

LONG-TERM SERVICES AND SUPPORTS IN BALTIMORE



A FRAMEWORK FOR
IMPROVING JOB QUALITY AND
CREATING A HIGHLY TRAINED
DIRECT CARE AND SERVICES
WORKFORCE

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Direct Services Collaborative**

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Executive **SUMMARY**



The current tight labor market can be seen and felt throughout the United States. From restaurants and retail stores to doctors' offices and daycare centers, we are all standing in long lines, being placed on hold, and sitting in waiting rooms. Hopefully, we are all practicing more patience as we adapt to the realities of the current economy.

There are some sectors of the labor force, however, where short staffing is much more than an inconvenience. One such sector is the subject of this report: the direct care and services workers (DSWs) who serve older adults and individuals with disabilities in long-term services and supports (LTSS) settings.

Staffing challenges have vexed nursing homes, assisted living facilities, and home- and community-based care settings since before the pandemic, and they are not likely to abate until systemic solutions are identified and implemented. As this report illustrates, the DSWs who work in LTSS settings in Baltimore City—and the thousands of people who depend on their care—need solutions sooner rather than later.

Through research and in-depth stakeholder interviews, the following themes emerged:

1

Inadequate compensation is the single biggest factor driving the workforce crisis.

Nearly all stakeholders, including DSWs, recognize that wages are not high enough to compete with restaurant and retail wages, and many are aware that they do not meet the criteria for a living wage. Further, in some LTSS settings, such as home care, lack of benefits may be tied to the practice of misclassifying workers as independent contractors, which denies them employment benefits such as earned sick or vacation leave, extra pay for overtime hours, or even protection by workers' compensation programs.

2

Medicaid reimbursement rates are not high enough to allow many LTSS providers to increase wages to necessary levels.

Because so much of the care provided in Baltimore and throughout Maryland is funded by Medicaid, the program's reimbursement rates drive workforce dynamics. Providers and advocates consistently assert that Maryland's reimbursement rates have not increased at a level necessary for LTSS owners and operators to offer competitive compensation to DSWs.

3

DSWs in nursing homes and assisted living facilities see low staffing ratios as diminishing job quality.

Nearly all DSWs in these settings report dissatisfaction with staffing ratios. Many say that these low ratios make it very difficult to provide the level of care that they want, or are able, to provide. The increased workload that results from low staffing ratios adds to burnout and exhaustion, as well as the feeling that DSWs are being asked to do the jobs of two or three people.

4

Respect and appreciation help but are insufficient on their own.

DSWs point to symbols of appreciation from their employers as improving their job satisfaction, which may improve retention on the margin. However, respect and appreciation will not alone solve the systemic problems underlying the workforce crisis.

5

Holistic training and support are appreciated, but also are insufficient on their own.

Similarly, good quality training provided in conjunction with holistic supports and wraparound services can help provide DSWs with the tools they need to obtain certifications, feel supported in their workplaces, and remain in care jobs. However, training and support alone will not solve the problem.

Solutions to the LTSS workforce shortages are not easy ones. To that end, the Maryland Regional Direct Services Collaborative is committed to working with relevant stakeholders to develop and support solutions that help to improve job quality for direct care and services professionals and resolve the workforce crisis in Baltimore City and beyond.

Acknowledgements



This report is a culmination of more than six months of interviews, research, focus groups, and surveys all aimed at examining the direct care and services workforce crisis in Baltimore City. While the geographic focus of this report is Baltimore City, we hope that state and national stakeholders will find relevance herein as well.

The Collaborative wishes to thank the following individuals for their consistent hard work and dedication to the report: Mike Bullis, treasurer; Jeneva Stone, board member; Kristina Williams, administrator; Amy York, board chair; Dr. William Leahy, founding board chair of the Collaborative; and Ron Carlson, founding executive director of the Collaborative, whose vision and dedication helped lay the foundation for the work of this report.

KARE, a labor marketplace that connects qualified caregivers and nurses with senior care communities and nursing homes, fielded the DSW survey in Baltimore City from Sept. 19 to Oct. 3, 2022. The assistance of Katie Rhone, KARE's vice president of HERO development, is greatly appreciated in this effort.

The majority of our focus group interviews with direct care and services professionals could not have been possible without the diligent assistance and very hard work of the following individuals from the 1199SEIU United Healthcare Workers East: Loraine Arikat, Claudia Balog, James Crosby, Shiara Fayson, and Nichelle McGirt.

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INTRODUCTION

The Maryland Regional Direct Services Collaborative (referred to herein as the Collaborative) is a network of organizations and individuals working together to build and sustain a well-trained frontline direct care and services workforce in the Maryland region. Formed in 2018, the Collaborative seeks to proactively address the critical issues impeding the availability of needed care and support services for older adults and persons with disabilities, whether through education, training, policy reform, or leadership in the design, support, or implementation of new program initiatives.

This report was produced with the support of the Abell Foundation, a private organization focused exclusively on Baltimore City. Abell provides grants to nonprofit community partners, funds research to better inform civic conversation, and makes catalytic investments in new businesses that offer significant social and economic benefits to the city.

While sometimes wider ranging in its scope, this report focuses on the City of Baltimore, where more than 14 percent of the population of 576,498 are over the age of 65 and 12 percent of those who are under 65 are living with a disability.¹

The findings in this report focus on individuals who provide a variety of direct care and personal assistance in the City of Baltimore. This includes assistance with activities of daily living (ADLs) or similar self-care tasks resulting from disease, chronic illness, and/or disability.

This work is done in various LTSS settings,

which include nursing homes, assisted living facilities, and individuals' homes through home care agencies or individuals' direct employment of home care workers.

Doing this work are certified nursing assistants (CNAs), geriatric nursing assistants (GNAs), home health aides (HHAs), personal care assistants (PCAs), direct support professionals (DSPs), and others who collectively make up the direct care and services workforce in the State of Maryland.

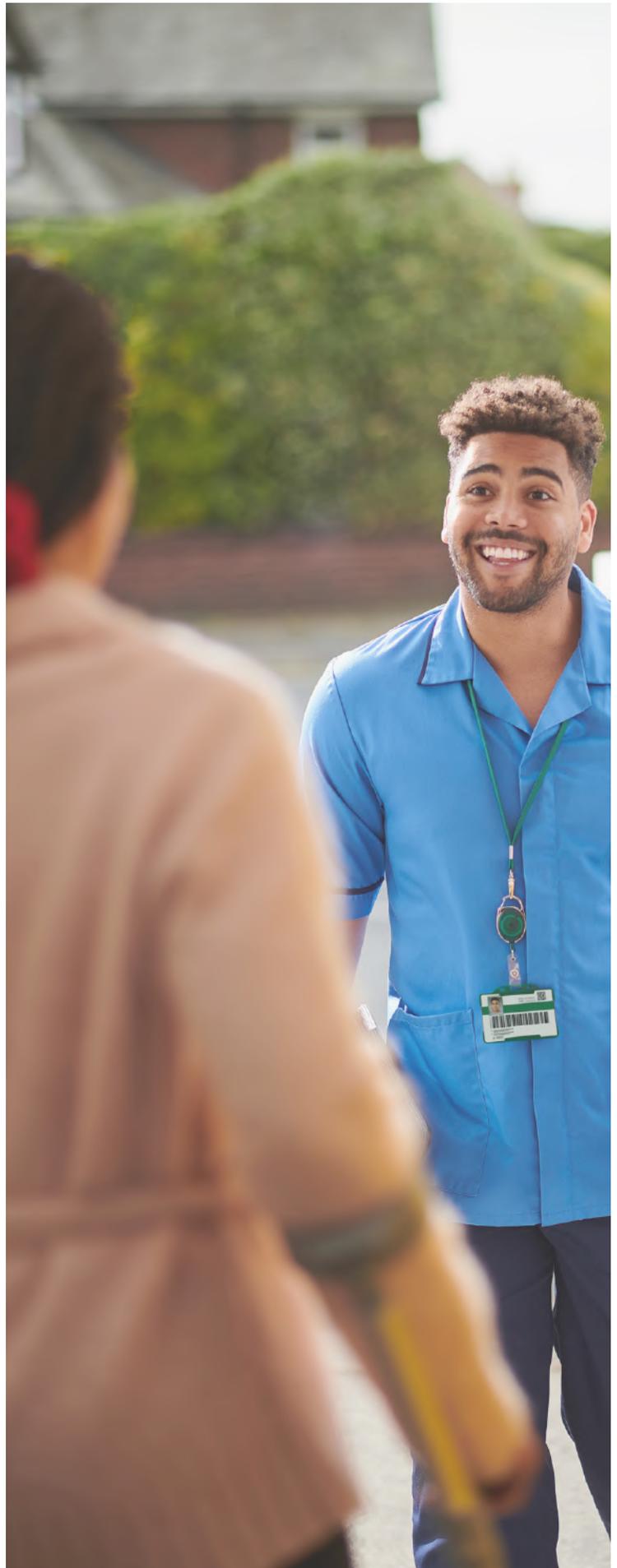
In addition to working closest to individuals within their respective settings, DSWs comprise the largest segment of the LTSS workforce at 4.6 million workers nationally, including 2.4 million home care workers, 675,000 residential care aides/personal care assistants, 527,000 nursing assistants in nursing homes, and about 1 million direct care workers employed in other settings.²

While 4.6 million is certainly a large number, there was a critical gap in the supply of well-trained DSWs even well before the pandemic. In Maryland, a 2018 study commissioned by the Collaborative and conducted by PHI, a leading research firm specializing in issues related to elder care and disability services, found that the state will need nearly 40 percent more DSWs to meet growing LTSS needs by 2024.³

A word about language: the term "direct care and services workers," or "DSWs," is widely used in the nomenclature of the

field of healthcare and LTSS settings. These roles are also often referred to as “care partners,” to reflect a person-directed approach to care in which CNAs, GNAs, and HHAs work in partnership with the resident or client in their health journey. In addition, the term “direct care professional” is sometimes preferred among CNAs, thus eliminating “worker,” to reflect a more professional nature of their roles. The term “CNA Careforce,” was coined by the National Association of Health Care Assistants (NAHCA) Co-founder Lori Porter amid the pandemic and in an effort to counter what she describes is the demeaning “work” narrative of the professions.

These terms may be used throughout this report as we work to stay in step with the progress of the movement to reform LTSS and to respect the wishes of those who do this work.



BACKGROUND & METHODOLOGIES

To produce this report, the authors collected and analyzed publicly available data from a variety of government sources. Further, author Meg LaPorte conducted dozens of interviews and focus groups, and distributed and collected questionnaire responses, from multiple and diverse stakeholder individuals and organizations.

The stakeholders interviewed for this report are as follows:

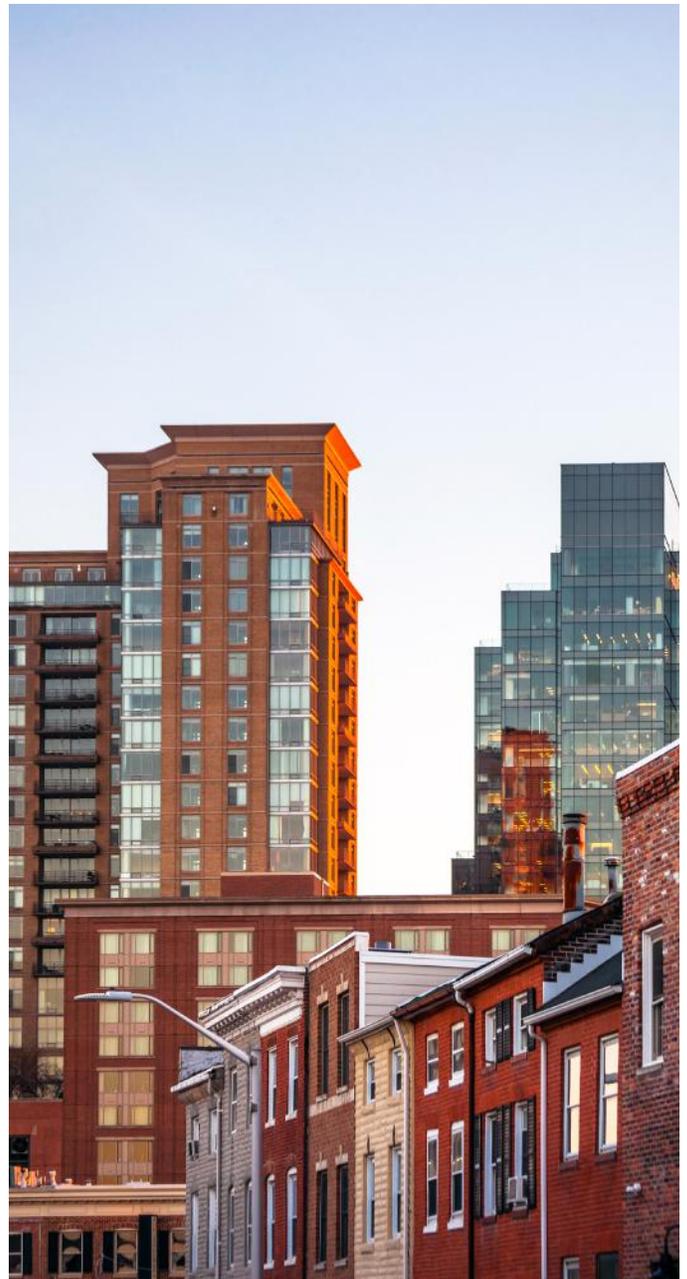
- Employers of direct care and services professionals.
- Organizations that represent nursing homes, assisted living facilities, and home care agencies.
- Organizations that represent direct support professionals.
- Individuals with expertise in direct care and services workforce development, recruitment, and retention.
- Consumers and family members of those who depend on DSWs.
- Direct care and services professionals.
- Maryland and Baltimore City employees.

SIZE, WAGES, AND DEMOGRAPHICS OF THE DSW WORKFORCE IN BALTIMORE CITY AND MARYLAND

There is an unfortunate lack of clear and reliable state and local data concerning the DSW workforce. These data issues result in part from inconsistent use of terms used to describe different categories of DSW and in part from government agencies' failure to collect adequate data on the workforce—despite the fact that most of the work is publicly funded. Nevertheless, the available data paints a picture of the basic outlines of the workforce in Baltimore City and Maryland.

The Maryland Department of Labor (MDOL) Office of Workforce Information and Performance publishes estimates of occupational and wage data drawn from the Maryland Occupational Employment and Wage Statistics (OEWS) Program and the Quarterly Census of Employment and Wages (QCEW) Program. The Department publishes both statewide and local data.⁴

There are two relevant occupations in the MDOL's data, referred to as “healthcare support occupations.” They are: “home health and personal care aides” and “nursing assistants.” Maryland-wide, the data from 2021—the most recent year for which estimates are available—show 28,130 home health and personal care aides with a median hourly wage of \$14.08 and 27,180 nursing assistants with a median hourly wage of \$15.18. PHI's 2020 estimates of median annual earnings are \$23,100 for home care workers, \$27,200 for workers at assisted living facilities, and \$27,200 for workers at nursing facilities.⁵



For Baltimore City specifically, the Department's estimates for 2021 include 1,770 home health and personal care aides with a median hourly wage of \$13.80 per hour, and 4,320 nursing assistants with a median hourly wage of \$14.62 an hour. Notably, these wages fall below state medians. Of further note regarding these workforce estimates, these data may not include a number of individuals who work part-time in these roles but do not self-report under these titles. For example, consumer-directed caregivers are not likely to be captured in these figures. In addition, there is well-recognized fluidity within this field, leading to even less likelihood of self-identification within these roles. The upshot is that there are likely more home health and personal care aides in Baltimore City than the Department's estimates suggest.

Maryland's DSWs are overwhelmingly Black women: according to PHI's Maryland data, 84 percent of home care workers, 85 percent of workers at assisted living facilities, and 95 percent of workers in nursing homes are women, while 68 percent of home care workers, 80 percent of workers at assisted living facilities, and 76 percent of workers in nursing homes are Black. Nearly 50 percent of Maryland's DSWs have not completed formal education beyond high school. Meanwhile, 47 percent of Maryland's home care workers receive some form of public assistance, while 42 percent of workers at assisted living facilities and 36 percent of workers in nursing homes receive public aid.⁶

Baltimore's numbers are similar. PHI's data on Baltimore City and County show that 89 percent of home care workers, 87 percent of workers at assisted living facilities, and 90 percent of workers in nursing home are

women, while 66 percent of home care workers, 87 percent of workers at assisted living facilities, and 87 percent of workers in nursing homes are Black. Nearly 50 percent of the Baltimore-area's DSWs have not completed formal education beyond high school. And 48 percent of the Baltimore area's home care workers receive some form of public assistance, while 43 percent of workers at assisted living facilities and 42 percent of workers in nursing homes receive public aid. Interestingly, 40 percent of Baltimore area home care workers work part time, as compared to 34 percent of workers at assisted living facilities and 23 percent of workers in nursing homes.⁷



CHALLENGES ACROSS SETTINGS

Staffing shortages and recruitment and retention challenges abound across LTSS settings in the Baltimore region, in Maryland, and across the United States. While some employers are seeing light at the end of the tunnel in Baltimore City, recruitment and retention of DSWs often remain below pre-pandemic levels.

The statistics are stark: According to recent estimates, median annual turnover for nursing assistants in nursing homes was nearly 100 percent between 2017 and 2018, while turnover in home care was about 64 percent in 2021. We are left with estimates of turnover because as PHI has made clear, “a large-scale, comprehensive assessment of turnover across the full direct care workforce does not exist.”⁸ PHI notes that “turnover is difficult to measure without systematic processes to collect workforce data at the provider and state levels,” and unfortunately neither Baltimore City nor Maryland collects significant data about this workforce. This is despite the fact that most of the care is publicly funded.

While data on turnover across LTSS settings in Baltimore City could not be obtained for this report, we attempted to uncover the extent of the problem via interviews and other existing resources.

Employers interviewed for this publication reported continued struggles with recruiting and retaining staff in and around Baltimore. What’s more, DSWs reported feeling exhausted and often frustrated with “working short,” a term used to describe working on shifts (in nursing homes and assisted living facilities) that are short staffed. Still others are working more shifts and without being compensated appropriately for overtime work.

In their efforts to alleviate labor shortages, employers have deployed some creative solutions designed to boost retention and recruitment, as well as boost morale. Some initiatives encompass a wide range of staff recognition and appreciation efforts, such as employee-of-the-month programs, gift card distribution, and free meals. Others have created or restarted programs that recognize employees for their hard work and excellent attendance rates. One particularly inventive organization rewards its employees with tickets to football games and events at M&T Bank Stadium.

Data Illustrate Problems Across Settings

At the national level, a survey of nursing homes and assisted living facilities conducted in January 2023 found that nearly half (45 percent) of nursing home providers said their workforce situation has worsened since May 2022; 84 percent were facing moderate to high levels of staffing shortages; and 96 percent were finding it difficult to hire additional staff. In addition, 97 percent said the lack of interested or qualified candidates was a major obstacle to hiring new staff, and more than nine out of 10 nursing home providers said they have increased wages and offered bonuses to try to recruit and retain staff.⁹

Results of the Baltimore DSW focus groups confirm that wages have increased to some degree since the onset of the pandemic. However, DSWs in Baltimore generally report that wages have not increased to levels needed to keep up with inflation, the difficulty of their work, and the specter of higher wages in other fields such as retail.

Turnover data in home- and community-based (HCBS) settings is generally not available for Baltimore City or Maryland. That said, our interviews and research uncovered reports of extreme staffing shortages and very high turnover.

The precise number of home care workers is difficult to measure and different organizations land on different totals, in part due to differences in workforce definitions.

PHI reports 2.6 million home care workers nationally in 2021, a sum representing more than double the home care workers in 2011.¹⁰ According to the Peterson-KFF Health System Tracker, a nonprofit organization that does health system research and analysis, 1.54 million Americans were employed in home health services in February 2020, versus 1.60 million in December 2022. This represents a recovery of all jobs lost at the beginning of the pandemic. However, as the group points out, “between 2017 and early 2020, employment in home health had been growing at an average rate of 0.3 percent per month. If this growth had continued from 2020 through the most recent month, home health service employees would number 1.70 million in December 2022, rather than 1.60 million.”¹¹

A March 2022 report from the Medicaid and CHIP Payment Access Commission (MACPAC) found that high turnover, “driven by low wages, lack of advancement opportunities, and worker dissatisfaction,” all contribute to shortages of HCBS workers. Although the report cites PHI’s research findings that “HCBS workers have a turnover rate of 40 to 60 percent annually,” it notes that limited data are available to characterize workforce shortages at the national level.¹²

The same MACPAC report cites a 2021 survey of HCBS agencies, which found that 77 percent have turned away new referrals, 58 percent have discontinued certain programs or services, and 84 percent have delayed programs due to staffing shortages. In 2018, the average vacancy rate for DSP positions was 11.9 percent for full-time roles and 18.1 percent for part-time roles.

Demand for LTSS on **The Rise in Maryland**

Maryland's shortage of DSWs is complicated by the fact that the state's population is rapidly growing older, thus driving up demand for LTSS. As noted in the Maryland State Plan on Aging for 2022 to 2025, the percentage of Maryland's population aged 60 or over is expected to increase from 22.6 percent in 2020 to 26.6 percent by 2040. Individuals 85 and older are the fastest growing segment of the population; this cohort will grow in number, statewide, from 122,092 in 2020 to 314,961 by the year 2045, a 158 percent increase.¹³

As noted earlier, more than 14 percent of Baltimore's population of 576,498 are over the age of 65 and 12 percent are under 65 and living with a disability.

As the PHI report noted, with only 5 percent expected growth among working-age adults in the state, the ratio of working-age adults to those aged 85 and above in the state will shrink from 32:1 in 2015 to just 12:1 by 2045.



Regulatory and Funding Landscapes Across LTSS Settings in Baltimore City

The relevant legal, regulatory, and funding landscapes across LTSS settings in Baltimore City are generally the same or almost the same as they are statewide. However, the requirements and funding sources for home care agencies, assisted living facilities, and nursing homes are very different.

To at least some degree, each care setting is regulated by Title 19 of Maryland's Code for "Health - General" and by Subtitle 7 of Title 10 of the Code of Maryland Regulations. Certain services for people with qualifying developmental disabilities are regulated under Title 7 of Maryland's Health-General code. But the degree of regulation—and the sorts of funding systems—vary significantly between these LTSS settings.

Home- and Community-Based Services

Home care agencies are mostly regulated by state law but may also be regulated by federal law to the extent that they must comply with federal Medicaid rules. Outside of the context of developmental disabilities, most must obtain a license from the Maryland Department of Health (MDH) to operate as a “residential service agency” or RSA—a bureaucratic term for the more colloquially used “home care agency.” A total of approximately 250¹⁴ home care agencies operate within Baltimore City, while approximately 70 are headquartered there.¹⁵ There are approximately 1,750 licensed home care agencies statewide—a number that has increased by several hundred over the last few years. There are approximately 40 provider entities that provide personal supports through HCBS in Baltimore City under the Developmental Disabilities Administration.

A comparatively small percentage of the home care provided in Maryland is funded by private insurance or paid out of pocket. The single biggest funder of home care in Maryland is Medicaid. The vast majority of Medicaid-funded care is provided through MDH’s by its Office of Long-Term Services and Supports (OLTSS) and the Developmental Disabilities Administration (DDA).

Programs operated by OLTSS generally require that care be provided through RSAs. Maryland no longer permits payment under these programs to “independent provider” home care workers. Nor does it offer a self-directed “cash and counseling” program under which consumers may receive a set amount of money along with counseling concerning how to prudently spend it on in-home care (although MDH has been working to create such a program for several years). Instead, programs operated by OLTSS generally provide for RSAs to receive a flat reimbursement rate from the state for each 15-minute unit of care provided by a home care worker through that RSA. As of January 2023, that rate is \$23 per hour. This flat rate does not vary by region; care performed in Baltimore City is reimbursed at the same rate as care performed anywhere else in the state. From this sum, RSAs must pay wages for DSWs along with all associated costs (payroll taxes, workers’ compensation insurance, etc.) and overhead. The rate has increased a bit over the last several years; before July 1, 2022, it was just \$20.54 per hour.

There is greater variation in programs operated by DDA. Some Medicaid consumers with developmental disabilities are permitted to self-direct their services. This means that they have employer authority (decision-making authority to recruit, hire, train, and supervise the staff and service providers they want to hire) and budget authority (decision-making authority over how the Medicaid funds in their budget are spent to purchase authorized services). In other words, these individuals receive a fixed dollar amount—determined by the state based on their needs—and act as their care workers' employers, hiring them and determining the basic terms and conditions of their employment.

Other Medicaid consumers with developmental disabilities arrange their care through a provider model similar to the model operated under OLTSS programs. Under this model, provider entities—many of which are nonprofit organizations—receive funding to pay for services identified in individuals' person-centered plans as determined by the state. Medicaid reimbursement rates vary by the type of services provided and—unlike in programs operated by OLTSS—by regions of the state. Montgomery County supplements the rate to account for its higher cost of living and minimum wage.



Assisted Living Facilities



Assisted living facilities are generally not regulated by federal law, leaving state law as the source of regulation. Maryland defines assisted living programs as residential- or facility-based programs that provide “housing and supportive services, supervision, personalized assistance, health-related services, or a combination thereof that meets the needs of individuals who are unable to perform or who need assistance in performing the activities of daily living or instrumental activities of daily living in a way that promotes optimum dignity and independence for the individuals.” Assisted living facilities must obtain a license from the Maryland Department of Health.

As of December 2022, a licensee list published by the Department’s Office of Health Care Quality showed 411 assisted living facilities in Baltimore City. The number of residents each facility is licensed to house ranges between two and 151, with the vast majority

licensed for between three and eight residents. The majority of these locations are houses in residential neighborhoods.

Funding for assisted living facilities can be described as a patchwork quilt. Government programs such as Medicare and Medicaid generally do not directly fund room and board at assisted living facilities, although individuals living in these facilities may use money they receive from government programs to pay for some of these costs. Much of the cost of room and board at these facilities is paid out of pocket or through private insurance. While government programs typically do not directly fund room and board, they frequently fund the supportive services individuals receive in assisted living settings. For example, many residents receive Medicaid-funded care through one of the programs administered by OLTSS described above.

Nursing Homes

Nursing homes are heavily regulated by both federal and state law, with federal law providing a significant amount of the regulation. Nursing homes must obtain a license from the Maryland Department of Health. As of December 2022, a licensee list published by the Department's Office of Health's Office of Health Care Quality showed 24 long-term care facilities located in Baltimore City. The number of residents each facility is licensed to house ranges between 29 and 242, with most facilities licensed for between 100 and 200 residents.¹⁶

In Maryland, the biggest single source of funding for nursing home residents' care is Medicaid, with 64 percent of residents having their care funded by Medicaid, as compared to 17 percent by Medicare and 19 percent out of pocket or other sources.¹⁷ Medicare provides funding for short-term stays for rehabilitation or other purposes; for example, it may provide all the funding for up to 20 days and a portion of the funding after that, but only up to a maximum of 100 days. Medicaid may fund all or part of the cost of longer-term care at a nursing home.

Unlike in-home care and assisted living facilities, some of Maryland's nursing home workers are unionized. The collective bargaining agreements between workers and nursing homes also affect the operations of the facilities—not only by potentially increasing

workers' pay but also by potentially decreasing staffing ratios and impacting other metrics that may affect job quality and quality of care. Due, at least in part, to the involvement of unions in nursing facilities, the median hourly wage of workers in these facilities



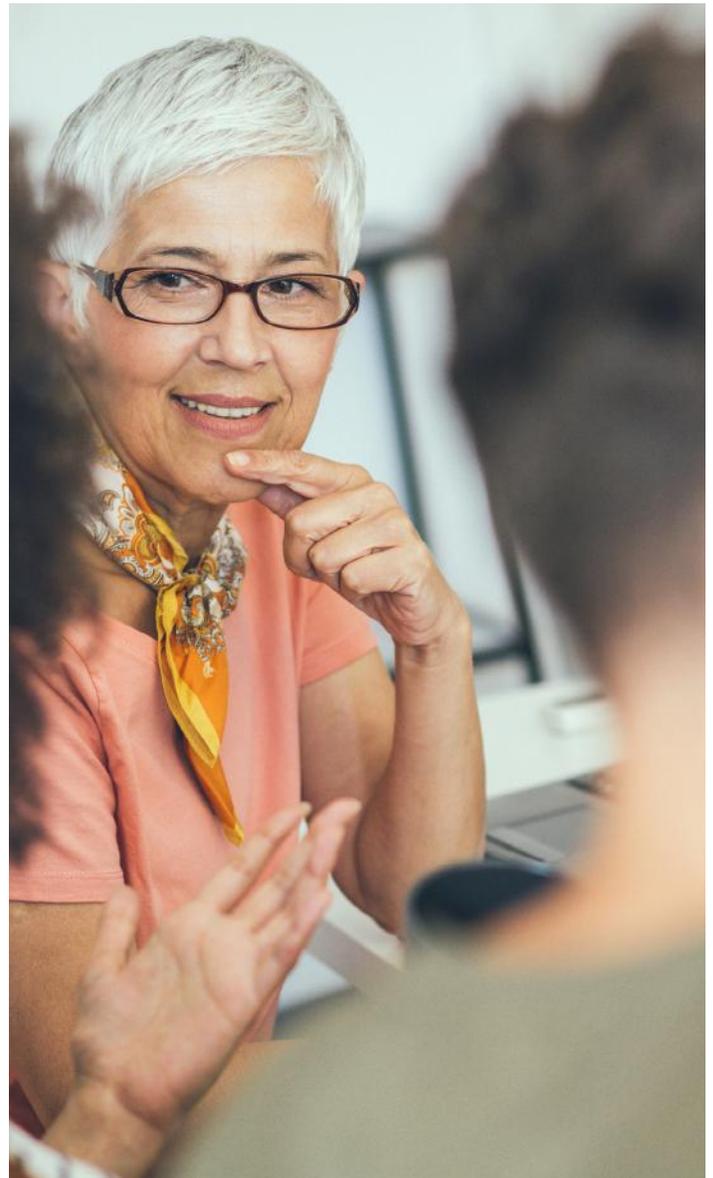
FOCUS GROUP INTERVIEWS

We conducted a series of five focus groups—in person and via Zoom and telephone—with 27 individuals who work in home care, nursing homes, and assisted living facilities in the Baltimore area. The results demonstrate significant concerns about wages and benefits, exhaustion from having to care for high numbers of residents during inadequately staffed shifts, and frustration from not feeling respected or appreciated by their employers.

A majority of those interviewed described having worked across multiple LTSS settings and for a range of people, including elders and individuals with developmental, intellectual, and physical disabilities.

The focus group sessions, which took place in late September and early October of 2022, included individuals who had worked in their positions for a range of three years to more than two decades. Nearly all held CNA and GNA certifications, and many noted they also had obtained, or were planning to obtain, medication tech certification, thus making them eligible to work in a broader range of LTSS settings.

Analyses of these hour-long interviews paint a picture of a workforce that is committed to its work and passionate about caring for elders and people with disabilities. Many described caring for a relative, such as a grandfather, mother, a child, before becoming DSWs.



Short Staffing Leads to **Stress and Burnout**

With regard to the challenges of working short-staffed, many DSWs expressed concern about high staffing ratios in nursing homes and assisted living facilities. “In our nursing home, we currently have three GNAs to 34 residents on the 7:00 a.m. to 3:00 p.m. shift, but on a bad day it’s one GNA to 34 people,” said one participant. “On a good day you might get a nurse who’s willing to help you but on other days you might have to go to the nurses to ask for help.” Another cited three GNAs for 50 residents on her first shift.

One DSW expressed that working short-staffed is “stressful and it makes me want to leave; I’m tired and stressed and burned out.”

Yet another expressed concerns about temporary nursing assistants (TNAs), a category of worker created during the pandemic under a waiver that enabled people who took brief, online courses to become TNAs so they could help in LTSS settings, primarily in nursing homes. “They bring in temps, and they don’t really know the residents and won’t give them the care they deserve,” she said. “When you have regular staff, and they get burned out, but you pay them what they deserve, it will be a whole lot better.”

Management **Turnover Evident**

In a notable response to the question, “What makes you stay in your job?,” one participant said that the nursing home where she worked “was a family type of setting when I started 20 years ago ... then management changed. As much frustration as I do have now, I still want to take care of people. Also, they have [the] same nonsense down the street” at other facilities. Similarly, another said that “because there is so much turnover as far as the management, what I see is the care for residents has gotten worse. They make it worse because they are cutting corners and making up rules, but it’s also hurting the residents in the long run.”

When asked why some had not gone to work for a staffing agency, the responses ranged from “I love [the work] and I love the residents” to “I have invested too much time to start over.” Still another reported that her employers had begun to show how they appreciate staff and were doing a “little better by simply asking us how our day is going.”

Focus Group

Participants Quotes

The following excerpts, compiled by topic from the focus group interviews, offer additional insights into the realities of DSWs' work and how to address the workforce shortage in Baltimore.

Pay and Benefits:

- “The pay rate is the biggest issue and respecting employees and appreciating them. The little things count. They gave us lunch today. They also sometimes give us gift cards for coming in extra.”
- “I was at \$14 per hour, and I went to an agency where I now get \$16.50 per hour but no overtime. They were giving overtime to a few, but they won't pay the overtime rates.”
- “Pay your workers—just pay them.”
- “The main issue is the pay rate. Pay and ratios. Myself and another GNA, we have at least 15 to 16 people a day.”
- “They fought [for our raise] but another \$2 would be better. We deserve it. All of the new people are getting the same amount as what we waited for. It doesn't make sense.”
- “I thought of quitting because ... it's sometimes difficult working with people [when it's a] bad lineup of clients. One idea [that would make for a] good relationship with agencies and workers, is if there is a way for clients to give feedback to the agency—and then give bonuses—which would help motivate the workers. [It would be] a good way to make more money.”
- “I make \$16.50 per hour but I won't work with an agency unless they pay \$20 per hour or more.”
- “What I can make on a six-day shift with agencies is more than I make in two weeks at a nursing home.”
- “I work privately, I get clients mostly by referral and I post on social media to get more. I have been doing this for the past five years. I just attended a lot of workshops. I also work with DoorDash on weekends. I have not thought about leaving; I love it, but at some time back then I thought of stopping because I wasn't being paid well. But I later got a higher paying client after attending the workshop.”

Staffing Ratios and Quality of Care:

- “They write GNAs up for not doing something when you’re short staffed. [GNAs] are getting very frustrated and doing the best they can, and the residents are not getting proper care ... it’s impossible.”
- “I work on the graveyard shift, where there is one CNA per 20 or more patients.”
- “For me, the underlying issues are short staffing, not being paid enough, and being disrespected by management.”
- “Sometimes there are two [GNAs] when there should be three on a given day, but our pay is still the same.”
- “The [resident-to-staff] ratios are ridiculously high. On the regular, we have at least 15 to 16 people; and sometimes there are two of us to 32 or 34 residents.”
- “There is not a lot of accountability in nursing homes or hospitals. I work on the weekends—on the graveyard shift—where there is one GNA per 20 or more patients. They only respect you because they need your body.”

Respect and Appreciation:

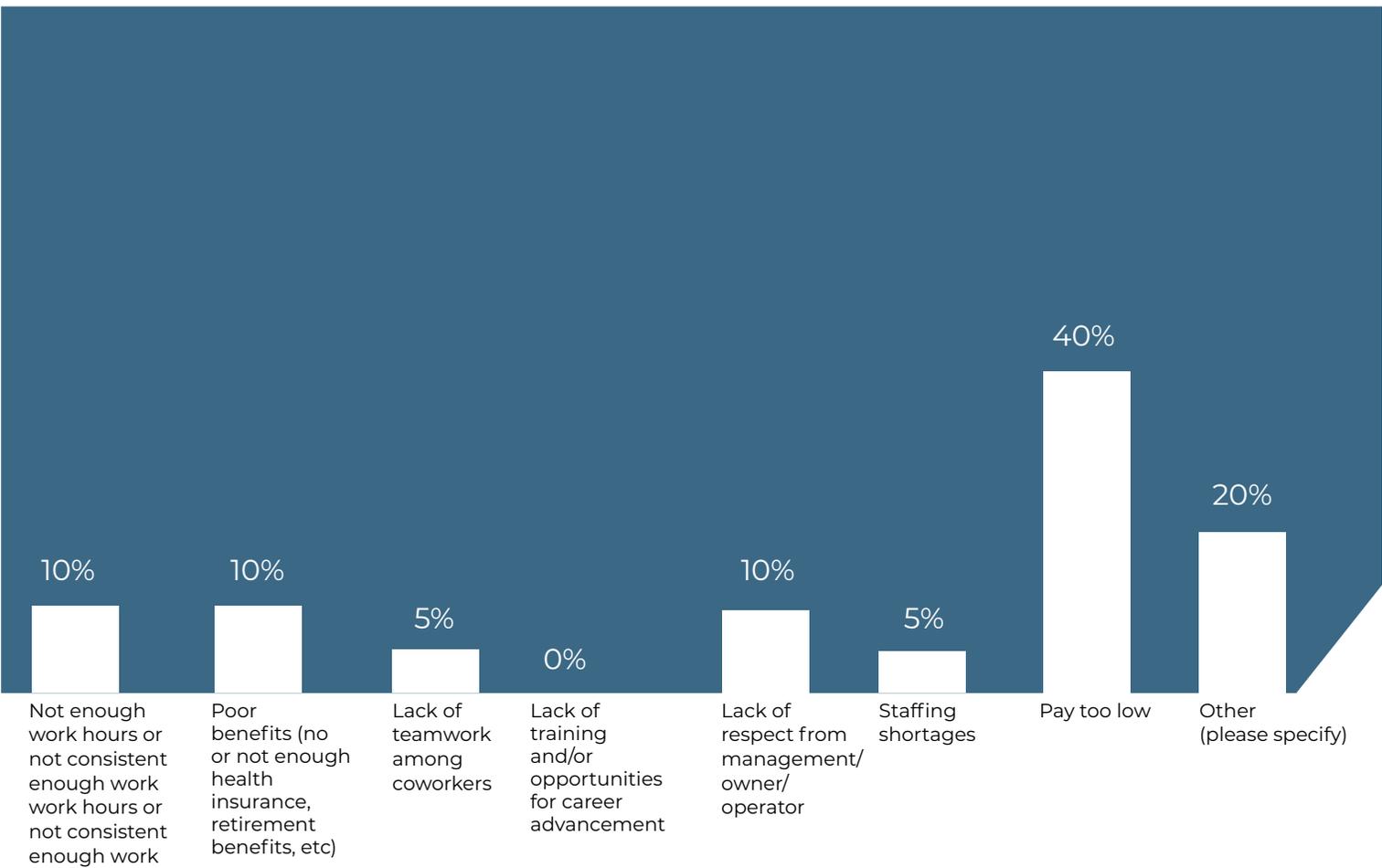
- “My [home care] clients and their families appreciate me more [than] my boss [does]. What keeps me around is not the [home health] agency itself.”
- “It would make sense if we were included [in the care plan meetings]. It should be that way. How are you not listening to the person who is caring for [residents]?”
- “[Care work is] in my bloodline. I treat people like I would be treated. We don’t get recognized for anything on the night shift.”
- “During the pandemic we had to be social workers. We had to be family members and social workers because no one else was there. It was overwhelming. Yes, we deserve more money and respect.”
- “I love making a difference in other people’s lives. I know what I do helps them to stay living independently in their own homes, and my clients love to see me walking in the door.”
- “The administration doesn’t appreciate us enough. I worked on Easter, and they said it wasn’t a holiday.”
- “I am in it for the patients. The family appreciates me more than the agency does. The company respects you because they need your body.”
- “Better pay would motivate me to stay full time. Overall, a good management team is one that will communicate about everything that is going on.”
- “I appreciate the little things that show our work is not in vain.”

BALTIMORE CNA/GNA SURVEY

We administered a survey to 78 CNAs and GNAs who work either in a nursing home, assisted living facility, or home care agency (or a combination of settings) in Baltimore to help us gain a better understanding of the staffing crisis in the city. The responses paint a picture of DSWs who want better pay, better benefits, and more consistent work, as well as better staffing ratios.

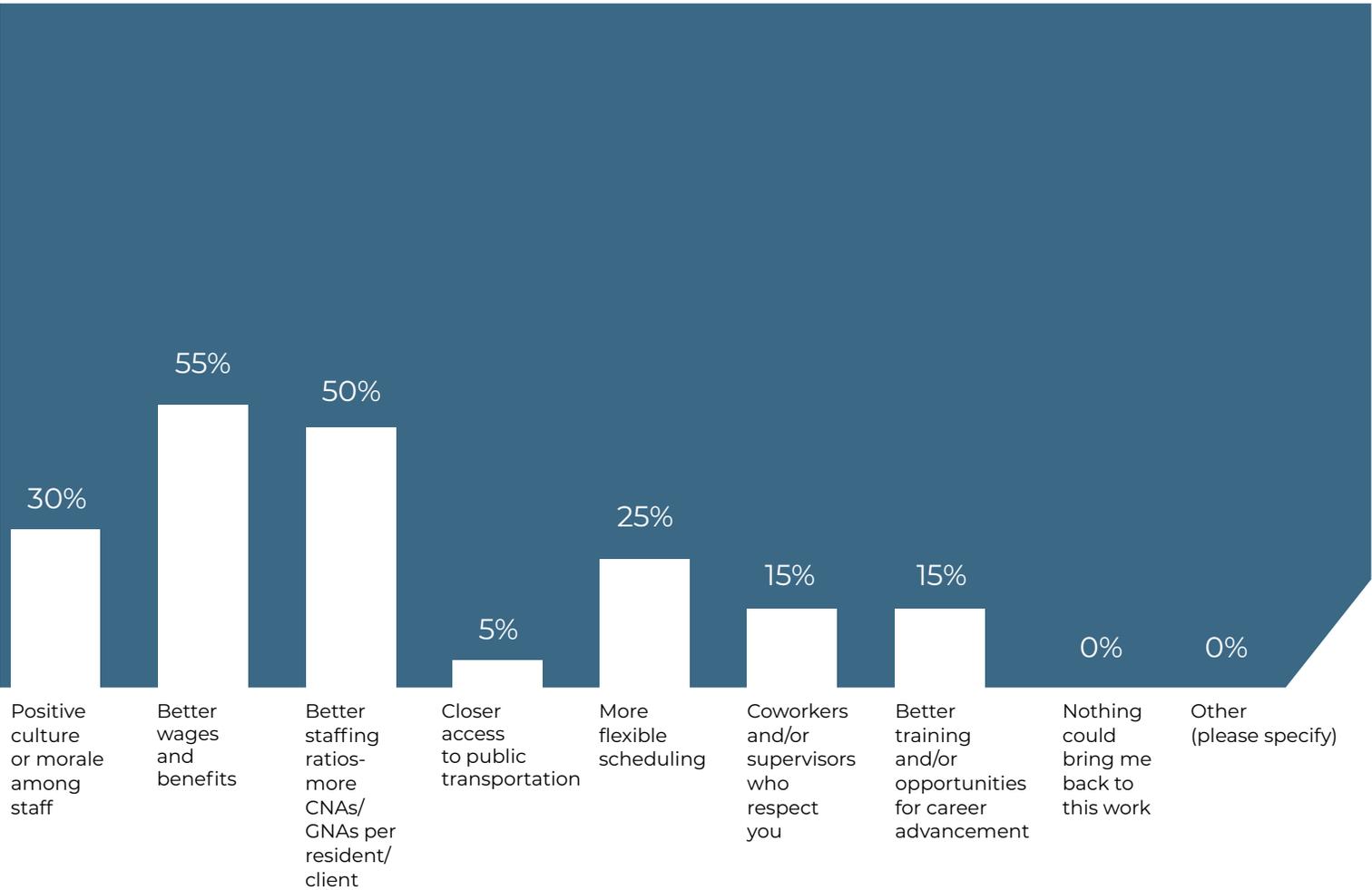


In response to a question about what motivates, or has motivated, DSWs to leave their jobs, the majority of respondents indicated it was due low pay, followed by “not enough work hours or not consistent enough work” and “poor benefits,” and “lack of respect from management/owner/operator.”





When asked what it would take for an employer to hire them back, the plurality of 11 respondents chose “better wages and benefits,” followed closely by 10 selecting “better staffing ratios” (more CNAs/GNAs per resident/client). Six chose “positive culture or morale among staff.”



We also used the survey to ask specifically about staffing ratios among those who worked in nursing homes or assisted living facilities. The majority indicated that they had to care for 10 to 20 residents while on first or second shift during the past four weeks. Five respondents indicated they had to care for between five and 10 residents, while another five indicated they had to care for between 10 and 15 residents. Three respondents had to care for 25 or more people during one shift.

For respondents who had worked on third shift during the past four weeks, six had to care for 10 to 15 residents, while another six had 25 or more individuals to care for during their shifts.

2022 National Association of Health Care Assistants' Nationwide Survey of CNAs

According to a 2022 national survey of CNAs conducted by National Association of Health Care Assistants (NAHCA), the most significant challenge for this sector of the long-term care workforce is staffing shortages, often referred to as “working short” for those who work in nursing homes and assisted living facilities. The survey, which yielded nearly 650 responses, consisted of eight questions centering on the work of CNAs amid high turnover and chronic shortages.

The results offer a window into what underpins the CNA staffing crisis and how it affects quality of care:

- Poor wages and benefits were cited as the primary reasons why CNAs have left, or are considering leaving, their jobs.
- Working amid short-staffed shifts was the most pressing challenge for CNAs, according to more than half of the respondents.
- Burnout/exhaustion and lack of respect from leadership were the second and third biggest challenges, respectively, for CNAs.
- Respondents reported the following data about the number of patients (per one CNA) they cared for during their shifts over the previous four weeks:
 - 36 percent of those who worked either first or second shifts cared for 15 to 20 patients/residents.
 - 33 percent of those who worked third shift care for 25 or more patients/residents.

Following are some of the written responses from CNAs in the March 2022 national survey:

- “Unappreciated, overworked, exhausted. Company allowing residents ... to cuss, hit, throw things at staff and nothing done about it.”
- “I left my job because the 12-hour shift was too much for me. I had 14 to 16 [residents] per night with showers and baths and [taking blood pressures] twice per shift, especially at 10:00 p.m. and again at 4:00 a.m. I spent more time waking my patients up all night. It was miserable.”
- “I feel like the lack of respect for the job that we do is the largest problem. Until society sees firsthand what CNAs do and recognizes the value we bring to patient care and experience, they will not take our jobs seriously.”
- “The shortage is obviously the number one factor, but the degrading and disrespect we receive from not only the corporations but also the families, as we are trying to do our best.”

Source: National Association of Health Care Assistants, March 2022.

DSWs AND THE LIVING WAGE



DSWs very clearly identified low wages as a chief concern in our focus groups and interviews, in our survey, and in a national survey NAHCA conducted last year. The fact is that the pay rates for DSWs in this country hover at or below what is considered a living wage in nearly all areas of the country, and especially in Baltimore City. This is a concern that warrants attention and cannot be ignored.

Massachusetts Institute of Technology (MIT) describes a living wage as “the hourly rate that an individual in a household must earn to support his or herself and their family.” The assumption is the sole provider is working full-time (2080 hours per year).

MIT’s Living Wage Calculator provides information for individuals as well as households with one or two working adults and zero to three children.¹⁸ The living wage for Baltimore City is currently calculated at \$17.99 per hour for a one-adult household with no children and \$38.03 per hour for one adult with one child. For a two-adult household with no children, a living wage is considered to be \$28.97 per hour and for a two-adult household with one child it is \$35.68 per hour.¹⁹

Median wages for DSWs in Baltimore City fall below even the living wage for a one-adult household with no children, with wages for home care workers farthest below this standard at just \$13.80. Given wage growth in other sectors, such as retail, these extremely low DSW wages are almost certainly a prime driving force behind the workforce shortage in Baltimore’s LTSS settings.

“They fought [for our raise] but another \$2 would be better. We deserve it. All of the new people are getting the same amount as what we waited for. It doesn’t make sense.”

Researchers Find Return on Investment in Living Wages

According to research published by the LeadingAge LTSS Center @UMass Boston in Sept. 2020, one in eight direct care workers in the United States lived in poverty, and three-quarters earned less than the average living wage in their states. “Raising the pay of direct care workers by 15 percent—at a cost of \$9.4 billion in 2022—would yield an impressive return on investment, including concrete benefits for a variety of stakeholders,” the think tank concludes.²⁰

Additional findings from the report assert that “care recipients would receive more consistent and reliable care; workers would enjoy enhanced financial security; LTSS providers would see fewer staffing shortages, reduced turnover, and higher productivity. In addition, local economies would expand as [DSWs] increased their spending and depended less on government assistance to make ends meet.”

The same report found that 16.8 percent of DSWs also rely on safety net programs. “Boosting pay to reach living wages would lead to \$556 million worth of savings in Medicaid payments alone, as well as \$1.6 billion in savings across all benefit programs and tax credits,” the Center contends.

Our research found that DSWs in Baltimore City do rely on social programs to supplement the shortfall in income. What’s more, nearly all workforce development programs interviewed for this report had recently provided assistance with transportation, childcare, or other services to their clients.

Claudia Balog is assistant director of research for 1199SEIU United Healthcare Workers East, the largest union representing frontline caregivers in the country. In the Baltimore area, 1199SEIU represents staff in nursing homes, including, but not limited to, CNA/GNAs, LPNs, dietary workers, housekeepers, and other support staff. “Our position is that we will never solve the staffing issues if these are jobs that don’t have living wages,” she says.

Although wages have increased somewhat since the start of the pandemic, LTSS employers contend that very low Medicaid reimbursement rates are to blame for their inability to offer even higher wages. As our employer interviews demonstrate, higher Medicaid reimbursement rates would be helpful in the effort to combat these workforce challenges.

EMPLOYER PERSPECTIVES

Through a series of some 20 interviews with C-level executives, administrators, and executive directors, in addition to other representatives of LTSS employers, we gained an understanding of the issues they face with regard to staffing, recruitment and retention, wages and benefits, and more.

For those employers that provide Medicaid-funded care, the single most frequently raised issue was that Medicaid rates are not increasing at levels necessary to allow employers to offer competitive wages. This issue arose repeatedly in conversations with home care agency employers and nursing home employers. LTSS employers that are privately funded have responded to the changing economy by charging clients more, something Medicaid-funded employers are unable to do.

Another prevailing theme in some employer interviews was that DSW jobs should not be considered long-term careers. Instead, as some noted, because of the job's physical demands and low pay, there should be a career ladder that encourages CNAs to move into other, better paying positions. Registered nurse, licensed practical nurse, administrator, or other positions within a nursing home or in home care work, are common considerations for such ladders.

Countering this view are workforce experts who believe that CNA jobs should be elevated to a more professional role with additional training, certifications, and designations, so that individuals who choose the work can “grow where they are planted.”

Lori Porter, Co-Founder and CEO of the National Association of Health Care Assistants (NAHCA), asserts that elevating the CNA profession (within all LTSS settings) is a key component to alleviating their mass

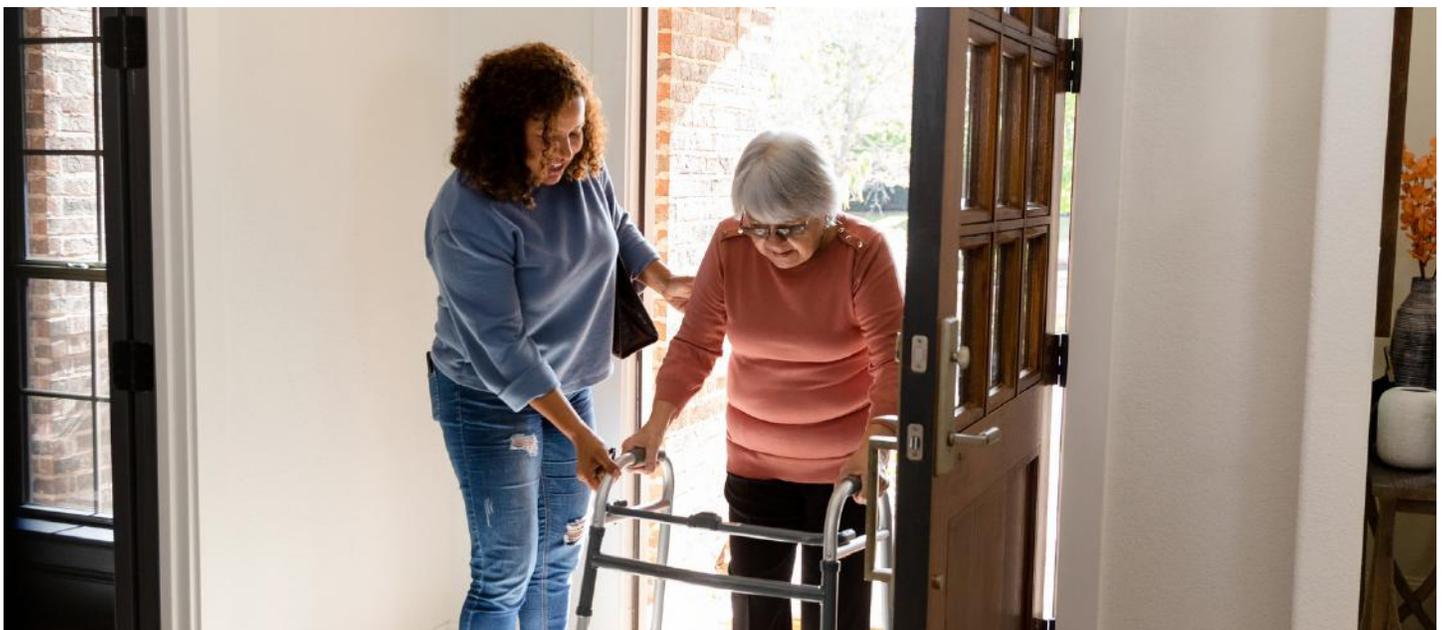


“I love making a difference in other people’s lives. I know what I do helps them to stay living independently in their own homes, and my clients love to see me walking in the door.”

exodus and constant turnover. “This will take a career ‘lattice’ that encompasses excellent training and education. CNAs want to learn, and they want to be trained—in dementia care, infection control, end-of-life care, and so much more,” she says. “There is a great deal of focus on career ladders, but studies have shown that most CNAs don’t want to become nurses. They want to stay where they are planted because they love what they do.”

Senior Vice President and Co-Director of the LeadingAge LTSS Center @UMass Boston Robyn Stone expressed similar sentiments about the CNA profession.

Having researched workforce issues for many years, she acknowledges that direct care staffing challenges are not new and suggests that elevating the role of direct care professionals is a likely solution. “We have to do something around competitive wages and benefits, and it must be tied to clear core competencies as well as higher wages,” she says. “These are seen as primarily unskilled professions, but we must understand that they are frontline support professionals because they provide a great deal of functional and mental health support. In addition, they are responsible for quite a bit, particularly in home care settings.”



Vaccine Mandates Spur Resignations

The majority of employers reported that while they lost few, if any, employees during the pandemic, direct care staff began to resign once vaccine mandates were imposed. This was especially true among assisted living facilities and nursing homes. “We lost a lot of staff in Baltimore when the vaccine mandate was enforced,” a nursing home company executive who manages nursing facilities in and around Baltimore City, told us. “It affected our skilled nursing facilities more acutely. We tried to be creative with exemptions and work with everyone. A large number did get vaccinated, but it was worse in Baltimore. While we lost 5 percent, we were already hanging on by a thread.”

Timothy Scherer is director of an assisted living facility in the Baltimore County region. His community did not lose any team members during the pandemic, he says. “But when we imposed a vaccine mandate, 30 percent (CNAs and certified medication techs) left because they refused to get vaccinated.” It took him more than a year to refill those positions, he added.

Some Employers See Improvement

Two employers in Baltimore have had recent success with staffing levels in their respective communities, as reported recently by the *Maryland Daily Record*. “I’d say the biggest challenge during the pandemic was with recruiting and retaining nursing assistants and medical technicians,” Phil Golden, executive director and principal at Springwell, an assisted living and memory care provider, told the publication in December 2022. Springwell averaged about 100 agency shifts per month from March to July of 2022, he said, but was able to bring that number down to 35 agency shifts in October 2022. As of December 2022, Springwell was 92 percent to 93 percent staffed, according to the article

Aileen McShea Tinney, president and CEO of Keswick, a nursing home located in the Roland Park neighborhood of Baltimore, told the *Maryland Daily Record* that the staffing situation had improved during the last few months. “Staffing at Keswick ... has increased by almost 10 percent since October 2021, though Keswick still has a 10 percent vacancy for all nursing positions,” she said..

Quotes and excerpts from our interviews offer further understanding of the landscape of challenges they face and how they impact hiring, culture, pay, and more:

- “We had a large group of PRN [on call or as needed] CNAs who wanted a pay raise, and we said we would look at it for everyone. I maintained communication with them throughout the process. Within a week of announcing the wage increase three PRNs moved to full-time positions here.”
- “The new CNA/CMT [certified medical technician] rate, after doing an evaluation, was raised to \$16.60 for those who have their CNA only, and \$17.50 for those who have both CNA and CMT. What’s nice is that we can have CNAs trained to be [certified medication technicians] in house.”
- “Because our services are cost reimbursed, and unless you get federal and state governments to provide that reimbursement, it’s a direct correlation in terms of wages. There has been wage enhancement and progression, particularly in the last couple of years.”
- “There are markets where local municipalities reward not working. Another factor [in the staffing shortage] was the stringency of vaccine mandates. After they ended the add-ons for unemployment, I was sure they would come back. But they didn’t.”
- “Many people spent a lot of time at home and evaluated their lives. We had six employees who died during COVID. People evaluated their lives and decided they weren’t going back; that they don’t need the money that badly.”
- “Inflation has wreaked havoc on costs. For CNAs, their job is a calling; however, it is a much harder job than working at Target. It used to be that we could pay three or four times more than McDonald’s and Chick-fil-A, but now they are paying \$16, \$17, or \$18 per hour. You can’t raise the price of a hamburger to match it; we get paid by the government. We were at the top of the non-skilled market, and now we are in the middle. A Medicaid rate hike would be a game changer.”
- “Our [facilities] in Baltimore are doing much better than we were a year ago. We also recently stopped using agency staff in Baltimore for the first time since April of 2020. We have some very high-quality CNAs, but I don’t think the work ethic is as strong as it was a couple of years ago.”
- “We have good benefits, support, and culture. We refer to that position as the backbone and the heart and soul of long-term care. You have LPNs and RNs but the ways nursing homes have been structured, GNAs are not at the top of the pyramid. I do believe retention issues happen when people don’t feel appreciated and when their voices and experiences are not heard and responded to. That’s where our attention is.”
- “The [Baltimore City One-Stop Career Centers] should offer full wraparound supportive services to help the whole person, so they can be prepared when they begin their jobs. We are finding literacy is a huge challenge and that creates an issue in connecting people to jobs. The workforce centers could do more in terms of literacy, computer skills, case management, and their culture to really emphasize what they contribute to society in terms of working.”

HCBS Employers Largely in Crisis Mode

Our interviews with HCBS employers and stakeholders helped us to gain a better understanding of the challenges they face amid steep shortages and demand for care.

Tracey Paliath is director of government relations for the Maryland Association for Community Services (MACS), an organization that represents developmental disability service providers that employ DSPs across the state. There is an “incredible workforce crisis” among some direct services providers in the state, she says. Results from an informal survey of its members last year found that one in three providers had vacancy rates of between 30 and 60 percent, she added. “The situation is very difficult for MACS members. They are losing staff to Target, Amazon, and Costco all the time.”

Private Pay Versus Medicaid

Danny O’Brien, founder and CEO of Avila Home Care, an agency that offers assistance with ADLs and supportive services in Baltimore City and the surrounding area, has little to no issues with recruitment and retention of DSWs. “I have 500 caregivers on my roster, and I’ve never placed a help wanted ad,” he says. “There have just been a couple of times I’ve had to say no to clients because we didn’t have enough during the right hours. But by and large, we are doing fine.”

O’Brien credits his problem-free workforce situation to his philosophy of “caring for the caregiver.” Although wages at Avila are comparatively high, they are not the highest in the area, he says. “I interview every caregiver personally, and it is not uncommon for someone to walk out of the interviews having shed tears and say they’ve never been to an interview like that before. We want to affirm the dignity of their calling.”

It bears noting that Avila’s clients are all private pay, rather than Medicaid.

Additional interviews with HCBS providers yielded the following feedback:

- “Some employers are able to pay higher wages to 1099 [contractors] because they’re not paying payroll taxes. We offer benefits, including a 401k, and paid time off. But it seems like people in this category don’t care about this as much. We have been successful in getting Medicaid rate increases through and it’s been helpful, although not a total solution. We pass all of it onto the caregivers.”
- “There are significant challenges with regard to the workforce right now. A lot of organizations are facing this, but a lot of what I know is second hand from other people. We get a steady stream of qualified caregivers without having to place ads.”
- “We do what everyone says they do; we love and care for our caregivers.”
- “[DSWs] want to work for an organization that views caregiving as a sacred calling. They leave the interview, many talk to each other; and most have more than one job.”
- “I don’t mind giving them overtime. If they’re great and available, I don’t mind. If I have someone who doesn’t have to work a second job and works those hours with me, that’s a win for me.”
- “[Home care workers] tell me that they cannot work in nursing homes because it’s untenable.”

Home care employers that rely on Medicaid reimbursement to pay for services are having a much harder time finding and keeping staff, says Caitlin Houck, executive director of Maryland National Capital Homecare Association. “The Medicaid rate for home care in Maryland does not cover the cost of care,” she says. “It prevents us from being able to keep pace with competitors both inside and outside of the home care industry, and it’s not going away anytime soon.” Agencies are either turning away new patients or unable to fulfill a beneficiary’s total service hours because of the staffing shortage, and therefore losing business, Houck said. “It’s now an access-to-care issue.”

Matt Auman, CEO of HomeCentris Healthcare, a large Baltimore-based home care provider, agrees with Houck’s assessment. “We are really, really struggling with caregiver shortages, and leaving [thousands of] hours unstaffed because we cannot find or afford to pay higher wages with Maryland’s current reimbursement rate.”

PROVIDER ADVOCATE PERSPECTIVES

“Providers who rely heavily on Medicaid, like most nursing homes, are not able to raise wages and pass the added expense on to the customer—or resident,” said Allison Ciborowski, president and CEO of LeadingAge Maryland. “This is a challenge, as it limits what providers can pay employees and keep their organizations financially sound. Many providers have worked to continually offer higher wages and comprehensive benefits to their staff. But until improvements are made to the reimbursement process, widespread change will not happen.”

“[The workforce shortage issue is a national problem, it was a problem before the pandemic, and it was exacerbated as a result of the pandemic. It is also lingering more in skilled nursing settings nationwide,” said Joe DeMattos, Jr, president and CEO of the Health Facilities Association of Maryland. “I think the larger issues with [direct care] employment in healthcare are related to childcare and transportation,” he says. “We have nursing homes inside and just outside of Baltimore that are not served by bus routes, and that’s a big problem. And for single member households, even if the wages were significantly higher, they cannot cover transportation and childcare. So wraparound services are important. There must be a public-private partnership that tackles childcare and transportation.”

LifeSpan Network, an association that represents nursing home, assisted living, adult daycare, home care, hospice, and hospital providers in Maryland, recently began enrollment into the state’s first-ever hybrid asynchronous CNA/GNA training program, with all of the course content online and labs that are required in person once per week. “We recognize the need for individuals to be able to take classes outside the normal workday, so we worked with national leaders to put this course together,” said Kevin Heffner, LifeSpan president and CEO.

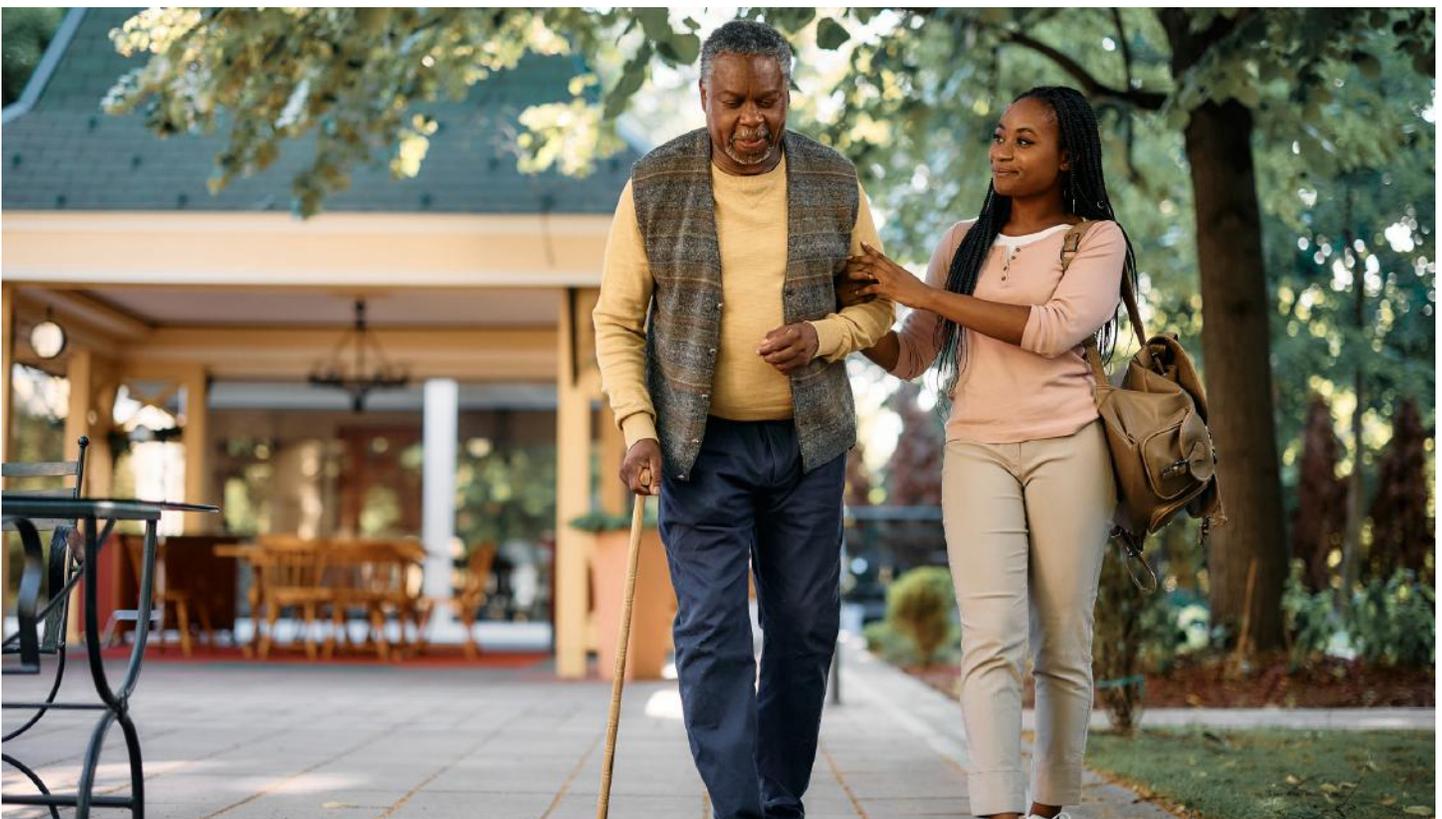
In addition, the association is “aggressively planning” to promote and recruit for the CNA profession in high schools and urban centers, Heffner says. “We are partnering with the Governor’s Workforce Development Board, Dwyer Workforce Development, and others to create and implement a recruitment initiative that will include Mike Rowe [host of “Dirty Jobs” and founder of the mikeroweWORKS Foundation] who has agreed to serve as the statewide spokesperson for the initiative.”

Advocates Push to Eliminate GNA Requirement for Nursing Homes

CNAs who wish to work in nursing homes must obtain an additional GNA certification via testing administered through the Maryland Board of Nursing. Amid the staffing shortage, many nursing home employers in the state view this as an added impediment to recruitment. LifeSpan supports elimination of the GNA certification, citing it as an unnecessary barrier that prevents CNAs from working in any setting of their choosing. “It restricts the flow of workers and poses a challenge for us to build a pipeline of workers so that we can meet future demands,” says LifeSpan’s Heffner. In testimony before the Maryland General Assembly in February 2023, he pledged to “continue to do our part on that,” in addition to collaborating with community colleges and other private career schools to move the initiative forward.

Danna Kauffman, an attorney and lobbyist who represents long-term and post-acute care providers across the state, has heard from LTSS employers for some time about staffing shortages. While she notes that providers are still “desperate for staff,” she is seeing signs of improvement. In her opinion, the state has a bigger issue in “the need to get more CNAs into the sector and into healthcare.”

Related to this is a widespread backlog at the Maryland Board of Nursing with regard to testing dates and sites and processing certifications, said Kauffman. Numerous entities interviewed for this report cited problems with newly graduated CNAs having to wait weeks and sometimes months to receive their official certification.



ELDER CARE THOUGHT LEADER PERSPECTIVES

The DSW workforce is an ongoing subject of research and education at all levels of academia and government. Direct care professionals across all settings are burned out and fed up, says NAHCA's Porter. As a former CNA, as well as a licensed nursing home administrator herself, she has been leading NAHCA for 27 years. Her experience has inspired her to coin the term "CNA Careforce" when referring to the profession that her organization represents. What's more, she believes that the term "worker," is demeaning and does little to advance the profession and acknowledge the skills that CNAs must learn and deploy in their line of work.

Porter asserts that "if you have great CNAs working for you, you know that they do the work not just for the pay, which is very important, but because they love their residents or clients." They become family members who count on them to show up and care for them day in and day out, she adds. "Imagine how this played out during the pandemic and that might help you better understand why so many are burned out and fed up—not just because they endured the trauma of the frontline, but because they are now having to work constantly in a short-staffed environment," she says. "Our survey showed that DSWs' biggest challenge was having to do the job of two or three people on one shift because there are not enough other CNAs for residents in the nursing home. As for home care, they are picking up shifts and working overtime, but not getting recognized either financially or culturally for their work."

Porter supports the imposition of minimum staffing requirements in nursing homes, which some states have implemented since the pandemic and Pres. Biden has pledged to impose nationally.²¹ She acknowledges the conundrum now faced by administrators and operators—that there are not enough CNAs available to hire. The solution to this, she says, is recruitment and first-class training. But even that may not be enough to solve the problem for nursing homes, she recognizes, because many CNAs do not want to work in

"GNAs are getting very frustrated because they are working short. Residents are not getting the care they should get because there are not enough GNAs."

nursing homes given their current state. “I hear from my members all the time that quality care is bad, again because of short staffing and being stretched too thin,” she says. “But we need to somehow right this ship so that nursing homes become places where everyone wants to work—because caring for older adults is a calling.”

LeadingAge’s Stone emphasizes that a standardization of competencies and knowledge would open up better opportunities for growth for those who want to continue as specialists and move up a ladder. “The more you work on retention,” she adds, “the less one would have to work on recruitment.” There are great staffing models out there that create great work cultures. If you have small groups and teams, you have the opportunity to create a healthy culture, which goes a long way toward retention, Stone says.



CONSUMER AND LABOR UNION PERSPECTIVES

As Executive Director of the National Consumer Voice for Quality Long-Term Care, Lori Smetanka advocates on behalf of nursing home residents. She also recognizes that the current workforce challenges in long-term and post-acute care are not new. “Workforce issues were certainly exacerbated by the pandemic. These are jobs that people do not want to take because the pay is low and there are little-to-no benefits,” she says, noting that her members are well aware of the fact that there are staff shortages happening now in the nursing home where they reside. “They are witnesses to it every day. High workloads, inadequate training, lack of respect, lack of opportunities to increase job responsibilities or any kind of job growth. All these factors came to a head as the pandemic hit.”

Smetanka adds that she now hears from her constituents that “things have gone backwards [in nursing homes] and that, since the pandemic, quality has deteriorated and residents are not getting the care they need.” Related to this, she says, are job conditions that continue to be very poor, staff who are not adequately trained, and minimum training standards that need to be increased.

“I’ve heard these concerns from not just nursing home residents, but also advocates, state and local ombudsmen, and families.” In addition, Smetanka said, “while there may be a shortage of workers in this country, the bigger problem is that these are jobs people don’t want to take. We need to make them good jobs to attract people to them and to reduce turnover.”

In her work, 1199SEIU’s Balog says she has heard from union members and home care workers in the Baltimore area who have experienced the stress of working in a short-staffed environment and its adverse impact on quality of care. “We are hearing reports that resident-to-CNA staffing ratios are high and not sustainable.”

The organization is now working to build a program that brings prospective CNAs into a pipeline by delivering more training opportunities for workers, such as helping housekeepers move into CNA positions, for example.

THE ROLE OF WORKFORCE DEVELOPMENT INITIATIVES



Baltimore is home to several workforce development entities run either by nonprofits or private foundations, as well some centers run by the city. These organizations, including Dwyer Workforce Development, Bon Secours Community Works, the Caroline Center, and the Baltimore Alliance for Careers in Healthcare, offer promising practices and solutions to issues standing in the way of effectively recruiting and training prospective DSWs.

In addition to offering career skills training and wraparound services for individuals interested in becoming CNAs, PCAs, and other health care tech certifications, some entities offer placement and case management services.

Administered by the Mayor’s Office of Employment Development (MOED), the Baltimore City One-Stop Career Centers provide “a full range of assistance to job seekers and businesses,” according to the office’s website. These centers “strive to provide customer-driven workforce services for all customers” through “a variety of employment and support resources to assist job seekers in achieving their employment goals.” To this end, job seekers meet with consultants to discuss career exploration, get referred to training programs, obtain assistance with résumé preparation, and attend workshops to enhance job seeking skills and work readiness. While the career centers do not offer training, MOED partners with the Veterans Administration and businesses and private workforce development initiatives to refer individuals for training, skills training, and wraparound services.

Wraparound Services Aim to Boost Retention

Colin Smith is director of strategy and impact for Bon Secours Community Works, a Baltimore-based nonprofit that has a healthcare training program that offers CNA/GNA certification through a contract in partnership with schools such as IT Works Learning Center. The organization provides wraparound services in the areas of behavioral health; case management; and employment services, such as soft skills training and financial literacy, career planning, legal assistance, transportation, and childcare, among other services. “We typically enroll about 100 students per year,” says Smith. “We support students through wraparound services including case management and job placement, and we try to follow them for a year after graduation to support job retention and

advancement, although sometimes we lose touch with graduates.

Karen Hammer is the former director of academic and career advancement at Caroline Center, a nonprofit workforce development organization serving women in Baltimore. “Caroline Center provides a safe and supportive community (their trainees like to call it ‘a sisterhood’), where women can learn and become their best selves,” Hammer says. She too has seen CNA wages go up over the last few years. “Everything has also gotten more expensive—and CNAs are far from having a living wage,” she adds.

Another thing Hammer has noticed is that students’ interest level in working in long-term care has waned. “It was close to nil in the last several cohorts and even before the pandemic,” she says. “People want to go to hospitals, which is likely fueled by fear of the work it takes amid a short-staffed environment.” She adds that



she has heard that the current cohort has shown more interest in long-term care.

Hammer heard from a recent Caroline graduate, who, in her first week on the job, had a day where she had 15 patients to herself to care for. “These situations are causing people to leave because it’s overburdening them,” she says.

Dwyer Workforce is a Baltimore-based nonprofit healthcare workforce development program that provides “job training and placement services, need-based wraparound services, and case management to individuals who lack opportunity and aspire to pursue a career in the healthcare industry.”

In an interview with Dwyer’s Chief Operating Officer Maria Darby, she notes that they are focusing on the retention side of things via wraparound services to help students (whom they call “scholars”) stay on course by working with them and with employer partners to ensure job placements once they graduate.

“Helping our scholars find childcare services or connections is one of those things that comes up often,” she says, as “the need is extreme, and the solutions are limited.” Dwyer helps scholars navigate the rather limited services offered through the state, Darby adds.

The goal is to ensure that scholars stay in their training courses so they can graduate and go into the workforce, Darby stresses. “We want to help them succeed and we want to help our provider partners hire the CNAs they need to care for their residents and clients.”

“There is not a lot of accountability in nursing homes or hospitals. I work on the weekends—on the graveyard shift—where there is one GNA per 20 or more patients. They only respect you because they need your body.”

PROMISING PRACTICES AND POTENTIAL SOLUTIONS

Given the breadth and depth of the workforce shortage among direct care and services professionals across the country, many promising practices and potential solutions have emerged. Advocacy organizations, research entities, and individual advocates have identified, analyzed, and proposed solutions to overcome the workforce challenges from many angles. These include novel and innovative retention efforts; recruitment strategies; workforce development and training programs; minimum staffing requirements; and, not surprisingly, wage increases, benefit packages, and bonus programs.

PHI's State Policy Strategies for Strengthening the Direct Care Workforce, published in 2022,²² compiled 24 specific policy strategies organized according to the eight comprehensive solutions previously identified in "Caring for the Future: The Power and Potential of America's Direct Care Workforce" as follows:

- Reform Long-Term Care Financing.
- Increase Compensation for Direct Care Workers.
- Strengthen Training Standards and Delivery Systems for Direct Care Workers.
- Fund, Implement, and Evaluate Direct Care Workforce Interventions.
- Improve Direct Care Workforce Data Collection and Monitoring.
- Center Direct Care Workers in Leadership Roles and Public Policy.
- Rectify Structural Gender, Racial, and Other Inequities for Direct Care Workers.
- Shift the Public Narrative on Direct Care Workers.

These solutions offer an excellent framework for alleviating the workforce staffing crisis through holistic and comprehensive approaches to reforming LTSS.

Given that the Baltimore DSWs are primarily Black women, particular attention to PHI's strategy addressing structural gender, racial, and other inequities is warranted. DSWs across the United States are predominantly women (87 percent), people of color (61 percent), and immigrants (27 percent), according to PHI, which notes that "gendered assumptions about caregiving and racist policy decisions have devalued direct care jobs and weakened protections for this workforce" for generations. In addition, PHI contends that restrictive immigration policies have had a disproportionately negative impact on workers in low-wage sectors like LTSS. "States can proactively address the structural inequities that harm the lives and employment experiences of direct care workers and other state residents," PHI recommends.

In addition to the recommendations found in PHI's publication, which we endorse, following is a selection of solutions that have originated outside of Maryland or are national-level initiatives that stakeholders may learn from and build upon as they consider approaches for Baltimore City:

1. [Maine's Medicaid Rate and Wage Increase Model](#): Maine recently implemented an innovative model to improve DSW wages while ensuring that providers are able to cover increased costs resulting from higher wages.²³ Recognizing that Medicaid funds most direct care and services, Maine passed and implemented a law requiring that all "essential support workers," such as DSWs, whose work is funded by Medicaid, be paid at least 25 percent more than the state's minimum wage. When the law took effect in January 2022, Maine's minimum wage was \$12.75, creating a \$15.94 hourly wage floor for the state's Medicaid-funded DSWs.²⁴ The state's minimum wage is now \$13.80, providing these workers an hourly wage floor of \$17.25. Just as importantly, the law provides for annual "rebasings" of Medicaid rates. In other words, the state's Medicaid program collects hard data from providers through cost reports and uses that data to ensure that Medicaid payments to providers are enough to cover the law's wage requirements. Thus, Maine's model contains three parts: first, it requires that providers pay workers more; second, the state collects hard data from publicly funded providers about providers' expenses; and third, it ensures Medicaid rates are adequate to meet the law's wage requirement.
2. [Cooperative Home Care Associate's Worker Co-op Model](#): Worker-owned cooperatives present an alternative model that does not necessarily depend on the passage of new legislation in Baltimore City or Maryland. The most well-known direct care cooperative is Cooperative Home Care Associates (CHCA).²⁵ Based in the Bronx, a borough of New York City, CHCA started with just 12 home care aides and now employs more than 2,000 staff. DSWs are invested in their employer, which offers workers a share of CHCA's profits and helps keep turnover very low. CHCA also offers workers training and support on the development of new skills, coaching, advancement opportunities, and guaranteed placement, all of which add up to a career path that does not exist in many other workplaces.
3. [Washington State's Publicly Run Long-Term Care Insurance Model](#): Not all direct care and LTSS models are funded by Medicaid, and not all those needing care qualify for Medicaid. To create a broader long-term care safety net, in 2019 Washington State enacted the LTSS Trust Act.²⁶ Administered as a payroll tax much like Social Security, workers pay into the LTSS Trust by contributing 0.58 percent of their wages.²⁷ A typical worker earning approximately \$50,000 annually would contribute about \$300 a year to the trust. After contributing for a certain number of years, each person is entitled to a lifetime benefit of \$36,500 for LTSS. The state government estimates that the Trust will save the state \$3.7 billion by 2052 by reducing the burden on Medicaid. This system could allow for higher pay for DSWs than Medicaid currently provides, improving DSW job quality.

4. [California's Master Plan on Aging](#): This document presents an example of a statewide plan charting a path forward while giving localities a menu of options to choose from to support their local DSW workforces. It outlines five bold goals and 23 strategies to build a "California for All Ages by 2030." Among the strategies outlined are the Good Caregiving Jobs Creation initiative, which aims to grow wages through caregiver training and professional development opportunities, job placement support, and improved job quality and California's Healthcare Career Pathways (HCP), a collaborative partnership with ombudsman services around the state to [address](#) the critical shortage of healthcare workers. In addition, California Gov. Newsom announced in late February 2023 more than \$400 million in grants to "build upon and expand the state's nation-leading health care workforce and infrastructure."
5. [WisCaregiver Careers](#): A free program administered by the Wisconsin Department of Health Services, the Wisconsin Health Care Association, and LeadingAge Wisconsin, WisCaregiver Careers is designed to provide jobs, training, incentives, and rewards to encourage people of all ages to start a career in health care by working with nursing home residents. Participants follow a step-by-step process to become nursing assistants. The program funds training and testing for 3,000 new nursing assistants through nearly every technical college in the state and at numerous private and facility-based training sites. The training has been so successful that the state is now expanding it to include home care workers. In the process, Wisconsin is creating something akin to a universal worker certification program for the home care workforce, [PHI reported](#) in a February 2023 article. When launched in May of this year, the program will provide home care workers with standardized training and certification, access to a job registry, recruitment and retention bonuses, and a career ladder in the health care industry.
6. [National Institute of CNA Excellence \(NICE\)](#): Described as a one-stop virtual career center for everything CNA related, including recruitment, certification, job placement, continuing education, and ongoing career support, NICE offers a comprehensive approach to preparing CNAs by educating learners on essential skills such as team-building, conflict resolution, and communication.²⁸ It seeks to accomplish this via a cloud-based training program enhanced with animated simulations; informative interviews with real-life medical personnel; and videos, quizzes, and practice tests. The NICE CNA course goes beyond helping students learn required skills and achieve CNA certification and addresses the emotional and interpersonal challenges of the job, as well as its rewards.

7. [National Technical Assistance and Resource Center](#): Funded by the federal Administration for Community Living in late 2022, this initiative is aimed at supporting recruitment, retention, and professional development for individuals who provide home and community-based services.²⁹ Through a five-year grant totaling over \$6 million, it establishes a national center to expand and strengthen the direct care workforce across the country. According to its website, “this initiative will provide technical assistance to states and service providers and facilitate collaboration with stakeholders to improve recruitment, retention, training, and professional development of the direct care workers who provide the critical services that make it possible for people with disabilities and older adults to live in their own homes and communities.” The center’s website also offers resources on direct care workforce federal initiatives.
8. [NAHCA’s Enclave Principle](#): The National Association of Health Care Assistants (NAHCA) created an initiative known as the Enclave Principle that “presents a new and strategic way to recruit and retain CNAs.”³⁰ Enclave uses a four-phase approach based on the principles of creating a CNA department and selecting and training a director of certified nursing assistants, or DNA. According to NAHCA’s Porter, the two Enclave pilot programs have improved retention as well as recruitment. In addition, says Porter, it elevates all CNA positions within the nursing home and improves morale among staff overall.
9. [“State Policy Strategies for Strengthening the Direct Care Workforce”](#): As noted earlier, this report, published by PHI, is a compilation of 24 specific policy strategies, including “concrete examples,” for improving direct care job quality and stabilizing the workforce. The strategies are organized according to the eight comprehensive solutions as outlined in an earlier PHI report.
10. [The Green House Project \(GHP\)](#), a not-for-profit organization that creates “non-institutional eldercare environments that empower the lives of people who live and work in them,” has helped hundreds of nursing homes and assisted living facilities across the country implement a model of care that flattens the traditional organizational hierarchy, removes formal nurse supervision of direct care workers, and implements both a “consistent assignment” and “universal worker” approach to care. Research on GHP has demonstrated higher staff retention, improved job satisfaction, and better quality of care for residents. In addition, at the center of GHP’s approach to long-term and post-acute care is a “small-house” model design that includes private rooms and bathrooms for all residents as well as staff who are empowered to provide “person-directed, relationship-rich living” environments. This design is believed to be the reason why Green House homes had significantly less [COVID-19 incidence and mortality rates than in traditional nursing homes that have less than 50 and greater than 50 beds](#) during the pandemic.

11. [The Eden Alternative's Empowered Teams Training](#): The Eden Alternative, a not-for-profit organization whose mission is to improve the well-being of elders and their care partners by transforming the communities in which they live and work, has a training course titled Empowered Teams. The course teaches communities to redesign the traditional nursing home into “neighborhoods” with consistent assignment staffing and self-directed work teams led by a guide. The training is designed to teach and grow teams that give everyone, including direct care staff, skills that they don’t usually learn in traditional model nursing homes, such as the development of a team mission, vision, and values; time management and budgeting; team interviewing and hiring; root-cause analysis; managing complaints; and more.

12. [Moving Forward Nursing Home Quality Coalition](#): Formed in 2022, this coalition of individuals and organizations focuses on advancing seven goals outlined by the National Academies of Sciences, Engineering and Medicine (NASEM) in an April 2022 report aimed at improving nursing home quality. Moving Forward committee members, along with a network of experts, nursing home residents, and the general public, are working to develop, test, and promote action plans that will improve the way the United States finances, delivers, and regulates care in nursing homes. The coalition’s Workforce Committee’s [action plan](#) outlines the importance of ensuring that payment for nursing home care “must account for the full costs of delivering quality care to nursing home residents, including costs associated with paying nursing home staff livable and competitive wages and employment benefits, such as health insurance, paid time off, and others. The committee will document a detailed plan that builds on existing workforce initiatives and sequences action steps and collaboration with state and federal agencies.”

The following selection of solutions, created or based in the State of Maryland, may have relevant application to Baltimore City:

1. [Montgomery County Medicaid Supplement](#): If a county has a higher cost of living and/or a higher minimum wage than the rest of the state, Medicaid providers may find it difficult to cover all their costs. To address this issue for entities providing services to people with developmental disabilities, Montgomery County has for many years supplemented state Medicaid reimbursement with a county-level “DD supplement.”³¹ More recently, the Montgomery County Council specified that providers receiving this supplement were required to pay DSWs providing services in the county at least 25 percent more than the county’s minimum wage. The county requires that provider entities report on their use of the funds to ensure that payments are used for this purpose. This county-level model presents an option that Baltimore City could implement even without state or federal support, and there is no need (or reason) to limit such a supplement only to providers serving people with developmental disabilities. Baltimore City could raise dedicated funds for this purpose, and then provide a supplement to providers on the condition that providers pay DSWs at least 25 percent more than minimum wage. The city could also require that providers track and produce records of how they are spending the money.
2. [Maryland Department of Labor’s Direct Care Workforce Innovation Program](#): This program is designed to provide matching grants to eligible entities to create and expand successful recruitment and retention strategies. Baltimore could establish a similar program or support local initiatives’ applications for the funds.
3. Community College School of Aging Services: Conceived and originated by Ron Carlson, former executive director of the Collaborative, this initiative is aimed at developing and testing innovative approaches to integrative workforce training and setting career pathways in aging services. Through the establishment of associates degrees in aging services, with a curriculum focused on gerontology and long-term care management, the program would educate individuals for all roles within the field via interdisciplinary training to work with older adults.

RECOMMENDATIONS

Given the themes and findings, we make the following recommendations:

1. Push for state-level legislative and policy changes that both increase Medicaid funding for care and ensure that publicly funded DSW jobs offer living wages and benefits. Given that Medicaid funds so much of the care provided in Baltimore City, it is the single biggest lever for effective change. Maryland sets a wide range of key Medicaid rules through state laws, regulations, and policies within the Maryland Department of Health. Baltimore City's Mayor and state legislative delegation should unite around a core message: Maryland should both increase funding for Medicaid-funded care and ensure that all Medicaid-funded DSW jobs offer living wages and benefits. Maine's model of increasing Medicaid funding while also requiring that DSWs receive wages that are at least 25 percent greater than the state's minimum wage offers a successful case study to draw from.
2. Leverage the Baltimore City Health Department's Division of Aging and Care Services to collect more first-person data on the City's DSW workforces. There is an unfortunate lack of comprehensive data about Baltimore City's DSW workforces. This lack of data makes it harder to understand the forces driving the DSW workforce crisis and how to solve it. Every Maryland county has an Area Agency on Aging. Baltimore City is located within its health department and is called the Division of Aging and Care Services. It should do more to collect data on wages, benefits, turnover, and retention of DSWs in the City.
3. Consider dedicating funds to supplement wages for Medicaid-funded DSWs. Maryland does not yet ensure that DSWs who provide Medicaid-funded services are paid living wages. Baltimore City should consider a dedicated funding stream to make up the difference, helping to stabilize the DSW workforce until the state acts.
4. Connect DSWs to all available social services and supports. Though there are promising services offered by Baltimore City agencies and nonprofits, there is not yet a comprehensive effort to connect the City's DSWs to all available social services and public benefits. Such an effort could leverage existing supports to make DSW jobs more appealing.

5. Invest in initiatives that offer DSWs access to obtainable and meaningful career pathway and advancement opportunities, such as career ladders (to licensed practical nurse, nurse, or administrator roles) and lattices (additional certifications for dementia care, infection control, end-of-life care, and more) that involve additional training matched with a raise in pay, an elevation in title, and/or new responsibilities or functions.
6. Explore the possibility of establishing a worker-owned cooperative. While not a panacea, worker cooperatives can help improve wages and retention. The Bronx's Cooperative Home Care Associates offers an attractive model to learn from.

Finally, we suggest all DSW stakeholders review a new tool known as the "[Direct Care Workforce State Index](#)," created by PHI this year to help policymakers, advocates, and other stakeholders understand how states support DSWs, where they can improve, and how they compare to other states.

We look forward to further discussion of these recommendations as we continue conversations with stakeholders in Baltimore City and beyond.

NOTES

¹ Maryland Department of Aging, Maryland State Plan on Aging. <https://aging.maryland.gov/Pages/StatePlanonAging.aspx>.

² “Direct Care Workers in the United States: Key Facts 2021,” Sept. 7, 2021, PHI. <https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2/>.

³ Scales, PhD, Kezia, “The Direct Services Workforce in Long-Term Services and Supports in Maryland and the District of Columbia,” PHI. <https://www.phinational.org/wp-content/uploads/2018/09/DSWorkers-Maryland-2018-PHI.pdf>.

⁴ Maryland Department of Labor, Office of Workforce Information and Performance: <https://www.dllr.state.md.us/lmi/wages/aboutnum.shtml>.

⁵ Workforce Data Center, PHI Policy Research: <https://www.phinational.org/policy-research/workforce-data-center/#states=24&var=Earnings>.

⁶ Scales, PhD, Kezia, “The Direct Services Workforce in Long-Term Services and Supports in Maryland and the District of Columbia,” PHI.

⁷ Scales, PhD, Kezia, “The Direct Services Workforce in Long-Term Services and Supports in Maryland and the District of Columbia,” PHI.

⁸ “Understanding the Direct Care Workforce,” PHI: <https://www.phinational.org/policy-research/key-facts-faq/#:~:text=WHAT%20IS%20THE%20TURNOVER%20RATE,recent%20research%20in%20each%20case>.

⁹ “Long-Term Care Jobs Report,” American Health Care Association/National Center for Assisted Living, Jan. 2023: <https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/LTC-Jobs-Report-Jan2023.pdf>.

¹⁰ PHI, Policy Research, Workforce Data Center: <https://www.phinational.org/policy-research/workforce-data-center/#tab=National+Data>.

¹¹ Telesford, Imani, “How Has Health Sector Employment Recovered Since the Pandemic?,” Jan. 20, 2023, Peterson-KFF Health System Tracker: <https://www.healthsystemtracker.org/chart-collection/what-impact-has-the-coronavirus-pandemic-had-on-healthcare-employment/>.

¹² Medicaid and CHIP Payment Access Commission, “State Efforts to Address Medicaid Home- and Community-Based Services Workforce Shortages,” March 2022: <https://www.macpac.gov/wp-content/uploads/2022/03/MACPAC-brief-on-HCBS-workforce.pdf>.

¹³ Maryland State Plan on Aging 2022 to 2025: <https://aging.maryland.gov/Pages/StatePlanonAging.aspx>.

¹⁴ Baltimore County Department of Aging, Baltimore City Health Department, Division of Aging, Baltimore County Commission on Disabilities Community Resources 2019: <https://health.baltimorecity.gov/sites/default/files/communityresources2019.pdf>.

¹⁵ Maryland Department of Health, Office of Health Care Quality, Licensee Directory: <https://health.maryland.gov/ohcq/Pages/home.aspx>.

¹⁶ Maryland Department of Health, Office of Health Care Quality, Licensee Directory: <https://app.smartsheet.com/b/publish?EQBCT=08adff96ac8c4d18a97bf909162a2250>.

- ¹⁷ Distribution of Nursing Facility Residents by Payer Source, 2022, KFF: <https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- ¹⁸ Massachusetts Institute of Technology Living Wage Calculator: <https://livingwage.mit.edu/>.
- ¹⁹ MIT Living Wage Calculator: <https://livingwage.mit.edu/counties/24510>.
- ²⁰ Weller, Christian et. al, “Making Care Work Pay,” LTSS Center @UMass Boston: <https://www.ltsscenter.org/wp-content/uploads/2020/09/Making-Care-Work-Pay-Report-FINAL.pdf>.
- ²¹ Musumeci, MaryBeth, et al, “State Actions to Address Nursing Home Staffing During COVID-19,” KFF, May 16, 2022: <https://www.kff.org/medicaid/issue-brief/state-actions-to-address-nursing-home-staffing-during-covid-19/>.
- ²² Kezia Scales, PhD, “State Strategies for Strengthening the Direct Care Workforce, 2022,” PHI: <https://www.phinational.org/wp-content/uploads/2022/04/DCW-State-Strategies-2022-PHI.pdf>.
- ²³ State of Maine, Department of Labor, Bureau of Labor Standards, New Wage Increases (Me. Rev. Stat. tit. 22, §§ 7401-7404): https://www.maine.gov/labor/labor_laws/minimum_wage_faq.html.
- ²⁴ Maine Revised Statutes Annotated, Title 22 – Health and Welfare, Subtitle 5 – In-Home and Community Support Services for Adults with Long-Term Care Needs, Chapter 1627 – Essential Support Worker Reimbursement, sections 7401 through 7404.
- ²⁵ Cooperative Home Care Associates: <https://www.chcany.org/about>.
- ²⁶ Washington State Department of Social and Health Services, Long-Term Services and Supports, Long-Term Services and Supports Trust Act: <https://www.dshs.wa.gov/altsa/stakeholders/long-term-services-and-supports-ltss>.
- ²⁷ Washington State, Long-Term Services and Supports, Long-Term Services and Supports Trust Act Infographic: <https://www.dshs.wa.gov/sites/default/files/ALtsA/lts/documents/LTSS%20Trust%20Act%20One-Page.pdf>.
- ²⁸ National Institute of CNA Excellence: <https://www.nicecna.org>.
- ²⁹ Administration for Community Living, “Programs and Policy Areas, Strengthening the Direct Care Workforce”: <https://acl.gov/programs/direct-care-workforce>.
- ³⁰ National Association of Health Care Assistants, The Enclave Principle: <https://www.nahcacna.org/enclave/>.
- ³¹ Montgomery County, Maryland, County Council, Dec. 8, 2017 Memorandum: https://apps.montgomerycountymd.gov/ccllims/DownloadFilePage?FileName=1461_1_533_Bill_35-17_Action_20171208.pdf.

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