Study on Access to Choices for Care with Community Based Long Term Care Providers

Presented to:

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Executive Summary

The Vermont Department of Aging and Independent Living (DAIL) contracted with Flint Springs Associates (FSA), a Vermont-based consulting firm to conduct a study on access to Choices for Care (CFC) services and consider implications of opening Choices for Care to alternate direct service providers such as non-medical home care agencies (NMCHA).

DAIL identified the following three issues for the study to address:

Issue #1: Assess the ability of Vermont's home and community-based long-term care providers to provide CFC direct services, particularly in the context of staffing shortages.

Issue #2: Determine whether allowing NMHCAs to become CFC providers would have the potential to increase the volume of services participants are able to receive.

Issue #3: Determine other potential solutions that may exist to increase the CFC services provided to individuals in home-based settings.

To gather information toward answering the research questions, FSA:

- Examined datapoints in DAIL's WELLSKY A&D and Vermont Department of Health Access (DVHA) MMIS databases to determine the size and extent of gaps between needed and provided personal care.
- Conducted structured interviews with eight of Vermont's home health agencies (HHA) and Bayada to assess their ability to provide CFC direct services given the Direct Care Workforce shortages.
- Conducted structured interviews with Vermont Legal Aid Long Term Care (LTC) Ombudsmen to understand concerns raised by CFC recipients regarding access to services.
- Conducted structured interviews with nine NMHCA's operating in Vermont to assess the level of interest and capacity to provide CFC services as a Medicaid provider.
- Explored potential solutions to addressing Direct Care Workforce shortages and increasing access to CFC services during the above structured interviews.
- Conducted a review of the literature to identify potential solutions to addressing Direct Care Workforce shortages and increasing access to CFC services.

Key findings were as follows:

- Issue #1: Ability to provide needed services to CFC participants.
  - Of the nine Home Health Agencies, including Bayada, interviewed, seven verified they are finding it difficult to provide needed services due to staffing shortages.

  - HHA self-reported aggregate data suggests that, on average, HHA's seek to schedule, i.e. "target", 58% of authorized hours of service; 80% of such "targeted" hours of service are provided. These percentages vary across individual HHAs; how "targeted" hours are determined is left to each HHA as no uniform standard exists which must be followed.

- Analysis of individual CFC participant data from WELLSKY A&D and MMIS databases assessed the degree to which authorized services were provided. Two approaches were used in these analyses. First, the analysis examined the proportion of allocated service budgets (WELLSKY A&D data) that were delivered (MMIS expenditure data). Across all HHA's, 19% of allocated services were delivered. This percentage differed significantly by level of service need; 21% of allocated personal care services were provided to high-highest need CFC participants, as compared to 17% of allocated services delivered to moderate need CFC participants. Additionally, there were significant differences between HHAs with a range from 9% to 31% of allocated services provided. Second, the analysis determined whether CFC participants with active case plans who appeared in the WELLSKY A&D database also appeared in MMIS expenditure data indicating that at least some expenditures were made on services. Results showed that there was an indication of service provision for 69% of CFC participants authorized to receive personal care. Percentages differed across HHA's ranging from 47% to 86% of participants authorized to receive personal care appearing to have received services.

- It is not certain that the measure used in this analysis to represent the degree to which need services were provided is reliable and valid. That is, the proportion of allocated service dollars (WELLSKY A&D data) that were paid (MMIS data) may not represent a robust match. For example, the time-period for a WELLSKY A&D allocation may not match the time funds were expended. A case study could be used to examine the relationship more thoroughly between the two databases and develop a reliable measure of possible gaps between allocated and delivered service. Moreover, a case study would help to better understand the reasons for gaps between allocated and delivered services. DAIL should consider conducting a case study of qualitative and quantitative information for CFC participants receiving personal care as well as homemaker, companion, and respite services who represent HHAs across the state and three levels of service need (high-highest, high, and moderate).

- Issue #2: Allowing NMHCA's to serve CFC participants:
  - Nine NMHCA's operating in Vermont are willing to provide CFC services, however, most identified caveats to providing that service (e.g., issues that may compromise the safety of direct care workers, minimum hours of service required).

  - Six of nine NMHCA's interviewed are willing to accept the Medicaid rate for personal care. One agency reported it needs more information to determine whether it would accept the rate, while two agencies stated the current reimbursement rate of $38.32 per hour would not be financially sustainable.

- Conversations are needed to clarify concerns and limitations that NMHCA's would have for serving CFC clients, and to identify required criteria each would have to meet to become Medicaid eligible providers for Choices for Care.

- Issue #3: Other potential solutions identified through interviews with HHAs, LTC Ombudsmen, and NMHCAs:
  - Expand Adult Family Care Homes for CFC participants.

  - Develop a system of Home Share options for CFC participants.

  - Create a "pool" which lists direct care workers and connects them to service providers across the state.

  - Grow the direct care workforce by attracting immigrants to Vermont and recruiting them into the direct care workforce through easing current restrictions on gaining work and drivers licenses.

- Issue #3: Potential solutions identified through a review of the literature:
  - Develop a statewide registry that matches direct care workers and providers. While in some states, matching systems have been established to connect direct care workers to individual participant employers, what Vermont may consider is creating a system that allows organizational providers greater access to the pool of direct care workers and, in-turn, give current and potential workers wider access to employment options that meet mutual needs.

  - Convene a multi-pronged, multi-disciplinary, long-term effort to apply a comprehensive approach to building and retaining a skilled direct care workforce. The literature is filled with models that can guide efforts Vermont might choose to undertake.

Introduction

The Vermont Department of Aging and Independent Living (DAIL) contracted with Flint Springs Associates (FSA), a Vermont-based consulting firm to conduct a study on access to Choices for Care (CFC) services and consider implications of opening Choices for Care to alternate direct service providers such as non-medical home care agencies (NMCHA).

DAIL identified three issues to research in the study, each with specific questions to be considered. The following section describes the methods FSA applied to assess each issue.

Issue #1: Assess the ability of Vermont's home and community-based long-term care providers to provide CFC direct services. FSA conducted research to address three questions posed by DAIL.

- *How many people are going without CFC agency-directed direct care services that they need?*
  To address this question, FSA compared the allocated amount of service to the amount of service provided. Service budget allocation is determined through an assessment process conducted by DAIL nurse case managers using the Independent Living Assessment (ILA) tool. Measures of service delivery included HHA monthly self-reports to DAIL and expenditure data in MMIS.

  Examined first was data contained in monthly reports on high-highest need CFC participants the HHAs provide to DAIL. These reports include aggregate data on the hours of service (primarily personal care) provided; aggregate hours of service allocated to participants; and, the aggregate number of "targeted" service hours, i.e., the amount of service the agency and participants agree to schedule.

  HHAs report that often CFC participants do not use the amount of service allocated by DAIL for a variety of reasons and instead note "targeted" hours more accurately represent participants' service need. It is important to understand that each agency may arrive at the targeted number of hours differently as there is no standardized method for reaching this calculation.

  Two additional sources of data regarding service allocation and delivery were utilized: DAIL's WELLSKY A&D database and the Department of Vermont Health Access (DVHA) MMIS database.

  The DAIL WELLSKY A&D database tracks several data points including the allocated dollar amount for personal care, homemaker, respite, and companionship for each CFC participant. This allocation is based on the ILA assessment as discussed above. WELLSKY A&D data includes the agency providing services, participant level of need (i.e., highest, high, and moderate) as well as demographics of participants (town of residence, zip code, and race/ethnicity). The numbers for race/ethnicity were too small for analyses.

While DAIL's WELLSKY A&D database does not track the amount of service delivered, DVHA's MMIS database holds information about dollars spent on services in its MMIS database. FSA matched data from WELLSKY A&D and MMIS to determine the degree to which budgeted services were in fact delivered.

- *What is the breadth and depth of this problem – is it statewide, regional, by service, etc.?*

  Using data from HHA's monthly reports, WELLSKY A&D and MMIS, FSA identified the overall percentage of allocated and targeted hours of service individual HHA's are providing to clients in their catchment area. This percentage was also used to determine if there were differences due to region, service agency, type of service, level of service need, and participant demographic characteristics.

- *What providers are struggling the most and why?*
  To gather input on this question, FSA conducted structured interviews with the directors and most case management directors of Bayada and eight of the nine designated HHAs serving Vermont. The interviews focused on learning:

  - What populations of CFC clients do they serve, i.e., high/highest, moderate?
  - What challenges do they face to serving any/all levels of CFC needs?
  - What is needed to address these challenges?
  - What strategies do they use to recruit and retain direct care workers?
  - What other strategies do they suggest to build the direct care workforce?

<u>*Issue #2:* Determine whether allowing NMHCAs to become CFC providers would have the potential to increase the volume of services participants are able to receive.</u>

FSA conducted structured interviews with the owners/directors/managers of nine Non-Medical Home Care Agencies operating in Vermont to understand:

- What geographic region(s) do they serve?
- What is each agency's current workforce capacity?
- How many clients do they currently serve?
- What types of home care services do they provide?
- What experience have they had providing Choices for Care services?
- To what extent, if any, do they have contractual arrangements with the HHAs to provide CFC services?
- How are current clients referred to them?
- What issues, if any, do they have recruiting and retaining direct care workers?
- What interest and/or capacity do they have in becoming Medicaid eligible to provide CFC services?
- What level of CFC services (high, highest, moderate) do they currently provide?
- Whether the agency would be willing to provide personal care services at the current reimbursement rate of $38.32/hour?

- Whether they do or would be willing to provide training, 24/7 coverage, on-site supervision, conduct background checks and utilize an electronic visit verification (EVV) system?
- What additional conditions and/or caveats would need to be addressed to provide personal care services to CFC clients?

Issue #3: Determine other potential solutions that may exist to increase the CFC services provided to individuals in home-based settings.

FSA sought input by:

- Conducting a literature review to identify efforts across the country that have increased and/or promise to increase access to CFC services for individuals in home-based settings.
- Asking representatives from the HHA's and NMHCA's we interviewed for their input on this issue.

Allocated and Provided Services

How many people are going without CFC-agency directed care services that they need?

To address this question, FSA analyzed data to determine the degree to which there were gaps between the amount of needed and delivered services. Aggregated data that home health agencies (HHAs) report to DAIL monthly as part of their participation in the Designation waiver was examined. These data are limited to personal care, respite, and companion services for participants in the high/highest need category.

Table 1 summarizes findings from HHA reports submitted October 2022 through August 2023. During that period, on average, HHAs served 89 high/highest need CFC participants per month. Participants were authorized to receive about 93 hours of service each month based on ILA conducted by DAIL Case manager nurses. Because HHA's find that participants may not want or feel they need the amount of service authorized by DAIL, the HHA's asked that monthly reports to DAIL also include the number of "targeted hours" which represent the amount of service the agency and participants agree to schedule. How individual agencies arrive at the number of "targeted hours" may differ as there is no standardized method exists for reaching this calculation.

As shown in Table 1, the difference between authorized and provided hours of service is larger than between targeted and provided hours of service. On average, agencies provided 58% of authorized hours or service and 80% of targeted hours. These percentages varied across agencies, ranging from 31% to 82% of authorized hours delivered, and from 49% to 89% of targeted hours delivered.

Table 1: Average Monthly Allocation and Delivery of Personal Care Services to High-Highest Need Participants by Home Health Agencies

(Source: HHA Monthly Reports to DAIL)

Home Health Agencies (Number of Months reporting)	**Personal Care** Average Number or Percent per Month per Home Health Agency								
	CFC Participants Served	Authorized Hours	Authorized hours per Participant	Total Targeted Hours	Targeted hours per Participant	Percent of Authorized hours that were Targeted	Hours of Service provided	Percent of Targeted hours Provided	Percent of Authorized hours that were Provided
Total	**89.3**	**8302.8**	**93.0**	**4,802.4**	**53.8**	**58%**	**3,823.1**	**80%**	**46%**
Caledonia (11 months)	28.9	1,441.6	50.0	979.5	33.9	68%	828.3	85%	57%
Franklin (11 months)	34.4	2,098.9	61.1	1,728.8	50.3	82%	1079.1	62%	51%
VNH (11 months)	110.8	4,242.3	38.3	2,436.0	22.0	57%	2,059.3	85%	49%
Bayada (11 months)	368.0	48,866.3	132.8	28,398.2	77.1	58%	22,977.9	81%	47%
VNA of SW (11 months)	77.7	3,878.3	49.9	2,213.4	28.5	57%	1,650.0	75%	43%
UVMHN (11 months)	60.8	3,937.3	64.7	1,876.5	30.9	48%	1,664.1	89%	42%
CVHHH (3 months)	26.0	1,493.5	57.4	890.0	34.2	60%	568.0	64%	38%
Addison (11 months)	33.1	1,686.6	51.0	696.0	21.0	41%	596.9	86%	35%
OEVNA (7 months)	41.0	2,063.5	50.3	1,358.0	33.1	66%	658.9	49%	32%
Lamoille (4 months)	25.0	1,691.0	67.6	523.4	20.9	31%	395.1	75%	23%

The monthly report also includes data on respite and companionship services. But as seen in Table 2, only four agencies provided data on these services to DAIL. Addison reported the number of authorized services but not delivered services. Several agencies are

not delivering respite and companion service to high/highest need CFC participants. Three agencies were not accepting referrals for respite and companion services. This is consistent with the waiver which prioritizes personal care. Of those who did report, from 40% to 68% of allocated respite/companion services are provided.

Table 2: Average Monthly Allocation and Delivery of Companion/Respite Services
(Source: HHA Monthly Reports to DAIL)

Home Health Agency	**Companion/Respite Services** Average Number or Percent per Month per HHA					**Not accepting referrals** (Number of Months reporting)
	Hours of service authorized	**Targeted hours of service**	**Hours of service provided**	**Percent of Authorized service that was provided**	**Percent of Targeted service that was provided**	
Addison County HH and Hospice	1038.3					
Caledonia Home Health Care & Hospice	904.6	404.9	162.1	18%	40%	
Lamoille Home Health Agency						
UVMHN Home Health & Hospice	1912.7	522.0	355.5	19%	68%	
VNA & Hospice of the Southwest Region						Not accepting referrals (6 months)
Franklin County Home Health Agency	880.7	98.5	58.2	7%	59%	Not accepting referrals (6 months)
Visiting Nurse and Hospice for Vermont and New Hampshire						Not accepting referrals (1 month)
Bayada Home Health						
Central Vermont Home Health & Hospice	841.5	113.3	63.99	0.05	56%	
Orleans Essex VNA & Hospice						

What is the breadth and depth of the problem?

To track the possible differences between the authorized amount of service (allocated in WELLSKY A&D database) and the actual amount of service delivered (paid in MMIS), FSA matched data from the two databases using first and last name as there were no other unique identifiers available. We were able to match data from both WELLSKY A&D and MMIS on 944 CFC participants with active care plans in FY23 (July 1, 2022, to June 30, 2023) receiving personal care services.

To address the breadth and depth of the gap between allocated and delivered services, FSA looked at possible differences by types of service (personal care, respite, companion, and homemaker services), HHAs, regions of the state, level of need (high/highest, high, moderate), and demographics of CFC participants.

Unlike personal care services, homemaker, respite, and companion services were often provided through a combination of agency directed, consumer directed and/or surrogate directed service. Given the complexity of the resulting data, it was too time consuming for this project to determine the amount of service each agency was allocated to provide and the amount of paid service that was associated with participants' agency, consumer or surrogate directed services. Therefore, the following discussion focuses entirely on agency direct personal care services.

One possible measure of gaps between allocated and delivered services is the percentage of allocated services that are delivered. That is, the total amount spent on services divided by the amount allocated. The analysis found that on average 19% of allocated funding was spent on personal care services. The standard deviation was 19%, indicating individual participants' percentages ranged from 0 to 38%. This low proportion of allocated services that are delivered may be the result of one or a combination of several factors including:

- Inaccuracies due to incorrect matching of data for individual participants across the MMIS and WELLSKY A&D database. For example, more than one allocation for personal care may be included in the WELLSKY A&D data. These allocations may or may not have matched the expenditures in the MMIS data.
- Allocated services may be more than participants need or want, for any number of reasons (e.g., supportive family members may provide services, individuals may be hospitalized).
- Allocated services may be more than an agency is able to provide.

While the percentage of allocated services for which there is an expenditure is not a perfect measure, it does allow for comparisons across agencies, regions, and participant characteristics. For example, Table 3 shows that the proportion of allocated services delivered is significantly higher ($p>.05$) for the high-highest need participants (21%) than for moderate need participants (17%).

Table 3: Percent of Amount Allocated for Personal Care services (WELLSKY A&D data) for which there were Expenditures (indicating delivered services- MMIS data) by Level of Need

Level of Need	Average Percent of Allocated Services for which there were Expenditures	*Standard Deviation**	Number of Unique CFC Participants
High highest	21%	*20%*	490
High	18%	*18%*	15
Moderate	17%	*18%*	439
Total	19%	*19%*	944

*Standard Deviation is a measure of distribution; larger standard deviations indicate widely spread scores. Most scores occur within one standard deviation above and below the mean (average).

There were statistically significant ($p<.01$) differences between HHAs in the percent of allocated services that were delivered (see Table 4). Franklin County HHA delivered the highest proportion of allocated services, 39% of services allocated to high-highest need participants. Lamoille provided the lowest proportion of allocated services, using this measure.

Table 4: Percent of Amount Allocated for Personal Care Services for which there were Expenditures (indicating delivered services)
(source: WELLSKY A&D and MMIS databases)

Home Health Agency	Moderate need			High highest need		
	Mean	N	Std. Deviation	Mean	N	*Std. Deviation*
Addison	13%	11	9%	11%	36	*11%*
Bayada	19%	242	18%	23%	279	*20%*
Caledonia	31%	12	24%	22%	15	*18%*
Central VT	14%	13	20%	19%	22	*19%*
Franklin County	24%	16	18%	39%	15	*22%*
Lamoille	9%	19	9%	9%	17	*10%*
Orleans-Essex	15%	37	13%	10%	19	*12%*
Rutland / South	15%	25	11%	20%	36	*19%*
UVMHN	11%	47	12%	20%	31	*20%*
VNA of VT & NH	25%	17	34%	18%	20	*16%*
Statewide Total	17%	439	18%	21%	490	*21%*

There were no significant differences due to regions where participants live or age.

Table 5 provides information for high-highest need CFC participants. It shows that across HHA's,195 individuals, or 28% of high-highest need participants received less than 10% of

allocated services, and 119 (17%) received between 10% and 25% of allocated services. Again, as shown in Table 5, there were differences across HHAs.

Table 6 shows results for moderate rather than high-highest need participants. As shown in Table 6, 28% of moderate need participants received less than 10% of allocated services. More moderate need participants (22%) than high-highest need participants (17%) received between 10% and 25% of allocated services.

Table 5: Number of CFC Participants at High-Highest Need Receiving Less than 10% or 25% of Allocated Services
(source: WELLSKY A&D and MMIS databases)

Home Health Agency	**CFC Participants receiving less than 10% of allocation**		**CFC Participants receiving 10% to 25% of allocation**		Number of High-Highest Need Participants
	Number of unique individuals	Percent of all High-Highest Need Participants	Number of unique individuals	Percent of all High-Highest Need Participants	
Addison	17	40%	14	33%	43
Bayada	104	26%	61	15%	400
Caledonia	5	24%	1	5%	21
Central VT	8	21%	9	23%	39
Franklin	1	5%	2	10%	20
Lamoille	12	50%	4	17%	24
Orleans-Essex	14	41%	3	9%	34
Rutland/South	10	24%	15	36%	42
UVMHN	14	34%	5	12%	41
VNA of VT & NH	10	23%	5	12%	43
Statewide total	195	28%	119	17%	707

Table 6: Number of CFC Participants at Moderate Need Receiving Less than 10% or 25% of Allocated Services
(source: WELLSKY A&D and MMIS databases)

Home Health Agency	CFC Participants receiving less than 10% of allocation		CFC Participants receiving 10% to 25% of allocation		Number of Moderate Need Participants
	Number of unique individuals	Percent of all Moderate Need Participants	Number of unique individuals	Percent of all Moderate Need Participants	
Addison	3	25%	7	58%	12
Bayada	93	26%	69	19%	357
Caledonia	0	0%	5	36%	14
Central VT	9	45%	1	5%	20
Franklin	2	8%	6	25%	24
Lamoille	11	46%	6	25%	24
Orleans-Essex	13	30%	14	33%	43
Rutland/South	7	23%	14	47%	30
UVMHN	28	41%	11	16%	68
VNA of VT & NH	7	21%	3	9%	33
Statewide total	173	28%	136	22%	625

Using the percentage of allocated service budgets that are spent on services to measure the degree to which needed services are delivered has limitations as noted above. Another way to measure "provided services" is to examine the appearance of CFC participants in both WELLSKY A&D and MMIS databases. A participant with an active case plan who appears in the WELLSKY A&D database but not the MMIS database, had an allocation for services, but no funds were spent on providing services. A participant who appears in both WELLSKY A&D and MMIS, had funds expended to provide services. This does not provide a measure of how much of allocated services were provided, but it does indicate whether at least some of the services outlined in the case plan were delivered.

Table 7 includes appearance data (i.e., participant appears in WELLSKY A&D and/or MMIS) for the high-highest need CFC participants across HHAs. There were significant differences ($p<.001$) between HHAs in the degree to which there was an indication that services were provided.

For example, 86% of Rutland and 84% of Addison high-highest need clients appeared in both WELLSKY A&D and MMIS databases indicating that they received personal care services. On the other hand, 47% of VNA of VT and NH clients appeared to have received allocated personal care services.

Table 7: High-Highest Need CFC Participant Appearance in Databases as Indication of Services Provided or Not Provided

(Source: WELLSKY A&D and MMIS databases)

Home Health Agency	**In WELLSKY A&D Only -- no indication of services provided**		**In both WELLSKY A&D and MMIS -- indicating services provided**		Total Number of High Highest Unique Individuals
	Number of High Highest Need Participants	Percent	Number of High Highest Need Participants	Percent	
Addison	7	16%	36	84%	43
Bayada	121	30%	279	70%	400
Caledonia	6	29%	15	71%	21
Central VT	17	44%	22	56%	39
Franklin	5	25%	15	75%	20
Lamoille	7	29%	17	71%	24
Orleans-Essex	15	44%	19	56%	34
Rutland/South	6	14%	36	86%	42
UVMHN	10	24%	31	76%	41
VNA of VT & NH	23	53%	20	47%	43
Statewide total	217	31%	490	69%	707

Table 8 includes appearance data (i.e., participant appears in WELLSKY A&D and/or MMIS) for the moderate need CFC participants across HHAs. As with high-highest need participants, there were significant differences ($p<.001$) between HHAs in the degree to which there was an indication that services were provided. For example, Addison provided services to 92% of moderate need clients, while VNA of VT and NH served 52% of moderate need clients.

Table 8: Moderate Need CFC Participant Appearance in Databases as Indication of Services Provided or Not Provided

(source: WELLSKY A&D and MMIS databases)

Home Health Agency	**In WELLSKY A&D Only -- no indication of services provided**		**In both WELLSKY A&D and MMIS -- indicating services provided**		Total Number of High Highest Unique Individuals
	Number of High Highest Need Participants	Percent	Number of High Highest Need Participants	Percent	
Addison	1	8%	11	92%	12
Bayada	115	32%	242	68%	357
Caledonia	2	14%	12	86%	14
Central VT	7	35%	13	65%	20
Franklin	8	33%	16	67%	24
Lamoille	5	21%	19	79%	24
Orleans-Essex	6	14%	37	86%	43
Rutland/South	5	17%	25	83%	30
UVMHN	21	31%	47	69%	68
VNA of VT & NH	16	48%	17	52%	33
Statewide total	186	30%	439	70%	625

To better understand the reasons for gaps between allocated and delivered services, DAIL should consider conducting a case study. The study should include data available through WELLSKY A&D and MMIS as well as case notes or other qualitative information which can explain differences between allocated services, targeted services, and delivered services. The study should include CFC participants receiving personal care as well as homemaker, companion, and respite services who represent HHAs across the state and three levels of service need (high-highest, high, and moderate).

It is not certain that the measure used in this analysis to represent the degree to which need services were provided is reliable and valid. That is, the proportion of allocated service dollars (WELLSKY A&D data) that were paid (MMIS data) may not represent a robust match. For example, the time-period for a WELLSKY A&D allocation may not match the time funds were expended. A case study could be used to examine the relationship more thoroughly between the two databases and develop a reliable measure of possible gaps between allocated and delivered service.

What providers are struggling the most and why?

Analysis of Data:

One way to assess how much agencies are struggling to meet service needs is to use the agency self-reported data presented in Table 1. This data shows, for example, that Lamoille met 23% of authorized service hours with hours of service, but 75% of targeted hours. Caledonia provided 57% of authorized service hours and 85% of targeted service hours. Looking at authorized hours alone, suggests that Lamoille struggles more than Caledonia, but looking at targeted hours indicated that Lamoille is not far behind Caldonia. Without a standard definition and way to measure targeted hours it is difficult to draw conclusions about the degree to which agencies meet service needs from these data.

As detailed in the section above, there were significant differences between HHAs in the degree to which allocated services were provided. By one measure, the percent of allocated services for which there were expenditures, Franklin Conty HHH seemed to do best with 31% of allocated services delivered. By another measure, appearance in both MMIS and WELLSKY A&D databases, Rutland and Addison seemed to provide the highest percentage of services.

Home Health Agency Interviews

To understand what struggles and challenges HHAs experience in meeting CFC participants' service needs, and what strategies they use to address these, FSA conducted structured interviews with the directors and case managers at eight of nine agencies and with Bayada, which we summarize below. (A bulleted list of interview findings can be found in the Appendix.)

Agencies identified several challenges to meeting service needs due to staff shortages. These included the severe cuts to staffing resulting from the Covid pandemic, and the difficulty in replacing those workers. Factors which contributed to this struggle included:

- Wages for workers are not competitive with other industries and still reimbursement rate does not cover HHA costs, including travel expenses for workers, premiums for evenings and weekends.
- Direct care is hard work, requires more than a warm body. Caregivers must want to do the work.
- Workers need flexible schedules to attend to children and other responsibilities, and CFC participants need consistency – a challenging balance.
- Staffing shortages mean that participants may not only not receive the hours of services they need, but also may not be able to receive services at the times they prefer.
- Many agencies have seen significant reductions in the number of applicants – in part due to the changing workforce that allows people to work from home.

Only two agencies, Addison and Lamoille, felt they were not challenged by staffing shortages in providing clients needed services. These agencies identified several factors they felt contributed to their ability to recruit and retain workers. One noted that the COVID pandemic served as a “rallying cry” as compared to many agencies which report it left them with severely reduced workforces. Both agencies emphasized the steps they take to create a supportive culture for direct care workers. These steps included:

- Creating an organizational structure with a “flat hierarchy” in which:
    - All agency staff, including the director, willingly provide direct care if needed.
    - Benefits are the same for all FT (30 hours) regardless of position.
    - Every employee has the director’s cell number.

- Elements of supportive culture include:
    - Flexibility in hours worked, and times of day.
    - Staff appreciation activities such as celebrations, gift cards, flowers going above and beyond.
    - If a child is home from school for vacation or illness, rather than caregiver calling in, office staff will look after child while parent is providing care to CFC participant.
    - Treat workers like family and value workers’ family life.
    - Assist workers to navigate issues that would keep them away from work (e.g., loan for car repair).

Non-Medical Home Care Agencies

To determine if allowing non-medical home care agencies (NMHCA) to become CFC providers would have the potential to increase the volume of services participants are able to receive, FSA conducted individual interviews with the directors, owners and/or managers of nine agencies that provide home care services within Vermont. These included:

- Northeast Kingdom Health Care
- Hope Home Care Services
- Home Instead
- TLC
- Griswold
- Homecare Assistance
- Synergy Homecare
- At Home Senior Care
- Care in Vermont

Our interviews provided an understanding of the variety and differences each agency presents in terms of geographic region(s) served, current workforce capacity, current number of clients served, types of home care services provided, experience providing Choices for Care services, contractual arrangements with CFC Designated Agencies, and workforce recruitment and retention issues.

Five NMCHA's interviewed are stand-alone organizations, four are part of larger organizations that work outside of the state as well as within Vermont. Six of the nine do not have contracts with the designated home health agencies or Bayada but may provide Choices for Care Services for persons who use consumer or surrogate managed CFC. Several noted that some referrals to those clients come through the local Area Agencies on Aging (AAA) through the Flexible Choices option.

Eight of the nine agencies reported that their caregivers do provide the range of CFC services to their clients including personal caregiving, homemaker, companionship, and respite, thus noting that the skill sets of their workers can meet the range of needs from high/highest to moderate. One NMHCA reported providing services only to clients with "moderate" service needs.

When queried about current staffing levels, approximately half of the agencies reported experiencing a significant decrease in their staffing capacity from pre- to post-COVID, which in turn has impacted the numbers of people they are able to serve. Current staffing levels range from a high of 90 – 100 to a low of 10. Only one NMHCA reported having gained staff in the current year.

The number of clients served by the NMCHAs vary similarly. The agency reporting having upwards of 100 staff reports the highest client caseload at 75, and the agency with 10 staff is providing services to approximately 30 clients.

✓ Are there NMHCAs who would want to become Medicaid providers across the state?

In each interview with the nine NMHCA directors we explored their interest, ability and concerns related to becoming a Medicaid provider for Choices for Care Services. Overall, six of the nine agencies stated a general willingness to provide CFC services as a Medicaid provider but articulated certain caveats/conditions that would need to be addressed to lead them to a final decision.

Each person we interviewed was first asked whether their agency was willing to accept the personal care reimbursement rate of $38.32 per hour. Six agencies felt the rate was acceptable. Two noted outright that the rate would not be sustainable as their cost for doing business exceeds $38.32/hour. TLC, as an example, notes it requires $47.00/hour to provide staff services. One other agency was not able to commit and felt it would need more information and time to reach a decision.

DAIL anticipates that if any NMHCA's are deemed eligible to provide Medicaid-based CFC services, the department will have to establish certain criteria that the agencies meet. While DAIL has not settled on a final set of required eligibility criteria, it anticipates that minimally an agency would have to meet the following:

- Provide training – with a possible minimum of 12 hours/year for personal care givers.
- Conduct on-site supervision of staff at intervals.
- Have 24-hour support available to provide last-minute coverage when assigned staff can't report to a workplace due to circumstances such as personal or family illness, transportation breakdown, etc.
- Conduct background checks of potential hires.
- Have in place an Electronic Visit Verification (EVV) system that can provide data to the state.

As a result, we asked, and learned, that all nine agencies currently meet the above criteria with their staff and new hires. Whether the type and amount of training conducted currently by each agency would satisfy DAIL's requirements is unclear and will likely require negotiation for the future. Most agencies actively use an EVV while others noted their software has the capacity and they would be willing to activate it.

Beyond the above criteria, each agency representative was asked what conditions would need to be in place to enable taking on this role, and also, what, if anything would be a "deal-breaker". Several themes emerged. First, people stressed that the safety of their workforce is a key issue. Three persons specifically said they would not send their staff into situations where any form of violence, physical aggression, hoarding or the known presence of firearms existed – and if any of these conditions emerged during a caregiving event, they would stop serving those clients. Two agencies noted they would not let staff serve persons in need of Hoyer Lift for transfers to avoid endangering the physical health of their workers.

One agency said that to take on this role it would need to negotiate terms up front including:

- Ensuring a minimum number of hours per client, which would enable paying its caregivers for a 40-hour week.
- Having the ability to accept or reject clients referred, versus being obliged as the Designated Agencies are, to take anyone referred.
- Conducting an initial assessment of safety before accepting a referred client.

Finally, two individuals expressed concerns related to case management. A general comment suggested that case managers need to work more closely with the care-giving agencies to ensure follow-up that results in clients receiving truly needed services. Another respondent noted that in certain instances, case managers don't always refer people to the correct services and gave the example of an individual deemed eligible for CFC services who (in this person's opinion) would have been better served by a referral to developmental services. Whether this observation is indicative of a widespread practice, or simply descriptive of an individual event would require different research. It is important to note that some Vermonters may be eligible for both developmental services and CFC and may choose the program that best meets their needs.

- ✓ What is their capacity to serve CFC participants?

The question of current capacity in terms of the number of caregiving staff and number of clients is addressed earlier in this section. However, we raised the question about whether each agency would need to recruit additional staff to its workforce to become a Medicaid provider of CFC Services, and if so, how they would do that.

The responses varied. Two agencies reported recent success in increasing the direct care workforce to meet increased demands and therefore felt this would not be a problem. In one of these cases, the agency noted that its existing caregivers are responsible for most recruitments, bringing in new hires through word-of-mouth and personal networking. This agency gives a cash bonus to workers who are able to refer new recruits. Additionally, it reaches out to Technical Centers around the state, to interest students in caregiving opportunities.

Another agency conducts “a lot of marketing” through its local newspaper and notes that as a result it recently increased its workforce from 10 employees providing 300 hours of service per week to 32 employees providing 900 hours of service weekly.

However, other agencies said that within their respective regions, increasing the number of direct care workers is challenging as the potential workforce is finite and spread among the existing home health care agencies. From this point of view, these employers did not feel confident that their entry into the pool of Medicaid providers would necessarily increase the capacity within their region to provide more services to CFC recipients.

Table 9 summarizes what we learned from each NMCHA interviewed.

Table 9: Summary of Non-Medical Home Care Interview Findings

NMHCA	Contract with HHA, Bayada	Serves ARIS Clients, Transitions, ADPs, AAA, VA*	National, Franchise or Local	Willing to provide all 4 CFC Services	Would accept Medicaid Rate	Training, on-site supervision 24hr support, background checks, EVV	Caveats to providing services to CFC clients
Northeast Kingdom Healthcare	No	ADP, AAA	Local	Yes	Yes	Yes	No guns, opioids, physical aggression, morbidly obese, need transfer, hoarding
Hope Home Care Services	HHA	AAA	Local	Yes	Yes	Yes	N/A
Home Instead	No	ARIS	National	Yes	Yes	Yes	N/A
TLC	HHA	Transitions	Local	Yes	No – not sustainable	Yes	Assure minimum hours/client, conduct initial safety assessment
Griswold	Did not know	Did not know	Franchise	Yes	Yes	Yes	N/A
Homecare Assistance	No	ARIS	Franchise	Yes	No	Yes	N/A
Synergy Homecare	No	AAA, VA	Franchise	Yes	Yes	Yes	No MH issues, transfers, Hoyer lifts, safety concerns
At Home Senior Care	No	AAA	Local	Moderate Needs	Maybe	Yes	Not informed enough to respond
Care in Vermont	No	Senior Solutions	Local	Yes	Yes	Yes	No violence

*ARIS = Fiscal Intermediary for Self-Directed Services, ADP = Adult Day Program, AAA = Area Agency on Aging, VA = Veterans Administration

Other Potential Solutions to Increase CFC Services Provided to Individuals in Home-Based Settings

FSA conducted interviews and a literature review to identify other potential solutions to increase the CFC services provided to individuals in home-based settings. Prefacing a summary of our findings, the obvious should be stated, i.e., there is no single solution, no "silver bullet", that will address the current and projected shortage of direct care workers needed to meet the projected demand for home-based care. Our summary is intended to present a range of ideas and approaches that might be considered as part of a multi-faceted approach to building adequate and meaningful home-based service capacity to serve Choices for Care participants.

Responses from Vermont - Several themes and specific ideas emerged from our interviews with:

- Vermont Home Health Directors and Case Managers
- Vermont Legal Aid Long-Term Care Ombudsmen
- NMCHA Owners and Directors

Attend to the Agency Culture: Amongst the HHA's and NMCHA's that reported success in recruiting and retaining direct care workers, a theme around creating a culture where workers are acknowledged, respected and "treated like family" was consistently articulated. Multiple examples were provided of ways in which the importance of workers was demonstrated. These include the following:

- Children of workers who are home from school due to snow closure, or mild illness, etc., can be brought to the office and cared for by staff while their parent goes to a client.
- Loans are offered for car repairs or new tires.
- A company car is provided to a worker whose auto is not in poor repair.
- Reimbursement at the government rate is provided for mileage and travel time between clients.
- Retention bonuses are given, recognizing a worker's longevity.
- Staff parties to celebrate birthdays, events, and holidays are put on by the agency.
- Staff donate vacation time for their peers.
- Non-tiered organization in which all staff are trained and capable of taking on any task.
- Full benefits given for 30+ hours/week.
- Benefits are provided for those who work 20+ hours/week.
- Guaranteed hours regardless. If the client is not available, the worker can provide help at the agency office.
- Pay for education, especially training for LNA certification.

The following quote with a HHA Director sums this up:

"*Culture – flexibility is a huge piece. The management team knows every employee, when things are going on at their home we know, acknowledge, and respond. Most [DCW's] are older but for those who are younger and have children, if school closes or they can't go, the kids come and stay at the agency. We lend equipment like tables and chairs for events. It's more*

like a family here – we make cupcakes. We give a birthday bonus ($100) check, gift cards, anniversary cards to every person, handwritten notes throughout the year. We'll order pizza if things are down. Just listening, as simple as that…. People feel appreciated."

Recruitment activities like job fairs and advertisements in local print and electronic media were not reported to be effective in bringing in new hires. Multiple times respondents said that people who were scheduled for hiring interviews never showed up, and attributed the difficulty attracting new hires, especially younger ones, on the competition posed by businesses like McDonalds which offer similar wage and benefits packages for less challenging work.

Build out a system of Adult Family Care Homes and Home Share options: Three of the five LTC Ombudsmen we interviewed and one NMHCA owner advocated for Vermont building a larger Home Share system. Two options were described. Home Share options would support the desires of many people in need of some form of personal care to remain in their homes, instead of either moving into a facility or into another person's home. This system would allow the individual to maintain autonomy over their life with the help of a shared living provider who moves in with them.

Building a larger Adult Family Care Home Share System, as another option, would increase the workforce by having the work come to the caregiver's home. When asked to describe what a system of Adult Family Care and/or Home Share resources would look like, no clear vision was provided. Instead, they noted the importance of digging into the issue, identifying the need both in terms of numbers and type/complexity of care.

Legal Aid reports that most of the complaints it receives from CFC consumers are focused on the HHA's and relate to issues including clients reporting being charged too much for services, the agency not providing allocated service hours, and clients reporting they have to spend their benefits just to remain "in the cue" while waiting for approved services to be delivered. From Legal Aid's perspective, having more home-based resources either in a caregiver's residence or in the client's home would reduce what they report as undue financial strain on individuals eligible for services.

Create a collaborative approach to sharing and serving clients: One respondent suggested that right now, the available workforce is "rather fixed" and that the best way to serve the full client population is for agencies, both NMHCA's and the HHA's, to share clients. In this scenario, all clients would be part of a pool which is accessible to all agencies. Any agency would be able to assign available staff to a client in need and be reimbursed by that client's Medicaid benefits.

Bring in workers from out of state, out of country: Given the difficulty the majority of HHA's and NMHCA's report in recruiting and retaining more workers, it was suggested that Vermont create a strategy to build up the workforce by attracting workers from out of state and by creating mechanisms to for immigrants to settle in Vermont more easily. Beyond working to bring in immigrants, members of Vermont's existing New American communities should be considered a potential workforce resource to be tapped into. If interest lies within this segment of our population, training should be made available such as the City of Burlington PCA training program for New Americans.

*Recruit High School Students from Technical Centers: S*ome agencies have reached out to the Vermont Technical Career Centers to offer students internships and eventual employment with the opportunity to earn an LNA, paid for by the agency, while working as a direct care worker. There are no numbers as to the success of this strategy but, again, it can serve as one component of a larger systemic approach to increasing the workforce.

Review of the Literature on Solutions Intended to Increase CFC Services Provided to Individuals in Home-Based Settings

It is important to begin this section with the following observations:

- First, our review which provided a look at the breadth of plans and strategies underway in many states across the county, did not find outcome measures of success toward achieving a direct care workforce capable of meeting the current and growing need for these services. This is most likely because approaches are either still in some phase of planning or implemented too recently to have outcome data.

- Second, approaches that are being planned, or in some phase of implementation in the states cited in our review are multi-dimensional in scope, cross-disciplinary in terms of the stakeholders involved, and long-term in their line of vision. In nearly all the examples reviewed, at least one cross-disciplinary task force was established to study the issue, make recommendations, develop strategies, create plans. And in multiple sites, new, cross-agency policies and protocols were established toward building resources such as workforce data bases, shared credentialing, data collection on quantity of workforce, quantity of demand, etc.

While there are multiple sources of information and state-specific reports describing actions being taken and policies under development, four documents in particular provided the most comprehensive and detailed descriptions of planning, strategies, and actions underway in a wide range of states across the country. They include:

- *The Workforce Crisis: How States are Responding to Shortages in the Health Care Workforce: National Academy for State Health Policy (NASHP), 2022*

- *State Strategies for Sector Growth and Retention of the Direct Care Health Workforce: National Governor's Association (NGA), 2021*

- *State Policy Strategies for Strengthening the Direct Care Workforce: PHI, 2022*

- *State Efforts to Address Medicaid Home-and Community-Based Services Workforce Shortages: Medicaid and CHIP Payment and Access Commission (MACPAC), 2022*

As DAIL moves forward to explore additional potential solutions to bridging the gap between demand for Choices for Care services and direct care workforce supply, these reports can provide more detailed guidance on potential solutions and ways to address them. The scope of the problem nationally is described in nearly every source of information reviewed. According to a report on the Direct Care Workforce from the National Academy for State Health Policy, between 2019 and 2029 the demand for home health and personal care aides is expected to grow by 33.7 percent. At the same time the country's aging population will narrow the ratio of working-age adults to retirement-age adults from 4 to 1 to 3 to 1. Acknowledged in much of the literature is that State Medicaid-funded long-term services and supports (LTSS) systems are not well-positioned to compete for this shrinking pool of workers, similar to what Vermont service

providers, both HHAs and NMHCAs reported. The median wage for this workforce continues to remain below the median wage for other occupations with similar entry-level requirements (including janitors, retail salespersons, and customer service representatives). Finally, 85% of direct care workers earn below 200% of poverty; 45% access public assistance.

Most state-wide efforts described in these reports have implemented or are developing approaches to increasing the workforce, and therefore availability of services, through strategies focused on:

- Wages and benefits
- Training
- Recruitment and retention
- Support for family caregivers
- Data collection and monitoring
- Centering Direct Care Workers in leadership roles and public policy
- Addressing and rectifying structural inequities for DCWs

Given DAIL's interest in approaches to increase access to services around the state, this section points to a few examples that, while not simple to implement, may fall within the department's capability to develop.

Currently Vermont providers of Home-and Community-Based Services (HCBS) are individually engaged in the work of recruiting and retaining direct care workers. The majority of directors of both the HHA's and NMHCA's reported that staffing capacity and therefore service capacity has been significantly reduced since COVID. One potential solution for addressing the shortage is to research the use of matching registries. According to PHI, ten states are using matching registries (State Policy Strategies for Strengthening the Direct Care Workforce - PHI (phinational.org)). The concept, also suggested in our interview with Mohamed Basha, owner of TLC, is based on creating a pool, in essence a "system", in which direct care workers and providers across the state can be matched based on criteria including, but not limited to, service needs, worker credentials, training, skills, availability, and amount of service hours needed and offered. Additionally, the registry can be a mechanism for storing information about a worker's experience, continuing education efforts, academic and/or training achievement. In that sense the registry also becomes a source of data about the workforce size, qualifications, training needs and regional capacity.

Another discussion that emerges in the literature is the importance of addressing disparities in the direct care workforce. Low wages and benefits are associated with the prevalence of women and in many settings the prevalence of women of color and/or immigrants who do this work. A registry can not only track and help to address systemic disparities, but also identify the need for culturally competent training for workers, which may require trainings in multiple languages, or subjects that address cultural norms of workers and clients.

If DAIL is interested in this idea the following states can provide examples to research.

Massachusetts is using an on-line registry, Connect To Care Jobs www.ConnectTOCareJobs.com to connect jobseekers with employers including both health care facilities and LTSS providers. The site's home page provides access to registration for both jobseekers and employers and provides data on the direct care workforce. The tool is a product of Advancing States – www.ADvancingstate.org.

Tennessee has established portable, stackable credentials allowing direct care workers to earn competency-based micro-credential badges. Every 4 badges earned leads to achievement of a higher occupational designation, meaningful to those who would like to move up the career ladder and pay scale.

To address the needs of self-directed consumers, *Minnesota* created Direct Support Connect, www.DirectSupportConnect.com, a statewide job board where workers, and beneficiaries can create detailed profiles and search for potential matches.

Iowa – a caregivers forum recommended providing a central and secure place to store records of DCW trainings, certifications, credentials, continuing education and experience and ensure the workforce and their trainings will be able to follow workers from one workplace or population served to another. (Portability).

Beyond this specific recommendation, the strategies described in our review are long-term, multi-pronged approaches that require leadership and collaboration across government and with key stakeholders including providers, consumers, and importantly direct care workers. In addition to efforts to increase wages and benefits, find effective ways to attract and retain the workforce and build a skilled and competent workforce, more interest and information is emerging around two approaches:

- The unionization of the HCBS workforce.
- Supporting family caregivers through paying them wages, introducing them to peer mentors with lived experience and offering specific training to build skills needed to care for their family member.

If DAIL is interested in learning more about approaches states are taking in these directions, the reports referenced above are good, initial sources of information.

Findings in Conclusion:

- Issue #1: Ability to provide needed services to CFC participants:
  - The majority of Home Health Agencies verified they are struggling to provide needed services due to staffing shortages.
  - HHA self-reported aggregate data suggests that, on average, HHA's seek to schedule or "target" 58% of authorized hours of service; 80% of such "targeted" hours of service are provided. These percentages vary across HHAs; "targeted" hours are determined by each HHA without a uniform standard to follow.
  - Analysis of individual CFC participant data from WELLSKY A&D and MMIS databases assessed the degree to which service needs were met. Two approaches were used in these analyses. First, the analysis examined the proportion of allocated service budgets (WELLSKY A&D data) that were delivered (MMIS expenditure data). Across all HHA's, 19% of allocated services were delivered. This percentage differed significantly by level of service need; 21% of allocated personal care services were provided to high-highest need CFC participants, as compared to 17% of allocated services delivered to moderate need CFC participants. Additionally, there were significant differences between HHAs with a range from 9% to 31% of allocated services provided. Second, the analysis determined whether CFC participants with active case plans who appeared in the WELLSKY A&D database also appeared in MMIS expenditure data indicating that at least some expenditures were made on services. Results showed that there was an indication of service provision for 69% of CFC participants authorized to receive personal care. Percentages differed across HHA's ranging from 47% to 86% of participants authorized to receive personal care appearing to have received services.
  - It is not certain that the measure used in this analysis to represent the degree to which need services were provided is reliable and valid. That is, the proportion of allocated service dollars (WELLSKY A&D data) that were paid (MMIS data) may not represent a robust match. For example, the time-period for a WELLSKY A&D allocation may not match the time funds were expended. A case study could be used to examine the relationship more thoroughly between the two databases and develop a reliable measure of possible gaps between allocated and delivered service. Such a measure is needed to determine the size and breadth of gaps between services needed and delivered. This includes any differences across the state, agencies, level of service need, and demographic characteristics of CFC participants. Moreover, a case study would help to better understand the reasons for gaps between allocated and delivered services. DAIL should consider conducting a case study of qualitative and quantitative information for CFC participants receiving personal care as well as homemaker, companion, and respite services who represent HHAs across the state and three levels of service need (high-highest, high, and moderate).

- Issue #2: Allowing NMHCAs to serve CFC participants:

- Nine NMHCA's operating in Vermont report a willingness to provide CFC services, but with a range of caveats that must be addressed (e.g., issues that may compromise the safety of direct care workers, minimum hours of service required).
    - Six of nine NMHCA's interviewed are willing to accept the Medicaid rate for personal care. A seventh agency responded needing more information to determine if the rate is adequate. The remaining two agencies stated the current reimbursement rate of $38.32 per hour would not be financially sustainable.
    - Conversations between DAIL and the NMHCA's are needed to clarify concerns for and limitations to serving CFC clients, and to identify required criteria DAIL would have for NHMCA's to become Medicaid eligible providers for Choices for Care.

- Issue #3: Potential solutions identified through interviews with HHAs, LTC Ombudsmen, and NMHCAs:
    - Expand Adult Family Care Homes for CFC participants.
    - Develop a system of Home Share options for CFC participants.
    - Grow the direct care workforce by attracting immigrants to Vermont and recruiting them into the direct care workforce through easing current restrictions on gaining work and drivers licenses.

- Issue #3: Potential solutions identified through a review of the literature:
    - Develop a statewide registry that matches direct care workers and providers. This would allow providers greater access to the pool of direct care workers and give current and potential workers wider access to employment options that meet mutual needs.
    - Convene a multi-pronged, multi-disciplinary, long-term effort to apply a comprehensive approach to building and retaining a skilled direct care workforce. The literature is filled with models that can guide efforts Vermont might choose to undertake.

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APPENDIX A:
Summary of Home Health Agency Interviews

Population served:

- Bayada – 99% of served are high/highest need – Standard is to fill 98% of hours requested, currently at 83% -- need enough referrals to hold on to staff. Their retention rate goal is 90%, dipped below this month.
- UVM – 120 receive CFC, 62 get services and CM. Moderate needs are different from high/highest need. Wait list for moderate, financial eligibility through self-report, clinical through home visit.
- CVHHH – provide 1/3 of clients with services, provide 50% or less of hours wanted. Services provided by Bayada, ARIS. Provide services to 75% of moderate needs. 60% of clients are high needs, 40% are moderate.
- Northern counties – High needs no wait list for CM, majority of CFC are ARIS.
- Northern high=50%, moderate =50%
- Franklin county – 35 highest, about 10 moderate – priority is personal care, provide homemaker – meet about 50% of services requested.
- Orleans—130 High and moderate, all high get PC services, homemaker on pause due to lack of staff. If hired more PCAs could serve more moderate needs.
- Addison – 60/40 high to moderate needs – meets about 80-85% of needs, 100% staff capacity.

Challenges:

- Reimbursement rate – lose money on personal care services.
- Lack of staff means participants may not get the specific times they want.
- Decreased number of caregivers while increased number of clients.
- Covid led to large staff losses (2/3) -- for Addison it was a rallying cry.
- Decline in number of applicants.
- No applicants – difficulty getting people to come through the door.
- Not just hiring a warm body, person has to want to do the work.
- Very hard work – increased acuity, substance abuse, mental health issues, dementia
- Balancing staff desire for flexibility and clients need for consistency.
- Many of per diem workers are single mother, kids get sick, workers stay home (except Lamoille which brings children into office)
- Agency not reimbursed for covering PCA travel expenses.
- Hardest to staff early morning, evenings and weekends.
- In rural areas it is harder to find staff.
- Chittenden county cost of labor highest in state
- Need backup caregivers.

- With ARIS people can pay PCAs much more
    - Private agencies (non-Medicaid) can charge for missed time.
- Lack of data to use for accountability, quality of outcomes –e.g., %of clients going to skilled nursing, hospital.

<u>Strategies for recruitment/retention:</u>

- Increased wages for direct care workers (increased reimbursement rate made this possible). Related strategies included:
    - Benefits for staff – some agencies offer the same package to all staff, including direct care workers.
    - Sign on bonus
    - Retention bonus
    - Cover travel expenses – mileage and time; use IRS rate for reimbursing staff.
    - Higher wage for working nights/weekends.
- Offer consistent or guaranteed hours (thus pay)
    - Guaranteed hours pilot (get paid even if don't make scheduled hours due to client changing needs)
    - Hours not guaranteed but work to ensure hours are filled. Find something for PCA to do, come into the office, do QA, equipment checks.
- Train PCAs in house
    - PCA career ladder (3 levels with pay raises)
    - Support further education (LNA, nursing)
    - Bayada offers mentoring program.
    - Monthly PCA meetings to do education.
    - Online training to learn about specific conditions (e.g., ALS)
- Create a supportive culture through leadership, organizational structure, and support.
    - "Flat hierarchy"
        - All staff willing to provide direct care if needed (including director)
        - Benefits same for all FT staff (30 hours)
        - Every employee has the director's cell number.
    - Supportive culture for DCW
        - Flexibility – give PCSs hours they want, time to go to appointments.
        - Staff were given cell phones.
        - Working bridges program through which agency has on site help for workers to navigate issues that would keep them away from work (e.g., loan for car repair)
        - Demonstrate staff appreciation with celebrations, gift cards, flowers, "cheers for peers."
        - Treat workers like a family, and value workers' family life ("family first")
        - Program that enables workers to donate vacation time to other staff who run out of vacation days.
- Recruitment strategies:
    - Community outreach:
        - Reach out to community in which CFC participant needing services lives – e.g., posters in local grocery store; reach out to American Legion to do homemaker services for Vets; hire people without experience and provide training.
        - Bayada has a staff position dedicated to recruiting.
        - Outreach to schools, churches to find potential caregivers.

        - Pay staff to volunteer in their community.
    - Direct care workers actively recruit new caregivers.
    - Advertise in local media, social media.
    - Job fairs – not much success

Other strategies to provide services:

- Look for alternative ways to meet needs:
  - Grocery delivery services.
  - Laundry delivery services.
  - Private cleaning companies.
  - Use flexible funds.
- Educate families about staff shortages.
  - Start assessing staffing needs for an individual by asking them if there is a family member, friend or neighbor able to provide care.
- NEKHH works with the Council on Aging to develop a network that participants can tap into for short term needs (e.g., ramp into house).
- Bayada only provides CFC personal care services.

What is needed:

- Finding people called to do this work.
- Increase funding so agencies can increase wages and provide benefits.
- Recruit people from outside Vermont.
- Develop way to train, address language and tech barriers for New Americans.
- Address housing, childcare issues.
- Rethink requirement for reliable car or provide funds to help with transportation.