Findings from Medicaid Home and Community-Based Provider Organization Surveys

Executive Summary

Understanding Michigan's Long-Term Supports and Services Workforce

A report prepared for:
Michigan Office of Services to the Aging
Michigan Department of Community Health

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So What? Consulting

About this Project

This Executive Summary of the findings related to surveys of MI Choice, CMH, and Home Help provider organizations is a part of an effort by the Michigan Office of Services to the Aging to study the size, stability, and compensation levels of the direct-care workforce supporting participants in Michigan's Medicaid-funded home and community-based services programs. Summaries and detailed analysis of survey findings are available at **www.PHInational.org/michigan**.

PHI MICHIGAN

PHI Michigan is a regional program of PHI (**www.PHInational.org**). PHI works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. Using our workplace and policy expertise, we help consumers, workers, employers, and policymakers improve eldercare/disability services by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect, and independence.

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Introduction

In 2010, the Michigan Office of Services to the Aging (OSA), along with similar agencies in seven other states,[1] was awarded federal funding through the State Profile Tool (SPT) to collect basic data on the direct-care workforce in home and community-based services (HCBS) programs. Working with the Michigan Disability Rights Coalition (MDRC) and PHI, and in consultation with the SPT consumer advisory council, OSA opted to survey provider organizations working in three of Michigan's Medicaid-funded HCBS programs:

- MI Choice HCBS Waiver Program[2]—MI Choice Employer Workforce Survey (MEW Survey)
- Home Help[3]—Home Help Employer Workforce Survey (HH-EW Survey)
- Habilitation Supports Waiver (HSW) and 1915 (b)/(c) Waiver[4]—Community Mental Health Employer Workforce Survey (CMH-EW Survey)

This survey effort was based largely on guidance provided by the National Direct Service Workforce Resource Center (DSW-RC)[5] to states for the development and creation of a minimum data set (MDS) of workforce measures. In the white paper, *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection*, the DSW-RC provided recommendations to states on how to develop an MDS—tools for data-driven decision-making—based on three key pieces of workforce data:

Workforce Volume—Number of full-time and part-time direct-care workers

Workforce Stability—Turnover rate and job vacancies

Workforce Compensation—Average hourly wages and availability of benefits

Specifically, a direct-care workforce MDS can help a state achieve the following goals:

- Identify and set priorities for long-term supports and services reform and systems change.
- Inform policy development regarding direct-care workforce improvement initiatives, including efforts to improve workforce recruitment and retention.
- Promote integrated planning and coordinated approaches for long-term supports and services.

1 The seven other states involved in the national State Profile Tool Project are: Arkansas, Florida, Kentucky, Maine, Massachusetts, Minnesota, and Ohio.

2 The MI Choice HCBS Waiver program provides home and community-based services to seniors and people living with disabilities who would otherwise require services in a nursing home. Services include homemaker, private duty nursing, and personal care services.

3 The Home Help program provides "personal care services" to qualified Medicaid recipients. This includes activities of daily living (assistance with bathing, toileting, dressing, etc) and some independent activities of daily living (shopping, cooking, etc.). The program serves over 60,000 people, more than any other Medicaid-funded HCBS program.

4 The HSW and 1915 (b)/(c) waivers provide home and community-based supports to individuals with developmental and cognitive disabilities and mental illness. Services are provided in a managed care system through Pre-Paid Inpatient Health Plans, which are comprised of Community Mental Health Service Programs. Community living supports, which include personal care and home health services, and private duty nursing are among the available services.

5 The National Direct Service Workforce Resource Center (DSW-RC) supports efforts to improve recruitment and retention of direct service workers who help people with disabilities and older adults to live independently and with dignity. This Resource Center provides state Medicaid agencies, researchers, policymakers, employers, consumers, direct service professionals, and other state-level government agencies and organizations easy access to information and resources they may need about the direct service workforce. The Center brings together the nation's premier resources on the topic of the direct support workforce. The DSW Resource Center is funded and supported by the Centers for Medicare & Medicaid Services (CMS) under the U.S. Department of Health and Human Services.

- Create a baseline against which the progress of workforce improvement initiatives can be measured.
- Compare workforce outcomes for various programs and populations to better evaluate the impact of policy initiatives.
- Compare state progress with the progress of other states and with overall national performance (where data from other states are available).

The surveys of these three different provider groups represent the first attempt by Michigan state agencies to quantify the direct-care workforce specific to home and community-based services and capture basic workforce data and issues specific to these programs. OSA engaged PHI to develop and implement the survey of employer organizations and analyze the findings by program.

Minimum Data Set: Workforce Volume, Stability, and Compensation

Table 1 provides an overview of the basic workforce data collected from the provider organizations that responded to surveys mailed in Spring 2012.

Table 1 – Workforce Data across Michigan's Medicaid Home and Community-Based Programs

Workforce Volume			
	CMH Employer Workforce Survey	**Home Help Employer Workforce Survey**	**MI Choice Employer Workforce Survey**
Survey Population	440	190	539
Survey Response Rate	28% (123)	21% (40)	31% (167)
Number of Direct-Care Workers (DCW) Employed or Contracted[6]	10,640	1,320	4,841
Average Number of Direct-Care Workers per Employer Organization	123	44	40
Percent of DCWs Employed Full-Time and Part-Time	Full-Time: 44% Part-Time: 56%	Full-Time: 45% Part-Time: 55%	Full-Time: 31% Part-Time: 69%
Workforce Stability			
Average Annual Turnover Rate	32%	39%	32%
Average Number of DCWs Leaving Each Organization in Last 12 Months	40	17	13
Number of Job Vacancies Within a One Week Period	408	56	280
Workforce Compensation			
Average Starting Hourly Wage Rate	$8.73	$9.09	$9.09
Average Current Hourly Wage Rate	$9.75	$9.68	$9.87
Percent of Employers Offering Health Insurance to DCWs	63%	53%	59%
Percent of DCWs Covered by Employer-Sponsored Health Insurance	26%	15%	14%
Percent of Employers Offering Paid Sick Leave to Full-Time DCWs[7]	53%	53%	40%
Percent of Employers Offering Paid Vacation Leave to Full-Time DCWs	70%	45%	56%

6 All of these results are based on survey respondents and may not be representative of all employer organizations in the respective programs.

7 The average number of hours worked per week to be considered full-time across all three surveys was 36 hours.

Summary of Findings

Although the three Medicaid long-term supports and services (LTSS) programs are administered differently and serve different populations, the three surveys revealed several consistent workforce themes.

Provider organizations identified low wages, part-time hours, and lack of mileage reimbursement as significant challenges to attracting direct-care staff.

- Providers across all three LTSS programs note the wage level as one of the most significant barriers to both recruiting and retaining direct-care staff. Survey findings show that the average starting and current hourly wages are lower than median wages for Michigan direct-care occupations reported by the Bureau of Labor Statistics in May 2011 ($10.45 for home health aides, $9.96 for personal care aides, and $12.11 for nursing assistants).[8] Given these comparative figures, Michigan's home and community-based providers are at a competitive disadvantage in recruiting and retaining direct-care staff compared to nursing homes and other long-term supports and services employers. Reimbursement rates and methodologies could better reflect competitive market labor costs or a family self-sufficient wage rate.[9]
- On average, 60 percent of staff employed by responding provider organizations work part-time, at less than 36 hours per week. This high level of part-time work compounds the challenges of the low wage rates, creating a significant recruitment and retention challenge, according to survey respondents.
- Only one-third of respondents report reimbursing direct-care staff for mileage and/or gas for travel between participants. Direct-care workers are often required to drive between participants' homes throughout the course of a workday.

In 2006, the National Association for Home Care and Hospice estimated that home care workers in Michigan travel 161.3 million miles annually.[10] With gas prices regularly exceeding $3.50/gallon, getting to participants' homes can be difficult for workers. Given the wages that direct-care staff earn, it is likely that a significant portion of their wages for a given day goes directly to their own transportation costs to get from worksite to worksite, making the work financially unsustainable. Yet, there is no clear policy from the Michigan Department of Community Health for these programs that either a) includes transportation costs in the calculation of the rate paid to providers, or b) requires providers to reimburse workers for their transportation costs incurred while serving participants.

8 Bureau of Labor Statistics (May 2011). State Occupational Employment and Wage Estimates, Michigan. Available online: **http://www.bls.gov/oes/current/oes_mi.htm#39-0000**.

9 According to the Michigan League for Public Policy (MLPP), the self-sufficiency wage for a single person is $10.83 per hour. MLPP defines economic self-sufficiency as "the level at which a household is able to meet all of its basic expenses without relying on government or non-profit assistance." *Economic Self-Sufficiency in Michigan: A Benchmark for Family Well-Being* (June 2011). Available online: **http://www.milhs.org/wp-content/uploads/2010/07/SSJune2011.pdf**.

10 National Association for Home Care and Hospice (June 2008). "Escalating Energy Costs Threaten Health Care for Critically Ill and Homebound Seniors: Home Care Nurses, Aides, and Therapists Drive 4.8 Billion Miles per Year to Reach Shut-In Patients," Available online: **http://www.docstoc.com/docs/40740920/Escalating-Energy-Costs-Threaten-Health-Care-for-Homebound-Seniors**.

Retaining staff is a challenge for many HCBS organizations.

Survey respondents were asked to describe their experience in retaining staff and to report the number of direct-care workers who had left employment in the previous 12 months. Across all three surveys, providers report an average turnover rate of 34 percent, and a sizeable level of provider organizations (39%) report that retaining staff was difficult or almost impossible. In addition, each provider organization responding to this survey reports losing an average of 23 direct-care staff in the last 12 months.

A 2004 report shows that an organization spends an average of $2,500 to recruit, screen, train, and hire a new worker.[11] Given these figures, each Medicaid HCBS provider organization could spend an average of $57,500—or $6.25 million across all respondents—to replace those who left employment over the last 12 months. This same 2004 report describes employee replacement costs as a "hidden tax which ultimately is paid by taxpayers for high industry turnover costs."

Research shows that the reasons for turnover are varied, but the most consistent are low wages and transportation costs. A recent report analyzing the home care and personal care industry highlights several studies linking increased wage rates with lower turnover.[12] Michigan's own *Voices from the Front* study in 2004 showed that increasing wages by $1 per hour reduced the likelihood that a worker would leave by 15 percent.[13] Several other studies from across the country link wages and transportation costs to turnover, including a Wyoming study showing a 20 percent decrease in turnover as wages increased and a Maine study demonstrating that reimbursing workers for transportation lowered turnover as much as a significant wage increase.[14] [15]

Providing affordable health care coverage is difficult for HCBS provider organizations.

The largely Medicaid-funded home and community-based services sector rarely offers affordable health insurance coverage to its largely part-time workforce.

- Of responding provider organizations, 42 percent do not offer health insurance to their direct-care staff.
- For the 58 percent of the LTSS employers who do offer health insurance, most pay less than 25 percent of the premium costs for health care coverage.
- Only 18 percent of direct-care workers employed by responding organizations across all three programs receive employer-sponsored health insurance.

These factors contribute to an uninsured rate of 40 percent among Michigan's home care workers, a rate substantially higher than that of certified nursing assistants working in the

11 D. Seavey (October 2004). *The Cost of Frontline Turnover in Long-Term Care*, Better Jobs Better Care Report, Washington, DC: Institute for the Future of Aging Services, American Association of Homes and Services for the Aging. Available online: **http://phinational.org/sites/phinational.org/files/clearinghouse/TOCostReport.pdf**.

12 PHI (December 2011). *Caring in America: A Comprehensive Analysis of the Nation's Fastest-Growing Jobs: Home Health and Personal Care Aides*. Available on-line: **http://phinational.org/policy/caring-america-guide-americas-home-care-workforce**.

13 M. Mickus, C.C. Luz, A. Hogan (2004). *Voices from the Front: Recruitment and Retention of Direct Care Workers in Long Term Care Across Michigan*, Michigan State University. Available online: **http://phinational.org/sites/phinational.org/files/clearinghouse/MI_vocices_from_the_front**.pdf.

14 B.D. Sherard (2002). *Report to the Joint Appropriations Committee on the Impact of Funding for Direct Staff Salary Increases in Adult Developmental Disabilities Community-Based Programs*, Wyoming Department of Health. Available online: **http://www.pascenter.org/documents/WY_2002.pdf**.

15 L. Morris (2009). "Quits and Job Changes Among Home Care Workers in Maine," *The Gerontologist*, 49(5): 635-50. Available online: **http://gerontologist.oxfordjournals.org/content/49/5/635.abstract**.

state's nursing homes and the state's overall population.[16] This disparity adds to home and personal care jobs being less attractive compared to others in the LTSS sector. The implementation of the Affordable Care Act—including the including the expansion of Medicaid to individuals with income under 138 percent of the federal poverty level and the availability to enroll in coverage through the Health Insurance Exchange, both slated to begin in October 2013—provides new coverage options for direct-care workers. MDCH has an opportunity to inform LTSS providers and their staff about critical decisions to be made regarding health care coverage in the coming year.

Core competencies and training for the home and community-based direct-care workforce must be expanded.

The MI Choice waiver, Home Help, and CMH waiver programs have different requirements, capacities, and existing infrastructures to support and provide initial and ongoing training for direct-care workers serving elders and people living with disabilities. However, results from all three sectors point to essential training topics that can inform and help build coordinated training systems to meet the needs of providers, participants, and workers.

Table 2 – Top 10 Required Training Topics (in order of priority) – MI Choice and Home Help[18]

Top 10 Training Topics – MI Choice	Top 10 Training Topics – Home Help
Infection Control	Personal Care
Safety/Emergency	Safety and Emergency
Personal Care	Documentation
Transferring/Lifting	Infection Control
Confidentiality	Providing Services Based on Needs of the Individual
Documentation	Nutritional Support
Consumer Rights	Consumer Rights
Communication	Consumer Confidentiality
Providing Services to Meet Needs	CPR
CPR	Administering Medications
Understanding Social Needs	Understanding Mental Illness
Using Technology to Support the Consumer	Understanding Social Needs

MI Choice and Home Help training

Current training requirements and resources for direct-care staff employed in the MI Choice and Home Help programs are very modest. Employers are often left to deliver training themselves, resulting in inconsistent and inefficient training across a given LTSS program.[17]

The survey respondents were asked to identify required training from a list of training topics. The survey results provide a broad picture of what employers believe to be essential training topics and methodologies for both the MI Choice and Home Help workforce (**Table 2**).

16 PHI (September 2011). "State Facts: Michigan's Direct-Care Workforce." Available online at: **http://phinational.org/sites/phinational.org/files/clearinghouse/PHI-StateFacts-MI.pdf**.

17 The "Building Training…Building Quality" training demonstration, funded with a Health Resources and Services Administration (HRSA) grant to OSA, is identifying training competencies for personal care attendants in the MI Choice program and providing support to employers in delivering that training. This pilot is being implemented across six waiver agencies in four areas of the state. For more information, go to: **http://phinational.org/policy/state-activities/phi-michigan/priorities/training/btbq**.

18 Training topics are listed in order from highest to lowest percentage of employers indicating that the topic is required.

With MI Choice and Home Help employers' training interests in such close alignment, a coordinated training program across these two HCBS systems might be valued by employers, workers, and most importantly, participants.

CMH waiver program training

Current competency, curriculum, and training standards for the CMH-funded waiver workforce are more fully developed—involving both Medicaid and state licensing requirements—with trainings delivered both by provider organizations and local CMH employees. This system gives post-employment preparatory training to thousands of new workers who serve thousands of participants.

MDCH and the Michigan Department of Human Services (MDHS) have separate responsibilities that impact the training of direct-support workers. MDCH policies outline modest competency and training requirements for the direct-support workforce regulated by the Bureau on Behavioral Health and Substance Abuse.[19] Aides serving adults are to be trained in first aid and "in the beneficiary's plan of service, as applicable."

As the licensing agency for adult foster care homes, MDHS is responsible for training requirements for staff who work in adult foster care (AFC) homes serving CMH-funded beneficiaries/participants. AFC homes can seek an additional credential from MDHS—certification—to serve CMH-funded beneficiaries/participants. The additional credential requires the training of direct-support staff in the curriculum, "Providing Residential Services in Community Settings: A Training Guide."[20]

Developed in the late 1990s, this residential service curriculum has become the foundational piece for initial training for almost all direct-support staff working in CMH-funded services. However, people trained in the posted curriculum are not assured that employers will recognize and accept their successful completion of the training when they change jobs—even within the CMH system. In some areas of the state, local CMH polices and individual employers require the retraining of trained workers because they do not feel assured that the content of the training or quality of trainers adequately prepare workers for their participants or settings. These retraining requirements—whether required by CMH or employer policies—seem to reflect a systemic lack of confidence in the curriculum and training entities.

Almost all provider organizations currently rely on a combination of in-house training sessions or contracts with outside organizations, including the local CMH staff. Nearly one-third (30%) of provider organizations solely do the training themselves, likely due to the concerns about the current training system. Even with a training infrastructure and state-approved curriculum, one-third of providers report that the inability of staff to perform essential job duties is a challenge to retaining direct-support workers.

The Legislature has recognized the problems and challenges of training within the CMH system and has asked MDCH for resolution. In FY 2013 appropriations for MDCH, the department is asked to develop a plan to "maximize uniformity and consistency" in provider contract

19 Medicaid Provider Manual, Mental Health/Substance Abuse section and Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services and HCPCS/CPT Codes, March 12, 2012.

20 The residential services curriculum can be found on the MDHS website section on AFC homes at **http://www.michigan.gov/dhs/0,4562,7-124-5455_27716_27717-224979--,00.html**. The training materials have changed to reflect current realities. The food pyramid has been replaced with the food plate. These changes in the posted curriculum must be approved by MDHS for direct-care staff working in certified AFC homes.

provisions related to "training requirements for direct-support staff." Using the findings in this report to develop core competencies and specialized or advanced competencies can help move CMH-funded services towards uniformity, consistency, and efficiency in worker training. Starting with agreed-upon competencies, other states have developed high-quality, adult-learner centered curricula that support and drive the philosophies and goals of person-centered planning, freedom, integration, and participation.

Within the robust and experienced CMH training system, these full survey results provide areas for improvement and a list of training topics that seem to comprise a set of core competencies for this workforce.

Conclusion

This survey effort provides the foundation for OSA or another state agency to create a data warehouse on the direct-care workforce, and possibly other occupations serving home and community-based programs. Findings from the three employer surveys that were a part of the State Profile Tool provide baseline data on direct-care workforce volume, stability, and compensation, establishing an initial minimum data set (**Table 1**, page 3) to inform state goals, programs, and priorities.

CMS and the DSW-RC encourage states to collect workforce data on an ongoing basis to identify workforce trends, plan for program changes, and develop and analyze interventions to address workforce challenges. Only by having reliable program-specific information and data on the needs of workers and employers can Michigan adequately meet the growing demand and shifting preferences regarding delivery models for long-term supports and services.