State Advisory Council on Aging

2016 Annual Report

to the

Michigan Commission on Services to the Aging

DIRECT CARE WORKERS: Training, Certification, Accountability, Retention

Commissioner Michael J. Sheehan, Chairperson

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APRIL 2016

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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGING & ADULT SERVICES AGENCY
LANSING

NICK LYON
DIRECTOR

April 15, 2016

Dear Chairperson Wishart and Fellow Commissioners:

I am very pleased to present the 2016 Annual Report of the State Advisory Council on Aging (SAC). Recognizing both the importance of growing and retaining Michigan's direct care workforce and the imminent direct care workforce issues, on February 20, 2015, the Michigan Commission on Services to the Aging charged the SAC with researching and preparing a report on the training, licensing and/or certification, accountability and living wages of direct care workers.

Acting on this charge, the SAC invited two experts to the March and June 2015 meetings; Clare Luz, Ph.D., of Michigan State University presented research findings about the *Building Training…Building Quality* program; and Hollis Turnham, J.D., of PHI, a national organization dedicated to quality care through quality jobs, provided data and demographics about Michigan's direct care workforce and future needs. The SAC formed four workgroups to study this important topic:

- Marketing the Value of Direct Care Workers;
- Interdisciplinary Care Team Model;
- Transportation Models; and
- Direct Care Worker Training.

Each workgroup held six conference calls beginning July 2015 through February 2016 to study issues and hear from additional experts. Workgroup leaders and Aging and Adult Services Agency staff recorded and summarized the information gained during the conference calls, and shared the summaries with workgroup members. Subsequently, the workgroup leaders prepared short presentations for the October 2015 and March 2016 SAC face-to-face meetings. Based on a thorough review, the SAC prepared final recommendations for presentation to the Commission.

On behalf of the SAC, I am pleased to share these recommendations with you. We look forward to receiving your feedback about the report and our recommendations. The SAC deeply appreciates your interest and continued support.

I also wish to express our thanks to former Executive Director Kari Sederburg and the staff of the Michigan Department of Health and Human Services, Aging and Adult Services Agency for their assistance and support during the year. We also appreciated Commissioners Dona Wishart and Gerald Irby for attending SAC meetings. Finally, I wish to thank the Commission for allowing me the opportunity to chair and work with the SAC.

Sincerely,

Commissioner Michael J. Sheehan
Chairperson, State Advisory Council on Aging

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STATE ADVISORY COUNCIL ON AGING
2016 ANNUAL REPORT

Direct Care Workers

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EXECUTIVE SUMMARY and RECOMMENDATIONS

It would be inaccurate to say that a crisis is looming with direct care workers (DCWs). The crisis is not looming; it is already here. The continued development of a strong direct care workforce to support Michigan's older adults and persons with disabilities to live quality lives in their homes must be a state priority if we are going to support Michigan residents in living independently with dignity and purpose.

In February 2015, the Michigan Commission on Services to the Aging (CSA) charged the State Advisory Council on Aging (SAC) to research the complex issues associated with this important topic. The SAC studied the issues between March 2015 and March 2016, heard from numerous experts and worked in four workgroups via telephone conference calls:

1. Direct Care Worker Training
2. Interdisciplinary Care Team Models
3. Transportation Models
4. Marketing the Value of DCWs

Following discussion and research, the SAC adopted the Training Workgroup's definition of DCWs.

> "DCWs, also known as direct services professionals, provide much-needed supports and services to older persons and those living with disabilities in a home setting or a long-term care facility. They assist with both activities of daily living (ADLs), and instrumental activities of daily living (IADLs). ADLs are personal activities people may need assistance with, such as bathing, eating, ambulating and transferring, using the bathroom, and dressing and grooming. IADLs include household cleaning, meal planning/shopping, and food safety/meal preparation and getting to appointments."
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> "While a professional license is not required, DCWs may supplement the care provided by other licensed professionals or may provide the only assistance an individual receives, depending on the needs, resources and choices of the individual. DCWs include certified nursing aides (CNAs), certified home health aides (HHAs), personal care aides (PCAs--MI Choice Waiver program), home help/in-home service providers, and self-employed DCWs." (See Appendix A for comprehensive DCW definition.)

The SAC considered current Michigan direct care workforce data compiled by PHI (Paraprofessional Healthcare Institute), a national organization dedicated to *Quality Care Through Quality Jobs*. There are 171,490 DCWs and over 6,000 businesses providing supports and services to people in their own homes, at their jobs and residential facilities, (PHI, 2014). By 2022, Michigan will need 24,000 more trained DCWs than we currently have, due to increasing numbers of older adults and people with disabilities in Michigan (PHI, 2016).

Older adults represent the fastest growing portion of the population in Michigan. DCWs provide the majority of paid in-home long-term supports and services (LTSS). These workers make it possible for older adults to remain at home, providing assistance with tasks of daily living such as bathing, dressing, cooking, and transportation. Michigan must be **better** prepared to meet this demand.

The SAC reviewed the current DCW practice and training standards. Federal laws require Medicare and Medicaid-certified nursing homes and Medicare-certified home health agencies and hospices to employ trained certified nurse aides (CNAs) who have completed 75 hours of training that includes 16 hours of supervised practical or clinical training. Several other states require more training, 76-120+ hours.

There are no state minimum training requirements for other DCWs in Michigan. The Aging and Adult Services Agency (AASA), a division of the Michigan Department of Health and Human Services, partnered with PHI and Michigan State University (MSU) to address the lack of training. Together, a U.S. Department of Health and Human Services grant was implemented. The grant, known as the Personal and Home Care Aide State Training (PHCAST) grant, was awarded by the Health and Human Services Administration (HRSA). Michigan was one of six states (CA, IA, MA, ME, MI & NC) to implement or expand DCW training, using this grant funding. Michigan's PHCAST curriculum model is called the *Building Training…Building Quality (*BTBQ) program.

The SAC strongly supports standardizing DCW training and endorses using the BTBQ curriculum model on a statewide basis. This program has been piloted in five regions across the state. MSU conducted a program evaluation of the pilot, which trained 393 DCWs. MSU concluded that those individuals gained considerable knowledge from the training (Luz, Swanson, Ochylski, and Turnham, 2014). Revisions to the curriculum based upon the evaluation findings will be completed this summer. It is anticipated that the BTBQ program will be implemented.

The SAC agreed upon the following key recommendations for improving the State's direct care workforce:

1) Market the value of our DCWs.
2) Form a state-wide coalition to advocate for:
    a. Implementing an agency/advocacy group-managed registry of DCWs that will track levels of training and advancement and that is linked to background checks and a registry of home health care agencies to support professionalism and oversight. There are 1,000 agencies in Michigan; legislation will be needed.
    b. Standardizing education training programs that are portable, affordable, measurable and trackable for instructors/trainers and DCWs. We recommend using the best practice model--BTBQ adult-learner-based training, which emphasizes common vocabulary, skills, and person-centered approaches.

c. Expanding the BTBQ pool of trainers, offering a state trainer certification with instructor training each year, and maintaining a list of qualified trainers, which is updated every two years. Trainer support meetings and trainers' input for improving the BTBQ training will be important, as well as input from hospitals, their home health programs and home care providers.
d. Working with community colleges and others to assess their local communities' ability to pay for tuition to determine how much to charge students, and ask high schools'/community colleges' scholarship programs if there are funds to assist students. Training stipends to DCWs to attend trainings should be considered.
e. Changing Medicaid policies to support reimbursement for pre-employment training of PCAs.
f. Aligning the CNA and BTBQ training and consider strategies for bridging these trainings into career ladders—enabling DCWs to explore new areas of direct care work, add skills and move in several directions rather than just upward. Career nursing and nurse aide programs are being developed across the nation that provide additional training to develop advanced skills necessary to provide care and supports to people. See "Resource" links for more information.
g. Developing a DCW reference website that includes professional requirements for DCW and CNAs certification and advanced skills training.
h. Devising a training reporting/data collection process and an acquisition of funding resource plan to train trainers and to hold trainings.

3. Advocate for ensuring living wages for DCWs with the Governor, Legislature, and private sector; develop information sheets about the benefits as well as show how the current home care provider reimbursement rates do not support the costs of employing DCWs. Include a description of employers' legal obligations including yearly evaluations, training/continuing education, background checks, drug screens (11% disqualified for a life time/no appeal process), bonding and insurances.
4. Support funding of DCW background checks, which should include a review of all registries including Michigan's Internet Criminal History Access Tool (ICHAT) and the Offender Tracking Information System (OTIS). The national trend is moving towards requiring fingerprinting of all DCWs. Promote future legislation/policies and funding for fingerprinted background checks (BGCs) of DCWs. The benefit to this is that the current Michigan State Police "rap-back process" runs all collected fingerprints monthly to tag those who may have new convictions. Screen DCW students. These actions must be a requirement for all DCWs to protect our vulnerable adults.
5. Study potential DCW tax-deductible savings programs for employers, employees, and independent professionals.
6. Advocate for the wider inclusion of DCWs on interdisciplinary care teams (ICTs).

7. Support funding of ICTs using a variety of public and private sources that may offer opportunities to pilot ICT innovative approaches.
8. Commit to a long-term multi-jurisdictional public transportation system, supported by increased funding priorities for transportation.
9. Identify community partnerships to facilitate public transportation options that cross county lines and that provide low-cost private transportation options for DCWs.
10. Develop a subcommittee or blue ribbon panel that includes community partners to discuss data collection and help craft more robust solutions for multi-jurisdictional public transportation.
11. Support a recommendation to the Governor's Office to begin a review and possible reorganization of the existing 60 executive transportation offices.
12. Form public-private partnerships to house the BTBQ instructor training, BTBQ curriculum, and data collection of instructors/trainers, trainings conducted and the number of DCWs' completing training. Continue exploration of collaboration with MSU, Community Services Network (CSN) and Area Agencies on Aging (AAAs).

REPORT INTRODUCTION

It would be inaccurate to say that a crisis is looming with direct care workers (DCWs). The crisis is not looming; it is already here. The continued development of a strong direct care workforce to enable Michigan's older adults and persons with disabilities to live quality lives in their homes must be a state priority if we are going to support Michigan residents in living with dignity and purpose.

Witness these realities:

- There is no uniform standard of training that assures older adults and people with disabilities that those DCWs entering their homes to provide supports and services are adequately trained.
- In fact, if a worker has not been hired by a private agency, that worker may have had no training or a background check.
- There is no state registry for all DCWs with information on training and/or certifications.
- Because of limits on State reimbursement, many DCWs can earn more at Walmart or as waitstaff working the same number of hours.
- Many private care providers are not applying for Area Agency on Aging contracts because they cannot make a profit.
- Reliable transportation presents a critical barrier to growing the direct care workforce. Especially in rural areas, DCWs have almost insurmountable transportation problems.
- DCWs often are viewed with disdain by the medical community even though they are on the front line providing supports and services.
- Because DCWs are often not treated with respect as part of a team, retention rates are appallingly low.
- Categories and definitions of what DCWs are vary widely among long-term care settings, hospitals and agencies.

Due to concerns about these realities, in February 2015, the CSA charged the SAC to research the complex issues associated with this important topic. The SAC studied the issues between March 2015 and March 2016, heard from numerous experts and worked in four workgroups (below) via telephone conference calls:

1. Direct Care Worker Training
2. Interdisciplinary Care Team Models
3. Transportation Models
4. Marketing the Value of DCWs

Following discussion and research, the SAC adopted the Training Workgroup's definition of DCWs.

> "DCWs, also known as direct services professionals, provide much-needed supports and services to older persons and those living with disabilities in a home setting or a long-term care facility. They assist with both activities of daily living (ADLs), and instrumental activities of daily living (IADLs). ADLs are personal activities people may need assistance with, such as bathing, eating, ambulating and transferring, using the bathroom, and dressing and grooming. IADLs include household cleaning, meal planning/shopping, food safety/meal preparation and getting to appointments."
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> "While a professional license is not required, DCWs may supplement the care provided by other licensed professionals or may provide the only assistance an individual receives, depending on the needs, resources and choices of the individual. DCWs include certified nursing aides (CNAs), certified home health aides (HHAs), PCAs (MI Choice Waiver program), home help/in-home service providers, and self-employed DCWs." (See Appendix A for comprehensive DCW definition.)

The SAC considered current Michigan direct care workforce data compiled by PHI.

There are 171,490 DCWs and over 6,000 businesses providing supports and services to people of all ages in their own homes, at their jobs and in residential facilities. Michigan's DCWs (based on 2014 numbers reported by the Michigan Labor Market Information Agency) include:

- Personal Care Aides—24,780 (Working in programs like the MI Choice Waiver Program and in community mental health-funded programs)
- Home Health Aides--36,910
- Certified Nursing Assistants (CNAs)--48,800
- Independent Providers (Working in the Home Help Program)--61,000

Demographics of DCWs in Michigan:

- 87% are women
- Average age is 39—DCW ages range from 18 to 90+
- 64% are white; 28% are African American
- Uninsured—35%
- Some college or a degree—53%;
- Households at 200% of poverty—49%
- Households receiving public benefits-48%

By 2022, Michigan will need about 24,000 more trained DCWs than we currently have due to increasing numbers of older adults and people with disabilities. Older adults represent the fastest growing portion of the population in Michigan. DCWs provide the majority of paid in-home long-term supports and services (LTSS) that make it possible for older **adults to remain at home**, including assistance with tasks of daily living. Michigan must be prepared to meet this demand.

The SAC reviewed the current DCW practice and training standards: Federal laws require Medicare and Medicaid-certified nursing homes to employ trained certified nurse aides (CNAs) who have completed 75 hours of training, including 16 hours of supervised practical or clinical training. Michigan is one of 19 states to require only the minimum of 75 hours. CNAs are certified for two years and are eligible to be recertified for an additional two years if their renewal forms provide documentation of employment as a CNA for at least eight hours within the initial two-year period. CNAs are also required to have 12 hours of continuing education each year for a total of 24 hours each two-year renewal cycle.

Additionally, federal laws require Medicare-certified home health agencies and hospices to employ nurse aides who have completed 75 hours of training, 16 hours of supervised practical or clinical training, and 12 hours of continuing education in a 12-month period. Michigan is one of 34 states to require only the minimum 75 hours of training, whereas 10 states require 76-119 hours and six states require 120+ hours.

There are no set state minimum training requirements for other DCWs in Michigan. The Aging and Adult Services Agency (AASA), a division of the Michigan Department of Health and Human Services, partnered with PHI and Michigan State University (MSU) to address the lack of training. Together, a U.S. Department of Health and Human Services grant was implemented. The grant, known as the Personal and Home Care Aide State Training (PHCAST) grant, was awarded by the Health and Human Services Administration (HRSA). Michigan was one of six states (CA, IA, MA, ME, MI & NC) to implement or expand DCW training under the Michigan *Building Training…Building Quality* (BTBQ) program. The BTBQ program targeted DCWs called PCAs who provide LTSS to participants in the MI Choice Waiver program serving older adults and people with disabilities at home.

The BTBQ team strove to identify key characteristics of a “gold-standard” DCW/PCA training program that would lead to a competent workforce, improve the lives of DCWs/PCAs and the participants they serve and be a model for the nation. Through partnerships with AASA, MSU, PHI, an RN project director, waiver agents and community collaborators, these goals were achieved. The BTBQ 77-hour core curriculum was adapted from the PHI Personal Care Services curriculum with the

assistance of multi-disciplinary regional workgroups and input from Michigan's aging and disability networks. It is based on ten federal competency requirements, emphasizes Michigan's Department of Health and Human Services-endorsed, person-centered principles, values and essential elements, and is taught using adult-learner teaching strategies.

The SAC supports standardizing DCW Training and endorses using the *Building Training…Building Quality* curriculum model on a statewide basis. This program has been piloted in five regions across the state. MSU conducted a program evaluation of the pilot, which trained 393 DCWS. MSU concluded that those individuals gained considerable knowledge from the training. Pilot learners included Michigan Works! referrals, interested individuals, CNAs, and independent direct care worker providers including home help. Learners had to pass each module's quiz with a score of at least 80% and had to perform all of the return demonstrations with a score of 100%. See the BTBQ report link under "Resources" for more information.

The BTBQ training curriculum has been revised based upon input from the BTBQ learners and trainers, to better meet the training needs of Michigan's direct care workforce. Next steps toward implementation of the BTBQ include piloting the revised training modules, along with determining the key modules that should be taught first to get DCWs working faster, refining the instructor training program, and finalizing how best to oversee the statewide implementation. To ensure success, it will be important to make sure classroom recruitment and graduation rates are high, and that graduates can be paid a living wage in order for them to continue working in the field. We will need support from the state to implement the program.

SAC Workgroup Summaries and Detailed Recommendations

Each workgroup researched their topics and heard from experts. During face-to-face meetings the SAC reviewed each workgroup's report and together vetted the complex issues and recommendations. The final recommendations are outlined below. Some workgroups' recommendations were combined when they were similar.

Direct Care Worker Training

The SAC Direct Care Worker Training Workgroup first focused on defining DCWs (See Appendix A.) and reviewing Michigan's DCW data. Second, the best approaches for managing standardized training for DCWs and their trainers across the state were studied, and the main focus was on the *Building Training…Building Quality* (BTBQ) curriculum. Next, recruitment and retention issues were examined with the goal of developing a well-trained and motivated direct care workforce to ensure that safe,

quality supports and services will be provided. Finally, administration of the BTBQ training and how to lower costs and provide easy access to the training were reviewed. This included who should provide the BTBQ training oversight and how to keep selected training records of DCWs, trainers, and courses conducted.

Challenges:

- Funding - The cost of training includes paying the instructors/trainers, copying the trainer and learner curriculum and handouts, and procuring the training site.
- Training Location - Finding low-cost training locations/classrooms with beds and Hoyer lift so people can be trained on moving people from their bed to a chair, etc.
- Class Size – Optimum class size is 12-14. Additional efforts must be taken to ensure a full class.

Recommendations:

Direct Care Worker Training:

1. Standardize portable, measurable and trackable trainings for instructors/trainers and DCWs that are recognized by the state, using the BTBQ adult-learner-based training, which emphasizes common vocabulary, skills, and person-centered approaches.
2. Certify the BTBQ training by the State and provide oversight.
3. Form public-private partnerships to house the BTBQ instructor training, BTBQ curriculum, and data collection of instructors/trainers, trainings conducted and the number of DCWs' completing training. Continue exploration of collaboration with MSU, Community Services Network (CSN) and AAAs.
4. Work with MSU and other partners to develop and maintain a DCW BTBQ registry, including employment history and position longevity.

Instructors/Trainers:

1. Collaborate with the Commission on Aging, Aging network, AAAs, Michigan Directors of Services to the Aging, private home care agencies, Michigan In-Home Care Association, Michigan Home Care Association (MHCA), high schools and community colleges to hold instructor DCW trainings using the BTBQ training.
2. Expand the BTBQ pool of trainers, offer a state trainer certification with instructor training a certain number of times each year, and maintain a list of qualified trainers, which is updated every two years. Hold trainer support meetings and gather trainers' input for improving the BTBQ training.

3. Train nurses, social workers and other health professionals to teach the modules. Those requiring nurse supervision are taught by nurses and the other modules related to communication and person-centeredness, etc. can be taught by other facilitators/trainers (social workers, DCWs, other health professionals/community college professors).

DCW Training Costs/Tuition/Graduation:

1. Work with community colleges and others to assess their local communities' ability to pay for tuition to determine how much to charge students, and ask high schools'/community colleges' scholarship programs if there are funds to assist students. Offer training stipends to DCWs to attend trainings.
2. Advocate for changes to Medicaid policies, which do not support reimbursement for pre-employment training of PCAs. In a July 2011 bulletin to State Medicaid Agencies, CMS ruled, "Costs associated with requirements that are prerequisite to being a qualified Medicaid provider are not reimbursable by Medicaid. However, costs associated with maintaining status as a qualified provider may be included in determining the rate for services." This language has been used to deny Medicaid funding for pre-employment training initiated for PCAs working in a Medicaid home and community-based waiver program.
3. Seek funding to support trainers to document the DCWs' completion of modules into a statewide system and a contractor to process certificates and maintain the database. Provide recognition of completion with graduation ceremonies and a certificate of completion and support DCWs initiative to seek continuing education and further advancement.

Continuing Education and Advancement:

1. Align/crosswalk the CNA and BTBQ training and consider strategies for bridging these trainings. Career nursing and nurse aide programs are being developed nationally to provide additional training to develop advanced skills necessary to provide care and supports. See Resource links for more information.
2. Supporting career ladder programs leading toward becoming a CNA is very important, as some long-term care insurance companies require that trained CNAs provide supports and services. Michigan Works! agencies may be more willing to consider partnering to offer the BTBQ if it is aligned with the state's CNA training program.
3. Promote continuing education for DCWs and expand the BTBQ to include other modules for job readiness—résumé building, interview skills and business dress.

4. Develop advanced training modules where DCWs can sit for a certification exam if they choose on topics such as autism and oral health (Seek grant funding from Delta Dental.)
5. Promote DCW peer mentor programs that offer advanced DCW training, such as the PHI Peer Mentor Program.
6. Adapt appropriate BTBQ modules for on-line training with a proctor; consult with others, like the Michigan Home Care Association that has worked with the Institute for Education, to offer 60 hours of online training and 16 hours under the supervision of a registered nurse with special training requirements.

Background Checks:

1. Support funding of DCW background checks, which includes a review of all registries including Michigan's ICHAT; promote future legislation/policies and funding for fingerprinted background checks (BGCs) of DCWs. The benefit to this is the current Michigan State Police "rap-back process" that runs all collected fingerprints monthly to tag those who may have new convictions. Screen DCW student applicants before they begin working, and allow DCW students to begin training while waiting for the results of the BGC.

Interdisciplinary Care Team Models

In response to the growing need for DCWs, this workgroup researched Interdisciplinary Care Team models (ICT) and the inclusion of DCWs on these teams. While ICTs are used in some supports and services programs, and expansion has been discussed for a number of years, both adaptation of ICT models and incorporating DCWs onto care teams have been slow. There are several examples of successful models in Michigan that use ICTs with DCWs participating, such as the Program of All-inclusive Care for the Elderly (PACE) program and the MI Choice Waiver program. We believe that Michigan is poised to be in the vanguard of states providing appropriate, effective, compassionate and skilled care to older adults, with DCWs as active participants in their care. Our purpose in this report is to assist the state in moving towards that goal.

Identified Needs for Interdisciplinary Care Team Success

Members of the Interdisciplinary Care Team:

- *Person/participant*: Those receiving supports and services.
- *Direct Care Worker*s: (See earlier definition and Appendix A.)

- *Healthcare Professionals*: Individuals with a professional license who assist in the identification, prevention, and/or treatment of an illness or disability. They can include doctors, nurses, social workers, therapists, etc.
- *Caregivers:* Unpaid individuals (spouse, significant other, family member, friend, or neighbor) involved in assisting older adults and persons with disabilities who are unable to perform certain activities on their own.
- *Other Supportive Services Professionals:* These are individuals employed by or volunteering for a program providing supportive services, usually in a community-based setting. They may include senior companions, home delivered meals drivers and others. They are often the eyes and ears of the healthcare system, gathering important daily information on the health and well-being of seniors living independently and often the only person the individual may see daily.
- *Define Interdisciplinary Care Team*: The setting may impact who is included on the team and how the team interacts, but it does not affect the goal, which is improved health care and quality of life outcomes. The ICT's supports and services should be person-centered honoring individual decisions, preferences, choices and abilities.

  "An interdisciplinary team brings together a group of individuals with diverse training and education to work on an identified task. These healthcare teams can include doctors, dentists, nurse practitioners and registered nurses, occupational therapists, pharmacists, physician assistants, physical therapists, social workers, nutritionists, and clergy. Team members collaborate to address patient problems that are too complex for one discipline or even many sequential disciplines to solve." (VISN 3 Geriatric Research, Education & Clinical Center, 2014).

Interdisciplinary Care Team Best Practice:

Best practice of care should include building positive relationships while developing mutual respect over time with the person being provided supports and services and all ICT members, both licensed and non-licensed, including DCWs. All ICT members should follow this best practice in order to improve care coordination and health outcomes. ICTs are not a new concept, but implementation of this approach has been slow in coming.

Inclusion in the care team may vary depending upon circumstances and location, e.g. the care team in a PACE program or nursing home may not include a senior companion or home delivered meals driver input, but community-based services, e.g. MI Choice Waiver—PCAs/DCWs, might include them as part of the team. *Inclusion should not be based on whether they make decisions, but because they are in place and can provide important insight into a person's status.* People with complex morbidities and multiple

needs who are also heavy users of healthcare resources may be most affected by this care approach.

Challenges of successful interdisciplinary care team philosophy, approach and structure:

- *Culture of Healthcare* - Healthcare's culture is traditionally very hierarchical and may be reluctant to include non-licensed DCWs who may be in the better position to contribute useful information from daily contact. Some medical schools are beginning to train for greater collaboration, but their assumption is that the DO/MD will lead and this may not suit an interdisciplinary care team for success.
- *Funding* - Pilots, implementation projects, research, training, and team meeting time need to be funded. Without additional funding, many programs and health care agencies will not include DCWs in the interdisciplinary care team as it will be an unfunded additional burden.
- *Program and service delivery in different locations requires different models* and lessens the ability for ICTs to jointly meet about people's support needs. New models may be developed, and use of new technology may facilitate adoption in order to improve care coordination and healthcare outcomes for rural areas and programs in which multiple disciplines and services are not co-located.
- *Training that emphasizes common vocabulary, skills and approaches, is portable, measurable and trackable*: This will facilitate communication and common assumptions, improve DCW working skills, lead to greater respect, higher wages and job pathways. (See Appendix B: References)
- *Differentials in language, education, skills, and cultures* of different team members - Respect for all at the table, recognizing the value of different viewpoints, needs to be emphasized. Commonly adopted training that is portable may help to overcome some of these challenges.
- *Role and value of DCWs not clearly understood by people needing support or their families* - DCWs are often seen differently depending on the care settings. For example, the role of DCWs may be more clearly understood in an assisted living setting and their professionalism and credibility may benefit from being affiliated with a respected healthcare organization. However, it appears that DCWs providing services in the home may not benefit from such an association and may be seen as more of a maid than a healthcare worker.

Recommendations:

1. Advocate for inclusion of DCWs on interdisciplinary care teams (ICTs) and promote the importance of ICTs in positive healthcare outcomes for adults.

2. Support funding for ICTs with a variety of public and private sources, which may offer many opportunities for public/private partnerships to pilot ICT innovative approaches. Reimbursement for ICTs can be included in the overall cost of providing services, such as Medicaid Waiver or PACE programs, but must be acknowledged by the Centers for Medicare and Medicaid Services and others as a reimbursable cost, or else the ICT approach will continue to be implemented sparsely. While programs based on a capitated reimbursement may be able to include such a cost in their overall cost of care, for home health agencies, this additional requirement without funding will almost certainly limit its implementation.
3. Develop pilots that can be adapted to other contexts and demonstrate improved health outcomes. This will allow for a range of successful, evidence based-models that can be implemented in different care settings. It will require funders to step up and to support a variety of different approaches. There are significant opportunities for public/private partnerships in this area. Programs with different services co-located, such as PACE, or Mi Choice Waiver programs, may need different models or other programs, where services may be less centralized or localized. Developing, piloting and funding implementation projects should increase research about healthcare outcomes and improve adoption.

The ICT Workgroup's recommendations about training, registries and background checks have been combined with the other workgroups' recommendations.

Transportation Models

The Transportation Workgroup surveyed research that revealed a dearth of knowledge about transportation obstacles and potential solutions for DCWs to get to work and training. The workgroup studied national and statewide government and nonprofit reports about transportation models that might benefit DCWs. The workgroup further examined a number of Michigan's 79 transportation systems. Additionally, several transportation experts described their roles in various transportation initiatives addressing issues regarding transportation barriers for caregivers. The transportation experts included Tari Muniz (AASA representative on the Governor's Traffic Safety Advisory Council); Roberta Habowski (AAA 1B's Senior Mobility Specialist); and Clark Harder (Executive Director of the Michigan Public Transit Association).

Challenges:
Federal and state transportation funding, through projects or grants, is funneled through local communities and serves a local population, as opposed to a cross-jurisdictional region. DCWs in rural communities, traveling to multiple homes in one day, especially

struggle to maintain direct care work because local transportation structures either do not exist or are extremely limited. Private transportation, when available, is often costly or focused only on care recipients and not DCWs. Those DCWs who rely on their own personal vehicles may not have the money to pay for gas or maintenance.

Michigan State government leaders on the House Appropriations Subcommittee on Transportation have defined their objectives as:

- Developing approaches to combine transportation funding-related expenses across multi-department budgets
- Providing more coordination among existing services and
- Providing better alternatives for public transportation to fill current gaps.

However, implementation of this objective is two to six years in the future.

Opportunities:

Recent projects have emerged to connect workers to jobs in other counties. For example, the Job Access Reverse Commute (JARC) connects workers from Genesee County to Oakland County seven days a week. MTA also developed a program to bring people with disabilities from Flint to work at a Meijer's grocery store in Lansing. These projects arose through community partnerships with businesses and other stakeholders who sought to connect workers with jobs.

In addition to developing partnerships between public transit and private companies, private programs like Volunteers of America and Goodwill Automobile Donation Program might further alleviate transportation burdens among DCWs. For example, Goodwill has two Workers on Wheels (WOW) programs in Michigan (in Traverse City and Kalamazoo) which serve approximately twenty-five counties. This program may allow workers meeting eligibility criteria to apply for donated cars.

Community partnerships and long-term commitment to multi-jurisdictional public transportation will help DCWs better secure and maintain employment. A one-size-fits-all-approach will not likely succeed given the immense diversity in transportation needs and options available throughout the state. However, more focused attention on working with community partners throughout various jurisdictions will help identify the needs of various communities including developing plans that allow for crossing geographic boundaries for public transportation.

Recommendations:

1. Making a long-term commitment to multi-jurisdictional public transportation, supported by increased funding priorities for transportation and identifying solutions through research and community engagement. This should include

enhancing voucher systems for persons living outside traditional transportation routes and encouraging MDOT to provide training and support for expansion of "small dial-a-ride" county services.

2. Identifying key community partnerships that could help facilitate public transportation options that cross county-lines (e.g. JARC program, partnership between Flint and Meijer's grocery store) and that provide low-cost private transportation options for DCWs (e.g. Goodwill Automobile Donation Program).

3. Developing a subcommittee or blue ribbon panel that includes community partners and/or inviting transportation experts (e.g. Clark Harder, Chairman Canfield) to a selected portion of a Commission meeting to discuss data collection and help craft more robust solutions for multi-jurisdictional public transportation.

4. Supporting a recommendation to the Governor's Office to begin a review and possible reorganization of the existing 60 executive transportation offices. It should encourage fund development for rural county and multi-jurisdictional transportation initiatives. Additionally, it should propose legislation that would increase available funding streams for the development of rural and multi-county transportation systems. This funding could assist both workers and users needing to cross jurisdictional boundaries with additional transportation options in rural communities.

Marketing the Value of Direct Care Workers

In response to the increased demand for DCWs, the SAC *Marketing the Value of DCWs* workgroup looked at the challenges faced if Michigan does not have a strong marketing program to support and attract DCWs. While there is great concern over the increased training needed for DCWs, wages were also a concern. The workgroup identified potential avenues to increase public awareness regarding the value of our DCWs and also ways in which to provide uniform education and statewide support programs.

Needs for Marketing the Value of DCW Success:

Define DCWs - Use the SAC-approved definition and use the term DCWs as the most inclusive way of describing this workforce. (See Appendix A.)

Define *Marketing the Value of DCWs'* Goal - To recognize and market the positive value of our DCWs and share the workgroup's research and resources with the public on the

impact of DCWs on the quality of care, life, outcomes, and healthcare costs for older adults and/or people with disabilities who need supports in their home.

Cost Savings of DCWs Providing In-home Supports and Services

In-home supports and services cost:

- The average cost to provide 44 hours of supports and services to an individual who pays privately in their own home is about $34,320 annually. This example is based on 2,288 hours per year paid @ $15.00 per hour. If the DCW is working through an agency they may only be making approximately $9.00 per hour. (Please refer to employer costs on page 21.)
- The MI Choice Waiver Program pays approximately $15.00 per hour to participating agencies for those individuals who need between 1 hour and up to 24 hours of care each day. Waiver agencies are paid on average $27,000 annually by Medicaid for providing supports and services to an individual. This is based on average hours of 1,800 per year, almost 35 hours per week, or about 5 hours per day for a DCW (called a personal care aide in the BTBQ pilot program). Agencies must cover employee costs such as: taxes, insurance, and training out of the billable $15.00 per hour MI Choice Waiver rate (see chart outlining employer expenses on page 21).
- As shown in the chart below, DCW's are earning an approximate gross wage of $9.00 per hour with a net wage of $7.00 per hour (of the $15.00 billed).

Federal Income Tax	Medicare	Social Security Tax	State Tax
10 – 14 %	1.45%	6.20%	4.25%

Example of Employee Net Wages:

$9.00	Employee Gross Wages
-$0.90	(10%) Federal Income Tax
-$0.13	(1.45%) Medicare
-$0.59	(6.20) Social Security Tax
-$0.38	(4.25%) State Tax
$7.00	**Employee Net Wages**

Nursing home cost:

- The average cost of living in a skilled nursing facility (SNF) per year is $66,000 (Medicaid cost for FY 2015). While the cost of SNF care is often higher than the cost of in-home supports, the services provided in the SNF setting include 24-hour care with licensed nursing staff—RNs, LPNs and CNAs. SNFs often provide care to people with complex health needs. Additionally, SNFs provide many people short-term rehabilitation, which improves their transition home following an illness or injury.

Savings Recommendation - "In 2012, the Center for Disease Control in Atlanta, Georgia, determined in a report that 'Nearly one half of all adults in the United States have a chronic illness. That is roughly 117 million people and 85 percent of healthcare costs that are spent on chronic illness.' This said, it is likely that some kind of home care services rendered by DCWs will be required for adults and people with disabilities within their life time. We are a society which is living longer, and there is and will continue to be a need for more and better-trained DCWs."

"The cost of direct care/medial services can be astronomical. In view of this fact, it may be expedient for states or the federal government to encourage employers or other entities to set up voluntary or non-voluntary contributory accounts similar to health savings and my Retirement Account (myRA), accounts which could include a tax deduction element. Employers should be encouraged to contribute to these tax-deferred saving accounts. Additionally, such a plan could supplement or work in tandem with private pay long-term care insurance plans." (SAC Direct Care Worker Training Workgroup)

Challenges:

- Attracting More DCWs to the Field: DCWs are among the fastest growing occupations in the state, with over 171,470 DCWs currently employed. By 2022, Michigan will need 24,000 more trained DCWs.
- Costs:
  1. Uncompetitive wages and inadequate health insurance
  2. Training and continuing education
  3. Burden of employment costs for Professional DCW Agencies – Employers are left paying 0.5% of all employee wages for those receiving subsidies through the Affordable Care Act.
  4. If an agency pays $9.00/hour it actually costs the agency $11.15/hour, which does not include annual in-service training, uniforms, background checks or health insurance. (Health insurance adds $4.02/hour.)

Facility Type	FICA (Federal Insurance Contribution Act—Social Security)	Medicare	FUTA Fed. Un-employment Tax	2016 SUTA (State Un-employment Taxes	Affordable Care Act	Prof. Liability Ins.	Workers Comp. Ins.	Employee Fringe Benefit Costs
MI Home Care Agency	6.20%	1.45%	0.80%	5.45%	0.50%	3.60%	5.58%	23.58%

Example of Employer Costs:

$9.00	Employee Wage
$0.59	(6.20%) Federal Insurance Contribution Act - Social Security
$0.13	(1.45%) Medicare
$0.07	(.80%) Federal Unemployment Tax
$0.49	(5.45%) State Unemployment Tax
$0.05	(.50%) Affordable Care Act
$0.32	(3.60%) Professional Liability Insurance
$0.50	(5.58%) Workers Compensation Insurance
$11.15	**Employer Cost on $9.00/hour Wages**

Recommendations:

1. Market the value of our DCWs:
    - Develop and provide fact sheets.
    - Publicize information/facts/statistics throughout the year: DCWs in-home vs. nursing home, value of background checks, and agencies with DCWs available.
    - Encourage statewide recognition of successful training programs and the DCW graduates.

2. Form a statewide coalition focused on DCWs advocating for:
    - Ensuring an agency/advocacy group-managed registry of DCWs is developed.
    - Standardizing education programs across the state, managed by a centralized assigned public/private advocacy group.
    - Supporting background checks maintained on a registry, which may include fingerprinted background checks, state criminal record name-based checks, state and federal registries, and recipient rights checks.
    - Developing and providing a reference website for information on DCW requirements.
    - Seeking DCW training administration, oversight and implementation information from other similar coalitions in other states.

3. Advocate for ensuring living wages for DCWs with the Governor, Legislature and private sector; develop information sheets about the benefits of hiring DCWs as well as show how the current home care provider reimbursement rates do not support the costs of employing DCWs. Include a description of employers' legal obligations such as yearly evaluations, training/continuing education, background checks, drug screens, bonding and insurances. (Support efforts to implement a

waiver option when a DCW has been rehabilitated--11% DCWs are disqualified for a life time without an appeal process.)

4. Study potential tax deductible savings programs:
    - Look into ways of marketing and educating Michigan employers and employees on contributions to tax-deductible (deferred) savings programs that can assist in the high costs of home care services in later years. (e.g., health savings accounts, myRA accounts, etc.)

Summary of the SAC Workgroups' Key Recommendations

The CSA's charge to the SAC to research how to support Michigan's direct care workforce is timely and crucial to the future of Michigan's aging population. This SAC report provides the CSA with in-depth key recommendations by 39 SAC members who worked closely together to show how Michigan must support the growth of a strong, well-trained, and fairly paid direct care workforce. Michigan's direct care workforce must provide quality supports and services to older adults and people with disabilities to enable them to live in their homes as they age. The SAC looks forward to working with the CSA in support of implementing these key recommendations listed below over the next few years.

1. Market the value of our DCWs.
2. Form a state-wide coalition to advocate for:
    a. Implementing an agency/advocacy group-managed registry of DCWs that will track levels of training and advancement and that is linked to background checks and a registry of home health care agencies to support professionalism and oversight. There are 1,000 nonprofit and private agencies in Michigan and legislation will be needed.
    b. Standardizing education training programs that are portable, affordable, measurable and trackable for instructors/trainers and DCWs. We recommend using the best practice model--BTBQ adult-learner-based training, which emphasizes common vocabulary, skills, and person-centered approaches.
    c. Expanding the BTBQ pool of trainers, offering a state trainer certification with instructor training each year, and maintaining a list of qualified trainers, which is updated every two years. Trainer support meetings and trainers' input for improving the BTBQ training will be important, as well as input from hospitals, their home health programs and home care providers.
    d. Working with community colleges and others to assess their local communities' ability to pay for tuition to determine how much to charge students, and ask high schools'/community colleges' scholarship programs if there are funds to assist students. Training stipends to DCWs to attend trainings should be considered.
    e. Changing Medicaid policies to support reimbursement for pre-employment training of PCAs.
    f. Aligning the CNA and BTBQ training and consider strategies for bridging these trainings into career ladders—enabling DCWs to explore new areas of direct care work, add skills and move in several directions rather than just upward. Career nursing and nurse aide programs are being developed across the nation that provide additional training to develop advanced skills

necessary to provide care and supports to people. See “Resource” links for more information.

g. Developing a DCW reference website that includes professional requirements for DCW and CNAs certification and advanced skills training.
h. Devising a training reporting/data collection process and an acquisition of funding resource plan to train trainers and to hold trainings.

3. Advocate for ensuring living wages for DCWs with the Governor, Legislature, and private sector; develop information sheets about the benefits as well as show how the current home care provider reimbursement rates do not support the costs of employing DCWs. Include a description of employers’ legal obligations including yearly evaluations, training/continuing education, background checks, drug screens (11% disqualified for a life time/no appeal process), bonding and insurances.
4. Support funding of DCW background checks, which should include a review of all registries including Michigan’s Internet Criminal History Access Tool (ICHAT) and the Offender Tracking Information System (OTIS). The national trend is moving towards requiring fingerprinting of all DCWs. Promote future legislation/policies and funding for fingerprinted background checks (BGCs) of DCWs. The benefit to this is the current Michigan State Police “rap-back process” runs all collected fingerprints monthly to tag those who may have new convictions. Screen DCW students. These actions must be a requirement for all DCWs to protect our vulnerable adults.
5. Study potential DCW tax deductible savings programs for employers, employees, and independent professionals.
6. Advocate for the wider inclusion of DCWs on interdisciplinary care teams (ICTs).
7. Support funding of ICTs using a variety of public and private sources which may offer opportunities to pilot ICT innovative approaches.
8. Commit to a long-term multi-jurisdictional public transportation system, supported by increased funding priorities for transportation.
9. Identify community partnerships to facilitate public transportation options that cross county-lines and that provide low-cost private transportation options for DCWs.
10. Develop a subcommittee or blue ribbon panel that includes community partners to discuss data collection and help craft more robust solutions for multi-jurisdictional public transportation.
11. Support a recommendation to the Governor’s Office to begin a review and reorganization process of the existing 60 state and local transportation offices.
12. Form public-private partnerships to house the BTBQ instructor training, BTBQ curriculum, data collection of instructors/trainers, trainings conducted and the number of DCWs’ completing training. Continue exploration of collaboration with MSU, Community Services Network (CSN) and AAAs.

Appendix A: DIRECT CARE WORKERS (DCWs) DEFINED

DCWs, also known as **direct services professionals,** provide much-needed supports and services to older persons and those living with disabilities in a home setting or a long-term care facility. They assist with both activities of daily living (ADLs), and instrumental activities of daily living (IADLs). ADLs are personal activities people may need assistance with, such as bathing, eating, ambulating and transferring, using the bathroom, and dressing and grooming. IADLs include household cleaning, meal planning/shopping, and food safety/meal preparation and getting to appointments. While a professional license is not required, DCWs may supplement the care provided by other licensed professionals or may provide the only assistance an individual receives, depending on the needs, resources and choices of the individual.

Certified nurse aides (CNAs): About 50,000* DCWs in Michigan are certified as nurse aides who assist with ADLs and sometimes IADLs as well. CNAs usually work in nursing homes, hospices, and certified home health agencies, but may also choose to work in other settings. CNAs must complete a federally- and state-regulated, 75-hour CNA training program and pass a proctored exam that includes return demonstration of hands-on support skills usually practiced in a licensed, skilled long-term care facility/nursing home. CNAs must complete 12 hours of continuing education under the supervision of a nurse every year to keep their license in good standing.

Certified Home Health Aides (HHAs): About 35,000* DCWs are certified home health workers in Michigan who work for a Medicare licensed certified home health agency and provide ADL and IADL supports. The Certified HHA is also required to complete the 75-hour training and skills return demonstrations in order to be certified and must also complete 12 hours of in-service (continuing education) each 12-month period as required by law and federal regulations.

Personal Care Aides (PCAs): In Michigan, there are about 12,000* PCAs; many of these PCAs support participants eligible to receive Medicaid-covered supports as part of the MI Choice Waiver program in people's own homes rather than in a nursing home. These DCWs assist people with ADLs, IADLs, offers comfort and companionship and works for a home care agency. With specific training, PCAs may also provide health-related supports. Depending on the setting and employer, PCAs may be called personal assistants, personal care aides, direct care or program staff, attendants or caregivers. Many home care agencies offer training to newly hired PCAs and provide continuing education. However, in Michigan there are **no** formal requirements for PCAs to be certified.

Home Help Providers (HHPs)/In-home Service Providers: Michigan has over 60,000* HHPs who support adults choosing to stay in their home but are in need of some assistance with ADLs. The Michigan Department of Health and Human Services (MDHHS) program provides funding for individuals to hire in-home service providers (family or friends, but not spouses) who can assist with daily activities, supporting people to remain in their own homes. HHPs are not required to be certified. Some local MDHHS offices may recommend HHPs attend locally-based training classes.

Self-employed DCWs: An unidentified number of DCWs are independently self-employed who are hired directly by individuals. Although many DCWs may have previous experience working for a home care agency, in Michigan there are no formal training requirements or certification for DCWs.

**Since the DCWs as outlined in the categories mentioned may work in more than one DCW category, the numbers listed above may include some duplication.*
SAC February 5, 2016

Appendix B: References

Paraprofessional Healthcare Institute, (2016), *Michigan: Size of Direct-Care Workforce, 2014*. http://www.phinational.org/policy/states/michigan

Paraprofessional Healthcare Institute, (September 2011). *State Facts, Michigan's Direct-Care Workforce*, p. 2.

Paraprofessional Health Care Institute, (PHI) Quality Care Through Quality Jobs, Peer Mentoring. http://phinational.org/search/site/peer%20mentoring

Luz, C., Swanson, L., Ochylski, D., and Turnham, H. (2014). *Michigan's "Building Training…Building Quality" Personal and Home Care Aide State Training Program, Final Report for the Michigan Office of Services to the Aging, pgs. 20 and 24.*

VISN 3 Geriatric Research, Education & Clinical Center (GRECC), Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum, Module #2: Interdisciplinary Teamwork, 2014, pgs.1-10. www.nynj.va.gov/docs/Module02.pdf

Appendix C: Resources

Resources Examined by SAC Members:

- [PDF] MICHIGAN'S "BUILDING TRAINING…BUILDING QUALITY ...http://www.michigan.gov/osa/1,4635,7-234--342682--,00.html
- PHI (Paraprofessional Healthcare Institute) http://www.phinational.org/sites/phinational.org/files/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf
- Workforce Surveys http://phinational.org/policy/state-activities/phi-midwest/michigan/publications
- National Landscape of Personal Care Aide Training Standards http://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/Report-The_National_Landscape_of_Personal_Care_Aide_Training_Standards.pdf
- How Poverty Wages Undermine Home Care in America http://phinational.org/sites/phinational.org/files/research-report/paying-the-price.pdf
- Matching Service Registries Project http://phinational.org/policy/resources/phi-matching-services-project
- HRSA: Personal and Home Care Aide State Training Program http://bhpr.hrsa.gov/nursing/grants/phcast.html
- Direct Care Alliance http://www.directcarealliance.org/index.cfm?pageId=547
- AZ Direct Care http://www.azdirectcare.org/Direct_Care_Workers.html
- Dept. of Health & Human Services http://aspe.hhs.gov/daltcp/reports/2011/cnachart.htm

Direct Care Worker Training:

- http://www.michigan.gov/documents/osa/Michigan_PHCAST_BTBQ_Final_Report_December_18_2014_477161_7.pdf
- http://www.cael.org/pdfs/13_career_lattice_guidebook
- http://www.homecaremi.org/
- http://www.iowapreparetocare.com
- http://www.masslive.com/news/index.ssf/2012/08/in_massachusetts_regulation_li.html
- http://madirectcare.com/direct-care-workforce
- http://www.michigan.gov/osa/1,4635,7-234-64084-377987--,00.html (Michigan PHCAST BTBQ Final Report and Executive Summary December 18, 2014)

- Paraprofessional Health Care Institute, (PHI) Quality Care Through Quality Jobs, 2016. http://www.phinational.org/
- Paraprofessional Health Care Institute, (PHI) Quality Care Through Quality Jobs, State Facts, Michigan's Direct-Care Workforce, 2011. http://www.phinational.org/

Interdisciplinary Care Team Models:

- VISN 3 Geriatric Research, Education & Clinical Center (GRECC), Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum, Module #2: Interdisciplinary Teamwork *http://www.nynj.va.gov/docs/Module02.pdf*
- http://hartfordign.org/uploads/File/gnec_state_of_science_papers/gnec_interdisciplinary_care.pdf Models of interdisciplinary care
- www.nicheprogram.org/knowledge_center/.../**interdisciplinary**%20**teams** ***(Livonia model)***
- hhttp://www.ncbi.nlm.nih.gov/pmc/articles/PMC1533997/
- http://partnershipforsolutions.org/DMS/files/TEAMSFINAL3_1_.pdf Mt. Sinai paper on interdisciplinary care teams... dated 2003!!
- http://www.eldercareworkforce.org/research/issue-briefs/research:care-coordination-brief/
- Equal Times: "A minimum wage isn't a long-term solution for a long-term care crisis." (Hit control and click on the link to open it.) http://www.equaltimes.org/a-minimum-wage-isn-t-a-long-term#.VehcCpfTBNA
- http://www.azahcccs.gov/commercial/DCW/default.aspx
- http://www.californiahealthline.org/insight/2014/new-overtime-law-has-farreaching-effects-on-home-health-care-industry

Transportation Models:

- Aging Population: Projections 2010 – 2060 For The Eu27 (December 2013), http://epthinktank.eu/2013/12/19/aging-population-projections-2010-2060-for-the-eu27/
- Better Life Index (October 2015). http://epthinktank.eu/2015/10/01/better-life-index/
- Briefing - eHealth - Technology for Health (March 2015), http://www.europarl.europa.eu/RegData/etudes/BRIE/2015/551324/EPRS_BRI(2015)551324_EN.pdf
- Briefing - The Silver Economy Opportunities from Aging (July 2015), http://www.europarl.europa.eu/EPRS/EPRS-Briefing-565872-The-silver-economy-FINAL.pdf
- Capital Area Transportation Authority (Lansing, MI), www.CATA.org
- Community Home-Based Care In Resource-Limited Settings: A FRAMEWORK FOR ACTION; (2002), http://www.who.int/hiv/pub/prev_care/isbn9241562137.pdf

- Dailey, W.F., Morris, J.A., & Hoge, M.A. (2015). Workforce development innovations with direct care workers: better jobs, better services, better business. *Community Mental Health J.* 51, 647-653.
- Ejaz, F. K., Noelker, L.S., Menne, H.L., & Bagaka, J.G. (2008). The impact of stress and support on direct care workers' job satisfaction. *The Gerontologist*, *48*(special issue 1), 60-70.
- Federal investments in training and availability of data for workforce projections (2014)
- Gray-Stanley, J.A., & Muramatsu, N. (2011). Work stress, burnout, and social and personal resources among direct care workers. *Research in Developmental Disabilities*, *32*(3), 1065-1074.
- Health Literacy Puts Healthcare In Your Hands (July 2015), http://epthinktank.eu/2015/07/17/health-literacy-puts-healthcare-in-your-hands/
- Helping Seniors Stay Mobile, itnamerica.org/helping-seniors)
- Home-Based Long Term Care (2000), http://apps.who.int/iris/bitstream/10665/42343/1/WHO_TRS_898.pdf
- Home Health Care In Europe (2008), http://www.euro.who.int/__data/assets/pdf_file/0005/96467/E91884.pdf
- How Can Health Systems Respond to Population Aging? (2009) http://www.euro.who.int/__data/assets/pdf_file/0004/64966/E92560.pdf
- How to Prepare for the Future Long-term Care Workforce? (Chapter 6) http://www.oecd.org/els/health-systems/47884930.pdf
- Kemper, P., Heier, B., Barry, T., Brannon, D., Angelelli, J., Vasey, J., Anderson-Knott, M. (2008). What do direct care workers say would improve their jobs? Differences across settings. *The Gerontologist*, *48*(special issue 1), 17-25.
- Leading Age, DCW Retention (Strategies for Success, 2010) http://www.leadingage.org/uploadedFiles/Content/About/Center_for_Applied_Research/Publications_and_Products/Direct%20Care%20Workers%20Report%20%20FINAL%20(2).pdf
- Livable NY Resource Manual. Transportation Models (10 Pages of resources/websites for Transportation Models), http://www.aging.ny.gov/livableny/ResourceManual/MobilityAndTransportation/V8.pdf
- Long-term Care: Growing Sector, Multifaceted Systems (Chapter 1) http://www.oecd.org/els/health-systems/47884520.pdf
- Long-term care (OECD, 2011 study); www.oecd.org
- MDOT website: http://www.michigan.gov/mdot/0,4616,7-151-9615_29684_29686-31837--,00.html
- MDOT Transportation Report: Improving Mobility and Transportation Options for Michigan's Rural Seniors, https://www.michigan.gov/documents/mdot/Spotlight_-_Aging_Rural_Drivers_413716_7.pdf.
- Michigan Department of State - Traffic Safety Division Alternative Transportation Services/Transit Authorities by County Map, http://www.michigan.gov/sos/0,4670,7-127-1640_14837_64607-299780--,00.html
- Michigan Home Help website, http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42549_42590---,00.html.

- Michigan's Senior Transportation Network, http://michigan.gov/documents/miseniors/Transportation05_175052_7.pdf
- National Direct Service Workforce Resource Center, https://www.disability.gov/resource/national-direct-service-workforce-dsw-resource-center.
- Report: Improving Mobility and Transportation Option for Michigan's Rural Seniors http://www.michigan.gov/documents/mdot/Spotlight_-_Aging_Rural_Drivers_413716_7.pdf
- Strategies to improve recruitment, retention, and development of direct support workers (University of Kentucky), http://chfs.ky.gov/NR/rdonlyres/0B29A6DB-200B-450B-8D06-97BA247452C1/218114/Direct_support_report_final.pdf
- Strengthening the Direct Service Workforce in Rural Areas (CMS, August 2011), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/downloads/rural-area-issue-brief.pdf
- Van de Weerdt, C., Baratta, R. (2015). Changes in Working Conditions for Home Healthcare Workers and Impacts on Their Work Activity and on Their Emotions; Production, vol.25 no.2, http://www.scielo.br/scielo.php?pid=S0103-65132015000200344&script=sci_arttext

Marketing the Value of DCWs:

- Building Training…Building Quality (BTBQ) Training Report: http://www.michigan.gov/osa/1,4635,7-234-64084-377987--,00.html
- Iowa PHCAST grant project: http://www.phinational.org/policy/issues/training-credentialing/personal-and-home-care-aide-state-training-program-phcast
- Massachusetts MassHealth PCA Program: http://www.nilp.org/il-services/pca/
- New Mexico Coalition (The): http://nmdcc.org
- Paraprofessional Healthcare Institute (PHI): www.phinational.org
- Relias On-line Learning System: https://reliaslearning.com

Appendix D: Experts

Barry Cargill, Executive Director, Michigan Home Care Association

Roberta Habowski, AAA 1B's Senior Mobility Specialist and serves on the Governor's Traffic Safety Advisory Council, the Council's Senior Mobility Workgroup and several local mobility transportation workgroups

Clark Harder, J.D., Executive Director of the Michigan Public Transit Association and former Chairman of the House of Representatives' Transportation Committee and Vice Chair of the House Committee for Seniors and Retirement.

Russ Knopp, Board Chairman, Michigan In-Home Care Association

Clare Luz, Ph.D., Assistant Professor, Department of Family Medicine, Geriatric Division, College of Human Medicine, MSU, and Member of the Michigan Personal Home Care and State Training (PHCAST) Grant Team

Tari Muñiz, Departmental Analyst, AASA, AASA's representative on the Governor's Traffic Safety Advisory Council and the Council's Senior Mobility Workgroup

Marcus Paul, President, Right at Home

Anita Stineman, Ph.D., R.N., Associate Clinical Professor, University of Iowa. Member of the Iowa Personal Home Care and State Training (PHCAST) Grant Team

Hollis Turnham, J.D., Michigan Manager PHI-Midwest Office and Member of the Michigan Personal Home Care and State Training (PHCAST) Grant Team

Leanne Winchester, M.S., R.N., Project Director, Massachusetts Department of Health and Human Services, State Training and Member of the Massachusetts Personal Home Care and State Training (PHCAST) grant team

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Glen Arbor, MI

Angela Perone –1B
Ypsilanti, MI

Jean Peters – 10
Traverse City, MI

SAC Roster Continued

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Redford, MI

Mary Lou Proefrock – 8
Reed City, MI

Patricia Rencher –1A
Detroit, MI

Donald Ryan — 3A
Kalamazoo, MI

Mona Sashital – 1B
Northville, MI

Gary Scholten -- 14
Holland, MI

Linda Strohl – 4
Sawyer, MI

Terry Vear -- 2
Hillsdale, MI

Susan Vick – 9
St. Helen, MI

Wendy White -- 7
Midland, MI

Kathleen Williams-Newell -- 1A
Detroit, MI

Virginia Wood-Broderick -- 2
Grass Lake, MI

John Zimmerman –10
Traverse City, MI

Ex-Officio Members

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Lansing, MI

Susan Avery, Director
Michigan Women's Commission
Detroit, Michigan

Elizabeth Adie Thompson, Alternate
Michigan Women's Commission
Detroit, MI, and SAC Editor

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