DIRECT CARE WORKFORCE RECRUITMENT AND RETENTION -- PROPOSALS TO ADDRESS THE DIRECT CARE WORKFORCE STAFFING CRISIS

The Problem

Across all sectors in Long-term Care (SNF, ICF/ID, ALF, Home Care, Home Support, Adult Day Health and providers of services to individuals with developmental disabilities) providers are facing staff shortages and are challenged to find new workers to replace those who are leaving. According to two surveys that the DC Coalition for Long-Term Care fielded last year, within the last 15 months,[1] over 50 percent of home health agency respondents did not have enough Home Health Aides to staff all clients on every shift. Across all sectors serving older adults and people with disabilities, the vast majority of employers were concerned or extremely concerned about meeting their future staffing needs. Some Home Health Agencies are not taking new referrals unless the client already has an aide. Other employers are struggling daily to fill positions.

Similar findings were evident in surveys conducted by both national (ANCOR, 2021 & National Core Indicators, 2020) and local organizations (DC Coalition of Disability Service Providers, 2019 & 2020) with respect to the workforce serving people with developmental disabilities. Over 43% of Direct Support Professionals left their positions in 2019 with one-third leaving in the first six months of employment (NCI, 2020).[2]

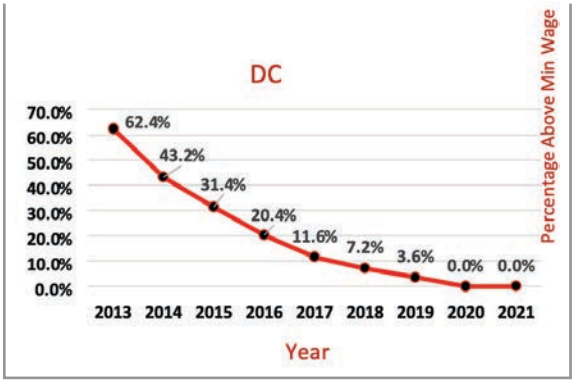
The COVID-19 pandemic drastically accelerated the shortage of direct support staff across all sectors. In February 2020, ANCOR conducted a survey of providers of community-based I/DD services to glean a deeper understanding of how they experience the human and financial impacts of the DSP workforce crisis. The results of that survey revealed that at alarming rates, providers were discontinuing services, turning away new referrals, delaying the launch of new programs, struggling to adhere to quality standards and more.

By nearly every count, providers find themselves in a significantly more precarious situation than in early 2020. Nationally, 58% of providers are discontinuing programs and services, indicating that they had to discontinue programs or service offerings due to insufficient staffing. This represents a 70.6% increase since the beginning of the pandemic. Without access to services, these vulnerable populations are at a higher risk of hospitalization and institutionalization at a time of limited capacity. Further, 92% of providers continue to grapple with the impact of the pandemic on recruitment and retention. We now have stark evidence to confirm the direct support workforce crisis has been made much, much worse by the COVID-19 pandemic.

And that crisis is growing. Today there are ~ 36,000 D.C. residents who have difficulty with self-care and/or with living independently. Of these, 19,500 are persons 18 to 64 who need temporary or permanent care, while 16,700 are 65 and over and unable to live independently without support. These numbers are projected to increase by 10% every five years. Without sufficient numbers of high quality, direct care staff, the District of Columbia cannot serve the needs of this growing population of older adults and people with disabilities. Family caregivers and our healthcare system, including acute care hospitals, will be overwhelmed.

According to the DC Health Sector Partnership's Annual Health Care Occupations Report, the highest-demand, highest growth entry level career health occupations are: Certified Nursing Assistant (CNA), followed by Certified Medical Assistant (CMA), Home Health Aide (HHA), Licensed Practical Nurse (LPN) and Pharmacy Technician (PT). The Partnership projects that 13,000 workers will be needed for these positions in the next five years. Yet, despite the high demand and the fact that the District receives millions in federal workforce development funds, education and training programs for these positions are resource-constrained and lack capacity to keep pace with the industry's workforce needs.[3]

The Pay Issue - A primary reason for the current crisis are the low wages paid to these essential health care workers. Certain Medicaid providers are required by law to pay direct care staff the District's living wage, and Department of Health Care Finance uses the District's Living Wage rate to calculate the rates paid to providers. Historically, there was a significant difference between the District's minimum wage and the Living Wage, which made direct care more attractive for workers. For example, in 2013, wage rates for Direct Support Professionals (DSP) were 162.4% of the 2013 Minimum Wage. By July 2020, with a $15/hour minimum wage, there was no longer any economic reason for a job seeker in this industry to choose to become a DSP. In 2021, the District's minimum wage and living wage were set at $15.20/hour.[4] As of July 1, 2022, both will increase to $16.10/hour.



DC Living Wage Funding Above DC Minimum Wage

Direct care work, however, is not a minimum wage job. It takes training and skill to care for vulnerable residents competently and compassionately. Unlike other minimum wage workers, CNAs and HHAs must take and pass a certification exam, complete annual continuing education credits and are subject to oversight by the Board of Nursing. Further, as noted below, these payment rates are no longer competitive when compared to other allied health positions and jobs that require less skill and involve far less responsibility. Overwhelmingly, providers state that the inability to provide comparable wages to the private market has decimated the workforce. Reimbursed in DC as a minimum wage position, providers have continuously competed for workers with entry-level industries offering less demanding work. Incumbent direct care workers are also leaving for these higher paying, less demanding positions.

According to the US. Bureau of Labor Statistics, within the DC metropolitan area in 2020, the mean salary of a CNA was $33,680; while the mean salary of an HHA was $29,290.[5] In the twelve months

ending May 2020, the hourly mean wage for Home Health Aides was $14.06. *On average, home health aides were paid less per hour than ticket takers, retail salespersons, childcare workers, maids and housekeeping cleaners, motel and hotel desk clerks, office cleaners and recreation workers. With an average wage of $16.19 per hour, nursing assistants fared slightly better but still received less pay than janitors, crossing guards, tellers, office clerks, school bus drivers and light truck drivers.* CNAs were also paid far less than other allied health workers including Pharmacy Technicians ($19.08/hour), Medical Assistants ($19.83/hour), Phlebotomists ($20.02/hour), and Community Health Workers ($26.12/hour). (See Table 1). Such rates are not competitive, particularly now, in today's job market where an entry level warehouse position at Amazon pays $19, Amazon drivers are paid $24/hour, dog walkers are paid over $18/hour and Bank of American just raised its minimum hourly wage to $21/hour. DC LTSS employers are not only competing with retail employers but with hospitals throughout the region that can pay considerably more (particularly for nurses) and with people who can afford to pay $25-$27/hour to private home care agencies serving the private pay market.

> My 78 year old mom has had major back surgery twice and suffers greatly with mobility. I was able to get her qualified for Home Health Aide Services, but finding an agency was challenging. I called over 15, in some cases with no response to messages left. One agency verbally accepted her case but never followed back up. We were eventually assigned to another agency. The Home Health Aide assigned was very vocal about the low pay, given her training. By her 3rd week, she quit. She said she had to have more money to take care of her family." – DC Resident

Table 1 – Comparison of Home Health Aide and Certified Nursing Assistant Mean and Average Wages to Other Health Sector and non-Health Sector Jobs in the DC Metro Area, for the 12-month period ending May, 2020.[6]

Area:Washington-Arlington-Alexandria, DC-VA-MD-WV,[7] May 2020				
Occupation (SOC Code)		**Annual mean wage (2)**	**Hourly median wage**	**Annual median wage (2)**
Community Health Workers (211094)	26.12	54330	23.93	49770
Light Truck Drivers (533033)	22.49	46790	21.00	43680
School Bus Monitors and Protective Service Workers, All Other (339098)	21.67	45080	19.02	39560
Office Clerks, General (439061)	20.88	43440	19.53	40590
File Clerks (434071)	20.24	42100	18.20	37860
Phlebotomists (319097)	20.02	41640	19.43	40410
Medical Assistants (319092)	19.83	41240	18.95	39420

Pharmacy Technicians (292052)	19.08	39690	18.40	38280
Counter and Rental Clerks (412021)	19.08	39690	18.17	37800
Tellers (433071)	18.02	37470	17.74	36890
Crossing Guards and Flaggers (339091)	16.51	34350	16.19	33680
Janitors and Cleaners, Except Maids and Housekeeping Cleaners (372011)	16.30	33900	15.40	32030
Baggage Porters and Bellhops (396011)	16.26	33820	14.89	30960
Nursing Assistants (311131)	**16.19**	**33680**	**15.46**	**32150**
Recreation Workers (399032)	15.97	33210	13.94	29000
Building Cleaning Workers, All Other (372019)	15.90	33060	14.95	31100
Hotel, Motel, and Resort Desk Clerks (434081)	15.55	32350	14.61	30380
Maids and Housekeeping Cleaners (372012)	15.44	32110	14.58	30330
Childcare Workers (399011)	15.33	31880	15.17	31540
Retail Salespersons (412031)	15.08	31360	13.71	28520
Ushers, Lobby Attendants, and Ticket Takers (393031)	14.10	29330	14.24	29620
Home Health and Personal Care Aides (311120)	**14.06**	**29240**	**14.40**	**29960**
(2)BLS calculates annual wages by multiplying the corresponding hourly wage by 2,080 hours.				
SOC code: Standard Occupational Classification code -- see http://www.bls.gov/soc/home.htm				
Date extracted on: Nov 04, 2021				

Low wages are also impacting the pipeline of new workers. As one health sector education provider recently shared, courses for jobs in the healthcare sector with higher wages such as medical assistant, patient care technician (a hospital-based job) and phlebotomist have waiting lists, while course offerings for CNAs are undersubscribed. Further, once employed, many newly hired workers leave for higher paying jobs in retail, banking and other sectors. Home health agencies and other providers share similar reports. High turnover rates are extremely costly to providers and negatively impact quality of care.

Another problem is that pay rates are not scaled to recognize additional years of experience or training. For example, in Maine, a CNA who has attained certification as a Certified Medication Aide is paid over $20/hour. Although the DC Board of Nursing created a new certification for Certified Medication Aides (MA-Cs) in 2019 (positions that employers and clients want),[8] DHCF has not factored higher pay rates for MA-Cs into reimbursement rates for Medicaid providers. Without higher reimbursement, there is no incentive for a CNA or HHA to take the additional 100 hours of training needed to become certified as a Medication Aide, and no schools are offering the training because they perceive no demand.

Investment in Workforce Development Lags - Low wage rates also are the primary reason for the lack of investment in promoting and developing this workforce. In conversations with training schools, UDC, WIC and OSSE, we have heard repeatedly concerns regarding investing in the direct care health care workforce because the wages are too low. DC is eligible to receive $10-$20 million in federal workforce investment dollars through the Good Jobs Challenge, a major federal initiative funded under the American Rescue Plan Act, but these dollars also likely will bypass this sector because to qualify, the targeted jobs must be "good jobs" defined as paying a wage that exceeds the local prevailing wage.

Lack of progressive wage rates that recognize different levels of skill and experience also make it difficult for employers to retain staff and are a serious impediment to establishing Apprenticeship programs that would qualify for federal workforce investment dollars. To be eligible for these dollars, an apprenticeship program must be registered through DOES. However, under Department of Labor and Department of Employment Services rules, one of the requirements for registration is being able to demonstrate a progressively increasing scale of wages commensurate with the skill levels acquired.

This cycle of underinvestment and disinvestment simply perpetuates a cycle of historic economic and racial disparities that predominately impact women of color and immigrants who have been systematically kept out of higher paying jobs. And it exacerbates health disparities because families with wealth are able to hire available aides away from publicly financed agencies and facilities by paying higher wages, leaving those who are dependent on Medicaid, or who make too much for Medicaid but not enough to pay high out-of-pocket costs, struggling to find sufficient support.

Proposals such as Recruitment and Retention Bonuses acknowledge difficult work conditions, but do not solve the staffing crisis. Providers across settings can testify that recruitment bonuses can exacerbate turnover and drive-up provider costs because new workers often leave after the bonuses are earned. While retention bonuses are appreciated and recognize

the hard work of staff, the promise of one or two bonus payments is not sufficient to keep direct care staff on the job when they can leave and earn significantly more at a job that is much less demanding and less stressful. As long as wages remain low, neither recruitment or retention payments will entice workers to this important work.

Using Medicaid Dollars to Raise Wages and Support Workforce Development in Long-Term Care is a Smart investment. – The District enjoys a Medicaid match rate of 70%. This means that for every dollar DC spends on a Medicaid reimbursable service, the Federal government reimburses the District 70 cents. In other words, the District bears only 30% of the cost of increasing wages for our workers. Increased wages support families and communities. Given the demand for jobs and opportunity for upward career mobility, further investments in the health care sector will help these workers and their families achieve economic stability and self-sufficiency.

Solutions

Members of the LTC Workforce subcommittee have been gathering information about best practices from other states. For example, Tennessee plans to use enhanced FMAP funding from ARPA to invest nearly $140 million in wage increases for direct care workers. This is on top of dedicating $60 million to additional workforce development initiatives. Tennessee's Office of Long-term Services and Supports has publicly stated their commitment to finding ways to source these wage increases when the federal dollars run out in March 2024.[9]

Building upon ARPA funding and leveraging state dollars, New Jersey just increased the Personal Care Assistant rate to $23/hour.[10] New Jersey also implemented a 10% Medicaid rate increase for nursing facilities and mandated that 60% of the money must be used towards increased CNA wages.[11]

Michigan implemented a wage pass through for workers including CNAs providing care in both long-term care facilities and in-home settings,[12] and Governor Whitmer has already publicly expressed interest in making this wage increase permanent.[13]

And in North Carolina, a Medicaid budget provision was just approved to implement HCBS direct care worker wage increases. Providers will need to distribute at least 80% of rate increases to increase wages.[14]

These are just a few examples of States that have acknowledged that wage increases are a necessary tool to recruit and retain direct care workers. We recognize that many of these strategies require the involvement of other agencies. For example, we need to work with the Board of Nursing to address regulatory barriers and develop competency-based standards for direct care staff to make it easier for workers to move between sectors.

We also need to work with the DC Council, the WIC, DOES and OSSE to increase capacity to train workers and to provide no-cost training to residents (and others) who are committed to working in DC. (Although public charter schools and UDC offer free tuition for DC residents, private schools can cost $1400 to $1600 for a CNA or HHA training program). And we need to work on regional solutions. But District payors such as DHCF, DDS and DACL must play a role as well. Indeed, we believe the role of these agencies, which are the primary payors for LTSS in DC, is critical.

Our Priority Asks:

Priority 1. The District of Columbia (including DHCF, DDS and DACL) must support increased pay for Direct Care Workers (CNAs, HHAs and DSPs) **by establishing a real livable and competitive hourly wage rate of $22/hour and use that rate to calculate and increase reimbursement rates for providers of long-term services and supports**. As with the current Living Wage law (D.C. Code §2-220 et seg.), these rates would be adjusted annually for inflation. Publicly funded employers would be required to pay direct care staff this new, higher minimum livable wage rate and pass through any annual adjustment to ensure that wages do not fall below the new minimum and remain competitive.

Rationale: According to the Massachusetts Institute of Technology, in 2020, the actual living wage that an individual in a DC household must earn to support him or herself is $20.49/hour – significantly higher than the District's upcoming living/minimum wage of $16.10. See: https://livingwage.mit.edu/counties/11001. According to BLS, the consumer price index (CPI) rose 7% from December 2020 to December 2021.[15] **Thus, applying this adjuster, a real living wage for a DC direct care worker (CNA, HHA, DSP) in 2021 should be $21.92/hour.** Raising the hourly minimum wage for DC Direct Care Workers to $22/hour in 2022 not only would have a meaningful impact on the ability of employers to recruit and retain staff, but it would also have a meaningful impact on the economic well-being of these workers and their families.

Priority 2. Recognize that provider costs associated with responding to COVID 19 are permanent and will not disappear once the PHE is over. Enhanced rates paid during COVID must continue.

Rationale: COVID 19 has established new standards and new protocols for safety and infection control for all health care providers. The costs associated with these (screening and testing of staff and visitors, pivoting to different modes of service delivery if a staff or client test positive, training, cleaning supplies and PPE, among others) are now required expenditures and must be factored into provider rates on a permanent basis.

Priority 3. Recognize and reward advanced training, skills and experience. Provide for progressive wage/salary increases based upon advanced education, training and tenure.

Rationale: A major challenge faced by providers is retention. Direct Care staff are leaving their jobs because they can get higher wages (with less training and skill) in other service sectors. We must provide for progressive wage/salary increases for CNAs, HHAs and DSPs that advance their education and attain higher level certifications such as dementia care specialist and the Medication Aide Certification (MA-C), or we will continue to see high rates attrition. Progressive wage/salary increases are also keys to building career pathways that allow these workers to attain economic stability and upward mobility for themselves and their families.

Priority 4. Pay adjusters for complex care (i.e., individuals with dementia) across all provider types. Currently, institutional providers (Hospitals, ICFs and SNFS) are paid based upon acuity levels and in SNFS, adjusters are available for vent patients and residents whose care needs require higher levels of staffing including behavioral health and bariatric cases. However, adjusters are not available in

HCBS settings. One critical area of need is in dementia care. Recognizing there is a growing need to address dementia care, and that dementia care requires higher levels of staffing, DHCF should provide for a rate adjuster for provider-types that have special expertise in and can offer high quality dementia care in an HCBS setting.

Priority 5. Support and pay for training. Recognize training (including internship stipends) as an allowable cost that can be factored into provider rate methodologies and reimbursement.

Priority 6. Factor in inflation to Provider Payment Rates. With respect to annual rate increases, utilize a readily recognizable and trusted index as the inflation adjuster and apply the adjustment annually to each Provider's entire rate.

Priority 7. Lower the Age at which District Residents can train and work as Direct Care Staff. Currently, the Health Occupations Regulatory Act (HORA) sets 18 years as the minimum age requirement for CNAs, HHAs and DSPs. We are asking for legislation to amend the Health Occupations Regulatory Act (HORA) and its implementing regulations to allow 17-year olds to become CNAs, HHAs and DSPs.

Rationale: Under current law and regulation, you must be 18 to become a CNA or HHA or to work as a Direct Care Worker (CAN, HHA or DSP). The age restriction has made it very challenging to establish youth training and apprenticeship programs and has been a big impediment to embedding training programs in high schools because a 17-year-old cannot complete their clinical rotation until they turn 18. This prevents them from getting credentialed. Lowering the age for CNAs, HHAs and DSPs would allow high school students who complete the training program to work part time while in school and to graduate with a certification that qualifies them for an entry level job in the fast growing, high demand health sector at a very early stage in their careers. Lowering the age for CNAs, HHAs and DSPs also increases the potential pool of workers.

[1] Survey of Home Health Agencies: https://www.dclongtermcare.org/wp-content/uploads/2021/01/COVID-19-Impact-on-HHAs-Survey-Results.pdf; Survey of facility-based Providers: https://www.dclongtermcare.org/wp-content/uploads/2021/01/CNA-Survey-12.21.2020-FINAL-.pdf

[2] Direct Support Workforce and COVID-19 National Report: Six-Month Follow-up Institute on Community Integration at the University of Minnesota in partnership with the National Alliance for Direct Support Professionals. April 2, 2021

[3] According to the DC Health Care Partnership Subsector Analysis, "Among healthcare occupations that do not require a postsecondary degree, personal care aides will comprise the largest workforce in both DC and the broader interstate metro area. The DC personal care aide workforce will increase by 2,500 employees between 2020 and 2030. This volume is more than double the projected nursing assistant workforce (4,567), which will rank as the second-largest non-degree occupation in DC and the DMV area.

[4] On January 1, 2022, the District's Living Wage increased to $15.50 an hour, a 30 cent increase over the minimum wage. However, effective July 1, 2022, both the Living Wage and minimum wage will be $16.10/hour

[5] U.S. Bureaus of Labor Statistics, Occupational employment and Wage Statistics, May 2020, Washington-Arlington-Alexandria, DC-Va-Md-WV. https://www.bls.gov/oes/current/oes_47900.htm#31-0000. There is no specific Bureau of Labor Statistics occupational classification for direct support professionals. They are often categorized along with home health aides, personal care assistants, and certified nurse assistants.

[6] Source: US Bureau of Labor Statistics, Occupational Employment and Wage Statistics Query System, available at: https://data.bls.gov/oes/#/geoOcc/Multiple%20occupations%20for%20one%20geographical%20area

[7] The Washington-Arlington-Alexandria, DC-VA-MD-WV Metropolitan Statistical Area includes the District in Columbia; Calvert, Charles, and Prince George's Counties in Maryland; Arlington, Clarke, Culpeper, Fairfax, Fauquier, Loudoun, Prince William, Rappahannock, Spotsylvania, Stafford, and Warren Counties, and Alexandria, Fairfax, Falls Church, Fredericksburg, Manssas, and Manssas Park cities in Virginia; and Jefferson County in West Virginia. See US.Bureau of Labor Statistics, Occupational Employment and Wages in Washington, Arlington, Alexandria – May 2020, Technical Note at: https://www.bls.gov/regions/mid-atlantic/news-release/occupationalemploymentandwages_washingtondc.htm

[8] A recent survey of employers across the LTSS spectrum found overwhelming interest in hiring MA-Cs. See, DC Coalition on Long-Term Care, Medication Aide Survey, November 19, 2021.

[9] Source: See PHI webinar: "How Should States Invest in the Direct Care Workforce," October 19, 2021. Webinar: How Should States Invest in the Direct Care Workforce? (10-19-21) - YouTube

[10] Source: Office of the Governor | ICYMI: New Jersey to Invest $634M to Enhance Medicaid Services for Older Adults and Individuals with Disabilities (nj.gov)

[11] Source: NF SFY2021 Rate Increase FAQ.pdf (nj.gov)

[12] Source: Coronavirus - Long Term Care COVID-19 Plan (michigan.gov)

[13] Source: Governor_Whitmer_2021_State_of_the_State_Remarks_as_Prepared_for_Delivery_714535_7.pdf (michigan.gov)

[14] Source: https://medicaid.ncdhhs.gov/blog/2022/01/14/special-bulletin-covid-19-214-direct-care-worker-hcbs-wage-increase

[15] Source: US Bureau of Labor Statistics, The Consumer Price Index: 2021 in Review, January 14, 2022, available at https://www.bls.gov/opub/ted/2022/mobile/consumer-price-index-2021-in-review.htm

[16] Although, we have not had the opportunity to conduct a comprehensive rate study, in speaking with multiple employers, we have confirmed that:

- The proposed rate is in line with what some employers are already paying; and
- Across the LTSS spectrum, employers support this increase provided that the higher reimbursement rate and annual adjustment is reflected in the rates paid by public payors to providers.