trusted community partners and accommodate language and cultural preferences in these efforts.

EXAMPLES



- In 2017, **Massachusetts** passed a law requiring a public registry for home care workers in its State Home Care Program. The registry verifies the type of training received and credentials earned by these workers, allowing employers to make hires without duplicating training.¹²⁴
- **North Dakota** includes “unlicensed assistive persons” in its direct care workforce registry. These individuals are able to assist registered nurses under their direction.¹²⁵
- **Alaska** recently started using a database called “Connect to Care.” Employers can upload the positions they are trying to fill (including skills, hours, etc.) and workers can search and match with available positions.
- **Michigan** is creating a virtual site called the MI Care Career, modeled after [Care.com](#) with critical input from DCWs. DCWs, employers, and care recipients will be able to develop profiles and be “matched” based on care needs, skills, completed trainings, location, work hours, etc.¹²⁷

CONCLUSION

Strengthening the direct care workforce requires a thoughtful, comprehensive, and collaborative approach in states that includes all sectors working in partnership. Tackling only one issue at a time (e.g., wages, training, or hours) will not be effective or create a long-term, sustainable strategy of change. Instead, states should use their administrative, legislative, and funding levers to address all the Action Areas outlined in this Guide in parallel.

The increasing needs of older adults and people with disabilities who want to remain in their homes, coupled with the dire need to strengthen and expand the direct care workforce, has shown that ARPA funds could not have come at a more ideal time. For the first time in decades, ARPA funds offer states a unique opportunity to make significant investments in their direct care workforce and test and implement changes that had not previously been possible.

The real work is only just beginning, but states have the tools, resources, and momentum they need to move ahead and begin to strengthen the direct care workforce across the country.

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APPENDIX: DCW STRATEGY INDEX

ACTION STEP: Higher wages/benefits and non-wage benefits/supports for DCWs

	Sample Strategies	Implemented in
Stakeholder buy-in	Statewide coalition with stakeholder engagement across all sectors; include legislators	NM, NJ, PA
State-level leadership	Establish legislative care caucus	MI
	Legislation that supports DCWs	CO, IA, IN, MN, NJ, NV, WA
County/city/local-level leadership Many of these examples come from localized strategies for addressing the workforce crisis.	Millage bonds to pay for senior services	OH
	High-level and entry-level training	NY
	Establish a network of DCW centers	PA through Transitional Paths to Independent Living (PHI)
	Enforce labor laws	NYC Council passed law creating Labor Policy and Standards , a city office charged with enforcing local labor laws, and established Paid Care Division , a public advocate for home care workers
	Create a home care jobs innovation fund	NY
	Establish home care workgroup	In WI, Kenosha has a coalition of public and private organizations that work together to raise awareness, develop solutions, etc.
	Provide transportation services	Putnam County in NY, Homewatch Caregivers

Action Step: Professionalization of the Workforce

Wages	Increase minimum wage	AZ
	Wage pass-throughs	Multiple states
	Increase wages — premium/hazard pay	MI, AK
	Set wage requirements for publicly funded LTSS programs or designate funding for DCW wages	CO, NYC region, MA, MN, NJ
	Set a sector-specific minimum wage	NY, ME
	Tie reimbursement rates to quality standards — rewards high-road employers and allocates funds in an evidence-based manner	RI, TN, WY
	Offer one time recruitment/retention bonuses	WI
Training	Provide training	NJ, CA, ME, DE, CO
	Offer free training tuition or substantial training fund	NY
	Offer talent development grants to pay for training such as Advanced Home Care Aide Registered Apprenticeships	MI, WA
Competency and credentials	Set DCW competency and training standards	IA, AZ, WA, CA

	Create credentials for all trained DCWs	
	Allow advanced scope such as medication administration, with training	IN
	Establish training reciprocity across DCW settings and occupations and states	MI
<i>Benefits</i>	Incentivize employers to offer affordable health insurance	MT
	Provide paid leave	VA, RI, VT
<i>Online portal</i>	Establish a “matching” service registry for DCWs and care recipients/employers to connect	MN, WA

Action Step: Valuing Direct Care Workers

<i>Within provider agencies</i>	Statewide survey of DCWs	MN
	Hiring staff who are committed to lifting DCWs up and advancing the work	CA
<i>Within state agencies</i>	Stakeholder workgroups to talk about DCW issues	CA, NY
<i>Architecture</i>	Small Home SNFs/Green House model Eden Alternative model	
<i>Outreach</i>	Marketing and public awareness campaigns	AARP, CO

Action Step: Data Collection, Monitoring, and Evaluation

<i>Data Collection</i>	Collect data through cost reports from Medicaid-funded programs	NY
	Promote cost-transparency (e.g., consolidated cost reports)	CA
<i>Monitoring and Evaluation</i>	Conduct regular (longitudinal) data collection through state administered surveys to determine trends in turnover, vacancy rates, compensation, etc.	WI, MN, MI
	Analyze how much money would be saved for the state if DCW wages were raised (e.g., raising wages would then lead to DCWs being able to step away from public assistance programs)	MI, NY
	Require managed long-term care plans to implement interventions and measure impact	AZ
	Commission LTSS studies with workforce component	MI

ABOUT THE AUTHORS

Courtney Roman, MA, is a senior program officer at the Center for Health Care Strategies (CHCS), where she works on initiatives related to improving care delivery and financing for individuals who are dually eligible for Medicare and Medicaid and those in need of long-term services and supports. She leads a variety of CHCS projects, including Helping States Support Families Caring for an Aging America, a learning collaborative of states committed to improving family caregiving policies and programs; Family Engagement in Medicaid, a scan of state Medicaid agencies to identify best practices to meaningfully engage families of children with special health care needs as well as the broad child and youth population; and an environmental and economic scan of the direct care workforce in the state of Michigan.

Prior to joining CHCS, Ms. Roman was a patient and family engagement manager at the National Partnership for Women & Families, in Washington, DC. Her work included building a nationwide network of patients, family caregivers, and advocates that partnered with the Center for Outcomes Research and Evaluation at Yale University to shape health care quality outcomes measures and provide technical assistance to members of the network. She also provided technical assistance to patients, families, advocates, and providers involved in Affordable Care Act-related programs and demonstrations across the country to help them better collaborate to achieve quality improvement goals.

Ms. Roman has a master's degree in sociology from The American University and a bachelor's degree in sociology from the University of Delaware.

Clare Luz, PhD, an associate professor of family and community medicine at the Michigan State University College of Osteopathic Medicine, is a gerontologist with over 40 years in the aging field. Her community-based research focuses predominantly on the eldercare workforce shortage, particularly among direct care workers. In addition, she studies other aspects of quality of life for vulnerable older adults, long-term care health services, and the intersection of aging, health, and the arts.

She is the founding director of MSU AgeAlive, dedicated to elevating aging-related research, teaching, and outreach, in partnership with community, to promote well-being for all people of all ages and abilities. Dr. Luz is also the founding director of IMPART Alliance, an organization dedicated to helping Michigan build an infrastructure that expands and supports direct care workers through training and advocacy. She was the principal investigator for the Michigan Building Training...Building Quality™ (BTBQ™) six-state federal demonstration project, a comprehensive direct care worker (DCW) training program upon which IMPART Alliance curricula are based. She is also the co-chair of both the statewide Michigan Department of Health and Human Services DCW Advisory Committee and the statewide MI DCW Coalition of employers, DCWs, clients, and other stakeholders who are jointly generating innovative, feasible, affordable strategies to tackle the critical DCW shortage by improving DCWs' economic well-being. Dr. Luz has served on the Michigan Long-Term Supports and Services Advisory Commission, the Michigan Society of Gerontology board, and the National Quality Forum's Home and Community-Based Care Committee.

Carrie Graham, PhD, is the director of long-term services and supports at the Center for Health Care Strategies (CHCS). In this role, she oversees CHCS' portfolio of work to improve care delivery for older adults and people with disabilities who need long-term services and supports (LTSS).

Dr. Graham has been working in the field of aging research, health policy, and evaluation research for 20 years. Prior to CHCS, she was the principal investigator of several studies examining how different aspects of health reform in California have impacted health care and LTSS for seniors and people with disabilities. Most recently, she led a multi-institution evaluation of California's efforts to integrate care for dually eligible beneficiaries in managed care delivery systems. She was recently promoted to full professor at the University of California, San Francisco (UCSF) Institute for Health and Aging and holds a joint appointment at UC Berkeley in the School of Public Health.

In 2018, she spent the year in Washington, DC, as a health and aging policy fellow in the Health Subcommittee of the U.S. House of Representatives, Committee on Ways and Means. In this role, she worked on Medicare policy including prescription drug pricing, skilled nursing facilities, post-acute care, surprise billing, and LTSS. After returning to California in 2019, she was appointed as senior policy advisor to Governor Newsom's Master Plan for Aging.

Dr. Graham holds a doctorate in medical sociology from UCSF and a master's degree in gerontological studies from the Scripps Gerontology Center at Miami University. She obtained her bachelor's degree from University of California San Diego in sociology and African studies.

Nida Joseph, MPH, is a program associate at the Center for Health Care Strategies (CHCS). In this role she supports efforts related to integrating care for individuals dually eligible for Medicare and Medicaid and reforming long-term services and supports systems.

Prior to joining CHCS, Ms. Joseph worked as a contact tracer for New York City, where she played a fundamental role in controlling the spread of the COVID-19 virus by connecting newly diagnosed cases and contacts to appropriate resources and informing them about updated COVID-19 guidelines. She also previously worked with Centerlight Healthcare, a Program of All-Inclusive Care for the Elderly organization, where she acted as a liaison between all major departments within the plan and advocated on behalf of its participants to improve their care experience.

During her graduate studies, Ms. Joseph held an internship with Health CUNY, which is a university-wide initiative that seeks to improve student health and academic success. Here, she developed a resource guide for students facing hardships as a result of the COVID-19 pandemic, specifically regarding health care access and housing insecurity. She was also a part of a research team that was working to implement a university student health plan.

She holds a master's degree in public health from the City University of New York School of Public Health and Health Policy and a bachelor's degree in health sciences from Florida Atlantic University.

Kate McEvoy, JD, is a program officer for the Milbank Memorial Fund. In this capacity, she leads the Fund's state leadership programs and network and guides the Fund's healthy aging work. Ms. McEvoy was previously director of health services in the Connecticut Department of Social Services, where she oversaw care delivery and payment reform work in Medicaid, CHIP, and long-term services and supports.

She is a former president and vice president of the National Association of Medicaid Directors Board of Directors and served on the steering committee of the Reforming States Group, the predecessor to the Milbank State Leadership Network. She also contributed to state health reform initiatives as assistant comptroller for the State of Connecticut.

An elder law attorney by training, Ms. McEvoy spent her early career working for a regional Agency on Aging and as a legislative liaison for the Connecticut Association of Area Agencies on Aging. She is a past chair of the Elder Law Section of the Connecticut Bar Association, is the author of a treatise on elder law, and led several major coalition-based projects around advance directives. She has a JD from the University of Connecticut School of Law and a BA in English and economics from Oberlin College.

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Milbank Memorial Fund
645 Madison Avenue
New York, NY 10022
www.milbank.org