



ILLINOIS PARTNERS

for

HUMAN SERVICE

More Essential Than Ever:

Rebuilding the Illinois Health and Human
Services Workforce in the Wake
of the COVID-19 Pandemic



November 2021

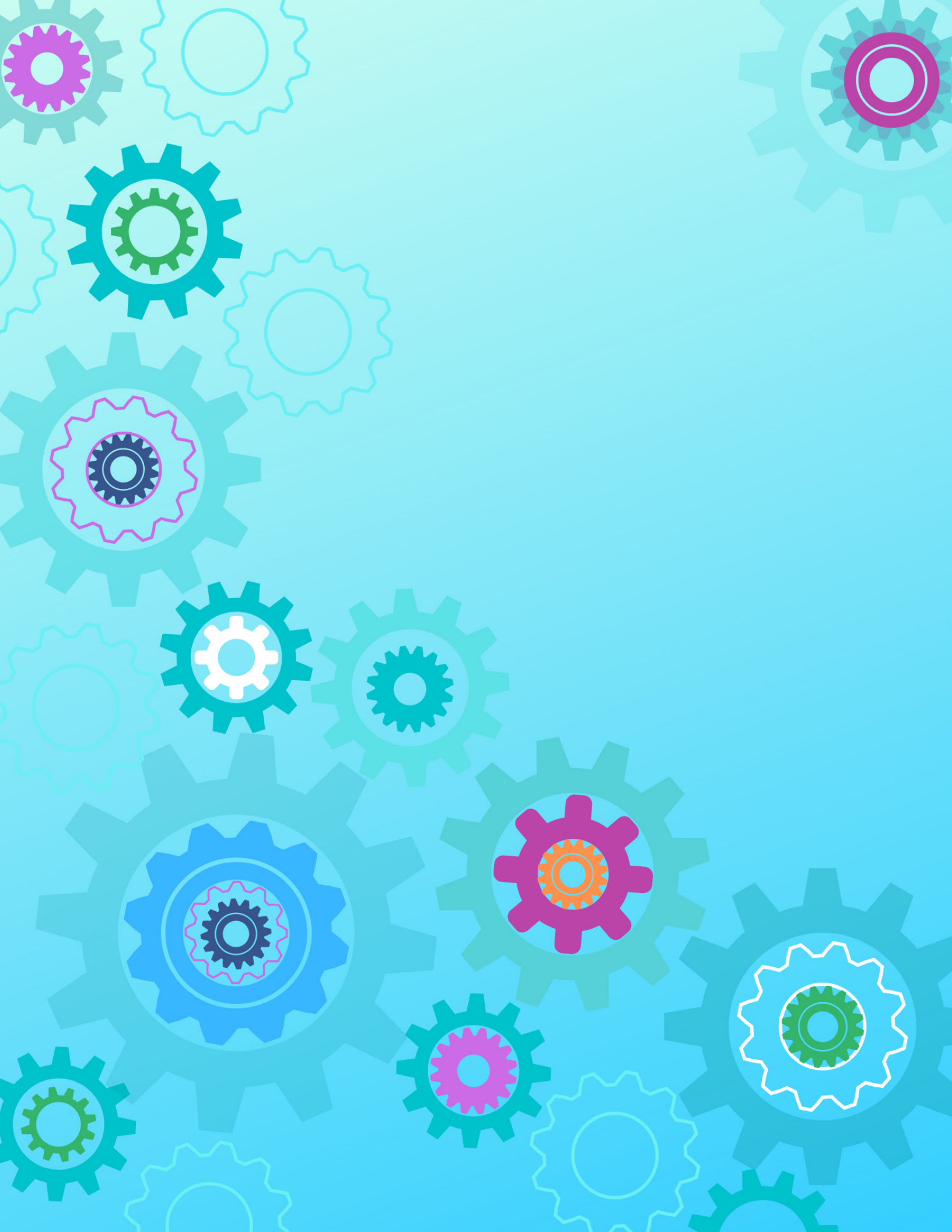


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LETTER FROM OUR Executive Director

Dear Reader,

Our relationship to work is transforming. The priorities of employees are fundamentally changing as people make difficult choices, driven by their concern for safety, their adaptation to new service models, obligations to care for their children or aging parents, and a desire to have a healthy work-life balance. These shifts, brought to the forefront during the last 18 months, will reverberate for years to come.

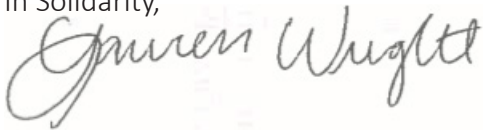
What does this transformation mean for the health and human services workforce, which has shouldered the burden of care throughout this pandemic? While the sector is certainly experiencing a crisis, I am reluctant to call it a “workforce crisis.” To do so suggests that the workforce is the problem, when in fact our problem is much deeper. Health and human services in Illinois have been experiencing systemic disinvestment for more than twenty years, and our workforce is bearing the brunt of the sector’s shaky foundation.

With these issues in mind, this research highlights sector-wide workforce trends in hiring, vacancies, and turnover, and identifies associated effects caused by COVID-19 on the health and human services workforce. Three key themes emerged:

1. The health and human services workforce is majority female. Black and Latina/x/o people are disproportionately represented among lower-wage, frontline staff. **Therefore, investing in the health and human services workforce is inherently a gender and racial equity issue.**
2. Community-based organizations are experiencing **record levels of turnover and having unprecedented difficulty filling vacancies.**
3. Unlike other sectors, health and human service employers, dependent on state contracts and rate reimbursement, cannot raise the price of their goods or services to increase employee wages. **Therefore, the state must commit to bold and actionable fiscal and policy measures to ensure the sustainability of the health and human services workforce.**

Complex problems require complex solutions. While there are short- and long-term recommendations at the end of this report, we know there are no quick fixes. Twenty years of disinvestment and a global pandemic led us to this moment of reckoning. It will take a fundamental paradigm shift to emerge successfully and prove we value our communities by fully investing in their well-being. There is no better time to recommit to this work than now.

In Solidarity,



Lauren Wright
Executive Director, Illinois Partners for Human Service



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For a full list of survey and focus group participants, see Appendix.



Executive Summary

Early in the COVID-19 pandemic, the health and human services sector quickly pivoted to ensure that vital services were not disrupted in the communities they serve. Since then, sector employers and workers have exhibited resiliency, creativity, and ingenuity in navigating challenges while continuing to fulfill their missions in the midst of an ongoing public health crisis. They do so despite historically insufficient state funding that undermines workforce stability, particularly among low-wage, essential, frontline, and direct service workers.

Illinois Partners for Human Service (Illinois Partners) conducted statewide research to identify what factors are most affecting the health and human services workforce in the wake of the pandemic. This new survey of nonprofit community health and human service organizations, including focus groups, builds upon prior [Illinois Partners' research](#) that shows how low state reimbursement rates, underfunded contracts, low wages, high turnover, and systemic inequities are affecting the ability of health and human service professionals to provide sustainable and quality care to Illinoisans. In this research, Illinois Partners collected detailed financial and wage data from 48 organizations including demographic information for over 12,600 health and human service professionals. This survey data was supplemented by five geographically-based focus groups with a total of 16 organizations. Prior to this research, non-proprietary demographic data with associated wages was not available for the Illinois nonprofit community health and human services workforce.

Key Findings

Workforce Demographics

- 77% of health and human service employees are essential frontline workers;
- Nearly 77% of employees identify as female;
- 52% of the workforce is Black, Indigenous, Latina/o/x and people of color (BILPOC);
- 54% of frontline workers are BILPOC while nearly 59% of senior leadership is White;
- Disparities in wages for hourly compensation are influenced by job category, geography, and organizational size.

Impact of COVID-19 on Finances and Operations

- 93% of survey respondents reported COVID-19 revenue increases;
- 76% reported increases in COVID-19 expenses;
- Smaller organizations experienced more volatility, with bigger swings in pandemic and non-pandemic revenue (both positive and negative), than their larger counterparts;
- Emergency COVID-19 funding helped but is not sustainable and does not fix workforce issues;
- For some, COVID-19 mandates (e.g., capacity limits) resulted in more costs for fewer clients.

Turnover, Vacancies, and Hiring Barriers

- The periods in which the most organizations experienced their highest turnover during the study period (compared to pre-pandemic levels) was at the onset of the pandemic (January-March 2020) and in the last quarter of fiscal year 2021 (April-June 2021);
- 57% experienced higher vacancies during the study period than their pre-pandemic baseline; another 28% reported double or more vacancies;
- Lack of applicants and lower wages were the most commonly reported hiring barriers;
- The sector is collectively experiencing increased workforce challenges with record levels of vacancies, turnover, and growing wage gaps, likely influenced by the COVID-19 pandemic.

Based on these key findings, public officials and sector leaders may clearly assess where inequities exist and strive to eliminate them. A common call among all survey participants was for the State of Illinois to acknowledge and take the lead on addressing these issues. We recommend the following solutions, because doing so will maximize human potential and benefit all of our communities.

Recommendations

- **Fiscal Year 2023:** The State budget should make a significant investment toward pay equity by increasing reimbursement rates and other state contracts to [fully fund the cost of services](#) and add funding for scheduled minimum wage increases, associated benefits, and wage compression. In doing so, FY23 health and human service agencies' budget proposals must clearly delineate any amount appropriated above the FY22 baseline.
- **Short-Term Recommendations:** The State should:
 - Establish a cohesive, consistent, and equitable funding methodology for the sector to keep pace with the costs of living and doing business;
 - Raise the cap on overhead expenses in state contracts; reduce the rigidity and complexity of administrative rules;
 - [Improve GATA](#) and reduce the frequency, redundancy, and complexity of reporting requirements;
 - Permit some capital expenses to be covered under state contracts;
 - Ensure timely and predictable payments; and make it easier for contractors to move money among line items.
- **Long-Term Recommendations:** The State should strengthen a variety of programs that support the health and human services workforce pipeline such as:
 - Expand and simplify scholarships, tuition reimbursement, and loan forgiveness;
 - Improve professional development and training opportunities;
 - Invest in bilingual and culturally competent professionals;
 - Bolster paid leave and access to affordable, quality child care;
 - Enact legislation to compensate public and private employees equitably;
 - Provide access to mental health services and COVID-19 testing;
 - Reduce reliance on Fee-For-Service (FFS) models;
 - Require managed care companies to standardize and simplify practices statewide;
 - Revise credentialing and licensure rules to create more flexibility in hiring practices.

Introduction

The ongoing public health crisis further exposed the financial and systemic vulnerabilities of health and human services—a sector that is essential to the well-being of Illinoisans from Rockford to Chicago to Southern Illinois—and is instrumental in providing vital resources on the front lines during uncertain times.

Health and Human Services

The health and human services sector plays an integral role in fostering human potential for all members of society, providing the essential elements to build and maintain physical, emotional, and economic well-being at every phase of life. [Health and human service](#) organizations are also major employers, whose employees provide services to ensure safe and stable housing, nutrition, and health and mental health services for children, young parents, adults, families, people with disabilities, and older adults. By supporting people throughout their lives, health and human service providers construct and sustain well-being for everyone. The importance of these services was evident, and more critical than ever, as the nation and our state grappled with the devastating impact of COVID-19 on our communities.

Illinois Partners for Human Service

Illinois Partners for Human Service (Illinois Partners) is the largest shared voice of health and human service organizations in Illinois, with a [coalition of more than 850 partners](#) representing every community, county, and legislative district in the state. Illinois Partners mobilizes our coalition to engage in collective advocacy to ensure the ongoing strength of our sector so that all Illinoisans are able to reach their full potential.

Impact of COVID-19 on Health and Human Services

A stable health and human services workforce is vital to the well-being of our communities. From the onset of the pandemic, the sector exhibited enormous resilience and ingenuity, pivoting to new service models, rapidly scaling telehealth and safety protocols, and distributing resources at unprecedented levels. These frontline employees worked tirelessly while being tested like never before. Yet, our previous research has shown time and again that over the past 20 years the health and human services sector has been negatively impacted by funding shortages, low state reimbursement rates, underfunded contracts, wage disparities, systemic inequities, and high turnover rates. The impact COVID-19 laid bare the financial and systemic vulnerabilities of health and human services, even while providers continued operating on the frontlines throughout the pandemic.

As the state begins to recover and adapts to a new normal, **the health and human services workforce will continue to experience profound and multi-faceted challenges that warrant a vigorous and systemic response** from elected officials and sector leaders.

Research Purpose

In recent years, Illinois health and human services providers have clearly and consistently reiterated that workforce is the number one challenge for the sector. When [Illinois Partners surveyed our coalition in late 2020](#), the need for additional funding to cover compensation was resoundingly identified as a top priority, including the cost of implementing the new minimum wage. In order to build on related existing knowledge, Illinois Partners recognized the need for publicly available, non-proprietary, disaggregated demographic and wage data about the nonprofit community health and human services workforce.

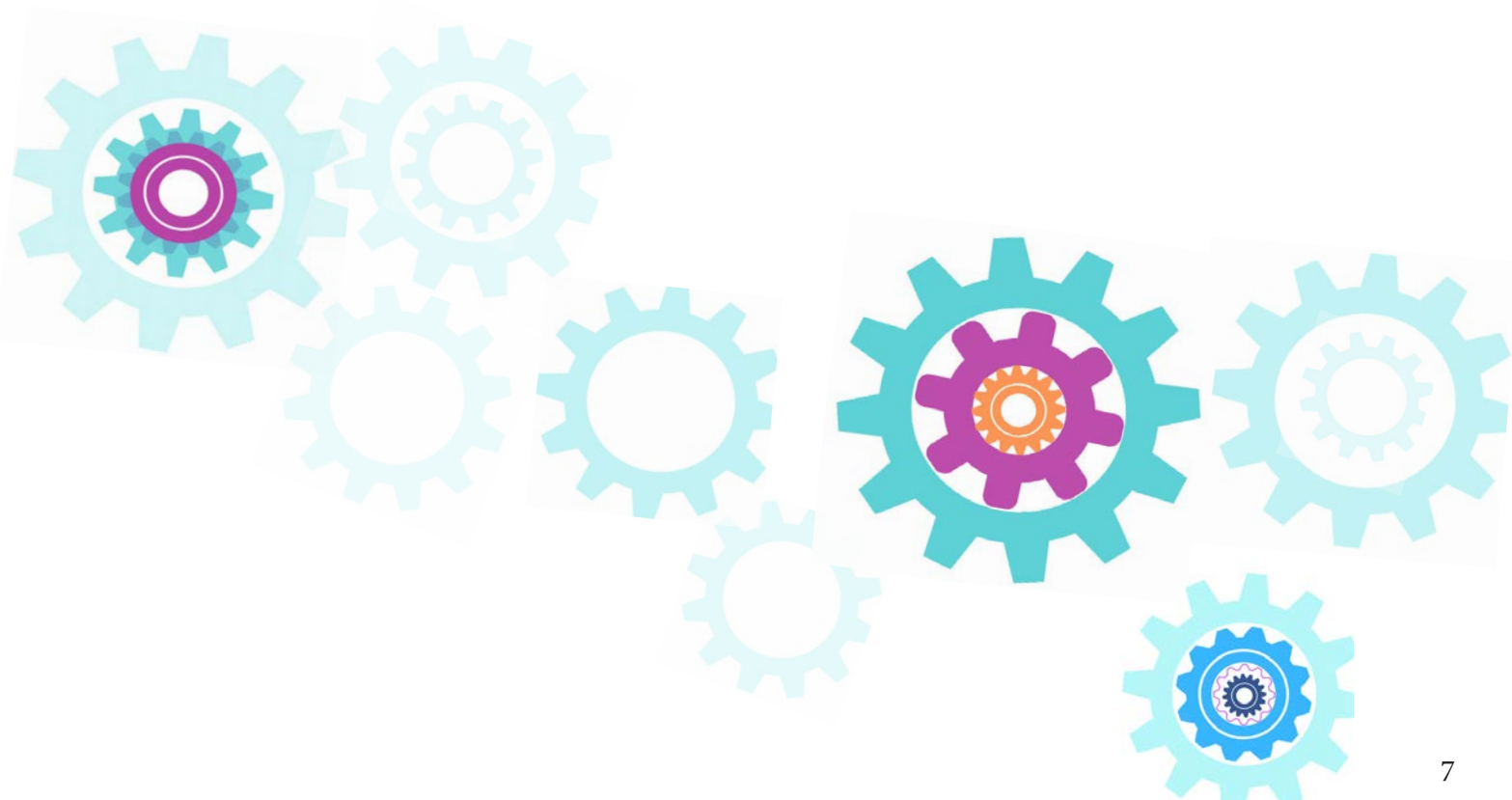
The purpose of this report is to focus on the importance of supporting and investing in Illinois' human services workforce. The research was framed around the following questions:

- **What factors impact the stability of the health and human services workforce in Illinois?**
- **What are the ongoing challenges facing the health and human services sector?**
- **What is needed to stabilize and strengthen the health and human services workforce in the future?**

Moving Forward

As our state shifts toward post-pandemic recovery, this research identifies inequities and can be used to inform policies to ensure a more equitable recovery for the health and human services workforce. The data tell an important story, showing that **without major investment in the sector, Illinois could face a shortage of essential workers and community resources in future years that will compromise well-being throughout the state.** The recommendations at the conclusion of this report should help state officials, in both the executive and legislative branches, identify concrete actions that will help move the needle in real ways. In addition to providing this research to state officials directly, Illinois Partners will equip our coalition to conduct advocacy at local, regional, and statewide levels, to engage in dialogue about geographically unique workforce issues, and to facilitate organizational assessment and strategic planning related to diversity, equity, and inclusion.

This report is intended to generate a broader discourse around the challenges health and human services face in Illinois so that stakeholders are compelled towards actionable solutions to stabilize the sector. It is premised upon the beliefs that dynamic and skilled employees are at the heart of a robust sector, and that they should be supported and compensated at a level that reflects their value. These findings must be incorporated into our collective advocacy as if the very well-being of our communities depends on it, because it does.



Methodology

Survey

Our coalition partners were invited to participate in a workforce survey that was compiled via Survey Monkey in August and September 2021; invitations were amplified through health and human service trade associations. The survey data collected reflects more than 12,600 employee records from 48 nonprofit health and human service providers throughout Illinois, 21 organizations with fewer than 100 employees and 27 with 100 or more employees. The survey was developed by Illinois Partners in conjunction with coalition partners who helped refine and pilot the data collection mechanisms. [Short](#) and [long-form](#) templates were provided with instructions to guide each organization through the process, and to facilitate data collection prior to accessing the online survey. Specific survey questions are included in the long-form template. General survey topics included:

- Employer size, geographic area, and type of service;
- Sources of revenue;
- Impact of COVID-19 on revenue, expenses, and operations;
- Turnover, vacancies, and general barriers to hiring;
- Employee demographic data according to job category.

The distribution of survey participants by geography is shown in Figure 1 and is further categorized by size of organization. Figure 2 lists the top areas of service provision.

Figure 1.

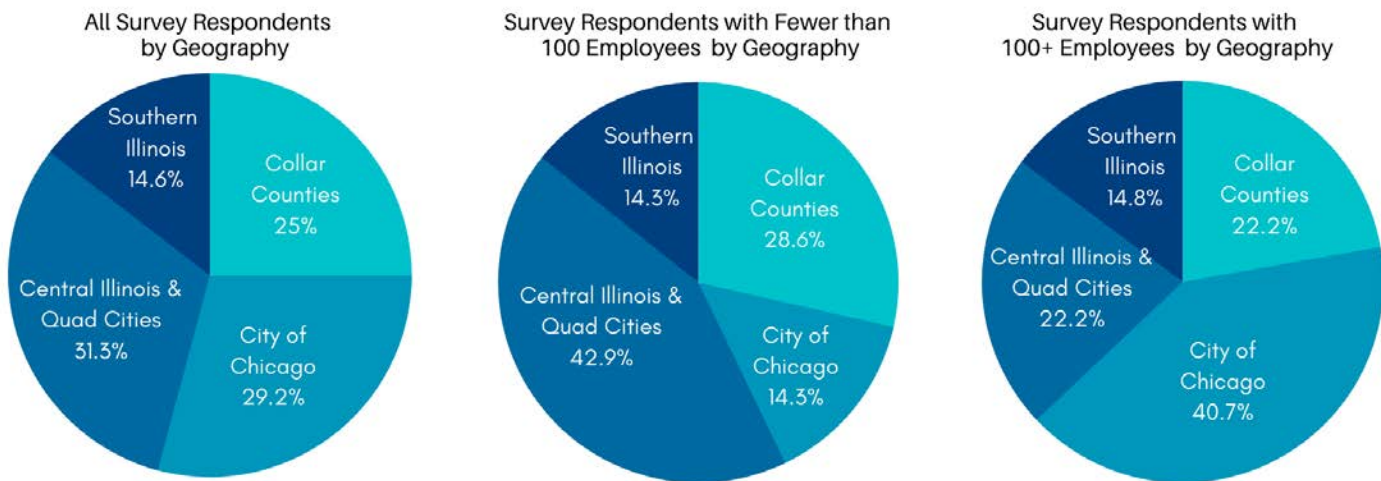
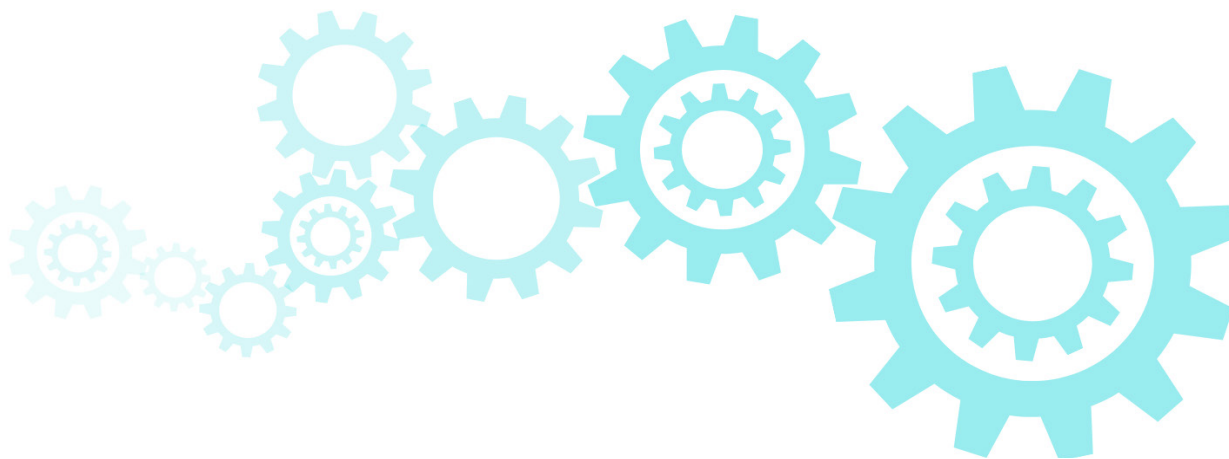


Figure 2.





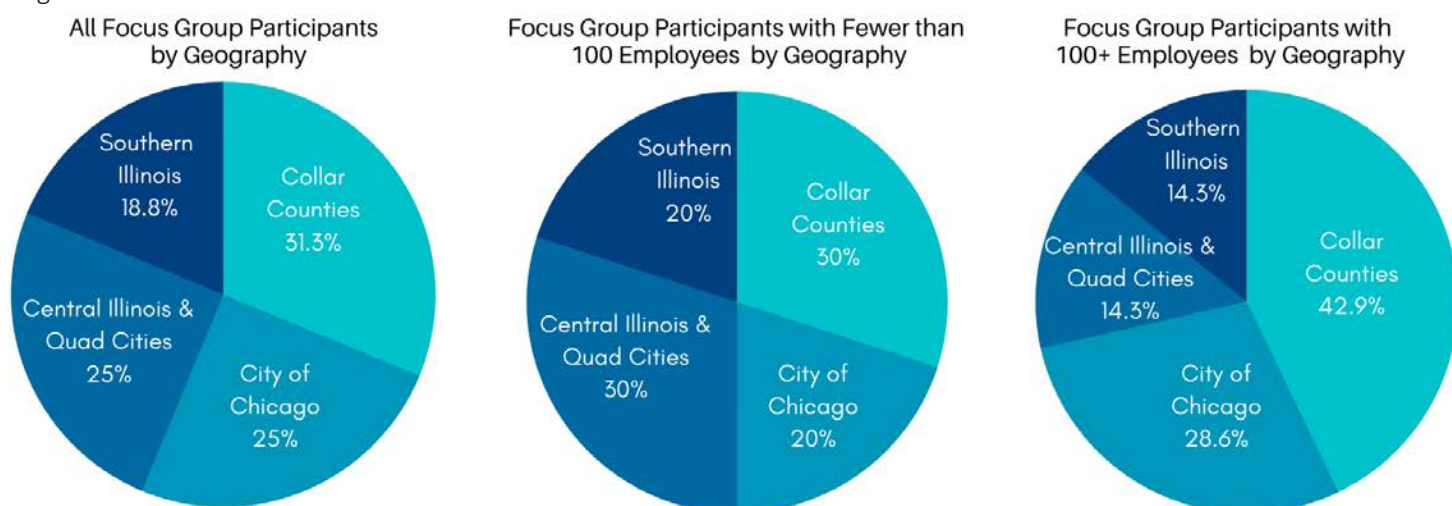
Focus Groups

Five focus groups were conducted by staff throughout Illinois to supplement quantitative survey data and gather qualitative information from partners. Participants were recruited through an email invitation and targeted outreach by regional staff in their respective geographies to ensure that participants included representation across gender, race, and service type. Participants' questions were shared in advance via email; formal preparation was not required for participation.

Focus groups convened for 60-75 minutes through Zoom video conferencing from September 13-15, 2021 for partners in the City of Chicago and Collar Counties (a total of three groups); Central Illinois and Quad Cities; and Southern Illinois. There were two to four participants per group. Individual participants were CEOs, executive directors, or human resources professionals with knowledge of employment data. A total of 16 organizations were represented statewide, five of which participated in both the survey and the focus group; of the 16 participants, 63% were employers with fewer than 100 employees.¹

On-screen multiple choice poll and discussion questions were presented uniformly at each focus group session. These questions were designed to complement the online survey in terms of both sequence and topic.² Focus groups were recorded with permission to support note taking and qualitative analysis. Related data are anonymized throughout this report to protect privacy except where specific permission was granted. The distribution of focus group participants by geography is shown in Figure 3 and is further categorized by size of organization.

Figure 3.



¹ See Appendix

² Id.

Limitations

- **In some cases, participants provided partial responses.** Some participants did not disclose or provide responses to every survey section, thus analysis is based on the number of responses provided and discussion for each topic is based on data available for that topic.
- **Providers operate in varied locations and with varying sizes of service areas.** Geographic data is based on the location of providers' administrative headquarters. In many cases, providers operate in multiple counties; others operate statewide.
- **The first-hand perspective of frontline workers has limited representation in these findings.** For example, focus group participants were primarily chief officers and managers with knowledge of employee data. Therefore, certain data, such as the reasons for employee separation, is limited to information reported to health and human services personnel.
- **The demographic data is limited to categories from the U.S. Equal Employment Opportunity Employer Information Report.** For purposes of consistency in the data collection process, the categories from the federal Equal Employment Opportunity Employer Information Report EEO-1 were used. The [EEO-1 Component 1 report](#) is a mandatory annual data collection that requires all private sector employers with 100 or more employees, and federal contractors with 50 or more employees meeting certain criteria, to submit demographic workforce data, including data by race/ethnicity, sex, and job categories. As such, reporting is limited to those categories and omits other categories such as employees with disabilities and employees from certain ethnicities, such as people of Middle Eastern or North African descent.

Illinois Partners for Human Service recognizes these categories are neither inclusive nor comprehensive across multiple measures and fail to accurately capture the true breadth of human identity in our workforce and beyond. However, for the purpose of consistency in our data collection process, we have used these government-defined categories.



Workforce Demographics

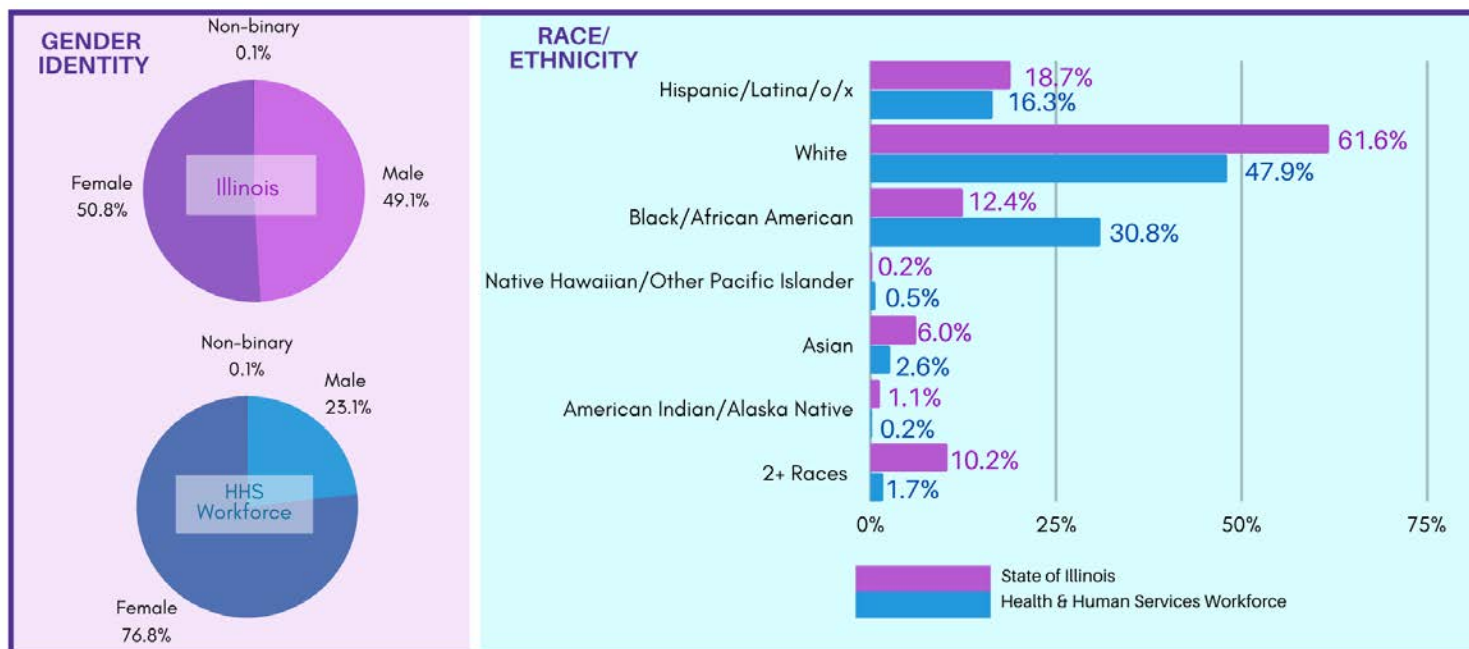
The organizations surveyed have a predominantly female workforce and a greater representation of Black, Latina/x/o people as compared to the general population of Illinois, especially among frontline workers.

Results of our survey are presented through various lenses: for the state as a whole, by geographic regions, by size of organization, and/or by job categories. The geographic regions are defined as Central Illinois and Quad Cities; City of Chicago; Collar Counties; and Southern Illinois. Job categories are defined as leadership/management and frontline for organizations with fewer than 100 employees, or as [EEO job categories](#)³ of executive/senior-level officials and managers; first/mid-level officials and managers; professionals; technicians; sales workers; administrative support workers; craft workers; operatives; laborers and helpers; and service workers for providers with over 100 employees. Organizations with more than 100 employees are required to file an EEO report annually using the detailed 10-category system. Reporting was simplified for organizations with fewer than 100 employees to reduce their burden since they are not required to submit EEO forms.

For the purpose of this reporting and to provide side-by-side and combined comparisons of small and large organizations, the detailed EEO categories in some cases were condensed into management/leadership and frontline staff designations. Executive/senior level officials and first/mid-level officials and managers comprise the leadership/management staff, and the remaining eight categories (professionals, technicians, sales workers, administrative support workers, craft workers, operatives, laborers and helpers, and service workers) constitute frontline staff for our analysis.

We recognize that this categorization may represent a broad assumption, particularly for the professional category, that likely overestimates the number of employees who are considered frontline staff. However, when appropriate, we chose this approach to simplify the visual presentation and facilitate comparison. The survey sample and focus group distributions reflect our broader coalition in terms of organization size, services provided, and geographic location.

Figure 4. Demographic Data for the Health and Human Services Workforce Compared to the General Population of Illinois⁴

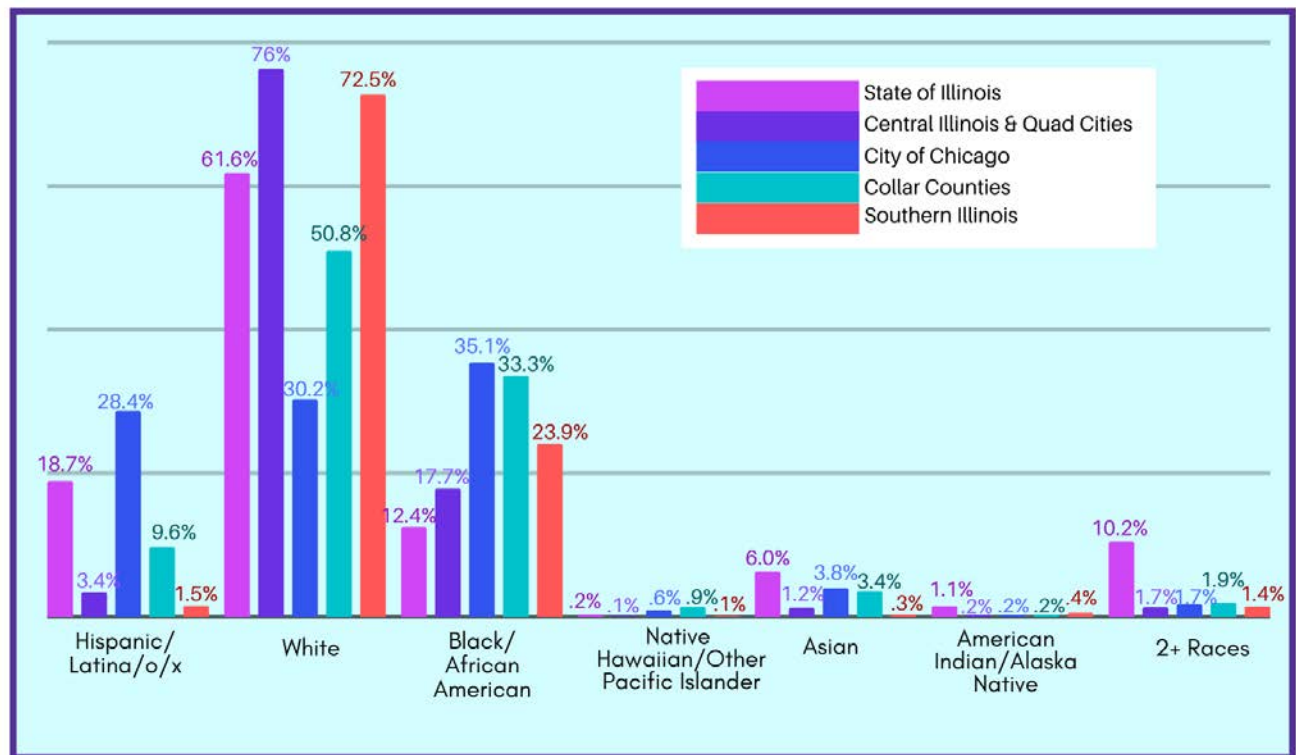


3 EEO-1 Component 1 Job Classification Guide, U.S. Equal Employment Opportunity Commission, <https://eeocdata.org/pdfs/EEO-1%20Component%201%20Job%20Classification%20Guide.pdf>

4 Illinois population data was collected from datausa.io

Figure 4 (page 11) illustrates that the health and human services organizations surveyed have a predominantly female workforce. Of the employees from organizations surveyed, nearly 77% identify as female, significantly more than the overall population of Illinois where over 50% identify as female. Through the geography lens, there is some variation in that statistic, ranging from 72% in the Central Illinois and Quad City region to 82% in the Collar Counties. At the same time, the majority of the overall workforce, 52%, is BILPOC.

Figure 5. Race/Ethnicity Workforce Data by Geography as Compared to the General Population of the State of Illinois



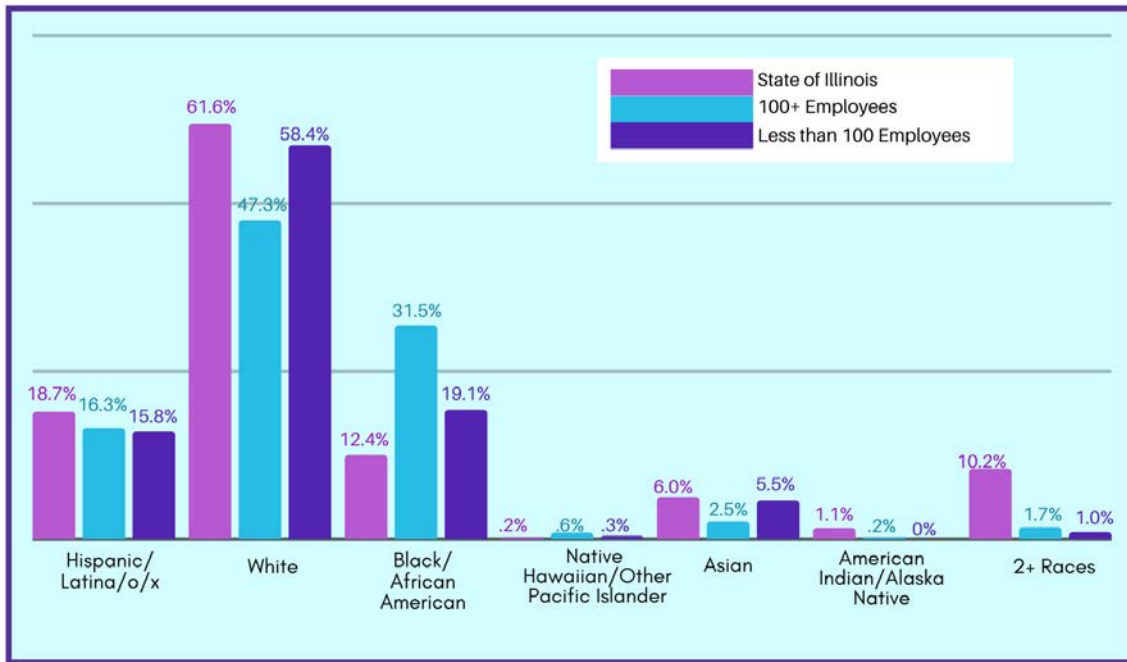
“The long-term implications are clear: the pandemic has exacerbated inequalities between women and men, as well as racial and ethnic inequalities in employment outcomes and economic independence. As Illinois emerges from the pandemic, it is critical that stakeholders weigh the gendered and racial consequences of COVID-19 to develop policies to support women’s and minorities’ employment.”

- IDES June 2021

https://www2.illinois.gov/ides/xxlmi/Annual%20Report/Women_and_Minorities_Unemployment.PDF

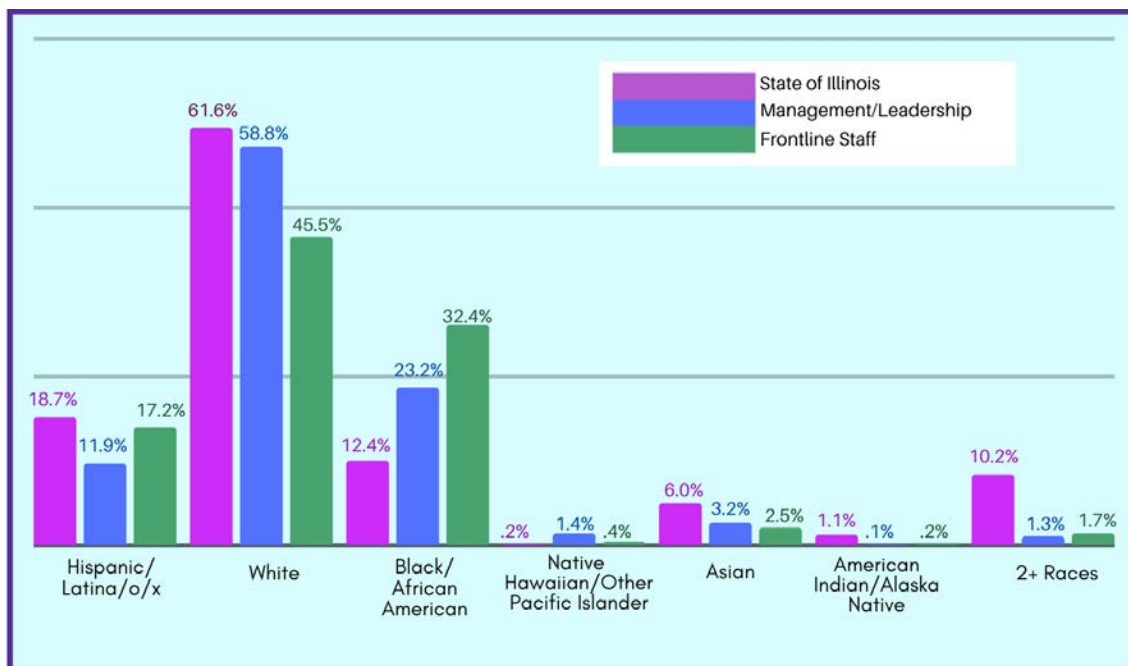
Race and ethnicity have greater variation geographically than gender identity, as shown in Figure 5. Organizations surveyed in the City of Chicago have more Black or African American employees, at 35%, than any other race/ethnicity, while 28% are Latina/o/x employees, and 30% are White. The Collar Counties have a similar proportion of Black or African American employees, approximately 33%, but 50% of employees are White. While all race/ethnicity categories have some representation, employees in Southern Illinois and Central Illinois and Quad Cities are 70% White with approximately 20% Black or African American employees.

Figure 6. Race/Ethnicity Workforce Data by Size of Organization as Compared to the General Population of the State of Illinois



Race and ethnicity for larger and smaller organizations and the State are shown in Figure 6. Organizations with more than 100 employees were predominantly BILPOC (52%), while organizations with fewer than 100 employees were predominantly White (58%). Latina/o/x were represented nearly equally. Asians represent a greater portion of organizations with fewer than 100 employees, 5%, compared to 2% at organizations with more than 100 employees.

Figure 7. Race/Ethnicity Workforce Data by Job Category as Compared to the General Population of the State of Illinois



From Figure 7, it can be inferred that frontline essential workers are more than 54% BILPOC compared to just over 41% for leadership/management. Frontline staff are more likely to be Latina/o/x, Black or African American, American Indian or Alaska Native, or Multiracial than their leadership/management counterparts.

Human Service Wages

Long-term, insufficient, and stagnant investment from the state was the most frequently mentioned reason for historically low wages among frontline workers.

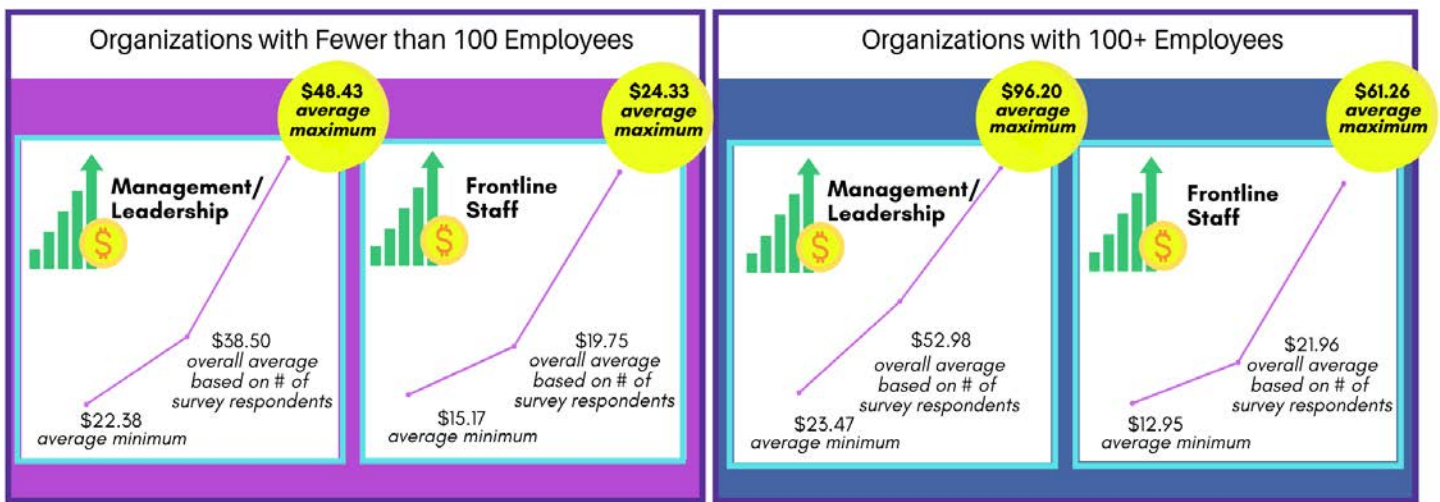
The survey captured quantitative data showing the range of wages paid by health and human service employers to different types of workers, including executive/management and frontline staff. In focus groups, more open-ended questions were asked to identify what factors contribute to the wage ranges of frontline health and human service workers, and how those wage ranges impact hiring practices.

Of the health and human services organizations surveyed, frontline workers constitute the vast majority of employees. For organizations with fewer than 100 employees, 77% are frontline staff, and for organizations with more than 100 employees, 86% were considered frontline staff, though that percentage is likely inflated.

Table 1 (on page 15) includes detailed graphics with the nuances of the 10-job categories from the EEO reports of demographic and surveyed wage data for organizations with more than 100 employees. Some job categories such as sales workers, craft workers, and operatives are predominantly male while all other jobs are predominantly female. Technicians, sales workers, and laborers and helpers are predominantly Black or African American. Employees are predominantly White in the following categories: craft workers, professionals, first/mid-level officials and managers, and executive/senior-level officials and managers. Employees are 60% or more BILPOC in the following categories: technicians, sales workers, administrative support workers, operatives, laborers and helpers, and service workers. Operatives are most likely to be Asians and Native Hawaiian or other Pacific Islanders.

Figure 8 identifies how wages varied by size of organization and job category. Frontline workers are paid less than leadership/management; leadership/management at small organizations are paid less than leadership/management at larger organizations.

Figure 8. Workforce Wage Ranges by Job Category and Size of Organization



Average minimum: The average of the lowest wage offered by each of the survey respondents
Average maximum: The average of the highest wage offered by each of the survey respondents

Table 1 shows detailed wage information for organizations with more than 100 employees sorted by job category and differentiated by gender identity and race/ethnicity. While not inclusive of all organizations surveyed, the overall results from the survey are heavily weighted by the data in Table 1 since larger organizations represent 94% of the employee data collected during this survey.

Table 1. Employee Wages and Demographics by Job Category* for Organizations with Over 100 Employees

Job Category	# of Employees	Average Wage Range based on # of Organizations	Male	Female	Non-binary	Hispanic/Latino/a/x	White	Black/African American	Native Hawaiian/Other Pacific Islander	Asian	American Indian/Alaska Native	2+ Races
(1.1) Executive/Senior Level Officials & Managers	272	\$41.76 - \$96.20	35.3%	64.7%	0.0%	9.2%	71.7%	13.6%	0.0%	3.3%	0.4%	1.8%
(1.2) First/Mid-level Officials & Managers	1400	\$23.47- \$50.44	23.1%	76.8%	0.1%	10.6%	57.6%	26.2%	2.1%	2.1%	0.1%	1.3%
(2) Professionals	5065	\$18.48 - \$61.26	21.2%	78.7%	0.1%	15.0%	53.3%	26.5%	0.1%	3.1%	0.2%	1.8%
(3) Technicians	760	\$19.90 - \$30.45	38.2%	61.8%	0.0%	7.2%	36.6%	51.6%	0.0%	1.8%	0.7%	2.1%
(4) Sales Workers	42	\$17.74- \$23.63	71.4%	28.6%	0.0%	7.1%	9.5%	83.3%	0.0%	0.0%	0.0%	0.0%
(5) Administrative Support Workers	1175	\$13.84- \$25.89	15.2%	84.8%	0.0%	22.2%	41.1%	32.8%	0.2%	2.2%	0.1%	1.4%
(6) Craft Workers	41	\$16.62 - \$22.67	92.7%	7.3%	0.0%	22.0%	63.4%	7.3%	0.0%	2.4%	0.0%	4.9%
(7) Operatives	67	\$14.09 - \$19.09	89.6%	10.4%	0.0%	9.0%	16.4%	7.5%	43.3%	20.9%	0.0%	3.0%
(8) Laborers & Helpers	97	\$14.61- \$17.71	25.8%	74.2%	0.0%	30.9%	18.6%	49.5%	0.0%	0.0%	0.0%	1.0%
(9) Service Workers	3028	\$12.95- \$23.83	20.9%	79.1%	0.0%	21.6%	37.1%	38.0%	0.1%	1.4%	0.1%	1.7%

*Categories as defined by Federal EEO-1 Standard Form

Contributing Factors

The specific contributing factors for low wages among frontline workers, as communicated by focus group participants, relate to reimbursement rates and underfunded contracts paid by the State of Illinois. Rates and contracts do not 1) cover employers’ full costs, 2) allow employers to provide competitive wages and benefits, 3) keep up with the cost of the minimum wage mandate and related wage compression⁵ or 4) meet increased demand for services. Even if the State increases rates and fully funds minimum wage and compression⁶ without subsequent annual adjustments to reflect the cost of living, progress will not be sustainable.

Employers' responses varied widely on the minimum wage. Some respondents reported being able to get ahead of the mandate; others have not. Reactions have been a reflection of both business decisions as well as available resources. Since Chicago is already at \$15/hr for minimum wage, City of Chicago providers are more likely to be ahead of the state’s mandate, and thus, generally reported higher wages in focus groups than did providers in other regions of the state. Our prior research established that Chicagoland benefits from a much

“They don’t understand that one dollar an hour more in wages costs us way more than a dollar when you figure in all the associated costs we incur, such as taxes, fringes, etc.”

***-- Dennis Jenkins,
Caritas Family Solutions***

⁵ [Minimum Wage Survey Infographic](#), Illinois Partners for Human Service

⁶ Id.

higher level of philanthropic resources compared to the rest of Illinois,⁷ yet has a higher cost of living. In contrast, focus group participants from other geographic areas discussed their struggles to reach the current \$12/hr level in the absence of equivalent increases in State contracts. **To get to \$12, employers report cutting every possible expense and sometimes finding savings through attrition, which drives up the workload for other staff while compromising their ability to serve clients.** Additional pressure comes from failing to keep pace with other employers—including fast food restaurants, retailers, and gas stations—that pay higher hourly wages.

Focus group data also suggests that the need for experienced and credentialed frontline staff creates upward pressure on their wages. Additionally, providers in almost every focus group said they conduct market analysis and salary surveys to assess their wage competitiveness, yet still struggle to fill positions even when adjustments were made.

“Rates have not kept up with the cost-of-living adjustments. We have not therefore been able to pay staff what they deserve to be paid. And that has been the case for years.”

*-- Puneet Leekha,
Chestnut Health Systems, Inc.*

Impact of Low Wages

As a result of insufficient public investment, surveyed health and human service employers report that they compete with one another and even more so with the State and private employers to pay wages that attract qualified personnel.

In contrast to other private employers, nonprofit health and human services employers cannot increase the cost of their goods to fund payroll increases. Moreover, philanthropy alone cannot meet the need, especially outside of Chicago.⁸ Public funds and private grants often cap or forbid spending on personnel and fringe benefits. As a result, some employers rely on part-time staff without benefits to keep costs down and/or development staff and private fundraising to pursue alternative sources of funding. However, without a dedicated funding source for adequate compensation, some participants reported difficulty sustaining development staff. Others conducted related furloughs or layoffs during the pandemic, which has future operational consequences.

Wages are an Equity Issue

Failing to pay for the true cost of health and human services reinforces gender and race wage gaps in Illinois.

It is important to note that demographic data shows the representation of employees who are BILPOC is lower among executive and management positions than among essential frontline workers in the sector. The health and human services workforce is predominantly women; low-wage jobs, often funded through the State’s reimbursement rates, are more likely to be held by people of color.

Relatedly, focus groups identified the growing need for bilingual or multilingual workers due to shifting demographics in the general population as another factor influencing the wages of frontline staff.⁹

⁷ [Government is the Foundation of Well-Being: Why Philanthropy Cannot Replace Government in Helping Illinois Communities Reach Their Potential, Illinois Partners for Human Service, \(2018\)](#)

⁸ Id.

⁹ Olsen, D. (2021, August). [Illinois Census data show state more diverse racially and ethnically since 2010 State Journal-Register](#), and [Illinois Early Childhood Asset Map \(2019, February\) Census Bureau Data on Languages Spoken by Children](#).

Workers with these skills deserve compensation reflective of their value, yet employers struggle to provide compensation at that level. Full funding for bilingual positions is an important equity issue as failing to do so disrupts the quality and quantity of care and services available to persons with a first language other than English, many of whom are people of color.

Incremental Success and Progress

To create a more equitable and standard system of reimbursement for the health and human services sector, the State should build upon the progress made in some areas to better support all areas of service provision that rely heavily on State funding.

Anecdotally, federal funding for certain programs, such as the Older Americans Act for Area Agencies on Aging and Medicaid for Federally Qualified Health Centers (FQHCs), appears to have protected stability during the study period. In some cases, employers were able to pay slightly higher wages for jobs funded by those sources. While this factor varies around the state, there may be opportunities to learn more and replicate successful funding models by looking at those types of jobs more closely.

For instance, due to the disparity between State and federal reimbursements, FQHCs receive more money for the same service when mental health provision is billed through the federal government rather than through the State. Similarly, the State's incremental adjustments to certain reimbursement rates have alleviated some pressure, such as for developmental services. Child care providers also recognize the bonus program for child care as an important and effective new support.¹⁰ However, in areas like mental health, employee wages are not benefiting from comparable rate increases or bonus programs.



¹⁰ Illinois.gov. (2021, September). Gov. Pritzker Announces Nation-Leading Childcare Investments to Support Parents and Providers in COVID-19 Recovery [Press Release]. <https://www.illinois.gov/news/press-release.23884.html>

Financial Stability

Top Funding Sources

The top two sources of funding for the organizations surveyed were the State of Illinois¹¹ (40% of dollars) and Fee for Service (33%).¹² Figure 9 shows the breakdown of funding sources for surveyed organizations. Figure 10 shows the breakdown for smaller and larger organizations.

Figure 9. Overall Funding Sources Breakdown

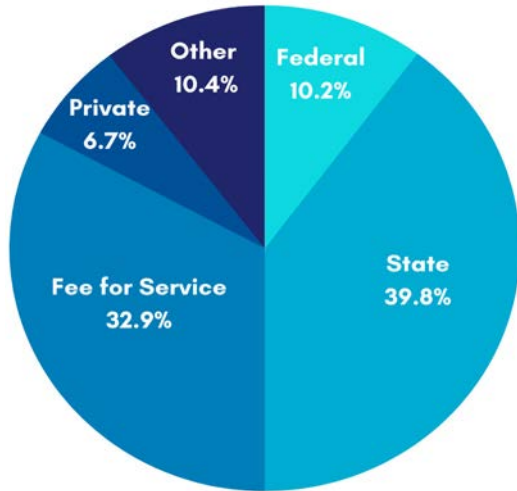


Figure 10 . Funding Sources by Size of Organization

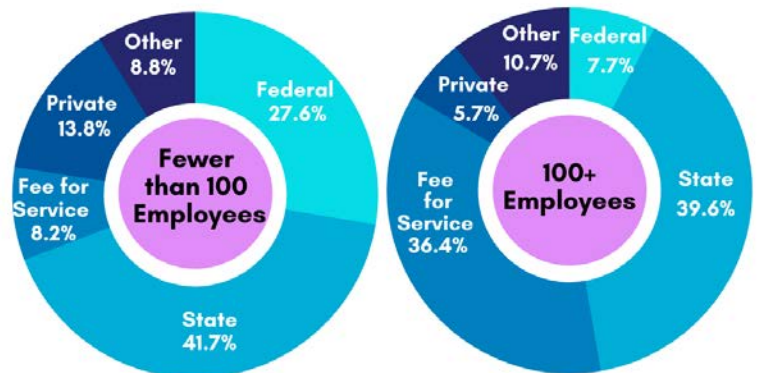
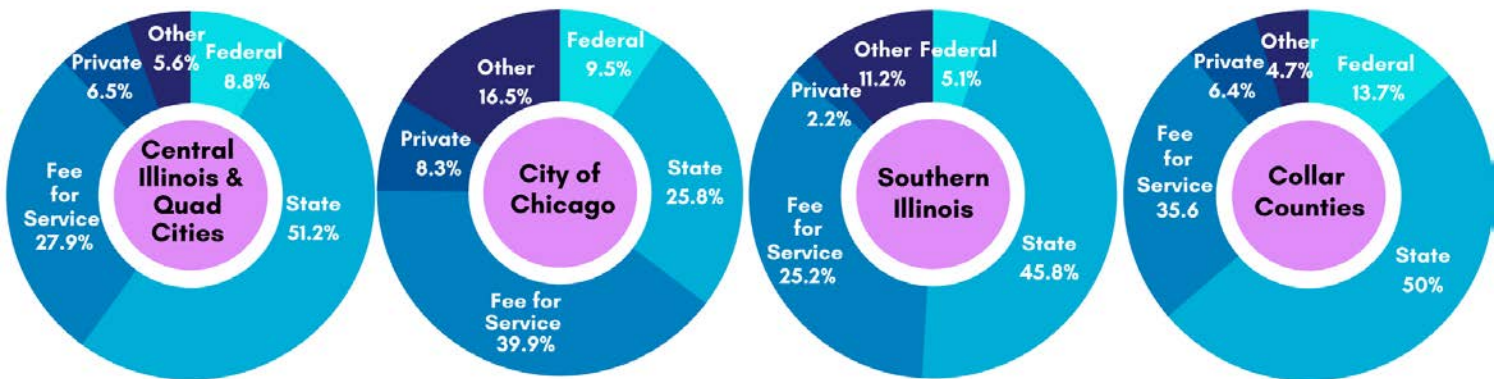


Figure 11 shows how the breakdown differs geographically. The top three Illinois agencies that fund these organizations are the Department of Human Services (44% of respondents), the Department on Aging (14%) and the Department of Children and Family Services (12%). More than 18% of respondents receive funding from other non-specified state agencies.

Figure 11 . Funding Sources by Geography



Changes in Revenue and Expenses

The onset and urgency of the COVID-19 pandemic triggered unprecedented investment in health and human services from a variety of sources. Ensuring that everyone had access to housing, food, goods, and services to survive a global pandemic became a common purpose, and funders across the spectrum heeded the clarion call to support these life sustaining efforts. This attention was especially significant given the number of providers forced to cancel in-person fundraisers that typically constitute a significant portion of their private funding revenue.

¹¹ This includes federal dollars that pass through a state agency.

¹² This finding is consistent with prior research conducted by Illinois Partners at the state and local levels. Human services providers primarily derive revenue from contracts with the State of Illinois.

Between January 1, 2020 and June 30, 2021—the period studied in this research that intentionally correlates with the start of the COVID-19 pandemic and the ensuing period of heightened response—nearly \$1.4 billion in revenue flowed into the health and human service organizations surveyed. Over this 18-month period, **non-COVID-19 revenue**, described as revenue from general operations not impacted by COVID-19, increased for 52% of respondents, decreased for 27%, and stayed the same for 20%. For those that experienced an increase in non-COVID-19 revenue, larger organizations with more than 100 employees saw an average revenue increase of 17%, while smaller organizations with fewer than 100 employees saw an average revenue increase of 25%. Conversely, for those that experienced a decrease in non-COVID-19 revenue, larger organizations with more than 100 employees saw an average revenue decrease of 3%, while smaller organizations with fewer than 100 employees saw an average revenue decrease of 15%.

“We don’t get money back for overhead or computer systems, things we are required to have and need to run a good program.”

*-- Liz German,
YWCA McLean County*

Revenue prompted by COVID-19 through emergency assistance programs such as the Paycheck Protection Program (PPP), Coronavirus Aid, Relief, and Economic Security Act (CARES), and funding from State and federal agencies, among others, increased for 93% of survey respondents. For those that experienced an increase in **COVID-19 revenue**, larger organizations with more than 100 employees saw an average 4% increase in COVID-19 revenue while smaller organizations with less than 100 employees saw an average increase of 10%.

Variations in non-COVID-19 revenue were reported in different regions of the state. For organizations that experienced a decrease, the average loss was two times higher among organizations in the City of Chicago compared with the average loss for organizations in Southern Illinois, Central Illinois and the Quad Cities.

For organizations that experienced a non-COVID-19 revenue increase, the City of Chicago saw the lowest increase at 8%. Central Illinois and the Quad Cities had the largest increase at 14% each. Collar Counties had the greatest increase of COVID-19 funding at 13% on average while Southern Illinois had half as much at 6%.

Non-COVID-19 expenses (general operating expenses not affected by COVID-19) increased for 66% of respondents, decreased for 20%, and stayed the same for 12%. The average reduction in expenses from January 1, 2020 to June 30, 2021 was \$280,000 for small organizations and \$641,000, for large organizations. The average increase in expenses for small organizations was \$1.7 million and \$4.2 million for large organizations. The variation amongst the regions of the state was highly variable and primarily driven by the number of large organizations surveyed in the region.

COVID-19 expenses increased for 76% of respondents. Small organizations experienced an average increase of \$600,000 in expenses directly related to the pandemic, while large organizations saw an average increase of \$2 million. For both non-COVID-19 expenses and COVID-19 expenses, again, the differentiation amongst the regions of the state was highly variable and primarily driven by the number of large organizations surveyed in the region.

Recent Financial Changes Did Not Alleviate Workforce Issues

While emergency COVID-19 funding helped alleviate financial pressures, it did not provide a solution to the sector's ongoing workforce issues or remedy negative employee morale.

Nearly all of the organizations surveyed experienced increased pandemic revenue during the 18-month study period and nearly half had increases in non-COVID-19 related funding. Small organizations reported larger gains amidst those increases compared to their previous baseline than larger organizations for both COVID-19 and non-COVID-19 revenue. Meanwhile, two-thirds of respondents also reported increased expenses between January 1, 2020 and June 30, 2021.

Circumstances began to improve for many organizations in varying degrees as emergency COVID-19 funding became accessible while opposing pressures affected net revenue and expenses. New or increased funding streams were reported as one-time funds, absorbed by higher demand for services, used to create infrastructure for changing service delivery models, and/or passed directly to subgrantees or clients. The emergency COVID-19 funding was significant and important for health and human services to weather the first 18 months of the pandemic; however, the funding sources were not sustainable and did not provide a solution to alleviate ongoing workforce issues.

Cost-cutting measures helped lessen financial pressures, but respondents reported a negative impact on employee morale and working conditions. For example, COVID-19 capacity limits led residential programs to move from double- to single-occupancy rooms to control the risk of spread, which diminished overall client volume in facilities. Similarly, community day programs reduced the number of participants on site, sometimes dramatically, to comply with state mandates regarding congregate settings (from 60 to 14 in the case of one provider) impacting the number of reimbursable hours. Child care centers also struggled as safety regulations forced the implementation of lower staff-to-child ratios, resulting in more expenses to serve fewer children.

In focus groups across all regions, participants expressed the following frustrations:

- New funding streams are often directed to new programs rather than underfunded existing programs;
- Public funding documentation leads to significant administrative burden;
- The timing in payment distribution trails behind the immediate responses required by COVID-19;
- Insufficient or nonexistent funding for capital improvements and infrastructure inhibits many providers from addressing pressing facility needs that jeopardize the safety of staff and clients.



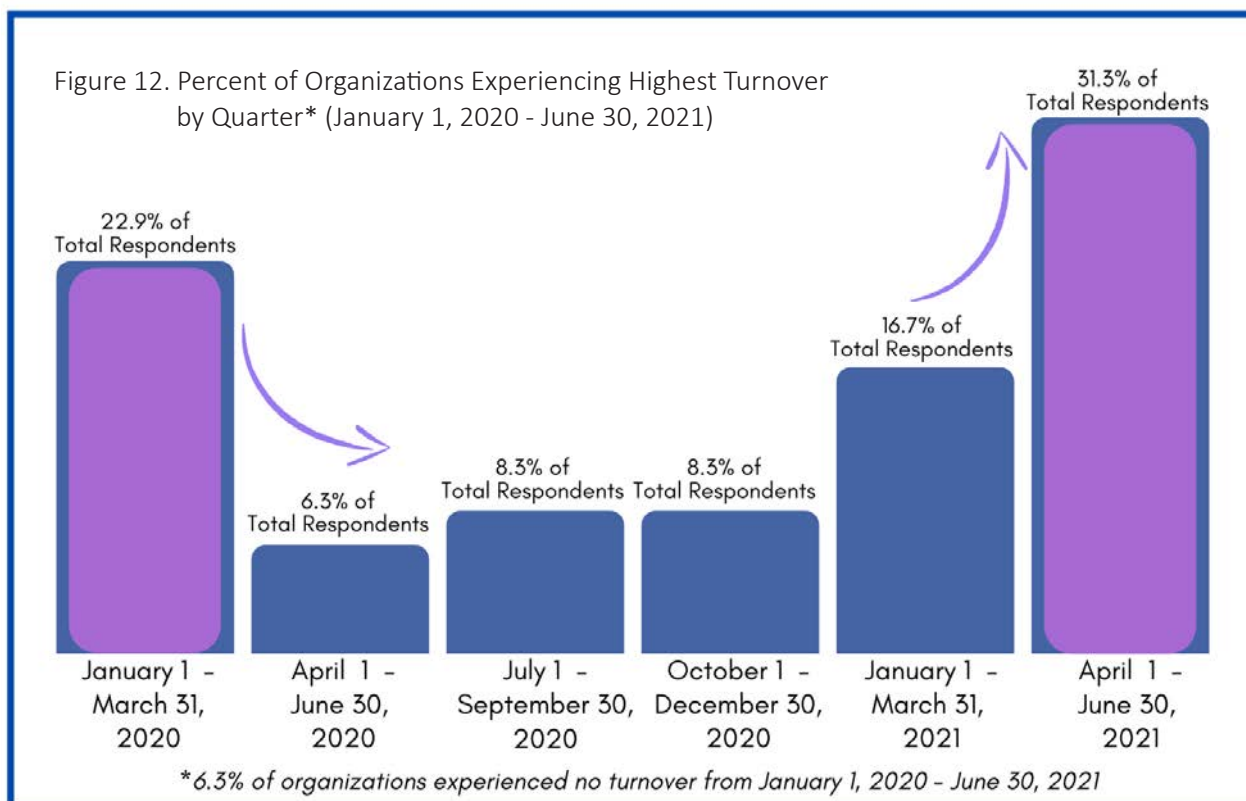
Workforce Challenges

Low wages. A shrinking health and human services talent pool. Increasing vacancies. High turnover rates. Challenges attracting and retaining candidates. Challenges with filling positions in rural areas.

These factors, combined with low state reimbursement rates, funding shortages, and systemic inequities, create a perfect storm for the health and human service workforce. A strong health and human services sector is essential for helping Illinoisans weather life's storms. This report offers a broad range of administrative and legislative solutions that will have significant short- and long-term implications on the workforce crisis and help strengthen the overall sector.

Turnover

Turnover was measured with a pre-pandemic baseline using the last quarter of calendar year 2019 (October 1, 2019 - December 31, 2019) and for the quarter with the highest turnover during the 18-month study period (January 1, 2020 - June 30, 2021). As shown in Figure 12, the majority of organizations experienced their highest turnover at the beginning of the pandemic or in the most recent quarter surveyed (April 1 - June 30, 2021). Fewer organizations had turnover from April 1, 2020 - March 31, 2021, though an increase was noted at the end of that timeframe. The largest number of organizations experienced their highest turnover from April 1 - June 30, 2021.

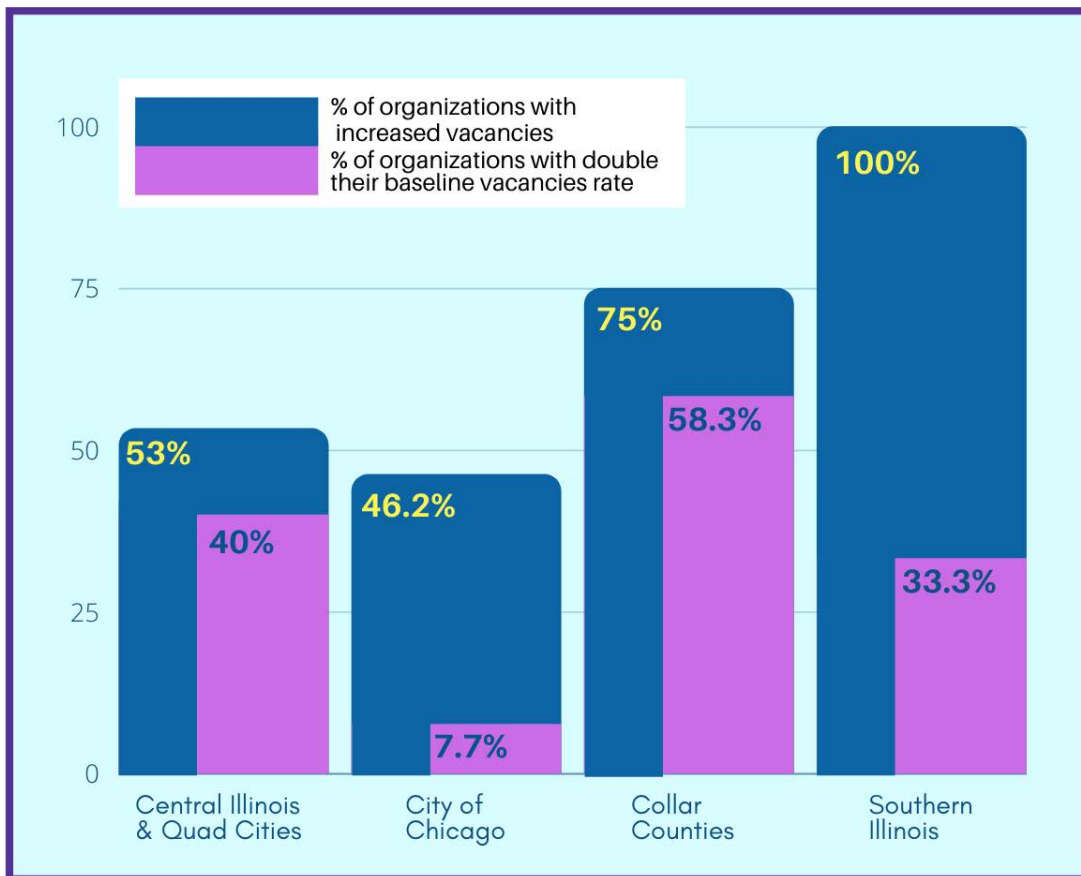


According to Johns Hopkins University's Center for Civil Societies COVID-19 Jobs Update¹³ for June 2021, the nonprofit sector contracted at the onset of the pandemic, losing more than 13% of pre-pandemic jobs. Of those, approximately half of which were jobs in categories defined as Health Care and Social Assistance. The Jobs Update suggests that it will take 15 months to recover to pre-pandemic levels though turnover was a significant concern for health and human services even prior to the pandemic.

Vacancies

When comparing the pre-pandemic last quarter of calendar year 2019 (October 1, 2019 - December 31, 2019) to the 18-month period during the pandemic (January 1, 2020 - June 30, 2021), 27 organizations had greater vacancies during the pandemic (13 at organizations with fewer than 100 employees and 14 at organizations with more than 100 employees) than they did in the last quarter of 2019. Vacancies doubled, or more than doubled, at 13 organizations, as shown in Figure 13.

Figure 13. Vacancies: Pre-COVID-19 vs. Quarter with Highest Turnover



Focus group participants reported vacancies and turnover as ongoing issues historically when exploring changes in the applicant pool over time. The survey data shows that turnover began to stabilize in the second quarter, which some attributed to staff reluctance to make changes or pursue other options at a time of great uncertainty.

However, as normalcy slowly returned, along with reopenings, providers reported an uptick in vacancies. In recent months, participants experienced the following: “Almost no applicants where we used to have hundreds;” only three applications for seven open positions in 45 days; turnover doubled at a residential program; and a vacancy rate four to five times higher than mid-2020.

High Vacancy Jobs

Focus group participants reported that certain jobs have higher vacancies and turnover than others. Specifically, those jobs include direct services, such as those in domestic violence intervention; behavioral health; youth services; medical technicians; registered nurses; foster care workers; home-based caretakers; and bilingual positions across disciplines. Jobs often excluded as eligible expenses in grants and more likely to pay low wages include certain administrative personnel such as finance, facilities management, development, and executive administrative support. For example, a provider reported multiple candidates accepted a facilities position that had been vacant for more than two years only to leave the post in less than a week.

Factors Contributing to High Vacancies

To identify which factors contribute to vacancies in health and human service jobs, focus group participants completed a live, on-screen anonymous poll where we asked: “Which of these hiring barriers does your organization experience?” Participants were asked to choose their top three barriers. “Wages” and “Lack of Applicants” were the most commonly selected responses across all focus group; 80% of organizations identified both of these factors among their top three. Fifty percent selected “turnover when trained” as the next most common reason for vacancies.

Many focus group participants reported an uptick in vacancies and emphasized the primary reason as the inability to compete with higher wages and better benefits offered by other employers. Providers reported seeing applicants’ dismay when they learned the salary range, particularly when they can “earn more elsewhere in a safer environment, like Target.” Additionally, nonprofit child care providers compete directly with for-profit centers that often accept only private pay at higher rates, which facilitates higher wages for staff. Other contributing factors include the need to work remotely rather than in person; concerns about COVID-19 safety and risk of exposure; unwillingness to comply with federal or State vaccine mandates; bolstered unemployment benefits;¹⁴ family obligations, including remote schooling and related parenting responsibilities; “burnout;” shifts to telehealth in private practice; and the inherent lack of flexibility in certain health and human service jobs.

"These days we consistently ask ourselves, 'Can we recruit if we pay this amount? How about this incentive? What about this bonus? And we already have a loan repayment program.' Yet, we still struggle to find and keep people. Ultimately, if the rates don't increase, we can't hire more staff. If we don't have staff to see clients, we can't accommodate our client loads and in turn we are paid even less money. We feed into this continuous loop of workforce shortage that feels like a death spiral."

*-- Shea Haury,
Comwell*

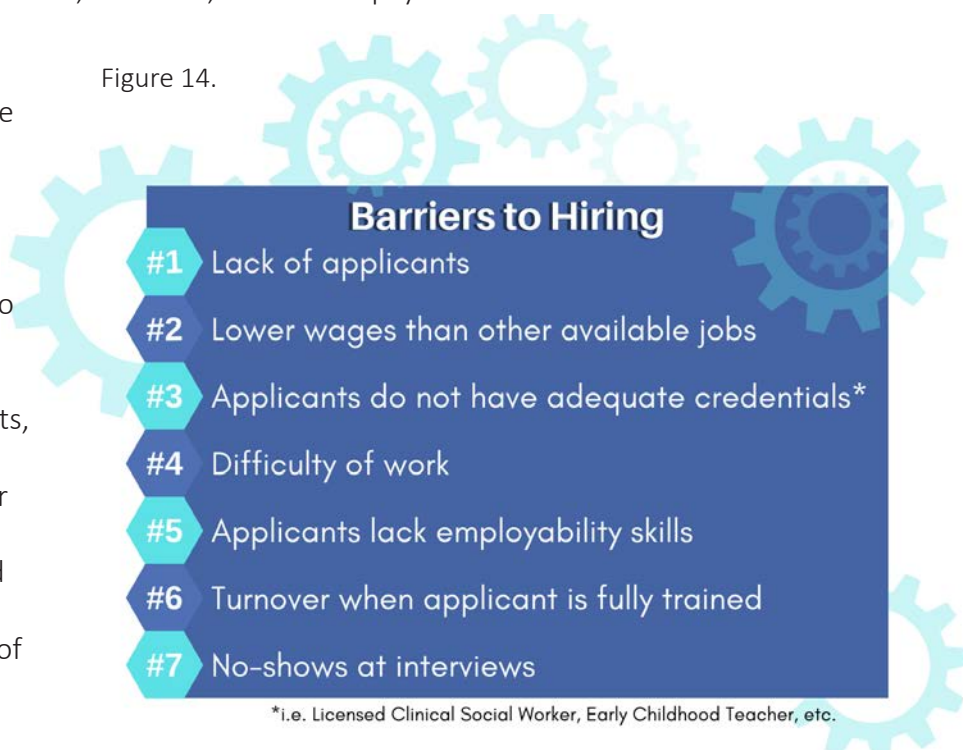
¹⁴ There is an ongoing national debate about what factors contribute to high turnover and vacancies in the workforce.. For more information, see recent research including “[Early Withdrawal of Pandemic Unemployment Insurance: Effects on Earnings, Employment and Consumption](#)” (8/20/21) and local and national media coverage such as [this article on WGLT](#) and [this article on CNBC](#).

Hiring Barriers

This research suggests that the health and human services talent pool is shrinking, while simultaneously, the skillsets of prospective employees are proving to be insufficient or mismatched for the needs of the organizations. Focus group participants reported that prior to the most recent few years, employers had a much larger reserve of qualified applicants when seeking replacements due to turnover. Respondents also identified the lack of an accessible pool of viable candidates as an issue of ongoing, if not growing, concern—across all geographies and areas of service—even among those with the lowest vacancy rates. More applicants fail to align with the jobs for which they are applying, and more often employees lack the official credentials to manage their workloads. Several employers said they are now considering less qualified or uncredentialed applicants for positions that have historically required candidates with more experience. Providers also feel that incentives must be offered to potential candidates to hire from the limited pool of workers. These incentives have led to higher costs, including retention bonuses; increased pay for weekend shifts; overtime; and hazard pay.

The top barriers to hiring from the survey are shown in Figure 14. There was little variation in the rankings based on size of organization and geography, especially for the top 3 barriers. Several notable exceptions to the top 3 were: the City of Chicago was heavily impacted by applicants not having adequate credentials rather than having a lack of applicants, Central Illinois and Quad Cities reported more impact from turnover when an applicant was fully trained rather than a lack of credentials, and Southern Illinois was more impacted by no shows at interviews than lack of credentials.

Figure 14.



In addition to the quality of the talent pool, focus group participants discussed other hiring barriers. For instance:

- Employers are having difficulty filling positions in rural areas;
- Unfilled vacancies are compounding existing workforce shortages which hinder operations;
- Current shortages are creating more work for the sector. For example, a lack of caregivers for persons with disabilities in their homes is undermining the independent living capacity of clients, thus shifting demand to more labor intensive residential facilities;
- Vacant positions are being left open to achieve savings through attrition. For example, one employer at a small organization reported that they lost 2.5 FTE during the pandemic, but have replaced only 0.5 FTE because of flat funding and increasing costs. "We are just leaving them vacant and trying to make do."

Who is Leaving and Why?

Before COVID-19, turnover in the health and human services sector was high and was driven by low wages. In addition to draining resources, turnover has serious public health and public safety implications. When health and human service employers lose staff, clients end up on wait lists and needs go unmet. In this study, we aimed to understand what effects, if any, COVID-19 had on turnover, by looking at quarterly data for patterns and the reasons for separation reported by employers. We also aimed to understand the reasons for high turnover beyond the COVID-19 pandemic and what solutions employers recommend.

Some organizations had dramatic changes in turnover while others illustrate the persistent nature of turnover in the sector. Almost every surveyed organization had turnover during the 18-month study period.

The survey results showed that in the pre-pandemic baseline quarter, the fourth quarter of 2019, 85% of organizations experienced some degree of turnover. All organizations with more than 100 employees experienced turnover, compared to 66% of organizations with fewer than 100 employees. During the study period, 93% of organizations experienced turnover; only two organizations with fewer than 100 employees did not experience turnover. The first quarter of 2020 included the beginning of the pandemic and the executive order calling for a lockdown on March 20, 2020. During this time, 23% of organizations experienced their highest level of turnover during the pandemic to date. However, the second quarter of 2021 surpassed the first quarter of 2020 as the quarter when most organizations experienced turnover. Approximately 31% of organizations experienced their highest turnover in the second quarter of 2021, which was nearly five times more than organizations that experienced their highest turnover during the same period in 2020.

The average tenure of employees who separated from their organization was 2.6 years; 2.9 years for organizations with fewer than 100 employees, and 2.4 years for organizations with more than 100 employees. The majority of employees separated with less than three years of service. The most frequent reason for turnover during the peak turnover period was voluntary separation, but the underlying reasons for those voluntary separations were unspecified. Some organizations may not conduct exit interviews or collect data about the reasons for voluntary separations. It is unclear whether those unspecified reasons for voluntary separation may include any of the next three most commonly reported reasons for turnover: 1) compensation, 2) family circumstances, and 3) leaving the health and human services sector.

Reasons for Leaving

Focus groups participated in an on-screen, live, anonymous poll, which asked them to identify the top reason for turnover at their organization.

“Wages” was the number one reason for turnover selected by approximately 60% of respondents across all focus groups while 27% identified “left the sector” as the second most common reason. As one focus group participant explained, **“The factors have always been less stress, more pay. That’s why people leave.”** Multiple focus group respondents reported losing staff to related employers that pay higher wages and benefits, such as hospitals, insurance companies, and State agencies.

Other reasons for voluntary separations included lack of support in the workplace; changing expectations about tenure among millennials; long hours; adverse effects of the work on mental health; secondary

trauma impacting staff with lived experience in their areas of service; lack of advancement opportunities; child care disruptions; not returning after parental leave; and the pressure that tenacious vacancies place on remaining staff driving burnout, including direct service workers, human resources personnel, and management needing to perform direct service work due to demand and shortages. Another emerging trend reported by participants was an increasing number of professionally trained workers leaving to work remotely for large online organizations or providers not headquartered in their communities.

Across the board, focus groups reported higher turnover among essential frontline and part-time staff, which is consistent with the survey data. One provider said that most staff members are either long-term employees approaching retirement or younger, or entry-level employees who do not plan on staying in their current positions. Due to the low wages and burnout from recent months, some staff approaching retirement are opting to retire early, while younger employees are leaving for high-paying, lower-stress jobs. The pressure from both ends of the spectrum is a significant concern for sector leaders.

“We have to start thinking about the workforce as well as the work.”

***-- Linda Tortolero,
Mujeres Latinas
en Acción***

Solutions to Workforce Problems

Failing to tackle the health and human services workforce challenges with a broad range of solutions will have significant long-term implications. The in-person nature of health and human services work makes attracting workers increasingly challenging at a time when the prevailing workforce expectations include a remote working option. Providers in focus groups reported spending a lot of time testing ways to attract and retain workers to set themselves apart from employers-like hospitals and insurance companies-that have more resources.

For example, they are:

“Salaries that looked OK in 2013 are not OK now.”

***-- Stephanie Schmitz Bechteler,
Chicago Urban League***

- Posting salary ranges on job descriptions;
- Paying referral bonuses to employees and sign-on bonuses to new hires;
- Providing flex schedules and offering more hybrid and part-time work options;
- Reimbursing for certifications; re-evaluating benefit packages;
- Rebranding their agencies;
- Eliminating contract positions;
- Conducting “stay” (in contrast to “exit”) interviews, focus groups and internal surveys;
- Shifting to paraprofessional positions rather than professional;
- Consolidating programs and units of care;
- Exploring options for offering paid-time-off to part-time employees.

Longer term, focus group participants stressed the need to redouble efforts to build a health and human services workforce pipeline. This includes better reimbursement rates and capacity funding. However, beyond that, health and human service employers are asking:

- 1. How do we attract mission-focused people to the sector?**
- 2. How do we embed nonprofit sector training and skill building in higher education curricula?**
- 3. How do we create a ladder of advancement opportunities for workers?**

The problem is not only a matter of wages; it is also about the level of respect for the sector among the general public and the perceived desirability among younger generations for working in health and human service professions.

Providers report that not enough students are pursuing related degrees to fill the sector's workforce pipeline. While some tuition support and loan forgiveness exists, current programs are not sufficient. One long-time provider was denied entry into a loan forgiveness program for clinical staff without an easily understood reason. The provider is reapplying, but even if they are approved, it will take up to two years to receive loan forgiveness funding for eligible staff.

Participants also emphasized the need for more training and support for future workers and current staff. More recently, perhaps due to the collective trauma of COVID-19, there is a growing need for behavioral health workers and behavioral health support for employees. Some focus group participants discussed the need for both legislative solutions and changes to administrative rules to provide more flexibility in credentialing, licensing, and billing requirements.



Impact of COVID-19 on the Workforce

The COVID-19 pandemic necessitated constant change management beginning in March 2020. This change has resulted in positive and negative outcomes for the health and human services workforce.

In addition to collecting financial data related to the pandemic, this research sought information about program reductions and closures. In both the survey and focus groups, the open-ended question, “How did COVID-19 affect your operations?” was asked. Responses consistently reflected an overhaul of many traditional practices, dramatic alterations to programs and operations, the demand for increased services, and the need to build capacity while addressing workplace safety to ensure employee well-being.

“While the local outbreak of COVID-19 has impacted our ability to host congregate shelter, it has not prevented our organization from ensuring that clients have access to safe, consistent, and isolated emergency hotel-placed housing. The physical space of our center has been adapted due to the inability to host congregate activities, groups, and workshops; those spaces are being temporarily utilized to manage donated food and supplies.”

-- April Redzic, DuPagePads

Programs, Operations, and Demand for Services

A wide range of programs were reduced or forced to close due to the COVID-19 pandemic, according to survey results. In addition to reduced programming, some organizations were forced to limit their service geography or pivot to new modes of operation. Many providers reported increased administrative burden at a time when they were already stretched thin by service demand; others noted changes to their standard operational purview. For example:

- Restricted by capacity limits, congregate programs moved to an individual service model while some with existing individual services shifted to digital platforms;
- Transportation providers began making food deliveries for meal services, food pantries, and emergency federal nutrition programs;
- Healthcare providers added COVID-19 test collection sites, mobile van services, telehealth, and COVID-19 vaccinations to their services;
- Volunteer organizations shifted to virtual interviewing and on-boarding processes, and facilitated mentor and mentee meetings exclusively online;
- New services were implemented by providers to meet the immediate community needs, including providing unemployment assistance; emergency cash, housing and utility assistance; food distribution;
- Others were unable to fill beds in residential settings because of low enrollment, decreased referrals, and decreased capacity as mandated for safety reasons;
- Some providers were unable to expand services due to restrictions and capacity limitations;
- Service utilization for healthcare was diminished by fear and a reluctance to re-engage with healthcare.

Referrals that typically came through mandated reporters in schools decreased, since in-person learning was unavailable or limited during the first year of the pandemic. The process of referral essentially broke down, affecting those who required services for abuse, neglect, and behavioral health. Also, referrals for comprehensive services for persons with substance use disorders were reduced as a result of an overwhelmed and backlogged justice system contending with reduced hours, closed courts, and the inability to use video conferencing or hearings.

As the workforce shifted to **remote work** and web-based service delivery, staff, and clients were impacted in differing ways. In some cases, COVID-19 exposed Illinois' digital divide, cutting off access to care, causing people to disengage, and complicating client surveys and assessments. Conversely, telehealth eliminated barriers such as transportation for others, leading to a significant improvement in no-show rates (decreasing from 40% to 5% for one provider) as well as not incurring travel expenses for staff that would normally conduct in-home visits, such as those for foster care.

*[The impact of COVID-19 included]
 “few applications for open positions,
 more vacancies, fewer staff applying
 for leadership roles, a new vaccination
 requirement just announced may
 cause more staff to leave, some client
 dissatisfaction with video services,
 increased overtime and bonuses required
 due to position vacancies or staff
 quarantine, staff feeling overwhelmed and
 burned out by new COVID-19 surge, staff
 retention has suffered the most with
 many staff departing at the start of
 our new fiscal year.”*

-- John Markley, Centerstone

Figure 15.



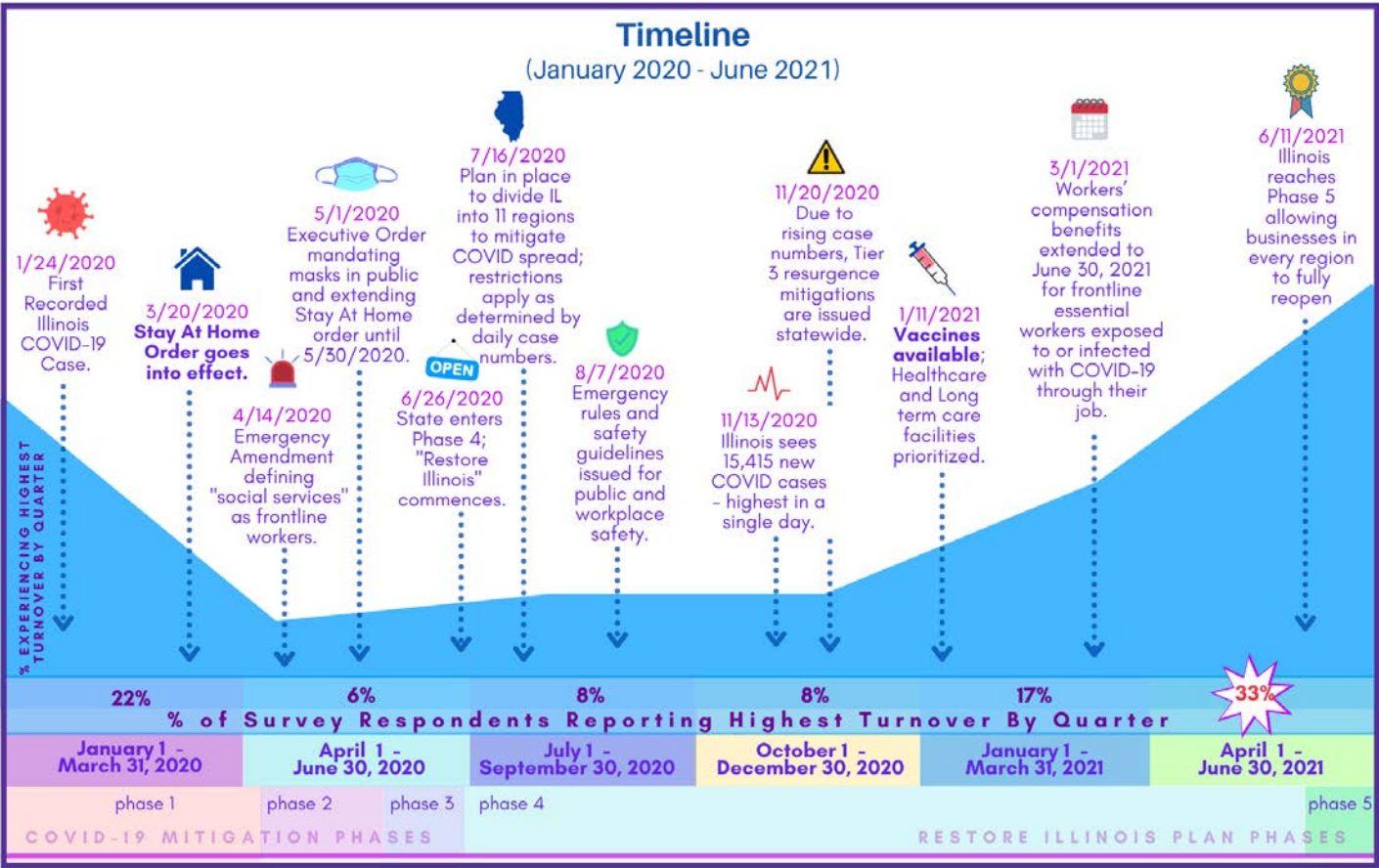
Amidst these changes, **demand for services** did not change uniformly. Employers that were well positioned for telehealth and other online services generally reported an increase in demand while sometimes struggling to meet that demand due to gaps in their workforce. In contrast, those that provide in-person, relationship-based activities experienced significant decreases in enrollment with the switch to online programming. Staff at senior meal programs pivoted almost immediately from serving in congregate settings to home delivery. One such provider described this heavy lift, saying they had “mind-blowing increases in hours to meet demand without increased staff. [I] can’t believe we did it.”

Focus group participants revealed a constantly changing environment and major shifts in practice requiring a tremendous degree of time-consuming, high-level planning. Subsequently, direct service staff had to learn new skills and roll out new service models. One provider said, “things that used to take an hour are now taking us two hours to do.” In addition, job duties were scrambled. For example, finance and mental health personnel diverged from their prescribed responsibilities to help clients applying for COVID-19 assistance. In another instance, a child care center that relied on college student workers saw a sizable portion of their workforce literally leave town when local campuses closed. These patterns increase the workload for remaining employees leading to burnout, shortages, and turnover.

Workplace Safety and Employee Well-Being

At the height of the pandemic, the immediate needs of employers were additional PPE, increased sanitization protocols, and improved ventilation and tech requirements, including equipment for employees to work remotely. With this extreme shift, respondents reported that their employees experienced high levels of stress, anxiety, and burnout, which led to record turnover and persistent vacancies in some organizations. Family demands impacted workforce stability as employees managed the changing needs of their families as well. Many health and human service employees, who our research shows are more likely to be women, are also parents, juggling their own kids' school closures and quarantines, which contributes to these ongoing challenges.

Figure 16.



Recommendations

These recommendations are meant to inspire meaningful discourse around how to work towards actionable, pragmatic, and impactful solutions to best support and sustain the sector's workforce.

This research shows that the health and human services workforce is predominantly women, and that low-wage jobs in the sector, which are funded through the state mechanisms, are more likely to be held by people of color. Thus, in addition to supporting other positive outcomes for employers, improving support for the health and human services workforce will mitigate gender and race based inequality in Illinois. The solutions offered below require legislation in some cases, and in others require changes to administrative or executive rule. They are a synthesis of the feedback we received from research participants, consolidated into these three categories:

1. FY23 budget recommendations;
2. Short-term policy and administrative recommendations;
3. Long-term policy and administrative recommendations.

FY23 Budget Recommendations

Participants stressed that the workforce challenges they face cannot be adequately addressed without legislation to fully fund the actual cost of health and human services. The gap between current Illinois rates and contracts and the real cost of services is well documented and in need of reconciliation. Thus, before adding any new health and human service programs, the FY23 budget should include a significant investment toward pay equity by identifying appropriations above the FY22 baseline for both:

1. Increased reimbursement rates and contracts to fully fund the cost of services, and
2. Scheduled minimum wage increases, including associated benefits and wage compression.

For clarity and accountability, FY23 budget documents should clearly delineate the amount appropriated above the FY22 baseline for the real cost of services (including overhead and fringe benefits), scheduled minimum wage increases, and related wage compression.

Short-Term Policy and Administrative Recommendations

The short-term recommendations below will create more nimble health and human service providers, improve workforce morale, and contribute to better client outcomes. To implement these changes, State contractors, especially those with multiple state agency grants, should be invited to share their recommendations and experiences with state officials. In the meantime, the State should:

1. **Establish a cohesive, consistent, and equitable methodology to determine reimbursement rates and other contractual payments** to keep pace with the costs of living and doing business to ensure the workforce does not fall behind after FY23.¹⁵
2. **Support the health and human services workforce by raising the cap on overhead expenses in state contracts.**¹⁶ Arbitrarily limiting overhead means provider capacity is limited without reliable administrators, buildings, and equipment to run programs. It also inhibits their ability to be competitive with the State and other sectors, including retail and hospitality, for employees if they are unable to offer comparable benefits. When rates and contracts do not cover these costs, providers with better connected boards, wealthier donors, and newer buildings fare better than less resourced organizations, which are often located in and/or serve BILPOC communities thus perpetuating systemic inequity.

¹⁵ For example, to at least 20%. Overhead is a combination of expenses related to doing business that are sometimes excluded from, or capped at 10% in grants. In this research, overhead includes expenses like salaries for certain types of workers (i.e., leadership, administrators), benefits people receive for working (i.e., fringe benefits), and the physical spaces in which people work (i.e., mortgage and rent, maintenance, capital improvements).

¹⁶ There are precedents for this in certain programs that go beyond a simple cost of living adjustment ([COLA](#)), such as the biannual rate adjustment required for Doula services in [HB158](#) in 2021, the comprehensive approach to the school funding formula taken in recent years, and the developmental services "Guidehouse" study.

3. **Reduce the rigidity and complexity of administrative rules to help control overhead costs and alleviate the ongoing stress caused by bureaucratic burdens.** The state should improve GATA; reduce the frequency, redundancy, and complexity of reporting requirements; permit some capital expenses to be covered under state contracts,¹⁷ ensure timely and predictable payments, and make it easier for contractors to move money among line items.

Long-Term Policy and Administrative Recommendations

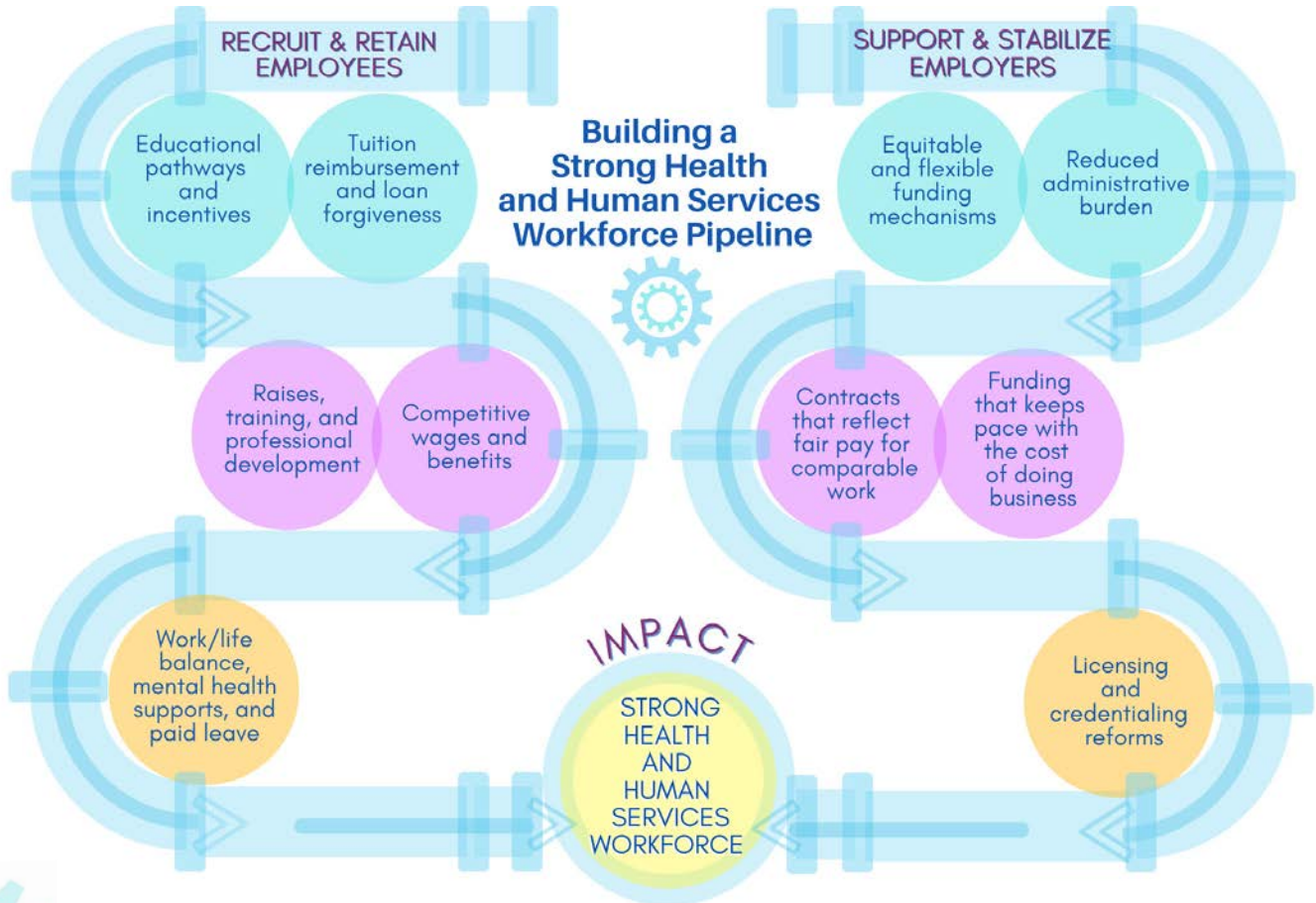
1. **The State should expand and strengthen a variety of programs that support the health and human services workforce pipeline including retention.** A strong and stable health and human services workforce pipeline will help to sustain the sector's workforce, ensure workers are available in the areas where they are needed most, and reduce trends in employee turnover. Specifically, the State should:
 - Cultivate respect for jobs within the sector through educational programs beginning as early as grade school, and continuing into high school through elective or required coursework;
 - Expand and simplify loans/loan forgiveness, scholarships, and tuition reimbursement programs for health and human service professionals;
 - Tie such programs to the location of the employer rather than to a specific type of degree to incentivize a robust workforce in the locations where vacancies are high;
 - Improve professional development and training opportunities, including trauma-informed care, culturally specific and multilingual programming related to ethnicity, race, disability, learning differences, LGBTQ, indigenous populations, and migratory groups, etc;
 - Make equitable delivery of services a priority by supporting a workforce that includes bilingual and culturally competent professionals;
 - Bolster benefit packages to include features such as paid leave (parental, elder care, personal) and access to affordable, quality child care.
2. **The legislature should enact legislation to support public and private community-based health and human service employees equitably.**¹⁸ State health and human service employees earn more and have better benefits than private nonprofit community health and human service employees in similar jobs. Regardless of the employer, the workforce experiences a high degree of stress and secondary trauma triggered by the intimate nature of working so closely with clients. Many health and human service professionals in this line of work have lived experience in their area of service provision as well. COVID-19 and the heightened racial tensions of 2020 amplified this reality. Health and human service workers in the private sector deserve the same pay, support, training, and wellness benefits that public sector employees receive, including access to essential resources, such as mental health services and COVID testing.
3. **The State should reduce reliance on Fee-For-Service models in favor of outcome-based/capacity grants.** COVID-19 exposed the weaknesses of paying on a Fee-For-Service basis. This reliance on requiring volume as a business model incentivizes treatment over prevention, diminishes the importance of personalized care, and exposes providers to risk for external variables they cannot control. Outcome-based and capacity-grant style funding both support flexibility and incentivize prevention, which will cost the State less. Simultaneously, the State should require managed care companies to standardize and simplify practices statewide.

¹⁷ The Rebuild Illinois capital appropriation for human services was \$15 million, which was insufficient to meet the capital needs of the entire human service sector.

¹⁸ See an example of this type of proposed legislation in [Massachusetts](#).

4. **The executive and legislative branches should work together to revise credentialing and licensure rules to create more flexibility in hiring practices.** Legislative and administrative rule revisions can help reduce barriers to care and eliminate redundant or wasteful training requirements. Some rules could be relaxed to allow billable services from certain credentialed providers that currently cannot bill.

Figure 17.



Conclusion

Central to this report and the recommendations presented is making equitable access to essential services for all Illinoisans a priority. Robust public investment in the sector is one component in achieving this outcome, but so too is the acknowledgment of systemic racism and a commitment to address it. The report's recommendations are by no means a panacea for all of the issues presented. However, they will help sustain the health and human services workforce in concrete ways as we keep working together for systemic change within state government, the sector, and the communities our coalition partners serve.

Appendix

Illinois Partners for Human Service expresses our appreciation for our coalition partners who provided invaluable information for this research through completion of our survey and/or participation in our focus groups.

AgeOptions
Allendale Association
Alternatives (for the Older Adult, Inc.)
Arrowleaf
Asian Human Services
Association for Individual Development
Aunt Martha's Health and Wellness
Big Brothers Big Sisters of Central Illinois
Big Brothers Big Sisters of Metro Chicago
Boys & Girls Club of Bloomington-Normal
Boys and Girls Club of Lake County
Caritas Family Solutions
Carole Robertson Center for Learning
Casa Central Social Services
Centerstone
Central Illinois Friends
Chestnut Health Systems
Chicago Urban League
Chinese American Service League
ComWell
Cunningham Children's Home of Urbana
Decatur Community Partnership
DuPage Pads
Easterseals Joliet Region, Inc.
ECIAAA
EP!C
Erie Neighborhood House
Family Focus
Family Service Association of Greater Elgin
Freedom House

Gateway Foundation
HANA Center
Heartland Alliance
Heartland Health Services
Illinois Coalition Against Domestic Violence
Kenneth Young Center
LIFE Center for Independent Living
Lutheran Child and Family Services of Illinois
Lutheran Social Services of Illinois
Mano a Mano Family Resource Center
Metropolitan Family Services
Milestone, Inc.
Mujeres Latinas En Accion
New Moms
Northeastern Illinois Area Agency on Aging
Pathway Services Unlimited, Inc.
Project Oz
RRAF
SEIAOA
SHOW BUS Public Transportation, NFP
Sinnissippi Centers
Specialized Training for Adult Rehabilitation, Inc.
Spero Family Services
St. John's Community Care
TASC
The Center for Youth and Family Solutions
Thresholds
YouthBuild McLean County
YWCA McLean County
YWCA Metropolitan Chicago

Focus Group Questions

1. Poll: Total # of employees (< 100; > 100)
2. Poll: % of employees that are Black, Indigenous, Latino, and Persons of Color (BILPOC); (do not collect this data; <20%; >20%)
3. Poll: % of employees that identify as female (<50%; >50%)
4. Poll: # of employees that identify as nonbinary (do not collect this data; 0; less than 5; more than 5)
5. Discussion: How did COVID-19 affect your operations?
6. Discussion: How do the State's current funding practices impact the health and human services workforce in your organization?
7. Discussion: What factors contribute to the wage ranges of frontline health and human services workers? How do those wage ranges impact your hiring practices?
8. Discussion: How has your vacancy rate and applicant pool changed over time?
9. Poll: Which of these hiring barriers does your organization experience? Choose up to three. (Applicants don't have adequate credentials; Applicants lack employability skills; Difficulty of work; Lack of applicants; Lower wages than other available jobs; No-shows at interviews; Turnover when applicant is fully trained)
10. Discussion: How has turnover changed at your organization over time, and how has turnover affected your organization? What factors have the greatest impact on workforce stability?
11. Poll: What is the most frequent reason for voluntary separation at your organization? Choose one. (Accepted job outside of community health and human service setting; Moved out of state; Family circumstances; Job duties; Compensation; Better benefits; Separated due to COVID-19; Unknown)
12. Discussion: What administrative or legislative changes would help improve the workforce challenges you are experiencing?

Access **Survey Questions** via this [link](#).