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Advancing the Home Care Workforce:

A Review of Program Approaches, Evidence, and the Challenges of Widespread Adoption

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EXECUTIVE SUMMARY

Demographic and policy trends in the United States have combined to create unprecedented demand for home-based, long-term care services for the elderly, with expected growth for decades to come. Home care workers like home health and personal care aides provide most of the care for the increasing elderly population, many of whom have chronic and complex medical and social needs and prefer to age at home. Despite the critical role of those providing this care, home care workers are undervalued, underpaid, and rarely acknowledged as members of client health care teams. This undervaluation contributes to low job satisfaction and high home care worker turnover and attrition, which may negatively affect clients' health and employers' bottom lines. As a result, advocates argue that opportunities for skill and career advancement for home care workers can improve their job quality, satisfaction, and livelihoods while also contributing to positive downstream outcomes for clients, employers, and even health systems.

This report, *Advancing the Home Care Workforce: A Review of Program Approaches, Evidence, and the Challenges of Widespread Adoption,* was commissioned by the Ralph C. Wilson, Jr. Foundation with an objective to examine program approaches to advance the roles of home care workers with a deeper dive into some of the contextual factors that may impact uptake specifically in in Western New York and Southeast Michigan due to the Foundation's geographic focus in these two regions. Findings emerged from a literature review and interviews with content experts representing a range of stakeholder groups.

Chapter 1 reports our national program scan findings, including the characteristics of different program approaches, evidence, and emerging best practices. The 20 programs or planned initiatives identified are using one or more of the following approaches to advance the roles of home care workers:

1. Creating formal, advanced roles that provide an internal career ladder, promotion, and wage increase
2. Upskilling workers on specific tasks or medical conditions to increase specialty knowledge and skills
3. Optimizing the role of home care workers by integrating them in clients' care teams
4. Providing foundational professional and life "soft skills" training to set workers up for success in their current roles

While few programs have been evaluated, and designs are limited in their generalizability, there are promising trends. Several studies show that these programs benefit workers by increasing their pay and job satisfaction and benefit clients by improving some of their health outcomes and reducing rates of hospitalizations. Although the evidence that employers benefit, e.g., through worker retention, is scarcer, it may also be a promising area of impact. Lastly, some evidence

demonstrates that the reductions in health care utilization among clients could translate into cost savings for health systems and payors.

Although variation exists in the program characteristics identified in our scan, several components appear to be central to effective planning, implementation, and evaluation. These include: (1) prioritizing worker respect and wage recognition; (2) providing multiple pathways for advancement; (3) integrating workers with the client's health care team; (4) engaging stakeholders, including workers and employers, in program planning; (5) planning for sustainability from program onset; (6) building a strong evaluation design into the program plan; (7) considering the equity and socioeconomic factors impacting workers; and (8) integrating adult-learner centered, competency-based curricula and training methods.

Chapter 2 examines barriers and opportunities for large-scale adoption of initiatives to advance the roles of home care workers. Based on interviews, we find that the key systemic issues preventing the spread of these models include: the low social status and discrimination faced by home care workers; the highly fragmented nature of the home care and home health industry; and the fact that health systems have historically rejected the integration of home care services. However, a tremendous opportunity exists to make changes in these areas, based on a significant influx of resources included in the American Rescue Plan and the potential additional funding in the proposed American Jobs Plan.

Chapter 3 examines the regional contexts of Western New York and Southeast Michigan and their implications for the home care industry and future funding initiatives. In both regions, demographic trends show a growing need for the home care workforce over the next three decades. However, the feasibility of addressing this ever-increasing demand is determined by state-specific policies, stakeholders, and existing infrastructure. In New York, for example, legislative efforts to create an 'Advanced Home Health Aide' certification never gained traction because funds were not appropriated for program implementation. In addition, recent Medicaid reforms and budget cuts are threatening to make access to home care services even more difficult.

Consequently, the home care population in the western part of NY, where there are already very few home care agencies, may become increasingly complex. On the other hand, New York maintains one of the few home care worker training registries in the country, providing workforce tracking and analysis opportunities. Michigan's strength lies in the significant momentum built behind ongoing coalition building and advocacy, including a full menu of policy and program proposals that are "shovel ready".

In the final chapter, we propose a set of broadly applicable options that stakeholders and policymakers may wish to consider as they make strategic investments to strengthen the home care workforce. These are not mutually exclusive and could be combined for a multi-level approach, as follows:

1. **Invest in coalitions** to strengthen state policies and programs that aim to improve wages and benefits and professionalize the home care and home health workforces.
2. **Support a public relations campaign** on the value of home care workers.
3. **Generate the business case for health systems to integrate home care workers**
4. **Build the evidence for a return on investment for home care agencies**
5. **Invest in the development of on-demand training apps.**
6. **Provide Internet hotspots for home care workers** to increase access to training.
7. **Support the development of guides for employment agencies** that will aid in program design, implementation, and evaluation.
8. **Gather workforce data** by funding widescale surveys of home care workers.
9. **Fund a report on managed care organizations** and their potential to incentivize advanced roles for home care workers with increased wages.
10. **Fund a report on opportunities for mergers and acquisitions** across home care, home health, and home hospice agencies industries.

Table of Contents

List of Tables

List of Figures

1. Background

Over the next 30 years, the number of people over 65 living in the U.S. is expected to double, while the population over 85 will reach a staggering 19 million.[1] Many of these seniors will require assistance with personal care and daily living activities due to health-related challenges.[2] Nearly 14 million are expected to have Alzheimer's or other dementia.[3] At the same time, the overwhelming majority of this population would prefer to age at home,[4] creating what appears to be an insatiable demand for home care workers now and for decades to come.

The federal and state governments are attempting to respond by advancing a range of policies, including Medicaid waivers, to support the long-term care support services (LTSS) and strengthen the Home and Community Based Services (HCBS) workforce.[5,6] While Medicare funds part-time or intermittent home health aide (HHA) services to address personal care needs, it does not pay for long-term supportive care, e.g., home personal care aides (PCAs) or nursing facilities. Medicaid is, therefore, the largest payer for long-term care services in the U.S., including home care provided by PCAs.

Section 1915(c) HCBS waivers and Section 1115 demonstration waivers provide states with multiple avenues for funding long-term HCBS for their Medicaid enrollees, some of which were made possible under the Affordable Care Act (ACA).[5] Two widely adopted Medicaid LTSS delivery system options are managed care (MLTSS) and self-directed models. In the former, financing and delivery of LTSS is capitated (as opposed to fee-for-service) to promote care coordination, quality, and access. In the latter, Medicaid participants are responsible for managing their own LTSS services and have the authority to recruit, hire, train, and supervise the workers providing their care. Chapter III of this report provides information on Michigan and New York specific LTSS delivery models and funding.

The workers who provide most caregiving in the models described above, as well as in nursing facilities, are referred to collectively as 'direct care workers' (DCWs). This workforce comprises three main categories of workers who assist clients with activities of daily living (ADL), such as personal care and instrumental activities of daily living (IADL) that allow seniors and younger people with disabilities to live independently.[7] Direct care workers include personal care aides, home health aides, and nurse aides. Though there is a wide degree of overlap between these workers' roles, the training and certification requirements, regulation, and funding mechanisms across the three categories vary significantly (Table 1). For this report, we use the term 'Home Care Workers' (HCWs) to refer to the two categories of worker that usually provide services in the home, which are the focus of our discussion in this report: personal care aides (PCAs) and home health aides (HHAs).

Table 1: The Direct Care Workforce

Personal Care Aides (PCAs)[a]	Home Health Aides (HHAs)[a]	Nurse Aides
• Also known as home care aides, personal care attendants, direct support professionals • Typically work in home care settings • May be employed by an agency or hired by an individual • **Training:** Not regulated by the federal government; States may have their own training requirements (MI:0; NY:40 hrs.) • **Average Salary:** $11.40 (MI: $9.75; NY: $10.98)[8] • **2018 Employment:** MI: 43,960[9] NY: 224,180[10] • **Projected Growth 2018-28:** MI: 24%[9] NY: 56%[10]	• Primarily work in the home through home health agencies • Typically work under RN supervision • **Training:** Federally regulated at a minimum of 75 hours, though states may exceed; 120 hours is recommended[1] (MI & NY: 75 hrs.) • **Average Salary:** $11.77 (MI: $9.87; NY: $10.37)[11] • **2018 Employment:** MI: 26,850[12] NY: 213,120[13] • **Projected Growth 2018-28:** MI: 23%[12] NY: 66%[13]	• Also known as nursing aides or Certified Nurse Assistants (CNAs) • Primarily work in nursing facilities • Work under RN supervision • **Training:** Federally regulated at a minimum of 75 hours though states may exceed; 120 hours is recommended[1] (MI: 75; NY: 120 hrs.) • **Average Salary:** $13.38 (MI: $13.18; NY: $15.87)[14] • **2018 Employment:** MI: 51,660[15] NY: 100,870[16] • **Projected Growth 2018-28:** MI: 2%[15] NY: 14%[16]
[a] Type of home care worker (HCW)		

Despite the critical role these workers play in caring for the fastest-growing demographic in the United States, HCWs are chronically and systemically undervalued, underpaid, and not widely acknowledged or integrated as members of healthcare teams. The home care workforce is therefore largely hidden and disconnected from the broader healthcare system. This undervaluation can be at least in part attributed to systemic racism. Home care workers are predominantly women of color, and many are immigrants. Average wages for HCWs are less than $12 per hour, many do not receive health care benefits, and one out of six live in poverty, while about half live in low-income (<200% federal poverty line) households.[17] These trends are consistent for HCWs in Michigan[18] and New York.[19,20]

Training requirements are also a challenge. While federal mandates require at least 75 hours of training for HHA certification, experts recognize this as insufficient. There are no federal training requirements for PCAs, and state standards – when they exist – vary widely.[21] For example, while

NY requires 40 hours of training for agency-employed PCAs, Michigan does not regulate PCA training, except for some broad content requirements for certain agency-employed workers.[21] Few opportunities for career mobility exist within the direct care workforce, despite guidance from experts and advocates across multiple sectors recognizing advanced training and role recognition as key to professionalizing the home care workforce, building and retaining a highly-skilled direct care workforce, and ultimately protecting the health and well-being of seniors while reducing avoidable health care system utilization.[22–24]

Not surprisingly, the professional, social and economic challenges faced by HCWs result in high worker turnover rates, jeopardizing their supply. At the same time, projected national job growth for HCWs is approximately 34% over this decade,[25] with similar trends projected in MI and NY for both PCAs and HHAs (Table 1). In Southeast Michigan, seniors 65 or older will comprise one-quarter of the population 15 and older by 2040 (see Appendix 1), while the state is already facing a shortage of about 34,000 HCWs.[26] In Western New York, the old-age dependency ratio (the number of individuals aged 65 and over per 100 people of working age 15-64) is expected to increase dramatically over the next two decades, reaching a staggering 47.43% in Niagara county alone (see Appendix 1). By 2026, the largely rural region is estimated to have added 6,200 HCW jobs over a decade.[19]

Experts argue that increased training and opportunities for advancement can lead to higher wages and benefits, job satisfaction, and rates of retention for HCWs, including PCAs.[27,28] They further posit that lower turnover rates can improve the quality of care clients receive, thereby improving health outcomes and ultimately increasing health systems savings.[22,24,29] The aim of this report is to review the evidence of these relationships and provide specific considerations for stakeholders interested in these issues in Michigan and New York.

In the sections that follow, we conduct a national scan of programs that advance the roles of HCWs, with a primary focus on the PCAs who provide long-term care for the elderly in home-based settings. First, we identify and classify training approaches to creating advanced roles. Next, we review the evidence of their effectiveness. We then include the expert opinions of leaders whom we interviewed and summarize key takeaways on best practices. Next, we examine the barriers and opportunities for widespread adoption of these kinds of programs. Lastly, we have included a section that focuses on home care in Michigan and New York, with analyses of the counties of interest where we could find data. We also offer a set of appendices with more detailed information in each area.

2. National Scan

Methods

We conducted a national scan of programs that provided opportunities for the advancement of HCWs serving the elderly. Our search sought to capture the breadth of innovations in home care workforce development and career success, in addition to a more narrowly defined goal of achieving 'advanced roles'. We identified programs through a review of scholarly peer-reviewed journals, as well as the grey literature. We conducted scholarly searches in PubMed (clinical focus), CINHAL (nursing and allied health focus), and ERIC (education and training focus). We used general internet searches and a review of key stakeholders' websites to identify relevant gray literature. See Appendix 2 for a detailed description of literature review methods.

We also conducted 12 semi-structured interviews with home care experts and stakeholders representing various sectors, including industry, advocacy, research, and the unions. See Appendix 3 for a list of interviewees. The interviews augmented our literature review by 1) providing contextual and historical information that helped us to better understand the home care landscape and interpret findings from the literature review, 2) ensure we had not missed any of the effectiveness research, and 3) identify consensus on best practices.

Our initial goal was only to identify programs targeting PCAs because we saw them as the most disadvantaged workers. However, we found few evaluations of PCA-only programs. Also, many of the agencies that oversee HCW programs employ both PCAs and HHAs, and leading experts have posited that the lessons gleaned from program models targeting HHAs could be applied to the PCA workforce.[30] We, therefore, expanded our search also to include programs targeted to HHAs. Whenever possible, we try to distinguish between programs for HCAs, HHA, and those that more broadly refer to "home care workers" or "direct care workers".

2.1. Program Variation

Our scan identified 20 programs or initiatives that sought to advance or elevate the roles of home care workers within the past decade (see Table 2and Appendix 4). Important scan sources included two previous national reports on home care worker innovation models, conducted by Leading Age in 2020[30,31] and comprehensive reports detailing the home care workforce, published by PHI.[2,17] While program components and aims differed, all programs identified sought to advance the roles of HCWs in ways that would improve worker, client, employer, and/or health systems outcomes.

Table 2: Home Care Worker Programs and Initiatives: Role Advancement & Elevation

Program Name	Location	Dates (Active Y/N)	DCW Type	Funder	Approach				Core Training	Evaluated Y/N
					Adv. Role	Upskilling	Integration	Soft Skills		
1. Building Training…Building Quality (BTBQ)[32]	MI	2011-13 (Y)[a]	PCA	Federal	X	X		X	X	Y
2. Care Connections Project[2]	NYC	2015-16 (N)	HHA	State	X	X	X			Y
3. Care Team Integration of the Home-Based Workforce[33]	CA	2013-15 (N)	PCA	Federal		X	X	X		Y
4. Cooperative Home Care Associates[34]	NYC	1985- (Y)	PCA, HHA	Self	X	X	X		X	N
5. Direct Care Worker Apprenticeship, The Apprenticeship Institute[35,b]	MI	N/A	PCA, HHA	N/A	X				X	N
6. Family Care Advocate Training for Experienced Aides[36]	AR (CA, TX, HI)	2013-16 (Y)[a]	PCA	Federal		X				Y
7. Intervention in Home Care to Improve Health Outcomes (In-Home)[37]	Nat'l	2015 (N)	HCWs	Private		X	X			Y
8. Homecare Aide Workforce Initiative (HAWI)[27]	NYC	2013 ('multi-year')	HHA	Private	X			X	X	Y
9. Jewish Home Lifecare Peer Mentor Aide program[38]	NYC	2008 (3 yr. goal)	HHA	Private	X	X				Y
10. Massachusetts Supportive Home Care Aides[17]	MA	1995 - (Y)	HHA	N/A	X	X				N
11. New Jersey Nurse Delegation Project[39]	NJ	2008-10 (N)		Private & State		X				Y
12. New York Advanced Home Health Aide Program[40,b]	NY	N/A	HHA	None	X	X				N
13. Partners in Care Health Coaching Pilot Program[41]	NYC	2013 (N)	HHA	State		X	X			Y
14. Personal and Home Care Aide State Training (PHCAST)[42]	Nat'l	2010-14 (N)	PCA	Federal	X	X		X	X	Y
15. Quality Improvement in Long Term Services and Supports or QuILTSS[43]	TN	2019[c] (Y)	DCW	State	X	X			X	N
16. Transformational Healthcare Readiness through Innovative Vocational Education (THRIVE)[44]	NY, OH, MI	2019 (Y)	PCA, HHA	Private				X		N[d]

17. SEIU Healthcare NW Training Partnership (SEIU NW)[45]	WA	2007-(Y)	PCA	Employers	X	X		X	X	Y
18. St. John's Enhanced Home Care Pilot Program (St. John's)[46]	CA	2012-13 (N)	HCW	Private		X	X			Y
19. Universal Health Care Worker, CA[31,b]	CA	N/A	PCA	Private	X	X				N
20. Universal Health Care Worker, MI[b]	MI	N/A	HCW	N/A	X	X				N
Notes: Primary program citations are contained in this table rather than throughout the body of the report. [a] A version of this program is still active, but not in the form in which it was analyzed for this report [b] Program is not yet implemented; [c] Training component of program; [d] Evaluation in progress										

While most programs have been implemented, four included in this report are still in the planned phase. About half of the programs we identified focused solely on PCAs, while the remainder targeted HHAs or "home care workers" generally. Geographically, these programs were heavily concentrated on the coasts, with seven in New York alone (1 statewide; 5 in NYC; 1 in western NY). We identified two initiatives in Michigan, though only one has been implemented. Most programs represented isolated, local-level pilots in metropolitan areas. None of the programs we identified were based in rural areas. However, there are training curricula that exist online that could be used in any region, e.g., Elsevier's Home Care Suite.[47]

As shown in Figure 1, four categories of program approaches to advancing the home care workforce emerged from our review: 1) those that formalize advanced roles to move the HCW up within the home care profession (Advanced Roles); 2) those that provide specialty certification or training to enhance and expand HCW knowledge and "hard skills" (Upskilling); 3) those that integrate HCWs into the consumer's care team (Care Team Integration); and 4) those that provide foundational professional and life skills training to support HCWs in their current roles (Soft Skills). These program approaches are not mutually exclusive; in fact, almost all of the programs we identified had elements of more than one approach, and many of them also included basic entry-level HCW training (Table 2).

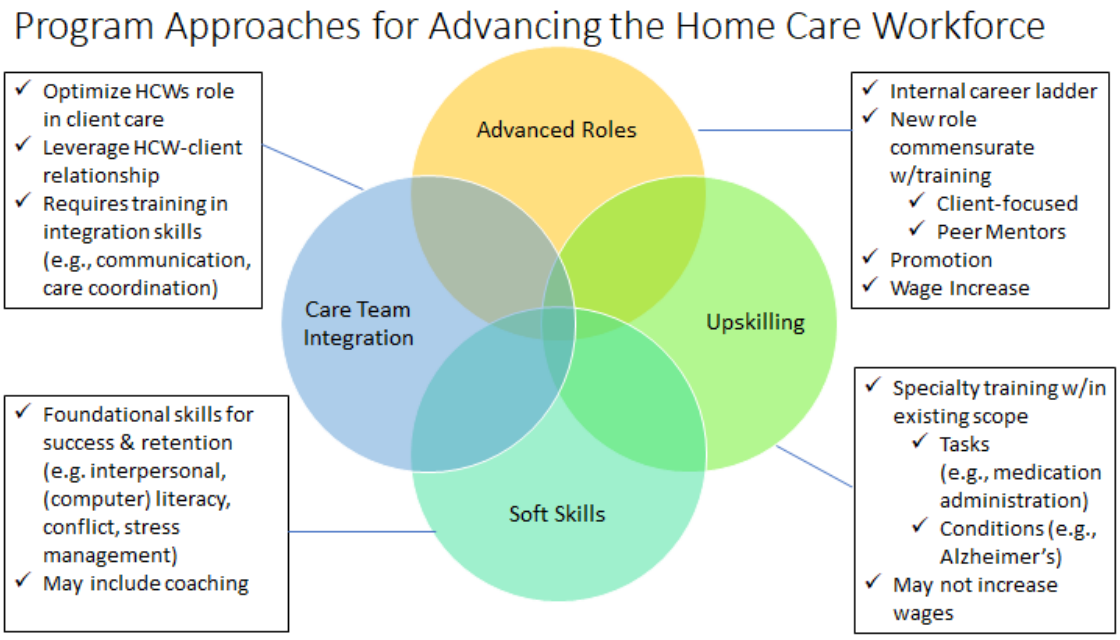

Figure 1: Program Approaches for Advancing the Home Care Workforce

2.1.1. Advanced Roles

PHI defines advanced roles as those that allow employees to grow in their careers and contribute to their organizations in new ways that help them sustain a sense of progress and advancement.[17] They further note that workers in advanced roles should be formally recognized by an elevation in title, function, and compensation.

Advanced roles for HCWs have been promoted by advocates for the direct care workforce[48] and older adult population alike.[23] They recognize that the low wages and stagnant job opportunities that plague this workforce result in dissatisfaction and high attrition among workers, ultimately harming the clients who rely on them to receive care and remain safely at home. Advanced roles have the potential to benefit workers through increased job satisfaction and wages, clients through higher quality of care, employers through improved employee retention, and the health system through cost savings resulting from decreases in ER visits, hospitalizations, and other client health outcomes.

Formal advanced roles identified in our scan had several objectives:

- providing advanced levels of client care
- improving worker outcomes or employer operations
- advancing the role of PCA to that of an HHA
- some combination of these three forms

Client care-focused advanced roles in the programs we identified typically included training in paramedical skills, disease management, or care coordination, resulting in a designated title and wage increase. For example, The Care Connection Project (NYC), a partnership between PHI, three home care agencies in NYC, and a managed care organization, created senior aide positions for HHAs to improve patient care transitions. Care Connections Senior Aides (CCSA) received 240 hours of training in chronic disease knowledge, communication skills, enhanced observation, recording and reporting skills, and care team participation. They made home visits to provide coaching and support to other HCWs, helped with caregiving challenges, and served on the consumer's interdisciplinary care team. Senior Aides received an annual salary and benefits amounting to a significant wage increase.

Advanced roles can also be employed to provide support for entry-level HCWs through peer mentorship. This approach is defined as *training experienced direct care workers in coaching and problem-solving competencies to serve as Peer Mentors who support new workers, helping them navigate caregiving challenges and other issues that arise during the transition into direct care work*.[17] For example, Cooperative Home Care Associates (NYC), the largest worker-owned home care agency in the country, has used peer mentorship since the late 1980s. Located in Bronx, NY, their program seeks to provide worker support, coaching, and internal career advancement opportunities. Initially, there was only one level of peer mentorship, in which a mentor was assigned to every new trainee to provide telephonic support for the first 90 days of their employment. In addition to listening and helping to problem solve, the peer mentorship program provided a natural early alert system; peer mentors could notify the staff RN if trainees and their clients needed additional support or intervention. Later, a second level of peer mentor was added, elevating mentors to a full-time, salaried job. This elevated peer mentor also benefits from being able to interface with other agency staff who can help facilitate supportive services (e.g., child care, transportation) for HCWs facing challenges. (Personal communication, March 26, 2021)

Some training programs may offer more than one type of advanced role for HCWs. Washington state's SEIU Healthcare NW Training Partnership (SEIU NW), the largest training provider in the nation for HCWs, is an important example. In addition to providing PCA basic training and continuing education, SEIU NW offers two types of advanced roles: a formal advanced role designation, earned by completing the nation's first registered apprenticeship for HCWs (Advanced Home Care Aide), and a peer mentor role. Upon training completion, Advanced Home Care Aides and peer mentors receive wage increases of $0.75/hr. and $1.00/hr., respectively.

2.1.2. *Upskilling*

Upskilling is intended to bridge the gap between workers' entry-level preparation and the competencies required to meet the complex needs of today's long-term care consumers through additional training. As compared to formal advanced roles in which HCWs may acquire different skill sets, upskilling typically focuses on bolstering training in areas within workers' existing scope of responsibilities and does not necessarily result in a promotion or wage increase.[17] Advocates we interviewed maintained that upskilling of HCAs is essential to seniors' ability to age in place and receive LTSS in the home. However, the feasibility of upskilling PCAs and other HCWs is heavily determined by states' nurse delegation and scope of practice regulations, which are codified in their nurse practice acts. This is especially true of nurses' ability and willingness to delegate the administration of medications to HCWs. Nurse delegation considerations are discussed further in subsequent sections of this report.

Eldercare advocates emphasize the need for HCWs to receive training in areas and tasks relevant for the geriatric population, including mental health, palliative care, Alzheimer's Disease and Related Dementias (ADRD) care, and effective communication with the interdisciplinary care team and family members. "Hard skills" taught may include medication maintenance and administration, wound care, insulin monitoring, and pain management.[23] The programs we identified that employed upskilling aimed to develop knowledge and competencies related to ADRD, mental health, chronic disease management, medication administration, diabetes care, heart failure, and health coaching.

The state of Massachusetts provides a long-standing state model for upskilling through their Supportive Home Care Aide program, instituted in 1995. Training consists of 75 hours of HHA training plus 12 hours of advanced specialty training in either mental health or ADRD care. Continued upskilling support is provided through quarterly team meetings, case reviews and in-services, and ongoing supervision. Supportive Home Care Aides receive higher average starting wages than other DCWs in Massachusetts.[49]

The Family Care Advocate Training for Experienced Aides (AR) provides a more localized example of an upskilling program for PCAs. Based at the University of Arkansas for Medical Science's Schmieding Center for Senior Health and Education, the 40-hour Family Care Advocate training was restricted to experienced caregivers and focused on chronic disease management and communication. Additionally, experienced advocates were eligible to complete a 16-hour ADRD training. A CMS Healthcare Innovation Award allowed the center to extend the program to satellite sites in CA, HI, and TX and provide a microfinance option for trainees, but both initiatives were terminated at the end of the grant period.

The Partners in Care Health Coaching Pilot Program, an NYC-based initiative, provided an alternate approach to upskilling by training HHAs to be health coaches. HHAs had to have at least

one year of experience to be eligible for the one-week intensive training, which would lead to health coaching specialization for high-risk heart failure or chronically ill older adults. Training modules focused on concepts including self-management and readiness to change, goal setting, and motivational interviewing, as well as other supportive strategies for engaging consumers in their health care. The heart failure program aimed to provide additional support to patients during the first 30 days post-hospitalization. The program for chronically ill older adults used HHA health coaches to set goals with their clients, review the client's chronic condition, and encourage medication adherence. We found no evidence that HHA health coaches were compensated for their program participation or received higher wages.

2.1.3. Care Team Integration

Home care workers play an integral role in elderly clients' care and ability to remain at home. These workers – especially PCAs providing long-term care for Medicaid recipients - spend more time with clients' than other members of their health care team and can help maintain care continuity for clients with complex needs and multiple providers.[22] As such, they have ample opportunity to build relationships with clients and their families, understand their medical and social needs and preferences, and observe, record, and report changes in clients' condition or health that could prevent more serious medical problems or hospitalizations.[23]

'Care team integration' approaches elevate the role of HCWs by providing specialized training and opportunities that facilitate their inclusion in clients' interdisciplinary health care teams. Beyond the potential benefits of this model to workers themselves (e.g., job satisfaction) and their clients (e.g., reduced hospitalizations), other care team members stand to benefit from listening to home care workers' observations and understanding their contributions to consumer health.[17]

We identified six programs that modeled the integration of HCWs into the care team. Two are worth describing in detail: a large demonstration program and a local pilot.

In 2011, the California Long-Term Care Education Center (CLTCEC) received a CMS Health Care Innovation Award for their demonstration project, Care Team Integration of the Home-Based Workforce (CA). This large-scale project involved over 6,000 long-term care consumers participating in the state's In-Home Supportive Services (IHSS) program and their consumer-directed caregivers. A multi-stakeholder engagement approach was used to design a competency-based, ~75-hour training curriculum for caregivers in more than four different languages. Training included advanced consumer care skills and care team integration. The training was designed to encourage caregivers to take on enhanced roles of monitor, communicator, coach, navigator, and care aide. They utilized role-playing to practice identifying problems and communicating them to the care team. A unique component of this program was that it also provided training to consumers to activate their participation in self-directed care and

provider integration. The program also developed an empowerment tool for home care workers and their consumers to help facilitate communication with case managers and physicians. Workers received a $95 stipend for completing program training but no wage increase. An extensive formal evaluation was a required component of the grant, as discussed in the next section.

The St. John's Enhanced Home Care Pilot Program (CA) was a one-year pilot based in Los Angeles to enhance care coordination, chronic disease management, and paramedical task training. As part of the program, consumers allowed HCWs to become part of their patient-centered health team, including attending all medical visits throughout the program. Specialized training was developed with expert and worker input within California's In Home Supportive Services System program to prepare HCWs for care team integration. Modules focused on quality-of-life issues and paramedical tasks, as well as mental health. Additionally, a care coordinator position was developed to serve as the primary contact and support person for participating HCWs and coordinate clinic-based services and other integration activities. Ninety-seven HCWs participated in the 6-week specialty training and care team integration program. Program completion was not associated with a wage increase.

2.1.4. Soft-Skills

The fourth type of program approach aims to set HCWs up for success by providing vocational and soft-skills training for entry-level workers. These programs potentially improve provider retention and success through the provision of training that builds foundational competencies in life and professional skills. The Transformational Healthcare Readiness through Innovative Vocational Education (THRIVE), which operates out of the Cleveland Clinic (Northeast OH), Ascension Michigan (Southeast MI), and Catholic Health (Western NY), represents one example of a soft-skills approach to advancing the home care workforce. Funded by the Ralph C. Wilson Jr. Foundation, the program aims to ensure long-term success and retention of HHAs and PCAs by providing new workers with life skills support, enhanced training, and a dedicated Workforce Coach during their first year of employment. Skill-building areas emphasized throughout the first year include conflict management, interpersonal and communication skills, and resiliency. The program also helps workers problem solve issues like child-care or transportation difficulties that may hinder employment success. An evaluation is underway, led by the RAND Corporation.

Federal initiatives have also supported the role of soft-skill building as an integral component of PCA workforce development. The HRSA-funded Personal and Home Care Aide State Training (PHCAST) demonstration project, mandated under the Affordable Care Act, funded six state demonstration grants (CA, IA, ME, MA, MI, NC) to support the development of competency-based training for PCAs. State grantees had the freedom to design their training curriculum but were required to cover nine core competency areas that included soft-skill building. Grantees

included competency modules on computer literacy, teamwork, time and stress management, conflict management, communication, and interpersonal skills.[50]

3. Evidence

This section reviews the evidence for the program models described above, particularly evidence of outcomes that benefit workers, clients, employers, payers, or other stakeholders. Overall, 11 of the programs we identified conducted a formal evaluation or outcomes study (though others report limited outcomes without a complete evaluation),[2,49] with six publishing findings in peer-reviewed journals (see Appendix 4).

As shown in the summary table below (Table 3), most of the programs that included an evaluative component reported positive outcomes, although the quality of the evidence was variable. In some programs, like the Care Team Integration of the Home-Based Workforce (CA), Building Training…Building Quality (BTBQ; MI), and the Homecare Aide Workforce Initiative (NYC), a formal evaluation was a required component of the grant. Other programs identified in our scan have not been evaluated at all or were never implemented (see Appendix 4).

Table 3: Evidence Synthesis for Programs that Advance the Home Care Workforce

Impact on Workers ➢ Higher earnings of up to 60% for workers in some advanced roles and graduates of upskilling programs, compared to other HCWs[2,36,49] ➢ Program graduates work more hours per week than comparison groups of HCWs[36,38] ➢ High rates of job satisfaction (77%, 91%) following program [27,32]
Impact on Clients ➢ Reduced rates of hospitalization and re-hospitalizations by 43-50%[33,46] ➢ Reduced rates of ER visits up to 50%[2,33,46] ➢ 40% improvement in medication compliance[46] ➢ Significant improvements in client self-reported "healthy days" and health maintenance practices[41,46]
Impact on Employers ➢ Programs employing peer mentoring approaches as part of their training models have reported a 50% higher retention rate of peer mentors and significantly higher retention odds of all program graduates compared to other home care workers[27,38]
Impact on Payers and the Health Care System ➢ Reduced ER visits and hospitalizations associated with a care team integration program are associated with projected health care system cost savings $12k/client[33] ➢ Care team integration programs resulted in improved communications with primary care physicians by 10% and 80% attendance by home care workers at all client medical visits[33,46]

3.1. Worker Outcomes

Most of the evaluations we identified assessed program impact on HCWs, with outcomes that included program satisfaction, knowledge and skills, wages, and employment status. Findings were consistently positive across program models.

Four programs in our scan that included upskilling approaches reported positive learning or competency gains. HCWs in St. John's Enhanced Home Care Pilot Program (CA) reported improved ability to perform more highly skilled paramedical tasks and medication management. HCAs in the Care Team Integration of the Home-Based Workforce Pilot Program (CA) passed at least 80% of their demonstrated competency checks. The Family Care Advocate Training for Experienced Aides (AR, CA, HI, TX) program evaluation found that participants were more likely to report learning stress reduction techniques and skills specific to caring for patients with cognitive impairment than a control group. Scores on post-tests measuring knowledge gains for BTBQ (MI) trainees who attended the program's dementia in-service also increased significantly compared to pre-test scores (92% vs. 82%).

Four programs identified in our scan assessed program impact on HCW wages or employment. Graduates of the Family Care Advocate Training for Experienced Aides (AR, CA, HI, TX), an upskilling program for HCAs focused on chronic disease management, communication, and care coordination, self-reported working more hours per week (42 vs. 39) and earning higher wages (average of $9.37/hour vs. $8.96/hour) than a comparison group of trainees. Peer mentor aides from the Jewish Home Lifecare Peer Mentor Aide Program (NYC) for HHAs worked significantly more hours per week than other aides at the organization (40 vs. 28). An analysis of HCWs in Massachusetts found that wages rose with more advanced positions; Supportive Home Care Workers, who specialize in mental health or Alzheimer's care, earned a starting wage and average hourly wage higher than all other HCWs.[49] Lastly, Care Connections Senior Aides' (NYC) salary increased by 60 percent for HHAs compared to entry-level wages of HCWs.

3.2. Client Outcomes

Of the programs we identified that examined client health or well-being outcomes, all reported positive findings. Most of the programs that assessed client outcomes were focused on both upskilling and care team integration.

Two programs examined hospitalizations or ER visits as outcomes. The Care Team Integration of the Home-Based Workforce (CA) evaluation was a two-part intervention that included training PCAs to keep clients safe and healthy at home and integrating them on the client's care team. Using data from six health plans, the study found that the program was associated with reductions in client hospitalizations and emergency room visits at one and two years after worker training was implemented. The rate of reduction of hospitalization utilization was greater than

that of a comparison group and greatest for frequent utilizers of the health care system. Similarly, The Care Connections Project (NYC), which was focused exclusively on creating advanced roles for HHAs and care team integration, was associated with an eight percent drop in emergency department visits in 2015 compared to the previous year.

Other evaluations used self-reported measures to assess consumer outcomes. The St. John's Enhanced Home Care Pilot Program (CA), which focused on an enhanced role in consumers' care and health care teams, reported significant positive consumer health outcomes for all metrics assessed, including consumer self-reported "healthy days" and a 40 percent improvement in medication compliance throughout the pilot. Additionally, 85 percent of consumers in the program strongly agreed that their health benefited from participating in the program. The Partners in Care Health Coaching Pilot Program (NYC), which trained HHAs to serve as health coaches, also found significant improvements in consumer self-reported health maintenance practices and overall health.

Michigan's BTBQ program (initially a PHCAST demonstration program but now housed at the non-profit coalition IMPART Alliance) also found positive consumer outcomes. A peer-reviewed program analysis concluded that consumers working with BTBQ-trained PCAs had significantly fewer self-reported falls and ED visits compared to those whose PCAs did not have BTBQ training.[51] However, because BTBQ is a multi-faceted entry-level training program, patient outcomes cannot be attributed directly to the program component that advanced HCA roles (peer mentoring, dementia specialty training).

3.3. Employers Outcomes

The need to demonstrate a positive return on investment (ROI) for employers to sustain and scale programs is well recognized.[17] ROI outcomes may include increased employee retention, efficiency, or other gains that would increase revenue or diminish employer losses due to worker attrition. Our review identified just three programs that assessed (or were in the process of evaluating) employer outcomes, all of which focused on retention. Two of these programs represented formal advanced role models via peer mentoring opportunities, while one represents a soft-skills training model.

An evaluation of the Jewish Home Life Peer Mentor Aide program (NYC) found that HHAs who were promoted to Peer Mentor Aide had a retention rate of 87% compared to the agency's overall HHA retention rate of 57%, based on one year of outcome data. Peer Mentor Aides received a promotion, hourly wage increase, and monthly stipend and also worked significantly more hours than other HHAs at the agency.

Another peer mentor program, The Homecare Aide Workforce Initiative (NCY), used payroll data to examine retention rates for program participants (n=434) vs. non-participants (4,397) at 3, 6,

and 12 months after hire. At each of these time points, graduates of the peer mentoring program had higher retention rates than the comparison group.

Evaluation of the THRIVE program (western NY, northeast OH, southeast MI) is currently in process and being conducted by RAND Corporation®.

3.4. Health System Outcomes

The number of studies demonstrating the health systems benefits of programs to advance the home care workforce is small. However, it is important to recognize that positive client health outcomes – especially reductions in ER visits and hospitalizations – signal potential cost savings for payers and those health systems that have assumed higher risk under value-based payment arrangements such as Accountable Care Organizations (ACOs).

The only evaluation we identified that explicitly calculated cost savings was that of the Care Team Integration of the Home-Based Workforce pilot program (CA). They estimated that the reductions in ER visits and hospitalizations for some program participants produced cost savings of up to $12,000 per client.

St. John's Enhanced Home Care Pilot Program (CA), which provided enhanced training for HCWs to better integrate them in clients' health care teams, also speculated that observed improvements in client health outcomes would lead to direct health systems savings by reducing the need for more costly health care services, though the evaluation did not quantify projections.

Lastly, some care team integration programs reported promising results in HCWs making inroads with the health care system. For example, PCAs in the Care Team Integration of the Home-Based Workforce (CA) increased their communications with clients' primary care physicians by 10% post-training. The St. John's evaluation (CA) reported that HCW trainees attended 80% of all clients' medical visits.

3.5. Other Outcomes

Programs that elevate HCWs may also provide other important benefits. For example, caring for an aging loved one can cause significant strain for family caregivers. The Care Connections Project (NYC), which trained senior aides to improve client care transitions, reported that in addition to reducing ER visits, caregiver strain appeared to improve for at least half the family caregivers involved in the program.

According to a recent report, elevating the home care workforce by professionalizing the field and paying workers commensurate to their training and duties may have ripple effects that benefit systems and communities on a much wider scale. In Making Care Work Pay, LeadingAge researchers performed economic simulations demonstrating that raising the pay of HCWs would result in fewer staffing shortages and higher productivity (an employer benefit), the growth of

local economies due to worker spending increasing, and significant cost savings for state and federal governments due to reductions in workers' use of public assistance programs like Medicaid.[52]

3.6. Limitations

The programs described in this report show promise, yet significant research gaps have hindered the ability to demonstrate a solid evidence base for their effectiveness, making it difficult to convince employers and health systems that they should invest in such efforts.

The first gap is that many of the programs included in this scan have not been evaluated. This includes programs or initiatives that may arguably demonstrate advanced role and upskilling best practices, such as Massachusetts Supportive Home Care Aides, Cooperative Home Care Associates, the value-driven QuILTSS (TN) workforce development program, and the Care Connections Senior Aides Project (NYC) (though the latter reports limited outcomes, no formal evaluative source is documented).

Even when the programs were evaluated, outcome measures had weaknesses. They relied heavily on self-reported measures and qualitative analyses, even for wages, work hours, retention, and client health outcomes. And even for those self-reported measures, the studies primarily focus on process and short-term worker outcomes, such as numbers of trainees, training retention, training satisfaction, and learning gains measured upon program completion. More distal measures of program impact, like worker retention and patient health outcomes, were less frequently reported. Moreover, outcomes of interest to health care systems and payers regarding health care cost savings were limited to simulations.

Lastly, the designs had limitations. They did not include an analysis of different components of the intervention (independent variables) that could be causing the effect. For example, they were unable to disaggregate basic training, soft skills, and upskilling components. Neither did they account for the significance of contextual and institutional factors, making results impossible to generalize to other settings. While a handful of studies did employ comparison groups, only one program evaluation randomized control group assignment.[32] Further, no comparisons of the alternative program approaches have been conducted using comparative effectiveness study designs.

4. Emerging Best Practices

Our literature review revealed a range of program models that serve to elevate and advance the roles of HCWs. Although there was variation in individual program characteristics, several standard core components central to effective planning, implementation, and evaluation were observed. Interviews with 12 experts, some of whom were also stakeholders, supplemented the review and allowed us to identify areas of consensus around "best practices" in designing training programs for advanced roles of HCWs (see Appendix 3 for list of interviewees). We discuss these below and summarize them in Table 4.

Table 4: Summary of Emerging Best Practices

- **Worker Respect and Wage Recognition:** Programs that created formal advanced roles for home care workers commonly acknowledged their advanced training and professional development with a promotion, wage increase, and other benefits.
- **Multiple Pathways for Advancement:** Rather than a "one size fits all" or "one and done" approach, programs that offer multiple pathways or career lattices for professional development and career advancement appear to be more successful.
- **Care Team Integration:** Integrating home care workers into the broader healthcare team appears to optimize workers' roles and result in positive client health outcomes.
- **Stakeholder Engagement**: Involving a diverse group of stakeholders - including employers and home care workers themselves - in program design, implementation, and evaluation facilitates program success and buy-in, which may help make programs more sustainable.
- **Planning for sustainability:** Program sustainability is inextricably linked with funding. State-sponsored programs are more sustainable, though foundations have been able to get buy-in from employers to retain advanced role positions created out of initial grant funding.
- **Strong Evaluations:** The ability to demonstrate program effectiveness and gain continued buy-in from stakeholders is linked to the strength of program evaluations. Research savvy evaluation partners can aid in rigorous evaluation planning and execution.
- **Addressing Equity and Socioeconomic Factors:** Home care workers represent inherently marginalized populations and face multiple socioeconomic factors. Efforts to address equity in program designs can increase access to training and professional development opportunities for workers.
- **Training Approach:** Train-the-trainer models, competency-based curricula, and adult learner-centered training methods that emphasize interactive, practical learning opportunities are preferred home care worker training elements, although experts agree that COVID-19 may have opened an opportunity for on-demand distance learning.

4.1. Worker Respect and Wage Recognition

Many programs made efforts to recognize workers' value and advancement formally. This recognition came through formal title changes denoting upward career movement in the programs we identified that created advanced roles for HCWs. Examples of formal titles included "Advanced Home Care Aide Specialist", "Supportive Home Care Aide", "Level 2 Peer Mentor", and "Senior Aide". Several programs also instituted wage increases or compensation commensurate with advanced roles or specialty training – a factor advocates, and experts consider necessary to retain and sustain a strong home care workforce. Although applied inconsistently across programs in our scan, all those instituting formal advanced roles incorporated a pay increase. However, even when wage increases have been instituted for PCAs, they are still recognized as too low for a living wage for workers.[45] In most cases, workers in advanced roles received hourly wage increases. However, Care Connections Senior Aides and Cooperative Home Care Associates Level II Peer Mentors (both HHA programs based in NYC) are salaried, offering consistent pay with earnings significantly greater than those of entry-level HCWs.

In addition, while the provision of health care benefits is associated with HCW job satisfaction and intent to stay at their jobs, many HCWs lack employer-sponsored health insurance. The SEIU Healthcare NW Training Partnership (WA), which offers a suite of basic and advanced training opportunities for PCAs, also provides medical, prescription drug, vision, and dental benefits to home care aides in Washington and Montana through the program's sister Health Benefits Trust. The Trust is sponsored by a labor-management partnership, which includes the workers' union, the state of Washington, and home care agencies. A case study on the training partnership revealed that aides highly valued health coverage.

4.2. Multiple Pathways for Advancement

Many of the programs identified in our scan offered more than a "one size fits all" or "one and done" approach to career development by providing multiple pathways for HCWs to enhance their skills or advance in their roles. For example, the SEIU Healthcare NW Training Partnership (WA) offered career advancement opportunities ranging from formal advanced roles of a peer mentor and advanced aide, to upskilling in diabetes care or medication administration, to management opportunities within the training organization. The Apprenticeship Program in Michigan aims to develop a 'staged credentialing' program model in which HCWs advance from PCA to HHA to CNA with increased training. Other training programs, such as QuILTSS (TN) and several of the PHCAST models, have promoted clearly defined career lattices, along with graphics to aid in the visualization of career advancement from entry-level to professional management roles.

4.3. Care Team Integration

Several of the programs we identified that created formal advanced roles and enhanced training opportunities for HCWs also worked to integrate them into clients' health care teams. Despite the recognized complexities and challenges associated with care team integration noted in program evaluations, the model offers some of the strongest evidence available that optimizing the roles of HCWs can improve client health and well-being outcomes and lead to associated health care cost savings.

4.4. Stakeholder Engagement

Overwhelmingly, strong partnerships and stakeholder engagement were credited by program leaders as a key component in program planning, implementation, sustainability, and evaluation. Stakeholder groups commonly cited across the programs we reviewed included state agencies, community colleges, non-profits, and higher education institutions (see Appendix 4). These entities played roles in curriculum development, training facilitation, and data-driven program assessment. For some programs, such as the Advanced Home Health Aide initiative (NY), the Care Team Integration of the Home-based Workforce (CA), and several of the PHCAST demonstration projects, multi-disciplinary stakeholder advisory groups were convened to guide program efforts and leverage resources for statewide program models.

Two stakeholder groups rose to the top in the literature as crucial to fostering program success: employers and workers. Several of the programs we identified were employer-based (implemented at-home care agencies for their workers), often collaborating with training partners like PHI. In other examples, employer engagement was recognized as an important facilitator of training program scalability and built into the program design. In Building Training…Building Quality (BTBQ; MI), employer engagement was actively sought to garner program recognition and buy-in by attendance at employer meetings and the distribution of communications materials. Employer agencies were also provided a list of BTBQ program graduates to aid them in identifying and hiring highly qualified candidates.

Home care worker engagement has informed training program designs, evaluations, and even employer business models. In designing the Massachusetts Supportive Home Care Aide curriculum, for example, project consultants conducted focus groups with workers, using their feedback to help in developing a training curriculum that was not only evidence-based but worker-supported.[53] From an evaluation perspective, most of the assessed programs included worker perceptions and reactions as part of their assessments, including satisfaction with training and feedback on how to improve them. In the most detailed example of engaging HCWs to enhance training opportunities and provide high-quality jobs, Cooperative Home Care Associates of NY represents a worker-owned home care agency. Worker-owners have majority voting rights,

receive annual dividends, and are encouraged to take leadership roles. They also have guaranteed employment upon training completion and are offered full-time hours and benefits – factors associated with HCW job satisfaction and retention.

4.5. Sustainability

Many of the programs we identified in this national scan are no longer active or appear inactive based on web searches that did not provide evidence of their current operation. This includes all grant-funded programs for which the initial grant funding period (usually 1-3 years) ended. However, a handful of enduring programs have employed alternative funding mechanisms, providing valuable lessons in funding and planning for program sustainability.

Instituted in 1995, the Massachusetts Supportive Home Care Aide program is a state-based initiative codified in regulations of the commonwealth's Executive Office of Elder Affairs. As such, it is an employer-recognized and client-sought advanced HCA role, with about 70% and 50% of agencies offering Supportive Home Care Aide services in Alzheimer's care and mental health, respectively.[49] Since the 1980s, Cooperative Home Care Associates of NY, has embraced investing in workforce training and development as part of their "worker-centric" business model and bottom line. While the agency has used private foundation funding for program design and implementation efforts in the past, ongoing costs associated with workforce development, such as the salaried peer mentor position, are built into the business's operating budget. However, program leaders acknowledge the cost necessitates other staff hiring restrictions (personal communication, April 20, 2021). Similarly, agencies that partnered with PHI to implement the Care Connections Senior Aide Project (NYC) and that which ran the Jewish Home Lifecare Peer Mentor Aide program (NYC) demonstrated a commitment to honoring the advanced roles created under pilot program funding by retaining workers at their increased salary levels.

Washington's SEIU Healthcare NW Training Program represents arguably the most progressive and sustainable funding model. Through a collective bargaining agreement, most program revenue comes from participating employers, which includes the State of Washington. This revenue funds administrative costs and state certification for home care aides; students do not have to pay for tuition, materials, or testing fees. The partnership remains a thriving, broad-scale, and sustainable model nearly 15 years after it started. In addition to offering basic and advanced training opportunities to almost 50,000 HCAs each year, in 2014, the partnership announced plans to expand its apprenticeship model nationwide and founded a multi-stakeholder collaborative to plan the effort.

4.6. A Strong Evaluation Plan

Evaluations of programs that aim to advance the home care workforce present an opportunity to build the evidence base for the meaningful impacts they can have on workers, clients,

employers, health systems, and other stakeholders. Important lessons gleaned from the evaluation components of programs identified in the national scan include working with partners to develop and execute strong evaluation designs and including outcomes measures that have the potential to demonstrate an ROI for employers and health systems. Concerning the former, many programs noted the value of partnering with experienced third-party researchers to design and conduct evaluations. In most cases, university partnerships were solicited for evaluations, while private-sectorconsultants such as the RAND Corporation® were utilized in others. We observe that these evaluation partners commonly employed rigorous study designs, included comparison groups in their analyses, and in some cases, published results in peer-reviewed scholarly journals.

PHI notes that data linking worker advancement approaches to client and health systems outcomes can leverage worker training and compensation adjustments.[17] While many programs we identified did not include these outcomes in their evaluations, those that did all reported positive findings, as discussed in the prior chapter. These programs may represent promising practices in evaluation design and data sharing. For example, the Care Team Integration of the Home-Based Workforce pilot program (CA), with evaluation partner UCSF, included multiple client outcome measures in the evaluation design, including healthcare utilization data obtained from clients' health plans. This objective data was used to demonstrate marked decreases in client ER visits and hospitalizations post-program implementation and were further used to demonstrate significant potential health care cost savings. The Homecare Aide Workforce Initiative (NYC) represents the only program we identified that demonstrated the potential of workforce training benefits for employers using objective retention measures. Third-party program evaluators used payroll data to demonstrate increased retention among trainees compared to a comparison group. Despite the recognized challenges associated with obtaining proprietary or third-party data, the programs included in our scan that were able to do so provide persuasive evidence for their effectiveness.

4.7. Addressing Equity and Socioeconomic Factors

There was broad recognition of the socioeconomic barriers HCWs face across the programs we assessed. Programs representing all models addressed these challenges through multiple efforts to make access to training and advancement opportunities more equitable.

Immigrants make up a significant proportion of the direct care workforce, and PHI recommends that workforce programs account for cultural and linguistic differences. Several programs, including the SEIU Healthcare NW Training Partnership (WA), Care Team Integration of the Home-based Workforce (CA), and PHCAST demonstrations, acknowledged worker language barriers by translating training materials and sessions into multiple languages or offering interpretation services. Building Training…Building Quality (MI) prioritized concordance between trainees and

trainers after noticing a clear lack of cultural and professional diversity among initial program trainers. The program performed a follow-up recruitment period to target a more diverse pool of potential trainers who would more closely represent program trainees, eventually hiring two PCA program graduates to serve in trainer roles. The program's final evaluation report notes the importance of understanding program participants' backgrounds to meet their training needs.

Socioeconomic barriers present major challenges to workforce development and advanced training opportunities. Low wages hinder training opportunities when workers cannot afford to pay for training or when the opportunity cost of missing work to attend a training is too great. Programs identified in our scan addressed this challenge in different ways. The Family Care Advocate Training Program (AR; CA, HI, TX) used grant funds to provide micro-financing loans to low-income PCAs for training costs. However, there was minimal uptake of this option among trainees and higher than expected rates of default for those who did use it. In line with expert recommendations, several programs in our scan made training and development programs free. Others compensated HCWs $25-95 for their participation in enhanced training programs, though participants and program leadership acknowledged training stipends for some programs as being too low.

Transportation and childcare are two of the most commonly cited barriers to training and workforce development among HCWs, which was well-recognized among most programs. Although infrequent, we identified innovative solutions to address these challenges in the programs we assessed. For example, the Massachusetts PHCAST model partnered with Head Start programs to help students overcome obstacles related to child-care[42] while the Homecare Aide Workforce Initiative (NYC) offered case management for HHAs to address personal challenges like childcare that could hinder job success. Online trainings were implemented by some programs to increase accessibility for rural workers or those facing other transportation challenges, while others sought out training sites that would be most convenient for workers – leveraging partnerships with community colleges and non-profit organizations to do so.

Lastly, while socioeconomic barriers inherently plague the direct care workforce, some programs recognized increased vulnerability among subsets of workers in their program designs, actively seeking out their participation. For example, the Homecare Aide Workforce Initiative (NYC) and The Family Care Advocate Training Program (AR, CA, HI, TX) used targeted recruitment efforts to identify and support low-income workers most likely to benefit from participation.

4.8. Training Approach

Consistent themes were observed in preferred program training approaches, including trainer model, modality, and curriculum design. Several programs relied on train-the-trainer models to scale and disseminate training efficiently. Programs note that this training model served the

additional benefit of providing potential opportunities for HCWs to advance into trainer roles and recruit trainers representing trainees' diversity.

Most of the programs we identified employed competency-based curricula and employed adult learner-centered teaching methods. Competency-based training approaches focus on successfully demonstrating competencies as the training outcome indicator rather than training hours completed. Adult learner-centered teaching methods focus on the student experience, emphasizing reflection, problem-solving, and high degrees of interaction. Given these training approaches' interactive and demonstrative nature, it is not surprising that almost all the programs we identified provided in-person training that offered practical learning experiences. Despite the preference for in-person training and evidence suggesting its effectiveness over online models, program leaders and experts have acknowledged the importance of online training modalities to increase access for rural, and other workers for whom attending in-person training is challenging. COVID-19 has now presented a heightened need to offer online training. Several of the programs in our scan have adapted their training for online delivery – or are in the process of doing so, – including the SEIU Healthcare NW Training Partnership and Building Training…Building Quality (MI).

5. Barriers and Opportunities for Large-Scale Adoption

In prior sections, we identified some of the effective components of training programs designed to elevate and advance home care workers and how they have been funded, and whether they have been sustainable. In this section, we examine factors that affect the uptake, or what we call the large-scale adoption, of these kinds of programs, from a stakeholder perspective. Our analysis draws on published commentaries and our interviews (see Appendix 3). A summary of the main points is provided in Table 5.

Table 5: Summary of Barriers and Opportunities for Uptake of Home Care Worker Training Programs

1. Worker uptake of the program depends on increased wages, social status, and the costs (including transportation and time constraints).
2. The low social status of workers is a barrier to families and clinicians recognizing the value of training and integration.
3. Nurse Practice Acts and concerns about liability continue to constrain advanced roles.
4. Labor Management Partnerships have been highly successful but are largely limited to large coastal cities.
5. Fragmentation of home care and home health industry and small size of most firms is a major barrier to uptake.
6. Health systems and MCOs do not yet see the value proposition but could be important change agents.
7. The most widely adopted programs had significant grassroots advocacy leading to state sponsorship.
8. The Federal government plays a role as payer and regulator, as well as the sponsor of innovative programs. The American Rescue Plan provides significant new funding for states that can be used to invest in the direct care workforce.
9. Philanthropy has played a role in creating training programs but has rarely helped with scaling up the initiatives.

- **Worker uptake of the program depends on increased wages and social status, as well as the costs (including transportation and time constraints)**

The literature and our expert interviews suggest that while training leads to feeling more comfortable in the job and better prepared, wage increases and recognition are key ingredients to ensure worker uptake and the sustainability of programs. That said, the ongoing THRIVE program (western NY, northeast OH, southeast MI) provides an interesting natural experiment that will help establish ether it is possible to improve retention through soft skills training, without wage increases tied to the educational achievement.

Workers' access to broadband and comfort with the internet has been noted as important barriers to using distance modalities for training before COVID-19. However, experts acknowledge the need to balance a preference for in-person training with the realities presented by the pandemic and the ongoing struggle faced by rural workers to attend on-site training, leading to expanded opportunities for on-demand training that workers can access at any time and any place. In theory, this should make training less arduous and time-consuming for workers, which is still an empirical question, and experts note continued disparities in internet access and computer literacy among HCWs.

Implications:

- As discussed in the prior section, increased wages and respect are essential components of any programs that are likely to be widely adopted and sustained.
- Despite the view among experts that face-to-face training is more effective, it may be worth exploring whether workers are more accepting of on-demand, online training post-COVID-19 and, if so, how to facilitate worker uptake.

➢ **The low social status of workers is a barrier to families and clinicians recognizing the value of training and integration.**

The low social status of home care workers, both by virtue of their economic, educational, and cultural conditions and the type of work they perform, has impeded progress in developing workforce development programs and career pathways.

The low social status of home care workers means that often clinicians do not value their reporting, making programs that seek to build bridges to the healthcare team, sometimes through advanced roles, more difficult.

When families view caretakers as low status, they are less likely to elicit and trust the care worker's observations. Experts point out that because families usually serve as gatekeepers or intermediaries to the health care team,[54] this lack of respect also makes it more difficult for home care workers to report their observations and concerns to health care teams directly.

Given that there is evidence that training models that include integration of care workers effectively improve client health, addressing issues of respect and enhancing the social status of care workers is likely to be a key requirement of any investment that will be widely adopted and sustained. Experts we spoke to agreed that technology could facilitate worker communications with the client's care team, as was piloted in the Care Connections Project (NYC). However, they pointed out that this mode can only be successful if members of the care team are willing to use it as a two-way communications channel to report back to the HCW. We are unaware of any programs that have successfully implemented this communications model.

Implications:

- Until the issue of social status is addressed, programs may be limited in their impact and their uptake. There is a need to educate both clinicians and families on the greater role caregivers can play on the client's health care team.
- Technology has the potential to assist in that goal, but only if buy-in and commitment from health care team providers are obtained.
- A public relations campaign, such as the Johnson and Johnson campaign to elevate the social status of nurses, could be designed to increase the social status of home care workers. COVID-19 presents an opportunity to highlight their work.

➢ **Nurse Practice Acts and concerns about liability continue to constrain advanced roles.**

Within the broad topic of integration, the relationship with nurses is particularly complicated due to state nursing scope of practice laws. Beyond the low status of HCWs, nurses have also been reluctant to delegate more complex health tasks such as giving patients their prescribed medications, ostensibly because of liability issues. However, many experts believe there is also a cultural challenge that needs to be addressed within the nursing profession to understand the value of delegation and their role as supervisors. The work from AARP on LTSS including nurse delegation has helped shine a technical light on which tasks are being delegated in which states but has not necessarily changed attitudes sufficiently.[55] Nursing unions also play a large role in reforming nurse delegation regulations.

Implications:

- More focused work on training nurses to effectively delegate to home care workers is important.
- More work on modernizing scope of practice laws is needed.

➢ **Labor Management Partnerships have been highly successful but are largely limited to large coastal cities.**

Experts agree that the home care and home health care industry is highly fragmented and has, at least up to now, had a wage structure and business model that has prevented it from leveraging its workforce in a strategic vision that includes more stable employment, career paths with increased pay, and quality improvement systems.

One at least partial exception to this characterization is in unionized settings. Unions are primarily present when a large payer, like the state (private insurance plans or Medicaid), has leverage with the agencies that are dependent on them for business. Where union-based labor management partnerships (LMPs) have been formed, there is a mandated funding stream for workforce development. SEIU's Healthcare NW Training Partnership (WA) is the prime example

of this, having been highly successful in creating training and career ladders in this sector and sustaining programs over time. As exemplified by New York City's Cooperative Home Care Associates, the idea of worker cooperatives is a related strategy that, in specific settings (urban and highly unionized), also has shown promise. Where unions and cooperatives have partnered with state government to design additional mandates and regulations (e.g., Washington), it has positively impacted the industry itself.

Implication:

- Where there are conditions that are ripe for union entry into a market, policies and programs can encourage LPMs that focus on training and career paths. Showcasing exemplars of this strategy in short reports for review by states and industry leaders could help alleviate fears of unionization and help encourage adoption.

- **Fragmentation of home care and home health industry and the small size of firms are major barriers to uptake by agencies.**

While unionized settings represent a hopeful scenario, they are few and far between. Most home care unions are in large east or west coast cities and are therefore less relevant for a large swatch of the country, particularly rural areas in right-to-work states. In these regions, change is likely going to depend on developing a business model that can lead to greater consolidation and integration with other health care industry segments.

The three (or more) types of payment streams and aims for home care and home health are one reason the industry has failed to coalesce and become more financially viable. Home care companies are generally separate from home health companies, which in turn are separate from home hospice care companies. This is driven by the funding streams and their different programmatic aims. Medicare's short-term and intermittent treatment of illness and recovery from the home (and the equivalent in the private insurance market) often rely on part-time or contracted labor. Medicare's hospice homecare is a more stable segment but is generally stand-alone. And then Medicaid's long-term services in-home care (and the equivalent in the out-of-pocket market) allows aging in place and aims to prevent nursing home admissions.

This fragmentation has been shown to prevent improvement in wages for workers.[56] As Alfers argued in our interview with her and in her monograph on the topic,[57] aligning these funding streams and program aids as an interconnected continuum would help "optimize employee skills, better train workers for specific tasks, develop cross-functional teams. It could also expand the market that can be efficiently addressed by an individual firm...". A related issue is the size of the agency. In a study of the home care industry, Alfers found that the 50 largest firms in the industry account for only 25% of total market revenue, suggesting a proliferation of small mom and pop firms and severe industry fragmentation.[57] A GAO report shows that two-thirds of the per-visit cost differentials between low and high Medicare profit margin home health agencies result from

variability in fixed overhead costs (e.g., administrative expenses, equipment, training) versus variable cost differences (e.g., transportation, service provider wages).[58] The scope for reducing variable costs is limited since, for example, transportation is unavoidable to reach clients and there is little room to reduce workers' already low wages. Therefore, the main determinant of whether an agency is more profitable is its ability to spread the fixed costs across multiple visits and clients, indicating that there are economies of scale in the sector.

This is important because larger companies may be more able to invest in the workforce. Larger companies can "develop and disseminate best practices, standardize and differentiate job functions, develop industry-wide career ladders and lattices, and advocate for the industry to prevent backsliding in reimbursement structures."[57]

Our interview with franchise company leaders confirms that large conglomerates have economies of scale that make both training costs and increased wages for advanced roles more palatable. These larger conglomerates may also be more concerned about the value of their brand, which presumably would benefit from minimum training standards, low turnover, and career advancement pathways for their workers. Small mom and pop agencies, on the other hand, may be in more rural areas with higher transportation costs and, as a result, have fewer resources and less competitive pressure, resulting in lower workforce development investments.

It is not entirely clear why more of these franchises have not emerged in the marketplace. This could be a result of the low payments under Medicaid. The Home Instead franchise is primarily private out of pocket, which may give them more leeway in tailoring a variety of packages for consumers. But the larger driver may simply be that there are so few barriers to entry in this industry and that this leads to the entry of sub-optimal firms. For example, there are no requirements for a background in health or medicine, and start-up agency costs are generally below $100,000.[57] Licensure and accreditation of entities providing non-medical home health care are heterogenous, and many states have no requirements.

A final consideration regarding the industry and its incentives to invest in workforce development is that, even among larger firms, the return on investment for the creation of advanced roles with high pay is dependent on additional revenues generated by the payer. This lesson has not been lost on state planners, and most models have some additional payment for specialized roles. Even when some additional payment for advanced services has been negotiated with a state Medicaid agency as a result of advocacy efforts, however, the amount may not be sufficient to break through the inertia of a small firm with little background in healthcare or vision for an alternative industry dynamic.

The New Jersey Nurse Delegation Pilot Program is a case in point. Implemented in 2008 and ending in 2011, the program involved additional payment to home care agencies for advanced

services provided by HCWs under nurse's supervision, though the HCWs themselves did not receive higher compensation. The program had buy-in from all stakeholders, including the state Board of Nurses, Medicaid, and home care agencies. Early evaluations showed positive effects on worker satisfaction with delegation tasks and client health and quality of life improvements, with no evidence of adverse client health outcomes related to delegation tasks. Despite the extraordinary institutional alignment, the program ultimately ended due, according to our informant, to the "inertia" of the home care agencies, which presumably did not find the additional payment to be worth the trouble of training home care workers for new roles.

Implications:

- It is important to create opportunities for economies of scale.
- It would be beneficial to the industry if CMS convened states and considered ways to better align services that are covered and to standardize the qualifications of those permitted to provide services should be aligned across payers.
- Policies that reward franchises, mergers, or other participation in health systems could help increase the size of firms. This may include additional regulations, workforce requirements such as certification systems. For example, bringing those states with no standards up to the level of the more advanced states, like Washington and New York, would, in effect, require workforce development investments where that may have been none.
- More knowledge is needed about how much payments for advanced services need to be in order to modify agencies' behaviors and spur them to conduct training or contract with an outside training program, such as Elsevier's, and how much is needed to improve worker retention.

➢ **Health systems and MCOs do not yet see the value proposition but could be important change agents.**

Even under current value-based payment arrangements, such as ACOs, health systems have not yet seen the ROI for engaging with, much less investing in this workforce's professionalization. Some systems have begun to understand that home health is important as a means for reducing ER visits, 30-day readmission penalties, and preventing and/or shortening skilled nursing facility stays and have begun to partner with home care agencies or to purchase them. But unless a health system also owns a home care company (in which case their main concern is reducing turnover), there seems to be little discussion about the potential benefit of professionalizing this workforce.

Similarly, most states include home care services in the mandated coverage offered by Medicaid managed care organizations (MCOs), suggesting that, while they are currently inactive in this

space, they could become an important leverage point for spurring change in the home care industry. MCOs could set standards and/or require some portion of the payment to be invested in workforce development. Alternatively, they could use their resources to establish training programs and allow agencies to bill more for workers who have completed training programs and/or have advanced job functions. In addition, MCOs often own their provider organizations. As with health systems, partnerships and/or purchasing of small home care and home health agencies could also be explored.

One example of the power of payers to use value-based purchasing to reward employers for HCA workforce development initiatives is Tennessee's QuILTSS program. Under this model, HCW training comprises a quarter of the total quality points that may be earned by LTSS service delivery providers, which are then factored into providers per diem rates. Further, providers that employ better trained and qualified staff are compensated at a higher rate. Although this value-based payment model currently only applies to nurse facilities, it holds great promise for serving as a model across LTSS settings, including in home care.

Implications:

- Given the importance of integration and of creating economies of scale in the home care industry, it may be worth exploring ways that health systems would be interested in partnering with, or even purchasing, home care and home health agencies.
- Additional research is needed to establish the ROI for health systems under various payment reforms.
- It may be worth convening local MCOs in the two regions to explore ways that they can contribute to advancing the homecare workforce.

- **The most widely adopted programs had significant grassroots advocacy leading to state sponsorship**

The role of state government in determining the context for adoption and sustainability of workforce programs cannot be overstated. The state (with input from stakeholders) is responsible for creating and defining certifications and their training requirements, licensure standards for home care agencies, and, of course, they determine Medicaid reimbursement rates, minimum wages and benefits, workplace safety standards, and rules regarding nurse delegation. In addition, states can sponsor training.

As reviewed in prior sections, we know that the program models that were most sustainable had significant state involvement. For example, Massachusetts' state-sponsored Supportive Home Care Aide training program, which has been active since 1995, is now codified in legislation. In some cases, the state role resulted from a groundswell of advocacy efforts and public demand.

In Washington, the SEIU Healthcare NW Training Partnership represented the culmination of two decades of advocacy and organizing efforts to raise public awareness of the need to bulk up the home care workforce and associated training requirements and form a labor management partnership between workers and employers. These actions resulted in public support of two state ballot initiatives for higher training and certification standards of HCWs and also laid the groundwork for what became the nation's largest HCW training provider. In short, while not a guarantee of success, state support is critical to most successful programs.

Implications:

- Building public awareness around the critical role of the home care workforce and associated adequate training needs – though not alone sufficient to transform the industry – is necessary to create widespread support and bolstering political will for initiatives that advance this workforce and raise training standards.
- Public perceptions and support may be especially important in right-to-work states, where workers lack strong union influence.
- Stakeholders may wish to take into consideration the state policy environment to identify and leverage opportunities to work strategically to inform and advance state-supported workforce initiatives.

➢ **The Federal government plays a role as payer, regulator, and sponsor of innovative programs.**

The Federal government plays a critical role as a payer, especially for Medicare, and determining broad parameters for Medicaid. But it also plays an important role in direct funding for at least six of the programs we identified. Some of these were pilots under CMS Healthcare Innovation Awards (The Care Team Integration of the Home-Based Workforce Pilot Program [CA], and Family Care Advocate Training for Experienced Aides [AR; CA, HI, TX), or HRSA (Michigan's Building Training…Building Quality), while others form part of Medicaid waivers (Tennessee's QuILTSS).

While preparing this report, the American Rescue Plan (ARP) Act of 2021 was passed, including a massive commitment to investing in the home care workforce.[6] It is beyond the report's scope to speculate as to what this will mean for the nation, and New York and Michigan in particular, but there is no doubt it will have tremendous importance for the field.

The first relevant element of the proposed law is an increase in the federal matching rate for Medicaid HCBS spending by 10% through March 2022. This supplemental Medicaid funding stream must be used to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program" and can be applied to multiple HCBS expenditure mechanisms.

States appear to have broad authority and autonomy over how funds are used. Examples of workforce-directed activities states might fund could include paid sick leave, worker recruitment initiatives, and increased wages for HCWs. State initiatives that aim to advance the role of HCWs seemingly meet funding eligibility criteria, so long as they operate under Medicaid.

States must maintain their current level of HCBS spending to qualify for the rate increase, and the increase would be added to each state's existing federal matching rate, which is 65.48% in Michigan and 73.71 in New York. Kaiser Family Foundation (KFF) estimates that the rate increases could amount to an additional $11.4 billion dollars in federal HCBS spending when the rate increases are in effect.[59] The dollar amount individual states receive would be proportionate to the size of states' HCBS programs, which depends on states' size and policies.

Using program survey data that details state-reported HCBS Medicaid expenditures and CMS financial reports, KFF estimates Medicaid HCBS spending for April 2021 through May 2022 to be $1,391,405,000 in Michigan and $12,609,573,000 in New York, with federal dollars authorized by the ARP providing each state with an additional $139,141,000 and $1,260,957,000, respectively.

In addition to the ARP, the American Jobs Plan, while still only in the proposal form, also focuses on improving jobs for essential home care workers. At a minimum, this new funding environment appears to provide an auspicious context for stakeholders and policymakers interested in improving the field. Hopefully, a portion of these funds will be directed required to be spent on workforce development. The influx could even draw the attention of business interest outside the industry, including health systems.

Implications:

- Federal programs and policies have a significant impact on states, and, as such, it is important to facilitate the engagement of state advocacy groups at the national level.
- All States will have the opportunity to shape how the ARP funds are used for this workforce.
    - The additional infusion of funds provides a potential rebuttal for the argument that state Medicaid agencies cannot make further workforce investments due to funding shortages.
    - Being able to demonstrate that this supplemental funding has a meaningful impact on employer and systems-level outcomes – particularly Medicaid cost savings due to improved client health and decreased health system utilization – would provide strong justification for future Medicaid reimbursement rate increases and other CMS funding requests.

- **Philanthropy has played a role in creating training programs but has rarely helped with scaling up the initiatives.**

Experts agreed that philanthropy has played an essential role in funding pilots and encouraging coalitions. A preliminary list of foundations that are active in the homecare and home health workforce training field is included in Appendix 5. However, they also expressed frustration that grants are often two-year projects, and sustainability and scale-up remain elusive.

One successful exception is the Jewish Home Lifecare Peer Mentor Program (NYC), funded by a private family foundation. The evaluation notes that while grant funding provided initial program support, the wage increases and cell phone stipends associated with Peer Mentor Aide status became part of the employer agency's operating budget.

Implications:

- The challenge for philanthropy, we believe, is to continue to fund pilots and evaluations and 1) identify strategic opportunities for sustainability and 2) to weaken upstream barriers and strengthen facilitators.
- Large-scale adoption of home care worker training and advanced roles likely requires addressing state and federal policies, private industry structure, as well as the socially constructed perceptions of home care workers' value.

6. Regional Context

In this chapter, we turn our attention to counties in Western New York and Southeast Michigan.[60] For both regions, we examine demographics trends and current home care programs. In addition, based on additional data we were able to collect that was different in the two states, we included additional analyses. For Western New York, we report on an analysis we conducted of a home care training registry. For Southeast Michigan, we describe an emerging stakeholder coalition focused on developing the direct care workforce. Additional data we were able to collect is provided in Appendices 5 to 9.

To examine demographic trends, we used data from the last five years and focused on two main population-level indicators: current and projected old-age dependency ratios. Old-age dependency ratio is defined as the number of individuals aged 65 and over per 100 people of working age defined as those aged between 15 to 64 years old.[61] We observed that the Western New York counties of interest have a relatively older population than the rest of New York. In contrast, Southeast Michigan counties of interest have a slightly younger population than the rest of the state. These trends are projected to continue in the future. See Appendix 1 for more details.

6.1. Western New York

6.1.1. Home Care in Western New York

Home care is available in New York through several mechanisms[62], as follows:

1. Medicaid Managed Long Term Care (MLTC) Programs
2. Community First Choice Option (CFCO)
3. Consumer Directed Personal Assistance Program (CDPAP)
4. Expanded In-home Services for the Elderly Program (EISEP)
5. Private Pay Home Care Services Program Pilot (Upcoming)

The MLTC offers personal care at home and in adult daycare settings. Enrollment in MLTC is mandatory for those who are eligible for both Medicare and Medicaid (dual eligible), are over 21 years, and need long-term care services for more than 120 days. About twelve MLTC plans are available in the Western New York region, and nearly 11,000 individuals are enrolled in these plans in the western counties of interest. See appendices 6 and 7 for more details.

CFCO was approved in 2015 under New York's State Medicaid Plan Amendment SPA 13–35. CFCO allows long-term services and supports that were previously only available through a waiver to be Medicaid State Plan Services. Additional federal money is available for home-based services performed by an HCW. CFCO participants can choose to hire personal caregivers, or New York state can choose them on their behalf.

CDPAP is a consumer option that gives consumers the freedom to choose their provider. However, they must also be responsible for recruiting, hiring, training, supervising, and terminating caregivers. Consumers must also arrange for backup coverage when necessary, arrange and coordinate other services, and keep payroll records. Potential consumers of home care can visit New York State Home Care Agency profiles and search for providers by name, region, service type, or county. Alternatively, consumers can hire a family member as a paid caregiver, with some exceptions. Such privately hired caregivers are not required to have any certification. Additionally, CDPAP allows consumers to pay for services through a middleman known as a "Financial Intermediary" (FI). The FI handles the payment and logistics of arranging for home care. About 139,000 New Yorkers use the CDPAP.

The Expanded In-home Services for the Elderly Program (EISEP) provides frail older adults with access to personal care. EISEP is available to individuals older than 60 who need assistance with Activities of Daily Living (ADLs) who are not eligible for New York Medicaid. The program aims to delay placing frail, elderly state residents in nursing homes. Since 2011, a consumer-directed option was introduced that enables EISEP participants to hire, train and manage their caregivers, including family members.

Lastly, in July 2020, the New York Department of Health invited Licensed Home Care Services Agencies (LHCSAs) from three counties (Nassau, Suffolk, and Westchester) to participate in a 'Private Pay Home Care Services Program Pilot' through its Accountable Care Act (ACA) Marketplace.[63] Under this pilot, New Yorkers will be able to shop for home care services for themselves. This program aims to delay the need for consumers to enroll in Medicaid. The pilot was created based on recommendations from the Medicaid Redesign Team, II (MRT II).[64]

Implications:

- One implication of the growing consumer-directed home care segment is that it will make it all the more important to identify strategies to increase home care workers' recognition and respect.
- If scaled up statewide, the Private Pay Home Care Services Program Pilot could have significant consequences for home care service provision in New York. It will create a new market for home care agencies that includes consumers that may be able to pay higher rates for services and possibly willing to pay for different levels of skills among home care workers. The enhanced demand may also help to mature the industry and increase wages.

6.1.2. Changes to Home Care Services in New York Medicaid

Several sections of the FY 2022 budget will alter how home care services are provided in the state.[65]

The first change pertains to the eligibility for home care under Medicaid. According to a recently submitted 1115 waiver demonstration amendment,[66] applicants in need of personal care services in New York will require a '30-month lookback' to assess eligibility instead of the current requirement of a 60-month lookback. The proposed plan is to begin this policy on January 1, 2022. Applicants and their spouses (if any) will need to submit records of all financial assets for the 30 months before the application. This is a seemingly positive development. Typically, if a new Medicaid applicant makes asset transfers during the lookback period to reduce their total financial assets and qualify for Medicaid, a penalty period (a period of Medicaid ineligibility) is established for that applicant. Under the new rule, financial transactions during a shorter timeframe will be subject to review to be eligible for New York Medicaid. Thus, the likelihood of an increase in penalty periods may be reduced due to the new rule. However, some critics argue that this change will lead to a longer period for collecting documents required for applications and delays in application processing. Further, New York's waiver application notes that about 3,840 new applicants seeking home care services will be subject to an average penalty period of around one month due to the new changes. This penalty period will generate savings for the state. By implementing this amendment, New York hopes to save $8.9 million through the end of 2022.

The second important change is that new regulations will limit personal care services available under CDPAP.[67] An applicant's treating physician can no longer prescribe personal care services or CDPAP services. Instead, services must be prescribed by an independent physician contracted with the New York State Department of Health (NYSDOH) and approved by an independent assessment from an assessor under contract with the NYSDOH instead of the local Medicaid office and managed long-term care plan (MLTC). The consumer will need to arrange an assessment by this independent physician to apply.

Finally, to qualify for personal care services or CDPAP, and for enrollment into MLTC plans, new applicants after October 1, 2020, must need assistance with physical maneuvering with more than two Activities of Daily Living (ADLs). For persons with dementia or Alzheimer's diagnosis, they must need supervision with at least one ADL. New applicants for Medicaid seeking home care will no longer be informed of the availability of CDPAP.

Implications:

- Access to PCAs in New York could be significantly reduced by the changes in the personal care services lookback period and the tightening of rules regarding personal care services prescription.
- As a result, program participants will be more medically complex, creating heavier workloads and, possibly, the need for upskilling and advanced roles.
- In the future, most of the newly eligible Medicaid applicants in Western New York will likely seek home care through agencies rather than on their own. Under the new regulations in New York, if new Medicaid applicants seeking home care are not informed about the consumer-directed options (CDPAP), it might reduce the number of CDPAP participants. To receive home care, new consumers may be directed to either current MLTC plans or to the Private Pay Home Care Services Program Pilot.

6.1.3. New York's Advanced Home Health Aides (AHHAs) initiative

New York's Medicaid Redesign Team (MRT) was formed in 2011 by Governor Cuomo to devise strategies to reduce costs and improve care in New York State's Medicaid system.[68] The Workforce Flexibility and Change of Scope of Practice Work Group of the Medicaid Redesign Team (MRT) first proposed the idea of home health aides performing advanced tasks.[69] An AHHA Advisory Workgroup was then created in 2014 under Program Bill 37.[70] Based on its recommendations, Chapter 471 of the Laws of 2016 amended Article 139 of the Education Law, known as the Nurse Practice Act, to permit Advanced Home Health Aides (AHHAs) to perform advanced tasks with appropriate training and upon assignment by registered nurses and under supervision by such nurses.

Despite this legal framework being in place, AHHAs are still not common in New York. Experts reported several reasons for this. They point to employer concerns about a dubious return on investment. They also report fear of liabilities among nurses that would be potentially delegating tasks to the AHHAs.

Implications:

- The barriers represented by employer concerns about return on investments and fears of liabilities among nurses are both factors to consider in any pilot investments in the future.

6.1.4. Key Stakeholders

- ***Advocacy groups***

Several direct care workforce advocacy groups are active in New York state. Paraprofessional Healthcare Institute, Inc. (PHI) is a non-profit organization based in New York City. It has performed substantial advocacy work on improving the job quality of the direct-care workers in

the New York and has also made state-specific recommendations. LeadingAge New York is another active advocacy organization that is also a care provider. It performs significant advocacy for HCWs and regularly releases reports such as New York state budget reviews. The stated mission of the Home Care Association of New York State (HCA-NYS) is "to promote and enhance the quality and accessibility of health care and support at home". The organization represents a large number of direct care providers, runs advocacy efforts at both the state and the federal level and also makes comprehensive education programs available to its members. All three advocacy organizations mentioned here were part of New York's Advanced Home Health Aide (AHHA) workgroup.

- ***Industry associations***

The New York chapter of Argentum, the largest national association representing the assisted living industry, provides leadership and strong advocacy efforts in the state. It played a significant role in the passage of the Assisted Living Reform Act of 2004 in New York. It works with NYS Department of Health (NYSDOH) and participates in several NYSDOH workgroups. The West New York (WNY) chapter of the Alzheimer's Association is a non-profit volunteer organization that focuses on support for Alzheimer's disease. It serves Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties, with education programs, support services, and other resources for care partners and those living with dementia. In addition, the Greater New York Hospital Association (GYHA) is another key stakeholder.

- ***Home care training providers***

We identified multiple home care training providers operating in Western New York that can be key stakeholders for efforts around advanced roles. Venture Forthe Inc, has been working for more than 20 years in the region and has emerged as the leader in certifying personal care aides in Western New York. It has more than a dozen locations, most located in Western New York. Willcare (part of LHC group) with presence in Niagara Falls, Buffalo and Jamestown is another home care agency that operates several training programs in the region.

- ***Managed care organizations***

Preliminary analysis of enrollment in New York's Managed Long-Term Care (MLTC) program revealed that Fidelis Care and iCircle care are plans with highest enrollments in the Western New York region. Erie and Monroe counties each had more than 4,000 MLTC enrollees as of March 2021 (see Appendix 7 and 8). These organizations might be interested in advanced roles.

6.1.5. Analysis of Home Care Registry for Western New York

New York maintains a Home Care Registry (HCR).[71] The HCR ensures that the individuals employed by home care agencies to provide home care services have been adequately trained and are suitable to provide services to New Yorkers in their homes. The HCR provides information about home care workers who have successfully completed a state-approved training program in New York State. Information to the HCR is voluntarily reported by workers and home care service agencies that choose to provide information. Data from the HCR is available via the New York State Department of Health data website.[72]

Two main types of direct care workforce training are available in New York: Personal Care Aides (PCA) and Home Health Aides (HHA). The PCA training includes 40 hours of Home Care Curriculum (HCC), while the HHA training includes the HCC and 35 hours of Health Related Tasks Curriculum (HRTC), for a total of 75 hours, the equivalent of the federal requirement under CMS. A certificate is issued upon the successful completion of each program. In practice, New York home health agencies generally provide additional training to newly hired employees. A typical PCA training may include up to 43 hours of training, while newly hired HHAs can receive up to 90 hours of training. A Personal Care Aide Upgrade (PCA Upgrade) training is also available for PCAs that wish to obtain an HHA certificate.

We used HCR data from 2014 to 2019 and analyzed trends in training certifications in nine Western New York counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Monroe, Niagara, Orleans, Wyoming.

As seen in Figure 2, training certificates issued for successful completion of PCA training went up significantly between 2014 and 2019. Around 1,778 individuals were issued a PCA training completion certificate in 2014, while the combined total of PCA and HHA certifications was 2,708. In 2018, these figures increased to 2,721 and 3,438 for PCA and HHA certifications, respectively. PCA certifications increased by more than 50%, while HHA certifications increased by about 25%. In 2014, PCA certifications accounted for 65% of the total (PCA and HHA combined) certifications. This proportion increased steadily to about 84% in 2019.

These trends do not align with those seen in other parts of New York state. The total number of certifications and the proportion of PCA certifications steadily declined from 2014 to 2019 in the rest of New York (Figure 3). This trend was mainly precipitated by counties surrounding New York City (Figure 4).

There are several possible explanations for this difference. First, the cost of training programs could be a possible explanation. The majority of the certifications issued in the western region were by training programs approved by the New York State Department of Health (NYSDOH). The

New York State Education Department (NYSED) can also approve HHA and PCA training programs. Programs approved by NYDOH cannot charge tuition fees, while those approved by NYSED can.

It is also possible that the higher proportion of PCA training certifications could be due to the demand for such roles in Western New York. Stakeholders interviewed by PHI for their report mentioned that there is a greater need to recruit and train PCAs in the region compared to the need for HHAs.

Another interesting finding concerns the 'PCA Upgrade' training. While about 102 of such training programs were conducted between 2014 and 2019, only 484 certificates were issued overall. This is a small portion of the total number of PCA certificates issued in the same period: about 12,115.

This may be partially explained by high turnover and low retention rates in the direct care workforce. It could also indicate that there is limited interest among the PCA workforce to upgrade their skills to those of HHAs. This does not appear to have been the case in counties around New York City. Between 2014 and 2019, about 22,538 PCA upgrade certifications were issued compared to 44,731 PCA certifications.

The PHI Buffalo home care report offers an additional explanation[73]:

> *"Other stakeholders indicated that workers themselves are not always incentivized to take career development opportunities. For example, a home care provider said that her agency once offered an HHA training program "as a way to reward current [PCAs]" ... However, uptake of the program was low because, even with the pay differential, workers did not want to work the shorter shifts available for HHA assignments (citing concerns such as added travel time and wear and tear on their vehicle) and, as a result, the training program was discontinued…. Any disruption in a home care worker's workload can be problematic and may disincentivize participation in elective advancement programs."*

The next set of analyses we conducted compares counties within the Western New York region (Figures 5 and 6). Niagara, Erie, and Monroe had the highest numbers of PCA certifications. Niagara had more PCA certifications (5,794) than the other two counties combined (Erie = 2,806 and Monroe = 2,544). These top three counties accounted for nearly half of all PCA training in the Western New York region. Allegany and Wyoming had the lowest PCA certifications. Higher urbanicity and the resulting unequal distribution of potential workforce could be possible explanations of this trend.

The final set of analyses focuses on the training agencies and cities in which they operated (Table 6). Venture Forthe Inc. was the overall regional leader in certifications and the top training agency for Niagara and Monroe counties. Aftercare Nursing Services was the leading training agency in Erie County. Table 7 also notes cities that had the highest certifications in each county.

Additionally, Figure 7 shows the location of home care agencies in Western New York counties. It underscores the geographic disparities in agency distribution.[74]

Implications:

- These data suggest that any future pilot of advanced roles in Western New York should be heavily focused on the PCA workforce rather than on the HHA workforce. This is because the region's direct care workforce training scenario is significantly different from the rest of New York state. The ratio of PCA to HHA certifications is about 4:1 for the region, while it is close to 1:4 in the rest of New York.
- Potential training partners for an advanced role pilot could be found in either Niagara, Erie, or Monroe counties, where the more productive agencies operate.
- A virtual or online program might expand the geographic reach of training and reduce the current training pattern concentrated in cities.
- An advanced role program in the region would likely need to address transportation and other workforce-related issues. One of the major reasons for a documented lack of demand for upskilling among the region's PCA workforce was that PCAs do not wish to disrupt their existing working schedules and alter their extant travel patterns.

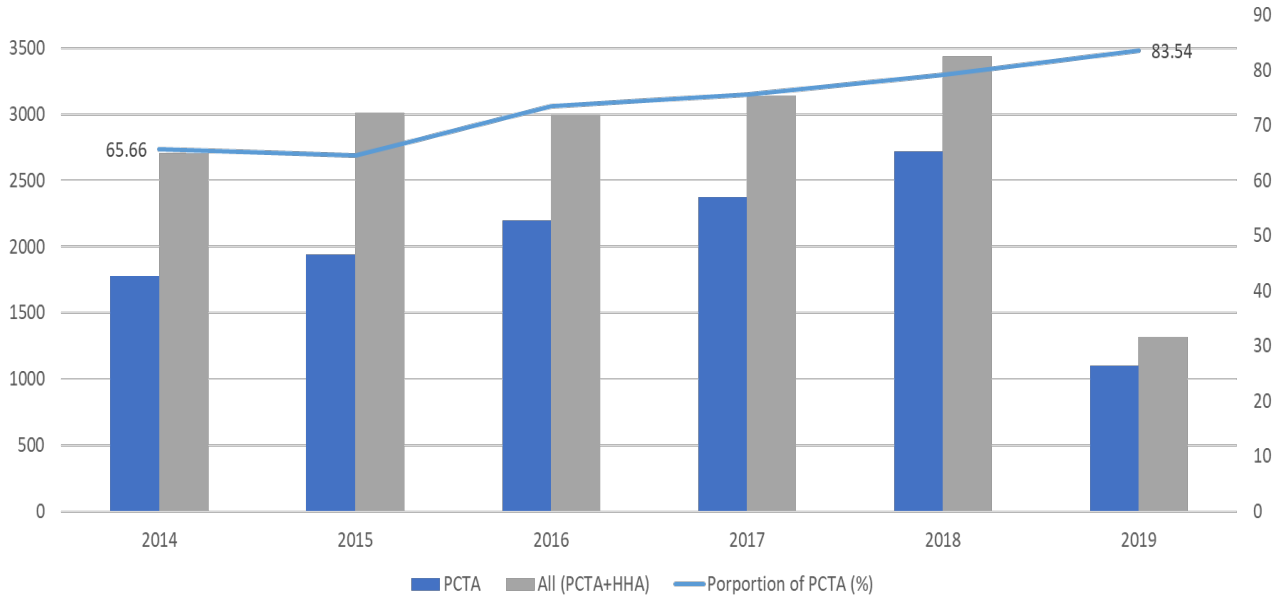

Figure 2: Personal Care Aide Training Certifications in Select Western New YorkWestern New York Counties, 2014-2019

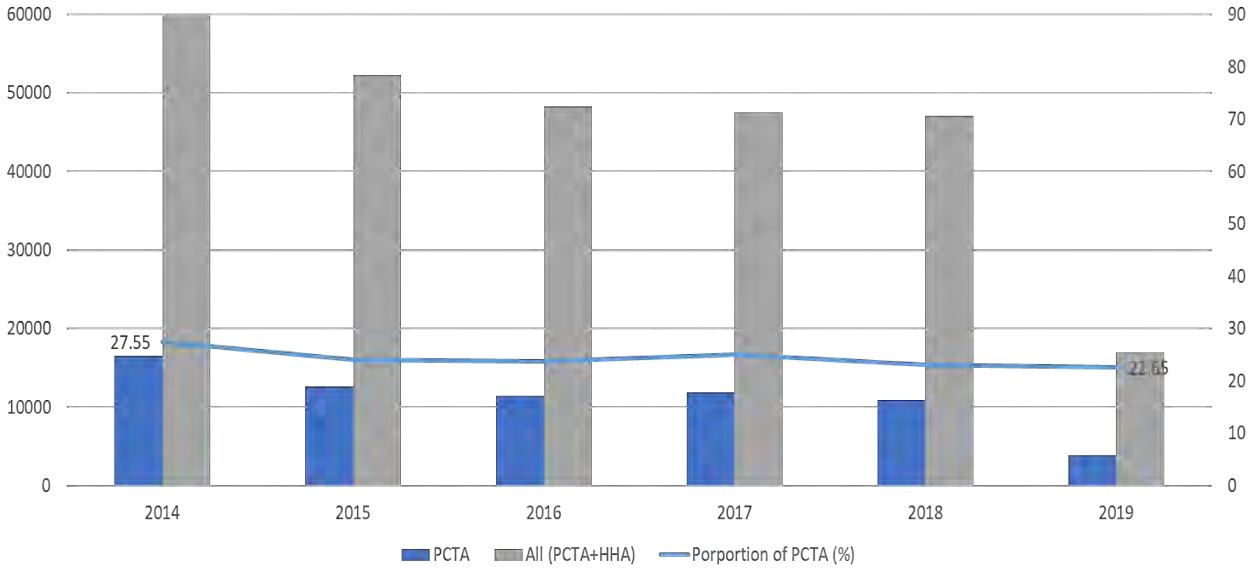

Figure 3: Personal Care Aide Training Certificates in Non-Western New York Counties, 2014-2019

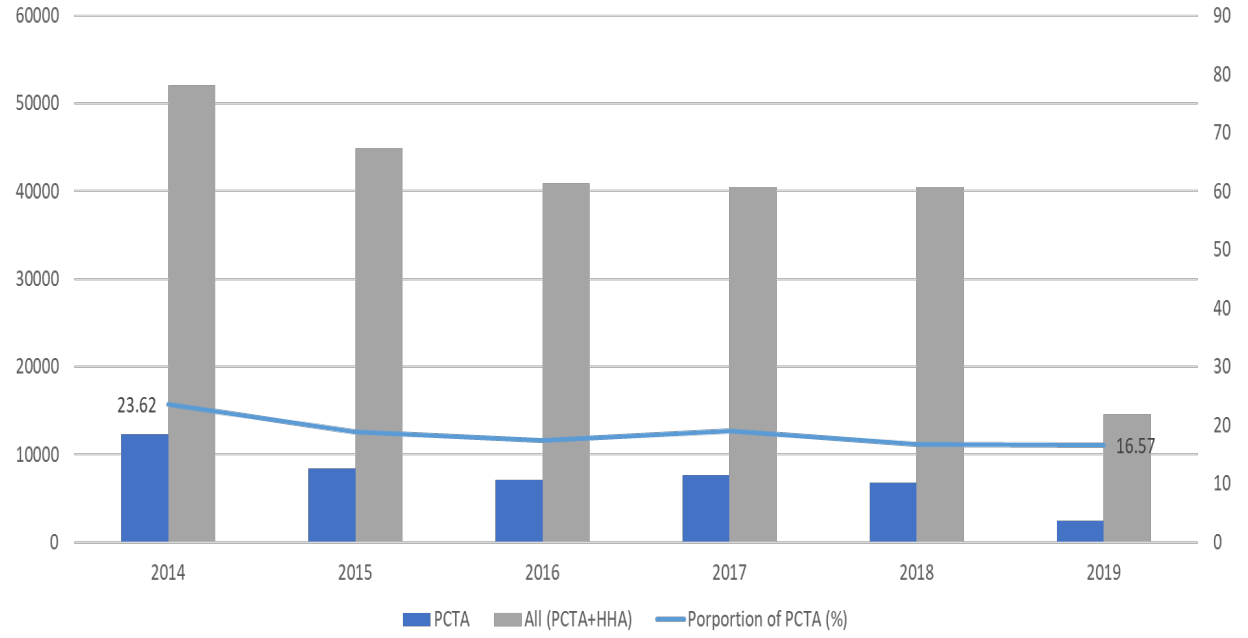

Figure 4: Personal Care Aide Training Certifications in New York City Region, 2014-2019

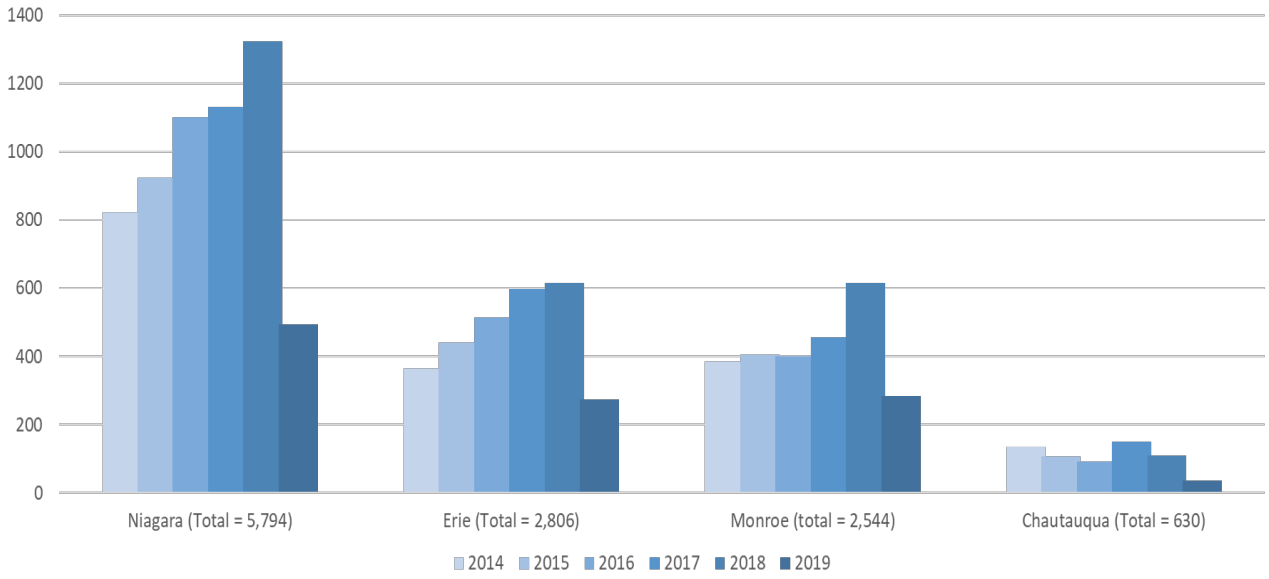

Figure 5: Personal Care Aide Training Certifications in Select Western New York Counties, 2014-2019

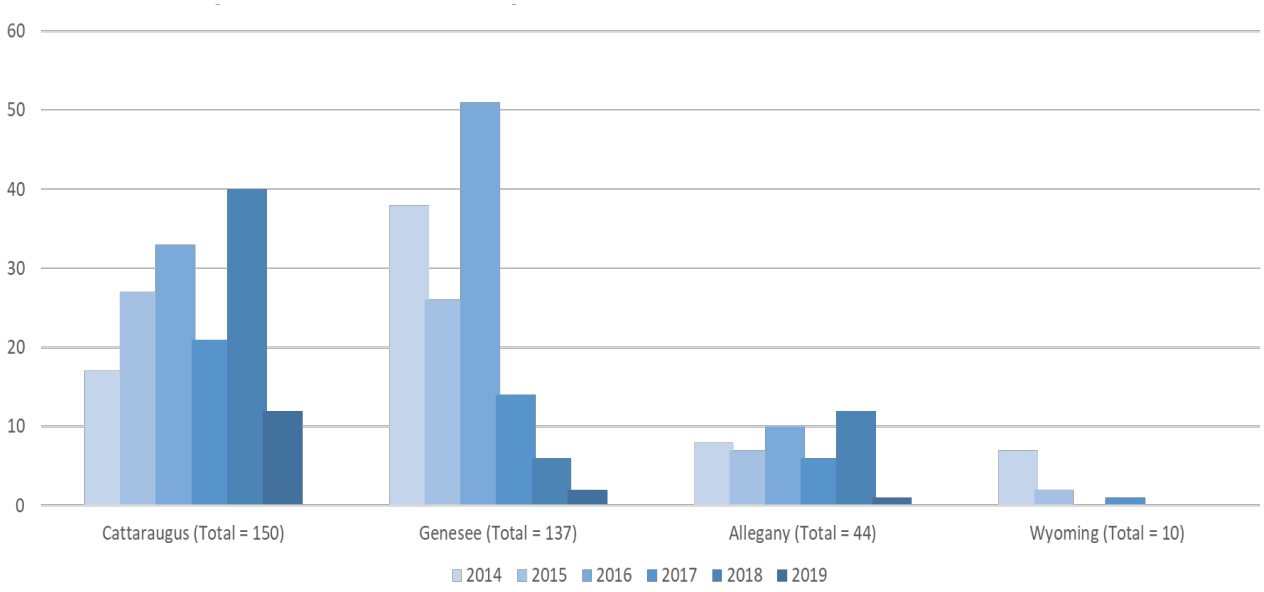

Figure 6: Personal Care Aide Training Certifications in Select Western New York Counties, 2014-2019

Table 6: Top Training Agencies for PCA Certification in Select Western New York Counties, 2014-2019

County	Leading Training Agency	City	Year	Total Agency PCTA certifications	Total Agency PCTA and HHA certifications
Niagara	Venture Forthe, Inc.	Niagara Falls	2014	775	775
			2015	863	863
			2016	980	980
			2017	963	963
			2018	1,119	1,119
			2019	456	456
Erie	New Hope Learning Center	Buffalo	2014	107	170
	Aftercare Nursing Services	Cheektowaga	2015	167	167
			2016	207	207
			2017	249	249
			2018	267	267
			2019	122	122
Monroe	Venture Forthe, Inc.	Rochester	2014	170	170
			2015	210	210
			2016	229	229
			2017	256	256
			2018	388	388
			2019	187	187
Chautauqua	Willcare	Fredonia	2014	50	103
			2015	26	81
	Willcare	Jamestown	2016	33	69
			2017	48	60
			2018	44	44
	New Vision Services, Inc.	Jamestown	2019	15	15
Allegany	Jan & Bev's Home Care, Inc.	Wellsville	2014	8	8
			2015	5	5
			2016	10	10
			2017	6	6
			2018	12	12
			2019	1	1
Cattaraugus	Willcare	Olean	2014	13	28
			2015	26	52
			2016	25	47
			2017	19	34
			2018	38	40

			2019	12	12
Genesee	Companion Care of Rochester - Batavia	Batavia	2014	32	32
			2015	26	26
			2016	51	51
			2017	14	14
			2018	6	6
			2019	1	1

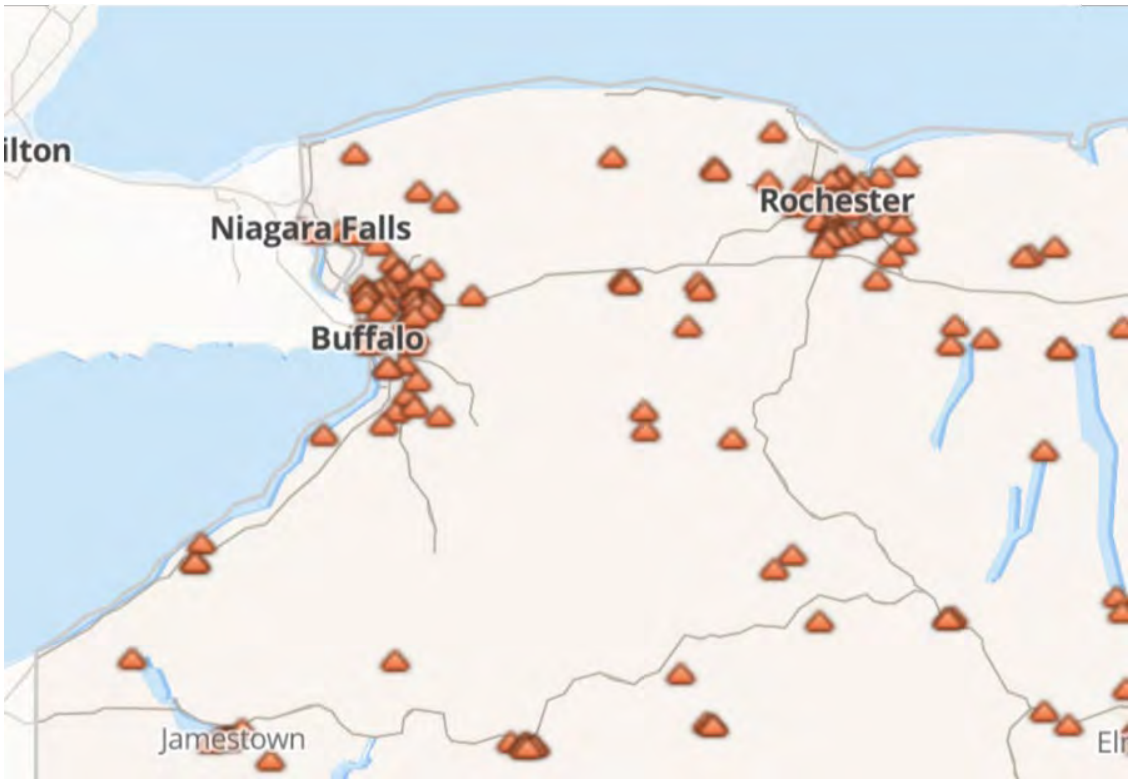

Figure 7: Location of Home Care Agencies in West New York

6.2. Southeast Michigan

6.2.1. Home Care in Southeast Michigan

Home care is available under several programs in Michigan[75], as follows:

1. MI Choice Waiver, Michigan's Medicaid waiver option for obtaining home care
2. Michigan Home Help, a consumer-directed option
3. Michigan Health Link, a program for those eligible for both Medicaid and Medicare

The MI Choice Waiver began in 1992 as the Home and Community Based Services for the Elderly and Disabled (HCBS/ED) waiver program.[76] it aimed to provide choices that allow individuals to live independently while receiving nursing facility level of care in their home or in a community setting. All adults eligible for the state's Medicaid program who need the care provided in nursing homes can stay in their homes and receive personal care services. Services are provided through select MI Choice waiver agencies, some of which are Area Agencies on Ageing. Participants may either receive services through an agency or direct their own services. Family members, such as adult children, can be hired to provide care services. Workers who provide services under the MI Choice waiver program are required to receive training in five topics: first aid and CPR; good health practices; housekeeping and household management; universal precautions and blood-borne pathogens; and observing, reporting, and recording information. However, MI Choice participants can determine how many hours of training to provide and assess worker competency and job preparedness. MI Choice serves approximately 16,000 individuals each year. About 60% of MI Choice Waiver participants were elderly (65 years and above) for agencies operating in Southeast Michigan.

Michigan Home Help is a program for elderly and disabled Michigan residents administered by the Michigan Department of Health and Human Services (MDHHS). It provides personal care services to individuals who qualify for Medicaid and need hands-on assistance with at least one Activity of Daily Living (ADL). It includes a consumer-directed option whereby program participants can select their caregivers. Friends and family members, except parents and spouses, can be hired and paid for providing care. All care providers must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS). Home Help consumers have complete freedom over training workers they hire, as well as over many other aspects of employment. There are no major training requirements under Home Help except one: all providers must be trained to perform each task required for a given program participant properly. Around 50,000 individuals are enrolled in Home Help. According to a December 2019 MDHHS data brief, an estimated 66,000 workers provide services to Home Help enrollees.[77] During the COVID-19 pandemic, MDHHS paid agency providers an additional $2.52 per hour for Home Help services provided and will continue to do the same till September 2021.[78]

The last option, Michigan Health Link - is a managed care program for persons who are eligible for both Medicaid and Medicare (dual eligible). It began in 2015 and is a partnership between three entities: MDHHS, the Centers for Medicare & Medicaid Services (CMS), and Integrated Care Organizations (ICOs). It is available in 25 counties of Michigan, including two counties in the Foundation's area of interest: Macomb and Wayne. This program is a financial alignment demonstration project operated with the Medicare-Medicaid Coordination Office. It is an integrated managed care option that provides streamlined access to all covered Medicare and Medicaid services through a single health plan (ICO). About 35% of the 106,000 dually eligible individuals in Michigan were enrolled in MI Choice Waiver. About 28% of the enrolled beneficiaries required personal care. Five out of seven ICOs participating in Health Link operate in Wayne and Macomb counties. Table 7 includes March 2021 enrollment figures for these five ICOs. An evaluation of the Health Link program noted that individual providers experienced challenges regarding payment delays during the early implementation phase.[79].[79] Providers were not paid for months, which led to the unenrollment of many beneficiaries from the program.

Implications:

- Given the mandatory registration requirement, the Michigan Home Help CHAMPS system can be leveraged to collect detailed data on Michigan's direct workforce. This represents a significant opportunity to improve workforce data in the state. This could be a goal of advocacy work that the Foundation may wish to support in the state, and it could be an important source of data for program evaluation if it were implemented.
- Despite their early challenges with personal care services, Health Link ICOs could be potential partners for a pilot on advanced home care roles. They may also be helpful in generating evidence on downstream outcomes, such as hospitalizations and readmissions, as a means to assess return on investment.

Table 7: Michigan Health Link Enrollment, March 2021

Program	Macomb Region	Wayne Region	Total
Aetna Better Health of MI	952	3,437	4,389
AmeriHealth Michigan	690	2,304	2,994
HAP Empowered Health Plan	999	3,402	4,401
MI Complete Health	735	2,205	2,940
Molina Healthcare of MI	2,146	9,996	12,142
Total	**5,522**	**21,344**	**26,866**

6.2.2. Prior Statewide Efforts

- *Innovations for paying for direct care workforce training*

  Despite the efforts of the IMPART Alliance, ensuring payment for its BTBQ training remains an issue for home care agencies in Michigan. As seen in other states, agencies are not always incentivized to invest in training due to high attrition rates. Alternate funding streams for recovering training costs are available to home care agencies in Michigan. Michigan Department of Labor and Economic Opportunity offers support via its Going PRO Talent Fund.[80] The Going PRO Talent Fund makes awards to employers to assist in training, developing, and retaining current and newly hired employees. It can provide support of up to $1,500 per employee. In 2019, an Area Agency on Aging received Go PRO money and engaged in a subscription agreement with the IMPART Alliance. Several home care agencies have made use of the Talent Fund. For instance, ComForCare Home Care in Washtenaw will receive $51,830 in FY 21.[81] In recent years, some agencies have explored a subscription-based model for delivering BTBQ. Such low- or no-cost, flexible training models can reduce upfront and total training costs for agencies.

- *Financial supports and wage increase*

  Stakeholders in Michigan have previously used multiple methods to support the direct care workforce financially. The first method involves providing a one-time cash bonus for retention. In 2019, Michigan's Region VII Area Agency on Aging used cash bonuses to encourage home care workers to stick with the job.[82] The agency offered direct care agencies a chance to apply for bonus grants of $1,000 per employee. Eighty HCWs who had been on the job for at least a year and had a good work record from 18 agencies received bonuses. A year after receiving the bonus, almost all workers remained on the job.

  Additionally, agencies have offered occasional cash support based on the personal situation of an HCW. For instance, support was provided to pay for replacing car batteries or to pay for car insurance. While the provision of such support is highly dependent on individual situations, transportation and child care needs were some of the common reasons for which workers sought assistance.

  During the COVID-19 pandemic, Michigan announced a $2 wage increase for its direct care workforce. It was intended to cover a $2.00 per hour increase in HCW wages. In February 2021, this wage increase was extended along with a $.24 per hour increase for agencies to cover their additional costs associated with implementing this increase.[83] These amounts were paid in addition to the wage the HCW was earning since March 1, 2020. This increase was also available to workers hired directly by home care consumers. In January 2021,

Michigan Governor Gretchen Whitmer advocated making permanent the $2 per hour hazard pay increase to HCWs.[84]

- *Widening the direct care workforce pipeline*

  In recent years, to tackle the shortage of direct care workforce in Michigan, the IMPART Alliance focused on increasing worker supply. In Fall 2019, a pilot for PCA Technical Training was launched at Grand Ledge High School near Lansing.[82] The pilot was based on the BTBQ curriculum. Over the next 3-5 years, the IMPART Alliance hopes to expand the pilot statewide using public school funds. To create career pathways for new entrants, Michigan's Aging and Adult Services Agency (AASA) is exploring options such as a bridge program from BTBQ to local community college courses such as Certified Nurse Assistant (CNA) and medical technician, etc. Offering training to a previously untapped population and offering them career progress opportunities can widen the pipeline and stabilize the future workforce.

6.2.3. Upcoming Policy Actions

In August 2020, the Michigan Department of Health & Human Services Aging & Adult Services Agency (AASA) released the Michigan State Plan on Aging 2021 – 2023.[85] One of the goals under this plan is to increase the number of HCWs in Michigan. The first objective of this goal is to ensure that 30% of home care agencies have adopted direct care workforce competencies. Statewide competencies will be developed in partnership with the DCW Advisory Committee and the IMPART Alliance. Another objective is to ensure that agencies are using curricula that map with adopted competencies. Finally, a statewide media campaign to promote the training will be undertaken by AASA. These developments are expected to improve the quality and availability of training and increase the skills of the direct care workforce.

Implications:

- There is significant momentum in Michigan around state-level changes that the Foundation may wish to support.
- Given that the supply of workers is a major challenge, the goal of improving wages and benefits will likely need to be part of any investment made by a stakeholder.

6.2.4. Absence of Meaningful Data in Michigan

Despite multiple statewide and local direct care workforce initiatives, Michigan lacks a single, comprehensive source of data that can be used to assess its direct care workforce. Multiple disparate sources of data exist but cannot be accessed easily. The IMPART Alliance is currently in the process of creating a HCW registry. Discussions with stakeholders revealed that community colleges that train HHAs might have data on certifications issued by them. Additionally, Michigan Home Help has an offline registry to match potential participants to HCWs. An online version of this registry is not available.

6.2.5. Key Stakeholders

- ***The IMPART Alliance:*** In Michigan, the Integrated Model for Personal Assistant Research and Training (IMPART) Alliance represents a unique partnership between academic researchers, state agencies (MDHHS Aging and Adult Services agency), and advocacy groups (PHI) for developing standardized direct care workforce training programs.[86] The Alliance continues the work done under Building Training...Building Quality (BTBQ), which began in 2010 as a U.S. Department of Health and Human Services grant (Personal Home Care Assistant State Training [PHCAST]). BTBQ is a 77-hour curriculum that emphasizes person-centeredness, uses interactive, adult-learner instructional strategies, and includes content related specifically to home care. During the ongoing COVID-19 pandemic, BTBQ turned into a completely virtual training program. Upon successful completion of training, certifications are issued by BTBQ, which are considered as 'industry endorsed' (but not state-endorsed).

  Along with training development, the IMPART Alliance, working with the Michigan Statewide Direct Care Workforce Advisory Committee, is also working to establish a 3-level, stackable 'Universal Home Care Worker' credential and related competencies for the direct care workforce (personal communication, March 19, 2021). Currently, the committee is reviewing competencies from multiple sources such as Centers for Medicare and Medicaid Services (CMS) and direct-support organizations. The aim is to finalize a competency list that can be adopted at the state level.

  In the future, the IMPART alliance hopes to continue making progress on multiple fronts. It is working within multiple state-level coalitions, creating a registry of HCWs, and bringing in untapped populations into direct care work by delivering training. To scale up its BTBQ training, it is actively working to increase the number of trainers by adopting a 'train the trainer' approach. It has also produced a list of multiple funding options to pay for direct care workforce training.

- **Essential Jobs, Essential Care:** To address multiple issues related to Michigan's direct care workforce, IMPART Alliance and PHI launched a multi-year statewide advocacy initiative with support from W. K. Kellogg Foundation.[87] This initiative will collaborate with diverse stakeholders and focus on three policy areas – improving compensation, workforce innovations, and strengthening data collection.

- **DCW Advisory Committee:** To coordinate efforts to address the direct care workforce in Michigan, a Direct Care Workforce Advisory Committee was created. The DCW Advisory Committee provided input to the State Plan on Aging 2021-23.[85] It is also slated to collaborate with Michigan's Aging and Adult Services Agency (AASA) to develop a media campaign plan

to promote DCWs and DCW training. The Committee also works with the Michigan State Advisory Council (SAC) on Aging.

- **State Advisory Council on Aging (SAC):** The SAC is a 40-member body appointed by Michigan Commission on Services to the Aging (CSA).[88] It advises the Commission on various issues, including those related to the Direct Care Workforce. SAC made several recommendations in its 2016 annual report on the training, certification, and retention of Michigan's direct care workforce.[89] Some of them are involved in forming a state-wide advocacy coalition, ensuring living wages for HCWs, including HCWs in interdisciplinary care teams, and forming community partnerships to facilitate low-cost transportation options for HCWs. In its 2019 annual report, the Council curated a list of innovative practices about the direct care workforce adopted by Michigan's Area Agencies on Aging.[90]

7. Recommendations

Identifying ways to modify structural barriers that have kept the home care workforce subjugated in low wage and low social status positions with no career advancement opportunities is a huge challenge.

This field has benefitted from considerable attention from philanthropy and from advocacy movements thus far. The research in this report indicates that the core elements of successful models are relatively well known, even if the level of outcomes evidence remains less than ideal. There also appears to be consensus around what the facilitating factors are, as well as many of the barriers to widespread adoption.

It is in this context, GWU proposes the following approaches and actions, including advocacy, pilots, products, and additional research as summarized in the table below.

Table 8: Summary of Recommendations

Type of Investment	Strategy
Advocacy	1. **Invest in coalitions** to strengthen state policies and programs that aim to improve wages and benefits and professionalize the home care and home health workforces.
	2. **Public relations campaign** on the value of home care workers. Lessons from CHWs and other campaigns like J&J Future of Nursing. One arm aimed at clinicians.
Local Pilots	3. **Generate business case for health systems to integrate HCW through Pilot.** Pilot with a large health system or CHC to build home services, using satellite clinics as hubs. Include training of clinicians.
	4. **Evidence of ROI for home care agencies**. Pilot with closed rural environment (one agency, one health plan), with a plan to scale.
Products	5. **On-demand training apps.** Invest in the development of on-demand training/support workers can access during work. Points earned with bonus. Possible advanced role training option specific to each state's reforms with certifications, including.
	6. **Internet hotspots** for home care workers.
	7. **Guides for Agencies** • Advanced roles for PCAs

	• Evaluation of advanced roles
Research	8. **Survey of PCAs**
	9. **Report on MCOs** and their potential to incentivize advanced roles for home care workers with increased wages.
	10. **Report on opportunities for mergers and acquisitions** across home care, home health, and home hospice agencies industries. How would the value proposition of advanced roles improve if there were better alignment?

7.1. Advocacy

We propose two advocacy strategies that are upstream determinants of whether advanced roles can be widely adopted.

The first recommendation is a bottom-up strategy to strengthen state-level coalitions of advocates and stakeholders with the aim of improving regulations, payment policies, and state sponsorship of training programs. The second is a top-down strategy of designing a public relations campaign to elevate the public's and healthcare clinicians' view of home care workers' value.

1. ***Invest in strengthening state coalitions to drive state programs and policies***

   Rationale*:* Our review shows clearly that the state-sponsored programs and state policies have had the most impact and are the most sustainable over time. In addition, we have shown that where the best state programs and policies exist, there has been a strong coalition of advocates driving the process of change. Moreover, recent state and federal actions (and an elderly-care-friendly federal administration overall) have created opportunities for action and increased funding. It is likely that collective and strategic action will be needed to leverage these opportunities fully.

   Local Context*:* There are already organized networks of advocates in both New York and Michigan, and there has been interest on the part of both governments in welcoming multi-stakeholder recommendations.

   In Michigan, the State-Wide Direct Care Workforce Advisory Committee includes a cross-section of interest groups and advocacy leaders. As described in the prior section, they have already begun developing recommendations. In addition, IMPART Alliance has partnered with PHI to reach out to stakeholders across the state and organize a coalition (Kellogg Foundation funded). PHI produced an extraordinary roadmap for state-level changes needed to advance the direct care workforce in a document to lift workers out of poverty, improve

data on strengthening the workforce (including a registry like New York's), and investing in workforce innovations.

In addition, the Advisory Committee has begun work on developing competencies, and a certification proposal for a universal home care worker that would be portable across populations and settings have three stackable levels, as well as optional additional certification for specialty training in areas such as dementia, end of life care and medication distribution. In our view, these are transformational proposals that would open the door to real changes in the counties of interest to the Foundation.

In New York, a similar cross-section of interest groups in the area of LTSS comprised the AHHA advisory workgroup. This group has now been disbanded, leaving a gap that must be filled in order to move uncompleted work forward. While the HHA proposal was codified, it has not been implemented, and there is work to be done to fund the development of curricula, identification of funding sources for training, and understanding the readiness of agencies to employ HHAs. Very little work has been done on the PCA training and potential advanced roles within that worker category. Additionally, as in Michigan, the issue of wages, benefits, and data collection (to improve on the current registry) must be addressed before western counties can tackle the problem of shortages. Lastly, the recent reforms of home care reimbursement described above represent a threat to PCAs; advocacy is needed to anticipate and respond to its effects.

Aims: In addition to the change agendas specific to these two states (given their different home care reimbursement policies and regulatory environments), there are additional topics that would be important to address, including:

- Developing recommendations for states on how the American Rescue Plan Act of 2021 and the proposed American Job Act could be leveraged
- Recommendations to reform the State Nurse Practice Act with additional delegation to home care and home health workers.
- Consideration of ways to create both worker and agency incentives to complete training for advanced roles, e.g., pass-through bonuses and increased reimbursement rates for advanced roles.
- Exploration of prospective payment that would reward MCOs and health care organizations and systems that acquire or develop their own home care and home health care services (see recommendation #3).
- Advocacy at the Federal level to increase the minimum wage.

2. ***Fund a campaign to raise the social status of home care workers***

   Rationale: Low social status is widely recognized as a major barrier to the adoption of advanced roles in home care. The public does not see this work as specialized, and therefore has not fought for better working conditions and wages. Clinicians do not view these workers as team members. And family members of clients, who generally serve as an intermediary between the client and health care team, do not necessarily trust the care worker to communicate directly with health care teams. Campaigns to raise the status of workers have been successful in other fields. Community health workers (CHWs) have fought to advance their own agenda and are now widely respected, and their employment has vastly expanded. A public relations campaign was developed by Johnson and Johnson to elevate the public's perceptions of nursing with extraordinary success.

   Aims: This recommendation includes two parts, which could be implemented together or separately. The first is to assess the history of a similar occupation with low status in healthcare that has been able to change public perceptions and advance integration with the health care teams: CHWs. The second is to study the lessons of the Johnson and Johnson campaign and to use these and the CHW findings to plan and conduct a public relations campaign that aims to elevate perceptions of home care worker value among families, clinicians, employers, and workers themselves. The campaign could also identify ways to engage the public in organizing to promote HCWs.

7.2. Program Pilots

These two recommendations seek to convince local healthcare leaders of homecare's opportunities for growth. The first focuses on health systems, likely an Accountable Care Organization (ACO) that includes dual-eligible and SNFs. The second focuses on home care agencies.

3. ***Develop a pilot program to help a large health system (or community health center) in rural counties to expand their business to acquire or grow their own homecare and home health care offerings****.*

4.

   Rationale*:* Our review suggests that among the most important barriers to advanced roles with higher wages are 1) the fragmentation of the home care and home health industry and 2) the small size of most firms. Both constrain the goal of developing economies of scale that allow for investments in the workforce and standards for its diversification of roles. This is especially problematic in rural areas, where workers must travel further to get to clients (cost for the company and for worker) and where there are especially severe shortages of workers. Additionally, all of the experts interviewed argued that integration of home care workers with the health system is a major goal, such that the care team benefits from home workers report

and home care workers benefit from the training and mentorship, as well as the social status of inherent in integrated models.

We believe that all three of these structural issues could be addressed if home care and home health care services became part of an integrated health care system. Ideally, the organization hosting the pilot would form part of an Accountable Care Organization (ACO). ACOs are allowed to keep a portion of cost savings over time and are rewarded for improved health outcomes and include dual eligible who wish to sign up. Given the current funding streams from Medicare and Medicaid, as well as the private market, and given the growing demand for such services, the expansion would be relatively low risk. Health systems would benefit from regular reimbursement streams for these services, in addition to the saved savings and rewards they could generate. Workers would use satellite clinics as a hub to reduce travel time and to decentralized services without reducing integration.

Aims: The aim would be to increase home care services in rural areas by using existing satellite clinics as hubs, thereby growing the number of clients and creating economies of scale that allow for workforce development, workforce support services such as transportation, advanced roles, and integration with the clinical teams, and increased wages.

5. ***Pilot advanced roles with one home care agency in a closed rural setting with one payer.***
   ***Rationale*:** The evidence base continues to be weak for the ROI on advanced roles for home care agencies. Studies that do exist are unable to control for contextual factors, and they do not evaluate the effects of component parts of different programs. This makes it difficult to use the evidence to persuade other employers to experiment with advanced roles.

   Aims: The aim would be to conduct a pilot in a relatively controlled (closed) rural setting, with one large agency and one large payer, in order to limit confounding factors. Based on the results, a second phase could be developed to disseminate results and provide technical assistance (see the recommendation to create guides below) to other home care agencies that are open to experimenting with advanced roles campaign.

7.3. Products

6. ***Training Apps***
   Rationale: While experts we interviewed insisted that adult learning is most effective using face-to-face small group sessions, COVID-19 has brought with it new distance, on-demand technologies that may be changing the landscape of learning opportunities. In addition to more traditional online courses, there are also interactive decision support learning apps such as Human Diagnostics,[92] as well as apps that are intended to be motivational such as Walking

Apps. These types of innovations might allow home care workers to access learning on the job and to save time and transportation costs related to face-to-face training programs.

Aims: The aim would be to develop and test just-in-time online training that includes gamification and rewards that can be incorporated into the workday. If the technology is used as intended, sessions are incorporated that are specific to standardize training for advanced roles in New York and Michigan.

7. ***Internet hotspots for home care workers***

   Rationale: There may be areas of the two regions in Michigan and New York lacking broadband and workers and client homes with no wireless. Access to online learning is an increasingly important opportunity for home care workers (Recommendation #5)

   Aims: To ensure all home care workers have access to the internet, and secondarily, to develop a database of home care workers beneficiaries (see recommendation #8 to conduct a survey of PCAs below)

8. ***Guides for Agencies***

   (A) Advanced Roles for PCAs Guide

   Rationale: Experts report a hesitancy on the part of smaller firms to experiment with advanced roles. A technical assistance guide might provide a roadmap that would give agency leaders more confidence.

   Aims: The aim of the guide would be to facilitate the adoption of advanced roles by home care agencies.

   (B) Evaluation Guide

   Rationale: Most training programs and the development of advanced roles are still not being evaluated at all.

   Aims: Consistent with recommendation #4, the aim would be to produce an evaluation guidebook that would encourage agencies to gather, report, and analyze data systematically.

9. ***Survey of PCAs in the two regions***

   Rationale: There is no information on the current PCA workforce in the two regions. This data could help inform policies and programs.

   Aims: To design and conduct a survey of PCA that could be repeated as a panel survey every two to four years as a means to (a) better understand the needs of the workforce and (b) to track workers' situations over time as different policies and programs evolve. Findings would be used to inform the development of future advanced role initiatives.

Activities: Data from the hot-spotting program could provide a census of workers to survey. Incentives for survey completion would be needed. The survey would include demographics, challenges they face in their lives and at work, training, perspectives on and barriers to pursuing advanced roles, etc. Note: PHI is currently conducting a similar survey in Arizona.

10. ***Report on regional MCOs and their potential to incentivize advanced roles for home care workers.***

    ***Rationale*:** Managed Care Organizations that cover home care services exist in both states, yet they have not been included in state coalitions or pilots as far as we know. Like health systems, they could play an important role in spurring the adoption of advanced roles by agencies if they were convinced that there is value in the integration of these services into health systems.

    Aims: To assess the readiness of MCOs to become more significant players in directing home and health care agencies to invest in the workforce.

    Activities: (a) identify and determine MCOs in both states currently including direct care services in their plans (this could involve analysis of claims), and then (b) interview these MCOs leaders on their perceptions and interest in greater involvement in building this workforce. See Appendix 7 for details on MCOs operating in western New York.

11. ***Report on opportunities for mergers and acquisitions across home care, home health, and home hospice agencies industries in the two regions.***

    Rationale: As we argued under Recommendation #3, our review suggests that the fragmentation of the industry constrains the wage structure of the home care industry and that economies of scale would help the industry to mature.

    Aims: The aim of this study would be to explore the potential for mergers and acquisitions specific to the two regions of interest.

    Activities: Commission a business consultant to study the question of how the value proposition of advanced roles might improve if there were better alignment across home care, home health, and home hospice agencies in the two regions and make recommendations regarding the potential for mergers, acquisitions, or other strategies, to grow the size of agencies.

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Questions

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