

Colorado's Care Economy

- Changing Demographics Highlight the Need for Statewide Research and Reform

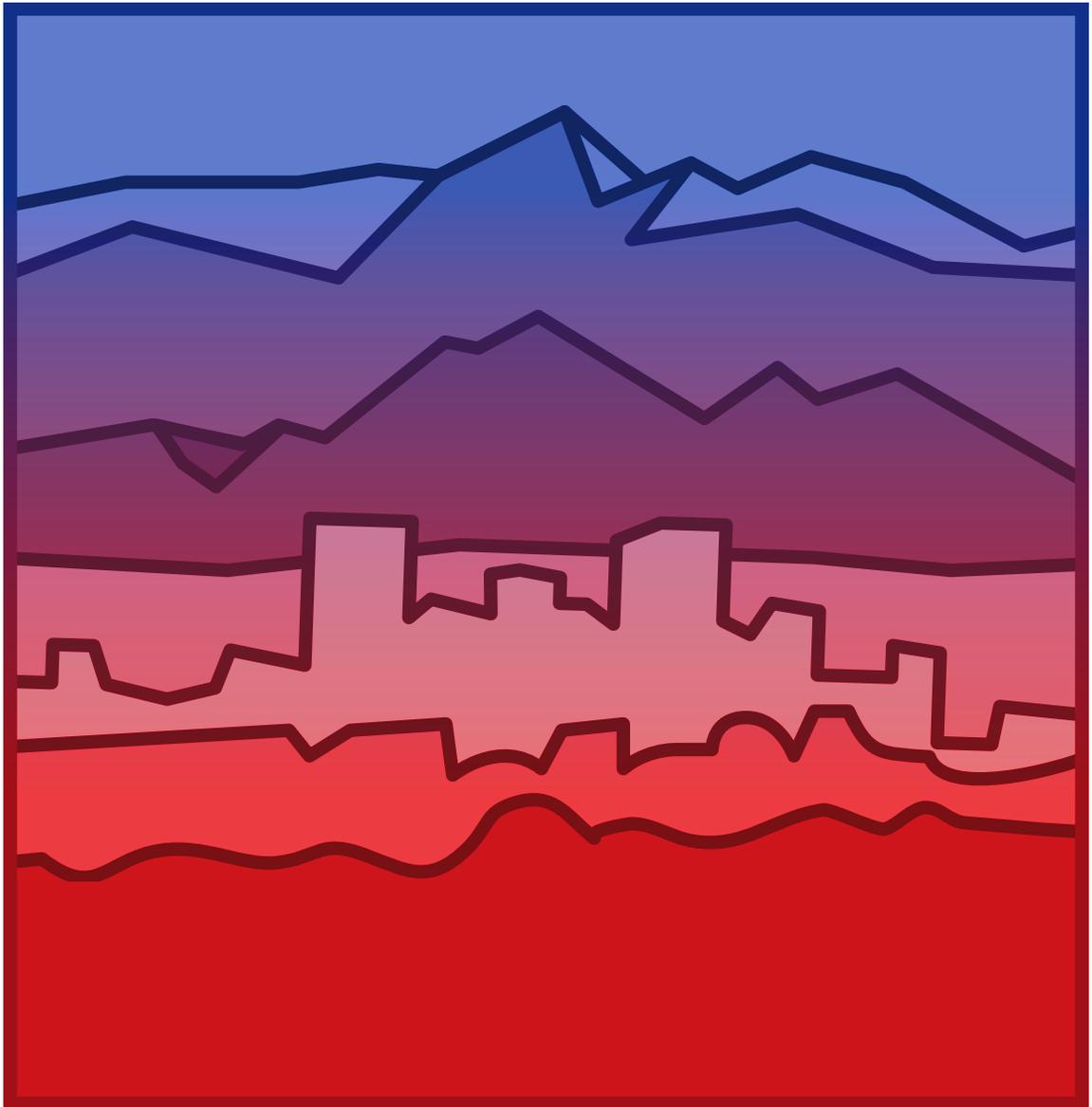




TABLE OF CONTENTS

Introduction 3

Methodology 3

Consumer Needs

- The Aging Population 4
- People Living with Disabilities 9
- Future Demand for Care 11

Workforce Needs

- Home Care Providers 12

Personal Stories 16

- Direct Care Worker 16
- Consumer 16
- Family Caregiver 17

Policy Solutions 18

- Caring Across Generations Policy Pillars 18
- Policy Recommendations 20

About the Partners 21

References 22



INTRODUCTION

As Coloradans, we believe that individuals deserve the freedom to live how they choose. As we age, that means being able to live at home with our families and in our communities—and retain our dignity and independence regardless of circumstance. While this is not the reality now, it should be. And it can be.

With the Baby Boom generation retiring, our country is on the verge of a major demographic shift. As millions of parents and grandparents grow older and require care, we can't imagine a situation that forces them to leave the homes they worked so hard to earn in order to get the care they need.

For too many Coloradans, aging at home is not an option. They cannot get the level of care they need – and they do not want to burden their families.

We have an opportunity to expand the home care workforce to bring that care into our homes – where we feel most safe and secure, where we are surrounded by our loved ones. A strong caregiving workforce allows aging Americans to spend their golden years in the places and with the people that matter most. And it helps families strike that balance between caring for parents and kids, holding down jobs, and planning for their own futures.

Now is the time to create the workforce that supports us, our family members and neighbors, to live and age with the respect, independence and choices we deserve, in our own homes and communities. We can create a system that values and respects the work of this workforce by ensuring that these jobs pay fair wages and provide a career ladder for workers in this sector.

The following report on the status of Colorado's caring economy analyzes how these trends are currently affecting Colorado and how we expect our state to change and grow in the future. The report includes data collected and analyzed by the Bell Policy Center, stories highlighting the need identified by the data, and potential short-term and long-term solutions that can be gained through state and federal policies.

METHODOLOGY

Data included in this report was collected and analyzed by the Bell Policy Center.

Data used for this report was extracted from a number of sources. Data on both the Colorado disabled population and home health care professionals were drawn from the U.S. Census Bureau's Current Population Survey (CPS) March Supplement for the ten year period 2003-2012. The sample of those who reported their specific disability (hearing difficulty, vision difficulty, etc.) is from 2009-2013. The sample was extracted from the Integrated Public Use Micro data Sample (IPUMS) program at the University of Minnesota. The sample of home health care workers was limited to those using census codes 3600-Home Health Care Aides (HHA) or 4610-Personal Care Aides (PCA) under 'Occupation' at the time of the survey. Eight counties were represented, with some unreported. The lack of a county listing is most likely for confidentiality. One possible sampling concern to consider is the occupation definitions the Census Bureau uses; it is possible many people who are self-employed or provide unpaid care for their families would not self define as home health aides or personal care aides. Because of underreporting there is also a significant possibility that undocumented immigrants make up more of the home health care aide population than shown here. While only 13% of workers identified themselves not as citizens, a report from The Center for Immigration Studies estimates that 33% of Colorado immigrants in the country are undocumented (<http://cis.org/2012-profile-of-americas-foreign-born-population#state>). In addition, data on the current number and projected number of home health aides and personal care aides and their average salaries comes from the Colorado Department of Labor and Employment, LMI Gateway, Occupational Profile. Finally, several charts and data listed here were created by the Colorado State Demography Office and are cited as such in the report.

For the purposes of this report the CPS racial categories were re-coded as follows: White (not Latino/a and White, only one race), Black (not Latino/a and Black/African American, only one race), Asian (not Latino/a and Asian or Pacific Islander, only one race), American Indian (not Latino/a and American Indian/Alaska Natives, only one race), Mixed-race (not Latino/a, multiple races), and Latino/a (Latino/a, one or more races).

CONSUMER NEEDS

The Aging Population

Colorado is currently a very young state; it has the 4th lowest share among the states of a population over age 65, but this will change dramatically over the coming years. Between 2000 and 2010 Colorado's overall population grew by 17%, already well over the national average of just under 10%. However, its population 65 and over grew by a massive 32% (133,552), and is projected to grow even more rapidly over the next twenty years.

Growing Aging Population. Historic migration to Colorado has led to a current age distribution with very few people over the age of 65 (11%). However, the aging of the younger population, especially the "Baby Boomers" born between 1946 and 1964 is predicted to well over double the population over 65, increasing by about 150% between 2010 and 2030. Figures 1 and 2 show the projected decrease in 18 to 44 year olds and increase 65 and over Coloradans (State Demography Office).

Between 2010 and 2020, Colorado's 65+ population is anticipated to increase by 61%, growing from 549,629 to 891,970 people. We are currently in the fastest growing decade for the population over 65, and by 2030, the population over 65 is projected to be 1.2 million people. After 2030, the growth rate for the 65+ is expected to slow to a similar annual growth rate as the total population, around 1.5%. Figure 3 is a visual representation of the shift in our state population's age over a 60 year span (State Demography Office).

While currently the Eastern Plains and more rural areas of Colorado have a larger share of those 65 and older, that will shift to the Metro and Western Slope areas starting in 2020. Figures 4 and 5 on page 6, illustrate the projected change in percentage of the elderly by county and differences in the aged population by region (State Demography Office).

Seniors with Disabilities. Currently 34% of those 65+ are living with a disability. It is projected that 69% of the population aged 65 and older will have a disability at some point, 35% of those 65 and older will enter a nursing home, and 50% of the 85 and older will need assistance with everyday tasks. See figure 6.

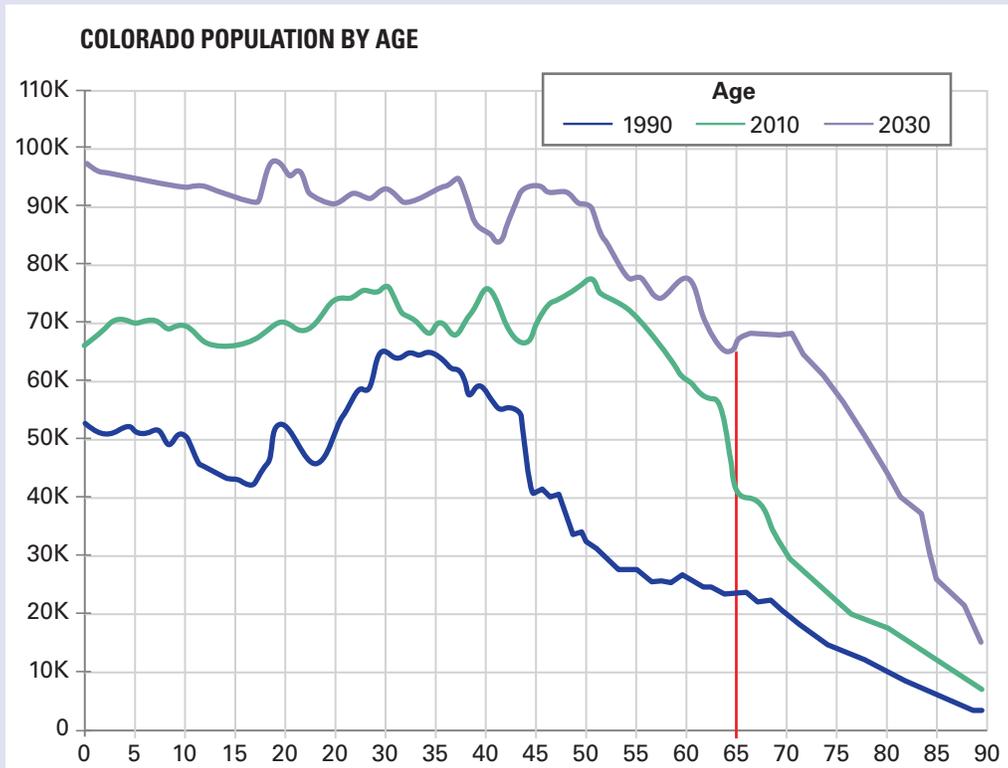


Figure 3. (Colorado State Demography Office)

SENIORS LIVING WITH DISABILITIES

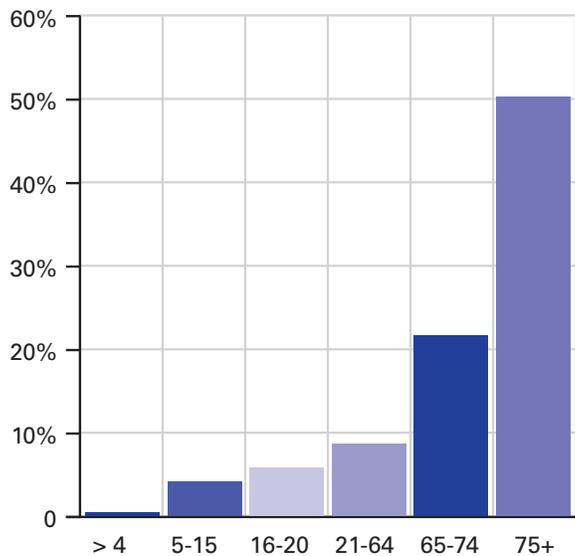


Figure 6. Disability Status Report for Colorado (Erickson, 2011)

PAST & FUTURE PROJECTED GROWTH RATE FOR THE POPULATION OVER 65 IN COLORADO

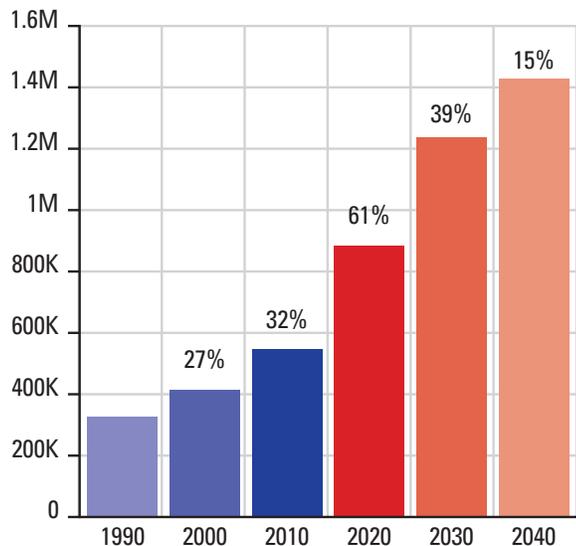


Figure 1. (Colorado State Demography Office)

SHARE OF COLORADO POPULATION, BY AGE

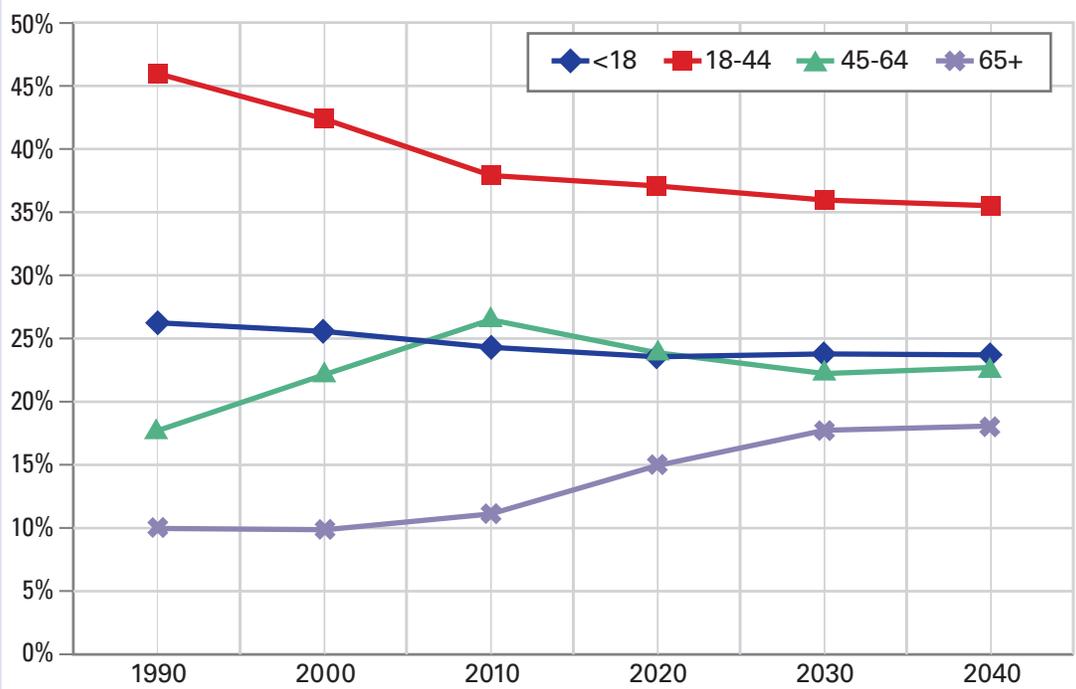


Figure 2. (Colorado State Demography Office)

AGE 65+ POPULATION PERCENT CHANGE 2000-2010

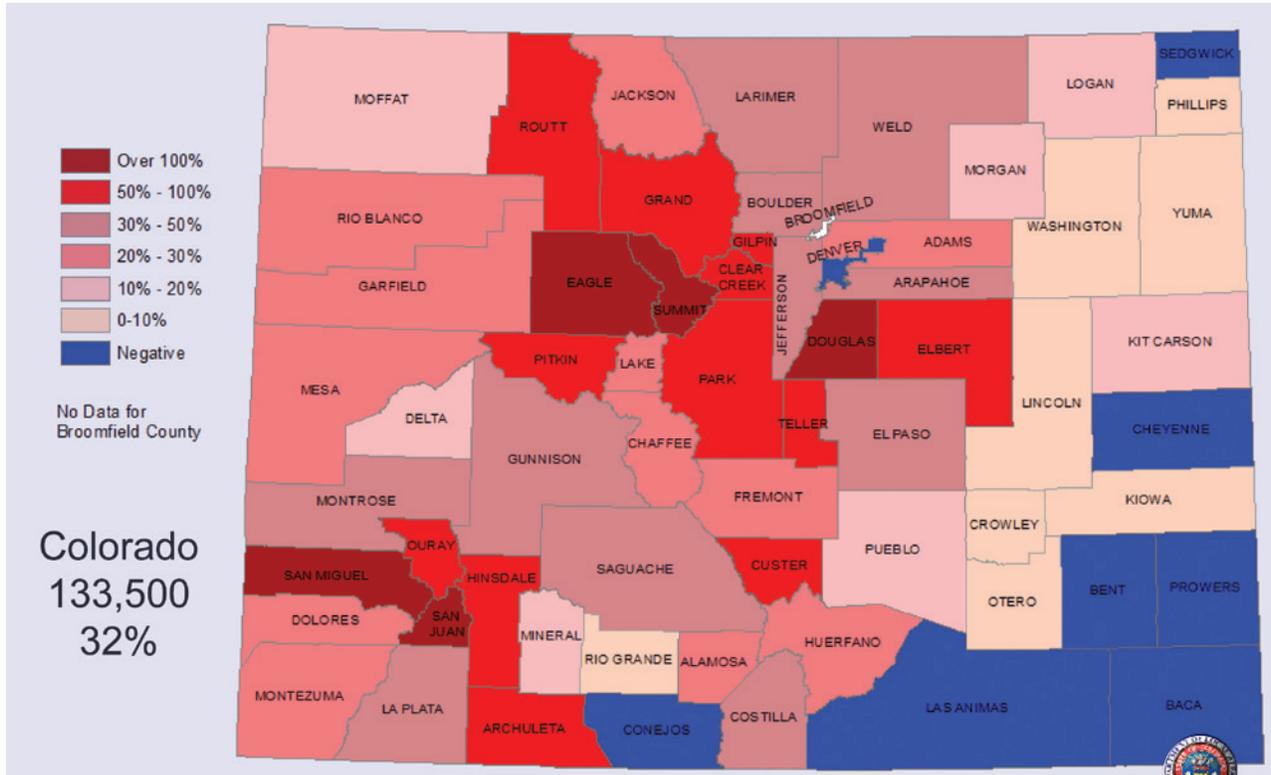


Figure 4. (Colorado State Demography Office)

Source: Census Bureau

Map Produced By State Demography Office

PERCENT OF THE COLORADO POPULATION 65+, BY REGION

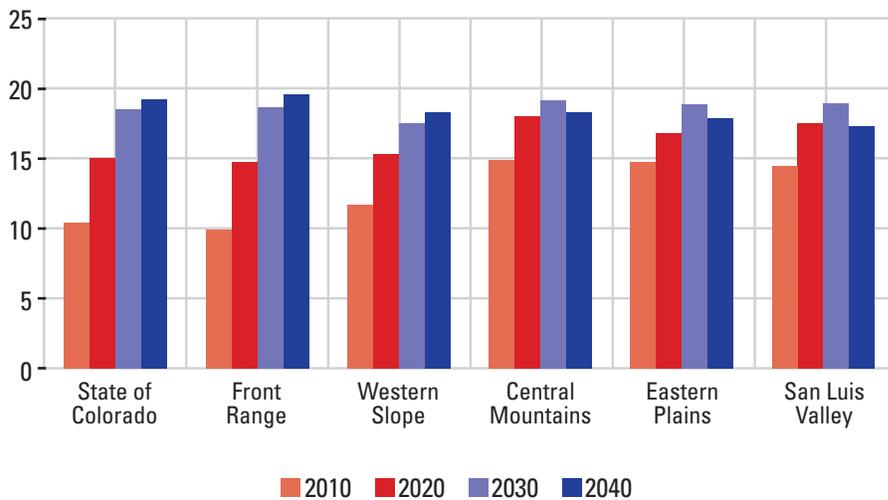


Figure 5. (Colorado State Demography Office)

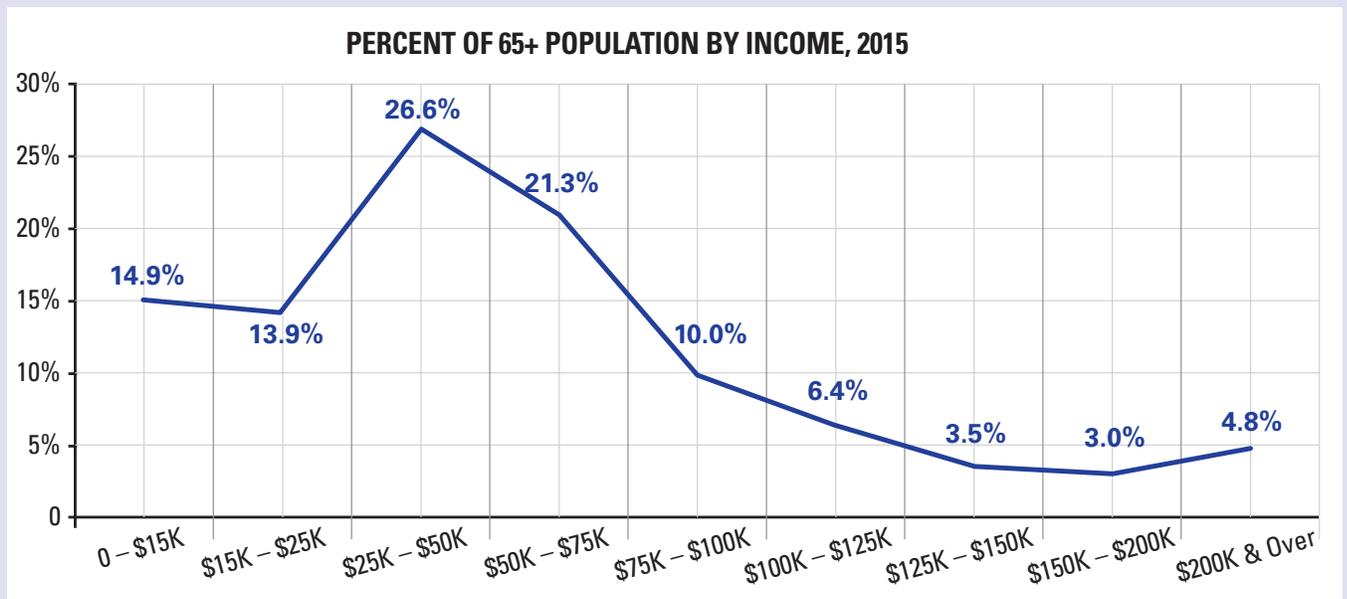


Figure 7. (Colorado State Demography Office)

Income and Poverty. As illustrated by figure 7, over half (53%) of Coloradans aged 65 and older are expected to have incomes totaling \$50,000 or less in 2015. This is slightly below Colorado’s median family income of about \$57,000 in 2012. Over 400,000 or 83% of Colorado’s seniors are projected to have incomes of \$100,000 or less in 2015. On the other end of the income scale, 22,000 or almost 5% of Coloradans aged 65 and over are expected to have incomes of \$200,000 or more. Figure 8 illustrates senior poverty rates by county (State Demography Office).

Race. Colorado’s overall population will become more diverse in the coming decades, and figure 9 shows that this holds true for older Coloradans as well. Non-white racial and ethnic minorities aged 65 and older are projected to grow by 319,000 or 356% from 2010 to 2040. The number of Latino/as aged 65 and older will

grow faster over this time period than other racial and ethnic groups and will represent an increasing portion of Colorado’s older population.

The number of Latino/as aged 65 and older is projected to grow by 49,000 or 83% from 2010 to 2020 and by 74,000 or 70% from 2020 to 2030. As a result a little more than 18% of all Coloradans aged 65 and older are projected to be Latino/a by 2040, almost double their 10% share of Colorado’s older population in 2010.

Conversely, the share of Coloradans aged 65 and over that are White, Non-Latino/a will decline from 84% in 2010 to 82% in 2020. The portion will drop further to 78% in 2030 and 72% in 2040. While the number of White Non-Latino/a Coloradans aged 65 and older is expected to increase by 282,000 from 2010 to 2020 and by 573,000 between 2010 and 2040, their share of the Colorado’s older population is expected to decline by 12 percentage points from 2010 to 2040.

People Living with Disabilities

Sex. People living with disabilities in Colorado are evenly divided by gender, which aligns with The Colorado Disability Status Report (Erickson 2011) that says 10.2% of females of all ages and 10.2% of all males reported living with a disability.

Age. Coloradans living with disabilities are a fairly young population, with a mean age of 33 years old; the oldest and youngest people surveyed were at the extremes of zero and 99 years old. See: *Age distribution of Coloradans living with disabilities, figure 10.*

Marital Status. Considering the ages in this population, it is perhaps not surprising that single/never married is the largest percentage of Coloradans living with disabilities (46%), followed closely by those married with a spouse (42%).

Race & Ethnicity. According to the census data drawn in this report, Coloradans living with disabilities are mostly White, which is similar to Colorado's general population numbers. However, as the Colorado 2011 Disability Status Report found,

AGE DISTRIBUTION OF COLORADANS LIVING WITH DISABILITIES

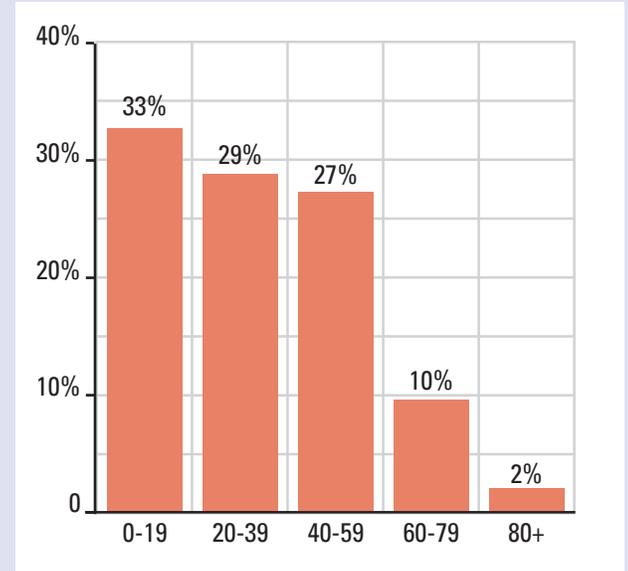


Figure 10.

RACIAL MAKEUP OF COLORADANS LIVING WITH DISABILITIES

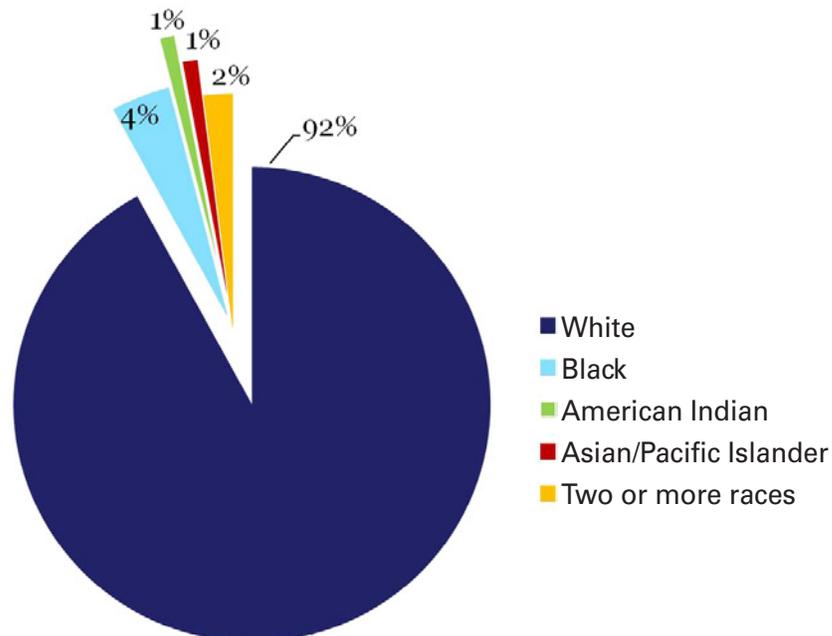


Figure 11.

severe racial disparities came into play with 21.4% of Native Americans reporting living with a disability while only 8.4% of White working-age people report living with a disability. Living with a disability was reported by 15.2% of African Americans, 4.5% of Asians and 11.9% among people of some other race(s). The vast majority of Coloradans living with disabilities (76%) reported as 'not Latino/a' on a measure of ethnicity. In the same vein, the majority of the Coloradans living with disabilities are citizens (88%), with only 7% identified as not citizens. See: *Racial makeup of Coloradans living with disabilities, figure 11 on page 9.*

Education. Educational outcomes were clustered around high school graduates/GED, some college- no degree, and those with a bachelor's degree. See: *Distribution of educational outcomes for Coloradans living with disabilities, figure 12.*

Employment Status. More than half of Coloradans living with disabilities are employed, with 26.5% of respondents saying they were not in the labor force and the rest distributed among several categories

such as unable to work and unemployed. This is a somewhat more positive view than that of the 2011 Colorado Disability Status Report, which found that only 42.6% of working-age people (aged 21-64) living with disabilities were employed. More troubling, only 28.2% of Coloradans living with disabilities were working full-time. This report found that of those who reported working part-time in the last year, a little less than half said it was because they wanted to work part time, meaning most would rather work full time.

Type of Disability. The most common personal care difficulty among Coloradans was a physical disability. Hearing difficulties, limited mobility, and difficulty remembering were clustered together in the middle of the pack, and vision difficulty was the least common disability among Coloradans. This aligns with data from the 2011 Colorado Disability Status report which found that 1.8% reported a visual difficulty, 1.9% a self-care disability, 3.3% a hearing disability, 4.0% a cognitive disability, 4.1% an independent living disability, and 5.1% an ambulatory disability.

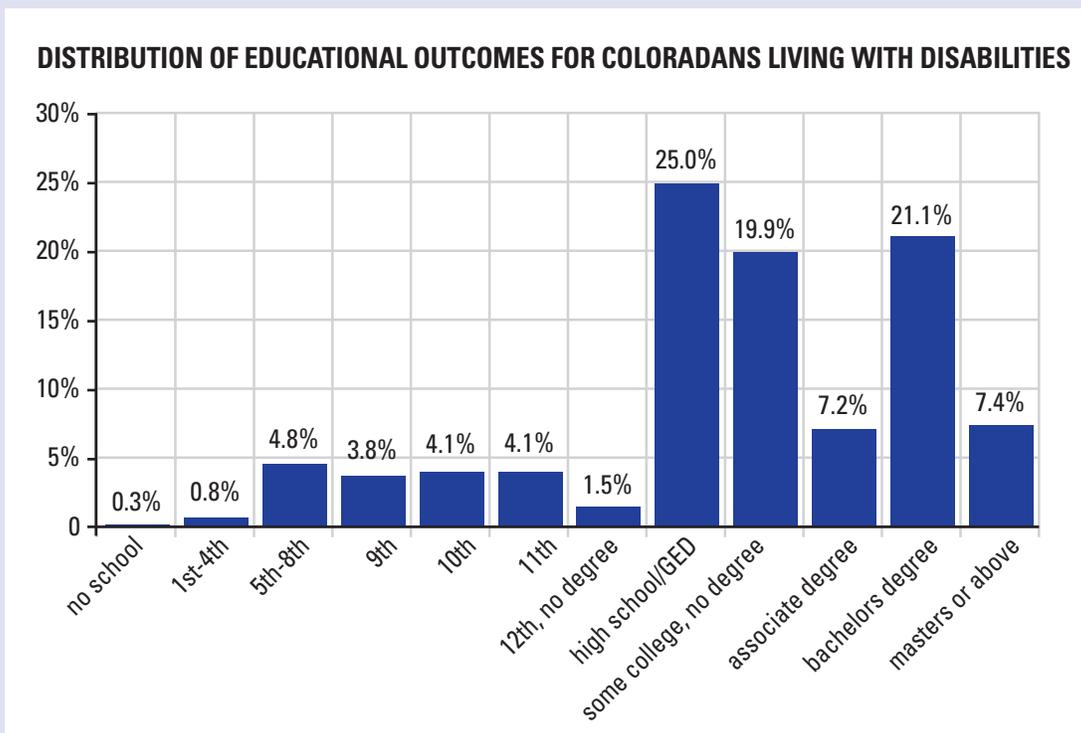


Figure 12.

PROJECTED AVERAGE ANNUAL GROWTH OF OCCUPATIONS, 2012 – 2022



Figure 13. CDLE, CMI Gateway occupational employment and future employment outlook.

Future Demand for Care

Nationally, there is currently a historical high of 2.5 million home health care workers. As the population ages, the profession is expected to increase at rates four to five times that of jobs in the overall economy. In Colorado alone, employment of home health aides is projected to grow by 50% between 2008 and 2018, while employment of personal and home care aides is expected to grow by 46% from 2008 to 2018 (CDLE). See: *Projected growth of Colorado home health care jobs, figure 13.*

The aging of the “Baby Boomer” generation, projected to fuel an increase in the 65+ population in Colorado of 150% between 2010 and 2030 will cause a natural increase in demand for home health workers as both old age and disability rates rise in Colorado (State Demography Office). According to the 2011 Disability Status Report for Colorado, 10.2% of people of all ages

are living a disability and 50.3% of persons 75 and over lives with a disability. Figure 6 on page 5 shows the increase in demand as people age.

Despite this extremely rapid growth of home health occupations in Colorado by 2020, we will face a large care gap between those needing services and those who can provide them. According to projections from the Colorado Department of Labor and Employment, in 2020 Colorado will have 24,000 personal care aides and 24,429 home health aides to care for a projected 891,970 Coloradans aged 65 and older. At a roughly 18:1 ratio, that is not sustainable, especially given that a third of Coloradans age 65 and older are currently living with a disability.

WORKFORCE NEEDS

Home Care Providers

Who will be providing in-home care for our aging population in Colorado? Two occupations jump to the forefront of discussion: personal care aides, categorized as a Healthcare Support occupation; and home health aides, classified as a Personal Care and Service occupation (PHI, 2014). Home health aides and personal care aides share similar basic duties of in-home care and basic health and life assistance. Sixty-seven percent of home health care workers in Colorado identified as a home health aide, and 33% identified as a personal care aide.

Personal Care v. Home Health Aide Training. However, while personal care aides have no federal training requirements, home health aides who work with Medicare agencies are required by the federal government to have at least 75 hours of training, 16 of which must be clinical (PHI, 2014). Like most states, Colorado does not require any additional training; only 16 states require more than the federal minimum (PHI, 2014).

Personal Care v. Home Health Aide Wages. With this slight difference in training, home health aides tend to be better paid than personal care aides, making a median annual wage \$3,914 higher than their personal care aide peers.

PAY DIFFERENCES OF HOME HEALTH AIDES AND PERSONAL CARE AIDES IN COLORADO- MEDIAN WAGES 2013

RateType	Home Health Aides	Personal Care Aides	Difference
Entry level annual wage	\$18,446	\$17,459	\$987
Median annual wage	\$24,328	\$20,414	\$3,914
Experienced annual wage	\$27,270	\$22,425	\$4,845
Entry level hourly wage	\$8.87	\$8.39	\$0.48
Median hourly wage	\$11.70	\$9.81	\$1.89
Experienced hourly wage	\$13.11	\$10.78	\$2.33

CDLE, Median Wages 2013, LMI Gateway Occupational Wage Data

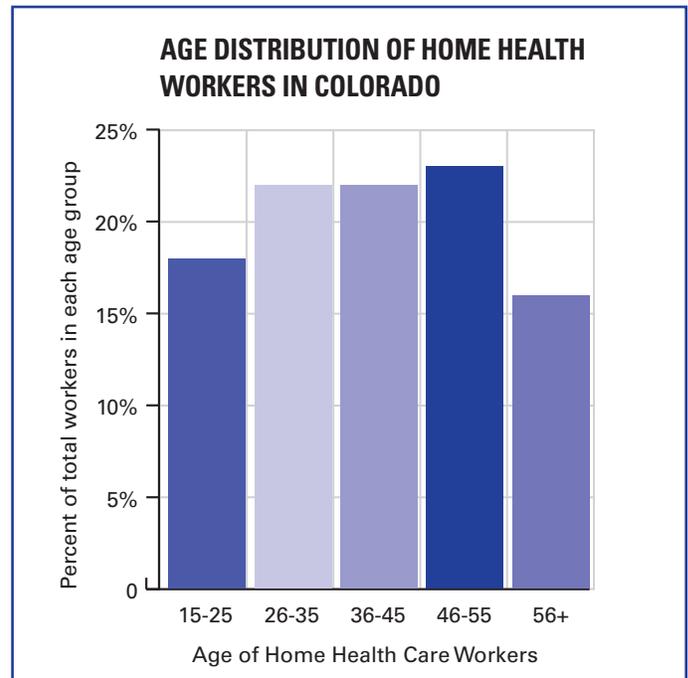


Figure 14.

Age. The mean age of a home health care worker in Colorado is 40 years old, with the youngest worker self reporting as 15 and the oldest 77. Figure 14 shows the distribution of workers by their age group, with most being in their prime working years. Nationally, the age of workers in-home health care skews older (Seavey, 2011). Though we cannot know from the Census data, it is possible Colorado's younger home health care workforce may be caused by its younger than the national average workforce in general. See: *Age distribution of home health workers in Colorado, figure 14.*

Sex. Females make up the vast majority (88%) of the home health care worker population in Colorado. This mirrors the national rate of 88%–90% female workers.

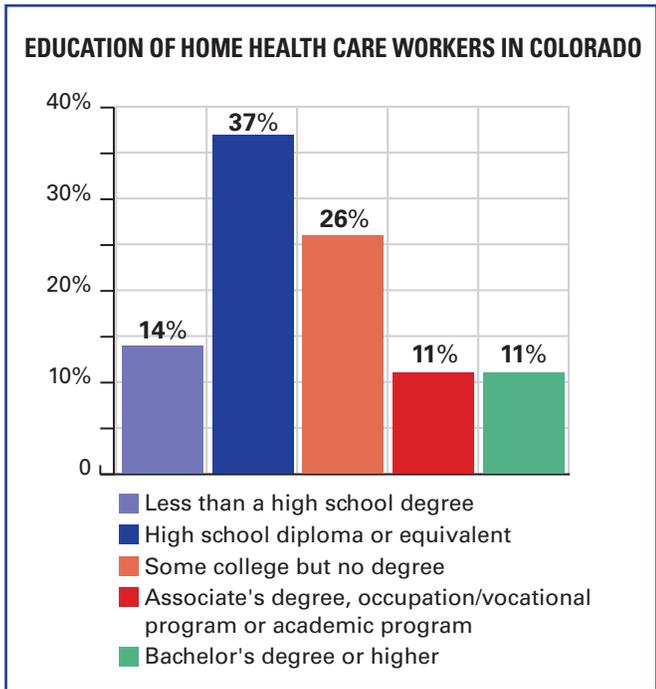


Figure 15.

Race & Ethnicity. Sixty-seven percent of home health care workers reported as White, with Latino/a the second largest population at 25%, then Asian, Black, American Indian and mixed race combining for the remaining 8.5%. Latino/a workers make up more than their share of the population within the home health care occupation while Black, American Indian, and

Asian/Pacific Islander workers were proportional to their Colorado populations as a whole (United States Census Bureau, 2012). The rest of the US is less proportional with about 31% of all home health care workers being Black and 15% being Latino/a (Seavey, 2011).

Citizenship Status. Most home health care workers in Colorado are natural born citizens (78%), while a few were born abroad of American parents (1%), a small percentage reported as being naturalized citizens (8%) and a small minority reported as not being a citizen (13%). This compares to national data which suggests that 49% of workers are non-white and 22% are foreign born (Leana, 2012).

Education. The majority of home health care workers in Colorado have less than a college–no degree. Nationally, 55% of personal care aides report having a high school diploma or less while 60% of home health aides report the same (Seavey, 2011). See: *Education of home health care workers in Colorado*, figure 15.

Work Setting. Eighty-seven percent of home health care aides are privately employed-wage or salary workers, 6% are self-employed (most not incorporated), another 6% are employed by the federal, state or local government and 1% report as an unpaid family worker.

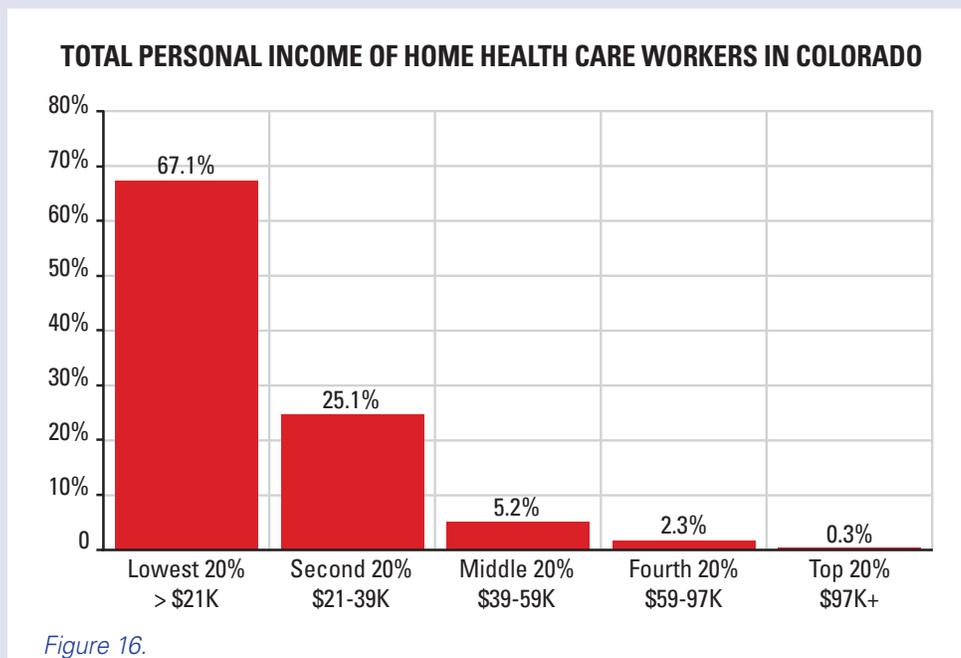


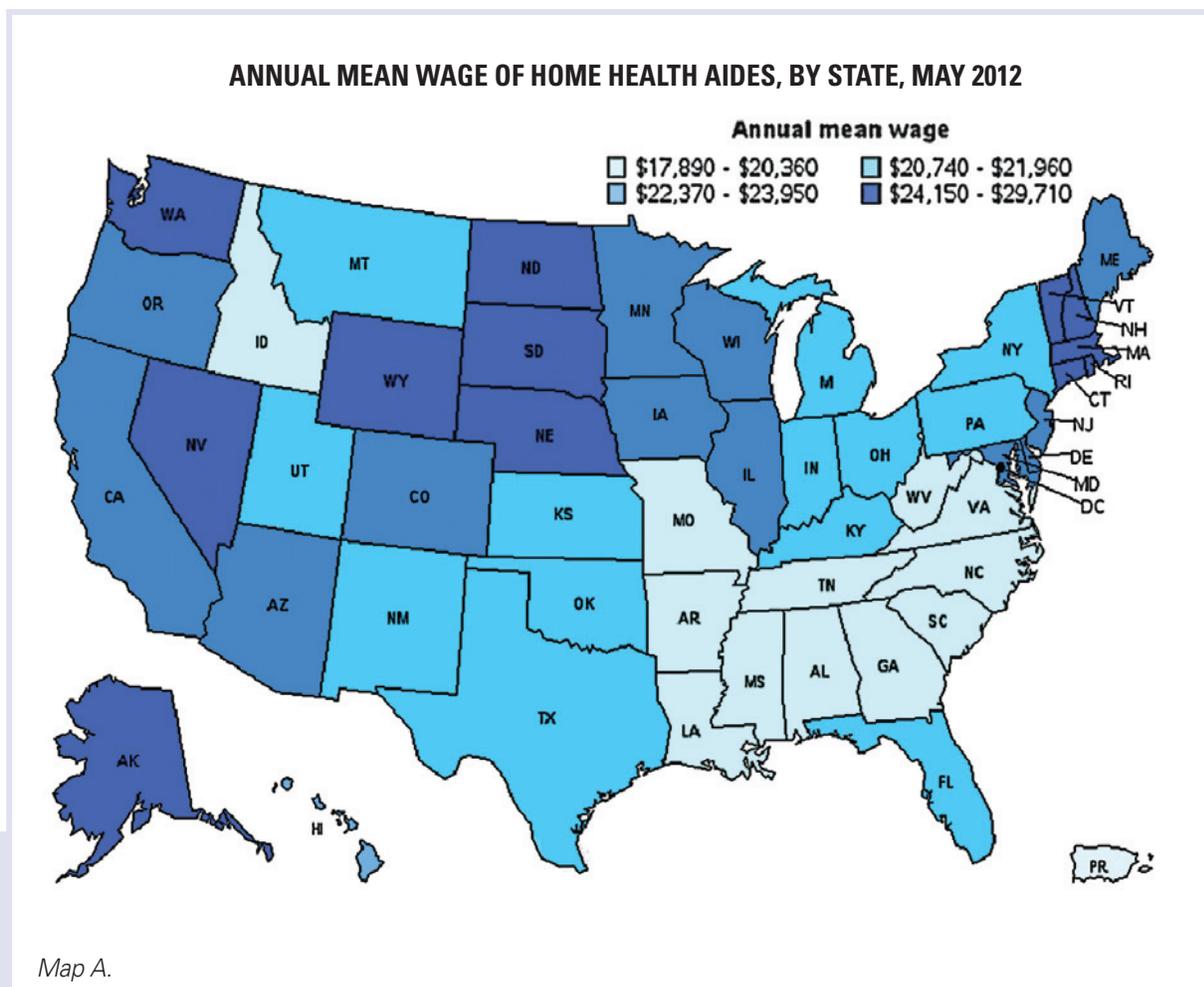
Figure 16.

Wages. While most home health care workers are privately employed their wages tell a story of poverty. Twenty five percent of workers reported having a total personal income of \$9,999 or less, and another 34% reported income between \$10,000 and \$21,000. As Figure 3 shows, approximately 90% of all home health care workers fall into the bottom two income quintiles while just 4% are in the top two. See: *Total personal income of home health care workers in Colorado, figure 16.*

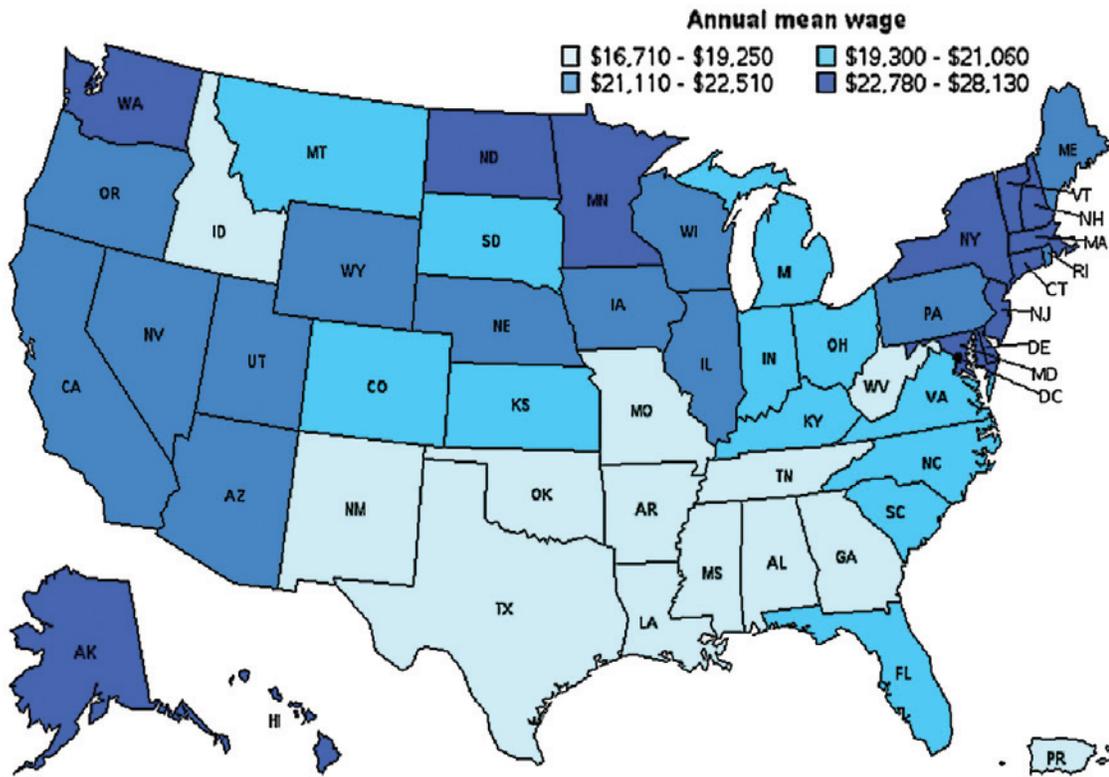
It should then be no surprise that 14% of home health care workers have incomes below the federal poverty line (FPL) for a family of one. Another 9% are within 100-124% of FPL and 4% are within 125-149% of FPL. All combined, 27% of home health care workers earn at 149% of the FPL or below. If the measure of self sufficiency was used instead of the FPL these numbers

would grow significantly, as 250% of FPL is generally used to approximate self sufficiency. Nationally, more than half of personal care aides receive some form of public assistance such as food stamps, Medicaid, cash welfare payments (Erickson, 2011).

By comparison, for the general population of Colorado the annual mean wage in 2013 was \$48,923. The median hourly wage was \$18.04 and the median annual wage was \$37,521. We know that female-headed, three-person households are extremely vulnerable to falling under the poverty line and are also one of the most common family formations under the poverty line. To be a single-headed household of three you needed to make more than \$19,530 in 2013 to be above the poverty line. In the general Colorado population, only those family formations in about the 10th percentile of income and below fall



ANNUAL MEAN WAGE OF PERSONAL CARE AIDES, BY STATE, MAY 2012



Map B.

below the poverty line.

As seen in *maps A* and *B*, Colorado lies on the upper half of mean wages for home health aides, and the lower half of states for personal care aide pay in 2012. For home health aides, the average annual pay in Colorado was \$23,090, or \$11.10 per hour. North Dakota (which only employs 1,879 home health aides compared to Colorado's 14,570) paid the highest average salary, \$29,710 annually or \$14.28 an hour. Nationally, the mean annual wage is \$21,830 and \$10.49 an hour (CDLE).

In May 2012, Colorado average annual pay for personal care aides was \$20,280, or \$9.75 per hour. Alaska paid the highest average salary, \$28,130 annually or \$13.53 an hour. The national average pay is \$20,830 annually or \$10.01 an hour (CDLE).

The top industries that employ home health care workers in Colorado are: social assistance (36.5%); ambulatory health care services (25.8%); administrative support services (6.0%); private households (0.1%);

nursing and residential care facilities (confidential %); and hospitals (confidential %). The last two categories account for 31.6% of the worker population, but since the data is 'confidential' the distribution between them is unclear (CDLE).



The following section provides the personal stories of three Coloradans directly impacted by the issues raised in this report.

DIRECT CARE WORKER

Araceli Diaz de Leon Thornton, CO

I first worked as a home care provider in Texas in the late nineties, before moving to Colorado. I had some minimal training, but no Certified Nurse Aide's (CNA) license. I cleaned my clients' rooms, helped

them put on prostheses, changed bed pans, and put out medication.

I would also take my clients grocery shopping in my own car. I was only paid about \$6.40 an hour [Ed: Approximately \$9.50 in 2014 dollars]. After

moving to Colorado, I saw an increase in my

wages, but never more than \$7.75 [Ed: Approximately \$11.49 in 2014

dollars] as long as I had only the most basic training. It was difficult to find

opportunities for further training, acquiring a license, or otherwise using

my experience to get a better position. When I first started doing in-home care

in Colorado, I was promised more pay raises, but they never materialized,

leaving me stuck at the \$7.75 wage.

When my mother became ill, I had to drastically cut back on my daytime

work hours. With three kids, I couldn't afford to work less, though, so I had to get a second job at night to make ends

meet. I worked as a dishwasher at a nursing home on the night shift. The

nursing home provided the opportunity to get further training and acquire my

CNA license. With my CNA's license, I was able to work at the nursing home

during the days. While the pay was better with my license, the nursing home work was not as personal as



caring for people in their homes. I had to take care of as many as fourteen clients at once. I could not come close to providing the level of personal care and attention I had been able to with my in-home clients.

As my mother became sicker, I eventually had to leave the nursing home job to care for her. As a family caregiver, I was not paid, so this was a period of acute hardship for our

family. It was important to me and her both that as she got older, she would be able to be with her family. I would gladly go back to providing in-home care for our elders if I could be in a private home, helping other elders stay close to their families, too. If there were better pay and a better chance to advance and use my experience in provide in-home care, it would be easier for me to do it. But with how little in-home care pays in Colorado, I just couldn't make it work. Today, I work as a domestic worker, cleaning homes and provide childcare.

CONSUMER

Beverly Grant Denver, CO

I am a single mother with three children, and I run a small catering business. My daughter Blayre is 23 and has significant developmental disabilities. Blayre requires full, round-the-clock support for daily living needs. Currently, through a Medicaid waiver program (Consumer Driven Attendant Support Services; CDASS) and Social Security Insurance (SSI), I am able to pay for nine hours of care, six days a week for a total of fifty-four hours a week. Even with these programs, I end up spending more of my own money out of pocket for Blayre's care. The fifty-four hours of care that the Medicaid waiver program and SSI pay for allows me to run my small business. Though this support is essential, there's still a huge time gap, especially when I have to work unusual hours as a caterer. There are 24 hours in a day. . .Blayre can never be alone.

The paid care is provided by a combination of a Certified Nurse's Assistant (CNA) and one of our family members who has had training in how to support Blayre. They're paid between \$12 and \$15 an hour. I have a good relationship with the CNA who currently takes care of Blayre, which I am very grateful for. I had to look hard to find a good CNA – word of mouth, online,

through agencies, anything. It has been a big challenge to find a CNA that I like and trust because Blayre is completely vulnerable. She is unable to speak, so if Blayre experiences something negative, she couldn't tell me. CDASS



allows me control over hiring, setting schedules, and assigning duties for Blayre's support, which has been critical to finding a CNA that I can work with to get Blayre high quality care. I would like to be able to give this CNA more work, but I can't afford to because my budget through Medicaid isn't big enough. I am given an annual budget set by the state and cannot go over it. If I do exceed my budget for Blayre's care, I'm worried that I would risk being cut from CDASS entirely, which would make it practically impossible to care for Blayre in-home.

For all the challenges of providing in-home care for Blayre, I am absolutely certain that this is the best option for my daughter. The only other possibility is institutionalization, which is expensive. It can also be isolating and depressing for vulnerable populations; there are scores of documented cases of abuse. It's something that I worry about, but it's family and we always have to do what we can for family. Blayre will always be with me at home. I know that keeping Blayre at home might be impossible without CDASS. I believe that more money and support is needed, especially for people with significant needs, because they cannot function or thrive sustainably without that support. Programs like CDASS need to be supported more because they create jobs, they keep families whole and healthy, and it's a more sustainable solution than institutionalizing them

FAMILY CAREGIVER

Shelby Ramirez Westminster, CO

In 2012, my youngest daughter Vanessa became very ill with no diagnosis in sight. After a few months and many doctor visits later, they found she had gallstones and needed immediate surgery. After her surgery, she continued to be ill and needed a second surgery because the surgeon had left a few gallstones behind, and they continued to make her very sick.

I had to take unpaid time off work again in order to continue to take care of Vanessa, and during this time my elderly father became very ill with diabetes and needed immediate eye surgery to save his vision. At the time I was the sole income provider for my family, and having to take care of both my daughter and my father took an enormous amount of time away from work, on top of spending every hour dedicated to their in-home health care.

With working a low wage job barely making it from paycheck to paycheck it is already a struggle to pay utilities, food and rent, but having to take unpaid time off was overwhelming. Every day when I should have been focused on my family's recovery I was preoccupied about the loss of income, when I should have been focusing on my daughter and my dad, therefore affecting the quality of care my family received.

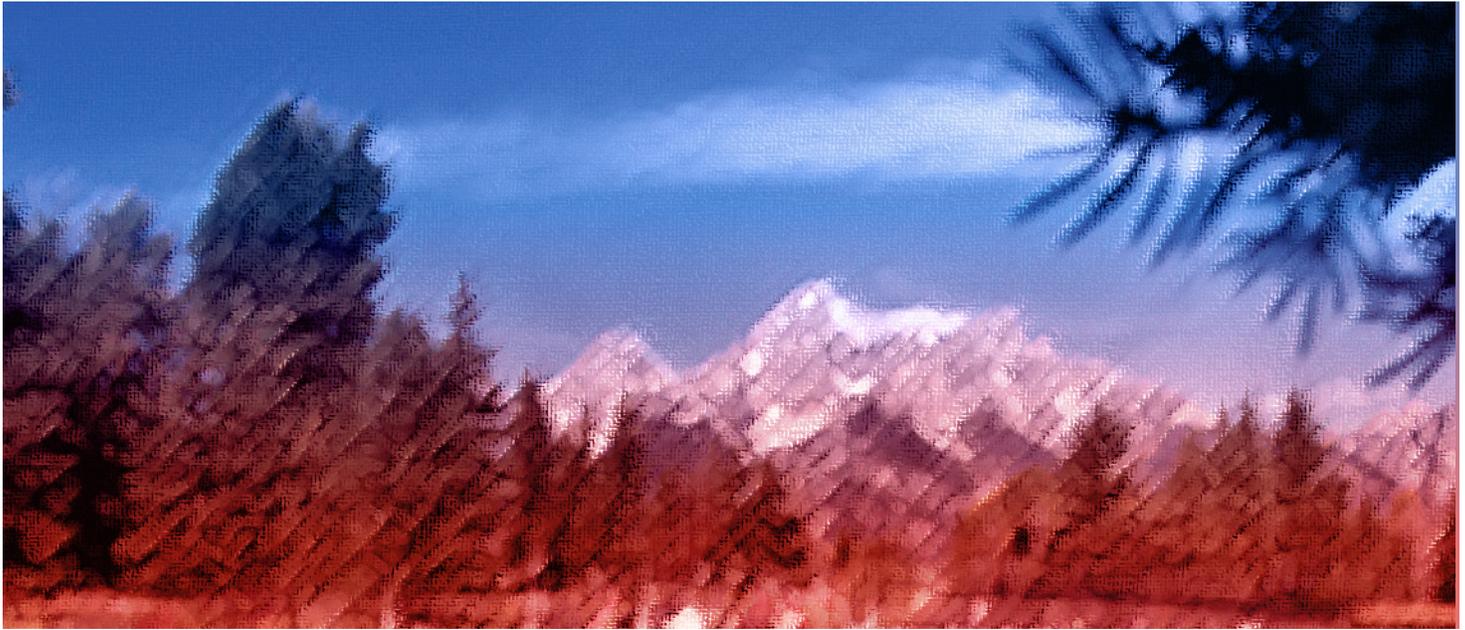


During this time I was very stressed from not having enough money for medications for my daughter and dad. I was forced to have to choose between paying rent and utilities, or buying the medicines and healthy food they both needed for their recovery. With me

bringing in the only income, I was all they had to depend on. I made the choice to buy their medication and healthy food to ensure a successful recovery. This meant I could not pay rent or utilities.

I work a low wage job, the stress of not having paid time off and struggling to pay bills put my own health in jeopardy, and I became physically ill from the high levels of stress. In addition, I was constantly worried about what the consequences would be once I returned to work after taking so much time off.

There are many families in the same situation that have to choose, do I take time off work and not have money coming in or do I take care of what means the world to me and that's my family. There is such a great need to have paid family medical leave insurance in order for all families to survive detrimental health issues within their own families.



POLICY SOLUTIONS

Every 8 seconds, another person turns 65 in our country. At the same time, we are moving into the third decade of the Americans with Disabilities Act and are progressing in our work to become more accessible and inclusive. Changing the way we care offers an opportunity to reinvigorate our economy, strengthen our communities, and uphold our national ideals. By working together, we can increase every person's access to the quality care and support they need at a price they can afford, and millions of high quality in-home care jobs can be created.

There are many policy changes that will allow us as a state and a country to take advantage of the growing demographic shift and ensure our stability into the future. We can make sure that the new care jobs are good quality and ensure a level of professionalism by offering training, creating models for career advancement and paying a living wage. We can also make supports more accessible through matching service registries and expanding and improving public financing of home care.

Caring Across Generations Policy Pillars

The Caring Across Generations campaign has proposed a set of broad national policy pillars to move toward the goals of caring for elders and people with disabilities in their homes and preparing a well-trained caregiving workforce. They are intended to set forth an array of policies that are potential solutions to the challenges

posed by the growing need for home care. Colorado may have needs that are not addressed by these, or that would be better served by alternate policy solutions but these pillars provide guidelines for future policy changes.

Support for Consumers and Families

Caregiving is an issue that affects us all. Rooted in the principle of interdependence between caregivers and people in need of long-term services and supports, Caring Across Generations proposes a set of policy solutions to ensure that seniors and people with disabilities receive care and services that are high-quality, dignified and affordable.

Caring Across is committed to proposing policies that create a comprehensive approach to making long-term care affordable and accessible in our communities. We are examining ways to provide additional public funding for long-term services and supports, reforming the private market for long-term care insurance, and creating refundable tax credits for working age individuals whose incomes are too high for them to qualify for Medicaid, but too low to pay for care. Caring Across Generations is also committed to policy reforms that would eliminate the institutional bias in Medicaid. To support family members who are providing care for their loved ones, we are proposing the creation of a social insurance program to provides paid family and medical leave, as well as social security caregiver credits for those who leave the workforce to provide care.

Job Creation

Around 10 million adults, half of whom are under the age of 65, are estimated to be in need of long-term services and supports. Ninety percent of these individuals report receiving unpaid care, while 13% of them report using at least some paid care. Many have unmet care needs because their family caregivers are overburdened, they cannot afford to hire home care workers, or government-funded programs provide insufficient coverage for long-term services and supports. In addition to the expected growth of more than 1.6 million direct care workers by 2020, Caring Across Generations estimates that an additional 828,500 home care jobs would be needed over the next decade to serve the needs of more than three million additional individuals. Caring Across Generations supports providing increased federal funding to create and improve these critical home care jobs.

Training and Career Ladders

Caring Across Generations wants to improve the quality of home care in America. Seniors and people with disabilities deserve care workers with the knowledge, skills, and support to do their jobs well. Current federal training requirements for home health aides have not been changed in more than 20 years, and there are no federal standards for training or certifying personal care attendants. This fragmented structure of training requirements hurts workers, too, by limiting mobility between jobs and prospects for career advancement.

Job Quality

Home care is one of the fastest growing industries in our economy, providing critical daily care, services, and supports to millions of individuals and families across the country. However, the quality of home care jobs is very poor. Home care workers often face low wages, few benefits, high turnover, and a high level of job stress and hazards. As Americans, we believe hard-working employees should earn fair wages, should have earned sick time to care for themselves and their families, and be free of abuse and exploitation by bosses; this includes home health care workers.

At the same time, Caring Across Generations is committed to ensuring that increased costs from raising wages and improving benefits do not lead to reductions in services to consumers, and CAG supports the establishment of state-based registries to connect consumers and providers of in-home services to expand care.

Roadmap to Citizenship

Immigration reform presents a remarkable opportunity to address the critical, rapidly growing need for quality in-home care while allowing millions of immigrant care workers to come out of the shadows, improving care and empowering workers to contribute to economic growth.

Our vision for immigration reform also includes providing a legal means for future care workers to enter the country when there is a shortage in the domestic care labor markets. Fair wages and strong job protections, including the right to change employers, to seek citizenship, and to full protections under the federal and state law to the same extent that other US workers are protected, are also integral to stabilizing America's care system while providing quality care for consumers and fair and just treatment for workers.

Sample policy recommendations aligned with policy pillars:

- Improve the quality of home care jobs by raising the wages of both publicly and privately funded home care workers and providing paid sick days;
- Develop national training standards for home care workers based on providing person-centered care and informed by efforts to identify core competencies, skills and knowledge to provide quality care;
- Establish clearly articulated career pathways for home care workers;
- Provide a broad path to citizenship to ensure that home care workers, domestic workers, seniors and people with disabilities are included;
- Support additional public funding for long-term services and supports;
- Create refundable tax credits for working age individuals whose incomes are too high for them to qualify for Medicaid but too low to pay for care;
- To best support family members providing care for loved ones, create a Family and Medical Leave Insurance program, as well as social security caregiver credits for those who leave the workforce to provide care.

Policy recommendations

Federal action on reforming our long-term services and supports (LTSS) system is moving forward, but it will take time. In the meantime, states, the primary default funders of long-term care through their Medicaid programs, are grappling with the need for more resources and reforms to meet the growing demand for long-term care services.

As we rely on states to meet this growing demand, we need to create critical resources at a federal level to explore state policy options and then use those resources to support state efforts to develop and implement innovative solutions. To fully support efforts to reform long-term care services and supports, change must come at both the state and federal level.

Federal

Pass federal legislation to establish a home care state innovation fund, creating a federal grant program to provide two types of awards: State Planning Grants and Pilot Project Planning Grants.

State Planning Grants could support states to study, analyze and document the long-term service and support (LTSS) needs of their populations, the availability and affordability of insurance and other financing options, and the adequacy of the workforce to meet projected demand in order to develop solutions to ensure LTSS for all state residents who need it.

Pilot Project Planning Grants would support the implementation of pilot projects to test strategies for LTSS financing, workforce development, and consumer support/quality of support, identified by states that have already undertaken such a planning process.

State planning grant funds are to be used for:

- a) Collecting and analyzing data about the state's long-term care system and the workforce that provides LTSS
- b) Devising policy proposals that would meet the varied needs of the population in need of LTSS; *and*
- c) Working with key constituency groups and the public to reach consensus on viable policy and program options. Funds may be used to establish a formal state sponsored commission to accomplish the above or to support more informal broad-based stakeholder advisory panels for the same purpose.

Colorado

There are many policy opportunities in Colorado that would help to continue to meet the needs of the growing population in need of long-term care. One such proposal is to create a long-term care commission to study and document issues related to the long-term care workforce and delivery system and to issue policy recommendations to address these issues.

The commission should include a diverse range of stakeholders including individuals from and organizations representing the aging community, workers, family caregivers, and people living with disabilities. The commission's responsibilities could include the following:

- Identifying problems with current long-term care capacity, programs, and services
- Documenting the long-term service and support needs of Colorado's population
- Researching the availability and affordability of insurance and other financing options
- Considering issues related to care workers who provide long-term services and supports, such as:
 - » Whether the number of such workers is adequate to provide long-term services and supports to individuals with long-term care needs
 - » The potential mechanisms for creating additional home care jobs to meet the growing need for long-term care
 - » Wages, working conditions, and other workforce development necessary to deliver high-quality services to such individuals
 - » Development of entities that have the capacity to serve as employers and fiscal agents for workers who provide long-term services and supports in the homes of such individuals
- Developing policy recommendations that would meet the varied needs of the populations in need of long-term care support and services

ABOUT THE PARTNERS

About Caring Across Generations

Caring Across Generations (CAG) is a multi-faceted campaign that is changing the way America cares for seniors, supports people with disabilities, and values caregivers and care workers. CAG brings together aging Americans, people with disabilities, their families and care workers to protect all Americans' right to choose the care they need to live and age with dignity in the place and with the people that matter most to them. Recognizing the value of the relationship between those who need care and those who provide it will create an economy and a society that works better for all of us. We can create millions of high quality care jobs that provide the support for every family to care for their loved ones.



Colorado Partners

9to5 Colorado is a statewide chapter of 9to5, a grassroots membership-based organization created to address the issues of women directly affected by low-wage jobs, welfare, low-income childcare, nonstandard work, unemployment, and discrimination. The mission of 9to5 is to build a movement to achieve economic justice by engaging directly affected women to improve working conditions. 9to5 combines grassroots organizing, public and electoral policy campaigns, civic engagement, advocacy, public education, and leadership development in efforts to strengthen the safety net for low-income families and to improve employment policies, while laying the basis for longer-term goals, especially the creation and retention of family-supporting jobs and the elimination of all forms of discrimination and oppression.



Colorado Jobs with Justice

is a coalition of twenty unions, community groups, faith-based and student-youth organizations. It is one of the oldest chapters of the national Jobs with Justice network, which has a more than twenty-five year history of working for social and economic justice.



Centro Humanitario Para Los Trabajadores (El Centro)

Centro Humanitario Para Los Trabajadores is Denver's only day laborer center promoting work, dignity and community. The mission is to promote the rights and well-being of day laborers in Colorado through education, job skills, leadership development, united action and advocacy.

Since 2002, over 1,500 workers have accessed El Centro's programs, including countless employment and self-improvement opportunities that directly benefit low-income laborers, domestic workers, and immigrants. El Centro's dedication and continued efforts have played a crucial role in promoting awareness and advancing reforms that address everyday struggles and hardships, as well as structural barriers, surrounding this underrepresented and often invisible, community.



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