Master Plan for Aging
Recommendation Form

To submit your recommendation, fill out as many of the fields below as possible. It is fine to leave some blank. Recommendations can be submitted at engage@aging.ca.gov. Initial recommendations are requested to be submitted by December 13, but they may be submitted after this date as well.

Issue Statement:

The rapid aging of the US, and California's, population has been well documented: by 2035, senior citizens will outnumber children for the first time in our country's history. While there is a rising gray tide across the nation, California is on track for a gray tsunami. There are over six million seniors in California today, and that number is projected to grow by three million to comprise over 20% of the state's population by 2030, with the most significant growth among Asian and Latino seniors.

The concomitant crisis in care for our elders is staggering. Currently, there are 1.2 million California seniors enrolled in MediCal and eligible for publicly subsidized long-term care, while 4.8 million are uninsured. By 2030, there will be a labor shortage in California of between 600,000 to 3.2 million paid direct care home workers (and an estimated 3.8 million unpaid family caregivers). Although there is currently insufficient data to project how many direct care workers will be needed in group residential care,the direct care occupations of Home Health Aide and Home Care Aide are the fastest growing in the state.

There is an urgent need to build a workforce development strategy that will meet the paid direct care workforce shortfall. Foremost among the multifold challenges to recruitment and retention are the poverty-level wages and grueling working conditions of direct care workers – issues that must be addressed head-on in order to create sustainable jobs. Person-centered training models that emphasize cultural and linguistic competency, incorporate advances in medical support technology, and incentivize high road employment practices through cost-savings are essential to meeting workforce demand and improving care and health outcomes for seniors.

MPA Framework Goals:

Goal 1: Services & Supports. We will live where we choose as we age and have the help we and our families need to do so.

MPA Framework Objective:

1.1: Californians will have access to the help we need to live in the homes and communities we choose as we age.

Goal 3: Health & Well-being. We will live in communities and have access to services and care that optimize health and quality of life.

MPA Framework Objective:

3.1: Californians will live in communities with policies and programs that promote well-being throughout our lifespans.

3.2: Californians will have access to quality, affordable, and person-centered health care through delivery systems that are age-friendly, dementia-friendly and disability-friendly.

Goal 4: Economic Security and Safety. We will have economic security and be safe from abuse, neglect, exploitation, and natural disasters and emergencies throughout our lives.

MPA Framework Objective:

4.1: Californians will be economically secure throughout our life span with access to housing, food and income as we age.

4.2: Californians will be protected from abuse, neglect, and exploitation as we age.

Strategic Recommendation:

Establish a Direct Caregiver Workforce Development Task Force.

- Members: consumer and worker advocates; educational institutions; foundations.
- Advisory group: stakeholders from State certifying and regulatory agencies; health insurers; private homecare and residential care employers.
- Objectives:
    - Spearhead research to fill in data gaps re. private pay caregiver workforce.
    - Assess how to adapt and scale successful public and private pay caregiver training and workforce development programs.
        - Explore public/private partnerships.
        - Design policy incentives for high-road private employers.
    - Produce blueprint for a workforce development strategy that meets workforce shortage and improves working conditions, care and health outcomes.

Target Population and Numbers: Paid direct caregivers.

<u>Summary</u>

Paid direct care workers are non-medical staff who provide assistance with activities of daily living ("ADLs") and instrumental activities of daily living ("IADLs"). Paid direct caregivers may act as Home Health Aides or Home Care Aides (aka Personal Care Aides); however, many perform the same jobs without licensing or registration. 20% of direct care is subsidized by MediCal/Medicare; 80% is paid for with private funds.

- Paid homecare workers: over 558,000 (EDD 2014)

-79.2% women
-70.3% people of color: 38.3% Latinx; 21.3% Asian; 10.7% Black
-48.5 % foreign-born
-median wage: 10.05/hour
-median annual salary: $14,000 (half the median for all California workers)
-more than twice as likely to live in low-income household
-1 in 4 fall below federal poverty line

- Caregivers at Residential Care Facilities for the Elderly ("RCFEs"): insufficient data for official count

  -overwhelmingly immigrant and African-American women
  -frequently housed on-site in shared quarters
  -Often on call 24/7
  -Commonly paid a fixed sum per week or month, amounting to less than $4/hour

Narrative

The most recent survey (conducted in 2014) estimates there are 558,000 paid homecare workers in California (a doubling from 2006). Homecare workers are almost 80% female, 72% people of color, and nearly 50% foreign-born. In 2015, median wages for homecare workers were $10.05 per hour (compared to $18.88 per hour for all workers), and their medial annual earnings were less than half the median for all California workers ($14,000 compared to $35,000). Homecare workers are more than twice as likely to live in a low-income household, and one in four fall below the federal poverty line.

Of the 558,000 paid homecare workers counted in 2014, 410,000 (over 70%) were In Home Supportive Services ("IHSS") workers, providing care to individuals who qualify for Medi-Cal. Only 20% of California seniors are eligible for IHSS services. The remainder – 80% of the elder population – can only employ home caregivers through private homecare agencies or directly (referred to as the "gray market"). The vast majority of families who can afford private homecare at all pay for the services out of pocket, as homecare is not covered by health insurance and very few Californians have long-term care insurance.

Group residential care is also primarily paid for out of pocket by families. Residential Care Facilities for the Elderly (RCFEs) are staffed primarily by direct caregivers, who, like homecare workers, are underpaid and overworked. Created as an alternative to nursing homes, RCFEs are non-medical facilities that provide residents with lodging, meals, housekeeping, supervision and assistance with activities of daily living. In California, there are 7,300 licensed RCFEs – six times the number of skilled nursing facilities (and more than a quarter of the total nationwide). Less than 5% of RCFE residents receive public assistance (in the form of Medi-Cal waivers) to subsidize their care. 40% of RCFE residents have Alzheimer's Disease and Related Dementias (ADRDs). Although the level of care has risen alongside the number of residents living with ADRDs and other acute medical conditions, understaffing and egregious workplace violations

are widespread. It is common for workers to live on-site (often in shared, makeshift accommodations), to be on-call 24 hours a day, and to be paid a fixed salary that amounts to less than $4 per hour. There is very little official data on the RCFE workforce. However, information gleaned from state and federal enforcement actions and wage claims indicates that RCFE caregivers are overwhelmingly immigrant and African-American women.

Detailed Recommendation:

Establish Direct Caregiver Workforce Development Task Force (Task Force), to be convened by the Labor and Workforce Development Agency (LWDA).

The Task Force will focus on the following objectives:

- Spearhead research to fill in data gaps re. private pay caregiver workforce.
    - There is limited demographic information available regarding the private pay caregiver workforce – due in part to inconsistent recordkeeping requirements for homecare agencies and RCFEs, and to the large gray market in caregiving.
    - Work with educational institutions, foundations and state agencies to identify data gaps and create plan to collect missing information, specifically regarding RCFE and gray market workforce.
- Assess how to adapt and scale successful public and private pay caregiver training and workforce development programs.
    - There are a handful of workforce development and training programs focused on direct caregivers, primarily serving IHSS workers, that may serve as models to be modified for the private-pay direct care workforce.
    - Evaluate current initiatives based on available data on outcomes.
    - Explore public/private partnerships: Identify public (e.g. educational institutions) and private entities (unions, CBOs, health insurers) that would benefit from collaborating on workforce development and training.
- Design policy incentives for high-road private employers:
    - Examine current WIB High Road Training Partnerships to determine viability/transferability in non-union settings.
    - Consider regulatory changes to increase/incentivize compliance.
    - Identify potential financial savings, benefits, and subsidies related to better paid and trained workforce.

Evidence that supports the recommendation:

<u>Quality Care through Quality Jobs</u>

- Better Care – Quality & Access:

- Better wages and working conditions increase job satisfaction, reduce turnover, allow for caregivers to receive training and provide consistent, superior care.
- Targeted direct caregiver training results in increased knowledge and skills in care delivery and improved communication with the consumer and the consumer's care team.

- Better Health: Enhanced care tools and care team building results in fewer Emergency Room visits and hospitalizations.

- Lower Costs: Reduced urgent medical interventions (ER visits and hospitalizations) results in substantial cost savings to Medicaid and Medicare.

Sources

1. California Long-Term Care Education Center, "Care Team Integration and Training of Home Care Workers – Impact Study." (2018) https://cltcec.org/cost-savings-roi/ This report documents the improvements in care and cost savings resulting from IHSS caregiver training.

2. Future Health Workforce Commission Final Report (2019): https://futurehealthworkforce.org/our-work/finalreport/. This report details California's looming health workforce shortage, makes workforce recommendations on how to alleviate this shortage, and provides impact assessments of a Universal Homecare Worker Proposal.

Examples of local, state or national initiatives that can be used as an example of a best practice:

- **Local:**
- **State:**
  - Shirley Ware Education Center: IHSS and hospital workers - https://www.seiu-uhweduc.org/about/shirley-ware-education-center/
  - California Long Term Education Center: IHSS workers - https://cltcec.org/
  - UCLA Geriatric Workforce Enhancement Program: IHSS workers - https://gwep.med.ucla.edu/pages/
  - Opportunity Junction: CNA training - https://opportunityjunction.org/need-a-job/cna-training
- **National:**
- **Other:** Cooperative Homecare Associates: IHSS and private homecare workers (New York) - http://chcany.org/

Implementation:

- **State Agencies/Departments:** [action to be taken by Governor or specific state agencies]:
    - Establish Caregiver Workforce Development and Enforcement Task Force ("Task Force"), anchored by the Labor and Workforce Development Agency.
    - Participation by the following state agencies in an advisory capacity as needed for data collection: Department of Social Services, Department of Public Health, Employment Development Department, Department of Industrial Relations (Division of Labor Standards Enforcement, Division of Apprenticeship Standards), and Workforce Development Board, Department of Aging (State Ombudsman)
- **State Legislature:**
    - NO POSITION
- **Local Government:** Participation in Task Force by the following entities in an advisory capacity, on an as-needed basis:
    - County government agency with IHSS administrative experience
    - Local area Agency on Aging
    - Aging Ombudsman Services
- **Federal Government:** Participation in task force in an advisory capacity as needed for data collection by representative of Health Resources & Services Administration (HRSA).
- **Private Sector**: Participation in Task Force in an advisory capacity on an as-needed basis by representatives from:
    - Health insurers
    - Private home care agencies
    - Private RCFE operators
- **Community-Based Organizations:** Participation in the Task Force by
    - Caregiver advocates, e.g.:
        - Labor: United Domestic Workers/AFSCME Local 3930; SEIU Local 2015
        - California Domestic Worker Coalition: member organizations
    - Consumer and family advocates, e.g.:
        - Association for the Advancement of Retired Persons (AARP), Alzheimer's Association, California Family Caregiver Alliance; Elder Services Ombudsman
- **Philanthropy:** Participation in Task Force by foundations focused on health and workforce research and seed funding, e.g. SCAN Foundation, Irvine Foundation
- **Other:**
    - Participation in Task Force by educational institutions focused on recruiting and training caregivers:
        - Community Colleges with healthcare paraprofessional programs, e.g. American River College, Mt. Diablo Adult Education

        - Four-year colleges with geriatric disciplines, e.g. UCLA, UC Davis, UCSF, UC Berkeley
    - Participation in Task Force by organizations managing successful caregiver training and workforce development programs, e.g.:
        - Shirley Ware Education Center, https://www.seiu-uhweduc.org/about/shirley-ware-education-center/
        - California Long Term Education Center, https://cltcec.org/
        - Opportunity Junction, https://opportunityjunction.org/need-a-job/cna-training
        - Cooperative Homecare Associates (NY), http://chcany.org/

Person-Centered Metrics:

- Improved health outcomes: fewer ER visits and hospitalizations.
- Lower staff turnover.
- Enhanced economic security and health outcomes for trained staff and their families, with higher wages and benefits.

Evaluations:

- **Short-term (by 2020):** Convene Task Force.
- **Short-term (by 2022**):
    - Complete data collection.
    - Draft blueprint for sustainable direct caregiver workforce development that emphasizes improved working conditions and wages, skills training and healthcare team building, policy and cost-savings incentives for high road employers, and reinvesting cost savings into wages, benefits and training.
- **Mid-term (by 2025):**
    - Implement demonstration workforce development and training projects.
- **Long-term (by 2030):**
    - Evaluate and scale demonstration projects.

Potential Costs/Savings:
Research and program evaluations that document cost savings to Medicaid and Medicare.

1. California Long-Term Care Education Center, "Care Team Integration and Training of Home Care Workers – Impact Study." (2018) https://cltcec.org/cost-savings-roi/ This report documents the improvements in care and cost savings resulting from IHSS caregiver training.

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looming health workforce shortage, makes workforce recommendations on how to alleviate this shortage, and provides impact assessments of a Universal Homecare Worker Proposal.

Prioritization: HIGH.

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