PHI QUALITY CARE THROUGH QUALITY JOBS

CONGRESSIONAL TESTIMONY

Investing in Direct Care Workforce Interventions to Improve the Quality of Services and Supports for Older Adults and People with Disabilities

Testimony before
Health, Employment, Labor, and Pensions Subcommittee
and
Higher Education and Workforce Investment Subcommittee

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My name is Robert Espinoza, and I am the Vice President of Policy at PHI, a New York-based, national nonprofit organization that works to transform eldercare and disability services by promoting quality direct care jobs as the foundation for quality care.

For three decades, PHI has been the nation's leading expert on the direct care workforce through its research, policy analysis, and direct consultation with policymakers, payers, providers, and workers—providing a unique 360-degree perspective on the long-term services and supports (LTSS) system and its workforce in the United States. Over the years, PHI has also designed a broad range of groundbreaking workforce interventions in diverse parts of the country that have optimized and elevated the role of direct care workers in LTSS delivery through training, advanced roles, coaching supervision, and more. Our interactive curricula and training programs designed for adult learners help direct care workers build the knowledge, skills, and confidence to deliver quality care. We work with employers to create entry-level training opportunities with a direct pathway to employment, and we provide high-quality specialty and in-service training to hone the skills of currently employed aides. Our training also supports advanced roles for direct care workers and promotes continuous learning. In its federal advocacy, PHI has worked successfully on bipartisan policy initiatives for decades.

On behalf of PHI, I would like to thank Chairman DeSaulnier, Ranking Member Allen, and the other Members of the Health, Employment, Labor, and Pensions Subcommittee; as well as Chairwoman Wilson, Ranking Member Murphy, and the other Members of the Higher Education and Workforce Investment Subcommittee, for the opportunity to discuss the direct care workforce and how the Direct Creation, Advancement, and Retention of Employment (CARE) Opportunity Act would support this vital job sector by providing a robust, targeted, and coordinated investment in workforce interventions to improve training, advancement, recruitment, and retention.

I will begin this testimony by describing the direct care workforce, including its roles, responsibilities, size, key characteristics, and primary challenges, as well as the impact of these challenges on workers themselves, the individuals they support, employers, and family caregivers. I will then describe how the Direct CARE Opportunity Act would help address a significant need in this country by funding a coordinated array of workforce interventions in direct care while building a much-needed evidence base on these critical approaches.

THE DIRECT CARE WORKFORCE

Direct care workers support older adults and people with disabilities with critical daily tasks and activities across settings, from private homes to residential care homes (such as assisted living) to skilled nursing homes. This workforce comprises three main occupational groups—personal care aides, home health aides, and nursing assistants—but are known by a variety of job titles in the field. Direct care workers who are employed directly by consumers, either through Medicaid

programs or private-pay arrangements, are often called "independent providers." Workers who support individuals with intellectual and developmental disabilities are known as "direct support professionals."

Our research shows that there are 4.6 million direct care workers in the U.S., which makes this workforce larger than any other single occupation in the country.[1] Because of growing demand—spurred mainly by the reality that from 2020 to 2060, the population of adults aged 65 and over will almost double, from 56.1 million to 94.7 million[2]—the direct care workforce has grown significantly over the years and will continue to surge in the years ahead. Between 2018 and 2028, the direct care workforce is projected to add more than 1.3 million new jobs.[3] Home care will add nearly 1.1 million jobs in that period, representing the largest growth of any job sector in the country. The growth in the home care workforce in particular—over workers employed in nursing homes and residential care settings—is the result of a shift over the last three decades to dedicate more federal spending to home and community-based services, spurred by consumer preference and the passage of the Americans with Disabilities Act in 1990 and the 1999 *Olmstead vs. L.C.* decision, which requires states to deliver LTSS "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[4]

However, across the country, long-term care employers struggle to recruit and retain these workers, given the growing numbers of older adults and people with disabilities who need LTSS and the persistence of poor job quality in direct care, described below. Among older adults, the total number of paid LTSS users aged 65 and older is expected to grow from 7.4 million in 2020 to 14.4 million in 2065, and 56 percent of people turning 65 between 2020 and 2024 will require some form of paid LTSS at some point in their lives.[5] Moreover, nearly 820,000 people nationwide are on waiting lists for home and community-based services.[6] Yet direct care workforce interventions lack the resources and scale to match these growing numbers and the overall need nationwide, despite a growing but insufficient evidence base demonstrating their impact and potential.[7]

Among these workers, 87% are women, 59% are people of color, and 27% are immigrants.[8] The median age for direct care workers is 43, though roughly one in four (27 percent) is aged 55 and older. As our country has rapidly aged, so has this workforce; today, many direct care workers are older adults supporting other older adults. The diversity of this workforce also means that many workers must contend with entrenched, societal inequities that exacerbate the many challenges they face on the job, as detailed in the next section.

KEY CHALLENGES

Despite their enormous value, direct care jobs have been poor-quality jobs for decades, harming workers, employers, consumers, and family caregivers. One of the primary challenges facing direct care workers is inadequate compensation. The median wage for these workers in 2019 (our

most recent year of data) was $12.80, which was only 19 cents higher than the median wage in 2009. (In LTSS, which is primarily covered by Medicaid, low wages are often shaped by inadequate funding for the entire system and low reimbursement rates under Medicaid and other public payers that limit providers from raising wages and implementing job improvements.[9]) Low wages and part-time employment force direct care workers to access public assistance; 45% of direct care workers live in or near poverty, and 47% access some form of public assistance, such as food and nutrition assistance, Medicaid, and/or cash assistance.

Within an already marginalized workforce, disparities abound. Women, people of color, and immigrants in direct care have long faced widespread gender inequality and racial discrimination in education and employment (among other areas), which contributes to ongoing disparities in earnings, as one example.[10] The median earnings for women of color in direct care is $37,600, and 53 percent of women in color in this workforce live in or near poverty, compared to $47,100 and 38 percent among white men in direct care, respectively.

Wages for direct care workers are neither livable nor competitive. Our research shows that in all 50 states and the District of Columbia, the direct care worker median wage is lower than the median wage for other occupations with similar entry-level requirements, such as janitors, retail salespersons, and customer service representatives.[11] In 46 states and the District of Columbia, the direct care worker median wage is less than a dollar higher than the median wage for occupations with *lower* entry-level requirements (like housekeepers, groundskeepers, and food preparation workers).

The training landscape for direct care workers—including its standards, curricula, and general infrastructure—also presents enormous challenges to ensuring that these workers succeed in their roles.[12] Throughout the country, training requirements for direct care workers are insufficient and vary widely across states, long-term care settings, and job titles. (Federal requirements apply to home health aides and nursing assistants but not personal care aides, the largest growing segment of this workforce.) Moreover, disjointed training regulations make it difficult for workers to translate their experiences across settings (from home care to residential care, for example), limiting their career mobility and the versatility of the workforce overall, a limitation exposed and amplified during the COVID-19 pandemic. (Given that training requirements vary by state, credentials for direct care workers are also not portable across states—another barrier during this pandemic.) Direct care workers also struggle with limited advancement opportunities, poor supervision, and limited respect and recognition on the job, yet workforce interventions that would better prepare and support workers in this job sector are limited.[13]

Poor job quality in direct care affects everyone in the long-term care system. Workers experience heightened economic insecurity and are often forced to leave this sector for other fields. (Two recent studies showed that the turnover rates for nursing home staff and home care workers are 99 percent and 65 percent, respectively.[14]) Poor job quality can also be dangerous for workers

and clients; in 2016, the injury rate per 10,000 workers was 144 injuries among personal care aides, 116 among home health aides, and 337 among nursing assistants—compared to 100 per 10,000 workers across all occupations in the U.S.[15]As a result of poor job quality, their employers—home care agencies, nursing homes, and a range of residential care providers — struggle to recruit and retain workers. This challenge will magnify in the years ahead; between 2019 and 2029, the long-term care sector will need to fill about 7.4 million job openings in direct care, including the 1.3 million new jobs referenced earlier and an additional 6.2 million jobs that will become vacant when workers leave the field or exit the labor force altogether.[16]

Consumers and their family caregivers (broadly defined to include families of choice) also suffer the impacts of poor job quality. Without proper training or advanced roles that equip workers and optimize their contribution (as two examples), older adults and people with disabilities cannot receive quality care. High turnover among these workers also disrupts continuity of care and at its worst, means that some consumers do not receive support at all. Moreover, many family caregivers rely on direct care workers for respite and support—and without this assistance, must deal with the severe financial and emotional challenges of caregiving on their own, including the need to limit work or leave their jobs entirely.[17]

The COVID-19 crisis has amplified all these challenges—disproportionately harming older adults and people with complex conditions across LTSS settings and reinforcing the essential yet undervalued nature of the frontline workforce that supports them. It has become devastatingly clear that this job sector deserves a significant federal investment to improve direct care job quality and strengthen and stabilize this workforce, now and for the future.

THE DIRECT CARE OPPORTUNITY ACT

The Direct CARE Opportunity Act would help address many of the challenges outlined above by investing more than $1 billion (or $300 million per year) over five years (through 2027) in recruitment, retention, and advancement strategies in direct care, designating at least 30 percent for advancement opportunities.[18] Among the Act's requirements are: detailed planning and needs assessments from grant applicants, including examinations of the populations being served and projections of unmet need and direct care job openings at the local level; consultations with the people being served (and related experts) as strategies are developed; and a direct care wage and benefits assessment.

A few critical dimensions of this bill include: its focus on high-demand geographic areas (including rural and urban areas) and demographic diversity (to identify and support more vulnerable populations of workers and consumers); and its robust requirement for evaluating the impact of all funded interventions on employment, care, and cost outcomes, which would boost the evidence base on workforce interventions in this field.

In many parts of the country, direct care workforce interventions have led to positive outcomes for workers, employers, and consumers. Yet these interventions need significant funding to be extended, replicated, and brought to scale to reach larger and growing populations of workers—and new interventions are needed to address the many challenges facing these workers described above. Moreover, the large-scale investment from the Direct CARE Opportunity Act would allow for national coordination and evaluation, ensuring that federal leaders invest in the most effective and essential strategies for the future. The job transformation it would create in direct care would also promote economic development, given that high quality jobs increase consumer spending, decrease public assistance rates, reduce costly turnover, and promote cost savings in health care spending.[19]

Funding is especially needed to implement and evaluate direct care workforce interventions that:

- Effectively deliver entry-level and specialized training, advanced roles, recruitment and retention, supervision, e-learning, and technology;
- Create new models of service delivery across long-term care settings, including universal worker roles, models that connect workers to other services (such as housing supports), and models that maximize the direct care role through upskilling, care integration, and meaningful career ladders;
- Strengthen workers' abilities to support individuals with dementia and other prevalent chronic conditions; individuals dealing with social isolation and loneliness and other issues related to mental health; more vulnerable people, such as people of color and LGBT individuals; people living in neglected regions of the country, including both rural and urban areas; and the new population of individuals living with long-term COVID-19 complications; and
- Adequately fund evaluations of these interventions to assess their impact on workers, employers, and the outcomes often sought by LTSS payers: primarily positive client health outcomes and reductions in health care spending.

EXAMPLES OF DIRECT CARE WORKFORCE INTERVENTIONS

Over the years, workforce development leaders and other innovators have designed, implemented, and evaluated a range of interventions for the direct care workforce. Below are examples of interventions that illustrate the potential of the Direct CARE Opportunity Act.

- **To upskill home care workers to better support consumer health in Arkansas, California, Hawaii, and Texas,** a training program that reached nearly 3,500 home care workers showed improvements in workforce retention, among other outcomes.[20]
- **To promote care integration for home care workers in California,** a competency-based training for more than 6,000 home care workers improved recruitment and

retention, reduced repeat emergency department visits and rehospitalizations, and generated cost savings of as much as $12,000 per trainee.[21]

- **To create advancement opportunities for home care workers in New York,** a partnership between a managed care plan and three home care providers created a salaried advanced role focused on care transitions that reduced emergency department visits and caregiver strain.[22]
- **To enhance training and supports for home care workers in Washington State,** a training program has provided more than 6 million hours of entry-level training and continuing education, as well as medical, prescription, vision, hearing, emotional wellness and dental plans for workers, a retirement plan, and employment services.[23]
- **To develop the nursing assistant workforce in Wisconsin,** a pipeline-development program worked with community colleges and other training sites statewide to train thousands of workers and place them in nursing home jobs, boosting the labor pool.[24]
- **To strengthen the pipeline of home care workers in New Mexico,** a Spanish-language, 15-week program trains immigrants as home care workers, providing scholarships to cover the costs of tuition and childcare.[25]
- **To help home care consumers and independent providers connect with one another online in California,** four Centers for Independent Living offer a QuickMatch matching service registry.[26]
- **To improve recruitment and retention of home care workers in New York City,** a partnership with three home care agencies relied on targeted recruitment, a train-the-trainer program, peer mentoring, and supportive services and case management.[27]
- **To improve recruitment of direct care workers in rural Minnesota,** a social media campaign used paid ads to target key groups of potential workers and encourage them to apply online through their mobile devices, improving recruitment and hiring figures.[28]

While these interventions have helped their participants and advanced the long-term care field, they represent a small fraction of the approaches needed to support this rapidly growing workforce and the individuals it supports. The limited scale and early success of these interventions affirm that a robust, targeted, and coordinated investment in direct care workforce interventions will more effectively move the needle on training, advancement, and recruitment and retention throughout the country.

CONCLUSION

The Direct CARE Opportunity Act would provide a much-needed investment in interventions that strengthen and stabilize the direct care workforce, a rapidly growing workforce that provides essential services and supports for millions of older adults and people with disabilities. It would improve their jobs and economic security, facilitate recruitment and retention among their employers, improve care for their clients and residents, and promote economic development—all

while building the evidence base on effective interventions for this job sector. We encourage Congress to enact this bill and begin transforming this critical workforce.

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[1] Except where otherwise indicated, all direct care workforce data presented here are cited from: PHI. 2020. *Direct Care Workers in the United States: Key Facts*. Bronx, NY: PHI. http://phinational.org/resource/direct-careworkers-in-the-united-states-key-facts/.

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