Webinar: Strengthening the Direct Care Workforce in Your State Transcript
Milbank Memorial Fund
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Christine Haran:

Hello, and welcome to the Strengthening the Direct Care Workforce in Your State webinar from the Millbank Memorial Fund. This webinar will be recorded and a link to the recording and the slides will be made available next week. We invite you to post your questions in the chat box throughout the webinar, and we will address them in the Q and A after the presentations. Millbank Program Officer Kate McEvoy is your moderator today. Kate.

Kate McEvoy:

Good afternoon. Thank you so much, Christine. And thank each of you for joining. My name is Kate McEvoy, as Christine mentioned, and I'm a program officer at the Millbank Memorial fund. We welcome you to strengthening the direct workforce in your state. This is a virtual briefing session sponsored by the Millbank Memorial fund in collaboration with the center for healthcare strategies, my fellow panelists, and I are thrilled to see such a large group of you gathered today because I know that reflects both the broad interest and also sense of urgency about the issues that we be discussing together today. We are featuring an important new resource, the direct care workforce policy and action guide, the guide and the work that we hope flows from. It is about a number of things first, recognizing the many interrelated factors that contribute to the direct care workforce shortage.

Second identifying specific and actionable strategies in four areas of focus, wages and benefits, professionalization of the role of direct workforce elevation of the social value of the role of the people who perform this work and also, and not least important improvement of data collection in analytics, as well as evaluation of direct workforce interventions. We are also acknowledging that states are at different stages of readiness and development with these issues. And that is really what the guide is all about, you know, approaching where you are and identifying strategies that will work for you. We also want to support states in building coordinated statewide plans of action that are tailored to your particular needs, but I would be remiss if I didn't wind up to say that this is also fundamentally about the people who do this work, what we can do to learn from their lived experience to advise and inform what we choose to do and how we evaluate its impact today, I will set brief context for why Millbank has chosen to focus in this area then to let bring life and insight to the guide.

We are incredibly fortunate to be joined by esteemed colleagues who bring tremendous expertise and insight to this discussion. So I'll start by saying just a bit about Millbank. Christine, if we could just go back, thank you. Millbank is an over 100 year old endowed operating foundation that as many of you know, focuses on nonpartisan analysis, communication and collaboration, and really supporting state leaders, both in executive branches and legislatures in identifying and applying policy solutions that help to attack areas in population health. Our aim always is to provide trustworthy evidence and experience. And I think that the guide you'll find embolizes both and this really relates to the longtime work of the fund in primary care and cost growth benchmarks, but more recently focusing on state leadership development and practice related to healthy aging.

So that really was theory of the work. Next please. So we really want to start by identifying some context. Clearly we have an enormous gap currently and anticipated to worsen between the demand for

long term services and supports in the whole range of settings and the capacity of the current direct care workforce. Courtney will be sharing significant detail around the nature of the workforce. But I do want to talk first about some of the roots of these issues. Well known to all we're anticipating a huge uptick in the incidence of older adults in the population that age wave related people with disabilities. Although there are many opportunities to benefit from use of technology and other new strategies. The direct workforce remains an essential feature of supporting independence choice and self-direction, and then we're also concerned obviously by various shifting sands and Tradewinds around our longstanding overreliance on what we call informal care.

That's really because family systems have long been the linchpin of long term services and supports, but are challenged in capacity by a lot of different dynamics of family composition, geography. And again, these features are compelling and known to us very well next. So we, in addition to that piece, if we can go to the next slide, thank you. In addition to those phenomena we're urgently and acutely on notice of the influence of structural racism as it influences the current realities for people who do this work not only the direct workforce itself, but also people who receive these long term services and supports, I do want to say this is a particular area, the focus for mobile bank we're grappling with challenging aspects of our own history. So you will see that as a very important focus point in each of the areas of emphasis for the guide.

And then I have provided detail just to confirm what is also well known to us. There are longstanding realities faced by the, the largely women who do this work that are compelling and severe, and really have to heighten our sense of forward momentum around resolving issues like the inadequacy of wages and the, the dearth of benefits. And that really takes an examination that is nuanced because some folks who do this work do benefit from courage of public programs, others are at income levels that is slightly too high to benefit from them. So again, looking at that in a very specific way also I think we've been concerned about not having sufficient platforms for people who do this work to exert their experience and influence over the policy making process and even the sort of identification of the challenge to be addressed in our response the pandemic severely worsened.

Many of these features, and I have to say having served as a Medicaid director during the pandemic was one of the most anguishing aspects of my service. Really seeing these things laid bare and despite a lot of structure and goodwill in the state in which I was situated and effort it was clear that despite very well coalesced advocacy by people who did the work, there were many areas that required much more attention and investment than we had been giving. Historically finally, we saw a lot of issues associated with role definition and really folks who do this work being off the radar screen of regulatory agencies who may be involved in positions that are more medical in nature. And the need to really identify that, especially where in the context of a pandemic special attributes are assigned to being called an essential worker that were not necessarily imbued as rights and protections for the direct workforce. Next, please.

Our theory of change from Milbank's perspective is that knitting together comprehensive response that involves different levers on the state level is the best means of elevating. The people who do this work will help support not only their economic security, but will help to increase social valuation of the role, reduce turnover and help to influence improved quality of care. And as I began to say, we feel like states along with the people who do this work and private advocates and partners are an incredible position of

strength from having an array of levers that they can apply in ways that make sense on, on that local basis next, please,

This is really a profile of the Direct Workforce Guide that we issued yesterday. This is an applied partnership with the Center for Health Care Strategies, and it really does capture this aspect of the multidimensionality of the set of challenges that we're seeking to address, and also underscore the coalition based aspect of the, the opportunities often untapped, but waiting to be maximized at the state level next, please, I am so privileged to be joined today by outstanding speakers who really reflect a range of perspectives and personal experience with these set of issues. I first like to acknowledge Courtney Roman of the Center for Health Care Strategies, Courtney was the lead and the fulcrum point for every aspect of this guide from the initial field work and interviews with state leaders to drafting, to selection and profiles of state's best practice.

We also would like to recognize her colleagues, Dr. Carrie Graham and Nia Joseph, who respectively contributed expertise and insight, reflecting both a national view and applied practice in California, and also great support for the data gathering and analysis and development of the comprehensive index at the end of the guide. And Courtney will share more about that. Dr. Claire Luz of the Michigan State University College of Osteopathic Medicine brought lifelong insights as a gerontologist, lived experience with Michigan's efforts to convene diverse stakeholders around these issues, and constant fidelity to the voice of those who actually do the work, so very privileged to be joined by her. And, last but not least, I'd like to thank Julia Figueira-McDonough. She is consultant to the Blue Shield of California Foundation, and she acted both as a respondent to the guide and also helped advise the direction of our program today. She will be speaking on California's efforts to stage this work. So without further ado, I'd like to segue to Courtney who will be profiling this amazing new resource. Courtney.

Courtney Roman:

Hi everybody. Thank you so much, Kate, for that incredibly kind introduction. I'm Courtney Roman, I'm a senior program officer at the Center for Health Care Strategies. It's great to be here with you all. Next slide please. So I'm really looking forward to sharing highlights from a new resource that was just released, as Kate mentioned. It's the Direct Care Workforce Policy and Action Guide. CHCS in partnership with the IMPART Alliand and the Milbank Memorial Fund published this with support of course from the Milbank Memorial Fund and the Michigan Health Endowment Fund. But before we go through all of that, I wanted to first spend just a few moments level setting on what we mean by direct care workers for the purposes of this discussion, as well as in our guide. So the term "direct care workers" refers to individuals who provide essential services through behavioral health, community, mental health, and long term care systems to support individuals with intellectual and developmental disabilities and older adults in a range of care settings. And of course in their own homes estimates suggest they're around 4.5 million direct care workers in the us most are paid through Medicaid. But their services may also be covered by private insurance, by Medicare or directly by their clients. And, and most also have a core set of responsibilities centered around assisting with hands on personal care activities of daily living rehabilitation and rehabilitation. Next slide.

So when it comes to the direct care workforce here in the US, we have a major problem. The combination of an aging society and an extremely challenging and unsupported job have led to the current situation where we find ourselves estimates suggest that the national turnover rate for direct care workers is between 40 to 60% home care agencies report in excess of 80%. Exact numbers are challenging to calculate, but some estimates suggest there will be a shortage of 151,000 direct care

workers by 2030 and 355,000 by 2040. Yet the need for home community services continues to climb as more and more individuals wish to receive care in their homes. Next slide.

So how can states best move forward? As Kate mentioned, CHCS has developed this guide and it specifically designed for state leaders who are committed to strengthening the direct care workforce and looking for ways to broaden existing efforts, or even just get started. It's meant to help states understand the complexity of the issues regarding the current direct care workforce shortage and the role they can play in, in strengthening and improving this absolutely critical workforce. So the guide was officially released yesterday and it includes an overview of the direct care workforce crisis levers for state leaders to use, to strengthen the direct care workforce action steps, to create meaningful change across sectors, examples of state innovations to better support, direct care workers, and finally ideas to address racial and ethnic and income disparities experienced by direct care workers. And I want to spend just a moment here, really sharing what I mean by this next slide.

So on the left side of the slide, you'll see some of the profound inequities that are found within the direct care workforce, direct care workers are mostly women. They're disproportionately women of color and immigrants, and some estimates suggest more than half. So around 2.8 million of direct care workers or people of color in terms of wages Latina direct care workers are in the lowest of any group right around 18,000 annually. So these desperately low wages mean that 40% of the direct care workforce qualifies for publicly funded programs, such as snap and Medicaid and further exacerbating. This financial issue, the vast majority do not have access to employer sponsored retirement benefits. And in drafting this guide, there was nothing more important to our team than identifying the inequities within and surrounding the direct care workforce and really pulling those out and highlighting states that are slowly chipping away at these deeply rooted disparities.

There isn't one perfect answer. But you'll find the guide offers concrete examples throughout of states that are making changes. And our aim was to offer states and opportunity to see that these important shifts can happen. So I'll share some of those examples in just a few minutes, next slide. So the guide identifies three levers that are available to develop a coordinated approach for bolstering the direct care workforce administrative funding and legislative. And in addition to the levers, our team also identified four key action areas to really guide states in organizing their efforts. So in the next few slides here, I'm just going to walk through each of those action areas and offer some examples next slide. So the first action area is increasing wages, benefits, and supports now not surprisingly solutions for better supporting direct care workers. Usually start by focusing on raising wages and offering higher wages is an essential way to draw new workers to the profession, to reduce turnover and to improve direct care workers, economic security.

This can sometimes feel like a very daunting action though to take on because it's not as straightforward to raise wages, as you may think so, but there are ways to really effectively do this. So first one strategy is to pay a living wage. Several states have set minimum wage requirements for direct care workers funded through Medicaid while others have set it for entire sectors of the direct care workforce. So for example, New Jersey legislation established a minimum wage for nursing facility certified nurse aid, that's $3 higher than the statewide minimum wage. And in terms of an equity example in California, some agencies offer higher pay for direct care workers who are bilingual and those who complete equity training a second strategy is through collective bargaining. Not all states are going to be able to go this route, but some have successfully partnered with organized labor to establish bargaining rights for

direct care workers. So for example, in Connecticut collective bargaining for personal care assistance was first authorized by executive order. And then it was implemented through an enabling statute and that led to higher wages to paid sick time and to dedicated training funds. Next slide.

So next is supporting professionalization of the direct care workforce for many years. Stakeholders and advocates have been calling for this, particularly through developing the hallmarks of any profession competency, standards, training, and skills, building credentials. One strategy states use is a core competency approach to credentialing. So for example, Arizona has enacted uniform training requirements that ensure a baseline level of skill and credentials for all personal care aids. And that includes family caregivers across all Medicaid long-term care programs. A second strategy is providing stipends that are tied to training. So for example, in Rhode Island the Rhode Island college developed a 30 hour behavioral health certificate training program. That's specifically for direct care workers and it's available no cost to them, and it offers them a stipend and a credential upon completion. Another example that focuses on equities in California, again an adult day center offers all direct care staff a monthly stipend of $400 that can be applied to where health insurance, car insurance or other personal needs.

Next slide. So the third action area is to elevate the social value of direct care workers. And this could not be more important. A concerted cultural shift is needed across the broader healthcare system and the public in general where director workers are valued for the skill work they perform as healthcare professionals deeply rooted culture change of course takes time, but there are concrete steps states can take to help change the perception of direct care workers. So first shifting the public narrative state leaders and stakeholders need to be talking about the direct care workforce differently at every opportunity, whether that's at career fairs, high school apprenticeships through public awareness campaigns there is app there's also an absolute non-negotiable need to hear directly from direct care workers on how they think of their positions and, and their work and drawing on direct care worker stories and lived ex lived experience can be a very powerful influence on public opinion and policy.

So for example, the Indiana family and social services administration created a direct support workforce advisory board. And that includes 17 direct care workers to represent a variety of settings and regions and backgrounds. And Colorado is using a significant portion of their American rescue act funds to invest in public awareness campaigns. A second strategy is to prioritize direct care workers, safety, wellbeing, and health state leaders should really ensure direct care workers are considered essential and, and make sure that they're eligible for PPE for sick leave and paid time off. Cause those are things that all their other healthcare professional peers regularly receive. So for example, Virginia's legislature passed paid sick leave law at the height of the COVID pandemic. And in terms of an interesting equity example in New Mexico, there's a training agency there that offers direct care workforce training that's linguistically and culturally appropriate, and they also provide free in-house childcare since the majority of their trainees are female.

Next slide. The last action area is to improve data monitoring and evaluation. One of the biggest gaps in data for the direct care workforce is with race, gender, sexual orientation, and gender identity, immigration status, and income. So by improving collection of those data points, states are better able to really understand the demographics of the direct care workforce. So for example, the Texas health and human services commission recognized in 2018, they were not adequately measuring the scope of

direct care workforce challenges. So they added new questions about worker turnover, retention, and compensation to their existing provider surveys to really help guide Medicaid policy making and workforce planning in the state. And lastly evaluating existing direct care workforce improvement efforts is so important. The New York State office for Aging engaged Cornell University and the City University of New York to examine the economic impact of increasing wages for direct care workers on individuals and the community and reducing their reliance on public assistance programs. So, as I mentioned earlier, the guide was released yesterday and contains numerous other examples and strategies for states to draw from. We hope it's helpful to all. And now I'm so pleased to turn things over to my colleague, Julia who's going to discuss ongoing efforts to strengthen the direct care workforce in California. So Julia, your turn.

Julia Figueira-McDonough:

Great. Thank you so much, Courtney. I wanted just take a moment to acknowledge the tremendous work that went into putting this guide together and to congratulate the teams at CHCS, Milbank, and Michigan State. And to thank you for creating such an important tool. I am joining you today from Los Angeles, California, the ancestral and present day of the Gabrielino peoples. I'm really happy to be here today to learn more about what other states are doing to support their direct care workforce and to share some of what California has been up to California. Next slide please has long been known as the golden state. We are the nation's most populous state at just under 40 million people. Also its most diverse. We have the highest state GDP at over 3 billion and our proposed budget for the coming fiscal year just came out and came in at over 300 billion.

We're known for having progressive Medicaid policies and programs, including our in-home supportive services program. We have over 570,000 independent providers, the majority of whom provide consumer directed care to Medicaid eligible individuals. Our MediCal, which is our Medicaid state program is expanding coverage to cover most undocumented Californians by 2024. And overall our me program is undergoing a major transformation through a five year initiative. That's really focused on better coordinating fragmented health and social services and prioritizing care for people with especially complex needs, including seniors and people living with disabilities. Next slide please. Also in California, we live with the highest poverty level in the nation at over 15%. We also live with extreme income inequality and an exorbitant and sky riding skyrocketing cost of living, which has resulted in a well-publicized and heartbreaking housing and homelessness crisis. We have a high Medicaid uses rate.

One in three Californians, rely on Medicaid and that rate is disproportionately higher among communities of color like the rest of the nation. We have a rapidly aging population though, interestingly in California at an even more rapid rate by 2030, 19% of CA Californians will be over 65 and our overall population is diminishing slightly most significantly. Our younger workers, the makeup of our direct care workforce mirrors that of the rest of the country and reflects both the legacy and current reality of racism that has historically devalued this work and the people who perform it as well as our state's particular demographics: 80% of California's direct care workers are women. Almost half are immigrants and just over half are paid so poorly that they rely on public assistance. There are signs that long term services and supports are becoming a statewide priority. In the last few years, we've had a couple of investments directed by the legislature toward creating a statewide long term care insurance benefit requiring the commission of an actuarial report modeling different versions of what that benefit would look like.

And in this legislative cycle, we had two bills put forward to create an LTSS benefits board, a trust fund, and a benefits program, which unfortunately stalled, but the coalition of advocates that brought those forward are committed to reworking and bringing those bills. Back next year, the direct care workforce has also been elevated in recent years. Next slide please. As a statewide priority a few years ago, our future health workforce commission issued a report that included a recommendation for establishing and scaling a universal home care worker, family of jobs with care, career ladders and associated trainings. And a couple of years ago, a future of work commission included as one of their priority recommendations, the elimination of working poverty with a specific focus on the care sector. And last but not least the master plan for aging included as one of its five bold goals, caregiving that works.

And within that, the specific target to create 1 million high quality caregiving jobs by 2030, there are two agencies in California whose work touches on long term services and supports first is our health and human services agency or HHS. It is composed of 12 departments and those in lighter blue at the top, those six departments are the ones who are charged with providing all Medicaid funded long term services and supports in the state HHS accounts for over 30% of the overall state budget in California. Next slide, please, by contrast the labor and workforce development agency, our labor agency accounts for just under 1% of the state budget, it includes seven departments that are charged with regulating working conditions and promoting workforce development in all settings in all sectors. And the direct care sector is as it is in the rest of the country, one of the fastest growing and poorest paid in the state, making it a priority for the labor agency.

However, despite the labor agency's broad enforcement responsibilities, it does not have the power or the funding to directly increase wages. And it is not directly involved in administration or delivery of long term services and supports, which brings us to the importance of collaboration. Next slide please. While HH S's primary focus has always been on the person receiving care. The labor agencies is on the person delivering that care, recognizing the crucial connection between quality jobs and the quality and availability of care. The two agencies have prioritized strengthening their partnership. So we view collaboration on a few different levels. There's collaboration between the two agencies and also collaboration within the agencies, as you've seen their HHS, its alone has has 12 departments and within those departments, multiple divisions and lastly the collaboration between the state agencies and external stakeholders, one of the overarching principles behind the master plan for aging is to break down silos. So that care is not so difficult to access. And that really begins with the various agencies and departments responsible for providing those services, taking the time to build partnerships.

So I wanted to talk in a little bit more detail about one example of how we've begun to build this partnership. Last year, California invested an unprecedented amount in the direct care workforce, almost a billion dollars and through our conversations about all the different directions that money was going in, it became clear that it would be helpful to catalog those investments and share that information. So as we know, most government agencies are often at maximum capacity fulfilling their regular responsibilities and providing essential day to day services. So they don't always have the time or the resources to take on additional work here. The work provided added value because it facilitated internal coordination as well as external stakeholder engagement. And it was made possible through philanthropic support, which I just wanted to highlight so that people can consider the role that philanthropy may play in supporting these kinds of initiatives. As in the case with this guide it was a

group of foundations in California that funded the work that went into the master plan for aging. California has a senior advisor for social innovation, whose purpose is to focus on public private partnerships to support state initiatives. And in this example, the additional resource was me. You're my position with the labor agency, which was funded first by the open society foundation's leadership and government fellowship. And now with the general support of blue shield of California foundation.

So as far as steps that we took to get this project off the ground from the labor agency perspective, we identified key partners and built a partnership with the department of aging within HHS, which is the department, which really has taken on the leadership role in coordinating within the agency, the larger agency. And in fact, was the lead agency in the production of the master plan for aging. So we relied on the department of aging for help creating tools to gather information and for help with corralling participation amongst the various departments we held monthly or Sunday, monthly extra and intra agency direct care workforce meetings to level set. So for example, we had presentations by the labor agency on background, on the direct care workforce, demographics of the direct care workforce economics of the direct care sector information that our partners at HHS might not have been as familiar with.

And together we chose priorities and decided to plan a presentation to disseminate the information that we were collecting in the form of a webinar. From there we took on the decidedly unglamorous task of assembling a Google spreadsheet with categories of information that we thought would be the most helpful to our various stakeholders and followed up with the individual departments to ensure that the information we had was complete and accurate and tried to synthesize or summarize that data into a format that would be more accessible, digestible for a wider audience. We worked with the department of aging communications people to create visuals for the webinar and spent a good amount of time thinking about outreach extremely broadly to include not just our government partners from across the spectrum, but also to include what have been sort of two separate advocacy communities, the the group of advocates or stakeholders that advocate for older adults and people living with disabilities.

And then the group of advocates who advocate on behalf of workers. So the next slide is a example of one of the slides from this presentation, which summarizes the investments by job category setting and department. We had of course, several other slides that broke down the information in more detail and provided the opportunity for the programs or the departments that were leading the programs, receiving the investments to talk more about those programs. And we emailed this information to, and these slides to all of the registered participants and made them those slides also available on our websites. So I think part of what we've accomplished by taking this small step is, and these efforts are ongoing. These programs are evolving. But the, I think what the first step really helped accomplish was providing a baseline for strategic planning between the two agencies and also between the various departments within those agencies.

It also facilitated stakeholder engagement, which is crucial by providing important information so that so that we could prov we could receive crucial feedback from stakeholders. And we're hoping that the planning meetings that went into this project will be transitioned into regular internal HHS labor agency, direct care workforce strategy meetings, so that we can continue to coordinate our efforts to support this workforce. And this partnership, I think also paved the way for the current HHS labor agency

collaboration on our coming year budget, which includes a 1.4 billion investment in health workforce for all, what we have yet to do really falls into three broad categories. Some of which were touched on by Courtney raising wages, being the first and perhaps the most important all of the investments, both current and proposed or most of them, the vast majority are for training.

There's some amounts set aside for stipends related to training and care work done during the height of the pandemic, but not for permanent wage increases in part because of the temporary nature of these funds, which are mostly ARPA funds, as Courtney noted, there are some exceptions and on the related topic of benefits this, we all are aware. I'm sure that the vast majority of direct care workers do not receive benefits through their work. And this is a kind of a tricky question because so many of our workers are reliant on public benefits. It requires some calibration when we're talking about, you know, raising the wages and providing benefits and ensuring that workers don't fall off of benefits cliff. So as Courtney noted, there are exceptions here as well, but you know, our goal is to make these exceptions, the rule to generalize in statewide so that all direct care workers have access to these additional benefits and livable wages.

And lastly the standardization of central and centralization of training and certification we currently have a patchwork of requirements managed by multiple departments, and we understand this works against building a sustainable pipeline. We hope to work toward a more accessible, coordinated professionalized system. And that brings us to the million dollar question, which is how do we build towards structural systemic change. There is a specific recommendation in the master plan for aging to convene a direct care workforce solutions table, which we are still hoping to do in order to produce a blueprint for sustainable direct care workforce development. And part of that process will be looking to other states to assess the feasibility of their successful programs in California for more on what such a program could look like and all that it could accomplish. I'll turn it over to professor Claire of Michigan State university and the IMPART Alliance.

Clare Luz:

Thank you. Good afternoon, everybody. And thank you, Julia, and to the rest of the panel and everybody who's in attendance. I am really glad to be here to share some highlights of the good work that is happening in Michigan on behalf of direct care workers. And my presentation actually will reflect much of what Courtney and Julia have already said. And I know and will say up front that we have a lot to wor to learn from other states. So we're anxious to be in touch with you if, if you would like to, we would, would love to make contact just a quick word on impart Alliance in part Alliance was established formally in 2016 with a grant from the Michigan health endowment fund, but it grew out of years and years of developing direct care worker, training programs and research with federal and state funding and in partnership with the state and many, many community partners.

Our institutional home is the College of Osteopathic Medicine at Michigan State University. But our sole mission really is to serve the whole state and to help Michigan build an infrastructure that can support the direct care workforce. So Michigan, like all states is facing an acute shortage of direct care workers. Providers are feeling the pain they're shuttering their doors. Some of them individuals and family members are struggling to find enough qualified, direct care workers to cover the hours of needed support. And that has far reaching consequences. It's not just about meeting basic needs, right? It's also as one young woman who needs daily support said to me, good, make the difference between just living

and thriving states are struggling to trying to address the shortage in a range of ways, some of which you have heard about today, and I'm going to tell you more about Michigan's approach.

And this slide here tells you how acute the shortage is in Michigan. It is estimated that we need approximately 36,000 more direct care workers than we currently have. And of course the shortage is not just about the number of direct care workers. It's also about the high turnover rate that Courtney talked about earlier, which destroys continuity of care keeps the system all turned up and is astronomically expensive. It's also not just, it's not, it is about it, not wanting just warm bodies. We need this workforce to be available and qualified and kind, and we know that they are in a pivotal position because they typically spend more time with an individual than any other member of a support team. And if they are qualified, they can avert costly life changing events and sometimes make the difference between life and death. And this is not just a problem with the long term supports and services world.

It really affects all of us in so many ways. The, the economy, economic development, health systems, non-health care systems, businesses, and so forth. So it is important not just to the direct care workers and the people they support, but it is in the best interest of all of us to make sure that this workforce stabilizes and is economically secure. So part of my message today is that it is not all doom and gloom. I am actually encouraged by what is happening in Michigan and by other states and individuals and organizations across the us who are really taking this on, including some of you on this call, California, as Julia just mentioned the center for healthcare studies, Phi the mill bank Memorial fund, and so many others. So I have been advocating on behalf of direct care workers for several decades now, and I have never been more hopeful than I have than I am right now than I have been over the last two years change is coming and it has to, we don't really have a choice.

Now is the time, slide please. So what is happening in Michigan feels like nothing short of a movement, a seismic shift. It's exciting to be a part of. There is currently tremendous drive in momentum to rise to the challenge at the state level. So let me just give you a few examples slide, please like California in 2020, the Michigan department of health and human services recognized the de to make the direct care workforce a major priority and included some broad goals in our state plan on aging, including increasing the number of qualified and supported multicultural direct care workers, supporting opportunities for increased wages, improving retention, and elevating this workforce by promoting its collective value. They also included some very specific goals slide, please, to develop statewide competencies for all direct care workers, develop educational curricula guidelines that map to these competencies develop basic intermediate and advanced career pathways and implement a statewide media campaign, promoting direct care workers and training. There is a work plan that de details, very specific steps to take, to reach these goals with target dates for completion, they all were hoping will be done by the end of 2023, also in 2020, the Michigan department of health and human services director of what was then called the aging and adult services administration, or ASA established a statewide direct care workforce advisory council. And asked me to co-chair it slide please.

And this has been a really remarkable experience. I think for all of us, it's a big deal to have this kind of support from within DHHS, really unprecedented and a huge step forward. And our charge was to do what advisory councils do, which is to advise and identify goals, provide subject matter expertise, leverage resources, make recommendations. Now my perspective is that this committee has been extraordinary in many ways, almost historical. It is the first time that I have ever been in a group where

there is representation from all long term supports and services settings from behavioral health, aging services, Medicaid, regulatory folks, advocates, direct care workers, and many others. And it's really quite simple. We're all talking to each other, something we hadn't been doing before. We're breaking down silos, finding common ground. We're seemingly committed to the same goals and pulling in the same direction.

And this kind of coordinated leadership at the state level has allowed us to come to some really I think foundational and critical agreements such as we learned early on, we really needed to have a common definition of what we mean when we say direct care worker. This is a very basic important thing to do. Courtney showed a slide earlier of definition that is similar to the definition we use and which is inclusive of all direct care workers. We also agree that the reasons for the shortage are multifactorial and must be addressed as such. They are inextricably connected. So raising wages alone will not work. Training alone will not work. A patchwork. A bandaid approach is not going to get the job done. We agreed that it is a statewide issue, demanding a statewide response, and we needed a coordinated statewide strategic plan. And we also agreed that the advocacy and recommendations that come out of this council need to raise up all direct care workers versus a subset of direct care workers that work in a particular program or setting or with particular population, which in my view, and which is actually supported by the literature can sometimes lead to unintended divisive consequences.

So we have been meeting monthly now for two years, and I can honestly say that every meeting leaves me impressed and grateful. It's really a privilege to work with this group. We started with three work groups that are active. And I'm just going to tell you about the first one slide please.

So this work group focuses on professionalizing, the direct care workforce. And by that, I mean establishing competency standards, training guidelines, and credentials that match to these guidelines, career pathways, all of the hallmarks of any professional Courtney mentioned. And the premise is that this should lead to higher wages and greater respect and economic stability as it does for other professions. So many of you know, that there are federal competency and training requirements for certified nursing assistance, home health aides, some in hospice, but there's really nothing comparable at the federal level for most, most other direct care workers. So step one really is to establish competency guidelines, some quality standards. It's really hard to develop training programs without knowing the standards that you're training people to. We did develop a list of competency professional and ethical guidelines informed by national standards. And we submitted these to the Michigan department of health and human services for consideration.

And I am really happy to say that we were notified last week, that the department has accepted these competency standards and now recognizes them as Michigan's recommended direct care workforce competencies. So we can now wrap training guidelines and credentials and career pathways around these competencies. And we are already setting goals for what a model training program could include. And one of our main goals really is to in increase training options for employers and direct care workers, not limit them. And we plan to do this using a number of strategies that can move direct care workers more quickly into the direct care workforce, into the job market, without sacrificing quality. This includes things like we're creating three stackable training levels each with associated competencies and

credentials. We're establishing ways in which individuals who already have skills and competencies and credentials can get credit for it and be recognized and test out of additional training.

We're creating a system. We hope of reciprocity, so that job skills are portable and can transfer from job to job. And ideally, an individual who has all the core skills will be able to work in all long term supports and service settings with all populations across all programs and payers, the current system of each program payer setting, setting, having their own training requirements is really highly inefficient and confusing and expensive, and it reduces employer and direct care worker training options. So we're trying to move away from that. This is really exciting work to be included in, let me tell you about a few more things that have been happening in Michigan. That also give me hope slide please.

So also in 2020 you know, a few good things did happen in 2020 in part entered into a partnership with Phi. And for those of you that don't know about Phi, they are a national organization dedicated to lifting up direct care workers across the, the United States through research data tracking advocacy training. They are, well-established highly respected as one of the country's primary authorities on direct care workers. And I recommend visiting their website, which is just full of valuable resources. So Phi received a grant from the Kellogg foundation to work with three states to lift up direct care workers through policy reform in three areas, wages and benefits, innovative strategies, including professionalization and data collecting better data using the data that we have in better ways. This initiative is now called Essential Jobs, Essential Care, or EJEC. And they chose Michigan as one of the states and IMPART Alliance as their anchor organization in Michigan.

The other two states are New Mexico and North Carolina. And the cross state relationships that have developed have been invaluable. One of the goals was to establish a statewide direct care workforce coalition, which we have done. And in just the past year, that coalition has grown from 100 members to over 600 members. And the beauty of a coalition is that people begin to know what is happening around the state. They don't feel so alone. We're not going to be redundant and have everybody sort of replicating you know, reinventing the wheel. They can be mobilized quickly for advocacy actions. They can approach decision makers with consistent Mets messaging instead of each organization with its own agenda and its own asks, approaching decision makers which may be counterproductive and actually undermined the common goals. So this also was a very huge step forward, and I believe it helped lead to Michigan providing most direct care workers with a $2 wage increase or premium pay during COVID using cares funds, which the legislature and governor then increased to $2 and 35 cents an hour and included in the fiscal year, 2022 approved budget, a big step forward.

And we know it's just the beginning. We have to get that up to a living wage. So there's still work to be done, but the director workforce advisory committee and this coalition are now working very closely together, which makes progress even more possible. So many other good things are happening that I would love to share, but I'm soon going to be out of time. I've li listed some of them on the next slide slide, please. And let me just point out two of these initiatives, there is a new bipartisan legislative care….which is focused on caregiving, and we are working very closely with them. And one of the results of these, all of these collaborations really is a joint proposal that a group of us worked on and submitted

to the Michigan department of health and human services and several legislators to establish a statewide direct care workforce training and credentialing infrastructure.

And we just learned last week that this proposal is in the house budget, which is very exciting news. It's not in the Senate budget. We hope it will make it to the final budget, but the fact that it's in the house budget is a huge success and very encouraging. So other successes slide please, these successes premium pay for direct care workers putting the 2 35 in the general budget, competency guidelines, codes of ethics and professional standards, curricula, credentials, training, infrastructure proposal, all of these successes are propelling us forward in a way that we could never have imagined even two years ago. And we have identified key components that have made these successful, these successes possible slide, please.

So here's a list of some of the key components of success statewide leadership, as we've all been talking about, that includes all stakeholders. Everybody should be at the table and, and have by and feel like they have a voice and that they're being respected. Building relationships based on respect, transparency, trust collaboration versus competition is really important recognition of interrelatedness of solutions, the common definition of a direct care worker advocacy on behalf of all direct care workers, staying committed, passionate patient persistent. And I'd like to think that impart Alliance has been able to help by serving as a neutral convener. This has been our experience in Michigan, but, you know, through working on the Millbank Memorial Fund project and guide that we are celebrating today, I believe all of us are in agreement that whatever your state, these are important components to cultivate. So what is next for Michigan slide, please?

So none of us, you know, despite all of these successes and feel good stories, none of us are under any illusion that the successes mean that the work is done far from it. There is still so much work to do. This is a long road we're all on and we're committed to it. And these next steps are just a few other pieces to the puzzle that have to be considered. We have to get the wages up to a living wage with cost of living increases and paid overtime. And over, over paid time off all of those things, benefits raise the Medicaid cap to make all of this more affordable, establish occupational codes for all direct care workers and more, and I'm really excited to be on this journey with this team with all of you. And I would like to close by circling back to where Kate started to have sustainable successes. We really believe we have to tackle the deeply rooted causes of the shortage in the first place, the racism, the sexism, the ageism and we have to advocate for reforms that give direct care workers, respect, and above all else, economic security. So I'm going to close here and turn it back over to Kate to bring us home and we have time for questions shortly. I'm sure. So thanks so much for your attention,

Kate McEvoy:

Claire, Julia, Courtney, I, I just want to thank you so much phenomenal remarks. And I think we've, we've seen in the chat people are finding this to be so useful and actionable inspiring. It's fascinating to see, you know, Julia, as you talk about, you know, cultivating the seeds of this work you know, leaping off the California Master Plan on Aging and all the coalition building and potential energy and momentum you have, and then seeing a state like Michigan as Claire had described, which is an example for us, all of being further down the developmental curve, you know, having done that hard, but absolutely

necessary work of kind of equalizing influence by through coalition building common definitions and really selected strategies that have manifest highly practically and established a strategic agenda that will add and amplify that over time.

So I just love the progression of the discussion. And thank you all so much for catalyzing this. I, we have a number of questions that have been posed by folks who've joined us today. And I do want to start with a few questions about the guide itself and its potential. I first wanted to say that Claire turning to you we have a question from Katherine Kennedy about how we might wish the guide to be used for research purposes and related activities. May I turn to you to comment on that?

Clare Luz:

Yes, it's an excellent, excellent question. I'm actually using it for research purposes myself, and I mention it often. I talk to people about what we're doing in Michigan and, and often get the question, well, what are they doing in other states? And so I've re reflected on the work that we've been doing. And I've been able to bring up examples and say, this is the work that's being done in Arizona, in Colorado and Alaska. And to figure out if it's a model that would work for us in Michigan, we are actually, as I said, in the process of trying to come up with a, a more standardized curricula, but not a, not a one size fits all, because that's never going to happen. So, you know, I consulted the guide and some other experts in the field on if there are any other models that are the states that are, are trying to do something similar at the state level, have some a more standardized curricula that maps to competencies and there are several states doing it.

We're going to probably use those as a template. So that's one way to use it for research. I think that the guide is just the tip of you know, we had so many examples. It, we, we had so much rich data to work with and it was almost hard to select what to put in the guide. But if you trace it back to, you know, our reference, our citations, our references, and, you know, wanted to take a, an idea that we posed and look into it a little more deeply about why we included it in the guide and the research that we did in order to make sure that this was evidence based. That's another way to use it for research purposes. I, I hope that's what you had in mind. And other panelists can probably add more to it.

Kate McEvoy:

So sorry to be muted. I definitely will invite others to join you in commenting, but I, I, I feel like we'd like to turn that back to those of you who are joining us today. Also, I see an incredible breadth of participation, state officials, folks in advocacy community. We see many academics on the list. We invite you to be in touch with us to really be generative about this. We hope that this is a leaping off point rather than something that feels like it's at a closure in the way that Claire said this is designed to be a catalyst for, for engagement. So I really say tell us how we can further partner on that. I also want to get at an opportunity to answer a question from Robin stone around the sort of the breadth of the data and the definition and the guidance. I wanted to start with Courtney around that. Rob imposes, a specific question of whether the data encompasses folks with intellectual disabilities folks with mental health disabilities. And maybe you could go back Courtney just to reinforce that aspect of the breadth of the definition.

Courtney Roman:

Yes, that is a great question. Robin, and thanks Kate. It does include all of that. We worked really hard to interview states that were that had, that included that in their definition and, and were talking to agencies that did, that did both and we really wanted to be as comprehensive as we possibly could be. When, when putting when putting this together.

Clare Luz:

Yeah, I add something because I saw there was a question directed at me about whether or not the behavioral health community, IDD, is included in everything we were doing. And absolutely. Yes. and that has been one of the joys of the advisory committee and the coalition is that we're trying to make sure that everybody's voice is heard and that, you know, I come out of aging services. So it, this has been a real education for me, and I'm thrilled to now be learning so much more about the disability community and to be partnering with colleagues so that we can make sure that things like the definition are all inclusive or the competencies, you know, we had a team of people working on those competencies and we had people from all of these different populations, served all of these different sectors to make sure that there were examples in there. And that the, the range of voices was being heard.

Kate McEvoy:

That's so inspiring to hear that clear, because I do feel like one of our longstanding challenges has been the sort of compartmentalization of this and that tends to be exacerbated by funding streams and departmental organizational structures on the state level you know, different constituencies and advocates. And I think it, it is compelling looking at Michigan's experience not only identifying the breadth of the coalition, but the, the need for transcending those particular categories of service. You know, and one of the questions that was asked is, you know, how did you think about universalizing the standards? You know, given the fact that there have been you know, I think constructive tensions about around the sort of unique facets of serving various populations,

Clare Luz:

Which is I, I can jump in.

Kate McEvoy:

Well, I, I would love to direct that to you, Claire. Yes.

Clare Luz:

Okay. I wasn't sure. Well, as I was just talking about, we made a concerted effort to make sure that the council at least is working on behalf of all direct care workers. And that means direct care workers working in behavioral health and mental health and aging services, you know, across the whole board. And as, you know, direct care workers go by many, many titles names, right. So people often say, well, what do you mean by direct care worker? But we're using it as an umbrella term, it actually includes the certified nursing assistance, home health aides, DSPs, PCAs, you have all the different labels that are put on it, but, you know, the direct care workers in slightly different worlds, right? Mental health has different training requirements, for example, than aging services.

So if we're going to appeal to all direct care workers and raise up all direct care workers, then we have to have people from those fields represented at the table. And so it is something we, we work very hard

on. And I, I know there are a couple of my colleagues on the phone and I just, I wanna, I was wishing that I could just say, you know, jump in here and explain how he did it, but it's, it's really making a commitment to equity across all categories and lifting them all up and it's process oriented. You have to identify who are all of the stakeholders and then start building relationships with all of them and finding the common ground and everybody staying focused on the common ground. Not, you know, the, the collaboration, not the competitiveness, the higher good that we all are reaching for. So it's, it's really a concerted effort and assembled this this group of people, which is wonderful. And I'm, I just hope that we, you know, we keep it together and <laugh>, I keep working and making some good strides forward. I hope that helps.

Kate McEvoy:

Yeah. I, I think that is enormously helpful and it's a practice it's a way of, of working that is intentionally different than has been the case historically. So, I think that so much of what you talked about, from the how of doing that, was enormously helpful to all of us. I I'd like to turn to, to Julia, Julia you know, because of your expertise in labor I wondered if I could start with you, there was a number of questions about the, the wage issues. Mm-Hmm <affirmative> and just ask if you have thoughts on two of them that I'll just flag briefly one we had a question from about whether, you know, there is some opportunity to agree on a national living wage as opposed to a national minimum wage. And then there was a reference to the MIT data as a potential, you know, premise for that. Also, there is a question about whether what, what you feel about making wage increases based on longevity. So as opposed to sort of broad brush wage increases, may I start with you on those for any thoughts that you might have?

Julia Figueira-McDonough:

Sure. yeah, those are great questions. I think the wage question is always the sticking point, right? <Laugh> I think, you know, on the federal level, we all had hope, right. And we had hope when there was the push last year for raising the minimum wage across the country to 15. Right. And that didn't go anywhere. I think we're in a complicated situation politically at the federal level. We had hope with build back better, that that would, you know send funds our way that would enable us at the state level, you know to sort of uniformly across states, raise the wages to approximate something more look like a livable wage and all of that is stalled, right? So I think most states have sort of turned, not in words, but turned to each other and to look for examples of how to get this stuff done and, you know, turned inward to try to figure out what levers might exist at the state level.

Since it doesn't look like politically that's going to happen on the federal level, and we just can't depend on it, it'd be great if it happens. And it looked like we were really close, but I, it doesn't seem like it's going to happen in the near future. So I think that there are on, at the state level, which also involves federal funding a range of potential levers, right. For, for raising the wage. And many of them are highlighted in the guide, right. Have to do with including, you know, wage pass throughs with direct care ratios. I know that in Michigan, I think that there is some thought into looking into like putting in requirements in the contracts between the Medicaid the Medicaid contracts with managed care organizations. And I think that's something that I think many states are moving more towards you know handling their long term services and support through managed care organizations.

So I think it makes a lot of sense to pay attention to how we can integrate wage standards into those contracts and living wage standards into those contracts. I think at the end of the day, there's no way around increasing investment, right. That this but there are you know, ways in which we can either

incentivize or require in the delivery of Medicaid funded services through the state, you know, make these requirements or these incentives happen in our in our programs or our contracts. And the question of longevity, I'm assuming, I think that, does that mean seniority perhaps like, you know, how long someone…

Kate McEvoy:

How I think that's how I interpret it. Yeah.

Julia Figueira-McDonough:

Yeah. You know, that's a great question that I haven't, to be honest, given much thought to, I know that in California, for example, the standardization and categories end up requiring training that is somewhat complicated because we have this large Medicaid-funded in-home supportive services workforce—many of whom are family care providers. We don't actually have any required training for that group of workers. There is more and more provided optional training. And I think there has been talk about when we talk about standardizing curricula and training requirements, whether we might kind of grandfather in some of those providers, who've been working for a certain amount of time already. So I think it, it, that has been a consideration when we talk about, you know, how we might you know create core curricula and core competencies is how do we account for people who've been doing this for a long time who may or may not have the ability or the desire to do additional training or gain additional certifications.

Kate McEvoy:

I really appreciate that you know, reference because it does keep going back to the kind of looking at the totality and means of responding. So wages yes, but also perhaps that means of preferential treatment with someone with a lot of lived experience and you know, learned expertise as compo compared to a, a formal curriculum that might be at a more introductory premise. So I really like what you said about that, Julia I do want to acknowledge you know, both you and Claire have talked a lot about you know, the inner relationship of these issues with Medicaid, reimbursement and Medicaid being an important progenitor of the, the driving of what's of what people receive in the way of wages.

Susan Elmore urging us not to lose sight of the fact that there are plenty of folks who are either above the income parameters for Medicaid or age into need for services people who have later onset intellectual or disability developmental disabilities, I think is the premise of her question and trying to think about this in the sort of larger schema of Medicaid, having significant influence, but there being folks outside that system that also have needs that are not being well met. So I don't know if Claire or Julia would like to say anything about that.

Clare Luz:

I'm going to let Julia start.

Julia Figueira-McDonough:

I think that's such an excellent question. Yeah, I think, I think there are a couple of points there. You know, one is the, the ongoing efforts at, at different states, different states to increase coverage for long term care. A, a couple of which I highlighted in California, and I know other states are trying to expand that. And then the other is, you know, I think at least in California, we've been having conversations

about how, you know, where the state has the most direct influence is over state funded programs or Medicaid funded programs. Right. An idea that by raising the floor for those programs, we could raise the floor for the whole sector that is not necessarily, you know the case. But I think that is where, you know, the bulk of the effort and attention has been with that assumption that it would raise the floor for the whole sector.

But I, yeah, that aside, I think there are things that can be done, you know, as well for you know, incentives for private employers to provide higher wages and benefits and better jobs in California. We have both a robust apprenticeship program, which we are hoping to grow, to include direct care workers. And oftentimes those are pub those are private employers as well as something called a high road training partnership. And none of this is required. It's all voluntary for employers to participate. But there are policy incentives for them to do so, as well as incentive of just, you know, gaining a well trained workforce that is, and, and reducing turnover and all of associated costs that Claire referred to. So those are a couple programs we have in California, and I think there are creative ways to incentivize employers in the private sector to create better jobs.

Clare Luz:

Yeah, I would agree with all of that. And I know funding for training and higher wages is always a question and people are concerned rightfully so about unfunded mandates. So we don't want, you know, I think for the state leaders on the call, it's not, you can't just say, we're going to raise wages over here and not raise the Medicaid cap or provide other funding sources over here to help cover those higher costs to employers. So, you know, again, it goes back to these, all of these systems are so connected and the providers and the direct care workers are already suffering. They, we can't, you know, for example, at the moment, the competency standards are not required, their guidelines only. And the training guidelines that we're developing will be too. But if we get to a day where they're not, and we were encouraging people to have certain amount of training, we can't just say, you know, okay, you have to do this training and then not provide some sort of way to help pay for it. So it goes back to Kate, all of your discussions about the lovers that we have available to us at the state level.

Kate McEvoy:

Right. That's a perfect segue. I find astonishingly, I find that we are at time this the richness and complexity of this discussion can hardly be bounded by this brief interval of time this afternoon, but we really want to thank all of you for joining us. Just a phenomenal turnout, reflecting, incredible expertise among you that we hope will have the benefit of sharing ongoing. Thank you very much to Courtney, to Claire, to Julia, for their outstanding remarks. And we hope you leave energized, ready to craft. Like I said, state specific coalition based person centered solutions that focus on elevating the people who do this work in a comprehensive way that really can make change. We look forward to additional engagement for you, and please keep in touch. Thank you so much for joining, and please do use the guide. Take care.