HOMECARE AIDE WORKFORCE INITIATIVE (HAWI)

EVALUATION: EXECUTIVE SUMMARY

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BACKGROUND

By 2020, the United States will need between 4 and 5 million direct care workers to serve the rapidly increasing numbers of older adults and other Americans who live with disabilities or other chronic conditions and require hands-on assistance with bathing, dressing and a host of other daily tasks. Addressing the critical need for carefully selected and well-prepared workers who can provide high quality, compassionate care to individuals in need of supportive services, the Harry and Jeanette Weinberg Foundation announced the launch of the Homecare Aide Workforce Initiative (HAWI) in January 2013.

A large, multi-year, foundation-funded initiative,[i] HAWI was designed to improve care for the growing number of older adults who receive home health services by improving the skills, job satisfaction, and retention of the home health aide (HHA) workforce. The HAWI initiative consisted of two main programs: 1) an innovative HHA *entry-level* workforce program to enable aides to earn required credentials and enter quality jobs; and 2) a *Specialty Aide* program to build HHAs' advanced skills in areas including cultural diversity, dementia, falls prevention, palliative care and end of life.

The subject of this report is HAWI's HHA *entry-level workforce* program, designed and directed by the Paraprofessional Health Care Institute (PHI) and implemented by three New York State (NYS) licensed home care agencies affiliated with the UJA Federation of New York: 1) Home Assistance Personnel, Inc. (HAPI); 2) Best Choice Home Health Care, and 3) Selfhelp Home Care Services (Selfhelp). Specifically, we report the results of a program *evaluation* conducted by a research team at the VNSNY Center for Home Care Policy and Research in New York City (NYC) and independently funded by the Weinberg Foundation. The period of the evaluation covers a total of 32 entry-level training courses that ran from January 2013 through June 2014.

EVALUATION OBJECTIVES

The objectives of the evaluation were to assess the *implementation* of the entry-level program; examine its *impact on HHA satisfaction, retention and continuity of patient care*; and extract *generalizable lessons for future HAWI implementation and dissemination*. Accordingly, this evaluation report addresses three main questions:

1. *What are the core components of HAWI, and what factors are associated with successful adoption and implementation?*

[i] In addition to the Weinberg Foundation, other HAWI funders were: the UJA Federation of New York, the New York Community Trust, the Tiger Foundation, the Surdna Foundation, and the New York Alliance for Careers in Healthcare through the NYC Workforce Development Fund and the National Fund for Workforce Solutions/Social Innovation.

2. *What was the impact of HAWI on HHAs' course completion, their job satisfaction and perceptions, and their intent to stay on the job?*

3. *What was the impact of HAWI on key outcomes that affect entry-level workers and the older persons who are their clients? Specifically, to what extent can HAWI be associated with:*

    i. Greater satisfaction among new graduates
    ii. Increased hours and/or regularity of work
    iii. Increased retention among new HAWI hires
    iv. Increased continuity of care for clients

In brief, the evaluation report discusses: 1) *how well – i.e., with what degree of fidelity – HAWI was implemented;* 2*) the extent to which the model yielded the intended results; and 3) implications for future replication of the HAWI entry-level model by agencies in NYS or elsewhere.*

METHODS

To address these questions, the research team collected data from four main sources: 1) direct observation of HAWI training sessions and workshops and review of program documents; 2) interviews and meetings with key stakeholders at HAWI participating agencies; 3) survey data collected at baseline, graduation and three months post-graduation from approximately 500 HAWI trainees who consented to participate in the research; and 4) data from the agencies' vendors for payroll data management. The latter data source included information on HHA visits and employee characteristics with a look-back period to 2008 for two agencies and 2010 for one.

We used these qualitative and quantitative data for several purposes. First, we drew from program documents, from our direct observations of training and from our interviews with key stakeholders to understand the *underlying philosophy and substantive content of the HAWI model*, to learn *how faithfully the model was implemented* "on the ground" and to identify *environmental and organizational factors* that influenced implementation. Second, we gathered program statistics and analyzed trainee survey data to examine the *characteristics of the participants, their graduation and hire rates and their perceptions of their training and early employment experience*. Third, we analyzed agencies' payroll data to calculate *HHA hours worked, their job retention rates at 90 days and 6 months from the start of employment, and continuity of client care,* capturing trends both before and after HAWI start-up.

For logistical reasons the evaluation could not employ a randomized design that would have assigned trainees or agencies to HAWI or to a "usual training" control group. Nevertheless, we do have four to six years of trend data on HHA hours worked and retention rates at each of the participating agencies, and these data allow us to determine whether significant changes were associated with the introduction of HAWI. In Parts V and VI of the report, where we discuss the findings of HAWI participant surveys and payroll analyses, we describe our data sources and analytic approaches in greater detail. We also discuss the implications of our findings, including potential limitations in interpretation stemming from the evaluation design.

ACTORS

On the ground, PHI and the three participating home care agencies were the key actors responsible for HAWI's implementation.

PHI, established in 1991 to "improve the lives of people who need home or residential care – by improving the lives of the workers who provide that care," was *HAWI's chief program designer and change agent.* As such, PHI was responsible for incorporating recently modified NYS training requirements into a robust entry-level program and coaching participating agencies to implement it in their organizations. PHI's role as change agent was not a new one. Over a period of nearly fifteen years PHI has become nationally renowned for its work in three areas: 1) training, support and curriculum development for direct care workers; 2) national and state strategies and policies for strengthening the direct care workforce; and 3) coaching and consulting for eldercare and disability service providers.

The three home care agencies that participated in HAWI's entry-level workforce program were: *1) Home Assistance Personnel, Inc. (HAPI), a part of Jewish Home Lifecare; 2) Best Choice, a part of CenterLight Health System, Inc.; and 3) Selfhelp Home Care Services, a part of Selfhelp Community Services, Inc.* Each agency is a NYS *Licensed Home Care Services Agency* (LHCSA) licensed under NYS law to employ and provide HHA and personal care services to individual clients, and each of the HAWI agencies employed between 700 to 1000 HHAs at the time of HAWI start-up. As is true for most NYC LHCSAs, the HAWI agencies principally served Medicare and Medicaid beneficiaries and relied primarily on contracts with Medicare/Medicaid certified agencies or managed long term care and other health plans as a source of clients and revenues**.** Each HAWI agency also was part of a larger system ranging in size from $70 million to $1.5 billion in annual revenues in 2012-2013. Given the size of each participating agency relative to its parent system, each enjoyed a somewhat different position of influence within that system.

THE EXTERNAL ENVIRONMENT

Throughout the United States, state changes in training requirements, minimum wages and permitted scope of practice are affecting direct care workers and the organizations that employ them. Changes in long term care policy are occurring with equal or greater speed, also affecting direct care employers and their workers. In this respect NYS is emblematic of the nation and provides a vivid case study for learning about the opportunities and challenges entailed in implementing workforce change in a dynamic policy environment.

On the opportunity side, over the last decade, emerging NYS policies and approaches to building HHA workforce capacity have reflected policy makers' growing awareness of the importance of training a high quality HHA workforce. In addition, restructuring of the NYS Medicaid program, begun in 2011, has underscored the need for well-trained HHAs to provide the home and community-based services that are a centerpiece of the State's new long term care strategy. In this respect, the NYS political environment was ripe for testing a model such as HAWI.

On the constraint side, multiple political and economic factors converged within the timeframe of HAWI's implementation to introduce significant changes in the NYS financing and service system and to create increased financial pressures for LHCSAs. These changes included imposition of a global cap on Medicaid expenditures, cuts for Medicaid personal care and certified home health services, and limits on administrative and direct labor costs for organizations with more than 30 percent revenue from Medicaid. During this time NYS also embarked on an ambitious "Medicaid Redesign" effort that completely reorganized the Medicaid personal care and long term care sector, transferred thousands of Medicaid personal care clients from fee-for-service to managed long term care (MLTC) plans, and disrupted long-standing relationships between the LHCSAs and what had been their traditional client referral sources.

These ongoing state policy changes have created significant challenges and uncertainty for LHCSAs and have threatened the financial viability of many agencies in a competitive market. They also have made it necessary for the leaders of the HAWI agencies, like other LHCSAs, to manage many, sometimes competing, priorities, of which workforce training and employee retention are only one.

THE HAWI MODEL: CONTENT AND IMPLEMENTATION

A. Content

HAWI's entry-level program is a multi-faceted innovation consisting *of five core components and multiple subcomponents, plus additional recommendations for a guaranteed job placement policy and an agency-level cross-functional team.*

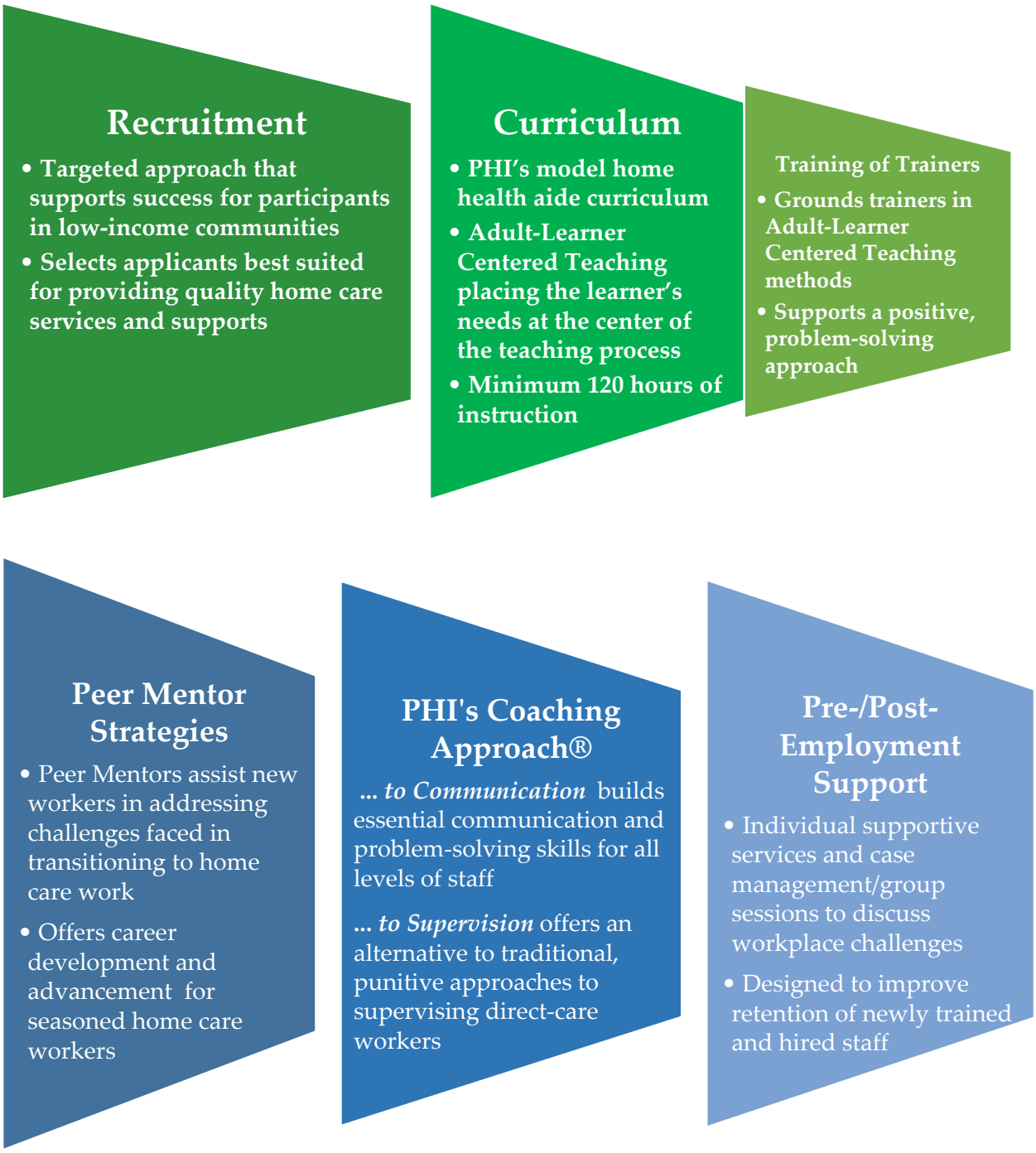
HAWI's five core components are:

1. Special HHA recruitment and screening procedures designed to select the most able, work-ready trainees
2. Customized adult-learner centered HHA training with a model HHA curriculum and training of trainers
3. Peer mentoring for HHAs
4. Coaching of HHA supervisors
5. Supportive services/case management for HHAs both pre- and post-employment

Additionally, both the customized training and recruitment and selection components consist of a number of subcomponents.

With so many moving parts, HAWI was obviously a *complex innovation*. Further, HAWI's *compatibility* with prior standard operating procedures varied by program component across the participating agencies. Moreover, each agency perceived the *relative advantage* of HAWI somewhat differently, depending in part on how satisfied the agency was with new workers' performance and job retention in prior years.

HAWI Components



B. Implementation

The HAWI model's training component and its subcomponents – including HAWI's customized curriculum, more intensive time commitment on the part of both trainers and trainees and emphasis on adult learner-centered team-based learning with the addition of Peer Instructors to the classroom – *were the most faithfully and consistently implemented parts of the model across all three participating agencies.* Fidelity to HAWI's training approach can be attributed partly to PHI's intensive technical support for training; in part to the "positive reinforcement" provided by the obvious enthusiasm of trainees and Peer Instructors in the classroom; and in part to the realization of agency directors and instructors that their prior training approaches were not necessarily "state of the art" or maximally effective.

Other components and subcomponents of the HAWI model – in particular, PHI's recommended recruitment and screening strategies, case management services, coaching supervision and peer mentoring – *were implemented unevenly both within and across the three participating agencies.*

SUBSTANTIVE RESULTS

A. Participation

During the HAWI evaluation period 599 trainees entered HAWI training and 502 graduated. Of the 502, 472 completed the graduation survey administered at course completion. Among those graduates who consented to participate in the evaluation, 440 subsequently were identified as available for the 3-month post-graduation survey (including 30 who had left the job before 3 months); 233 responded. (Figure 2 in the body of the report presents a graphic description of the flow of participants from day 1 of training to 3-month follow-up.)

B. Perceptions of Trainees and New Hires

Judging by the survey responses of HAWI graduates, *the HAWI training component was highly successful.*

A full 100% of responding graduates reported that the training was excellent, very good or good, with 75.7% reporting the training was excellent.

Graduates also expressed a high level of *confidence in their preparation for working with clients,* and responded to open-ended survey questions with numerous comments highlighting their comfort in the classroom, relationships with instructors and teaching assistants, and camaraderie among the students. Relationship-building was one of the areas that distinguished the adult learner-centered model from the traditional didactic style of teaching.

Further, *six out of ten (62.3%) of the newly hired HAWI graduates who responded to the 3-month follow-up survey reported that they were "very satisfied" with the job*, while another

28.7% reported that they were "satisfied." *This suggests that the training did a good job of setting expectations for over 90% of the new hires.*

The overall volume of new hires' comments about HAWI's Peer Mentor and Case Management components was relatively low compared to comments about training. Moreover, some respondents either did not know about these components or viewed them as unnecessary.

Additionally, open-ended comments about agency supervisors suggest that HAWI's coaching supervision component was not as effective as it might have been. Even though three-quarters of HAWI respondents "agreed" (33.8%) or "totally agreed" (39.6%) that "my *supervisor* treats me with respect," a sizeable minority (26.6%) of HAWI new hires reported that they disagreed, were unsure or were neutral about this statement. This level of dissatisfaction was echoed in the number of respondents who said that the single most important thing that could be done to make their job better would be better treatment by their supervisor.

Based on the perceptions of HAWI survey respondents, *the results of other important HAWI components – namely, the peer mentoring, case management and coaching supervision – must be viewed as mixed.*

Over a third (36.6%) of respondents said they were "very" (9.7%) or "somewhat" (26.9%) *dissatisfied with pay*, while only 16.7% were very satisfied. Additionally, *54.9% of the new hires said they would like to be working more, with only 45% reporting they were "getting enough" hours.* Further, the open-ended responses on what would make the job better underscored the structural barriers to job satisfaction and retention – namely, difficulty obtaining enough work hours, the issue of being assigned "short-hour" cases and not being able to piece together a full-time schedule, wages, benefits, and general support for workers.

The limits of HAWI's impact can be seen in HAWI respondents' attitudes toward their pay and hours.

C. Findings on Hours Worked, New Hire Retention and Client Continuity of Care

In addition to the survey data collected from HAWI participants, the evaluation team acquired secondary data from the agencies' vendors for payroll data management. These data included information on HHA visits and employee characteristics with a look-back period to 2008 for two of the agencies and to 2010 for the third agency. Altogether, a total of 4,831 HHAs were included in the payroll analyses. All of these HHAs fell into one of three groups: 1) all HHAs with a hire date prior to February 11, 2013 (which marked the end of the first HAWI training cycle); 2) all HHAs hired on or after February 11, 2013 who did not have HAWI training; and 3) all HHAs hired on or after February 11, 2013 who were HAWI graduates. We used these secondary data to calculate: (1) average hours worked per week, (2) HHA job retention at 90 days (three months) and at 180 days (six months) from the start of employment, and (3) client continuity of care.

Hours Worked per Week

The participating agencies assigned, on average, 28 hours of work per week to HAWI new hires. This was equal to both the 28-hour average of new hires in the years prior to HAWI start-up and the 28-hour average of non-HAWI new hires during the period post-HAWI start-up.

The trends in the average hours per worker per week were quite stable over time, for each agency and overall.

While the 28-hour average did not satisfy the majority of HAWI survey respondents, it is possible that without special efforts by the participating agencies, the HAWI new hires might have been assigned even fewer hours. This is because HAWI new hires did not arrive with a client "in hand" in the way that other new hires in 2013 may have if they moved to one of the participating agencies by virtue of the continuity of care provisions in the state's transition to managed long term care.[ii] Thus *without a special effort HAWI new hires might be expected to have had the fewest hours of any new employees served by a participating agency. Instead, they achieved parity in hours worked.* Given the limits of our data, however, we are unable to determine to what extent this conclusion may be warranted.

Retention

The average 90-day retention rate of HAWI new hires was 88%, compared to 79% for HHAs hired before February 11, 2013, and 76% for those hired after February 11, 2013 without HAWI training. Moreover, the superior retention of HAWI new hires persisted at six months, with 76% of HAWI new hires still on the job, compared to 70% of HHAs hired prior to February 11, 2013 and 64% of those without HAWI training who were hired after February 11, 2013.

Further, when using multivariate analyses to examine retention, we found that, *controlling for age and hours worked per week, HAWI new hires were more than twice as likely to be retained at three months and 64% more likely to be retained at six months as HHAs hired before the training was offered.* In contrast, there were no significant differences between new hires in the other two groups (pre-HAWI versus post-HAWI start-up with no HAWI training).

HAWI new hires achieved demonstrably higher three-month and six-month retention rates than both new employees hired prior to HAWI start-up and those without HAWI training who were hired during the HAWI implementation period.

Given the multiple changes in the NYS policy environment, particularly the Medicaid expenditure cap and the redesign of the long term care system with its disruption in long-time

[ii] Those provisions essentially required that aides caring for a client transitioned to managed long term care be employed by the agency with the managed care contract for a period of 90 days. Further, the state required that the plans of care of transferred clients also remain intact for the 90-day period.

patterns of client referrals and its shift to managed long term care, we had expected that the "noise" in the environment might have obliterated any signs of HAWI impact. This concern, however, seems to have been unwarranted.

Continuity of Client Care

Using the agency payroll data, which provided visit information at the client level, we applied previously established methods to calculate client continuity of care prior to and after HAWI start-up. The continuity measure is an index ranging from 0 to 1.0, where 0 represents no continuity (i.e., each visit to a client from the start to the end of service is provided by a different HHA), and 1 represents perfect continuity (where all visits to a client from the start to the end of service are provided by the same HHA).

From this analysis we determined that continuity of care at the HAWI agencies was quite stable over time – 0.66 to 0.67, with 1.0 being perfect continuity. Given the long average length of client stays (111 days) at the HAWI agencies and the fact that more HHAs are likely to be involved in caring for clients with lengths of stay more than 90 days (as vacations, sick days and the like occur), this level of continuity can be considered "respectable." Moreover, the average continuity score of the 50% of clients with periods of care that were 90 days or less was 0.7, an even better performance. Many client advocates expected that continuity of client care would suffer in the period 2012-2013, as NYS Medicaid Redesign was implemented. Our data show that this was not the case for the HAWI agencies.

CONCLUSIONS

Both the survey responses of HAWI program participants and their superior three- and six-month retention rates show that HAWI was a resounding success.

We believe that *a logical chain of association* can be traced from the HAWI model – particularly its carefully implemented training component – to the satisfaction, confidence and expectations of the training graduates – to the superior three- and six-month retention rates of HAWI new hires. [1]

Because the other components of the HAWI model were less consistently implemented than the multi-faceted training component, their contribution to these results is difficult to assess. Nevertheless, all three of the participating agencies appreciated the importance of identifying, preparing and selecting the most able, job-ready training candidates, even if they did not adopt

[1] Although we believe there is a *logical* chain of association, we cannot establish a *formal statistical* chain of association. To do so would require linking the survey responses of individual HAWI respondents to their individual payroll data and determining if the most satisfied and confident respondents were the ones who had the highest retention rates. We could not do this because to promote candor we offered anonymity to the survey respondents and therefore do not have their individual identifiers.

all of HAWI's recommended recruitment strategies and screening tools. The support of Peer Mentors and Case Managers, albeit imperfect, clearly reached at least some of the trainees and new hires at least some of the time. Moreover, the overall HAWI philosophy, if not all the details of the HAWI model, found a responsive audience in the directors of the HAWI agencies and their superiors, who clearly wanted HAWI to succeed*. Altogether, we conclude, this combination of factors contributed to HAWI's positive outcomes*.

A. Implementation Fidelity

- *The training component and subcomponents of the HAWI model were the most faithfully and consistently implemented parts of the model across all three participating agencies. In contrast, the other components and subcomponents of the HAWI model were implemented unevenly across the three participating agencies.*

- *Uneven implementation of other components – namely, the peer mentoring, case management and coaching supervision – appears attributable to several factors:* a) the sheer *complexity* of the HAWI model in organizations with limited managerial resources; b) the *significant modification* of long-standing operating procedures and reallocation of scarce resources that would have been required to institute all the changes entailed in carefully adhering to recommended new approaches; and c) *varying perceptions about the relative advantage of HAWI components compared to what was already in place.*

- *Dedicated, cross-functional team meetings with PHI input, support and prompting were important during the early months of HAWI to help the agencies maintain focus on the program and put together the necessary pieces for successful program start-up.*

- *The presence of active HAWI champions within the participating agencies was critical for adherence to the model.*

B. Substantive Results

- In light of the myriad challenges introduced by changes in NYS policy and disruption/transformation of the long term care system, the *fact that the participating sites were willing and able to partner with PHI in implementing an ambitious entry-level workforce program and that they (and their payroll management vendors) and their new workers overwhelmingly cooperated in carrying out the evaluation is a significant HAWI achievement in itself*.

- Based on the survey responses of HAWI graduates and new hires, *the HAWI training component was highly successful. In contrast, the results of other important HAWI components – namely, the peer mentoring, case management and coaching supervision – must be viewed as mixed, reinforcing the qualitative observations of the evaluation team that these components were not as consistently implemented as the HAWI training component.*

- *The limits of HAWI's impact can be seen in HAWI respondents' less favorable attitudes toward pay and hours worked – critical aspects of the HHA job that were governed by powerful external factors largely outside HAWI's control.*

- *HAWI may have had an indirect impact on the hours assigned to new workers, but this is difficult to determine.* Many outside observers had expected HHA hours to plummet as a result of Medicaid cost containment and the shift to managed long term care. The fact that they did not may be a tribute to the agencies, to the way in which the state managed the transition to managed long term care, or both.

- *The demonstrably better three-month and six-month retention rates of HAWI employees vis-a-vis both new employees prior to HAWI start-up and new employees hired over the same period appear to be a robust HAWI "effect."* Nevertheless, because new hires in the period after HAWI start-up were not randomly assigned and likely differed from HAWI graduates in ways we could not measure (e.g., prior training experience and prior years served as an HHA), we cannot definitively rule out the possibility that other factors in addition to or instead of HAWI might account for this favorable retention difference.

  For example, staff at the participating agencies may have "favored" HAWI new hires simply because they graduated from the HAWI training program and not necessarily because they performed better on the job due to the HAWI training. Conversely, HAWI new hires may have "favored" the participating agencies simply because they trained there and not because of the substance of the HAWI training. We also should caution that the six-month time horizon, which was all that was feasible within the time period of the evaluation, is still a relatively short period of time for assessing turnover.

- *The remarkable stability in client continuity of care at the HAWI agencies over the period 2008-2014 is an impressive achievement of the HAWI agencies given the upheavals in the policy environment during the HAWI implementation period*. However, it cannot be attributed directly to HAWI for at least two reasons: NYS continuity of care provisions, which may have protected clients newly transferred to managed long term care from short-term changes in HHA assignment; and limits of the payroll data, which made it impossible to cleanly separate out HAWI-served clients from clients served by other HHAs.

C. Recommendations

1. *The HAWI training component* – including HAWI's extended curriculum, its adult learner-centered approach and its emphasis on team teaching and team learning with the addition of Peer Instructors to the classroom – *is a "winner." HAWI's curriculum, teaching methods and teaching aids,* along with the *technical assistance* necessary for successful implementation, should be disseminated as state of the art HHA training and *should be promoted for national replication.*

2. The comprehensive HAWI model as presented to the HAWI agencies is too complex. *The model should be distilled to its essential, "core" components*. Further, *there should be clarification of the types and extent of adaptation that can be accommodated* with the

expectation that positive results will not be compromised. The centerpiece of the more streamlined HAWI model should be HAWI's *enhanced curriculum* with its emphasis on a) a combination of health care content, clinical/personal care skills, critical thinking, communication and problem-solving; and b) interactive, hands-on team-learning and team teaching incorporating peer instructors as course assistants and role models.

3. In situations where individual home care agencies are "buying in" to the HAWI model or accepting a grant for the purposes of implementing the model, *agreement in advance should be secured on adherence to the core components and on the principle of identifying mutually acceptable adaptations to those components should the need arise.*

4. One or more *methods to finance the incremental costs of HAWI training* should be tested, such that these costs are not borne by individual trainees, who are predominantly low income, or by individual home care agencies, which generally do not have the scale, expertise or the depth of resources to mount or sustain the HAWI model on their own. In particular, *centralized training should be tested* as an option for creating a cadre of expert teachers, addressing the space constraints of individual agencies, and gleaning economies of scale related to trainee through-put, teacher productivity, facilities operation, space and the like. Further, to make centralization appealing to HHA employers and to make the promise of a job a genuine prospect for trainees, *opportunities should be created within the centralized model for prospective HHA employers to "put their stamp" on the training and gain a sense of responsibility toward training graduates.*

5. As a final recommendation we believe that any future evaluation of HAWI replication, including testing of a more centralized training approach, should seek to incorporate *a staged roll-out design* so that there would be ample opportunity to monitor and track new hires from participating agencies for a period of six months prior to graduation of the first trainees of a HAWI replication. This would allow the evaluation team to collect and analyze more detailed survey data on a more or less contemporaneous group of new hires and enhance the ability to draw causal inferences.