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Forging a Sustainable Future for California's Direct Care Workforce

A Primer for Philanthropy, Worker & Consumer Advocates

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Contents

Introduction 4

Part 1. Background on the Direct Care Workforce 5

Part 2. Public Funding for Long-Term Services and Supports 8

- Medi-Cal and Medicare 9
- California Advancing and Innovating Medi-Cal 10
- LTSS Funding by Setting 11
  - Congregate Residential Care 11
  - Home and Community Based Services 12

Part 3. Potential Levers to Raise the Wage Floor 15

- State and Federal Policy 15
- Organizing 18
- Government Partnerships 19
- Strategic Enforcement 19
- Alternative Models 20

Part 4. How Do We Build Sustainable Career Pathways? 21

- Direct Care Worker Training and Regulation: Where Are We Now? 22
- Current Barriers to Direct Care Worker Progression 23
- Lessons from Past California Initiatives 24
- Promising California Models 25
- What Can We Learn From Other States About Training? 26
- Essential Ingredients for Successful DCW Training 27
- How Are Other States Building Sustainable Pathways? 28
- Challenges Facing Statewide DCW Pathway in California 30

Conclusion 32

Introduction

The crisis facing the paid direct care workforce has been well documented: a rapidly aging population; an alarming shortage of direct care workers; abysmal pay and working conditions prevalent throughout the sector – vulnerabilities that were starkly and heartbreakingly highlighted by the coronavirus pandemic. In the past few years, California has committed to addressing the direct care crisis in multiple reports issued through various commissions and committees, including the Future Health Workforce Commission, the Future of Work Commission, and the Master Plan for Aging. In order to evaluate the state's progress implementing the many recommendations set forth therein, and to propose viable alternatives, a deeper understanding of the direct care sector is essential.

Direct care work, devalued by design, pays poverty wages and is overwhelmingly performed by women of color – a legacy of slavery, systemic racism and legal exclusion that has long defined professional caregiving in the United States. The vestiges of legally-sanctioned economic segregation are evident in the demographics of today's direct care workforce: in California, 80% are women, 72% are people of color (12% Black/ African American, double the percent of the overall state population), and nearly 50% are foreign-born. Direct care workers earn so little that over half qualify for public benefits. Working conditions are often grueling – direct care recently surpassed commercial fishing and logging to become the most dangerous occupation in the country.

Yet direct care occupations are the fastest growing in California, with a projected labor shortage of between 600,000 to 3.2 million by 2030. The need for a workforce development strategy that meets this shortfall is urgent. Foremost among the multifold challenges to recruitment and retention are raising the wage floor and building accessible, family-sustaining career pathways. A prerequisite for both is a familiarity with the essential aspects of public funding for long-term services and supports. Although there is significant expertise among consumer advocates on Medicaid funding and reimbursement for LTSS, that expertise has not historically encompassed the workplace. Conversely, worker advocates – while they possess in-depth knowledge of tools for increasing job quality – are less familiar with the long-term care funding structure. Likewise, the experience and knowledge base of most philanthropic organizations is generally focused on either direct care consumers or direct care workers, but rarely both.

The information summarized here is meant to bridge that gap, in support of collaborative efforts to define workforce policy in the direct care sector. Toward that end, this primer is divided into four interconnected parts. Part 1 provides essential background on the direct care workforce – defining the work, describing the workforce, working conditions and pay. Part 2 provides an overview of public funding for LTSS (and, by extension, direct care work), organized by setting and program. Part 3 builds on public funding basics to identify potential levers for increasing wages. Part 4 outlines the current landscape for building direct care worker career pathways and explores what models could be constructed on the foundation of a higher wage floor. Finally, this primer proposes a way forward for California that incorporates promising small-scale initiatives underway here, and progressive programs and policies being implemented in other states and at the national level.

Background on the Direct Care Workforce

Direct care occupations encompass the delivery of long-term services and support in people's homes, in community-based settings such as adult-day care, and in congregate living settings such as nursing homes and assisted living facilities.[1] In most cases, the bulk of direct care is comprised of assistance with activities of daily living. ADLs include eating, dressing, bathing and toileting. Direct care also is made up of intermediate activities of daily living. IADLs include housekeeping chores, meal preparation and medication management. ADLs and IADLs are performed by workers who are not licensed medical professionals. Some direct care workers are certified to also perform clinical tasks such as blood pressure readings and range of motion exercises under the direction of nursing or medical staff.

What kind of jobs do Direct Care Workers do?

Personal Care Aide

(PCAs) aka personal attendant, personal assistant, caregiver, companion. Assist with ADLs (eating, dressing, bathing, and toileting), often with IADLs (housekeeping chores, meal preparation, medication management), sometimes help individuals go to work and remain engaged in their communities.

Home Health Aide

(HHAs) provide essentially the same care and services as CNAs, but at home or in community settings under the supervision of a nurse or therapist. HHAs may also perform light housekeeping tasks.

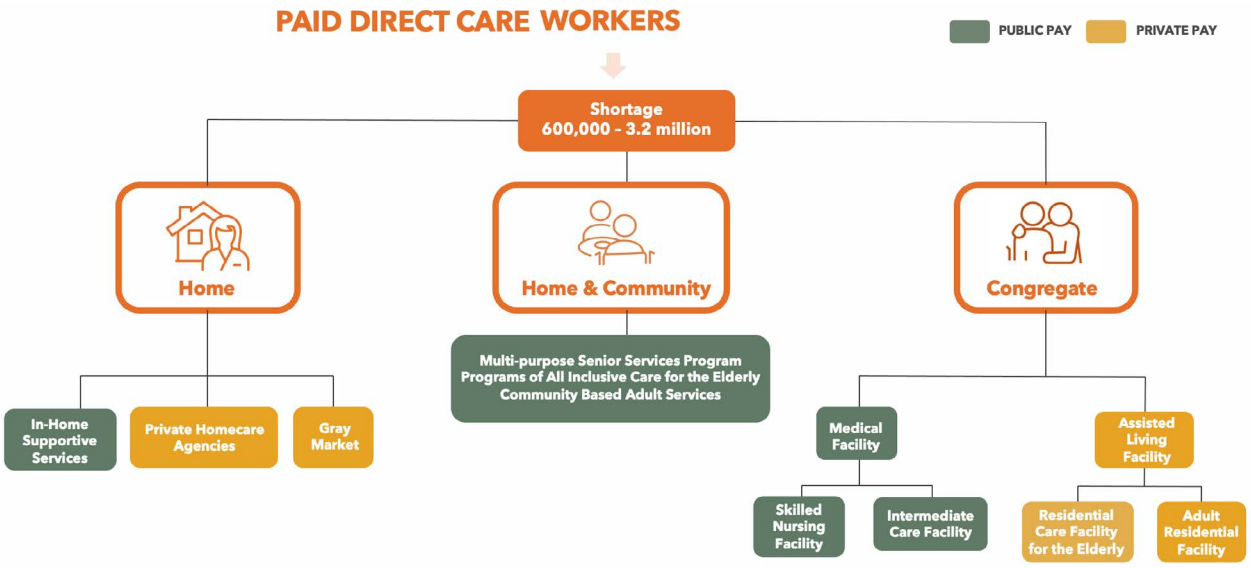
Certified Nursing Assistant

(CNAs) Under direction of nursing or medical staff, CNAs assist with general patient care, assist residents with ADLs, and perform clinical tasks such as range-of-motion exercises and blood pressure readings.

Direct Support Professional

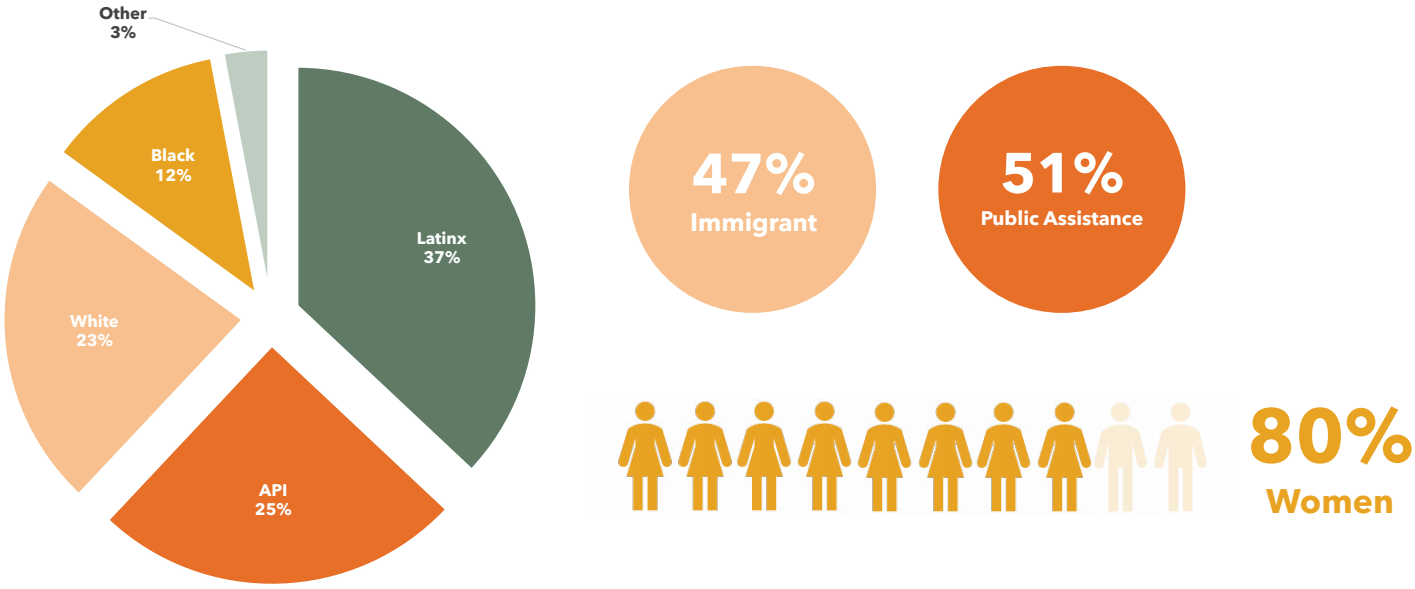
(DSPs) support persons with ID/DD with ADLs/IADLs, including at times administering medication, developing behavioral management plan, and managing medical records.

Where do Direct Care Workers provide care?

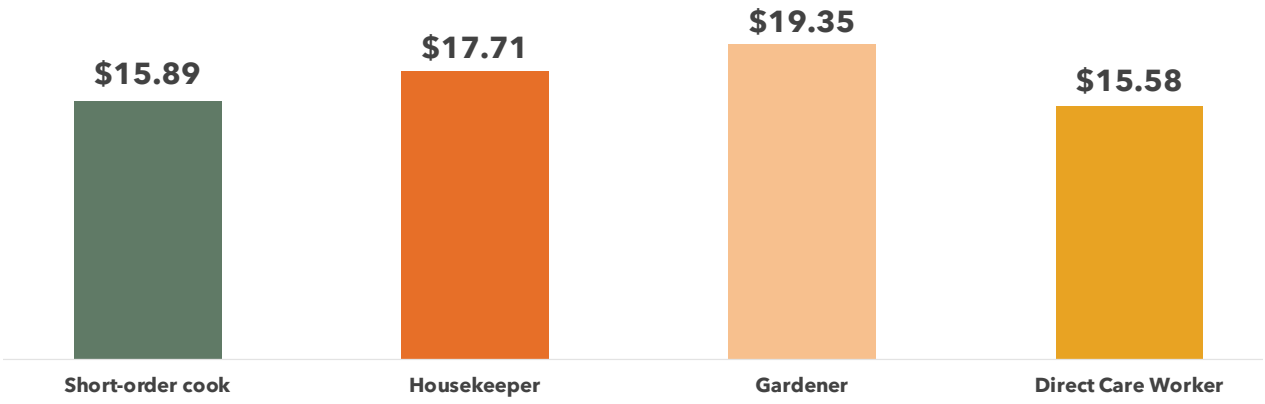


Because professional caregiving in the United States has historically been done by Black women, domestic workers were explicitly excluded from the federal labor protections borne of the New Deal and are still living with the economic consequences today. Direct care workers are among the poorest working Californians, paid an average of $16.27 an hour, less than half the state's median wage. Inextricably, women of color are dramatically overrepresented in direct care, with Black/ African American and Asian caregivers comprising 12% and 25% of the workforce, respectively, double their percentage of the statewide population.

Who are Direct Care Workers?[2]

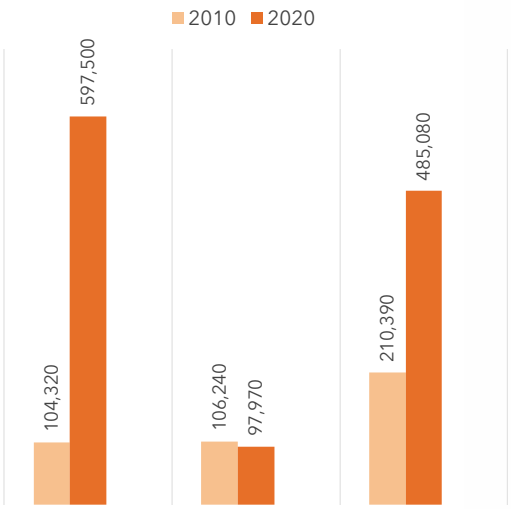


How much do Direct Care Workers earn?[3]

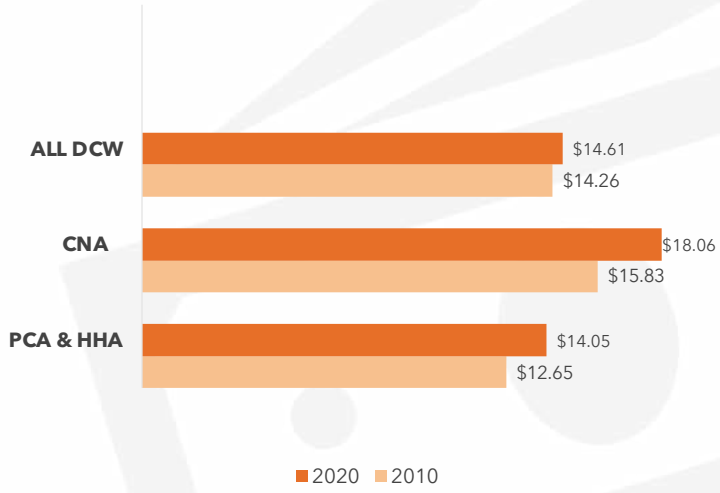


Wage Comparison

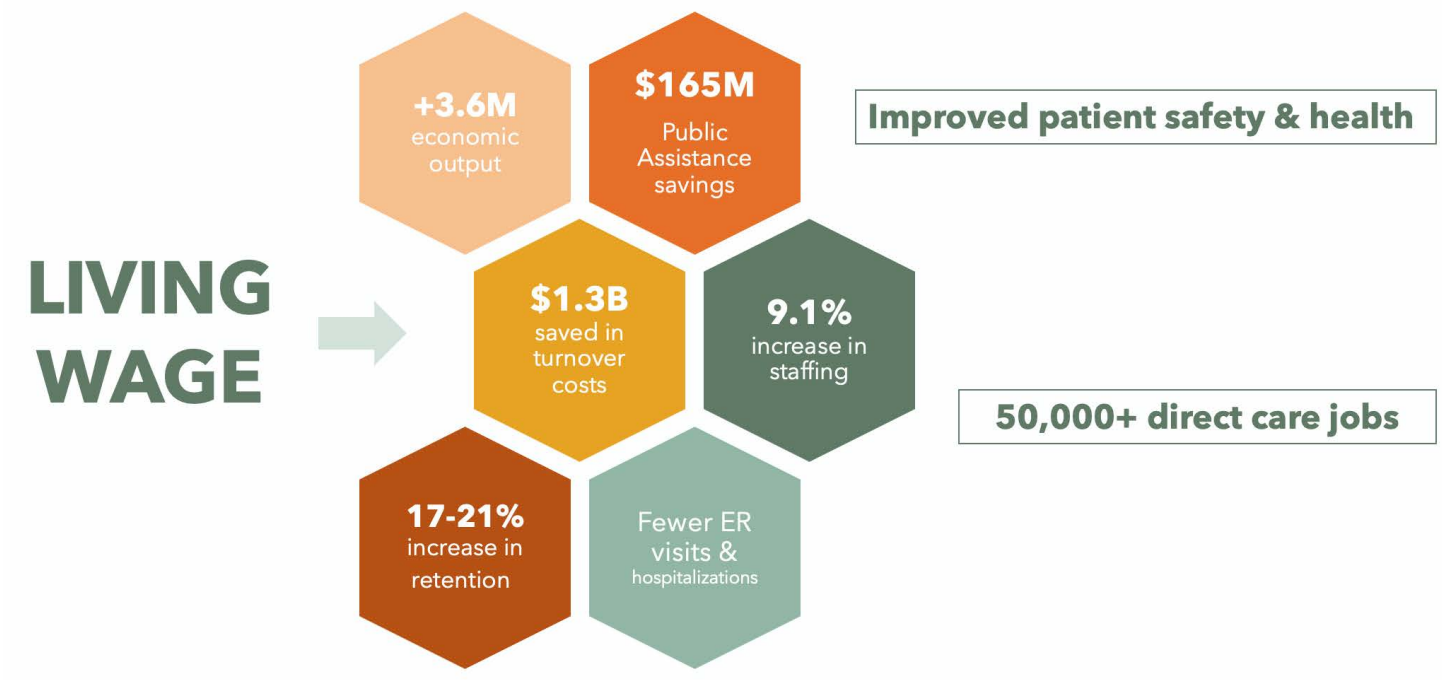
Job Growth



Median Hourly Wages



What if Direct Care Workers earned a living wage?[4]



Public Funding for Long-Term Services and Supports

The benefits of a living wage for direct care workers, consumers and California as a whole are straightforward. The road to higher wages is more complex. A basic understanding of public funding for LTSS is an essential starting point.[5] Figure A summarizes funding sources by program and setting. Figure B illustrates the relationship between federal, state and county funding for LTSS.

Figure A.

Publicly-Funded Long-Term Services and Supports				
SETTING	Congregate Institutional	Home & Community Based Services		
PROGRAM	Skilled Nursing Facilities	In-Home Supportive Services	•Assisted Living Waiver •Home & Community Based Alternatives •Community Based Adult Services •Multi-Service Senior Program	Program of All-Inclusive Care for the Elderly (PACE)
FUNDING SOURCE	Medicare +/or Medi-Cal[1] 50% Federal + 50% State	50% Federal, 32.5% State, 17.5% County OR 56% Fed, 28.6% State, 15.4% County[2]	50% Federal + 50% State	Medicare + Medi-Cal
AUTHORITY**	Entitlement 1905(a)(4)(A)[3]	State Option 1915(i), 1915(j) 1915(k)	State Option 1115, 1915(c)	State Option Balanced Budget Act of 1997
# OF WORKERS	53,000	650,000	25,000+[4]	

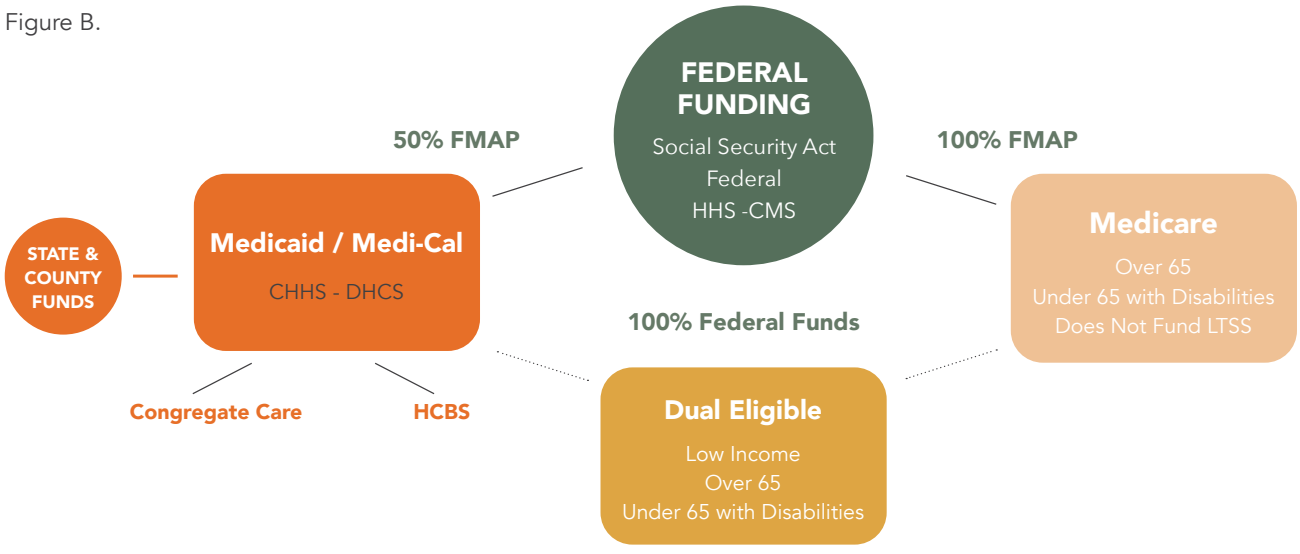
[1] In California, Medicare was the payor for 23% of SNF stays in 2020. The 50/50 funding split refers to Medi-Cal funded stays.

[2] These funding splits account for the programs that serve the majority of the IHSS consumer population – the Personal Care Services Program, IHSS Plus Option, and the Community First Choice Option. The IHSS-Residual program serves 1.5% of IHSS recipients and is 65% State + 35% County funded.

[3] All statutory references are to Titles XI and XIX of the Social Security Act (1965).

[4] This figure includes workers providing care through CBAS and MSSP only. There is insufficient information available to determine what portion of the approximately 100,000 workers registered with DSS as home care aides provide services that are funded by Med-Cal.

Figure B.



Medi-Cal and Medicare

Millions of Californians who live with disabling conditions or chronic illnesses require assistance with activities of daily living such as bathing, dressing and eating. Those who are eligible for **Medi-Cal** may qualify to receive long-term service and supports from a range of state programs that are financed using a combination of federal, state and local funds. The 1965 Medicare and Medicaid Act amended the Social Security Act to provide health insurance to older adults and low-income individuals. Medi-Cal is California's version of Medicaid. Medi-Cal is administered and regulated at the state level by the Department of Health Care Services, within the state's Health & Human Services Agency. To be eligible for Medi-Cal, an individual's income must be below $17,933[6] and until 2024, when the asset test will be eliminated, their assets must not exceed $2,000.

The proportion of California's Medi-Cal program that is paid for by the federal government is determined by the Federal Medical Assistance Percentage, also referred to as the federal Medicaid matching rate. FMAPs vary from a floor of 50% to a high of 74%. California's FMAP is currently 50% for the vast majority of Medicaid services. The FMAP formula has remained essentially unchanged since the inception of the Medicaid program, with the exception of a few temporary increases during national economic downturns, extensions of Medicaid coverage via the Affordable Care Act, and in response to states of emergency – the most recent example being the federal increases authorized by the American Rescue Plan Act discussed in more detail in the HCBS section, below.

In addition to Medi-Cal, adults over 65 and people living with disabilities are eligible for Medicare. Medicare is a federal insurance program paid out of Social Security deductions. Individuals over 65 who have made Social Security contributions are entitled to the benefits, as well as people under 65 with disabilities who have been eligible for Social Security disability benefits for at least two years, and those of any age with end-stage renal disease. Medicare is not based on financial need; anyone who meets the age or disability requirements is eligible. It is a widespread misconception that Medicare pays for LTSS. Medicare does not provide long-term care coverage or custodial care unless medical care is needed – meaning it does not pay for assistance with ADLs.[7]

Individuals who qualify for both Medicare and full Medi-Cal benefits are dual-eligible enrollees. There are 1.4 million dual-eligibles in California, representing almost 20% of all dual-eligible enrollees nationwide. Although acuity and cost vary widely among dual-eligibles, they make up on average the highest-need, highest-cost portion of Medicare and Medi-Cal populations. People of color are disproportionately represented among dual-eligibles,[8] and dual-eligibles are in poorer health than the general Medicare population.[9]

Because the income and asset thresholds are low, only 20% of Californians qualify for Medi-Cal, leaving millions, often dubbed the forgotten middle, to fend for themselves when it comes to finding and paying for long-term care. Given the exorbitant cost of private LTSS, many older Californians on a fixed income impoverish themselves, either deliberately spending down their assets in order to qualify for public benefits or exhausting their life savings on increasingly expensive private care. This phenomenon has inspired a movement for an expanded public long-term care benefit in California that is an important piece of state and nationwide advocacy around improved access to long-term care.[10]

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California Advancing and Innovating Medi-Cal

California is currently undergoing a major transformation of its Medi-Cal system. Led by the state Department of Health Care Services, California Advancing and Innovating Medi-Cal is a five-year initiative that will add new programs and significantly reform existing ones. CalAIM strives to better coordinate health and social services, toward the goal of maximizing Californians' health and life trajectory through a more equitable and person-centered approach. CalAIM prioritizes improving care for people with especially complex needs, including seniors and people living with disabilities.

CalAIM builds upon prior initiatives that have moved Medi-Cal **from a primarily fee-for-service model to one that uses Managed Care Plans or organizations.** Over 70% of dual eligibles are already enrolled in some form of Medi-Cal managed care. By 2023, almost all dual eligibles were enrolled in a Medi-Cal MCP. The specific impact on long-term care delivery systems respective settings and programs is outlined below.

Because seniors and people with disabilities rely on medical care and LTSS funded by Medicare and Medi-Cal, care delivery for this population is especially fragmented, and Cal-AIM's objective of standardizing and simplifying service delivery is therefore particularly meaningful. These reforms would incentivize managed care programs to help seniors and people with disabilities to stay in their homes, rather than move to a nursing home.

CalAIM is part of a broader effort to address the **historical bias toward institutional long-term care over home and community based LTSS.** Receiving care in a nursing home is considered an entitlement, meaning state Medicaid programs are legally required to cover the cost, while states have the option to choose whether and to what extent to provide home and community based services, commonly referred to as "at state option." During the past 30 years, Congress has created new authorities and incentives for states to offer HCBS (most commonly in the form of waivers, explained in greater detail below).[11] By 2013, HCBS spending surpassed that on nursing homes, comprising over 59% of Medicaid LTSS spending nationwide in 2019. This trend is visible in California, where Medi-Cal funded more than $20 billion in HCBS during fiscal year 2020, serving over 1.2 million low-income residents. In 2021, the American Rescue Plan Act increased the Federal Medical Assistance Percentage for Medicaid HCBS through March 2022, resulting in an additional $3 billion in funding for Medi-Cal HCBS over fiscal years 2021-22.[12]

LTSS Funding by Setting

For older adults, long-term service and support can be provided in a variety of locations, from congregate residential care to home and community-based settings. Congregate residential care can mean a residential care facility for the elderly, often referred to as six-beds or assisted living. Or for those who require everyday nursing care, a skilled nursing facility or nursing home. Public home and community based services are delivered through many different channels, including In-Home Supportive Services, Medicaid waiver programs and PACE, the Program of All Inclusive Care for the Elderly.

Congregate Residential Care

Skillled Nursing Facility

Although Medicare pays for some nursing home care, primarily for short-term rehabilitative stays upon hospital discharge, the majority of nursing home care is funded by Medicaid. Older adults who meet the nursing home level of care threshold are entitled to care in a skilled nursing facility. Subject to federal regulation, each state creates their own reimbursement system for SNFs as part of their **Medicaid State Plan**. As of Jan. 1, 2023, Cal-AIM requires that all institutionalized Medi-Cal members in every county residing in SNFs be enrolled in a Medi-Cal MCP.

There are roughly 53,000 Californians providing direct care in SNFs, for over 400,000 residents every year. About 20% of SNFs in California are unionized. The Service Employees International Union Local 2015 represents over 18,678 certified nursing assistants in 32 counties, as well as licensed vocational nurses, housekeepers and dietary staff.

In 2004, California enacted AB 1629 to revamp its system for Medi-Cal reimbursement of free-standing nursing homes, including skilled nursing facilities.[13] The legislation created a mechanism in the Welfare & Institutions Code (Section 14126.021) to implement a facility-specific, cost-based reimbursement system.[14]

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As part of CalAIM and the broader transition to a Medi-Cal managed care system, significant reforms to the reimbursement rate methodology took effect on Jan. 1, 2023. Three specific reforms are designed to improve job quality.

First, the Workforce & Quality Incentive Program establishes performance-based directed payments to be disbursed based on eligibility criteria determined by the Department of Health Care Services in consultation with representatives from the long-term care industry, organized labor, consumer advocates and Medi-Cal managed care plans. The Medi-Cal managed care plans will make the directed payments to network SNFs pursuant to the agreed upon milestones. At least two of the metrics shall be tied to workforce measures.

Second, for the 2023 calendar year, 85% of the temporary Medicaid payments associated with the COVID-19 public health emergency were required to be spent on additional labor costs, including increased wages or benefits, shift costs, incentive payments, staff retention bonuses, pay differential for workers employed by more than one facility and overtime payments to nonmanagerial workers.

Third, beginning in 2024, DHCS will establish a workforce adjustment to the base reimbursement rate. Skilled nursing facilities may qualify for an enhanced base reimbursement rate if they meet certain workforce standards to be determined in consultation with representatives from the long-term care industry, organized labor, consumer advocates and Medi-Cal managed care plans. The criteria may include, but are not limited to, maintaining a collective bargaining agreement or comparable legally binding written agreement with its direct and indirect care staff, payment of prevailing wage for its direct and indirect care staff, payment of an average salary above minimum wage and participation in a statewide, multiemployer joint labor-management committee of SNF employers and workers.

Residential Care Facilities for the Elderly

Residential care facilities for the elderly provide housing for older adults who require assistance with activities of daily living, but do not need daily nursing care. RCFEs range in size from small six-bed facilities, called six-beds or board and cares, to larger assisted living facilities that can house hundreds of residents. Most RCFEs are primarily private-pay, but Medi-Cal eligible residents who meet the nursing home level of care may be enrolled in the **Assisted Living Waiver** program.

The ALW does not pay for room and board, but rather for services that enable recipients who are at risk of institutionalization (i.e. being moved to a SNF) to continue to safely reside in the residential care facility. ALW services include assistance with personal care, ADLs, laundry, meal preparation, medication management, transportation, recreation and social services, and are provided by RCFE staff. The assisted living waiver can also pay for care coordination.

Home and Community Based Services

Home and community based services are long-term services and supports provided in a home or community-based setting (i.e. outside of a skilled nursing facility) to consumers who are eligible for a nursing facility level of care. In other words, home and community-based services offer an alternative to receiving care as a nursing home resident.

Each state's Medicaid program is governed by a **Medicaid State Plan** – its contract with the federal government for the provision of Medicaid-funded services. The Medicaid State Plan must, among other things, define who is eligible for Medicaid services and describe required and additional services the state Medicaid agency will provide. To make any significant change to its Medicaid State Plan, California must apply to the Centers for Medicare & Medicaid Services for either (1) a State Plan Amendment or (2) an exemption or Medicaid waiver from portions of Title XIX of the Social Security Act.

SPAs and waivers differ in several ways. First, SPAs are usually meant to solidify a policy or program change, while waivers are used to test an innovative programmatic or policy change. Second, the amendments do not generally have an end date, while waivers are approved for a specific duration. Third, SPAs must cover all beneficiaries statewide, while waivers may limit the population and geographic area they serve and restrict the number of available slots. Finally, waivers must be cost-effective or budget-neutral, while there is no such requirement for SPAs.

State Medicaid agencies have several home and community based services options, which are a combination of State Plan and waiver authorities. **California's Medi-Cal program uses all four of these options**, among others, to provide LTSS to older adults.

1. **1915 (c) Home & Community Based Waivers (1981):** Allows states to provide services not usually covered by Medicaid, as long as these services are required to prevent institutionalization.
2. **1915(i) State Plan HCBS (2006):** Allows states the option to offer a wide range of HCBS without securing a waiver, including offering LTSS before recipients need institutional care.
3. **1915(j) Self-Directed Personal Assistance Services Under State Plan (2007):** Allows states the option to disburse cash prospectively to participants who direct their services and purchase non-traditional goods and services other than personal care.
4. **1915(k) Community First Choice (2010):** Allows states the option to provide "Community Based Attendant Services and Supports" at an additional 6% above FMAP.

In-Home Supportive Services

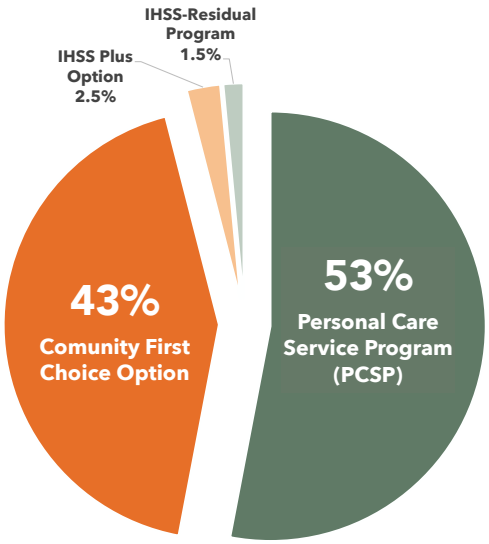
By far the largest Medi-Cal home and community-based services program, In-Home Supportive Services is authorized by a combination of 1915(i), 1915(j) and 1915(k). There are more than 650,000 IHSS providers serving over 750,000 recipients statewide. IHSS is carved out of Cal-AIM. IHSS is funded with federal, state and county dollars, and is actually comprised of four separate programs.

Although the Department of Health Care Services oversees all Medi-Cal programs, including IHSS, it delegates state-level management of IHSS to the Department of Social Services. Each county's welfare department handles the day-to-day administration of the program, with separate units within each welfare department to determine Medi-Cal and IHSS eligibility. The public authorities are separate entities established by the counties to manage IHSS provider enrollment, provide trainings, maintain a provider registry and act as the employer of record for collective bargaining purposes.

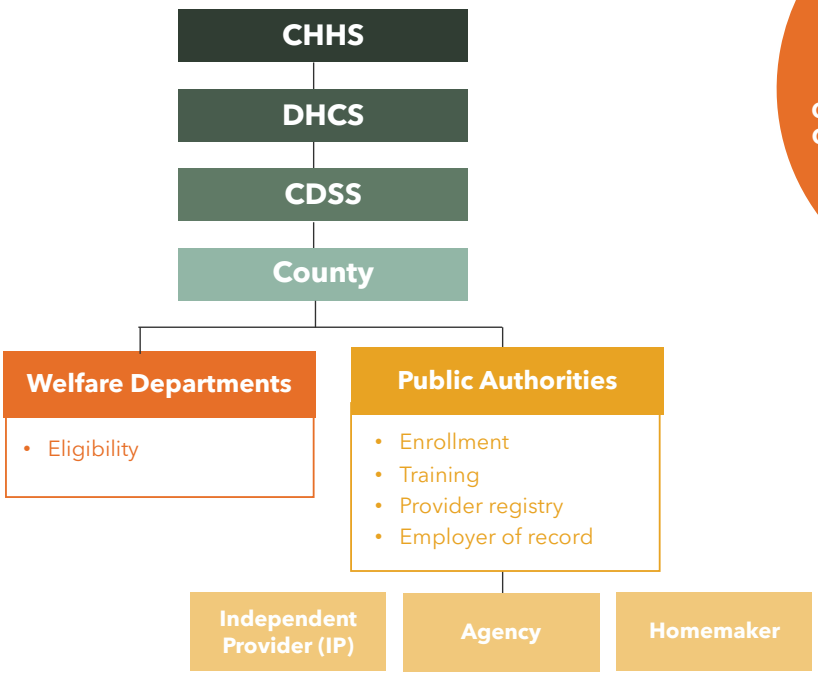
IHSS providers are represented by two unions: the United Domestic Workers of America, AFSME Local 3730 (UDW) and the Service Employees International Union, Local 2015 or SEIU 2015. Local 2015 represents over 500,000 IHSS providers in 37 counties. UDW covers the other 21 counties and represents approximately 150,000 IHSS providers.[15]

There are over 650,000 IHSS providers, represented by UDW AFSCME Local 3730 and SEIU Local 2015.

IHSS Programs



IHSS Administration



Waivers, PACE and Community Supports

Outside of In-Home Supportive Services, most publicly-funded LTSS are delivered either through Medicaid waivers authorized by sections **1115** and **1915(c)** of the Social Security Act or through the Program of All-Inclusive Care for the Elderly (PACE), an integrated Medicare/ Medical program authorized by the Balanced Budget Act.[15] Some of the benefits offered through Home and Community Based Services programs include: personal care services, assistance with chores and meal preparation, protective supervision, in-home nursing care, case management and home modifications. Waivers do not pay for housing. For older adults, the most significant waiver programs are:[16]

Community-Based Adult Services (CBAS): Authorized by Section 1115, offers nursing services; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; meals; and transportation.

Multipurpose Senior Services Program (MSSP): Authorized by Section 1915(c), offers case management, personal care services, respite care, home modifications and repair, adult day care, protective supervision, meals, money management; and communication services.

Assisted Living Waiver (ALW): Authorized by Section 1915(c), provides services for Medi-Cal recipients to either (1) safely transition from a SNF to a RCFE or public-subsidized housing; or (2) offers those at risk of being institutionalized the option of utilizing ALW services to continue to reside in a RCFE or publicly subsidized housing.

Home & Community Based Alternatives (HCBA): Authorized by Section 1915(c), provides care management services for those at risk of nursing home placement.

The **Program of All-Inclusive Care for the Elderly (PACE):** Authorized by the Balanced Budget Act of 1997, provides a comprehensive service delivery system that integrates Medicare and Medicaid financing, and becomes the sole source of LTSS for dual eligibles who choose to enroll.

In addition to the IHSS workforce, there are upward of 25,000 Californians providing long-term care in home and community settings to over 70,000 Medi-Cal eligible individuals throughout the state.[17] They are employed by an array of entities, ranging from the state itself to private, for-profit entities and nonprofit community-based organizations that contract with the state or managed health care plans as Medi-Cal providers. The structure of each non-IHSS HCBS program varies, but all programs rely on contracts with separate entities to provide direct services and care, and those separate entities directly employ the direct care workers.

Enhanced Care Management is a statewide comprehensive care management program and an integral piece of the Cal-AIM initiative. ECM builds on two smaller managed care programs, Whole Person Care Pilots and Health Homes Program (HHP), focused on higher-need populations. ECM features 14 **Community Supports** designed to address social drivers of health. Six Community Supports specifically support independent living for seniors and people living with disabilities: Respite services; Nursing facility transition/ Diversion to assisted living facilities; Community Transition services/ Nursing facility transition to a home; Personal care and homemaker services; Environmental accessibility adaptations (home modifications); and medically supportive food/ meals/ medically tailored meals. MCPs may offer any of the 14 preapproved Community Supports. Cal-AIM does not require but is structured to incentivize MCPs to provide Community Supports.

Over 25,000 DCWs provide non-IHSS HCBS to more than 70,000 Medi-Cal eligible individuals.

Potential Levers to Raise the Wage Floor

Understanding the contours of public funding for LTSS allows us to identify potential levers to raise the wage floor for the people who deliver those services. This section describes how upward pressure on wages can be exerted through: state and federal policy measures that directly and indirectly target Medicaid reimbursement and wages; strategic enforcement; worker and consumer organizing; government partnerships; and support for alternative models of providing care.

State and Federal Policy

Policy measures that ***directly*** target direct care wages and Medicaid reimbursement rates include:[18]

Wage pass-throughs mandate that SNF operators and HCBS providers pay a set amount above the state minimum hourly rate for certified nursing assistants and other non-administrative employees. This rate increase is to be paid out of the Medi-Cal reimbursement received by the provider, in effect passed through from the government to the worker. The current wage pass-through required for CNAs in California is just $.78 additional per hour. New Jersey's AB 4482 is an example of recent wage pass-through legislation, setting the minimum wage for all employees providing direct care in long-term care facilities at $3 an hour above the prevailing state minimum wage. Enforcement of wage pass-throughs requires rigorous auditing.

Wage Adjustment Rate Programs involve specific terms such as written, legally binding commitments (e.g. collective bargaining agreements) to increase eligible employee wages and benefits. Employer participation is voluntary, but required for reimbursement of the Medi-Cal portion of incurred additional labor costs. California had a WARP from 2003-04, and will be implementing another in 2024 (as discussed in the Skilled Nursing Facility section).

Direct Care or Medical Loss Ratios are direct requirements (versus quality-based incentive programs) on how Medicaid reimbursement is spent, specifying a minimum percentage of revenue that must be used for direct patient-related services. Direct patient-related services are defined primarily as staffing services, including wages and benefits for direct care staff. They are intended to improve patient care by capping the amount that nursing home operators can spend on administrative costs and related third-party contracts, or reserve for profit. In the past few years, New Jersey, New York and Massachusetts passed legislation mandating direct care or medical loss ratios ranging from 70% to 90%.[19]

In 2022, AB 2079 (Wood), which would have created a direct care or medical loss ratio of 85% for SNFs in California, was passed by the legislature but ultimately vetoed by the governor. Under AB 2079, a skilled nursing facility that failed to meet the 85% benchmark would have been required to pay a pro-rata dividend back to the Department of Health Care Services. Failure to pay the dividend would result in additional sanctions.[20] Assemblymember Wood reintroduced identical legislation in 2023 that was converted into a two-year bill.[21]

At the federal level, the Centers for Medicare & Medicaid Services has requested public comment on the inclusion of a possible direct care spending mandate in the proposed update of nursing home payment policies for 2024.[22] And in May 2023, CMS published a proposed rule, Ensuring Access to Medicaid Services, that would require at least 80% of all Medicaid payments for homemaker, home health aide and personal care services be spent on compensation for direct care workers.

Upward pressure on wages can be exerted through state and federal policy that directly and indirectly targets Medicaid reimbursement and wages, strategic enforcement, worker and community organizing; government partnerships, and support for alternative models of providing care.

Industry-Specific Minimum Wages have been mandated in certain sectors – including, most recently in California, the health care sector. SB 525 (Durazo) established a higher minimum wage of $25/hour for certain health care workers employed in a variety of settings, including some skilled nursing facilities, residential care facilities, home health agencies, and sometimes in a patient's home.[23] Skilled nursing facilities and residential care facilities are only covered, however, if they are owned by a hospital or affiliated entity or health care system; most SNFs in the state do not meet these criteria. Similarly, only when a health care worker is employed by an entity owned or operated by an acute care hospital will services delivered in the home be covered. The vast majority of direct care workers will not fall under SB 525's protections.[24]

Living Wage Ordinances have been adopted by dozens of California municipalities over the past couple of decades.[25] LWOs vary in scope and scale, but generally require that entities holding contracts with the city or county adhere to a specified enhanced minimum wage for their employees that provide labor on said contracts.[26] The enhanced minimum wage, called a living wage, applies to a range of industries, as long as the contract is paid for with public funds and passes a minimum threshold amount.[27] Many municipalities set one wage rate for employers who provide health and/or retirement benefits, and another, higher wage rate, for employers who do not. Several LWOs also require compensated time off for employees.[28]

In the past two years, Michigan, Colorado and New York have mandated enhanced minimum wages for Medicaid-funded HCBS contractors. In 2022, the governor of New York signed a final budget that includes a plan for over $7 billion in spending on a permanent $3 an hour wage increase for home care workers over a two-year period.[29] Although the raises in Michigan and Colorado are currently time-limited,[30] and the state Medicaid programs in all three states differ significantly from California's, they merit further investigation.

Living Wage Incentives can be offered to private entities that contract for the provision of home and community based services. As with the Workforce and Quality Incentive Program, DHCS could provide a supplemental payment or enhanced Medi-Cal reimbursement, to providers who meet stronger quality standards. In this case, the standards would relate to workforce, and measure wages, benefits, retention, training and other indicia of quality jobs. The Department of Health Care Services could also establish a workforce adjustment to the base reimbursement rate for managed care plans and other HCBS providers, centered on certain criteria like entering into a collective bargaining agreement, paying a wage above minimum, etc.

Similarly, a version of the Wage Adjustment Rate Program could be applied to Medi-Cal funded HCBS contracts. Where an employer enters into a written, legally-binding agreement to increase eligible employee wages and benefits, the employer becomes eligible for reimbursement of the Medi-Cal portion of additional labor costs.[31] Enhanced reimbursement can also boost needed skills in the workforce by incentivizing training tied to wage increases.[32]

The Bipartisan Infrastructure Law and the Inflation Reduction Act allocated $80 million to develop and scale equitable pathways to good-paying infrastructure jobs through the Building Pathways to Infrastructure Jobs Grant Program. The Good Jobs, Great Cities Academy, is part of that program and will support cities in incorporating care infrastructure into their project designs.

Workforce Development: The **Better Care Better Jobs Act** was originally introduced in 2021, in conjunction with Build Back Better, but did not pass out of committee. It was reintroduced by Rep. Debbie Dingle of Michigan and Sen. Robert Casey of Pennsylvania in January 2023. Some key objectives of the Better Care Better Jobs Act include: a permanent 10% increase in Medicaid match funding to states for expanding access to HCBS and strengthening the HCBS workforce; $100 million for state planning grants, encouraging innovative models that benefit direct care workers and care recipients; and a requirement that states ensure provider payment rates are sufficient and all increases are passed through to direct care workers in wages. Sen. Casey also introduced the **Home and Community-Based Services Relief Act**, which would extend the 10% FMAP increase for two years, with those funds directed toward increasing direct care worker pay, providing paid family and sick leave, paying for transportation, recruitment and training, and supporting family caregivers.

In April 2023, President Biden signed the historic Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers. As its name suggests, the Executive Order focuses on expanding access to both childcare and long-term care, while increasing support, compensation and job quality for family caregivers, early educators and long-term care workers. The EO directs multiple federal agencies, including Health and Human Services and the Department of Labor, to implement strategies to improve direct care workers' wages and access to benefits.

The most significant policy measures ***indirectly*** targeting direct care worker wages and Medicaid reimbursement rates focus on financial transparency. Skilled nursing facilities often use complex ownership structures to siphon unreported profits. The key to these hidden profits are "related parties": companies through which the nursing home can outsource services and supplies that the parent company controls. Payments to the related parties, for things like rent, insurance, management, medical equipment, and linen are often inflated so they look like legitimate expenses but are actually

used to route off-the-books dollars into the pockets of the owners. Concurrently, an increasing number of nursing home have been acquired by private equity companies and real estate investment trusts, a shift that research has correlated with poorer quality care.[33]

To tackle this problem, California passed the Corporate Transparency in Elder Care Act (SB 650, Stern). Starting in 2024, an organization that operates, conducts, owns, manages, or maintains a skilled nursing facility or facilities is required to prepare and file with the office an annual consolidated financial report that includes data from all operating entities, license holders, and related parties in which the organization has an ownership or control interest of 5% or more and that provides any service, facility, or supply to the skilled nursing facility. In November 2023, CMS published a Final Rule (88 FR 80141) setting forth requirements to disclose ownership and managerial information for all Medicaid-funded skilled nursing facilities. A separate proposed rule (88 FR 61352) would require states to report to CMS the percent of Medicaid funding to SNFs spent on compensation for direct care workers and staff. These transparency measures are considered essential building blocks for meaningful reform of nursing home financing.

Organizing

Organizing, whether through collective bargaining or public campaigns, is another tool for exerting upward pressure on direct care wages.

Statewide Collective Bargaining: The average wage for In-Home Supportive Services providers is just above the state minimum wage of $15.50 an hour. IHSS providers do not receive vacation or paid holiday time off. They have limited access to employer-sponsored health benefits and no retirement security. A majority of IHSS providers are enrolled in Medi-Cal and other public assistance programs. Annual turnover in IHSS is 33%. Wages and benefits for IHSS providers are negotiated at the county level through collective bargaining between the public authorities and unions, leading to uneven wages and benefits across the state for the same work. In December 2022, the LA County Board of Supervisors voted to increase wages for IHSS providers there by $1 an hour over the following two years.[34]

AB 1672 (Hanley), the "Our Care Counts" bill, introduced in 2023, would have consolidated employer responsibility for collective bargaining to one state level entity that can negotiate with SEIU 2015 and UDW over wages, health benefits, retirement, training, scheduling, and other terms and conditions. This would facilitate collective bargaining and allow the state to implement policies that will increase recruitment and retention of the IHSS workforce as well as improve quality of services.

AB 1672 was withdrawn in favor of a $1.5 million budget allocation for the Department of Social Services to conduct a cost-benefit analysis of different approaches to transitioning to statewide bargaining, to be completed by January 2025.

A majority of IHSS providers currently earn so little that they qualify for public benefits. A small wage increase could send them over the "benefits cliff," rendering them ineligible for public benefits, and in a more precarious financial position, likely losing access to essential medical care. In order to sustain a family without reliance on public benefits, a living wage calculation must account for minimum food, childcare, health insurance, housing, transportation and other basic necessities, along with regional cost-of-living differences.

> Wage increases must rely on comprehensive living wage calculations or risk sending low-wage workers over a "benefits cliff."

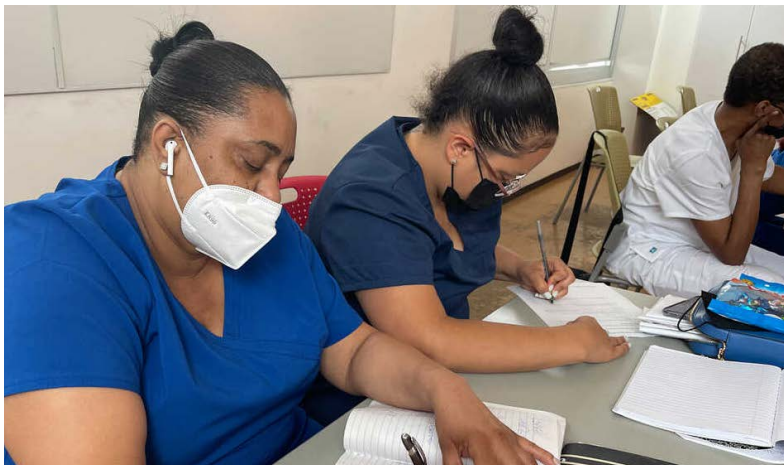
Government Partnerships

Government partnerships that bring together state agencies, employers, workers, consumers, and community-based advocates can help lay the foundation for policies designed to increase wages and improve working conditions.

The High Road Training Partnerships (HRTP) initiative is a project of the California Workforce Development Board. The industry-based, worker-focused training partnerships build skills for California's "high road" employers – firms that compete based on quality of product and service achieved through innovation and investment in human capital, and can thus generate family-supporting jobs where workers have agency and voice. Participation in HRTPs is voluntary. Current and past HRTPs rely on partnership with organized labor – meaning that the workforce is in most cases already represented by a union. HRTPs are not a source of funding for wage increases, but an additional incentive and support for high-road employers to continue and improve best practices in terms of pay, benefits, training and worker leadership.

Industry-wide worker standards boards have gained considerable momentum recently as a tool for improving wages and working conditions across entire sectors. Government entities convene worker standards boards (also called industry councils or wage boards) to bring worker and employer representatives together in an official capacity to make recommendations, set and enforce workplace standards that cover all workers in a particular industry and jurisdiction – for example, as AB 1228 (Holden) did for fast-food workers in California. In the last five years, six states and three cities have passed laws convening worker standards boards in at least four different industries. [35]

In the spring of 2022, SEIU 2015 announced a proposal for the creation of a Skilled Nursing Quality Standards Board to be housed within the California Health & Human Services Agency, that would set minimum wage rates, benefits and workplace standards for skilled nursing facilities. The SN QSB was to be comprised of 10 state agency representatives, two employee seats, two advocate/ family seats, and two employer seats. The state entities would have included DPH, DHCS, CDA, LWDA, CWDB, Department of Health Care Access & Information, Division of Occupational Safety & Health, Division of Labor Standards Enforcement and the Department of Industrial Relations. Although the proposal stalled, it set forth a model for potential future legislation.



Strategic Enforcement

Strategic enforcement of wage and hour laws in the long-term care sector is a priority for the Division of Labor Standards Enforcement, a division within the Labor Agency. DLSE investigators regularly respond to complaints about pay and working conditions from home care, residential care facility, and nursing home workers. The DLSE also works with CBOs to identify bad actors in order to support employee and employer education, organizing and other enforcement measures. Enforcement of wage and hour laws could be greatly improved by enhanced coordination between the DLSE and the various departments within CalHHS that administer long-term services and supports.[36]

In addition to ensuring that unscrupulous employers are not profiting off public funds by cheating employees and consumers, effective enforcement is essential because it deters wanton disregard for wage and hour laws, slowing the race to the bottom and stymying unfair competition. Leveling the playing field clears the way for high road employers to invest in their workforce.

Alternative Models

Alternative models for delivering both care and compensation for caregiving provide a blueprint upon which broader policy reforms can be built.

Green or Small House Nursing Homes: The Green House or Small Home SNF model was developed by Bill Thomas in New York in 2001 and has since grown across the country with the opening of over 260 Green House homes in 32 states. The Green House movement centers on "destigmatizing aging and humanizing care through the creation of radically noninstitutional eldercare environments that empower the lives of the people who live and work in them." In practical terms, this translates to small nursing homes for eight to twelve residents in single rooms with en suite bathrooms situated around a living room and open kitchen and dining room.

Staffing patterns rely heavily on trained nursing assistants called universal workers, who receive support from nurses and therapists, without the extra supervisory and administrative layers that are typical of the traditional nursing home model. The team of universal caregivers provides personal, clinical and home care activities, and share the cooking, cleaning, laundry, ordering, scheduling and other duties. The homes have a nurse available 24 hours a day. The team approach has been shown to increase staff satisfaction, keep the workforce small, reduce turnover and support greater continuity of care.[37] Although there is limited data specific to compensation at small home skilled nursing facilities, the staffing structure lends itself to wage tiers keyed to additional training and responsibilities.

Health outcomes are measurably better in small home SNFs, a difference that was heightened during the coronavirus pandemic.[38] The devastating toll of COVID-19 in nursing homes evidenced the difficulty of infection control in congregate settings, especially where there are shared rooms, and has spurred renewed interest in the Green House or small home SNF model.[39] There is some optimism among advocates that the federal government is signaling an openness to establishing higher Medicaid reimbursement rates for small home SNFS, but details on the plan are yet to be released.

Cooperatives: A worker cooperative is an entity that is owned by its members, who provide labor in any number of sectors, and are renumerated as member-owners, rather than as employees. There is no legal requirement that member-owners possess work authorization, and there is no employment relationship between the contracting entity, in this case the county and the member-owners. The structure of worker cooperatives would allow undocumented direct care workers to legally participate in the In-Home Supportive Services program as member-owners of an authorized proprietary agency.[40]

There is precedent for such a model. **Cooperative Home Care Associates (CHCA)** in New York operates a home care agency for Medicaid recipients, those who are privately insured or private pay. CHCA has more than 2,000 member-owners and is the largest worker cooperative in the United States.

There is also precedent within California for state support of worker cooperatives. **AB 816** facilitates the creation of worker-owned cooperative businesses in California, and **SB 1407** establishes an Employee Ownership Hub in the Governor's Office of Business & Economic Development. **AB 82** established the Social Entrepreneurs for Economic Development Initiative, to support the entrepreneurship of immigrants and limited English proficient individuals, regardless of immigration status, who face significant employment barriers. The Pilipino Worker Center, whose membership is comprised primarily of direct care workers, is a SEED grant recipient. PWC runs a small home care worker cooperative called Courage LLC and hopes to expand by building the administrative infrastructure to support similar home care worker cooperatives in other parts of the state.

The federal **Worker Ownership & Readiness & Knowledge Act** (Consolidated Appropriations Act of 2023) allocates $50 million over five years to create an Employee Ownership & Participation Initiative within the Department of Labor to support employee ownership by encouraging new and existing state employee ownership programs.[41]

How Do We Build Sustainable Career Pathways?

What would it look like to build a direct care workforce development strategy on the foundation of a higher wage floor? To deal with the direct care workforce crisis, a traditional approach centered on building a career ladder from entry-level jobs to higher-skilled and better paid positions does not suffice. Low wages are the norm throughout the sector, with only slight differentials for acquiring more training and related certifications, and the highest demand will always be for personal care assistants (the fastest growing job category in the state and nation), for which no consistent training is currently required.

Instead, experts advocate reimagining direct care worker pathways by developing a lattice of training opportunities that will help attract and retain workers while supporting family-sustaining jobs. In conjunction with efforts to reform long-term care financing and policy, accessible career lattices form an integral part of raising the wage floor and meeting our ever-growing demand for care.

Across the country, advocates have launched efforts to build nontraditional direct care workforce career lattices by "professionalizing" the workforce – creating uniform training requirements, standards and in some cases new certifications. These efforts have focused on establishing core competencies for PCAs and designing accessible training opportunities tied to meaningful advancement in skills acquisition and compensation. Although varied in detail and implementation, programs developed in other states, and on a smaller scale within California, share certain common features that provide a useful roadmap for envisioning a statewide DCW lattice in California.

Direct Care Worker Training and Regulation: Where Are We Now?

For PCAs, training requirements vary by program and setting. Beyond an orientation, there is no mandatory training for IHSS Independent Providers. Optional specialized training is provided by labor-management training funds, nonprofits and the California Department of Social Services.

Outside the IHSS program, PCAs working in people's homes are called home care aides and are generally private-pay, although some provide services through home and community based services waiver programs. HCAs are encouraged but not required to register with the CDSS Home Care Services Bureau. HCAs must complete a minimum five hours of training/ orientation in order to register. HCAs must register as a condition of employment with a Home Care Organization, and many HCOs require training beyond the five hour state minimum. Unregistered HCAs do not receive mandated training and primarily work directly for consumers and/ or their family members.

PCAs who work in a residential care facility for the elderly must complete 20 hours of training before providing direct care, 20 hours within the first four weeks of employment, and 20 hours of continuing education annually. While RCFEs are regulated by CDSS, there is no registration requirement for RCFE direct care staff. Certified nursing assistants are regulated by the California Department of Public Health, must complete 160 hours of training, and a written and practical exam. In addition, they are required to log 24 hours of continuing education annually, and to renew their certification on a biannual basis. To become a home health aide, a caregiver must either complete 120 hours of training, or, if they are already a CNA, complete an additional 40 hours of training. There is no exam, but HHAs are required to log 12 hours of continuing education annually and register and renew their certification with the California Department of Public Health every two years.

Direct support professionals are regulated by the California Department of Developmental Services and must complete 70 hours of training within two years of employment – 35 hours in the first year, and 35 hours in the second. Alternately, DSPs may opt to meet the training requirement by passing the Challenge Test for each 35-hour training program.

Job Category	Personal Care Aide				Certified Nursing Assistant	Home Health Aide	Direct Support Professional
Types of Personal Care Aides	IHSS	Registered Home Care Aide	RCFE	Unregistered PCA	-	-	-
Training	Orientation Livescan	≥ 5 hrs Livescan + $35	40 hrs: 20 hrs before starting + 20 hrs within 4 weeks, + 20 hrs annually	None	60 hrs classroom + 100 hrs supervised clinical + written & practical exam +24 hrs annually	120 hrs OR CNA + 20 hrs classroom + 20 supervised clinical No exam + 12 annually	70 hours over 2 years OR written & practical exam
Setting	Home	Private Homecare & HCBS	Congregate	Private Homecare & HCBS	SNFs, Hospitals, HCBS	Home & HCBS	ALFs & HCBS
Regulation	CDSS, DHCS	CDSS, Home Care Service Bureau	CDSS, Senior Care Licensing Program	-	CDPH, Healthcare Workforce Branch, Healthcare Professional Certification & Training Section	CDPH, Healthcare Workforce Branch, Healthcare Professional Certification & Training Section	CDDS

Current Barriers to Direct Care Worker Progression

The DCW job family has not been professionalized in any uniform way. This is especially true for the job of PCA. Training requirements vary widely between programs and settings and are inconsistent in both time and content. In addition, there are no state-recognized credits or certifications for PCAs. As a result, existing training is not portable – meaning workers cannot easily move between programs and settings. It is also not stackable – meaning training received as a PCA does not count toward certification as a certified nursing assistant or HHA.

Although there is set training criteria for DSPs, they face the same limitations insofar as their training is neither portable nor stackable. CNAs may build upon their certificate by adding 40 credits to become a HHA, but there is no similar stackable credit toward becoming a licensed vocational nurse or registered nurse.

There are not enough CNA and HHA training programs to meet demand, and most programs are concentrated in urban areas. The majority of training programs, although approved by the California Department of Public Health, are offered by private entities, indicating a dearth of public investment.

CNA program Instructors must be RNs or LVNs who have a minimum of three years' experience, including at least one year in a SNF – qualifications that significantly limit the pool of potential instructors. Similarly, Home Health Aide program instructors must be RNs with a minimum of two years' experience, including at least one with a Home Health Agency. Inexplicably, the CNA exam is currently only offered in English – a major hurdle for a workforce that is almost 50% immigrant.

Insufficient funding and patchwork regulation have given rise to additional obstacles. For a low-wage workforce, the cost of training that is not subsidized or compensated may be prohibitive. Trainings are often inaccessible for other reasons – location, cost of transportation, lack of childcare, and English-only curricula chief among them. Curricula that do not recognize and confer value on skills gained by experience discourage participation by workers with less formal education. There is little incentive for workers to invest in training when there are no rungs within each role, and negligible wage differentials between PCAs, DSPs, HHAs, and CNAs.

Accessibility	Professionalization
Cost	Inconsistent training requirements
English only assessments & instruction	No formal certification
Low course availability	No credit for experience
Prohibitive instructor qualifications	Training not portable or stackable
Incomplete wraparound support	Low wage differential

Lessons from Past California Initiatives

The U.S. Health Resources & Services Administration funded six state-based Personal & Home Care Aide State Training demonstration projects at $5 million annually for fiscal years 2010-13. California, Iowa, Maine, Massachusetts, Michigan and North Carolina were awarded grants. In California, gerontology and nursing faculty, state, county and municipal health departments, Area Agencies on Aging, ombudsmen and family members were convened in an advisory committee to inform curriculum content and ensure appropriate and accessible training delivery.

The curriculum was designed around nine core competencies: 1) Roles and responsibilities of a personal and home care aide; 2) Personal care skills and nutrition support; 3) Consumer/ needs-specific training; 4) Basic restorative skills; 5) Consumers' rights, ethics and confidentiality; 6) Interpersonal skills; 7) Infection control; 8) Safety and emergency training; 9) Health care support, and also covered job readiness and customer service skills. Paramedical skills were not included.

The training consisted of 100 hours over 3.5 to 4 weeks, primarily in person, and was offered in English and Spanish. It was held at three community college campuses in Southern and Northern California, as well as on-site at an IHSScontract agency. Through a partnership with the California Association of Health Care Services at Home, the same curriculum was delivered online in a limited pilot program. Recruitment was conducted through the community colleges and CalHHS and focused on low-income, unemployed individuals, including former state employees whose jobs had been recently eliminated. Student success committees offered financial aid, food assistance, peer tutoring, weekly open labs and access to community college counseling services.

At the time of the demonstration, CDPH declined to recognize completion of the course and exam in the form of a credential or to create a new certification, citing cost as a concern.

In its 2019 Final Report, the California Future of Health Workforce Commission recommended the adoption of a new Universal Home Care Worker role and job family, consisting of three tiers. The first tier would include personal care and assistance with ADLs and IADLs – tasks that are within the scope of work for all PCAs, regardless of setting. The second and third tiers would be geared toward caring for individuals with more complex conditions, and would include paramedical tasks of increasing skill, such as administering oral medications, catheter care, injections and wound care – all of which fall outside the current scope of practice for PCAs not within the IHSS program. The UHCW recommendation is controversial because it would require legislative amendment of the Nurse Practices Act – a proposal opposed by the California Nurses Association.

The commission recommended the creation of an advisory committee comprised of educators, nurses and home care aides, policymakers, representatives from the private and public health care sector, and consumer advocates to guide the process of establishing competencies and compensation for each UHCW level and of designing a two-year demonstration program to test, among other impacts, the safety and efficacy of granting nurse delegation to UHCW Level 2s and 3s. The commission cited pilot projects in Australia and New Jersey that found no adverse outcomes to consumer health and higher levels of satisfaction among HHAs and consumers. Although initially opposed to the delegation tested by the pilot, the New Jersey State Nurses Association eventually supported regulatory change that allowed nurse delegation to HHAs, at the nurse's discretion and under a supervisory relationship between nurse and HHA.

The Future of Health Workforce Commission estimated a total of $7 million over four years for the convening of the advisory committee and the administration of the assessment and pilot project. To date, no part of the UHCW proposal has been implemented.

Promising California Models

Although California does not have a state-sanctioned core curriculum or certificated pathway for DCWs, there are programs within the state that have created their own standardized curriculum and support both internal and external career pathways.

The Center for Caregiver Advancement is a nonprofit funded in part by SEIU 2015's labor-management training partnership. CCA trains in-home supportive services independent providers and certified nursing assistants who are bargaining unit members at unionized nursing facilities. Training is optional, free and is offered in six languages. For independent providers there are two pathways that include core curriculum components, such as roles and responsibilities and communication and teamwork, with additional emphasis on two different topics: care team integration and Alzheimer's disease and related dementias, and a $300 stipend upon completion. CCA offers training to become certified as a CNA or Restorative Nurse Assistant, with a growing apprenticeship option that provides comprehensive wraparound support services. CCA also offers continuing education units for CNAs.

Homebridge is a nonprofit agency funded by the San Francisco Department of Disability & Human Services and private foundations. Homebridge operates under the in-home supportive Services contract mode, employing and training caregivers that provide care to IHSS recipients who are unable to manage their own care. Homebridge has built a robust internal career pathway for home care providers: All caregivers are required to complete a 48 hour basic training (HCP I); optional advanced skills training leads to increased responsibility and commensurate wage increases; and HCPs are supported by full-time care team managers (former HCPs). HCP IIIs may stack their training to enroll in CNA training (HCP IV-C); there is a staff position dedicated to externally placing certified nursing assistants. All time in training is paid, and full-time employees receive health benefits.

In 2022, California allocated an historic $600 million dollars for direct care worker training.[42]

IHSS Career Pathways, developed by CDSS, is built around five central training pathways, two general and three specialized: general health and safety; general adult education, including ESL and computer and digital literacy; complex physical care needs; cognitive impairments and behavioral health; and transitioning into home and community based living from out-of-home care or homelessness. Time in training is paid and participants will receive stipends.

The California Department of Aging's program, **Growing a Resilient and Outstanding Workforce (CA GROWs)**, is built on the same 5 central training pathways, but trains HCBS direct care providers outside of the IHSS program, including PCAs, social workers, activities coordinators, transportation providers and dieticians. CA GROWS provides stipends and incentives for participation.

What Can We Learn From Other States About Training?

Several states have standardized training requirements for PCAs (summarized in Appendix 1). The extent, content and contours of training vary significantly by state, demonstrating a wide range of potential statewide frameworks.

In Maine, the training curriculum is set by the state, and may not be modified by the training provider. Massachusetts developed an Acquiring Basic Concepts curriculum as part of its PHCAST demonstration and recommends, but does not mandate, that training providers follow the ABC curriculum. New York and Washington similarly developed model curricula, and allow training providers to develop their own courses and guides based on the state-specified modules. In Washington, the state must approve any modified curricula.

In New York and Massachusetts, training providers may be community colleges, proprietary schools and home care agencies. In Tennessee, a proprietary nonprofit called QuILTSS, Quality in Long Term Services & Supports, through a partnership with TennCare, Tennessee's Medicaid agency, provides optional training for personal care assistants. Washington legislated the creation of a labor-management training partnership that provides the majority of training to home care workers in the state.

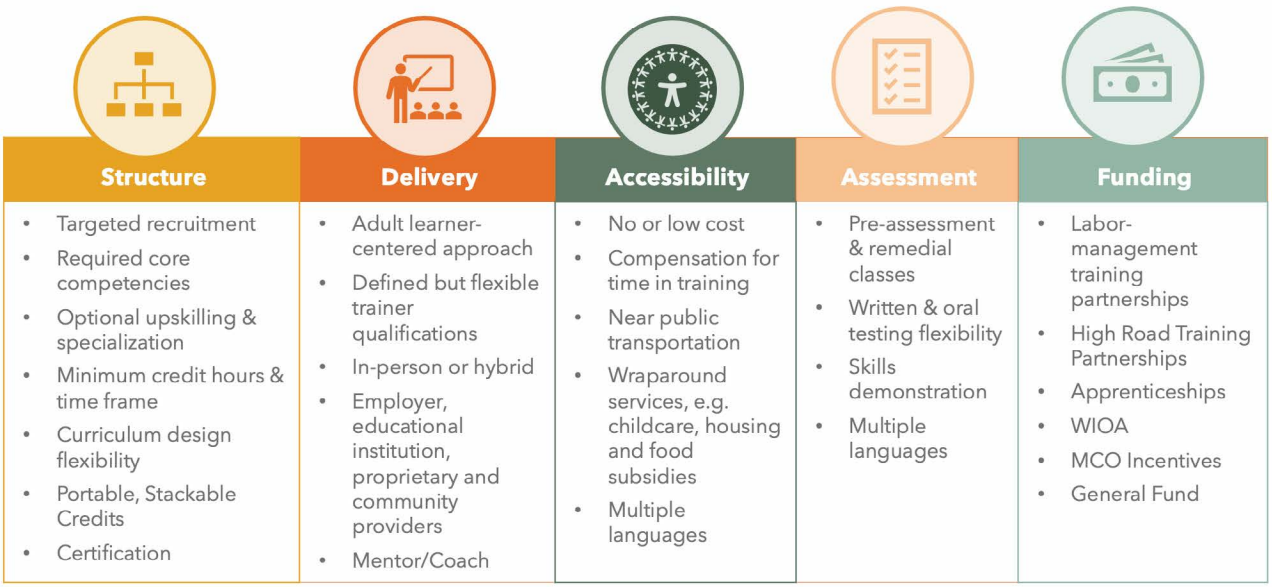
In most states, instructors must be certified or licensed as a health professional, and often have a minimum amount of experience in a long-term care setting. In Maine, trainers can by RNs or CNAs. In Massachusetts, RNs and licensed social workers may be instructors, and physical therapists are encouraged to lead training on mobility. In New York, in addition to RNs and social workers, health economists with a bachelor's degree in human services or education may also be trainers. In Washington, qualifications to be a community instructor are broader, including RNs with long-term services and supports experience in the past five years, associate degree holders in health and human services with six months of professional caregiving experience, and high school diploma holders with one year of experience in a LTSS setting.

Most states with standardized training have built their curricula to be stackable and portable in some form. In Massachusetts, workers are registered as certified home care workers upon successful completion of the required training. The state's goal is to expand the reach of the certificate so that it is accepted in different care settings that share the same competencies, and it has created a bridge program for home care workers that credits their training hours toward CNA and HHA certificate requirements. Washington has a similar bridge program. Although Maine and New York do not have dedicated bridge programs, certified home care workers may count a portion of their training toward CNA and HHA certificate requirements. In Tennessee, successful completion of the full DCW credential, including all 12 modules and three micro-credentials, counts as community college credit. The Tennessee legislature is currently considering wage increases commensurate with the stackable credentials.

All states use a combination of written exams and skills assessments. New York also incorporates oral testing. Testing and instruction support is offered in multiple languages in Massachusetts, New York and Washington. Washington conducts written assessments in 14 languages and will provide an interpreter to read the exam aloud if a written translation in the worker's primary language is not available.

Although most states pivoted temporarily to online delivery during the pandemic, training is primarily offered in-person or under a hybrid model. Tennessee is an exception, providing training exclusively online, including a virtual skills assessment.

Michigan recently adopted statewide direct care workforce competency requirements and guidelines and is evaluating a proposal for four stackable DCW certifications tied to increasing wage tiers. The requirements, guidelines and curricula were developed by a statewide coalition and advisory council composed of DCW advocates, academics and care professionals.



Essential Ingredients for Successful DCW Training

The DCW training programs and proposals within California and the standardized requirements in other states share common components that can serve as guideposts toward developing a statewide core competency framework in California. Identifying viable funding sources for building out-training and accompanying infrastructure is one essential element, explored in more detail below.

Labor-management training partnerships rely on contributions from participating employers that are negotiated as part of a collective bargaining agreement. In Washington, the state is the employer for Medicaid-funded home care. Students trained through the labor-management partnership do not pay tuition, testing or licensing fees or materials costs. In California, the In-Home Supportive Services infrastructure offers an opportunity to scale up successful training programs like those offered by the Center for Caregiver Advancement. However, the ability to agree on uniform contributions across the state is complicated by individual county-level bargaining.

High Road Training Partnerships are an existing industry-based, worker-focused initiative of the California Workforce Development Board, emphasizing equity, sustainability and job quality. HRTPs build skills for high road employers that compete based on quality of product, service, innovation and investment in family supporting jobs. HRTPs are funded by the Greenhouse Gas Reduction Fund and must incorporate environmental resiliency. The CCA was recently awarded a grant to train caregivers as first responders in climate-related disasters.

Apprenticeships are the original earn and learn model, a combination of paid on-the-job training and free related classroom instruction under the supervision of a trade professional. Governor Gavin Newsom set a goal of establishing 500,000 new apprenticeships by 2029, including in healthcare. Apprenticeships have been limited in direct care, but there is ample room and incentive for growth – especially given that less than 3% of current apprentices in California are women. The CCA runs a small certified nursing assistant apprenticeship that could be scaled up in partnership with employers to help bridge the critical skilled nursing facility workforce shortage.

As CalAIM transitions more Medi-Cal funded long-term care to Managed Care Organizations, the state can consider contract provisions that require MCOs to hire only workers with a minimum specified training, cover the costs of training or add a workforce innovation component to their programs that would include training and credentialing. Value-based payment structures could be leveraged to incentivize employers to provide training based on standardized curricula.

Federal funding for state-based training is routed through a variety of programs. Some examples include: the Department of Labor's Nursing Expansion Grant program, which provided $80 million in grants to increase the number of clinical and vocational nursing instructors and educators, helping to ease the bottleneck in the CNA pipeline; the Department of Labor's Employment and Training Administration's Youth Build, allocating $30 million in grants to non-profit organizations to provide healthcare-related employment training; and a national campaign helmed by CMS and the Health Resources and Services Administration, utilizing $75 million in scholarships and tuition reimbursement to incentivize entry into nursing home careers.[43] In addition, the U.S. Administration for Community Living awarded a 5 year, $6.5 million grant for the National Council on Aging to establish the Direct Care Workforce Strategies Center. The Center will develop and deliver core competencies and professional development for direct care professionals nationwide.

Finally, the **The Workforce Innovation & Opportunity Act** requires states to compose a state plan every four years for the allocation of federal funds for workforce development, education and training. California's current plan runs through 2023 and does not specifically address the direct care sector, although some federal funding to local workforce boards is spent on direct care training. Increased wages would encourage more referrals for training.

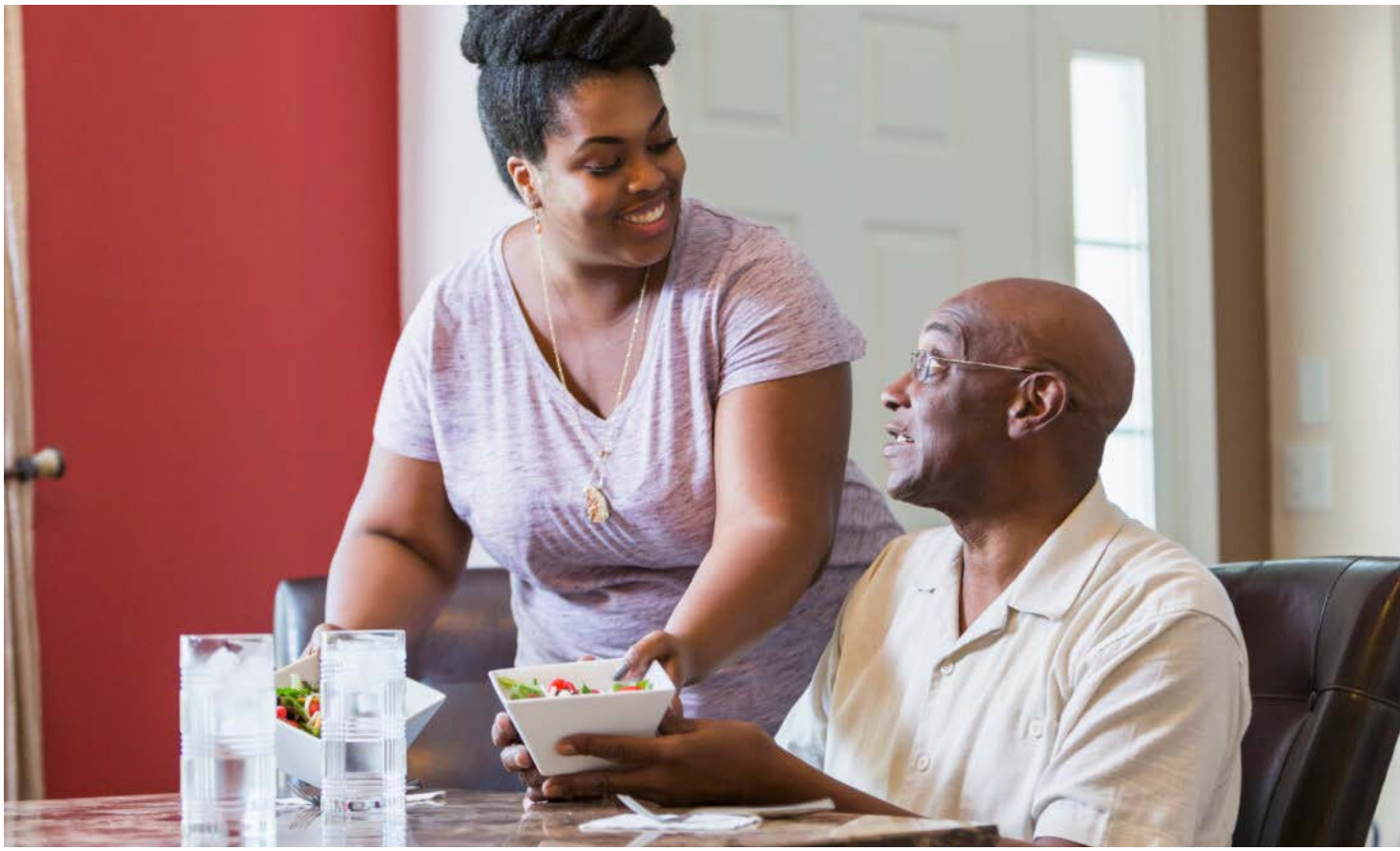
How Are Other States Building Sustainable Pathways?

A handful of the states that have made significant strides toward building sustainable direct care career pathways are profiled in Appendix 2. All have convened some sort of advisory body for the specific purpose of building the DCW pipeline. The accomplishments of DCW advisory bodies in other states are instructive: each state's efforts to build DCW career pathways differ in strategy, scope and shape, but provide concrete examples for California to consider as we reimagine our own distinct DCW landscape.

In most cases, the advisory bodies were established pursuant to legislation or executive order, although Michigan's DCW Advisory Committee was initiated by the leadership of the state's Department of Health & Human Services.

Advisory bodies are housed in the department that is charged with regulating the DCW in each state. In most states, that department is some version of Health and Human or Social Services. New Jersey is an exception, housing its Special Task Force on DCW Retention & Recruitment in its Department of Labor & Workforce Development.

Advisory body members are generally representatives from state health and human services and labor and workforce development departments; from the private and public health care sector; from consumer and worker advocacy groups and organized labor; service providers; and academics from the fields of nursing and public health. In New Jersey and Wisconsin, state legislators also sit on the advisory body. Individual DCWs and union representatives are included in the advisory bodies in all states except Michigan, where organized labor is not represented. Michigan's DCW Advisory Committee has voting members and subject matter experts that act as nonvoting consultants.



All advisory bodies are convened under broad mandates to identify strategies for increasing wages and developing training in order to improve care and bridge the workforce shortage. In Colorado and Washington, the advisory bodies were exclusively focused on training, while in New Jersey, Michigan and Wisconsin, they also looked at pay, benefits and rate increases.

Every state proposed initiatives to create standardized, statewide curricula, credentials and minimum training requirements. Colorado's Training Advisory Committee produced a report that includes a detailed minimum training curriculum draft. Wisconsin's Governor's Task Force on Caregiving's final report lists 16 policy proposals, among them a recommendation to create a tiered lattice for personal care assistant career advancement. Michigan's Department of Health & Human Services recently adopted competency guidelines, ethics and professional standards proposed by its DCW Advisory Group, and is considering the proposed curricula, credentials and career pathways. In Washington, the Long-Term Care Worker Training Group developed a comprehensive statewide curriculum and certification that is now required of all home care aides, with total hours of training depending on the relationship between the DCW and the consumer. Washington has also implemented wage tiers tied to advanced training and provides health benefits.

At the urging of a broader coalition including the DCW Advisory Council, Michigan's legislature enacted premium pay for DCWs using American Rescue Plan Act funds and committed to making the raise permanent once those funds expire. Colorado adopted a rate increase with an imbedded direct-care ratio, a model also recommended by Wisconsin's Training Advisory Committee, along with a proposal for an earnings disregard for DCWs, so that they are not forced off a benefits cliff.

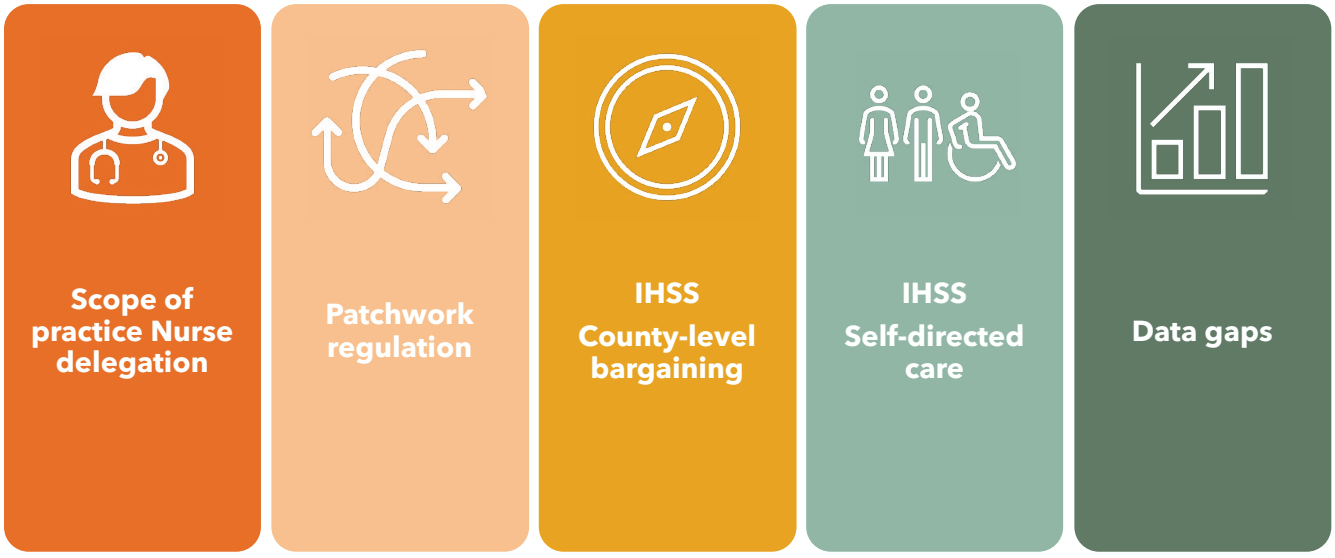
Challenges Facing Statewide DCW Pathway in California

Upskilling is an integral piece of building a sustainable direct care workforce pathway – training that builds upon entry-level preparation to acquire additional, often specialized skills to meet the increasingly complex needs of LTSS consumers. Upskilling plays a particularly important role for personal care assistants, but can bump up against scope of practice concerns. The California Nurse Practice Act prohibits the delegation of medical and nursing tasks to PCAs. Some upskilling stays within the current scope of PCA duties, focusing on personal care and assistance with ADLs and IADLs. However, any tasks that are considered paramedical – ranging from routine skin care, administration of oral medication and eye drops, assistance with inhalers and nebulizers, to tube feeding and catheter care – are outside the range of permissible duties for PCAs. Although PCAs who are IHSS providers are specifically exempted from these restrictions, a statewide training framework that includes paramedical upskilling would require amendments to the CNPA that are opposed by the California Nurses Association due to concerns over the impact on nurse scope of practice and quality of patient care.

Expanding **nurse delegation** with appropriate training and supervision strives to maximize nurses' and PCAs' contributions to improved care. There are few studies about the impact of nurse delegation, and none demonstrating that more restrictive regulations improve consumer safety or outcomes. Pilot projects in Australia and New Jersey encountered no adverse outcomes for consumer health and higher levels of satisfaction among HHAs and consumers. The Australia pilot evaluation found that the program reduced the need for duplicative nurse and PCA visits, freeing nurses up to focus on consumers with more complex needs.

The current **patchwork regulation** of the direct care sector contributes to fragmented and inconsistent training of direct care workers. Centralizing responsibility for training content, delivery, assessment, registration and certification would greatly facilitate professionalization of the workforce.

The unions representing IHSS providers advocate for the **consolidation of employer responsibility for collective bargaining to one state level entity** than can negotiate with representatives for all 650,000-plus providers at one time, enabling standardization of wages, benefits and training across the state. Statewide collective bargaining would facilitate implementation of policies geared toward increasing



recruitment, retention and quality of care, such as offering specialized training and higher wages to serve consumers with complex needs.

A guiding principle of the In-Home Supportive Services program is consumer or self-directed care: consumers select their own independent providers and determine what care the IP will provide. There is resistance among many IHSS consumers and providers to the idea of mandated training: self-directed care is a central tenet of the disability-rights movement, and many IPs are family members who have been caring for disabled family members for years. To address this issue, Washington requires significantly reduced training hours for family caregivers.

Developing, scaling and evaluating demonstration projects is key to gathering data on the effect of training, expanded scope of practice and higher wages, specifically positive health outcomes, reduced costs to long-term care payers, and financial well-being of workers. Accurate and accessible data on specific consumer needs would also facilitate better curriculum design, requirements and scale.

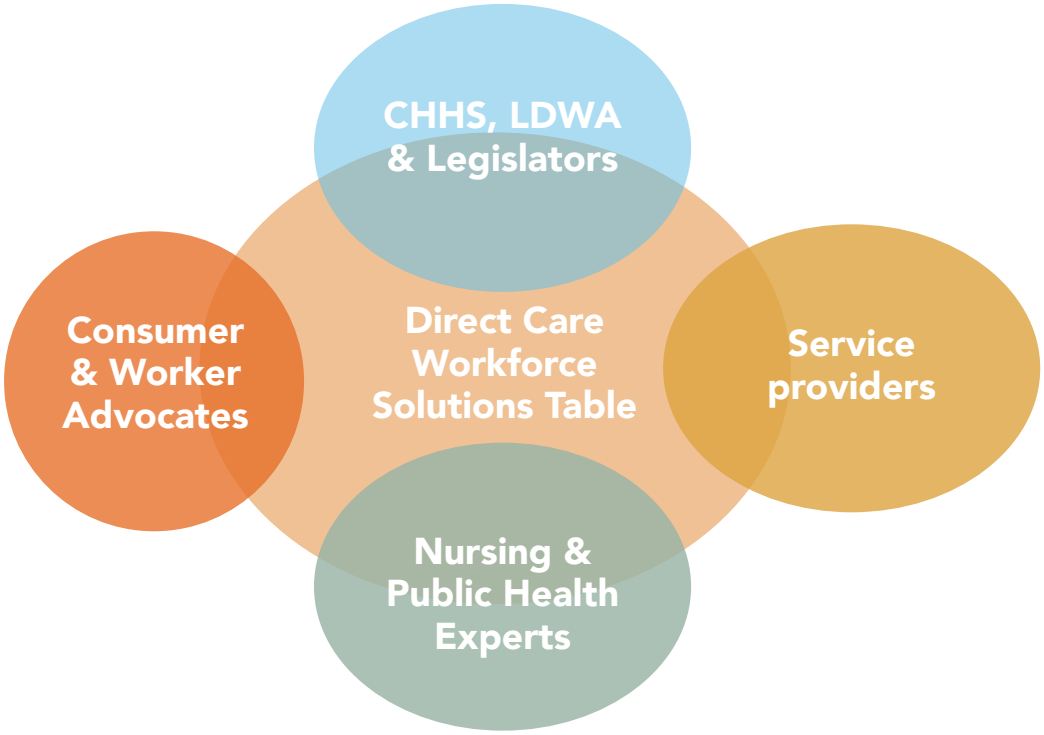
Conclusion

To effectively address the scale of the direct care workforce crisis, a coordinated strategy of equal scope must be mounted by advocates for both consumers and workers, within and outside of government. By outlining the myriad, complex components of the direct care sector, this primer strives to provide a framework for a full-court press to improve the quality of direct care jobs and care itself. As a starting point, priorities culled from the work of advocates in California and across the country are summarized in the table below.

There is one threshold state action that would enable the consideration, implementation, and coordination of a broad range of policy measures designed to improve direct care jobs: the creation of a direct care workforce advisory body. California has already articulated the need for a DCW advisory body. The Master Plan for Aging was developed pursuant to Executive Order N-14-19. Goal Four of the MPA is Caregiving That Works. Under Goal 4, Strategy B, the MPA highlights the goal of creating 1 million high quality caregiving jobs by 2030. Toward that end, the MPA recommends the creation of a Direct Care Workforce Solutions Table to deal with the critical DCW shortage. The DCW Solutions Table ("Solutions Table") is to be convened by the state Labor & Workforce Development Agency and California Health and Human Services. To date, no resources have been allocated to its creation.

The Solutions Table could be comprised of representatives from CalHHS, including the departments of Public Health, Social Services , Health Care Services, Developmental Services and Healthcare Access & Information; LWDA, including the Division of Labor Standards Enforcement and the California Workforce Development Board; consumer and worker advocacy organizations; service providers; consumers; DCWs; one state senator and one state assembly member and academic experts from the nursing and public health fields.

In addition to addressing the threshold question of lifting wages by focusing on funding for LTSS, a subcommittee or working group could be formed to specifically deal with training, certification and accessible career progression, focusing on three areas: defining the career pathway, gathering data and building infrastructure for training and certification. The potential levers for improving direct care jobs identified in this primer can be targeted by advocates both within and outside of a Solutions table.



Lift Wages

- Advocate for conditional wage-related Medi-Cal payment
- Ally with organizations moving legislation to centralize IHSS collective bargaining
- Organize to back public campaigns to raise wages
- Invest in alternative models of care and work
- Support federal legislation directing funds to DCWs

Define Pathway

- Propose universal care competencies for PCAs, drawing on national and state specific models
- Map core competencies to a proposed lattice, specifying commensurate wage-tiers
- Assess the need for nurse delegation and propose detailed requirements for appropriate oversight
- Outline a formal certification framework and identify a certifying body
- Draft a statewide training curriculum
- Support federal legislation directing funds to DCWs

Gather Data

- Assess current and projected need for congregate & home LTSS
- Develop capacity to track specific consumer conditions and r equired levels of care
- Survey research on livable wages and benefit disregards as basis for wage tiers
- Conduct survey of current and growth capacity of community colleges and independent educational nonprofits
- Design targeted demonstration projects and evaluation to test additional training, nurse delegation and higher wages, including impact on care

Build Infrastructure

- Construct model framework to centralize regulation, training & certification, either under existing department or newly created entity
- Identify & evaluate funding sources, including value-based reimbursement strategies and CalAIM transition

Endnotes

[1] LTSS are also delivered in Adult Residential Facilities (ARFs) where adults with intellectual and developmental disabilities reside.

[2] Direct Care Workers by Race and Ethnicity; Direct Care Workers Accessing Public Assistance, PHI Workforce Data Center (California, 2020)

[3] Occupational Employment & Wage Statistics Survey Results (2022 – 1st Quarter), Employment Development Department, State of California.

[4] Making Care Work Pay: How Paying at Least a Living Wage to Direct Care Workers Could Benefit Care Recipients, Workers, and Communities, Leading Age LTSS Center @ UMass Boston (September 2022).

[5] Although some long-term services and supports are paid for directly by consumers – either out of pocket or by (extremely rare) long-term care insurance policies – (and/ or are provided by family members and friends without compensation), private pay LTSS are prohibitively expensive for the majority of Californians. This brief focuses on public financing for LTSS. For a comprehensive assessment of California's private homecare industry, *see* Lives & Livelihoods: California's Private Homecare Industry in Crisis (UCLA Labor Center, 2022).

[6] The Medicaid eligibility threshold is 123% of the federal poverty level. For a family of four, this translates to an annual income of $36,900.

[7] After three days of prior hospitalization, Medicare will pay up to 100% for the first 20 days of skilled nursing care, and a portion of costs thereafter, up to 100 days. Upon discharge to home from a hospital or SNF, Medicare may pay for intermittent skilled nursing, home health care, or physical or occupational therapy for a limited time. Personal care at home is not covered by Medicare under any circumstances.

[8] In California, 70% of Medicare only enrollees are white, while only 33% of dual-eligible enrollees are white. By contrast, only 14%, 7% and 5% of Medicare only enrollees are Asian, Latinx and Black, respectively, while 34%, 21% and 10% of those same populations are dual-eligible enrollees.

[9] For example, dual-eligible enrollees are almost twice as likely to have diabetes, heart failure, and COPD; twice as likely to suffer from depression and anxiety; and many times more likely to live with schizophrenia, bipolar disorder, mobility impairment and intellectual disability.

[10] Leading the charge, SEIU 2015, AFSCME 3930 United Domestic Workers (UDW) and the National Domestic Workers Alliance (NDWA) have joined forces in a joint campaign for a LTC benefit in California. Past efforts in the state have included the *LTSS Feasibility Study Final Report*, released in 2020 by DHCS, and two related bills in the 2022 legislative session that would have created a LTSS Benefits Board and Trust Fund, but did not pass. California's Long Term Care Insurance Task Force, housed in the Department of Insurance, will produce an actuarial report assessing the feasibility of a statewide long-term care insurance benefit by Jan. 1, 2024. The complexity of an expanded LTSS benefit renders the inclusion of a detailed analysis in this primer impracticable.

[11] The piecemeal evolution of HCBS has also contributed to a patchwork of programs that is confusing for consumers to navigate and cumbersome for states to administer, where each service option often has its own review and approval process, financial and functional eligibility criteria, available services, reporting requirements and quality measures.

[12] Pub. L. 117-2, Section 9817. The FMAP increase ended on March 31.2022. States were originally required to plan for spending the additional HCBS funds by March 31, 2024. That date was extended to March 31, 2025, although California elected to set a deadline of December 31, 2024.

[13] Free-standing nursing homes also include Intermediate Care Facilities for the Developmentally Disabled (ICF/DD); ICFs for Developmentally Disabled-Habilitative (ICF-DD-H); ICFs for Developmentally Disabled-Nursing (ICF-DD-N); swing beds (beds at small, rural hospitals used to provide post-hospital skilled nursing care, as needed and subject to CMS approval); subacute care nursing facilities, including those that provide pediatric services; and nursing facilities classified as multi-level retirement communities (MLRC). DHCS' Long-Term Care (LTC) System Development Unit establishes the Medi-Cal reimbursement rates for SNFs.

[14] The stated aims of AB 1629 were to ensure individual access to appropriate long-term care services, promote quality resident care, advance decent wages and benefits for nursing home workers, support provider compliance with all applicable state and federal requirements, and encourage administrative efficiency. There are several academic studies that cast doubt on its efficacy in reaching these goals. *See, e.g.*, Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality and Costs, Charlene Harrington, et al. (2009).

[15] UDW also represents 22,000 family childcare providers across California through the newly-formed Child Care Providers United (UDW-CCPU).

[16] With the exception of CBAS, these HCBS are "carved out" of Cal-AIM. CBAS functions as a managed care plan (MCP) and is already part of Managed LTSS (MLTSS); it is unaffected by Cal-AIM.

[17] There are an additional approximate 100,000 home care workers registered with the California Department of Social Services, but it is unknown what percentage of those workers are paid with Medi-Cal funds (versus private-pay).

[18] For a comprehensive survey of Medicaid policies targeting increased wages in different states, *see* ***Addressing Wages of The Direct Care Workforce Through Medicaid Policies***, National Governors Association (November 2022).

[19] In New Jersey, **AB 4482** (2020) capped the maximum proportion of revenues that may be dedicated to administrative costs and profits at 10%, requiring that 90% be spent on patient care. In Massachusetts, nursing facilities must invest at least 75% of their revenues in direct care staffing costs. 101 CMR 206.12 (2020). In New York, SB S4336A was passed, requiring 70% of a facility's revenues be spent on direct patient care.

[20] In his veto message, Governor Newsom cited misalignment between AB 186 (the Medi-Cal reimbursement rate structure reforms described in Section III.A.1.A, above) and AB 2079 – namely that failing to meet the 85% direct care ratio required by AB 2079 could result in DHCS demanding repayment of incentive payments issued pursuant to AB 186.

[21] **AB 1537**.

[22] Although a direct care spending requirement for skilled nursing facilities has not been formally proposed through the rulemaking process, CMS has stated its intent "to make sure that the dollars get to the direct care workforce to ensure high-quality care." *See* **https://kffhealthnews.org/news/article/medicaid-nursing-home-payments-care-mandate/**

[23] Covered employers under SB 525 include: hospitals; specialty care, dialysis, psychology, rural health, community health and urgent care clinics; ambulatory surgical centers; county mental health and correctional facilities; home health agencies; and skilled nursing facilities and residential care agencies owned by a hospital or an entity affiliated with a hospital. The bill sets forth different schedules for complying with the higher minimum wage based on a variety of factors, including facility location and number of employees.

[24] A licensed skilled nursing facility "owned, operated or controlled by a hospital, integrated health care delivery system or health care system" is a covered employer under **SB 525**. (See Labor Code section 1182.14(b)(3)(v).) Few skilled nursing facilities meet this criteria in California, where most nursing homes are free-standing establishments owned by private investors. *See* ***HCAI LTC Annual Financial Data Profile*** (2022). SB 525 also covers free-standing skilled nursing homes when a patient care minimum spending requirement is in effect. However, no such requirement exists in California. (*See* supra note 20.)

[25] A complete list of municipal LWOs in California can be found here: **https://laborcenter.berkeley.edu/california-city-and-county-living-wage-ordinances/**

[26] LWOs are distinct from public works prevailing wage requirements. In California, the state requires the payment of prevailing wages on public works. Public works generally refer to construction-related labor performed on a project paid for with public funds. LWOs can apply to any publicly-funded contract over a threshold amount for specified services defined in the ordinance itself.

[27] Some municipalities maintain a general living wage requirement as well as distinct requirements for specific industries. The **city of LA**, for example, has a Los Angeles Hospitality Enhancement Zone, a Citywide Hotel Worker Minimum Wage, and a broad LWO that applies to all other city contracts.

[28] The **county of Santa Cruz**, for example, requires a living wage on county contracts of at least $18.10/ hr with benefits, or $19.74 without. The LWO also requires a minimum of 12 days compensated sick and vacation leave.

[29] The final budget allocation fell short of the 150% raise (above the current minimum wage) proposed by NY **SB S5374A** (May), known as the Fair Pay for Home Care Act.

[30] In Michigan, although the wage increase was styled as pandemic "premium pay" and is technically time-limited, advocates and legislators are working to make it permanent. Likewise, Colorado used ARPA funds to temporarily raise the minimum wage workers, then passed a permanent rate increase.

[31] Labor Standards Agreements and Labor Peace Agreements have been successfully implemented in other sectors, for example between the city of Los Angeles and its contractors at Los Angeles International Airport: **https://www.lawa.org/-/media/lawa-web/lawa-airport-operations/files/22-cspla-blanket-agreement.ashx**

[32] For example, Rhode Island used CARES Act funds to offer a free 30-hour behavioral health certificate program to direct care workers, along with a stipend and a credential upon completion. The state provided Home Health Agencies, Assisted Living Residences, Adult Day Care Centers and consumer-directed programs payroll support of $500 per employee for the stipends, and an additional 15.7% of the amount spent on stipends to cover associated payroll costs. The state legislature then enacted a **Behavioral Health Medicaid Rate Enhancement** for home health agencies with at least 30% of their direct care staff behavioral health-certified. The total amount of the rate enhancement must be passed through directly to behavioral health-certified workers.

[33] *See* ***Private Equity Investments in Health Care May Increase Costs and Degrade Quality,*** Columbia Mailman School of Public Health (July 21, 2023).

[34] In December 2022, the LA County Board of Supervisors voted to increase wages for IHSS providers there by $1 an hour over the following two years.

[35] For an accounting of worker standards boards created around the country over the last five years, *see* ***Momentum for Worker Standards Boards Continues to Grow***, Aurelia Glass and David Madland (Center for American Progress, 2023).

[36] For example, when DSS and CDPH send inspectors out to RCFEs and SNFs, respectively, to monitor quality of care, they could conduct a baseline assessment to determine whether there are indicia of underpayment or other wage and hour violations, and ensure that the DLSE receives that information. The DLSE could do the same, assessing staffing and safety and health concerns when they conduct inspections of long-term care facilities, and provide that information to DSS and CDPH. In cases where DLSE has reason to believe ahead of time that there are violations within DSS' or CDPH's jurisdiction, the departments could even plan joint inspections. A joint database could be created, which would also facilitate screening of provider applicants for the purposes of licensing and registration.

[37] The turnover rate at SNFs nationwide is 55%, while at a typical Green House or Small House nursing home, it is less than 8%. ***Nontraditional nursing homes have almost no coronavirus cases. Why aren't they more widespread?*** , Rebecca Tan, The Washington Post (November 3, 2020).

[38] In 2020, there were 25 COVID-related deaths per 1000 Green or Small House residents, compared to 86.9 deaths per 1000 traditional nursing home residents. ***Nontraditional Small House Nursing Homes Have Fewer COVID-19 Cases and Deaths***, Sheryl Zimmerman, et al. (March 1, 2021).

[39] California has tried to facilitate small home SNFs. In 2012, Senate Bill 1228 added a new subcategory of skilled nursing facilities in California, the small house skilled nursing facility (SHSNF), and established the **Small House Skilled Nursing Facilities Pilot Program** for the development and operation of up to 10 SHSNFs. However, only two facilities are known to have been approved under this provision.

[40] **California Welfare & Institutions Code section 12302** authorizes counties to provide IHSS to eligible recipients via independent providers (IP), contract providers (also called the agency model), or direct employment by the county (sometimes referred to as homemaker mode). The homemaker mode is rarely used due to cost. All counties use IPs, while only two also use contract providers. The vast majority of IHHS providers are IPs. The agency model fell out of favor principally because it is not consumer-directed.

[41] Over 100 worker cooperatives and 760 companies with Employee Stock Ownership Plans (ESOPs) operate in California, more than in any other state.

[42] In FY 2021-22, CDSS received $432.5 million, and the California Department of Aging received $162.5 million to train the IHSS and non-IHSS HCBS workforces, respectively.

[43] Although these programs do not focus exclusively on the direct care workforce, direct care workers are within their scope.

Index

Appendix 1: What can we learn from other states about training?

State	Hours	Providers	Instructors	Accessibility	Stackability/ Portability	Curriculum	Assessment
Maine	50	n/a	RN, CNA	English In person	Registered certificate Credit toward CNA	State curriculum required 14 modules	Written exam + Skills assessment
Massachusetts	60	Comm Colleges Proprietary schools HCAs	RN, SW, PT	English, Spanish, Portuguese, Haitian Creole In person	HCW Registry Multiple setting goal Bridge to CNA, HHA	State sponsored recommended 13 stackable modules	Written exam + Skills assessment
New York	40	Comm Colleges Proprietary schools HCAs	RN, SW, health economist	English, Spanish, Russian, Chinese	Registered certificate Credit for CNA, HHA	State sponsored model 12 modules	Written + oral exam +Skills assessment
Tennessee	15-30 (self-paced)	Proprietary non-profit QuILTSS Institute	Varies	English Online Success coach	Registered certificates 3 micro-credentials Comm College credential	12 stackable modules	Written exam + Virtual skills assessment
Washington	75	Labor-management training partnership	Employers Training partnership Comm Instructors	14 languages Hybrid	Bridge to CNA, HHA	State sponsored model	Written (or read) exam + Skills assessment
Michigan	TBD	TBD	TBD	TBD	4 stackable certifications	TBD, mapped to adopted core competencies	TBD

Appendix 2: How are other states building sustainable pathways?

Advisory Body	New Jersey	Michigan	Wisconsin	Colorado	Washington
Authority	• Legislation -> Special Task Force on DCW Retention & Recruitment	• Convened by MI Dept of Health & Human Services -> DCW Advisory Committee	• Executive Order -> Task Force on Caregiving	• Legislation -> Training Advisory Committee	• Legislation -> Long-Term Care Worker Training Group
Home	Dept. of Labor & Workforce Development	Dept of Health & Human Services	Department of Health Services	CO Health & Human Services Dept. (CHHSD) & Dept of Public Health & Environment	Dept. of Social & Health Services, Aging & Long-Term Support
Composition	• State HHS & Labor depts; consumer advocacy orgs; service providers; employers; union; 2 state senators & assembly members; 2 DCWs	• State HHS & Labor depts; consumer advocacy orgs; service providers; health care academics; 2 DCWs • 2 levels - Advisors: voting members & Consultants: non-voting subject matter experts	• Consumer advocacy orgs; service providers; employers; union; 2 state senators & assembly members; DCW; family caregiver; consumer	• State HHS & Labor depts; consumer & worker advocacy orgs; service providers; employers; DCW; consumer	• State HHS & Labor depts; consumer advocacy orgs; service providers; DCWs; union; PHI
Mandate	• Evaluate current workforce shortage & contributing factors • Recommendations for legislation & policy targeting recruitment & retention	• Strategic direction for MDHHS DCW initiatives & legislation	• Develop recruitment & retention plan • Assess compensation & benefits, including healthcare • Establish home care registry	• Establish process for reviewing and enforcing training for home care workers	• Provide recommendations re. training hours & content and certification requirements • Establish training partnership
Initiatives	• Rate increases (adopted in congregate care) • Statewide PCA training • Recruitment/retention bonuses • Quality incentive bonuses for home care agencies	• Core competency guidelines (adopted) • Code of ethics & professional standards (adopted) • Curricula, Credentials, Career Pathways • Training infrastructure budget proposal • Premium pay (adopted) • Turnover analysis	• Statewide DSP training • Professionalize career ladder with tiered reimbursement based on DCW wage survey • Rate increase + direct care ratio • Earnings disregard	• Standardized training curriculum, including specializations tied to wage increases • Expand data infrastructure to assess DCW supply & demand • Rate increase + direct care ratio (adopted) • Retention & hiring bonuses • Establish training fund	• SEIU 775 Benefits Group Training Partnership • Statewide curriculum for all home care aides (HCAs) • State certification for HCAs Wage tiers tied to advanced training • Continuing education • Health benefits for HCAs