

# State Strategies for Sector Growth and Retention of the Direct Care Health Workforce

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## Introduction

Entry level health care workers represent a critical component of the health care workforce. Although titles and minimum certification requirements vary by state and employer, these individuals, including Certified Nursing Assistants/Aides (CNAs), Home Health Aides (HHAs), Personal Care Aides/Assistants (PCAs), and Direct Support Professionals (DSPs), hereafter referenced as direct care workers, provide hands-on essential services for older adults, individuals with disabilities, and individuals undergoing intensive rehabilitation in facility and home-based settings.

The health care industry has long experienced challenges in recruiting and retaining direct care workers due to low wages, high physical demands and lack of upward mobility.<sup>1</sup> Before the COVID-19 pandemic, in many instances, individuals who might have considered direct care jobs could work in less physically demanding retail positions or other service industry jobs for the same or greater pay. The onset of the COVID-19 pandemic, however, brought with it a surge in demand for direct care workers while other industries experienced significant layoffs and business closures because of physical distancing restrictions and the economic downturn. This confluence of events provides an opportunity for states and employers to focus on strategies to enhance the recruitment and retention of direct care workers.

Ensuring an adequate supply of direct care workers requires multi-sectoral and multi-industry collaboration, including commitments from state and local government, employers and academic institutions. Several states and employers have made great strides in developing strategies to recruit direct care workers into jobs that have pathways toward higher earning and training, allowing for greater economic and career mobility.

This issue brief provides a series of multi-sector state and employer strategies to address recruitment and health sector retention of direct care workers while balancing workforce needs, job quality and wages. It focuses largely on jobs that pay less than or close to [200% of the federal poverty guideline](#) for a household of three in 2021 or \$43,920. The strategies have even greater relevance in the wake of the COVID-19 pandemic, but they are intended as longer-term opportunities to address the broader needs of the industry and direct care workers. Many of the considerations are drawn from strategies traditionally leveraged in broad sector-based workforce development planning, such as engaging workforce development boards and creating apprenticeship pathways.

### DIRECT CARE WORKFORCE BY THE NUMBERS



A report published by PHI in September of 2020 describes characteristics of the direct care workforce in the United States.

- ▶ 4.6 million workers
- ▶ \$12.12–\$13.90 average hourly wage
- ▶ 85–90% female
- ▶ 54–62% people of color
- ▶ 46–54% high school or less education
- ▶ 36–54% access public assistance programs
- ▶ 31–39% lack affordable housing
- ▶ 25–43% receive Medicaid, Medicare, or other public insurance coverage
- ▶ 25–31% primary caregivers for children under 18

### KEY CONSIDERATIONS INCLUDE:

- 1. Create a platform for cross-sector collaboration:** Work across state agencies and with employers and training programs to identify priorities and coordinate direct care workforce development policy.
- 2. Compare, standardize and streamline roles and regulatory requirements for direct care worker positions across state agencies:** Consider comparing direct care roles and streamlining requirements to increase professional progression and mobility for direct care workers to develop additional skills and advance in their careers.
- 3. Develop intentional recruitment and retention strategies:** Consider pipeline strategies that encourage entry into the direct care workforce and identify and support pathways that will remove barriers and facilitate transition to higher skilled jobs with better wages and career growth.
- 4. Tackle wage issues:** Examine Medicaid fee structure and the potential to use Medicaid dollars for wage pass-through (a policy where states require a portion of the Medicaid reimbursement be reserved for salaries).



**CONSIDERATION 1: Work across state agencies and with employers and academic institutions, such as community colleges, to identify priorities and coordinate in the development of pipeline and workforce development programs.**

States can align and streamline policy and programming by developing a platform for coordination and collaboration across the state agencies involved in policy development and oversight of direct care workers. Such initiatives may be formalized and/or implemented in various ways: a committee established through legislative or executive initiative; executive branch administration commitment; or shared/multi-agency state government coordinating position. States considering opportunities to expand or formalize coordination and cross-agency collaboration should, at minimum, consider engaging the following types of agencies:

State Agency or External Entity	Role in Direct Care Workforce Conversations
Licensure boards or other entities that regulate or have jurisdiction over direct care workers	<ul style="list-style-type: none"><li>▶ Occupational regulation</li><li>▶ Maintaining registry</li></ul>
Workforce development or labor agencies and any relevant boards or committees	<ul style="list-style-type: none"><li>▶ Workforce development programming</li><li>▶ Direct care occupational explorer tools</li><li>▶ Career support services</li><li>▶ Reporting supply/demand findings from employers</li></ul>
Departments of education, higher education, career and technical education	<ul style="list-style-type: none"><li>▶ Education/training for direct care roles</li><li>▶ Creating/supporting career pathways within or external to direct care roles</li><li>▶ Partnering with employers for work-based clinical training</li></ul>
Public health and human services agencies	<ul style="list-style-type: none"><li>▶ Occupational regulation</li><li>▶ Regulating the employing facility/agency (ex: nursing homes, home health agencies, etc.).</li><li>▶ Training provider</li></ul>
Medicaid Agencies	<ul style="list-style-type: none"><li>▶ Reimbursement of direct care services</li><li>▶ Supporting enrollment of employers that hire direct care workers</li></ul>

Coordination across these entities may minimize duplication of efforts, promote synergies and enhance direct care workforce policy and programming. Therefore, state coordinating entities examining direct care workforce issues should engage or include employer and educator representatives to ensure a mutual understanding of barriers to entry, supply and demand to establish a coordinated approach to direct care training and employment opportunities.



## STATE EXAMPLES:



**Colorado** – The [Long-Term Direct Care Workforce Workgroup](#) is an executive branch initiative, led by the Lt. Governor.<sup>2,3</sup> This entity convenes and coordinates state-level conversations regarding direct care workforce challenges. In an effort to enhance the use of data between agencies, a shared data analyst position has been created to coordinate between the state higher education agency and the workforce board as well as a statewide data trust that links various data sources to create better intelligence on related initiatives.



**Minnesota** – Direct Care Workforce Shortage Cross Agency Steering Team, established at the direction of the [Olmstead Subcabinet](#) in April 2017, is a workgroup that was formed by the Department of Human Services and the Department of Employment and Economic Development to develop recommendations for “expanding, diversifying and improving Minnesota’s direct care and support workforce.” This group, which is just one state initiative to address the workforce shortage, includes people from multiple state agencies, provider organizations, disability leaders, people who rely on direct support workers, direct support workers, family members, higher education and others. They meet quarterly and have completed several reports and a [work plan](#) identifying seven priority areas, outlined on page 37 [Minnesota’s Olmstead Plan](#), and they have been working with providers and other partners to attract more workers into this field.



**Iowa** – [Iowa CareGivers](#), a non-profit association that represents and supports the direct care workforce, distributed a 2019 Direct Care Worker Wage and Benefit survey to a sample of direct care workers, in partnership with the Iowa Workforce Development Agency. This survey was mailed to CNAs on the Iowa Direct Care Worker Registry and distributed to local public health agencies under contract with the Iowa Department of Public Health.<sup>4</sup> Iowa CareGivers hosted a forum in partnership with the state and invited state government stakeholders, community colleges, consumers, direct care workers, employers and others to review findings from the survey and make recommendations regarding the direct care workforce.<sup>5</sup>



## **CONSIDERATION 2: Compare, standardize and streamline roles and regulatory requirements for direct care worker roles across state agencies**

**R**egulation and executive branch agency requirements vary widely for the direct care workforce within and across states. Direct care roles are frequently defined in federal code, or more specifically within Medicaid and Medicare requirements. For example, training program requirements and approvals for nurse aides are defined in the Code of Federal Regulations for Medicaid and these training program requirements are implemented by (and may be expanded by) states.<sup>6</sup>

For other roles, such as DSPs who frequently work with persons with disabilities, the role itself is not defined in federal code. In the case of DSPs, there is widespread recognition of the variations in DSP competencies, credentials and role.<sup>7,8</sup> In 2014, the Centers for Medicare & Medicaid Services (CMS) identified core competencies for direct service workers in community-based, long-term support and services settings and produced [CMS Direct Service Workforce Core Competencies](#).<sup>9,10</sup> However, unlike for nurse aides, there is no guidance for state review and approval of training programs and no nationally recognized training to meet these competencies.



**States may establish training strategies or scope standards for direct care workers to supplement federal requirements where they exist. For example, in the case of nurse aides, 29 states have nurse aide training requirements beyond the federal minimum. For home health aides, 17 states have training requirements beyond the federal minimum. For direct service workers, in the absence of federal guidelines, 43 states have created training standards for DSPs or PCAs.<sup>11,12</sup>**

Variations in direct care worker training requirements exist across roles (home health, nursing facilities, or caring for individuals with disabilities). The specific training and experience required for one direct care role does not necessarily translate into the training or experience requirements of another direct care position, although they generally require similar levels of competency-based training (post-secondary coursework) within similar content areas (e.g., supporting activities of daily living and CPR).<sup>13</sup> Lack of consistency, or clear mapping of competencies, across direct care roles threatens portability of training and limits mobility of workers between direct care jobs. Further, it complicates the development and streamlining of career pathway opportunities for the direct care workforce.

In addition to lack of standardized training and competencies across direct care roles, the method direct care roles are classified by state labor agencies may be unclear. The federal Department of Labor, Bureau of Labor Statistics utilizes the Standard Occupational Classification system to classify workers into occupational categories. These codes are used for federal and state occupational reporting and tracking purposes and include several occupations that may be considered “direct care” under the “Healthcare Support Occupation” job family, including: Personal Care Aides, Nursing Assistants, Orderlies, and Home Health Aides.<sup>14</sup> The job title descriptions for three of these occupations includes “Patient Care Assistant,” and there is overlap in the tasks and work activities associated with each occupational code. The lack of clear distinction in roles, titles, tasks and activities ultimately threatens a state’s ability to quantify its direct care workforce, perform comparative analyses, and create streamlined workforce development initiatives and opportunities for direct care workers.



An example of description of direct care worker roles can be found below:

Common Role/Title	Standard Occupation Code/Title (by O*NET)	Long term services and support (LTSS) setting	Is the state required to credential this individual to practice in this setting?
Direct Support Professional	Orderlies (31-1132.00), Personal Care Aides (31-1122.00)	Home and Community-based Services or Institutional Settings (Intermediate Care Facilities)	Yes
Home Health Aide	Home Health Aide (31-1121.00), Nursing Assistants (31-1131.00), Orderlies (31-1132.00), Personal Care Aides (31-1122.00)	Home and Community-based Services	Yes, for federally certified home health agencies
Nursing Assistant	Nursing Assistants (31-1131.00), Orderlies (31-1132.00), Personal Care Aides (31-1122.00)	Institutional Settings (Skilled Nursing Facility)	Yes, in CMS settings

Variation in direct care titles and regulation (by state) can be found below:

State	Common Role/Title	State Regulatory Title	State Agency Responsible for Occupational Regulation
California	Direct Support Professional	Home Care Aide	<a href="#">California Department of Social Services</a>
	Home Health Aide	Home Health Aide	<a href="#">California Department of Public Health, Professional Certification Branch, Aide and Technician Certification Section</a>
	Nursing Assistant	Certified Nurse Assistant	<a href="#">California Department of Public Health, Professional Certification Branch, Aide and Technician Certification Section</a>
Indiana	Direct Support Professional	Direct Support Professional	<a href="#">Indiana Family &amp; Social Services Administration</a>
	Home Health Aide	Registered Home Health Aide	<a href="#">Indiana Department of Health</a>
	Nursing Assistant	Certified Nurse Aide	<a href="#">Indiana Department of Health</a>
Louisiana	Direct Support Professional	Direct Service Worker	<a href="#">Louisiana Department of Health, Health Standards Section</a>
	Home Health Aide	N/A (Individuals working in Medicare-certified agencies must receive the required training, but there is no state certification for Home Health Aides. Individuals working in home health may hold a CNA credential)	N/A
	Nursing Assistant	Certified Nurse Aide	<a href="#">Louisiana Department of Health, Health Standards Section</a>

State	Common Role/Title	State Regulatory Title	State Agency Responsible for Occupational Regulation
New Jersey	Direct Support Professional	Direct Support Professional	<a href="#">New Jersey Department of Human Services</a>
	Home Health Aide	Certified Home Health Aide, Certified Homemaker-Home Health Aides	<a href="#">New Jersey Division of Consumer Affairs</a>
	Nursing Assistant	<a href="#">Certified Nurse Aide or Personal Care Assistant</a> (if working in long-term care) Unlicensed Assistive Personnel (if working in acute care)	<a href="#">New Jersey Department of Health</a>
New York	Direct Support Professional	Direct Support Professional	<a href="#">New York State, Office for People with Developmental Disabilities</a>
	Home Health Aide	Advanced Home Health Aide, Home Health Aide, Personal Care Aide	<a href="#">New York State Department of Health</a>
	Nursing Assistant	Certified Nurse Aide	<a href="#">Prometric, on behalf of the New York State Department of Health</a>
South Dakota	Direct Support Professional	N/A (There is not currently a state regulated process for this role but there have been initiatives to encourage credentialing**,*)	<a href="#">N/A</a>
	Home Health Aide	N/A (This role is not defined in South Dakota statute or regulated by a state agency)	<a href="#">N/A</a>
	Nursing Assistant	Certified Nurse Aide	<a href="#">North Dakota State Department of Health oversees certification requirements, North Dakota State Board of Nursing approves nurse aide training curriculums/programs and registers qualified nurse aides</a>

Finally, the executive branch agency responsible for occupational regulation of direct care workers varies across states. In many states, the department of health oversees regulation and training for nursing assistants and home health aides while direct support professionals are regulated by the state human services/social services agency. Sometimes, a licensing agency establishes regulations. Variations within and between states may complicate a streamlined approach to direct care workforce development and threaten worker mobility.

Some states have developed strategies to enhance role and scope definition for direct care workers by streamlining training requirements for related roles or better defining job responsibilities for each role. Ultimately these strategies facilitate career path development both within the direct care sector and externally.

\* [https://www.dakotabilities.org/media/files/16Aug\\_DSP%20Credentialing%20Proposal\\_Final.pdf](https://www.dakotabilities.org/media/files/16Aug_DSP%20Credentialing%20Proposal_Final.pdf)

\*\* <https://dhs.sd.gov/developmentaldisabilities/docs/Annual%20Work%20Plan%20-%20%20FFY%202017.pdf>



## STATE EXAMPLES:



**Colorado** established a Training Advisory Committee in 2019 through Senate Bill 19-238 that made recommendations for standardizing training requirements for home care workers. This committee was led by the Colorado Department of Health Care Policy & Financing and included representation from multiple state departments. The committee ultimately made recommendations to standardize core training requirements and, in anticipation of additional growth and changes to direct care industry in the coming years, periodically review training content to ensure relevancy and alignment with Colorado Medicaid.<sup>15</sup> Additionally, the Colorado Direct Care Workforce Collaborative, a stakeholder group hosted by the Department of Health Care Policy & Financing, is undergoing an executive branch initiative to align and streamline direct care positions across state departments.<sup>16</sup>



**Wisconsin** had a Governor's Task Force on Caregiving that produced a final report in September 2020.<sup>17</sup> Governor Tony Evers incorporated several of the task force's recommendations in the Wisconsin 2021–2023 Executive Budget,<sup>18</sup> including a recommendation to develop a “person-centered direct support professional training to achieve consistent standards of healthcare practice” as well as the development of a “career ladder for caregivers leading to potential certification as a nurse aide.”



### **CONSIDERATION 3: Identify and support training opportunities that enhance accessibility of direct care jobs and create opportunities for career growth.**

**D**irect care jobs require limited training and education and therefore can serve as an accessible entry point for work in the health sector. Although demand for these roles is high and their services are critical, many states do not prioritize these roles in workforce development initiatives because the wages typically fall below thresholds set by states for inclusion in such initiatives. To address this issue, state education and workforce initiatives are focused on ensuring that these roles are only the first step on a clear career pathway that leads to higher wage opportunities. There are several solutions states may implement to address training needs, support recruitment, and build pathways for career progression.

Paid work-based learning opportunities, such as apprenticeships, support recruitment by removing training costs as a barrier to entry for qualified workers. Defined career pathways, such as those that articulate professional and technical education and translate experience into college credits and programming or recognized credentials, may support health sector retention by facilitating transitions to higher skills and higher wage jobs for direct care workers. Strategies such as these require coordination and collaboration across state workforce, education, and higher education entities.

#### **Apprenticeship and Work-based Learning**

The time and costs associated with training may keep some individuals who are interested in pursuing certain careers from doing so. In some instances, work-based learning models such as apprenticeships can address these barriers. These “earn and learn” models, such as apprenticeships and pre-apprenticeships, are opportunities that offer paid employment to individuals while they receive training and work toward certification or degree attainment. Health care occupations are consistently one of the highest priority sectors for state workforce investments. Apprenticeship models are rapidly emerging and expanding for direct care occupations and related health occupations, such as community health workers and health information technologists.

#### **TRAINING CONSIDERATIONS**



**Direct care worker roles typically require training beyond a high school diploma but less than a four-year college degree and are therefore considered “middle skills” jobs from a workforce development perspective.**

**Training for direct care roles may be regulated through multiple executive branch agencies—the Department of Education for high-school based trainings and career and technical education for entry-level careers; postsecondary entities for certificate and associate degree programs; and Medicaid or licensure boards for roles like CNAs. Some direct care roles are not state-regulated and may only be subject to employer requirements.**

**For state agencies to develop strategies that will promote career growth among direct care workers, coordination across state agencies is critical. These agencies are responsible for overseeing training requirements and scope of practice for direct care workers, as well as the jobs that may be part of a direct care career pathway.**



**APPRENTICESHIP** is a structured system of training designed to prepare individuals for skilled occupations. It combines on-the-job learning under the supervision of experienced workers with related classroom instruction. It is sponsored by employers, employer associations, or labor/management groups that can hire and train in a working situation. There are two types of registered apprenticeship oversight structures for states: States under the Office of Apprenticeship model have all registered apprenticeship program registration and oversight completed by federal U.S. Department of Labor staff through state field offices. States under the DOL-recognized State Apprenticeship Agencies have all registered apprenticeship program activity handled directly by state administrators and staff, acting on behalf of DOL

## Career Pathways

Turnover is a well-documented issue among direct care workers and, in many cases, workers are leaving the health sector completely for higher-wage jobs that require little to no training. Many direct care jobs require skills that may be easily translated through training into higher skills and higher wage health sector opportunities. However, the time and costs associated with additional training make the pursuit of these opportunities challenging.<sup>19</sup> By establishing career pathways that facilitate transitions to higher skills and higher wage jobs in the health sector, it is easier to retain qualified workers in the health sector.

Defined career pathways typically articulate the series of steps for credentialing and training needed to progress on a career trajectory, for example the pathway from a CNA to licensed practical nurse to registered nurse. These pathways can exist within one postsecondary institution and/or can incorporate articulation agreements that identify how technical or on-the-job training can translate into college credits. These strategies can reduce the overall cost of training by providing clear information for workers and learners on the ways in which they can progress professionally while receiving recognition for their professional experience and learning.

## STRATEGIC OPPORTUNITIES

### Maximizing use of state datasets to identify direct care career pathways



Executive branch agencies can identify career pathways using available state data sources (e.g., licensing/regulatory data, SLEDS/P-20 data) to better understand the career journeys for direct care workers and develop targeted programming. Although federal datasets are useful, they might not offer the granularity necessary for assessment of individual pathways. For example, the Bureau of Labor Statistics data, which is based on employer surveys, is an excellent source of aggregated employment information for states and large metropolitan areas but does not enable assessment of individual career journeys or common pathways within an employment sector. States can consider developing unique data infrastructures to identify career pathways and inform workforce development initiatives. State data sources, such as statewide longitudinal data systems, licensing/regulatory data, and other sources containing common individual identifiers can be leveraged to identify career pathways through mapping educational programming, occupational regulation data, and standardized occupation codes.

### Leverage federal programs to support direct care workforce development strategies



The Department of Labor distributes funding to states through Workforce Innovation and Opportunity grants and other discretionary funding, which is utilized to support workforce training and related services. While the structure of state workforce development systems varies across states, this funding allows states to identify and invest in critical occupational fields. The workforce system can be a catalyst for the meaningful connection of supply and demand data with industry partners. For example, Washington's Workforce Board and the University of Washington's Center for Health Workforce Studies have created the [Health Workforce Sentinel Network](#), which links the health care sector with policymakers, workforce planners and educators to respond to the needs of the health care workforce. Specifically, this network identifies emerging skill needs and roles required by [diverse healthcare settings](#) and employers across the state.

## STATE EXAMPLES:



[Alabama's Workforce Council](#) has initiated a project related to credential transparency and career pathway mapping. The Alabama Committee on Credentialing and Career Pathways created a rubric for identifying in-demand occupations. As a part of this project, careers are mapped to competencies, assigned to a credential of value, and mapped to a career cluster and career pathway. A technical advisory committee composed of health science subject matter experts supports health sector occupational discussions. Alabama plans to create a College and Career Exploration Tool which will leverage data obtained from a State Longitudinal Database Systems (SLDS) to inform career pathways mapping. In order to qualify as an "in-demand occupation," it must meet the following three criteria: 1) at least 70 percent of median regional wage, 2) show positive annual growth for the next ten years, and 3) project a minimum of 15 openings per year, as well as meeting one of the following: the median wage exceeds 70 percent of the Lower Living Standard Income Level, or; it requires a post-secondary degree, certificate, or credential for initial employment.<sup>20</sup> Although direct care workers' positions may not qualify as in-demand occupations because of their low wages, they are included in mapping because of projected growth, job openings, and they may be a step on the pathway to higher wage in-demand careers such as nurses or dietary specialists.<sup>21</sup>

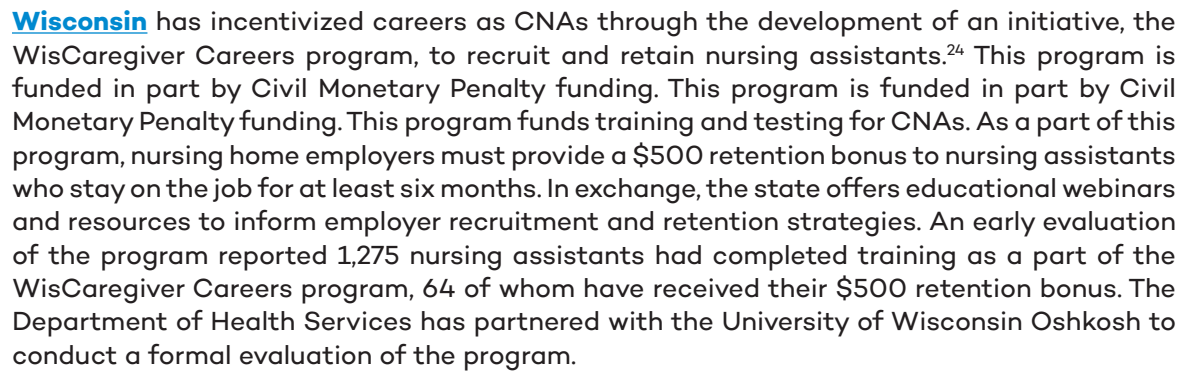
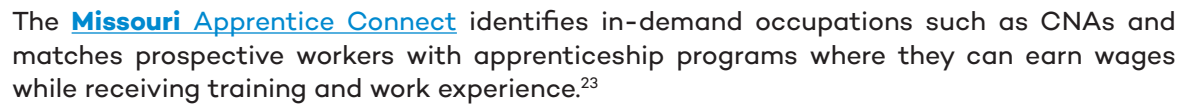
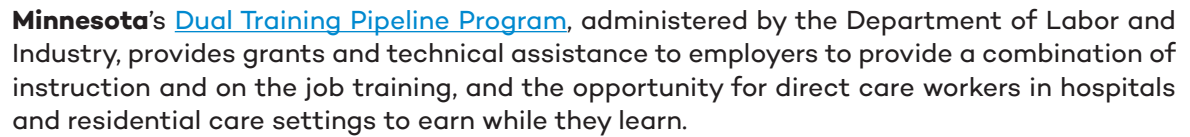
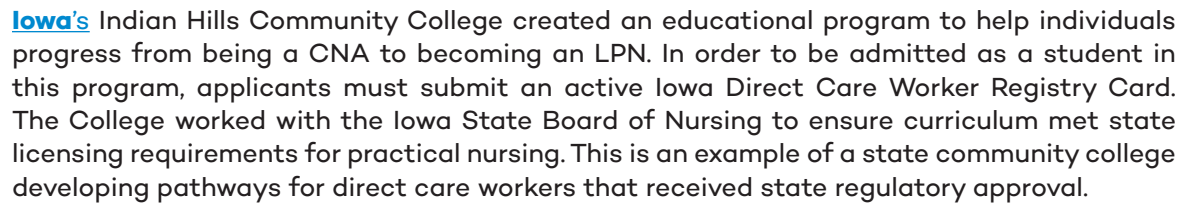


**Colorado** has created career pathways programs that target the state's top jobs. [My Colorado Journey](#) provides an overview of salary, job openings and growth rate of priority jobs, as well as potential pathways to higher-paid jobs. The state also prioritizes evaluating the strength of career pathways. This evaluation is accomplished through leveraging state data to track credentials and an individual's program completion.<sup>22</sup> While the data sharing program is relatively new, it will track key outcomes such as salary for graduates, exam results, and retention in key health jobs, which will inform future initiatives.

The [Colorado Collegiate Apprenticeship Program](#) is administered by the Colorado Department of Higher Education and is run in partnership with higher education institutions across the state. The apprenticeship model combines didactic classroom content with paid training opportunities in multiple sectors, including entry-level health care jobs and direct care roles.



The [Indiana Governor's Health Workforce Council](#) commissioned a study using state administrative data, [Certified Nurse Aide as a Pathway to Licensed and Professional Nursing in Indiana](#), that examined career pathways for Certified Nurse Aides. By linking state issued licenses with social security numbers, Indiana was able to determine how many individuals who previously held an Indiana CNA license went on to obtain licenses in Practical Nursing or Registered Nursing. Additionally, Indiana implemented legislation requiring licensees of certain health profession boards to provide supplemental information at time of state license renewal. By linking CNAs to subsequent nursing licenses and supplemental information, Indiana was able to determine the number of people who took this occupational pathway and examine individual characteristics. Individuals from underrepresented minority groups accounted for a greater proportion of LPNs and RNs who previously held a CNA than other populations. As a result of the findings from this study, Indiana's largest public community college developed a bridge program offering college credit to CNAs. The bridge program seeks to reduce cost barriers and enhance nursing career pathways for CNAs.







## CONSIDERATION 4: Evaluate Strategies for Addressing Wage Issues

Although the direct care workforce provides critical, high-demand services to many populations and settings, the wage for these jobs is typically low in comparison with other middle-skills jobs. In many cases, hourly wages for direct care workers do not constitute a living wage. Nationally, one in eight direct care workers lives in poverty.<sup>25</sup> Competition for workers from the gig economy, paired with lack of professional growth opportunities for direct care workers, can result in high turnover.

In addition to identifying and strengthening career pathways that lead to higher wage opportunities, reducing attrition remains essential if states are to build a direct care workforce pipeline. While many direct care workers will want to pursue pathways to higher-skilled and higher-credentialed jobs, some may prefer to remain in a position where direct care is their primary responsibility. For these workers, addressing wage issues is a top priority.

In 2019, the national average wage for direct care jobs was \$12.80.<sup>26</sup> While wages for these jobs are higher than the federal minimum wage of \$7.25, they do not provide a living wage, or the minimum wage necessary to meet basic needs for households where a direct care worker is the only breadwinner. The majority of direct care workers are women and many are single parents and people of color.<sup>27</sup> In 2019, the wage for families dependent upon direct care jobs fell below the national living wage of \$16.54 for a family of four.

Lifting workers and their families out of poverty while maintaining a robust direct care workforce requires multipronged solutions. Examining and developing targeted strategies for addressing wage issues is part of a comprehensive approach to enhancing workforce development in the direct care sector. Medicaid wage pass-throughs are one way states are addressing wage issues for direct care workers. Implementation of wage pass-through varies substantially between states, but common strategies include: earmarking portions (a percent or set dollar amount) of service reimbursement to be directed specifically to direct care wage or benefits, and; setting a wage minimum for a specific role or sector.<sup>28</sup> Absent these state strategies, it would be at the employer's discretion to direct reimbursement allocation to cover costs associated with providing a certain service. Wage pass-through strategies are commonly introduced as a tiered or incremental approach but are generally made permanent once fully implemented.<sup>29</sup> In the height of the COVID-19 pandemic, many states experienced an acute direct care workforce crisis related to increased workload demands, increased occupational exposure risk, and workers experiencing an increased demand in personal and family needs. In response, some states developed strategies to offer temporary or one-time bonuses to workers as a recruitment and retention strategy.<sup>30</sup>

### LIVING WAGE AND THE DIRECT CARE WORKFORCE

#### Tool for Identifying Estimated Living Wage in States and Counties



Living wage is frequently defined as the minimum income necessary for a worker to meet their basic needs. The federal poverty level is often used as the benchmark for determining an individual's ability to meet their basic needs. Although poverty thresholds account for a basic food budget, they do not consider other things that draw from income and are required for a person to work, such as childcare or health care. The Massachusetts Institute of Technology has developed a tool to estimate the living wage for each state and county in the United States: [Living Wage Calculator](#). Tools such as these can be useful for contextualizing state discussions regarding direct care workforce wage.

## STATE EXAMPLES:



**Colorado** implemented a wage floor of \$12.41 per hour for workers who provide Medicaid-covered services to consumers. Additional funding required for implementation was supported by a reimbursement rate request submitted by the Colorado Department of Health Care Policy and Financing.<sup>31</sup> As a part of requirements established by the law, the agency requires tracking and reporting of funding used for compensation increases.



**Massachusetts** implemented a requirement that nursing facilities invest at least 75 percent of their revenues toward direct care staff costs to hold facilities financially accountable for revenue spent to support direct care staffing. This requirement, referred to as the Direct Care Cost Quotient, serves to strengthen the direct care workforce and support in the recruitment and retention of staff. To ensure compliance, facilities are required to submit both an interim and final report to the Executive Office of Health and Human Services (EOHHS).<sup>32</sup>

**Massachusetts** Medicaid supported signing bonuses for residential care facility staff (CNAs, nurses, therapists/assistants, and social workers) who worked at minimum 64 hours (a bonus of \$500+) or 128 hours (a bonus of \$1,000+) in the first 15 or 30 days of their employment (respectively).<sup>33</sup> Facility employers paid the employee directly, then requested reimbursement for the signing bonuses from Medicaid through submission of a form and attestation to the Medicaid office.



Under **Minnesota** statute, PCA service provider agencies must use 72.5 percent of the revenue generated by the medical assistance rates toward worker salary and benefits, and provider agencies must submit documentation of how reimbursements were distributed as a part of provider enrollment, reenrollment and revalidation as a personal care assistance agency.<sup>34</sup>



During the COVID-19 pandemic, **Michigan** had a temporary Medicaid wage increase totaling an increase of \$2 an hour for RNs, LPNs, and CNAs who were providing care in a long-term care setting or an in-home behavioral health setting.<sup>35</sup> Governor Gretchen Whitmer highlighted the policy in her state of the state address and expressed interest in making the wage increase permanent.<sup>36</sup>



Through Executive Order, **New Hampshire** Governor Chris Sununu established the COVID-19 Long Term Care Stabilization Program, which provided stipends to qualifying full-time (>30 hours per week, \$300 per week) and part-time (<30 hours per week, \$150 per week) frontline workers.<sup>37</sup> This stipend was available to workers who provided services directly to individuals in residential, home, or community settings. Funding supporting this initiative was provided through the state general fund and Coronavirus Relief Funds.<sup>38</sup>



**New Jersey** implemented a temporary Medicaid rate increase during the height of the pandemic where 60 percent of the revenue was allocated directly to CNA wage/benefits.<sup>39</sup>

A regulation issued by the U.S. Department of Labor in 2013 ensured that direct care workers (home health and personal care workers) received the same basic labor protections (including minimum wage and overtime pay) as employees of other sectors.<sup>40</sup> Prior to this rule, many direct care workers were classified under the Fair Labor Standard Act as falling under a “companionship services” exemption to labor protections.<sup>41</sup>

## Conclusion

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**D**irect care workers provide essential and physically demanding services for older adults, individuals with disabilities, and others requiring life-saving and life-supporting help. However, they are generally paid lower wages than others with a comparable level of training and skill requirements. Demand for direct care workers has increased drastically over the last several decades and was highlighted during the COVID-19 pandemic, as direct care workers were in acute need for their “essential contributions” particularly in long term services and support (LTSS) settings.<sup>42</sup> Direct care workforce demand is expected to continue to increase in the future, as the U.S. population ages.<sup>43</sup> The development of strategies to ensure a sufficient and well-qualified direct care workforce became a top priority for many states during the pandemic and will likely be a priority for years to come. Governors are positioned to positively influence direct care workforce policy and programs within their states, as the examples outlined in this paper illustrate. They can serve as models for other states to devise comprehensive plans to retain direct care workers in each state.

State strategies for enhancing professional opportunities for the direct care workforce range from creating or strengthening cross-sector planning bodies to developing streamlined training/credentialing and career pathways. Platforms for cross-sector communication and strategy development ensure alignment between the numerous state government agencies, employers, training providers, and consumers that have a stake in the direct care workforce. Identifying opportunities to streamline and standardize the training and credentialing of direct care roles, especially those defined by state or federal programs, may improve the efficiency of workforce development initiatives and reduce administrative burden for state agencies and employers while improving employment opportunities for direct care workers. The development of work-based learning models can minimize barriers to entry for individuals interested in direct care jobs as well. The identification and/or enhancement of career pathways for direct care workers that leverage previous training/experience and streamline transitions to higher skills higher wage employment opportunities may be key to retaining workers in the health sector. Finally, solutions to address wage issues with direct care jobs, such as Medicaid wage pass-through policies, will enhance the economic outlook of workers and their families and may improve retention in these critical positions.

The direct care workforce represents a critical population with numerous challenges which include the physically demanding nature of the work and wages that do not match their social impact. Because of the cross-agency nature of the strategies needed to support the development and retention of this workforce, Governors are uniquely positioned to direct and align agencies and employer outreach to begin to address these challenges. The COVID-19 pandemic has underscored how vital direct care workers are to state health systems, and this brief has presented some of the strategies that states may want to consider as they invest in and support these frontline workers.



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