JOSH GREEN, M.D.
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

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STATE OF HAWAIʻI
DEPARTMENT OF HEALTH
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In reply, please refer to:
File:

January 8, 2025

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Thirty-third State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Nadine K. Nakamura,
Speaker
and Members of the House of
Representatives
Thirty-third State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Nakamura, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the Report to Coordinate with the State Health Planning and Development Agency in the Development of a Long-term Care Plan as Part of an Overall Health Care System Plan, pursuant to Act 159, Session Laws of Hawaii 2024.

In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:
https://health.hawaii.gov/opppd/department-of-health-reports-to-2025-legislature/

Sincerely,

Kenneth S. Fink, M.D., M.P.H., M.G.A.
Director of Health

Enclosures

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# REPORT TO THE THIRTY-THIRD LEGISLATURE

# STATE OF HAWAI'I

# 2025

Act 159 relating to Long-Term Care requires the Executive Office on Aging, an attached agency to the Department of Health, to coordinate with the State Health Planning and Development Agency in the development of a long-term care plan as part of an overall health care system plan.

Prepared by:

State of Hawaiʻi
Department of Health
Executive Office on Aging
December 2024

## Executive Summary

The Executive Office on Aging (EOA), an attached agency to the Department of Health (DOH) respectfully submits this report to the 2025 Hawaiʻi State Legislature in accordance with Act 159, HSL 2024 relating to Long-Term Care.

Executive Office on Aging was charged to coordinate with the State Health Planning and Development Agency in the development of a long-term care plan as part of an overall health care system plan.

The comprehensive long-term care plan shall:

(1) Identify essential components to ensure the availability of a full continuum of long-term care services, including homes, skilled nursing institutions, and other institutional and community-based services.

(2) Identify needed reforms to establish a sustainable long-term care system.

(3) Research programmatic changes and resources necessary to meet the State's long-term care public policy goals; and

(4) Explore funding options to support the provision of long-term care services, including the recruitment, training, and retention of a skilled workforce.

To guide the development of the LTC plan, EOA convened a Steering Committee (SC), consisting of the DOH State Health Planning and Development Agency, the Department of Labor and Industrial Relations, the University of Hawaiʻi – Center on Aging, the Department of Education, stakeholders, and community members. This report provides an update on the work of the SC members, who are committed to the vision that Hawai'i has an integrated, holistic, and person-centered long-term care system.

EOA met challenges that delayed the establishment of the LTC planner position. We anticipate recruiting for the position in the near future. The SC is committed to work on short range goals and objectives among the four domains that will lay the foundation for the ongoing LTC planning process. The LTC Planner will collaborate with and continue the efforts of the SC to develop a Statewide LTC Plan by December 2025.

## History of Long-Term Care in Hawaiʻi

Hawaiʻi has a proud history of developing programs and services that improve the lives of older adults.

In 1963, the Hawaiʻi State Legislature established the State Commission on Aging with the passage of Act 198. Led by a grassroots group of concerned citizens, community leaders, and legislators, these visionaries laid the groundwork for an infrastructure that would meet and support the future needs of Hawaiʻi's kūpuna. Act 198 also created the Policy Advisory Board for Elder Affairs (PABEA) and established a Committee on Aging in each county.

Predating the passage of the federal Older Americans Act in 1965, the State Commission on Aging addressed basic concerns, such as adequate housing and meals, and planned for a comprehensive program that would include education, healthcare, recreation, financial security, and employment. In 1977, Chapter 349 of the Hawaii Revised Statutes established the Executive Office on Aging (EOA) as the designated lead agency in the coordination and development of a statewide system of aging and caregiver support services.

In 1988, EOA released the LTC Plan for Hawaiʻi's Older Adults, A First Step in Planned Care. The Plan created 5 broad themes:

- Be client-centered and family supportive.
- Assure dignity, self-determination, and independence to the maximum extent possible for all older persons.
- Prevent and/or delay the need for institutional care.
- Promote partnerships within and among the public and the private sectors and elder consumers and their families.
- Anticipate future developments.

The LTC plan had three overarching policy recommendations:

- Services and Systems Development and Coordination
- Quality of Care
- Financing

## Addressing the Need of LTC in 2024

Building upon the early years and the relevant principles outlined in the 1988 plan, the SC was focused on the opinion that elders want to remain at home for as long as possible and the need to rebalance and reform LTC with quality, affordable and accessible care. They established the vision, mission, and values for the LTC Plan.

## LTC VISION

Hawaiʻi has an integrated, holistic, and person-centered long-term care system.

## LTC MISSION

To promote a sustainable long-term care approach as part of an overall health care system plan that spans the continuum of care through research, coordination, and development of policies, programs, and services.

## LTC VALUES

- Participant centered and family supported
- Assures dignity, self-determination, and independence to the maximum extent possible
- Prevents and delays the need for higher levels of care
- Supports access to high quality of care
- Values a quality of life for all
- Fosters partnerships within and among the public and the private sectors
- Maintains fiscally prudent services and supports
- Promotes education and public awareness; and
- Embraces innovation and promotes change

## LTC GOAL

Hawaiʻi's older adults and individuals with disabilities have a quality system of long-term care that encompasses the identified values and norms.

To achieve this goal, the SC structured the work into four Domains of Long-Term Care. Three of the four domains were identified in the 1988 LTC Plan and are relevant today. They are Services and System, Financing, and Quality of Care. Workforce was added as the fourth domain. Each domain is essential in reforming LTSS.

The report herein is the culmination of the work in progress following the LTC summit in February 2024 through October 2024. The goal of this period was to identify short term objectives and recommendations to guide the overall LTC Plan.

### *Domain 1) WORKFORCE*

Hawaiʻi, like the rest of the nation, is facing a critical shortage of direct care workers. Direct care workers (DCW) include nursing assistants, nurse aides, home health aides, personal

care aides and others who provide paid, hands-on long-term care and personal assistance to older adults and individuals living with disabilities or chronic medical conditions. DCWs are employed at large institutions, like hospitals and skilled nursing facilities, community-based residential care homes and nursing homes, and private residences. They assist with everyday tasks such as bathing, toileting, dressing, getting in and out of a bed or chair, eating, and other activities of daily living.

Hawaiʻi's shortage of DCWs has the potential to disrupt the standard of care that residents receive from their respective healthcare providers, especially when their health status requires increased support from paid caregivers. Social, geographic, and economic factors in the state create challenges to recruiting, training, and retaining enough qualified DCWs. The state's high cost of living, housing shortage, and inflation make it difficult to retain employees in low-wage jobs with insufficient benefits.

EOA contracted with the University of Hawaiʻi - Center on Aging to research, prepare, and write a statewide strategic plan to develop goals, recommendations, and strategies that can help build capacity – both in quality and quantity – in Hawai'i's direct care workforce.

The goal of the strategic plan is to raise public awareness on the importance of the direct care workforce and recommend policy solutions to build capacity in the workforce to support a robust and sustainable long-term care system in Hawaiʻi. The plan proposes strategies for consideration and action to improve the recruitment, training, and retention of Hawai'i's direct care workforce. Key goals and recommendations include:

Goal: Improve recruitment of direct care workers by supporting efforts to determine compensation models that are fair and livable, diversifying recruitment pools, and generating interest in aging at an earlier age.

Strategies:

- Improve retention of DCWs by promoting conditions that result in job satisfaction, including opportunities for training, continuing education, team-based decision-making, positive culture change, and productive communication.
- Strengthen the career pathway by supporting employees' professional development and personal growth, providing more opportunities to broaden their knowledge and skills, as well as advance in their chosen or related career.
- Enhance professional development by creating a universal care worker model in which students learn standardized core competencies on aging, with a focus on person-centered care as well as enhancement of psychosocial and cultural strengths.
- Develop data collection and evaluation strategies to better track progress, outcomes, and ultimately improve quality of long-term care settings.
- Raise public awareness about the importance of strengthening the direct care workforce in Hawai'i to sustain a robust long-term care system that enhances the lives of older adults and individuals living with disabilities.

- Elevate the societal value of DCWs through multiple channels of communication, including community and professional education, media campaigns, and organizational in-service trainings.

The next phase of this process involves developing action steps based on the ideas, issues, and options discussed in this report and building cross-sector support for continued planning and implementation. See Exhibit 1 – Full Report.

### *Domain 2: SERVICES AND SYSTEMS FOR OLDER ADULTS*

Integrate the services and systems of older adults towards a seamless system that addresses the needs of kupuna and the disabled. This integrated system must operate to serve those on Medicaid, those who rely on other publicly funded social service programs such as the State Kūpuna Care program, and those who can pay for services. The system will need to be responsive to the needs of the whole community.

The short-term objectives address access to in-home care and opportunities to grow the delivery of LTSS.

Objective 1: Shift the balance of delivering Medicaid long term services and supports away from institutional care to care at home and in the community.

Strategy 1: Understand and define opportunities for conflict free case management through the balancing incentive program.

Objective 2: Build capacity throughout the system to meet the unique needs of a growing population amid a rapidly changing healthcare landscape.

Strategies:

- Identify the gaps and issues faced by the system and various public funding sources (Aging Network, Medicaid Integration, private sources etc.)
- Review standards among payors both private and public to help create capacity among providers of care.
- Identify which workforce strategies will create capacity within the system.

Objective 3: Increase access to the Aging and Disability Resource Center (ADRC) to serve as a trusted source of information and assistance.

Strategies:

- Develop and implement an education and outreach campaign to increase awareness of the ADRC.
- Provide ongoing training on person-centered principles to ensure that ADRC consumers have a satisfactory experience.

- Ensure that ADRC counseling options includes “fee for services” for older adults, persons with disabilities, and individuals with ADRD who have the financial means to pay for services.

Objective 4: Create opportunities to expand the delivery of long-term services and supports among all payors.

Strategies:

- Modernize our services to meet the needs of tomorrow’s kūpuna.
- Increase the availability of publicly funded transportation.
- Ensure that older adults living with Alzheimer's Disease and Related Dementias are supported to have quality of life.
- Educate, promote, and brand services and supports throughout the state.
- Ensure that the costs of care are equitable and fair while retaining a strong workforce.

***Domain 3: FINANCING***

With the growing needs of the aging population and individuals with disabilities, the need to finance long-term care is critical. Communities across the nation need equitable and affordable systems to better serve workers, consumers, and family caregivers.

The following strategies were reviewed during the summit as it related to financing of LTC.

- Re-allocating financial incentives to HCBS (Home and Community Based Care)
- Utilize Medicare in addition to Medicaid
- Rewards for practicing AFHS (Age-Friendly Health Systems)
- HCBS rate studies and improvement
- Medicare COLA

The first strategy listed above may be the most promising by reallocating or rebalancing fund allocation from LTC institutional care (nursing homes, care homes, ARCH’s, etc.) to home and community-based services (HCBS). Nursing home annual costs per beneficiary here averaged about $230,000 in 2023. Some states, including Minnesota and Washington State, are demonstrating best practices to rebalance state Medicaid spending on LTC. Most states, including Hawaiʻi, spend 75% on nursing home and facility placement and 25% on HCBS. By anticipating and avoiding institutional placement and focusing resources on HCBS, Minnesota now spends only 25% of its Medicaid LTC allocation on facility placement and instead 75% on HCBS. Consequently, this results in significant state and federal savings, and happier seniors and their families. Considering the $230,000 average annual cost of a nursing home placement in Hawaiʻi, if we spent 40% of that cost on HCBS (about $100,000 per year), that would result in approximately $300/day for HCBS, and

$130,000 of savings in state and federal Medicaid spending per beneficiary. $300 per day of HCBS services spending would make an enormous difference in allowing seniors to age at home, with significant savings over institutional care.

The Centers for Medicare and Medicaid Services (CMS) AHEAD (Advancing All-Payer Equity Approaches and Development) grant awarded to Hawaiʻi and 5 other states could help demonstrate innovative and more effective ways of caring for kupuna through delivery system innovation involving community health workers or trained volunteers to provide high-touch elder home care, and with high-tech remote patient monitoring (RPM) and telemedicine access to nurses and physicians as needed. These delivery reforms need to be piloted and refined, but they could increase patient convenience and compliance in accessing primary, specialty, and behavioral health care, as well as social support services, and could reduce social isolation. Given the workforce shortage issues in health care here, we need to find ways to leverage doctors, nurses, and other caregivers in short supply to reach more patients effectively through delivery system innovation.

Medicare doesn't generally cover long term care services, although it does cover palliative care and hospice. However, savings and improvements to the program could be created by adding more HCBS resources focused on reducing avoidable emergency room visits and inpatient admissions and improving chronic disease management and the health of kūpuna. Advocating for improved HCBS in Medicare could be a benefit of the AHEAD grant.

The principles behind Age-Friendly Health Systems (AFHS) could also help improve health care efficiency and effectiveness for seniors. Finally, while Hawaiʻi and Alaska are the only states that have Congressionally approved funding for health care through a COLA (cost-of-living-allowance), our COLA has been flat for decades and needs to be indexed to inflation and to the increasing impacts of costs of living and housing in this state.

The next steps are to incorporate strategies from the AHEAD grant as part of the LTC plan. In addition, we need to incorporate strategies to move forward the principles of AFHS and utilizing palliative care and hospice.

### ***Domain 4: QUALITY OF CARE***

Quality of Care is complex in nature and has various levels of quality of care. Quality of care may be defined as 1) the objective, measurable elements of structures, processes, and outcome of care and 2) the subjective elements which reflect our society's core values and norms regarding adequate responses to physical, psychosocial, and spiritual needs of individuals.

One of the challenges faced over the last few months was identifying a partner to work on the Quality-of-Care domain. We had a champion who was going to work on Quality of Care,

but she received an offer to work in Washington D.C. and couldn't continue to help the Steering Committee.

The next step includes identifying a champion to address Quality of Care as we move forward with the other three domains.

## Challenges and Opportunities

EOA and its stakeholders were challenged to move forward with the identified objectives and strategies due to our own internal workforce challenges. In addition, the objectives and strategies are not inclusive as we need to plan out both mid and long-range objectives to effectively develop a plan that will span the test of time.

We understand the need to move forward on these short-term objectives while building out our long–range objectives to ensure we meet the goal of a quality system of long-term care.

Developing a comprehensive LTC plan will take the dedication of a long-term care planner who can mobilize the stakeholders in addressing the needs of the LTC system. Due to the complexity of the work, EOA has requested that the <u>LTC planner be extended for another biennium to develop the plan and follow up recommendations, identify needed reforms, effectuate policy change, and mobilize the community and stakeholders to implement the LTC plan.</u>

## Next Steps for 2025

- Reset the Steering Committee and find additional champions and stakeholders to identify the mid and long-range objectives and strategies of all four domains.
- Develop a timeline with objectives and due dates.
- Finalize the LTC Plan and have it available to the 2026 Hawai'i State Legislature.

# EXHIBIT “1”

## Strengthening Hawai‘i’s Direct Care Workforce

**Prepared by the Center on Aging**
University of Hawai`i at Mānoa
Thompson School of Social Work & Public Health
in cooperation with
The State of Hawai`i Executive Office on Aging

### Why We Must Strengthen Hawai‘i’s Direct Care Workforce

The ability to provide excellent long-term care for our kūpuna in their own homes, in hospitals, and in supportive living environments like skilled nursing facilities and care homes in the community depends on how well we can recruit, train, and retain direct care workers. Often referred to as the "backbone" of the long-term care system, these hardworking individuals devote a considerable amount of their working hours in direct contact with our older adult population and individuals with disabilities. They are an indispensable segment of the healthcare workforce and play an essential role on a care recipient's multidisciplinary care team.

Currently there is a critical shortage of direct care workers, and this situation will worsen if we don't take active steps now and in the years ahead to resolve the problem. Without sufficient well-trained direct care workers, kūpuna and individuals with disabilities will not be able to get the level of high-quality services that they need to age well and with dignity.

All stakeholders in Hawaii are encouraged to come together to help build a robust long-term care infrastructure. That is why the University of Hawaii at Mānoa Center on Aging has completed this state strategic plan called, "Strengthening Hawaii's Direct Care Workforce," in cooperation with the state’s Executive Office on Aging. This plan articulates a number of goals, recommendations, and strategies that can serve as a road map for reinforcing, enhancing, and invigorating the direct care workforce in Hawaii. The plan offers strategies that are ready for action, but it is also a foundation upon which future growth and innovative ideas are expected to evolve.

We invite our partners in government, academia, the private and non-profit sectors, and advocates in the larger community – including direct care workers themselves – to come together to achieve the goals set forth in this plan. Collectively we can contribute to building an age-friendly state for our kūpuna, for ourselves, and for future generations. To our direct care workers, we thank and appreciate you. We understand the vital and important work that you do. For those considering joining the direct care workforce in some capacity, we value you and will strive to make direct care work a professionally and personally rewarding career choice!

Christy Nishita, Ph.D., Interim Director
UH Mānoa Center on Aging

## EXHIBIT “1”

### Executive Summary

The state of Hawaii, like the rest of the nation, is facing a critical shortage of direct care workers. Direct care workers (DCW) include nursing assistants, nurse aides, home health aides, personal care aides and others who provide a substantial amount of the paid hands-on long-term care and personal assistance received by older adults and individuals living with disabilities or chronic medical conditions. Even the occupation of nurse aide goes by a number of job titles reflecting a range of responsibilities. DCWs are employed at large institutions like hospitals and skilled nursing facilities; community-based residential care homes and nursing homes; and in private residences. They provide assistance with everyday tasks such as bathing, going to the bathroom, dressing, getting in and out of a bed or chair, eating, and other so-called activities of daily living.

Hawaii's shortage of DCWs has the potential to disrupt the standard of care that residents receive from their respective healthcare providers, especially when their health status requires increased support from paid caregivers. This is not a problem unique to Hawaiʻi, but a convergence of social, geographic, and economic factors in the state may make recruiting, training, and retaining sufficient numbers of qualified direct care workers even more challenging. For example, the state’s high cost of living, housing shortage, and inflation make it difficult to retain employees in low-wage jobs with insufficient benefits.

The state’s Executive Office of Aging (EOA) contracted with the University of Hawai`i at Mānoa Center on Aging to research, prepare, and write this statewide strategic plan that uses key informant interviews, a comprehensive scan of the relevant literature, and other consultative research to arrive at a set of goals, recommendations, and strategies that can help build capacity – both in quality and quantity – in Hawaii’s direct care workforce.

The goal of this strategic plan is to help raise public awareness about the importance of the direct care workforce and recommend policy solutions to build capacity in that workforce in support of a robust and sustainable long-term care system in Hawaii. While it is important to increase the number of direct care workers in the state, it is also important that these workers receive excellent training – especially in the care of older adults and individuals with disabilities – and that they are able to earn a livable wage and perform their responsibilities in an environment of respect and dignity.

This plan proposes strategies for consideration and action to improve the recruitment, training, and retention of Hawaii’s direct care workforce. Key goals and recommendations include:

> Improve recruitment of direct care workers by supporting efforts to determine compensation models that are fair and livable, diversifying recruitment pools, and generating interest in aging at an earlier age.

**EXHIBIT “1”**

> Improve retention of DCWs by promoting conditions that result in job satisfaction, including opportunities for training, continuing education, team-based decision-making, positive culture change, and productive communication.

> Strengthen the career pathway by supporting employees’ professional development and personal growth, providing more opportunities for them to broaden their knowledge and skills, as well as advance in their chosen or related career.

> Enhance professional development by creating a universal care worker model in which students learn standardized core competencies on aging, with a focus on person-centered care as well as enhancement of psychosocial and cultural strengths.

> Develop data collection and evaluation strategies to better track progress, outcomes, and ultimately improve quality of long-term care settings.

> Raise public awareness about the importance of strengthening the direct care workforce in Hawaii to sustain a robust long-term care system that enhances the lives of older adults and individuals living with disabilities.

> Elevate the societal value of DCWs through multiple channels of communication, including community and professional education, media campaigns, and organizational in-service trainings.

The next phase of this process involves developing action steps based on the ideas, issues, and options discussed in this report and building cross-sector support for continued planning and implementation.

(End of Executive Summary)

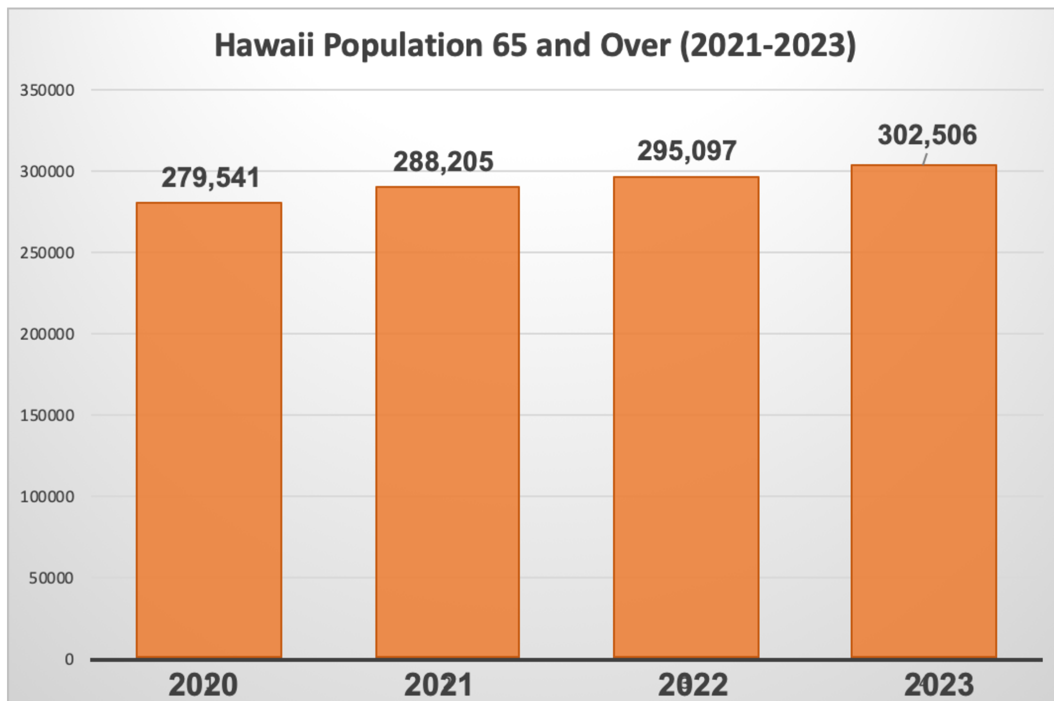
## EXHIBIT "1"

### Background and Context

### Hawaii's Growing Long-term Care Needs

Currently, approximately one-fifth of the population in Hawai`i is 65 and over and that proportion will continue to increase over the next decade. Of all the older adults in Hawai`i, a little over 19 percent live alone, and about 32 percent are married with no other family member living with them. Notably, among older adults who are *renters*, almost 38 percent live alone.[1] Moreover, Hawai`i has the highest life expectancy in the nation at 80.7 in 2020 (although there was slight dip to 79.9 in 2021).[2] Longevity is something to be celebrated, especially when an elder's quality of life can be maintained, but older people also tend to have more chronic illnesses.

**Figure 1. Hawaii Population Data 2021-2023**




Annual Estimates of the Resident Population for Selected Age Groups by Sex for Hawaii: April 1, 2020 to July 1, 2023 (SC-EST2023-AGESEX-15) Source: U.S. Census Bureau, Population Division. Release Date: June 2024

Older adults are at a significant risk of having multiple chronic diseases, also known as comorbidities or multi-morbidities, and associated functional impairment. Functional impairment refers to limitations in the ability to carry out day-to-day household activities and chores or experiencing interference in engaging in activities outside of the home. As they continue to age, many older adults live with a growing number of complex health issues that adversely affect their day-to-day functioning and overall quality of life. For some people and groups of older adults, these concerns are further compounded by the presence of memory issues.

## EXHIBIT "1"

Compounding the need for more direct care workers is a demographic shift in the older adult population in which a growing percentage of the population age 55 and over is childless (i.e., no biological children) especially at the younger end of the age spectrum (55-64) and part of a larger group called "solo agers" because these older adults were never married, are divorced, or are widowed.[3] Also important to note is that the majority of native Hawaiians now live outside of Hawaii, as confirmed by the 2020 U.S. Census.[4] Hawai`i's high cost of living, perceived limited career opportunities, exorbitant real estate prices, and other reasons have resulted in residents leaving the Islands for seemingly more affordable locales.[5] These kinds of demographic realities will have implications for future care because adult children have traditionally filled the role of caregiver when parents need increased care. In the absence of, or geographical separation from adult children, older adults who need increased care will have to rely on other providers of care, such as government agencies and community-based organizations.

Individuals with disabilities often benefit from the assistance provided by a DCW, and for older adults with disabilities, DCW assistance may be vital to their safety and wellbeing. The CDC defines a disability as "any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions)."[6] The CDC reports that more than 1 in 4 people in the U.S. is living with a disability of some kind.[7]

People with disabilities are a diverse group because there are many different types of disabilities but they generally involve, as stated above, an impairment, activity limitation, and participation restrictions, whether the disability was present at birth, was identified after birth in childhood, resulted from an injury at any point in life, or is related to a chronic medical condition developed in adulthood, and so on. Disabilities may present challenges in cognition, mobility, independent living, hearing, vision, and self-care.

Unlike older adults who have traditionally relied on adult children for unpaid care, younger people with disabilities may rely on their parents and other family members for such support (e.g., with activities of daily living and transportation). Depending on the level of care needed and the internal and external resources of the family, the DCW can be an essential part of the care team for individuals with disabilities, regardless of age, especially as parent caregivers or even grandparent caregivers get older themselves and possibly experience their own health issues. The lack of DCWs could seriously jeopardize the continuation of care provided earlier by unpaid family members at a time when those family members are either no longer able to provide the same or greater level of care or when they pass away. Strengthening the direct care workforce helps individuals with disabilities throughout the life course.

For all these reasons and others, DCWs will be needed more than ever in the coming years. The state of Hawai`i in collaboration with the healthcare industry and relevant academic institutions has a vested interest in strengthening the direct care workforce and jointly devising strategies for recruiting and retaining well-trained, conscientious direct care workers, despite the challenges in doing so.

## EXHIBIT “1”

Because this plan was commissioned by the state Executive Office on Aging, the focus and recommendations mainly surround older adults. However, many of the issues that impact older adults also impact individuals with disabilities in this state.

**Who are Direct Care Workers?**

Direct care workers (DCWs) provide a substantial amount of the paid hands-on long-term care and personal assistance received by older adults and individuals living with disabilities or chronic medical conditions. They are an integral and indispensable part of the long-term care system in Hawaii. They are trained to assist clients with their activities of daily living such as personal care management, note-taking at appointments, and communication with long-distance caregivers to keep them abreast of developments.

DCWs are employed in both acute and long-term care settings, as well as by home care agencies and directly by families or by elders themselves. They work in hospitals, health clinics, skilled nursing facilities, assisted living facilities, community-based adult foster family homes, adult residential care homes, private residences, continuing care communities, and in other supportive living environments. They are often on the frontlines of personal care, providing ongoing human contact and interaction. In an adult foster family home, for example, the care home operator is responsible for providing care 24 hours a day, 7 days a week. In a skilled nursing facility, the direct care worker dispenses “high-touch” personal care such as bathing, grooming, and dressing: activities that require compassion, trust, and attention to detail in the basics of physical and emotional care. Direct care workers are an essential part of the older adult’s healthcare team, a team that encompasses other professionals and paraprofessionals in allied health fields like nursing, medicine, physical therapy, occupational therapy, social work, and dentistry. As patient-support staff in healthcare centers, medical offices and clinics, direct care workers also contribute to the wellbeing of healthy older adults, not only those with impairments.

Beyond these practical tasks, direct care workers may also fulfill a psychological and social need for elders by providing company and companionship in the course of their duties. For example, a nursing assistant in a skilled nursing facility might develop an enduring friendly relationship with a long-term care resident who has few, if any, visits from people outside the facility. Because they work on the frontlines of care, direct care workers are in a position to notice when clients need additional nursing, medical, or psychological attention, which is particularly important when the person being cared for has communication challenges. In effect, direct care workers can serve as the "eyes and ears" of the long-term care system since they are in close direct contact with individuals whose care needs may change from one day to the next, or even one hour to the next, and can seek intervention on their behalf before evolving problems worsen.

INSERT DCW INFOGRAPHIC ABOUT HERE

## EXHIBIT “1”

*An Array of Job Titles and Educational Requirements*

Congress passed standard nurse aide requirements in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) to mitigate the low quality of care in nursing homes across the states. Previously, only a “handful” of states had any educational requirements for nurse aides.[8] While OBRA 87 established minimum state criteria for curricula, hours of training, practical/clinical exposure, program re-certification, training sites, instructor qualifications, exams and certification, nurse aide registries, and in-service training in entities receiving Medicare and/or Medicaid reimbursements, the COVID pandemic revealed a need for revisiting and revising facility standards. For example, the minimum federal requirement of 75 hours could be raised to 120 hours for better outcomes for residents, staff, and families.[9] 23 states remain at the minimum of 75 hours whereas 13 states mandate between 75 and 100 hours and 13 other states have nurse aide training set at more than 100 hours.

The direct care workforce includes certified nursing assistants, personal care aides, home health aides, geriatric aides, hospice aides, patient care assistants, paid companions, and others performing similar roles. While their specific job titles and specific duties may differ, they all tend to provide hands-on practical care for older adults and persons with disabilities (see Table 1).[10]

## EXHIBIT “1”

### Table 1. DCW Job Titles and Duties

| | |
|---|---|
| Direct Support Professionals | Typically provide support for individuals with disabilities in becoming active members of their communities, residing in inclusive environments, and pursuing employment in mainstream settings. DSPs are vital in providing support with daily tasks and complex needs, ensuring that individuals with disabilities have equal opportunities for success and inclusion in all areas of life.* |
| Home health aides | Provide some basic health-related services—such as checking a client’s pulse, temperature, and respiration rate—depending on the state in which they work. They also may help with simple prescribed exercises and with giving medications. Occasionally, they change bandages or dressings, give massages, care for skin, or help with braces and artificial limbs. With special training, experienced home health aides also may help with medical equipment, such as ventilators to help clients breathe.** |
| Nursing assistants<br>Other job titles: certified nursing assistant (CNA), geriatric aide, orderly, and hospital attendant | Provide basic care and help patient with ADLs, measure vital signs.** |
| Orderlies | Transport patients and clean treatment area, clean equipment, change linens, stock supplies.** |
| Psychiatric aides<br>Other job titles: psychiatric technician, psychiatric orderlies | Care for people who have mental conditions or developmental disabilities, administers oral or injectable medications, may restrain violent patients.** |
| Personal care aides | Providing nonmedical services, including companionship, cleaning, cooking, and driving. Some of these aides work specifically with people who have developmental or intellectual disabilities to help create a behavior plan and teach self-care skills, such as doing laundry or cooking meals.** |

*U.S. Department of Labor, Office of Disability Employment Policy (ODEP), “Direct Support Professionals (DSPs),” https://www.dol.gov/agencies/odep/program-areas/individuals/DSP
**U.S. Bureau of Labor Statistics, Occupational Outlook Handbook,https://www.bls.gov/ooh/

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To add to the complexities of understanding direct care, training requirements can differ. In Table 2, personal / home-care aides perform non-medical tasks and do not require formal training while nurse aides, orderlies, attendants, and home health aides perform more hands-on medical duties and require formal education per federal requirements for Medicare and Medicaid.

**Table 2. DCW Training and Education Requirements**

| Nurse Aides, Orderlies, and Attendants* | Home Health Aides* | Personal- and Home- Care Aides* | Direct Support Professional** |
|---|---|---|---|
| Federal requirements of 75 hours of training (for nurse aides); competency evaluation results in state certification; high school diploma and previous work experience not always required | Per federal rules, if employer receives Medicare/Medicaid reimbursement, workers must pass competency test (75 hours of classroom and practical training suggested); high school diploma and previous work experience not always required | Dependent on state, with some requiring no formal training; high school diploma and previous work experience not always required | Dependent on state with some requiring no formal training or previous work experience; high school diploma or GED typically required |

*Institute of Medicine. *Retooling for an Aging America: Building the Health Care Workforce*. National Academies Press, 2008
** U.S. Department of Labor, Office of Disability Employment Policy (ODEP), "Direct Support Professionals (DSPs),"
https://www.dol.gov/agencies/odep/program-areas/individuals/DSP

As discussed, there is wide variation across states in meeting the minimum Federal requirements for nurse aides. Since there is no standard requirement for personal care aides, the minimum quality of care is questionable. However, for Hawai'i, in 2018, Governor Ige mandated that personal care aides successfully complete a state-approved nurse aide course. Moreover, licensed home care agencies are required to have policies and procedures in place for supervision and a care plan for both personal care and home maker services. Although standardization for personal care aides in home care agencies is a significant improvement, there is no other correlating nurse aide requirements such as a personal care aide registry or continuing education.

### A Critical Need for Direct Care Workers

There is a national urgency to build a robust direct care workforce. It has been suggested that the national turnover rate for direct care workers is estimated to be between 40 to 60 percent, and that home care agencies surveyed report turnover in excess of 80 percent.[11] Other estimates suggest a national shortage of 151,000 direct care workers by 2030 and 355,000 by 2040. That shortage is already being felt by states today. Like other states, Hawaii needs to recruit and retain sufficient numbers of qualified direct care workers to ensure that

older adults and persons with disabilities have access to safe and good quality care wherever they are aging: at home, in residential care homes, at nursing facilities, and elsewhere.

According to PHI's most recent report outlining the 2022 data in their Direct Care Worker Index, there are 4.8 million Direct Care Workers employed nationally. Across the LTC continuum, nearly 2.9 million of DCWs are homecare workers, over 718,500 are residential care home workers, about 448,000 are nursing assistants, and another million are workers across various other settings such as acute care in hospitals. DCWs provide service to 9.8 million people through homecare, 1.2 million in residential care facilities, and 1.2 million in nursing homes. This workforce population is predominantly females (85%) and people of color (64%) along with immigrants occupying about 28% of filled positions.[12]

Data on earnings reflect low salaries among direct care workers. In 2019, inflation-adjusted incomes were lowest for home health aides ($22,286) and highest for orderlies and psychiatric aides ($29,042). Incomes of other healthcare workers such as OT assistants and aides, PT assistants and aides, dental assistants, medical assistants, pharmacy aides, and other healthcare support workers were on average higher ($31,735) than all DCWs.[13]

**Table 3: Direct Care Worker Projected Job Openings, 2022 to 2032**

| Industry | Growth | %Growth | Separations | Total Job Openings |
|---|---|---|---|---|
| Home Care | 738,100 | 26% | 4,761,600 | 5,499,600 |
| Residential Care Homes | 78,900 | 12% | 995,700 | 1,074,600 |
| Nursing Homes | -11,900 | -3% | 630,800 | 618,900 |
| Other Industries | 56,100 | 5% | 1,619,900 | 1,676,000 |
| All DCWs | 861,100 | 17% | 8,008,000 | 8,869,100 |

*PHI. "Workforce Data Center." Last modified September 2024. https://phinational.org/policy-research/workforce-data-center/.

The state of Hawaii, like most of the rest of the nation, is facing an unprecedented challenge in its capacity to provide long-term care for its aging population and individuals with disabilities. Although there are many factors contributing to this challenge, one of the most urgent is the ability to recruit and retain direct care workers. Hawaii's long-term care infrastructure depends on the existence of an adequately staffed and professionally trained direct care workforce. Acute-care hospitals, skilled nursing facilities (SNFs), adult residential care homes (ARCHs), community care foster family homes (CCFFHs), assisted living facilities (ALFs), continuing care retirement communities, and other types of supportive living environments typically employ direct care workers in varying capacities. Currently there are approximately 13,000 residents being cared for in 1,779 long-term care facilities statewide.[14]

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Hawaii DCW workers identify as 84% female, 87% POC, and 50% immigrants.[15] Healthcare Association of Hawaii's (HAH) 2022 Healthcare Workforce Initiative Report revealed 949 vacant direct patient care positions across their membership of acute care hospitals, skilled nursing facilities, type II adult residential care homes, home health agencies, hospices, and assisted living facilities. Although not all DCW positions in the 2022 report were tracked in previous 2019 data collection across all care settings, CNA and PCA position vacancies showed major increases of 78% and 416% respectively since previous data collected in 2019. Of the total number of vacancies, over half (578) are for direct care positions associated with LTC settings that primarily serve the needs of older adults and individuals with disabilities here in Hawaii (i.e. skilled nursing facilities, assisted living facilities, as well as home care and home health agencies). This is a snapshot of organizational data that demonstrates the need for further collection to find truly representative numbers of DCW job trends across settings at a state level.

**Direct Care Workers Enhance Older Adults' Quality of Life**

Direct care workers impact the lives of older adults and individuals with disabilities across the care continuum, as the following composite case illustrates.

Mrs. Garcia, a 79-year-old woman from Kaimuki, was admitted to the hospital after complaining of chest pain and shortness of breath. During her hospital stay, certified nurse assistants (CNAs) helped monitor and chart her vital signs (e.g., body temperature, blood pressure, pulse, and respiratory rate) and assisted with personal hygiene and toileting so that she wouldn't fall when walking.

After Mrs. Garcia recovered enough to be discharged from acute care, she spent several weeks convalescing at a community care foster family home in Waipahu which was operated by a CNA and a nurse aide. Mrs. Garcia had her own room in this house and received 24-hour supervision, along with home-cooked meals and companionship until she was ready to go back home. Because she lived alone in Kaimuki, she entered a contract with a home care agency to provide personal care assistance three hours a day, three times a week. Her personal care aide helped Mrs. Garcia with her activities of daily living so that she could safely age in place in her own home again. The aide helped her shower, get dressed, prepare meals, do laundry, perform light housekeeping, and go on errands. Occasionally a chore worker would come to do more extensive house cleaning. Mrs. Garcia also subscribed to a medical alert service so she could summon help at the push of a button.

As Mrs. Garcia's care needs increased, she was able to increase the number of hours and days that her personal care aide visited. This aide accompanied Mrs. Garcia to her primary care physician for check-ups and, with Mrs. Garcia's permission, told the doctor about her impressions of Mrs. Garcia's health status, including her concerns about Mrs. Garcia's cognitive impairments such as short-term memory loss, confusion, and disorientation. For example, on several occasions, Mrs. Garcia got lost while walking in her longtime neighborhood alone. Fortunately some concerned neighbors helped her find her way back home.

After a clinical exam and series of tests ordered by her doctor, Mrs. Garcia was diagnosed with Alzheimer's disease. With the help of her healthcare team, which included direct care workers and a social worker, she was able to settle her affairs and move into a continuing care community, which had a secure memory care unit staffed by qualified, compassionate team

members. A nurse aide took Mrs. Garcia by the hand, introduced her to her new home, and spent days and weeks helping Mrs. Garcia get adjusted to this new normal. Mrs. Garcia was anxious at first, but the aide reassured her day after day and said, "I'm here for you if you need anything, okay?" The aide and her co-workers became a familiar, supportive presence in Mrs. Garcia's world, and they walked alongside her – literally and metaphorically – during the last stretch of her life journey, which was filled with conversation, smiles, and meaningful activities appropriate to her abilities.

**Issues in DCW Workforce Development**

DCWs tend to be undervalued by society, seen as "low-skilled" or doing "women's work"[16] despite performing work that is both physically and mentally demanding and working with elders with challenging health problems (for example, someone in the moderate to later stages of Alzheimer's disease). This undervaluing is also tied to societal attitudes toward the populations they care for—often the elderly, disabled, or individuals with chronic illnesses. These groups are sometimes marginalized or viewed as burdens, and the care they receive is undervalued as a result.[17] The work has also been described as "invisible," meaning it happens in private homes, care facilities, or institutions out of the public eye. In addition to providing physical assistance, direct care workers offer emotional and relational support to the people they care for. In private residential settings, direct care workers have provided eldercare when family caregivers are employed outside the home or need respite from daily caregiving responsibilities. However, this work is intangible, despite being important to the well-being of those receiving care. This work is not always visible to the broader public or policymakers and it tends to go unrecognized and undervalued.[18]

Direct care workers often receive a lower median wage than other healthcare occupations. The median wage for direct care workers is most often determined by state Medicaid reimbursement rates in long-term care and long-term support and services. The problem — and this is true for most of the nation, including Hawaii – is that Medicaid reimbursement to healthcare providers (including long-term care facilities) is below market rates and thus not thought to be sufficient to fund operations at a sustainable level over the long term. This has contributed to the closure of a number of long-term care facilities in Hawaii. For example, in April 2022, Wahiawa General Hospital announced the closure of its long-term care services. An article in Honolulu Civil Beat explained:

*"About 60 residents of a long-term nursing home in Wahiawa are searching for new places to live as the facility prepares to close in three months.The hospital's chief executive, Brian Cunningham, blamed the decision to close the nursing home on a financial shortfall as well as difficulties in maintaining the infrastructure and retaining staff."*

This was a recent closure of a long-term care option for older adults and persons with disabilities. Others have preceded it.[19] In January 2023, Oahu Home Healthcare announced it would be shutting down due to "increased costs brought on by Medicaid reimbursement changes and the statewide labor shortage."[20]

**EXHIBIT "1"**

Workers outside of the Medicaid system are then subject to the state minimum wage. Some of the challenges direct care workers face in addition to wages are the lack of full-time hours and benefits. Many DCWs are employed on a part-time or temporary basis, which limits their access to higher wages and benefits. In addition, direct care workers often do not receive benefits such as healthcare, paid time off, or retirement savings, which contributes to job instability.

Low wages for DCWs do not match the demanding nature of the job. Direct care work is physically demanding (e.g., lifting patients, long hours on one's feet) and emotionally taxing (e.g., dealing with end-of-life care, patient mental health challenges). As a result, there are high turnover rates in the field.[21] Workers are seen as replaceable, and generally, employers do little to retain them. Direct care workers often have a number of immediate, less stressful job alternatives, such as those offered by the food and hospitality industries.[22]

Investments need to be made in workforce development or professionalization. In the spectrum of DCWs, from personal care aides to certified nurse aides, there is often a lack of standardized qualifications for DCWs and a common set of competencies focused on caring for older adults.2[2] Many DCWs receive minimal training, and there is often no ongoing education to help them develop new skills. Unlike nursing or other healthcare fields, direct care work has not been widely professionalized with standardized training or certification requirements. This lack of formal recognition keeps wages low and prevents direct care workers from being seen as essential healthcare providers, despite their evolving role. Care is increasingly being provided in the community as clients require assistance with more complex conditions. Therefore, direct care workers need to be trained in a range of new technical and interpersonal skills.[23]

Investments also can be made in new technology to reduce the daily care demands on direct care workers. Gerotechnologies, defined here as the tools and technologies that help create a safer and more efficient environment in which to grow older despite the accumulation of care needs, can play a critical role in long-term care and direct care work, especially as technologies become more innovative and affordable. Such technologies can be employed in homes or in supportive living environments like nursing facilities and hospitals to support direct care workers.

The direct care workforce often lacks clear pathways for career advancement. Without opportunities for further training, certification, or promotions, the job is seen as a dead-end position with limited ability to earn a "living wage"[24] or a decent standard of living without requiring government assistance or falling into poverty. Clear pathways need to be developed and structured- with resources and information on the different careers in the pathway, its educational requirements, and average salary. For example, a certified nurse aide to licensed practical nurse, to registered nurse is an example of a pathway that should be clearly defined and presented as an opportunity when recruiting DCWs. The lack of investment in DCW training and development furthers the perception that the job does not require significant expertise or preparation.

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**Geotechnologies to Support Direct Care Workers** (INSERT TEXTBOX AROUND HERE)

Gerotechnologies should not be viewed as total replacements for human caregivers but rather as intelligent devices to assist and support them to lessen workload demands, decrease physical strain on the caregiver's body, or to improve efficiencies in administrative and logistical tasks. The automation of certain personnel tasks, for example, such as time punch cards, the calculation of earned paid days off, and the scheduling of vacation and sick leave, etc., reduces paperwork and accelerates requests and approvals between employees and their supervisors. A company called Aldebaran developed a humanoid robot for use in medical settings like nursing homes. The robot, named Pepper (or presumably whatever you want to call it after you buy it), talks, moves, has a video monitor built into its chest, and can be an interface between staff and residents when staff are not physically in the vicinity. A website for the product lists these features[25]:

- *Remotely monitor patients: With Pepper’s camera and personalized healthcare solutions, medical staff can monitor their patients, offer immediate feedback, set up appointments, and much more. Telepresence allows patients to maintain a social link by allowing patients’ families to video call through Pepper.*
- *Check-in and entertain: Pepper can not only check-in/admit new patients into your healthcare center, but can also entertain family members and company in waiting areas. With many activities and a lot of information available to Pepper, there’s a lot for guests’ entertainment.*
- *Reduce medical staff stress: Alongside with telepresence and teleoperation solutions, Pepper helps reduce stress from medical staff and their workload, allowing them to focus on more imperative tasks.*
- *Safety first: Pepper can offer social distancing solutions, as well as the ability to educate and inform visitors about keeping health regulations in order to ensure the safety of everyone in your center.*

The robot "can be adapted to serve your needs," according to the informational material on its developer’s website. In a CBS News segment about the robot, an older woman using a walker is seen walking in an actual supportive living environment and when she sees the robot, she greets it with “Hi Pepper.” Pepper talks back to her: “I hope you are having a wonderful day.” In another scene, Pepper is shown having a conversation with a resident while showing her old photographs on a tablet screen built into Pepper’s chest. They talk about the photos. Another scene shows Pepper leading an exercise class and demonstrating simple movements which residents imitate.[26]

This specific robotic technology is not necessarily being endorsed here but rather used as an example of the kinds of innovative technologies that may be incorporated into the long-term care environment to assist with direct (hands-on) care, except the hands may not be human hands. Out of necessity due to its rapidly aging population and workforce shortage, the

country of Japan has been a global leader in developing robotic technology for eldercare. This article in the *MIT Technology Review* summarizes the uses of "care robots":

> *Care robots come in various shapes and sizes. Some are meant for physical care, including machines that can help lift older people if they're unable to get up by themselves; assist with mobility and exercise; monitor their physical activity and detect falls; feed them; and help them take a bath or use the toilet. Others are aimed at engaging older people socially and emotionally in order to manage, reduce, and even prevent cognitive decline; they might also provide companionship and therapy for lonely older people, make those with dementia-related conditions easier for care staff to manage, and reduce the number of caregivers required for day-to-day care. These robots tend to be expensive to buy or lease, and so far most have been marketed toward residential care facilities.*[27]

—--------------- END OF TEXT BOX -----------------------

**Policies Affecting the Direct Care Workforce**

<u>Federal Policy Directions</u>

At the national level, 2024 was a historic year for the adoption of public policy intended to improve safety and quality of care in nursing homes that receive federal funds. The U.S. Department of Health and Human Services, through the Centers on Medicare & Medicaid Services (CMS), finalized three rules that put into action the Biden-Harris administration's Action Plan for Nursing Home Reform.

The three rules, as described in an April 22, 2024 news release from CMS[28], are as follows:

1) *"Minimum Staffing Standards for Nursing Homes"* establishes, for the first time, national minimum staffing requirements for nursing homes to improve the care that residents receive and support workers by ensuring that they have sufficient staff.

2) *"Ensuring Access to Medicaid Services" ("Access Rule")* creates historic national standards that will allow people enrolled in Medicaid and the Children's Health Insurance Program (CHIP) to better access care when they need it and also strengthens home and community-based services (HCBS), which millions of older adults and people with disabilities rely upon to live in the community. This landmark final rule will set minimum threshold standards for payments to the direct care workforce, create meaningful engagement with Medicaid consumers, and advance provider rate transparency.

3) *"Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" ("Managed Care Rule")* will improve access to care, accountability

and transparency for the more than 70 percent of Medicaid and CHIP beneficiaries who are enrolled in a managed care plan. It will require a limit on how long enrollees have to wait for an appointment and allow people to compare plan performance based on quality and access to providers.

Rule #1 – the minimum staffing standards – may have the most significant impact on skilled nursing facilities in Hawaii because of the continuing shortage of direct care workers and nurses in the state. One of the requirements in the rule is that a registered nurse must be on site 24 hours a day, seven days a week. Residents of the facilities must have a minimum number of contact hours with nurses or aides. Consultation with these facilities in Hawaii should be done to determine how they will be impacted by the rule and what key stakeholders can do to support these facilities. In national media reports, a number of analysts, facility administrators, industry groups, and some congressional legislators have voiced concerns about nursing homes' ability to meet the staffing requirements at this time.

For example, the American Health Care Association (AHCA) released a statement in response to the rule. AHCA's statement called the rule "unconscionable" and said that it would require "hundreds of thousands of additional caregivers when there's a nationwide shortfall of nurses" and also referred to the mandate as an "impossible task." The organization said that a one-size-fits-all approach such as minimum staffing standards "could force many nursing homes to close and displace vulnerable seniors."[29]

On the other hand, resident advocacy groups have called the rules long overdue and even not going far enough. And the American Nurses Association (ANA) "supports enforceable ratios as an essential approach to achieving appropriate nurse staffing."[30] The organization said that appropriate nursing staffing levels result in better healthcare outcomes and greater satisfaction for both patients and nurses. ANA says that appropriate staffing levels are achievable and that it "supports all nurses in advocating for the staffing solutions they find most suitable in their practice settings."

One of the ways that ANA proposes to achieve appropriate nurse staffing is to implement the following retention strategies: eliminate mandatory overtime, present opportunities for autonomy, provide employee wellness programs, create a flexible culture, offer competitive salaries, create paths for professional advancement, develop recruitment strategies with retention in mind, and encourage direct lines of communication.[31] These strategies may well extend to the direct care workforce.

## EXHIBIT “1”

State Policy Efforts

The State of Hawaii is trying to anticipate the long-term care needs of its residents through a series of new laws, workgroups, and stakeholder meetings. In the legislative arena, On July 2, 2024, Governor Josh Green signed HB 2224 (“Relating to Long-Term Care”), which became Act 159. This law “requires the Executive Office on Aging, in coordination with the State Health Planning and Development Agency, to create a comprehensive long-term care plan to accomplish certain long-term care policy goals that ensure the availability of a full continuum of institutional and community-based services. Establishes and appropriates funds for one long-term care planner position within the Executive Office on Aging to oversee the development and implementation of the long-term care plan. Requires the Executive Office on Aging to submit a report to the Legislature.”[32]

Further, the University of Hawai`i at Manoa Center on Aging in the Thompson School of Social Work and Public Health has contracted with the Executive Office on Aging to research and prepare a state strategic plan on building the capacity and quality of the direct care workforce in Hawaii, a core deliverable of that project being this document.

Other organizations have committed resources to help improve the capacity of the state’s long-term care infrastructure. With guidance from the Council of State Governments, State Senator Sharon Moriwaki and Caroline Cadirao, director of the Executive Office on Aging, convened a panel of key decision-makers from across the long-term care spectrum of service providers and other stakeholders for a long-term care summit in February 2024. Members of this group have continued to meet regularly since then to strengthen the long-term care infrastructure through the coordination of goals, strategies, and actions.

On May 12, 2023, a gathering of concerned stakeholders, decision-makers and thought leaders in Hawaii convened at the Ala Moana Hotel for a half-day forum, discussion and call to action in response to the critical need for direct care workers in the state's long-term care industry. Titled, "A Call to Action to Build the Workforce Capacity in the Long-Term Care Setting," the forum's goal was to develop a comprehensive strategy to increase Hawaii's workforce in long-term care settings such as skilled nursing facilities, community care foster family homes, adult residential care homes and other supportive living environments. The event’s primary sponsor was the John A. Burns School of Medicine’s Geriatrics Workforce Enhancement Program with funding from the Health Resources and Services Administration. The UH Manoa Center on Aging and other organizations were co-sponsors.

Given the considerable interest and energy in our state to address our workforce capacity, this strategic plan is timely and critically important to focus and organize our implementation process. The methods to develop this report needed to be both systematic and thorough in order to lay out the best strategies and action steps to our partners and stakeholders in the aging and disability networks.

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### Methods to Develop Strategic Plan

**Approach**

The COA team used an exhaustive process to ensure that the latest thinking and information on the direct care workforce was included in this strategic plan. Our approach included a literature review of journal articles as well as an environmental scan of best practices on the local, state, and national level. The team recognized that considerable work has been done by national organizations.

Major national organizations have written reports on the topic of the direct care workforce, highlighting issues and needs, describing state best practices, and proposing policy solutions. In particular, reports were recently developed by:

- Paraprofessional Healthcare Institute (PHI)
- Council of State Governments (CSG)
- Milbank Memorial Fund
- LeadingAge
- National Governors Association
- Bipartisan Policy Center
- National Academy for State Health Policy

These reports highlighted best practices from across the states using different criteria. Innovative state policies and practices were identified and the team then took a deeper dive into these approaches.

The perspectives of key stakeholders in Hawaii were also critical. The team developed a list of stakeholders based on diverse sector representation.Twenty stakeholders agreed to have 45-60 minute online interviews or focus groups with at least two interviewees from the team. Table 4 shows the breadth of stakeholder experience and expertise in workforce development advocacy or program implementation.

**Table 4. Description of Key Informant Roles and Care Contexts**

| Number of interviewees | Industry sectors represented | Industry Roles | LTC Care Contexts |
|---|---|---|---|
| 6 | Government | Dept of Health | — |
| 5 | Health - Clinical | Palliative Care<br>School of Medicine | Facility Care |
| 3 | Health - home health | Employer | Adult Day Care<br>Facility Care |

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| 2 | Health - home care | Management / APRN Nurse | Home Care |
|---|---|---|---|
| 4 | Education | Community College / High School | Home care and Home Health |

Interviewees were emailed a list of questions and the Center on Aging's infographic defining DCWs (see Appendix A) and the care contexts that they work in. Semi-structured interview questions ranged from macro, meso, and micro levels of components that affect direct care workers recruitment, retention, or training. All interviews, where the interviewee(s) agreed to privacy and confidentiality conditions, were recorded and then transcribed using Otter.ai. Post-interview discussions by interviewers were conducted immediately afterwards.

Deductive and inductive thematic analysis of transcripts were conducted for within and across interviews and transcriptions completed within a 1.5 month time period before the next Advisory Board Meeting. Results were confirmed with the interview duo as well as the team before Advisory Board review. Key informants were given at least 5-7 days to review and revise any relevant direct quotes or summaries from their interviews.

**Input from Advisory Board**

Board members were selected based on feedback from the Director of Executive Office on Aging and other Board members. Their expertise reflects leaders in public and private domains in advocating for and implementing innovative workforce programs for older adults and individuals with disabilities.

The Board had a total of four online meetings in a span of seven months to provide feedback on the feasibility, appropriateness, sustainability, and effectiveness of emerging directions to explore from the concurrent environmental scan and key informant interviews. All members were kept abreast of COA progress and so members who could not attend could give feedback to the COA team via e-mail.

**Triangulation**

To develop policy recommendations and strategies, the COA team met at least twice a month to analyze and evaluate findings and best practices from all sources. The team used an iterative process to integrate and refine expertise concurrently from (a) an environmental scan of non-profit agencies that leverage state coalitions (e.g., the Council of State Governments [CSG] or Milbank Memorial Foundation), online resources from governmental agencies, and peer-reviewed academic journals, (b) key informant interviews/focus groups from relevant local stakeholders, and (c ) feedback from an eight member Advisory Board including the Director of the State of Hawai`i Executive Office on Aging. The triangulation of multiple data sources has led to a deeper understanding in selecting feasible, appropriate, effective, and sustainable strategies to strengthen Hawai'i's Direct Care Worker Workforce.

# EXHIBIT "1"

Drafted recommendations were assessed for feasibility (practical, possible), appropriateness (suitable and pertinent in Hawaii), sustainability, and effectiveness prior to inclusion in this report. Workforce development recommendations and strategies were categorized based on five goals, to: 1) strengthen recruitment, 2) enhance retention, 3) develop a career pathway, 4) assure quality, and 5) promote the societal value of DCWs. Note: Some organizations and agencies in Hawaii may be implementing some of these recommendations already, but our goal is to ensure that these recommendations are implemented and available statewide.

## Findings

This section reflects key findings from a literature review, environmental scan, and key informant interviews. It is organized around commonly-held goals in a comprehensive workforce development initiative. At its core, workforce initiatives should focus on the goal of recruiting an ample supply of direct care workers and retaining these direct care workers in the long-term care field. To support recruitment and retention, workforce initiatives should create educational and training opportunities to not only prepare them for their roles but pathways to advance in their profession, if they choose. The success of these initiatives will require good quality data on outcomes and continuous feedback loops to ensure quality. It will also require a societal shift in how we value our direct care workers. These goals are reflected in the following findings section.

### Recruitment Issues

Low recruitment rates of DCWs have historically challenged the development of a robust DCW workforce. A multitude of factors including inadequate compensation rates, demanding scope of work, social devaluing of direct-care professions, competition with other less demanding workforce sectors, along with stigmas associated with the areas of aging and disabilities present barriers to recruiting workers into open DCW positions across LTC settings.[33,34,35] High instances of job turnover have implications for both LTC organizations employing DCWs and the individuals they serve. Efforts to recruit and retain DCWs are inherently linked and interwoven together in larger workforce development models. Studies over the past two decades have demonstrated the significant relationship between staffing capacity and quality care provided to patients.[22] Thus, many strategies to bolster recruitment and retention such as providing adequate compensation and increasing Medicaid reimbursement rates, are overlapping and serve dual outcomes in meeting overall workforce goals.

#### Toward a Living Wage

Fair wages and benefits have been tied to workforce development advocacy in all fields and have implications for both the incentivizing and recruitment of DCWs as well as providing fair and sustainable compensation equivalent to the value of DCWs. States have addressed this issue of compensation in numerous ways and focused on wage raises, one time recruitment or

tenure-based retention bonuses, as well as other benefits and non-wage supports. Collective bargaining through coalition building and developing partnerships helped numerous states such as Connecticut and Washington State produce policies supporting higher wages and benefits for DCW populations. Wage increases based on job tenure look to provide adequate compensation based on the experience and contributions of DCWs rather than broader wage floors.

Due to the varied and unique circumstances and roles of individual DCWs across different settings, it is difficult to determine an appropriate numerical amount to set as a wage floor for DCWs in Hawaii. The Massachusetts Institute of Technology (MIT) succinctly defines the complex construct of "living wage" as what one full-time worker must earn on an hourly basis to help cover the cost of their family's minimum basic needs where they live while still being self-sufficient. According to their living wage calculator, for a single individual with now children living in Honolulu County a living wage would be approximately $26.90.[36,37] According to PHI's Workforce Data Center, the Hawaii median wage for home-health aides/personal care aides is $17.26, nursing assistants is $21.19, and overall DCW positions is $18.86 and do not meet median wage standard calculations for sole income responsible individuals.[15] LeadingAge's study into wage compensation in DCWs, advocates for policy that addresses "living wage" standards and promotes that providing DCWs with living wages would directly influence retention and turnover rates along with enhance quality of care amongst patients in LTC settings.[18] DCW advocacy groups like PHI view a living wage as base compensation with "...benefits, raises, bonuses, and other job supports layered on top."[23]

Loan repayment approaches may also support the larger goal of a living wage by helping DCWs reduce educational debt. Similar to the Healthcare Education Loan Repayment Program (HELP) announced by Governor Josh Green and the Hawaiʻi/Pacific Basin Area Health Education Center (AHEC) in 2023, the growing shortage of DCWs might be partly alleviated through a special appropriation from the Hawaiʻi State Legislature that provides educational loan debt repayment to certified nurse assistants and trained universal care workers. For example, in exchange for two years of full-time or half-time service in Hawaiʻi, CNAs and other DCWs would qualify for loan repayments. Priority would be given to workers serving on the neighbor island and rural areas. This program is expected to improve recruitment and retention of CNAs and UCWs working with vulnerable populations, especially in underserved areas. The loan repayment program would be a recruitment tool to attract prospective workers and populate the DCW pipeline. This program would work in conjunction with career lattice and other recruitment and retention programs.

Role of Medicaid Reimbursement Rates

Efforts to increase wages often target Medicaid reimbursement rates. Overall, Medicaid is accepted by many LTSS providers and is the driving force of wage increases as 40.5% of services are paid through Medicaid, 15% from Medicare, 12.1% from other insurance payors, 25.1% from self-pay, and 7.3% from other sources.[38] But these efforts should be accompanied by requirements that the increases go directly into workers' wages, as opposed to the

administrative overhead of employers. Numerous states have utilized wage pass-throughs that enable an increase in Medicaid reimbursement rates to be directly passed on to increased wage compensation for DCWs. While a wage pass-through is seen as a solution to increasing wages to DCWs working in Medicaid receiving facilities, state level data is lacking on its effectiveness in addressing workforce shortages.

For states that administer Medicaid and long-term services and supports (LTSS) through managed care organizations (MCOs), including Hawaii, state legislative leaders can use contract language to expand and strengthen the direct care workforce. In particular, Med-QUEST (Hawaii's Medicaid) contracts with managed care plans and could include strategies such as stipulations to increase wages and benefits, set measurable goals for expanding the direct care workforce, and improve service quality.[39]

Looking across the broad spectrum of LTSS, equitable Medicaid reimbursement rates are needed across institutional and community settings. In Hawaiʻi, Medicaid payments per day for a nursing home level patient is much higher at a nursing home than at an adult foster home. In addition, a key informant claimed that Medicaid pays foster care home operators three to six months after monthly billings. As one key informant stated, "a lot of people [are] closing their businesses too, or transferring their foster home to a care home just to get away from the Medicaid piece". This comment echoes physicians' Medicaid reimbursement delays that can range from 36.9 days to 114.6 days as reported in a study examining Medicaid reimbursement rates and payment delays to physicians across 21 states.[40] When speaking about Medicaid reimbursement rates, a key informant noted that foster care home operators have received increases but gave an example of the wide gap in rates. He highlighted that a foster care home operator receives $46 a day for a nursing home Medicaid eligible patient while a nursing home receives $300 a day. "They almost double the capability of us to house nursing home level kupuna in the community, and we get a significantly lower rate than the nursing home. And I find that amazing".

Use of Worker Registries

Direct care worker registries are another strategy to enhance recruitment. States such as New Mexico and California developed online platforms for employers to find workers and for families to find care workers. Key informants identified Hawaiʻi's need for a "one-stop shop" as a resource for families to find caregivers and openings in foster care or care homes. One key informant, a foster care and care home specialist, stressed the need for an online searchable database since families, remarkably, are using the "coconut wireless". In the age of Airbnb and Angie's List, he found it "amazing" that a comprehensive online resource was unavailable.

These registries can be a valuable resource for family caregivers as well. A key informant in clinical aspects of care described how older adults at the end of their life are "homebound" and the need for supportive care to complement capitated hospice care. This clinician also remarked that family caregivers need a resource to find support. "...[T]hey're

homebound. And that's why they need homecare, and I'll bet those caregivers are all burned out needing assistance and don't know where to find it because there's no one [stop] shop."

Diversifying Recruitment Pools

To fill direct care worker needs, the literature and key informants point to the need to diversify recruitment pools. The following strategies have been recommended, including non-traditional and foreign-born populations[41]:

1. *Family Caregivers*- Through their Medicaid LTC programs, all 50 states and Washington, D.C. offer some form of Consumer Directed Care option that allows Medicaid qualified individuals personal choice of doctors, medications, medical equipment and supplies, along with personal care aides. State Medicaid authorities have flexibility and discretion to determine HCBS providers allowed under consumer direction, and 43 states including Hawaii offer Medicaid recipients the option of choosing family members as their paid in-home caregivers. This option is offered through various waivers and models such as the 1915C waiver, but appointment of relatives is normally contingent upon the family member's completion of CNA training and certification.[42] Allowing employment pathways to formal care for family caregivers can support individuals aging in place while building capacity and sustainability in the home care workforce.

2. *Retirees or Adults transitioning to another career*- Adults now have a longer lifespan and could potentially be retrained for a second career and use their life experiences and "the care capacity" to become DCWs. Key informants stressed that retiring adults may not be exposed to this possible opportunity. For example, workers in hospitality may be a good fit for the health industry, "...with customer service, and speaking with people, that's half of health care, and being a direct care worker, right?"

3. *Volunteers*- In challenging the traditional model of care, one key informant suggested volunteers to be included in the care team which would allow licensed team members to work "at the top" of their licensure/competency. She didn't see training volunteers as a roadblock because of her previous experience with training volunteers as "candy stripers" or even training family caregivers to feed loved ones who have aspiration concerns. Another key informant from the adult day care industry showed agreement with using volunteers because of the activities that engage older adults. "They're…sitting with a kupuna, or they're playing game[s]…interacting. So it's not stressful. And it's not physical. It's just fun."

4. *Students in healthcare*- While volunteers may alleviate some of the workforce crisis, students already interested in careers in the healthcare sector may be interested in personal care aide positions to support themselves in school. One key informant noted that as students fulfill their pre-health requirements in pharmacy or nursing, they could be gaining experience with older adults and being paid.

5. *Immigrant workers* - The literature suggests that policy efforts could encourage pathways to domestic care jobs for immigrants in the form of work authorizations, pathways to citizenship, access to health, education, and legal resources, along with partnering with various state and federal agencies to generate support networks and policies in these areas.[43] LeadingAge's IMAGINE (International Migration of Aging and Geriatric Workers in Response to the Needs of Elders) initiative also poses policy recommendations such as temporary guest worker programs for DCWs and an expansion of the EB-3 worker visa program that would allow more immigrant DCWs into the U.S.

6. *Word of Mouth*- Research points to leveraging social networks of DCWs belonging to tight-knit immigrant communities or spreading employment information by "word-of-mouth" as an economical and self-sustaining method of recruitment.[44] Key informants confirmed that social networks, particularly immigrant communities, might be a sustainable means of recruitment and may even serve underserved populations. One of our key informants, who is Chinese speaking, shared a story of her father being cared for by the owner of a restaurant he frequented. The owner serendipitously had formal caregiving experience. She continued, "...often times I would say the immigrant community...their dedication to help their own people is pretty strong." Another key informant stated that not only would potential recruitment from diverse communities be "culturally and linguistically aligned with the client" but also "come from the communities that currently are underserved".

To further address issues in area of recruitment, the following states have implemented innovative practices and strategies:

**Table 5. State Recruitment Strategies**

| State | Innovation | For More Info |
|---|---|---|
| Connecticut | Connecticut's paid family and medical leave policy replaces 95 percent of wages for low-wage workers versus 60 percent of wages for higher-wage workers. This policy is aimed at supporting lower-wage workers such as DCWs who struggle to survive when utilizing wage replacement when on leave for personal and family care. | https://www.ctpaidleave.org/ |
| Hawaii | Earned income tax credits (EITC) provide a refundable tax credit to low- and moderate-income taxpayers. Along with the federal EITC, some states have developed their own EITC measures usually as a calculation of the federal EITC and allow eligible individuals to receive both the state and federal tax credit. Hawaii's refundable and permanent EITC was expanded in 2023 and effectively doubled by increasing its value from 20 percent to 40 percent of the federal EITC. | https://www.civilbeat.org/2023/05/working-families-win-with-eitc-expansion/ |
| Montana | The state is offering $7,500 bonuses for new hires including registered | https://dailymontanan.com/2024/01/17/dphhs-announces- |

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| | nurses, certified nurse aides, and direct support professionals at state-run facilities, Existing staff are also receiving retention bonuses to reduce dependence on contracted staff. | hiring-incentives-for-health-care-workers-bonuses-at-certain-facilities/ |
| Washington | The examination for home care aides in Washington state is offered in 15 languages with written or oral format options. The state's Department of Health will also provide an interpreter who will read the exam in the applicant's preferred language after they request a test accommodation. Provisional certification is offered to LTC workers with limited English proficiency to provide additional time to meet the home care aide certification requirements. | https://www.phinational.org/state-language-access-initiatives-are-helping-to-serve-an-increasingly-diverse-workforce-and-aging-population/ |
| New Mexico | Since 2015 a nonprofit organization in Albuquerque New Mexico has been offering a 15-week home health aide training program specifically for Latino immigrants. For participants, scholarships are available to cover the costs of tuition and childcare. The service EnCasa Care Connections was also developed to help consumers and workers find each other. | https://encuentronm.org/home-health-aid-2/ |
| Delaware | As part of their utilization of ARPA funding, Delaware created provision for special recruitment bonuses as well as retention payments for all DSPs across their network of HCBS services. An overall aim of their larger plan in this area is to promote equity among providers where limited workforce resources cause steep competition. | https://www.medicaid.gov/media/file/de-quarterly-update-hcbs-spending-plan.pdf-0 |
| New Jersey | Through increased provider payment rates within Medicaid qualified facilities, New Jersey is one state that requires direct care workers to receive $3 above the prevailing minimum wage, potentially providing care facilities a competitive recruitment advantage over other "entry-level" jobs that pay minimum wage. | https://www.nga.org/publications/addressing-wages-of-the-direct-care-workforce-through-medicaid-policies/ |

**Retention Issues**

Multiple individuals as well as environmental factors are associated with worker tenure and overall DCW position retention. High instances of turnover rates have implications for both LTC organizations employing DCWs and the individuals they serve. If direct care workers are understaffed and underpaid, there can be high turnover, burnout, and shortages, which compromise the quality and continuity of care.[39]

There is a growing body of research that seeks to identify the various self-reported reasons for worker tenure in DCW positions. Turnover and intent to leave within the first year of employment have been attributed to inadequate compensation, stressful working conditions, and limited career advancement opportunities. As is the case with recruitment, recent DCW retention studies point to wages as being a significant predictor of retention.[45] Providing consistent schedules and hours is also important in retention. A manager in a large employment agency underscored the success of their strategies by responding, "...we're able to retain them because we're able to offer additional hours...if…they don't have a current client to work

with…scheduling is one of the things that's an issue". She further explained their connection with facilities gives more opportunities for DCWs work in registration or administration to meet their hours.

Along with adequate wage compensation, protective factors for formal care workers include utilization of entry-level DCW experience as a stepping stone to clinical positions up the healthcare ladder. A study that examined DCW turnover in North Carolina nursing homes, adult care homes, and home health/home care agencies with the implementation of the WIN A STEP UP program. This program consisting of within facility training program offerings for CNAs along with completion incentives and retention bonuses was shown to be effective in lowering DCW turnover when implemented.[46]

Other research identified organizational culture and support as being integral to DCW perceptions of their role and intent to stay in their positions.[47,48] Organizational culture was also a major theme in key informant interviews that expressed a team-based model of care, emphasis on learning and being part of a family, and being flexible to meet the needs of DCWs. One facility-based key informant stated that the overall goal is to create a learning culture through different ways: "Invite cohorts from schools to do training in the facility, precepting with new clinicians with existing employees, and formal training for preceptors to act as coaches for anyone new to healthcare as a career or the facility. Ohana is one of the company values for the patient and each other as team members." In smaller settings (e.g., adult day care), a key informant underlined her flexible and unquestioning support of her DCWs. "I have no problem retaining my folks… I go the extra mile for them. A lot of my colleagues are corporate people, like they don't do that." Going the extra mile included having clear and high expectations while also valuing and meeting the needs of DCWs through flexible approaches like giving monetary loans, "no questions asked" or one month … to go to the Philippines."

<u>Job Satisfaction and Retention</u>

Among the myriad of job related factors associated with DCW workforce development, the construct of job satisfaction is shown to be particularly meaningful to job intentions, particularly worker retention and patient wellbeing outcomes.[49,50] Generally defined, job satisfaction looks at a combination of job-related factors that viewed together can demonstrate how much a worker likes or has a positive response to their job. Job satisfaction is an important construct of interest in many studies on DCW retention as it contributes to outcomes such as worker and patient wellbeing and intent to stay.[51,52] Conversely, job dissatisfaction among workers are due to poor relationships with supervisors, a lack of respect from other health professionals, and limited opportunities for advancement.[22] Not surprisingly, high job dissatisfaction is related to increased turnover.[53]

<u>Use of Technology to Support Retention</u>

Along with strategies to address the workforce directly, experts also view the increased adoption of technology and technological aids as necessary supports in the care of older adults

and individuals with disabilities. The COVID-19 pandemic underscored the need to develop technology to help alleviate the strain posed by DCW workforce shortages. Research into areas such as scheduling software, communication and monitoring innovations, and enhanced mobility aids has been of international research interest and highlights the utility of integrating technological elements into care settings.[54] A home care key informant viewed technology as streamlining management through aiding paperwork with reminders, DCWs clocking in and clocking out on an app, and other technology based advancements (e.g., Electronic Medical Records).

In the United States, information and communication technologies have been deployed in a wide variety of ways to aid in caregiving. In care facilities, cameras are often used to add a layer of surveillance for resident safety and protection. In the home, medical alert systems, electronic medication minders, fall sensors, lighting that is triggered by movement, and non-invasive monitoring technologies that evaluate patterns of behavior help older adults age in place safely and can even suggest when intervention may be necessary based on an analysis of collected data. For example, if sensors detect considerably lower activity than usual in the home, a wellness check may be triggered to ensure that the older person is okay. Assistive technologies are emerging. Wearable lower-limb exoskeletons, for example, show promise in enhancing physical function in older adults with conditions such as sarcopenia, stroke, Parkinson's Disease, osteoarthritis, and more.[55]

The confluence of Artificial Intelligence, Virtual Reality, the Internet of Things, health informatics and telemedicine is likely to have a profound influence on eldercare and has the potential to assist in and supplement direct care services. Possibly direct care workers themselves will be trained to use a number of these technologies in their work, providing a valuable and transferable skill set and improving safety and enjoyment for both the older adult and the caregiver.

The following states have implemented innovative practices to enhance retention efforts:

**Table 6. State Retention Strategies**

| State | Innovation | For More Info |
|---|---|---|
| Illinois | Legislation enacted in 2022 provides incentives for nursing homes to improve quality measures and recruiting/retaining qualified DCW staff. This act also supports the tenure of CNAs by basing wage step increases on years of experience in the field rather than in a particular facility. | https://hfs.illinois.gov/info/media/press-release.24981.html |
| Minnesota | Under its larger long-term HCBS plan, Minnesota established enhanced rates and budgets for support workers and the recipients of that care. Qualified support workers who provide personal/home care assistance to a Medicaid eligible individual in excess of 10 hours a day would be entitled to a higher reimbursement rate. | https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/pca-enhanced-rate/ |

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| Wisconsin | Under it’s Direct Care Workforce Funding Initiative, Wisconsin passed an appropriations bill in 2017 that increased the portion of funds in Medicaid managed care contracts that provide aid wages, bonuses, time off and benefits to DCWs. | https://www.dhs.wisconsin.gov/medicaid/ltc-workforce-funding-faq.htm |
| North Carolina | The North Carolina Partner Team developed an approach in which skilled nursing, home care, and assisted living providers could be rewarded for meeting standards of workplace excellence. This initiative uses a set of uniform criteria that include factors known to impact the recruitment, retention, and job satisfaction of direct care professionals. Home care, adult care homes, and nursing homes that are judged to meet those criteria and expectations receive a special licensure designation from the state’s Division of Health Service Regulation. | https://www.advancingstates.org/sites/nasuad/files/hcbs/files/152/7563/NOVA.pdf<br><br>https://www.advancingstates.org/sites/nasuad/files/hcbs/files/152/7563/NOVA.pdfps://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_131E/Article_6.html |
| New Jersey | In 2021, New Jersey implemented a form of wage-pass-through in response to the COVID-19 pandemic by increasing Medicaid nursing facility rates and required that facilities use at least 60 percent of this increase to bolster direct care staff wages. Legislators have continued to retain this increase in subsequent budgets. | https://pub.njleg.state.nj.us/Bills/2020/PL20/90_.PDF |
| Connecticut | First authorized by a gubernatorial executive order and later implemented though statute, a statewide PCA Workforce Council achieved increases in wages, paid sick leave, dedicated training funds, and other benefits through collective bargaining for personal care assistants (PCAs). | https://portal.ct.gov/pcaworkforcecouncil/ |
| Massachusetts | Along with implementing requirements aimed at holding nursing facilities financially accountable for revenue intended to support direct care staffing, Massachusetts developed signing bonuses for residential care facility staff bonuses for extended time worked in the first 15 or 30 days of their employment. These bonuses were Medicaid supported and made possible through direct bonus payment to employees and submission of a form and attestation to the Medicaid office. | https://www.mass.gov/doc/administrative-bulletin-21-02-101-cmr-20600-standard-payments-to-nursing-facilities-nursing-0/download<br><br>https://www.mass.gov/doc/resident-care-facility-bulletin-34-covid-19-signing-bonuses-for-resident-care-facility-staff/download |
| Virginia | In an effort to support the retention of home health workers, Virginia enacted the Paid Sick Leave for Home Health Workers legislation in 2021. Under Virginia’s Medicaid state plan, up to 40 hours of paid sick leave per year are allotted for DCWs who provide personal care, respite, or companion services to self directing consumers which can be used to attend to personal or family health and wellness needs. | https://legacylis.virginia.gov/cgi-bin/legp604.exe?212+ful+CHAP0449 |
| Washington | In it’s Aging and Long-Term Support Administration’s (ALTSA) Strategic Plan for 2021-2023, Washington State included A strategic objective and success measures dedicated to the development and fostering of organizational cultures in LTC settings that promote employee engagement. | https://www.dshs.wa.gov/sites/default/files/ALTSA/about/ALTSA-Working-Strategic-Plan-21-23.pdf |

# EXHIBIT "1"

## Professional Development and Career Pathways

DCWs report feeling unprepared for their work tasks due to a lack of training. Although there are federal training requirements for certified nursing assistants working in nursing homes, there is a patchwork of inconsistent standards among agencies, employers, and/or states in the number of training hours required. In fact, most DCWs do not receive the specialized training needed for persons with complex care needs.[39] In addition, faced with limited advancement opportunities, our long-term care systems face high turnover due to the lack of upward mobility.

### Professional Development

Professional development programs for incumbent workers offer education and training to enhance the skills of individuals in their current direct care work. In-person or online, synchronous or asynchronous opportunities for training are available. Online learning programs such as Relias and CareAcademy offer continuing education units (CEUs) for direct care workers, with courses in specialized areas like dementia, behavioral health, and chronic care management. Training needs to be built around "core competencies", foundational skills that DCWs should possess to be successful and thrive in their positions. These core competencies should be transferable from one type of setting or role to another rather than siloed within one industry or care setting.[39] Designing credentialing approaches that are based in core competencies create the potential to develop and measure quality standards for DCWs. Core competencies allow DCWs to demonstrate their knowledge and training and gives employers evidence of DCWs' skills.[39]

Key informants suggested the following training topics that would better prepare DCWs for the workplace:

1. Dementia Training- A clinician informant stated similarly that although "pretty much 90% of their patients have dementia…dementia is what really gives people a hard time…really, kind of contributes to burnout."
2. Autonomy for both older adults and DCWs-
    - Adopting a "philosophy of care" to "empower" older adults and give them more choices would not only provide better outcomes but also address equity of care for all older adults.
    - Independence is a valued competence and a gap: "from CNA into nursing, really putting everything together with … complex situations or multiple comorbidities, different patient load and … all these things happening, and putting that all together and using that judgment and being independent. So that seems to be a gap across the board"

3. Palliative care competencies- "The care home operators, … with a hands on care and all of that we would like to see some basic competencies in those places, and a consciousness about the value of palliative care so that they can make referrals

appropriately. And maybe at some point, we build these teams externally from the individual care homes, but the team would be available to multiple different care homes."

4. Person-Centered/Trauma Informed Care- "How do you provide trauma informed care? That's critical. I mean, you're the first line, you're the one to recognize these things. So I mean, there's a lot of things that still need to be taught, and it's not quite yet in the curriculum"

5. Business Management Training for Care Home Operators- In reflection of Hawaiʻi's multicultural communities and heart to care, one key informant added that these same communities could use business management support (e.g., billing). "a lot of the care that's endemic to their heart…and that's why they're in the business. …[T]hey could all use … better business management support … they can get behind…billing and things like that, because that's not their training."

Guided by Core Competencies

Core competencies should form the basis of any credentialing program. Credentialing can take many forms including certifications, licenses, non-credit certificates, micro-credentials (including badges), and for-credit certificates. The Colorado Workforce Development Council four components of a quality credentialing program (see: https://cwdc.colorado.gov/resources/guides-frameworks)

- Demand- The credential is in-demand by employers in the specific sector
- Evidence of Skills- The credential must have evidence of the skills and competencies gained
- Employment Outcomes- The credential has proof that it leads to jobs paying a living wage
- Stackability- The credential is part of a sequence of credentials that can be acquired over time to advance in a career pathway and increase earnings

Development of Career Pathways

A meta-analysis of career pathway programs found that it requires cross-sector partnerships between employers and educational institutions and are more successful if employers partner and provide input on the curriculum design.[56] In terms of outcomes, these pathways do increase employment in the targeted industries but its impact on medium or long-term earnings is less clear.[56] Nevertheless, quality entry-level training and defined career pathways are clearly beneficial. For example, a personal care aide training program called "Building Training . . . Building Quality", part of a national demonstration, found that an increased confidence in ability to do the job and "intent to stay" on the job.[57] Clients of personal care aides who received this training also had fewer emergency department visits and falls as well[58], suggesting that the training improved the care provided by the aides. The following are specific types of career pathway models:

## EXHIBIT "1"

*Earn and Learn Model*

Career pathway opportunities can start at any age or stage of one's educational stage. Stackable credentials can build on one another for multiple levels of career pathway advancement.[34] The "Earn and Learn" model is an "attraction tool" for both incumbent and new workers. A key informant deeply involved in a career pathway from CNA to LPN in the statewide Good Jobs Hawai'i grant remarked how the earn and learn model could be future investment direction as participants were not only attracted by receiving a stipend while they completed their studies and practicum, but were also supported to continue to CNA or from CNA to LPN levels of nursing.

Hawai'i's innovations in Good Jobs Hawai'i included many community partnerships and employer-driven program development. As an island state, the university community colleges are often challenged to find qualified instructors.[59] However, by leveraging CNA instructors in the community and offering administrative support through non-credit programs, Good Jobs Hawai'i enrolled 543 students in the CNA courses from January 1, 2023 - September 30, 2024. HAH was an active employer partner for Good Jobs Hawai'i by providing student internships for health sector occupations including certified nursing assistants. Member organizations, like Ohana Pacific, recognized that their potential pool of workers was "shifting" and they needed to adopt innovative ways to fill CNA positions. HAH adopted an earn and learn model where participants in the glide path would work as a CNA for two years and receive a stipend while they received on the job training for the next step in the nursing career ladder, LPN, and eventually RN. This new shift of workers needed wrap-around services (e.g., counseling services) in order to be successful since "their families don't even support it, because healthcare is foreign to them".

*Work-Based Learning Opportunities*

Work-based learning opportunities are hands-on learning experiences that serve as a vital component of  a career pathway. These experiences can expose individuals to different career opportunities (e.g., worksite tours), prepare individuals for the workforce (e.g., internships), and provide on-the-job training. These experiences benefit both our Hawaii State Department of Education (HIDOE) Career and Technical Education (CTE) students and teachers. Externships allow CTE teachers keep abreast of current industry standards and practices.: One key informant noted that since teachers are the ones who teach work skills as well as encourage students to participate in the career path, direct care employers could provide a week of work experiences where "our teachers do the actual work". Furthermore, partnerships need to be formed between HIDOE and LTC facilities so students gain experience in direct care. One key informant noted that: "...schools are looking for paid internships and paid opportunities for kids, as opposed to service learning, and then I don't know how accessible the long-term care facilities are for our schools".

Apprenticeships are on-the-job training. This opportunity can be provided locally in partnership with one's state Department of Labor, if there is a state apprenticeship agency

(SAA) and recognized or overseen by the National Office of Apprenticeship in the U.S. Department of Labor. Apprentices receive supervised on-the-job training along with job-related online training to gain needed skills. As training and on-the-job hours are completed, apprentices will earn higher wages by the end of the apprenticeship program. A nationally industry recognized credential is earned by the end of the program. Both Certified Nurse Aides and Home Health Aides have been vetted by industry and approved by the U.S. Department of Labor for use in a Registered Apprenticeship Program. More information can be found at www.apprenticeship.gov. The Work Innovation and Opportunities Act (WIOA) also funds Youth Apprenticeships for high school students (ages 16 - 18) or out of school (ages 18 - 24 years).

A key informant who works regularly with work-based learning opportunities for HIDOE described her dream scenario as having paid internships for 10,000 seniors since "schools are looking for paid internships and paid opportunities for kids, as opposed to service" but she added, "... I don't know how accessible the long term care facilities are for our schools". Stakeholders could examine models in other states that provide opportunities for students. In particular, Washington D.C. 's proposed Direct Care Worker Act of 2023 lowers the age of nurse aides to 16 and creates a universal care credential to combine competencies from nurse aide (facility care) and home health aide (in-home care) which are currently discrete.[60] Finally, similar to other states, Hawai'i's apprenticeship program is dominated by construction apprenticeships and may benefit from using incentives, intermediaries, and other strategies to expand to non-traditional sectors like healthcare.[61]

*Career Lattice*

Lattice models are a non-linear approach to career advancement in contrast to the traditional career ladder which moves only in a vertical direction. Through on-the-job training along with mentorship and apprenticeship opportunities, this model allows flexibility for workers to gain new skills and move laterally across different roles or even across different healthcare sectors, which could lead to future upward mobility. Along with providing specialized skill development for DCWs, this flexible approach also seeks to empower workers by further defining and elevating their roles and responsibilities which in-turn can bolster job satisfaction and reduce burnout.[22] Examples of latticed DCW roles include: medication management, palliative care, behavioral health, or dementia care specialists.[18]

Employer key informants were very interested in career lattices since this would create a flexible way for new or incumbent workers to move laterally or vertically within or possibly across facilities and organizations. States such as Oregon and places, like Washington DC, have developed portable credentials so that workers can work across different facility settings. For example, Washington, D.C.'s Direct Care Worker Amendment Act of 2023 combines the competencies of home health aides and certified nursing assistants (CNAs) into a universal credential. This credential enables workers to be adaptable and operate across various care settings. Other possible directions are to develop lattices within an organization or outside of the industry sector to/from the health care sector.

## EXHIBIT “1”

*The CNA+ Model*

CNA+ is an example of a lattice model focused on enhancing the skills and expanding the scope of practice of CNAs. Certifications in areas such as dementia, phlebotomy, wound care, or medication administration would be available to CNAs. This approach creates an ecosystem of differing levels of CNAs. These levels for CNA+ workers have defined roles, responsibilities, and a wage step up as well as specific job descriptions for preceptors and supervisors to support CNA+ workers in a new ecosystem. While a few states, like California, have created CNA+ programs to recruit and retain new DCWs, a key informant, also a nurse, was opposed to the idea as CNAs lacked the necessary pharmacological knowledge and background to make medication decisions. She stated that she was “floored” when she learned that some facilities use “med techs” who are not supervised closely. She was against the idea of CNAs giving medications because “it’s a nursing position”. However, she agreed that if CNAs “took a pharmacology class” then giving medications might be possible with supervision. Another key stakeholder, an administrator from a home care agency, commented that a CNA+ program would depend on what the Department of Health would approve in terms of licensing for a facility. She continued that since a licensed home care agency is non-medical, the additional skills for their caregivers would not benefit their agency.

From an employer perspective, differing requirements and job descriptions across facilities need to be taken into account when considering career lattice models. In a group key informant interview, two healthcare administrators working in career pathways shared their thoughts on creating a lattice for DCWs:

- ”I like the competency and the skills based, I think that maybe mapping those…against the different positions and care settings would be helpful. And some are more clean, and some are very muddied by employer to employer”.
- “...depends on the position that they're applying to, … if it's not a DOH regulated position, they wouldn't qualify for a DOH regulated position, right, unless they had that certification. So until it is recognized, or if there's some sort of like, like a ward clerk or a unit clerk, or something like that, or, I think maybe even like a patient service rep might be a real a good fit, because you don't necessarily need that credential…but it's hard to say, because the different, you know, like [name] mentioned, the different employers have very different requirements. Unfortunately, it's not consistent.”

*Universal Care Worker*

The Universal Care Worker (UCW) model consolidates multiple roles in one versatile position. UCWs are trained broadly to handle multiple types of care tasks. Instead of having distinct roles (e.g., nurses, aides, community health worker), the UCW streamlines and combines many of these roles into one by having skillsets found in both nursing and social work. Workers are trained to perform multiple tasks such as basic nursing care, housekeeping, meal assistance, as well as education and community outreach. This creates a continuity of care because a single care worker handles different aspects of a patient's care, creating a more

person-centered approach. This approach can improve efficiency and flexibility, and potentially improve job satisfaction.[18]

Nursing home alternatives such as The Green House Project, where care takes place in small home-like settings, emerged in the 1990s as a paradigm shift in the way we care for older adults. These models utilize UCWs who provide an expanded scope of daily duties such as cooking, light housekeeping, and social activities, as part of a larger effort to care for the whole person. While these models have lower staff turnover rates and better care outcomes than traditional facility settings,[62] the UCW model was designed for small home-like facilities. The culture shift in larger, existing facilities requires careful consideration and implementation in which DCWs understand their new roles and avoid becoming overwhelmed.[63]

When looking upstream in the career pipeline, the UCW model could allow for flexibility in career exploration for middle and high school students. A facility key informant expressed agreement to expose students to non-clinical positions, like social work, "There is so many other avenues of care out there that don't have to deal directly with.the bedside... We don't have any sort of formal program to do that for people, but I think that that's definitely top of mind for us moving forward." In helping to develop diverse healthcare skill sets for workforce growth, the utility of the UCW model extends to community college students broadly interested in health-connected careers. One key informant, who is a community college administrator, viewed CNA or medical assisting as possible foundational skill sets as participants are really … looking to have a diversified skill set in order to make the most impact"**.** Another key informant expressed interest in a broad range of skills for Community Health Workers that could include some EMR training to have "frontline skills…in rural communities…to support and address whatever they're confronted with".

<u>Develop Integrated Care Teams</u>

Strategies to develop and uplift DCWs should not only target the DCWs themselves but also focus on a culture shift within the organization. Leadership at long-term care facilities and agencies need to examine the roles of DCWs and leverage opportunities to empower them as part of a care team. Innovative care models that empower DCWs to be part of the care team and decision-making need broader implementation and scaling.

Home care and home health represent a distinct sector of the LTSS. Development of organizational culture within a workforce body that operates in dispersed in-home working environments presents unique challenges. In their 2021 visioning paper on professionalizing the caregiving workforce, LeadingAge highlighted California's consumer-directed In-Home Supportive Services (IHSS) attempt to foster connection and bridge institutional and in-home services. In partnership with the California Long-Term Care Education Center, IHSS piloted a training initiative for personal care aides (PCAs). The aim of this program was to integrate in the client expertise of PCAs into larger conversations of patient care planning, and empower PCAs as health monitors, coaches, navigators, and communicators and communicate with clients and

other care team members. The pilot program also sought to provide information and educate relevant health plans and medical groups about the initiative goals and rationale.[64]

The following states have implemented innovative practices to enhance professional development and career pathway efforts:

**Table 7. State Professional Development and Career Pathway Strategies**

| State | Innovation | For More Info |
|---|---|---|
| Arizona | Uniform training requirements were created to ensure a basic level of skill and credentials for all personal care aides across all Medicaid long-term care programs. A direct care workforce committee developed a training titled "Principles of Caregiving," and is sponsored by the state. | https://www.azahcccs.gov/PlansProviders/Downloads/DCW/Manual_%20Level%20I%20Fundamentals_English.pdf |
| California | Center for Caregiver Advancement piloted a care team integration training program in which home care workers were trained to serve in an enhanced caregiving role and to be effective members of care teams by being the link between in-home care and the health care delivery system. | https://advancecaregivers.org/wp-content/uploads/2021/03/CLTCEC-Home-Care-Integration-Training-Project-Brief.pdf |
| Georgia | HB 987 (2020) established memory care licensure and annual dementia training requirements for all DCWs and other long-term care staff in memory care centers. | https://www.legis.ga.gov/legislation/57623 |
| Hawaii | Maui's Hale Makua Health Services offers a CNA to LPN program. This program is an "earn and learn" model that delivers online didactic curriculum and hands-on clinical education at a student's place of work. | https://maui.hawaii.edu/cna-to-pn-bridge-program |
| Hawaii | Good Jobs Hawaii is a state-sponsored pathway program run through the University of Hawai'i Community Colleges. It offers free skills training in high demand industries, including certified nurse aids and adult care home operators. | https://uhcc.hawaii.edu/goodjobshawaii/ |
| Illinois | SB 2301 (2016) established minimum training requirements for staff of home health agencies who are providing care to persons with dementia. | https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0822 |
| Maine | All "personal support service workers" (i.e., personal care aides) are required to complete the state's Introduction to Health Care and Human Services training curriculum within six months of starting employment. This curriculum covers 10 of the 12 competency areas from the Direct Service Workforce Core Competencies set developed by the Centers for Medicare & Medicaid Services (CMS) | https://www.maine.gov/healthcaretrainingforme/ |
| Michigan | Professional Direct Care Workers Association developed a set of DCW competencies that have been vetted and endorsed by the statewide Michigan Department of Health and Human Services and | https://maps.engage.msu.edu/project/RSGIS461 |

| | | |
|---|---|---|
| | are now under review by state leadership. | |
| Tennessee | DCWs can earn a series of competency-based "micro-credential badges" beyond the requisite entry-level training. For each set of four badges earned, direct care workers achieve a higher occupational designation, from "direct service worker" through "community support specialist level III". | https://quiltss.org/pathways/ |
| Washington | Federally registered apprenticeship program for certified nurse aides and home care aides to become licensed practical nurses. These are the first registered apprenticeships in Washington specifically designed to target front-line long-term care providers and create pathways to become licensed practical nurses (LPNs). | https://wtb.wa.gov/long-term-care/ |
| Washington | In partnership with the State of Washington and caregiver union SEIU 775, "Carina" is a care matching service for both Medicaid and private pay families and individuals who are in need of home care services. Carina provides a safe method for care professionals to be matched with good jobs close to home. Carina has expanded to other states with various Medicaid and private pay coverage options. | https://www.carina.org/homecare/medicaid/washington |
| Washington, D.C. | Washington, D.C.'s Direct Care Worker Amendment Act of 2023 combines the competencies of home health aides and certified nursing assistants (CNAs) into a universal credential. This credential enables workers to be adaptable and operate across various care settings. | https://www.dclongtermcare.org/direct-care-worker-amendment-act/ |

**Societal Value of DCWs**

DCWs often face stigma and are perceived as performing "low-skill" labor. In particular, care provided outside of the hospital setting is considered less important.[65] Public awareness and recognition of direct care workers (DCWs) are critical to elevate their societal value and address the long-standing undervaluation of this essential workforce. Their work directly impacts the quality of care and the well-being of older adults and personal disabilities. In particular, direct care work involves "emotional labor", as workers often form trusted relationships with their care recipients.[23] These relationships are critical to the well-being of care recipients, yet this emotional labor is often overlooked. Our society generally does not acknowledge and honor the emotional and relational aspects of their work, and creates an opportunity to promote more respect for their work.

LeadingAge, a national leader in aging-related advocacy, released a communications toolkit in 2021 to aid LTC organizations in the recruitment of aging-care workers. Developed by the Opening Doors to Aging Services initiative, the toolkit strategies are geared toward helping providers provide meaningful messaging about the diverse spectrum of aging-care services. Raising awareness about the importance of direct care work can shift public perception. Increased recognition would not only improve job satisfaction and retention but could also lead to policy changes that offer better pay, benefits, and career advancement opportunities. In addition, recognizing the value of their labor and providing better wages and working conditions

is a matter of economic justice. Improving compensation and benefits would allow these essential workers to take care of their own families and live with dignity.[66] Public campaigns and recognition programs can ensure that these workers are visible, valued, and properly compensated.

**Table 8. State Strategies that Elevate the Societal Value of DCWs**

| State | Innovation | For More Info: |
|---|---|---|
| Arizona | Workforce Development Alliance launched a statewide Caregiver Campaign that highlighted the compassion and dedication of this workforce by sharing DCW stories and testimonies | https://azahp.org/azahp/awfda-altcs/caregiver-campaign/ |
| Maine | Caring for ME Campaign- Targeted effort to attract and develop direct care and behavioral health workers. Includes social media advertising, in-person events, and a website where individuals can explore careers, find job openings, and read stories that highlight the importance of direct care | https://www.maine.gov/dhhs/blog/dhhs-advances-health-care-workforce-development-strategy-2023-04-07 |
| Multiple states | Around 16 states celebrate Direct Support Professional Recognition Week, an annual event created by the American Network of Community Options and Resources (ANCOR) which is a national advocacy organization for direct support professionals. | https://www.ancor.org/event/direct-support-professional-recognition-week-2024/ |
| Wisconsin | WisCaregiver Careers, a nursing assistant recruitment program that was promoted through a marketing campaign that featured videos of nursing assistants describing the value and rewards of their jobs. | https://www.dhs.wisconsin.gov/dms/wiscaregivercareers-finalreport.pdf |

### Data and Evaluation

The lack of comprehensive data and evaluation on the direct care workforce is a significant barrier to understanding and addressing the needs of the direct care workforce. There is no standardized, centralized system for collecting data on direct care workers, who include home health aides, nursing assistants, and personal care aides. Registries can help with recruitment efforts by matching employers with job seekers, but also provide useful data for states to further understand the direct care workforce and identify gaps.[39]

Data needs to be collected in a standardized, consistent approach. Different agencies and states may collect data differently, leading to inconsistencies in how the workforce is tracked and evaluated. Data is needed to understand gaps, turnover rates, wage levels, and job conditions at a state level. Other information on job satisfaction or reasons for leaving the profession are based on small-scale surveys.

Furthermore, there is limited data on race, gender, sexual orientation and gender identity, and immigration status of direct care workers.[39] Disaggregated data is needed to

understand how these factors impact job conditions, wages, or career opportunities. With nuanced data, states can create targeted solutions to address these disparities.

In addition, there is limited data on the effectiveness of different direct care recruitment, retention strategies and policy changes. Evaluating the impact of policy changes, such as how Medicaid reimbursement rates affect the wages of direct care workers requires better data collection and analysis. Evaluation is also needed on the effectiveness of the training in preparing workers for their caregiving roles, job satisfaction, and care quality.[23] Evaluation of career pathway programs can examine its impact on educational attainment and wages.

In summary, the lack of relevant and meaningful data limits the ability to make informed decisions about how to strengthen the direct care workforce. Without accurate data, it’s challenging to plan for future workforce needs, especially with the increasing demand for long-term care as the population ages. As new recruitment, retention, or training approaches and strategies are piloted, evaluation on the outcomes and the effectiveness of the intervention become crucial. Better data is also needed to inform policy decisions that improve wages, benefits, training, and working conditions for direct care workers. Finally, understanding the connection between workforce conditions and care quality is essential for improving the well-being of both workers and care recipients.

**Table 9. State Data and Evaluation Strategies**

| State | Innovation | For More Info: |
|---|---|---|
| California | Data Dashboard on Aging tracks the number of direct care workers by type and examines the number of licensed workers per 1,000 older adults by county in order to determine where to target recruitment efforts | https://mpa.aging.ca.gov/DashBoard/CaregivingThatWorks |
| Colorado | A rate increase to a $15 per hour base wage requirement for frontline staff providing direct hands-on care implemented on Jan. 1, 2022 through April 15, 2023. All Home and Community-Based Services (HCBS) waiver providers rendering eligible waiver services must report compliance with the base wage requirements. A base wage dashboard was created to track compliance and change in wages by care setting. | https://hcpf.colorado.gov/direct-care-workforce-base-wage#Dashboard |
| Multi-state | Evaluation of “Better Jobs, Better Care” initiative- An evaluation analyzed the effects of the management practice interventions. Findings showed that DCW turnover rates were lower at sites that employed a ‘*retention specialist’* trained to systematically address low job satisfaction and turnover. | https://www.ltsscenter.org/resource-library/Solutions_You_Can_Use.pdf |
| Massachusetts | Massachusetts passed a law requiring a public registry for home care workers in its State Home Care Program. The registry verifies the type of training received and credentials earned by DCWs and eliminates duplicating prior training when employers hire new workers. | https://homehealthcarenews.com/2017/11/home-care-registry-becomes-law-in-massachusetts/ |

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### Other Considerations and Limitations

Hawai'i is in a unique position given its high cost of living and competition from other dominant industries, including tourism. Nevertheless, Hawaii's culture also presents opportunities. In particular, collectivist cultures and our respect for elders presents the opportunity for DCW recruitment from former family caregivers, youth, or those providing consumer-directed care. With our diverse communities, Hawaii can utilize caregivers from similar communities, language interpreters and accommodations across the pathway (i.e., recruitment, training, and continued professional development). Viewing language and culture as a resource, employers could offer extra pay for bilingual competency as some agencies do in California.[39] Although language and culture are often overlooked as resources in achieving health outcomes, cultural competence is important when caring for older adults. For Hawai'i, this may be also seen as community competence where "...cultural practices, foods, communication styles and all the other nuances that people have--is critical to providing good care".[67]

An ongoing theme in our literature review and environmental scan is the lack of comprehensive data and evaluation on direct care workforce needs and the effectiveness of different strategies. Strategies and interventions to bolster recruitment, retention, and career pathways have primarily taken place in facility settings versus home and community-based settings. Data is critical for making programmatic decisions and the development of meaningful policy to support further efforts.[68] The following two initiatives demonstrates the lack of data infrastructure, and makes state-level recommendations:

1. Advancing States' evaluation revealed wide variation of states' assessment of their interventions for DCW workforce. Major constraints were mainly evaluation capacity and time limitations to meet the ARPA spending deadline where states were racing to be innovative and evaluation of the "massive" investment was "somewhat of an afterthought".[69] Although this evaluation is the result of three focus groups of 14 top level individuals who represented 9 states, the findings are illuminating for suggestions in future evaluation of state initiatives to sustain efforts. First, while most states had an idea of success in terms of participants being "better off", at least one state, Colorado, had a theory of change for each initiative.[70] Focus group participants noted a lack of baseline data, as well as characterizing the needs of caregivers, DCWs, and some HCBS providers. Of the numerous recommendations for future evaluation efforts, "maintain a strategic plan" that aligns with state aims to achieve LTSS goals may be a strong step for states who already have a master plan on aging or a LTC Workforce Development Strategic Plan.[71] For states experiencing limited resources and lack of staff expertise, a center of excellence could remedy or support technical assistance.

2. The results of the working group, HCBS Federal Opportunities Regarding Workforce and Research Data (HCBS FORWARD), established by the U.S. Department of Health and Human Services with the U.S. Department of Labor recommended 1) development of a national survey for the HCBS workforce, 2) create and maintain a national survey for adults with disabilities (18-64) to broaden understanding of their need and receipt of

services and support by DCWs, 3) provision of support for state data collection efforts, and 4) maximizing existing federal and administrative data sources. The lack of state level data on HCBS workforce underlines underestimation of workforce stability, volume, compensation, training requirements, and then the ability to meet future needs and the impact of policies.[72]

Therefore, although this report highlights innovative strategies found in the literature and utilized by the states, it is currently unclear if these approaches are effective or evidence-based practices.

**Long-term Care Workforce Framework**

There is an interconnectedness to the workforce retention strategies. For example, approaches to bolster recruitment also benefits retention. The development of career lattices and pathways can be seen as a valuable incentive in the recruitment of DCWs. Taken together, both wage and non-wage strategies can be seen as supporting DCWs across their entire work lifespan. Supporting workers across their work lifespan can also lead to larger benefits to the long-term care system. COA set out to understand how societal contexts and different workforce factors interact to influence both workforce development goals and the larger goal to improve the quality of the long-term care system. The team identified and expanded upon a workforce development framework.[73]

This framework connects the workforce development strategies and outcomes identified in the results section above. In this framework, we acknowledge macro-level factors in the long-term care system that can influence the status of the direct care workforce. In particular, the availability of family caregivers and societal view of direct care workers shape policy on both the local and national level. Policies influence the organizational settings in which direct care is provided. Organizational culture and capacity influences the ability to recruit DCWs and provide them with career pathways and professional development. If organizations are able to provide these opportunities, they are better able to retain their DCWs, which then impacts patient satisfaction and quality of care. The framework also recognizes that good data and evaluation provides a feedback mechanism that ensures quality in the system.

(INSERT FRAMEWORK ABOUT HERE)

**Recommendations**:

The recommendations in this strategic plan reflect a comprehensive review of the literature and best practices in other states as well as feedback from key informants. The findings were triangulated by the team to ensure that the recommendations presented here are feasible and appropriate in Hawaii, as well as be effective in strengthening the direct care workforce over the long-term. The goal of this plan is to shape proposals in the upcoming legislative session as well as influence organizational policy change in the aging and disability networks.

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The implementation of these recommendations require strong leadership and a designated coordination center charged with identifying diverse and sustainable funding sources, bringing together stakeholders, and partnering with other long-term care improvement initiatives. In addition, implementation plans need to intentionally target our societal views on aging and elevate the critical work of both direct care workers and family caregivers. Alongside these longer term goals, short term "wins" will be important to gain momentum and sustain energy among stakeholders.

INSERT GRIDS ABOUT HERE

**Discussion:**

Strengthening the direct care workforce is essential to the broader goal of improving the quality, availability, and sustainability of long-term care in Hawai`i in general. Because direct care workers enable other healthcare professionals to focus on their primary responsibilities in the long-term care environment, everyone benefits from a well-trained, sufficiently staffed direct care workforce, especially the residents and clients receiving long-term care services and supports wherever they are aging: home, community-based, or institutional settings.

The goals and strategies proposed in this strategic plan are meant to stimulate further discussion and ideas for policy solutions, including help with framing the problem at hand, defining related terms and concepts, and formulating possible solutions in the form of government action such as legislation, resolutions, directives, campaigns, and initiatives. Many of these solutions can be best realized through partnerships with key stakeholders in academia, the private sector, community-based organizations, advocacy groups, and other concerned citizens and entities.

Further, funding will be critical to implementing the goals and strategies in this plan. New and existing state and federal funding streams need to be pursued in order to maintain established partnerships and create and sustain innovative workforce development programs, such as HAH's earn and learn glidepath in Good Jobs Hawaiʻi. For example, Hawaiʻi's Workforce Development Council's website provides current state and federal funding distribution of about $101M to support diverse populations as well as institutions who provide employment assistance.[74] One of the federal funding sources, WIOA, that funds employment supports, like apprenticeships, for adults and youth could be further leveraged for DCWs. Cross-sector partnerships could also explore federal funding for nursing ladders, health care sector career pathways as the grants are announced to pilot new programs through the Employment Training and Administration (ETA)[75] such as the Nursing Expansion Grant with $78 M released to public-private partnerships in 17 states.[76] Hawaiʻi could also further direct Medicaid MCOs to fund workforce development such as providing a workforce expert to guide organizations in recruitment and retention strategies or assist with career pathways or ladders.[77] In sum, now is the time for action as federal and state leaders are realizing the DCW workforce crisis and need for bold and sustained leadership.

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Moving forward, to sustain action and engagement of key leaders and stakeholders, a coordination center is needed. The UH Manoa Center on Aging can act as a "*Kupuna Workforce Innovation Hub*" to organize and facilitate the goals and strategies in this plan. In particular, the UH Center on Aging can support Hawaii's workforce development efforts to::

1. Coordinate aging education and training and standardize aging competencies
2. Coordinate partnerships across sectors and between workers and employers
3. Coordinate the collection of standardized data and indicators and evaluate new approaches and initiatives to assess outcomes

The Center on Aging can help to achieve consistency in aging-related core competencies and psycho-social training. Consistent with models elsewhere of university programs acting as workforce intermediaries – i.e., helping to bridge the gap between workers and employers by connecting education, training, and labor market needs – the COA can serve as a facilitator, bringing together job seekers, employers, UH Community Colleges, government agencies, community organizations, Healthcare Association of Hawaii, and the future Long-Term Care Planner at the Executive Office on Aging. COA would work with employers to determine their specific needs and then help to develop a "talent pool" of well-trained individuals with the skills to meet those needs, perhaps through the micro-credentialing of competency areas that allows learners to earn a competency badge recognized and valued by employers in the community. Furthermore, the Kupuna Collective (co-coordinated by COA) with its more than 300 individual members from more than 200 organizations can provide internship experiences for students and community members interested in field learning to prepare them for careers in aging (e.g., mid-level aging services management) or innovative volunteer opportunities not currently being addressed by other organizations). COA would not duplicate efforts already in progress but rather bridge and enhance those efforts for the most efficient and effective outcomes.

This "Kupuna Workforce Innovation Hub" would work in alliance with the non-partisan Council of State Governments, coordinated by Sen. Sharon Moriwaki and Executive Office on Aging Director Caroline Cadirao. Their leadership has resulted in ongoing cross-sector dialogue and efforts to build capacity and drive systems change in the recruitment, training, and retention of Hawai`i's direct care workforce. In addition to bringing together a wide range of key stakeholders in Hawaii, the task force that emerged out of this CSG relationship has resulted in technical assistance, coaching, access to subject matter experts, and opportunities for peer-to-peer learning and exchange. These actions are the precursors to systems change and can guide policy decisions at the state level that impact the long-term care roadmap in Hawai`i. These actions are also consistent with the Executive Office on Aging's "Hawaii State Plan on Aging: 2023-2027," in particular in regard to these two overarching goals: "Hawaii's older adults have opportunities to live well" and "Hawaii's older adults and persons with disabilities will age in place safely." The strengthening of the state's direct care workforce supports these strategic pillars in the state's master plan on aging and represents a collective investment in Hawaii's long-term care infrastructure.

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### Conclusion

This strategic plan has underscored the need for consistent data collection, ongoing data analysis, and evaluation of the effectiveness of workforce development strategies. Moreover, in the interest of health equity, researchers should study the underlying conditions and causes that lead to disparities in the long-term care environment and propose solutions that address those disparities, including ethnic differences in regard to life expectancy, access to health education and services, and other barriers to achieving optimum health. Disparities can exist across other dimensions as well, such as gender, sexual orientation, age, disability status, socioeconomic status, and geographic location. Good quality data across dimensions are needed to better understand the long-term care needs, challenges, and preferences of all of Hawai'i's people, who deserve to age with dignity and with the support of the broader community. Building a strong, resilient, and responsive direct care workforce – enriched by Hawai`i's unique cultural milieu – will ensure that the core of the long-term care system in Hawai`i is solid and stable for future generations.

Ideally the next steps will involve moving ideas from strategic planning to public policy and community action, including organizational culture change where needed and societal transformations in the increased awareness and valuing of direct care workers. As the goals and strategies proposed in this plan materialize into action steps, the sincere hope is that the recruitment, retention, and training of direct care workers will be successfully achieved throughout the state and across healthcare sectors. This outcome will take more than a village, however. It will take *many* villages working together toward common goals to build a stronger tomorrow and keep Hawaii the best place to grow older, as articulated in the vision statement of the Executive Office on Aging. The long-term care dilemma in Hawaii is not solely the government's problem to solve. It requires an "all hands on deck" approach involving all members of the community with a stake in aging well throughout the life course. The building of a robust eldercare infrastructure in Hawaii is an investment in the future for our communities, our families, and ourselves.

### Appendices

A. DCW Infographic
B. Model - Relationship between 5 workforce goals
C. Recommended Core Competencies in Aging for Direct Care Workers
D. Educational Approaches: How to Teach About Aging (P-20)

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