

**CARE FOR OUR COMMUNITIES: INVESTING
IN THE DIRECT CARE WORKFORCE**

JOINT HEARING

BEFORE THE

**SUBCOMMITTEE ON
HEALTH, EMPLOYMENT,
LABOR, AND PENSIONS**

AND THE

**SUBCOMMITTEE ON
HIGHER EDUCATION AND
WORKFORCE INVESTMENT
OF THE**

**COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED SEVENTEENTH CONGRESS**

FIRST SESSION

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CARE FOR OUR COMMUNITIES: INVESTING IN THE DIRECT CARE WORKFORCE

Tuesday, July 20, 2021

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT,
LABOR, AND PENSIONS,
SUBCOMMITTEE ON HIGHER EDUCATION AND WORKFORCE
INVESTMENT,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittees met, pursuant to notice, at 10:17 a.m., via Zoom, Hon. Mark DeSaulnier (Chairman of the Subcommittee on Health, Employment, Labor and Pensions) presiding.

Present: DeSaulnier, Wilson, Courtney, Bonamici, Takano, Norcross, Jayapal, Morelle, Wild, McBath, Levin, Stevens, Fernandez, Manning, Mrvan, Bowman, Pocan, Castro, Sherrill, Espailat, Scott (*ex officio*), Murphy, Allen, Walberg, Grothman, Banks, Fulcher, Miller-Meeks, Good, McClain, Harshbarger, Spartz, Fitzgerald, Letlow, and Foxx (*ex officio*).

Staff present: Phoebe Ball, Disability Counsel; Ilana Brunner, General Counsel; Rasheedah Hasan, Chief Clerk; Sheila Havenner, Director of Information Technology; Eli Hovland, Policy Associate; Carrie Hughes, Director of Health and Human Services; Ariel Jona, Policy Associate; Andre Lindsay, Policy Associate; Richard Miller, Director of Labor Policy; Max Moore, Staff Assistant; Mariah Mowbray, Clerk/Special Assistant to the Staff Director; Lorin Obler, GAO Detailee; Kayla Pennebecker, Staff Assistant; Véronique Pluiose, Staff Director; Banyon Vassar, Deputy Director of Information Technology; Cyrus Artz, Minority Staff Director; Rob Green, Minority Director of Workforce Policy; Amy Raaf Jones, Minority Director of Education and Human Resources Policy; Dean Johnson, Minority Legislative Assistant; Georgie Littlefair, Minority Legislative Assistant; Hannah Matesic, Minority Director of Operations; Audra McGeorge, Minority Communications Director; Chance Russell, Minority Legislative Assistant; Mandy Schaumburg, Minority Chief Counsel and Deputy Director of Education Policy; Michael Davis, Minority Operations Assistant; and Taylor Hittle, Minority Professional Staff Member.

Chairman DESAULNIER. The Subcommittee on Health, Employment, Labor, Pensions, and the Subcommittee on Higher Education and Workforce Investment will come to order. Welcome again, everyone. I note that a quorum is present.

The subcommittees are meeting today for a joint hearing on Care for Our Communities: Investing in the Direct Care Workforce.

This is an entirely remote hearing, and, as such, the Committee's hearing room is officially closed. All microphones will be kept muted as a general rule to avoid unnecessary background noise.

Members and witnesses will be responsible for unmuting themselves when they are recognized to speak, or when they wish to seek recognition.

If a Member or witness experiences technical difficulties during the hearing, please stay connected in the platform. Make sure you are muted and use your phone immediately to call the Committee's IT director, whose number was provided in advance.

Should the Chair experience technical difficulty or need to step away, Chairwoman Wilson or another majority Member is hereby authorized to assume the gavel in the Chair's absence.

In order to ensure the Committee's five-minute rule is adhered to, staff will be keeping track of time using the Committee's remote timer, which appears in its own thumbnail picture. Members and witnesses are asked to wrap up promptly when their time is expired.

Pursuant to Committee Rule 8(c), opening statements are limited to the Chairs and Ranking Members. This allows us to hear from our witnesses sooner and provides all Members with adequate time to ask questions.

I now recognize myself for the purpose of making an opening statement.

Today, we will be hearing about the valuable work performed by America's direct care workforce and the urgent care and need to expand these services for aging Americans and Americans with disabilities.

Direct care makes it possible for millions of Americans to live independently in their homes and their communities. The degree to which these vital services enhance the quality of life for aging and disabled Americans cannot be overstated.

They enable individuals who need assistance with activities of daily living to live healthy and productive lives and remain active participants in their communities. We know that people want to stay at home, and they want to stay in their communities as long as possible and as much as possible. Direct care workers are a crucial part to ending the unnecessary segregation and advancing the civil rights of individuals with disabilities as outlined in the Supreme Court's 1990 Olmstead decision.

Unfortunately these services are often unaffordable and inaccessible for those who need them most. Private insurance and Medicare often provide only limited coverage for home-and community-based services, forcing family Members and friends to care for loved ones, or, alternatively, to pay out of pocket for those services until their resources are depleted enough for Medicaid to kick in.

The demand for direct care is also rapidly outpacing the growth of the direct care workforce, and, unfortunately, individuals who need home-and community-based services often find it impossible to access the support they need.

The direct care sector is expected to add more than 1.3 million jobs between 2018 and 2028. Yet the number of people who will need direct care continues to exceed the number of workers who

can provide it. To address this shortage, we must understand the causes.

Direct care workers, disproportionately women of color, are chronically undervalued and overworked. Medicaid is, by far, the largest funding source for direct care services, and Medicaid reimbursement rates have not allowed wages to increase as fast as those in these occupations.

Today, roughly one in six in direct care workers lives in poverty, one in six of these workers lives in poverty. The turnover rate for direct care workforce in 2018 was 82 percent. And that was before the pandemic, which forced more than 200,000 direct care workers to leave their jobs.

Today, we will discuss the need to ensure access to direct care services for those who need them, and also support the worker force that delivers these services.

The American Jobs Plan calls for robust investments to expand access to home-and community-based services for Medicaid and to strengthen the workforce through higher wages, better benefits, and sector-based job training and supports.

The Direct Creation, Advancement, and Retention of Employment Opportunity Act, or Direct CARE Opportunity Act, also expands workers' earning potential and provides the financial assistance for transportation, childcare, and housing that workers need to stay in their jobs.

Our society and our economy depend on direct care workers. They deserve better, as do their clients. We are committed to that goal.

I now recognize the distinguished Ranking Member of the Subcommittee on Health—I am sorry. I now recognize the distinguished Ranking Member of the Subcommittee on Health, Employment, Labor, and Pensions for the purpose of making an opening statement.

[The statement of Chairman DeSaulnier follows:]

STATEMENT OF HON. MARK DESAULNIER, CHAIRMAN,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

Today we will be hearing about the valuable work informed by America's direct care workforce, and the urgent need to expand these services for aging Americans and individuals with disabilities.

Direct care makes it possible for millions of people to live independently in their homes and communities. The degree to which these vital services enhance the quality of life for aging and disabled Americans cannot be overstated. They enable individuals who need assistance with activities of daily living to live healthy and productive lives and remain active participants in their communities.

We know that people want to stay at home, and they want to stay in their communities as long as possible and as much as possible. Direct care workers are a crucial part to ending the unnecessary segregation and advancing the civil rights of individuals with disabilities, as outlined in Supreme Court's 1999 Olmstead decision.

Unfortunately, these services are often unaffordable and inaccessible for those who need it most.

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The demand for direct care is also rapidly outpacing the growth of the direct care workforce. And unfortunately, individuals who need home and community-based services often find it impossible to access the support they need.

The direct care sector is expected to add more than 1.3 million jobs between 2018 and 2028. Yet, the number of people who will need direct care continues to exceed

the number of workers who can provide it. To address this shortage, we must understand the causes.

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Medicaid is, by far, the largest funding source for direct care services, and Medicaid reimbursement rates have not allowed wages to increase as fast as those these occupations. Today, roughly 1 in 6 direct care workers lives in poverty. 1 in 6 of these workers lives in poverty.

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Our society and our economy depend on direct care workers. They deserve better as do their clients. We are committed to that cause.

I now recognize the distinguished Ranking Member of the Subcommittee on Health, Employment, Labor and Pensions for the purpose of making an opening statement. Mr. Allen, good morning.

Chairman DESAULNIER. Mr. Allen? Good morning.

I think you might be muted, Mr. Allen.

Mr. ALLEN. All right. There we go.

Chairman DESAULNIER. There you are.

Mr. ALLEN. You got me?

Chairman DESAULNIER. We got you.

Mr. ALLEN. Hey, thanks, Mr. Chairman. I thought I was right on schedule. I couldn't get in the hearing room, so I finally got in here. But we're here, and I want to thank my colleague, Dr. Murphy, for joining us in his role on his Subcommittee.

I do find it ridiculous that, even unelected bureaucrats are back to working in person before Democrats in Congress, the Workforce Investment and Opportunity Act, WIOA, provides an important source of funding for State and local workforce development systems that are tasked with addressing needs of the community.

The Federal Government does not have the knowledge or foresight required to dictate what States need. I believe we should err on the side of flexibility when designing and funding workforce development systems with taxpayer dollars.

Direct care workers are an important part of the healthcare workforce and care for our most vulnerable patients. Their work is often difficult and unrecognized, but our healthcare workers are valuable and should be recognized for the sacrifices they have made, especially during the COVID-19 pandemic.

We know there is an incredible amount of turnover in the labor market for direct care workers. We also know that most direct care workers did not pursue additional education after high school.

As Ranking Member of the Subcommittee on Health, Employment, Labor, and Pensions, I hope today's hearing can shed light on how Congress can help all workers, including direct care workers, gain the skills they need to improve their upward mobility, and sustain a fulfilling career.

New technologies and practices developed in the private marketplace are revolutionizing the healthcare field. We must ensure workers are not left behind. The Federal Government has an interest in sustaining a workforce pipeline that recruits, retains, and assists individuals interested in finding the right career for them, including careers within the healthcare workforce. But Congress cannot fall into the trap of having hundreds of different programs, each devoted to one particular occupation.

This is why I advocate for apprentice-style programs. Combining structured on-the-job learning, and classroom-based instruction gives individuals a low-risk option to determine if a job is a good fit for them. In the same way, earn-and-learn programs are another way to help folks find that rewarding career.

I look forward to working with my colleagues on both sides of the aisle to find innovative solutions to address the healthcare workforce challenges facing our Nation, and I look forward to hearing the witnesses' testimony today.

And, with that, Mr. Chairman, I thank you, and I yield back.

[The prepared statement of Mr. Allen follows:]

STATEMENT OF HON. RICK ALLEN, RANKING MEMBER,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

Thank you, Chairman DeSaulnier.

And thank you to my colleague Dr. Murphy for your remarks.

I find it ridiculous that even unelected bureaucrats are back to working in person before Democrats in Congress.

The Workforce Investment and Opportunity Act (WIOA) provides an important source of funding for State and local workforce development systems that are tasked with addressing the needs of the community. The Federal Government does not have the knowledge or foresight required to dictate what states need. I believe we should err on the side of flexibility when designing and funding workforce development systems with taxpayer dollars.

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I look forward to working with my colleagues on both sides of the aisle to find innovative solutions to address the health care workforce challenges facing our Nation. And I look forward to hearing the witnesses' testimony today.

Thank you and I yield back.

Chairman DESAULNIER. Thank you, Mr. Allen.

I now want to recognize the distinguished Chairwoman of the Subcommittee on Higher Education and Workforce Investment for the purpose of making an opening statement.

Chairwoman Wilson?

Chairwoman WILSON. Thank you, Chair DeSaulnier.

I want to add my thanks for our distinguished witnesses' time today. In addition to low pay and difficult working conditions, the direct care sector lacks the training and career pathways that workers need to join and remain in this profession.

Direct care is hard work. It is physically and emotionally demanding, and also requires knowledge of complex health conditions, such as Alzheimer's disease and dementia. Yet, training for entry level direct care workers varies widely, and is not reimbursed by Medicaid or Medicare, leaving many workers unprepared to safety—to safely provide quality, long-term care.

In addition, these workers often do not have the required education, qualifications to enroll in training programs, and would offer professional growth. Without these pathways, direct care workers often become stagnant without the opportunity to advance into higher-paying positions.

In most professions, workers can increase their pay as they increase their skills and experience. Direct care workers should have that same opportunity.

The American Jobs Plan dedicates resources to improve the lives of direct care workers. This mirrors the Direct CARE Opportunity Act, which invests in recruiting, retaining, and advancing the direct care workforce pipeline. Those resources will allow States and local organizations to pursue the best solutions in their regions, from training programs and registered apprenticeships to mentorship opportunities, to make direct care a more sustainable career.

Supporting a well-paid and well-trained direct care workforce is vital. It is vital for aging Americans; it is vital for individuals with disabilities.

In 2015, in my home State of Florida, 6,000 people died while waiting for home care services according to the Department of Elder Affairs. Sadly, this underscores the desperate need for increased investment in the direct care sector.

Strengthening this workforce pipeline is not only the right thing to do to support our Nation's direct care workers; it is also the smart thing to do. With the right investments, the direct care field will be able to offer millions of good-paying jobs with lower barriers to carrying—to entry, and ample opportunities for career growth.

As we recover from the pandemic, which erased millions of jobs, enhancing the direct care workforce would help people get back to work immediately, and secure quality long-term care for those who need it most.

I look forward to our discussions today, and I now yield to the Ranking Member, Mr. Murphy—Dr. Murphy, for his opening statement.

[The prepared statement of Chairwoman Wilson follows:]

STATEMENT OF HON. FREDERICA S. WILSON, CHAIRWOMAN, SUBCOMMITTEE ON
HIGHER EDUCATION AND WORKFORCE INVESTMENT

Thank you, Chair DeSaulnier. I want to add my thanks for our distinguished witnesses' time today.

In addition to low pay and difficult working conditions, the direct care sector lacks the training and career pathways that workers need to join-and remain-in this profession.

Direct care is hard work. It is physically and emotionally demanding and also requires knowledge of complex health conditions, such as Alzheimer's disease and dementia. Yet, training for entry-level direct care workers varies widely and is not reimbursed by Medicaid or Medicare, leaving many workers unprepared to safely provide quality, long-term care.

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I look forward to our discussions today and I now yield to the Ranking Member, Dr. Murphy, for his opening statement.

Mr. MURPHY. Thank you, Chairwoman Wilson, for yielding.

I would like to thank the witnesses for joining us today.

Direct care workers are an essential part of the healthcare sector. I personally have worked with these individuals for over 30 years and understand the dedication that they have to their craft. These individuals act as primary care providers of care, supervision, and emotional support for older Americans, people with disabilities, and individuals with chronic needs. As a physician, I understand the value that they bring to our healthcare system and the sacrifices that they make to serve our patients.

Data from the Bureau of Labor Statistics estimate that there are over 3 million direct care workers employed in the U.S. today. These jobs provide an important source of income for a diverse array of individuals.

As the United States population ages, and the need for direct care workers blossom, the Federal Government must consider how its programs foster an environment where more people are encouraged to enter the healthcare workforce. I believe the reauthorization of the Workforce Innovation and Opportunity Act is the appro-

appropriate time for this Committee to reassess Congress' role in us supporting a robust healthcare labor market.

In the existing WIOA structure, each State must create a one-stop delivery system that connects job seekers with in-demand jobs. Direct care services should be a part of those State and local workforce development board conversations.

But Congress cannot predict the future. Our laws must be nimble and allow each community to address its unique needs. I believe that supporting direct care workers through a comprehensive WIOA reauthorization will give individuals interested in these careers in the direct care field access to programs that will help gain the skills necessary to succeed.

Legislation like H.R. 2999, the Direct CARE Opportunity Act, is a duplicative—is duplicative to workforce programs that we already have in place. I am concerned that a new Federal program devoted exclusively to direct care workers may threaten the performance of the broader workforce development system.

Republicans on this Committee want to help all workers, including those in the direct care sector, by strengthening WIOA and other workforce development programs.

I look forward to hearing from witnesses today on how we can build up the healthcare workforce sector without detracting from other critical professions.

Thank you, Madam Chair. Thank you, and I yield back.

[The prepared statement of Mr. Murphy follows:]

STATEMENT OF HON. GREGORY F. MURPHY, RANKING MEMBER, SUBCOMMITTEE ON
HIGHER EDUCATION AND WORKFORCE INVESTMENT

Thank you, Chairwoman Wilson, for yielding. I'd like to thank the witnesses for joining us today.

Direct care workers are an essential part of the health care sector. I have personally worked with these individuals for over 30 years. These individuals act as primary providers of care, supervision, and emotional support for older Americans, people with disabilities, and individuals with chronic needs. As a physician, I understand the value they bring to our health care system, and the sacrifices they make to serve patients.

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Thank you and I yield back.

Chairman DESAULNIER. Thank you, Ranking Member Murphy. Thank you, Chair Wilson, very much for those comments.

We will now go to our witnesses, and it is my pleasure to introduce them. Thank you again for being here. We really appreciate it.

Robert Espinoza is the Vice President of Policy at PHI, where he oversees the National Advocacy Research and Public Education Division on the Direct Care Workforce.

Zulma Torres has worked in direct care for over 23 years, and works for Cooperative Healthcare Associates, a worker-owned licensed home care service agencies located in the Bronx.

Paul Burani is the head of business development for North America for Udacity, a company founded in 2011 to provide training services for workers facing changing technological landscapes.

And Representative Jessica Fay is a third-term Member of the Maine House of Representatives. She was appointed to serve as House Chair of the Commission on Study of Long-Term Care Workforce Issues.

Our instructions for the speakers are as follows.

Again, we appreciate the witnesses for participating today and look forward to your testimony. Your written statement will appear in full in the hearing record, and you are asked to limit your oral presentation to five minutes, please. After your presentation, we will move to Member questions.

The witnesses are aware of their responsibility to provide accurate information to the Joint Subcommittees, and, therefore, we will proceed with their testimony.

And, first, we will recognize Mr. Espinoza.

**STATEMENT OF ROBERT ESPINOZA, VICE PRESIDENT OF
POLICY, PHI**

Mr. ESPINOZA. Thank you, Chairman, and good morning.

On behalf of PHI, I would like to start by thanking Chairwoman Wilson, Ranking Member Murphy, and the other Members of the Higher Education and Workforce Investment Subcommittee, as well as Chairman DeSaulnier, Ranking Member Allen, and the other Members of the Health, Employment, Labor and Pension Subcommittee, for the opportunity today to discuss the direct care workforce and how the Direct CARE Opportunity Act would support this vital job sector.

Across the country, 4.6 million direct care workers support millions of older adults and people with disabilities in a range of long-term care settings, from their private homes to residential care homes, such as assisted living, to skilled nursing homes. Most of these workers are women, people of color, and/or immigrants, and 1 in 4 is aged 55 and older, all facts that underscore the entrenched societal inequities that many of these workers face both on the job and in their communities.

Largely because our country is aging rapidly, the direct care workforce has grown significantly over the years, and it will continue this trend. Between 2018 and 2028, the direct care workforce will add more than 1.3 million jobs—new jobs, including nearly 1.1

million jobs in home care, representing the largest growth of any job sector in the country. Already, the direct care workforce is larger than any other single occupation in the country.

However, despite their enormous value, direct care jobs have been poorer-quality jobs for decades, which harms workers, employers, consumers, and family caregivers. These workers struggle with poverty level wages, which our research shows are lower in all 50 States and D.C. than wages for other occupations with similar entry level requirements, such as janitors and retail salespeople. Training and advancement opportunities are also inadequate, which makes it increasingly difficult to recruit and retain these workers. These challenges affect everyone in the long-term care system.

Forced into crushing poverty, workers too often leave the sector for other fields. Employers struggle to recruit and retain workers and will need to fill millions of direct care job openings in the next decade. Without enough workers, older adults and people with disabilities cannot access the services they deserve, and family caregivers are often left without paid respite and support. The COVID-19 pandemic has amplified all these challenges.

To address these issues, the Direct CARE Opportunity Act would provide a significant and much-needed investment in the direct care workforce, coordinated at the national level to ensure that funding goes where it is most needed. It would invest more than \$1 billion over 5 years in recruitment, retention, and advancement strategies.

In direct care, it would require careful planning, needs assessment, and evaluation that would help build the evidence base on this workforce related to care outcomes, employment outcomes, and cost outcomes. Specifically, this funding could be used to support interventions related to entry level and specialized training, advanced roles, recruitment and retention, supervision and technology.

It could help create new models of long-term care service delivery related to upscaling care integration, career advancement, and universal worker roles. And it would support individuals with prevalent conditions, such as dementia, and more vulnerable people, such as people of color and LGBT people, just to name a few. It would help professionalize and transform these jobs, making them more attractive to job candidates now and in the future.

Already, the field has designed numerous examples of effective interventions, though it needs significant funding and coordination at the Federal level. We have seen successful training, recruitment and advancement programs in Arkansas, California, and New Mexico, among many other States. And these interventions have benefited workers, consumers, employers, and the economy alike, but they are small in scale, and they represent a tiny fraction of what will be needed to address the national workforce crisis in direct care.

I will close by saying that strategically investing in workforce development for this workforce is also a matter of economic development. High-quality jobs and workforce interventions can increase consumer spending, decrease public assistance rates, reduce costly

turnover, and promote cost savings in healthcare spending in an already expensive system with costs that balloon every year.

We encourage Congress to enact the Direct CARE Opportunity Act and begin transforming this critical workforce. As Marisol Rivera, care coordinator at Cooperative Home Care Associates in the Bronx, said, I think the role of the home health aide should be considered just as important as any other healthcare role.

Thank you, and I look forward to your questions and to your ideas.

[The prepared statement of Mr. Espinoza follows:]

PREPARED STATEMENT OF ROBERT ESPINOZA



CONGRESSIONAL TESTIMONY

**Investing in Direct Care Workforce
Interventions to Improve the Quality of
Services and Supports for Older Adults
and People with Disabilities**

Testimony before
Health, Employment, Labor, and Pensions Subcommittee
and
Higher Education and Workforce Investment Subcommittee

Committee on Education and Labor

United States House of Representatives

July 20, 2021

Robert Espinoza
Vice President of Policy
PHI

My name is Robert Espinoza, and I am the Vice President of Policy at PHI, a New York-based, national nonprofit organization that works to transform eldercare and disability services by promoting quality direct care jobs as the foundation for quality care.

For three decades, PHI has been the nation's leading expert on the direct care workforce through its research, policy analysis, and direct consultation with policymakers, payers, providers, and workers—providing a unique 360-degree perspective on the long-term services and supports (LTSS) system and its workforce in the United States. Over the years, PHI has also designed a broad range of groundbreaking workforce interventions in diverse parts of the country that have optimized and elevated the role of direct care workers in LTSS delivery through training, advanced roles, coaching supervision, and more. Our interactive curricula and training programs designed for adult learners help direct care workers build the knowledge, skills, and confidence to deliver quality care. We work with employers to create entry-level training opportunities with a direct pathway to employment, and we provide high-quality specialty and in-service training to hone the skills of currently employed aides. Our training also supports advanced roles for direct care workers and promotes continuous learning. In its federal advocacy, PHI has worked successfully on bipartisan policy initiatives for decades.

On behalf of PHI, I would like to thank Chairman DeSaulnier, Ranking Member Allen, and the other Members of the Health, Employment, Labor, and Pensions Subcommittee; as well as Chairwoman Wilson, Ranking Member Murphy, and the other Members of the Higher Education and Workforce Investment Subcommittee, for the opportunity to discuss the direct care workforce and how the Direct Creation, Advancement, and Retention of Employment (CARE) Opportunity Act would support this vital job sector by providing a robust, targeted, and coordinated investment in workforce interventions to improve training, advancement, recruitment, and retention.

I will begin this testimony by describing the direct care workforce, including its roles, responsibilities, size, key characteristics, and primary challenges, as well as the impact of these challenges on workers themselves, the individuals they support, employers, and family caregivers. I will then describe how the Direct CARE Opportunity Act would help address a significant need in this country by funding a coordinated array of workforce interventions in direct care while building a much-needed evidence base on these critical approaches.

THE DIRECT CARE WORKFORCE

Direct care workers support older adults and people with disabilities with critical daily tasks and activities across settings, from private homes to residential care homes (such as assisted living) to skilled nursing homes. This workforce comprises three main occupational groups—personal care aides, home health aides, and nursing assistants—but are known by a variety of job titles in the field. Direct care workers who are employed directly by consumers, either through Medicaid

programs or private-pay arrangements, are often called “independent providers.” Workers who support individuals with intellectual and developmental disabilities are known as “direct support professionals.”

Our research shows that there are 4.6 million direct care workers in the U.S., which makes this workforce larger than any other single occupation in the country.¹ Because of growing demand—spurred mainly by the reality that from 2020 to 2060, the population of adults aged 65 and over will almost double, from 56.1 million to 94.7 million²—the direct care workforce has grown significantly over the years and will continue to surge in the years ahead. Between 2018 and 2028, the direct care workforce is projected to add more than 1.3 million new jobs.³ Home care will add nearly 1.1 million jobs in that period, representing the largest growth of any job sector in the country. The growth in the home care workforce in particular—over workers employed in nursing homes and residential care settings—is the result of a shift over the last three decades to dedicate more federal spending to home and community-based services, spurred by consumer preference and the passage of the Americans with Disabilities Act in 1990 and the 1999 *Olmstead vs. L.C.* decision, which requires states to deliver LTSS “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”⁴

However, across the country, long-term care employers struggle to recruit and retain these workers, given the growing numbers of older adults and people with disabilities who need LTSS and the persistence of poor job quality in direct care, described below. Among older adults, the total number of paid LTSS users aged 65 and older is expected to grow from 7.4 million in 2020 to 14.4 million in 2065, and 56 percent of people turning 65 between 2020 and 2024 will require some form of paid LTSS at some point in their lives.⁵ Moreover, nearly 820,000 people nationwide are on waiting lists for home and community-based services.⁶ Yet direct care workforce interventions lack the resources and scale to match these growing numbers and the overall need nationwide, despite a growing but insufficient evidence base demonstrating their impact and potential.⁷

Among these workers, 87% are women, 59% are people of color, and 27% are immigrants.⁸ The median age for direct care workers is 43, though roughly one in four (27 percent) is aged 55 and older. As our country has rapidly aged, so has this workforce; today, many direct care workers are older adults supporting other older adults. The diversity of this workforce also means that many workers must contend with entrenched, societal inequities that exacerbate the many challenges they face on the job, as detailed in the next section.

KEY CHALLENGES

Despite their enormous value, direct care jobs have been poor-quality jobs for decades, harming workers, employers, consumers, and family caregivers. One of the primary challenges facing direct care workers is inadequate compensation. The median wage for these workers in 2019 (our

most recent year of data) was \$12.80, which was only 19 cents higher than the median wage in 2009. (In LTSS, which is primarily covered by Medicaid, low wages are often shaped by inadequate funding for the entire system and low reimbursement rates under Medicaid and other public payers that limit providers from raising wages and implementing job improvements.⁹) Low wages and part-time employment force direct care workers to access public assistance; 45% of direct care workers live in or near poverty, and 47% access some form of public assistance, such as food and nutrition assistance, Medicaid, and/or cash assistance.

Within an already marginalized workforce, disparities abound. Women, people of color, and immigrants in direct care have long faced widespread gender inequality and racial discrimination in education and employment (among other areas), which contributes to ongoing disparities in earnings, as one example.¹⁰ The median earnings for women of color in direct care is \$37,600, and 53 percent of women in color in this workforce live in or near poverty, compared to \$47,100 and 38 percent among white men in direct care, respectively.

Wages for direct care workers are neither livable nor competitive. Our research shows that in all 50 states and the District of Columbia, the direct care worker median wage is lower than the median wage for other occupations with similar entry-level requirements, such as janitors, retail salespersons, and customer service representatives.¹¹ In 46 states and the District of Columbia, the direct care worker median wage is less than a dollar higher than the median wage for occupations with *lower* entry-level requirements (like housekeepers, groundskeepers, and food preparation workers).

The training landscape for direct care workers—including its standards, curricula, and general infrastructure—also presents enormous challenges to ensuring that these workers succeed in their roles.¹² Throughout the country, training requirements for direct care workers are insufficient and vary widely across states, long-term care settings, and job titles. (Federal requirements apply to home health aides and nursing assistants but not personal care aides, the largest growing segment of this workforce.) Moreover, disjointed training regulations make it difficult for workers to translate their experiences across settings (from home care to residential care, for example), limiting their career mobility and the versatility of the workforce overall, a limitation exposed and amplified during the COVID-19 pandemic. (Given that training requirements vary by state, credentials for direct care workers are also not portable across states—another barrier during this pandemic.) Direct care workers also struggle with limited advancement opportunities, poor supervision, and limited respect and recognition on the job, yet workforce interventions that would better prepare and support workers in this job sector are limited.¹³

Poor job quality in direct care affects everyone in the long-term care system. Workers experience heightened economic insecurity and are often forced to leave this sector for other fields. (Two recent studies showed that the turnover rates for nursing home staff and home care workers are 99 percent and 65 percent, respectively.¹⁴) Poor job quality can also be dangerous for workers

and clients; in 2016, the injury rate per 10,000 workers was 144 injuries among personal care aides, 116 among home health aides, and 337 among nursing assistants—compared to 100 per 10,000 workers across all occupations in the U.S.¹⁵ As a result of poor job quality, their employers—home care agencies, nursing homes, and a range of residential care providers—struggle to recruit and retain workers. This challenge will magnify in the years ahead; between 2019 and 2029, the long-term care sector will need to fill about 7.4 million job openings in direct care, including the 1.3 million new jobs referenced earlier and an additional 6.2 million jobs that will become vacant when workers leave the field or exit the labor force altogether.¹⁶

Consumers and their family caregivers (broadly defined to include families of choice) also suffer the impacts of poor job quality. Without proper training or advanced roles that equip workers and optimize their contribution (as two examples), older adults and people with disabilities cannot receive quality care. High turnover among these workers also disrupts continuity of care and at its worst, means that some consumers do not receive support at all. Moreover, many family caregivers rely on direct care workers for respite and support—and without this assistance, must deal with the severe financial and emotional challenges of caregiving on their own, including the need to limit work or leave their jobs entirely.¹⁷

The COVID-19 crisis has amplified all these challenges—disproportionately harming older adults and people with complex conditions across LTSS settings and reinforcing the essential yet undervalued nature of the frontline workforce that supports them. It has become devastatingly clear that this job sector deserves a significant federal investment to improve direct care job quality and strengthen and stabilize this workforce, now and for the future.

THE DIRECT CARE OPPORTUNITY ACT

The Direct CARE Opportunity Act would help address many of the challenges outlined above by investing more than \$1 billion (or \$300 million per year) over five years (through 2027) in recruitment, retention, and advancement strategies in direct care, designating at least 30 percent for advancement opportunities.¹⁸ Among the Act's requirements are: detailed planning and needs assessments from grant applicants, including examinations of the populations being served and projections of unmet need and direct care job openings at the local level; consultations with the people being served (and related experts) as strategies are developed; and a direct care wage and benefits assessment.

A few critical dimensions of this bill include: its focus on high-demand geographic areas (including rural and urban areas) and demographic diversity (to identify and support more vulnerable populations of workers and consumers); and its robust requirement for evaluating the impact of all funded interventions on employment, care, and cost outcomes, which would boost the evidence base on workforce interventions in this field.

In many parts of the country, direct care workforce interventions have led to positive outcomes for workers, employers, and consumers. Yet these interventions need significant funding to be extended, replicated, and brought to scale to reach larger and growing populations of workers—and new interventions are needed to address the many challenges facing these workers described above. Moreover, the large-scale investment from the Direct CARE Opportunity Act would allow for national coordination and evaluation, ensuring that federal leaders invest in the most effective and essential strategies for the future. The job transformation it would create in direct care would also promote economic development, given that high quality jobs increase consumer spending, decrease public assistance rates, reduce costly turnover, and promote cost savings in health care spending.¹⁹

Funding is especially needed to implement and evaluate direct care workforce interventions that:

- Effectively deliver entry-level and specialized training, advanced roles, recruitment and retention, supervision, e-learning, and technology;
- Create new models of service delivery across long-term care settings, including universal worker roles, models that connect workers to other services (such as housing supports), and models that maximize the direct care role through upskilling, care integration, and meaningful career ladders;
- Strengthen workers' abilities to support individuals with dementia and other prevalent chronic conditions; individuals dealing with social isolation and loneliness and other issues related to mental health; more vulnerable people, such as people of color and LGBT individuals; people living in neglected regions of the country, including both rural and urban areas; and the new population of individuals living with long-term COVID-19 complications; and
- Adequately fund evaluations of these interventions to assess their impact on workers, employers, and the outcomes often sought by LTSS payers: primarily positive client health outcomes and reductions in health care spending.

EXAMPLES OF DIRECT CARE WORKFORCE INTERVENTIONS

Over the years, workforce development leaders and other innovators have designed, implemented, and evaluated a range of interventions for the direct care workforce. Below are examples of interventions that illustrate the potential of the Direct CARE Opportunity Act.

- **To upskill home care workers to better support consumer health in Arkansas, California, Hawaii, and Texas**, a training program that reached nearly 3,500 home care workers showed improvements in workforce retention, among other outcomes.²⁰
- **To promote care integration for home care workers in California**, a competency-based training for more than 6,000 home care workers improved recruitment and

retention, reduced repeat emergency department visits and rehospitalizations, and generated cost savings of as much as \$12,000 per trainee.²¹

- **To create advancement opportunities for home care workers in New York**, a partnership between a managed care plan and three home care providers created a salaried advanced role focused on care transitions that reduced emergency department visits and caregiver strain.²²
- **To enhance training and supports for home care workers in Washington State**, a training program has provided more than 6 million hours of entry-level training and continuing education, as well as medical, prescription, vision, hearing, emotional wellness and dental plans for workers, a retirement plan, and employment services.²³
- **To develop the nursing assistant workforce in Wisconsin**, a pipeline-development program worked with community colleges and other training sites statewide to train thousands of workers and place them in nursing home jobs, boosting the labor pool.²⁴
- **To strengthen the pipeline of home care workers in New Mexico**, a Spanish-language, 15-week program trains immigrants as home care workers, providing scholarships to cover the costs of tuition and childcare.²⁵
- **To help home care consumers and independent providers connect with one another online in California**, four Centers for Independent Living offer a QuickMatch matching service registry.²⁶
- **To improve recruitment and retention of home care workers in New York City**, a partnership with three home care agencies relied on targeted recruitment, a train-the-trainer program, peer mentoring, and supportive services and case management.²⁷
- **To improve recruitment of direct care workers in rural Minnesota**, a social media campaign used paid ads to target key groups of potential workers and encourage them to apply online through their mobile devices, improving recruitment and hiring figures.²⁸

While these interventions have helped their participants and advanced the long-term care field, they represent a small fraction of the approaches needed to support this rapidly growing workforce and the individuals it supports. The limited scale and early success of these interventions affirm that a robust, targeted, and coordinated investment in direct care workforce interventions will more effectively move the needle on training, advancement, and recruitment and retention throughout the country.

CONCLUSION

The Direct CARE Opportunity Act would provide a much-needed investment in interventions that strengthen and stabilize the direct care workforce, a rapidly growing workforce that provides essential services and supports for millions of older adults and people with disabilities. It would improve their jobs and economic security, facilitate recruitment and retention among their employers, improve care for their clients and residents, and promote economic development—all

while building the evidence base on effective interventions for this job sector. We encourage Congress to enact this bill and begin transforming this critical workforce.

- ¹ Except where otherwise indicated, all direct care workforce data presented here are cited from: PHI. 2020. *Direct Care Workers in the United States: Key Facts*. Bronx, NY: PHI. <https://phinational.org/resource/direct-careworkers-in-the-united-states-key-facts/>.
- ² Vespa, Jonathan, Lauren Medina and David M. Armstrong. 2020. *Demographic Turning Points for the United States: Population Projections for 2020 to 2060*. Washington, DC: U.S. Census Bureau. <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf>.
- ³ Campbell, Stephen. 2021. "Will COVID-19 Change Direct Care Employment? New Data Offer Clues." PHI Newsroom, April 12. <https://phinational.org/will-covid-19-change-direct-care-employment-new-data-offer-clues/>.
- ⁴ Scales, Kezia. 2019. *Envisioning the Future of Home Care: Trends and Opportunities in Workforce Policy and Practice*. Bronx, NY: PHI. <https://phinational.org/resource/envisioning-the-future-of-home-care-trends-and-opportunities-in-workforce-policy-and-practice/>.
- ⁵ U.S. Department of Health and Human Services. 2021. *Projections of Risk of Needing Long-Term Services and Supports at Age 65 and Older*. Washington, DC: HHS. <https://aspe.hhs.gov/system/files/pdf/265136/LTSSRisk.pdf>.
- ⁶ Musumeci, MaryBeth, Molly O'Malley Watts, and Priya Chidambaram. 2020. Key State Policy Choices About Medicaid Home and Community-Based Services. San Francisco, CA: Kaiser Family Foundation. <https://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medicaid-Home-and-Community-Based-Services>.
- ⁷ Hudson, Robert B. 2017. "The Need for and the Needs of the Direct Care Workforce." *Public Policy & Aging Report* 27(3):81-83. <https://doi.org/10.1093/ppar/prx019>.
- ⁸ Scales, Kezia. 2020. *It's Time to Care: A Detailed Profile of America's Direct Care Workforce*. Bronx, NY: PHI. <https://phinational.org/resource/direct-care-work-is-real-work-elevating-the-role-of-the-direct-care-worker/>.
- ⁹ Kaiser Family Foundation. 2015. *Medicaid and Long-Term Services and Supports: A Primer*. San Francisco, CA: KFF. <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.
- ¹⁰ Campbell, Stephen, Angelina Del Rio Drake, Robert Espinoza, and Kezia Scales. 2021. *Caring for the Future: The Power and Potential of America's Direct Care Workforce*. Bronx, NY: PHI. <http://phinational.org/caringforthefuture/>.
- ¹¹ Espinoza, Robert. 2020. *Competitive Disadvantage: Direct Care Workers Are Lagging Behind*. Bronx, NY: PHI. <https://phinational.org/resource/competitive-disadvantage-direct-care-workers-are-lagging-behind/>.
- ¹² Drake, Angelina. 2020. *Direct Care Work Is Real Work: Elevating the Role of the Direct Care Worker*. Bronx, NY: PHI. <https://phinational.org/resource/direct-care-work-is-real-work-elevating-the-role-of-the-direct-care-worker/>.
- ¹³ Meek, Suzanne, and Howard B. Degenholtz. 2021. "Special Issue: Workforce Issues in Long-Term Care." *The Gerontologist* 61(4).
- ¹⁴ Gandhi, Ashvin, Huizi Yu, and David C. Grabowski. 2021. "High Nursing Staff Turnover in Nursing Homes Offers Important Quality Information." *Health Affairs* 40(3). doi.org/10.1377/hlthaff.2020.00957; and Holly, Robert. 2021. "A Huge Victory: Home Care Turnover Remains Stable at 65.2%." *Home Health Care News*, May 19. <https://homehealthcarenews.com/2021/05/>.
- ¹⁵ Campbell, Stephen. 2018. *Workplace Injuries and the Direct Care Workforce*. Bronx, NY: PHI. <https://phinational.org/resource/workplace-injuries-direct-care-workforce/>.
- ¹⁶ Campbell, 2021.
- ¹⁷ AARP and National Alliance for Caregiving. 2020. *Caregiving in the U.S.* Washington, DC: AARP and NAC. <https://www.caregiving.org/caregiving-in-the-us-2020/>.
- ¹⁸ Direct CARE Opportunity Act (H.R.2999-117th Congress (2021-2022)). May 4, 2021. <https://www.congress.gov/bills/117/congress/house-bill/2999>.
- ¹⁹ Weller, Christian, Beth Almeida, Marc Cohen, and Robyn Stone. 2020. *Making Care Work Pay: How Paying at Least a Living Wage to Direct Care Workers Could Benefit Care Recipients, Workers, and Communities*. Boston, MA: LeadingAge LTSS Center @UMass Boston. <https://leadingage.org/making-care-work-pay>.
- ²⁰ Ahn, Roy. 2017. *HCLA Complex/High-Risk Patient Targeting: Third Annual Report*. Bethesda, MD: NORC at the University of Chicago. <https://downloads.cms.gov/files/cms/hcla-chopt-thirdannualrpt.pdf>.
- ²¹ Gallup, Amber, Judith Balazs Tomasson, and Vanessa Svihla. 2018. "Empowerment and Constraint: Design of a Homecare Worker Training Program." *International Journal of Design for Learning* 9(1): 149-157.

- ²² Scales, Kezia. 2017. *Success Across Settings: Six Best Practices in Promoting Quality Care through Quality Jobs*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2017/09/evaluation_brief_final.pdf.
- ²³ SEIU 77 Benefits Group. "About Us." <https://www.mysciubenefits.org/about/>.
- ²⁴ Wisconsin Department of Health Services. "WisCaregiver Career Program." <https://www.dhs.wisconsin.gov/caregiver-career/index.htm>.
- ²⁵ Encuentro. "Home Health Aide: A Worker-Centered Career Development Program for Home Health Care Providers." <https://encuentronm.org/home-health-aide-2/>.
- ²⁶ Campbell, Stephen. 2019. "How Can Matching Service Registries Recruit New Online Users?" *PHI Newsroom*, February 19. <https://phinational.org/how-can-matching-service-registries-recruit-new-online-users/>.
- ²⁷ Feldman, Penny H., Miriam Ryvicker, Lauren M. Evans, and Yolanda Barrón. 2019. "The Homecare Aide Workforce Initiative: Implementation and Outcomes." *Journal of Applied Gerontology* 38(2): 253-276.
- ²⁸ Espinoza, Robert. 2018. "Will Social Media Rescue Recruitment in Long-Term Care?" *PHI Newsroom*, June 14. <https://phinational.org/will-social-media-help-rescue-long-term-care/>.

Chairman DESAULNIER. Thank you, Mr. Espinoza, and thank you on the time. And thank you for your work as Vice President of Policy at PHI. I need to wear my glasses when I read.

I now recognize Mr. Torres—Ms. Torres.

STATEMENT OF ZULMA TORRES, HOME HEALTH AID, COOPERATIVE HOME CARE ASSOCIATES

Ms. TORRES. Good morning. Thank you to the Members of the Committee for inviting me to speak today.

My name is Zulma Torres. I am a wife, a mother, and a grandmother. I have worked at Cooperative Home Care Associates as a home health aide for over 23 years. I am also a proud Member of the 1199 SEIU Labor Union.

I am very honored to have the opportunity to bring my voice to support your efforts to make our jobs better and help our union. My company employers and training providers provide better programs and services. My training to become a personal care aide and home health aide was intense. Attendance, punctuality were very important. And if you were late or missed a day, you had to make up the work you missed. We learned and practiced demonstrating the required skills.

Cooperative wanted to make sure new recruits were serious about the work. At first, the job was challenging. I went into strangers' home introducing myself, and then providing some of the most intimate care and assistance possible. I learned early on that I had to understand my clients' situation and put myself in their shoes. I had to separate my personal feelings from my personal responsibilities.

My employer, Cooperative, is one of the best, both because it is a union employer, and is a worker owner. Cooperative supports us, and we have the opportunity to purchase a share of the company. We have financial literacy classes and peer mentoring to help with difficult work assignments. There are also opportunities to become promoted into office-based jobs.

Also, I am grateful to be part of the 1199 SEIU Union with 60,000 home care workers. In 2018, the union fought to increase

our wages to \$15 an hour. Now that minimum wage is in New York City.

We have health insurance, dental, a Member assistance program, and a home care pension benefit. We also have education benefits that cover everything from citizenship program, to register apprenticeships, to college tuition vouchers.

Now, the union is fighting for higher wages and to keep our great benefits. We should be salary workers with guaranteed hours. Home care worker is not minimum wage work. The union gives me a voice, advocates for us, and allows us opportunities like this to testify in front of Congress.

Today, I am happy to say that I am a home care worker, and we need more people to come—to go into the role so that they can live with dignity in their community and be able to stay in their home instead of high-cost emergency room visits and hospitalizations or be moved into an institution.

We need to make home care jobs good union careers with opportunities for care—for careers, advancement of higher wages. The quality of the job must improve with excellent recruitment, training, scheduling, and a good supervision worker opportunity, so they stay in the field.

This is why President Joe Biden committed to investing in home and community care jobs and providing workers with better opportunities to join unions as part of the Build Back Better Plan. It is so exciting.

Finally, I am happy that home care and community care workers are being treated as essential workers that we are.

Thank you.

[The prepared statement of Ms. Torres follows:]

PREPARED STATEMENT OF ZULMA TORRES

Testimony to the House Committee on Education and Labor
Health, Employment, Labor, and Pensions Subcommittee and Higher Education and Workforce
Investment Subcommittee

“Care for Our Communities: Investing in the Direct Care Workforce”

Zulma Torres, Certified Home Health Aide/Personal Care Aide Worker and 1199SEIU Member

Thank you to the Members of the committees for inviting me to speak today. My name is Zulma Torres. I have worked at Cooperative Home Care Associates, a worker-owned licensed home care service agency located in the Bronx, New York for over 23 years and I am a proud member of 1199SEIU United Healthcare Workers East. I am also a wife, the mother of three children, and a grandmother.

In this written testimony, I hope to address the following topics:

- The experience of entering the home care field in terms of the training requirements and what it takes to stay employed.
- The role and responsibilities of being a home health aide and personal care aide and what the work is like- both the challenges and the rewards
- The advantages of being a member of the 1199SEIU labor union and working at the largest worker-owned cooperative in the United States (or this country)
- How everything has changed since the onset of the Covid-19 pandemic, and
- The need for continuous training and support to do the work

I am writing to share my experience as a home care worker working in New York City. There are parts of the work that I treasure that have made me a much better human being. And there are elements of the work that need improvements. I am very honored to have the opportunity to bring my voice to the discussion to support legislation that will make our jobs better and help our union, my company and employers, and training providers be able to provide better services.

Becoming a home health aide.

It was almost 24 years ago when I bumped into my sister-in-law, Beatrice. She was coming from an orientation session for people exploring home care jobs at Cooperative Home Care Associates which was then located in the South Bronx. She suggested that I take a look into the program – maybe it could work for me. I took her advice. I thought about it that day, and the next morning I took the bus over to their office in August of 1997. I didn’t really know what to expect. They took my information at the front desk and told me everything that I needed to bring when I came back for the orientation. The process was very clear and I was clear that if I was able to attend the home health aide training program and learn the skills in class, that I would get a job working as a home health aide. The training was not easy and unfortunately, and while the training program at Cooperative Home Care was free there was no financial support to help with transportation or money for food or childcare while in the training. Fortunately, Cooperative Home Care Associates had a workforce development and training team with counselors that helped me learn how to access vouchers for childcare and told me the steps I would need to take to apply for benefits I was eligible for.

The training was serious. Attendance and punctuality were very important, and if you were late or missed a day, you had to have a really good reason and make up the work you missed. I could tell from the beginning that Cooperative wanted to make sure only the new recruits that were serious about the work made it to the end to get hired. I was glad to be one of those people, but I was also very nervous about the work. I was expected to go into a stranger's home, introduce myself, and then provide some of the most intimate care and assistance possible, as well as assist with grocery shopping, cooking, and housekeeping.

Working as a home health aide.

I must be very honest - I did not like my job in the beginning. There were some very challenging moments. I particularly remember one case in Brooklyn with a client who was very challenging and distrustful of having someone in her home, that taught me the patience and compassion that I carry with me to this day. This early experience allowed me to be more reflective and understanding of my clients' situations. From that point on I learned to put myself in my clients' shoes and separate my personal feelings from professional responsibilities. The passion that I have for my job now was born out of these early struggles with clients.

The hardest part of the job these past 23 years is that each patient and family that I have worked with has its own unique needs. Sometimes the most important element of the work is cooking- and if you do not prepare the food just right, it can damage your relationship with the client. Then, there have been patients that require a lot of physical support. They need help ambulating both in the house and when we go outside. In the house they need assistance to move from their bed to a chair or to the commode. Also, they need help going to doctors' appointments or to the park for fresh air. Some clients want to talk a lot. Some are very reserved and quiet. Often there are family members and family dynamics where I must be very careful to distance myself and sometimes require me to report information to my supervisor. I must be watchful and exercise compassion and sound judgement. It takes a lot of patience, good listening and communication, and a lot of adjusting to deal with these parts of the job.

In addition, home health aides have to assist with medical needs as well. So many of my patients are on so much medication. I am not allowed to give them medication, but I remind them when to take it and help them keep track of when refills are necessary. I help my patients by arranging transportation and escorting them to appointments for medical procedures like dialysis and podiatry. I also accompany them to their doctors' appointments and help them prepare by making a list of their medications and sometimes reminding them about symptoms they experienced or other things they may want to discuss with their doctor. In my role, I also observe and track my client's symptoms and changes to report to my supervisor at Cooperative. This can be very difficult because some patients allow their aide to be very involved and some are very private. You must work with them and show that you are there to help them. How you communicate really matters. I know that I can make the most difference in my patients' health when our communication is open and when they feel safe sharing with me. Sometimes they don't want their family members to know all of their business and they confide in me. I really take the time to get to know and understand my patients' needs.

Another part of the job with being a home health aide is administrative. Things have changed a lot over the years. We used to have to fill out a lot of paper work. Now, we have to use our cell phones to check

in and out of work using an app. We are also using cell phones, tablets or computers for training. Some older workers struggle if they have not kept up with technology. Still, it is important to write everything down when speaking to the office, especially when reporting things that happen with your client, or travel instructions for new cases. And it is very important to plan ahead when you are going to take time off. Otherwise, it's possible your patient will go without anyone caring for them and this is not acceptable for patients that don't have family or friends to fill in for their home health aide. I really try to put myself in the client and family's shoes while handling the work and making decisions. I want to treat them the way that I would want to be treated- with kindness and respect. Planning ahead is part of that- and it is not always easy, especially when also caring for your own family and the unknowns that come up. This work takes a lot of dedication and compassion.

Working during the Covid-19 pandemic

I worked on the front lines during Covid-19. It affected me and my family just like everyone else. It was scary not knowing what to expect, but as a home health aide I was determined to continue working with my clients because I know they needed me. I protected myself, I followed every protocol I had to at work and used the same protocols at home. My family enforced the same routines of wearing masks, wiping down surfaces with disinfectant, frequently washing our hands and every protection we could to keep our environment safe.

Traveling on subways and on the Metro North railroad was scary, but I thank God I was able to do it and I continue doing it today. In the beginning there were shortages of PPE, and I heard some workers had to take their own money to buy hand sanitizer and face masks. Thankfully at Cooperative the company was able to provide PPE to worker. We even received a large shipment of masks, gowns and face shields produced by another worker owned cooperative in North Carolina. I did not want to get sick, so I had to do whatever it took to feel comfortable with my patients and their family members. I feel my services are very necessary as a home health aide even though it seems we are at the bottom of the list for recognition. We cannot do our jobs from home—we have to go to our patients' home and hope that you don't bring infection to your client or back to your family. I worry about what will happen if my client gets Covid? What will happen if I get infected and infect my family and grandchildren? But, if I do not work, I cannot pay my bills. It is that simple. Homecare workers are heroes too, but we are never on the news.

It is time for us to be heard and that is something I am proud to be a part of now. It is awesome that I am sharing my experiences to inform what will be a very positive change for my fellow home care workers and union sisters and brothers. I will continue doing my job the best that I can. During Covid, even though we all worked at different sites, we had a team that we formed to protect one another the same way we protected our clients. We shared with each other where to get cleaning supplies when they were sold out at many stores and would pick up supplies at work and share with each other when more than one aide worked with a patient. I had to keep telling myself "It's OK. I can do this," and I have continued, and I will continue protecting myself until we eliminate the virus.

Advantages of working for a worker-owned employer that is part of a labor union

My employer, Cooperative Home Care Associates (CHCA) has around 2000 home health aides. Before COVID, there were many more, but things are very different. A lot of workers still do not feel safe going into homes- and a lot of patients do not want aides coming into their homes. I am getting called to cover extra shifts all the time because there are just not enough home care workers. I am also fortunate to participate in CHCA's guaranteed hours program that ensures that I am paid for a minimum of thirty (30) hours per week, even when the company does not have work for me.

My employer is one of the best – both because it is union employer and is worker owned. The mission is quality care through quality jobs and most people start at CHCA through their Home Health Aide Certification Training Program. The program builds the work culture- so aides know what to expect, understand the importance of their role and learn how to communicate well and take care of business. CHCA also has a lot of support for us. Everyone is offered the opportunity to purchase a share of the company and become an owner- and all owners get one vote. We have workers who are on the Board of Directors and the company holds meetings so we can learn about the business of homecare, ask questions, and participate in decisions. We also have programs like financial literacy and peer mentoring for support with difficult work assignments and to improve our skills and knowledge. There are also opportunities to advance and be promoted into office-based jobs.

Now that I have more experience, I have a hunger to be more involved with my 1199 labor union and Training and Employment Funds. All home health aides in New York State must have twelve hours of in-service instruction every year to maintain their HHA certification. CHCA provides those trainings and partners with the 1199SEIU Training and Employment Funds (TEF) where workers can enroll in education programs. TEF has classes and programs that thousands of workers take advantage of to achieve their personal and professional goals education and training goals. There are Citizenship classes, English for Speakers of Other Languages, High School Diploma and College preparation classes and Tuition Vouchers and Scholarships for home health aides. There are many programs to build skills as well. The 1199SEIU union and TEF have many registered apprenticeship programs to help workers learn on the job while preparing for career upgrades. There are several HHA Apprenticeships such as learning to become a HHA Peer Trainer or HHA Specialties. TEF has also registered apprenticeships for Certified Nurse Aide, Certified Central Sterile Technicians, Licensed Practical Nurse, Medical Coder, Patient Care Technician, and Community Health Worker. My employer has participated in the agreements required to provide pay while on the job learning in the HHA Apprenticeships with TEF. Earlier this year, I participated in TEF's Health and Wellness Initiative – a series of webinars: Dealing with Grief and Loss; Understanding Anxiety; Understanding Depression and Trauma Informed Care. So many of us home health aides and health care workers really needed these webinars to know that our stress and experiences during Covid were acknowledged and supported. The live webinars were very helpful. TEF also provided a \$25 pre-paid debit card for each webinar we attended. It really helps to receive paid release time or stipends to attend training sessions because otherwise, workers like me must choose between going to work because we need the money or losing work time to attend training. We should not have to make that choice since we need both.

As of now, I plan to attend as many webinars as possible, especially since I can do it from my smart phone. New technology helps us access training and to stay connected. Face-to-face meetings and classes are important, but I am glad we learned to use other tools like zoom and certain phone apps to help us get access to training and to attend union teletown halls to get information and to ask questions, especially early in the pandemic

Also, I am so grateful to be part of the 1199SEIU labor union. The union created the Training and Employment Funds and TEF is very worker centered and makes sure they are putting together training programs that meet our needs. The union also fought for us to have our wages increased to \$15 in 2018 which is now the minimum wage in New York City. We also have comprehensive health insurance, dental coverage, a members assistance program, and a home care pension benefit. The union seeks our input and responds to help meet our needs and that is especially important for workers like me so we do not feel isolated and alone since our work is in people's homes. As is the case in my company, my union provides a true community where I am able to connect with other workers and we learn and share with each other. Not only is the union fighting for more programs and support for home care workers, but also for higher wages with benefits. Homecare work, in my opinion is closer to nursing care than to traditional minimum wage jobs. Homecare is not minimum wage work. I feel very supported that 1199SEIU gives us a voice in our work, advocates for improvements like more funding for wages, benefits, and training services, and with opportunities like this to testify in front of Congress.

Conclusion

Home care workers are responsible for saving lives and we just do not get the credit and recognition. We are a critical part of the care for elderly, those living with a disability and sick people, but we are not seen or appreciated. Sometimes I just feel that I want to be known, not as just "the girl" or "the help" but as a part of the health care team that makes a difference in so many people's lives. I know that I am doing better than many HHAs in the US because I have a union job and the opportunity to own a share in my cooperative, but minimum wage is not enough. Home health aides are providing an essential service. When I walk into a patient's home, I see the relief and sometimes the smile on their face acknowledging not only that they need me, but that I have helped them remain in their home instead of in a hospital or nursing home. We should be salaried workers with guaranteed hours, not hourly workers that have to manage the uncertainty of how many hours we will have in our paycheck from week to week.

Today, I am happy to say that I am a home health aide. But we need to make sure that more people have access to these essential services we provide that allow home care recipients to live with dignity in the community. To make that a reality we need to make home care jobs good union careers with opportunities for advancement and wage gains along a career ladder. I believe that this is the only way to make sure that there are enough home care workers to meet the growing demand. I am blessed to work for Cooperative Home Care Associates and be part of 1199SEIU, but many homecare workers do not have quality jobs and that keeps people away from wanting to do this very difficult and much needed work. The quality of the job must improve, and employers must have good practices to recruit, train, schedule and supervise workers appropriately so they stay in the field. And literally, having enough home care workers makes the difference between someone being able to stay in their home or have more frequent higher cost emergency room visits and hospitalization or must leave their home and family and be moved into an institution. This is why President Joe Biden's commitment to investing in home and community care jobs and providing workers with better opportunities to join unions as part of the build back better plan is so exciting. Finally, homecare and community care workers are being treated as the essential workers that we are.

Chairman DESAULNIER. Thank you, Ms. Torres, very much. Thanks for being here.

We will now go to Mr. Burani.

Mr. Burani, you are on for five minutes.

STATEMENT OF PAUL BURANI, HEAD OF BUSINESS DEVELOPMENT, NORTH AMERICA UDACITY, INC.

Mr. BURANI. Thank you.

Good morning, Chairwoman Wilson, Chairman DeSaulnier, Ranking Member Murphy, Ranking Member Allen, and Members of the subcommittees. Thank you for the opportunity to appear before

the subcommittees to discuss workforce development in the United States.

I serve as head of business development for public-sector partnerships at Udacity, an online education platform committed to preparing the Nation's workforce for the careers of the future.

In today's world, technology is advancing at an accelerated pace. Corporations have invested about \$2 trillion in digital transformation to avoid getting left behind. Leveraging these technologies requires them to adapt, but executives consistently rank the shortage of skilled talent as their No. 1 risk factor. But they are not the only ones with something to lose.

A recent McKinsey Report had estimated that automation will displace up to 800 million jobs by the year 2030. Many of these jobs will be in the U.S. If we don't plan appropriately, that skill gap will widen, causing irreparable damage to our economy.

At Udacity, closing this skill gap is what we do. We design our curriculum with tech industry partners like Google, Amazon, Microsoft, and IBM. We deliver it through our Nanodegree programs, which provide instruction for employable technical job skills in fields like programming, data science, cybersecurity, and artificial intelligence.

These programs include both coursework taught by the experts and hands-on projects for students to demonstrate competency as practitioners in their field.

Udacity has educated over 15 million learners worldwide. We work with over 110 corporate clients, companies like Shell, Credit Suisse, Airbus, Mazda, and the U.S. Air Force. They trust us to help their employees acquire the skills needed to accelerate their company's digital transformation.

And, in the public sector, we upskill government employees, we build partnerships for social impact, and we run ambitious workforce development initiatives.

The reauthorization of the Workforce Innovation and Opportunity Act, or WIOA, presents a world of possibility. Our workforce system has successfully trained millions, but it needs to be modernized. Employers still face challenges hiring and retaining skilled talent, and millions of unemployed and underemployed Americans deserve a chance to land in a motivating career with growth potential.

To unlock this possibility, we can start with proposed structural changes. WIOA maintains a vast array of data about education providers, their programs, and performance. But these systems use outdated mechanisms, and are siloed by State, creating administrative burdens. Funding is mainly allocated locally to distinct workforce areas, raising barriers between employers and citizens across geographies, including those aligned to remote work.

Let's envision a WIOA system in which funding, governance, and operations are all executed at a more aggregated level, and support that with incentives for neighboring workforce areas to collaborate. Providers could better tailor their solutions to fit market needs. The system would enjoy better budget utilization, helping it educate more citizens, and job seekers would benefit from more diverse choices in the marketplace.

Next, we will look at channel investment. Among the diverse WIOA stakeholders, consider community colleges, for example. They have a history of thriving in the U.S. workforce system with strong employer connections, but they also have gaps in their curriculum, which could be addressed through partnerships with other providers.

Another example is the relationship between workforce boards and the public. They sponsor programs that need to inspire citizens to summon all their motivation and commit to self-improvement. It is a pretty tall order.

A more modern WIOA would increase its focus on marketing and operations to help the public better understand the role of the workforce system, and the opportunity it can deliver. This would improve the utilization of WIOA funds, speed up the delivery of solutions, and create a better fit between citizens' needs and the programs they pursue, leading to better performance outcomes overall.

Finally, a word about labor market innovation. The pace of technological change has created ripple effects that impact many facets of modern life. Consider the word "ransomware," which has permeated our daily news cycle. In 2014, the first year of WIOA, it was barely a part of the public lexicon, but this world is changing faster than ever before.

Investing in pathways to high-growth occupations helps to ensure that as trends like ransomware evolve, our solutions to combat them evolve even faster. This fast-paced evolution also causes collateral damage in our communities. Some learners might just worry about graduating, but others have a host of curve balls to worry about. Maybe they lack healthcare, or they can't find a babysitter. Maybe they study from the one corner of the house that gets a free Wi-Fi signal.

The WIOA of today incentivizes important outcomes, but many people in distressed communities are structurally disadvantaged from achieving those outcomes and get turned away. The WIOA of tomorrow should level the playing field for them, too.

We are here today because we know what the U.S. workforce system is capable of achieving. A more modern dynamic WIOA could help to fulfill that potential.

Thank you for listening and for joining the cause.

[The prepared statement of Mr. Burani follows:]

PREPARED STATEMENT OF PAUL BURANI



**HEARING BEFORE THE UNITED STATES REPRESENTATIVES
COMMITTEE ON EDUCATION AND LABOR
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND
PENSIONS AND THE SUBCOMMITTEE ON HIGHER EDUCATION AND
WORKFORCE INVESTMENT**

"Care for Our Communities: Investing in the Direct Care Workforce"

Tuesday, July 20, 2021, at 10:15 am (Eastern Time)
Written Testimony of Paul Burani
Head of Business Development in North America
Udacity

Chairwoman Wilson, Chairman DeSaulnier, Ranking Member Murphy, Ranking Member Allen
and Members of the Subcommittees.

Thank you for the opportunity to appear before the subcommittees to discuss workforce
development initiatives in the United States. Udacity is committed to preparing the nation's
workforce for the skills necessary for the careers of the future

I serve as Head of Business Development for public sector partnerships at Udacity. My team is
responsible for developing government and donor funded programs, to implement large
capacity building initiatives that upskill citizens from diverse backgrounds in North America.

In today's world, technology is advancing at an accelerated pace. Companies that do not
embrace digital technologies risk getting left behind. Yet the adoption of digital transformation
strategies requires skilled talent, and around the globe, employers face a growing challenge to
find the right talent to be able to thrive and grow. Consider the following points:

- An estimated 75 million jobs may be disrupted by machines and automation in the next five years, according to the World Economic Forum. ([WEF](#))
- Automation will displace 800 million jobs by 2030. ([McKinsey](#))
- Up to 375 million people will need to change jobs during that same span. ([McKinsey](#))
- Nearly nine in ten executives and managers say their organizations either face skill gaps already, or expect gaps to develop within the next five years. ([McKinsey](#))

- Worldwide spending on digital transformation is projected to grow 17% annually to reach \$2.3 trillion by 2023. ([IDC](#))
- "Talent shortage" is ranked by corporate executives as the #1 risk to organizational change. ([Gartner](#))

Udacity was founded in 2011, with a mission to train the world's workforce in the skills and careers of the future. We achieve this by helping to close the technology skill-gap that has become the critical and one of the top-most priorities for business leaders.

Our curriculum is designed in close partnership with the technology industry. Udacity works with 200+ industry experts who help build our content; these partners are among the world's most forward-thinking companies and industry luminaries, including Google, Amazon, Microsoft, Intel, Salesforce, Facebook, IBM, AT&T, and others. Our customers include a wide-ranging base of small and large entities including: Shell, Leidos, Airbus, Credit Suisse, Mazda, and the U.S. Air Force.

Udacity's curriculum is primarily delivered through our Nanodegree programs, which provide practitioner-level instruction or mastery for an employable technical job-skill. The Nanodegree program is a projects- and skills-based educational credential, consisting of a recommended set of courses, each aligned to a specific project.

Courses: These are the building blocks of each Nanodegree, and each course consists of online lessons designed to assist learners with the creation and successful completion of a relevant and practical project portfolio. They are taught by experts in their fields, and individually supported by technical experts and mentors.

Projects: Our projects are hands-on, based on real-world scenarios, and designed to demonstrate competency and build practitioner-level skills in a particular job field. Their focus is not merely to test skill level, but to give learners a chance to gain mastery in that specific technology.

Because these programs teach hands-on, practitioner-level skills to those who will be implementing a specific technology, our graduates have the knowledge and ability to hit the ground running -- either in a new job, or within their current job responsibilities. Udacity's curriculum is organized across seven distinct schools:

- Data Science
- Artificial Intelligence
- Programming
- Autonomous Systems
- Cloud Computing
- Business
- Cybersecurity

As of today, we have a total of 65 Nanodegree programs across these seven schools, as well as about 200 free courses. We continually release new Nanodegree programs and also update existing ones to be current.

Our development of new curriculum is focused on meeting new challenges at the intersection of technology and industry. In the healthcare field, for example, we offer a Nanodegree program titled "Artificial Intelligence for Healthcare". In this program, students learn a number of advanced applications for AI, such as how to utilize data to build predictive models that have the power to transform patient outcomes. Phenomena such as wearable medical devices and telemedicine are transforming the industry, and programs like these give healthcare professionals a glimpse of a future career path that is very attainable.

Udacity has educated over 15.4 million learners in over 200 countries, with over 172,000 Nanodegree certificates granted. We have collected countless stories of direct impact on the livelihoods of individuals such as Ryan Waite. A native of Gaithersburg, Maryland, Ryan was working two minimum wage retail jobs when he was accepted to a 4-year university, but he decided not to attend, because of concerns about taking on student loans. Instead, he won a scholarship for a Udacity nanodegree program in Front End Web Development, which he parlayed into an internship at NASA. Today, he works for GitHub (a subsidiary of Microsoft), and credits Udacity with helping him unlock his opportunities:

"The Nanodegree program got me to where I wanted to go. It not only gave me the skills I needed, but it gave me confidence in those skills."

Udacity also works with over 110 corporate clients globally, helping their employees acquire tech-forward skills to accelerate digital transformation journeys in their respective organizations. These relationships span numerous industry sectors, including Financial Services, Oil & Gas, Telecom, Automotive, Media and Aerospace.

Beyond the private sector, we also work with numerous government and non-government agencies in North America, Europe, Asia, Middle East, and Africa. These entities use Udacity Nanodegree programs for a wide variety of initiatives, including:

- Workforce development for growing populations
- Internal government employee upskilling
- Part of government-run universities
- Public-private partnerships to drive social impact

The reauthorization of the Workforce Innovation and Opportunity Act (WIOA) represents a unique opportunity to align the U.S. workforce system with the trends and challenges outlined above. According to the Department of Labor, this legislation is designed to achieve the following:

- Strengthen and improve our nation's public workforce system

- Help get Americans, including youth and those with significant barriers to employment, into high-quality jobs and careers
- Help employers hire and retain skilled workers

Much progress has been made since it was signed into law in 2014, and seven years later, we see an opportunity to build on this progress. This can be accomplished with concerted efforts in three distinct areas: Structural Changes, Channel Investment and Labor Market Innovation.

Structural Changes

Overseeing the workforce system in a vast economy such as the U.S. requires many moving parts to work together in synchronicity. We propose the following improvements to the WIOA structure, in order to drive efficiencies within the workforce system. These changes would help facilitate the entry of new, dynamic providers of educational programs -- while removing barriers to modernization faced by existing providers.

1. **Create a more scalable registry of providers.** Every state maintains its own individual Eligible Training Provider List (ETPL). The process for providers to maintain their catalog of programs is different in every state, causing huge administrative burdens for new providers, including those focused on emerging occupations with strong growth trajectories.
2. **Facilitate the mobility of dollars across labor markets.** People often live in one place and work in another, but the WIOA system is largely built on supporting learners and employers simultaneously in a single workforce area. If there were more incentives to collaborate with neighboring workforce areas, it would minimize sunk costs for the workforce boards and help providers achieve better scale with their instructional programs.
3. **Build a WIOA system which creates more economies of scale while still maintaining individual accountability.** Applicants still need to go through 1:1 consultations. Talent liaisons at the American Jobs Centers (AJCs) need to review individuals' documentation to approve WIOA funding. Providers still need to produce an invoice for every single learner. These kinds of bottlenecks limit the efficacy of the workforce system. If more aspects of WIOA funding, governance and operations were able to be executed at a program or workforce area level, the system would succeed in educating more citizens -- and these citizens would benefit from more diverse choices in the marketplace.
4. **Increase accessibility and transparency for all program performance data.** Extracting program performance data is an arduous process unique to each state. A better alternative would be to maintain a single resource harmonizing all geographies, providers, occupations (SOC codes), instructional programs (CIP codes) and the WIOA performance metrics associated with each. With better visibility into system/program

performance across all aspects of the market, providers can better tailor their solutions to fit market needs, which would foster better budget utilization and create efficiencies through longer lasting partnerships.

5. **Remove barriers to accessing hardware and broadband.** Just 11% of households lack a computer, and 15% lack access to broadband, but for the subset of Americans who are the focus audience of workforce innovation programs, those figures are much higher. If a student does not have access to a computer with a high speed internet connection, this can be an immediate disqualifier for remote learning programs. Removing these barriers would increase the addressable market for new workforce solutions.

Channel Investment

Labor markets are notoriously complex and intertwined with the economy at a local, regional, national and global level. Today's workforce system invites participation from diverse stakeholders (academic institutions, vocational/trade schools, workforce boards, jobs centers, and a wide array of learner archetypes) -- but more can be done to facilitate their collaboration.

1. **Incentivize community colleges to partner with more nimble providers.** Community colleges maintain strong employer relationships, which keeps them firmly rooted in the WIOA system. If the system empowered them to reach out to non-traditional educational institutions to fill curriculum gaps, the result would be better overall utilization of WIOA funds, a better fit between citizens' needs and the programs they pursue, and better performance outcomes overall.
2. **Foster a more dynamic relationship between workforce board & learners.** Workforce boards see the employer as their primary stakeholder; they solicit needs, match to providers on the ETPL, and then work with Jobs Centers (i.e. the operational arms of the workforce boards) to populate the programs with qualified learners. The WIOA system should increase its focus on marketing operations, facilitating the efforts made by workforce boards to be out in front of their communities. This would speed up delivery of services and create better alignment between expectations and available solutions -- reducing strain on the AJCs and driving better performance outcomes overall.
3. **Create more effective mechanisms for individuals to invest in their own career transformation.** One weakness of the fully-funded scholarship model is that when a learner isn't investing their own money, this can dilute their incentive to persevere through a challenging program. System-wide, WIOA manages to graduate roughly 7 in 10 learners, indicating significant volumes of resources wasted on the remainder. The reauthorization of WIOA presents an opportunity to explore new mechanisms to minimize the out-of-pocket cost to a student, without defraying it completely. Diversifying

the options for an alternative student-funded model would augment the potential audience for workforce innovation programs.

Labor Market Innovation

Our modern economy is driven increasingly by the pace of technological change. This change creates ripple effects in labor markets which affect the livelihoods of countless Americans. Even in the seven years since WIOA took effect, technological change has dramatically changed many facets of modern life. The collection and utilization of massive data sets has altered the way products and services are built, delivered and experienced. Artificial intelligence is powering automation of business processes, transforming the economics of entire industries. Ransomware attacks and other breaches of cybersecurity increasingly permeate the news cycle. And entire communities are being excluded from the gains. Thus, many of the organizing principles at the core of our workforce system no longer apply in 2021. By incentivizing WIOA's scope from the perspective of both industry and citizens, the entire workforce system can achieve greater overall impact.

1. **Incentivize workforce boards to invest a greater share of budgets in high-growth occupations.** WIOA funds career pathways into a wide variety of occupations that provide living wages to many Americans; this impact can be augmented with added focus on emerging occupations which provide people with significant economic mobility. For example, there are currently almost 700,000 job openings nationwide for the occupation "Software Developers and Software Quality Assurance Analysts and Testers" (15-1253) at a median annual salary of \$115,000.
2. **Incentivize distribution of funding toward distressed communities.** Because WIOA accountability is based on the achievement of system-wide performance indicators (e.g. job placement, median earnings), disadvantaged citizens are structurally disadvantaged from benefiting. Workforce boards are more incentivized to support the types of learners who are likeliest to drive those metrics -- overlooking many people who need help the most. The efforts to reauthorize WIOA should consider provisions for at-risk communities, and either apply different performance standards, or incentivize the utilization of complementary services (e.g. mentorship, soft skills).
3. **Create a taxonomy of priority skill pathways.** Upskilling is not always a direct path in which a person moves from the starting line to the finish line in a single fluid motion. There is increasing evidence of the importance of gateway jobs, i.e. an occupation that someone aspires to, en route to their ideal job. (Example: Recent research from Markle Foundation concluded that Client Service Representatives can become Computer Systems Administrators, by achieving the intermediate occupation of Computer User Support Specialist.) WIOA should make a provision for top-down guidance on skill pathways to its stakeholders, such as economic development and workforce boards. With a greater focus on the medium- and long-term drivers of career transformation, the

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workforce system can minimize the risk of program graduates falling back into support scenarios. If we improve the system's odds of moving citizens up and out, we help to secure the long term positive economic impact of upskilling programs.

Over many years, the U.S. workforce system has left a lot of positive change in its wake. In 2021, we believe that the aforementioned reforms will help create greater alignment between citizens, employers, and the educational resources that bring them together. We look forward to joining forces with like-minded legislators and thought leaders, to raise the bar for this fundamental pillar of our economy.

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Chairman DESAULNIER. Thank you so much for your time. Thanks for your timeliness.

And that will bring us to our final witness. We will now hear from Representative Fay.

Representative Fay, the floor is yours.

**STATEMENT OF HON. JESSICA FAY, STATE REPRESENTATIVE,
MAINE HOUSE OF REPRESENTATIVES**

Ms. FAY. Thank you.

Good morning, Subcommittee Chairs DeSaulnier and Wilson, Ranking Members Allen and Murphy, and Members of the subcommittees.

I am Maine State Representative Jessica Fay, and I represent House District 66 in the Maine Legislature. Thank you for inviting me here today.

In 2019, I served as the house Chair of Maine's commission to study long-term care workforce issues, and I am pleased to be able to share some of our findings.

Because Maine is the oldest State in the country, we are seeing the crisis build, and be exacerbated by the COVID-19 pandemic. I came at this issue with an open mind as a legislator, but also as a consumer and a family caregiver.

Statistically, most of us will need some form of assistance with activities of daily living during our lifetimes. In a pre-pandemic visit to a local high school vocational program, the director gave me a tour. The classrooms for coding, carpentry, and automotive were busy and full. When it came to healthcare, there were only a few students, notably all female, in the class.

As we walked away, I asked about participation in their CNA program, and learned that it was declining. I asked why, and his answer really disturbed me. He said, kids are smart and don't want to go into dead-end jobs. They understand the earning potential of various professions and choose their paths based on that.

If the public perception is that caring for older adults and people with disabilities is dead-end work, then an important part of the solution is to change that perception. We must address not only the workforce challenges, but also ageism and ableism that leads to the devaluation of the care necessary for older people and people with disabilities to live their best, most independent lives.

When we have an undervalued workforce caring for an undervalued population, we have a system that doesn't work for anyone. Increasing the pay for essential caregivers is a necessary component of attracting and retaining a diverse set of people to do this economically foundational work. It is a necessary piece of this solution, but not sufficient on its own to solve the crisis we face.

Another barrier is that this workforce is seldom included in conversations about economic development. In the quest for high-paying jobs, the foundational jobs are often left out of the conversation. It is important that when designing programs for economic development, we include caregiving jobs as a career choice.

During the pandemic, the lack of childcare had a significant impact on local economies as people left the workforce to care for their children. This is also true concerning care for older family Members and people with disabilities.

Professionalizing the workforce by offering ongoing paid professional development, supportive supervision, and opportunities for advancement in terms of both responsibility and compensation were all recommendations of the commission I Chaired. This will enhance the efficacy of programs designed to attract and retain direct care workers. Making sure personal care workers are considered part of the care plan and care team will aid in elevating the status of the work that they do.

With some guidance, educational facilities could develop and target education and certification programs for direct care workers. Apprenticeships, earn as you learn, and pre-apprenticeship programs are all ways to enhance the workforce. Creating a path to professional growth through career ladders will also be a critical piece of the puzzle.

Funding is a significant barrier to implementing the Committee's recommendations. MaineCare, known as—what Medicaid is known as in Maine—MaineCare providers are barely scraping by and even closing. They don't have money to train or do professional development with their workforce, let alone offer career advancement opportunities. Access to funding for training and retention and developing methods to increase the workforce as proposed in the Direct CARE Opportunity Act will certainly increase our ability to care for Mainers who need it.

In Maine, there are over 2,000 older Mainers and even more Mainers with disabilities who cannot access services they qualify for. There are empty beds in nursing homes and assisted living facilities due to staffing shortages, and people are spending longer time than necessary in hospitals because there is nowhere to discharge them to.

Maine is a small State with a population of 1.3 million people. We are older and more rural than any other State in the lower 48. We have significant work to do to address this crisis and to elevate and value the work that so many find so rewarding, yet difficult to make ends meet doing. We need to use many different strategies to make a change, and I am grateful to the Members here today for recognizing there is a crisis and who are working to craft solutions that will allow caregivers and those they care for to live their best lives.

Thank you.

[The prepared statement of Ms. Fay follows:]

PREPARED STATEMENT OF JESSICA FAY



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TESTIMONY OF MAINE STATE REPRESENTATIVE JESSICA FAY

HOUSE COMMITTEE ON EDUCATION AND LABOR

SUBCOMMITTEES ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS
AND
HIGHER EDUCATION AND WORKFORCE INVESTMENT

JULY 20, 2021

Good morning Chairs DeSaulnier and Wilson, Ranking Members Allen and Murphy and members of the subcommittees. I am Maine State Representative Jessica Fay, and I represent House District 66 in the Maine Legislature. Thank you for inviting me to testify at today's hearing entitled "Care for Our Communities: Investing in the Direct Care Workforce" to discuss the Direct CARE Opportunity Act.

In 2019, I had the privilege of serving as the House Chair of Maine's Commission to Study Long-Term Care Workforce Issues. I came at the issue with an open mind, as a legislator, but also as a consumer and family caregiver. Statistically, most of us will need some form of assistance with activities of daily living during our lifetimes. Because Maine is the oldest state in the country, we are seeing the crisis build – and be exacerbated by the COVID-19 pandemic.

In a pre-pandemic visit to a local high school vocational program in my district, the director of the program gave me a tour of their different offerings. The classrooms for coding, carpentry and automotive were busy and full. When we came to the health care area, there were only a few students – all female – in the class. As we walked away, I asked about participation in the CNA program and learned that it was declining. I asked what that might be attributed to and his answer really bothered me.

He said kids are smart, they don't want to go into dead-end jobs. They understand the earning potential of various professions and choose their paths based on that.

Value the Work

Early in the vaccine rollout, homecare workers (PSS and PCAs) in Maine, who aren't considered part of the health care workforce, had a hard time getting vaccinated. There was a lack of access

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simply because of their designation outside of the health care system, even though they were going into people's homes and providing essential care every day. This was not only a public health problem, but also a vivid reminder of how these workers are viewed.

When we have an undervalued workforce caring for an undervalued population, we have a system that doesn't work for anyone. Increasing the pay for essential caregivers is a necessary component of attracting and retaining a diverse set of people to do this economically foundational work. It is a necessary piece of the solution, but not sufficient on its own to solve the crisis we face.

One of the barriers I've seen in Maine is that this workforce is seldom included in conversations about economic development. In the quest for high-paying jobs in sectors like clean energy and tech, or even in the medical field, often the foundational jobs are left out of the conversation. It is important that when designing programs through states' Departments of Labor and Economic Development we include caregiving jobs as career choice. During the pandemic, we saw the lack of child care have a significant impact on local economies as people left the workforce to care for their children. This is also true concerning care for older family members and people with disabilities.

If the public perception is that caring for older adults and people with disabilities is dead-end work, then an important part of the solution is to change that perception. We must address not only the workforce challenges, but also ageism and ableism that leads to the devaluation of the care necessary for older people and people with intellectual and physical disabilities to live their best, most independent lives.

Raising public awareness about the need and value of caregiving jobs is one of the tools that can be deployed to begin to change the perception that this work is "dead-end"

Recruitment and Retention

Historically caregiving has been a highly gendered, often unpaid vocation. Given the need, Maine's current workforce of 30,000 doesn't begin to meet the number of hours of approved MaineCare services and we need to broaden the workforce. Our situation in Maine is a bit different than it is nationally when it comes to race and the participation in the caregiving workforce. Nationally, a significant percentage of the workforce is made up of black and brown women, while in Maine, our caregiving workforce is primarily older, rural white women. This is likely attributable to state demographics. We need to diversify our workforce by age, gender and race if we are going to solve our shortage.

Professionalizing the workforce by offering ongoing paid professional development, supportive supervision and opportunities for advancement in terms of both responsibility and compensation were all recommendations of the commission I chaired. By making sure that there is flexibility in the model that allows this to happen, both for rural and urban communities, but also by care setting and provider, I believe will enhance the efficacy of programs designed to attract and retain direct care workers. Additionally, making sure personal care workers are considered part of a care plan and care team will aid in elevating the status of the work they do.

Workforce Development

With some guidance, institutes of higher education, adult education programs and Career and Technical Education Centers, including high school vocational education programs, could develop and target education and certification programs for direct care workers. Apprenticeships, earn as you learn and pre-apprenticeship programs are all possible ways that funds could be used to enhance the workforce. Career and Technical Education Centers could also develop worker pools of students, including students with disabilities, interested in working as direct care workers on a part-time and/or flexible schedule basis. Creating a path to professional growth through career ladders will also be a critical piece of the puzzle.

Because the work is an important part of the care continuum, the Commission asked that all health care degree programs that require practicum experience include practicum requirements and rotations in the long-term services and support sector.

Qualifications and training

If we were able to conform entry-level direct care workers credentials in order to create a continuum, align qualifications across settings wherever possible and create a “universal worker” who could work in multiple settings, we could help address some of the bottlenecks that can occur when people do the same work in different settings and are paid differently. The Legislature recently asked the Maine Department of Health and Human Services licensing bureau to begin work on this. There was a statutory language change that aims to dispense with the alphabet soup of acronyms that refer to direct care work in different settings. I believe that this simplification of language will help not only the Legislature, but also consumers understand that we are referring to the work being performed and not the setting in which it is being performed.

Online and flexible training schedules with well-developed training tools can help potential workers access education without traveling long distances. A good example of this type of online program is the Maine Direct Service Worker Training Program, developed by the University of Southern Maine’s Muskie School of Public Service.

One of the most significant barriers to implementation of any of the recommendations the Commission made has been funding. MaineCare (Medicaid) providers are barely scraping by, and many are even closing, they don’t have money to train or do professional development with their workforce, let alone offer career advancement opportunities. Access to funding for training and retention and for developing evidence-based methods to increase the workforce, as proposed in the Direct CARE Opportunity Act, would certainly increase our ability to care for Mainers who need it.

In the State of Maine, there are 850 older and disabled Mainers in the Home & Community Based Services Waiver who cannot access service they qualify for. There are 250 Independent Services and Supports (state-funded) program clients who have no staffing at all, and there are 1,000 more on a waiting list. There are empty beds in nursing homes and assisted living facilities

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due to staffing shortages and people are spending longer than necessary in hospitals because there is nowhere to discharge them.

Maine is a small state with a population of 1.34 million people, we are older and more rural than any other state in the lower 48. We have significant work to do to address this crisis. We have significant work to do to elevate and value the work that so many find so rewarding yet difficult to make ends meet doing. We need all-hands on deck and many different strategies to make a change, and I am grateful to the members here today for recognizing there is a crisis and who are working to craft solutions that will allow caregivers and those they care for to live their best lives.

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State of Maine
129th Legislature, First Regular Session

**Commission to Study
Long-term Care
Workforce Issues**

January 2020

Office of Policy and Legal Analysis



STATE OF MAINE
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FIRST REGULAR SESSION

**Commission to Study
Long-term Care Workforce Issues**

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Executive Summary

The Commission to Study Long-term Care Workforce Issues was established by Public Law 2019, chapter 343, part BBBBBB, in recognition of the tight labor market and resulting workforce shortage of direct care workers across the long-term services and supports continuum including home and community-based services, residential services and other support services. The Commission was charged with studying the following issues related to the long-term care workforce:

- Measuring current demand for direct care workers and projecting future needs;
- Developing a campaign and statewide recruitment strategies to encourage more people to work in facility-based and home-based long-term care;
- Supporting career ladders throughout various long-term care settings;
- Identifying education needs and methods to fill education needs for direct care workers;
- Identifying barriers to hiring and methods to overcoming barriers to hiring;
- Developing strategies to improve the quality of long-term care jobs;
- Increasing opportunities for shared staffing among long-term care providers;
- Recommending public and private funding mechanisms to implement recommendations;
- Recommending a program to contribute to long-term direct care workers postsecondary education in related fields; and
- Recommending a pilot program to pool part-time home care workers' hours for purposes of providing greater employment opportunity and obtaining employee benefits.

The Commission held five meetings during the interim and is required to submit a report, with findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health and Human Services. Suggested legislation is included in this report for some recommendations, however, for most recommendations the Commission did not determine a preference for whether the Committee should direct executive departments by legislation or by letter. Every recommendation made by the Commission was a consensus although the representatives from the Departments of Health and Human Services and Labor chose not to take positions on recommendations. The recommendations to the Committee are as follows.

Reimbursement

1. Increase wages for starting direct care workers to no less than 125% of the minimum wage.
2. Direct the Department of Health and Human Services to explore limiting reimbursement rates for temporary staffing agencies providing direct care worker services for long-term services and supports.
3. Increase reimbursement rates to reflect current and future structural additions to provider costs, including increases in minimum wage, paid time off, electronic visit verification requirements, background checks and potentially fingerprinting.
4. Direct the Department of Health and Human Services to identify ways to consolidate tasks currently performed by multiple staff in both home and community-based and residential settings.

5. Direct the Department of Health and Human Services to explore options to develop an alternative reimbursement methodology that includes the following:
 - Accounts for acuity level of clients of home and community-based services, for both older adults and individuals with an intellectual disability or autism similar to the way case-mix is used in nursing facilities;
 - Allows additional reimbursement for merit or longevity pay increases for direct care workers;
 - Allows for increased reimbursement for specialized care including dementia care, bariatric care or behavioral needs;
 - Reimburses for ongoing training including for agency or nursing facility personnel taken off-line to conduct training of employees; and
 - Includes direct care workers as paid staff in any multi-disciplinary care planning team with a reimbursement rate to recognize the value of that work.
6. Support legislation to enact a Rate Setting Commission that is independent of the Department of Health and Human Services that evaluates reimbursement rates for all long-term services and supports.

Workforce recruitment and retention

7. Direct the Department of Labor, in coordination with the Department of Economic and Community Development and the Department of Health and Human Services, to develop and implement a multimedia public service campaign that promotes direct care worker jobs as a career choice. Ensure that the campaign materials include new Mainers, men, younger people including high school students, older people and individuals with disabilities.
8. Direct the Department of Labor to conduct job fairs through the State focused on direct care workers for all long-term care settings.
9. Direct the Department of Health and Human Services offer direct care training programs in languages other than English and for ESL individuals.
10. Direct the Department of Health and Human Services to explore options, including those models outlined by PHI and National Conference of State Legislatures, for supportive supervision and mentoring for direct care workers.

Workforce development

11. Direct the Department of Labor to work with the Department of Education, Maine's institutes of higher education, and Maine's Career and Technical Education Centers to develop and target education and certification programs for direct care workers, including high school vocational education programs including the following:
 - Apprenticeship programs for direct care workers;
 - "Earn as you learn" programs for direct care workers; and
 - Pre-apprenticeship program for Maine's Career and Technical Education Centers.
12. Recommend to the Joint Standing Committee on Innovation, Development, Economic Advancement and Business that it amends LD 799, An Act to Create the Maine Health Care Provider Loan Repayment Program, to specify that direct care workers be considered eligible health care providers and direct care occupations be included for

priority consideration by the Maine Health Care Provider Loan Repayment Program Advisory Committee that is proposed in the bill.

13. Direct the Department of Health and Human Services to work with Maine's institutions of higher education and Career and Technical Education Centers to develop worker pools of students, including students with disabilities, interested in working as direct care workers on a part-time and/or flexible schedule basis.
14. Require all healthcare degree programs that require practicum experience to include practicum requirements and rotations in the long-term services and support sector.

Qualifications and training

15. Direct the Department of Health and Human Services to examine qualification requirements for entry-level direct care workers to align qualifications across settings wherever possible without compromising consumer safety.
16. Direct the Department of Health and Human Services to immediately reconstitute, update and implement the Maine Direct Service Worker Training Program.

Expanding existing support systems

17. Direct the Department of Health and Human Services to remove as many barriers to family members and guardians being paid caregivers as possible and allowable under federal law and regulations.
18. Direct the Department of Health and Human Services to review the hours allowable for adult day health services, respite services and other similar programs for adequacy in allowing individuals to remain at home with family members as long as desired by both the caregivers and the individuals receiving services.
19. Direct the Department of Health and Human Services to raise the caps and create more flexible cost models for assistive technology and environmental modifications for members receiving home and community-based services.

Consumer-directed services

20. Direct the Office of Aging and Disability Services within the Department of Health and Human Services to convene a work group of stakeholders within the department that includes providers, advocates and consumers, to determine how to expand the consumer-directed options to individuals with developmental disabilities or autism and examine if consumer-directed options are fully utilized for all populations eligible for home and community-based services.

Pooling and connecting workers

21. Direct the Department of Health and Human Services to convene a stakeholder group of providers to explore methods to pool workers across providers and care settings or programs, including developing a method to provide benefits to the workers.
22. Direct the Department of Health and Human Services to explore creating a HIPAA-compliant digital platform to connect direct care workers, providers, self-directing

consumers and family members. The department must include providers in its exploratory effort.

Public Assistance

23. Direct the Department of Health and Human Services to explore options for increasing income levels for direct care workers who are receiving various public assistance benefits and ensure that department's case workers communicate this information to their clients.
24. Direct the Department of Health and Human Services to study public assistance programs across the spectrum to determine where higher income levels might be allowable under federal and state laws and rules and consider developing programs that provide more flexibility of increased hours among direct care workers and report findings to the Joint Standing Committee on Health and Human Services for statutory action.
25. Improve communication and navigation of maximum income levels to individuals receiving public assistance.

Grants

26. Direct the Division of Licensing and Certification in the Department of Health and Human Services to convene a work group to develop proposals for projects in nursing homes focused on best practices for recruitment and retention of direct care staff using Civil Money Penalty Reinvestment Program funds and submit those proposals to the Centers for Medicare and Medicaid Services.
27. Direct the Department of Health and Human Services to consider applying for a grant under the Lifespan Respite Care program grant offered by the ACL within the federal Department of Health and Human Services, or working with any appropriate organization that is eligible.
28. Direct the Department of Health and Human Services to investigate and apply for any grant opportunities that improve the quality of long-term care services and supports.

Oversight Committee

29. Enact an ongoing, independent Oversight Committee to review progress in implementing the recommendations of this Commission, address barriers to implementation, and make new recommendations as needed.

I. INTRODUCTION

During the first interim of the 129th Maine State Legislature, the Commission to Study Long-term Care Workforce Issues, referred to as “the Commission” in this report, was established by Public Law 2019, chapter 343, part BBBB. It held five meetings during the interim. The duties of the Commission are set forth in Part BBBB, section 4. The Commission was charged with studying the following issues related to the long-term care workforce:

- Measuring current demand for direct care workers and projecting future needs;
- Developing a campaign and statewide recruitment strategies to encourage more people to work in facility-based and home-based long-term care;
- Supporting career ladders throughout various long-term care settings;
- Identifying education needs and methods to fill education needs for direct care workers;
- Identifying barriers to hiring and methods to overcoming barriers to hiring;
- Developing strategies to improve the quality of long-term care jobs;
- Increasing opportunities for shared staffing among long-term care providers;
- Recommending public and private funding mechanisms to implement recommendations;
- Recommending a program to contribute to long-term direct care workers postsecondary education in related fields; and
- Recommending a pilot program to pool part-time home care workers’ hours for purposes of providing greater employment opportunity and obtaining employee benefits.

The Commission is required to submit a report, with findings and recommendations, including suggested legislation, to the Health and Human Services Committee by November 7, 2019.¹ Public Law 2019, chapter 343, part BBBB is contained in Appendix A and the full list of Commission members is contained in Appendix B. Suggested legislation is contained in Appendix C.

The Commission held five meetings on the following dates: September 11, September 26, October 24, November 14 and December 10. All meetings were open to the public and were broadcast by audio transmission over the Internet. Agendas of all Commission meetings and other information relating to the study can be found online at: <http://legislature.maine.gov/long-term-care-workforce-commission>.

II. BACKGROUND

Demographics

The Commission was enacted as part of the biennial budget in recognition of the tight labor market and resulting workforce shortage of direct care workers in both home and community-based services and residential services.² Background information presented by the Department of Health and Human Services at the first meeting relating to unstaffed hours and waitlists for services and the demographics of the population in Maine illustrates that the mismatch between

¹ The Legislative Council granted permission to the Commission to hold an additional meeting and the deadline for the report was extended to December 15, 2019.

² The Commission was originally enacted in 2018 in Public Law 2017, chapter 460, Part B-5 but all members were not appointed and the Commission never convened, and the language was included in the biennial budget in 2019.

services needed and workers available will only become more acute. In addition, PHI's presentation to the Commission on October 24, reiterated this current and increasing demand for direct care workers by citing the growing population of older adults nationally and in Maine, combined with consumer preferences for home and community-based care over institutional care, and policy and programmatic changes such as the changes to clinical eligibility for nursing facilities in 1990 in Maine that have resulted in the highest level of acuity in the country.³

Maine is currently the oldest state in the nation with a mean age of 44.3 in 2017.⁴ The Department of Administrative and Financial Services data cited by the Department of Health and Human Services shows the population aged over 65 years of age in Maine is growing. In 2016, two counties in Maine had more than 25% of the population aged over 65 years of age. In 2026, it is predicted that 14 counties will have more than 25% aged over 65 years of age and in 2036, all Maine counties are expected to have this demographic pattern.⁵ According to the department's presentation, 52-70% of individuals turning 65 today will eventually need some form of assistance with their activities of daily living.

Long-term services and supports continuum

Long-term services and supports span a continuum from non-clinical services such as homemaker services (housekeeping), meals on wheels and adult day services to the institutional services in nursing facilities and Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF-IIDs). In the middle of the continuum there is a variety of home and community-based services provided by personal support specialists (PSSs), home health nurses, CNAs, direct support personnel (DSPs), and other direct care workers in a client's home, and in adult family care homes, private nonmedical institutions (PNMIs) and other types of independent housing services. It is important to remember that clients receiving home and community-based services may qualify, based on acuity, for an institutional level of care. For example, clients receiving home and community-based services under a Medicaid waiver, by definition, qualify for an institutional level of care.

The payer sources for long-term services and supports for older adults, adults with disabilities or individuals with developmental disabilities or autism include MaineCare (Medicaid), state-funded programs, private pay, and limited Medicare reimbursement for skilled nursing facility services after hospitalization. A thumbnail sketch of the MaineCare and state-funded programs that provide long-term services and supports is as follows:

MaineCare (Medicaid) reimburses for long-term services and supports under the following sections of Chapter 101, the MaineCare Benefits Manual:

- Section 2 – adult family care homes;
- Section 12 – consumer-directed attendant services;
- Section 18 – home and community-based waiver services for adults with brain injury;
- Section 19 – home and community-based waiver services for older adults and adults with disability;

³ <http://legislature.maine.gov/doc/3430>.

⁴ <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>.

⁵ <http://legislature.maine.gov/doc/3181>.

- Section 20 – home and community-based waiver services for adults with other related conditions;
- Sections 21 and 29 – home and community-based waiver services, and support services, respectively for adults with an intellectual disability or autism;
- Section 26 – adult day health services;
- Section 40 – home health services;
- Section 50 – ICF-IID facilities;
- Section 67 – nursing facilities;
- Section 96 – private duty nursing services;
- Section 97 – PNM; and
- Section 102 – rehabilitation services.

State-funded (i.e. non-Medicaid) programs that reimburse for long-term services and supports include but are not limited to:

- Chapter 11 – Consumer-directed personal assistance services;
- Section 61 – Adult day services;
- Section 63 – In-home and community support services for elderly and other adults;
- Section 68 – Respite care for people with Alzheimer’s or related disorder; and
- Section 69 – Independent Services and Supports (the Homemaker program).

Service shortages – waitlists, unstaffed hours, closures and hospitalizations

An individual who qualifies or is eligible for services under MaineCare or state-funded programs may not necessarily receive those services. Medicaid is an entitlement program but states may create waitlists for services when they are provided under a Medicaid waiver. For state-funded programs, states may institute waitlists. Increasing the number of people who receive services under waivers or state-funded programs or increasing the number of hours or augmenting services requires additional budgetary funding. However, even when an individual who is entitled to services under Medicaid, or is approved and funded under a waiver or a state-funded program, that person may still not receive services if there are insufficient providers to provide services (unstaffed hours or funded offers seeking support in the community).

The Department of Health and Human Services provided information to the Commission on waiting lists and unstaffed hours at the first meeting.⁶ In 2019, there were 40 eligible individuals waiting for Section 18 services, 20 waiting for Section 20 services, 1,580 waiting for Section 21 services, 191 waiting for Section 29 services, 123 waiting for Section 63 services and 664 waiting for Section 69 services (see the department’s presentation for the specific date of each wait list). There are also members no longer on the waitlist who have funded offers for Sections 18 and 20 who are seeking support in the community or seeking a group home provider and therefore lacking services. For unstaffed hours, as of June 30, 2019 with data from one of two service coordination agencies, Section 63 clients had 512 registered nurse hours per month and 2,192 personal support hours per month unstaffed. For Section 19, unstaffed hours amounted to 728 RN hours per month and 2,114 PSS hours per month. Under Section 96, unstaffed hours were 1,842 RN hours per month and 2,674 PSS hours per month. Under the homemaker program, Section 69, there was 1,640 unstaffed hours per month. The unstaffed hours data does

⁶ <http://legislature.maine.gov/doc/3181>.

not include consumer-directed hours. In consumer-directed programs, the consumer is the employer managing the consumer's own hiring and firing rather than an agency, and unstaffed hours data is not collected and the extent of unstaffed hours is unknown. Particularly concerning is that when home and community-based service hours go unstaffed, vulnerable individuals lack the services intended to keep them both safe and independent. When these approved hours go unstaffed the likelihood the consumer will end up needing a higher institutional level of care or hospitalization both of which are more expensive.

The Commission also requested information from Department of Health and Human Services about the number of nursing facility and PNMI Appendix C beds in response to news stories about closures of nursing facilities or residential care homes. Sarah Taylor, Director of the Division of Licensing and Certification, briefed the Commission on September 26th. She stated that in 2014, the state had 105 nursing facilities and now there are 94. At the bed level, Director Taylor stated that between 2015 and summer 2019, Maine lost 337 nursing facility beds and gained 154 level 4, PNMI, Appendix C beds (there was no significant change to the number of beds at other levels of assisted living over the last two years). There are also three Certificate of Need (CON) reviews underway that could further change the numbers: Sandy River North Country plans to replace 121 nursing facility beds with a new 90-bed facility; Woodlands plans a new 42 bed assisted living facility in Madison; and Newton plans to replace a facility with 74 nursing facility beds and 38 residential care beds with a new facility with 64 and 30 beds respectively. Also important to this picture is occupancy data. Director Taylor stated that in 2015, nursing facility beds were at a 90.23% occupancy rate and residential care was at 91.29%. In the summer of 2019, the occupancy rates were 90.01% for nursing facilities and 89% for residential care. Therefore, although the state may be losing beds, the occupancy rates are not significantly different. The Commission recognizes but did not investigate whether nursing facility closures decreased the number of beds available in any given geographic area of the state leaving a significant unmet need.

It is unclear what the impact of staffing shortages is on nursing facilities and residential care homes. Rick Erb of the Maine Health Care Association (representing facility-based long-term care) was asked about the effect of staff shortages on admissions, closures of wings and/or unfilled beds. Dropping below mandatory staffing levels in nursing facilities is an immediate violation of federal laws and regulations so these facilities must resort to more expensive temporary staffing and overtime when necessary to maintain adequate staffing ratios. Mr. Erb stated that there are multiple examples of facilities closing wings or keeping beds empty due to lack of staffing and that it is universal around the state and not a regional issue. A survey of 81 facilities showed that 60% of those facilities had limited admissions due to staffing shortages in the last 90 days.⁷ Commission member Mary Jane Richards of North Country, whose company has two of the CON reviews mentioned above, and Director Taylor agreed that the impact of staffing shortages on occupancy needs to be tracked to provide a clearer picture of the interrelationship between nursing home closures, occupancy and staffing vacancy rates.

When no long-term services and supports are available at all, some individuals end up essentially living in hospitals after the medical crisis or event that sent the person there in the first place, has been treated. Lisa Harvey-McPherson from Northern Light presented information on hospitalized patients awaiting placement in a nursing or residential facility. She stated that using

⁷ <http://legislature.maine.gov/doc/3182>.

Eastern Maine Medical Center as an example, with 90 days of data, there were 47 patients each week in hospitals for more than 10 days. Some patients need specific services that can be identified such as bariatric or gero-psych or have guardianship issues, but there was still an average of 13 patients that did not fall into a specialty population. As mentioned above, there is no data for when non-specialty populations needing placements are not accepted because of staffing vacancies at facilities.⁸

Reimbursement rates

The Commission had extensive discussions at every meeting about reimbursement rates under MaineCare and state-funded programs, the need to increase wages for direct care workers and the inadequacy of the current reimbursement rates to cover the costs of providing services currently or account for future structural additions to cost. Reimbursement rates for direct care workers in nursing facilities and providing home and community-based services have been the subject of several legislative studies, rate studies and legislation in recent years.

Burns & Associates conducted a rate study of Personal Support Specialists (PSS) under MaineCare Sections 12, 19 and 96 and State-funded programs under Section 63 and Chapter 11 with a report along with a wage model issued on February 1, 2016. Burns & Associates collected cost data from providers in a survey mailed in December 2014 and used Bureau of Labor Statistics (BLS) data from 2014. The wage models were fully implemented over the course of two Legislatures. Rates were increased in Public Law 2015, chapter 267 (the biennial budget) for PSS services for MaineCare Sections 19 and 96, state-funded Section 63, and Adult Day health services; Resolve 2015, chapter 50 increased rates for Section 12. Resolve 2015, chapter 83, passed in April 2016, implemented 50% of the increases developed in the Burns & Associates wage model. Public Law 2017, chapter 459, Part B, enacted in July 2018, increased reimbursement effective July 1, 2018, to fully implement the increases developed in the wage model. However, Commission members noted that the wage models are already outdated and the shortfall between reimbursement rates and cost is increasing.

Nursing facility and PNMI reimbursement and employee pay was the subject of two legislative studies in 2013 and 2014. Public Law 2013, chapter 549, enacted in 2014, increased funding for nursing facilities, regularly rebases every two years so that cost settlements are based on more recent real costs, increased the peer group upper limit to 110% of the median for some costs, and established supplemental payments to facilities with more than 70% of MaineCare populations in the number of total residents. However, the appropriation in Public Law 2013, chapter 549 was insufficient to fund the provisions in the law requiring an additional appropriation the following year in Public Law 2015, chapter 267 (the biennial budget). Rick Erb noted, in a presentation to the Commission, that nursing facility unfunded costs have again returned to the level experienced prior to the enactment and funding of Public Law 2013, chapter 549.⁹

Public Law 2015, chapter 267 (the biennial budget) also increased rates to PNMIs and adult family care homes. In Public Law 2017, chapter 304, PNMIs were allowed to request an adjustment to the prospective rate in the form of an extraordinary circumstance allowance which includes increases in minimum wage or social security expenses, changes in the number of

⁸ <http://legislature.maine.gov/doc/3180>.

⁹ <http://legislature.maine.gov/doc/3505>.

licensed beds and changes in licensing requirements. In 2018, Public Law 2017 chapter 460, part B, required annual cost of living allowances attributable to increases in wages and salaries for personal care for nursing facilities, adult family care homes, PNMIs, adult day services and homemaker services until rate studies conducted by a third party are completed and increased the supplemental payments to low-cost high Medicaid nursing facilities. The law also granted a one-time 10% increase in wages and associated benefits and taxes for 2018 that only applied for one year. During the First Regular Session of the 129th Legislature, LD 1758, as amended by the Joint Standing Committee on Health and Human Services and the Joint Standing Committee on Appropriations and Financial Affairs, continues the 10% increase on an ongoing basis at a cost of \$5.9 million in general funds in fiscal year 2019-2020 and fiscal year 2020-21. This bill was initially held by the Governor. A letter to the Joint Standing Committee on Appropriations and Financial Affairs from the Governor clarified her position on the bill including allowing the funding to go forward.¹⁰

Direct Support Professionals rates for services provided under MaineCare Sections 21 and 29 to individuals with intellectual disabilities or autism were increased in Public Law 2017, chapter 459, part A, which was enacted in July 2018. That law also increased reimbursement for the direct care services in Sections 21 and 29. In addition, the law enacted a statutory requirement for rates to take into account “the costs of providing care and services in conformity with applicable state and federal laws, rules, regulations and quality and safety standards and local competitive wage markets.”¹¹ The law requires a regular review every two years.

Commission members and other providers presenting information and testimony at Commission meetings all stated that reimbursement rates are insufficient to allow for new and increasing costs. Initiated Bill 2015, chapter 2 increased the minimum wage with the first increase occurring in January 2017; the rate is \$12 an hour as of January 2020. Public Law 2019, chapter 156 requires paid time off to be provided to employees from January 1, 2021. Employers with over 10 employees will be required to provide at least one hour of paid time off for each 40 hours worked. Other structural additions to provider costs include federal electronic visit verification requirements, background checks and the possibility of fingerprinting. The Burns & Associates’ PSS rate study was based on 2013-14 costs and took place prior to any of these federal or state laws and regulations.

During the meeting held on November 14, the Commission had presentations from John Watson from Cedars, Jennifer Putnam for the Maine Association for Community Service Providers (MACSP) who provide Section 21 and 29 services, Rick Erb representing nursing facilities and residential care homes and Mike Stair representing Home Care & Hospice Alliance of Maine, to illustrate the lagging of reimbursement rates compared to current costs and upcoming expenses.¹² Jennifer Putnam stated that the January 2020 minimum wage of \$12 an hour is above the amount included in the reimbursement for Direct Support Professionals. The hourly rate paid in 2019 of \$27.72 an hour includes an hourly cost for labor of only \$11.20 (the rate also includes benefits, taxes, training, program expenses, general administration and a portion of the service provider tax) and that had been increased from \$9.17 an hour in Public Law 2017, chapter 459. Ms. Putnam also mentioned that even in Western Maine, it was not possible to attract DSPs at \$12/hour as this was less than employees at a local big box store or gas stations were earning.

¹⁰ <http://legislature.maine.gov/doc/3610>

¹¹ 22 MRSA §3195.

¹² <http://legislature.maine.gov/long-term-care-workforce-commission>

Employees started at \$12.75 an hour, over \$13 if they had qualifications and \$16.82 for OTs. It was also necessary to resort to overtime or temporary agency staffing which began at \$27/hour exacerbating the shortfall. Mike Stair's presentation estimates the impact of higher minimum wage, paid time off, electronic visit verification, fingerprinting, the new PSS curriculum requirements and revaluation bonds will have on costs to home care providers. John Watson's presentation illustrated the structural gaps inherent in the complicated methodology for reimbursing nursing homes that are gradually impacting access to care, particularly for MaineCare members.

Workforce Recruitment and Retention

A critical component of reducing the workforce shortage within the long-term services and supports field is increasing recruitment and improving retention rates. Providers across the continuum of care were represented on the Commission and all consistently reported difficulty in hiring workers and experiencing a level of employee turnover at the highest level they had ever seen. Members of the Commission and providers who testified spoke of turnover rates from 50% to 70% of employees in one year. One member of the Commission noted employees were leaving for smaller incremental increases in pay than ever before. According to the Department of Labor, personal care and service jobs are the most difficult to fill¹³ and are projected to grow from 2016 to 2026 by 3.9% from 33,574 to 34,881 jobs.¹⁴ National studies show a "conservative" estimate of turnover rate ranging from 45% to 66% with the average cost of turnover at \$2,200 per person.¹⁵

Sandy Butler presented her longitudinal homecare worker retention study from 2009-2011 using surveys and interviews to learn about factors contributing to turnover and retention with the caveat that her study had been carried out a few years ago prior to federal and state legislative changes to health insurance requirements and minimum wage increases (she is currently working on another study that is smaller).¹⁶ The workers in the survey were 94.6% women, 93.5% European American or Caucasian with 3.4% born outside the U.S., 62.5% earned less than \$20,000 a year, were generally in better health than the U.S. population although worse for body pain and occupational injuries, worked an average of 18 hours a week and generally liked their jobs. Survey data from those who left their jobs showed they were more likely to be younger, lack health insurance, have lower scores on mental health (depression and anxiety) and more intense feelings of personal accomplishment. Interviews honing in on the reasons for leaving showed three main themes: the job was not worthwhile due to low pay, lack of benefits and travel reimbursement, inconsistent hours and not enough clients in their area; personal reasons including family issues, medical problems, retirement, moving, returning to school or no longer caring for a family member; and burnout including agency problems, difficult clients, false accusations and death of clients. Dr. Butler highlighted surprising findings including more intense feelings of personal accomplishment related to leaving; lower physical function, e.g. disabilities, leading to longer tenure; and rural residence predicts a longer tenure possibly because of fewer job opportunities in those areas. She also found that lower wages did not

¹³ <http://www.maine.gov/labor/cwri/jvs/occupation.html>.

¹⁴ <https://www.maine.gov/labor/cwri/outlook.html>.

¹⁵ Scales, Kezia, PHL (2018), *Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employers*, p. 4 found at <https://phlnational.org/resource/growing-strong-direct-care-workforce-recruitment-retention-guide-employers/>.

¹⁶ <http://legislature.maine.gov/doc/3244>.

predict termination but that higher wages did predict longer tenure and that older workers were less likely to leave and more likely to stay longer in the job.

Testimony from commission members and by providers testifying at public comment periods indicate that providers have tried to attract and retain workers with pay increases, sign on bonuses, offering health insurance and paid time off, employee recognition days, birthday and rising star awards, free training and revolving loan programs for car insurance and repairs, but that turnover rates have remained stubbornly high. In addition, Commission members also heard from workers, including Commission member Rachel Small, that the health insurance offered was still too expensive to purchase.

Direct care worker training

The “direct care worker” umbrella includes a number of different job titles in different sections of MaineCare and state-funded programs, each with its own entry qualifications and training requirements. The term includes Personal Support Specialist (PSS), Direct Support Professional (DSP), Certified Nursing Assistant (CNA), Home Health Aide (HHA), Independent Support Specialist (ISS), Mental Health Rehabilitation Technician (MHRT), Certified Residential Medication Aide (CRMA) and several others. The Department of Health and Human Services briefed the Commission on the requirements within each program.¹⁷ The Commission had several discussions about whether it would be useful to have a common curriculum to enable movement of workers within the field.

Nadine Edris of the Muskie School of Public Service presented the training program called the Maine Direct Service Worker Training Program that was developed under a Health Resources and Services Administration grant awarded to the Department of Health and Human Services in 2010.¹⁸ Under this 3-year grant, the department established a cross-agency workgroup and partnered with the Muskie School to develop and test a competency-based, blended, coordinated training program for direct care workers. The curriculum included a common entry-level training with specialized, non-overlapping modules with job-specific content. The curricula were developed after Muskie examined state and federal laws, policies, rules and guidelines to identify the training requirements for 11 types of direct care workers,¹⁹ a core curriculum and specialty curricula for the three types of direct care workers: PSS, MHRT-1, and DSP.

The Maine Direct Service Worker Training Program adheres to adult learning principles using a variety of instructional materials and technological support. The core curriculum includes: roles and responsibility; personal care and home support; consumer needs, rights and choices; communication and interpersonal skills; safety; and documentation. The next level of training is specific to the jobs of PSS, MHRT-1, or DSP. A third level of optional trainings modules was also created, for example, dementia and challenging behaviors. The Muskie School collected and analyzed data in several areas such as student and teacher satisfaction with the material and formats, overall attrition rates, and attrition rates for each training delivery method (in-person and on-line).²⁰ The data was collected to further refine the training program. The training

¹⁷ <http://legislature.maine.gov/doc/3181>.

¹⁸ <http://legislature.maine.gov/doc/3261>.

¹⁹ PSS, CNA, CNA-M, CRMA, CDPA, DPS, FPSO, HHA, ISS, MHRT-1, and CIPSS (Muskie School of Public Service at the University of Southern Maine, 2017 found at <http://legislature.maine.gov/doc/3179>).

²⁰ The results are available at <http://legislature.maine.gov/doc/3178>.

program was successfully piloted several times by providers including Commission member Jillian Jolicoeur of Assistance Plus, but the curriculum was never fully implemented.

The Commission was also briefed on the update of the PSS curriculum developed by the Department of Health and Human Services, Division of Licensing and Certification. The curriculum had last been updated in 2003 and those materials are no longer in print. The new curriculum is required as of January 1, 2020. For Commission members who represent providers and train their own staff, this requirement provides an additional cost.

III. RECOMMENDATIONS

The Commission developed the following recommendations for review by the Joint Standing Committee on Health and Human Services. Several of the recommendations direct executive departments to raise reimbursement rates, convene stakeholder groups, develop projects, or explore policy options. Suggested legislation is included in this report for some recommendations. However, for most recommendations, the Commission did not determine a preference for whether the Committee should direct executive departments by legislation or by letter.

Reimbursement for Current and Future Structural Costs

Commission members had extensive discussions during each meeting about the need to increase wages for direct care workers. From a business perspective, the current reimbursement rates paid for long-term services and supports are insufficient to account for impending increases in minimum wage including the \$1/hour increase that goes into effect on January 1, 2020. In addition, the current reimbursement rates do not account for future structural additions to provider costs such as paid time off, PSS curriculum requirements, electronic visit verification and background checks and possible fingerprinting.

A significant new requirement for home and community-based service providers that is proving to be an expensive and complicated mandate is the electronic visit verification (EVV) requirements included in Section 12006 of the federal 21st Century Cures Act.²¹ Under the Cures Act, states must use an EVV system for Medicaid funded personal care services, including those covered by 1915(c) waivers and 1115 demonstrations, and home health services that require an in-home visit by a provider. The law requires the EVV system to be in place for personal care services by January 1, 2020 and January 1, 2023 for home health services (Section 40 services under MaineCare) although Maine, along with a number of states, has received an extension for the former to January 1, 2021 from the Department of Health and Human Services, Centers for Medicare and Medicaid Services. The Maine Department of Health and Human Services has established a deadline of July 1, 2020 for providers of personal care services to submit claims with EVV records. The records verify the type of service performed, the individual receiving the service, the date of the service, the location of the service delivery, the individual providing the service, and the time the service begins and ends. Noncompliance with the EVV requirements result in reductions in FMAP up to 1%.

²¹ Public Law 114-255.

The Maine Background Check Center Act²² establishes a list of offenses that disqualify any individual for employment as a direct access worker (although an individual may apply for a waiver of the disqualification under certain circumstances). Providers of long-term care services and supports are required to use the Maine Background Check Center (MBCC), a web-based system operated by the Department of Health and Human Services, to run a pre-employment background check for all direct care workers (the law also requires background checks on all workers who were employed at the time the law was enacted) and checks must be conducted every five years; the center also constantly monitors an individual's criminal history. The MBCC does not currently include fingerprinting so criminal background checks are limited to state level convictions, analysis of the abuse and neglect and sex offender registries and employment related registries (e.g. professional boards).

Currently, each background check costs \$56 and is not portable for the individual. This lack of portability combined with significant turnover rates, has caused the costs of completing background checks to become an increasing cost for employers that is not included in the current reimbursement rates. This problem may only become worse if the federal requirement to fingerprint childcare employees and applicants is expanded to employees and applicants in the long-term services and supports industry. While providers are not opposed to the concept, there is concern that there is no source of funding and current reimbursement rates are not sufficient to cover the current cost of background checks without adding fingerprinting (estimated to increase each background check by \$40²³).

When providers are unable to find staff in a tight labor market conditions, they have increasingly been forced to resort to hiring temporary agency staff to maintain staff to resident ratios at considerably more expense; providers do not receive additional reimbursement for this cost. Massachusetts recently capped rates that could be paid for temporary nursing staff at hospitals and nursing facilities.²⁴ Maine should explore this option as well.

Aside from the insufficiency of the current rates to account for minimum wage increases, Commission members stress that direct care workers do hard physical and emotional work and deserve to be paid more than the minimum wage. These workers provide critical services that ensure that older adults and individuals with disabilities remain safe in their homes and residential and nursing facilities, ensure consistent and quality care and offer choice. Building off the concepts contained in LD 399, An Act To Align Wages for Direct Care Workers for Persons with Intellectual Disabilities or Autism with the Minimum Wage, a bill that has been carried over on the Appropriations table, the Commission determined that direct care workers should be paid at least 125% of the minimum wage (regardless of the level of the minimum wage) to attract workers to this sector of employment.

Increasing wages for entry-level employees will have a ripple effect on wages as employees who have higher levels of qualification or more experience and are currently paid at a higher level than those entry-level employees will expect a similar increase in pay. All members of the Commission stressed the importance of a necessary increase in direct care worker pay and the need to increase reimbursement rates to allow for a similar increase at the same time. The

²² Public Law 2015, chapter 299.

²³ Testimony from Department of Health and Human Services for LD 45. Located at:

<http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=122958>.

²⁴ <https://www.mass.gov/doc/101-cmr-345-rates-for-temporary-nursing-services/download>.

Commission members are aware of the significant costs of such an increase and acknowledge it will require an appropriation through the legislative process.

The Commission wrote to the Health and Human Services Commissioner Lambrew requesting the department immediately increase reimbursement rates, including any requests for appropriations to ensure the quality of care provided and to prevent providers from going out of business. This letter is attached as Appendix D. Commissioner Lambrew responded to the Commission by letter suggesting the Commission direct its request to the Legislature for appropriations. The letter also states that the department is conducting an evaluation of MaineCare rate setting, and that the Governor recently supported LD 1758, An Act To Clarify and Amend MaineCare Reimbursement Provisions for Nursing and Residential Care Facilities, increasing funding for nursing facilities. Commissioner Lambrew's letter is attached as Appendix E.

Recommendations (immediate):

1. Increase wages for starting direct care workers to no less than 125% of the minimum wage.
2. Direct the Department of Health and Human Services to explore limiting reimbursement rates for temporary staffing agencies that provide direct care worker services for long-term services and supports.
3. Increase reimbursement rates to reflect current and future structural additions to provider costs, including increases in minimum wage, paid time off, electronic visit verification requirements, background checks and potentially fingerprinting.

Legislation to increase reimbursement rates is included in Appendix C.

Alternative Rate Reimbursement Methodologies

The recommendations above relating to starting direct care worker pay and current and future structural additions related to federal or state laws and rules are recommendations for immediate action. However, Commission members recommended that the Department of Health and Human Services consider alternative reimbursement methods that would directly and indirectly impact the workforce shortage and reimburse for quality and additional service provision. For example, current reimbursement for home and community-based services does not recognize the acuity level of clients, pay increased levels for specialized care, account for a worker's skill level or longevity, pay training costs or pay for the direct care worker to be part of the care planning team. The current rate methodologies also prevent efficiencies in work assignment.

Direct care workers and the organizations that employ them often find that individual workers are not able to perform certain tasks for clients because they are outside of their scope of practice resulting in more than one worker present in the home at one time. Commission members understand that there are complicated regulatory issues in terms of allowable tasks for certain credentialed workers, services that relate to activities of daily living versus instrumental activities of daily living, and program integrity. Providers and clients would like to be able to have blended workers that can provide care in the moment rather than one direct care worker

providing higher level medical tasks while waiting for an additional PSS or similar direct care worker to arrive to provide another service even though it might have been more efficient to provide all the tasks at once and be adequately reimbursed for them.

Recommendations (intermediate/long-term):

4. Direct the Department of Health and Human Services to identify ways to consolidate tasks currently performed by multiple staff in both home and community-based and residential settings.
5. Direct the Department of Health and Human Services to explore options to develop alternative reimbursement methodology that includes the following:
 - Accounts for acuity level of clients of home and community-based services, for both older adults and individuals with an intellectual disability or autism similar to the way case-mix is used in nursing facilities;
 - Allows additional reimbursement for merit or longevity pay increases for direct care workers;
 - Allows for increased reimbursement for specialized care including dementia care, bariatric care or behavioral needs;
 - Reimburses for ongoing training including for agency or nursing facility personnel taken off-line to conduct training of employees; and
 - Includes direct care workers as paid staff in any multi-disciplinary care planning team with a reimbursement rate to recognize the value of that work.

Rate Review

Commission members discussed the need for reimbursement rates for MaineCare and state-funded long-term services and supports to be reviewed and adjusted on a regular basis for two important reasons. First, the current system encourages providers to appeal to the Legislature for rate increases and therefore the Legislature reviews multiple bills each session requesting increases to reimbursement for a myriad of MaineCare and state-funded program rates. Providers of different services (not only long-term care rates) feel pitted against each other competing for scarce resources. Second, the increases to rates for home and community-based services provided to older adults as a result of the Burns & Associates study and corresponding legislation illustrate the non-dynamic nature of the current system of rate review – rates have already fallen short of increases to the minimum wage. Even services that do receive COLAs, such as nursing facilities, are still facing structural shortfalls because of arbitrary peer groupings used to set caps and upper limits, restrictions on allowable costs and time-lags in cost-reports.

The Commission recommends that a rate setting commission be established outside of the department to undertake the task of reviewing rate methodologies, including interested parties in those deliberations and making recommendations to the department for all long-term services and supports. At the time the Commission was meeting, the Joint Standing Committee on Health and Human Services had carried over from the first session to the second session LD 1052, An Act to Require Regular and Transparent Review of MaineCare Reimbursement Rates, and requested a presentation from the Department of Health and Human Services outlining its activities around rate review. Although the Commission recognizes that this recommendation is

at the intermediate level, that does not mean that this recommendation is of a secondary importance but that it recognizes that it will take more time to complete.

Recommendation (intermediate):

6. Support legislation to enact a Rate Setting Commission that is independent of the Department of Health and Human Services that evaluates reimbursement rates for all long-term services and supports.

Direct Care Workforce Recruitment and Retention

A key component of addressing workforce shortages in the long-term services and support continuum is attracting more workers to the direct care field and retaining those workers and elevating the importance of the work to society. The Commission stressed the need to attract additional workers to the direct care field including new Mainers, men, younger people including students, older people and individuals with disabilities. Campaigns to attract new workers need to include all populations in the marketing materials. For example, Commission members pointed out that it is important to de-gender the workforce – to both attract men to the direct care field and to have clients accept male caregivers. In Maine, six out of seven direct care workers are female.²⁵ Adults with disabilities are an untapped resource for the workforce. Adults with disabilities want to work but are much less likely to be employed than adults with no disability. From 2013 to 2017, 33% of working-age Mainers with disabilities were employed compared to 80% of those without a disability.²⁶

The Commission spent considerable time discussing employee turnover and retention. As stated above, providers are experiencing turnover rates of 50% and above in a single year in all long-term care settings in the State. Turnover is expensive, resulting in increased recruitment and training costs to the provider. The Commission sought examples from other states that have been implemented and evaluated with presentations from Stephen Campbell, Data and Policy Analyst from PHI and Samantha Scotti from the National Conference of State Legislatures. Mr. Campbell and Ms. Scotti stated that increasing recruitment and retention in this field requires a multipronged approach that includes raising the public profile of direct care jobs, increasing their worth and emotional value, strengthening the career ladder for direct care workers beyond entry-level jobs, creating additional rungs on the career ladder such as including direct care workers as part of a care team and creating peer mentors, and creating a unified entry-level training program for the variety of specific direct care worker positions found across programs and settings.²⁷

With respect to improving the public profile of a career as a caregiver, the perception and the reality is that direct care jobs are physically and emotionally draining with relatively low pay, few benefits and limited career advancement opportunities. Yet every direct care worker who spoke to the Commission described a rewarding job that they did not want to leave. They also described, as did the providers on the Commission and those who provided information to the Commission a related issue, lack of easily accessible information on open positions or potential candidates for employment.

²⁵ <http://legislature.maine.gov/doc/3430>, pp. 7-8.

²⁶ <https://www.maine.gov/labor/cwri/disabilities/index.html>.

²⁷ <http://legislature.maine.gov/doc/3430> and <https://phinational.org/resource/growing-strong-direct-care-workforce-recruitment-retention-guide-employers/>.

Recommendations (immediate):

7. Direct the Department of Labor, in coordination with the Department of Economic and Community Development and the Department of Health and Human Services, to develop and implement a multimedia public service campaign that promotes direct care worker jobs as a career choice. Ensure that the campaign materials include new Mainers, men, younger people including high school students, older people and individuals with disabilities.
8. Direct the Department of Labor to conduct job fairs through the State focused on direct care workers for all long-term care settings.

Recommendations (long-term):

9. Direct the Department of Health and Human Services to offer direct care training programs in languages other than English and for ESL individuals.
10. Direct the Department of Health and Human Services to explore options, including those models outlined by PHI and NCSL, for supportive supervision and mentoring for direct care workers.

Workforce Development Initiatives

Maine has a number of initiatives around workforce development, employee training, and quality jobs. Direct care work is often left out of these initiatives because of the low pay and status. If caregiving jobs were recognized financially and professionally for their value to the State and the individuals that caregivers serve, workforce and educational initiatives might include or focus on the direct care sector of the economy. Therefore, in addition to recommendations to increase wages, improve the public perception of direct care work, and develop a career ladder, the Commission has recommendations related to creating new opportunities and avenues for entry into the direct care field and providing additional training.

The Commission learned about the State Workforce Development Board, a statutorily created entity²⁸ responsible for assisting the Governor to perform the duties required by the federal Workforce Innovation and Opportunity Act of 2014 and the State Plan that it creates every four years. The plan focuses on the development and implementation of a systemic approach to engaging and responding to the workforce and business service needs of employers to develop a pipeline of workers in high growth, high demand fields.²⁹ The next four-year plan begins in 2020. Direct care work is a high growth field with high demand and it is essential to include it in the new state plan.

Another workforce training initiative is the Maine Quality Center and its Put ME To Work Program. The Center, established by statute in 1993³⁰ and located at the Maine Community

²⁸ 26 MRSA §2006.

²⁹ https://www.maine.gov/swb/reports/state_plan/2016-2020_state_plan/FINAL_Maines_2016-2020_WIOA_Unified_Plan.pdf p. 7.

³⁰ 5 MRSA §12727.

College System Office, is required to work in close coordination with the Department of Economic and Community Development, the Office of the Governor and other state and local education and economic development agencies. The Center offers workforce training grants to Maine employers interested in providing training for new or current employees. The training provided under these grants is free of charge. The Center's Put ME to Work Program supports employers with 50% of the start-up costs to create new training programs or enhance existing ones for high paying jobs (at least \$2.50 above minimum wage or at or above the median wage for the occupation). If direct care workers were paid what they were worth, providers of these services could participate.

The Commission also heard about two carry over bills aimed at reducing the cost of and debt from higher education: LD 394, An Act to Authorize a General Fund Bond Issue to Provide for Student Loan Debt Relief is carried over on the Appropriations Table; and LD 799, An Act to Create the Maine Health Care Provider Loan Repayment Program carried over by the Joint Standing Committee on Innovation, Development and Economic Advancement and Business. LD 799³¹ is focused on persons who enter the health care profession, but direct care workers are not considered eligible health care providers as the bill is currently drafted.

There are numerous opportunities for healthcare training programs at all levels and for community colleges or high schools to be involved as avenues for entry into the direct care profession. Providing funding to the institutions and financial incentives to individuals to enter the field or financial reimbursement or loan repayments to defray training expenses could attract people to the profession. Requiring students in healthcare degree programs to have practicum requirements or rotations in the long-term services and support sector could broaden a student's awareness and understanding, reduce stigma and attract students to the field. In addition, students at secondary school or in tertiary education could gain experience in direct care as well as providing a flexible, part-time job for a student.

Recommendations (intermediate/long-term):

11. Direct the Department of Labor to work with the Department of Education, Maine's institutes of higher education, and Maine's Career and Technical Education Centers to develop and target education and certification programs for direct care workers, including high school vocational education programs including the following:
 - Apprenticeship programs for direct care workers;
 - "Earn as you learn" programs for direct care workers; and
 - Pre-apprenticeship program for Maine's Career and Technical Education Centers.
12. Recommend to the Joint Standing Committee on Innovation, Development, Economic Advancement and Business that it amends LD 799, An Act to Create the Maine Health Care Provider Loan Repayment Program, to specify that direct care workers be considered eligible health care providers and direct care occupations be included for priority consideration by the Maine Health Care Provider Loan Repayment Program Advisory Committee that is proposed in the bill.

³¹ <http://legislature.maine.gov/LawMakerWeb/summary.asp?paper=HP0587&SessionID=13>.

13. Direct the Department of Health and Human Services to work with Maine's institutions of higher education and Career and Technical Education Centers to develop worker pools of students, including students with disabilities, interested in working as a direct care worker on a part-time and/or flexible schedule basis.
14. Require all healthcare degree programs that require practicum experience to include practicum requirements and rotations in the long-term services and support sector.

Qualifications and Training

The Commission had numerous discussions about the different entry qualifications and training requirements for different job titles under the direct care worker umbrella and for different sections of MaineCare or state-funded programs. For example, both a home health aide and a personal support specialist provides assistance with activities of daily living but a PSS must be at least 17 years of age and complete a 50-hour PSS training program while an HHA must be 16 years of age and may be required to complete a 180-hour certified nursing assistance training.³² Although each type of direct care worker may have different responsibilities, the absence of a common entry-level training curriculum was considered an unnecessary obstacle to portability of qualifications and training within the direct care field. Both providers and workers argued that efficiencies could be gained if entry-level training was uniform across most or all direct care worker positions, with specialized trainings and advanced level trainings available as needed or desired as part of a career ladder. Improved availability of these trainings, both in-person and electronically was also mentioned frequently as an important step to remedy the workforce shortage.

The Commission discussed options for improving efficiency in training direct care workers. During the presentation by Stephen Campbell from PHI, the Commission learned about uniform training programs in other states. Most notable to PHI was the condensed training started in Washington in 2012, and the uniform statewide and state-funded training curriculum started in Arizona in 2011.³³ In addition, the Maine Direct Service Worker Training Program developed by Department of Health and Human Services and the Muskie School under the Health Resources and Services Administration grant has been evaluated as a proven pathway and has been successfully piloted but never fully implemented.

The Commission understands the need for updating the PSS training curriculum as it had not been updated since 2003 and training materials are no longer in print. However, providers who train in-house are faced with additional costs to implement the new program and the new curriculum requirement was required as of January 1, 2020. The Commission wrote to Health and Human Services Commissioner Lambrew on December 17 requesting that the department suspend implementation of the new PSS training requirement until the Health and Human Services Committee has an opportunity to consider and potentially act upon the Commission's recommendation to reconstitute the Maine Direct Service Worker Training Program. This letter is attached as Appendix F. Commissioner Lambrew responded to the Commission by letter dated December 20, 2019, agreeing to delay the end date for utilization of the old curriculum from January 1 until April 1. The letter stated that the department could not suspend use of the

³² <http://legislature.maine.gov/doc/3181>, pp. 12-13.

³³ <http://legislature.maine.gov/doc/3430>, p. 26.

updated curriculum because training has already begun. An April 1st deadline would allow the Committee and the Legislature time to review the Commission's recommendations. Commissioner Lambrew's letter is attached as Appendix G.

Recommendations (immediate):

15. Direct the Department of Health and Human Services to examine qualification requirements for entry-level direct care workers to align qualifications across settings wherever possible without compromising consumer safety.
16. Direct the Department of Health and Human Services to immediately reconstitute, update and implement the Maine Direct Service Worker Training Program.

Expanding Use of Existing Support Systems

Making the most of existing support systems was often mentioned as a component of the solution that should not be overlooked. The Commission made a number of recommendations that do not directly impact the recruitment and retention of direct care workers but may impact demand by making the most of existing support systems. Finding ways to delay or prevent the need for higher levels of care and allowing individuals to remain at home when that is their desire is a component of the solution to the workforce challenge.

Family members as caregivers

Many older adults, adults with disabilities and individuals with intellectual disabilities or autism receive care in the home from family members. Most often, family members are unpaid and also must leave the paid workforce in order to provide care. Commission members determined that family members are a critical piece of the workforce puzzle and that it is important to provide supports, including an income, to those caregivers. Not only does it improve quality and satisfaction of the individual receiving care, it is critically important to the financial and emotional well-being of the caregiver. The Commission heard testimony from Representative Riley who had to leave the workforce to take care of her disabled son when he was a minor but could be employed as a PSS only after her son became an adult.

In the first session, the Health and Human Services Committee voted and subsequently the Legislature, enacted Resolve 2019, chapter 102, requiring the Department of Health and Human Services to request an amendment to the State's 1915(c) waiver from the Centers for Medicare and Medicaid Services by January 1, 2020, to allow members receiving home and community-based services under Section 19 to employ their spouse as a personal support specialist (PSS). In addition, the resolve also requires the department to determine whether employing spouses could be expanded to other sections of MaineCare and report findings to the committee by January 1, 2021. This model should be extended as much as possible to the home and community-based care spectrum.

Recommendation (intermediate):

17. Direct the Department of Health and Human Services to remove as many barriers to family members and guardians being paid caregivers as possible and allowable under federal law and regulations.

Adult day services

Adult day health services and respite services relieve pressure on family caregivers preventing or delaying the need for higher level residential services. Adult day health services are provided to eligible MaineCare members who are also medically eligible for the service. MaineCare members who are medically eligible for a nursing home qualify for up to 40 hours a week of adult day health services. Individuals not nursing home eligible but with dementia and meeting certain thresholds of cognitive loss and/or need for assistance with activities of daily living qualify for 16 or 24 hours a week. Respite services are also available as part of the supports waiver services for adults with developmental disabilities or autism (Section 29 of MaineCare). Commission members recognize the importance of quality adult day and respite services to caregivers – both financially, allowing a caregiver to remain in the paid workforce, and psychologically – as well as to the individuals attending these programs.

Recommendation (intermediate):

18. Direct the Department of Health and Human Services to review the hours allowable for adult day health services, respite services and other similar programs for adequacy in allowing individuals to remain at home with family members as long as desired by both the caregivers and the individuals receiving services.

Assistive technology and environmental modifications

Although assistive technology and environmental modifications do not directly impact the workforce challenges for direct care, these types of services can reduce the number of face-to-face or hands-on worker hours. Assistive technology refers to devices and services used to increase, maintain or improve a member's capabilities to perform activities of daily living such as motion-activated devices, remote-monitoring cameras, iPads or laptops, and electronic medication dispensers. Environmental modifications relate to physical modifications to the person's residence, such as building ramps or lifts or widening doorways. Assistive technology and environmental modifications must be approved and are subject to monthly or annual caps as well as overall spending caps within MaineCare services.³⁴ The concern of Commission members is that the caps are too low given the cost of technology as well as continual innovation, and it would be helpful for consumers of services if the funding were more flexible, for example combining annual caps to allow for a more expensive technology or modification to be provided. Commission members understand that the Aging and LTSS Advisory Group which convened beginning in May 2019 by the Department of Health and Human Services is likely to recommend amending cost models in such a way (bundling service over three years or moving them outside of the current program caps), as well as increasing access to occupation or assistive technology assessments.

Recommendation (immediate):

³⁴ <http://legislature.maine.gov/doc/3429>.

19. Direct the Department of Health and Human Services to raise the caps and create more flexible cost models for assistive technology and environmental modifications for members receiving home and community-based services.

Other Recommendations

Consumer-directed services

Older adults eligible for home and community-based services under the MaineCare program or state-funded programs can choose to self-direct their services by acting as an employer who manages their own services including hiring and firing their own caregivers. The Commission received presentations from Tom Newman, the Executive Director of Alpha One, a participant in the consumer-directed program, and from GT Independence, a fiscal intermediary, at the October 24, 2019, meeting. Individuals self-directing their care are required to use a fiscal intermediary to conduct administrative and payroll services, including preparing taxes, making payments and ensuring compliance with state and federal labor laws and regulations on behalf of members. The fiscal intermediary organization has a contract with the department to provide these services. The self-directed option began in the 1990s as part of the self-determination movement for individuals with disabilities.

The Commission learned that the Department of Health and Human Services had developed a one-page document outlining options available for every assessment level to ensure that eligible individuals are aware of the consumer-directed option that was about to go live at the time of the Commission's final meeting. It is unclear to Commission members whether there is a need for publicizing the consumer-directed option for older adults with disabilities or if eligible individuals are already fully aware of its availability. However, there was consensus on the Commission that the consumer-directed option should be available to individuals with developmental disabilities or autism on the waiver and currently receiving services under Sections 21 or 29.

Recommendation (intermediate):

20. Direct the Office of Aging and Disability Services within the Department of Health and Human Services to convene a work group of stakeholders within the department that includes providers, advocates and consumers, to determine how to expand the consumer-directed options to individuals with developmental disabilities or autism and examine if consumer-directed options are fully utilized for all populations eligible for home and community-based services.

Digital Platforms for matching workers and clients and pooling workers

Direct care workers often have multiple clients and work for more than one agency in an effort to accrue their desired number of hours. Workers also experience cancellations often unexpectedly cutting their hours and reducing income, for example when a client is in the hospital or has another appointment. At the same time, individuals approved for a certain number of hours of services are unable to find providers for those services. Commission members are interested in the idea of providers pooling workers including the provision of benefits. Members are also

interested in systems to match workers to clients and employers to more efficiently reassign workers with unwanted gaps in their schedule due to cancellations of clients for whatever reason. This could provide more hours of services for individuals who need them and it could potentially prevent the unexpected cuts in earnings for direct care workers.

During the PHI presentation in October, Stephen Campbell briefly discussed the idea of matching service registries which primarily exist in the consumer-directed field. Mr. Campbell stated that Alpha One provides this service through its website.³⁵ Mr. Campbell also discussed the positive impact of the Direct Support Connect program in Minnesota. The Minnesota website, created in response to that state's workforce shortage, allows direct care workers and employers of direct care workers to register and then matches them up so that they can contact each other directly.³⁶ Consumers who self-direct but do not chose Alpha One as the fiscal intermediary would also benefit from such a system in this State. However, it is unclear whether such a system could be extended beyond the consumer-directed programs, but it is important to explore ways to more efficiently fill direct care workers' available hours in light of unfilled hours.

Recommendation (long-term):

21. Direct the Department of Health and Human Services to convene a stakeholder group of providers to explore methods to pool workers across providers and care settings or programs, including developing a method to provide benefits to the workers.
22. Direct the Department of Health and Human Services to explore creating a HIPAA-compliant digital platform to connect direct care workers, providers, self-directing consumers and family members. The department must include providers in its exploratory effort.

Public assistance programs

Direct care workers often have high rates of reliance on public assistance programs such as SNAP, TANF, Medicaid, child care, housing assistance, and the Medicare Savings Program.³⁷ Commission members who are providers often hear that direct care workers are concerned about how much income they are allowed to earn before losing benefits; they want to ensure that these workers are fully informed and able to work as many hours as allowable. There are multiple federal and state laws and regulations that govern allowable income levels for various programs. For example, SNAP income levels are set at the federal level but there is flexibility within the TANF program for states to develop programs to encourage people into the workforce. To that end, the Legislature made changes to the TANF income cliffs in the first regular session of the 129th Legislature (Public Law 2019, chapter 484). Several members of the commission also mentioned that direct care workers would benefit from ready access to information on the income and asset limits of these programs. According to Commission member, Karen Fraser from the Department of Labor, the Social Security Administration addresses a similar concern from recipient of SSDI benefits through benefit counsellors who provide individual information for each person regarding their benefit and their working life.

³⁵ http://www.alphaonenow.org/pa_registry.htm.

³⁶ <https://directsupportconnect.com/dsc/>.

³⁷ <https://phinational.org/wp-content/uploads/legacy/phi-facts-3.pdf>.

Recommendation (intermediate):

23. Direct the Department of Health and Human Services to explore options for increasing income levels for direct care workers who are receiving various public assistance benefits and ensure that department's case workers communicate this information to their clients.
24. Direct the Department of Health and Human Services to study public assistance programs across the spectrum to determine where higher income levels might be allowable under federal and state laws and rules and consider developing programs that provide more flexibility of increased hours among direct care workers and report findings to the Joint Standing Committee on Health and Human Services for statutory action.
25. Improve communication and navigation of maximum income levels to individuals receiving public assistance.

Grant Opportunities

The Commission discussed opportunities for funding to attract people to the direct care field and to improve quality for recipients of services. Members discussed the Civil Money Penalty (CMP) Reinvestment Program several times. CMPs are imposed against nursing facilities for noncompliance with federal regulations. These penalties are paid to the Centers for Medicare and Medicaid Services but can be used by states to support activities that protect or improve the quality of care for residents of nursing facilities, including by improving staff training. It does not appear that Maine has fully utilized the CMP funding source.

A successful example of a CMP-funded program was the Music and Memory Program – Maine Partnership to Improve Dementia Care in Nursing Homes which was created in 2016 when the state received a grant. Brenda Gallant, the Maine Long-Term Care Ombudsman (and Commission member) was involved in the program to train and certify nursing homes in the Music and Memory program, provide additional skills, tools and strategies for staff to assist in the person-centered care of residents with dementia and to decrease antipsychotic medication use.

Stephen Campbell from PHI discussed similar programs in other states such as the WisCaregiver Careers program in Wisconsin that was partly funded with CMP funds. In Wisconsin, the aim is to add 3,000 nursing assistants to the long-term care workforce in nursing homes by offering free training and testing in almost all technical colleges in the state and then use the WisCaregiver Careers program to find employment and pay a \$500 bonus for nursing assistants who stay at least six months. The program includes a communications campaign that includes nursing assistants with diverse backgrounds, including men, in the videos. As of January 31, 2018, after approximately one year, 1,166 individuals had completed the training and 689 had completed the testing with 243 WisCaregivers employed in nursing facilities; most nursing facilities in Wisconsin participate in the program.³⁸

³⁸ <https://www.dhs.wisconsin.gov/caregiver-career/index.htm> and <https://phinational.org/wisconsin-partnership-could-transform-nursing-assistant-field/>.

Another potential source of federal grant funding is the Lifespan Respite Care Program run by the Administration for Community Living (ACL) within the federal Department of Health and Human Services. This program was enacted by Congress to provide coordinated systems of accessible, community-based respite care services for family caregivers of children and adults with special needs. The purpose is to expand respite services and improve the delivery and quality of those services. Competitive grants have been awarded since 2009 to agencies in 37 states and DC but Maine has never been the recipient of a grant.

In addition to the CMP and ACL grants, Commission members encourage the Department of Health and Human Services to investigate and apply for any grant opportunities that offer training to direct care workers or family caregivers or improve quality of care in any way. For example, Commission members have heard that the Health Resources and Services Administration will be offering grants in 2020 for direct care worker training on behavioral health.

Recommendations (intermediate):

26. Direct the Division of Licensing and Certification in the Department of Health and Human Services to convene a work group to develop proposals for projects in nursing homes focused on best practices for recruitment and retention of direct care staff using Civil Money Penalty Reinvestment Program funds and submit those proposals to the Centers for Medicare and Medicaid Services.
27. Direct the Department of Health and Human Services to consider applying for a grant under the Lifespan Respite Care program grant offered by the ACL within the federal Department of Health and Human Services, or working with any appropriate organization that is eligible.
28. Direct the Department of Health and Human Services to investigate and apply for any grant opportunities that improve the quality of long-term care services and supports.

Oversight Committee

Extensive analysis of the long-term care workforce was conducted in the past, most notably in 2009 and 2010 in response to LDs 400, 1059, 1078 and 1364 introduced in the 124th Legislature.³⁹ This earlier work produced two reports with many recommendations with specific steps toward implementation.⁴⁰ The Department of Health and Human Services provided the Commission with an update of work done since these reports.⁴¹ However, Commission members expressed frustration that many of the recommendations were not acted on and there was no oversight or awareness of the inaction. To prevent that in the future, the Commission recommends the establishment of an Oversight Advisory Committee in statute with members appointed by the Commissioner of Health and Human Services that operates independent of the

³⁹ LD 400, An Act To Implement the Recommendations of the Blue Ribbon Commission To Study Long-term Home-based and Community-based Care; LD 1059, Resolve, To Enhance Health Care for Direct Care Workers; LD 1078, An Act To Strengthen Sustainable Long-term Supportive Services for Maine Citizens; and LD 1364, An Act To Stimulate the Economy by Expanding Opportunities for Personal Assistance Workers.

⁴⁰ <http://legislature.maine.gov/doc/3169> and <http://legislature.maine.gov/doc/3170>.

⁴¹ <http://legislature.maine.gov/doc/3254>, p. 4.

department. Members should mirror the membership of this Commission, except that there would be no legislators. The Oversight Committee would have the following duties:

- Review progress toward implementing the recommendations of this report as acted on by the Health and Human Services Committee and the Legislature;
- Address barriers to recommendations;
- Make new recommendations as needed;
- Collate data from the department on usage of home and community-based services and residential services, unmet demand including unstaffed hours, vacancies for direct care worker positions and unfilled beds due to staffing shortages;
- Collate data from the C'WRI relating to current and future need for direct care workers; and
- Meet at least quarterly and submit ongoing and annual reports to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

Recommendation (immediate):

29. Enact an ongoing, independent Oversight Committee to review progress in implementing the recommendations of this Commission, address barriers to implementation, and make new recommendations as needed.

Legislation to enact the oversight commission is included in Appendix C.

APPENDIX A

Authorizing Legislation: Public Law, 2019 Chapter 343
Part BBBB, Section BBBB-1

APPROVED	CHAPTER
JUNE 17, 2019	343
BY GOVERNOR	PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND NINETEEN

H.P. 743 - L.D. 1001

An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds, and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2019, June 30, 2020 and June 30, 2021

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the 90-day period may not terminate until after the beginning of the next fiscal year; and

Whereas, certain obligations and expenses incident to the operation of state departments and institutions will become due and payable immediately; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

PART BBBBB

Sec. BBBBB-1. Commission To Study Long-term Care Workforce Issues.
Notwithstanding Joint Rule 353, the Commission To Study Long-term Care Workforce Issues, referred to in this section as "the commission," is established.

1. Members. The commission consists of up to 18 members as follows:

A. Two members of the Senate appointed by the President of the Senate, including a member from each of the 2 parties holding the largest number of seats in the Legislature;

B. Three members of the House of Representatives appointed by the Speaker of the House, including a member from each of the 2 parties holding the largest number of seats in the Legislature; and

C. Up to 13 members who possess expertise in the subject matter of the study as follows:

- (1) A direct care worker appointed by the President of the Senate;
- (2) A provider of home-based long-term care who is a member of a statewide association representing home-based long-term care providers appointed by the President of the Senate;
- (3) A representative of a statewide association representing nonprofit housing and senior service programming appointed by the President of the Senate;
- (4) A representative of an organization providing services to individuals with intellectual disabilities and autism including employment services and long-term home supports appointed by the President of the Senate;
- (5) A provider of facility-based long-term care who is a member of a statewide association representing facility-based long-term care providers appointed by the Speaker of the House;
- (6) A representative of an organization providing statewide homemaker services through the state-funded independent support services program within the Department of Health and Human Services appointed by the Speaker of the House;
- (7) A representative of an institution of higher education engaged in workforce development appointed by the Speaker of the House;

(8) A representative of a service coordination agency providing service coordination to people receiving home-based and community-based long-term care appointed by the Speaker of the House;

(9) A representative of an organization promoting independent living for individuals with disabilities appointed by the Speaker of the House;

(10) A representative of a business that acts as a labor intermediary helping unemployed and underemployed people obtain employment appointed by the Speaker of the House;

(11) The executive director of the long-term care ombudsman program described under the Maine Revised Statutes, Title 22, section 5106, subsection 11-C;

(12) The Commissioner of Health and Human Services, or the commissioner's designee, who may be invited to participate; and

(13) The Commissioner of Labor, or the commissioner's designee, who may be invited to participate.

2. Chairs and subcommittees. The first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission. The chairs of the commission are authorized to establish subcommittees to work on the duties listed in subsection 4 and to assist the commission. The subcommittees must be composed of members of the commission and interested persons who are not members of the commission and who volunteer to serve on the subcommittees without reimbursement.

3. Appointments. All appointments must be made no later than 30 days following the effective date of this Part. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members and after adjournment of the First Regular Session of the 129th Legislature, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this Part a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

4. Directive of commission. The commission shall study and make policy recommendations in each of the following areas:

- A. Measuring current demand for direct care workers and projecting future needs;
- B. Developing a campaign and statewide recruitment strategies to encourage more people to work in facility-based and home-based long-term care;
- C. Supporting career ladders throughout various long-term care settings;
- D. Identifying education needs and methods to fill education needs for direct care workers;
- E. Identifying barriers to hiring and methods to overcome barriers to hiring;
- F. Developing strategies to improve the quality of long-term care jobs; and

G. Increasing opportunities for shared staffing among long-term care providers.

The commission shall make policy recommendations for public and private funding mechanisms to implement the commission's recommendations.

5. Program. The commission shall make recommendations for the establishment of a program that will contribute to long-term care direct care workers' postsecondary education in related fields.

6. Pilot program. The commission shall make recommendations for the establishment of a pilot program to pool part-time home care workers' hours for purposes of providing greater employment opportunity and obtaining employee benefits.

7. Staffing. The Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

8. Administration. The Commissioner of Health and Human Services, the State Auditor and the State Budget Officer shall provide necessary information and assistance to the commission as required for the commission's duties.

9. Report. No later than November 7, 2019, the commission shall submit a report that includes its findings and recommendations pursuant to subsections 4 to 6, including suggested legislation, to the Joint Standing Committee on Health and Human Services. The joint standing committee may report out a bill regarding the subject matter of the report to the Second Regular Session of the 129th Legislature.

PART CCCCC

Sec. CCCCC-1. 25 MRSA §5101, as amended by PL 2017, c. 407, Pt. A, §104, is further amended to read:

§5101. Substance Use Disorder Assistance Program

1. Substance Use Disorder Assistance Program. The Substance Use Disorder Assistance Program, ~~referred to in this chapter as "the program,"~~ is established to support persons with presumed substance use disorder by providing grants to municipalities and counties to carry out ~~projects~~ programs designed to reduce substance use, substance use-related crimes and recidivism.

2. Eligibility; program targets; programs. Grants may be awarded to:

A. Municipal or county governments or regional jails for ~~projects~~ programs designed to assist persons with presumed substance use disorder by ~~diverting using liaison strategies both before and after arrest to refer~~ alleged low-level offenders into community-based treatment and support services. ~~Projects~~ Programs may include, but are not limited to:

(1) Referral of ~~program~~ participants in the Substance Use Disorder Assistance Program under subsection 1 to evidence-based treatment programs, including medically assisted treatment; and

APPENDIX B

Membership list, Commission to Study Long-term Care Workforce Issues

Commission to Study Long-term Care Workforce Issues

MEMBERSHIP

Appointments by the President of the Senate

Senator Erin Herbig	Senate Chair
Senator Jeffrey Timberlake	Member of the Senate
Kathy Callnan	Representative of statewide association of non-profit housing and senior service programing
Jillian Jolicoeur	Representative of an organization providing services to persons with intellectual disabilities and autism
Rachel Small	Direct care worker
Michael Stair	Provider of home-based long-term care who is a member of statewide association representing home-based long-term care providers

Appointments by the Speaker of the House

Representative Jessica Fay	House Chair
Representative Abigail Griffin	Member of the House
Representative Holly B. Stover	Member of the House
Sandy Butler	Representative of an institution of higher education engaged in workforce development
Debbie Gilmer	Representative of an organization promoting independent living for individuals with disabilities
Don Harden	Representative of an organization providing statewide homemaker services through the state-funded independent support services program within DHHS
Mary Jane Richards	Provider of facility-based long-term care who is a member of a statewide association representing facility-based long-term care providers

Betsy Sawyer-Manter	Representative of a service coordination agency providing service coordination to people receiving home-based and community-based long-term care
Amy Winston	Representative of a business that acts as a labor intermediary helping unemployment and underemployed people obtain employment
<u>Authorizing Legislation Named Members</u>	
Brenda Gallant	Executive Director of the long-term care ombudsman program described under the Maine Revised Statutes, Title 22, section 5106, subsection 11-C
Commissioner Jeanne Lambrew	Commissioner of Health and Human Services, or designee
Karen Fraser, Bureau Director	Commissioner of Labor, or designee

Staff:

Anna Broome, Senior Legislative Analyst
 Lynne Caswell, Legislative Analyst
 Office of Policy and Legal Analysis

APPENDIX C

Suggested Legislation

Recommended Draft Legislation

An Act To Implement the Recommendations of the Commission to
Study Long-term Care Workforce Issues

PART A

Sec. 1. 22 MRSA Chapter 1476 is enacted to read:

CHAPTER 1476
DIRECT CARE WORKER WAGES

§5319. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Activities of daily living. "Activities of daily living" means activities as defined in federal and state rules including those essential to a person's daily living including: eating and drinking; bathing and hygiene; dress, including putting on and removing prostheses and clothing; toileting, including toilet or bedpan use, ostomy or catheter care, clothing changes and cleaning related to toileting; locomotion or moving between locations within a room or other areas, including with the use of a walker or wheelchair; transfers or moving to and from a bed, chair, couch, wheelchair or standing position; and bed mobility or positioning a person's body while in bed, including turning from side to side.

2. Direct access. "Direct access" means access to the property, personally identifiable information, financial information or resources of an individual or physical access to an individual who is receiving services from a direct care worker in an institutional setting or in a home or community setting.

3. Direct care worker. "Direct care worker" means an individual who by virtue of employment generally provides to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or has direct access to provide care and services to clients, patients or residents regardless of the setting.

4. Home or community setting. "Home or community setting" means health and social services and other assistance required to enable adults with long-term care needs to remain in their places of residence or group homes. These services include, but are not limited to, self-directed care services; home health aide services; personal care assistance services; companion and attendant services; homemaker services; respite care; and other appropriate and necessary social services.

5. Institutional setting. "Institutional setting" means residential care facilities, licensed pursuant to chapter 1664; intermediate care and skill nursing facilities and units and hospitals,

licensed pursuant to chapter 405; and state institutions for individuals who have intellectual disabilities or autism or other related conditions.

6. Instrumental activities of daily living. “Instrumental activities of daily living” means the activities as defined in federal and state rules, including those essential, nonmedical tasks that enable a person to live independently in the community, including light housework, preparing meals, taking medications, shopping for groceries, using the telephone, managing money and other similar activities.

7. Self-directed care services. “Self-directed care services” means services procured and directed by the person receiving services or the person’s surrogate that allow the person to reenter or remain in the community and to maximize independent living opportunities. “Self-directed care services” includes the hiring, firing, training and supervision of direct care workers to assist with activities of daily living and instrumental activities of daily living.

§5320. Direct care worker minimum wage

Starting January 1, 2021, the minimum hourly wage paid to a direct care worker must be no less than 125% of the minimum wage established in Title 26, section 664, subsection 1. Increases to the minimum wage for direct care workers must begin on January 1st of each year at the same time as any increase in the minimum wage takes place.

§5321. Rulemaking

The department shall adopt rules providing reimbursement rates under this chapter that take into account the costs of providing the direct care worker minimum wage required in section 5320. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. Department of Health and Human Services adopt rules to provide reimbursement rates sufficient for structural costs. The Department of Health and Human Services shall adopt rules to increase reimbursement rates under Chapter 101 of the MaineCare Benefits Manual and any state-funded programs to take into account costs of providing care and services in conformity with applicable state and federal laws, rules, regulations, training requirements and quality and safety standards including, but not limited to: the costs of increases in wages for direct care workers pursuant to the Maine Revised Statutes, Title 22, chapter 1476; increases in minimum wages for any other workers pursuant to the Maine Revised Statutes, Title 26, section 664, subsection 1; earned paid leave pursuant to Title 26, section 637; background checks required pursuant to the Maine Revised Statutes, Title 22, chapter 1691; and electronic visit verification required under the federal 21st Century Cures Act, Public Law 114-255, Section 12006. The department shall consult with providers and other stakeholders that the department determines appropriate to determine appropriate reimbursement levels for services.

[Rulemaking authority to remain the same as in existing law, e.g. PNMI reimbursement rules are major substantive; most others are routine technical.]

PART B

Sec. 1. 5 MRSA §12004-I, sub-§47-L is enacted to read:

47-J	<u>Long-term care workforce oversight</u>	Not authorized	22 MRSA §5307
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Sec. 2. 22 MRSA §5307 is enacted to read:

§5307. Long-term care workforce oversight advisory committee

The long-term care workforce oversight advisory committee, as established in Title 5, section 12004-I, subsection 47-J and referred to in this section as "the oversight committee," is established to provide advice and oversight to the department and the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding long-term care workforce issues.

1. Membership. The oversight committee consists of 10 members as follows:

A. Eight members, appointed by the commissioner, are employers and providers of services in the long-term care industry employing direct care workers providing assistance with activities or daily living or instrumental activities of daily living to clients, patients or residents, in institutional and home and community settings;

B. One member, appointed by the Commissioner, is a recipient of self-directed services as defined in section 5319, subsection 7; and

C. The long-term care ombudsman established in section 5107-A is a member of the oversight committee.

For the purposes of this subsection, "direct care worker" has the same meaning as in section 5319, subsection 3.

2. Terms. Members of the oversight committee are appointed to staggered 2-year terms so that at least 4 members representing providers expire on July 1st of each year. If the commissioner fails to make an appointment prior to the expiration of a member's term, that member continues to serve until the commissioner makes an appointment for the remainder of that term. If a vacancy occurs prior to the expiration of a specified term, the commissioner shall appoint a person to serve the remainder of that term.

3. Duties. The oversight committee has the following duties:

A. Collect data from the department relating to the number of hours of services provided by direct care workers, the number of approved hours for which staffing cannot be provided due to staffing shortages, vacancies for direct care worker positions and the number of unfilled beds in residential care facilities licensed under chapter 1664 and nursing facilities licensed under chapter 405;

B. Collate data available from the Department of Labor relating to current and future need for direct care workers;

C. Review progress by the department in implementing recommendations provided to the department and the joint standing committee of the Legislature having jurisdiction over health and human services matters relating to long-term care workforce issues and address barriers to implementing those recommendations; and

D. Make recommendations to the department and the joint standing committee of the Legislature having jurisdiction over health and human services matters on proposals to increase the long-term care workforce and address shortages in services.

4. Meetings; report. The oversight committee must meet at least quarterly and submit an annual report to the joint standing committee of the Legislature having jurisdiction over health and human services matters no later than January 2nd of each year describing the oversight committee's activities and recommendations.

SUMMARY

This bill implements the recommendations of the Commission to Study Long-term Care Workforce Issues which was established by Public Law 2019, chapter 343, part BBBB. The bill does the following.

1. It requires direct care workers across the long-term care spectrum to be paid no less than 125% of the minimum wage. It requires the Department of Health and Human Services to adopt rules that take into account the cost of this increased wage in its reimbursement rates.
2. It requires the Department of Health and Human Services to adopt rules to increase reimbursement rates under Chapter 101 of the MaineCare Benefits Manual and any state-funded programs to take into account costs of providing care and services in conformity with applicable state and federal laws, rules, regulations, training requirements and quality and safety standards including, but not limited to, increases in the minimum wage, earned paid leave, electronic visit verification, background checks and other costs that are not provided for in the current reimbursement rates.
3. It establishes a long-term care workforce oversight advisory committee to collect and compile data related to workforce shortages and services provided to clients, review progress by the Department of Health and Human Services regarding recommendations provided to the department and the joint standing committee of the Legislature having jurisdiction over health and human services matters including the recommendations of the Commission to Study Long-term Care Workforce Issues, identify barriers to implementing recommendations and make recommendations on proposals to address long-term care workforce shortages. The oversight committee must submit an annual report to the joint standing committee of the Legislature having jurisdiction over health and human services matters.

APPENDIX D

Letter to Commissioner Lambrew regarding reimbursement rates



**Commission to Study Long-term Care
Workforce Issues**

December 17, 2019

Commissioner Jeanne M. Lambrew
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Lambrew,

We are writing to relay the concern of the Commission to Study Long-term Care Workforce Issues regarding the urgent need for the Department of Health and Human Services to increase reimbursement rates for state and MaineCare funded services for long-term service and supports including home and community-based services, PNMI and nursing facilities, and consumer-directed services for older adults and individuals with physical and developmental disabilities as soon as possible.

As you know, because you are a member, the Commission was established pursuant to Public Law 2019, chapter 343 (the biennial budget), Part BBBB in response to the workforce shortages experienced across the spectrum of long-term service and supports, from the Homemaker program to nursing facilities. Maine is currently the oldest state in the nation with a long-term service and supports system that is in crisis. Direct care workers, including those who are committed and would prefer to remain in their caregiving professions, are unable to make a living and are leaving the field for better paying jobs. Direct care workers do hard physical work that is also emotionally taxing and they deserve to be paid more than they are currently paid. Many are working long hours at multiple jobs, often without benefits, in an attempt to make ends meet. On the other side of the equation, consumers of these services are going without care that they need, and have been approved for, due to a severe workforce shortage. Older adults and individuals with disabilities who try to take care of themselves when someone else should be there poses a serious safety risk. As a result, these individuals are likely to end up in the hospital or in a nursing home with a higher level of care that is more expensive. Older adults and individuals with disabilities in this state deserve consistent and quality care from caregivers that they trust and can build relationships with.

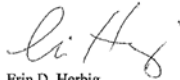
From the provider perspective, the current reimbursement rates are both inadequate and unsustainable. Providers are committed to providing services to people who live in this state who both need and are entitled to these services. However, from a business perspective, the system is in crisis. Several nursing facilities have recently closed and providers across the long-term supports and services spectrum are often operating at a loss. Providers also have many unfilled positions because they are unable to attract direct care workers. Reimbursement levels do not cover existing costs and future anticipated structural additions to costs will make the

situation worse. Providers will have to comply with state and federal laws and regulations including the upcoming increase in the minimum wage, the requirement to provide paid time off, insurance mandates, electronic visit verification requirements and background checks (including the possibility of finger printing) but there is insufficient funding to do that.

The Commission understands that the Department of Health and Human Services will be reporting to the Health and Human Services Committee regarding its efforts to establish a rational and regularly reviewed rate scheme. Providers need immediate relief in the form of a rate increase as well as ongoing predictability in rate review. Accordingly, we urge you to take all necessary steps to increase reimbursement rates as soon as possible, including any requests for appropriations, in order to prevent providers from going out of business, more committed direct care workers from leaving their chosen profession, and our older adults and individuals with disabilities from finding themselves in untenable and unsafe positions that lead to a higher, more expensive level of care.

We thank you for your attention to this very important matter.

Sincerely,



Erin D. Herbig
Senate Chair



Jessica L. Fay
House Chair

cc: Michelle Probert, Director of the Office of MaineCare Services
Molly Bogart, Director of Government Relations

APPENDIX E

Response from Commissioner Lambrew to the letter regarding reimbursement rates

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner



Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
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Tel: (207) 287-3707; Fax: (207) 287-3605
TTY: Dial 711 (Maine Relay)

December 20, 2019

Senator Erin Herbig, Chair
Representative Jessica Fay, Chair
Commission to Study Long-term Care Workforce Issues
#100 State House Station
Augusta, Maine 04333-0100

Dear Senator Herbig, Representative Fay, and Members of the Commission to Study Long-term Care Workforce Issues:

I wanted to respond in a timely way to your letter sent earlier this week that asks the Maine Department of Health and Human Services (DHHS) to provide "immediate relief in the form of a rate increase..."

The Commission's authorizing legislation directed its report to the Joint Standing Committee on Health and Human Services. The recommendations in your letter would require a legislative appropriation. Maine State Legislature has granted DHHS neither the blanket authorization nor unlimited appropriations to unilaterally increase reimbursement rates for MaineCare services. We respectfully suggest the Commission direct its request to the Legislature.

The Commission also notes a desire for "ongoing predictability in rate review," which we share. To inform the Legislature's consideration of your request among others, DHHS is conducting a comprehensive evaluation of MaineCare's rate setting system for all services, including those for long-term services and supports. This evaluation will include a comparison of what MaineCare pays to (1) five comparable state Medicaid programs; (2) Medicare; and (3) commercial health plans. The results will inform the next biennial budget. We are specifically looking to reform the complicated and outdated system of MaineCare reimbursement for nursing facility services. Governor Mills has directed DHHS to examine reforms that would promote simplicity, quality, value, transparency, and accountability.

Recognizing short-term challenges in institutional care settings, just last week Governor Mills announced her support for LD 1758, "An Act To Clarify and Amend MaineCare Reimbursement Provisions for Nursing and Residential Care Facilities." Combined with current rate increases, LD 1758 will increase MaineCare nursing facility rates by 5.5 percent on average for fiscal year 2020. Reimbursement to nursing facilities has increased cumulatively by 40 percent since fiscal year 2012. This is more than most other MaineCare services and should significantly bolster the ability of our nursing facilities to provide quality care.

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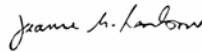
As many witnesses at Commission meetings explained, MaineCare reimbursement rates are neither the sole cause nor the sole solution to ensuring a high-quality, accessible long-term services and supports system and the workforce to support it. Under the leadership of the Office of Aging and Disability Services (OADS), DHHS has launched a comprehensive initiative to support aging in Maine. This includes a Long-Term Services and Supports Advisory Group. Its report, which will be published early in the new year, will describe ways to better coordinate care for Medicare-Medicaid dual eligible individuals as well as pathways for more home- and community-based options. These options will affect the workforce in that they empower consumers and families, which lessens the pressure on agencies and providers. And, harnessing assisted technology and other in-home supports will alleviate the need for home care workers for some Mainers.

We also continue to support workforce training, recruitment, and retention. This includes reviewing how DHHS programs can co-locate and collaborate with those of the Department of Labor. We are working on streamlining training curriculum, and are happy to respond to concerns as they arise, as noted in our response to your letter regarding the personal support specialist (PSS) curriculum timeline. The State is also addressing credentialing. For example, recent changes to recognize other states' certified nurse assistant (CNA) training programs has resulted in 1,200 new registered CNAs in the last year. In addition, we also are working on lateral matrices for workers to be able to navigate across careers within the health sector. DHHS is hiring a health care workforce coordinator for the State who will identify the most pressing shortages and develop strategies with the private sector including, but not limited to, enhanced training programs, recruitment initiatives, and retention promotion.

In closing, DHHS views front-line workers in long-term care facilities, home, and community-based settings as the heart of the system. The hidden word in their job description is "compassion." They care for our parents as their ability to live independently declines. They support our children with intellectual or developmental disabilities as they age.

We appreciate your commitment and look forward to working with you on actionable, evidence-based solutions that support older Mainers and people with disabilities, as well as the people who care for them.

Sincerely,



Jeanne M. Lambrew, PhD
Commissioner

JML/klv

cc: Michelle Probert, Director, Office of MaineCare Services
Molly Bogart, Director of Government Relations

APPENDIX F

Letter to Commissioner Lambrew regarding PSS training



**Commission to Study Long-term Care
Workforce Issues**

December 17, 2019

Commissioner Jeanne M. Lambrew
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

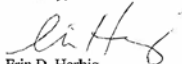
Dear Commissioner Lambrew,

We are writing to relay the concern of the Commission to Study Long-term Care Workforce Issues with the upcoming launch of the new Personal Support Specialist (PSS) curriculum by the Division of Licensing and Certification (DLC). We learned during the Commission meetings, that DLC has worked hard to update the current PSS curriculum which was last amended in 2003, and we commend DLC for completing this project. However, after hearing from a wide range of consumers, workers, providers, and stakeholders, the Commission will, in its upcoming report to the Health and Human Services Committee, recommend that the Committee direct the Department to reconstitute the Maine Direct Service Worker Curriculum developed under a HRSA demonstration grant awarded to DHHS in 2010.

If implemented as currently scheduled, the new PSS training will require providers who conduct their own trainings to invest a significant amount of money to update their training programs within the first 90 days of 2020. To prevent unnecessary expense to, and to minimize confusion and disruption of providers, consumers and PSS workers, the Commission respectfully requests that the PSS curriculum launch be delayed for a few months. Such a short delay is unlikely to negatively affect workers, providers, or consumers in any significant way and will give the Health and Human Services Committee time to review, consider, and possibly act upon the Commission's recommendation during the Second Regular Session. We hope that DLC will participate in the committee's deliberation on this topic.

We thank you for your attention to this very important matter.

Sincerely,


Erin D. Herbig
Senate Chair


Jessica L. Fay
House Chair

cc: Bill Montejo, Acting Director, DHHS/DLC
Molly Bogart, Government Relations Director, DHHS

APPENDIX G

Response from Commissioner Lambrew to the letter regarding PSS training

Janet T. Mills
Governor

Jessie M. Lambrew, Ph.D.
Commissioner



Maine Department of Health and Human Services
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11 State House Station
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December 20, 2019

Senator Erin Herbig, Chair
Representative Jessica Fay, Chair
Commission to Study Long-term Care Workforce Issues
#100 State House Station
Augusta, Maine 04333-0100

Dear Senator Herbig, Representative Fay, and Members of the Commission to Study Long-term Care Workforce Issues:

Thank you for sharing your concerns regarding the revised Personal Support Specialist (PSS) curriculum in your recent letter.

The Division of Licensing and Certification's (DLC) Workforce Development Unit was tasked with the challenge of revising the PSS curriculum in large part because the textbook associated with the program is out of print. There were also concerns regarding the scope of practice being taught in the course and potential conflicts with other relevant State Agency jurisdictions such as the Board of Nursing's (BON) Certified Nursing Assistant courses and the BON rules regarding delegation of nursing care to unlicensed assistive persons.

As part of the development of the new PSS curriculum, staff conducted a review of the draft PSS curriculum that was written in 2010 and utilized for the Direct Service Worker Training Project (DSWTP), which was funded through a grant from the Health Resources and Services Administration (HRSA). A determination was made that this draft curriculum would require revisions and updating due to content that conflicted with the BON scope of nursing delegation. DLC made the determination that it was more beneficial to start with a clean slate and the new revised PSS curriculum was shared with the BON to ensure that the curriculum did not conflict with BON rules.

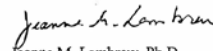
The implementation of the new PSS curriculum started on October 1, 2019. Stakeholders were sent notice of the new curriculum and the roll-out plan in September and were advised that, after December 31, 2019, DLC would only issue course certificates based on the new curriculum. Since utilization of this new curriculum has been in place since October 1, 2019 and there have been several trainers and courses conducted with this new curriculum, we are unable to delay the launch of this curriculum.

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However, the Department can accommodate the Commission's request for a delay in the end date for utilization of the old curriculum for an additional 90 days until April 1 to allow for further review and discussion. We will post this on the DHHS website and inform stakeholders of this extra time.

The Division of Licensing and Certification and the Office of Aging and Disability Services would welcome the opportunity to work with the Commission, Legislature, and stakeholders on the curriculum going forward.

Sincerely,


Jeanne M. Lambrew, Ph.D.
Commissioner

JML/klv

cc: William Montejo, Director, Division of Licensing and Certification
Molly Bogart, Director of Government Relations

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Chairman DESAULNIER. Thank you, Representative. Thank you for your testimony and your work and your commitment in this field.

Under Committee Rule 9(a), we will now question witnesses under the five-minute rule.

As this is a joint Subcommittee hearing, after the Chairs and Ranking Members, I will be recognizing Subcommittee Members based on seniority order of the full Committee.

I will be followed, after my questions, by Ranking Member Allen, and then Chair Wilson, and then Ranking Member Murphy.

So let me begin.

Again, Representative Fay and all the witnesses, thank you so much for your testimony. For a lot of us, we have experienced this with our parents and friends and neighbors and loved ones. My mom passed away a couple years ago at the ripe old age of 94, and my siblings and I were all very engaged in taking care of her. And it was a struggle. And her last 5 years, when she was in a nursing home after she lost her independence in San Francisco, I had multiple conversations with the staff there and with the employers of the difficulty of trying to provide services in that setting in a high-cost area like San Francisco.

But, equally, as someone who was involved in our public authority in the county that I represent and represented as a county supervisor many years ago, the challenges to provide for this care is really daunting.

So thank you all, and thank you, Representative Fay.

I want to ask you a question, Representative Fay. With the Olmstead decision and the ADA, our understanding of the position of people with disabilities in America has changed, and our social context has changed. The social model has changed dramatically from when I was young. We live farther apart from each other. Families are not always able to provide care and support.

Can you talk about the importance of strengthening the direct care workforce and meeting the goals of the ADA and meeting the

needs of people with disabilities and the aged, particularly in the context of this changing environment, where young people and family Members have economic pressures of their own to travel further and further to get employed, and they have to move employment frequently?

So, the social model having changed, it seems to me that we are slowly trying to adapt to this new social model that doesn't have families as closely located where traditionally they would provide many of these support systems.

Ms. FAY. Thank you, Mr. Chair, for the question.

The—the goal of the ADA is to allow people with disabilities to live as part of our communities, with barriers to that participation removed, and I think, if you require assistance in order to do that, and then there is no one there to provide that assistance, whether it is personal care, transportation, or other activities of daily living, then you are really unable to fully participate.

And so a direct care workforce shortage really is in opposition to the goals of the ADA.

Chairman DESAULNIER. Thanks.

I want to ask you. As somebody who served in local government and in the State legislature, now at the Federal level, this difficulty of our roles and the genius of our Founders in having local control, but also having a United States, and coming from a large State, the largest State, challenges, and from a large county in an urban area, as one of the Ranking Members mentioned—Mr. Allen, I believe—the importance of making it fit for the local community, what do you think is the appropriate role, again, in this very demanding, changing social model—the right role for the Federal Government to play in this regard, so that we can have a really effective conversation with our partners at the State and local level?

Ms. FAY. I think that is a really good question, and I think the word “partnership” is really important. Maine is a State that values our local control a great deal.

I will say that one of the significant barriers for—for us implementing any of the direct care workforce reforms that my commission recommended was funding. And I think, you know, allowing programs or funding programs—pilot programs that would—would allow us to do some evidence-based work on what is successful could be really, really helpful. But I think the term “partnership” is a really key word.

Chairman DESAULNIER. Thank you for that.

And I would say one of the challenges with—I agree with you, the part that pilot programs, but at a certain point, you have to bring them to scale, and I always found that was one of the biggest challenges. We were behind that. Great ideas, but actually deploying it and having it be client-based strikes me as a real struggle. And, of course, those goes to some of the comments we have had earlier.

With that, it is my pleasure to recognize the Ranking Member of the Health Subcommittee, Mr. Allen, for your five minutes of questions.

Mr. ALLEN. Thank you, Mr. Chairman.

Can you hear me OK? I think I am unmuted. Good.

Chairman DESAULNIER. Nope, you are on.

Mr. ALLEN. OK. Great. Super.

Well, listen, thank each of the witnesses for your testimony. I have firsthand experience with this in dealing with my mom and dad and my wife's mom and dad. And it is difficult, and—but I do believe that it is important that it not be a top-down approach, that it be a bottom-up approach.

And that is why I want to work with the States and all of our local communities to solve this problem, which is going to grow, as our Chairman reported. It is going to be—as our population ages, it is going to be more and more significant to our responsibility to take care of folks—and I am getting there—in our golden ages.

But, Mr. Burani, the COVID-19 pandemic revolutionized the doctor-patient relationship by accelerating the use of telemedicine and further integrating technology into treatment models. However, the modernization of this part of the healthcare industry could, unfortunately, leave some healthcare workers behind.

What are you and other similar education providers doing to make sure that healthcare workers have the tools and skills they need to adapt to technology and thrive during this period of rapid modernization?

Mr. BURANI. Thank you for the question, Congressman Allen.

I think that we need to appreciate, it is a relatively low-tech problem that we are solving for. We all, as individuals, can relate to the inconvenience of sitting in a waiting room, you know, waiting some unexpected amount of time for treatment. We know how hard it is to fit an appointment into a busy workday, or to juggle that with other constraints.

And I think that, to some degree, we have to appreciate that, due to the COVID-19 pandemic, as with many technologies that were adopted to adapt to this change, the genie is out of the bottle. And, as a result, the conveniences, the benefits of telemedicine have now become—let's call it mainstream.

As a result, I think what is important is to appreciate the benefits of it, the ability to lower costs, to reach more patients, and, in the process, make life less burdensome for practitioners and patients alike.

As—with respect to your question around upscaling healthcare workers to this rapid modernization, I think it really comes down to—I believe it was Chairwoman Wilson made reference to career pathways in her opening statement, and I think that is an important concept.

To appreciate the fact that these individuals have spent years, decades even, really entrenched in the system, they understand care innately and intuitively. And, for those that have a desire and an appetite to advance in their career, perhaps using the insights and perspectives from direct care in order to contribute to the modernization of the industry, we look at that through the lens of Nanodegree programs that my company represents at Udacity.

However, I think, more broadly speaking, we all just need to appreciate that skill development is an industry-agnostic topic. The skill shortage is affecting all sectors and represents a massive opportunity, but what comes with it is the risk of being left behind.

Mr. ALLEN. Right. Right.

Mr. BURANI. And so anything which provides that growth opportunity, we are in favor, and hope to support.

Mr. ALLEN. I remember talking to my mom and dad checking in with them, and I said, what did you do today? And they said, we spent the day at the doctor's office. So—and that was a regular occasion.

As far as the ransomware and cyber attacks that have wreaked havoc on our hospital's healthcare systems, recently a hospital just outside my district experienced a ransomware attack. From your experience, what can Congress do to improve data security, especially when it comes to health data, and how can we better educate healthcare workers to protect and secure patient health data?

And we have got about 34 seconds.

Mr. BURANI. Big topic for 34 seconds. But what I would say is, at a high level, we need to think about basic hygiene for safeguarding data. It comes to having a basic skill set broadly applied to a workforce that people understand how to lock down internal systems. But we also need to create governance models and accountability so that there is, you know, a clear sense of how this can be done at scale.

Mr. ALLEN. Great. Thank you, sir.

And, with that, Mr. Chairman, I will yield back.

Chairman DESAULNIER. Thank you, Mr. Allen. You're a fine son. I now recognize Chairwoman Wilson for her five minutes of questions.

Chairwoman WILSON. Thank you so much, Chair DeSaulnier, and thank you to all of our witnesses for lending your expertise and time.

Mr. Espinoza, you emphasized career advancement for direct care workers with 30 percent of funds reserved for career advancement activities. In your written testimony, you describe examples of promising career advancement and career pathway initiatives.

Tell us, what are the challenges to developing career pathways and advancement opportunities for the direct care workforce, and how can we develop additional rungs in the career pathways that offer meaningful increases in pay and responsibilities and incentivize long-term retention?

Mr. ESPINOZA. Thank you for the question, Chairwoman.

I think part of the problem is in our failure as a sector and as a country to understand the value that direct care workers offer, and to create meaningful career advancement opportunities for them to contribute more to the care team, and to optimizing the health of the clients and residents that they support.

I think, in most settings, the next formally recognized healthcare title above home health aide and nursing assistant positions is a licensed practical nurse. And yet, too often, arriving at that level requires weeks and months—years of training, I should say, and specifically to get into those roles and to be able to offer those opportunities. And, yet there are a number of ways in which we can create advancement opportunities that State—that keep workers within the direct care sector.

We also know that a lack of career growth opportunities contributes to poor job quality. It has been identified really as a barrier to attracting new workers and to retaining workers over time. And,

so, it's really important that we create these opportunities with an elevation in title, function, and compensation.

Some examples within direct care, direct care workers can advance into peer mentors, where they are supporting fellow workers and integrating them into these roles; care coordination, so that workers are communicating changes in clients' conditions and symptoms to other Members of the healthcare team; and, also, into internal administrative positions, such as assistant trainers or clinical coordinators.

One example is that, in 2015, PHI created a Care Connections senior aide role. Following 240 hours of training specifically in chronic disease knowledge; communication skills; enhanced observe, record, and report skills; and care team participation, home health aides were elevated to salaried Care Connections senior aide roles.

They made home visits to support the upscaling of hundreds of entry level home care workers, and they helped improve care transitions, solve caregiving challenges in the home. And it led—our evaluation showed that, from the initial 18-month demonstration project, there was an 8 percent reduction in the rate of emergency room admission among the 1,400 consumers impacted, reduced caregiving strain among family Members, and improved job satisfaction among home care workers.

The challenge for our field is there are not enough of these career advancement opportunities in this country to really grow to scale and to meet the growing demand that consumers and workers need and deserve.

Also, we need more coordination at the Federal level, where are the gaps within career advancement opportunities and advanced roles that our government should invest in.

Chairwoman WILSON. Thank you. Thank you so much.

Ms. Torres, you have been in the field a long time, and we know there is a very high turnover, and few workers stay in the field as long as you have. How do you think the high rate of turnover impacts the quality-of-care individuals receiving long-term care, and how do you think turnover impacts your job satisfaction? Do you think it makes your job more difficult?

Ms. TORRES. I know that a lot of home health aides stopped working during the COVID, and some clients refused services because they were afraid of infection. It was and still is difficult.

For me, I have a great team. All of us who care for our current clients that have a lot of need to get overnight care. We work together. It is difficult—it is a difficult job, but we have to find joy and satisfaction in our work.

Still, many workers, myself included, thinks that we should be paid more. We make a lot of sacrifices, and our job has been more difficult since the COVID. We have to put a lot of extra time and effort to make sure we are safe, and our clients are safe, and our families are safe.

For me, I care for my patients. I never stop coming to work.

Chairwoman WILSON. Thank you so much. Thank you.

I yield back.

Chairman DESAULNIER. Thank you, Madam Chair.

We will now recognize the Ranking Member, Mr. Murphy. The floor is yours.

Mr. MURPHY. Thank you, Chairman. I just kind of want to reiterate a few of the comments that were just made, because I have dealt, as I have said before, just as a physician, with direct care workers for over 30 years. And I truly, truly understand the dedication and devotion and difficulty that these individuals have in their workforce.

We are going to be faced now with a growing, aging population. Also, a lot more families are scattered, where eastern North Carolina, where I live, there are a lot more families that are staying close, and so their family Members can take care of other individuals. But, in other areas of the country, that is just not the case.

And, so, the increase in need for our direct care workers is going to increase exponentially. Actually, now, as I understand, it is the second largest occupational group in United States after retail sales, and we are going to have a problem in the future, really, if we don't connect—if we don't fix this problem.

Obviously, we talked about turnover. Turnover can be 50 percent in a year, or 80 or 90 percent in 2 years. So there is a massive turnover. I have really seen, however, firsthand, how dedicated individuals can truly, truly help those at home. They decrease emergency department visits. They save money. But then, on the other hand, sometimes the quality is not that great, and it actually affects poorly for patient care. So I just really appreciate the problem that we are facing.

Mr. Burani, let me just ask you a question. As you noted in your testimony, only seven of 10 learners programs actually graduate from the WIOA program. While this completion rate exceeds that of a lot of post-secondary institutions, it is Congress' job—and this is what our job is, to ensure that taxpayer dollars are spent efficiently and effectively.

In your testimony, you mentioned that a learner's incentive to persevere through a challenging program can be diluted when their own money is not invested. Do you have any suggestions about how we can reform the system to essentially give folks skin in the game, to allow individual buy-in that would also not exclude low-income individuals from participating?

Mr. BURANI. Thank you for the question, Congressman Murphy.

So, I think it is an important discussion, right, because seven out of 10 is a standard for the U.S. workforce system, and it is a classic case of glass half full, glass half empty. We certainly like to see that a majority of these enrolled students are making it through, but it does beg the question: What's holding back the other three out of 10?

I think that one thing that is important is to look at the training providers themselves, and understand what are the interventions and support and wraparound services that they are providing in order to sort of optimize those rates? It's not enough just to open a textbook and study. That didn't get anyone through college. And, nowadays, it is not enough to click on a video and watch it.

We need to participate, and we need to get our hands on the learning. Project work that creates practitioner-level skills is, you know, one of our sort of mantras at Udacity.

The other way to look at this is let's take a page from the book of traditional higher ed. Financial aid has very clear channels of engagement. We have merit-based financial aid. We have need-based financial aid. This really is a model that we could look at for short-term or nontraditional credentials.

And I do think that a combination of all of these factors would help to maximize those outcomes and get more value out of these tax dollars.

Mr. MURPHY. Thank you for the response. We do have a challenging problem in front of us. As I said, as we age a Nation, as we grow as a population, we are going to need more of these individuals. And the turnover rate that we have noted is just not acceptable, because it leads to a deficiency in care for these individuals.

And, when they are being taken care of, a family Member who is far away from, you know, children, et cetera, you want to leave them in good hands.

So thank you for your comments, panel Members. I am going to actually yield back.

Thank you, Mr. Chairman.

Chairman DESAULNIER. Thank you, Dr. Murphy, appreciate all those comments.

And now we will go to the distinguished gentleman from Connecticut, Mr. Courtney. And after Mr. Courtney, Mr. Walberg is next in the queue.

Mr. Courtney, the floor is yours for five minutes.

Mr. COURTNEY. Thank you, Mr. Chairman.

And thank you to the witnesses to talk about, obviously, an issue which is even bigger than COVID with the aging of our population, but certainly COVID I think put the spotlight on why the direct care workforce, you know, is so essential for the country.

You know, as we sort of talk about strategies to, you know, enhance and strengthen that workforce, I think it is important for a moment at least to look at the American Rescue Plan, which was signed into law on March 11th by President Biden.

One of the key components of it was to boost the Federal match in the Medicaid program, FMAP, by 10 percent for home-and community-based services.

Again, it sort of tracks somewhat the CARES Act, which, again, was a very bipartisan bill where Republicans and Democrats supported increasing FMAP, but, again, it was for a temporary period of time that was for the whole Medicaid program. Again, what we did in the Rescue Plan was surgically target that increase to home-and community-based services.

The State of Connecticut just released their plan a few days ago in terms of how they propose to use the allotment we will enjoy as a result of the Rescue Plan. And it will come as no great surprise that most of it is going to go into provider rates. It also targeted increases in terms of wages. It is not a short-term clip. They have actually come up with a way to sort of extend that out to 2025.

But clearly, you know, Representative Fay, you know, talking about her experience, you know, with, you know, the pecking order of direct care employment for job training is sort of dead end.

I mean, if we are going to have a strong demand signal for people who are contemplating going into this, we need to push out the American Rescue Plan match to make sure that that financial base is going to be there.

Again, I chaired the Medicaid Committee back in the day when I was in the Connecticut legislature and I know, you know, how that is now the biggest line item in Connecticut's and most State governments.

Representative Fay, what would it mean to have, again, a targeted boost for FMAP for Maine, as was contemplated in the families plan bill from the President to really provide, again, the financial underpinning so that we can, you know, implement some of these changes?

Ms. FAY. Thank you, Congressman Courtney. I think it would be a wonderful opportunity. One of the biggest barriers that we identified as a commission were reimbursement rates.

So our main care reimbursement rates for the work being done by essential caregivers was in some cases less than minimum wage. And one of the things that the 10 percent FMAP bump has allowed is—and our plan hasn't been completely released yet, so I am not 100 percent sure of what's going to be in it, but I do know that there will be some one-time bonuses for people who have been working to be able to continue to pay them a higher wage and to reimburse providers at a higher rate and a rate that allows them to compete with other sectors.

You know, hospitality and retail would be huge, because right now we are just not reimbursing them as if we value the work that's being done.

Mr. COURTNEY. Well, thank you. And, again, you know, at some point, you know, to try and tell a young person, you know, you should go into a training program for, you know, home healthcare or institutional healthcare but, you know, the financing system is just going to lapse back to its prior sort of State is just not, you know, going to really get people's blood excited.

You know, the other just point is, you know, we passed H.R. 447, which was the National Apprenticeship Act, earlier this year, which would size up the Fitzgerald Act apprenticeship program to get into healthcare as a way of getting not just pre-apprenticeship training, as is contemplated by WIOA, but also full apprenticeship training, so people really have that he were earn-as-you-learn ladder to acquire more skills.

I mean, would that model work, again, based on your experience, Representative Fay?

Ms. FAY. I do think so. I think one of the things that would be helpful to providers is to allow their employees to work. And if you can earn while you are working, I think that would be a wonderful thing.

Mr. COURTNEY. Thank you.

Thank you, Mr. Chairman. I yield back.

Chairman DESAULNIER. Thank you, Mr. Courtney. Thanks for being so punctual and thank you for not bringing up the Red Sox during your testimony, questions.

We will now go to Mr. Walberg, who will be followed by Representative Bonamici. Tim.

Mr. WALBERG. Thank you, Mr. Chair.

This is an important topic, of course, and I appreciate the panel being here. And we could go all sorts of directions but let me go to Mr. Burani.

One of the things I hear from employers across my district is that today's college graduates don't always have the skills needed by employers for in-demand jobs. In your testimony, you note that community colleges maintain strong employer relationships, which keeps them firmly rooted in the WIOA system. And you indicate that WIOA funds could be enhanced by allowing community colleges to reach out to nontraditional educational institutions to fill curriculum gaps.

Could you elaborate a little more on what you mean with this recommendation?

Mr. BURANI. Sure. Thank you, Congressman, for the question. I think it is an important topic because, as we know, in a diverse marketplace there are always going to be point players, and it's certainly not a case where you have one-size-fits-all solutions.

So starting with community colleges, their strengths are hyper-local relevance, right? They have been pillars of that community that they serve, which means strong relationships with the employers, endemically very well-entrenched in the WIOA system. But they suffer what a lot of institutions of higher learning suffer, which is the natural cycle of generating the learning content that is timely for the environment in which students are learning it.

So we use the example of cybersecurity, which came up earlier in this hearing. This is literally changing every day. Every attack, every response is an evolution and a pretty radical one in some cases. And so the need to be able to time the delivery to market as quickly as possible becomes important. Who better than a specialist provider of that learning content to partner with said community college to be able to allow both entities to play to their strengths.

Hopefully, that helps shed light on my earlier testimony.

Mr. WALBERG. Yes, I think that is important to understand, that we have capabilities. And if we promote flexibility in our educational system, that meets the needs of the real world as opposed to turfs. That could be a significant help to us.

You note in your testimony that Udacity works with over 200 industry experts, including companies such as IBM and Amazon. Can you describe the value of partnering with employers when developing course curriculums?

Mr. BURANI. There are a range of reasons why this is important from a partnership point of view. I will speak to two of them. The first one I touched on a moment ago, and it comes down to the refresh cycle. Technology is changing so fast that in order for this information to be timely, it needs to be—we need to minimize middlemen, so to speak.

It is the same reason that Encyclopedia Britannicas are disappearing from shelves around the homes nationwide, because the format and the vehicle for information dissemination has now become a barrier. And so having direct access to the engineers, the creators of those technologies, allows us to deliver that faster to market.

The second is, really, it comes down to credibility. We at Udacity don't consider ourselves to be the voice of cloud computing or artificial intelligence or machine learning. There are plenty of technology companies out there who have earned their place as the authorities on that.

What we do is we structure effective programs. We invest in pedagogy and research to scope and run these programs. And, therefore, by bringing in a technology partner, it adds credibility and creates a greater impact.

Mr. WALBERG. Makes all good sense. Again, turf is a key issue, but inflexibility with creativity.

Finally, Mr. Burani, as the economy recovers from the COVID-19 pandemic, it is critical that we assist the unemployed, underemployed, and dislocated workers succeed in transitioning to in-demand full-time employment. How can Udacity, through its partnerships with industry and workforce boards, help this effort?

Mr. BURANI. Really, it is a complex answer, because there are so many resources at our disposal. But just for the sake of simplicity, what I will say is that we aspire to make use of the infrastructure that is laid out in front of us. We look to provide job-ready skills so that there is something of value that these individuals carry with them out of their credential, and we measure as much as possible to make sure that we optimize our programs for maximum lifelong impact.

Mr. WALBERG. Thank you, I appreciate it.

And, Mr. Chairman, I yield back.

Chairman DESAULNIER. Thank you, Mr. Walberg.

We will now recognize the distinguished Member from Oregon, Ms. Bonamici.

Ms. BONAMICI. Thank you so much to the Chairs and Ranking Members, but truly thank you to the witnesses for being here today to discuss this important issue.

Throughout the pandemic, I have spoken with direct care workers who put their lives at risk caring for our loved ones. And, unfortunately, despite their heroic efforts, their work is far too often underpaid and undervalued. We know most home care workers are paid poverty-level wages. They lack access to training and support services and do not have access to paid sick time or other basic benefits.

Forty-four percent of direct care workers live in low-income households and 42 percent need to rely on some form of public assistance. These working conditions have a disproportionate effect on more than 86 percent of direct care workers who are women, nearly two-thirds of whom are women of color.

In Oregon, my home State, home care workers and personal support workers gained the right to form a union back in 2000, and through successful organizing and collective bargaining workers have raised their base pay. They worked with the State to provide a new model of healthcare for home care workers that provides premium assistance, out-of-pocket expense assistance, as well as dental, vision, and employee assistance benefits for eligible workers.

SEIU 503 also recently launched an innovative program to provide workforce training opportunities for direct care workers. Their Care Works Program is the first registered apprenticeship program

for certified nursing assistants in the State, and it focuses on mentorship and support services to strengthen retention in the workforce, which is so critical. But fair wages and benefits should be available to direct care workers, not just in Oregon but across the country.

Ms. Torres, you in your testimony noted the barriers you face accessing quality training when you started your career as a home health aide. So was the training sufficient to provide you the skills you needed to succeed, and how would access to supportive services like childcare and transportation, how would that have changed your experience?

Ms. TORRES. Can you repeat the question?

Ms. BONAMICI. Yes. Ms. Torres, you noted the barriers that you faced accessing quality training when you started your career, and how would access to supportive services like childcare and transportation change the experience, how would that have changed the experience for you?

I could rephrase it and say, would supportive services like childcare and transportation be important to people who are learning and training how to be a home healthcare worker?

Chairman DESAULNIER. I don't think she is—there we go.

Ms. TORRES. Sorry, I don't have the answer, but I will give you my point of view.

Ms. BONAMICI. OK.

Ms. TORRES. Yes. We had a really great—I had a great support team from Cooperative Home Care. Our training was intense. They were excellent. They made sure that we knew what we were doing. If we missed out on anything then we would have to make up the time, because they wanted us to go out there knowing exactly what we were doing.

And at lot of companies, we get a forward training, and it is intense. We take two tests. And it is awesome, because we go out there prepared, even though we become a little afraid when we are in the field, because we don't know where we are going, and it could become a little bit stressful. But once we get there, we access to the client and we make it comfortable and clear, not cluttered for them so they won't fall, and we get to know one another, and we build from there.

Ms. BONAMICI. That is wonderful. Thank you so much. I really appreciate your being here today to share your story.

And I want to get a question for Mr. Espinoza. I often speak with direct care workers in Oregon about the challenges with career development and with employers about retention.

So how could States better leverage local resources and partnerships with community colleges and other programs to improve the workforce development pipeline for direct care workers, and how can this Committee better incentivize the development of career pathways and support services to encourage workers to stay in these very important jobs?

Mr. Espinoza . Thank you for your question, Congresswoman. Creating a strong pipeline and addressing retention and reducing turnover I think are some of the goals that the interventions of the Direct CARE Opportunity Act would specifically address. I mean, we know that oftentimes providers name caregiver shortages and

caregiver turnover as the top threats. And the cost is expensive. It is \$2,200. It impacts quality of care, and it impacts workers.

We have seen across the country a variety of interventions that have improved retention, and this act would specifically support those kinds of programs and help us build the evidence base.

Ms. BONAMICI. Thank you, Mr. Espinoza.

And I know my time is about to expire, but just on a personal level, I spent a couple of years taking care of my mom in the last years of her life in various levels of assisted living and skilled nursing facilities. And the turnover is a serious, serious issue. It affects the quality of care, it affects the continuity of care, and it is expensive for the employer.

So we need to do all we can to improve these positions so that people stay in them, and they really are valued for, and paid and valued for the very, very important work these direct caregivers provide.

And I yield back the balance of my time. Thank you.

Chairman DESAULNIER. Thank you, Ms. Bonamici.

And we will now go on to Mr. Grothman for five minutes.

Mr. GROTHMAN. OK. Thank you. Can you hear me?

Chairman DESAULNIER. Yes.

Mr. GROTHMAN. Mr. Burani, I have a couple of general questions for you. First of all, I know a lot of the problem or at least when I talk to my local providers, they feel a lot of the problem is caused by people right now staying out, because of the unemployment.

Is that what you are seeing? Is this a nationwide thing, or is this just in Wisconsin?

Mr. BURANI. So I want to make sure I understand this question, Congressman. Is the question about the unemployment safety net creating sort of a different environment, which is driving decision-making?

Mr. GROTHMAN. Well, yes, decisionmaking of potential employees. I mean, I hear, be I talk to home care, be I talk to anybody in that field, therapy places, retirement homes, that sort of thing, they all tell me the same thing, that they are having a bigger problem finding people in the last year because of the excessive benefits. Is that so?

Mr. BURANI. So I think that this is probably a topic better addressed by a labor economist. I can tell you that from our point of view, we have seen pretty steady demand for our programs. And whether or not the baseline, you know, has the floor been raised, has the ceiling been raised is probably more of a macroeconomic discussion.

But what I can say is that, with respect to skill development and that aspect of the unemployment safety net and the benefits that are afforded to people that are out of work, underemployed, low income, et cetera, especially under the guidelines of WIOA, the COVID-19 pandemic has certainly created a surge, but we also have seen that there really is a lot of baseline demand, which probably reflects conditions that predated the pandemic by a long span.

Mr. GROTHMAN. Do you see people looking for training in these fields who already spent time in a traditional 4-year university?

Mr. BURANI. Yes, we do. The reality that I believe we are all facing at this point is that education is not a one and done milestone.

We tend to think of, you know, the span or the arc of a lifetime, you are born, you graduate, you get married, you have kids. This is not a pillar of our lifestyle. Lifelong learning really is the new normal, and we are not in an environment where a single degree is really appropriate or——

Mr. GROTHMAN. I guess what I am saying, is it apparent to you when someone with a 4-year degree comes there that they would have been better off, rather than getting involved in your field at age 25 or 30, better off being trained for this sort of job when they were 19 or 20?

Mr. BURANI. I would say in some cases, yes, that would be the case. However, we also need to realize the fact that this journey of educating oneself also has many twists and turns. How many people in this meeting knew what they wanted to be when they grew up at various ages?

I think that what we could say is, in hindsight, in some cases, it might have been a better investment to go into a short-term training program, maybe an apprenticeship, and save the tuition, the opportunity cost of a 4-year degree. But to be honest, it is a realm of opportunities, and it is a vast marketplace.

Mr. GROTHMAN. I would think so. I mean, do you see people going through your programs that have not only a 4-year degree perhaps but a student debt associated with that degree?

Mr. BURANI. Absolutely. In fact, one of the drivers for entry into one of these programs is that a lot of the alternatives involve taking on more debt. And I believe that is the individual calculus of any person who decides to join our program. They think about that.

Mr. GROTHMAN. So if they were in your program, first of all, if you repeat again, how quickly do you go through your program?

Mr. BURANI. Four months.

Mr. GROTHMAN. OK. So you could be a 19-year-old who already went through your program and is helping out in this vital area of the American economy, you could be doing that without debt as opposed to even graduating from a 4-year, having substantial debt, and then entering your program?

Mr. BURANI. That is absolutely right. And I think the environment that they are stepping into with this credential has become more and more inviting for those sorts of nontraditional educational pathways.

Mr. GROTHMAN. I think certainly we do, on a Federal level, have programs that encourage people to take that 4-year degree and not use the 4-year degree. Do you think you find that accurate from the people you are dealing with?

Mr. BURANI. I think that there are a range of outcomes, and I think that in some cases that could be the case, but it's become a lot more complex.

Mr. GROTHMAN. OK. Thank you very much.

Chairman DESAULNIER. Thank you, Mr. Grothman.

The Chair will now recognize the distinguished gentleman from California, Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman.

I want to first begin my question with Ms. Torres. Ms. Torres, could you please describe the work you do on a daily basis as a

home health aide. Just describe a typical day, the daily work that you do.

Is Ms. Torres still here? Ms. Torres?

Ms. TORRES. Yes.

Mr. TAKANO. There you are. Just tell us what your day is like, just the daily tasks, the work you do. Like when you get to a, you know, particular client's home, I mean, just can you tell me what that is like.

Ms. TORRES. I do overnights. I make sure I remind them of their medication. I assist with meals. I provide companionship. I really love my job. It is very rewarding. It is not only the necessary tasks. I do the necessary tasks that my clients will need to make them happy, to assist them, to see a smile on their face, to know that I am there for a reason and it is to help them. And they appreciate it, especially those that don't have family. So my nights of work is companionship, making sure that my patients are OK, reminding them, making sure they have eaten their breakfast, giving them a sponge bath, grocery shopping for them, if necessary, and making sure they are safe. Thank you.

Mr. TAKANO. Ms. Torres, I mean, how much physical—I mean, are some of your tasks physically, you know, exerting? Do you have to exert yourself physically? I mean, is it physically challenging at times to be able to—

Ms. TORRES. Yes.

Mr. TAKANO. It is.

Ms. TORRES. It is.

Mr. TAKANO. I mean, maybe helping lift people or you have to move people around, that can require quite a bit of physical exertion. So it is physically demanding work is what I am trying to say.

Ms. TORRES. Yes, it is. I use a Hoyer lift. I have to use my body mechanics to strengthen my body, and I have a lot of contact. It is very difficult.

Mr. TAKANO. How long are your days, typically? How long does your day go?

Ms. TORRES. Well, I do 12-hour shifts.

Mr. TAKANO. Twelve-hour shifts?

Ms. TORRES. Yes.

Mr. TAKANO. Twelve-hour shifts. And so you will work maybe 4 days out of the week?

Ms. TORRES. Yes. I work from 8 p.m. to 8 a.m. in the morning. I do 12 hours.

Mr. TAKANO. And do you have to go—is it just one client that you work with, or do you have a number of clients, you go different places?

Ms. TORRES. Right now, yes, I have one. But as a home health aide I will say my hours vary as needed.

Mr. TAKANO. Now, tell me, I wanted to ask what was it like during the pandemic, you know, and when the pandemic began, how long did it take before you were provided with proper PPE?

Ms. TORRES. They gave us some in the beginning. But we have a sister union in North Carolina, and they shipped us out a lot of masks and gloves and gowns and shields for us. So we were lucky, and we were blessed.

It took some time in the beginning, of course, because we didn't expect this to happen. And many a times we had to buy them ourselves until the shipment came in and they were able to give us more. So now, going forward, we are pretty well on that.

Mr. TAKANO. Great. Well, thank you. Thank you, Ms. Torres, for sharing that with us.

Mr. Burani, I just want to ask a question about the short-term training program. It is a 4-month program, but would you describe the pathways, the training pathway as one that is stackable, stackable credentials? You kind of get the first and this could lead to a 4-year degree at some point?

Mr. BURANI. So yes, it is a stackable credential. We have Nano-degree Programs that are structured at different skill levels, and the idea is to create pathways and even to bake in, you know, some decisions along the way. It is not identical to a 4-year degree, but there are parallels in terms of the outcomes and the skills.

Mr. TAKANO. But it could lead to one?

Mr. BURANI. We are not an accredited institution, so we don't compare our credential to a 4-year institution's credential.

Mr. TAKANO. OK. I am over time. Thank you, sir. I yield back.

Chairman DESAULNIER. Thank you, Mr. Takano.

The Chair now recognizes Representative Miller-Meeks for five minutes.

Mrs. Miller-Meeks. Thank you so much, Mr. Chair. And I thank our witnesses. And I think it is an interesting conversation, because although I am a physician, in my job prior to Congress I started out volunteering in a mental health facility, in nursing homes, then became a student nurse and then a nurse and then a physician. So I have had this spectrum, if you will, which interesting that Representative Takano would mention stackable degrees or education that builds upon itself. And throughout that, I have certainly seen healthcare change and also, you know, home care.

And one of the concerns I have—and I think Mr. Burani, this goes to your point—is one of the key problems in our workforce development system is that we place too much focus on jobs of the past as opposed to the labor market of the future.

And I think we in government trying to determine what the jobs of the future are we're woefully inadequate in doing so. For instance, one of the things the pandemic has shown us, it is so hard for people to come back into nursing homes after the events that had happened, especially in places like New York and New Jersey and Michigan. So that there may be a shift in the future, even though there was already a shift toward care at home, it may be more of a push for care at home rather than in a residential care facility.

And at the same point in time, we are seeing an explosion of technology. And so we now have technology that can do blood pressure monitoring at home. I am an ophthalmologist so eye pressure, glaucoma pressure checking at home. We can do EKGs at home. You can monitor and use technology to monitor medication boxes if you set up the medication when a patient has removed a medication or individual has removed a medication from their medication

box and whether they have taken it or not. At the University of Iowa, in our Aging Centers looking at determining falls.

So there is a variety I think of—I won't necessarily call it artificial intelligence, but it is in some ways artificial intelligence that is used to help us monitor people without someone physically being there.

So to that end, Mr. Burani, what role does Udacity play in preparing people for tomorrow's workforce, which I think is, as you have indicated, going to integrate AI and other methods of technology?

MR. BURANI. That is a great question, Congresswoman. Thank you. So I think it starts with understanding, being able to contextualize the industry. So you could look at, you know, the long-term growth of an occupation like a health information specialist. They are going to add approximate about 30,000 jobs by 2029, and that is valuable context for the direction of the industry. Earlier, we heard that it is the fastest growing industry.

Consider on a shorter-term basis that by 2024 more than one in three new jobs will be in the healthcare industry. Today, that is 2.3 million open jobs, and the top occupations are registered nurse or personal care aide. You are looking for skills like nursing, CPR, even records management.

But I think what we need to do is look at the occupations within healthcare. So if you were to take an occupation code like computer and mathematical, that subset is about 50,000 open jobs, but the median salary is about 50 percent higher. A third of these jobs don't even require a bachelor's degree.

And so what kind of titles are we talking about: Business intelligence analyst within healthcare, clinical informatics specialist. And they want computer science. They want programming languages like Sequel or Python. They want, you know, agile methodology in some of those sort of project management skill sets.

So whether it is AI or some other technology that is being applied to the healthcare industry, what we are really trying to do is just solve analog problems, problems from the nondigital world, like physician shortage and the burnout associated with that, all of the data that has been collected for eons in this industry through a clipboard and a ballpoint pen.

If we can manage these things at scale, through telemedicine, through data science and machine learning, we can get better at removing outliers from our diagnoses. We can get better at trend spotting, so that if there is another pandemic around the corner maybe we spot it a bit sooner.

It is very abstract and certainly warrants a longer conversation, but hopefully that helps to answer your question.

Mrs. Miller-Meeks. I agree it absolutely does warrant a longer conversation. I would love to talk with you more about the data acquisition, the amount of data out, how that goes into population health and public health, but my time has run out, so perhaps in another conversation we can continue this. Thank you so much.

And thank you, Madam Chair. I yield back my time.

Chairwoman Wilson of Florida.

[Presiding.] The co-Chair of the Committee had to step away to another Committee to vote, so I am assuming the gavel.

And I now recognize Chairman Scott.

Mr. SCOTT. Thank you and thank you for the recognition.

I would like to ask Representative Fay a couple of questions. Thank you for your service. I served in the State legislature and I know the sacrifices that are made by State legislators.

I think you have heard a number of people comment on the disappointment that people feel when they think a CNA is a dead-end position because somebody moving up to a CNA was just the first step in a long tradition, because you can go from CNA to an LPN to an RN and then to advanced practice, midwife, nurse anesthetist or even an independent clinical practice, and you would be amongst some of the best paid professions in the country. So considering that a dead end was certainly a disappointment.

But you served on the Committee that studied this issue. Did you issue a publicly available Committee report?

Ms. FAY. We did. We did. Thank you.

Mr. SCOTT. We will try to get that, because I am sure you have got some nice recommendations that we can take advantage of.

I was also intrigued when you said that sometimes there is no place to discharge people, because they don't have access to direct care. Did you make any attempt to quantify this, how many people were staying in an expensive hospital for the lack of direct care at home?

Ms. FAY. Thank you, Congressman. We didn't have access to that data at the time we were doing this. And I think the issue has really become exacerbated because of COVID, but it has also really shone a light on concerns.

So what I can do is check with our Department of Health and Human Services and see if there is any specific data available on that, and I can submit that in my comments later.

Mr. SCOTT. Good. Thank you.

I am not sure who this question, maybe Mr. Espinoza: Within just direct care—we have got different levels of certification within nursing. Would there be different levels of certification within direct care?

Mr. ESPINOZA. Thank you for the question, Chairman. You know, we would look at the opportunities. There would be advanced roles that would fulfill different roles, so there would be peer mentor roles, there would be care coordinator roles, et cetera. However, the occupations would be within you know personal care aide, home health aide, and nursing assistant.

We have seen some States adopt advanced home health aide occupations that do represent an elevation in title and compensation and responsibilities. So there are ways in which policymakers can create these advancement opportunities and different certifications, for example.

Mr. SCOTT. And what can be done to make training more available and consistent?

Mr. ESPINOZA. It is a great question. I think there are a variety of approaches. I mean, one is making sure that training requirements are as strong as possible for all occupations within direct care. Right now only home health aides and personal care aides have a Federal training requirement, but personal care aides do

not. And so the State requirements for personal care aides vary considerably across States.

I mean, certainly we would also argue for the importance of routing training in core competencies, making sure that programs are training workers across occupations. The potential of universal worker roles, for example, that could be funded through the Direct CARE Opportunity Act would be an opportunity to think about what are the core competencies and training approaches that these workers need across occupations so that they could be more portable across settings and in an ideal world across States. So those are the kind of opportunities that this act could support.

Mr. SCOTT. A direct care worker has, just for logistical reasons, a limit to the kind of caseload that they can handle. If they are properly trained and getting more money, how would they get paid? Medicaid, obviously, could increase pay. Does insurance, private insurance pay for these services?

Mr. ESPINOZA. It does, but in most instances the primary payer for Medicaid—the primary payer for long-term care is Medicaid. And this is part of the challenge is that too often what we hear is that providers do not receive a sufficient level of Medicaid funding or reimbursement rates to deliver the services that they need to deliver and much less to—

Mr. SCOTT. Well, we can fix that by just doing it, but you can't just do it to tell private insurance or self-pay, the self-pay, you just can't tell them to pay more. Would people be able to afford the services?

Mr. ESPINOZA. No. Unfortunately, these services are very expensive, and most people spend down their assets or income just to qualify for Medicaid.

Mr. SCOTT. Thank you, and I yield back.

Chairwoman WILSON. Thank you, Mr. Chair.

And now, Mr. Fulcher, Representative Fulcher.

Mr. FULCHER. Thank you. Thank you, Madam Chairwoman.

A question for Mr. Burani, if I may, please: Mr. Burani, I personally have the belief that a one-size-fits-all model in higher education is preventing more individuals from successful careers. And it seems to me that too often we hear the only pathway to success is through a bachelor's degree and a traditional 4-year college path, but companies like yours seem to prove that notion wrong.

Could you describe for me, first of all, do you agree? Second, if so, what are the types of learners, what is the profile of that learner that participates in Udacity's programs?

Mr. BURANI. Thank you, Congressman. I could not agree more. And I think that that is emblematic of the environment in which we find ourselves in 2021.

So, to your second question, the types of learners in our program, I would say there is not a specific type. It is a vast diverse spectrum of learners. So I'll give you some examples. We have some fascinating case studies we have been tracking over the years. A trucker who was sort of dissatisfied with the direction of his career and decided in his spare time on the road to start learning how to code and gained access to a scholarship program to nanodegree in programming from Udacity and ended up in a front-end web development career and has completely reinvented himself.

Another example I can give you is very different. So this earlier gentleman I believe was in his late forties. And we have got a kid who is no more than 18, 19 years old working two retail jobs at minimum wage to try and make ends meet and actually got accepted to a 4-year university, decided not to take that opportunity, and instead gained access to a Nanodegree Program through a partnership we had with Google, landed an internship with NASA, and now is gainfully employed by GitHub, which is a Microsoft subsidiary.

We work with learners who are incumbents in corporations, some of those that I mentioned in my opening statement. They are looking to us to drive big capacity building initiatives. So these are employees that are just looking for a way to move up.

But we work with distressed communities, dislocated workers from the pandemic, partnering with workforce development boards at a local level in order to find people that maybe don't fit any particular profile other than they are hungry for change. So we try to provide them with a platform to take control of their careers and come out with job-ready skills.

Mr. FULCHER. You also mentioned, Mr. Burani, in your testimony that the processes for providers to maintain their catalogs of programs is different in every State. I know that we have got some differences in my home State of Idaho, which creates a number of administrative burdens for new providers.

Would you talk to me about that process, the cumbersomeness, if that's a word, of the process for providers to be added to an eligible training provider list and what changes you might recommend to that process.

Mr. BURANI. Absolutely. This is an important topic, Congressman. So when we think about the structural underpinnings of WIOA, the system needs to know who is training, what they offer, what their performance is, because it needs to maintain accountability. So that is important.

However, what we find is that if you choose to engage in one State versus another, one workforce area versus another, some things are consistent, and some are not. Some States will require different types of records. They may ask for financial records for a private institution. That can get a little thorny. They may ask for certified documentation from a company officer.

There is a lot of inconsistency in this sort of structural blueprint for the system. And I would say a solution, I would liken it similar to the common application that a lot of people use to get into higher ed, right? You fill out one application, it gives you access to a lot of different institutions. Maybe that is a model we can look at with the reauthorization of WIOA.

Mr. FULCHER. Just very quickly, because I am just about out of time, but I am going to shift gears right quick. We have this tendency in Congress to throw money at things, and sometimes money is not always the answer.

How do we take a reform and tie the connection better between the learner and the taxpayer?

Mr. BURANI. This goes back to my opening statement. No. 1, have a more clear-minded, modernized view of what the labor markets of today need. No. 2 is to create some of the structural re-

forms, and No. 3 is to invest in channels and facilitate the collaboration between entities.

Mr. FULCHER. Thank you, Mr. Burani.

Miss Madam Chair, I yield back.

Chairwoman WILSON. Now Representative McBath. Representative McBath. Representative Jayapal. Representative Manning.

Ms. MANNING. Thank you, Madam Chair. And thank you for holding this very important hearing.

Representative Fay, I found your testimony, your written testimony to be informative and thought-provoking in framing the ways we need to professionalize and refer to caregivers. I have also found that so many people lack any real appreciation of caregivers until they need assistance for their own family Members. And then it is like an epiphany and suddenly they realize the importance of having trained professional people in those positions.

So I wonder if you could tell us how direct care workers are trained in your State and whether you have any recommendations regarding the importance of having statewide programs that are focused on providing training to this workforce, both in terms of ensuring quality and also the impact of training on retention and the development of career ladders for this workforce.

Ms. FAY. Thank you, Congresswoman. That's a big question. And in a big State that is both geographically large and also, we have significant rural populations, I think the answer depends on where you are.

So for—to answer the first part, the training happens depending on I think where you are, whether you have access to a vocational program or it's something that you are called to do, the work is work that you are called to do, or whether you are working for a provider or need a job. So our private providers will train personal care attendants. Anecdotally, I have heard that sometimes the training is short and not particularly comprehensive, and I think that's part of the professionalizing of the workforce.

So, you know, I am not trying to give a nonanswer answer, but it really does depend on where you are and what resources you have access to and what your motivation is.

Ms. MANNING. Thank you.

Mr. Espinoza, one goal of the Direct CARE Opportunity Act is to spur investment in new recruitment efforts for direct care workers. And in your written testimony, you describe some examples of promising recruitment initiatives.

Can you talk a little bit more about the elements of a successful recruitment program. How can recruitment efforts bring untapped labor pools into the direct care workforce?

Mr. ESPINOZA. Thank you for that question. Recruitment is a major challenge for us in the direct care workforce. Generally, we think about the various strategies that employers can use to recruit more workers, from improving the hiring process to strengthening entry-level training, providing employment supports, the kind of wraparound supports that Zulma testified to earlier, promoting peer support so that workers are getting that attention of other workers and learning about the job from other workers. Also ensuring effective supervision, developing advancement opportunities, recognizing and rewarding staff and measuring progress.

Typically, in a recruitment approach, the approach first looks at how do you attract and select the candidates that are best suited for providing quality services and support, and then they help employers establish the kind of partnerships or boost the kind of partnerships that will help them reach a broader pool of candidates. And really, how do you strengthen an employer's brand.

We have seen a variety of retention recruitment projects throughout the country that have really focused on bringing more workers into the sector, from a program in Wisconsin that brings more nursing assistants by training them and then connecting them to employers through partnerships in the field to an intervention in Minnesota where an assisted living facility in the rural part of the State partnered with a social media firm to develop paid ads to target key markets and drive them to apply online through their mobile devices.

So there are a range of recruitment processes that can be used to bring more workers into this sector and, of course, strengthen the retention once those workers are—take on these jobs.

Ms. MANNING. Thank you. My time has expired. I yield back.

Chairwoman WILSON. Thank you so much.

And now we have Ranking Member Foxx from North Carolina.

Ms. FOXX. Thank you, Madam Chairwoman.

My comments and questions will be for Mr. Burani. A well-skilled direct care workforce is critical for serving our most vulnerable populations but adding more Federal programs is often duplicative of broader efforts and creates an inflexible system that does not meet the needs of local employers.

Rather, Congress should work to reform our existing workforce development system to ensure all workers, including those in health-related fields, have the skills they need for a successful career path.

Mr. Burani, programs like WIOA have the potential to be a flexible and robust workforce pipeline for millions of Americans. In your view, what are the top three things in current law preventing this from occurring?

Mr. BURANI. Thank you, Congresswoman. That is a compelling question and narrowing it down to three is my challenge. I would say there is, in no particular order, one important priority is creating opportunities for distressed communities to thrive within this system. So what that means is effectively looking at the outcomes and the standards to which we hold these, appreciating that these populations may be structurally disadvantaged from thriving within the system simply because the way workforce boards are measured works against them and, therefore, leaves them cut out of the mix. How to do this is another conversation, but one that I think is very compelling and happy to always explore further.

The second is the host of structural reforms that I have discussed in my opening statement as well as in response to some of these other questions. And what I would say is that it goes beyond simply the mechanisms for managing training providers. We also want transparency into the performance data. It is hard to just take a pulse on WIOA and understand what is working and what is not, in which geography, for which learner, et cetera. And so I would

propose expanding structural reforms to also include more free access to that data.

And then if I had to pick a third and exclude others as a result, what I would do is I would think about how we can look at maintaining individual accountability while also broadening service delivery to a more aggregate level.

American Job Centers, for example, are tasked with liaising one on one with individuals and really taking a case management approach to letting people into these programs. As the training provider in this equation, we have observed countless times that that becomes the biggest bottleneck. It is not a job that can be approached with shortcuts. It simply needs to be modernized in such a way that service delivery can be a smoother process. Hopefully, that helps answer your question.

Ms. FOXX. That helps a little bit. And I think making the language a little simpler—you use a lot of big words that I think don't need to be used and we could use simpler ones.

But from your testimony and the answers you provide today, it is clear Udacity serves learners much more efficiently than the Federal Government does. While our time is limited today, I want to followup with you after this to better understand how we can focus taxpayer dollars to enhance our workforce development system and help the individuals gain the skills they need for a successful career.

And I appreciate Udacity's focus on producing lifelong learners. That is certainly an interest of mine. Our economy is rapidly evolving, as we have talked about, and it is important that individuals have the ability to upskill and reskill. That is very clear in this hearing today.

So how can individuals advance their career development with your company? If an individual learns one skill and then desires to learn additional skills in the chosen field, what avenues are there for the person to pursue that goal?

Mr. BURANI. That is an excellent question. I appreciate your compliment and your earlier feedback as well, Congresswoman Foxx. I think that it starts with understanding the multitude of options available. Udacity is but one training provider, and we are reaching a point where there are more specialists.

People need career guidance. They need to understand what is out there before they can begin to make decisions. We provide career services, and on occasions our programs also include soft skills, so they learn teamwork, collaboration, leadership and so on. And we feel like this helps to create more opportunities for lifelong learning.

Ms. FOXX. Well, thank you very much. And I hope you will put more of a focus on education than on the T word, because I think when you use that you are limiting, very seriously limiting people's options. Thank you very much.

And thank you, Madam Chair.

Chairwoman WILSON. Thank you.

And now Representative Morelle of New York.

Mr. MORELLE. Good morning. Thank you, Madam Chair. And thank you to both our Chairs for holding what I think is a very, very important hearing to discuss this topic, and certainly to all of

our witnesses for being here today and sharing their expertise. And I will say also that many of the questions that I had thought about asking, have been asked by my colleagues, so I want to thank them. I think this has been a really enlightened conversation.

You know, each year the nearly 20 million adults in the country who need assistance with self-care deserve the dignity of receiving these services in the comfort of their own home. But obviously, as the witnesses have testified, you can't ensure that those services will be provided in the appropriate way unless we have a robust direct care workforce, each of whom receives appropriate pay and has the opportunity to grow professionally within the healthcare system.

Just parenthetically, I note I was proud last year to introduce the Senior and Disability Home Modification Initiative, which would have helped support independent living for older individuals living with disabilities.

And I was proud to see some of the provisions related to older individuals become law with the passage of Supporting Older Americans Act, but I know we still have a lot to do when it comes to recruiting an effective workforce and retraining them with proper wages, improved working conditions, and advancement opportunities.

I just wanted to make note of a program. It is a Federal program, the Health Profession Opportunity Grant Program, also known as H-POG, or HPOG, which I think is a pretty effective healthcare training program that helps address workforce shortages for in-demand jobs.

And the program creates career pathways, such as apprenticeships and ongoing training, to empower advocates, many of whom are low income, to take on new jobs as nurses and technicians. It also supports many indirect aspects that people must consider and which you have talked about here this morning when working in those settings, including childcare, transportation, work supplies, application fees, et cetera.

So the program stands out because it has helped advance the careers of people who have been disproportionately left behind in workforce training programs, especially low-income single women of color, and it is more likely to result in a person being employed in a health program upon graduation. The availability of this program has been particularly an asset to my community.

Action for a Better Community is an organization that receives money from the program, and I have been blessed to be in contact with them, meet with the folks who have gone through the program. I think it is something we should continue to work on.

I wanted to just, if I can, ask a question of Representative Fay. I am a proud former Member of the New York State Legislature, so I have great appreciation, as many of my closing who served in State government, for that role.

I wonder how we might be able to utilize programs and how the States might be able to utilize programs like this Health Professions Opportunity Grant Program to leverage funds to improve recruitment and develop defined pathways for career advancement for the direct care workforce. You might be able to comment on

that, not simply HPOG, but as I have described it, perhaps other programs as well.

Ms. FAY. Thank you. Yes. And so I am thinking about that as we adjourned sine die last night fairly late. So I might be just a little foggier than I would be normally.

I would say it depends on the State. So in Maine, our workforce is really kind of disparate. And while our Department of Health and Human Services and MaineCare does the funding, at a level where we are talking about home healthcare, they don't necessarily have a jurisdiction over all of that. I mean, we have credentials and training. So I think—yes.

Mr. MORELLE. Yes, let me ask this, Representative: Would it be helpful, in terms of thinking of it, and do you think about it in terms of creating rungs on a career ladder. So that people come in—in terms of skill set—having relatively few skills but continue to work up and have a more defined? Would that be helpful, and is that something you think about in your responsibilities?

Ms. FAY. Oh, absolutely. I mean, we definitely—that was definitely one of the recommendations of the commission that I Chaired. And any assistance and guidance in making that happen I think would be helpful.

Mr. MORELLE. Very good.

Well, Madam Chair, I will have additional questions, and I appreciate the hearing very much. I see my time is up, so I will yield back. Thank you.

Chairwoman WILSON. You may submit them for the record if you want answers.

Mr. MORELLE. And we will do that. Thank you.

Chairwoman WILSON. So ordered.

Chairwoman WILSON. And now Representative Banks of Indiana.

Mr. BANKS. Thank you, Madam Chair.

Mr. Burani, Udacity has educated over 15.4 million learners since its founding in 2011.

Can you tell us, in what ways do you believe an effective reauthorization of WIOA can help Udacity further expand learning opportunities for even more individuals?

And are there reforms to the Higher Education Act, such as allowing Pell grant recipients to enroll in short-term workforce development programs that would allow you to successfully help more learners?

Mr. BURANI. Thank you, Congressman, for the question.

So, while we have had good success, to the tune of 15 million learners, the reality is that metric reflects our business around the world. And so we have run programs in a variety of contexts, direct to consumer, working with corporations, you know, at an enterprise level, as well as through the public sector, and that 15 million encompasses all of it.

We are in the early days of WIOA at Udacity, and to be honest, I think I can speak for, you know, the broader world of short-term credentials.

So, when we think about reauthorization, going back to my opening statement, certainly there are a lot of reasons to be encouraged by what this potential, you know, reauthorization actually signifies. Anything that helps bring more dynamic options and choice to the

learners' and employers' marketplace, we are in support of. If that helps students have a better range of options and if that helps employers have a more robust talent pipeline, we support it.

To your second question around the Higher Education Act, this is an area in which, generally speaking, what we can say is, as short-term credentials start to get their moment in the spotlight next to additional 2-year and 4-year degrees, we think that these programs should be open to accepting more learners from different backgrounds. And, if, you know, different grant eligibility becomes a topic for discussion, we support that.

Mr. BANKS. Good. Appreciate that.

You also mentioned in your testimony that Udacity offers over 60 Nanodegree programs. Can you describe what these—what that means? What do these programs entail?

Mr. BURANI. Yes. So a Nanodegree program is effectively a combination of technical learning and hands-on project work. So earlier, we spoke about industry partnerships for curriculum development.

If you were to enroll in a program to learn the fundamental skills of cloud computing, you would have an expert in cloud computing, potentially someone, you know, employed or connected to that industry who is effectively delivering this content through sort of bite-sized learning modules. And this experience is augmented by a series of supports, just interventions.

We have session leaders who effectively work not unlike graduate students in a higher-ed context, facilitating discussion and lab work and project submissions. We have got tutors and mentorship resources available. We have got community resources, because we acknowledge that a lot of our best learning comes from observing our peers.

And this also includes—I could go on and on, but there is career resources. There is an employer platform to help motivate students and remind them that there are interviews waiting on the other end.

The—these two components, the project work and the technical instruction, come together. And, over time, what we have done is we have optimized a lot of these interventions in pursuit of the best completion rates, the best career outcomes that we can find.

Mr. BANKS. How many—how many Nanodegree courses would it take for me to get—for me to receive a degree, let's say, in business?

Mr. BURANI. So a Nanodegree credential can be done with a single program, and it would be 4 weeks, roughly 10 to 15—I am sorry—4 months, 10 to 15 hours a week is the type of commitment we are looking for.

Mr. BANKS. And, for the purposes of this education for my colleagues on this Committee, how much would that cost?

Mr. BURANI. So, to the learner, we typically have—you know—what we do is, especially in the public sector, is we orchestrate funding through different entities in order to effectively grant a full ride. So, we position these as scholarships.

The reality is that there is a wide range of, sort of, commercial schemes in which we have kind of positioned our programs on a consumer level. If you were to come in through the website, you

would pay \$3.99 a month, and you would have access until you are complete, and \$3.99 a month is sort of like all you can eat.

Mr. BANKS. Well, this is fascinating and revolutionary. I appreciate that feedback.

My time has expired. I yield back.

Chairwoman WILSON. Representative Wild of Pennsylvania. Thank you.

Ms. WILD. Thank you, Madam Chairman.

I would like to direct my question to Ms. Torres. Good morning, Ms. Torres. Thank you for being here and thank you for the work that you do every day to care for people who are in need of extra help.

In my own family, we have experienced the need for direct care to my mother, who, in 2014, was diagnosed with brain cancer and came to live in my house using home hospice. And, because we—this came out like a bolt out of the blue, we had no warning that that was going to happen. We hadn't made arrangements, and I had no choice but to hire somebody to come in and take care of my mother while I went to work for a few hours a day. And she was very well cared for in the few months that she had left in her life, and I thank you and all who do this kind of work. It is so important.

Unfortunately, we know that the industry is known for its low pay and high turnover rates. The median wage for direct care workers is \$12.27 an hour. And, during the year 2018, the direct care workforce experienced a turnover rate of 82 percent.

So, I guess my question to you is: Do you see career advancement as something that you desire? And, if so, do you believe that there is any possibility for career advancement for you in your field? Do you have any kind of pathway to jobs with greater responsibilities and higher pay?

Ms. TORRES. Yes. I do believe that I can go forward with my job. I can build—they have opportunities—through the Cooperative, we have opportunities to get involved with office work, or through our union, if you want to become a nurse. There are opportunities. We just need more funding.

Ms. WILD. Uh-huh. And so you have—I assume you have experienced coworkers who have left their job because of the low pay. Is that true?

Ms. TORRES. Yes.

Ms. WILD. And have you considered doing that? Have you considered looking for other kinds of work because you just weren't making enough money?

Ms. TORRES. No, because I found a love for my job.

Ms. WILD. Well, thank you for that.

How do you believe that you could be affected if you were—what would it mean for your family if you were able to make more money?

Ms. TORRES. That would be awesome. That would be—

Ms. WILD. How many hours a week do you work?

Ms. TORRES. I work 36 hours a week. I am a night worker. I do overnights. I used to do a CVPAC [inaudible] but now I do overnights.

Ms. WILD. Do you receive any kind of benefits in your job, healthcare—

Ms. TORRES. Yes. Yes, I do.

Ms. WILD. Do you get vacation pay?

Ms. TORRES. I have—yes. I have PTO. I have 401(k). I am a worker-owner to the company. I have life insurance through my union, 1199.

Ms. WILD. OK.

Ms. TORRES. Health insurance, which is very important, because I have my son with me. So I do have benefits. And sometimes benefits are better than the pay in certain situations, because we need those for when we get sick.

Ms. WILD. So have—so, in your case, you feel that the work that you are doing is satisfying enough that you don't aspire to leave and go into another line of work?

Ms. TORRES. Uh-huh.

Ms. WILD. I believe that that is what you said.

What about the people that you work with? Do you know others who leave the job, which is such an important job, simply because they want a job that pays more?

Ms. TORRES. Yes, because we need raises. We need the money. And not everyone wants to stay on board knowing that they could make more money somewhere else. And it is difficult, because even though I love my job, my wages, I live check to check. I do transportation back and forth. I reside in Connecticut and work in New York. So that is also money, going back and forth.

Ms. WILD. Sure. Costs money.

Ms. TORRES. It would be great if it—paid my bills, right. You know, like everyone else. So, if we were to get a raise, it would be awesome for every home health aide? Why? Because they will find interest in wanting to go out to work. We could recruit more home health aides and give them the benefits that we are—that Cooperative and our union is offering. So that would be awesome.

Ms. WILD. And which union do you belong to?

Ms. TORRES. 1199 SEIU.

Ms. WILD. OK. Thank you so much. I appreciate your testimony. And I yield back, Madam Chair.

Chairwoman WILSON. Thank you so much. Thank you.

And now Representative Good of Virginia.

Representative Good?

You have to unmute, sir. We can't hear you.

Mr. GOOD. There we go. Thank—sorry about that. Trying to hit it, and it wasn't working for me.

Thank you, Madam Chairman, and thank you to all of our witnesses, and I appreciate your time with us today.

Mr. Burani, last Congress, the Republican Study Committee proposed the establishment of an E-Verify Program that would require all individuals to be confirmed through the Department of Homeland Security before being eligible for Federal jobs programs. This would mean that only people who are legal, eligible to work in the United States would be able to take advantage of Federal jobs programs.

Would you recommend that Congress implement this proposal?

Mr. BURANI. So, at Udacity, where we have typically focused our energy is on getting people through the system once they are allowed in. We haven't traditionally taken positions on eligibility of that nature.

Mr. GOOD. Well, I—the question of E-Verify—mandatory E-Verify for the Federal workforce is one that my office has been discussing for some time now, and a policy like this would be a simple fix to ensure that American workers are prioritized, and the rule of law is followed and upheld. So I certainly continue to strongly urge my colleagues to consider policies that would institute mandatory E-Verify for the Federal workforce.

But, Mr. Burani, I appreciate your focus on working within the existing framework that we have instead of adding to an already bloated welfare State like some on this Committee would seek to do.

Under current law, there are—and this relates to a previous questioner, but there are social welfare benefits that are reduced if a beneficiary increases their income. And the consequence of this can be a difficult tradeoff scenario where lower-wage workers must choose whether or not to continue receiving welfare benefits as they potentially increase their income. And this has—can have the effect of disincentivizing work or advancement for many lower-wage workers.

How would you suggest that be addressed?

Mr. BURANI. That is a good question, Mr. Congressman, and I think, you know, it takes a lot of analysis to understand the benefit cliff and how it is actually changing behavior. People who are entering programs such as ours are making an investment.

To the earlier question, you know, this is not necessarily a financial investment. However, the opportunity cost of stretching their lives even thinner, making sacrifices, potentially even taking themselves out of the labor market, need to be considered.

I think that the important thing is to look at the outcomes of these programs and to understand, as WIOA has stipulated since its enactment 7 years ago, that not only is credential attainment and job placement important, but also, we are looking at median salary. We are looking at it—the system looks at it after 6 months and after 12 months, because we want to see retention, and we want to see effectively a standard of living that has been sustained.

In our particular programs, the sort of archetype of a learner who upskills through a Udacity Nanodegree program has set themselves up for, in many cases, a much higher standard of living because they are entering high-growth pathways in which the supply and demand in the labor market has supported that.

So we believe that accountability and transparency into those outcomes, certainly in our world, helps to keep that momentum moving forward.

Mr. GOOD. I agree. And that is what we all aspire to do, is to help people get to those higher-wage situations.

In your testimony, Mr. Burani, you emphasized the importance of creating effective mechanisms that encourage individuals to invest in their own career transformations. What are some ways that you have seen individuals set themselves up for success by creatively developing their long-term skill sets?

Mr. BURANI. That is an excellent question, and I think that there are—there are so many paths to the finish line. But as is probably no secret to anyone in this discussion, they get what they put in, and, so, people that look for the path of least resistance might succeed, but, on balance, generally will not succeed as much as the people who look for ways to augment their learning experience.

Earlier, I mentioned career services that we offer. Some of them are mandatory project submissions. Some of them are discretionary. You can choose to have your resume reviewed, and you can choose to do the work to polish it up, ditto your LinkedIn profile.

You can hone your interview skills. You can also—you know, there is the variety of free courses that we offer as well as, you know, the marketplace in general. And, so, that is the best answer, is the more you can invest, likely the more you stand to benefit.

Mr. GOOD. Great answer. There is no substitute for hard work or being the CEO of your own career and taking responsibility. So thank you so much for your time.

And I yield back, Miss Madam Chairman.

Chairwoman WILSON. Thank you. Thank you so much.

Ms. McClain—I am sorry. Ms. McBath of Georgia, welcome. Welcome back.

Mrs. MCBATH. Thank you, Madam Chair, and thank you so much for convening this panel today and thank you to all of our panelists.

And everyone, thank you for sharing your testimonies with us. And I know that this is a vitally important topic, and I appreciate the focus of this Committee on continuing to serve all of our workers in America.

And I know that we have all experienced a time when an aging apparent, or a disabled family Member, really needed additional care in the home. I myself, as many of our colleagues have expressed earlier, had the responsibility to care for my ailing mother during the last years of her life, and finding a good, loving care provider was extremely important to our family.

And we know that nearly 20 million Americans need assistance with self-care and daily living, and that number just continues to grow as our population ages.

This is an issue that touches the lives of almost every American. And, when the time comes, we all want to leave our loved ones in the care of a compassionate and very capable individual. And we should treat those caretakers with the same compassion and the same respect that we expect them to treat our loved ones.

And, despite the essential nature of their work, you know, as we have been expressing, direct care workers face an extremely high turnover rate of about 80 percent. And these high rates of burnout, low pay, and limited benefits, and a feeling of being just so undervalued are all central to the challenges facing the direct care workforce.

However, we know that, you know, there are solutions for these problems. We have been talking about this today, and President Biden and this Committee have proposed bold action to address the direct care workforce shortage and ensure that these are good-paying, middle-class, high-quality jobs.

So my question is for Representative Fay. One of the elements that you touched on in your testimony is the need to raise the perception of direct care as a viable, meaningful career pathway.

Can you talk about proposals that your State is considering helping implement and achieve these goals?

Ms. FAY. Yes. Thank you, Congresswoman, for that question.

So I think the No. 1 issue is pay, is wage rates. And so, if we sort of set that aside, which is something that our commission did, because I think everyone on the commission was in consensus agreement that—that the pay was not commensurate with the work. And, if we value work by the amount of money that we pay people, then we are not doing justice to the value that this work provides to our loved ones, but also to our economy.

There is a parallel between the childcare workforce issue and the caregiving workforce issue as well.

So I think I will just—I will just stop there with the pay. You know—yes. That is where I will stop. Thanks. Sorry.

Mrs. MCBATH. OK.

Ms. FAY. I don't want to take too much time.

Mrs. MCBATH. Thank you so much for that.

And, Mr. Espinoza, individuals who are receiving consumer-directed care are often responsible for finding and hiring their own direct care workers, as my family and I had to do as well. And, while these—this gives these individuals, really, a great deal of individual choice—you know, we had a large choice of care providers regarding who provides, you know, services for families and, you know, we had to do the same for my mother.

Can you talk about some of those strategies that PHI actually recommends that helps connect people like us, families like us, with workers who can provide those kinds of services?

Mr. ESPINOZA. Yes. Absolutely. Thank you for the question, Congresswoman.

One of the best strategies I think that we have been seeing in the field are matching service registries or caregiver registries. These are online platforms that help home care consumers and workers find one another.

In California, there are four centers for independent living that offer matching service registries, and they include features for consumers and workers. They include the option for workers to record short messages. There are a variety of technological features that make that interaction more possible, and it allows them to connect based on preference, based on their needs, and based on their availability.

However, there are only matching service registries in 10 States. Many of them are chronically underfunded and do not embody the best of technological processes. And, so, certainly the Direct CARE Opportunity Act could make a big dent in this issue. It could ensure that all States have matching service registries, or that we find other viable ways to connect consumers and consumer-directed programs to workers.

Mrs. MCBATH. Thank you so much.

And, Ms. Torres, I just want to say in my last few seconds, thank you so much for everything that you do. The work that you provide and the care that you provide the residents that are depending on

you is truly, truly vital, and we just really appreciate everything that you do for this industry.

Ms. TORRES. Thank you.

Mrs. MCBATH. And I yield back.

Ms. TORRES. Thank you.

Chairwoman WILSON. Thank you, Ms. McBath.

And now Ms. McClain of Michigan.

When she finishes, the gavel will go back to Mr. DeSaulnier, who has returned to the meeting as co-Chair.

Ms. McClain of Michigan.

Mrs. McCLAIN. Thank you, Madam Chair.

Mr. Burani—thanks—sorry about that—your work involves upskilling individuals with vital skill sets that leads to promising careers.

Some of my colleagues across the aisle often argue that throwing more and more funding on new Federal programs is the answer for workforce development. This is simply not true, and, actually, could detract from existing workforce development efforts that already work.

I intend to actually introduce legislation addressing ways to promote awareness and information on these incredible programs and their beneficial role in shaping our next generation's workforce. I believe we need to focus on helping all workers, including those in direct care sectors, by strengthening really existing programs that will further help address the skills gap.

Can you speak about the current success and employment outcomes—the actual outcomes that these programs, such as Udacity, can lead to, you know, as well as any structural changes or reforms that could be better serve both prospective students and actually taxpayers?

Mr. BURANI. Yes. Thank you, Congresswoman, for this question.

I think that, you know, the way that we look at a successful program is largely within the context of the systems that support it. So WIOA's standard of performance is based on credential attainment. It is based on job placement, retention of that job for 6 and 12 months. It is based on the median salary coming out of that program.

So we look at all of these things, but we also use a broader definition of positive career outcomes. We have run programs around the world in which what we have done is measured the impact for a learner coming out of our program not only on the ability to attain the job offer, because that may or may not have been their goal. It may or may not have been the goal of the funders and the sponsors of this program.

We have run a program in Egypt, for example, where we are working with tens of thousands of graduates to put them in gainful freelancing work, and the attainment of a freelancing gig or a series of them would be a positive career outcome. So would a promotion, either in title or pay or both. So would the launch of a successful venture. It could even simply be that you self-report yourself as being happier on the job.

So we look at these positive career outcomes, and they are broadly defined. It gives us a basis on which to optimize our programs and really make sure that this technical curriculum paired with

the projects also is supported with the right wraparound services to maximize those outcomes.

Mrs. MCCLAIN. Sure. Thank you.

And then, workforce shortages in the healthcare industry have long been an issue but have only been really exacerbated by this pandemic. As our next-generation workforce takes shape, there will likely be advancements in technology in the healthcare industry, which will require, obviously, a robust workforce.

Can you speak to how programs and platforms, such as Udacity, can help address some of these shortages, and the skill sets they can provide for future healthcare and jobs?

Mr. BURANI. Yes. It is a fascinating topic, and we are in the early days at Udacity of looking at, sort of, sector-specific solutions of this sort. But I will give you one example.

We offer a program for artificial intelligence in healthcare, and this really provides what we see as a, you know, a very modern skill set, which is a bit of a lead pass for where we see the industry going.

Now, you will recall earlier, I spoke to the 2.3 million open jobs in healthcare, and the very small subset of those today that represent these types of technology, sort of, related skills. But we do see that changing over time, and that is due to all of the investment in digital transformation.

So our AI for healthcare Nanodegree will—you know, here is an interesting application. Using the data that comes from wearable devices to understand the context around some of these indicators, something as simple as your heart rate or pulse, right? If we understand the context, we understand the—you know, the altitude, or the accelerometer tells us that this person was actually moving quickly, right. This can now add important metadata for a practitioner to understand, I can rule out explanations A, B, and C, and focus my diagnosis on X, Y, and Z. So we hope to use that technology in a productive way.

Mrs. MCCLAIN. Thank you, sir. And thank you for all the guests today.

I yield back my time. Thank you.

Mr. DESAULNIER.

[Presiding.] Thank you, Chairwoman Wilson. Wonderful to partner with you.

And now, I would like to recognize the distinguished gentlelady from Michigan, Representative Stevens, for five minutes.

Ms. STEVENS. Well, thank you, Mr. Chair, and thank you for—to our witnesses for today's very important hearing on caring for our communities and supporting and investing in the direct care workforce.

Let me just couch this in the Michigan sense really quickly. Michigan has about 60,000 direct care workers who take care of our elderly peoples and peoples with disabilities in their own homes.

In addition to our current shortage of direct care workers, State officials estimate that Michigan is going to need an additional 178,000 direct care workers in the next 10 years to meet growing demand. That is more than twice the current workforce.

Currently, there are not any Federal or Michigan State training initiatives or certification requirements to work as a direct care worker in someone's home. We all know, and we have talked about today the pay being low, the benefits being virtually nonexistent. And, over time, it is becoming more and more common that the work is obviously—grows to be physically and emotionally demanding. Michigan home care workers are paid somewhere between \$9.50 and \$12.00 an hour without a lot of benefits.

So, Mr. Espinoza, you had mentioned in your testimony that COVID-19—that the COVID-19 pandemic worsened existing challenges for the direct care workforce. Could you just talk a little bit more about that specifically and the impacts that the pandemic had on our home care workforce and the people they support?

MR. ESPINOZA. Yes. Thank you for that question, Congresswoman.

What we saw in our experience and through our research was that, in the early stages of the pandemic, direct care workers were on the front line, but they were often there without enough PPE, without enough supplies, without childcare or paid sick days, and without proper compensation. In fact, we heard some horror stories in New York City, for example, where PHI's headquarters are based, of workers using garbage bags as gowns and purchasing their own protective equipment.

And many workers were being made—asked to make the impossible choice: Do I go to work and risk getting infected or infecting my families and clients without paid sick days, or do I stay home and collapse financially?

And employers and industry groups also sounded the alarm. Our research would show that about 280,000 workers left the direct care sector in the first 3 months.

Now, that said, over time, we have seen that these numbers have begun to settle and return back to normal, but there are still a variety of questions that I think the direct care workforce and the long-term care sector needs to address, really to strengthen jobs and to protect ourselves during the next healthcare crisis.

What has been—the mental health impact, for example, on workers who saw clients and family Members die, how does this affect turnover? What does it mean that this sector often lacks grief support and bereavement leave for workers? How should this sector improve safety standards, infection control and prevention, emergency preparedness? How do we recruit effectively when so many workers saw how dangerous and unprotected these jobs are, especially in nursing homes?

And how do we learn from the short-term measures that were adopted, from hazard pay to paid leave, to childcare centers in certain cities, or virtual trainings, to think long-term, to modernize the job, and to transform this sector in the long-term?

I mean, certainly we would ask for a Federal report on the lessons learned of this workforce and how to prepare for ourselves in the future.

MS. STEVENS. Great. Thank you so much for that really, really thorough explanation, and just all of your background.

And with my remaining time, Representative Fay, in your testimony, you talk about individuals who are eligible for home care

and community-based services going unstaffed because there is simply a shortage of workers to provide the services that the individual is eligible for.

Could you just tell us what is at stake when an individual is not able to access the care they need?

Ms. FAY. In some circumstances, people will die, because they can't access care. And that is part of what really keeps me doing this work. You know, making sure that there is a workforce there to care for folks that need it so that they can live their best lives is, I feel like, one of the most important things that I can do as a Representative.

So not being able to do the things that bring people joy or simply live with dignity is what is at stake here.

Ms. STEVENS. Thank you for that.

And, with that, Mr. Chairman, I yield back.

Chairwoman Wilson of Florida.

[Presiding.] Thank you, Ms. Stevens. I am back.

This hearing is impacting each and every one of us personally, and it has really just impacted our constituents, and this is very moving.

And now, we will hear from Mrs. Harshbarger of Tennessee.

Mrs. HARSHBARGER. Thank you, Madam Chairman.

My question is for Mr. Burani. I have been in the healthcare industry for 35 years, and I have absolutely serviced and worked right alongside with these direct healthcare workers as a pharmacist in making sure that we work with home health and hospice at the agencies as well as the healthcare providers in that. And I absolutely know there is a shortage of direct healthcare workers. You know, there is a shortage of registered nursing, especially in rural communities.

And, from Representative Fay's comment of what they saw from some research that this is a dead-end job, I absolutely agree with the Chairman that there—that is a marketing failure in my opinion, because this is just a springboard to so many other areas in healthcare as far as the nursing industry goes.

And, from the business component, more money does not equal better outcomes, and I can tell you that from my profession and being a business owner, too.

I looked at your testimony, though, and there are so many things that you recommended for the WIOA program as far as structural changes. And, just like you created more scalable registered providers, every State is different. Make that easy for them to, you know, compile that information.

I am looking at the facilitating the mobility of dollars across labor markets. I am a border State right at the tip of Virginia. So a lot of those people that may live in Virginia work in Tennessee or vice versa. That is a huge problem.

Increase the accessibility and transparency for all programs. You know, make a single source—single source where they can record that data. That is a no-brainer as well.

There is just—you have got a ton of good recommendations in here.

Incentivizing community colleges to work with employers. You know, we have community colleges in my district that do CNA pro-

grams or LPN programs. We have workforce development agencies who do the same. We have a hospital system who will train at no charge, do the CNA program to where they can go get certified.

You know, some of the things—you talk here about fostering a more dynamic relationship between the workforce board and learners, about the marketing operations. People don't know what they don't know, and marketing is a huge part of that. And, in your industry, with all the AI and things you have, this should incentivize people to come look at this.

But what I want you to talk about is to incentivize distribution of funding toward distressed communities. I have two distressed counties in my district, and, like I said, people don't know what they don't know. How do you get the word out to those people that there are opportunities out there, and how do we do that? How do we bring them into the fold and keep them there by giving them that opportunity, sir?

Mr. BURANI. Thank you, Congresswoman. I appreciate the feedback, and I appreciate your taking time to think through all that goes into these reforms.

So, when we consider this critical point of view around facilitating a relationship between workforce and the general public, you hit on exactly the problem. What do they know about the system that is designed to serve them?

The workforce board of any given county or metropolitan region or State is not a consumer brand. The closest thing to a consumer brand is the job center, which has a retail presence, and is where you go to get coaching and to look at the job board and maybe attend a career fair.

But what we need to do is—and I used this word “modernize” a lot today—we need to sort of 10X the sophistication of the relationship between the server and the recipient of that service. So understanding the range of programs, understanding the range of conditions or, you know, sort of status quo that these—

Ms. HARSHBARGER. Uh-huh.

Mr. BURANI [continuing]. programs are designed to serve.

And, to your point about distressed communities, structuring programs in such a way that we provide the supports. I will give you a very simple example. Our programs don't work if you don't have a laptop and a broadband connection.

Now, penetration of broadband is quite high at an aggregated level. But, when you go into distressed communities, those numbers plunge. So that requires us to broker those partnerships on the side. Sometimes we will work with community partners, sometimes the workforce board can nominate someone, or we have got to do the work to find those connections to get people to donate laptops.

And, so, I know there are always good ideas in the mix for how to make these provisions for distressed communities, but it needs to be more endemic to the workforce system versus a box that we check and something we pursue separately.

Mrs. HARSHBARGER. We will continue our conversation, sir, and great ideas.

And I yield back.

Mr. BURANI. Thank you.

Chairwoman WILSON. Thank you so much.

And now Mr. Levin of Michigan.

Mr. LEVIN. All right. Thank you so much, Chairwoman Wilson, and also to Chairman DeSaulnier for putting together this vital hearing on the direct care workforce.

You know, direct care professionals do the challenging work of taking care of the most vulnerable populations in our country, our young, our old, our folks who are sick. And, as our Nation ages over the coming decades, this direct care work will become ever more essential. And so, we will need more direct care professionals. But, if you look at the obstacles they face, it is no wonder that we see such high turnover in this field.

Direct care workers must contend with low pay, a lack of resources, lack of benefits, lower job agency and inadequate training options. And it is not due to marketing of workforce agencies.

I would—in Michigan, actually, our workforce investment boards are very strongly branded as Michigan Works, and the public knows about them. But these are just not jobs that enough people are able or willing to do, because they are so low paid, and they have so low—you know, low status in society, which is all of our faults—the fault of policy.

So, we have got to invest more in direct care to ensure that direct care workers are valued and have the resources and respect fitting this essential, complicated, and dangerous work that they do.

Mr. Espinoza, you mentioned in your testimony that, in all 50 States and D.C., the direct care worker median wage is lower than the median wage for other occupations with similar entry level requirements due in large part to the limited funds available through Medicaid.

So, as you know, the American Rescue Plan increased Federal funding for home-and community-based services by 10 percent. Can you talk about how these funds have enabled States or will enable States to improve wages for these workers? Will the money really get through to the workers?

Mr. ESPINOZA. Thank you, Congressman.

I think the American Rescue Plan can make a big difference in improving jobs and improving supports for people who need this level of support.

What it does specifically is it increases the Federal matching rate by 10 percentage points. It encourages States to use that additional funding to both expand home and community services, but also, in many instances, improve jobs.

Several States have put forth their spending plans, and we have seen a number of measures in those plans that would do a great deal for workers in those States.

So, for example, North Carolina recently introduced its spending plan, and some of its measures include \$210 million a year for recruiting, retaining, and building the network of HCBS direct care workers, also money for employment training for direct care workers, and money for a direct care workforce survey to better understand what the driving factors are for so many workers to come into the sector and leave the sector. And this would, of course, not

just address marketing, but it would address how do you transform the overall quality of the job.

New York has also put forth its spending proposal, and it includes about \$2.1 million for direct care workforce issues, including the long-term care workforce and the value-based payment readiness, improving jobs for direct support professionals, which are a segment of the worker—workforce that supports people with intellectual and developmental disabilities, but, also, issues like transportation, Medicaid rehabilitation rates, training and supports, and building evidence-based practices, and more.

So it shows, I think, both the possibilities that increased Medicaid funding can have on improving jobs and improving services, but, also, the incredible need that is needed in this sector in every State to strengthen recruitment and retention.

Mr. LEVIN. Does PHI have specific recommendations regarding increasing Federal Medicaid funding on a going-forward basis after, you know—after we have—what we have already done?

Mr. ESPINOZA. Yes, absolutely. I mean, we would argue for many of the items that we—that I mentioned just right now. But we would include how do you improve wages for direct care workers? How do you strengthen the training infrastructure for employers, including virtual, but also in-person and hybrid approaches? How do you create career advancement opportunities? Can this money be used to strengthen the data collection infrastructure so that employers and policymakers can better track workforce capacity and job quality? And how do you improve research and surveys on these workers?

Those are a handful of recommendations that we would issue, yes.

Mr. LEVIN. Well, thanks.

You know, Madam Chairwoman, I started working with healthcare workers who wanted to organize in the early 1980's, and I have—throughout this whole—all these decades, this workforce has never really been changed in terms of being paid adequately, having real career tracks, real opportunities for advancement, and the training and supports they need. It is high time we get that done. They need it, and the people they care for need it.

And, with that, I yield back.

Chairwoman WILSON. Thank you, Representative Levin. I agree with you 100 percent. It is our responsibility to change that scenario.

Mr. LEVIN. Yes, ma'am.

Chairwoman WILSON. Representative Fitzgerald, and then, after Representative Fitzgerald is recognized and speaks, I will pass the gavel back over to co-Chair, Mr. DeSaulnier.

Representative Fitzgerald, you are on mute.

Mr. FITZGERALD. Madam Chair, our—I am here. Are you ready?

Chairwoman WILSON. Ready.

Mr. FITZGERALD. OK. Thank you.

Mr. Burani, you know, in Wisconsin, over the last, and obviously, unique circumstances where a lot of these caretakers and the workers that are doing this very difficult job, their challenges have been increased significantly. You know, we are still working on the

steady pipeline of individuals that are willing to take this type of work on in the direct care space.

In those discussions, I mean, is there any relationship that you feel is being developed? And I would say probably more of a—in the traditional educational institutions, like tech colleges, or, you know, there are some instances, I would think, in which hospitals or clinics would provide OJT for some of these individuals. That would be kind of the first question I would have.

Mr. BURANI. So I want to make sure I understood your question, Congressman, so we are asking do we see entities in this ecosystem, the industry and the training providers actually moving closer together and working more closely in partnership?

Mr. FITZGERALD. That is right, yes. Yes.

Mr. BURANI. So I think that it is—yes. In—broadly speaking, absolutely. I think that you—there is a lot of evidence of it. On one extreme, you have got tech companies that are actually launching their own, quote/unquote, “universities,” their own upscaling programs, because the adoption of their products and services in many ways is bottlenecked by skill shortage. No surprise there. That goes back to, you know, the narrative we have been talking about all day long.

But I think that there is, you know, another aspect of this, which is—it is what the system is demanding. We have a—I think an increasing—the reality and the mandate for these educational providers of all stripes is to show these outcomes. I have been beating a dead horse today with that word, “outcomes.”

But the reality is, if you zoom out and you think about the student debt crisis, right. At the end of 2020, the first year—the first wave of graduates who came out during the pandemic, the joblessness rate of those graduates was 3.5 times what it was the year prior.

So, when you look at the average amount of debt, about \$36,000, 45 million Americans having that debt, you are measuring the impact to American GDP in the trillions, and it is literally becoming a bigger part of that pie. So I do think that organically, just basic supply and demand is pushing us in that direction.

Mr. FITZGERALD. Very good. And let me just followup with: So, if there is a reauthorization of WIOA, is there one thing that really—and I know you probably touched on this more times today, but is there one thing that really stands out that we should maybe make adjustments to or make changes to that could actually, you know, help us in determining whether or not the full reauthorization is warranted, or is there something that should be tweaked, I guess?

Mr. BURANI. That is an excellent question.

In preparation for today, I narrowed it down to about 15 for the purposes of brevity. I think that, you know, if we had to narrow it down to one, I would say we need to have a free flow of ideas and a free flow of awareness for all stakeholders in this ecosystem. What is it we are trying to do, and how do we make the most of the system that we have?

And that means learners of all archetypes. It means, you know, educational institutions of all—you know, traditional, nontradi-

tional, long-term, short-term. It means employers representing all industries.

There would need to be some sort of a forum, or some sort of a sort of consistent vehicle for all needs to be put out in the open for us to then realize that, actually, we are all more or less going for the same thing.

Mr. FITZGERALD. Got it. Very good. Very good. Thank you very much.

Madam Chair, I would—I would yield back.

Mr. DESAULNIER.

[Presiding.] Thank you, Mr. Fitzgerald. I will now recognize Mr. Bowman for five minutes.

Mr. BOWMAN. Thank you, Mr. Chairman.

Mr. Espinoza, thank you for all the work you do at PHI in the Bronx. As you know, part of my district includes the Bronx and is home to many caregivers.

As we emerge from the pandemic, we have an historic opportunity to build an America that works for all people by centering the care that all people need. So often, the very people who provide critical caregiving work in our communities are not able to care for their own loved ones, like an ill family Member or a young child.

Earlier this year, I introduced my Care for All agenda resolution, because we need to dramatically expand and strengthen the care economy and improve conditions and compensations for care workers nationwide.

In addition to better wages, can you talk about specific conditions, such as pathways to unionizing and free or low-cost childcare for care workers, that we need to consider in the face of rising demand for care work?

Mr. ESPINOZA. Yes. Thank you for the question, Congressman.

There are a variety of strategies that are needed to really strengthen the direct care workforce and ensure supports for the people they support. As you mentioned, I think unionizing, collective bargaining has been used as a strategy in many States to elevate wages, to provide benefits and a wide range of employment supports, to provide career advancement opportunities, and to create a collective voice that can advocate for change on the job and in their sector.

We have also seen in New York—we are affiliated with Cooperative Home Care Associates, and Zulma is speaking here from CHCA. Opportunities for worker-owned cooperatives, or other ways in which workers can have a voice in defining the quality of a job and ensuring that those supports are as strong as possible.

When you look at the research on direct care workers, what you see is these incredible challenges. I mean, certainly, we often point to poverty level wages, which forces about 45 percent of direct care workers into in or near poverty. But, because of that poverty, so many workers then rely on public assistance to survive, and, in many instances, it is low-wage jobs and the ability to access higher-paying jobs in fast food or retail in most States that are driving these workers out of the sector and are destabilizing the workforce.

So, as we think about strategies to strengthen this sector, certainly any of the interventions that the Direct CARE Opportunity Act support, from training to advancement opportunities, to re-

cruitment and retention innovation, to technology and other kinds of supports are critically needed, but so is the evidence base. How do we make sure that the Federal Government is investing in those interventions that are most effective that improve employment, that improve care, and that improve cost savings,

So, I think this is a critical opportunity for this country.

Mr. BOWMAN. Thank you, Mr. Espinoza.

PHI has a powerful resource that shows, in New York, 57 percent of home care workers are accessing some form of public assistance, which is a clear demonstration of underinvestment. President Biden's American Jobs Plan——

Mr. MURPHY. No it isn't, people——

Mr. BOWMAN. Excuse me. President Biden's American Jobs and Families Plan would make a significant investment in Medicaid's home-and community-based services, which is a necessary step in the right direction.

In addition to funding, what do you think needs to change about the way we talk and think about care work? How can that translate to Federal policy?

Mr. ESPINOZA. Yes. Thank you for the question, Congressman.

I think there are a number of representations about direct care workers that are inaccurate. One of them is that it is unskilled or low-skilled labor when, in fact, what we know through our work and what many people in this field know is that direct care requires a range of skills and knowledge.

The National Academy of Medicine encourages that direct care training include at least 75 hours of training, which acknowledges the level of skill, knowledge, and confidence that these workers need to succeed in these roles.

Another representation is that these workers aren't dealing with life challenges, or job-related challenges that are threatening their stability on the job, and yet what we know and what employers can show is that there are a wide range of challenges that they are facing both in their jobs and in their communities.

In the job, it includes everything from safety and workforce violence. It includes a lack of training, a lack of career advancement opportunities, often challenging situations with consumers, but also family Members, and, in general, a lack of recognition and respect for the critical role that they play.

And, for many of these workers who are women, people of color, and immigrants, they are facing challenges in their communities that make it that much harder to succeed on the role.

So I do think that challenging those misconceptions and valuing workers for the critical role they play by funding something like the Direct CARE Opportunity Act could do a great service for these workers and all of us who need this level of support.

Mr. BOWMAN. Thank you so much.

Mr. Chairman, I yield back.

Chairman DESAULNIER. Thank you, Mr. Bowman.

I will now recognize Representative Letlow for five minutes.

Ms. LETLOW. For all the witnesses, thank you for taking the time to testify before the Committee today.

After the past year we have had, it is clear just how important it is for our country to have qualified, trained professionals in the

healthcare sectors. Our doctors, nurses, and healthcare workers across all fields are vital in providing essential services and helping patients and families through some of their most difficult times.

While I understand the motive is good, I have serious hesitations with authorizing another massive new grant program for \$1.5 billion to address only one sector of the healthcare field. I believe we should be utilizing existing funding streams under the Workforce Innovation and Opportunity Act and the Registered Apprenticeship system to prioritize high-demand fields, such as direct care workers.

Additionally, having employers more involved in workforce education curriculum will help future employees come out of school prepared to handle the latest challenges and trends and ready to enter the workforce.

My question is for Mr. Burani. In your testimony, you emphasized the importance of facilitating the mobility of dollars across labor markets and incentives to collaborate with neighboring workforce areas. What specific reforms should be made to promote greater coordination across communities, and what benefits are there to incentivizing collaboration?

Mr. BURANI. Thank you, Congresswoman, for the question.

I think this is important. Let's just consider a hypothetical case study. You are in a specific county. You live there and are a contributing Member of that society, and you happen to be interested in upskilling yourself.

It could be that most of the career opportunities happen to be in the next county over. And, as a resident of one county, with employers buying into a program that is headquartered, for all intents and purposes, in another county, we encounter difficulties where that money does not flow freely unless there are partnerships established within those two distinct workforce areas.

Now, there is nothing holding back those workforce areas from collaborating, but that takes time and attention and energy and resource, and that is immediately creating drag on the process.

So there needs to be—it starts with a fundamental understanding of how the labor markets in this economy have evolved over time. There is more breadth—look at commute times. That is a perfect example of how geography has changed this dialog.

But also consider the growing—the rise of remote work. What we need to do is make provisions for these circumstances, and create abilities, either with a—you know, a—sort of a parallel hierarchy in which that particular type of partnership is facilitated, or some other workaround, some other carve-out that allows me in county No. 1 the ability to go with confidence and try to get involved in a workforce program that might not be in my backyard.

Ms. LETLOW. Thank you so much. I appreciate it.

I yield back my time.

Chairman DESAULNIER. Thank you.

We will now recognize Representative from New Mexico, Representative Leger Fernández.

Ms. LEGER FERNÁNDEZ. I want to thank both Chairs and Ranking Members. And I want to thank the witnesses for their excellent description about what—how important this care is to each of our

families, to each of our communities, to our country as a whole, how difficult the work is.

I really did appreciate Ms. Torres' description of the number of hours she works, the—you know, how heavy the work is, how hard the work is. But also, how much care she puts in that work. It truly came through. And so, for your testimony, I am extremely grateful, Ms. Torres.

I want to address my questions to two types of direct care workers: those working in rural communities, and those who are immigrants. I represent the Third District of New Mexico, a beautiful district, but it is the size of Pennsylvania. It is beautiful. It has got wide open landscapes and lots and lots of small rural communities, some in a sense that we were listening to Mr. Burani talk about. It is like multiple counties.

Representative Fay, you represent Maine, a State that is also very rural. Can you describe the specific challenges direct care workers face in rural communities and ways—maybe I will combine it—ways in which Congress can incentivize individuals to work in those rural communities?

Ms. FAY. That is a fantastic question.

So in our commission hearings we heard from rural direct care workers, and one of the primary barriers for them was travel time. So they are not reimbursed, home care workers are not reimbursed for their travel time. And if you are working in Penobscot County or Piscataquis County, it might take you an hour to get to your client and then an hour back. If you have more than one client, then you are doing an awful lot of travel.

So I think we can think of other things. Broadband access. We have electronic visit verification now, which is required. In some of those places, there is no internet access. You are required to have some sort of electronic device. And that can be a challenge, and providers don't have necessarily the funding available to them to pay for those devices.

So I think we could play that out in many different ways. But those are two of the most significant barriers that we discussed.

Ms. LEGER FERNÁNDEZ. Well, thank you very much. And I think that this testimony also highlights to us that in Congress we must address all of these complex issues, recognizing the interconnectedness, so that we work on broadband at the same time that we work on properly valuing our home care workers and our direct care workers.

Mr. Espinoza, you know, New Mexico has got a long history, culture, and economy based in valuing our immigrant and our immigrant workers. Although New Mexico, the border changed on us, we have always welcomed and honored our immigrant workers.

You mentioned in your written testimony that 27 percent of the direct care workforce are immigrants. And I know there has been discussion about the disparities immigrant direct care workers face compared to their colleagues.

You know, in another place where there is this interconnection, could you describe how offering undocumented immigrants a path to citizenship might help stabilize the workforce and eliminate disparities? Is that something you can speak to?

Mr. ESPINOZA. Yes, absolutely. Thank you for the question, Congresswoman. Just as background, our research shows that about one in four direct care workers is an immigrant, and that totals about 1.2 million immigrants. Our research also shows that that segment of the workforce, immigrants in direct care, is growing faster than U.S.-born workers. So it is part of the future of this sector.

Our research doesn't capture undocumented workers and it doesn't capture workers who are hired in the gray market. But certainly, we can assume that being an undocumented worker who is working in home care most likely runs a variety of challenges, right? They often fear retaliation from their employers. They often struggle with the challenges of navigating an immigration system and the rise of anti-immigrant hostility.

And a pathway to citizenship in particular would stabilize the job for those workers, but it would as importantly stabilize the workforce for consumers who need those workers, right, especially recognizing that immigrants are a big part of the future.

Ms. LEGER FERNÁNDEZ. Thank you for that. I would note that if we actually did the American Citizenship Act, it would provide a \$1.4 trillion benefit to our economy, as well as provide the workers in this industry we need.

My time is expired. I yield back.

Chairman DESAULNIER. Thank you, Representative.

Next would be Representative Spartz if she is interested in speaking. I don't see her. She was on. Give her a second. If not, we will go to Representative Sherrill.

Representative Sherrill, you are recognized.

Ms. SHERRILL. Thank you so much, and it is great to be here.

Representative Fay, your State and Nation have been struggling for years to develop a strong pipeline of direct care workers to meet the needs of our residents. You have said the shortage of direct care workers has become a real crisis in your State. Can you say more about why this is a crisis, and what have the impacts been on older and disabled residents, based on this?

Ms. FAY. I think the crisis was laid bare by the pandemic for reasons that we have talked about a little bit today. There are some problems for workers going into folks' homes I will say specifically.

In Maine there are some personal care attendants who are not characterized as healthcare workers and they didn't, for instance, early on have access to vaccines. So that was problematic for them and problematic for their clients and the people that they care for, because if you rely on someone else to help you cook meals then your nutrition suffers. If you require someone else to help you get to doctor's appointments, then your health suffers. And we also know that isolation has a significant impact on mental health.

So I think those are some specific impacts that we saw of the growing crisis in the workforce shortage. And that continues. We have a workforce crisis across the State in most sectors.

So we are now having the challenge of having to try to attract workers into this particular low-wage work, and then for reasons which I mentioned before the healthcare impacts to their clients is really negative.

Ms. SHERRILL. So is any of what you are discussing a funding need directed toward job training and recruitment of direct care workers, or it sounds as if it is not necessarily on the training end, that it is just that the actual payment, the low payment? I am just wondering if this is a recruitment and training problem or if it is simply wages need to be higher in this industry.

Ms. FAY. It is both. I think necessary to increase wages, but not sufficient. One of the things I mention in my testimony is the way we value the work. And if we are having folks whose work isn't valued caring for people who maybe have less of a voice, who are less visible, people with disabilities and older folks, then we have a system that is sort of a negative feedback loop. So we need to raise the wages, but we also need to raise the visibility and the way that we value these jobs.

Ms. SHERRILL. So given this, what would the effect of the American Jobs Plan's \$100 billion investment in workforce development on the long-term ability of the home care industry to recruit the level of staff it needs, what would that impact be?

Ms. FAY. I think the impact would be significant. In Maine, much of the work is funded—much of our direct care needs are funded through MaineCare, which is our Medicaid. And while the State matches, that is a significant impact on our State budget. And having ongoing funding and the ongoing ability to do workforce development through additional funding coming into the State would just be huge.

Ms. SHERRILL. Well, thank you so much. I really appreciate your testimony today.

Thanks, Mr. Chairman. I yield back.

Chairman DESAULNIER. Thank you, Representative.

I have got Representative Mrvan next. I don't see him on the camera, but if you are ready, please proceed.

Mr. MRVAN. Mr. Espinoza, in your testimony you note the astronomical turnover rate among home care workers of 65 percent. Can you tell us more about the impact of the high turnover on the continuity and quality of care and also outcomes for older people and people with disabilities who rely on long-term services and supports.

Mr. ESPINOZA. Yes. Thank you for the question, Congressman. As I mentioned earlier, turnover is one of the top threats that providers specifically named facing their agencies. They name caregiver shortages and caregiver turnover.

And two recent studies did show that the turnover rate for nursing staff and home care workers are about 99 percent and 65 percent respectively, and it often happens within the first 90 days.

Turnover has a huge impact on everyone in the system. It creates job instability and financial challenges for workers who must move from one job to another. It disrupts continuity of care for consumers. And oftentimes a worker will have quite a bit of valuable information on someone's health, someone's preferences, someone's experiences, and a lot of that can get lost when a worker turns over to another worker. And it affects employers. The estimated direct cost of replacing a nursing assistant or home care worker is about \$2,200, and that affects employers, and it affects the system.

There are ways in which interventions can dramatically address turnover and retention. We launched an initiative in 2013 that provided a 120-hour adult learner-centered home health aide training curriculum with about 500 trainees in New York City. And it led to a variety of improvements.

And, most importantly, in addition to the ways in which it improved patient-centered care or cultural competence, we found that 90 percent of participants completed the course and that trainees were more than twice as likely to be on the job at 3 months and 64 percent more likely to be on the job at 6 months.

So there are ways in which workforce interventions, if well-designed and evaluated in different parts of the country to allow for the local context, can make a big dent in addressing turnover and retention.

Chairman DESAULNIER. You are muted, Congressman.

Mr. MRVAN. I just wanted to give a quick narrative. I was able to join a symposium where it was long-term workers, and there was a family who had an individual who was disabled, a daughter, and ultimately the continuity of care was their most important aspect of what was going on in their life. And the continuity of care actually did play a role in the quality of care and the outcomes.

With that, I was just going to ask Ms. Torres if you could briefly just touch base on the value of continuity of care as you do this job.

Ms. TORRES. Could I have the question again?

Mr. MRVAN. Just if you would touch base on the continuity of care, how valuable it is to have a long-term employee with someone who needs long-term care.

Ms. TORRES. It is really important. It is really important because they need us. They need us. Some of them don't even have family members. And without us, they can't take their medication, take a shower, have something to eat. So we are so important to them, and they need us that much. So it is absolutely important to be there.

Mr. MRVAN. Well, I thank you for what you do.

And, again, I yield back my time. And thank you both for your answers.

Chairman DESAULNIER. Thank you, Representative.

The Chair will now recognize Representative Castro for five minutes.

Mr. CASTRO. Thank you, Chairman.

Immigrants make up over a quarter of the direct care workforce yet are largely unprotected and provide essential support for so many Americans.

And this is why I introduced the Citizenship for Essential Workers Act, to ensure that these workers who are risking their lives during COVID are now provided the protection that they deserve. We must ensure protections and support for our care workers, and we cannot overlook them any longer.

And so I had a question for Mr. Espinoza: Can you talk about the importance of immigrant direct care workers in the healthcare workforce and what challenges they face in this workforce, such as isolation and the risk of contracting COVID-19?

Mr. ESPINOZA. Yes, absolutely. Thank you, Congressman. I mentioned earlier that about one in four direct care workers is an im-

migrant, and we can assume that immigrants are also a big part of the gray market where many consumers, out of financial need, hire workers off the books, so to speak, and create those employment arrangements.

Our research shows that they are a vibrant part and a growing part of this sector. They come from 124 countries. They speak 157 languages. And yet we know that we are at a time in our country where anti-immigrant hostility is on the rise, and many workers feel unstable, not just in their jobs but in their communities.

So all of the challenges that all direct care workers face, like inadequate compensation, limited training and advancement opportunities, a lack of workplace benefits or general recognition and support, immigrants face as well, but they face it within a heightened context, because so often the instability they are facing doesn't end at the job. It continues on in their lives, in their homes and in their communities.

I do think there are a wide range of interventions that could be used to bolster supports for immigrants in this sector. Certainly, we would advocate for pipeline approaches that would bring more immigrants or foreign-born workers into this sector. We would also argue for interventions that support immigrants who are already here and working in direct care.

In New Mexico, an organization called Encuentro developed a really amazing home care training program that it delivers in Spanish and English for immigrants in home care. And it prepares them and employs them once they undergo the training, but it also helps them navigate life challenges and employment challenges.

So I do think, as our country becomes more diverse, that there are great opportunities for innovators in the field to think about how do we capitalize on a rich and diverse country? How do we draw on the strengths that immigrants bring to this sector?

Mr. CASTRO. Sure. And you touched upon some of the things that, as a Congress, as an American government, we can do to support them.

I want to ask you specifically about a few more things. First, with respect to workforce training, what can we do to provide better workforce training for this group of folks? And also, support that is available in their language and in their communities as well.

Mr. ESPINOZA. Thank you for the question, Congressman. In general, to improve training for these workers, we need a few strategies. One is we need to strengthen training requirements for all direct care workers, but especially personal care aides, which are a growing—probably the largest segment of the direct care workforce, yet there is no Federal requirement. And no State goes past 40 hours a week of training, right? So—40 hours training total for entry-level workers.

So we certainly need to strengthen training requirements. We need to standardize training and make them portable and stackable so that workers can work across occupations, but also, they can work across settings and across States. Too often workers need to be retrained again when they move jobs or when they move States, for example, right?

And we certainly need training that is culturally and linguistically competent, recognizing that so many workers are people of color and women and might benefit from training that is more appropriate for the kinds of challenges or learning styles that they have.

There are opportunities I think in the Direct CARE Opportunity Act to test and bring to scale those kinds of training interventions so that we can make sure that all workers have the knowledge and the skills and confidence to succeed in the jobs.

And we need more research specifically on the gray market. What does that sector look like? What are the experiences of workers, specifically immigrants, in that sector? And what are the experiences of consumers who, out of financial need, are turning to the gray market? And that is another place where I think Federal leadership can really make a dent in this workforce.

Mr. CASTRO. Well, thank you very much for those responses.

And I yield back, Chairman.

Chairman DESAULNIER. Thank you, Mr. Castro. I don't see anyone else. If there is anyone else, any Members who would like to speak, now is the time. If not, I am going to go to a little house-keeping work before we go to closing comments. And, again, thank you to all the witnesses for being here. Really great testimony, very helpful.

So, with that, I want to remind my colleagues that, pursuant to Committee practice, materials for submission for the hearing record must be submitted to the Committee Clerk within 14 working days following the last day of the hearing, so by close of business on August 3rd, preferably in Microsoft Word format. The material submitted must address the subject matter of the hearing.

Only a Member of the joint Subcommittees or an invited witness may submit materials for inclusion in the hearing record. Documents are limited to 50 pages each. Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the Committee Clerk within the required timeframe, but please recognize that in the future that link may no longer work.

Pursuant to House rules and regulations, items for the record should be submitted to the clerk electronically by emailing submissions to *edandlabor.hearings@mail.house.gov*.

Witness questions for the hearing record—I just want to mention again I want to thank the witnesses for their terrific participation today and your obvious interest and passion for this subject matter and expertise. Members of the joint Subcommittee may have some additional questions for you, and we ask the witnesses to please respond to those questions in writing. The hearing record will be held open for 14 days in order to receive those responses.

Again, I want to remind my colleagues that, pursuant to Committee practice, witness questions for the record must be submitted to the Majority Committee Staff or Committee Clerk within seven days. The questions submitted must address the subject matter of the hearing.

Now we will go to closing statements. And I want to recognize the distinguished Ranking Member of the Higher Education and

Workforce Investment Subcommittee, Dr. Murphy, for a closing statement. Dr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

I understand the difficult work—I want to thank all the Committee Members and the witnesses. I appreciate your counsel and a lot of good discussions today.

I understand the difficult work environment that direct care workers can find themselves in, because I have worked alongside them, as I have said previously, as a physician for over 30 years. Their contributions are meaningful. They make a difference in so many, many lives, especially toward the end of life. We are going to rely on these important individuals as our populations grow and as our population ages.

Our witnesses did a wonderful job today of illuminating some of the challenges that these and other healthcare workers face. I look forward to working with my colleagues on both sides of the aisle to consider how public policy can foster an environment where more people will consider the healthcare workforce as a valuable and rewarding career path.

The best way to do this is to strengthen WIOA. Healthcare occupations must be examined within the context of all professions to make sure that job seekers are fully informed. WIOA can help direct care workers gain the skills that they need to succeed in the long term, no matter which career path they can pursue.

Thanks again to all the witnesses. This was a very good Committee meeting.

Thank you, Mr. Chairman. I yield back.

Chairman DESAULNIER. Thank you, Representative Murphy, appreciate your comments.

And now I would like to recognize my co-Chair and thank her again for being able to step in for me. I had a couple other hearings going on at the same time, and one of them requires a little nimbleness, the Oversight Committee.

So Chair Wilson, thanks again, and happy to have you have any closing comments.

Chairwoman WILSON. Thank you, Representative DeSaulnier.

I want to thank our amazing witnesses for sharing their in-depth expertise and moving experiences. This has been a very insightful hearing. There are people in our country doing God's work. Thanks to all of the direct care employees in the Nation who help our families and our constituents every single day. We appreciate you.

As we all heard throughout our discussions, direct care is physically and emotionally taxing work. It is hard. Yet, while the demand for direct care services is surging, workers today aren't earning living wages or even receiving the necessary training to safely do their jobs. They need our help, and it is our responsibility to help them.

People are living longer and longer and desire to live in their own homes. That is why we need to secure significant resources for direct workers by passing the American Jobs Plan and the Direct CARE Opportunity Act.

These proposals would take significant steps toward recruiting and reinforcing the direct care workforce pipeline, and they would

help create millions of good-paying jobs as our economy recovers from the pandemic.

Most importantly, investing in our direct care workers would increase our capacity to help aging Americans and individuals with disabilities live with independence. We have to pay these employees what they are worth. As a matter of fact, their job description is priceless.

I am grateful for our discussions today, and I yield to the Ranking Member—and I yield to the Ranking Member for his closing statement.

Chairman DESAULNIER. We will go to the good son, Mr. Allen.

Mr. ALLEN. Thank you. It is great to be with you today. And I thank the witnesses for their helpful testimony.

COVID-19 brought attention to the immense sacrifices frontline workers make every day. They deserve our recognition and thanks. In fact, all of our medical professionals do.

As Republican leader of the Subcommittee tasked with developing healthcare and labor policies, I am particularly interested in supporting individuals who may be interested in entering the direct care workforce. In my mind, Congress must clear the way for State and local workforce boards to leverage private sector innovations occurring in their communities.

Mr. Burani's testimony shows us how critical it is to set folks up for long-term success. Creating additional single-interest government programs is short-sighted. Our Committee can do better than spending additional taxpayer dollars on short-term Band-Aids. We need to heal the root cause of our problem.

As this Committee considers a bipartisan reauthorization of WIOA, we must consider how we can address all workforce challenges facing our Nation, and they are many.

Thank you, Mr. Chairman, for the hearing today, and I yield back.

Chairman DESAULNIER. Thank you, Mr. Allen. It is always a pleasure.

I would now like to recognize myself for the purpose of making a closing statement. Again, thank you all, all of the witnesses, for participating. Really terrific. Ms. Torres, thank you, always most important to hear from the people actually providing the services, not to diminish the contributions of the other witnesses as well.

And to the Ranking Members and Chair Wilson, thank you so much. Certainly, I think if we can't agree on helping seniors, our moms and dads, our uncles and aunts, gosh, I don't know what we could agree with. And knowing and respecting that there will be some challenges with that, I do want to mention Ranking Member Murphy's comments about being good stewards of taxpayers' funding. I completely agree.

One of the interesting things that we talked about a little bit is just the effective and efficient role for the Federal Government and our partners at the State and local level and being client-based on their needs and listening to them and the workers like Ms. Torres.

So that is a real challenge, and I really appreciate all of the comments from the witnesses. You clearly see this in delivering these services in a very different social model. I always think of growing up in a rural community in New England, not far from Representa-

tive Fay, in Massachusetts that was changing into a suburban community outside of Boston, where all of my uncles and aunts and my grandparents were all within 15, 20 minutes, and we all shared. It was a really remarkable bond. But that time, for better or worse, is not the world we live in now. So you all know that, and how we adapt to that is so important.

And then last, just the urgency I feel, having been in this field for a while at the State, local, and now Federal level. People are suffering now and, indeed, people are losing their lives that could be extended and the quality of life could be extended if we acted with urgency collectively.

And I think of my own mom, and I really appreciate all the comments from Members about their personal experiences as well as their professional, but the issues around transfer trauma as she moved out of independence, but also the trauma of workers coming in and having to establish a relationship in a new environment when they came into her home.

So all of these things, I think there is a real opportunity for us to work together to really improve the system. And I would say, when we look at internationally and nationally, there are really good models. And as we look at workforce investment, a conversation I have had with Ranking Member Foxx for years, sometimes comical from our perspectives, but the importance of incentivizing best practices at Workforce Investment Boards at the State and local level so we can learn from one another, as Representative Fay has indicated, but not just accepting the status quo.

So, with that, as we reflect on the critical role that direct care workers play in ensuring that aging Americans and Americans with disabilities can live independently, I just want to thank everyone again.

Unfortunately, the challenge is real, as we discussed. Direct care workers are still not being provided the basic tools to make them successful for their clients: Fair pay, good working conditions, and continuing training that would allow them to join and stay in these professions and change the really horrible 82 percent turnover. And that is prepandemic. So some of the comments by some of my colleagues, the pandemic has clarified and made it worse, but we had a real problem before the pandemic.

So this chronic lack of investment in direct care workers must change if we are to secure the future of direct care workers and the clients that they serve. To that end, I am pleased we discussed how the investments in the American Jobs Plan, drawing from the Direct CARE Opportunity Act, would strengthen the direct care workforce pipeline.

I look forward to drawing from our conversations today and working with all of my colleagues to secure the support that our direct care workers need to provide long-term care for our communities and for our country.

Thanks again so much. And if there is no further business, without objection, the Joint Subcommittees will now stand adjourned. Thanks again so much.

[Questions submitted for the record and the response by Representative Fay follow:]

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July 28, 2021

The Honorable Jessica Fay
State Representative
Maine House of Representatives
141 Spider Hill Road
Raymond, ME 04071

Dear Representative Fay:

I would like to thank you for testifying at the Subcommittee on Health, Employment, Labor, and Pensions and the Subcommittee on Higher Education and Workforce Investment joint hearing entitled "*Care for Our Communities: Investing in the Direct Care Workforce*," held on Tuesday, July 20, 2021.

Please find enclosed additional questions submitted by Committee Members following the hearing. Please provide a written response no later than Wednesday, August 4, 2021, for inclusion in the official hearing record. Your responses should be sent to Rasheedah Hasan (Rasheedah.Hasan@mail.house.gov), Mariah Mowbray (Mariah.Mowbray@mail.house.gov), and Lorin Obler (Lorin.Obler@mail.house.gov) of the Committee staff. They can be contacted at 202-225-3725 should you have any questions.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Subcommittee on Health, Employment, Labor, and Pensions and Subcommittee on Higher
Education and Workforce Investment Joint Hearing
"*Care for Our Communities: Investing in the Direct Care Workforce*"
Tuesday, July 20, 2021
10:15 a.m. (Eastern Time)

Chairman Robert C. "Bobby" Scott (D – VA)

Representative Fay, in your testimony you explained that due to a shortage of direct care workers, there are 850 older and disabled Maine residents who qualify for home and community-based services but cannot get them, there are 1,000 Maine residents on the waiting list for the state-funded Independent Services and Supports program, and people are spending more time in hospitals than necessary because there is nowhere to discharge them.

- a) Can you tell us the approximate number of Maine residents who are staying in hospitals longer than medically necessary because they cannot be discharged to other settings (nursing homes, their own homes, etc.)?
- b) If available, can you provide an estimate of the additional annual costs associated with these longer than necessary hospital stays in the state?



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Dear Chairman Scott,

I appreciate the opportunity to answer additional questions raised at the hearing before the Subcommittee on Health, Education, Labor, and Pensions and the Subcommittee on Higher Education and Workforce Investment at the hearing entitled "Care for Our Communities: Investing in the Direct Care Workforce," held on July 20, 2021 via Zoom.

a) *"Can you tell us the approximate number of Maine residents who are staying in hospitals longer than medically necessary because they cannot be discharged to other settings (nursing homes, their own homes, etc.)?"*

I have reached out to Maine's Department of Health and Human Services to see if they have aggregated data for all of Maine's hospitals, but have not received a response as of the submission deadline. What I did receive is information – some specific, some not so specific – from two of Maine's primary hospitals/health systems about their patient census and some more specific data from one other hospital about discharges to nursing facilities.

Currently there is no way to concretely obtain the number of patients whose discharge is delayed due to access to home care, but the question is an important one and is something Maine's DHHS and providers should begin tracking.

From Northern Light Health:

"For the period of October 2020 through May 2021, Northern Light Hospitals had 406 difficult to place long stay patients with an average length of stay of 30 days. The longest length of stay during this timeframe is 284 days.

Our data set does track delayed discharge due to the nursing facility lack of staff. This represents 12 of the 406 patients. BUT we think this is lower than what the staffing impact really is."

Northern Light Health can only record lack of staff when the facility reports this as the reason they can't accept the referral. The most significant challenge we have is nursing facilities not having beds available for admission when we make a referral. This number is 188 of the 406 patients. It is possible that a portion of the 188 denied nursing facility admissions is due to lack of staff, even though it wasn't given as a specific reason for denial."

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Here is a link to a relevant survey done by Northern Light in 2019 at the request of the Commission to Study Long-Term Care Workforce Issues that has some interesting comments:
<https://legislature.maine.gov/doc/3182>

Another provider, Maine General Hospital in Augusta, who responded to my request for information did say they are seeing "increased issues, including a shortage of direct care workers to support patients at home with activities of daily living and a shortage of staff in long-term care and skilled nursing facilities." They have 20+ patients a day who could be discharged but there is not sufficient availability in appropriate settings. At Maine General, the "reasons for discharge delay are complex and multifactorial" and include workforce issues. They are also seeing an increase in older patients with dementia requiring referral to a memory care facility, which have very long wait lists.

b) If available, can you provide an estimate of the additional annual costs associated with these longer than necessary hospital stays in the state?

I have asked both the Maine Hospital Association and some of our regional medical centers what the cost per patient is, "on average," per day. That cost was estimated between \$2000.00 and \$2800.00 per day, per patient. Without an actual solid patient count for the entire state, it is difficult to provide an exact cost, but if we make significant assumptions, we can come up with a number based on extrapolation. There are 33 acute care hospitals in Maine, 10 of which are in the Northern Light system. If we extrapolate Northern Light's data to all hospitals, which would be 20 patients a day per hospital, or approximately \$33,000,000. The largest hospital in Maine, Maine Medical Center, is not in the Northern Light system and has recently indicated increased delayed discharges due to lack of staffing in facilities. Thus, it is likely that the numbers are higher.

Another hospital, MaineGeneral Health, estimates their cost is more than \$5 million a year, though due to the variability of the patient health status and needs, this is just an estimate.

I do want to reiterate to the Committee that these numbers are best guess estimates, as aggregated data either isn't available or hasn't yet been made available to me. It doesn't take into account that there are likely more overstay that aren't being included in these estimates. While I am glad to have been able to dig into these questions searching for answers, I was disappointed that Maine doesn't have this type of data easily available.

The Maine Department of Health and Human Services, in collaboration with the Department of Labor, have promised a plan which, using ARPA funding as well and the enhanced 10% FMAP for home and community-based services, will begin to address the essential care worker shortage in Maine. As of your Committee's deadline for testimony submission, those plans are not currently available to the public with specific details. These programs are being developed with one-time money and in order to really address this crisis, that funding must be ongoing, and I hope the DIRECT Care Opportunity Act will be a solution.

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I am encouraged by the concern expressed by members of both subcommittees about this issue and believe strongly that the solutions proposed by both reauthorization of WIOA with some modernization and the passage of the DIRECT Care Opportunity Act will help states begin to address the direct care workforce crisis.

I am available to try to clarify or answer additional questions.

Regards,
 Rep. Jessica Fay

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[Whereupon, at 1:43 p.m., the Subcommittees were adjourned.]

