An Assessment of the Personal Care Workforce Shortage

in the Ohio Area Agency on Aging PSA 2 Program Area

and Recommendations to Address

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Disclaimer: The views, thoughts, and opinions expressed in this document are solely those of the author and do not necessarily reflect any official policy or position of The Dayton Foundation or the Area Agency on Aging.

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There are two fundamental challenges to improving direct care jobs. The first is what might be termed cultural or attitudinal. Many of the key actors in the system have little respect for long-term care workers, and this disrespect is an important obstacle to any effort to improve the job. Other obstacles are more practical: care delivery is so extraordinarily complicated and piecemeal that the term "system" is hardly appropriate, conveying as it does a misleading impression of order and logic. The system's complexity makes any reform difficult to implement.

- Paul Osterman, Professor of Human Resources & Management at the
M.I.T. Sloan School of Management,
from Who Will Care for Us? Long-Term Care and the Long-Term Workforce

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INTRODUCTION

The Area Agency on Aging PSA 2 requested a Del Mar Encore Fellow from The Dayton Foundation to independently define, measure and develop sustainable strategies to address long term care workforce shortages in our region. The Felllowship began in August 2019 and concluded in August 2022. During this time, three objectives were pursued.

1) Determine the scope of long-term care workforce issues among the AAA provider network and the consumers it serves. This involved research & analysis of gaps in provider capacity, consumer care, and long-term care workforce shortage issues within the region and how it relates to those in the state, nationally & their trends.

2) Survey the broader landscape. This involved research and analysis of current long-term care workforce shortage issues (and trends) within the region, state, nationally & their trends and an identification of others' best practices.

3) Create a set of recommendations for sustainable interventions/initiatives the AAA and its provider network can use to combat long-term care workforce shortage issues.

During the course of this fellowship, a worldwide COVID-19 pandemic materialized, one that was particularly virulent for the elderly, changing the landscape of life for older adults and their options for care. As a result, this Fellowship pivotted to accommodate this new reality and the new world order resulting from the pandemic, the Government relief efforts that ensued, and the changes in labor and economic markets that followed.

This report covers all work conducted during this fellowship.

BACKGROUND

Seventy-seven percent of adults 50 and older want to remain in their homes for the long term -- a number that has been consistent for more than a decade.

- AARP Summer 2021 Home and Community Preferences Survey

"The ache for home lives in all of us."

- Maya Angelou

In 2019, the 54.1 million people -- 30 million women and 24.1 million men -- age 65 and above represented 16% of the U.S. population. That percentage is expected to grow to almost 22% by 2040[1]. According to the U.S. Census Bureau[2], the nation's population 65 and older has grown by over a third since 2010, driven by the aging of Baby Boomers (people born between 1946 and 1964). No other age group has seen such a fast increase. In fact, the under-18 population was smaller in 2019 than it was in 2010, in part due to lower fertility rates in the United States. By 2060, the number of adults in the United States age 65 and over will nearly double, to 94.7 million, and the number of those aged 85 and over will triple, to 19 million[3].

As people age, chronic medical conditions become even more prevalent: approximately 80 percent of those aged 65 and over have at least one chronic condition, and nearly 70 percent have two or more[4]. With increased age and medical challenges, the chances that an older adult will need help to live safely and securely increases. While only 3% of adults age 18 to 64, and slightly less than 4% of those 65 to 74, require assistance with activities of daily living (ADLs) -- eating, dressing, bathing, getting in and out of bed or a chair, walking, toileting, etc. -- the percentage doubles to 8% of those 75 to 84 and more than 21% for adults aged 85 and above[5]. Indeed, the U.S. Department of Health and Human Services estimates that nearly 70% of people who reach the age of 65 will ultimately need some kind of long-term services and supports. Nationally, nearly 20 million adults in the United States currently require assistance performing activities of daily living, as well as activities supporting these (such as shopping, making meals, and housekeeping). While this number includes those living at home and in nursing homes and assisted living, ~85% of these (17 million people) live in the community and receive help from 43 million family members, friends, or neighbors and approximately 2.4 million paid caregivers[4,5]. As the 65 and over population doubles in the years ahead, so will the demand for care, especially based in homes and the community. Unfortunately, at the same time, the pool of middle-aged women, who have traditionally provided care, will also be substantially smaller and the caregiver support ratio -- the ratio of potential caregivers, aged 18 to 64 years old -- will decrease dramatically. The caregiver support ratio is projected to fall from 31:1 in 2016 to only 12:1 by 2060[6].

Generations ago, older adults needing help with daily life were cared for by family members (generally female), and when there was no one to do it or the elder's condition deteriorated to more than the family could handle, the older adult entered a nursing home. In the early 1900's, most women in the United States did not work outside the home, and those who did were primarily young and unmarried. By the early 1990s, the labor force participation rate of women between the ages of 25 and 54 reached

just over 74 percent[7]. Thus, beyond a spouse, the likelihood that a family member would be home to care for an older adult has greatly decreased. Additionally, over the years, demographic trends have resulted in greater likelihood that older adults will live longer (life expectancy in the US is now 79 years old, up from 47 in 1900), will have never been married (4% currently and projected to grow to 6% by 2040), will have had no children (16% and growing), or will have no spouse, children, or siblings living nearby (22%)[8-10].

Home and community based services (HCBS) have become available and grown over the last 40 years to enable paid services for older adults that need help to live in their own homes or that have family caregivers that need respite. Home care services have enabled older adults to age at home, as most prefer, at a significant cost savings over nursing home care. According to Genworth[27], the 2021 annual median cost for HCBS homemaker services in Dayton, Ohio was $65,208, while the annual median cost for a semiprivate nursing home was $97,090. Because many older consumers are impoverished or will soon impoverish themselves paying for long-term care (at home or in a facility), Medicaid has become the primary payer for these long-term services and support (LTSS). Interestingly, while nursing home care is one of the services that must be included in state Medicaid plans, home care is not. Nonetheless, states have gradually shifted the balance of Medicaid spending for LTSS to home and community-based settings in recent decades. In every year since 2013, home and community based services (HCBS) have represented a majority of Medicaid LTSS spending. In 2016, 53% of the $167B spent on Medicaid LTSS went to HCBS, an increase from 39% a decade earlier[4.] Because Medicaid is funded through general federal and state tax revenues, it must compete with other priorities like education, roads, etc. In 2018, Medicaid accounted for 38.5% of Ohio's state budget[11]. Unfortunately, other budget challenges and priorities have resulted in a systematic underfunding of long-term care, few increases in reimbursement rates, and LTSS consumers on waiting lists for service.

Home health services rely on people (called home health aides or personal care aides, the two terms being used interchangeably in this report) to go into the older adults' homes to provide the non-medical help that seniors need to accomplish the daily activities of living. Home care workers are predominantly female (85 percent) and people of color (63 percent), and nearly one in three (31 percent) was born outside the United States[5]. The majority of home care workers (53 percent) have a high school education or less. The median age of home care workers in 2019 was 47 years old. The age distribution of the workforce appears to be shifting older -- from 2014 to 2019, the proportion of home care workers over 55 years old increased from 28 to 34 percent, the proportion of home care workers in the middle years (35 to 54) declined from 43 to 40 percent and those aged 16 to 34 decreased from 29 to 26 percent[5,12]. Lastly, low wages lead to a high rate of poverty in the home care workforce. Nearly one in five (18%) home care workers lives below the federal poverty line, 29% live below 138% of the poverty line, and 48% live below 200% of the poverty line[5]. Because of their low-income status, 53% of home care workers receive some form of public assistance, primarily Medicaid (33%), food and nutrition assistance (30%), and/or cash assistance (3%)[3,13,14]. Considering aides' demographic and socioeconomic profiles, it is clear that they represent historically and persistently marginalized groups, which no doubt complicates efforts to improve their image and the perceived and reimbursed value of their jobs[3].

In 2018, there were 2.26 million home health aides/personal care aides caring for older adults in their homes, this number having tripled from the 746,000 working twenty years before[6]. However, a 2019 PHI report estimated that 8-20% of home health aide/personal care aide positions were vacant at that

time[3]. Unfortunately, without comprehensive statewide HCBS data systems or registries, the validity of that estimate and the current vacancy rate (nationally or locally) are unknown. With the population aging, it was further estimated in 2020 that an additional 1 million workers will be needed to care at home for older adults by 2028[16]. The Bureau of Labor Statistics (BLS) estimated then that that would result in 4.7 million job openings for home care workers from 2018 to 2028 -- more new jobs than any other occupation in the U.S. economy[4]. Of the 4.7 million jobs, expanding the number of of home health aides by 1 million workers would require an additional 3.7 million new hires just to replace current workers leaving the workforce and leaving the field for other occupations. Updated 2022 estimates from BLS now project about 599,800 openings for home health and personal care aides each year, on average, over the decade[17] -- an almost 50% increase!

Direct care workers (DCWs), which include home care workers, adult day care workers, direct service providers for persons with disabilities, as well as aides in skilled nursing and assisted living facilities, leave the field for a variety of reasons, summed up as far back as 2001 in a report, sponsored by the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation, entitled, "Who will Care for US? *Addressing the Long-Term Care Workforce Crisis*"[6]:

> "Frontline worker jobs in long-term care are viewed by the public as low-wage, unpleasant occupations that involve primarily maid services and care of incontinent, cognitively unaware old people. This image is exacerbated by media reports that feature poor quality care by providers." (Robert Wood Johnson report)

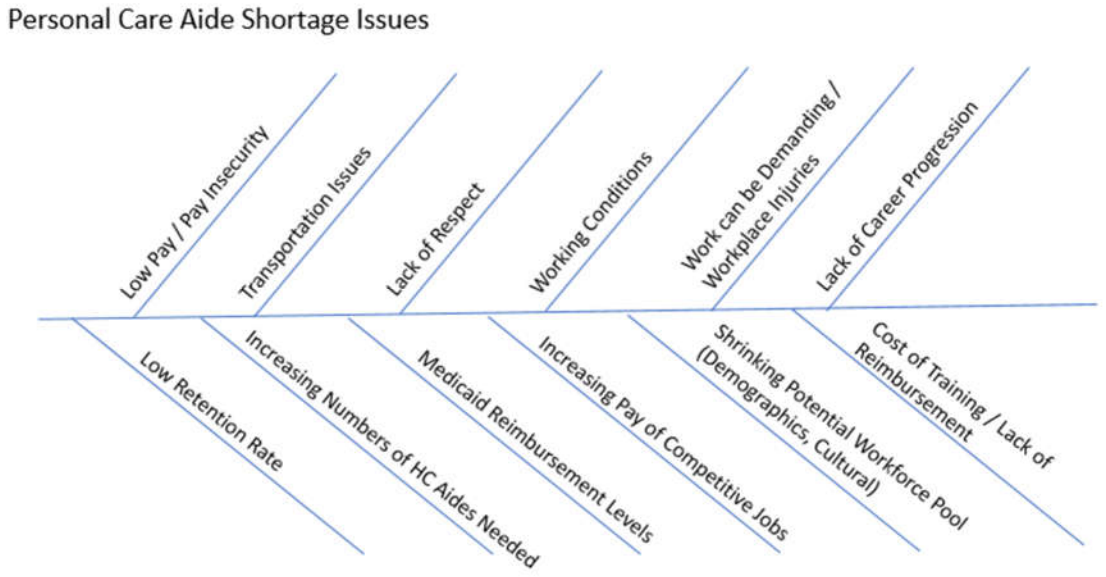
Further, in a 2007 national survey conducted by PHI[3], 97% of states responding reported that direct care worker vacancies and/or turnover constituted "a serious workforce issue." In 2018, the Home Care Benchmarking Study found that the median national caregiver turnover rate skyrocketed to 82%, from 67% the year before, and was so severe that more than half of the survey participants had to turn away new clients because they didn't have enough caregivers[18]. A Center for Health Care Strategies assessment in Michigan[19] found statewide turnover rates in 2020 for home health aides & personal care aides was 89%. They estimated the direct plus indirect cost to an employer of replacing each employee lost was roughly 25 percent of that employee's annual earnings. Turnover costs summed over all home health aides (HHAs) and personal care aides (PCAs) positions in Michigan in 2020 yielded business costs of over $375 million dollars. This estimate did not include any system-level LTSS costs, such as increased costs to Medicaid and Medicare due to reduced service quality and resulting illness and injury, higher levels of institutionalization due to insufficient home and community-based resources, etc.

A 2015-2016 survey[20] of 93 home care providers in Wisconsin found 93% of personal care providers reported difficulties in filling job openings and 70 percent were unable to staff all authorized hours. Likewise, a Massachusetts Home Care Aide Council survey in 2016-2017 found that 90% of home care agencies reported that workforce challenges were their top concern. In the local Dayton area, in 2019, LeadingAge Ohio data indicated that nearly 70% of health care providers that worked with them had unfilled STNA positions available throughout Southwest Ohio, and, between January 2019 and October 2019, there were nearly 2,000 STNA job openings in Warren and Montgomery counties[21]. It is unclear how many students are enrolled in the program or have completed it. A 2018 U.S. Government Accountability Office (GAO) study of HCBS programs in five states (Arizona, Florida, Mississippi,

Montana, and Oregon) noted that a top concern of officials in all five states was the challenge of workforce recruiting and retention, particularly given low wages[22]. A 2017 study of wages and benefits of direct care workers in Iowa[23] found that 28% of responding personal care workers also had another job and 19.4% were looking for work outside of the direct care field. More than half of those looking for new jobs cited better wages and benefits as reasons for leaving. Interestingly, although 9.6% were planning to retire in the subsequent five years, 70% said they would consider staying if they could get better health care coverage and 50% if they could get better pay.

PHI found in 2019 that wages for direct care workers (adjusted for inflation) had barely increased over the previous 10 years. Further, in all 50 states and the District of Columbia, the median wage for a direct care worker was ***lower*** than the median wage for other occupations with ***similar entry-level requirements*** (such as janitors, retail salespersons, and customer service representatives)[24]. In Ohio, the difference was more than $3 per hour! In 2021, according to the Bureau of Labor Statistics[25], the median national hourly wage for home health workers was at a new high of $14.15/hour but was 35% lower than that of workers across all occupations ($20.17/hour). Understandably, many states have now noted that it is extremely challenging for long-term care employers to recruit and retain these essential workers.

Because of rising Medicaid costs, increasing aide compensation has been deemed less feasible than efforts to improve direct care job working conditions. Noteworthy, though, is a 2009 study of home care workers in Maine[26] that examined the impact of wages, hours, and benefits on worker retention and found that "non-monetary job-related rewards" had a strong impact on ***intent to leave***, but compensation variables were better predictors of ***actual turnover***.



On balance, the home health aide job has well documented advantages -- most notably, the ability to help people one-on-one; the ability to manage one's own work and make a work schedule that fits in

with family, school, or other obligations; and the ability to work few hours per week to many hours per week). Workforce and recruitment efforts should protects these, as much as possible, and work the issues (shown in summary in the fishbone diagram above). While these issues have been well-documented by organizations such as PHI and LeadingAge, gerontologists, and the news media over the last twenty years, few substantive changes have been made in pay, benefits, or working conditions for home health aides in this time.

AREA AGENCY ON AGING PSA 2 AREA WORKFORCE SHORTAGE INITIAL ASSESSMENT

The Area Agency on Aging PSA 2 serves a nine-county area (Montgomery, Greene, Clark, Miami, Champaign, Darke, Logan, Preble and Shelby counties) in west central Ohio. In 2018, it served, on average each month, over 6000 individuals receiving long term services and supports to enable older adults and people with disabilities to stay safe and independent in their own homes.

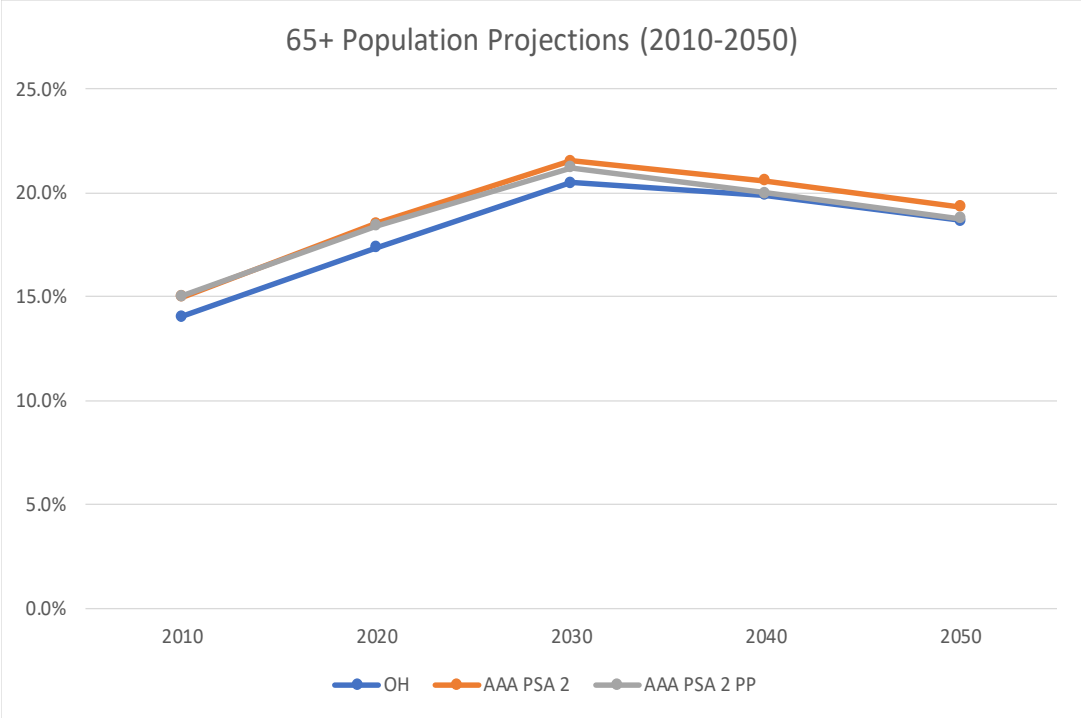
A study of the issues surrounding the home health aide/personal care aide (PCA, for short) workforce shortage in this area began with a look at the numbers (demographic and financial) and then proceeded to surveys and interviews with the system stakeholders – the leaders and case managers in the Area Agency on Aging, the owners and office managers of the home care agencies in the Agency's provider network, the aides working for those agencies, and lastly, but no less importantly, the customers of those agencies -- the consumers themselves.

While the number of individuals served is known, the number of personal care aides providing this in-home care is unknown. Because other studies have found that aides often have more than one job (which may be at another home care provider), because a new aide at a given provider agency may be one that just left another agency, and because an aide may provide service by mechanisms other than through an agency, a simple sum of aides working at the more than 100 agencies providing care in the AAA PSA2 provider network and their hiring vacancies would not provide quantitative answers to the number of aides currently working in this area and the actual workforce shortage (the number of vacant positions across the network required to provide services for consumers that have been approved for care but are waiting for service or those currently underserved).

It is more straightforward to look at the demographics of the older adult population in our area and project the increase in the level of services that will be required as the number of people age 65 and above increases and the number of those projected to need assistance with activities of daily living increases. Additionally, because the focus of this project was on the Passport program (Ohio's Medicaid-waiver program that provides cost-effective in-home care as an alternative to nursing home placement for eligible participants) that PSA2 manages directly in three counties (Montgomery, Greene, and Clark), the emphasis in demographics was on those three counties.

The figure below shows the percentage of the population aged 65 and above from 2010, projected out to 2050, analyzing data[28] from the Scripps Gerontology Center at Miami University. Thus, Passport area demographic trends are similar to statewide demographics.

In 2015, for the PSA 2 Passport area, 17% of these counties' population was age 65 and above, slightly higher than the state's and the nation's. Two percent of the population was aged 85 and above, consistent with the rest of the state. Fifty-one percent of those 65 and above were married; 41% were widowed, divorced, or separated; and 5% were never married. Thirty percent lived alone. Nine thousand, two hundred and eighty-four of these people age 65 and above were expected to have self-care difficulties -- 3202 people aged 65-74 (4%) and 6082 persons aged 75+ (11%).



By 2030, a 19% increase in population age 65 and above is expected, 13% from 2020-2030 alone. Using self-care numbers derived from the methodology used in an Administration for Community Living report[29] 2017 Provide of Older Americans, it was estimated that by 2020, the 9284 people needing help with self-care was expected to have jumped to 10,798 (+14%) and from 2020-2030 to 14,449 people (+34% in the decade). Further, it was estimated that the approximately 3353 aides need to serve these older adults in 2020 in Montgomery, Greene, and Clark counties would need to be increased by approximately 500 more aides by 2030 and likely 2000 will need to be hired in that time frame to ensure that, with retention challenges, the number needed in 2030 will be in place. Without this significant increase in aides, the wait for personal care services and the number of unserved or underserved will dramatically increase.

Since aide pay was so often mentioned as a prime issue with aide recruitment and retention, a consideration of the potential flexibility of provider agencies to raise personal care aide salaries was considered.

According to the Genworth Cost of Care Survey 2019[30], the median self-pay cost of a home health aide in Ohio was $23 per hour. According to the Bureau of Labor Statistics, the 2018 annual wage of personal care aides in the state of Ohio was $23,350 (or $11.31 per hour). The Ohio Medicaid reimbursement rate for personal care for consumers was $17.96 per hour. While agencies funded by Medicaid cannot compete salary-wise for potential aides with agencies funded by self-paying consumers, is there room within their budgets to pass through more of the reimbursement to aide wages?

In addition to wage salaries (~63% of reimbursement), agencies must pay

- Employees' FICA, FUTA (7.65% and 2.7% (new employee rate) of employee pay, respectively
- Benefits (health insurance, disability insurance, 401(K), etc.), *where offered*
- Aide recruitment and retention costs (including hiring and training costs, background checks, employee bonuses, hiring or referral bonuses, etc.)
- Unreimbursed operational costs (aide overtime, aide mileage, etc.)
- Agency professional liability insurance
- Regulation & compliance costs (including nursing oversight, required documentation, etc.)
- Overall agency management and operational costs (rent, utilities, scheduler, other overhead)
- Agency taxes
- Profit
- Etc.

With these costs, is clear that this is a low margin business and that personal care aide salaries cannot be significantly raised within current Ohio Medicaid reimbursement rates. Unless reimbursement rates can be significantly increased, the 34% of new personal care aides needed between 2020 and 2030 in the PSA 2 area (and the significant number of additional aides needed to overcome poor aide retention) will need to be enticed into the field by ways beyond wages themselves.

To better understand the specific workforce shortage in the PSA 2 area, input on its size and characteristics (plus ideas for remediation) was solicited from stakeholders throughout the process -- Area Agency on Aging leaders and case managers (during 2019), owners and office managers of home care agencies in the Area Agency on Aging PSA 2 provider network (2019-2020), personal care aides that work for these home care agencies (2020), and consumers that are the customers of the services they provide (2021). This input was sought by surveys (Area Agency on Aging), interviews (provider agencies and personal care aides), and discussion groups (consumers) and used questionnaires specific for each group. The results are included in the following sections. The survey instruments used for these sessions are included in the appendix.

AAA PSA 2 SURVEY RESULTS

AAA Survey:

Surveys were sent to leaders and a randomly-selected representative number of case managers in the Area Agency on Aging PSA2 with the intent of gaining a strategic view of its area's personal care aide staffing situation.

Survey Response Results:

- There is a moderate to severe shortage in personal care aides in the PSA 2 area. This is especially true in outlying areas but is also a growing issue in the suburbs and urban areas.
- The shortage is especially severe in outlying areas ((Brookville, Jamestown, Xenia, etc.), where few providers and aides are located and because many aides do not have their own reliable transportation or are unwilling to increase their own gasoline costs to provide services in these areas.
- As far as quality of service, it was noted that this is "hit or miss" and is, as in other occupations, strongly dependent on the person. That said, it was noted that it seems to take longer now for providers to find someone good and providers sometimes seem to settle for a "warm body," as opposed to a caring, well-trained aide. It was also noted that it is not unusual, even in areas where aides can be found, for it to take a succession of aides for a new consumer before a permanent one is found. Lastly, it was noted that the frequency of complaints about aides attending to their own personal business while on the job, and not to the consumer, seems to be increasing.
- Several suggestions were given around greater education and support for home care aides to be done in a collective manner by multiple providers. Suggestions were also made about creating a mentorship program and hiring people such that serving as an aide could be a step on their career path (i.e., nursing students and other care giving vocations).
- Many, many comments noted that poor pay is a contributor to the staffing shortage. It was said that being an aide is a "difficult job with pay that can be replicated in areas with far less consequence." A couple of former aides stated that they would no longer recommend the job to others. It was recognized that "We cannot guarantee a company would necessarily increase the wage they pay their employees just because they are getting more dollars per hour, or if they would invest it in producing a higher quality product."
- Overall, this personal care aide shortage has resulted in reduced numbers of new consumers that can be served or smaller numbers of service hours that can be provided to individual consumers, long times in getting an aide for a new consumer, situations where the consumer and their family has to provide back-up when an aide does not show up or leaves the provider, a greater risk of burnout for aides, and a more than desirable range in quality of aides serving consumers. The "amount of missed services that we are aware of weekly is always shocking to me."

- Some evidence of “provider hopping” was noted, where aides move from agency to agency to avoid consequences of poor performance or for other incentives. Not surprisingly, it was also noted that providers (and consumers) are seen to sometimes be too easy on personal care aides, so as not to prompt them to leave.
- While the number of new providers continues to increase, it is unclear whether they are drawing in new aides and providing new opportunities for the aides currently working in this area.

AAA PSA 2 PROVIDER INTERVIEW RESULTS

Interviews with AAA Provider Agencies:

Numerous requests for interviews with providers were made -- at an AAA Provider Fair, in agency publications to the provider network, and in letters to providers in various geographic areas selected for interview days across the PSA2 area. Twenty-nine agencies volunteered or agreed to be interviewed. Additionally, four agencies, not in the AAA network and funded by consumers with long-term care insurance or self-pay, were also interviewed to ensure that an understanding of any differences in agency or workforce issues due to payment source might be determined.

Interview Results:

- It is indeterminable how many personal care aides are currently working in the Dayton area or how the number of aides is changing with time. It is unclear how many aides are coming into this profession versus those moving around between providers. Providers indicate that they are mostly hiring experienced aides.
- Aides in the Dayton area are earning $9-17/hour (lower end is Medicaid or levy funded, higher end is private pay or post-hospital Medicare funded); most earn $10-12/hour.
- Competition for workers is fierce, since hospitals & nursing homes already pay more for STNAs and fast food/retail/distribution companies (Amazon, Chewy, Chick Fil A, Target, Costco, etc.) are broadly advertising wages of $13-15/hour. Providers are having to aggressively recruit; many formerly successful methods are no longer working; greater costs are associated with attracting fewer potential hires. Several providers noted that the challenges really began in early 2019. All but one provider interviewed so far would hire 10 good candidates today if they would walk in the door.
- For many providers, ghosting is a significant issue – from before-hiring to on-the-job. This adds uncertainty to accepting and staffing consumers and how best to attract and retain aides. It also adds to the cost of business and disruption to consumers.
- Most providers feel bad about the number of new consumers that AAA is looking to staff each day that they cannot accept (up to 10-15/day) and want to grow to handle the current and future AAA case load. It's unclear how they can do so. Many providers might be interested in innovative approaches (interns, volunteers, immigrants, etc.) but stressed that the details of how these might work will be critical.
- Most providers indicated that higher aide wages and contract reimbursement rates would be part of the solution to attracting and retaining more aides.
- The need to provide competitive wages, limited Medicaid reimbursement rates, and significant non-reimbursed costs are especially challenging for companies that handle predominantly AAA consumers. Margins for these companies are slim, although larger companies and those who have diversified businesses appear better positioned. Some companies are intentionally moving away from AAA consumers and toward private pay clients.

- There is a bimodal distribution of employees for most providers – those that have worked for the company for a number of years and those that have recently joined (this latter group is where the turnover is). The former employees tend to be older and are heavily relied on by their employer, while the latter tend to be younger and less experienced. There is concern about many in the first group retiring or leaving. Maturity, not age, appears to be the real discriminator between the two groups. Providers would welcome more mature job candidates but are unsure how to attract them or to hire them, especially if their experience isn't accompanied by formal training or supervised aide experience.
- Mandated training/job requirements are a barrier for hiring aides for Medicaid reimbursed clients but not for private pay clients
- There are challenging cultural issues on both the aide and consumer sides of the equation
- "Aides are the working poor working for the formerly working poor." Providers manage many related issues.

RESULTS OF INTERVIEWS WITH AIDES IN THE AAA PSA 2 PROVIDER NETWORK

Interviews with AAA Provider Agency Aides:

Requests were made to five agencies for their help identifying aides willing to be interviewed. The agencies were asked to ensure that aides they recommended were volunteers, were willing and able to be open and straightforward about the joys and challenges of being an aide, and were told that their interview would be up to an hour in length, and were told that all answers would be confidential. Twenty-four aides volunteered and were interviewed by phone. Each aide was gifted with a Kroger gift card after the interview.

Interview Results:

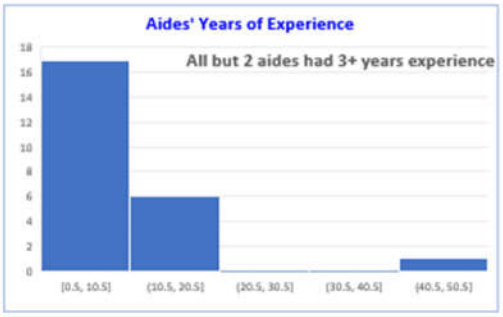
1. Job Satisfaction
    - Almost all aides saw themselves as a caregiver from a young age
    - Few planned to be an aide
    - Many commented on the importance of their interactions with their consumers
    - "love my job – wouldn't trade it for the world – clients are like family"
    - Proud of their work -- most saw respect from their patients & their families, their employers, and their own family
2. Future Plans
    - Several aides want to be nurses in the future, some older aides had wanted to in the past
    - Most planned to continue working in the field – liked job, don't like change, might need to for better pay
    - To attract more aides, look for someone laid back but motivated, someone with heart, someone not looking for easy money -- perhaps older, moms
3. Pay / Benefits
    - Most had a high school degree or GED, some more, including several nursing students – 7 were CNAs/STNAs
    - Variety of previous/concurrent jobs
    - Younger aides tended to live below the FPL and receive benefits
    - Older aides tended to have other income (family member, other job(s), Social Security)
    - Many were recruited by family or friends
4. Things They'd Like to Change
    - Pay
    - Benefits, especially health insurance
    - Paid time off
    - Hazard/HERO pay
    - "Some aides leave early – not mentored" – not much networking
    - "Every nurse should be an aide for at least 6 months"
    - Get more training on handling death, dealing with consumers' family members, dementia, stroke

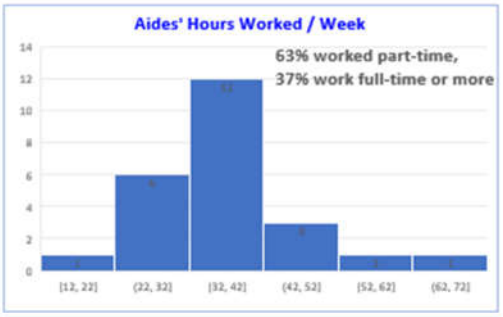
Demographics of Interviewed Aides

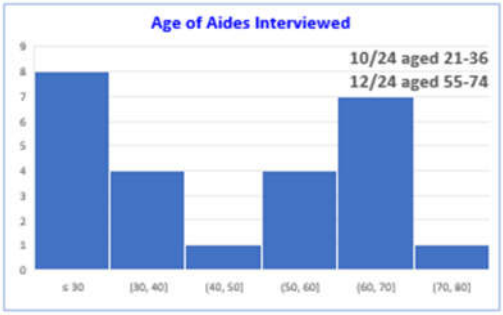
22 women,
2 men

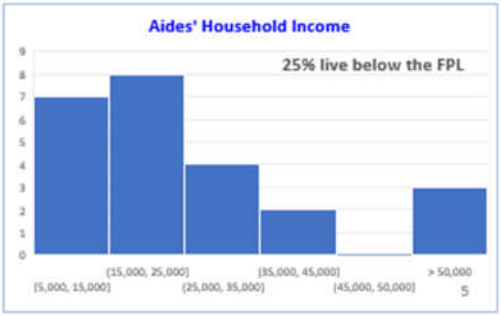
100% born in US

19 Caucasian,
5 African American









RESULTS OF AAA PSA 2 CONSUMER SURVEY SESSIONS

Consumer Survey Sessions:

To enable the "voice of the customer," five sessions were held with area older adults to get their thoughts on the home health care services they receive. Unfortunately, with the coronavirus pandemic, these sessions were delayed until COVID vaccinations were readily available. The first two sessions were held in the spring of 2021 (in-person) and the last three were held in the summer of 2021 (via Zoom). These were arranged with the help of St. Mary's Development Corporation, the Orchard at Shiloh, the Wesley Center, and the Dakota Center. More than 50 older adults attended one of these sessions and provided answers to the questions in the survey (the first two questions were surveyed individually on paper and the remaining questions through group discussion). Some of these discussions were, as might be expected, lively, particularly those sessions in which consumers had been personal care aides themselves in the past.

Consumer Session Results:

- On a qualitative scale from 1-10, most consumers saw their aides as a 7-10 in how critical their aide was to their health and well-being.
- On a qualitative scale from 1-10, consumers tended to rate the performance of their own aide as very high. If very low, consumers had already let them go, were getting or waiting for a new aide or were trying to rely on themselves, their family, and their neighbors and friends instead.
- A big complaint expressed by consumers at all sessions was an irritation with aides that "fudge" their time and do not get needed work done. This "fudging" occurs when time is kept on paper (with the consumer sometimes being asked to sign a blank form or one that can't be read by the consumer), when aides sign in and out electronically from their cars (perhaps then making use of their phone before they enter the consumer's residence), when errands are run on the clock primarily for the aide's purpose (and not the consumer's), and when aides spend much of their work time taking breaks, watching television, and on their phones (this was a HUGE issue discussed at all session).
- A disconnect between what the consumer had heard the company say the aide can and would do with what the aide was willing to do, and actually did, was noted. While this could be a miscommunication between the provider and consumer on allowable work and what could be expected to be done in the hours of personal care approved, consumers more often saw this as a disconnect between what work the aide wanted or was willing to do and what the consumer needed done. This was expressed with a number of examples. Two of these examples are: One where the aide was unwilling to run errands for the consumer because of the limited gas in the aide's car. The second was where the aide was often unwilling to perform personal care tasks for a mobility-limited consumer, resulting in the consumer hesitating to get too close to others for fear they would smell. Although the aide was clearly not doing their job, the consumer was hesitant to complain, for fear that the result might be no aide at all.
- Some participants said they are torn between wanting to ensure they have an aide and speaking up about issues with their aide. This observation about consumer behavior had been noted in interviews with provider agencies as well. They described cases where a consumer would tell

them that everything was going well, but the provider found out differently after the aide quit or was fired and months or years of issues and complaints suddenly spilled forth from the consumer.

- Consumers described trust issues surrounding aides in their homes. One example focused on the unease that resulted from an aide starting work for the consumer before issues were found in the aide's background search. Examples also included stories of past aides conducting theft and credit card fraud, as well as a tale of an aide thought to have told the consumer their life story in a manner to intimidate and frighten them before being told what the aide would and would not do. Some aides were suspected of looking around the consumer's home as if to take inventory and were thought to be looking for medication or money lying around.
- Some consumers noted long waits between aides, while others did not. It appeared that this might be related to, among other things, to whether the consumer lived near a bus line. There was the intent to test this premise by conducting a final session in a rural region. Unfortunately, increasing COVID case counts prevented these from being arranged with a rural partner.
- Lastly, an issue that came up in all sessions, but was not considered a major issue if there was a good relationship between the consumer and aide (and the aide could be mentored), was noted deficiencies in housekeeping skills of many aides. These deficiencies had also been highlighted in discussions with provider agencies (i.e., the "grilled cheese test"), and were noted to be particularly common in younger aides.
- Session attendees were clear on their thoughts on the characteristics of a good aide
    - Communicates well (listens/talks/asks questions) with the older adult being served. Consumers felt that most issues could be avoided or fixed if there was open, two-way communication between the consumer and aide. Some consumers felt that more conversation/companionship between the aide and consumer was a key part of the job, while others thought that only essential communication was needed.
    - Is courteous, trustworthy, timely, reliable
    - Works for a company that is professional, responsive, and accountable
    - Has a positive attitude, enters the consumer residence ready to work, relays confidence and capability
    - Has good hygiene, is vaccinated
    - Meets the consumer before the first visit; task list is agreed upon by the consumer, agency, and aide
    - Knows basic cooking skills, cleaning skills (including washing dishes and being willing to clean a toilet), laundry skills (including not overloading a washing machine & dryer and folding clothes)
    - Is an active member of the older adult's healthcare team – makes medical appointments, helps consumer with doctor- or therapist-prescribed home activities/exercises
    - Able to work with consumers with disabilities (limited vision, hearing, mobility, etc.)
    - Knows first aid
    - Is compassionate and flexible when the consumer's status and care needs change (e.g., when coming home from the hospital)
    - Unimportant is any race or ethnicity match/difference between the consumer and aide
- Consumers felt that aides did not always seem to have all the training needed for the job. They felt that some important subjects need to be emphasized or added to an aide's initial training:

    - Do NOT use your phone while working!
    - Communicate with those you serve, while you're working, and, if you are going to be late or will miss your work period, call!
    - Can you imagine yourself as an empathetic caregiver? Do you have the capacity to put someone before yourself?
    - First aid/CPR
    - Dementia training
    - Intergenerational training experiences
    - Dealing with challenging personality types
    - Customer focus training
    - Continuing education/training
    - Sharing realistic expectations
    - Technology use for recording information (for the older adult, as well as provider records)
- Lastly, in several sessions, particularly those with former aides, there was an understanding of the many good aides in the business, as well as an understanding of the difficulty of their jobs, the relatively low wages paid to them, and the transportation issues that many of them have.

IMPACT OF THE COVID PANDEMIC AND THE "NEW NORMAL"

In February 2020, less than 6 months into this project and a month after the first reported US COVID-19 case, the first known COVID outbreak occurred in a nursing home in Kirkland, Washington, infecting 27 of 108 residents and 25 of 180 staff members[31]. This resulted in the first COVID death in the U.S. and the first health care worker infected with COVID. Over the next two years, more than 200,000 long-term care facility residents and staff died of COVID. This number was at least 23% of all COVID-19 deaths in the U.S. (KFF). Because of the Federal Government's strong oversight of long-term care facilities, there was a centralized government pandemic response for nursing homes. Meanwhile, there was only a limited, fragmented, and delayed, response for HCBS, overseen by individual states. According to a September 2021 Government Accountability Office (GAO) report[32], CMS considered issuing regulations during the emergency, requiring states to provide monitoring information about HCBS, as it had done for nursing homes, but decided not to do so, citing a lack of infrastructure within CMS (such as exists for nursing homes) to take action on such information from HCBS providers. Unsurprisingly, although we know the number of COVID cases in long-term care facilities, there is no data on the number of cases of COVID among older adult consumers of HCBS or their paid caregivers[33]. There is data, however, that demonstrates that COVID was especially dangerous for older adults -- 75% of the million-plus COVID deaths over the last 2-1/2 years were adults 65 and over[34].

Anecdotally, we know that older adults and their families made many tough choices in the early days of the pandemic, due to widespread closures or the desire to prevent older adults from being around others that might infect them, especially in congregant facilities. In Ohio, five in six adult day program directors reported that with the pandemic, "participants had to move to higher and more expensive levels of care such as nursing homes and assisted living facilities"[33]. While some in-home care companies laid off workers, a greater number were short staffed. States did not uniformly recognize home care workers as "essential workers," as the Federal Government had done for workers in long-term care facilities and hospitals, delaying or preventing HCBS access to personal protective equipment (PPE), testing, vaccines, and hazardous duty pay. Additionally, because schools and childcare facilities were initially closed, some home care workers had to stay home for family reasons. Some families put services for their older family member on hold, choosing to care for their older loved one themselves. Lastly, with soaring national unemployment, the Federal Government's unemployment benefits (on top of state unemployment payments) meant that lower-wage workers (such as home health aides) could make more money by not working than they had working.

A study[35] of Michigan direct support professionals (six months after lock-down) found high DSP turnover was exacerbated by the COVID-19 pandemic because they often lacked access to paid time off if they became infected, had to quarantine, or lost reliable childcare. (Michigan DCWs). When interviewed, DCW's said that they (or a coworker) left because of testing positive for COVID-19 (12%), quarantine due to COVID-19 exposure (15%), fear of becoming infected (21%), childcare issues (16%), fear of infecting others (7%), family reasons (18%). It is expected that a survey of home health aides would have elicited similar results.

In the spring of 2020, with the arrival of the COVID pandemic and the temporary shuttering of many businesses in our region, it was clear that life had changed drastically (at least temporarily) and that new

thinking was needed to address the personal care aide workforce shortage locally. There was an unprecedented opportunity, with so many people out of work (and looking for it). This included restaurant, retail, and hospitality workers, many of whom have great people skills and on-the-fly problem solving skills. As of 20 April 2020, the National Restaurant Association[36] noted that "The restaurant industry, MORE THAN ANY OTHER INDUSTRY in the nation, has suffered the MOST SIGNIFICANT SALES & JOB LOSSES since the COVID-19 outbreak began." Indeed, "2 out of 3 restaurant employees have lost their jobs." An idea was born – to create a local program aimed at helping people, displaced by the coronavirus pandemic, to gain training and certification to become personal care aides. They would be able to find work in home and community based services in the short term, and even in the long term, as it is a flexible-schedule position that could fit with hospitality work, even when those jobs came back. The #OHIOSTRONGPCATRAINING program was developed in the spring and summer, including work to create partnerships with the Miami Valley Restaurant Association Ohio and with Ohio Job and Family Services in Montgomery and Greene Counties. While, ultimately these partnerships were not put into place at that time for a variety of reasons, partnerships with Ohio Job and Family Services locations serving the PSA 2 counties were deemed a good idea in the long-term. The #OHIOSTRONGPCATRAINING program was funded in late summer by a grant to the Area Agency of Aging PSA by the Administration for Community Living's Critical Relief for COVID-19 Pandemic Response funds and the Ohio Department of Aging. The program was promoted by a media campaign, including news releases to and interviews with local news organizations, social media posts, many letters and emails to businesses and business partnerships, and announcements to the Area Agency on Aging's provider community. The program (detailed in the next section) was launched in October 2020 and graduated 81 certified nurse aides with the pandemic response funding.

Initially in the PSA 2 area, the reduction in cases and the reduction in consumers essentially balanced out, with fewer available aides balanced by consumer cases put on hold. This changed by the summer of 2020, with the rise in missed personal care services found to be primarily due to "no available back-up," which had suddenly increased by 50% from the consistent level of the two previous summers. There was clearly no margin left in the local home health aide workforce. When asked about the workforce issue, leaders from area provider agencies noted:

- "With the stimulus dollars, we have experienced a higher turnover and no-call no-show rate than I ever have seen in my career!"
- "Our main issue is back up or fill in shifts when the primary caregiver calls off."
- "Workers have been incentivized by $300/week extra unemployment to stay home, that's $7.50/hr on a 40-hour work week."
- "It may be a temporary workforce until the McDonalds' and Burger King's open back up and are able to pay more than this industry."
- "We are focusing on retention."

Thus, the home care workforce shortage, which pre-pandemic had been thought to be exacerbated by an economic environment of very low unemployment (and high competition for workers) was no better during the pandemic level of very high unemployment (more than 36 million unemployment claims within the first two months[37]. However, no longer was competition for personal care aides a competition with retail, restaurants, and distribution centers only. There was now competition from

family and COVID concerns, disrupted childcare and remote schooling, and the greater money to be made from government unemployment benefits.

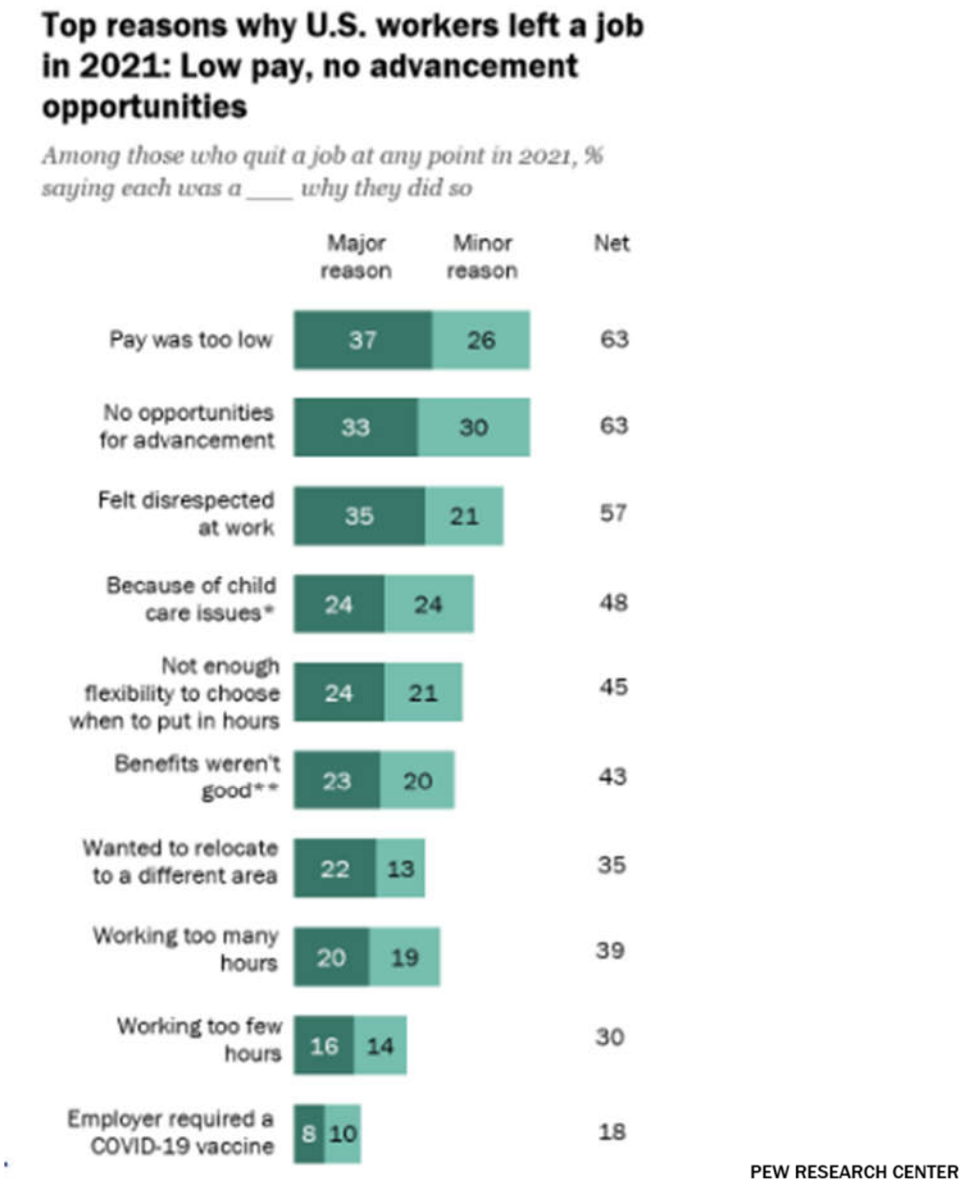
As the economy has started to move back to normal, it is not business as usual (pre-pandemic). In 2021, business media outlets focused attention on "The Great Resignation" and the great numbers of people that had left the workforce (or left specific jobs to go to another) during the pandemic. Some people who left the workforce had been at or close to retirement age and, with the higher risk at work for older persons of getting seriously ill or dying from COVID, decided to retire early. With time to consider their jobs, new inflation concerns, and a job market where there are 5 million more jobs in the U.S. economy than there are workers, workers have started to change jobs. Businesses have been offering higher pay and more benefits to lure workers across the wage spectrum, and in the past year, some 47 million Americans have changed jobs, according to the Bureau of Labor Statistics, jumping for the higher wages and other desirable attributes available at a variety of competitive positions. While switching jobs has a mixed reward history, now is one of the best times to do it, according to the Wall Street Journal. The pay differential between those who stay and those who changed jobs is growing, according to the Federal Reserve Bank of Atlanta. Job stayers, or people who stayed in their job for the past three months, increased their wages by about 4.7% as of June 2022. Meanwhile, those who switched jobs received a raise of 6.4%. The gap is the largest in two decades[38].

According to a Pew Research Survey[39], the number of job switchers is inversely proportional to salary, with 24% of low income employees quitting their job in 2021, 18% of medium income employees, and 11% of upper income employees. Their reasons for quitting in 2021 are shown in the figure below.

Unfortunately, low pay, few benefits, poor career advancement, and lack of respect are hallmarks of the home health aide job, and without changing this, it is reasonable to expect that aides that haven't yet gone job hunting soon will. Further, in addition to the more likely job switch of lower paid workers, the Pew survey found that adults younger than 30 (~70% of HHAs/PCAs) were more than twice as likely as older adults to have voluntarily left their job last year (37%), while those with less education were also more likely (22% of those with a high school diploma or less, which account for 54% of HHAs/PCAs).

Worse yet, the "turnover tsunami" is not expected to abate soon, according to the new Job Optimism Survey from Robert Half International Inc., which found this summer that 41% of U.S. workers plan to look for a new job in the second half of 2022. The survey found younger workers are most likely to pursue new jobs -- more than half (53%) of those aged 25-40 will be looking for new jobs – as are working parents (50%). In the survey, 65% of respondents noted an increased salary would be the main reason they would look for a new job[40].

Two and a half years since the pandemic began, and not yet post-pandemic, home care agencies in Ohio are turning away three out of every four referrals, according to the Ohio Council for Home Care and Hospice[41]. Similarly, the number of unserved and underserved consumers in our area continues to grow, reaching into the hundreds. Helping to lessen these are the #OHIOSTRONGPCATRAINING program, which has resulted in more than 75 personal care aides for staffing Area Agency on Aging cases through the PSA 2 provider network (from Fall 2020 through 2022), and an Area Agency on Aging PSA 2 participant-directed care (PDC) support program, which has resulted in more than 70 consumers staffed through PDC[42]. These have both undoubtedly helped the personal care aide workforce shortage in our area, but unfortunately, they have lessened but not stopped the bleeding. There is hope though.



As of 2021, the federal government made plans to address LTSS and other key parts of the country's social safety net. The American Rescue Plan Act of 2021 (ARPA for short) was passed, with short-term help for Medicaid expenditures for HCBS. According to an administration post on Medicare.gov in 2021:

> "The COVID-19 public health emergency (PHE) has laid bare the risks of institutional and congregate settings for older adults and people with disabilities, underscoring the urgent need to reduce the reliance on institutional services and expand access to high-quality home and community-based services (HCBS) to improve outcomes for people with long-term services and supports (LTSS) needs. HCBS allow millions of Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings.

> Consistent with many beneficiaries' preferences for where they would like to receive their care, HCBS have become a critical component of the Medicaid program and of broader efforts across the federal government to promote community integration of older adults and individuals with disabilities. As the primary funder of HCBS nationally, Medicaid plays a critical role in supporting states' efforts to strengthen these services for their beneficiaries. In November 2020, CMS released a toolkit to help states to rebalance their LTSS systems by increasing the share of spending and service use delivered through HCBS, relative to spending and services provided through institutional care.
>
> On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS beginning April 1, 2021, and ending March 31, 2022. States have until March 31, 2024 *(later extended to March 31, 2025)* to spend the additional funding they draw down. This increased funding, an estimated $12.7 billion, represents a rare opportunity for states to identify and implement changes aimed at addressing existing HCBS workforce and structural issues, expand the capacity of critical services, and begin to meet the needs of people on HCBS waitlists and family caregivers."

In our current economic environment, it is clear that significant (and likely long-term) investments in the HCBS workforce will be critical to keeping it from imploding. ARPA may enable this to start. Not surprisingly, workforce is at the center of Ohio's and most states plans, although it should be recognized that this workforce being addressed is not limited to the workforce caring for older adults in the home. It also includes at-home nursing and various community services for older adults and a variety of HCBS services for people with physical disabilities, intellectual or developmental disabilities, behavior health issues, children with complex medical conditions, and other specific populations. In September 2021, ADvancing States[43] tabulated the features in the states' initial ARPA plans and found that most included increased wages and/or bonus payments for workers, including retention bonuses. Recruitment initiatives were also proposed. Additionally, some states proposed more strategic plans to address workforce capacity, training, data infrastructure, career ladders, and benefits. It is hoped that these efforts will lead the way to the development of more stable, respected, high quality HBCS workforces.

The Ohio ARPA plan[44] is shown in the table below. The largest share of the funding is allocated for one-time direct payment to HCBS providers in recognition of the essential work performed and for relief from the negative economic impacts experienced during the ongoing COVID–19 public health emergency. Providers will be required to include investment directly into their staff through retention/sign-on bonuses. The second largest funding allotment is slated for the HCBS Workforce Development Strategic Plan, which is to be overseen by a multi-agency workforce team formed by the Ohio Department of Medicaid, the Ohio Department of Mental Health and Addiction Services, the Ohio Department of Developmental Disabilities, and the Ohio Department of Aging. The team will create a "recruitment initiative that will identify and implement data-driven strategies for recruitment, including efforts that acknowledge and incorporate the opinions and suggestions from the HCBS workforce. The work will include an assessment of needs across the state and partner with local universities, career technical schools, community colleges, and workforce boards to build out the needed capacity with a goal of establishing a stable pipeline of workers for the field, allowing ongoing efforts to be sustained.

Each of the initiatives funded will focus on the HCBS services workforce and will enhance, expand, and strengthen HCBS in Ohio. To complete this work and to quickly respond to this intense demand, a dedicated team will be needed through either a state team, a consultant/vendor, or public-private partnership where expertise can be leveraged."

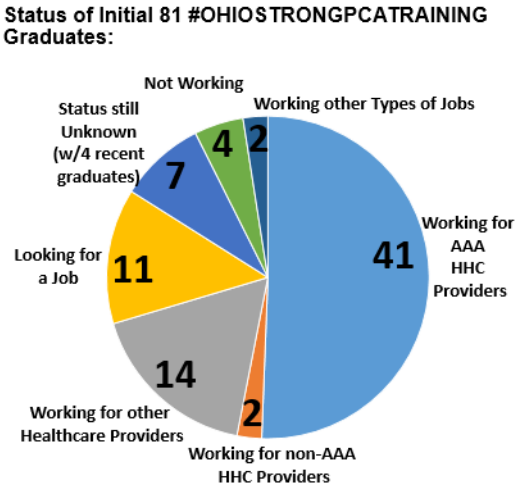
Although Ohio is to be strongly commended for allocating so much of its funding to long-term workforce strategic development efforts, after a year, there has been limited ***apparent*** progress to date sharing the results of a needs assessment and defining the team's overarching strategy for partnering, for how the requisite data will be gathered, for how initiatives will be identified (beyond some ideas listed in the initial Ohio ARPA plan) and incorporating the opinions and suggestions of Ohio's HCBS workforce, and for how final initiatives will be selected and money allocated to them.

JOINT ARPA HCBS Proposals	Proposed Total Funding (w/Match)	Proposed HCBS Allocation (State Share)
1. Immediate Provider Workforce Relief		
Provider Workforce Support Funding	$469,552,919	$164,343,522
Subtotal Provider Relief	**$469,552,919**	**$164,343,522**
2. Workforce Support - Sustain and Expand		
HCBS Workforce Development Strategic Fund	$212,000,000	$212,000,000
System Supports for HCBS Workforce	$18,000,000	$9,000,000
Subtotal Workforce Support	**$230,000,000**	**$221,000,000**
3. Technology Enhancement		
Improvements in Information Technology and Program Infrastructure	$20,000,000	$10,000,000
Using Telehealth and Technology to Support Individuals in the Community	$15,000,000	$7,500,000
Developmental Disability Technology Advancements	$20,000,000	$10,000,000
Subtotal Technology Enhancement	**$55,000,000**	**$27,500,000**
4. Other Program and System Enhancements		
Address Gaps in Services	$27,500,000	$13,750,000
PACE Expansion	$50,000,000	$50,000,000
Supports for Individuals Receiving Services and Informal Caregivers	$63,000,000	$56,500,000
Eliminating Disparities and Addressing Social Determinants of Health	$20,000,000	$10,000,000
Multi-System Youth	$33,500,000	$11,725,000
Developmental Disability Enhancements	$15,500,000	$7,750,000
Subtotal Other Programs and Enhancements	**$209,500,000**	**$149,725,000**
Grand Total	**$964,052,919**	**$562,568,522**

CNA Training for Displaced Greater Dayton-Area Workers (#OHIOSTRONGPCATRAINING)

The #OHIOSTRONGPCATRAINING program was created in the spring of 2020 to be a win-win program to train pandemic-displaced workers for HCBS jobs caring for the elderly and the disabled in their homes. The Ohio Department of Aging funded this program from Administration for Community Living's Critical Relief for COVID-19 Pandemic Response funds to ensure long-term care services were available to those in need both during and after the pandemic. The program was launched in the fall of 2020 and funded Certified Nurse Aide training, given by local licensed providers, for pandemic-impacted workers. The program was set up to have people working as an aide in approximately 3-6 weeks of their application into the program. Applicants submitted a completed application and signed commitment form, and after review, a check of required databases (in accordance with OAC 173-9-03) was conducted. Assuming these yielded an impact of the pandemic on the applicant and no hindrances to him/her working in HCBS, the application was accepted, and the applicant was sent to one of four external training sources that had agreed to work with the program. Payment for the attendee's training was paid to the training source directly after their registration and, in most cases, after training conclusion. With applicants recommended by selected providers, we were also able to work with the provider to pay for a stipend and other expenses for the candidate during training. For applicants not referred by a specific provider agency, a virtual job fair was planned to be held to facilitate applicant introductions to agencies within the PSA 2 provider networker. Unfortunately, with only a handful of students graduating at a time, this ended up being limited to information being emailed to each graduate about providers hiring at that time and an offer to help, if needed. It was unfortunately clear, after the fact, that more help than this was needed by some graduates to get a job.

The program continues to this day. The ACL / ODA COVID-19 Pandemic Response funding was fully spent in September 2021. Through those funds, 81 people completed program training. The status of those graduates at that time is shown below. An assessment of the program yielded confirmation that candidates had come from across the Dayton metro area, with a majority from Montgomery County.



Participants had come from a variety of prior jobs in a number of different industries – food service, health care, retail or service industry, factory work, childcare, and others. While the most number of trainees had previously worked in health care, retail sales, and fast food service, trainees had also previously been in occupations as diverse as a machinist, an airline employee, a freelance designer, a phlebotomist, and a managing cosmetologist. We found a loose correlation between the likelihood of a candidate's graduation from training and their previous job tenures and the level of responsibility or expertise required for those previous jobs. We found that people who had previously committed to jobs and had gained the expertise required for them were more likely to commit to PCA training, complete training, and find an aide position. Additionally, we determined that working closely with provider agencies in the PSA 2 network was key to advertising the program, mentoring participants, and hiring them after graduation.

In August 2021, Montgomery County approved the use of Human Services Levy funding for the program. Since then, 74 people have graduated, bringing the total number of graduates to 155. Follow-up with the latest graduates confirms that more than 50% of them work in HCBS, with 48% working for providers in the Area Agency on Aging provider network.

Unfortunately, despite the success of this program, the ability to refer new home health cases to the AAA provider network still remains difficult. Many older adults in the PSA 2 region are currently underserved or underserved. Data is not available to confirm, but we suspect that the number of this program's graduates is less than the number of aides lost to other opportunities in this "great resignation" employment environment.

BENCHMARKING OF PCA WORKFORCE ISSUES

The long-term services and supports landscape is complex. While Medicare pays 52% of LTSS revenues, out-of-pocket payments account for 16%, private long-term care insurance 11%, and the remaining 20% comes from a variety of other public sources, including the Department of Veterans Affairs, the Older Americans Act, other non-Medicaid state programs, and Medicare Advantage plans[45]. Each source has its own unique set of eligible recipients and rules & regulations. Additionally, for Medicaid, each state's program looks different. While federal regulations require that all Medicaid programs share some common characteristics and must cover a range of acute and post-acute care benefits for all Medicaid-eligible individuals, eligibility requirements and covered services are laid out by each state in a "state plan" that the Center for Medicare and Medicaid Services must approve. Personal care at home is not one of the services that must be included in the plan, but it is included in states' plans to restrain nursing home costs, meet Olmstead requirements, etc. However, to contain the rising costs of home care, states can limit the number of beneficiaries or the amount of services provided through Medicaid HCBS waiver authority[4]. So, in addition to the many differences between states related to population, wealth, and political culture, the long-term care landscape between states varies. This complicates benchmarking of HCBS practices and new ideas. Nonetheless, because of the magnitude of the personal care aide workforce challenge, there have been a number of different approaches taken to, among other things, raise the visibility of the workforce shortage issue and the public's understanding of the importance of this work, increase pay and benefits for personal care aides, increase aide career opportunities, strengthen aide training and care quality, etc. These are described below. It should be noted that with the unique opportunity afforded by the 10% increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS from the American Rescue Plan Act in mid FY2020 (March 2021), the number, scope, and innovation level of states' initiatives has dramatically increased. That said, not all have full final approval from the Center for Medicaid Services yet, and the level of detail in the published plans varies greatly. Also, the effectiveness and impact of most of these efforts will not be known for several years.

1) State Level Emphasis / Legislative Advocacy on HCBS:

Advocates for LTSS have worked for a number of years to reform various aspects of their state's system[46]. ***Hawaii*** has the longest history at attempting reform, reaching back to the 1980's. Much of their efforts have been on legislation to create and fund programs supporting family caregivers, including those whose older family member does not qualify for Medicaid. The Kupuna Caregivers program, begun in 2017, provides up to $70 per day to unpaid family caregivers of older adults to cover the costs of adult day services, home-delivered meals, homemaker services, personal care, respite care, and transportation. Reform initiatives in ***California***, ***Washington*** and ***Minnesota*** date back to 2012-2013 (and even earlier considering efforts in the 1980s and 1990s focused on rebalancing state and Medicaid funds toward home and community-based services). Their focus has been on legislation to create alternative LTSS programs. The state of ***Washington*** passed the first state mandatory long-term care insurance program (The WA Cares Fund)[47] in 2019 which will help pay for eligible long-term care related expenses. WA Cares Fund provides everyone with a modest level of coverage ($100 per day, up

to a lifetime benefit of $36,500, which will be adjusted annually for inflation) at an affordable cost. People who want more can buy supplemental private insurance, akin to how Social Security and 401(k) plans work together. Workers will begin contributing to the program in 2023 and benefits will begin being paid to eligible persons in 2026. Additionally, ***Michigan***[46] recently commissioned a study to explore the feasibility of a universal long-term care insurance program, including workforce considerations[4]. The state of ***Maine***[46] had a failed ballot initiative in 2018 to create The Universal Home Care Trust Fund, which would have provided in-home assistance to all residents of Maine aged 65 years or older and to people with disabilities. Funding would have come from increased taxes on higher wage earners. The initiative failed, in part, due to a lack of support from legislators and both gubernatorial candidates that year. In 2013, **Minnesota**[48] passed legislation creating the Community First Services and Supports (CFSS), a new care program, offering those who need home services more choice, control and flexibility. It has two models from which a consumer can choose. In the first, the agency provider model, the older adult selects a provider that serves as the caregiver's employer. The agency will recruit, hire, train, supervise and pay CFSS support workers. In the second, the budget model (elsewhere known as a consumer-directed model), the older adult will employ their own support workers and have a budget rather than service units. He/she will be responsible for the recruitment, hiring, training and supervision of these support workers, with the aid of a financial management services provider to help the consumer comply with applicable laws. The CFSS program will begin in late 2022.

Colorado, ***Wisconsin***, ***New Jersey***, ***North Carolina***, ***Michigan***, and ***New Mexico*** have more recently begun the stakeholder engagement and policy development process leading to new LTSS legislation[46]. In 2019, ***Colorado*** passed legislation implementing a minimum wage of $12.41/hour for direct care workers, setting requirements on how funding was spent, and appropriating the funding for it[48]. They raised the minimum wage for DCWs in a HCBS setting to $15/hour in 2022[49]. In 2019, the Governor of ***Wisconsin***[50] signed an executive order establishing the Governor's Task Force on Care Giving (including legislative members and members from the LTSS and workforce communities) to analyze strategies to attract and retain a strong direct care workforce, support families providing care for their loved ones through respite services and other support, and establish one or more registries of home care providers and develop a plan to provide referral or matching services for individuals in need of home care. The Task Force delivered their final report with sixteen defined recommendations in late 2020. It appears that one of these sixteen recommendations (focused on training) will be financed by ARPA funding. In 2020, ***New Jersey***[48] passed legislation establishing a Special Task Force on Direct Care Workforce Retention and Recruitment at the Department of Labor and Workforce Development. This Task Force is to, among other things, evaluate current direct care staffing levels in the state and develop recommendations for legislation, policies, and short-term and long-term strategies for the retention and recruitment of direct care staff. No public notice of recommendations has yet been released. ***North Carolina***, ***Michigan***, and ***New Mexico*** worked with PHI to create the 2020 Essential Jobs, Essential Care multi-state advocacy initiative[51]. The initiative was aimed at improving jobs for direct care workers at the state level by focusing over two years on advancing policy solutions for direct care workers through increasing wages and reimbursement rates, promoting workforce innovations, and improving data collection. **New York** and **New Jersey** were added to the initiative later. Michigan's IMPART Alliance pursued strategies which include development of a Policy Roadmap and establishment of a statewide DCW Coalition with a wide and diverse stakeholder membership. The coalition has grown rapidly over the past year, as they build a movement they hope can approach policy makers with a unified voice and

consistent messaging and make a big impact through collective action. Noteworthy to date is the 2022-2023 budget that ***North Carolina***[52, 107] recently passed that includes a number of budget items to help stabilize the direct care workforce. It provided a one-time bonus for eligible direct care workers up to $2,000 and increased Medicaid reimbursement rates to HCBS providers to enable increased direct care worker wages. It is the ***intent*** of the General Assembly to ***assist*** in increasing the hourly wages of direct care workers to a minimum of $15 per hour, therefore providers receiving a rate increase will be ***encouraged*** to use at least 80% of the funding that results from that rate increase to increase the rate of pay paid to its direct care employees.

All of the endeavors have involved multi-year efforts focused on developing and mobilizing a groundswell of demand for policy changes into specific programs. Several involved small expenditures in sequential years to first assess viable alternatives and financial viability. Increasing success has been associated with efforts with bipartisan legislative support and new money, which bodes well for the many state efforts conducted now under ARPA funding.

In early 2021, The Center for Healthcare Strategies (CHCS)[48] conducted a scan of 11 states (***Colorado***, ***Illinois***, ***Indiana***, ***Iowa***, ***Massachusetts***, ***Minnesota***, ***Nevada***, ***New Jersey***, ***Tennessee***, ***Washington***, and ***Wisconsin***) to look at how their ARPA plans will support direct care workers. Each state has their own approach to using ARPA HCBS Medicaid increases. While most are focused on providing financial assistance to providers, there is also a focus on training. ADvancing States[43] quickly characterized the initial ARPA plans of ***all 50 states***. They found that the biggest areas that states were planning to focus on were: general program improvements (23 states), strategic plan development (19), rate increases (28), rate/actuarial study (25), requirements for funds to be passed down to direct care workers (18), DCW bonus payments (15), bonuses for recruitment and retention (29), pay for performance (15), provider training and certification (38), caregiver support (24), transition services (22), and general technology improvements (19).

2) Coalitions/Unions:

As noted previously, ***North Carolina***, ***Michigan***, and ***New Mexico*** worked with PHI to create the 2020 Essential Jobs, Essential Care multi-state advocacy initiative[51]. This initiative not only focused on advocacy, it involved coalitions in each of the participating states. ***Michigan*** State University-led IMPART Alliance's coalition includes researchers, direct care workers, consumers, agencies and others working together for solutions to developing a competent direct care workforce (https://www.impartalliance.org/). While the coalition has action alerts with talking points and a method for enabling members to easily send messages to the Governor and their state legislators through a free text messaging service, the coalition does not appear to have any legislative or lobbying members. The ***New Mexico*** Caregivers Coalition (NMCC) was created more than a decade ago, through funding from the Developmental Disabilities Planning Council, to advocate for and support paid professional caregivers as well as family caregivers. The coalition touts its membership of 4,500 agencies and individuals and the benefits it has brought to many (https://www.nmdcc.org/). Its focus appears, like Michigan, to be on supporting individual caregivers and not on strategic workforce program development or advocacy. The relationship does not appear to be close with state leaders, as the CEO of NMCC was quoted saying to PHI[50], "….The administration has got to reckon with us now. They know

we've got good ideas and great policy proposals." ***North Carolina***'s coalition is a diverse mix of consumer, provider, and advocacy organizations that represent the state's aging population and speak on its issues. In June 2021, North Carolina Coalition on Aging, jointly with PHI, provided recommendations to the North Carolina Department of Health and Human Services (NCDHHS) on allocation of ARPA dollars. Two of its four recommendations, to increase home care worker wages (toward $15/hour) and to create a Home and Community Based Services (HCBS) Fund, which, among other things, can fund pilot projects to improve recruitment and retention of home care workers (https://nccoalitiononaging.org). In ***Indiana***[53], the Family and Social Services Administration (FSSA) created a Direct Support Workforce Advisory Board, choosing 17 of more than 90 DCW applicants to represent a variety of settings, regions, backgrounds, education, experience, and populations served. This board meets at least once a quarter and is currently contributing ideas and feedback to the state's Indiana Direct Support Workforce Plan.

It is clear that coalitions can be an important part of effectively strengthening and sustaining the direct care workforce, including their support of direct care worker individuals, their information gathering and release to stakeholders and the public, their creation of "burning platforms" critical for significant change, their focusing of plans and messages, and lastly their advocacy to state government. It is also clear that this cannot be addressed piecemeal, but instead needs a comprehensive approach involving advocates, providers, consumers, direct care workers, and state government.

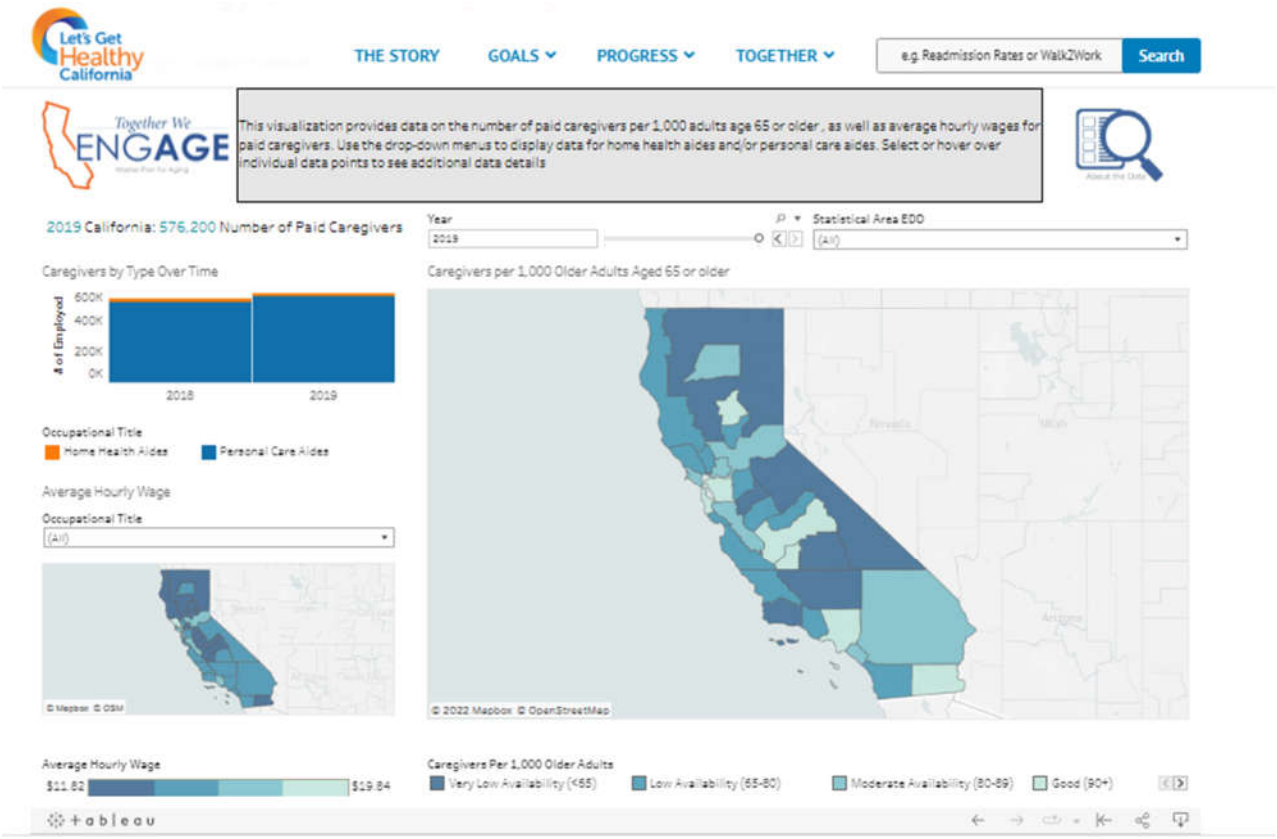
While few direct care workers have unionized, the Service Employees International Union[54] has organized home care workers in a number of states, including ***Washington***, ***Montana***, ***California***, ***Minnesota***, ***Iowa***, ***Missouri***, ***Kansas***, ***Illinois***, ***Indiana***, ***New York***, ***Connecticut***, and ***Massachusetts***. In ***Connecticut***[55], collective bargaining for personal care assistants (PCAs) was first authorized by gubernatorial executive order, then implemented through an enabling statute. This resulted in dramatic increases in wages, paid sick leave, dedicated training funds, and other benefits negotiated through a statewide PCA Workforce Council. Additionally, all PCAs who do not qualify for Husky/Covered CT (or have access to health insurance through another job, spouse or parent) are eligible for a Premium Assistance card equal to 6% of annual income to buy health insurance on the exchange. In ***Washington***[55,] collective bargaining has allowed for increases in the direct care worker wage scale overall, as well as a broad compensation package that includes health care, vision, and dental benefits; paid time off; and retirement savings (the first of its kind in the nation for people who provide in-home care). For members in ***Massachusetts***[56], the latest union contract kept workers their 10% pandemic pay ($18 per hour), which had been set to expire in June 2022. Plans are for bargaining toward $20/hour in 2023. In ***California***[57], San Francisco union members won wages of $18.75 per hour, "a new standard for home care workers."

3) **State Data on HCBS:**

According to a September 2021 Government Accountability Office (GAO) report[32], CMS "considered issuing regulations during the emergency requiring states to provide monitoring information about HCBS, as it had done for nursing homes, but decided not to do so," citing a lack of "infrastructure within CMS (that exists for nursing homes) to respond to such information from HCBS providers." Beyond enabling what might, in the future, be required for federal government oversight (such as what might

have been required if the Build Back Better Act had been enacted) there is a case to be made that it is difficult for a state to assess unserved or underserved HCBS cases or the capacity of the HCBS system to address them without a system of data. In 2021 study of Michigan DSPs[35], 44% reported working in more than one setting (MI DCW 6-month follow-up). All indications are that home care workers do the same, working for multiple agencies to maximize their schedule and finances. Additionally, as in other job fields, there are indications of aides switching agencies to maximize wages, so it is difficult to tell whether new hires are job switchers. So, even a metric as simple as the number of the number of people serving as home health aides / personal care aides is unknown. The real capacity of the HCBS system and evidence on how it is impacted by economic environment, state policies and programs, and demographics cannot be currently measured or conveyed to stakeholders (including the public). Thus, while most states understand anecdotally that they have an insufficient supply of home health workers, tracking those numbers and making those figures publically available can help state leaders and HCBS stakeholders act in a timely fashion, plan effectively for the future, and analyze improvements with specific programs and over time.

In 2015 and 2016, because no state data system was available, the ***Wisconsin*** Personal Services Association[20], representing home care agencies in the state, surveyed its membership asking about staffing challenges. Although they did not ask detailed questions about retention and turnover and retention, they found that 9 out of 10 providers were having difficulty finding staff to fill open cases. In 2016, ***Iowa*** Workforce Development[3] worked with nonprofit advocacy organization Iowa CareGivers to survey hospitals and long-term care providers on staff vacancies, benefits, work hours, hiring issues, and



barriers to retention. They found a combined vacancy rate of 15% for personal care aides and home health aides, with "lack of applicants" being the most commonly cited explanation.

In ***California***[58], however, Governor Gavin Newsom not only issued an executive order in 2019 calling for the creation of a Master Plan for Aging, but also calling for an associated Data Dashboard for Aging to track progress toward the Plan's targets over ten years. The Data Dashboard is publicly accessible and user-friendly, and can be found at https://letsgethealthy.ca.gov/mpa-data-dashboard-for-aging/. An example of data that can be found in the database is shown above.

Colorado[49] is planning, in initiatives under ARPA, to pay providers retention and hiring bonuses for direct care workers and, in parallel, expand their data infrastructure to better understand the current supply and demand for the direct care workforce, and provide data for evidenced-based effects of workforce investment strategies. The data collection process will also provide the Department with information on provider compliance and pre and post wage data. In ***New Mexico***[51], the inclusion of related workforce data collection provisions in the state's HCBS spending plan will inform future legislative decisions. Similarly, ***North Carolina***'s HCBS spending plan[51] also includes, on PHI's recommendation, a workforce survey initiative designed to identify key workforce challenges and generate recommendations for statewide, systems-level solutions.

The vision of a state HCBS data system[3] would include an improved and integrated data monitoring and reporting systems in home care to facilitate better understanding of the workforce shortage and the connections between workforce investments, recruitment and retention, and care quality outcomes. Online data registries have the benefit of producing data that states can use to further understand the composition of their direct care workforce and identify gaps.

In 2017, ***Massachusetts***[4] passed a law requiring a public registry for home care workers in its State Home Care Program. The registry verifies the type of training received and credentials earned by these workers, allowing employers to make hires without duplicating training. ***North Dakota***[55] includes "unlicensed assistive persons" in its direct care workforce registry. These individuals are able to assist registered nurses under their direction. ***Texas***[59] will be contracting, under its ARPA funding, to develop a Texas-specific direct care employer registry, to enable direct care workers and employers (including consumer-directed employers), to "find the best fit for open positions."

4) Pay/Bonuses/Reimbursement Rates/Living Wage:

A survey published last winter from the John A. Hartford Foundation[108] found that Americans strongly support raising wages for direct care workers, especially when they found out how low the current wages are. Seventy-two percent of survey respondents overestimated how much direct care workers make, and after being given wage details, 73% thought that DCWs were underpaid.

As discussed previously, fundamental to the instability in the home health care workforce are the relatively low wages paid to these workers, because of limited Medicaid reimbursement rates. This manifests in many home care workers living below or just above the poverty level and receiving government benefits. A recent study[55] in New York demonstrated that raising wages for DCWs (from

approximately $22,000 annually to $40,000 in New York City, $35,000 on Long Island and in Westchester County, and $30,000 for the remainder of the state) would significantly reduce Medicaid enrollment. Wage increases, health care coverage, and payroll taxes would cost approximately $4B for New York State annually; however, the combined value of new savings, tax revenues, and stronger economic impact due to increased compensation would result in a net gain of $7.6B for the state.

Because of concern that higher reimbursement rates will benefit providers with little passed on the home health care workers, some states' higher reimbursement rates have also included "wage pass-throughs," requiring that a given percentage of the increase be passed through to the home health care workers. ***Minnesota*** has already required via statute, that 72.5% of Medicaid payments to home care agencies go directly to worker compensation, while ***Texas***[59] allows personal care providers to access additional rate add-on funding if they agree to spend 90% of it on worker wages that are not increased on an on-going basis.

Wage pass-throughs are not a cure-all, however, particularly if they are too low to make a meaningful difference, if they are enacted on only a short-term basis, or if they are not carefully monitored to ensure implementation. This last point requires robust data to ensure that wage pass-throughs for workers are implemented as intended. A telling warning of what can happen if that doesn't happen comes from ***Massachusetts***[3] nursing homes. In 2017, the state allocated $35.5M to boost wages for nursing assistants. In 2018, however, the state found that 12 nursing homes had not distributed those funds to workers as expected.

However, limited evidence indicates wage pass-throughs are a viable option for improving home care workers' compensation. An early study[3] of data from the 1996 and 2001 panels of the Survey of Income and Program Participation found that nursing assistants, home health aides, and personal care aides in states with pass-through programs (23 states at the time) earned as much as 12% more per hour than the same workers in other states, after the pass-throughs were implemented.

Because higher wages may not enable an aide to support their family, particularly if the aide is the sole provider and there are children in the household, calls for "living wages" have increased. PHI[3] has recommended that quality jobs for direct care workers require a living wage that accounts for the local and regional cost of living (a formula based on common expenses such as housing, food, clothing, transportation, and more). This living wage would be set as a base wage, with benefits, raises, bonuses, and other job supports layered on top. Because direct care workers' median wage of about $12 per hour, which has remained virtually stagnant over the last decade, drives many of these workers into poverty or out of this sector, establishing a base wage for direct care that is aligned with the cost of living would make it affordable for workers to pursue these jobs. Since PHI has not defined what the formula for a base wage would look like, MIT's Living Wage calculator (https://livingwage.mit.edu/metros/19380) was used for Dayton, Ohio. Because the calculator considers the living wage for a family unit, it factors in the number of adults providing for the family and the number of children in it. For Dayton, a living wage[60] would vary from $11.67 per hour (for each of two working adults in a family with no children) to $23.92 per hour (for a family of two adults, no children, with a single breadwinner) to $55.25 per hour (for a family with a single breadwinner and three children). Despite the various assumptions that could be used to determine a living wage rate, it is clear that these wages would be significantly higher than those that currently fit into Medicaid reimbursement rates. Currently, the ***District of Columbia*** funds LTSS providers who, by regulation, must

pay personal care aide wages to meet a living wage requirement. The current DC Minimum Wage and Living Wage[61] increased to $16.10 on 1 July 2022.

In two ***California*** studies, the relationship between wages and HCBS worker retention were determined in the early 2000's. In the first study[3], the impact of wage and benefit increases (during a 52-month period from November 1997 to February 2002) on retention rates were determined for 18,000 independent providers in the In-Home Supportive Services (IHSS) program in San Francisco. The findings showed that a near doubling of wages and the addition of health care benefits was associated with an 89 percent increase in the annual retention rate of new workers and a 57 percent decrease in the turnover rate. In a 2004 study[3], the impact of wages and benefits on recruitment and retention among 2,260 independent providers working in eight counties in California showed that two-thirds of respondents reported that commitment to their consumer was the most important factor in their job selection, and flexibility was the second most important reason for taking the job, regardless of wages, benefits, and personal characteristics. However, wages became a significant recruitment and retention tool when they rose above $9 per hour (in 2004 dollars -- or about $14.13 per hour in today's dollars), for both family and non-family providers. The implication from these findings is that recruitment can be improved with higher wages when wages reach a minimum threshold. While it is unlikely that $14.13 per hour would be a ***significant*** recruitment tool today, it is clear that years of stagnant wages have eroded the competitiveness of direct care worker jobs and the companies out recruiting for them, and significant increases in pay could be an important recruitment and retention tool.

Fifteen states[3] reported implementing wage increases for direct care workers in fiscal year (FY) 2018, and 24 states reported increases for FY19. Fourteen states reported wage increases for both years. Most increases were small. Twenty-nine states[55] are using ARPA funds to provide bonuses to DCWs specifically for recruitment and retention, and six states will offer higher wages for completing certain classes. ***Montana***[4] implemented a rate increase through the 2017 budget process that specifically raised direct care worker wages. For developmental disability service providers, the new law required an increase in wages of at least 75 cents an hour per employee. For other home care workers, the law mandated a wage increase of $1.50 an hour per employee in 2017, and a further increase of $2.25 per hour in 2018. The law restricted these increases to direct care workers only and explicitly excluded licensed nurses or other members of staff. ***Massachusetts*** and ***Texas*** used Balancing Incentive Program (BIP) funding[3] for slightly increased wages for home care workers. Massachusetts increased home care workers' wages by 5% while Texas increased attendant care workers' wages from the state minimum of $7.25 to $7.86 per hour, then to $8.00 per hour. ***Wisconsin*** has increased rates for all HCBS direct services by 5%, to address an immediate, on-going, unmet funding need in all service areas and is including the funding identified by an HCBS ARPA funded actuarial firm to ensure future Wisconsin HCBS service access and stability.

New models in the HCBS landscape that impact the payment and delivery of LTSS also present opportunities to invest directly in the home care workforce. For instance, states can include, in contracts with MLTSS plans or value-based payment arrangements, standards related to compensation or other workforce quality standards. ***Tennessee***, ***Arizona***, and ***Pennsylvania*** have also included workforce requirements in their managed care contracts[3]. Arizona recently required managed long-term care organizations to collect workforce data, develop workforce development plans, and coordinate with providers to implement workforce interventions. In Pennsylvania's new managed care system, plans are

required to promote direct care workforce innovation through training, advancement opportunities, and participation in care coordination activities.

Several states have set minimum wage requirements for direct care workers who are funded through Medicaid, while others have set a minimum wage for entire sectors of the direct care workforce. The latter approach is more effective to ensuring all DCWs receive pay increases, regardless of setting, program, or payer. In April 2020, DCWs in ***Michigan*** received a $2.00 wage increase in the wake of the COVID-19 pandemic, using CARES Act funding. In October 2021, the wage increase was included in Michigan's state budget with a bump to $2.35 per hour[14,62]. Stakeholders and advocates in the state are looking for ways to help the state make the pay increase permanent[63]. Effective this year in ***Colorado***, a $15.00 per hour base wage requirement for all Direct Care Workers in HCBS settings went into effect using ARPA funding[64]. Although state DCWs have called for a living wage of at least $24 per hour[65], $15 per hour is the current base wage that will be effective through mid-April 2023, after which the General Assembly will decide whether to pass a permanent rate increase. In ***New Jersey***[55], legislation established a minimum wage for nursing facility certified nurse aides that is $3 higher than the statewide minimum wage (upon reaching $15/hour in 2024, the statewide minimum wage will be indexed to the Consumer Price Index). Since the minimum wage was increased in 2018, the governor's budget proposals have included annual rate increases to support competitive wages for direct support professionals, personal care assistants, DCWs in nursing homes, and home health aides, as well as maternity care providers, private duty nurses, community-based mental health and substance use disorder providers, and homeless shelter staff. In July 2021, the Governor earmarked $240 million for wage increases for direct support professionals, certified nurse aides, personal care assistants, Medicaid transportation providers, and childcare workers.

Some states have begun to provide one-time or recurring cash stipends to DCWs. While one-time payments do not have the impact of permanent wage increases, they do signal to direct care workers that they are valued and do have potential to improve morale. ***California***[55] provided $500 to all direct care workers during the first year of the COVID-19 pandemic. Later, this policy was embedded in its ARPA spend plan, which provides additional "Care Economy" payments to all DCWs. During the pandemic, California also provided hotel room reimbursement for DCWs who wished to protect their families because they were supporting care recipients who had tested positive for COVID. ***North Carolina's***[52] 2022-2023 state budget provides a one-time bonus for eligible direct care workers up to $2,000 and increased Medicaid reimbursement rates to HCBS workers providers to enable increased direct care worker wages for DCWs who provide care to Medicaid and NC Health Choice beneficiaries. The General Assembly's intent is to increase the hourly wages of direct care workers toward a minimum of $15 per hour, therefore providers receiving a rate increase will be required to use at least 80% of the funding that results from that rate increase to increase the rate of pay paid to its direct care employees.

Lastly, with regard to pay, direct care workers need sufficient hours or full-time equivalent guaranteed. They cannot always pay their bills if a consumer suddenly dies or goes into the hospital, for instance. States can explore strategies for ensuring the DCWs have a choice of whether to work part- or full-time, that their hours are stable, that those working part-time have benefit options, and that overtime hours are compensated appropriately. Employers' long-standing reliance on part-time labor, including the direct care workforce after overtime labor requirements were ruled applicable, has had a definite impact on the creation and sustainment of the country's labor shortages.

In ***Ohio***, Cincinnati's Council on Aging conducted a six-month trial of increasing pass-through wages for home health aides and personal care aides serving older adults in Warren County homes. The reported results were mixed, but it may have impacted surrounding counties as, at the time, aides appeared to prefer to want to work in Warren County[66]. Therefore, impacts of wage increases should be thoughtfully managed, if surrounding areas provide or could lure away workers because of wage differentials.

Better compensation and support for home care workers will make home care jobs more attractive and sustainable, increasing employee retention and driving down of turnover costs. For consumers and state budgets, a larger and more stable workforce will help enhance service access and quality, and help reduce avoidable hospitalizations and other costly outcomes. A better-compensated workforce will also rely less on public assistance and put more money into the economy through higher spending on transportation, housing, food, and other goods and services[3].

5) Employee Benefits/Supports:

Many LTSS stakeholders have recognized that direct care worker wages alone are not the answer to the current workforce shortage. Even if living minimum wages were mandated into law, the benefits (particularly health insurance and educational benefits) offered by competitive employers (hospitals, retail, distribution, and other companies) and the poor image of the home care worker could still make recruitment and retention of the home care workforce very difficult. Benefits that should be considered for direct care workers include health insurance, paid sick days, grief and bereavement leave, child care, financial support mentoring, etc.

Nationwide, 51% of unionized direct care workers have insurance through their employer or union, while, by comparison, only 31% of non-unionized direct care workers have health insurance through their employers[4]. Many are poor enough to be eligible for Government assistance, but 10% lack any form of health insurance at all, including public coverage or an individually purchased plan. Further, few have access to paid sick days to allow workers to take time off to recover from an illness, manage medical care for themselves or a family member, deal with a family death, or bond with a new child. Unfortunately, many employers do not offer these benefits. This, unfortunately, remained true, even through a worldwide pandemic. Some states have used federal and state subsidies to reduce costs of exchange-based health insurance coverage. For direct care workers who cannot afford private health insurance but are ineligible for Medicaid, having access to exchange-based health insurance coverage is critical. ***Massachusetts*** offers ConnectorCare Health Plans[55] through its state health insurance exchange that offer low premiums, no deductibles, and low out-of-pocket costs. The state has a waiver arrangement under which it claims its state investments for federal Medicaid match in order to offer these plans. In ***California***, one county (Contra Costa County)[67] has its Medicaid managed care plan offering health insurance to DCWs who provide at least 45 hours of care per month as In-Home Support Service providers — a personal care assistance program offered to Medicaid beneficiaries with disabilities.

Because child care is such an important issue for parents working as direct care workers, the COVID-19 pandemic has highlighted how challenging it can be for aides when childcare facilities are closed or they need to work multiple shifts or changed hours. ***Massachusetts***[55], in response to statewide childcare

facility closures amid the COVID-19 pandemic, supported the direct care workforce by providing emergency childcare to those most in need. The state's Exempt Emergency Child Care Program offered free backup childcare for parents working in health care, human services, public health, public safety, and law enforcement. ***New Jersey***[55] offered Emergency Childcare Assistance to Essential Employees (including DCWs) through May 2020, during which eligible essential employees were provided subsidies of up to $450 per week to cover childcare costs. In addition, the state provided various grants and enhanced payments to childcare providers and implemented a temporary program to help families with school-aged children with unanticipated childcare costs due to remote learning. ***Minnesota***'s governor signed an executive order in March 2020 providing free childcare to "emergency workers," which included all DCWs, for all children under 12 years of age[55].

Lastly, financial mentoring is an often-overlooked, but important, benefit for direct care workers, who like other low-wage workers, may not have had the opportunity to develop financial literacy skills that can help maximize their economic stability, build their assets, weather short-term economic challenges, and plan for the future. ***Colorado***[49] is doing research into DCW compensation for both direct care workers and case managers. They also plan to fund a contractor to "soften" the benefit cliff (childcare, housing, education) and/or provide child care, explore funding for shift differentials, and identify other practices that could better support low-income workers. This follows the Colorado Cliff Effect Pilot Program (CEPP) (described at https://www.bellpolicy.org/2018/03/29/colorado-cliff-effect-pilot-program/), authorized in 2012 and implemented in 15 counties across Colorado, which helps families whose incomes have increased above the eligibility limit, sometimes by very small amounts, by slowly adjusting their child care payments instead of abruptly stopping all subsidized payments at once. In **New Mexico**, ARPA funding plans[51] include a planned partnership with the Federal Reserve Bank of Atlanta to bring their Career Ladder Identifier and Financial Forecaster (CLIFF) tool (https://www.atlantafed.org/economic-mobility-and-resilience/advancing-careers-for-low-income-families/cliff-tool) to the state to help strengthen the social safety net for direct care workers and other low-wage workers. The CLIFF tool is designed to show how public assistance losses intersect with local in-demand career paths. Further, the dashboard shows the financial tradeoffs associated with career advancement and the net gains to the taxpayer when workers advance. It can simulate policy and programmatic changes and show how the dollar value and composition of public assistance changes with increases in income. For individuals, it can also be used to identify when wage gains make a family worse off or no better off financially than they were before the wage increase.

6) Direct Care Worker Training and Certification:

Because allowable tasks and care quality strategies for direct care workers differ from state to state, and between different populations that direct care workers might be serving within the same state, the content and number of hours for required certification training for different direct care workers vary. Thirty-eight states plan to use their ARPA funds to address provider training and certification, and six states are planning to authorize additional wages for training completion[43].

Through a 2010 Patient Protection and Affordable Care Act (PHCAST)[4] demonstration project, funded under the Affordable Care Act, six states (***California***, ***Iowa***, ***Maine***, ***Massachusetts***, ***Michigan***, and ***North Carolina***) developed their own competency-based personal care aide training programs, based on PHI's

10-part Competencies for Direct Care Workers. The curricula were designed to be applicable across LTSS settings, not just in home care. More than 4,500 new and incumbent direct care workers were trained through PHCAST over a three-year period. Lower training attrition rates were related to in-person training, more personalized trainee supports, and offering the training in the trainees' primary language. Types of trainee support included stipends, scholarships, case management, transportation, child care, mentoring, and assistance from local social service providers. In 2012, ***Washington***[4,68] began mandating that all long-term care workers providing personal care services to adults in the state (both workers hired through agencies as well as consumer-directed aides) complete a 75-hour, competency-based training to achieve certification as a home care aide, along with 12 hours of continuing education per year. The curriculum is designed to be transferrable across care settings (universal or portable) and stackable (e.g., trainees can leverage their existing training toward additional certifications, such as becoming a nursing assistant). Noteworthy is that although trainees have reported high satisfaction with the program, it has also experienced challenges, including a relatively low certification rate (approximately 60%), leading to concerns about workforce supply, and difficulties in preparing home care aides to balance the required training content with individual consumers' needs and preferences, raising concerns among members of the consumer-directed community.

Thirty-eight states have plans to use ARPA funds for provider training and certification[43]. However, most of these states' emphasis on training is modest, and several are focused solely on better training of direct support professionals caring for clients with intellectual and developmental disabilities and/or behavioral health needs. Four states' training plans are noteworthy. In ***Michigan***, the IMPART Alliance was previously awarded a grant from the Michigan Department of Labor and Economic Opportunity to lay the groundwork for a statewide direct care training infrastructure, including developing consensus on core competencies, training, and credentials; pilot testing training curricula; developing a credentialing plan and career pathways; and more[4]. Under ARPA, Michigan[69] plans to build a centralized recruitment and training center, with regional hubs and outreach programs to widen the training pipeline. Additionally, the recruitment and training center would include both a training arm and credentialing arm to ensure DCWs receive stackable, client-centered training and credentials to further their careers as Universal DCWs — meeting all competency standards for work with any population, program, setting, etc. The thinking behind this is, "We need to get away from a siloed, fractured system and toward one that is more portable, coordinated, standardized, and based on professionalism and efficiency". In ***Maine***[70], the ARPA training initiative is designed to enhance Maine's HCBS direct care workforce portability, by developing certifications across MaineCare HCBS supports and services, to the extent feasible and appropriate, enabling direct care workers to work across HCBS populations. Additionally, work will focus on training pathways that begin with courses in technical high schools, enabling provisional certification and employment, and leading to further educational advancement through Maine's community colleges. ***Colorado***[64] will also be developing competency-based "universal worker" structured training as well, designed for use by individuals working in a variety of settings and with different populations. This training would be given online or in-person (using a train the trainer method for rolling it out in-person). In ***Rhode Island***[71], ARPA funds will be used to invest in advancing certifications for CNAs, PCAs and other HCBS workers. Recognizing that direct care work is often a gateway into the healthcare profession, particularly for women of color, plans include the establishment of a Health Professional Equity Initiative to provide support to longer-term direct care workers who may want to seek professional healthcare degrees to advance their careers.

In ***Wisconsin***[81], plans are to use ARPA HCBS funding to implement statewide training modules and offer grant funding opportunities for providers to invest in workforce training, including the development and implementation of specialized DCW and manager training programs. In ***Massachusetts***[43], plans include creating an educational training curriculum for a group of home health or in-home nurse preceptors and developing a model curriculum for home health or in-home nursing certification. In ***California***[55], the Department of Aging has directed $150 million of ARPA funding to provide stipends linked to training for direct care workers. The state is currently using input and recommendations from providers and DCWs to plan and shape the program.

7) Advanced Positions/Aide Professionalism

Enabling home care aides to grow within their jobs means not only recognizing the greater experience that can come with more years on the job, but also by giving them opportunities to gain new knowledge, skills, and abilities to be able to take on new duties and new roles. This is enabled by requiring core competency-based training that is stackable and transferrable between different LTSS roles.

Within the home health aide sphere itself, there have been several attempts to build ladders within the job by opening up the allowable practice and skills of the aides. In 2016, with lead funding from the ***New York*** State Department of Health, PHI created a salaried advanced role for home care workers—called a Care Connections Senior Aide[4]. Partnering with Independence Care System (ICS), an affiliated Medicaid Managed Long-Term Care Plan, and three New York licensed home care agencies, eight Care Connection Senior Aides received advanced training and were then deployed to provide coaching and support for home care workers and family caregivers and serve as a resource to the interdisciplinary care team, strengthening ongoing knowledge and communication about clients' conditions. During the 18-month pilot testing of the role, benefits included a reduction in caregiver strain and an 8% drop in emergency department visits (compared to the previous year)[72]. In 2016 as well, the New York Nurse Practice Act was modified to create an Advanced Home Health Aide role[73]. The revised law gives certified home health aides an additional career path by providing them with the opportunity to perform more advanced skills. The added tasks which could be performed by an advanced home health aide included administering certain medications that are routinely taken by a patient (which are given by mouth, in the eye or ear, nasally, on the skin, vaginally, rectally or inhaled through the nose or mouth) or pre-filled medications that are easy to give, such as injections of insulin or epinephrine, as well as selected emergency injections and other tasks defined in regulations. Advanced home health aides, however, performing these tasks must be supervised by licensed registered nurses employed by their home care agency (or other LTSS agency) by a home visit with the AHHA and client every 14 days. Because of a lack of designated funding for AHHAs' increased wages and increased nurse supervision costs, unsurprisingly, the use of this advanced role has been limited.

In ***California***[3], the idea of a "universal home care worker" occupation was proposed by the California Future Health Workforce Commission, which was convened in 2017 to create a comprehensive strategy for closing the gap between the existing health care workforce and the one that will be needed in the future. As one of their recommendations for strengthening the "capacity, effectiveness, well-being, and retention of the health workforce," the commission recommended a universal home care worker occupation with three competency-based levels:

- Level 1: Personal care (ADLs and IADLs)
- Level 2: Level 1 plus "paramedical tasks for those with moderate functional limitations and cognitive decline," such as oral medications and catheter care; and
- Level 3: Level 2 plus "paramedical services for the most complex individuals.

The cost to "establish and scale a universal home care worker family of jobs with career ladders and associated training" was estimated to be $7M over 10 years. A California Healthcare Foundation[74] assessment earlier this year of the 2019 recommendations of this Commission found that while over $700M had been spent on areas covered by the recommendations, the universal home care worker recommendation, like only one other recommendation, had little to no progress. This recommendation had no state budget or policy actions taken.

In Massachusetts' Extended Care Career Ladder Initiative (ECCLI)[73], launched in 2000, the primary goal was to enhance nursing home resident / home care client care quality and outcomes while also addressing the problems of recruiting and retaining skilled HHA and CNA workers. One of the first state-initiated efforts in the United States to address the issue of frontline workforce quality improvement in LTSS, ECCLI required that all participating nursing homes and home health organizations create career ladders for CNAs and HHAs and include modest hourly wage increases linked to completion of one or more learning modules. With the challenges of covering clients during aide training, finding the right fit for the aide back in the agency, and sustaining program funding, the program was not continued after the state funding ended (DCW BP).

In ***Massachusetts***[56], an Advanced Aide Position is being created and funded through union negotiations. "Many of us do high level care with consumers including working with catheters and bowel programs and hoyer lifts, without any additional training or pay. Our new contract will bring us closer to an advanced aide program where we will get the training and certification we need and the pay to go along with it." Janice Guzman, Worcester, MA.

It is clear that beyond the work to define more highly skilled aide job descriptions and get them approved under nurse practice acts, being able to increase reimbursement rates from Medicaid and other funding streams for that more highly-skilled care is critical to being able to pay advanced aides higher wages and incentivize them to pursue advanced training and certification. Along with the benefits to aides in higher salaries and in provider agency recruitment and retention, upskilling aides benefits the consumers that they serve, enabling aides to care for the increasingly complex nursing-home level needs of the consumers that they serve, Since home care workers spend more time and develop more sustained relationships with consumers than any other paid provider, and therefore tend to have the most extensive knowledge of consumers' needs, preferences, and wellbeing, aides are best-positioned to help consumers manage their health on a day-to-day basis and "observe, record, and report" any changes of status to clinical partners. In this way, they can play an instrumental role as ***part of the health care team*** in supporting consumers' health-related quality of life and avoiding adverse and costly outcomes, such as emergency department visits and unnecessary hospitalizations. To fulfill this role effectively, home care workers require dedicated training on the signs, symptoms, and management of common conditions among consumers. Of particular importance are those that are ambulatory-care sensitive, such as asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, hypertension, bacterial pneumonia, and urinary tract infections[3], and complex chronic conditions, such as Alzheimer's and Parkinson's.

8) Career progression / Internships / Apprenticeships:

Most direct care workers today work for organizations with few opportunities for professional advancement or higher pay. While many professions have a clear trajectory or career ladder, the direct care workforce does not. Most DCWs do not have official credentials or certifications and report that the experience and training they do earn or complete does not result in higher wages or may not follow them if they change jobs. Providing paths to a professional career that can command higher wages and respect would support both recruitment and retention. Research has shown doing so could help stabilize the workforce, reduce costly turnover, and lead to better client outcomes[55]. Sixteen states are addressing career ladders in some fashion with their ARPA funding[43].

In most settings, the next formally recognized health care title above home health aide and nursing assistant positions is a licensed practical nurse (LPN). But while the former certifications can be obtained in a matter of weeks or months with few educational prerequisites, LPN credentials require a year or more of training in addition to a high school diploma or equivalency. The time, financial resources, and educational experience required to pursue an LPN career are out of reach for many direct care workers, particularly those balancing multiple jobs and family caregiving responsibilities. Yet, while these workers consistently express interest in acquiring new skills and fairer rates of pay, many also see the work they do at the direct care level as a career and are not interested in leaving the field[4]. Of the 24 personal care aides interviewed during this fellowship by the author, more than half either wanted to become an LPN in the future or had wanted to do so earlier in their career and had never quite figured out how to make it happen.

State leaders should promote career pathways by mandating high quality, portable, stackable trainings and ensure that they are tied to credentialing systems, education stipends, apprenticeship programs, wage increases, etc. While this could readily lead to more advanced aide training and advanced aide positions, the ability to progress beyond an aide to a nurse, therapist, or other healthcare provider requires much to make it a reality. Many hospitals in the Dayton metro area offer educational benefits[75], so a hospital nurse aide not only receives higher pay and more benefits than a home health aide, they likely have tuition assistance as well to grow into an LPN or other higher-paying positions. Additionally, a home health aide quite likely will have no mentoring to figure out how to navigate advanced education and the funding for it. Currently, there are students in nursing working as aides in the PSA 2 area. While one local non-AAA provider has sought to work directly with nursing educational programs, the nursing student/aides in the PSA 2 network have been recruited by aides in their own families and/or they have chosen this work because they think that the one-on-one "patient experience" will be valuable before they get too far in their nursing program and after, as they begin their nursing career. This model of working in the field during education is common in other educational paths, such as engineering, for both the experience that the student gains while in school and the money that they earn toward funding their schooling. This cooperative education[76] (or more commonly, co-op program), like other internship programs, also benefits the company that the student works for because they have the advantage of getting to know the student early and pursue hiring them before graduation. While home care providers would not frequently gain this benefit, unlike a hospital, it would give providers a recruitment tool for other aide hires through the student's school network.

Multiple states have apprenticeship programs and career ladder progressions in place or in development. ***Washington*** State is piloting an Advanced Home Care Aide Specialist apprentice program[77,78], in conjunction with Service Employees International Union 775 (SEIU) and the Training Partnership. This program will test new advanced skills training and will benefit specific care providers and their care recipients. Individual Providers who have already taken the state-mandated 75 hours of training, hold an active Washington State Home Care Aide certification, have worked over 600 career hours, and who care for a qualified recipient are eligible for the program, which involves 70 hours of additional training focused on a person-centered approach to caregiving, medication management, treatment and care plans, monitoring and reporting changes in a client's health, healthy ways to cope with difficult or tense situations, assisting those they serve to become more involved in their healthcare, and practicing healthy ways to care for themselves. The program also offers unlimited access to peer mentor support to help apprentices effectively and confidently apply their new skills on-the-job. Apprentices are paid for the 70 hours of Advanced Training (one class weekly for 8 weeks) and receive a $0.75 per hour raise after successfully completing the apprenticeship. ***Washington***[48] is also now in the early phase of developing a career pathway for aides. In April 2021, the Washington legislature passed the 2021-2023 state operating budget, appropriating $450,000 for FY2022 "solely for the nursing care quality assurance commission, in collaboration with the workforce training and education coordinating board and the department of labor and industries, to plan a home care aide to nursing assistant certified to licensed practical nurse (HCA-NAC-LPN) apprenticeship pathway. The plan must provide the necessary groundwork for the launch of at least three licensed practical nurse apprenticeship programs in the next phase of work. The plan for the apprenticeship programs must include programs in at least three geographically disparate areas of the state experiencing high levels of long-term care workforce shortages for corresponding health professions and incorporate the participation of local workforce development councils for implementation." Funding has not yet been allocated for the launch or implementation of the program[79].

Indiana[+] developed and implemented a bridge program for certified nursing assistants within Indiana's community college network after the Indiana Governor's Health Workforce Council commissioned a study of state administrative data looking at career pathways of certified nursing assistants (CNAs). By linking social security numbers and state-issued licenses, the state was able to determine how many individuals who previously obtained an Indiana CNA license went on to receive licenses in practical nursing or registered nursing. By connecting demographic data to the administrative data, Indiana was then able to identify increased diversity and representation among those nurses that previously held a CNA license.

In ***Colorado***[80,49], through interagency agreements, the state has hired (using ARPA funding) term limited staff to sit within the Colorado Community College System, Colorado Department of Higher Education, and Colorado Department of Labor and Employment to work with these staff (and others within sister agencies) to develop career pathways for direct care workers into allied health professions. These new staff will also work with the Office of Community Living workforce team and the Long-Term Care Workforce group on this effort.

Wisconsin[81] also proposes to invest a portion of the ARPA HCBS enhanced funding to develop professional career ladders for personal care workers. The purpose of this initiative is to expand opportunities for professional advancement in the field of direct care through a statewide professional

credentialing and continuing education system, which also recognizes tenure and expertise among existing members of the direct care workforce. The career ladder initiative will be implemented in a way to recognize the professional skills of direct support workers, while also maintaining the state's commitment to self-direction. Career ladder development will be informed by the development and implementation in SFY22 of a Staff Stability Survey that will assess the HCBS workforce across Wisconsin. This survey will provide important information statewide on factors such as direct care workforce participation (both full-time and part-time), turnover, worker tenure, wages, benefits, and existing agency recruitment/retention strategies. These will inform workforce development, quality improvement, and stability efforts. Another component of this initiative is the development of a professional statewide registry for direct care workers, which will incorporate data on professional credentialing and specialty education and experience. In ***Massachusetts***[82], plans call for increasing internship opportunities at earlier stages of curricula, particularly for those studying to become direct service professionals of various types in trade schools or higher educational institutions. There will be "additional consideration for 'in-home' internship opportunities." In ***New Jersey***[83], as well, a new $1 million pipeline and career advancement program to create opportunities for direct care workers is focused only on direct support professionals.

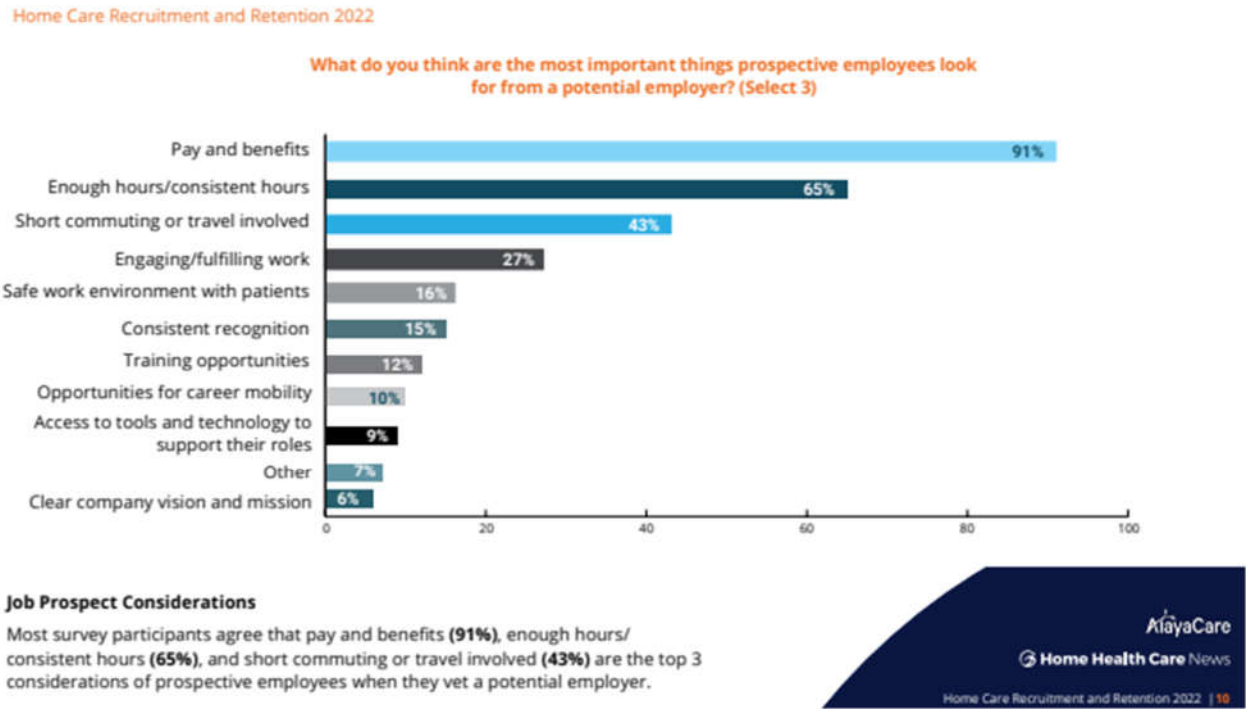
In ***Tennessee***, 91 of 95 counties are federally designated as Health Professional Shortage Areas (HPSA). As a result, the Rural Health Association of Tennessee (RHA of TN) offers an apprenticeship preparation and paid apprenticeship program that emphasizes healthcare careers in rural areas of Tennessee. Eligible participants are Tennessee youth, ages 16-24, who show an interest in and aptitude for healthcare professions. After acceptance into the program, they take online training, then RHA of TN works with the youth to find an apprenticeship position and/or they are referred to other community resources. Apprenticeships supported by the program include home health aide and include on-the-job experiences with additional instruction and mentoring. Additionally, in ***Tennessee***[4,84], multiple state organizations have come together with the QuILTSS (Quality Improvement in Long Term Services and Supports) Institute to form a public-private partnership to help address the crucial shortage of Direct Service Professionals (DSPs). The DSP Apprenticeship Program is a one-year, work-based learning program where the apprentice receives supervised on-the-job training, coupled with job-related online training. As the apprentice completes training and achieve hours-worked milestones, they will earn increased wages -- totaling $3.50 or more per hour.

In ***Ohio,*** Sinclair College[21], in partnership with LeadingAge Ohio and ApprenticeOhio, launched Ohio's first competency-based State Tested Nursing Assistant (STNA) health-care apprentice program in November 2019. It has two tracks -- STNA+ Home Health Aide and STNA+ Patient Care Technician. Students who are not yet an STNA work an entry level job at a health care business while they are taking classes. It's a competency-based, instead of a time-based, apprenticeship program, and while students are working, they are also getting measured on different competencies. The students can get ApprenticeOhio grant money toward the Sinclair training cost and many of the employers also have sponsored billing programs to pay for the school after the grant money runs out. The apprenticeship followed established partnerships Sinclair set up with Graceworks Lutheran Services, Otterbein Senior Life, and Premier Health. ApprenticeOhio[85] also has a Home Health Aide apprenticeship available with an HHA Disabilities Specialty apprenticeship currently available with only one employer.

9) Recruitment of Direct Care Workers

With the poor retention of home health aides, due to the loss of workers from the pandemic and better competing offers, and the difficulties enticing them into home care with the up-front requirements, need for transportation, and poor pay, states are looking at how they can help providers recruit.

A Summer 2022 survey of home care professionals, conducted by Home Health Care News and AlayaCare[86], found that the top three staffing-related pain points were an aide shortage, the increasing cost of business due to inflation, and HHA turnover. Focusing on aide recruitment, as the chart below shows, home care providers thought that the most important things that prospective aides are looking for are overwhelmingly (1) pay & benefits, (2) enough & consistent hours, (3) minimum travel, and (4) engaging/fulfilling work. A recent study from LeadingAge LTSS Center @UMass Boston[87] concurred with the last point. Their research found that personal care assistants (PCA) said they were attracted to their jobs because they wanted to help people and provide older adults with the care and compassion they need to live independently. They suggested that these motivations should be showcased in PCA recruitment campaigns.



Indiana[53] is implementing a statewide recruitment campaign to highlight the importance of direct service work and connect candidates with direct service opportunities in their community. This will include a one-stop website for providers and employees to post and find direct service work. Additionally, Indiana plans to develop a comprehensive direct service workforce strategy, based in part on a research review of evidence-based best practices used by other states and organizations that led to increased recruitment, retention, and career satisfaction among the direct service workforce. This

research will be conducted in collaboration with state university partners and will be followed by a workforce summit with providers, direct support workers, the Department of Workforce Development (DWD), educational institutions, individuals served, and others to share the results of the research review and to hear from direct support workforce subject matter experts. As part of the implementation of this comprehensive strategy, the state plans to explore how to use a pay-for-outcomes strategy with regard to provider recruitment and retention strategies. One example of a potential pay for performance measure is the percentage of staff hired with a certain level of training.

In ***Maine***[70], the ARPA plan allocates the single largest portion of funding to retention and recruitment bonuses for direct support workers and their first line supervisors. A Direct Service Worker Council will be created to advise on workforce initiatives, and a robust market analysis will also conducted to identify longer-term strategies. Following these will be one or more marketing campaigns to attract new workers to the field.

To address recruitment and retention challenges exacerbated by introducing a value-based payment program into home care (which they had previously introduced successfully in nursing home), the state of ***Tennessee***[4] decided to provide up-front assistance. The state has has made direct grants to providers to strengthen recruitment and retention and improve data collection. They have also developed a new workforce training program.

In ***Colorado***[49] to support recruitment of new individuals into the field and make training easy and accessible, ARPA funding will create a Direct Care Workforce website. This website will enable potential hires to receive information and resources about DCW positions and to view job boards for quick placement into positions. It will also show staff member recruitment in progress. The state is also exploring additional options for the site. ***Colorado*** is also creating a training fund to support workers in high demand jobs, as well as to fund upskilling opportunities. Funds could be distributed directly to a prospective or current worker through an employer, who would provide the training to their employees, or to a training provider. Additionally, funds could be used to expand standard training, provider resources, or trainer availability where gaps exist

In ***Arizona***[4], managed long-term care plans are required to assist providers in their networks with direct care workforce development. A managed LTC plan in southern Arizona, Mercy Care, committed to invest $2M from 2018 to 2022 to strengthen the workforce. Activities being supported include an innovation fund that providers can access to launch recruitment and retention projects, as well as a marketing campaign and free training for workers.

North Carolina intends to address direct care worker recruitment by creating a Direct Care Jobs Innovation Fund[88]. This fund would be dedicated funding for projects that improve recruitment and retention for direct care workers. Some activities that this fund could focus on would be improvements to technology systems to improve worker communication; job supports such as childcare, educational opportunities, and transportation support; and career advancement such as retention payments or career coaching. This fund would allow the state to test the best approaches to achieving the goals of supporting direct care workers, that will then be expanded throughout the state.

Many retention and recruitment activities over the last two years have focused on wages. Recognizing that inadequate compensation drives many direct care workers out of these jobs and turns away potential new job candidates, several states and many providers have made short-term wage increases

for direct care workers. In April 2021, for example, ***Michigan***[4] increased pay temporarily for home care workers employed by Medicaid-funded agencies, offering a $2 per hour raise, while ***New Hampshire***[4] provided a $300 weekly increase to all Medicaid-funded direct care workers. ***Arkansas***[4] also announced a pay increase for all direct care workers employed by Medicaid-funded providers, boosting their base pay with an additional $125 to $500 a week, depending on hours worked and the acuity of beneficiaries. While many of these hazard pay measures have expired, a number have been sustained with ARPA funding. The constant tension between short-term emergency measures and long-term job improvements needed for this chronically underfunded workforce points toward the Medicaid-centric LTSS system not being sustainable as-is and the need for transforming LTSS financing once and for all.

10) Transportation

Feedback from graduates of the #OHIOSTRONGPCATRAINING program living in Centerville and Springboro, as well as from the husband of a consumer living in Oakwood highlighted the issue of transportation difficulties for aides without a car (or a working car) when they and/or their consumers did not live close to them or to bus lines. Additionally, differences in wait times for a new aide were noted in discussions with consumers in different consumer feedback session locations. Considering these locations, wait times seemed to be inversely correlated with consumer distance to bus lines. To look further into this, a consumer feedback session in a rural county was planned, but its scheduling was disrupted by an increase in COVID cases. However, the impact of transportation difficulties was consistent with previous feedback from Area Agency on Aging case managers, who had identified hard-to-staff suburbs and rural areas.

One of the challenges with direct care worker pay is the challenge of transportation. According to credit reporting agency Experian, the average monthly car loan payment in the U.S. was $503 per month for used car loans originated in the first quarter of 2022,. This is more than 22% of an aide's salary, when he/she is working 40 hours per week at the average national rate. This expense doesn't include required insurance, gasoline, or maintenance and repair costs. Because income level, living location, and credit scores all can affect vehicle price, loan rates, and insurance rates, this can be an even greater economic issue because of systemic inequities for disadvantaged populations, like the majority of aides.

Even with public transportation available most of the way, aides can spend hours riding multiple vehicles to get to and from work (OSU, FL). Jason Reece, an Ohio State University assistant professor in city and regional planning, says being dependent on the transit system can limit people's job prospects, especially for African-Americans. In the Columbus metropolitan area, African-American households are three times more likely than white households not to have a car. "If you think about issues like employment and economic empowerment for that community in particular, transportation is going to be a tremendous barrier," Reece says. When using public transit, African-American commuters also have longer travel times, on average, than white commuters and that gap has only increased since 2000. Reece says Columbus' transportation problem only grew as jobs moved to the suburbs, places traditionally underserved by COTA buses. Travel difficulties also contribute to HCBS access difficulties in rural areas[89].

There are lessons to be learned from transportation programs that were initiated, not for aides' daily challenges with transportation, but because of the increased challenges with public transportation due

to COVID. Early in the pandemic, mass transportation was disrupted in large urban centers. Because of aide and consumer concerns about aides traveling to the consumers' homes they served by public transportation, programs in ***New York*** and ***New Jersey*** were developed to address these concerns. In New York, Massapequa-based nonprofit All Things Home Care launched the "Adopt a Senior" program[90] to raise money to subsidize transportation costs for home health aides. Eighty percent of All Things Home Care's employees didn't own a car, relying solely pre-pandemic on mass transportation. Since other options, like a ride-share costing $44 round trip, were not realistic, the agency decided to fund the rides themselves, particularly for Sundays, which was already their most difficult day to staff. All Things Home Care partnered with the Burning Bush Family Foundation to provide about 50 rides to half a dozen aides each week, and the organizations then sought to raise money to expand the service further. Meanwhile, in New Jersey, Denver-based LogistiCare[92] extended the work it did under contract as a nonemergency Medicaid transport contract by partnering with rideshare service Lyft and selected home care facilities to ferry essential home care workers in Passaic and Bergen counties, giving them more than 10,000 rides from September to December 2020 alone. In another example in this time period, in White Plains, New York, Steps Home Care[92] provided rideshare Uber service to and from their clients for their workers, who predominantly lived in the Bronx and would normally use public transportation to get to and from their Westchester County jobs. The Steps Home Care president noted, "This way they're coming into contact with one person (the Uber driver) instead of a train full of people." This also helped ensure timely client service and increased aide retention.

In ***Ohio***'s ARPA plans[44] under the HCBS Workforce Strategic Development Fund is an intent (or perhaps a suggestion?) to "Establish a fund to provide transportation support for HCBS workers as one of the many barriers to recruiting and retaining home health aides is access to reliable and affordable transportation." No additional information on this is known.

11) Diversity/Equity

The results of a 2021 Associated Press-NORC Center for Public Affairs Research poll[93] found that white Americans were more likely than people of color to say they have good in-home services accessible, 37% to 27%. Sarah Szanton, a professor at Johns Hopkins University's nursing school, described aging as "the sum of people's life experiences across the course of their life." [93] Thus, years of injustice and inequality would be expected to impact an older adult's aging path. Further, Jacqueline Angel, a professor of health, social policy and sociology at the University of Texas, said demographics factor into a person's "physical, mental, social and even spiritual and emotional well-being." Because disadvantages accumulate over time, Angel continued[93], they are too wide for aging programs to fully close the gap. However, "one has to provide the resources that will be able to curb the disparities in health, income and overall quality of life," she said. "It's more critical now than ever to be able to do that given the pace of our aging racial minority population." Thus, greater equity in served HCBS consumers' quality of life is needed, perhaps even if this requires inequities in service delivery. It is suggested that more needs to be done to determine whether equity is being pursued aggressively enough within the HCBS services.

While the workforce of home health aides is already diverse (though less so in management positions), PHI data reveals that "in an already marginalized workforce, women, people of color and immigrants generally fare worse in this job sector than do their counterparts, and they experience unique

challenges that merit targeted attention."[94] The challenges with transportation for minority individuals noted in the section above serve as one example. To address these inequities, PHI recently launched the Direct Care Worker Equity Institute, which they hope will spotlight the structural inequities and profound disparities facing direct care workers.

Known state activities to address equity are currently limited to training. In ***Connecticut***[55], home health agencies receive an +1% in reimbursement rate if their staff members participate in state-sponsored racial equity training. In ***California***[55,95], the Health Careers Pathway (HCP) program has resulted in various collaborations between secondary schools, community colleges, universities, and others, with the purpose of advancing educational opportunities and access to health careers. Activities funded by the program include training potential direct care workers and increasing diversity by helping students with "addressable barriers," such as food shortages, unstable housing, lack of transportation, childcare, etc.

12) Public Image of Direct Care Workers

Home health aides are the unsung heroes that help older adults continue to live and thrive in their homes as they age and struggle with daily living. Although they make less than the workers at a neighborhood McDonald's, they must have taken 75 hours of mandated training AND testing and be background checked (both often at their own cost) before they can even start their first day of work. They must a have a variety of different skills and be able to work alone up-close-and-personal with an older adult (most with more serious health issues than ever before). They are responsible for getting to each of their client appointments with whatever transportation means that they can arrange, and they then hope that the client is not dead or in the hospital, because then they won't get paid and may not be able to pay their bills. They never know, as they get to the door, the mood or physical condition that they will find the older adult in and the issues they will be dealing with as they do the tasks for which they are paid. And yet, this is "just work in the home" or "babysitting" or "being a companion," not "real work". In many cases, as they do their work, the aides develop close relationships with their clients, providing a loving heart, a shoulder to lean on, a friend to confide in when their older adult has none other, and they are left grief-stricken after the older adult dies, while they struggle to be placed quickly with another client so they can be paid. They see changes in their clients that they highlight to nurses, therapists, and doctors, sometimes with thanks, other times with no one listening. After all, "they're just an aide." Yet, without these aides, the older adult would be in a nursing home, back in the hospital, living with stressed-out relatives, or dangerously alone.

Although the services that home health aides provide to older adults across the country are essential, they are generally not valued by society. There is a deeply rooted, historical, sociocultural devaluation of domestic and care work in the United States, which directly relates to institutional sexism and racism, compounded by ageism and ableism[55].

Increasing the social value associated with being an aide is critical to elevating this work and addressing workforce shortages and inequity. A concerted cultural shift is needed across the broader health care system and the public in general, so that home health aides are valued for the skilled work they perform as health care professionals. State leaders can do this in specific, concrete ways. In addition to the above-mentioned economic and advancement supports (e.g., higher wages, training, and building a

career pathway), the following are ways that states can help change the perception of aides and other direct care workers. It is critical that, in addition to increasing the pay, benefits, and working conditions for these unsung heroes, that we help change the way that they are viewed by the public, by leaders in the U.S. Department of Health and Human Services and the state departments of aging, and with elected leaders in states and in the federal government. Without a vigorous campaign, the loss of paid caregivers will either not accelerate at the rate needed to care for the increased number of clients as our population ages or we require drastic measures to prevent an even greater shortage. Thus, a collective message needs to developed that will talk about this job differently at every level and opportunity[48]. If the pendulum can swing on how this profession is viewed, it would go a long way toward making lasting changes. States could launch public education campaigns focusing on the critical role of home health aides and the benefits of their work. Drawing on aides' stories and lived experience could be a powerful influence on public opinion and policy. Indeed, with funding from the Michigan Health Endowment Fund, the Center for Health Care Strategies (CHCS) worked with stakeholders to identify concrete steps the state of Michigan can take to expand and strengthen its direct care workforce. They recommended, among other things, that ***Michigan*** consider partnering closely with direct care workers and care recipients to craft and test messages for how to talk about the profession, as they will be the best source of ideas on how to frame the messaging around the work, its importance, and value[48]. ***Wisconsin*** conducted a similar marketing campaign in 2018-2019 to promote their WisCaregiver Careers program and included videos of nursing assistants describing the value and rewards of their jobs[4].

Colorado and Arizona are using portions of their ARPA funds to invest in public awareness campaigns[55], reframing the direct care worker position, raising awareness, and communicating the value of the work. The ***Arizona***[96] Department of Education is implementing twenty-seven home health aide programs in public high schools throughout the state, through which graduating seniors receive training to become DCWs. This will provide the opportunity for young adults to learn about the direct care workforce at a young age and to understand the skills and competencies they will acquire to further their careers. It is hoped that this will help to shift public perception. Additionally, Arizona is launching a statewide Caregiver Campaign -- a public education campaign to highlight the roles and importance of these workers in the labor market to appeal to folks who might be well suited for these roles. They have invited DCWs to submit testimonials for the campaign. ***Colorado*** plans to conduct a public awareness campaign that will not only bring awareness to, but will also help and professionalize, the Direct Care Workforce. The marketing effort will be through media, messaging, and an organized set of communication methods[4].

13) New Models for Recruitment and Service

With the challenges of the aide workforce shortage and the pandemic, new approaches or more aggressive use of non-standard approaches to service and to the recruitment of caregivers are being pursued. Among these are expanded use of consumer-directed care and registries of aides and user-friendly joint registries of consumers and aides to facilitate matching.

Participant-directed care (also known as self-directed care or consumer-directed care) is already available under Medicaid HCBS in all 50 states. A number of states indicated expansion of these services

under ARPA funding. In ***Maine***[70], more than $4M has been dedicated to expansion of Self-Directed Services and Supports.

As far as matching service registries -- online job boards that help consumers and workers find each other and establish employment relationships -- are currently active in 14 states[4]. They can also connect workers and consumers with other resources, including training and background checks. ***Alaska***[55] recently started using a database called "Connect to Care." Employers can upload the positions they are trying to fill (including skills, hours, etc.) and workers can search and match with available positions. ***Michigan***[62] is creating a virtual site called the MI Care Career, modeled after Care.com, with critical input from DCWs. Direct care workers, employers, and care recipients will be able to develop profiles and be "matched" based on care needs, skills, completed trainings, location, work hours, etc. (Milbank) The team designing MI Care Center consulted with stakeholders in Minnesota where a similar model was successfully implemented and considered their lessons and best practices in shaping the MI Care Career platform[97]. ARPA Phase I funding plans call for establishment of a statewide database of credentialed direct care workers[62].

Expect more to come on the technology side. In Europe, a startup is creating a digital platform for live-in care for older adults . The artificial-intelligence-driven app, called Marta[98], will be scaled up in the European markets of Germany, Poland, Romania and Lithuania. While these markets are much smaller that the US, there are real challenges there. Germany alone has more than 4 million people seeking at-home care and there are only 280,000 caregivers able to do this. Lastly, ConnectToCareJobs.com[99,100] is a special project of ADvancing States, supported by Centene Corporation (https://www.connecttocarejobs.com/#/). The tool seeks to fill staffing gaps in a timely fashion and will allow nursing homes, assisted living facilities, residential care facilities, and long-term acute care hospitals to identify the specific staffing needs they have on specific days. At the same time, individuals who are licensed and/or trained for the various roles in these facilities can register their availability and willingness to fill shifts. An algorithm then matches the workers and the facilities – in real time. U.S. states and territories have the ability to manage which facilities are included to enable those in crisis to get preference and to monitor the matching as well. In future releases, the tool will include matching for hospitals, home care agencies, hospice, and individuals who self-direct their care.

14) Volunteers

Volunteers already provide significant value to older adults through their support to Older American Act programs, as determined by a 2021 Administration for Community Living Volunteerism Study[101]. The study found that these workers, which represent a significant invisible labor force for these programs, provide an annual economic value of approximately $1.7 billion to OAA Title III programs, $14 million to OAA Title VII LTCOP, and $28 million to SHIP!!! Volunteers, who were often found to volunteer for up to 10-15 years, played a critical role in the capacity of these programs reaching one in five older adults. Indeed, the study summarized that serving as many older adults as these programs do would not be possible without the significant and continuous contribution of volunteers, and it is likely that, without volunteers, these OAA programs, at assessed 2019 funding levels, would face great challenges in reaching those in need.

Because volunteers cannot be sought for work which paid employees already provide[102], defining roles that volunteers to the Area Agency on Aging network could do that would help address the personal care aide workforce shortage need to be defined carefully.

Already, in a number of areas around the country, volunteers provide rides for older adults visiting the doctor or going out into the community for events, shopping, visits with family and friends, etc. However, volunteer-provided transportation programs depend on their ability to recruit and retain drivers, but many potential drivers are now deterred by their insurance agents telling them that their car insurance rates might go up, that they might need a commercial policy or that they could lose their coverage. Moreover, the AARP Public Policy Institute (AARP) has noticed an increase in anecdotal reports from nonprofit volunteer-provided transportation program managers of drivers having difficulty securing insurance for their volunteer services. AARP commissioned the Texas Transportation Institute (TTI) to explore this and found that efforts to regulate and insure the rideshare industry has exacerbated insurance challenges for people who drive as volunteers[103]. There is more to come on this. With regard to personal liability, volunteers are usually asked to sign waivers of liability to hold the nonprofit for which they volunteer blameless in case something happens to them. Because home health aides and others going into older adults' homes must be covered by liability insurance from their agency in case something goes wrong within that home, it is expected that a volunteer entering an older adult's home might need to be covered by liability coverage as well.

To provide volunteer non-medical assistance to older adults, adults with disabilities, or family caregivers, in late 2019, the Oasis Institute, in partnership with the Caregiver Action Network (CAN), the National Association of Area Agencies on Aging (n4A) and Altarum's Program to Improve Eldercare, was awarded a five-year cooperative agreement from the Administration for Community Living to implement the National Volunteer Care Corps. This program, now called Community Care Corps, funds "innovative local volunteer models" to evaluate their effectiveness in different communities nationally. Through two cycles of independent review committee and competitive grant-making process to date, grants have been awarded to a variety of community programs providing new services for older adults in a variety of ways[104]. While some of the awarded programs are focused on helping older adults directly in their homes, these are new services for the awarded organizations. Other grants have been awarded to organizations adding services focused on social isolation prevention, support for family caregivers, and errands and shopping for older adults.

There is also a Government volunteer program that has been in place since 1974 that could help. The AmeriCorps Seniors volunteers in Senior Companion Programs[105] "provide assistance and friendship to adults who have difficulty with daily living tasks, such as shopping or paying bills. Their assistance helps these adults retain their dignity and remain independent in their homes rather than having to move to more costly institutional care. AmeriCorps Seniors serve from 5 to 40 hours a week and receive hourly stipends. They must be age 55 or older and meet established income eligibility guidelines." In addition to the stipend, they receive accident, personal liability, excess automobile liability insurance coverage; assistance with the cost of transportation; recognition; training; and, as feasible, meals during their assignments. The Senior Companions provides grants to organizations to engage low-income Americans aged 55 and older in providing supportive, individualized services to help homebound seniors and other adults maintain their dignity and independence. In 2020, in Ohio, Seniors Companions provided

independent living support to more than 1070 individuals[106]. Upcoming grant opportunities can be found at https://americorps.gov/partner/funding-opportunities.

15) Final Thoughts

Both PHI and LeadingAge @UMass Boston have published much in the areas of state and local efforts to address the direct care workforce and LTSS funding. Three noteworthy reports are recommended for further reading – Leading Age's "Learning from New State Initiatives in Financing Long-Term Services and Supports"(2021)[46], PHI's "State Policy Strategies for Strengthening the Direct Care Workforce"(2022) [110] , and PHI's "Localized Strategies for Addressing the Workforce Crisis in Home Care"(2019)[111]. Additionally, PHI is expected to publish the final report from their Essential Jobs, Essential Care project within the next year, covering statewide coalitions, workforce development efforts, and political advocacy in 5 states – Michigan, North Carolina, New Mexico, New York, and New Jersey.

DISCUSSION / SUMMARY

The unpopular, yet consistently recognized, foundational issue in addressing the shortage in the home health aide workforce in Ohio that provides Medicaid HCBS services is -- low Medicaid reimbursement levels. These levels limit the amount that a provider agency can pay their aides, making recruitment and retention very difficult. It limits the quality of care that consumers can receive, because many good aides will leave the job without competitive pay (or never get into the job), and there is little incentive to mandate specialized training and create advanced aide positions when they will not result in increased agency reimbursement or aide wages. Moreover, at the current levels of reimbursement, providers cannot provide aides benefits, meaning that competitive offers of employment from hospitals, skilled nursing facilities, as well as retail, fast food, distribution centers, and others will continue to provide both higher wages and better benefits. Additionally, the transportation issues that must be dealt with by the aide getting to consumers' homes; the lack of peer contact, mentoring, and back-up in the workplace; the poor reputation for these jobs in the broader community: and especially the lack of guaranteed pay when a consumer isn't available for service (for whatever reason) are additional factors that impact the competitiveness of this job. While schedule flexibility and the ability to provide essential care for another person one-one-one are the biggest selling points for these jobs, in a time of growing inflation (when the cost of living is going up sharply) and extremely low unemployment (when competitors are greatly increasing their hiring incentives), it is difficult for providers to retain and recruit staff. It's even more challenging because the demand is going up and will continue to go up, due to demographics and other factors, like the number of Medicare Advantage programs adding home health services to their plans to reduce hospital admissions and readmissions. Unfortunately, there are no silver bullets that the Area Agency on Aging can offer its providers.

The timing of solutions to the workforce shortage is critical. Provider agencies in our area have noted a bimodal distribution of aides. The first group is a core group of more mature (often older) aides that have been in their jobs for a while and can be counted on to get their job done well and to do whatever else needs to be done, like taking on extra shifts when a new aide has suddenly quit. The second group is more likely newer (often younger) aides that come into the job and may leave unexpectedly, without any notice. This is the group with the most recruitment and retention churn. Concerning is that the first group has been the foundation for service in the PSA 2 Passport area. Yet they are aging themselves and are statistically more likely to need to quit to take care of an ailing family member, become physically unable to do the job, or decide to retire. It is critical that we find a way to recruit enough more aides into what they see as a positive work environment, so that they can begin to be counted on to sustain services.

Challengingly, the magnitude of the workforce shortage in Ohio isn't even known. There are no statewide statistics on the aide vacancies that would need to be filled to fully serve the consumers that have been approved to date or official targets for aides needed per region at dates in the future. There is no empirical data on what positive and negative impacts result from specific agency, payer program, or state mandated actions or pilot programs. With a rough estimate of a 34% increase in the number of aides needed locally between 2020 and 2030, and no fundamental changes in the system, the ability to get there and to know whether things are on track for getting there (or not) is impossible to know.

Unfortunately, the public and state policy makers in Ohio do not appear to recognize the urgency of the situation. This year, in their "State of the State" messages, twenty state governors mentioned plans to strengthen the direct care workforce in their state and to tackle shortages. Nine governors focused on retention strategies for their current DCW workforce, especially those burned out from the pandemic. Yet in the Ohio State of the State address, Governor DeWine's speech[109] did not include any reference to direct care workers in his long list of people who had stepped up during COVID. Moreover, he referred to older adults only once, "Because of your support, we have enabled thousands of Ohio seniors to stay in their own homes longer…" And yet his speech focused on people, and he used the word child (or children, childhood, etc.) twenty-seven times – "for they are our future." One wonders why Governor DeWine is not worried about the future of our home and community based services and how we may be setting up to burden our children with the care of their parents and grandparents when they get older, because we may lack the government safety net to allow older adults to live independently.

Moreover, there is, unfortunately, no public outcry that the HCBS situation is not just suboptimum, it is unsustainable as-is. There is no real data to show this to the public and to state legislators. The legislators hear regularly from stakeholders in the LTSS system, but they do not have their constituents flooding them with calls and emails about the services that they or their loved ones are not getting or their fear that when they or their spouse needs care, there may be no aides to provide it. Moreover, sadly, even if the public saw the numbers, they might not recognize that health care aides are not just babysitters, they help provide older adults with nursing home level care while the older adult (someone's husband, mother, grandfather, godmother, lifelong friend, etc.) is able to live at home, surrounded by their family, friends, and neighbors. With no home care, these older adults would need to move into a much more costly nursing home; move in with already-stressed family members; be readmitted to the hospital for a chronic condition, injury, or medical crisis; or perhaps die alone at home.

Fortunately, the ARPA funds available through 2025 have helped to shore up wages or provide bonuses for home health aides. Unfortunately, these funds are not meant to set up long-term liabilities, so without changed state priorities for boosting reimbursement rates, a federal requirement for specific home care capabilities and capacity, or some other event not envisioned at this time, it is expected that the situation could be significantly worse three years from now. The importance of Ohio's HCBS Workforce Development Strategic Plan funding to help prevent this cannot be overstated.

If reimbursement rates can be adjusted to a level closer to a living wage (whatever that looks like), there are many improvements to the job -- how the state of Ohio defines and pays these jobs, trains people for them, certifies them, and helps them move onward in the health care system, if desired -- that would strengthen the long-term support and services system. Additionally, supports for aides (transportation, child care, mentoring, and additional training [especially job specific skills, but also more general homemaking, financial literacy, etc.]) would make the job more supportive of the aides and the older adults served.

Lastly, the filter through which the public views this job and the people that perform it is undoubtedly inequitable. Like other female-dominated caring professions that our society is reliant on (i.e., nurses, teachers, child care workers), the value of the work done and the people doing it is under-recognized and the impact of a potential loss of this caregiving under-appreciated. Moreover, because home health

aide positions do not require a college education and are represented by a high percentage of minority and immigrant workers, elitism, racism and a current anti-immigrant bias cannot help. Getting to the personal, especially the personal impact of what aides do (or will do) for someone's loved one could help overcome these biases in a public media campaign. Yet, these biases have and continue to impact the aides themselves and must be addressed in their own right.

It is important to continue to stem the loss of aides with the kinds of programs PSA 2 has actively supported over the last 2 years (e.g., more consumer-directed aides and paid CNA training for aides [#OHIOSTRONGPCATRAINING]), as well as an innovative non-PCA services budget model being developed to free up personal care aides. It is absolutely critical to do **NOW** all that is possible in the short and long term to impact this workforce – before it is too late.

RECOMMENDATIONS

The following PSA 2 actions, at both the local level and the state level, are recommended.

State Level:

Actively engage with the $212M ARPA HCBS Workforce Development Strategic Plan and the workforce group overseeing it. Strategic initiatives to be advocated might include:

1. A statewide media campaign, rolling out ***as soon as possible***, to raise the image of home health aides, illuminating the heart and passion of the HHA workforce and its criticality to the lives and health of their consumers, highlighting their hero status. This campaign would be needed to help with recruiting and retention, even if DCW wages were $15-20 per hour. It is especially critical since they are not.
2. A statewide data system for direct care workers. A place to start might be having the workforce group charter a small group to contact other states on their DCW data systems/registries and their lessons learned on setting them up and using them. In parallel, initial data might be gathered from an initial survey of AAAs on the number of consumers served, unserved, and underserved to pair with data from providers on aides working for them (including specific names [so aides with multiple HHA jobs are not doubled counted] and average number of hours worked), hourly rate being paid to their aides, and recruitment and retention data. With no publically announced wage pass-through provisions in the Ohio ARPA Provider Workforce Support funding, it is assumed that providers chose how much of their payments they could afford and wanted to pass on their employees as bonuses, leading to a broad range of aide compensation. Understanding the exact level of pain the state is in as far as services that can't be provided and the DCW capability needed to provide it, as well as the current capacity, would be helpful as a baseline moving forward. Understanding how the ARPA payments made to date to providers has helped recruitment and retention is also important.
3. A statewide analysis of MyCare Ohio contracts to determine the best way that the state can incentivize the managed care plans to become active participants in working the workforce shortage solution.
4. A statewide year-long pilot of higher reimbursement rates & aide wages, with a parallel actuarial analysis of what these rates take AND add to state coffers.

Actively engage with the $212M ARPA HCBS Workforce Development Strategic Plan and the workforce group overseeing it on more tactical, but no less important, initiatives such as:

5. An ARPA plan-included project to "Establish a fund to provide transportation support for HCBS workers as one of the many barriers to recruiting and retaining home health aides is access to reliable and affordable transportation." There may be a plan for this project already and a project proposer. If not, potential partnerships, with companies such as nonemergency Medicaid transport companies, Uber/Lyft, cab companies, the Ohio Automobile Dealers Association (who are used to ferrying single customers around), etc., could be explored, as well as estimating the magnitude of service needed to support transportation-limited potential

workers. As the PSA 2 area has a broad mix of urban, suburban, and rural areas, it might make a great pilot test site.

6. A statewide pilot on the creation of career development/career ladders, focused first on defining the viability of career pathways for HHAs, focused first toward aides becoming LPNs, and helping aides or others to fund those paths. Since there is also a nursing shortage in the U.S., can early-career employers (home health organizations) work with later career employers (nursing employers such as home health providers, skilled nursing facilities, hospitals, etc.) to create pipelines that benefit both sets of employers and the aides?

In the longer term, stakeholders in the state of Ohio need to invest in creating a broad, statewide Direct Care Worker Coalition with realistic consensus objectives and the experience & patience needed to work the political ropes.

Local Level:

1. Get the word on the workforce shortage out to the local public. It might help potential consumers be more realistic on service delivery expectations and, more importantly, help incentivize people to contact their state-level elected legislators about working this problem before it's too late. Consider contacting Michigan's Impart Alliance and looking into their Action Alerts as a benchmark for a potential tool for PSA 2 (or more broadly O4A).

2. Work with the providers to set up a local AAA and provider group (Home Care Alliance?) that could represent the entire PSA 2 provider network and focus on strategic recruiting activities. This group could help represent the provider network at technical high school job fairs and other opportunities, could assist with provider linking to local county Ohio Job and Family Services, and could help #OHIOSTRONGPCATRAINING graduates and others who are struggling to find a HHA job.

3. Consider working with churches and senior centers to recruit middle age to younger older adults as aides. This might need to wait, if COVID cases rise this winter, but starting with a few willing organizations and seeing if a visit to them, could succeed in drawing in those people who are passionate about taking care of others, might be worth an initial small investment of time and effort.

4. Consider working with Job and Family Services, United Way, and/or others to pilot the idea of an aide mentor, using existing resources, to provide aides with guidance on navigating benefits, finances, problem solving, etc.

5. Continue to follow the development of the consumer-directed aide mobile app being developed by the Council on Aging of Southwest Ohio. Consider being a beta test site for them, if needed.

6. In the longer term, while volunteers will not fix the PCA caregiver shortage, they might help family caregivers cope until more help arrives. Beyond Trualta and respite services, consider expanding what PSA 2 offers for local family caregivers (especially while their older adult is waiting on services). Consider the feasibility and cost: benefit ratio of setting up a group of volunteers, for things such as linking experienced family caregiver volunteers 1:1 with new caregivers for mentoring, via groups for support, or providing a breather for a caregiver by

relieving them for an hour or two (so they can get their hair cut or medical attention, for instance) or by doing shopping or running errands for them. For older adults living on their own, volunteer companion services might decrease social isolation, even if the older adult already has home health service, and, for those without service, a volunteer might also help them with shopping and errands.

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APPENDIX 1: SURVEY OF AREA AGENCY ON AGING (PSA 2) LEADERS AND CASE MANAGERS

1. How many older adult consumers does the Area Agency on Aging currently serve?
2. How many aides from all of the home care providers are currently providing services to these consumers?
3. What level of shortage in home care aides do you currently experience to provide services to these consumers?
4. With a projected 12.5% growth of adults aged 65+ in Montgomery , Greene, and Clark counties over the next 10 years (by 2030), do you anticipate a 12.5% growth in the aides AAA needs to be able to call on to provide services to its consumers?
5. Beyond the numbers, do you have any evidence (or even perception) that the quality of care that consumers are receiving by AAA's providers is going up, staying constant, or going down?
6. Are there technology or other solutions that you think might help AAA and its providers serve its consumers?
7. What options have been previously worked (or even just considered) to address the home care aide workforce shortage?
8. If you could, how would you change the care model to see that the needed services are provided to the older adults that need them?
9. Do you think that different living situations, like more multi-consumer housing options or more multi-generational living situations (beyond traditional families) would help?
10. Would there be a benefit of providing services to consumers just before they reached the nursing-facility level of care -- to move to other housing, improve living conditions, navigate future services needed -- to prevent a more critical situation?
11. Are there any solutions to working the home care aide workforce shortage that you think should be investigated? That would concern you?
12. Are there any solutions to working the home care aide workforce shortage that would concern you?

APPENDIX 2: SURVEY FOR AAA PROVIDERS

Provider Name: **Date:**

Question Number	Question	Expected Responses	Answer
AGENCY INFORMATION			
1	First, some basic information about your agency. In what year was {AGENCY} established to provide home health/home care services?	(Year)	
2	Is {AGENCY} part of a chain?	Yes or No	
3	What is the name of the chain? (All other questions will refer to home health/home care aides at this agency and this location)	(Name)	
AGENCY CONSUMER REFERRALS & PAYMENTS			
4	What are {AGENCY}'s patient referral sources for (home health/home/hospice) care? Any others? Does this agency have any other (home health care/home care/hospice) patient referral sources? (Select all that apply)	1 AAA 2 Insurance Provider/ Payer Source 3 Community Organization 4 Hospital 5 Nursing Home 6 Assisted Living Facility 7 Physician's Office 8 Outpatient Medical /Surgical Center 9 Rehabilitation Facility 10 Patient/Family/Friend 11 Other Home Health/ Hospice Agency 12 Other (Specify)	
6	Which of the referral sources you mentioned refers the greatest number of home health/home care patients to this agency? What would you say are the main sources of this agency's home health/home care patient referrals?	1 AAA 2 Insurance Provider/ Payer Source 3 Community Organization 4 Hospital 5 Nursing Home 6 Assisted Living Facility 7 Physician's Office 8 Outpatient Medical /Surgical Center 9 Rehabilitation Facility 10 Patient/Family/Friend 11 Other Home Health/ Hospice Agency 12 Other (Specify)	
6	What are {AGENCY}'s patient payment sources for home health/home care?	1 AAA 2 Passport Insurance Provider 3 Private Insurance Provider 4 Private Pay 5 Other	
7	What are the relative percentages of (AGENCY's} funding sources for home health/home care aides to total business income? What is the funding range per hour for each funding source for home health/ home care aide services?	(List), (%), ($ Pay/hr or unit of service)	
HOME HEALTH/HOME CARE AIDE NUMBERS			
8	How many home health/home care admissions did {AGENCY} have during calendar year 2018?	(Number)	
9	How many home health/home care discharges did {AGENCY} have during calendar year 2018?	(Number)	
10	How many home health/home care aides did {AGENCY} hire during calendar year 2018?	(Number)	
11	How many home health/home care aides have left/were discharged during calendar year 2018?	(Number)	
12	What is the number of home health/home care patients currently being served by {AGENCY}?	(Number)	
13	What is the number of home health/home care aides currently serving consumers from {AGENCY}?	(Number)	
14	Looking at trends, what was the number of home health/home care aides serving consumers from {AGENCY} in 2014?	(Number, No information)	

15	What is the number of home health/home care aides you anticipate needing to serve consumers from {AGENCY} in 2024?	(Number, No information)	
16	How many home health/home care admissions did {AGENCY} have during calendar year 2018?	(Number)	
17	How many home health/home care discharges did {AGENCY} have during calendar year 2018?	(Number)	
18	How many home health/home care admissions did {AGENCY} have during calendar year 2018?	(Number)	
19	How many home health/home care discharges did {AGENCY} have during calendar year 2018?	(Number)	
20	What is the average tenure (in months or years) of the home health/home care aides at {AGENCY}?	(Number)	
21	Is that higher, lower, or the same as the tenure of your home health/home care aides at {AGENCY} in 2014? If it has changed, why do you think that is?	(Higher/Lower/Same. Reason)	
HOME HEALTH/HOME CARE AIDE HIRING			
22	What means have you used to attract home health/home care aides to this {AGENCY}? SELECT ALL THAT APPLY	1 Advertisements 2 Job postings 3 Facebook 4 Referral bonuses 5 Other	
23	What means that you have listed have been the most successful in attract home health/home care aides to this {AGENCY}?	(Methods, Reason or Don't know)	
24	Has this changed over time? Why do you think that is?	(Yes, No, Don't know), (Reason)	
25	Are there other methods you have considered and not tried? Why?	(List), (Reason)	
26	Do you employ consumer-directed home health/home care aides? How many of your health/home care aides are consumer-directed?	(Number)	
27	Are there applicants that you don't/can't hire? Why? How do their numbers compare to numbers of applicants hired?	Yes or No, (Reason)	
HOME HEALTH/HOME CARE AIDE RETENTION			
28	What is the reason given by home health/home care aides that have left in the last 2 years?	1 Higher pay elsewhere 2 Don't like the job 3 Job not respected 4 Transportation issues 5 Workplace Injury 6 Family/personal issues 7 Health issues 8 Didn't say or Ghosted 9 Other	
29	Have you established a current {AGENCY} retention rate for home health/home care aides?	(Percentage, Don't know)	
30	Have you established a current {AGENCY} vacancy rate for home health/home care aides?	(Percentage, Don't know)	
31	What is the range of pay for your home health/home care aides? Do you pay overtime?	(Pay/hour), (Yes/No), (Rate)	
32	Do you provide home health/home care aides benefits in addition to salary?	1 Health insurance 2 Transportation reimbursement or travel time pay 3 Education or career advancement 4 Bonuses	
33	How many hours do most of your home health/home care aides work?	(Number)	

HOME HEALTH/HOME CARE AIDE SHORTAGE & POTENTIAL SOLUTIONS			
34	In the past month, was this agency unable to admit patients because of lack of staff? If so, how many? Is this representative of other months in the last year?	(Yes, No, Don't know), (Yes, No, Don't know)	
35	In the past month, was this agency unable to admit patients because of lack of clinical capabilities? ([For example, patients with special or complex medical needs) If so, how many? Is this representative of other months in the last year?	(Yes, No, Don't know), (Number, Don't know), (Yes, No, Don't know)	
36	Has consumer satisfaction with services changed with difficulty in hiring home health/home care aides? How?	(Yes, No, Don't know), (Description)	
37	Have you increased your pay range for home health/home care aides in the last 2 years? Have you relied on overtime to staff your consumers over the last 2 years? If so, what are the limits to that as an incentive for hiring and retention?	(Yes, No), (Yes, No), (Open-ended)	
38	How many aides would you hire now if you could attract good candidates?	(Number)	
39	What cultural issues, if any, hamper your ability to attract/retain home health/home care aides?	(Open-ended)	
40	What competition do you worry most about when hiring home health/home care aides?	(Open-ended)	
41	Is there a population of candidate home health/home care aides that we need to pursue that perhaps we haven't (or not aggressively enough) in the past?		
42	What changes could you and/or others make to increase your ability to attract/retain home health/home care aides?	(Open-ended)	
43	Are there technology or other solutions that might help you provide the needed services to all of the consumers referred to you with a lower number of home health/home care aides?	(Open-ended)	
44	Are there community partnerships that could increase your ability to attract/retain hime health/home care aides?	(Open-ended)	
45	If you could, how would you change your business model to be able to provide the needed services to all of the consumers that are referred to you now and the higher number of consumers that will be referred to you in the future?	(Open-ended)	
46	What other issues pertinent to your employ of home health/home care aide workers should we discuss?	(Open-ended)	

APPENDIX 3: SURVEY FOR AAA PROVIDERS' HOME HEALTH/HOME CARE AIDES

Aide Identification Code: **Date:**

Question Number	Question	Expected Responses	Answer
Intro			
1	Are you working with {AGENCY} as a home health aide, a home care aide, a CNA, or something else?	1 A home health aide, 2 A home care aide, 3 A CNA, 4 Something else?	
2	Are you an employee of {AGENCY} or are you a contract worker?	(Employee, Contract worker)	
3	Do you currently providing assistance with ADLs, or activities of daily living, to one or more consumers in their homes?	(Yes, No)	
Demographics			
4	The new few questions are to get some information on you. Please remember that ALL answers are confidential and your answers will not be identified to anyone in any way. How old are you?	(Age)	
5	What is your gender?	a. Female b. Male c. Neither/Other	
6	What is your ethnicity?	a. White b. African American or Black c. American Indian or Alaska Native d. Asian e. Native Hawaiian or Pacific Islander f. Other (Specify)	
7	Were you born in this country?	(Yes, No)	
8	What is the highest grade or year in school that you have completed?	1 1st grade 2 2nd grade 3 3rd grade 4 4th grade 5 5th grade 6 6th grade 7 7th grade 8 8th grade 9 9th grade 10 10th grade 11 11th grade 12 12th grade 13 1 year college, trade school 14 2 years college, trade school 15 3 years college, trade school 16 College graduate 17 Post college	
9	In general, would you say that your health is excellent, very good, good, fair, or poor?	1 Excellent 2 Very good 3 Good 4 Fair 5 Poor	

10	What languages do you speak?	Select all that apply: 1 American sign language 2 Cantonese/Mandarin 3 Creole 4 Czech 5 English 6 French 7 German 8 Hindi 9 Polish 10 Portuguese 11 Russian 12 Spanish	
11	Which of the following categories best describes your total household income last year, before taxes? Please include any income you and other family members may have received from jobs, public assistance, interest, or any other sources. Please stop me when I get to the right category . . . (Your best estimate is fine.)	1 Less than $10,000 2 $10,000 to under $20,000 3 $20,000 to under $30,000 4 $30,000 to under $40,000 5 $40,000 to under $50,000 6 $50,000 to under $60,000 7 $60,000 to under $70,000 8 $70,000 to under $80,000 9 $80,000 or more	
12	How many people in your household are adults, age 18 or older, not including yourself?	(Number)	
13	Is/Are there another person(s) in your household over age 18 currently working full-time or part-time?	(Yes, No)	
14	How many people in your household are children age 17 or younger?	(Number)	
15	Of your children, how many of them require child care while you are working at {AGENCY}?	(Yes, No)	
16	How much time from work did you miss because of problems with child care during the last month? (Your best estimate is fine.)	(Time in hours or days)	
17	Not counting care you get paid for, are you currently taking care of a family member, relative, or friend who has a disability or health problem?	(Yes, No)	
18	During the past month, did you miss any time from work because of having to take care of a family member, relative, or friend? How much?	(Yes, No), (Time in hours or days)	
19	Now I would like to ask you about sources of income and support you may be receiving. Do you currently get: 1 Cash welfare for families and children, which is also known as TANF or Temporary Assistance for Needy Families? You may knowTANF as AFDC, or Aid to Families with Dependent Children. 2 SI or Supplemental Security Income? 3 Food stamps?	FOR EACH BENEFIT (1-3): (Yes, No)	
20	Do you currently live in public housing, receive a rent subsidy, such as Section Eight, or pay a lower rent because the government pays part of the cost?	(Yes, No)	

Motivation for Job, Hiring, Training			
21	How did you learn about being a home care aide as a possible job?	1 Family member or friend was one, recommended it 2 Providing care to a relative/friend and became interested 3 Relative/friend receiving care 4 Worked in other health care setting, e.g., nursing home 5 Newspaper 6 TV 7 Radio 8 School/job training program 9 Unemployment/employment agency 10 Other (Specify)	
22	Why you initially decide to become a home care aide? For each item, please tell me whether this is a reason you chose this type of work. Was it because . . .. 1 Relative or friend was receiving care 2 Provided care to a friend or relative 3 Like helping people 4 Thought it would give you time to interact with patients or the elderly 5 Prefer home care setting to facility 6 Family member or friend was also a home health aide 7 Wanted to work in health care 8 Job was steady and secure 9 Home health aide jobs available 10 Home health aide jobs close to home 11 Work hours fit schedule 12 Want to eventually become a nurse or social worker 13 Is there any other reason you chose this type of work? What was the more important reason?	1 Relative or friend was receiving care 2 Provided care to a friend or relative 3 Like helping people 4 Thought it would give you time to interact with patients or the elderly 5 Prefer home care setting to facility 6 Family member or friend was also a home health aide 7 Wanted to work in health care 8 Job was steady and secure 9 Home health aide jobs available 10 Home health aide jobs close to home 11 Work hours fit schedule 12 Want to eventually become a nurse or social worker 13 Other (Specify)	
23	Since you first became a home care aide, how long have you been doing this kind of work, including the time at your current job? (Do not count any time between jobs or time spent on a leave of absence.)	(Time in months or years)	
24	What were you doing before you first became a home care aide? Were you mainly. . . working as a certified nursing assistant (nursing home, acute care, ambulatory care, or home care?, working at some other type of job, going to school (high school, college, other?), staying home with children, were you unemployed, or were you doing something else?	1 Working as a certified nursing assistant 2 Working at some other type of job 3 Going to school 4 Staying home with children 5 Unemployed 91 Something else	
25	If another job, 1 What job(s)? 2 What industry? 3 How long? 4 How much did you earn, before taxes and other deductions just before you left that job? Please include tips, commissions, and regular overtime pay. 5 Why did you leave?	1 (Job title), 2 (Industry), 3 (Length of time there), 4 (Salary), 5 (Reason)	

26	Where did you receive training to become a home health aide?	1 Agency where currently working 2 Agency other than where currently working 3 Nursing facility 4 Community college, vocational, technical school program 5 High school 6 Not received in the U.S. 7 Somewhere else	
27	How well did your home health aide training prepare you for what it is actually like to work in a home care setting? Did you feel… well prepared, somewhat prepared, or not at all prepared?	1 Well prepared 2 Somewhat prepared 3 Not at all prepared	
28	For all the home health aide training you have had, including training to become a home health aide and any training you received since you started working in the field, please tell me for each area whether the training you received was excellent, good, fair, or poor. If you haven't received training in an area, just tell me. a. Patient care skills such as helping with eating, bathing, dressing, and walking b. Talking with patients c. Discussing patient care with patients' families d. Organizing your work tasks so that everything gets done on time e. Dementia care f. Working with patients that act out or are abusive g. Preventing personal injuries at work h. Assisting with duties that don't directly involve patients, such as meal planning, or care of the home i. End of life issues and coping with grief j. Abuse and neglect issues k. Relating to patients of different cultures or ethnicities, or with different values or beliefs	Fore each area (a–k): 1 Excellent 2 Good 3 Fair 4 Poor 5 Not received	
29	Have you taken any home health continuing education classes, including in-service training, in the past two years?	(Yes, No)	
30	In general, how useful have these home health aide continuing education classes been in helping you do your job? Would you say . . . very useful, somewhat useful, or not at all useful?	1 Very useful, 2 Somewhat useful 3 Not at all useful	
Working Conditions			
31	During the last month, have you worked with a single patient, or multiple patients? If a single consumer, do you live with that consumer?	(Single, Multiple), (Yes, No)	
32	Next, regarding your patient caseload and schedule, how many visits did you make to consumers during each week? (Include all visits to all consumers.)	(Number)	
33	How many patients did you see a. once that week? b. twice that week? c. three times that week? d. four times that week? e. five times that week? f. six times that week? g. seven times that week?	Number for each (a-g)	
34	During those visits, how many patients did you care for?	(Number)	
35	Are you assigned to care for the same patients on most weeks you work, or do the patients you are assigned to change each week you work?	(Yes, No)	

36	When you're working with consumers, how much time do you have to give individual attention to them when you are performing your duties? Would you say you have . . . more than enough time, enough time, or not enough time? Why?	1 More than enough time 2 Enough time 3 Not enough time	
37	How often do you use languages other than English on your home care aide job at {AGENCY}? Would you say. . . always, sometimes, or never?	1 Always 2 Sometimes 3 Never	
38	How often do you have difficulty communicating with patients because they speak a different language than you? Would you say . . .always, sometimes, or never?	1 Always 2 Sometimes 3 Neve	
39	How often do you have difficulty communicating with patients because they have a different background, different values, or beliefs than you? Would you say . . . always, sometimes, or never?	1 Always 2 Sometimes 3 Never	
40	Since you started your job with {AGENCY}, have you had any... a. back injuries including pulled back muscles? b. other strains or pulled muscles? c. human bites? d. animal bites? e. scratches, open wounds, or cuts? f. black eyes or other types of bruising? g. burns? h. other injuries from your job? Include work-related injuries that you reported to the agency, that required medical attention or that caused you to miss work	For each injury (a-h): 1 Yes 2 No	
41	How did these injuries happen?: 1 Lifting, repositioning, bathing or handling patients 2 Slips, trips, falls 3 Aggression, violence, abuse by patients 4 Bumping into, hitting, or using equipment 5 Performing household chores 6 Other (Specify)	Select all that apply: 1 Lifting, repositioning, bathing or handling patients 2 Slips, trips, falls 3 Aggression, violence, abuse by patients 4 Bumping into, hitting, or using equipment 5 Performing household chores 6 Other (Specify)	
42	As a result of these injuries, did you miss work? How much?	(Time in hours or days)	
43	Have you experienced discrimination from any of the following at your current job? a. patients b. patient's family members or friends c. agency management d. members of the care team e. any other sources (Specify)	For each (a–e): 1 Yes 2 No	
44	When it comes to your current job, how many hours do you usually work in an average week for {AGENCY}? (Your best estimate is fine)	(Number)	
45	About how often do you have to stay past your shift? Would you say . . . never, rarely, sometimes, or often? Why?	1 Never 2 Rarely 3 Sometimes 4 Often (Reason)	
46	Are you paid for that time?	(Yes, No)	
47	Would you prefer to work more or fewer hours on this job, or is the amount of hours you work about right?	1 More hours 2 Fewer hours 3 About right,	
48	If more, do you have more than one job?	(Yes, No)	

49	If fewer, what are the reasons you cannot work more hours on this job?	Select all that apply: 1 Agency has enough employees, does not require more hours, no overtime 2 Child care, family issues prevent working more hours 3 Going to school 4 Another job 5 Other (Specify)	
50	Does your agency pay overtime to home care aides that work more than 8 hours in a day, or over 40 hours in a week? Do you like working overtime? Why or why not?	(Yes, No) (Yes, No) Reason	
51	Over the past month, have you primarily been traveling around to different locations, for your assignments, or working at one location?	1 Traveling around to different locations 2 Working at one location	
52	Over the past month, how have you been traveling from home to (your first patient/the agency) and from (your last patient/the agency) back to your home? (Don't include transportation between patients) If mode has changed over time, what have you used most recently? If more than one mode, which is the one that you use most often? If a car, do you drive yourself, carpool, or get a ride from someone?	1 Drive by yourself 2 Get a ride from others home health aides back to your home? 3 Public transportation 4 Walk, bicycle 5 Taxi, van, or car service 6 Carpool 7 Other (Specify	
53	During the past month, did you miss any time from work because of problems with transportation?	(Yes, No)	
54	How much time from work did you miss because of transportation problems?	(Time in hours or days)	
55	Do the hours you work include travel time? If so, a. from home to your (first patient/agency) and from your (last patient/agency) back home? b. between {AGENCY} and patients? c. anywhere else?	For each location (a–c), (Yes, No) a. from home to your (first patient/agency) and from your (last patient/agency) back home? b. between {AGENCY} and patients? c. anywhere else?	
56	Are you reimbursed for your mileage or travel expenses?	(Yes, No)	
57	Are you paid for your travel time . . . a. from home to your (first consumer/agency) and from your (last consumer/agency) back home? b. between (your agency and) consumers? c. anywhere else?	(Yes, No)	
58	Is health insurance coverage available to you at {AGENCY}? 1 For you? 2 For your family? 3 Do you use it?	(Yes, No) 1 (Yes, No) 2 (Yes, No) 3 (Yes, No)	
59	Are you enrolled or do you participate in any government programs that pay for medical care such as Medicare or Medicaid? Have you been in the past?	(Yes, No), (Yes, No)	

60	Now about any benefits that are available at {AGENCY}. (This would include benefits that are offered after a certain number of months on the job, and includes benefits offered to you whether you use them or not.) Does {AGENCY} offer you . . . 1 paid sick leave? 2 paid holidays off? 3 any other paid time off, such as vacation or personal days? 4 extra pay for working on holidays? 5 a retirement or pension plan? 6 paid child care or child care subsidies or assistance? 7 dental/vision or drug benefits? 8 disability and/or life insurance? 9 bonuses? 10 time off for good work? 11 tuition reimbursement or subsidy? 12 a bonus for new employee referrals? 13 a cell phone for work? 14 any other benefits?	FOR EACH BENEFIT (1-14): (Yes, No)	
61	Regarding your supervisor at the {AGENCY}, please let me know if you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with each of the following statements: a. (My supervisor) provides clear instructions when assigning work b. (My supervisor) encourages me c. (My supervisor) is supportive of progress in my career, such as further training d. (My supervisor) listens to me when I am worried about a patient's care e. (My supervisor) tells me when I am doing a good job	For each statement (a–d): 1 Strongly agree 2 Somewhat agree 3 Somewhat disagree 4 Strongly disagree	
62	I'd like you to continue thinking about {AGENCY}. I'm going to read you a few statements and for each one, tell me whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree: a. I am respected by my agency for my work and encouraged & recognized for it b. I am involved in challenging work c. I am trusted to make patient care decisions d. I am confident in my ability to do my job	FOR EACH STATEMENT (a–d): 1 Strongly agree 2 Somewhat agree 3 Somewhat disagree 4 Strongly disagree	
63	How important do you think your work is? 1 Very important 2 Somewhat important 3 Not important at all	1 Very important 2 Somewhat important 3 Not important at all	
64	To what degree do you feel patients and their families respect you, as part of their health care team? Would you say . . . a great deal, somewhat, or not at all?	1 A great deal 2 Somewhat 3 Not at al	
65	To what degree do you feel your supervisor respects you, as part of the health care team? Would you say . . . a great deal, somewhat, or not at all?	1 A great deal 2 Somewhat 3 Not at al	
66	To what degree do you feel other members of your patient's health care team respect you, as part of the team? Would you say . . . a great deal, somewhat, or not at all?	1 A great deal 2 Somewhat 3 Not at al	
67	To what degree do you feel your family, friends, and other members of the public respect you, as part of your patient's health care team? Would you say . . . a great deal, somewhat, or not at all?	1 A great deal 2 Somewhat 3 Not at al	
Job Satisfaction			

68	Now, I'd like to ask you a few questions about how satisfied you are with your current job as a home health aide at {AGENCY}. Again, your answers are confidential. Overall, how satisfied are you with your job? Are you . . . extremely satisfied, somewhat satisfied, somewhat dissatisfied, or extremely dissatisfied?	1 Extremely satisfied 2 Somewhat satisfied 3 Somewhat dissatisfied 4 Extremely dissatisfied	
69	I'm going to read you a list of job characteristics and I would like you to tell me if it is a reason why you continue to work in your current job. Do you continue to work in your current job because: a. you enjoy caring for others? b. flexible schedule or hours? c. you are able to work independently and have some control over your job? d. the salary or pay is good? e. the benefits? f. you enjoy job security? g. you enjoy working with the other members of the care team? h. you enjoy working with your supervisor? i. the opportunity for overtime? j. you feel good about the work you do? k. career advancement? l. any other reasons? (Specify)	FOR EACH REASON (a–l): 1 Yes 2 No	
70	Which of the following are the most important to you for a working environment in which you want to work? 1 Enjoy caring for others 2 Flexible schedule or hours 3 Able to work independently and have some control over your job 4 The salary or pay is good 5 The benefits 6 Job security 7 Enjoy working with the other members of the care team 8 Enjoy working with your supervisor 9 The opportunity for overtime 10 Feel good about the work you do 11 Career advancement 12 Other reason (Specify)	Important/Most important Reasons: 1 Enjoy caring for others 2 Flexible schedule or hours 3 Able to work independently and have some control over your job 4 The salary or pay is good 5 The benefits 6 Job security 7 Enjoy working with the other members of the care team 8 Enjoy working with your supervisor 9 The opportunity for overtime 10 Feel good about the work you do 11 Career advancement 12 Other reason (Specify)	
71	Are you extremely satisfied, somewhat satisfied, somewhat dissatisfied, or extremely dissatisfied with the following aspects of your current job? a. doing challenging work? b. the benefits? c. the salary or wages? d. learning new skills?	For each job aspect (a–d): 1 Extremely satisfied 2 Somewhat satisfied 3 Somewhat dissatisfied 4 Extremely dissatisfied	
72	What aspects of your current job do you find frustrating or dissatisfying? a. Issues with your supervisor or agency b. Issues with consumer(s) or consumer famil(ies) c. Issues with job duties d. Working hours e. Working conditions f. Travel problems (distance, location, transportation difficulties) g. Coworkers (interaction or lack of interaction with them) h. Workload; too little, too much i. Pay and/or benefits j. Other (Specify)	FOR EACH REASON (a–j): (Yes, No)	

73	If a friend or family member needed care and asked your advice about receiving home health care from {AGENCY}, would you . . . definitely recommend it, probably recommend it, probably not recommend it, or would you definitely not recommend it?	1 Definitely recommend 2 Probably recommend 3 Probably not recommend 4 Definitely not recommend	
74	If a friend or family member asked your advice about taking a home health aide job at {AGENCY}, would you . . . definitely recommend it, probably recommend it, probably not recommend it, or would you definitely not recommend it?	1 Definitely recommend 2 Probably recommend 3 Probably not recommend 4 Definitely not recommend	
75	How long do you anticipate working in your current position and profession? Do you have plans for looking for a different job either as a home health aide or doing something else? Please remember, this survey is confidential.	(Yes, No, Not sure)	
76	What are the reasons you think you would leave?	Select all that apply: 1 Different job or opportunity 2 Schedule 3 Retirement 4 Travel problems 5 Pay 6 Moving to a different area 7 Workload; too little, too much 8 Lack of respect or appreciation 9 Supervisor 10 Job too physically demanding 11 Nothing, no complaints 12 Other (Specify)	
77	If you change jobs in the future, do you think your next job will be as a home health aide or doing something else? If 'something else', What else would you do?	1 Home health aide 2 CNA 3 Medical assistant 4 LPN/LVN 5 RN 6 Other type of health care worker 7 Something else 8 Don't plan on having another job	
78	If you had to decide whether to become a home health aide again, would you . . . definitely become one, probably become one, probably not become one, or would you definitely not become one? Why do you feel this way?	1 Definitely become one 2 Probably become one 3 Probably not become one 4 Definitely not become one, (Reason)	
79	If you had to decide whether to take your current job as a home health aide again at {AGENCY}, would you . . . definitely take it, probably take it, probably not take it, or would you definitely not take it?	1 Definitely take it 2 Probably take it 3 Probably not take it 4 Definitely not take it	
Ideas for the Future			
80	Would you want this job to progress to another job or career? What would that be?	(Open-ended)	
81	Do you have ideas on how others can be encouraged to become home care aides?	(Open-ended)	
82	What characteristics would they have that would make them best suited for this work?	(Open-ended)	

APPENDIX 4: CONSUMER SURVEY QUESTIONS

1) How long have you had your current aide? Less than 6 months, 1 months to a year, more than a year but less than 2 years, more than 2 years (Pre-meeting form)
2) What activities of daily living does your aide help you with? (Pre-meeting form)
    - Bathing, grooming
    - Going to the bathroom
    - Dressing
    - Eating
    - Walking or changing positions
    - Companionship
    - Shopping
    - Preparing meals
    - House cleaning
    - Laundry
    - Finances
    - Mail
3) Does your aide make all their scheduled visits? Beginning on time? Ending on time? Getting the tasks expected done complete?
4) Does you aide behave in a professional manner? Show respect and courtesy for you? Listen to you? Do things the way that you like things done?
5) Is your personal care aide informed and up-to-date about all the care or treatment you get from doctors, nurses, and therapists? Are they part of your home health care team?
6) What has your experience been trying to get or keep a personal care aide? Has that changed with time?
7) What has been the biggest barrier to getting or keeping an aide? What has been the most helpful?
8) What is the most important thing you're looking for in a personal care aide? Have you found that in the aides you've had?
9) If you could change one thing about your current aide what would it be?
10) How critical has your personal care aide been to your health and well-being on a scale of 1-10 (with 1 being very poor and 10 being exceptional)?

11) How well would you rate the overall care that you get from your aide on a scale of 1-10 (with 1 being very poor and 10 being exceptional)? Would you recommend your aide and the company that he/she works for to friends & family?
12) How well has your personal care aide, their company, and your Area Agency on Aging case manager communicated with you?
13) Do you have also others (family members, friends, neighbors) that help you, in addition to your personal care aide? If so, how would you rely on your aide differently if those others couldn't help you?
14) Are there any other things we should know about your satisfaction with your personal care aide and the services that they provide to you?