Strengthening and Stabilizing the Direct Care Workforce in Oregon

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September 30, 2022

Slide 1:

- Background on the project:
    - PHI is a national research, advocacy, workforce innovation, and consulting organization that is dedicated to promoting quality direct care jobs as the foundation of quality care for older adults and people with disabilities.
    - We were contracted by the Aging and People with Disabilities Strategic Initiatives Unit within the Oregon Department of Human Services (ODHS) to produce a set of evidence-informed recommendations to support the Unit's collaborative direct care workforce wellbeing and capacity-building efforts.
- We started the project in August, and I am here today to present the findings.

Slide 2:

- Before I go any further, I would like to clarify who we're talking about today.
- Using the formal occupational titles from the Bureau of Labor Statistics, we are talking about personal care aides, home health aides, and nursing assistants.
- These workers provide essential daily care to older adults and people with disabilities across long-term services and supports (LTSS) settings primarily, including in private homes, community settings, residential care, and nursing homes. Direct care workers are also employed in hospitals and other settings, but our focus is on this workforce in LTSS.
- Their responsibilities include assistance with personal care and daily activities, and they may also provide independent living supports or certain types of clinical care depending on their role and setting.
- In Oregon, this workforce comprises nearly 48,000 workers, including:
    - Personal support workers, homecare workers, and personal care attendants in the consumer-directed space;
    - Home care aides employed by home care agencies;
    - Direct support professionals who support individuals with intellectual and developmental disabilities; direct care workers in assisted living and other residential care settings; and certified nursing assistants, including CNA1 and CNA2

Slide 3:

- PHI's remit in this project was three-fold.
- First, we aimed to quantify and describe the direct care workforce in Oregon, including with regards to demographic characteristics, wages and other economic indicators, current size and projected demand

    - For these analyses, we used public survey data, including from the Bureau of Labor Statistics, Projections Central, the U.S. Census Bureau's American Community Survey, and the O*NET Program.
- Second, we completed a rapid policy scan to identify direct care workforce and related policies and programs that have been implemented in Oregon in the past five years.
    - We used a framework laid out in PHI's State Policy Strategies guide to structure this rapid scan—this framework includes 8 domains for policy intervention, such as compensation, training, and workforce data collection, amongst others.
    - We conducted this scan through online research, document review, and outreach to state experts.
- Third, we synthesized the findings from the workforce analyses and rapid policy scan to inform the recommendations that I'm presenting today.

Slide 4:

- I'll start by briefly summarizing the findings from the workforce analysis.
- Here, we compared three broad groups of direct care workers by the setting they work in: home care workers, residential care aides, and nursing assistants in nursing homes. Within those groups are the different job titles described earlier, for example "home care workers" here includes homecare and personal support workers, personal care attendants, some direct support professionals, and agency-employed aides.

Slide 5:

- First, as we know, direct care workers are predominantly women, 81% overall, although there are a higher percentage of men working in nursing homes than in other settings.

Slide 6:

- The median age of all direct care workers in Oregon is 37, but nearly a quarter are aged 55 and above.
- There are some important variations in age by setting, however, which is important when thinking about targeted recruitment strategies—the home care workforce tends to be older, whereas there are substantially more younger workers in residential care and nursing homes.

Slide 7:

- Nearly a third of direct care workers are people of color, primarily Hispanic/Latino—except in nursing homes where there is a substantive population of nursing assistants who identify as Asian or Pacific Islander.

Slide 8:

- About 17 percent of direct care workers were born outside the United States—but among nursing assistants in nursing homes specifically, 25 percent are immigrants.

- These estimates are important again for considering targeted recruitment efforts as well as strategies for supporting existing members of this workforce.

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- Turning to economic indicators, we can see that median wages for direct care workers were $15.38 per hour in 2021 (latest available data).
- Looking back over the past decade, inflation-adjusted median wages *have* increased incrementally...

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- But, and we will return to this important point, these columns on the far right show that median wages for direct care workers fall short of median wages for similar jobs in competitive industries, meaning other jobs with similar *or lower* entry-level requirements to direct care (like food services, retail, and so on).
- So looking at home health aides and personal care aides, which is the majority of this workforce by far, their median wages are nearly $4.00 less than median wages for other jobs that these workers might consider doing instead.

Slide 11:

- As a result of low wages, this is an economically unstable workforce.
- Fully forty percent of direct care workers in Oregon live in low-income households, defined as living below 200% of the federal poverty line. The largest proportion of DCWs living in low-income households are those who work in residential care settings, followed by home care workers.

Slide 12:

- And that means that financial independence is out of reach of many direct care workers.
- A key indicator here is that nearly half of this workforce—and more than half of home care workers—are eligible for and relies on some of public assistance to meet their basic needs—primarily food and nutrition assistance and/or Medicaid.

Slide 13:

- Our final indicator is health insurance coverage, which of course pertains to workers' financial stability *and* their health and wellness.
- This slide shows that more than one in 10 direct care workers is uninsured in Oregon. Rates and types of coverage vary: notably, home care workers (again, the largest segment of this workforce) are the least likely to have insurance through their employer or union and most likely to rely on Medicaid or the marketplace.

Slide 14:

- All of these demographic and economic indicators matter when we're thinking about how to recruit and retain enough direct care workers to meet ever-growing demand—as our population grows older and people live longer with complex conditions.
- In the past decade, from 2011 to 2021, the direct care workforce added 15,500 new jobs (growing by nearly 50%).
- Looking ahead, we can see that this workforce is expected to add nearly 10,000 more new jobs within the *next* decade—that's about 20% growth, and represents more job growth than any other occupational groups in the state except fast food workers and cooks.
- Importantly, as you can see here, all 5 occupations with the most projected growth in the state in the next decade will be drawing from the same labor pool of entry-level or near-entry-level job candidates. (And remember—median wages are consistently higher for all of these competing occupations.)

Slide 15:

- And new jobs are not the full story, either.
- When we also account for existing jobs that will need to be filled as workers leave the occupation or exit the labor force altogether (*plus* new jobs), nearly 65,000 direct care workers will need to be hired in total from 2020 to 2030.
- Again, that puts direct care among the top five occupations with the most total expected job openings in the state.

- In summary—Oregon's direct care workforce is large and without a doubt will need to continue growing to meet demand. Concerted workforce development and job quality improvement efforts will be needed to ensure the provision of services for older adults and people with disabilities, to shore up one of the state's largest workforces overall, and to support and promote equity for this largely female and people of color workforce.

Slide 16:

- To that end, I'd like to talk through six recommendations to strengthen and stabilize the direct care workforce in Oregon.
- I'll say this now, and I'll repeat myself at the end: Oregon is already a national leader when it comes to direct care workforce efforts. There is a lot of progress underway—and these recommendations aim to build on and leverage that progress to move the state further along.

Slide 17:

- Here are the six recommendations, which I will talk through in turn, highlighting key opportunities and considerations.
- These recommendations are informed by the workforce data that I just talked through as well as the findings from our rapid policy scan.

- To note, I've included the key findings from the rapid policy scan—but I'm not going to talk through all of those findings here, both in the interests of time and because I don't want to suggest that we've completed an exhaustive analysis of the policy landscape. Instead, you can think of these policy scan findings as key coordinates in the landscape to return to, selectively and as relevant, when digging into any one of the recommendations provided here. (So forgive me for moving quickly past those slides—hopefully you had a chance to review them in advance and/or you can read them in due time after today's presentation.)

Slide 18:

- The first recommendation is to engage direct care workers in developing strategies and solutions.

Slide 19:

- The rationale here is that direct care workers hold unique insights not just about the care they provide but also on how to improve the quality of direct care jobs and the delivery of LTSS overall—and we should always start there.

Slide 20:

- We found a few examples of efforts to engage direct care workers in formal committees, councils, and workgroups.
- I am sure there are also plenty of other ways that direct care workers' voices are being elevated—through union representation, through the Oregon Home Care Commission, through the RISE Partnership efforts, at the employer level, but these are the main initiatives that we identified.

Slide 21:

- One specific opportunity for Oregon is to move beyond these siloed efforts by convening a statewide direct care workforce taskforce or similar body that includes direct care workers from across occupational roles and settings.
    - Maine offers a great model of a direct care worker advisory council to consider.
- More broadly, efforts to engage direct care workers must be underpinned by material supports, considering the time and financial pressures and structural barriers faced by these workers—that means stipends for their time; support with childcare, transportation, and other logistics; but also leadership training and coaching to help boost their capacity to participate in meaningful ways; and other forms of ongoing support.
- And finally, aside from committees and councils, there are a range of other ways to gather input from direct care workers every step of the way, from interviews, focus groups and surveys to listening sessions or town hall meetings.
    - I've provided a parallel example of how licensed nurses were surveyed to help inform the RN Wellbeing Project in Oregon.

Slide 22:

- The second recommendation is to establish and fund minimum wage floors across direct care occupations and settings.

Slide 23:

- The rationale is that ensuring livable and competitive wages for all direct care workers will enhance equity *for* and *within* the workforce as well as increase recruitment and reduce attrition.

Slide 24:

- The findings from the policy scan confirm that there absolutely efforts in place to increase wages for specific segments of the direct care workforce, including through the homecare collective bargaining agreement, the efforts to establish a long-term care wage board and a taskforce on HCBS workforce standards, and the new wage pass-through requirement for direct support professionals. There is also evidence, with Senate Bill 1549 (next slide), that the state is proactively managing temporary staffing costs so that more money can be invested in stabilizing this workforce than in filling the gaps.

Slide 25:

- Policy scan findings.

Slide 26:

- The overall opportunity now is to look at establishing a livable and competitive wage floor—or prevailing wage, to use language from other sectors—for all direct care workers.
    - Livable and competitive means that wages should be high enough both to enable workers to achieve financial independence (which of course reduces the cost of other public programs) and to make these jobs competitive with jobs in other industries (considering evidence earlier that median wages are consistently lower for direct care workers than for workers in other industries)—which will thereby improve recruitment and retention.
    - Colorado offers a good example by recently setting a minimum wage of $15 per hour for direct care workers providing Medicaid-funded home and community-based services (whether that's sufficient bears discussion, but importantly, it is $2.50 above the state' overall minimum wage, so there is one clear competitive edge there). Another example is New York's Fair Pay for Home Care bill, which would set home care wages at 150% of the regional minimum wage.
- It's also important to consider a range of other factors when setting a wage floor for direct care workers
    - One key factor to consider is existing wage requirements or mandates (such as the homecare collective bargaining agreement).

    - On that point, I'd like to highlight Washington's parity law, whereby negotiated wages and benefits for independent providers—meaning home care workers in the consumer-directed model—must be converted into an amount that is "added to or subtracted from the home care *agency* vendor rate"—with the requirement that any increase is used for improving wages and benefits. Meaning, any improvement in employment conditions for independent providers is also realized for agency-employed workers.
- Other factors to consider include: the level of training that is required for each occupational role within direct care, the acuity or needs of the population being served, and other factors like geography and tenure on the job.
    - With regards to tenure (time on the job), it's important to mention that the current homecare collective bargaining agreement includes a commitment to developing wage tiers tied to each year of service—to encourage retention in the field. That's the kind of model that's needed across direct care workforce compensation policy.
- Finally, we also heard in our conversations with experts that introducing cost reporting requirements for home care agencies and community-based care providers, similar to those that are in place for nursing homes and providers of intellectual and developmental disability services, could help inform reimbursement rate calculations and track where the funding goes to ensure that it actually reach workers as intended.

Slide 27:

- The third recommendation is to ensure direct care training is aligned and transferable across occupations and settings.

Slide 28:

- The rationale is that aligning training across occupations and settings will empower workers, improve their career opportunities, enhance the flexibility of the workforce, and reduce costly duplication and gaps.

Slide 29:

- In terms of the policy landscape, there has been a lot of recent momentum to improve training standards, delivery systems, and opportunities for direct care workers, including as laid out in the Home Care Commission's workforce development strategic plan; through legislation related to training requirements for different segments of the workforce; and via the Home Care Commission's slate of new certifications, the Long-Term CareWorks CNA Apprenticeship, and the trainings offered by Oregon Care Partners.
- This slide and the next two slides contain more details on each of these developments, for your further reading.

Slide 30:

- Policy scan findings.

Slide 31:

- Policy scan findings.

Slide 32:

- So—building on all of this progress—here are some specific opportunities to ensure that direct care training and career development is maximally aligned and transferable.
- First, we heard that there may be some confusion among direct care workers (especially those in HCBS) about which trainings they are required to take, or eligible to take, and from which training providers. The sub-recommendation here is to make sure that clear and comprehensive information is getting through to workers and employers.
- A second opportunity is to take steps to address training access barriers. Two priorities that we heard about are to expand trainings into more languages, where needed, and to provide support with online training for those who have limited access to or familiarity with technology.
- A third opportunity is to conduct a crosswalk of all the current training standards and programs to ensure that there is as much alignment as possible—and look for any potential to enhance transferability of training credentials across direct care occupations and settings. For example, could there be an abbreviated training with a challenge test for current homecare workers to become certified as CNA1s, or vice versa? Washington State offers an example on that point.
    - The idea is to create more easily navigable pathways for direct care workers within direct care, so that we keep the workers in the field with new job opportunities (in new settings, with new populations)—with minimal barriers to making those moves.
- A fourth opportunity is to identify ways to expand access to existing training programs for direct care workers who are not currently eligible—so that more of this full workforce receives the training they want and need. For example, could workforce development funding be leveraged to create training slots in the Carewell training for non-union workers, or could there be a low-cost buy-in option for their employers? Maybe the answer is no, but I think it's really worth exploring since there are a range of quality training programs already in place.

Slide 33:

- We also clearly heard a specific call for more training on mental and behavioral health topics, given that many direct care workers are supporting consumers with these needs—sometimes in quite challenging circumstances—but without sufficient preparation or targeted skills.
    - Here I'd suggest learning from Rhode Island's innovative Direct Care Behavioral Health Program, as linked on the slide.
- And finally, echoing the previous recommendation about compensation, this last bullet is a reminder to think about tying Medicaid or other public reimbursement rates to training credentials, to ensure that those who have completed additional training are compensated accordingly. Home Care Commission certifications are a great example to build on, because each one is associated with a clearly defined wage differential.

Slide 34:

- The fourth recommendation is to enhance employment supports for direct care workers.

Slide 35:

- The rationale here is that on-the-job and wraparound supports can boost workers' personal and economic wellbeing, support their retention, and augment care delivery.

Slide 36:

- The policy scan identified several initiatives that direct care workers can (or could potentially) benefit from, including the FutureReady Oregon workforce development initiative, and the OregonSaves and the new Paid Leave Oregon program.

Slide 37:

- We also highlighted the CNA Apprenticeship model again here, the nurse wellbeing effort, and the Behavioral Health Initiative for Older Adults and People with Disabilities, and I'll say a bit more about those on the next slide.

Slide 38:

- The first specific opportunity here is to leverage funding and expertise through FutureReady Oregon and other workforce development initiatives to offer wraparound supports for direct care trainees and workers. Part of the challenge here is to make sure that direct care workers are a focus of these workforce development initiatives, which is not a given and which may require education and advocacy.
- The second point here is not to start from scratch when designing ways to support direct care workers, but rather to replicate, translate, or scale-up existing models
    - Models to consider include the peer mentoring program that is built into the CareWorks CNA Apprenticeship and/or the RN Wellbeing Project.
- The third opportunity here is to provide targeted support for direct care workers who are serving individuals with behavioral health needs. I've already talked about the need for more training on this topic, but here we're suggesting that more support in the field could also be helpful.
    - One option is to assess and consider strengthening connections between direct care workers and Behavioral Health Specialists, who are already out there and tasked with building capacity to serve this population. There may be more that they can do to directly interface with and support direct care workers.

Slide 39:

- The fifth recommendation is to improve direct care workforce data collection.

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- The rationale here is that robust data from across direct care occupations and settings can help identify workforce priorities, inform equity-focused solutions, and evaluate outcomes.

Slide 41:

- There are already several relevant measures already in place in Oregon, including the study of residential care facilities that is mandated through Senate Bill 703 (which will involve interviewing direct care workers themselves), the staffing data reporting requirements for intellectual and developmental disabilities service providers, and the quality metrics reporting system for residential care and assisted living communities in the state.

Slide 42:

- The first opportunity here is for Oregon to consider participating in the NCI-AD (Aging and Disability) Staff Stability survey when that option becomes available to all states next year—as that will provide complementary data to the staffing data collected from I/DD providers already.
- Or the state could consider other mechanisms for collecting and reporting staffing data.
    - Texas provides a good example of collecting data on wages and benefits, turnover, recruitment, retention, and job vacancies through Medicaid cost reports.
- Another opportunity is to review and likely improve the staffing quality measures that have been introduced for assisted living and residential care communities, which are fairly limited in their current form, and consider introducing staffing quality measures in other programs and services as well.
    - I've flagged the new HCBS Quality Measure Set from CMS and the National Quality Forum's quality measurement report as key resources here.

Slide 43:

- As well as establishing or strengthening regular data collection mechanisms, Oregon could consider funding a survey of direct care workers to ask them about their job experiences, challenges, and aspirations—this also aligns with our first recommendation about directly engaging workers.
    - The slide includes links to one completed and one planned workforce survey from Arizona and Utah, respectively.
- Finally, we recommend finding opportunities to disaggregate direct workforce data wherever possible to identify differences across the workforce and workforce interventions by gender, race/ethnicity, immigrant status, and other intersectional identities.
    - On this point, I've suggested consulting a new report from the Center for Advancing Racial Equity and Job Quality in Long-Term Care. Although the report is more federally focused, there is a lot of useful information and guidance for states as well.

Slide 44:

- The final recommendation is to implement and evaluate targeted recruitment programs.

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- Here, we suggest that recruitment efforts must extend across direct care occupations and settings, reach different segments of the labor force, utilize updated recruitment methods, and directly link to training and employment opportunities.

Slide 46:

- Looking to the current policy context, there are two new online platforms available or in the works, namely Carina and the Connect to Care Jobs platform (as it is currently named)—in different ways, these can help connect job seekers to direct care jobs. There is also funding in the state's American Rescue Plan Act HCBS spending plan to develop a website and marketing plan for recruitment into the behavioral health/substance use disorder system.

Slide 47:

- In terms of opportunities and considerations, we start by suggesting that the state consider launching a broad marketing and recruitment campaign that features direct care workers from across occupations and settings—to show the various job options and career pathways that are available in this field overall.
    - We would suggest that the campaign use targeted, tested messaging for different populations (men, older workers, workers from immigrant communities, lapsed direct care workers) and address different needs, preferences, and values among job seekers.
    - I've provided the example here of WisCaregiver Careers, which was a very successful pipeline development, training, employment, and retention program in Wisconsin's nursing home sector which has been replicated in a number of other states since.
- Second, we see an opportunity for agencies to come together to make sure that direct care workers are a key focus of workforce development efforts in the state—in other words, recruitment strategies and pipeline programs may be best led by workforce development experts through the state's employment and workforce development infrastructure, but with input from ODHS and other stakeholders about the specifics of the direct care workforce.
- Our final point here is to consider how the state could support employers in designing their own targeted recruitment programs—as well as providing guidance on improving job quality and creating equitable and inclusive workplaces.
    - On that point, Project ECHO is a strong mechanism for getting information out to nursing homes; that might serve as a model for a similar effort in HCBS.

Slide 48:

- I've shared a lot of content with you today, a sort of smorgasbord of ideas and opportunities and considerations. I want to end by elevating three cross-cutting themes—this is what I would really like you to leave with, if nothing else.
- I've distilled these themes to three words: focus, coordinate, and integrate.

Slide 49:

- This slide is going to be dense, but I wanted you to have this explanation for the record.
- The first cross-cutting theme is the need to FOCUS on the direct care workforce as a priority workforce in the state. Direct care workers are one of Oregon's largest and fastest growing occupations, and as such they are central to Oregon's economy overall—and to the lives of older adults and people with disabilities in the state. Therefore, this workforce should be a **primary focus** of the state's broader workforce and economic development efforts (e.g., FutureReady Oregon) and a focus of specific health and long-term care initiatives. When in doubt, focus on direct care workers—that will directly impact long-term care, benefit the economy overall, and advance equity in the state.
- The second theme is coordinate. As I said at the start, Oregon is a national leader in trying to tackle direct care compensation, training, career advancement, data collection, and more—but these efforts , as we have seen, are often segmented or siloed, which creates duplication and gaps. Training standards, credentials and certifications, recruitment strategies, and registries—all of these could be better **coordinated** and aligned across Aging and People with Disabilities, the Office of Developmental Disabilities Services, the Health Systems Division, and other agencies and departments.
- And finally, there is a need to integrate efforts across the different topics and domains that we have discussed today—because given the magnitude and complexity of the direct care workforce crisis, we need comprehensive approaches rather than any single strategy or solution. There are no silver bullets here, no single actions that will fix the problems we face. The recommendations presented here are intended to provide a foundation for developing a multi-faceted, **integrated** approach to elevating the value of direct care workers, improving their job quality, and bolstering this workforce for the future.

Slide 50:

- And that is where I will end today's presentation. Here is a snapshot of all the information and resources that you can find on the PHI website, which is PHINational.org.

Slide 51:

- And here are the photo credits for the Oregon photos in this presentation, as well as a link to PHI's state policy strategies guide, which provides specific ideas and state examples on many of the topics that we've covered today.

Slide 52:

- And finally, here are my contact details. I'd also like to end by acknowledging Stephen McCall, PHI's former Data and Policy Analyst, who co-led this project until he moved to a different organization at the beginning of this month.