WASHINGTON STATE LONG-TERM CARE WORKFORCE LEGISLATIVE REPORT

Fall 2024

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ACCESS THE REPORT

The full report "2024 Long-Term Care Workforce Legislative Report" can be accessed on the Long-Term Care Workforce Page for the Workforce Board.

Frequently Used Abbreviations

NAC: Nurse Aide – Certified
HCA: Home Care Aide
LTC: Long-Term Care
E2SSB 5582: Engrossed Second Substitute Senate Bill 5582
SNF: Skilled Nursing Facility
NH: Nursing Home
ALF: Assisted Living Facility
HHS: Home Health Service
ESD: Employment Security Department
WABON: Washington Board of Nursing
WTB: Workforce Training and Education Coordinating Board
PTO: Paid Time Off

Executive Summary

Washington is home to more than 8.0 million people.[i] As the population grows, so do the needs for long-term care services. Estimates indicate that the population of residents aged 65 or older will grow 14 percent by 2030 from its current 1.5 million population. An additional 1.6 million residents of Washington are characterized as disabled[ii] with approximately 54,000 of those qualified to receive long-term services for intellectual or developmental disabilities.[iii] Finally, an unknown number of residents require long-term care (LTC) services because of traumatic injuries or illnesses.

In long-term care settings, extensive and prolonged staff vacancies leave beds empty and result in service delays due to an inability to safely and effectively care for a highly vulnerable population. Providers across the continuum of care, including home caregivers, must turn away potential clients because the providers lack the skilled staff needed to properly care for those in need. Meanwhile, LTC providers who struggle with reimbursement rates that fall short of covering the actual costs of labor-intensive care face significant financial losses, leading to reductions in the availability of needed services and supports. These factors contribute to the decrease in available long-term care services further exacerbating an already critical demand for LTC.

The state, and the nation, cannot afford the reduction in capacity of LTC providers. The lack of an adequately staffed, well-trained, and well-respected workforce is the primary dilemma facing LTC providers. A 2007 report authored by the Institute for the Future of Aging Services (IFAS) described the findings of a coalition of federal, state, and local agencies that examined the LTC workforce and the challenges facing the industry's future needs.[iv] The IFAS report was largely supported by an independent report released in 2006 by the National Commission for Quality Long-Term Care, "Out of Isolation: A Vision for Long Term Care in America."[v] The IFAS and National Commission reports largely agreed on three key issues related to the workforce challenges facing the LTC industry. These issues are:

1. There is a well-documented shortage of competent professional and paraprofessional personnel to manage, supervise, and provide LTC services in facility-based and home care settings because of high turnover, large numbers of vacancies, and difficulty attracting new employees.
2. The instability of today's LTC workforce has contributed to:
    a. Service access problems and, in many cases, seriously compromised safety, quality-of-care, and quality-of-life for care recipients.
    b. Excessive provider costs due to the need to continuously recruit and train new personnel and use temporary, higher-cost contract staff.
    c. Extreme workloads for both nurses and paraprofessional staff, inadequate supervision, less time for new staff to learn their jobs, and high accident and injury rates exceeding those in the construction and mining industries.
3. As a result of growing demand from the Washington population and a shrinking of the traditional caregiver labor pool, the future of LTC will be immeasurably worse without decisive action by both the public and private sectors.

Since the publication of the IFAS report, additional unrelated efforts have produced reports drawing similar conclusions. A 2013 Report to Congress found:

> *"The issues of service delivery, workforce, and financing long-term care services and supports (LTSS) have challenged policymakers for decades. Most individuals who need LTSS receive needed assistance from a family caregiver. Those who need paid LTSS in a nursing home or in their own home must negotiate a complex patchwork of expensive services. Most individuals and their families do not have the personal financial resources needed to pay for an extended period of assistance and many end up on Medicaid. As a result, federal and state governments today pay for 62 percent of paid LTSS—over $130 billion a year. The need for LTSS and the cost to governments will grow drastically over the next two decades with population aging, increasing the already underfunded government health care programs."*[vi]

The first year of the Long-Term Care Workforce Initiative laid the foundation for efforts to develop remedies for the LTC workforce shortages in the state. Despite Washington being recognized as a leader for the quality of the LTC workforce, the state still faces many challenges. The most current research reinforces previous findings that shortages continue to plague the LTC industry, creating challenges to provide quality care for those in need of LTC services.

Over the past year, the LTC Workforce Initiative's work has shifted from a primary focus on challenges to an examination of potential solutions. The remedies to existing and future workforce challenges are not simple. The solutions involve multiple approaches, often beyond the conventional. For example, a licensed practical nurse (LPN) apprenticeship program is a *part* of the solution, not "the solution." There is no single approach that will "cure" the state's LTC crisis.

As a key component of the LTC Workforce Initiative, four subcommittees, each with a unique focus related to the LTC workforce, meet monthly, and are instrumental in the development of recommendations intended to improve the LTC workforce. The subcommittees include representation from state agencies, employers, care workers, educators, and labor organizations. The recommendations were developed with input from all partners and reflect broad support of the contributors. As with any collaborative, differences arose and, wherever possible, were addressed to reflect the needs of each contributor. These recommendations range from improved educational opportunities to efforts that meet the specific needs of rural communities in the state.

These recommendations are summarized below and are further expanded upon later in this report. Based on the Initiative's work in 2024, the LTC Workforce Initiative is recommending:

1. **Support the development of workforce policies that offer caregivers (individual providers and agency staff) consistent hours per pay period to ensure a dependable source of income.**
   Providing consistent hours per pay period allows workers to manage their personal finances, improving job satisfaction and ultimately contributing to a stable workforce and improved patient care.

2. **Fund expansion of skills labs to support healthcare training in rural, isolated, and underserved communities.**
   Local availability of training resources increases training opportunities, leading to greater training and education of caregivers and better outcomes for patients.

3. **Promote and support employee-centered management training for supervisors across all LTC venues.**
   Supportive leadership promotes recruitment and retention of trained staff while promoting career growth for caregivers.

4. **Assess the use, ethical considerations, and potential for expansion of existing and developing technologies in LTC settings.**
   The use of developing technologies has the potential to improve efficiency and reduce the administrative burden on direct caregivers in LTC settings, resulting in improved job satisfaction for providers and quality-of-care for those receiving care services.

5. **Provide funding for the continuation and expansion of the marketing campaign authorized by E2SSB5582 (2023) with a focus on the recruitment of nursing staff in LTC and rural and underserved communities.**
   Nursing in LTC has long been overlooked and not adequately promoted as a career path for new and experienced nurses. The legislative mandate to promote career opportunities in nursing in LTC and underserved communities has the potential to grow the workforce while emphasizing career opportunities.

6. **Promote the distribution of information on opportunities for loan forgiveness and repayment programs for LTC providers.**
   Promoting opportunities for loan forgiveness or accelerated loan repayment encourages direct care workers to remain in LTC or underserved communities thus contributing to a stable work environment and quality care for patients.

7. **Support the development and evaluation of a robust statewide residency program for LTC nurses through funding and programmatic support.**
   The development and evaluation of a robust statewide residency program in LTC puts this career pathway on a par with other skilled nursing specialties.

8. **Continue funding for the Washington State Student Nurse Preceptorship Grant Program.**
   This request would establish on-going funding for the preceptorship program authorized by the Washington State Board of Nursing during the 2023 Legislative Session (E2SSB 5582).

9. **Expand the current number of Department of Social and Health Services Quality Improvement Program Nurses to allow for more increased support and technical assistance for LTC providers.**
   The services offered by these specialized professionals expand the support of the caregivers, reducing stress and potential for harmful outcomes for the patients.

10 **Expand the current capacity of Residential Care Services Behavioral Health Quality Improvement Consultants (BHQIC) to allow for more support and technical assistance for LTC providers.**
The technical support of the BQIC has the potential to improve care services, increase staff confidence and retention and improve the quality of care for those receiving LTC services.

11. **Provide support for the Washington Department of Veterans Affairs (DVA) training programs.**
The requested support and funding for DVA from policymakers to ensure its training program meets the needs of both staff and LTC residents. With continued support, the agency will be able to proactively meet its regulatory training requirements while also supporting numerous essential training activities annually.

12. **To improve the processes for home care aide testing, we recommend the implementation of solutions that would integrate testing into training, allow caregivers to test where they train, and shorten the time between training and testing.**
The changes to the testing protocols have the potential to improve the retention of HCAs, impacting on the availability of qualified staff in home care situations. These changes could contribute to better outcomes and reduced costs.

Other recommendations are still in development, requiring additional consideration. Together, these changes are anticipated to improve the availability of care workers in LTC, ultimately leading to a more stable LTC workforce and improved quality-of-care for those in need. Continued support for this Initiative will enable ongoing work in this space.

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Our Vision for Long-Term Care in Washington

In 2023, the Long-Term Care Workforce Initiative's stakeholders articulated the vision for the *Ideal State* of long-term care (LTC). LTC is broadly defined as:

"… a variety of services designed to meet a person's health or personal care needs when they can no longer perform everyday activities on their own."[vii]

The Initiative's Ideal State of Long-Term Care

A high-quality system of coordinated long-term care support services that provide accessible choices in care settings.

A regulatory environment that encourages collaboration and support while maintaining the focus on patient safety.

A well-trained, equipped, and respected staff who provide quality, empathetic care in a stable, nurturing work environment, supported by access to comprehensive career pathways, lifelong learning opportunities, and recognition of the value and skills provided by the direct care workforce.

This definition is not exclusive to elder care. It includes anyone needing LTC such as those with intellectual and developmental disabilities and disabilities associated with traumatic injuries and illnesses. It is imperative that LTC services represent the diverse needs of Washington's eight million residents.[viii]

An individual's need for LTC may arise slowly over time because of aging or it may arise suddenly. Critical health events like strokes and heart attacks or catastrophic injuries can change the course of one's life in an instant. No matter the cause, the end results remain the same: a need for prolonged care services over all or a portion of a person's lifespan.

LTC services and supports are for anyone requiring assistance with chronic care needs and activities of daily living. These services and supports are offered in a variety of settings, including in-home care, residential care, and skilled nursing facilities (SNFs). The type of setting is heavily influenced by what the client wants, the acuity of their needs and financial circumstances.

Hundreds of thousands of people in Washington rely on LTC every day. Projections indicate that this population will continue to grow substantially over the next several decades.

Barriers to Our Vision

> "Our clients, they need us… We take care of them like they are our family."
>
> – Direct Care Provider

Washington is facing an LTC workforce crisis. Our state's population has a growing need for caregivers but has too few caregivers to meet increased demand. This report investigates the foundations of this problem and explores policy solutions to address the issue. Many of these solutions are long-term, intensive, and evolving with technology. There is no simple solution. Instead, there are many elements of the LTC ecosystem that must be addressed to create a stable, effective resolution to the current crisis.

In 2023, during the first year of this three-year initiative, the Workforce Training and Education Coordinating Board (Workforce Board) prepared a detailed report: Washington Long-Term Care

Workforce Initiative Legislative Report; Fall 2023. The report identified three key challenges to the LTC workforce environment:

1. There is a well-documented shortage of competent professional and paraprofessional personnel to manage, supervise, and provide LTC services in facility-based and home care settings because of high turnover, large numbers of vacancies, and difficulty attracting new employees.
2. The instability of today's LTC workforce has contributed to:
    a. Service access problems and, in many cases, seriously compromised safety, quality-of-care, and quality-of-life for care recipients.
    b. Excessive provider costs due to the need to continuously recruit and train new personnel and use temporary, higher-cost contract staff.
    c. Extreme workloads for both nurses and paraprofessional staff, inadequate supervision, less time for new staff to learn their jobs, and high accident and injury rates exceeding those in the construction and mining industries.
3. As a result of growing demand from the Washington population and a shrinking of the traditional caregiver labor pool, the future of LTC will be immeasurably worse without decisive action by both the public and private sectors.

More recently, PHI—a leading research and policy institute on direct care workforce studies – released their 2024 Direct Care Workforce State Index, an annual report that highlights a state-by-state analysis of the direct care workforce.[1] PHI reported that Washington overall ranked number one in the country, ahead of Rhode Island, Oregon, Maine, and New Jersey (rounding out the top five).

The state was ranked number one on the Worker Supportive Policies Index, which scores both universal state labor policies and policies specific to the direct care workforce. The state was also ranked number six on the Direct Care Workforce Economic Index, which scores livable wages, wage competitiveness, benefits, and access to affordable housing. These favorable rankings are reflective of the commitment that Washington has made to providing quality LTC services and supports for the direct care workforce.[ix]

Despite the exceptional reviews, our state still has significant staffing challenges in the LTC industry that reverberate across the entire healthcare sector. Turnover and low recruitment have directly contributed to the current state of LTC in Washington and across the nation. For decades, insufficient resources and inconsistent approaches to solving staffing problems have been addressed in a host of reports. Past efforts to remedy the needs of the LTC industry have made an impact on aspects of the LTC workforce, but much remains to be done. Remedies for these challenges will be complex and will require a focused, cooperative, collaborative, and sustained effort.

The members of the Long-Term Care Workforce Initiative believe that with the support of state and federal lawmakers, we can make the changes necessary to have a thriving, valued workforce providing quality, empathetic care for Washingtonians who need it.

[1] PHI defines the direct care workforce as Nursing Assistants – Certified (NACs) and Home Care Aides (HCAs).

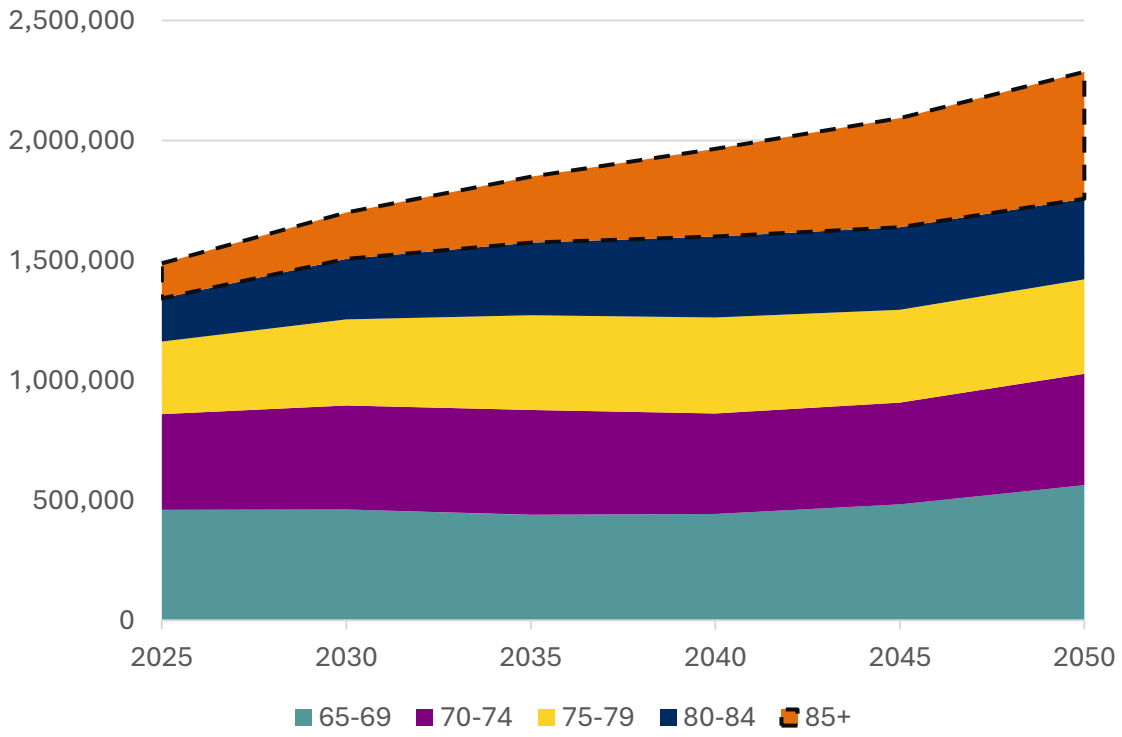
Root Causes of the Long-Term Care Workforce Crisis

Increasing Demand for Long-Term Care

Older Adult Washington Residents

When considering who needs LTC services, the population that comes to mind first is the older adults and aging. The demand for LTC services is rapidly growing in step with the aging population. Washington's population is expected to grow by almost 5 percent from 2025 to 2030 and by 22 percent by 2050. However, the number of residents over the age of 65 will grow by 14 percent from 2025 to 2030 and by 54 percent by 2050. For those over 85, growth is expected to be 33 percent and 263 percent, respectively. This translates from about 146,000 people aged 85+ residing in Washington today to about 530,000 people within the next 25 years (refer to **Chart 1**: Projected Population Growth of Older Adult Age Groups, 2025-2050).[x]

Chart 1: Projected Population Growth of Older Adult Age Groups in Washington, 2025-2050

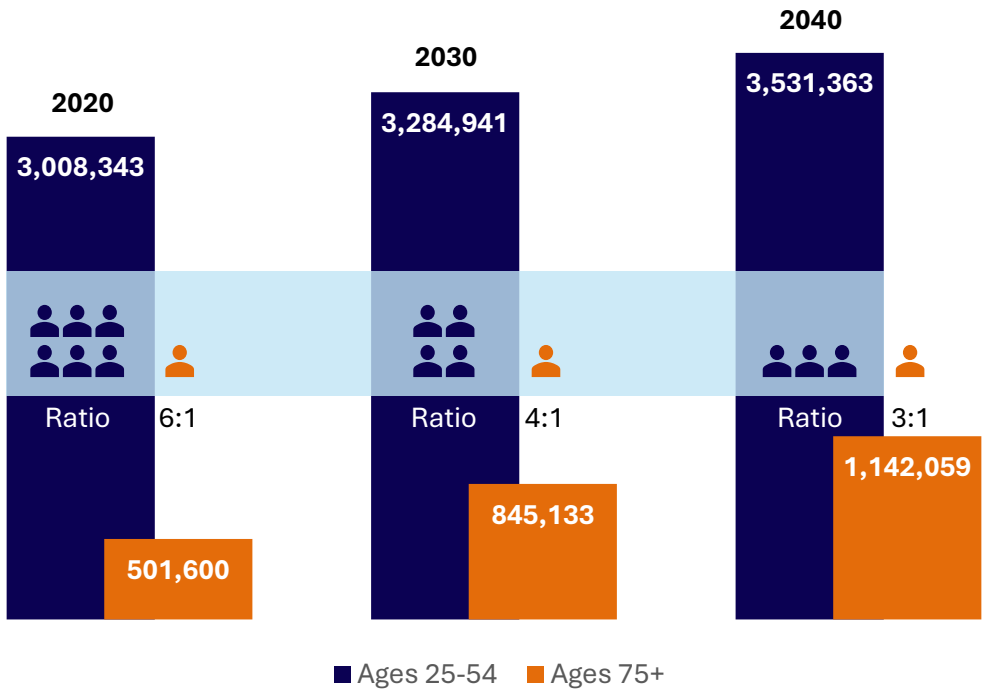


Source: Office of Financial Management, Population Demographics

This dramatic increase in the population aged 85+ is especially significant. The United States Administration on Aging found people aged 85+ are nine times more likely than adults aged 65-74 to live in a nursing home. They also found that 22 percent of those aged 85+ are more than twice as likely to need help with activities of daily living (e.g., eating, bathing, toileting, etc.) compared to adults ages 75–84.[xi] More than half of Washingtonians over the age of 65 are expected to need paid LTC for an average of 3.2 years.[xii]

The disproportionate increase in the older adult population compared to the total population puts strain on adults of working age; many of whom care for both their own children and older adults while balancing a job. Simultaneously, the relative decrease of the working age population compared to the non-working population puts pressure on the taxable base and public resources. Greater economic emphasis will be placed on service sector activities in health care and social assistance in later sections of this report. Refer to **Chart 2**: Projected Dependency Ratio in Washington, 2030-2040).

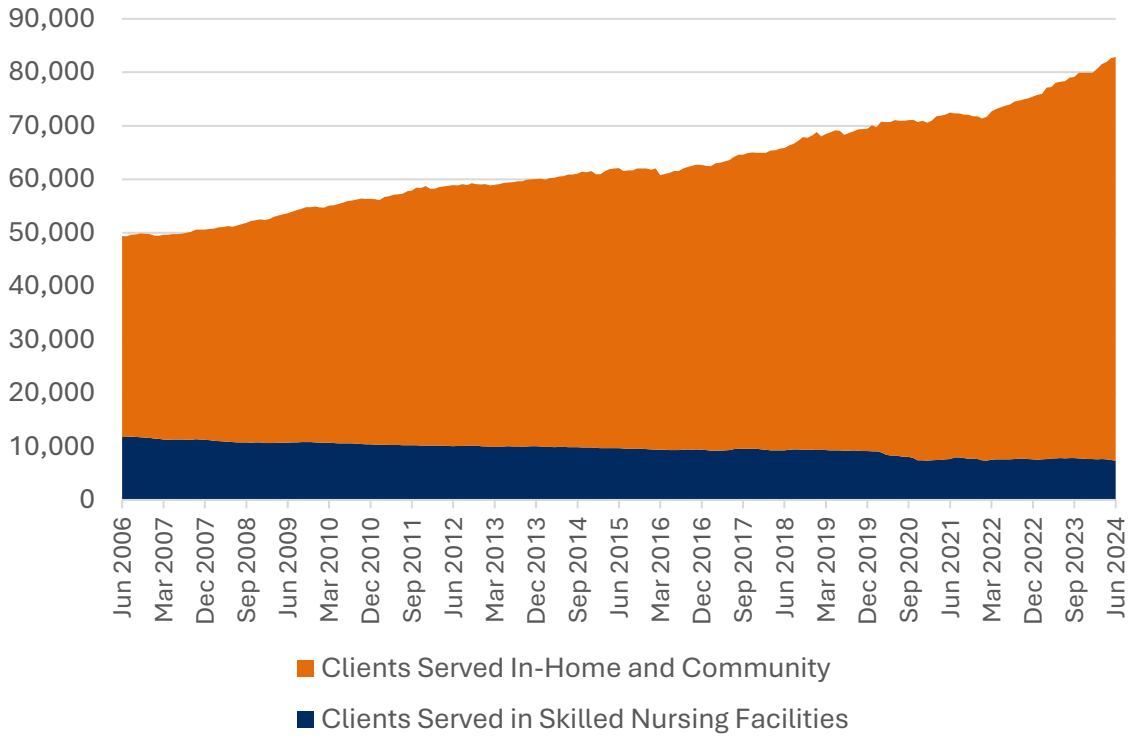
Chart 2: Projected Dependency Ratio in Washington, 2030-2040



Source: Department of Social and Health Services, Aging and Long-Term Support Administration

Aging Washingtonians needing LTC are increasingly residing in in-home and community settings instead of SNFs. This is a positive development in line with the United Nations Principles for Older Persons.[xiii] In-home and community settings tend to be the preferred settings for residents and families and are more cost effective.[xiv] Today, SNFs primarily serve higher acuity clients. The proportion of Department of Social and Health Services Aging and Long-Term Support Administration (DSHS ALTSA) LTC clients, i.e. Medicaid beneficiaries, being served in in-home and community settings has increased from 76 percent in 2006 to 91 percent in 2024. The increase in in-home and community settings is demand driven (refer to **Chart 3**: ALTSA Clients Being Served by Setting in Washington, 2006-2024).

Chart 3: ALTSA Clients Being Served by Setting in Washington, 2006-2024



Source: Aging and Long-Term Support Administration

Individuals with Disabilities

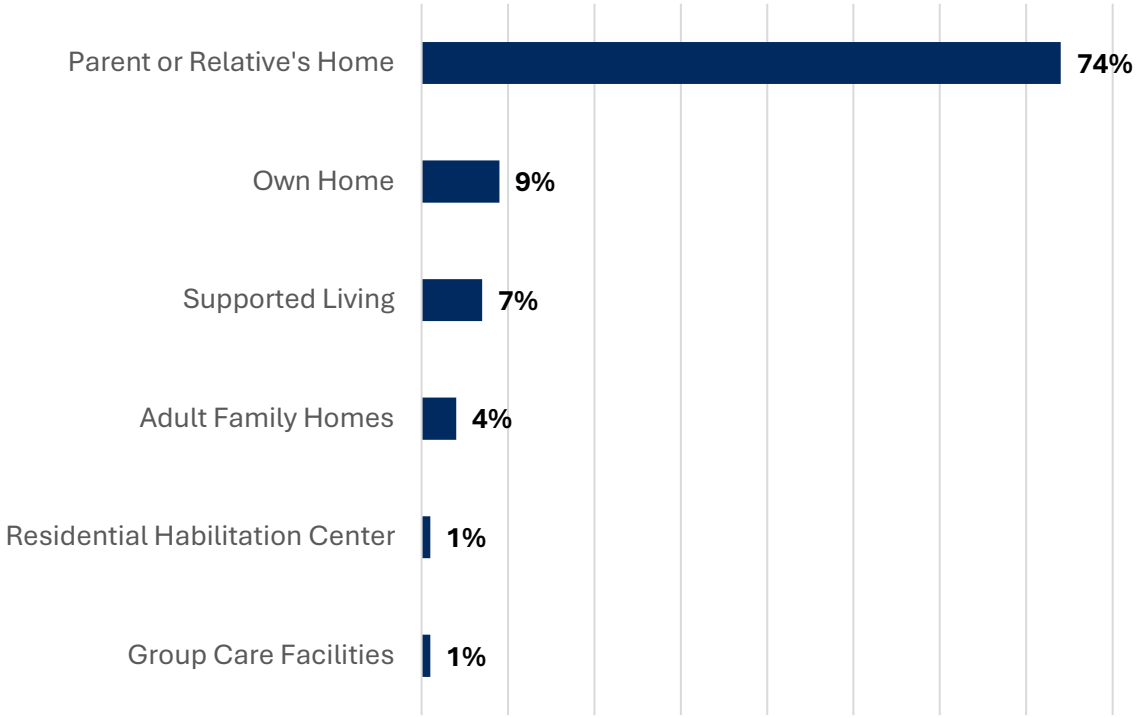
The Centers for Disease Control and Prevention (CDC) estimate that 1.6 million residents in Washington have a form of intellectual, developmental, or physical disability.[xv] Types of disabilities include challenges related to cognition, hearing, vision, mobility, self-care, and independent living.[xvi] These disabilities may arise from a variety of catastrophic injuries or illnesses, congenital complications, or developmental delays. Many of these individuals with disabilities require LTC services to meet their daily needs for living.

As of 2023, there are over 54,000 Washington residents that qualify for services regulated by the DSHS Developmental Disabilities Administration (DDA).[xvii] Approximately 70 percent of DDA clients reside in in-home settings, usually with their parents.[xviii] Family caregivers are a crucial support for those needing LTC, and many of these family caregivers are unpaid – often due to eligibility constraints.

Paid in-home caregivers are typically independent providers (IPs) providing indispensable support and medical care for a range of conditions including attention deficit hyperactivity disorder, autism spectrum disorder, cerebral palsy, hearing loss, fragile X syndrome, Tourette syndrome, and other intellectual, physical, and developmental disabilities.[xix] Every individual diagnosed with an intellectual, physical, or developmental disability is unique in their healthcare needs.[xx] Some individuals require little-to-no care, whereas others require 24-hour care over their lifetime. The care needs of these individuals add yet another layer of complexity to the LTC workforce challenges, and they often reflect the setting in which the individuals reside. Refer to **Chart 4**: DDA

Client Proportions by Setting in Washington.

Chart 4: DDA Client Proportions by Setting in Washington



Source: Developmental Disability Administration

<u>Traumatic Illnesses or Injuries</u>

Previously independent individuals may suffer debilitating illnesses or injuries resulting in paraplegia/quadriplegia or traumatic brain injuries (TBIs) that leave them needing LTC. [xxi] Estimating the numbers of individuals needing care related to TBIs can be difficult. In 2023, there were more than 13,000 TBI emergency room visits, hospitalizations, and incidents of death in Washington[xxii], and statistics indicate that the risk of TBI is dramatically increased for those over the age of 60. In 2023, there were 3,000 TBI cases for this age group alone.[xxiii]

The Long-Term Care Workforce in Washington

Demographics

Washington's LTC workers are often from communities traditionally underrepresented in healthcare professions. For example, according to 2022 US Census data,[2] those identifying as Black or African American make up a disproportionate number of workers in LTC compared to the racial composition of all workers (aged 18-65) in the state, as well as compared to all healthcare workers. Yet the number of Black, Indigenous, and People of Color in nursing positions (across all healthcare areas) decreases as the educational requirements for those nursing positions increase, such as for licensed practical nurse (LPN) and registered nurse (RN) positions. This disparity is especially stark for Hispanics/Latinos (of any race), who, though they make up 13.7 percent of Washington's population, make up only 3 percent of RN positions.

> "There're not a lot of culturally trained caregivers, and not only tribal culture, but also dementia… Training would be amazing to have."
>
> - Direct Care Provider

There is also a disproportionate number of immigrants, both US citizens by naturalization and non-US citizens, working in LTC. US citizens by naturalization and non-US citizens make up 19 percent and 14 percent, respectively, of home care aides (HCAs) and nursing assistants-certified (NACs) in the LTC sector in Washington. Additionally, about 85 percent of the LTC workforce are women, according to the latest US Census data.

Types of Long-Term Care Workers

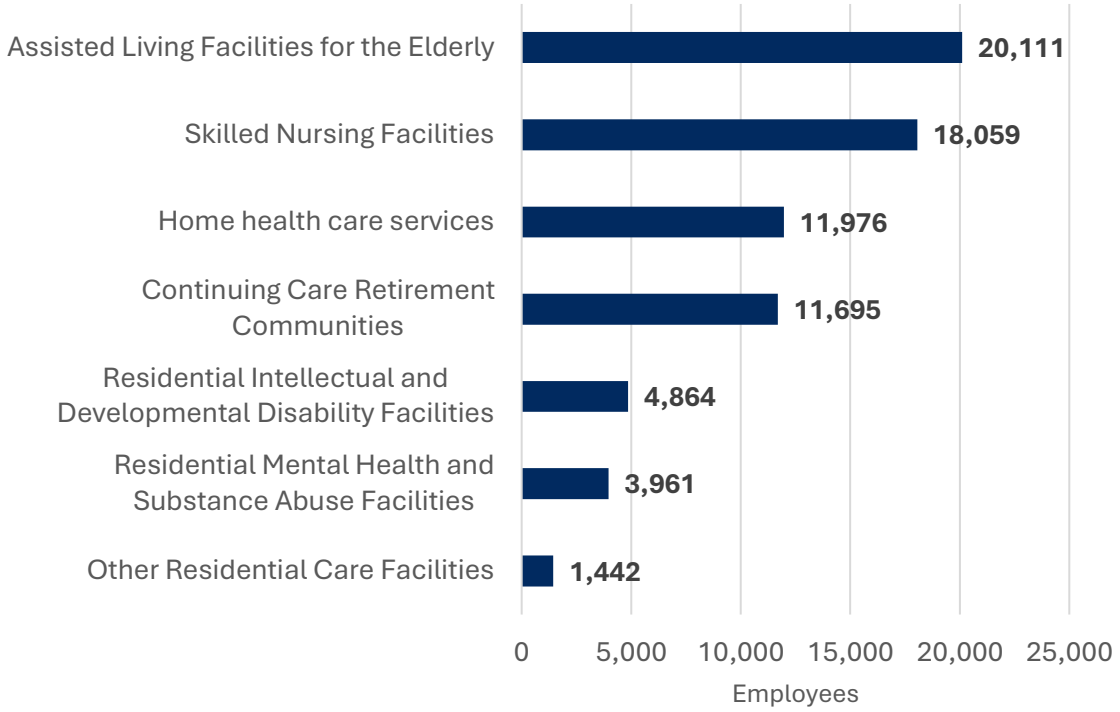
Meeting the needs of the population requires both unpaid caregivers and paid care providers. IPs are the most common caregivers in Washington, both paid IPs (typically HCAs) and unpaid IPs (typically family members). According to DSHS, 72 percent of IPs are family members related to the person served. Traditional nursing roles such as RNs, LPNs, and NACs also provide LTC. And finally, a host of credentialled and non-credentialled professionals working as administrators, housekeepers, cooks, and more provide indirect LTC support. Refer to **Appendix 2**: for Types of LTC Disciplines.

Across all settings, the LTC industry in Washington employs at least 72,000 people, with median earnings of about $50,000 per year (Refer to **Chart 5**: Average Annual Employment by Setting in Washington, 2023). However, this data only includes covered employment[3] for occupations within the LTC industry. The occupational composition differs between both industry type (all healthcare and social assistance sectors) and employer, with substantial differences in earnings by occupation.

[2] The latest available data at the time of writing this report.

[3] Covered employment refers to occupations covered by Unemployment Insurance Benefits.

Chart 5: Average Annual Employment by Setting in Washington, 2023



Source: Employment Security Department, Covered Employment (QCEW)

The occupational focus of this report examines RNs, LPNs, NACs, and HCAs employed within LTC. NACs and HCAs comprise most paid caregivers but are certainly not the only occupation involved in direct and indirect care. Most of these occupations are employed outside of LTC in other healthcare and social assistance sectors.

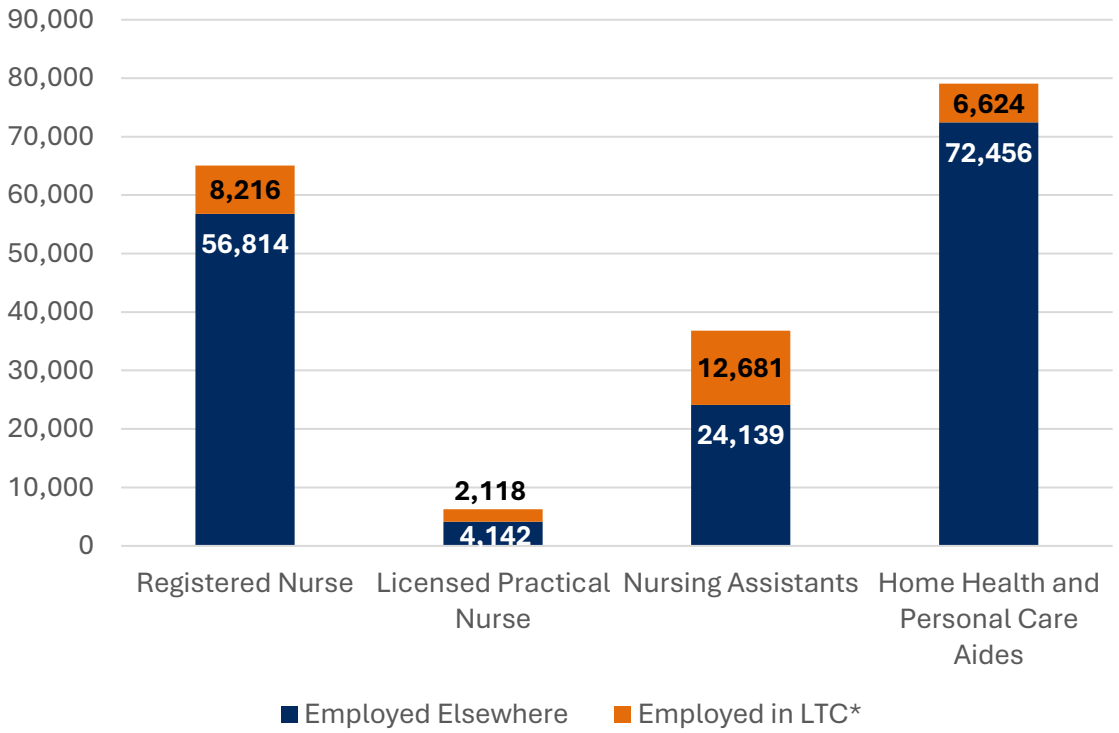
Narrowing the focus on specific roles within the LTC sector is limited by available data. However, new occupational data collected by the Employment Security Department (ESD) through the unemployment insurance system will become available after 2025, which will allow future reports to take a closer, more in-depth look at the LTC workforce. Additionally, ESHB1503 mandates the collection of demographic data for licensees in healthcare. This bill takes effect in January 2025. These efforts will provide a better, more accurate, and timely understanding of the demographics of the healthcare workforce, occupational structures, wages, hours, and employment changes across different settings and geographies.

Other key pieces of information needed for a proper assessment are workforce supply data. This information is often difficult to gauge. For example, NAC licensing was paused in 2023 as the public health emergency from the Covid pandemic ended. The two-year hiatus confounded attempts to determine the current number of NACs across the state. In addition, many nurses obtain NAC licensing despite no intention of practicing as an NAC. The result, licenses do not necessarily reflect the numbers actively engaged in caregiving. This complicates calculations regarding the numbers available versus the numbers projected to meet the demands of the healthcare industry in the state. Additional work is needed to project the future state of the workforce supply and

demand by occupation to more accurately tailor programs to increase entry and retention, particularly for NACs, HCAs and other occupations that are heavily shared across care settings beyond LTC.

Nonetheless, US Census data from the five-year American Community Survey can provide some useful state-level estimates of the LTC workforce—such as hours worked, wages, and demographics—that when combined with ESD's labor market data, provide some interesting insights. Using this method, it is possible to estimate the proportion of specific LTC occupations as a share of the total number of those occupations employed in Washington (refer to **Chart 6**: Estimated Counts of Persons Employed by Occupation in Certain LTC Sectors, 2024).

Chart 6: Estimated Counts of Persons Employed by Occupation in Certain LTC Sectors, 2024



Sources: U.S. Census 5-Year ACS (2017-2022);
ESD 2023 Occupational Employment Statistics survey

Note: The LTC sectors in **Chart 5 include: home health care services, individual and family services, residential care facilities, and skilled nursing facilities. This does not include all employers of independent providers, who are often HCAs. Most HCAs are likely employed in the LTC sector. The US Census data is also less recent than the Occupational Employment Statistics survey data, which means that the share of occupations employed in LTC is underrepresented here. What is clear is that LTC sectors employ a substantial share of these healthcare occupations. New occupational data collected through the ESD Unemployment Insurance system will clarify this data gap.*

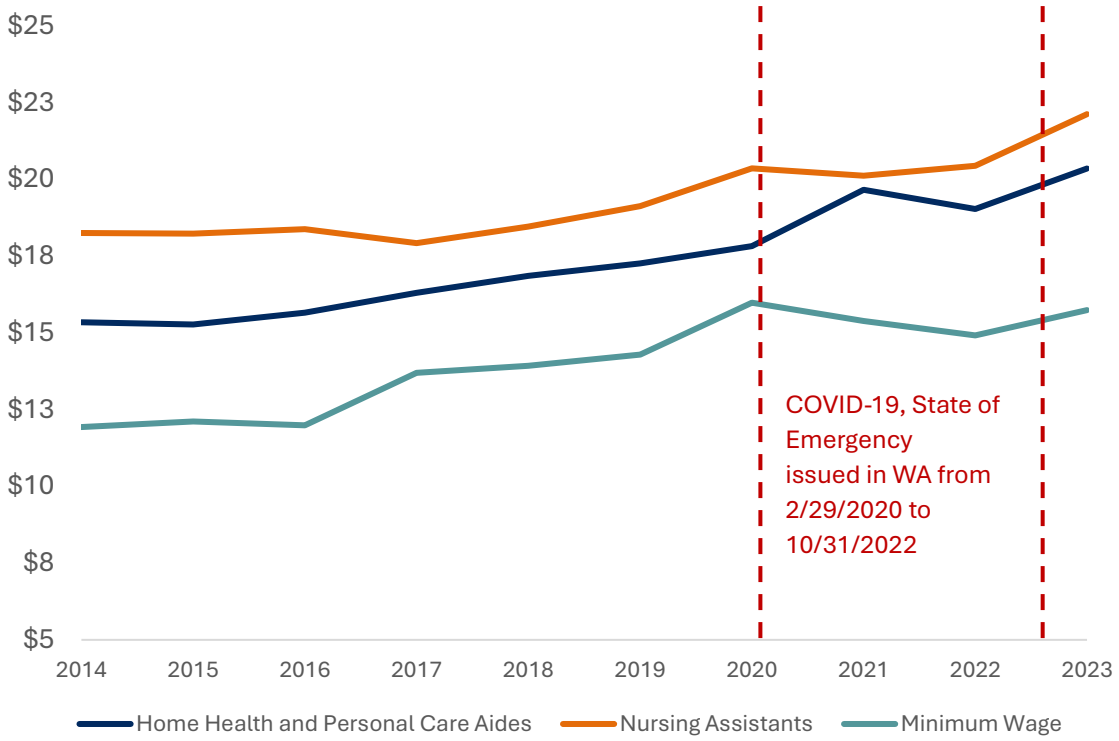
Wages and Benefits

Median earnings for direct care workers in LTC are key barriers to recruitment and retention. According to the US Census, the average individual income for all Washingtonians in the labor force

was $78,640 in 2022.[xxiv] There are some county outliers in terms of earnings, with King County and Benton County being the highest paid. When considering median individual income for only those in the direct care labor force, this figure drops to $52,540.

Median annual earnings for all direct care workers, i.e. NACs and HCAs, are $28,945.[xxv] This is 2.7 times lower than the state average labor force earnings, and just 55 percent of the state median. These earnings result in 28 percent of direct care workers falling within 200 percent of the Federal Poverty Level, which qualifies them for public assistance such as Medicaid, cash transfers, and food and nutritional assistance.[xxvi] Refer to **Chart 7** for Direct Care Worker Median Hourly Wages in Washington, 2014 to 2023.

Chart 7: Direct Care Worker Median Hourly Wages in Washington, 2014 to 2023



Source: PHI. "Workforce Data Center." Last modified September 2024

*Inflation adjusted 2023 USD
* Note: Wages are for NACs and HCAs working in LTC sectors only and do not include hospitals or other acute care service sectors.

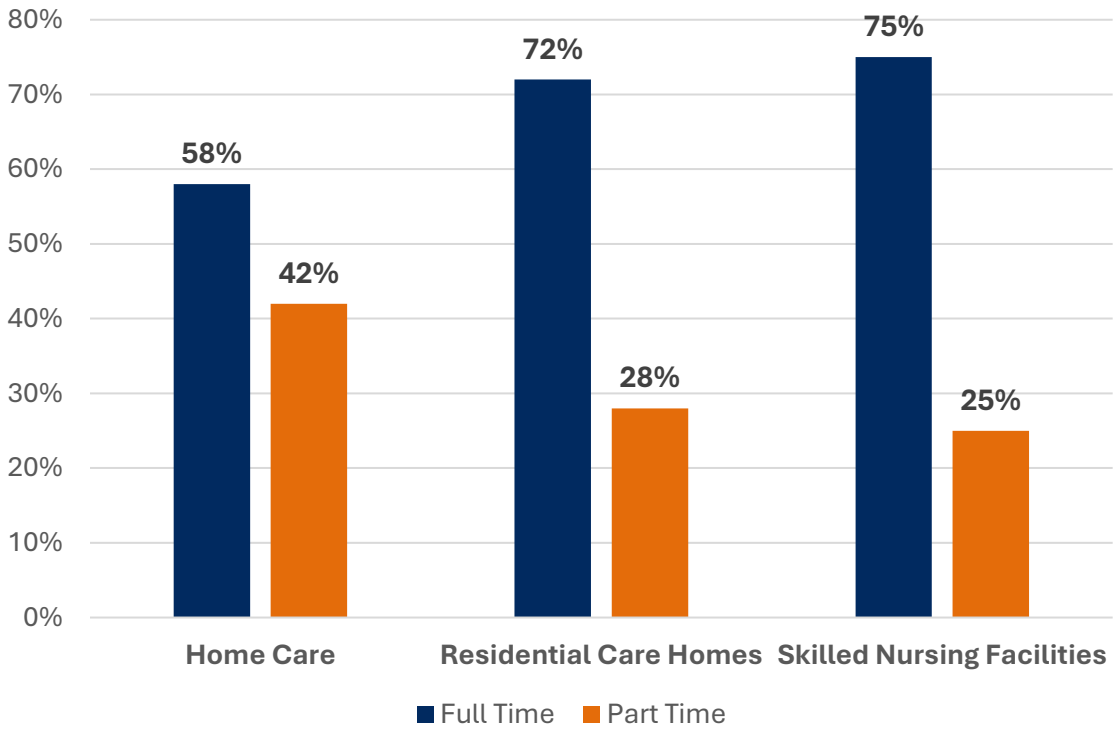
The real earnings gap, adjusted for inflation, between the state minimum wage and the wages of NACs, has barely changed—from $6.32 in 2014 to $6.38 per hour in 2023. This is a change of 0.9 percent. HCAs on the other hand, have seen real earnings increase relative to the minimum wage of $1.20 per hour, which is a 35.2 percent change between 2014 and 2023.

Some of these earnings disparities may be due to the employment status of workers. Many NACs and HCAs, for example, only work part-time. This is not necessarily a preference of the worker.

Based on evidence gleaned from focus groups and business case studies conducted by this Initiative's efforts, many direct care workers would be willing to work more hours but cannot, due to limited available hours or due to their own caregiving responsibilities, as many direct care workers are also parents of young children or care for another relative. (Refer to **Chart 8**: Percentage of Direct Care Workers Employed Full-time or Part-time, 2022).

Another factor contributing to lower earnings occurs when in-home care clients pass away or are admitted to the hospital. When this happens, caregivers face a work disruption resulting in reduced working hours in the pay period and smaller paychecks. This issue is addressed in **Recommendation 1** of this report (Refer to **Appendix 3**: Case Study 3 for more details).

Chart 8: Percentage of Direct Care Workers Employed Full-time or Part-time, 2022



Source: Source: PHI. "Workforce Data Center." Last modified September 2024

Washington has made efforts to address wage issues by allocating nearly $48 million in the 2023 state budget to target wage increases for the lowest-paid jobs in nursing facilities using Medicaid funding. These jobs include direct care workers and indirect care staff, such as dietary, laundry, housekeeping, reception, and transportation roles. This was accomplished by raising the Direct Cost (DC) and Indirect Cost (IDC) medians in the rate setting calculation from 105 percent to 111 percent for DC and from 90 percent to 92 percent for IDC. These rate setting calculations determine the size of Medicaid reimbursements to employers. DSHS has also been directed to work with stakeholders to develop a verification process to demonstrate how providers will use this funding to increase the targeted wages.[xxvii]

Washington is one of only 22 states that adopted a wage pass-through policy. Since 2017, community-based settings are required to use a certain portion of Medicaid reimbursements for raises to direct care workers. A 2024 issue brief from the US Assistant Secretary for Planning and Evaluation reported that this policy was associated with a $0.71 reduction in the hourly wage gap between HCAs and other entry level jobs (in 2019 dollars).[xxviii]

Although wage pass-through polices are found to be effective at increasing hourly rates, they are still insufficient at addressing inadequate direct care worker compensation. In addition, the issue brief concluded that caregivers need to be offered additional support, such as career development opportunities, childcare, paid time off, and mileage, for the field to be competitive. Regarding lack of advancement, Kezia Scales, the Vice President of Research and Evaluation at PHI, explains:

> *"You go in as a home care worker earning a certain wage. You develop all that rich experience and knowledge and skills, and you are still a home care worker earning pretty much the same wage 20 years later."*

Additionally, PHI found that in 2021, 34 percent of direct care workers were housing cost-burdened in Washington, meaning that their housing costs (including rent, mortgage payments, and/or utility bills) exceeded 30 percent of their household's total income.[xxix] That said, considerable improvements in earnings have been made; wages for direct care workers have increased by 26 percent, which is a $4.37 wage increase from 2014 to 2023 (inflation adjusted in 2023 USD).[xxx] (Refer to **Chart 7** Direct Care Worker Median Hourly Wages in Washington).

These findings and recommendations are further supported by business case study research conducted throughout 2024. In addition to expanded compensation, interviews with LTC administrators suggest that organizational leadership and culture play a critical role in retaining staff and satisfying their needs (refer to **Appendix 3** for Case Studies 1, 2, and 3).

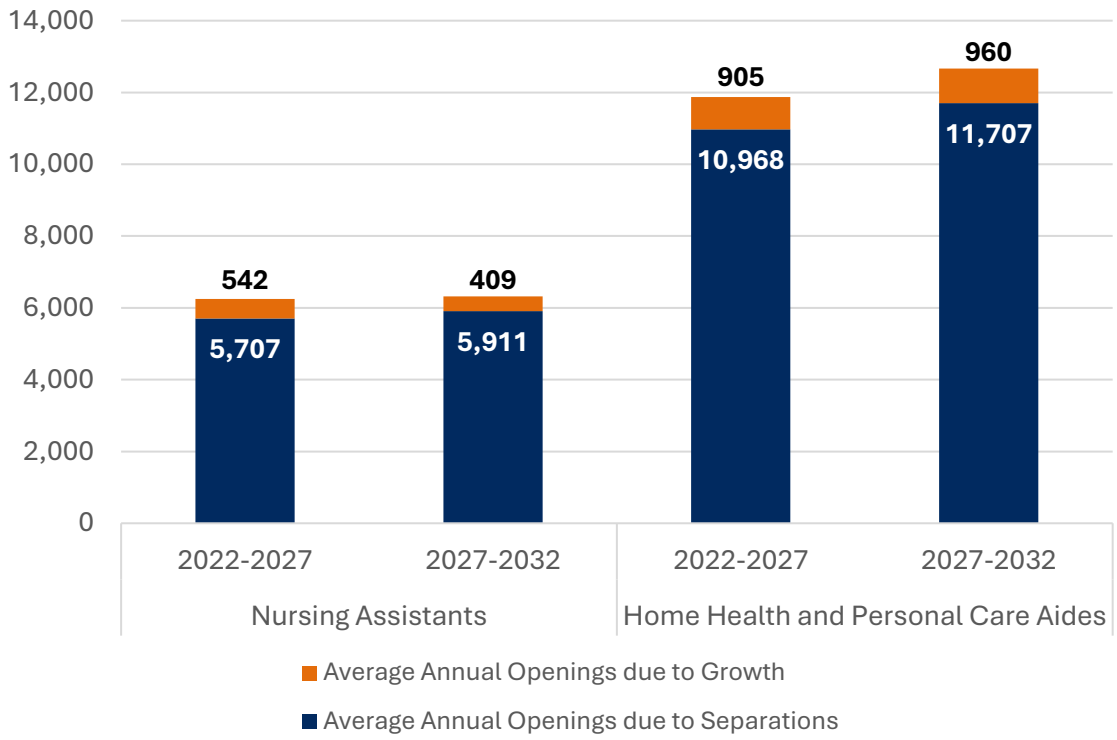
<u>Turnover</u>

LTC is a growing industry in Washington. NACs and HCAs, for example, are the backbone of direct care—and are some of the fastest growing occupations in the United States.[xxxi] These workers are often underpaid, over-worked, and under-valued. The annual turnover rate for these workers is around 50 percent, which has detrimental effects on quality-of-care outcomes for patients and residents. High turnover is a serious impediment to providing high-quality LTC services. Centers for Medicare and Medicaid Services (CMS) has found an annual turnover rate of 52% for direct care nursing staff at SNFs.[xxxii] A study published in the Journal of the American Geriatric Society found "higher turnover was consistently associated with lower quality-of-care."[xxxiii]

> "Basically, the problem is that people are quitting their jobs because people are sick of it. I get told a couple times a month that I'm being fired because I've done something wrong on tabulating hours, something that's really not important."
>
> – Direct Care Worker

The LTC sector struggles to meet service demand while also filling vacancies due to separation (refer to **Chart 9**: Projected Annual Job Openings for Nursing Assistants and Home Health and Personal Care Aides in Washington).

Chart 9: Projected Annual Job Openings for Nursing Assistants and Home Health and Personal Care Aides in Washington



Source: Washington State Employee Security Department, Projections

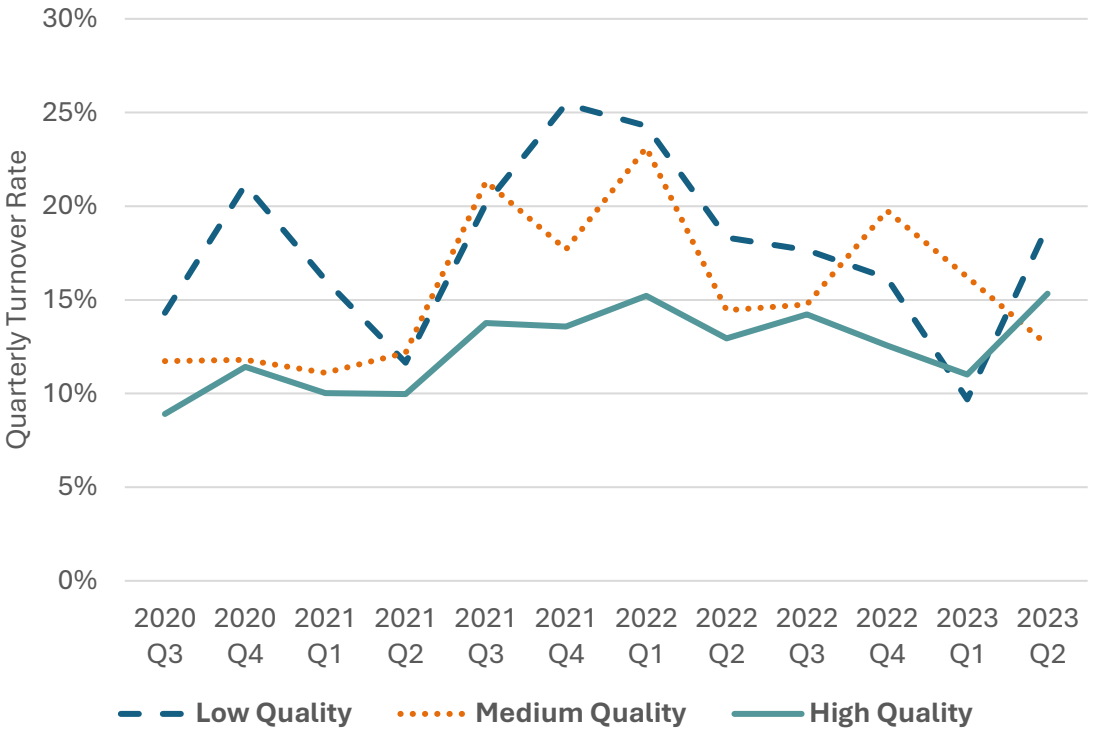
In order to examine turnover in LTC in Washington, the Workforce Board and the University of Washington Center for Health Workforce Studies (UW CHWS) have partnered on a quantitative investigation. However, due to data limitations, findings from this are based on Payroll-Based Journal (PBJ) data for SNFs, which are required to report workforce data to CMS. Other settings, such as assisted living facilities and adult family homes, are not subject to these regulations. An analysis of the data shows no improvement in quarterly turnover rates for direct care nursing staff in SNFs over the past several years (refer to **Charts 10 and 11** for turnover proportions by job category for direct care nursing staff and RN administrative roles in Washington).[4]

The data also point to a correlation between turnover proportions of direct care workers in different facilities and quality-of-care ratings. Facilities with a high quality-of-care rating[5] (4 or 5 stars) tend to have lower rates of turnover than facilities with a medium (3 stars) or low (1 or 2 stars) quality-of-care rating. (See **Chart 10** for quarterly turnover rates of NACs by quality-of-care rating of SNFs and **Charts 11 & 12** for LPN, RN and RN Administrative role turnover by quality-of-care rating). Refer to **Appendix 4**: Methodological Details.

[4] Longitudinal data going further back are unavailable due to limitations on the type of data previously collected.

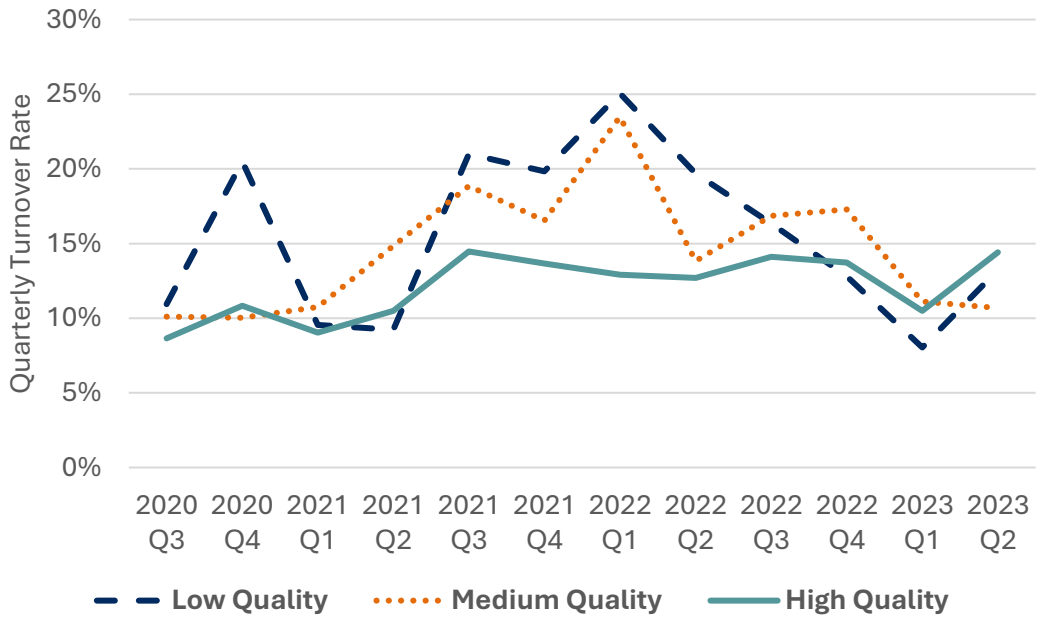
[5] Nursing homes with 5 stars are considered to have much higher-than-average quality and nursing homes with 1 star are considered to have much lower-than-average quality. There is one overall 5-star rating for each nursing home, and there are separate ratings for health inspections, staffing, and quality measures.

Chart 10. NAC Quarterly Turnover Rates by Quality-of-Care Rating of SNFs, 2020 Q4 – 2023 Q2.



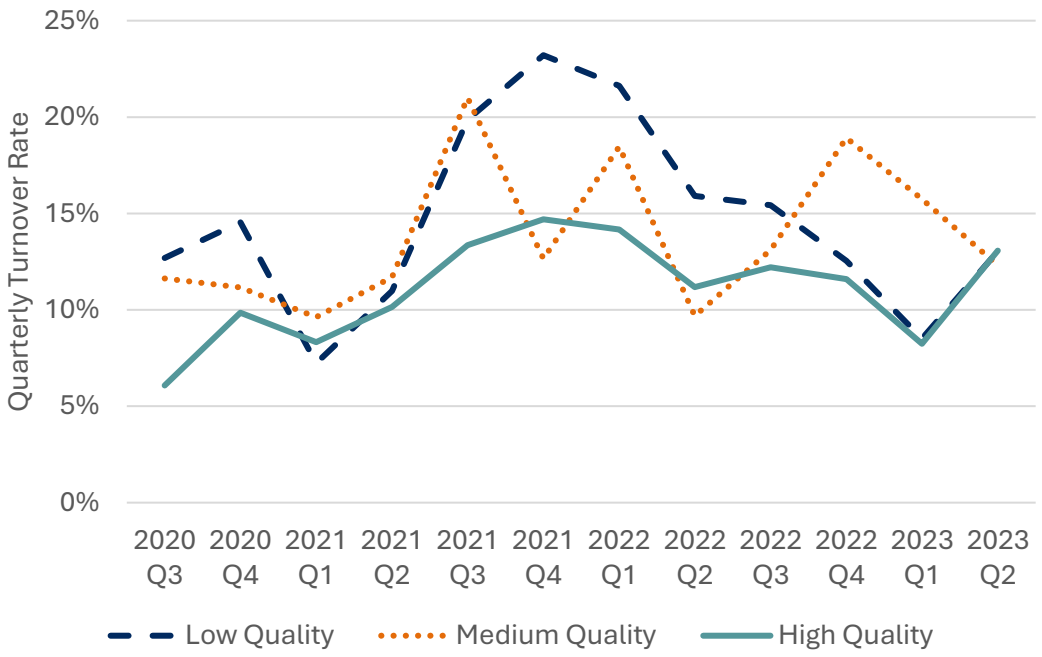
Source: UW CHWS analysis of Medicare Payroll Based Journal Data

Chart 11: LPN Quarterly Turnover Rates by Quality-of-Care Rating of SNFs, 2020 Q4 – 2023 Q2.



Source: UW CHWS analysis of Medicare Payroll Based Journal Data

Chart 12: RN and RN Admin. Quarterly Turnover Rates by Quality-of-Care Rating of SNFs, 2020 Q4 – 2023 Q2.



Source: UW CHWS analysis of Medicare Payroll Based Journal Data

> "There're so many things to like about working in a skilled nursing facility. You get to meet a lot of people. My favorite thing is seeing a resident come to your facility and then they get to go home, they get rehabilitated."
>
> – Direct Care Worker

Among the 192 SNFs in Washington, the average proportion of nursing staff that turned over between June 2020 and May 2023 ranged from 3 percent to over 65 percent. When examining relationships between turnover and quality during this time, we found that turnover was independently associated with lower quality-of-care in SNFs, even when accounting for differences in overall staffing levels and facility characteristics such as size, profit status, payer mix, in-hospital versus freestanding location, chain status, and urban versus rural location. Specifically, a 5 percent increase in the proportion of nursing staff that turned over was associated with a statistically significant 28.4 percent reduction in the number of quarters with high quality-of-care (4 or 5 star) ratings.

Salary Disparities Between Industries

A substantial level of turnover is possibly due to workers leaving the LTC sector for higher paying jobs of the same occupation elsewhere in healthcare or in higher paying LTC settings, such as SNFs (refer to **Table 1**: Earnings Comparisons between Occupation and Industry).

Table 1: Earnings Comparisons between Occupation and Industry

Average Earnings	RN	LPN	NAC	HCA
Across All Industries	$115,525	$78,463	$48,443	$43,821
Skilled Nursing Facilities	$71,157	$65,210	$29,242	-
Residential Care Facilities	$53,665	$41,903	$31,178	-
Individual and Family Services	$55,223	-	$32,170	$23,894
Home Health Care Services	$71,326	$35,982	$26,722	$25,936

Note: Inflation adjusted to 2024 USD
Note: Small sample sizes for certain industries and occupations prohibit accurate estimation of wages and have been excluded (n < 200)

Source: US Census 5-Year ACS (2017-2022) and ESD QCEW (2024)

A direct care worker from a stakeholder group convened through a recent RTI (a non-profit research institute) study commissioned by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the US Department of Health & Human Services to investigate State Efforts to Improve Direct Care Workforce Wages noted:[xxxiv]

> *"There's less reason to be a CNA if you can leave and go work in fast food or retail for a similar amount of money."*

This is a valid argument. The retail industry—characterized by low barriers to entry into the workforce—offers similar hourly wages to the LTC sector. In Washington, average hourly wages for all retail workers are $22.77, and for entry-level positions within the industry, such as a cashier or retail salesperson, average hourly wages are $18.35 and 20.23 (inflation adjusted).[xxxv] Average hourly wages for all direct care workers in Washington are only slightly higher at $20.48 per hour (inflation adjusted).[xxxvi] Industry turnover rates for home health care services, SNFs, and assisted living facilities are, not surprisingly, also like that of retail trade.[6] Turnover among leadership can also create feelings of instability among staff members. Leadership professionals, such as nursing home administrators, leave their positions after a little more than a year on average.[xxxvii] Burnout, a lack of resources, and difficulty with corporate management were all cited as factors contributing to turnover.[xxxviii] With high rates of turnover, institutional knowledge and existing relationships with those receiving care is continually lost, ultimately leaving workers and providers dedicating more and more resources to training new staff.

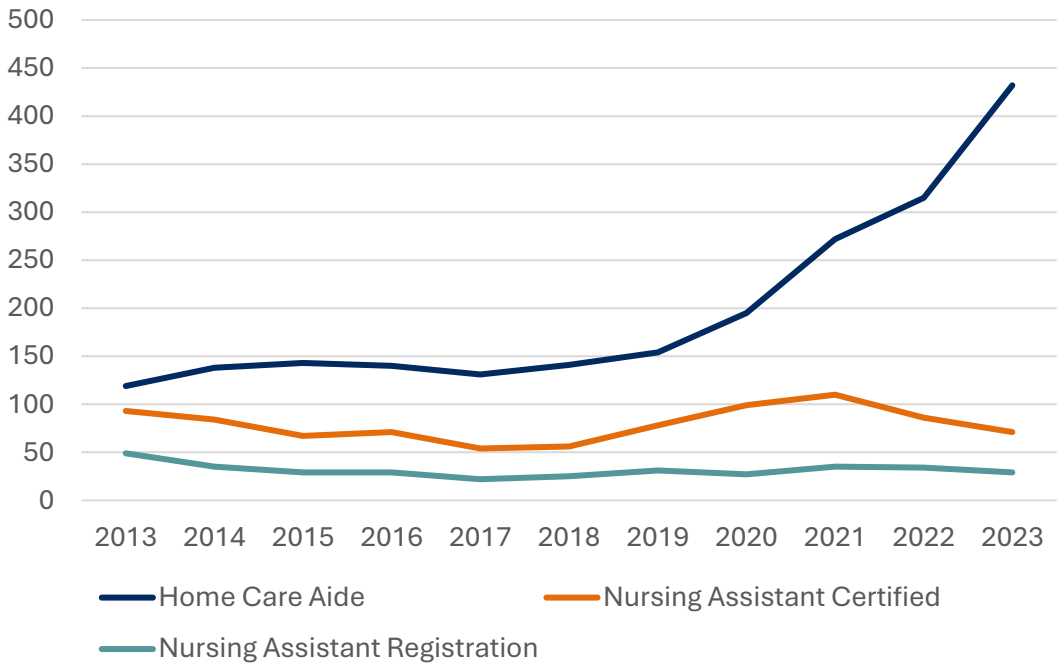
[6] US Census, Quarterly Workforce Indicators, 2024

Recruitment and Retention

Costs borne by workers may be an additional factor impacting recruitment and retention. The annual fee to be a certified in-home caregiver in Washington is $100.[xxxix] The licensing fee for NAC ($95) which is >LPN ($93). Two-part skills exams also add cost ($100 for NACs). If this could be incorporated into the training, it reduces the timeline to licensing and cost to student. For HCAs, it would take 140 hours of work to offset this cost even with the average wage pass through. HCA and NAC academic programs have an average tuition of $680 and $1,163 respectively with program durations of 2-6 weeks depending on the program intensity.[xl] Delays in certification, which are more acute for HCAs, can further hinder onboarding, resulting in some workers quitting before their credential to practice is issued (refer to **Chart 12**: Average Days to Issue Credentials by Year).

> "I have a lot of challenges. One is burnout. There are a lot of people working a lot of hours, and it's really bad… Another one is trauma. People go through a lot of things at work and see a lot of things. You cannot expect them not to feel anything. It's like expecting water to not be wet. My third one is moral injury. This is something that goes against your moral code of ethics. [I have a friend who works at an agency in New York], and during COVID he was told, 'Don't go in there. Just sit there, you're getting paid, and go home after your shift'."
>
> – Direct Care Worker

Chart 12: Average Days to Issue Credential by Year



Source: WA Department of Health

UW CHWS, in partnership with the Workforce Board, further investigated these workforce issues through a series of in-depth interviews with a representative sample of the HCA workforce, the majority of whom are IPs, for the preliminary findings reported below (refer to **Appendix 4**: Methodological Details). HCAs from the interviews identified three areas of challenges to enter and remain in the LTC workforce: *administrative burdens, training,* and *work conditions*.

Challenge 1: Administrative Burdens

Administrative burdens included communication barriers, lack of interagency coordination, complex administrative processes, and regulatory challenges that reduced HCAs' job efficiency and increased their stress.

One key challenge reported by participants was communication barriers. Many HCAs experienced unclear and delayed responses when seeking information or assistance related to paperwork, training, and other processes related to entering the workforce or maintaining their job. This issue was compounded by the lack of reliable, designated staff available to answer questions or address their needs, leaving workers unsure of and confused about where to turn for support or clarification:

> *"The communication was really poor as far as **what the requirements were and whether or not there is or is not a possibility to get an extension [for the training]** .... the union was like, "Yeah, we provide the training. But we can't give you an extension. It has to be through DDA to give you an extension, or DOH." And then I would call them, and they would say, "No, absolutely not. It's CDWA. We pay CDWA as the agency to handle all this stuff." So, I would call CDWA and then they'd say, "It's the union who's providing the training." So, **there was this loop of me going through all these people. For the last month, that's been my life, just calling these people**."*

These communication barriers were closely interrelated with lack of interagency coordination, especially since the transition to the Consumer Direct Care Network Washington (CDWA) for management of recruitment, payroll, and monitoring credentials for HCAs who are independent providers. CDWA is the consumer directed employer for DSHS. CDWA employs thousands of IPs who provide in-home personal care and respite services.

HCAs frequently depend on information scattered across different agencies and websites, making it difficult to access the resources they need. Furthermore, the lack of an integrated tracking system further complicates their ability to efficiently manage tasks such as tracking work hour limits or required training, adding to the administrative burden.

HCAs also face significant obstacles due to complex administrative processes that often slow down essential tasks, creating additional layers of difficulty for workers. The following quote illustrates these administrative difficulties with the application process:

> *"If you want to become an individual provider, which pays much better, honestly, and it's more flexible, which I find most caregivers want all that flexibility, then **it just takes a long time because you apply with CDWA, then you have to wait for somebody to finally process that and then get you to the next step.** And then the fingerprint signing, and if you don't remember to send them the email with the 10-digit code from the fingerprint appointment that you signed up for, well, now it's 30 days before you hear back saying, "Oh, are you still interested?" And you're like, "Yeah, I already did my fingerprints." And they're like, "Well, we needed you to email us the code, so we're going to have to go back and reprocess that. Do you have the code?" Most people don't keep that. They don't keep the screenshot. **So, guess what? Now they're starting that over.**"*

Navigating evolving regulations adds to the administrative burden, making it harder for HCAs to stay compliant and focus on their primary caregiving responsibilities. These burdens were frequently cited as main reasons for stress and dissatisfaction in the workforce. Over time, these challenges can erode job satisfaction, making it difficult for employees to focus on meaningful work, ultimately contributing to burnout and higher turnover rates. Several participants also reported that these challenges serve as barriers to recruitment:

> "*People do throw in a towel because it's very frustrating and it takes so long to just get started and they're like, it's just not worth it. It's not worth the 20 bucks, $21 an hour or 20 whatever they start at now, 20 bucks. They're like, 'I'm going to McDonald's and make that now.*"

Challenge 2: Training

Required training to enter and remain in the workforce presents another set of challenges for HCAs. First, many HCAs expressed difficulties in accessing these training courses, including being unable to register for required in-person training due to registration caps, an insufficient number of trainings available within a given time frame, and inconvenient times and locations. One participant stated:

> *"There's so many organizations involved and there's the union and there's the Consumer Direct of Washington, and she [another caregiver] literally couldn't get any training classes and so they suspended her for two weeks while she tried to work through that."*

Another example included the difficulties with getting compensated for continuing education hours. Details were described by this participant:

> *"...the training partnership through the union has to upload your stuff, which takes almost 30 days now to say, yep, she's completed everything. Then once that's done, then their computer system triggers something and then it has to be sent over to CDWA. And then CDWA's whoever department has to check off a box saying we've received word that says she's done it. So yes, she's done it. And then the next person puts a thing in saying that an authorization, they put an authorization in. Then you can go in under your admin balance and you can see that your continuing education is available to claim.* ***So, from the time you put in all 12 hours doing your CE to the time hopefully you end up actually getting paid is around two months****."*

Some HCAs also faced barriers related to technology or lacking the necessary tools to participate in online training as described in this quote:

> *"I have one caregiver who doesn't have internet, doesn't have a computer. She happens to be one of them that works for an agency, so she can go into the agency office and use the computer and take the training. But like I said, a lot of caregivers, they don't make a lot of money, so there's a lot of them that don't have internet, don't have computers, and difficult when most of the training now is online."*

Other participants expressed concerns about the relevance of the training content. Some felt the material didn't align with the complex and unique needs of their clients, as it often focused on populations or scenarios unrelated to their work. Additionally, some participants found the training sessions overwhelming, with dense information that was hard to retain, creating further barriers to workforce entry.

One participant explained:

> *"It was a lot of information in a short period of time. And I know that quite a few of my classmates did not pass. I'm still in contact with them, and they still, they're not caregivers anymore because they said it's just too much to cut through."*

Challenge 3: Work Conditions

UW CHWS found that caregivers experience job difficulties due to their work environment. The individualized and home-based nature of the job made direct care workers feel isolated and unsupported, especially when dealing with difficult client interactions or unsafe environments. The following quote demonstrates these challenges, which are compounded by the lack of individualized and consistent support:

> *"You're supposed to take breaks as an employee. That's part of state law. And when I got to work in this particular household with the children, the mom corrected me really quickly and was like, "No, no, no. You don't take breaks when you take care of other people." And I've not really had anybody to go to, to be like, "Is that right?" And now, I'm just really struggling not having any breaks of any kind. All just work hours and hours and hours and start to just feel like I'm descending into a Saturday sometimes without any breaks."*

Other challenges reported by participants included difficulties that go beyond their work environment. Participants faced unpaid costs such as mileage, travel time, and overtime without compensation which added to their stress and further strained their financial situation. Some HCAs indicated that the instability of benefits such as health insurance made it harder for workers to feel secure and valued in their roles.

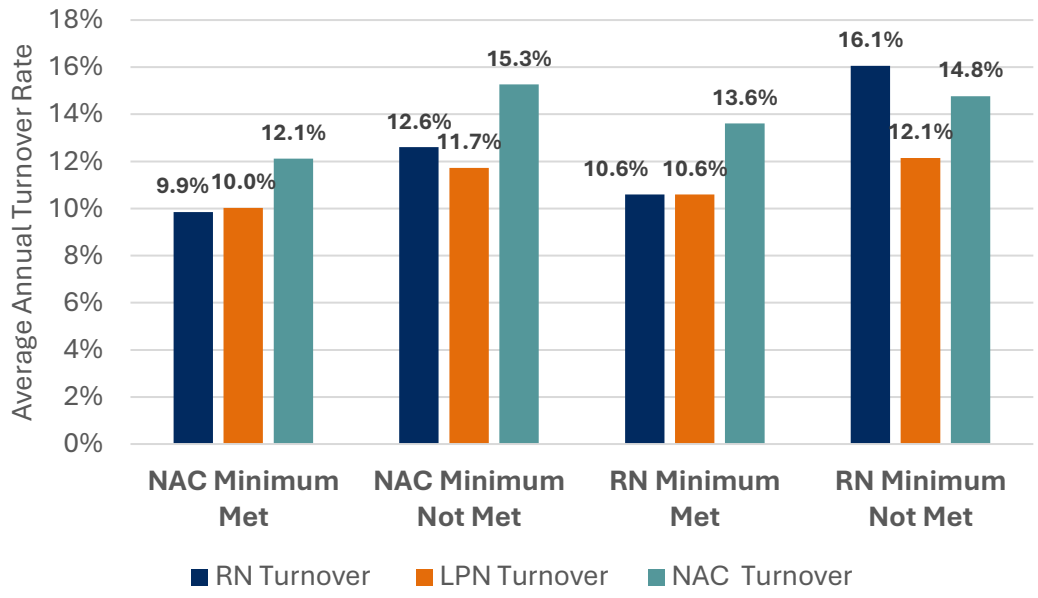
Proposed Minimum Staffing

Another issue of turnover is the potential impact that federally mandated minimum staffing standards by CMS would have on care outcomes.[xli] Higher ratios of staff-to-resident days are shown to improve quality-of-care outcomes. The proposed staffing standards would increase the number of staff hours per resident day. However, the federal model does not reflect the high quality of care or valuable workforce contributions provided by LPNs. The marginalization of LPNs may discourage growth of this workforce as evidenced by a decline in LPN enrollment. With fewer workforce roles, a heavier reliance is placed on the remaining professions. In the end, the new standards could result in unintended consequences that would negate such improvements and be burdensome for SNFs already struggling with turnover.

UW CHWS found higher average turnover rates during quarters in which the proposed minimum staffing requirements were not met (refer to **Chart 13** for turnover rates by standards met, and **Chart 14** for compliance met by hours per resident day (HRPRD)); further evidence that retention is

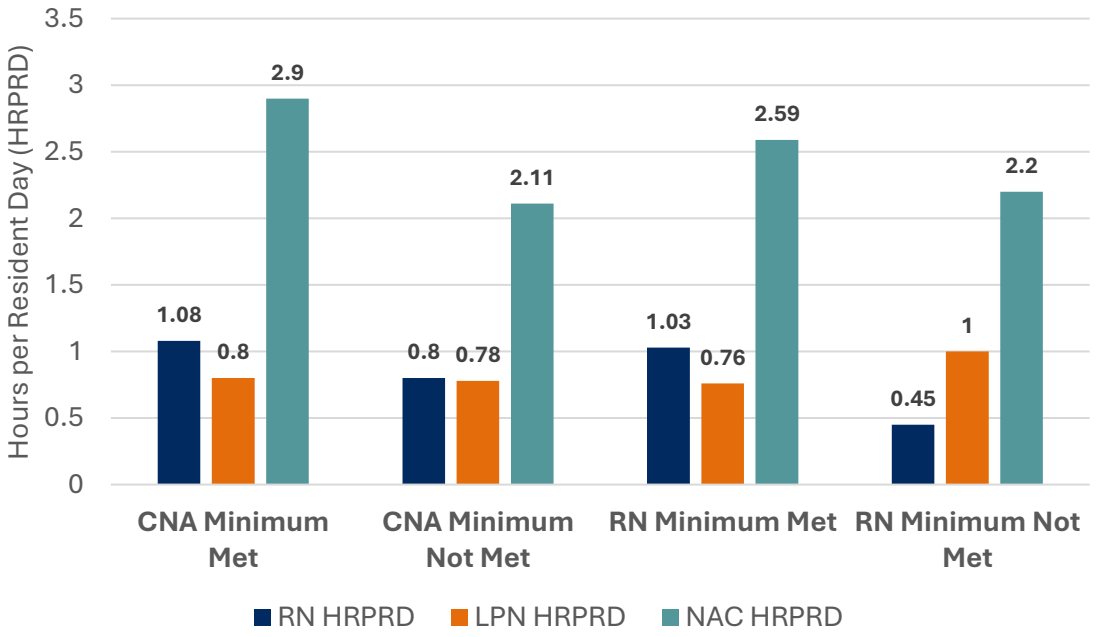
an important driver of meeting such requirements, and by extension, achieving higher quality-of-care outcomes.

Chart 13: SNF Turnover Rates by Occupation and Compliance with Federal Proposed Staffing Minimums, 2023



Source: UW CHWS analysis of Medicare Payroll Based Journal Data

Chart 14: SNF HRPRD by Occupation and Compliance with Federal Proposed Staffing Minimums, 2023

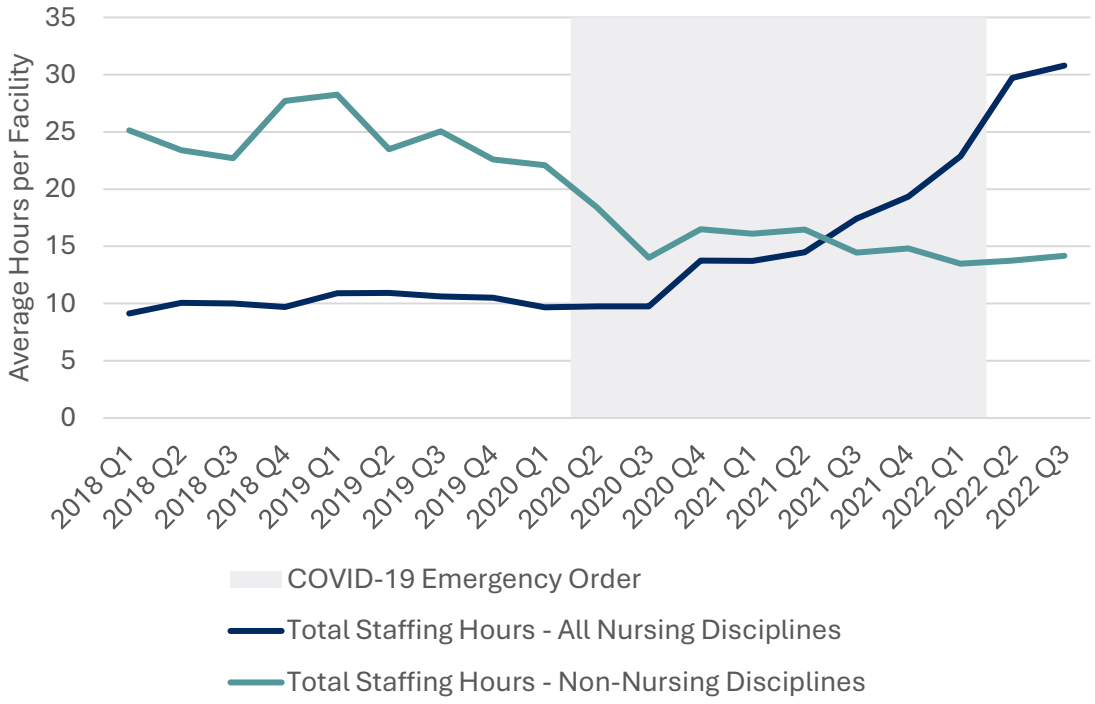


Source: UW CHWS analysis of Medicare Payroll Based Journal Data

Contract Staffing

SNFs have had to increasingly rely on contractors to fill the gaps in nursing staff shortages since the pandemic (refer to **Chart 15**: Average Contractor Staffing Hours in Washington SNFs). Temporary staffing is expensive. Private staffing agencies can charge as much as 50 percent more per hour than permanent employees. Pay discrepancies between temporary and permanent staff can create further workplace tensions and exacerbate turnover.[xlii] .[xliii] Furthermore, many facilities reported losing permanent staff to staffing agencies due to higher wages and more flexible scheduling. Ultimately, the lack of continuity in staffing also contributes to lower quality due to less familiarity with residents/facility culture and procedures.

Chart 15: Average Contractor Staffing Hours in Washington SNFs



Source: UW CHWS analysis of Medicare Payroll Based Journal Data

Direct Care and Indirect Care Worker Positions Have the Longest Vacancy Times

Washington's Health Workforce Sentinel Network is a joint project of the Health Workforce Council and UW CHWS. The Sentinel Network publishes biannual self-report surveys of employers' workforce needs. These include related to recruitment, retention, and in-demand skills.

Assisted living facilities and SNFs are both represented in Sentinel Network survey responses. Consistently, both types of settings report the greatest difficulty and longest durations filling vacancies for direct care and indirect care workers (Refer to **Charts 16 and 17** for top occupations with exceptionally long vacancies for SNFs and assisted living facilities, respectively).

Chart 16: Top Occupations with Exceptionally Long Vacancies – Skilled Nursing Facilities

Top occupations with exceptionally long vacancies*							
Rank	Fall 2020	Spring 2021	Fall 2021	Spring 2022	Fall 2022	Spring 2023	Fall 2023
1	Nursing assistant	Registered nurse	Registered nurse	Registered nurse	Nursing assistant	Registered nurse	Registered nurse
2	Registered nurse	Nursing assistant	Licensed practical nurse Nursing assistant	Licensed practical nurse	Licensed practical nurse Registered nurse	Licensed practical nurse Nursing assistant	Licensed practical nurse
3	Licensed practical nurse	Licensed practical nurse	Occupational therapist Physical therapist	Nursing assistant	Cook / Food services	Cook / Food services	Nursing assistant
4	Occupational therapy assistant Physical therapist Physical therapy assistant	Occupational therapist Physical therapist Social worker Speech-language therapist	Speech-language therapist	Cook / Food services	Dietitian / Nutritionist	Environmental Services Occupational therapy assistant	Occupational therapist Physical therapist

← Most cited

Source: Health Workforce Council Sentinel Network

Chart 17: Top Occupations with Exceptionally Long Vacancies – Assisted Living Facilities

Top occupations cited as having exceptionally long vacancies*							
Rank	Fall 2020	Spring 2021	Fall 2021	Spring 2022	Fall 2022	Spring 2023	Fall 2023
1	Nursing assistant	Nursing assistant	Nursing assistant	Nursing assistant	Licensed practical nurse Registered nurse	Nursing assistant	Nursing assistant
2	Licensed practical nurse	Licensed practical nurse	Registered nurse	Cook / Food services	Nursing assistant	Cook / Food services Home health aide or home care aide	Cook / Food services
3	Registered nurse	Registered nurse Personal care aide	Home health aide or home care aide	Home health aide or home care aide Licensed practical nurse	Cook / Food services	Environmental services	Home health aide or home care aide Licensed practical nurse
4	Home health aide or home care aide	Cook / Food services Home health aide or home care aide	Licensed practical nurse	Registered nurse	Home health aide or home care aide	Multiple occupations cited at the same frequency	Environmental Services Registered nurse Personal care aide
5	Personal care aide Cook / Food services Housekeeping	n/a	Personal care aide	Environmental services	Environmental services		Multiple occupations cited at the same frequency

← Most cited

Source: Health Workforce Council Sentinel Network

Historic Response to LTC Challenges in Washington

LTC workforce challenges, though much more critical today, are not new. In the early 1980s, faced with a demographic projection that the number of Washingtonians over age 65 was poised to double, the state became an early adopter of new federal opportunities to support people with significant disabilities in their homes and similar environments. The formula was simple. People with disabilities, older adults, and their families preferred to receive services in their own homes where they were close to family, friends, and pets—and where they could live meaningful lives by participating in their communities and in family events. They would be able to maximize their self-determination and keep as much control as possible over the daily decisions impacting them.

> "Everywhere you go, the frontline caregiver is the most important person in the building. But do they feel valued? Are we investing into them, in education access? Because I believe the organization can only grow as much as the people."
>
> – Direct Care Provider

State policymakers and budget writers made changes to the law with budget appropriations aligned with what Washingtonians and their families wanted. On average, in-home LTC services were far less expensive for those only requiring support on an "as-needed" basis instead of costly around-the-clock care in institutions when that level of care was not always necessary.

> "My daughter is 24 years old today, and I care for her… I sometimes cannot work outside the home… If I can't care for her, who's going to care for her? … You can't just take someone off the street to do this job…. Being a parent provider is not easy. I love my daughter to death, and I will do anything for my daughter…[but] I get burnt out just like every other caregiver."
>
> – Direct Care Worker

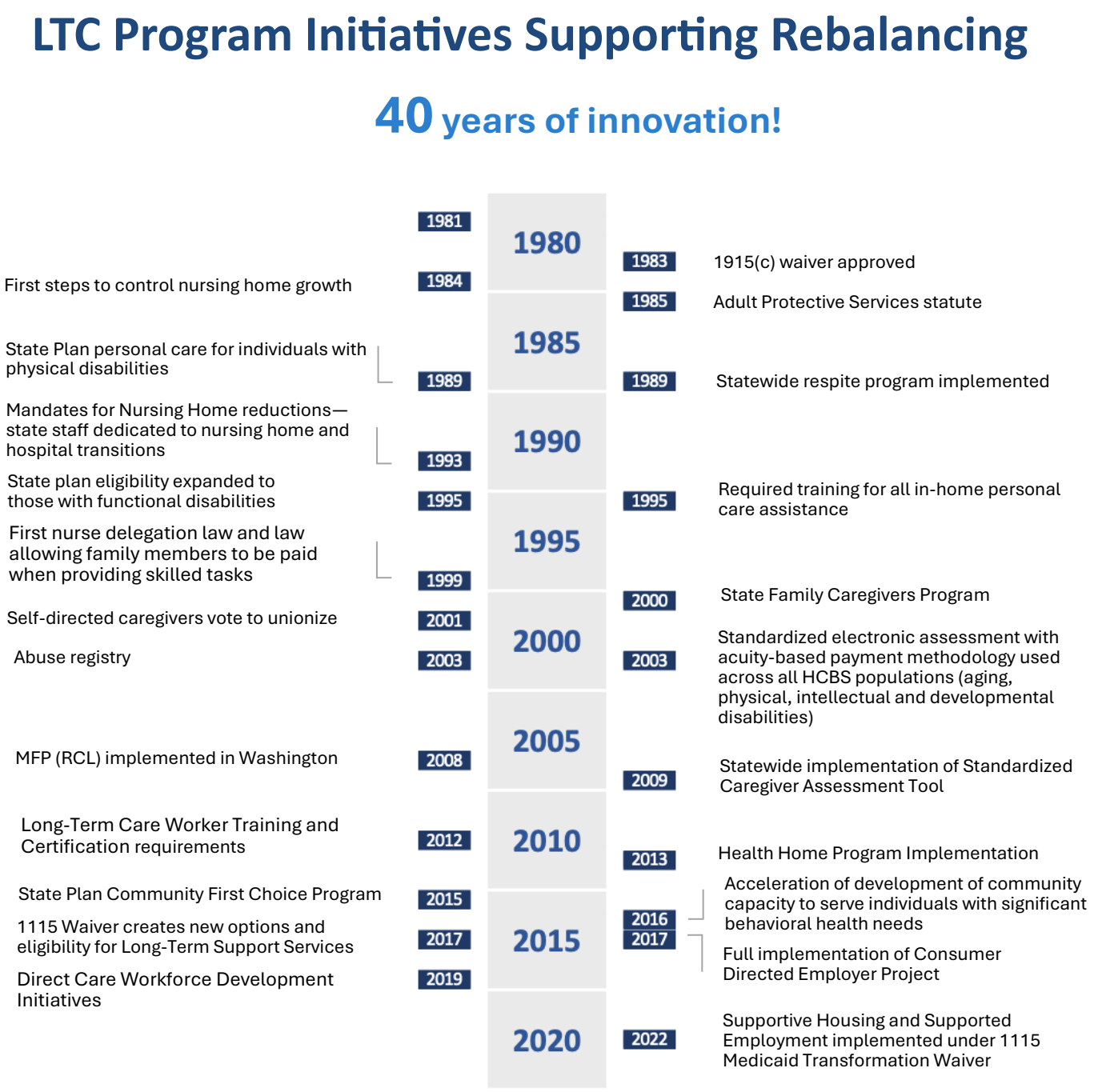
In 1995, the Legislature passed a statute that directed further development of LTC support systems providing choice and flexibility. It was paired with reductions in nursing home beds for both Medicaid and non-Medicaid clients. At that time, roughly 53 percent of all individuals receiving Medicaid-funded LTC received their services in a SNF.[xliv]

This rebalancing of Medicaid-funded care helped the state adopt a primarily "aging-at-home" model, focused on the customer's quality-of-daily-life. The state created the HCA position with a training program and funded the SEIU 775 Benefits Group to support the 40,000 IPs. A network of community trainers was also developed to support LTC worker training not covered under labor agreements with SEIU 775. By funding the training of these IPs, the state made in-home care more accessible. Washington was lauded nationally for its model, which proved to lower the cost of LTC, make services more accessible, and increase satisfaction ratings from care recipients and their family members.[xlv]

> "I'm part of the family. They share with me what's going on."
>
> – Direct Care Worker

Since that time, multiple governors and many state legislators have supported legislative innovations with appropriations to create a responsive service delivery system. These include statewide training and a certification for HCAs that is portable across settings and funding sources. It is the only certification of its kind in the nation (refer to **Figure 1**: Historical timeline of LTC Services Innovation in Washington).

Figure 1: Historical timeline of LTC Services Innovation in Washington



This program allows workers to begin work with five hours of training and then complete the remaining 70 hours of training while they are working. Most employers pay for the training and the certification exam, which is available in 12 languages to reflect the diversity of individuals who make up the direct care workforce.[xlvi]

Washington's success in this arena has made the state a national leader. 91% of individuals receiving Medicaid-funded LTC are served in their own home or in community residential settings such as adult family homes, assisted living facilities, and enhanced services facilities.[xlvii] Three quarters of these individuals live in their own homes. Further, Washington is consistently ranked in the top two states by AARP due to its high-performing system of LTC services and supports (Long-Term Services and Supports State Scorecard).

The policy solutions described above alleviated past LTC dilemmas but have lost potency over time as the proportion of those not in the labor force has grown, meaning there are relatively fewer people of working age now both in terms of a taxable labor pool and available of caregivers.

LTC Workforce Initiative Successes

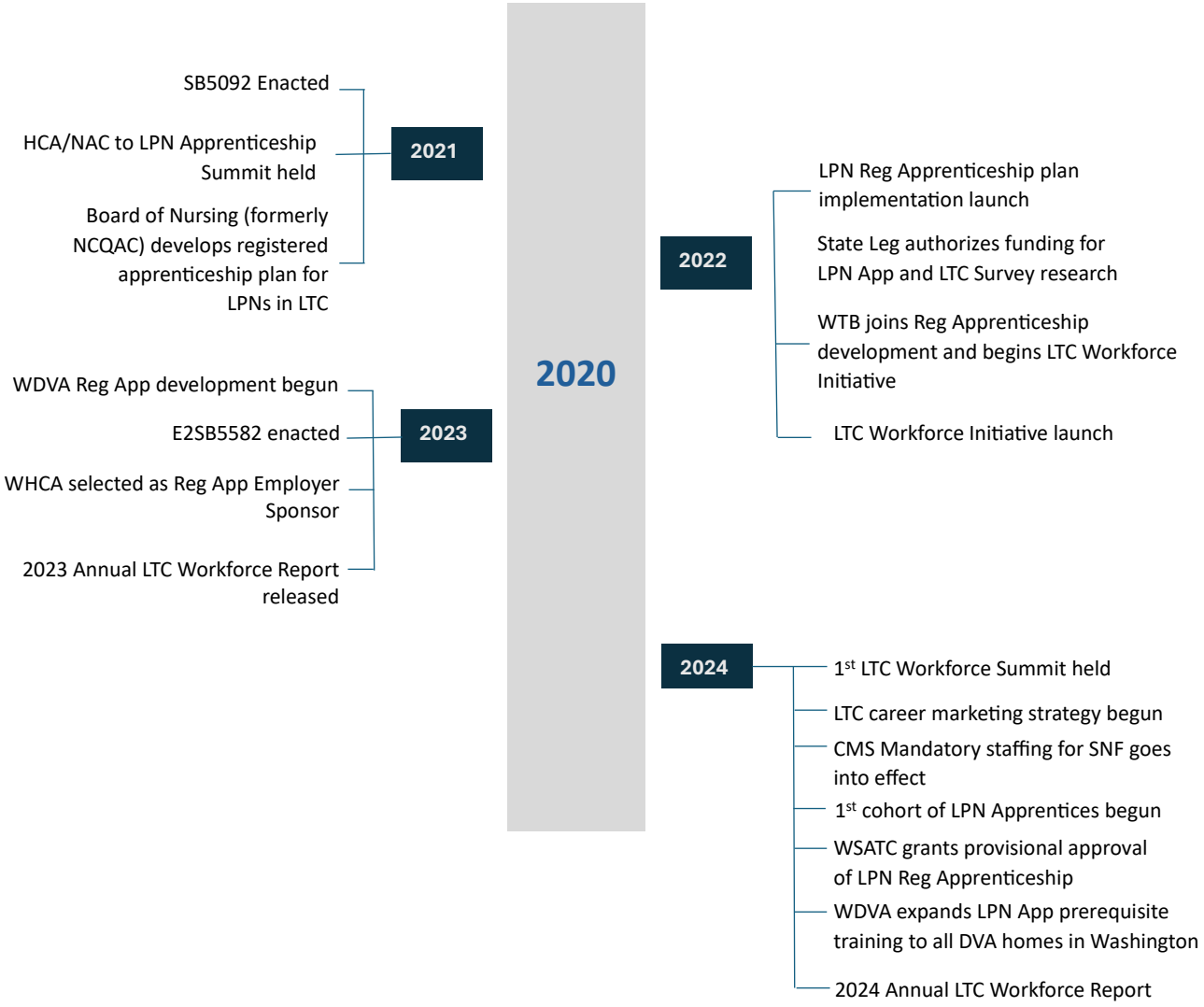
Figure 2 shows Washington's recent progress towards addressing the LTC workforce crisis. Persistent challenges related to stabilizing the LTC workforce remain. Keeping in line with the state's progressive approaches to LTC, the LTC Workforce Initiative is a research-based, stakeholder-led approach to investigate the root causes of the workforce crisis and identify actionable solutions.

Current State of Long-Term Care

Long-term caregivers in Washington are struggling. Current caregivers are emotionally and physically taxed. While Washington has specific training regulations in place, the industry faces continued challenges with training and testing delivery. Many issues contribute: existing staff shortages, inflexible work environments, insufficient Medicaid reimbursement rates, low pay and benefits, uncertain hours, a lack of acknowledgement of direct care workers as a critical part of the healthcare delivery system, and the impacts of regulatory oversight that can feel punitive rather than solutions focused.

Services are often delayed and/or are not available in a customer's chosen form (e.g., home care vs. facility care). Washington's LTC provider community continues to offer a range of care options supported by a professional workforce that is engaged and committed to providing quality services. Facilities, agencies, and caregivers provide compassionate, skilled care, often through innovative programs for their staff as well as those receiving care.

Figure 2: Historical description of LTC Workforce efforts in Washington since 2020



The 2022 state budget authorized two efforts related to the LTC workforce through the Workforce Board. Both efforts have focused on efforts to recruit, hire, train, license, and retain LTC staff across the state. The first established research-supported efforts to develop sustainable solutions to the LTC workforce challenges. The Workforce Board convened a broad-based coalition to contribute their expertise to develop solutions to LTC workforce challenges. This coalition makes up the LTC Workforce Initiative. The second authorized project established a Nursing Assistant-Certified (NAC) to Licensed Practical Nurse (LPN) Registered Apprenticeship Program within the broader LTC Workforce Initiative. This first-of-its-kind program in the United States launched its first cohort of participants in September 2024.

In two years, both efforts have produced numerous successes that are indicative of the collaborative efforts of Initiative partners and their willingness to see both what is and what can be.

1. LPN Registered Apprenticeship Pilot Program

This innovative program is designed to create access to a nursing career track. The program is intended to attract and retain talent in long-term care (LTC) professions within the state of Washington while expanding the number of Licensed Practical Nurses in skilled nursing facilities. It is also designed to provide a career path in nursing to individuals who might not otherwise have that opportunity based on socio-economic conditions. Students have the benefit of this unique part-time practical nurse training that is connected to on-the-job training with their employer. Employers provide journey level LPNs to support and provide one-to-one mentorship to the apprentice. Clinical skills that are being taught academically are being practiced in the work environment with the oversight of preceptors.

Senate Bill 5092 (2021) provided the legislative charge for WABON to lead the development and plan the necessary infrastructure to launch an LPN Apprenticeship pilot. Specifically, the legislature designated it as a home care aide-to-nursing assistant-to-licensed practical nurse (HCA-NAC-LPN) registered apprenticeship pilot designed to reach students in at least three geographical areas of the state. The legislation awarded funding and directed that WABON work in collaboration with Labor & Industries (LNI) and the Workforce Board with a focus on LTC facilities experiencing staffing shortages. The pilot also received federally legislated funding in 2022—sponsored by Representative Dan Newhouse and Senator Patty Murray and awarded through the Human Resources and Services Administration (HRSA) after being signed off by President Biden as part of the "Community Project Funding / Congressionally Directed Spending" initiative. The work on development of the LPN Apprenticeship pilot began with a WABON hosted summit in October 2021.

Background

On November 9, 2023, WHCA Apprentice, LLC was awarded a contract and $500,000 in grant funds through the Workforce Training and Education Coordinating Board to design and implement a Licensed Practical Nurse (LPN) Registered Apprenticeship Program (LPN RAP) to address the long-term care workforce. Funding for this effort was established by the Washington State Legislature and Governor through ESSB 5187, Chapter 475, Laws of 2023.

Washington Health Care Association (WHCA) is the parent organization of WHCA Apprentice, LLC, which serves as the program sponsor. While WHCA is a trade association representing skilled nursing facilities, participation in the apprenticeship program is open to all skilled nursing facilities in Washington regardless of trade association affiliation or membership. State oversight of the program is three-pronged. In addition to the Workforce Board, it includes oversight through WABON and L&I.

Overview

The LPN Apprenticeship pilot program consists of:

- One Related Supplemental Instruction (RSI) Provider (academic): Edmonds College was the only academic provider to have a curriculum approved by WABON and is the contracted RSI Provider.
- Six Training Agents (employers): Skilled nursing facilities are contracted to provide employment, on the job training, and onsite clinicals to the apprentices in the program.
- Four Training Agents have active apprentices in the 2024 cohort.
- Five apprentices are in the 2024 cohort. Eight apprentices began classes in September. Two withdrew from the apprenticeship program before it was registered on October 17. A third failed first quarter, thereby losing eligibility for the program.

The program currently has two dedicated FTEs, a program manager and a program assistant, and utilizes administrative oversight and centralized operational services through an inter-company agreement with the parent organization, WHCA.

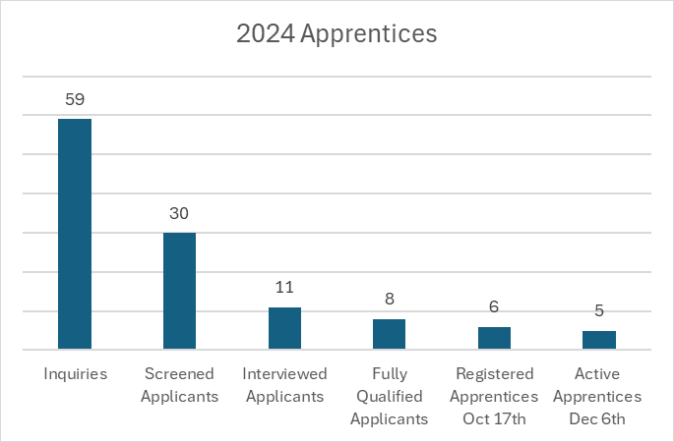
Infrastructure Development

Developing the LPN RAP in ten short months and having an infrastructure in place for the first cohort to begin September 2024 has been a significant undertaking. The sponsor was charged with ensuring compliance with all applicable federal, state, and local rules and laws including those specific to Department of Health (Practical and Registered Nursing) and to L&I (Apprenticeship). The abbreviated timeline and the complexity of multiple layers of agency regulations and law impacted the infrastructure of the program as follows:

- Because of the clinical skills requirements of practical nurse credentialing, the pilot was isolated to skilled nursing facilities as employers. While other long-term care settings were explored, it was found that residential settings do not provide the necessary opportunities for the apprentice to learn and practice the needed skills on the job.
- Remote labs were placed on hold. The academic RSI Provider did not have the capacity to design and establish remote labs in participating skilled nursing facilities within the timeframe available. The concept proved to be too complex to be fully vetted and negotiated alongside other more critical contract negotiations that were underway. The sponsor grappled with operational and fiscal challenges, e.g., if labs were placed in employer facilities, but equipment and infrastructure were paid for by an outside source, who would own the labs and what would happen to the equipment and technology if the facility terminated participation in the program? Funds for remote labs were not included in the sponsor's contract and therefore fell outside of the sponsor's negotiating realm. The sponsor made the difficult call to put remote labs on hold with a plan to revisit the topic for a future cohort. Instead, labs for the 2024 cohort are all held at Edmonds College campus, limiting apprentice participation to a commutable distance from Edmonds.

- The application process for the first cohort of apprentices mirrored minimum qualifications and timeline of the Edmonds College Practical Nursing program. Initially, the deadline was set for mid-June, but later it was extended by two months. The sponsor reviewed apprentice applications and conducted apprentice interviews, while simultaneously searching for and negotiating with facilities for the role of providing employment and on the job training to potential apprentices as contracted training agents.
- Because there was only one academic provider with WABON-approved Related Supplemental Instruction (RSI) curriculum, the sponsor deferred to the entrance criteria and academic requirements of the RSI Provider, Edmonds College. For example, grade requirements for the apprenticeship pilot were set to match the grade requirements that the RSI Provider had for its traditional PN program.
- On October 17, the Washington State Apprenticeship & Training Council (WSATC) voted in favor of approving the LTC-LPN Apprenticeship program standards. Six apprentices were registered and granted credit for OJT and coursework completed to date.

Cohort One: 2024



In April of 2024, WHCA Apprentice, LLC launched a web interface and began to market the apprenticeship program via social media, WHCA newsletters and through WABON with the goal of facilitating applications and completing the screening process in June. Because infrastructure was still under development and training agents had not yet been identified, the sponsor made the decision to build an ongoing inquiry that would allow potential applicants to interface with staff, ask questions, and seek direction to apply for the program. Once an application was received, sponsor staff worked with the RSI provider to screen the candidate making sure that all criteria were met. Criteria included an application to the Edmonds College PN program, prerequisite GPA requirements, an application to financial aid, and minimum grades on the standardized exam for nursing school applicants (TEAS test).

While thirty applicants were received, many did not meet the screening criteria. Eight apprentices were approved to begin coursework in September. Since classes began, three apprentices have left the program. As of December 2024, cohort one is made up of five individuals with diverse backgrounds and from various walks of life. Current apprentices range from age 25 to 41. Eighty percent of cohort one apprentices identify as mixed race or a person of color with representation of:

- Black/African American
- Hispanic/Latino/Spanish
- American Indian/Alaska Native
- Asian

- Native Hawaiian or other Pacific Islander

Four of the five apprentices reported themselves as head of household, with three reporting that they were responsible for providing care to a child/children or health care support for someone in their household.

Apprentice Attrition

Since the program's launch on September 23, three individuals have exited the apprenticeship.

- In October, one apprentice chose to leave to remain in a non-patient-facing director position at their facility. Program requirements stipulate that apprentices must work in a patient-facing NAC role.
- Another apprentice left in October due to unwillingness to meet the shift requirements of their training agent, seeking to work no more than one shift per week. Apprentices are expected to work 21–25 hours weekly to stay on track with their OJT.
- In December, one apprentice was removed from the cohort after failing to achieve the required 3.0 grade in the NURS 115 class, a program requirement.

Prior to program commencement, eight apprentice candidates completed a needs survey to provide demographic and support data. Analysis of the three apprentices who left the program revealed common trends:

- All had over 10 years of NAC experience.
- All transitioned from roles with higher wages than NAC positions, such as Medical Assistant and Director of Activities.
- Based on this initial review, apprentices with more dependents appear more likely to leave the program. The average number of dependents among the initial September starting cohort was 2 per apprentice, while those who exited averaged approximately 2.66 dependents.
- All three cited financial concerns.

Additionally, certain challenges were identified by individual apprentices who exited: lack of reliable internet, absence of a support system entering the program, and reliance on public transportation.

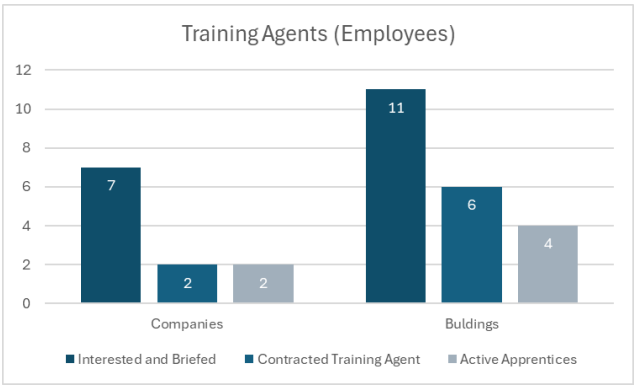
Apprentice Wraparounds

Recognizing that apprentices are supporting others, working, going to college and are required to maintain 80 percent or better score in all academic classes, the sponsor of the program felt it important to provide an optimal opportunity for the apprentice to succeed. A limitation of thirty-five work hours per week was set for apprentices during the academic year in contracts with the employers (training agents). This could negatively impact the financial wellness of the apprentices so the sponsor has set up “wraparounds” in the form of needs grants and hardship funds for which the apprentices may apply. Other standard supports are included in the program for cohort one including coverage of fifty percent of tuition and academic fees, equipment and scrubs, and the availability of loaner computers.

Two apprentices were awarded hardship grant funding in the first quarter of the program. One apprentice received housing support in the form of a rent payment for a month. Another apprentice received transportation support through a month of rental car usage.

Employers (Training Agents)

In April, the Sponsor began soliciting skilled nursing facilities to participate in the program as training agents. The sponsor briefed seven companies with approximately eleven buildings that could be good candidates to serve as employers in the program. The sponsor considered proximity to Edmonds college, the quality scores of the buildings, and the likelihood that the provider could provide a positive experience for the apprentice. While all eleven companies expressed support and interest, several felt the program was too risky or costly. Barriers to entry identified by employers included the following:



- Costs of paying higher wages to the apprentice and potentially backfilling for LPNs and/or preceptors while they provide 1:1 oversight, training, and clinicals, outweighed the costs of simply paying full tuition for an employee to go through a standard LPN program.
- Concerns about additional scrutiny from surveyors who may not understand the program and therefore question the apprentice's role in the building and/or the supervisory structure for this individual.
- Being able to meet the state's staffing mandates and pending federal staffing mandates when LPNs/RNs were pulled from their regularly scheduled duties to attend meetings with the college and while they were providing 1:1 oversight or clinical instruction to the apprentice.
- Additional liability exposure should something go wrong during patient care provided by an apprentice.
- One facility signed an agreement and had an apprentice not qualify for the program. To date, they have chosen to remain training agents with the consideration that they may have apprentices on-site in the 2025 cohort.
- One facility had an apprentice leave the apprenticeship program after starting classes, leaving the Training Agent without an apprentice.

Six buildings represented by two companies signed agreements to participate in the program:

Active Apprentices	Building	Location	Company
1	Bainbridge Island Health & Rehab	Bainbridge	Pennant
2	Mountain View Rehab & Care Center	Marysville	
0*	Olympia Transitional Care & Rehab	Olympia	
0*	Rainier Rehab	Puyallup	
1	Alderwood Post Acute and Rehab	Lynnwood	Hill Valley
1	Lacey Post Acute & Rehab	Lacey	

* Facility with an agreement to serve as a training agent though does not have an apprentice in the pilot cohort.

Pilot Funding

The projected costs for Cohort 1 are $1.014 million. In addition to the pilot grant funding of $500,000 of state funds awarded to the sponsor through the Workforce Board, WHCA Apprentice, LLC secured a federal grant from the United States Department of Labor for $599,145. The federal grant has required enrollment of no less than 24 registered apprentices by June of 2025. Currently the program has five apprentices in Cohort 1, with the goal of sixteen registered apprentices for Cohort 2. Discussions are underway about expanding the pilot to the east side of Washington. The sponsor estimates $500,000 in additional funds will need to be secured to launch a second cohort on the westside. The goal of expanding to the Eastside will remain on hold until 2026 to give the sponsor adequate time to determine lab space, secure training agents, and negotiate academic delivery. It is roughly estimated that expansion to the Eastside would cost between $1 million to $1.5 million.

2. Washington Department of Veterans Affairs Apprenticeship/Sponsorship

An ongoing partnership between the Washington Department of Veterans Affairs (DVA) and the Workforce Board is facilitating the development of a DVA-specific LPN registered apprenticeship program. Since January 2023, the Workforce Board, WABON, and LNI have contributed to the efforts of DVA to establish a pilot apprenticeship program in one of their four Veterans Homes.

The DVA apprenticeship program is distinct from the WHCA Apprentice, LLC-sponsored LPN RAP with private employers but will draw from the experiences of that effort. DVA is also working to develop a new job classification for their facilities—a nursing technician. This classification is a key component in an HCA or NAC's transition to an LPN and in ensuring wage growth for apprentices. DVA's effort is strongly supported by the Workforce Board.

Realizing that apprenticeship development can take time, DVA has recognized the immediate need for nurses and has launched a pre-nursing sponsorship as well an LPN sponsorship. While DVA continues exploration and development of an LPN registered apprenticeship program, they have put in place these interim programs to ensure they continue to develop new nursing staff. In partnership with Olympic College in Bremerton, Washington, five students have diligently worked towards completion of their prerequisite coursework, and three began nurse training in Fall 2024 through the DVA sponsorship program. Further, in collaboration with the Workforce Board, DVA has begun an expansion of this program across the state in their other three Veterans Homes.

3. Engaging Collaborations Across the State

The LTC Workforce Initiative was initially convened in 2022. Many of the Initiative's early contributors had worked on previous efforts with WABON and eagerly committed to continuing this work. Over the past year and a half, over 150 contributors representing the LTC industry, healthcare, business communities, educators, advocates, direct caregivers, and state/federal agencies have voluntarily committed their time and expertise to finding broad, holistic solutions to the challenges associated with LTC staffing. These partners represent the broad spectrum of communities across the state including urban, rural, isolated, underserved, and marginalized communities. The Initiative partners are a diverse group of individuals representing each of the different LTC settings. The Initiative, supported by four distinct subcommittees and guided by a leadership committee, has

considered a range of subjects related to licensing, education, leadership support, regulatory oversight, and other promising practices in the state.

4. Four Active Subcommittees Led by Long-Term Care Workforce Initiative Participants

The LTC Workforce Initiative is broken down into four broad categories, each represented by a specific subcommittee. The subcommittees (described below) are chaired by Initiative contributors and supported by the Workforce Board staff. At the monthly meetings, topic-specific discussions are held, which include findings from the latest research efforts, information about promising practices, and identification of barriers and solutions. This information has been used to craft the specific recommendations considered in this report.

Long-Term Care Ecosystem

The Long-Term Care Ecosystem Subcommittee has turned its focus to some of the more eclectic aspects of the LTC workforce. These include the use of technology to support direct care staff with the aim of increasing the time critical nursing staff has available to provide direct patient care. This subcommittee has expressed great interest in the ongoing marketing project (authorized by the 2023 ESSB5582) to recruit nurses to LTC and rural communities. Finally, this subcommittee has expressed interest in the training and licensing of refugee and immigrant healthcare professionals and recruiting these populations into the LTC workforce. Discussions are underway to look at the barriers preventing foreign-born and -trained skilled healthcare providers from practicing at the level of their training in Washington.

> Q: What would make your job easier?
>
> A: "Training in my own language. Language is important in every culture."

HR & Worker Support

In FY 2024, the HR & Worker Support Subcommittee's conversations primarily focused on direct care worker retention as it is more cost effective for facilities (and potentially better for workers) when efforts are focused on retention as opposed to recruitment. To this end, the subcommittee has discussed fostering workplace cultures of respect that encourage direct care workers to remain with their employers. The subcommittee has also recommended that employers focus on providing opportunities for direct care workers' career advancement, including "grow your own" models and promoting avenues for student loan forgiveness. Finally, direct care workers participating in the subcommittee identified concerns related to the scheduling stability and the need to provide consistent hours for each pay period. Variability in hours and subsequent variability in income can ultimately contribute to a worker's decision to seek other employment, negatively impacting provider retention and workforce shortages.

Education & Career Pathways

The Education & Career Pathways Subcommittee has discussed many of the barriers to entry and career advancement within LTC. As an example, delays in HCA and NAC credentialing have caused issues with the retention of new caregivers, and the cost associated with HCA credentialing/testing and NAC fees have created a financial barrier. The subcommittee also discussed recent programs like DOH's nursing preceptorship program and the UW LTC Nursing Residency Program. These discussions included how the Initiative could best support DOH and UW and help them expand upon these efforts. The subcommittee has had additional conversations on the developing LPN

RAP and the barriers to setting up medical apprenticeships in general, such as the WAC that limits the amount of tuition colleges can charge apprentices.

Rural & Underserved Communities

The Rural & Underserved Communities Subcommittee has specifically focused upon the impact of challenges upon those communities that do not enjoy the same resources as more densely populated areas. Solutions that are proposed for densely populated and urban communities often don't readily translate into solutions for rural or underserved communities. Discussions have focused on "grow your own" strategies for developing workforce talent, innovative strategies for recruitment and staffing, and factors associated with training and education.

5. Long-Term Care Workforce Summit

The first Long-Term Care Workforce Summit, co-sponsored by the Workforce Board and DSHS, was held on July 9th, 2024. The one-day in-person meeting of LTC leaders from across the state met in SeaTac, WA. The summit featured a keynote address on research from Dr. Kezia Scales, Vice President of Research and Evaluation at PHI, and a panel discussion on LTC workforce challenges by representatives of federal agencies. In addition, a facilitated discussion with a host of direct caregivers offered insight into the providers' life experiences and challenges they face performing their daily work duties.

During the Summit, contributors had an opportunity to network with colleagues and complete a critical task for the Initiative: discussing and prioritizing key policy recommendations to bring relief to Washington's LTC workforce needs. Following the Summit, the Initiative's leadership team finalized a set of recommendations to be put forward for consideration by the Governor's Office and the Legislature, with each recommendation aimed at influencing the LTC workforce in the state. The recommendations are included in this report.

Planning for the 2025 Long-Term Care Workforce Summit began in early November 2024. DSHS's ALTSA division will again co-sponsor the meeting with the Workforce Board. Discussions have begun to consider how this Summit will complement the Aging Summit sponsored by DSHS.

6. WA529 GET Fund

The Workforce Board has established a WA529 Guaranteed Education Tuition (GET) Fund that will support NACs pursuing nurse training through the LPN RAP. The funds, which become available in June 2026, will be used to support students completing their prerequisite coursework prior to enrollment in the LPN RAP. The Workforce Board is administering the GET Fund and is developing policies and protocols for awarding funds to qualified students in the future.

7. Collaborative Efforts to Influence the Long-Term Care Workforce in Washington

The Workforce Board is represented in statewide activities working to address the needs of those receiving LTC services and the needs of those providing LTC services. The Dementia Action Collaborative under DSHS focuses on services available to residents of the state. DSHS's ALTSA division and the Workforce Board routinely contribute to complementary efforts that include the Workforce Development Team, which focuses on caregiver recruitment and retention efforts, and

the Direct Care Workforce Collaborative to support the efforts of the LTC Workforce Initiative. Recently, both agencies were invited to participate in the Peer Learning Collaborative, an initiative of the Direct Care Workforce Strategies Center. Finally, the Workforce Board is represented as part of the Apprenticeship and Higher Education Coordinating Committee as directed by ESB5904 and is coordinating a mandated marketing effort to promote nursing professions in LTC and in rural communities as directed by E2SSB5582.

8. Marketing Effort for Long-Term Care and Rural Communities

In ESSB5582, the 2023 Legislature authorized $250,000 for a marketing campaign with a focus on recruitment of nurses into LTC and/or rural and underserved communities. After running a competitive solicitation, the Workforce Board awarded a contract to Quinn Thomas (QT), a full-service, award-winning marketing agency with deep experience leading healthcare campaigns for Pacific Northwest public sector organizations. The team is comprised of 20 communications strategists, media and stakeholder relations, creative, and research leaders.

QT is a leading agency in the Pacific Northwest for public sector organizations that are charged with addressing the biggest healthcare challenges facing communities. Their current and past work has included campaigns to engage diverse audiences for the Washington Health Care Authority, Washington Health Benefit Exchange, and Oregon Health Insurance Marketplace.

Together, QT and the Workforce Board are developing a marketing campaign with input from contributors to the LTC Workforce Initiative. This effort is a statewide marketing campaign with a goal of raising awareness and generating interest in nursing and LTC careers. This campaign aims to reach both entry-level and experienced workers by reshaping perceptions and highlighting the rewarding aspects of these roles.

The overarching goal is to cultivate a positive image of LTC nursing careers, emphasizing stability, growth potential, and community impact associated with these vital roles. Ultimately this campaign will support the state's efforts to increase the supply of nurses in Washington.

The marketing campaign will tell this story through paid digital advertising channels and short-form video content, focusing on social media platforms where our target audience is most active. The campaign will be delivered statewide in both English and Spanish, with an emphasis on rural and diverse, multilingual communities. Other key deliverables include a microsite that showcases various LTC professions, a partner toolkit, and strategic messaging aimed at dispelling misconceptions about LTC careers.

To date, we have completed several key milestones, including:

- Industry research of similar recruiting campaigns.
- Recruitment of 12 advisory board members to guide campaign development from public, private, and educational positions.
- Audience research to hone in on key workforce candidates and how to best reach and engage them.

Campaign Specifications

The campaign, which is anticipated to launch in January 2025 and run through June 2025, has a goal of building a positive image of LTC nursing careers, including entry-level roles. The campaign will target three groups, (1) ages 18-22, (2) ages 22-30, and (3) ages 30-45, promoting nursing careers that include NACs, HCAs, LPNs, and RNs. This campaign will focus on paid digital ad channels, leverage platforms where our audiences already consume content, and short-form video content (15 seconds).

The campaign overview will include:

- Messaging
    - LTC is a career path you can stay in for 30+ years
    - A high volume of traditional and nontraditional training programs and apprenticeships are available for new LTC workers
    - LTC is an opportunity to serve your community, make your family proud, and move up the career ladder. Many LTC career paths are very well paid
    - LTC is an opportunity to establish meaningful relationships with your charges, which is highly different from acute care
- Microsite development (overview of key professions, measure campaign performance, link to key resources like the Washington CareerBridge site)
- Digital advertising
- Partner toolkit development (social graphics, career path resources, career conversation starters)

This effort is not without challenges. These include:

- Lack of awareness of LTC career paths
- Perception that LTC careers are boring, not challenging, or can be depressing
- Perception that there are few opportunities to advance your career in LTC
- Workforce shortage
- The high volume of career paths can make it challenging to build a single cohesive message

Steps to Solutions for 2025 and Beyond

While the state has much to celebrate, there is still a long way to go to move Washington from the Current State to the Ideal State of LTC visualized by stakeholders. The workforce needs are diverse and complex. Approximately 150 LTC Workforce Initiative contributors are sharing the knowledge they've gained from their years of professional experience. These dedicated, engaged individuals continue to offer their pro-bono support, expertise, and insight into developing a broad range of recommendations to address staffing challenges in the LTC workforce. Many of these individuals

have worked on previous efforts with the WABON.[7] They have eagerly returned to continue the work, recognizing the value that this effort brings to the LTC workforce.

Washington's population growth augments the tremendous challenge to recruit and retain a well-trained, professional LTC workforce. Managing LTC workforce growth and development is complicated, involving a broad range of disciplines and multiple agencies each tasked with unique responsibilities. Competing interests complicate the challenges of growing the workforce. However, by breaking down silos and establishing a culture of sharing resources and collaborative problem solving, solutions can be more readily developed and implemented. To this end, the state has made great strides in the past decades.

The policy recommendations developed by the LTC Workforce Initiative are the culmination of months of discussion and input from over 150 LTC professionals and subject matter experts. Over the past year, each of the four targeted Initiative subcommittees met monthly and engaged in discussions about the needs of the LTC industry and workforce. These discussions were often supplemented by input from agencies and professionals tasked with oversight and/or implementation of policies and legislation guiding the workforce. While developing these recommendations, Initiative members considered many factors that are potentially influencing workforce needs and possible solutions to workforce challenges. These recommendations were drafted over months of discussions, reviewed by leadership, prioritized and edited by the members, and adopted by the Initiative Leadership team.

The following recommendations are not all-inclusive, as there are other areas that the subcommittees are continuing to discuss. The subcommittees have recognized the need to consider diversity, equity, and inclusion in the workforce and various challenges associated with the state's diverse, multilingual caregiver population. Discussions about the refugee and immigrant population, for example, are complex. Identifying and adapting policies related to training and licensing for this segment of the population has also been recognized as an essential topic for the Initiative. When considering these policy recommendations, note that these are only parts of a complex solution needed to respond to a workforce crisis that has been decades in the making.

LTC Workforce Initiative Foundational Recommendations

1. Long-Term Care Reimbursement Rates

To address critical recruitment and retention needs, policymakers should fund LTC reimbursement rates at the level necessary for LTC employers to provide competitive wages and benefits, including training benefits. Policymakers should ensure these rates keep pace with inflation. To the greatest extent possible, additional reimbursement funds should be specifically dedicated to worker compensation in support of workforce stability.

2. Continuation Funding of the Long-Term Care Workforce Initiative

Extend funding for the Workforce Board's LTC Workforce Initiative for an additional four years to maintain the momentum of the Initiative and its partners. The Initiative was created by a state budget proviso in the 2022 Legislative Session. The LTC Workforce Initiative brings together providers, educators, agencies, and facilities at all levels to help create consensus on the next

[7] Formerly the Nursing Care Quality Assurance Commission (NCQAC)

steps needed to improve workforce outcomes. Policymakers receive detailed analyses of the LTC workforce and yearly reports with policy recommendations to support the workforce and those in need of LTC. This request was partially funded in the Governor's December 2024 budget proposal.

3. Licensed Practical Nurse Registered Apprenticeship Program

Continue support of the developing Licensed Practical Nurse Registered Apprenticeship Program (LPN RAP) (current funding expires at the end of FY 2025). The LPN RAP pilot has been a collaborative effort since 2021, in which partner employers support dedicated LTC caregivers to achieve LPN certification through a registered apprenticeship training modality. This apprenticeship collaboration includes employers representing more than 50 Washington LTC facilities, community and technical colleges, state agencies, and the apprenticeship sponsor, WHCA Apprentice, LLC. Continued funding through June 30, 2027, at minimum, will ensure the LPN RAP's initial two cohorts are supported through their completion of the program, and continued funding will better set the program up for long-term sustainability.

4. Provide Permanent Funding for the DSHS ALTSA Home and Community Services Workforce Development Team

The Home and Community Services (HCS) Workforce Development Team was established to advance the recruitment and retention of direct care workers as a part of the Department of Social and Health Services Aging and Long-Term Support Administration (DSHS ALTSA). To date, this grant-funded team has achieved a list of accomplishments that have positively impacted current and potential frontline care workers. These accomplishments include engaging with nearly 1,000 individuals interested in becoming a caregiver in the last year. Other accomplishments have included targeted marketing, education and training, and strategies for retaining highly trained LTC staff. Permanent funding is crucial for this team to continue their momentum uninterrupted at a time when the lack of front-line care workers is critical.

LTC Workforce Initiative Stakeholder Recommendations

1. Support the development of workforce policies that offer caregivers (individual providers and agency staff) consistent hours per pay period to ensure a dependable source of income.

Direct care workers have expressed concerns regarding scheduling and supervisory support that impacts their ability to provide quality, consistent care, as well as impacts the caregiver's ability to enjoy a stable, supported work experience. Variability of hours, particularly for caregivers working in in-home settings, can impact retention and create major challenges for low-income families. This situation is particularly difficult as caregivers may lose working hours in the case of the loss of a client, client hospitalization, or other circumstances outside of the caregiver's control.

> *"If I drop below 120 hours per month, I lose everything and I'm not able to care for myself… Caregivers' lives can change from month to month."*
>
> – Direct Care Worker

It is essential to emphasize that rural caregivers face additional hurdles due to geographic isolation and limited availability of healthcare resources. Ensuring consistent hours and stable income for all caregivers is crucial, but it is even more essential in rural settings where healthcare facilities are sparse, and travel distances are significant. Strategies must be tailored to address the specific realities of rural healthcare provision, where the caregiver population is limited and where community ties are strong but stretched thin. Moreover, the option for a substitute caregiver list is vital for rural areas to manage frequent staff shortages and ensure that caregivers can sustain their livelihood without the added burden of travel or relocation.

> *"[Direct Care Workers] need better wages… We're not getting enough PTO, we're not getting enough wages. So [my family] is currently facing an eviction. Our rent is going up, and we can't afford it. Our rent is going up to $2500 – there's no way."*
> – Direct Care Worker

Strategies:

a. Assemble representatives from DSHS, SEIU 775, the Workforce Board, Consumer Direct Care Network Washington, and direct care workers to review existing policies and practices related to HCA staffing and support. Identify the key elements related to the concerns raised by direct care workers and DSHS staff. Review policies related to rural communities.

b. Explore and create incentives for implementing or piloting strategies supporting caregivers, including establishing scheduling that provides a predictable number of hours for in-home caregivers and ensuring stable income and uninterrupted benefits. As a component of this recommendation, establish a substitute list that direct care workers can use to find a substitute caregiver or pick up additional shifts as needed.

> *"[To hit your hours to keep your health insurance], you need to use your PTO to hit those hours… If my client goes to the hospital, I have to use my PTO to make up the difference… In 15 years of caregiving, I have taken a vacation twice."*

c. Recognizing the unique challenges associated with the rural communities, convene representatives to develop potential policy changes addressing the specific challenges faced by providers in rural and underserved communities.

   Providing consistent hours per pay period allows workers to manage their personal finances, improving job satisfaction and ultimately contributing to a stable workforce and improved patient care.

2. Fund expansion of skills labs to support healthcare training in rural, isolated, and underserved communities.

Mobile/community skills labs create opportunities for training LTC workers in communities that do not have established educational facilities. The availability of skills labs in communities where LTC providers live, and work reduces the complications these workers experience while trying to complete training/testing. Include testing and training in an expanded number of languages. Assess the need for training programs/centers across communities, and determine the resources needed for new centers to operate.

Programs in other states with rural and remote populations could also be explored as alternative models, such as the Community Health Aide Program in Alaska. For example,

> *"Community Health Aides (CHAs) are selected by their communities before receiving training. Training centers are located in Anchorage, Bethel, Nome, and Fairbanks. Traditionally, there are four sessions of CHA training, each of which lasts three to four weeks. Currently, there are distance learning opportunities for session training limiting time spent away from their communities. Between sessions, CHAs work in their clinics completing a skills list and practicum. After completing the four-session training curriculum and clinical skills preceptorship and examination, the CHA qualifies as a Community Health Practitioner (CHP). CHA/Ps at any level of training may obtain certification by the Community Health Aide Program Certification Board (CHAPCB)."*[xlviii]

Strategies:

a. The Workforce Board/DSHS should conduct research to identify the areas where the mobile/community facilities are most needed.
b. What resources already exist in the state? Are these duplications?
c. What are the policy/legislative barriers to establishing new resources? Can modifications be made?
d. What is the equipment needed to establish each resource? What is the cost of putting it together?
e. What are the staffing needs for each resource? Cost? Availability?

"One of the things is language. Spanish is not the only language [other than English] … Sometimes we are told by the agency that there are interpreters or translators who can help us, but when we try to contact them, we have to wait… We need to prioritize the care of those who speak different languages"

Local availability of training resources increases training opportunities, leading to greater training and education of caregivers and better outcomes for patients.

3. Promote and support employee-centered management training for supervisors across all LTC venues.

The relationship between a frontline caregiver and their manager is a critical component in skills improvement and worker retention. A strong, supportive relationship between a manager and their staff can greatly reduce turnover, boost morale, and improve worker productivity and client quality-of-care. In an employee-centered management style, emphasis is placed on supporting the personal and professional growth of the employees. This style of leadership has the potential to improve managers' ability to support their staff and, ultimately, improve retention and care outcomes for clients.

Strategies:

a. Establish what management positions need to be included in these training opportunities, making sure to include managers of floor staff.
b. Conduct survey research to determine the level of interest for this leadership training.

c. Explore opportunities for incorporating management training into existing training requirements that are a part of professional licensing requirements.

d. Identify what training resources currently exist that meet the needs of management training. Tailor training to be venue-specific and mindful of generational differences in leadership styles.

e. Establish possible methods to encourage participation in this training.

f. Identify resources to support this work. Could CMP money be used for this?

Supportive leadership promotes recruitment and retention of trained staff while promoting career growth for caregivers.

4. Assess the use, ethical considerations, and potential for expansion of existing and developing technologies in LTC settings.

Strategies:

a. Conduct an industry-supported assessment of the use and capacity for technological interventions across LTC settings, including a review of implementation costs. The assessment should include existing technology such as Point, Click, Care (PCC). This assessment must be cognizant of the unique characteristics of various communities across the state, including community access limitations.

b. Engage with the Artificial Intelligence (AI) Task Force under the Attorney General's office to explore opportunities to better understand the legal and ethical implications of AI in LTC.

The use of developing technologies has the potential to improve efficiency and reduce the administrative burden in LTC settings, giving staff more time to provide direct care and ultimately contributing to improved quality-of-care.

5. Provide funding for the continuation and expansion of the marketing campaign authorized by E2SSB5582 (2023) with a focus on the recruitment of nursing staff in LTC and rural and underserved communities.

Nursing in LTC has long been overlooked and has not been adequately promoted as a career path for new and experienced nurses. New nursing students are typically exposed to LTC as a part of their first clinical rotation, which does not allow new students to experience the type of care that is routinely afforded to LTC residents. The current marketing campaign is in the early phases, and it will require focused efforts to educate nurses about opportunities in LTC and recruit staff at all levels into a career that is challenging, rewarding, and full of opportunities for growth.

Strategies:

a. Extend and expand the funding that was provided for this work in the 2023 Legislative Session running through 2025. Current funding leverages existing work at DSHS and other LTC marketing efforts, amplifying the impact. An ongoing effort would continue the encouragement for LTC as a healthcare career of choice.

b. Expand upon the existing marketing strategy to promote a greater number of LTC professions. Additionally, expand current marketing efforts into a broader range of

languages (current efforts will include English- and Spanish-language marketing materials) to reach a wider audience.

c. Research existing marketing efforts both within the state and nationally (i.e. Wiscaregivers.com) for successful strategies. These strategies must include marketing to middle school and high school students, refugees and immigrants, rural communities, and members of groups historically excluded and underrepresented from healthcare careers.
d. Conduct ongoing research to identify promising marketing strategies and provide support for the evaluation of the marketing campaign effectiveness.

The legislative mandate to promote career opportunities in nursing in LTC and underserved communities has the potential to grow the workforce while emphasizing career opportunities.

6. Promote the distribution of information on opportunities for loan forgiveness and repayment programs for LTC providers.

In their 2023 annual report, the state's Health Workforce Council recommended requiring eligible healthcare employers to provide Public Service Loan Forgiveness educational materials and information about the Office of the Student Loan Advocate when hiring new employees, annually, and at the time of employee separation. Policymakers should encourage the distribution of information among eligible LTC service providers and employees regarding the Public Service Loan Forgiveness Program and/or loan repayment options through the Washington Health Corps Loan Repayment Program. Promoting opportunities for loan forgiveness or accelerated loan repayment encourages direct care workers to remain in LTC or underserved communities thus contributing to a stable work environment and quality care for patients.

7. Support the development and evaluation of a robust statewide residency program for LTC nurses through funding and programmatic support.

LTC is often overlooked as a career opportunity in nursing, in contrast to acute care nurses who enjoy specialty training and residency opportunities as a component of their career pathways. Career growth has been demonstrated to promote retention and job satisfaction, which are key concerns in LTC staffing in the current environment. To offer another specialty career option with a focus on LTC, Washington should support the development and evaluation of a robust statewide residency program for LTC nurses through funding and programmatic support.

Strategies:

a) Continue the development of a robust LTC residency pilot program in all LTC venues that is accessible to any paid LTC nurse in Washington. Make this program available in multiple languages to attract a diverse representation of LTC-specific trained nurses.
b) Modify this training so that it is available in an online format, thus increasing access to a wider population.
c) Identify factors that are most impactful in rural areas such as:
    i. Rural providers as host agencies
    ii. Partnering with community and technical colleges in rural areas
    iii. Train-the-trainer models in rural areas
d) Establish incentives for participating facilities, particularly in the first two years of operation. The need for facility financial support may decrease as the residency contributes to workforce development and stability.

e) Establish an evaluation of the pilot program that includes monitoring of the residents' completion and tenure in LTC.
The development and evaluation of a robust statewide residency program in LTC and puts this career pathway on a par with other skilled nursing specialties.

8. Continue funding for the Washington State Student Nurse Preceptorship Grant Program.
This request supports continued funding of the preceptorship program authorized by the Washington State Board of Nursing during the 2023 Legislative Session (E2SSB 5582). A report due September 30, 2025, will provide data on outcomes related to the Washington State Student Nurse Preceptorship Grant Program and its effectiveness in securing qualified preceptors and clinical placements for prelicensure nursing students in Washington. Already, precepted experiences have increased in each of the past seven quarters of the program. In 2023, there were 1,269 precepted experiences, and in 2024 (YTD), there were 2,137 precepted experiences – a 68.4% increase in the last year.

Strategies:

a. Explore options for multilingual preceptors
b. Options for preceptors in remote/isolated communities
c. What are the regulatory barriers to nurses receiving preceptor pay? Does this impact the overall number of nurses who are willing to precept new nurses? How do we overcome this barrier?
d. Review the application process as it particularly impacts small communities. The application process is detailed and time-consuming. Streamline application? Rural communities – do they have the staff to precept? Grant funding to cover administrative costs. Is it cost effective?

This request would establish continuing funding for the preceptorship program authorized by the Washington State Board of Nursing during the 2023 Legislative Session (E2SSB 5582).

9. Expand the current capacity of DSHS Residential Care Services Quality Improvement Program Nurses to allow for more support and technical assistance for LTC providers.
This request would expand the existing capacity (from 8 to 12) of technical support staff in the Quality Improvement Program (QIP). Residential Care Services (RCS) recently presented evidence of a reduction in the number of citations in facilities where QIP Nurses had provided technical support which improved care practices, staff confidence and retention, and ultimately correlated with improved quality-of-care for the residents. This program is widely appreciated by providers who have utilized these services. With program expansion, there is also the potential to review options for increasing the scope of the role to provide support in additional program areas.

Strategies:

a. Conduct information gathering to establish where the greatest need is located with an emphasis on remote/isolated communities that do not have access to other similar resources.
b. Explore options for recruitment and training experienced LTC nurses who are approaching retirement or are considering employment options due to burnout or injury.

The services offered by these specialized professionals expand the support of the caregivers, reducing stress and potential for harmful outcomes for the patients.

10. Expand the current capacity of DSHS Residential Care Services Behavioral Health Quality Improvement Consultants (BHQIC) to allow for more support and technical assistance for LTC providers.

CMS recently enacted regulatory changes that mandate the delivery of appropriate behavioral health services to meet the psychosocial needs of residents and reduce the dependence on pharmacological interventions. In addition, facilities are required to provide behavioral health training that is consistent with the newly mandated federal guidelines.

The Behavioral Health Quality Improvement Consultant (BHQIC) program's mission is to improve the LTC facility interventions and approaches and understanding of mental/behavioral health needs while also increasing understanding of their minimum licensing requirements. BHQICs aim to aid facilities in creating interventions that improve staff comfort and capabilities when serving residents with challenging behaviors while improving the quality-of-life of residents. BHQICs also aim to improve staff retention and comfort and decrease burnout by providing tangible, person-centered interventions and techniques within licensing standards. This program is widely appreciated by providers who have utilized these services.

This request would expand the existing capacity (from 6 to 12) of technical support staff in the BQIC Program. RCS employs the Behavioral Health Support Team (BHST) which was established in 2018. The BHST's role is to provide technical assistance to LTC providers around residents with challenging behaviors. Currently, six BQICs and one trainer serve all adult family homes, assisted living facilities, nursing homes, and certified community residential services and supports facilities statewide (upwards of 6,000 facilities to date). Additionally, the one trainer serves all the above-mentioned facilities and enhanced services facilities. With program expansion, there is also the potential to review options for increasing the scope of the BQIC role to provide support in additional program areas.

Strategies:

a. Conduct information gathering to establish where the greatest need is located with an emphasis on remote/isolated communities that do not have access to similar resources.

b. Explore options for recruitment and training of experienced LTC behavioral health specialist nurses who are approaching retirement or are considering employment options due to burnout or injury.

The services offered by these specialized professionals expand the support of the caregivers, reducing stress and potential for harmful outcomes for the patients.

11. Provide support for the Washington Department of Veterans Affairs (DVA) LTC training programs.

Washington DVA is seeking support for its agency-wide LTC training program. The agency has requested additional support and funding from the Legislature to ensure its training program meets the needs of both staff and LTC residents. By ensuring staff are properly trained, the agency can ensure employees receive the necessary competencies to perform their duties effectively and

provide the highest level of care to Washington's aging veteran population. Additionally, the agency will be able to proactively meet its regulatory training requirements while also supporting numerous essential training activities annually. DVA is implementing accurate tracking and monitoring systems to maintain compliance with training requirements. These strategies create increased capacity in clinical training positions which can then effectively meet required annual skills verifications and ensure high standards of clinical proficiency, service delivery, and quality-of-care for residents. The strategies also play a key role in employee engagement and retention, as well as highlighting the agency as an employer-of-choice while in a national caregiver deficit. The support and funding will be used to ensure that WDVA fulfills its training program needs of both staff and LTC residents. With continued support, the agency will be able to proactively meet its regulatory training requirements while also supporting numerous essential training activities annually.

12. To improve the processes for home care aide testing, we recommend the implementation of solutions that would integrate testing into training, allow caregivers to test where they train, and shorten the time between training and testing.

Home care aide (HCA) licensing is dependent upon a HCA's ability to demonstrate proficiency of relevant skills to effectively provide quality care to a person receiving LTC. In 2023, the Legislature authorized DOH to pilot a program that incorporates skills testing into training programs (ESSSB5278) rather than postpone testing until after the training is complete. HCA training is currently provided through independent training agencies and the Service Employees International (SEIU) 775 Benefits Group. To address this issue, the LTC Workforce Initiative, in conjunction with the SEIU 775 Benefits Group and DOH, recommends that DSHS-approved HCA training programs administer the DOH HCA certification exam so that tests can be incorporated into training programs. To implement this, DOH will require funding from the 2025-2027 biennial budget for rule writing and staffing for implementation and oversight. The Benefits Group will require funding from the 2025-27 biennial budget to develop and implement a testing program that can be integrated into their training program. The Benefits Group will then require ongoing funding to administer the tests as part of its HCA training program. The changes to the testing protocols have the potential to improve the retention of HCAs, impacting on the availability of qualified staff in home care situations. These changes could contribute to better outcomes and reduced costs.

Situation

Keeping up with the rapidly growing demand for LTC is a pressing policy issue facing Washington. By 2050, the number of Washington residents over age 65 is expected to increase by 64%[xlix] . Approximately 70% of adults over age 65 develop severe LTC needs, highlighting the urgent need to develop a well-trained LTC workforce.[l]

Training and testing standards in Washington help ensure that LTC workers can safely provide care for older people and people with disabilities. Traditional HCAs must complete 75 hours of basic training and pass a two-part certification examination. Testing and training responsibilities are split between DOH, DSHS, and their contractors. DOH owns the HCA credentialling process and creates and validates the exam. DOH contracts with Prometric, a national testing organization, to administer both the knowledge and skills exams. DSHS owns the training process and approves training curricula and instructors. DSHS works with the SEIU 775 Benefits Group, which provides training through its Training Partnership to bargained caregivers.

After research and collaborative stakeholder input from DSHS, SEIU 775, facility training programs, community training programs, and the SEIU 775 Benefits Group, along with association leadership, stakeholders determined the best way to reduce credentialing timelines for HCAs is to incorporate the skills and written exams into the training programs. When a caregiver completes training and passes their exams, DOH will be provided with confirmation of completion of training.

Issues

Due to inefficiencies arising from the distribution of training and testing responsibilities across multiple agencies and their partners, only one third of caregivers have historically been able to take the exam within DOH's mandated time frame between training and testing. According to the State Auditor's performance audit, Prometric struggles to schedule applicants in a timely manner, and caregivers reported that taking the test at a different time and location than their training posed a substantial barrier to completing the exam[li] . This is only one of many challenges caregivers face related to the current exam process. Other challenges include:

- Last minute cancelled testing events, often after multiple caregivers have travelled long distances to the exam site.
- Sudden cancellations of individual interpreters.
- Breakdowns in data feeds that prevent scheduling authorizations from reaching Prometric.
- Caregiver difficulty contacting Prometric customer service.
- Caregivers who are unable to navigate the Prometric online scheduling portal.
- Caregivers without debit or credit cards are unable to pay for exams in the Prometric portal.
- Low pass rates, often caused by nerves in unfamiliar exam settings.

DOH is currently piloting a training and testing program with Brookdale Senior Living. Brookdale offers caregiver exams within the training programs at five Brookdale locations. Through the pilot workgroup, DOH has developed a proctor training webinar, facility site requirements, proctor agreements, and many other instructions and exam site documents and supplies. The pilot has now tested 60 caregivers with an 88% pass rate, significantly higher than the typical 70% pass rate. DOH has also received positive feedback from the caregivers, facilities, and trainers.

As the largest caregiver training operator in Washington, the SEIU 775 Benefits Group is well-positioned to make a positive impact on the HCA testing process by administering the certification exam to its affiliated caregivers. The Benefits Group expects to train approximately 6,500 students seeking HCA certification in FY 2025, with projected increases in future years. By incorporating the certification exams into their training program, the Benefits Group can simplify exam scheduling, enable caregivers to test at the same location that they train, improve completion rates, expand testing accessibility by providing interpreters for caregivers testing in their preferred language, and ultimately enhance caregiver retention.

Integrating exam administration into HCA training programs would require additional funding. In particular, the SEIU 775 Benefits Group will require startup funding to begin building a testing program that can be integrated into its statewide training network. Some exam administration responsibilities may include scheduling, computer-based exam hosting, proctoring, test

site/supply acquisition and maintenance, results reporting, caregiver and employer communications, and call center services. These responsibilities will impose unique costs on the Benefits Group's statewide training program, which does not have a centralized workforce or facility like a small regional community provider. Startup costs are needed to convert training sites, develop necessary software, and integrate with existing training data systems. In contrast to facility-based employers who realize cost savings from reduced turnover, the Benefits Group cannot offset these administrative expenses.

Additional Solutions for Consideration

Immigrant members of the community play a substantial role in the direct care workforce and represent an opportunity to play a bigger role in addressing the workforce shortage in direct care. Reliance on foreign-born workers will only increase as Washington's population continues to age and birth rates decline.[lii]

PHI recently suggested recommendations designed to grow and support the immigrant direct care workforce. Some of these recommendations will require more discussion and changes to legislation and/or policy, such as lobbying for a special 'Caregiver Visa' to build out the direct care worker pipeline by offering a pathway to permanent residency in the US or increasing federal public supports regardless of immigration status.[liii]

A Cornell University Law School policy white paper recognizes that broad US immigration reform is unlikely at the congressional level but argues that certain targeted reforms might be achievable. For example, supplements to the H-1B program and the Conrad visa program could be added to establish new avenues for healthcare recruitment.[liv]

At the state-level, some of PHI's policy recommendations related to workforce innovation might be feasible, such as immigrant-specific interventions to improve training, recruitment, and retention. This could include expanding language supports in the training, testing, and certification/licensing process for direct care workers. Any investments in these types of interventions should also be monitored and evaluated to increase the evidence base for such policies.[lv]

Further, the Cornell white paper proposal "would authorize state governors to ask the Department of Labor and/or the Department of Homeland Security to approve additional worker petitions to authorize the hiring of immigrants by employers in their respective states."[lvi]

Past LTC initiatives have identified access limitations, English language requirements, and lack of supports for non-English speakers as training barriers. In December 2018, WABON[8] recommended supports for skills testing evaluation for HCAs and NACs in languages other than English.[lvii]

Workers under the age of 18 are subject to child labor laws that restrict the types of work available to them. However, they are eligible for certain types of food service and housekeeping jobs. Child labor law violations that occur within the healthcare industry are usually within the dietary and housekeeping departments. Common violations include working outside the limitations on hours of work, operating powered machinery, or working jobs declared hazardous[lviii] by the US Secretary of Labor.[lix]

[8] Then known as the Nursing Care Quality Assurance Commission (NCQAC)

Programs aimed at high schoolers could provide new job opportunities, while building out a talent pipeline to address workforce shortages in caregiving. In a 2019 paper published in Health Affairs, Joanne Spetz, et al see a "potential for creating high-quality home care jobs with career pathways for high school students, displaced workers, and older people who need to work past retirement age." They suggest demonstration programs could be developed in communities with high unemployment rates and higher-than-average shares of elderly people.[lx]

Future Goals of the Initiative

The Initiative's work is a complex effort, impacting hundreds of thousands of LTC workers and Washingtonians in need of LTC. The Initiative is an assembly of highly qualified professionals who are actively engaged with the LTC workforce and recognize the impact that current workforce challenges have on the care delivery system. Recognizing both the challenges and the needs of the LTC industry, the Initiative has developed a set of dynamic goals. These goals also recognize the diversity found in the LTC workforce and in the population that direct care workers serve. The future goals of the LTC Workforce Initiative include:

1. Incorporate all communities and Washington residents that are either currently, or in the future, needing LTC services into the scope of the Initiative.
2. Facilitate and promote open communication and collaborative efforts to remedy the challenges associated with LTC workforce shortages.
3. Provide support for ongoing efforts to develop policy solutions for recruitment, retention, education, licensing, and service delivery models associated with the delivery of LTC services across the state. Encourage open discussion among contributors that leads to improved service delivery and workforce development.
4. Engage the input of individuals and family members who are receiving LTC services regarding their observations and needs related to their care.
5. Continue providing support for potential apprenticeship candidates completing their prerequisite coursework.
6. Continue and expand research collaboratives across the state with an expanded focus on:
    a) Quality outcomes for those receiving LTC services
    b) Impact of efforts on the workforce
    c) Impact on communities and providers that are part of the continuum of healthcare services in the state
7. Establish the Initiative as a national model, building on the recognition enjoyed by Washington as a leader in efforts to meet the needs of the LTC workforce.
8. Initiate preliminary discussions about the potential establishment of a Direct Care Worker Center. These discussions should include:
    a) Strategic mission and vision
    b) Leadership models
    c) Contributing partners
    d) Research on existing models
    e) The role of the Center
    f) Development and sustainability plans

Appendix 1: Long-Term Care Workforce Initiative Members

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Appendix 2: Long Term Care Disciplines

Credentialled (Nursing) Disciplines	
Director of Nursing	Registered Nurses with Administrative Duties
Registered Nurses	LPN with Administrative Duties
Licensed Practical Nurses (LPN)	Certified Nursing Assistants
Nurse Aides in Training	Medication Aide/Technician
Credentialled (Non-Nursing) Disciplines	
Administrators	Medical Directors
Other Physicians	Physician Assistants
Nurse Practitioners	Clinical Nurse Specialists
Pharmacists	Dieticians
Feeding Assistants	Occupational Therapists
Occupational Therapy Assistants	Occupational Therapy Aides
Physical Therapists	Physical Therapist Assistants
Physical Therapy Aides	Respiratory Therapists
Respiratory Technicians	Speech Language Pathologists
Therapeutic Recreation Specialists	Qualified Activities Professionals
Other Activities Staff	Qualified Social Workers
Other Social Workers	Mental Health Service Workers
Independent Providers	Dietary Manager
Non-Credentialled Disciplines	
Maintenance	Maintenance Supervisor
Housekeeping	Housekeeping Supervisor
Cooks	Dishwasher
Landscapers	Meal Delivery
Activities Aides	

Appendix 3: Business Case Studies

Case Study #1: Workforce Lessons from LA Vue

La Vue[9] is a high-quality non-profit long-term care facility that offers a continuum of care, ranging from independent living, assisted living, to skilled nursing convalescent and rehabilitation services in Western Washington. Independent living hosts the largest number of residents, at 789 out of 1,120 residents.

Jane Doe, the Licensed Nursing Home Administrator at La Vue, respects the valuable work carried out by staff, which—along with residents and their families—create a positive and compassionate culture of community. She adds,

> *"La Vue really lives up to its values, with an emphasis on quality care. The organization constantly reinvests into its facilities and staff."*

La Vue recognizes that workers value communication and want to see management involved and responsive to staff needs. Day-to-day worker engagement, listening, and responding to such needs is part of the leadership culture at La Vue.

Formally, La Vue regularly conducts employee satisfaction surveys, which administrators follow up on with staff whenever any issues or unmet needs and wants arise. It also enables administrators to better understand what is working well with staff. The quality of resident care is ultimately dependent on staff.

Direct care worker turnover is relatively low, 20 percent compared to the industry average of Washington State, which is around 50 percent on average per year. Doe elaborates,

> *"La Vue has one of the highest staff to resident ratios in the area. Plenty of staff leads to lower levels of burnout. Staff don't feel overburdened, and expectations of staff roles are clear."*

La Vue also reports having above average compensation and benefits, with wages pegged to above average market rates and on a graduated scale based on years of experience. Experience is also transferable, meaning staff with 10 years' experience from other LTC facilities can be hired at that higher level. Staff can make upwards of $30 per hour. Moreover, La Vue offers benefits such as paid time off, health insurance, and retirement plans. Doe says,

> *"Given rising health insurance costs, La Vue has been absorbing these increases instead of passing them on to employees and has been doing so for the past four years."*

[9] The names of individuals, organizations, and locations have been disguised to protect the confidentiality of interviewees for this case

Staff development scholarships are also available, which not just include healthcare related training such as nursing education—but can be for any staff, such as groundskeepers pursuing HVAC repair.

La Vue also provides grants through its philanthropic operations to local community colleges to provide scholarships to future nursing assistants. It has also partnered with a local higher learning institution to provide nursing scholarships. Doe explains,

> *"These scholarship programs benefit the entire long-term care ecosystem. There are no strings attached with work requirements attached to La Vue".*

"Recruitment, of course, is always a challenge, Doe adds. La Vue primarily advertises jobs through its own website and Internet job posting boards. Being fast and responsive to applicants has been a priority given the competitive landscape for attracting talent. As an administrator, Jane Doe is concerned about the regulatory environment. Ideally, she would like to see a more collaborative, and less punitive approach to enforcing quality care standards. La Vue, like many other employers in the long-term care sector, is also worried about recent changes to federal staffing requirements for nursing homes. Doe concludes,

> *"These new requirements on staffing ratios could have a negative impact on operations. For example. We employ LPNs to provide, which are not included in new staffing requirements. As a result, we might have to adjust our budget to no longer support the type of direct care worker."*

Case Study #2: 'Rounding' at Sunshine Health Facilities

In 2021—amid the Global COVID-19 Pandemic—Sunshine Health Facilities (Sunshine), a long-term care setting in Spokane, Washington offering skilled nursing and assisted living supports and services, was struggling with staff burnout. Monthly turnover rates were above 50 percent; resident numbers were also crashing, which was running Sunshine's financials into the ground.

Resident counts, referred to as the Census, drives Medicaid payments, which is the primary revenue source for most settings. Regulations governing long-term care require a specific ratio of staff hours to residents. If a setting does not have staff on hand, they are forced to rely on contract staffing, which can be up to 50 percent higher than average staffing costs.[10] Replacing trained staff is also time-consuming and expensive, costing anywhere between six and nine months of an employee's salary.[11]

It was a volatile situation. High levels of staff turnover exacerbate burnout for existing staff, further driving turnover, and can negatively impact resident health and wellbeing. Falling census numbers were shrinking the revenue base while staff costs were simultaneously increasing disproportionality to reduced staff on hand. Something needed to be done to stabilize the business.

Strategic planning is part of Sunshine's DNA. It was during a strategy session that the CEO and owner of Sunshine proposed a solution to the staffing crisis: Rounding.

Roundings are scheduled, structured discussions in which leaders purposefully engage staff. It was an HR driven solution that required a change in the organizational culture that began from the top down. Matt Flemming, the COO of Sunshine adds,

> *"It's not rocket science, but it's easier said than done. If I didn't hold my team accountable for the execution of our plan… it would just be another initiative that created busy work for the team with little to no impact on results."*

In January 2022, a Rounding Committee was formed to 'hardwire' the practice, such that it became an integral part of the business's management practice. The committee was composed of the Chief of Operations, the Chief Commercial Officers, and HR directors and administrators. The Committee met monthly to assign Rounding with individual staff to be completed by leaders, who would report back to the Committee on specific due dates. On average, an employee could expect a Rounding with leadership at twice per year. Findings from roundings were reported back out to staff monthly.

Rounding is a tool that captures information directly from staff. It asks staff key questions that leaders can act on to be more responsive to their staff:

- What is working well?
- Who stands out and needs recognition?

[10] Nursing Home Staffing Shortages and Other Problems Still Persist - The New York Times (nytimes.com)
[11] The Real Cost of Turnover in Healthcare (oracle.com)

- Do they have the equipment, tools, and training needed for their job?
- What can be done better?

Information gleaned from these reports is subsequently captured, reported to leadership and staff, and then acted on: with particular emphasis on recognizing information and providing the right tools, equipment, and training to staff. The Rounding tool should be used as part of a continuous process (refer to Figure 1).

Figure 1: Rounding Tool

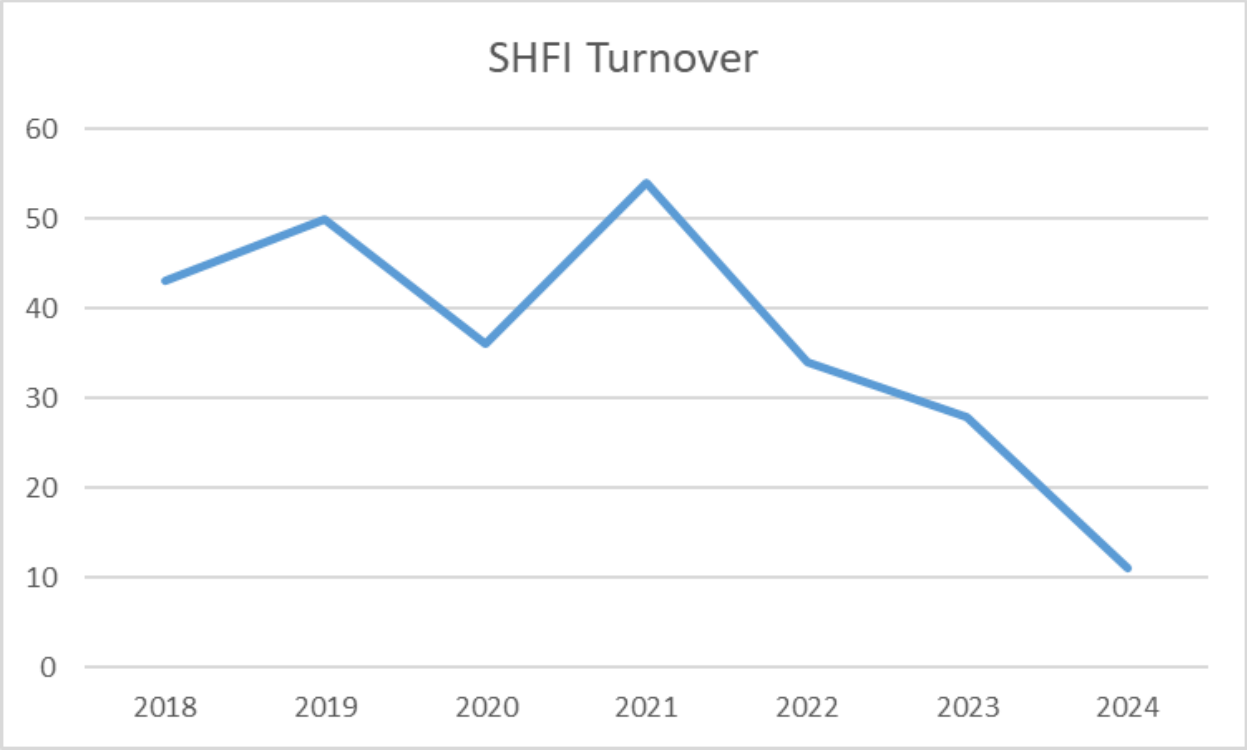
Source: Sunshine Health Facilities

However, this information, as Flemming explains, "does not replace current one-on-ones or team meetings. Rounding are intentional conversations, not a brief, unscheduled discussion".

By April 2022, Sunshine had completed its Rounding pilot. In June, Sunshine began training its leaders on the new practice, and by that July, rounding with all Sunshine staff went live. It was a deliberate process that took over half a year.

The implementation of Rounding at Sunshine coincided with a drastic reduction in turnover, which took the business well below average turnover rates for the industry (refer to Figure 2).

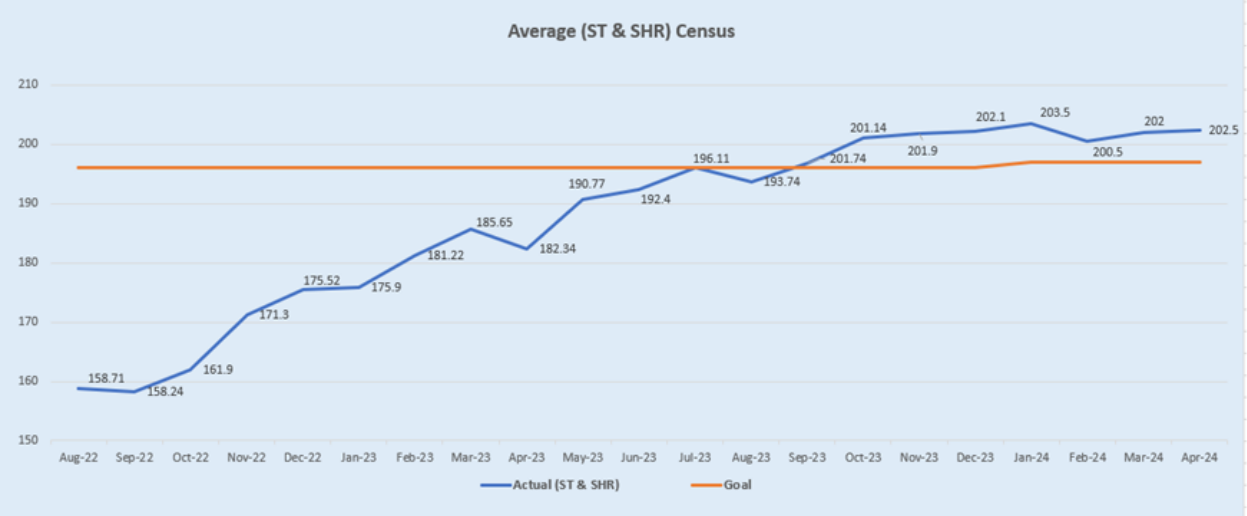
Figure 2: Sunshine Health Facilities Annual Turnover Rates



Source: Sunshine Health Facilities

In addition, Sunshine had succeeded in stabilizing its staffing to resident ratios (refer to Figure 3).

Figure 3: Staff-to-Resident Ratios



Source: Sunshine Health Facilities

The reduction in turnover rates had a profound impact on business operations. About one year after Rounding was rolled out, the practice had been fully integrated into workplace culture at Sunshine.

Staff appreciated the recognition and feedback they received from leadership and felt valued. Any concerns and issues they raised were being addressed and shared with the entire organization. Around that same time, all business lines at Sunshine were reporting month-over-month profitability.

The success of the staff Rounding initiative has led to a new pilot being rolled out in 2024: Resident Rounding.

Flemming shares his conviction on Rounding by sharing a quote from Richard Branson,

> *"If you take care of your employees, they will take care of your business".*

Case Study #3: Agape in Home Care

Tim Cooke is the is the co-founder and administrator for Agape in Home Care, providing services for the older adults throughout Snohomish, King, Pierce, Thurston and Spokane Counties. Agape was founded to be a bridge from survival jobs for the under-employed, namely immigrants to career-level jobs by providing opportunities for training and career advancement. Agape's caregivers serve the older adults, those with lifelong disability, and those recovering from addiction, and by being the best at what they do, they qualify for ongoing promotions. According to Cooke,

> *"I was captured by my co-founder's vision [a Christian pastor from Rwanda] to raise the spirits of immigrants in America, who often get stuck in low wage 'survival' jobs. These jobs require a skill level at which the worker is much more qualified."*

The founding mission of Agape is to make the lives of caregivers better by providing them with a supportive work environment in which they can thrive at delivering high quality in-home care services to those who need it. Essential to this vision is practicing on-the-job training helping caregivers advance either vertically into more administrative, managerial, or leadership roles, or horizontally through cross-training. Cooke adds,

> *"We practice a 'hire from within' policy for office support and management positions. Everyone either 'graduates' up within the organization or out to better opportunities within this or other industries with the support of Agape. The challenge, is that both 'graduations' reduce our caregiver pool."*

Recruitment, as is common with all long-term care settings, is the biggest challenge faced by Agape. This function is ideally done through 'word-of-mouth'. Job-postings are also used, but Cooke admits it is difficult within the confines of a short advertisement to fully capture some of the intangible cultural elements that make Agape an attractive place to work.

Most of Agape's caregivers are immigrants from African origin. This too creates some cultural challenges between caregivers and clients. Cooke states,

> *"The ancient Greeks had many words for love. Agape means unconditional love. This is the brand promise of Agape, which is an organization founded on Biblical principles. I believe these core principles resonate both with our caregivers, many of whom identify as Christian, and our clients. In any case, Agape is an inclusive organization that has zero tolerance for discrimination. As our elders age, they often lose the cognitive abilities to filter some thoughts and end up saying things that are culturally insensitive to caregivers, adding to the challenge of staff retention."*

To address recruitment, Cooke is working on a two-pronged solution:

- Working with schools to build out a talent pipeline for students completing NAC and HCA programs,
- Exploring more targeted job advertising through social media, such as Facebook, to better reach demographics like Agape's caregiving staff—while also being clearer about the benefit Agape has to offer.

Cooke also muses that adding the role of Caregiver to the current list of workers who are fast-tracked when applying for temporary work visas would make recruiting easier. That list is called the 'Schedule A' and the roles currently included are nurses and physical therapists.

Care within the home is often preferred by many caregivers over providing care within a clinical setting. Cooke explains,

> *"Clinical settings, such as hospitals and skilled nursing facilities are physically and mentally demanding because the ratio of client to staff can be fifteen to one. The type of rehabilitate care can also be more complex than in-home care, due to the more acute nature of those settings. Care within the home is provided through one-on-one relationships between the client and caregiver. These relationships are vital to many caregivers, who find tremendous meaning in their work. Promoting this could be a potential draw for recruits"*

Another challenge, which is unique to in-home settings, is matching clients and caregivers. For example, if a client passes on, there is usually a gap of an undeterminable amount of time until a caregiver can be placed with a new client. Disruptions of this nature create retention problems. There is also often a mismatch in terms of the shifts in which a caregiver is available, and when a client wants the services provided.

Affordable housing is also an issue. Many clients live in areas where caregivers can't afford housing, which increases commute times. Longer commutes are stressful for immigrants who come from regions that do not share the United States' reliance on cars. Many learn to drive automobiles as adults out of necessity and their lack of lifelong familiarity with driving makes commuting more daunting.

Cooke believes certain policy options would improve working conditions for in-home caregivers. He argues rules concerning caregiver pay could be more flexible. For example, adopting a bench rate of pay to keep caregivers on staff between clients could reduce turnover. Rules concerning overtime pay, which are meant to help workers, may have an adverse effect. According to Cooke,

> *"Almost all our caregivers want to work more than 40 hours per week, and we have the hours to give, however the economics of this industry combined with overtime laws, dictate that we cannot afford to pay overtime. Therefore, we must cap caregivers at a maximum of 40 hours per week and because shifts are not perfectly divisible by 40, we often end up under-utilizing caregivers each week. This is an inefficient use of our local workforce who is available and willing to provide more service hours. The overtime rules are meant to protect the caregiver, but they just get around the regulations by working with multiple employers in order to increase total hours above 40 per week."*

The point of view of some employers is that the unintended consequence of employers unable to affordably offer more than 40 hours per week is impacting the caregiver because rather than being able to stay with a long-term employer where they establish a credible work history and can attain benefits of seniority, they are forced to job-hop from employer to employer and start from scratch each time. Caregivers find themselves applying for new jobs, interviewing, attending orientation classes, training and other overhead activities that are not spent providing care. Most employers have a minimum number of hours before a caregiver qualifies for benefits. According to Cooke, due to the nature of employers not being able to afford overtime pay, caregivers will often have three

jobs of 20 hours per week each without benefits rather than the stability of one job providing 60 hours and benefits.

Appendix 4: Methodology

A separate report detailing the complete analysis and findings of the University of Washington Center for Health Workforce Studies (UW CHWS) will be made available in calendar year 2025. Links to that report will be appended to this document once published.

Quantitative Methodology

Purpose and Methods

The University of Washington Center for Health Workforce Studies (UW CHWS) quantitative study of the Washington State long-term care workforce focused on two areas related to staffing in skilled nursing facilities (SNFs): 1) Turnover of nursing staff, and 2) Staffing levels in the context of newly announced requirements for federal minimum staffing standards from the Centers for Medicare & Medicaid Services (CMS).

Turnover of Nursing Staff

Turnover calculations: Payroll Based Journal (PBJ) daily detailed staffing data from CMS was used to create quarterly turnover rates for all job roles in 192 SNFs located in Washington State.[lxi] At the time of analysis, the UW CHWS team had access to data for SNFs operating from Q3 2020 through Q2 2023.

The CMS staffing turnover measure was used to create quarterly turnover rates for each SNF[lxii]. Specifically, for each SNF, the denominator for each job role's quarterly turnover rate included all employees who had worked at least 120 hours in the 90-day period prior to the start of that quarter. Then, during the quarter, employees were counted in the turnover numerator if they had 60 consecutive days of not working in that SNF.

Average quarterly turnover by job role was calculated in two ways: 1) the proportion of total staff and 2) the sum of unique staff members.

Turnover and Quality Analysis: Variables and Data Sources

Turnover: To examine relationships between turnover and quality of care, the UW CHWS team calculated average turnover rates for all nursing staff (RNs, RNs with administrative duties, LPNs, LPNs with administrative duties, NACs, Medication Aides, and Nurse Aides in training) as described above using PBJ data between June 2020 and May 2023 in the 192 Washington-state SNFs.

Quality: To reflect quality throughout the study period, we used 2018-2023 Nursing Home Compare (NHC) files to calculate quarterly averages from the monthly overall 5-star ratings for each SNF. An average quarterly score of 4 or 5 was considered high quality. Then, the UW CHWS team calculated the percentage of quarters that each SNF had high quality 5-star ratings.

Covariates: Turnover data with data from multiple sources of SNF facility characteristics were merged: Urban versus rural location was determined from the Office of Management and Budget's definition, as this definition is used to define rural SNFs in the CMS Minimum Staffing Standards final rule.[lxiii] From 2018-2021 Long Term Care Focus files, the UW CHWS team included chain affiliation and payer mix variables reflecting the percentage of residents whose primary payer was

1) Medicaid and 2) Medicare.[lxiv] From 2018-2023 NHC files, we used indicators of facility ownership (non-profit, for-profit, or government), location in a hospital versus freestanding, and bed count.

Turnover and Quality Analysis: Statistical Modeling
Multivariable logistic regression models using a quasibinomial family to account for overdispersion were used to estimate the association between nursing turnover and the percent of quarters with a high quality of care rating. the UW CHWS team adjusted for overall staffing, profit status, size, payer mix, in-hospital versus freestanding location, chain status, and urban versus rural location.

Skilled Nursing Facility Minimum Staffing Standards
The CMS recently announced federal minimum staffing standards of 0.55 RN hours per resident-day (HRPRD), including RNs with administrative duties, 2.45 nurse aide (NA) hours HRPRD, and a total of 3.48 HRPRD for all RN, nurse aide (NA), and LPN staff combined that will be phased in over the next five years[lxv]. Compliance with the total HRPRD standard will be required starting in 2026 for urban SNFs and 2027 for rural SNFs and compliance with the RN and nurse aid HRPRD standards will be required starting in 2027 for urban SNFs and 2029 for rural SNFs.

The 0.55 RN requirement includes the following disciplines from the Payroll Based Journal: RNs, RNs with administrative duties, and RN Directors of Nursing. The 2.45 NA hours includes CNAs, Nurse Aides in Training, and Medication Aides. The total HRPRD standard includes RNs, RNs with administrative duties, RN Directors of Nursing, LPNs, LPNs with administrative duties, CNAs, Nurse Aides in Training, and Medication Aides. To eliminate the early COVID-19 period, the UW CHWS team used PBJ data for 190 Washington State SNFs reporting paid staffing and census hours from January 1, 2021 through December 21, 2023 in our analysis.

the UW CHWS team calculated descriptive statistics for the average staffing levels and proportion of all days when SNFs met minimum standards, included below:

Summary of overall staffing levels and proportions of days between January 2021 and December 2023 meeting minimum staffing standards (N=190 SNFs)			
	RN HRPRD	**NA HRPRD**	**Total HRPRD**
Mean (SD)	0.93 (0.65)	2.55 (1.67)	4.29 (2.92)
Median	0.85	2.47	4.15
	Met RN 0.55 HRPRD	**Met 2.45 NA HRPRD**	**Met 3.48 Total HRPRD**
Mean (SD)	77% (42%)	52% (50%)	79% (40%)
Median	100%	100%	100%

The UW CHWS team then stratified SNFs by facility characteristics and calculated similar descriptive statistics for the proportion of quarters meeting staffing standards. Quality of care ratings were taken from the January 2024 Nursing Home Compare files.

Summary of proportions of days between Q1 2021 and Q4 2023 meeting minimum staffing standards by facility characteristics (N=190 SNFs)			
	Met RN 0.55 HRPRD, Mean (SD)	**Met 2.45 NA HRPRD, Mean (SD)**	**Met 3.48 Total HRPRD, Mean (SD)**
Rural SNFs (N=21)	71% (45%)	43% (50%)	67% (47%)
Urban SNFs (N=169)	78% (42%)	52% (50%)	81% (40%)
For Profit SNFs (N=146)	74% (44%)	46% (50%)	77% (42%)
Non-Profit or Government SNFs (N=44)	87% (33%)	71% (46%)	88% (32%)
Chain SNFs (N=142)	76% (42%)	48% (50%)	78% (41%)
Non-Chain SNFs (N=46)	78% (41%)	61% (49%)	82% (39%)
Low Quality of Care Rating (N=22)	75% (43%)	49% (50%)	75% (43%)
Medium Quality of Care Rating (N=37)	73% (44%)	55% (50%)	79% (41%)
High Quality of Care Rating (N=131)	78% (41%)	51% (50%)	80% (40%)

Turnover and Minimum Staffing Standards

Then quarterly turnover rates for RN, LPN, and NA job roles were averaged across Q3 2020 through Q2 2023 and compared to the staffing minimums to describe relationships between turnover and meeting the minimum staffing standards.

Average turnover rates and staffing hours per resident-day (HRPRD) in quarters when staffing minimums were met versus not met (N=192 SNFs)						
	NA Minimum Met	**NA Minimum Not Met**	**RN Minimum Met**	**RN Minimum Not Met**	**Total Minimum Met**	**Total Minimum Not Met**
RN Turnover	9.85	12.6	10.6	16.06	10.68	14.84
LPN Turnover	10.03	11.72	10.6	12.14	10.36	14.24
CNA Turnover	12.12	15.27	13.61	14.77	13.36	16.19
RN HRPRD	1.08	0.8	1.03	0.45	0.99	0.63
LPN HRPRD	0.8	0.78	0.76	1.0	0.81	0.69
CNA HRPRD	2.9	2.11	2.59	2.2	2.63	1.82

Qualitative Methodology

Purpose and Methods

The University of Washington Center for Health Workforce Studies (UW CHWS) qualitative study used individual qualitative interviews to identify challenges and potential solutions to improving recruitment, satisfaction, and retention of direct care workers across long term care (LTC) settings in Washington. The study aims to address the following research questions:

Q1: What challenges and supports do direct care workers experience in providing care to patients and maintaining their job across LTC settings?

Q2: Which changes do direct care workers recommend for improving labor conditions, preparation, and retention in LTC settings?

Q3: What are the common challenges and potential solutions across LTC settings?

Direct care workers providing care in institution-based or community-based LTC settings were recruited. Eligibility criteria included the following: HCAs and NACs working in skilled nursing facilities/nursing homes, assisted living facilities, adult family homes, and/or home care settings. Purposive sampling was used to ensure even representation across settings. Study invite emails were distributed to the applicant list of the Washington Direct Care Workers Collaborative, managed by the Aging and Long-Term Support Administration at Washington State Department of Social and Health Services, as well as to staff and direct care workers from LTC agencies and facilities.

Individual in-depth interviews were conducted via Zoom using a semi-structured interview guide. The interview guide included questions pertaining to the job history and background, job preparation and training process, current labor condition and job satisfaction, and recommendations for improving recruitment and retention. Each interview lasted for approximately 45 minutes and was facilitated by two research team members. The interviews were audio-recorded and transcribed verbatim.

Data was analyzed using an inductive approach to thematic analysis. All qualitative research team members coded the first three transcripts independently and developed a codebook. Subsequent transcripts were coded by two team members, who alternated between primary and secondary coder roles. Disagreements were resolved through discussion, with a third team member assisting as needed to address discrepancies. The codebook was refined iteratively throughout the coding process. The research team reviewed the codes and determined and refined preliminary themes for this report.

Participants

The preliminary findings are based on data from 10 interviews with HCAs, conducted from February 2024 to May 2024. Most of the HCAs were independent providers (n=9). Participants' experience in the field ranged from 1 to 30 years. Most were White (n=8), with one participant identifying as Black and one as Asian. Nine participants were female. Regarding education, one participant had a high school diploma, four had some college education, and five held a bachelor's or higher degree. The

HCAs worked in both urban areas, including King, Clark, Pierce, and Spokane counties, and rural areas, such as Lewis, Skagit, and Whitman counties.

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