



MICHIGAN'S DIRECT-CARE WORKFORCE: A SMART TARGET FOR CREATING BETTER OPPORTUNITIES, BETTER JOBS

In his inaugural address, Governor Rick Snyder expressed a commitment to building Michigan's economy by focusing on jobs. Specifically, he stated, "We must create more and better opportunities and jobs for the underemployed, and the structurally unemployed. The reinvention of Michigan must not leave anyone behind."

PHI is very encouraged by this commitment to the people of Michigan and suggests that a smart target for these efforts is Michigan's already growing and vital direct-care workforce of nursing assistants, home health aides, and personal care attendants.

First, about PHI...

PHI: QUALITY CARE THROUGH QUALITY JOBS

With offices in Lansing and a staff of four across the state, PHI (formerly Paraprofessional Healthcare Institute) is a national non-profit organization that works to improve the quality of jobs for direct-care workers. PHI does this by serving the interconnected interests of people who need long-term care supports and services and the frontline caregiving staff who provide those supports and services.

PHI's guiding premise is "Quality Jobs = Quality Care." In other words, ensuring that those frontline caregivers—most often called "direct-care workers"—have quality jobs will result in higher-quality care and support for the elderly, people living with disabilities, and others who need in-home and residential supports and services. (More on PHI is at the end of this paper.)

MICHIGAN'S DIRECT-CARE WORKFORCE AT A GLANCE

According to state and federal data resources, there are approximately 155,000 direct-care workers in Michigan.¹

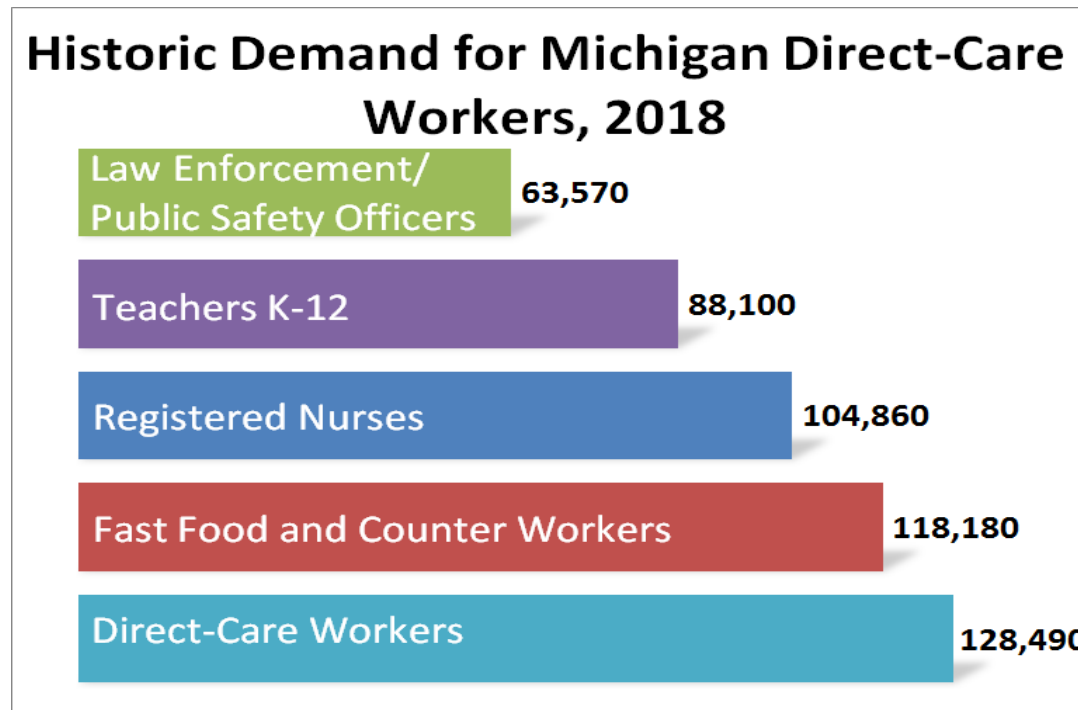
Michigan's direct-care workforce of certified nursing assistants, home health aides, and personal care attendants provide 80% of the hands-on care and support to elders and people living with a disability. Nursing homes, home care agencies, assisted living facilities, adult foster care homes, homes for the aged, and individual consumers are the primary employers of this workforce.

¹ Workforce data comes from various sources, including the Michigan Labor Market Information (www.milmi.org), the Department of Community Health, the Census Bureau and the U.S. Bureau of Labor Statistics (www.bls.gov).

The State of Michigan also plays a role in the employment of this workforce through Medicaid funding of long-term care supports and services. These services account for approximately 20% of Medicaid’s expenditures. The Michigan Medicaid program pays for about 70% of nursing facility care.² Medicaid also pays for all home and community-based services (HCBS) through the Home Help and MI Choice programs, which serve more than 65,000 people annually. The Specialty Supports and Services program provides HCBS to those with mental illness and/or an intellectual and developmental disability.³

DIRECT-CARE JOBS: THE FASTEST GROWING SECTOR IN HEALTH CARE

Health care continues to generate job growth in Michigan. The state’s direct-care workforce—which comprises 28% of health care jobs in Michigan—has grown considerably and will continue to do so, especially compared with all other occupations in the state.⁴



This increase in demand for direct-care workers stems from a growing aging population. Over the next five years, the number of Michigan residents age 65 and over is expected to grow from approximately 1.35 million to 1.54 million.⁵

² Health Care Association of Michigan (HCAM) – Legislative Guide for Today’s Nursing Facilities. Available online at www.hcam.org.

³ A full description of the array of long-term care supports and services in Michigan is available in the [Michigan Profile of Publicly Funded Long-Term Care Services](#), published by the Michigan Department of Community Health.

⁴ PHI (2009). State Facts: Michigan’s Direct-Care Workforce. Available online at <http://www.directcareclearinghouse.org/download/PHI-StateFacts-MI.pdf>.

⁵ See #3.

The long-term care sector of the health care workforce will add thousands of new jobs over the next decade. In fact, home health aide is the fastest growing occupation in Michigan: according to PHI projections, 14,470 new home health aide jobs will be created between 2008 and 2018, an increase of 44%.

The bulk of the growth in the direct-care workforce for the decade starting in 2008 will come from those workers providing home and community-based services (HCBS)—home health aides and personal care assistants—as opposed to those providing services in residential settings, such as nursing facilities or assisted living. Home health aides and personal care assistants account for 70% of the new demand in the direct-care workforce.

- Michigan’s direct-care workforce grew by one-third between 1999 and 2007.
- In the decade between 2008 and 2018, the workforce is expected to grow by 27%, compared with the overall job growth rate in Michigan of 5.6%.
- All three direct-care occupations—home health aides, personal care attendants, and certified nursing assistants—are among the 15 fastest-growing occupations in the state.

Even with the documented past growth and future demand, these jobs are rarely included by policymakers in planning for the delivery of LTCSS services or workforce development. The shortage of nurses and physicians in Michigan is well-known. The shortage of direct-care workers is not.

Without recognition of the size and importance of the direct-care workforce, Michigan will continue to have difficulty creating and maintaining quality jobs for direct-care workers—and in turn, quality care for long-term care consumers.

PLANNING FOR MICHIGAN’S FUTURE LONG-TERM HEALTH CARE NEEDS: BARRIERS AND SOLUTIONS

BARRIER #1: Inadequate Workforce Data – Planning for Michigan’s future health care needs will rely largely on workforce data relating to the demand for long-term care. Much of the workforce data that is currently available on the direct-care workforce is from federal or state sources, such as the Bureau of Labor Statistics or the Michigan Labor Market Information. While this data is useful in providing an indication of the scope of this workforce, it does not allow for workforce analysis at the program, setting, or service delivery level.

SOLUTION:

Michigan should continue its efforts to build a Workforce Measures Database which accurately identifies the volume, stability, and compensation of the direct-care workforce within Long-term Care Supports and Services (LTCSS) programs and settings. This level of data will help the state in planning service delivery needs within the LTCSS system. Also, in this time of challenging budgets, this basic data will help the state understand how reductions, shifts, or increases in funding for LTCSS services will impact jobs and consumers in this important sector.

BARRIER #2: Fragmented Training System – Michigan currently has a fragmented, and largely outdated, means of training and credentialing people who provide LTCSS across an array of settings, employers, and programs. Two categories exist:

- CNA Training – The most common credential among the LTCSS workforce is for certified nursing assistant (CNA). The CNA training and credential are designed for workers who provide services and supports to people living in nursing facilities. However, because CNA training is the most recognized and available training program, many employers throughout the entire LTCSS field recruit based on this credential, regardless of the care setting in which they operate. The state’s CNA training program is currently based on the minimum federal requirement of 75 hours designed by the federal government in 1987. The state and federal minimum standards have not kept pace with practice standards and training techniques that have evolved over the last 24 years. For example, the state’s minimum CNA training require only four hours on the topic of dementia care.
- Home and Community-Based Services Training – The other area where training for the LTCSS workforce is lacking is for home care and personal care attendants. These workers operate within the state’s Medicaid-funded programs and services; they work in settings ranging from private homes to community living settings such as assisted living, homes for the aged, or adult foster care homes. Few training requirements exist, and as a result there is not a coordinated training system or infrastructure for this segment of the LTCSS workforce. Although many of these providers recruit staff based on whether they have the CNA training and credential, employers often have to provide additional training to better equip staff for the different settings and consumer base they serve.

SOLUTION:

Enhance the CNA training requirements to extend beyond the federal minimum and provide training on competencies relevant to today’s service needs and settings. The following recommendations were developed by over 20 organizations working through the Governor’s LTCSS Advisory Commission:

- The Michigan Department of Community Health, in collaboration with stakeholders, should develop a new *Michigan Model CNA/Hospice Aide Curriculum* based on agreed competencies; the curriculum should foster adult learner–centered training methodologies.
- New or expanded competency areas should include: person-centered care, end-of-life care, electronic medical records, team building, effective communications, self-care, and dementia care.
- The same Public Health Code disciplinary processes should be to applied CNAs and hospice aides as those applied to other licensed health care professions;
- Clearer standards should be established for approving trainers within the approved training programs.

- Michigan Works! agencies need to include incentives to support training in general, and a sectoral approach to training specifically.

BARRIER #3: Non-Competitive Wages and Benefit Levels – Another challenge to meeting the growth and demand for this workforce is that these jobs pay wages and have benefit levels that make them unattractive and unsustainable—even in a state with unemployment at 12.4%.⁶

- Wages – Data on the wages of Michigan’s direct-care workers indicate that a large number of them are underemployed. Census data tells us that almost half of direct-care workers’ households have an income at or below 200% of poverty (\$37,060 for a family of three).⁷ The median hourly wage for the Michigan direct-care workforce is \$10.43, compared with \$16.26 for all wages in the state. Most Home Help providers have an hourly wage of \$8.50.
- Benefits - Nearly one-third (31%) of direct-care workers are uninsured. Health insurance coverage is unaffordable for direct-care workers and the large and small businesses that employ them.⁸ Having access to affordable health care coverage is a key part of retaining workers in this field.⁹

BARRIER #4: Reimbursement Policies – Michigan’s Medicaid program is a significant revenue source for over 6,000 LTCSS employers. Nursing homes rely on public funding—including Medicaid—for 80% of their revenue. The MI Choice HCBS waiver program, the Home Help program, and the state’s Community Mental Health system are funded exclusively by Medicaid and other public funds. What this means is that many of the state’s home care agencies, adult foster care homes, and homes for the aged rely heavily on public funding for their revenue, and do not set the prices for the services they provide. Without being able to control large portions of their revenue, many of these employers who want to pay a competitive or family self-sufficient wage simply cannot.

SOLUTIONS, BARRIERS #3 and #4:

There are no easy answers. One opportunity for improving health care benefits for direct-care workers is to maximize enrollment and outreach in the coverage to be offered under the Affordable Care Act (ACA). The direct-care workforce will be a key audience for new coverage available through expanded Medicaid eligibility and the Michigan Exchange under the ACA starting in 2014. There are several strategies from other states that can be explored to increase participation, such as targeted outreach to the direct-care workforce and Medicaid

⁶ Bureau of Labor Statistics (November 2010). Unemployment Rates, Seasonally Adjusted. Available online at <http://www.bls.gov/lau/home.htm>.

⁷ Bureau of Labor Statistics (2009). May 2009 State Occupational Employment and Wage Estimates – Michigan. Available online at http://www.bls.gov/oes/current/oes_mi.htm#31-0000

⁸ PHI (April 2008). Beyond Reach? Michigan Long-Term Care Employers Are Struggling to Provide Health Coverage for Employees. Available online at <http://hchcw.org/wp-content/uploads/2008/05/hchcw-mi-survey-factsheet.pdf>.

⁹ PHI (October 2007). Fact Sheet: Health Insurance Vital to Job Retention.

rate incentives to LTCSS providers to encourage them to offer and maintain employer-sponsored health insurance coverage.

In setting reimbursement rates for services, wages and benefits for direct-care workers must be considered and improved, even in the face of Michigan's economic crisis. The consequences of ignoring this workforce are costly: an unstable and underemployed workforce that provides inadequate care, resulting in hospitalizations.

CONCLUSION

Effective approaches to these challenges will require a change in our mindset as a state. With more than 6,000 businesses in Michigan, direct-care workers and their employers need to be seen as a target for economic gardening efforts as Michigan goes forward. Direct-care jobs are here and multiplying; and long-term care employers are valuable parts of local and state economies. The return on investing in the direct-care workforce is significant and immediate.

PHI stands ready to offer its state and national expertise to all policymakers, in partnership with all LTCSS stakeholders, to support quality care through quality direct-care jobs.

MORE ON PHI

PHI'S mission, "Quality Care through Quality Jobs," is based on our *Elements of a Quality Job and Quality Care* frameworks. The *Quality Job* elements are focused on the areas of opportunity, compensation, and linkages.¹⁰ We advance these elements in by promoting state and federal policies that improve training, wages, and benefits for direct-care workers. PHI also does training and organizational development with employers and state agencies in Michigan that are interested in creating workplace cultures and delivery systems that embody our *9 Elements of Quality Care*.

Our Michigan work is funded largely by the Charles Stewart Mott foundation, as well as by consulting work we do with public and private entities. Our main office is in the Bronx, New York, with other offices in Pennsylvania, Massachusetts, and here in Michigan.

¹⁰ More information on PHI's Quality Care through Quality Jobs mission and Elements of Quality Care/Jobs frameworks are available at <http://phinational.org/about/qcqi/>.