Findings from Surveys of MI Choice and CMH Self-Directed Workers *Executive Summary*

Understanding Michigan's Long-Term Supports and Services Workforce

A report prepared for:
Michigan Office of Services to the Aging
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So What? Consulting

About this Project

The Michigan self-determination workforce surveys are part of a larger effort by the Michigan Office of Services to the Aging to study the size, stability, and compensation levels of the direct-care workforce supporting participants in Michigan's Medicaid-funded home and community-based services programs. Detailed analysis of survey findings are available at **www.PHInational.org/michigan**.

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Background

Self-directed long-term supports and services (also known as consumer direction) allow participants to hire their own direct-care workers to assist them with personal care services such as bathing, meal preparation, and housekeeping. This model of service delivery, known as "self-determination" in Michigan, has grown in recent years, with all but one state offering this option within their Medicaid program.

Despite this growth and wide acceptance, operational challenges hinder states in their efforts to maintain self-determination as a delivery system for long-term supports and services (LTSS). One of the main barriers is securing and maintaining a workforce to deliver these in-home services.[1] Part-time and unpredictable schedules for workers, participants' heavy reliance on family members and friends for support, and poor infrastructure to assist participants in finding workers are issues and barriers that have been identified in some Medicaid self-determination programs across the country.

Strengthening self-determination programs requires looking more closely at the paid workforce that supports participants in these programs. Infrastructure investments are likely needed to keep self-determination a viable option for participants. A first step in identifying effective investments to sustain self-determination is gaining a better understanding of this part of the direct-care workforce.

With grant funding from the Centers for Medicare & Medicaid Services, the Michigan Office of Services to the Aging (OSA) worked with the Michigan Disability Rights Coalition (MDRC) and PHI to develop and implement surveys for workers supporting self-directing participants in two of Michigan's Medicaid home and community-based services (HCBS) waiver programs. Specifically, the State Profile Tool provided the funding for each of these surveys as a part of the effort to analyze Michigan's publicly funded HCBS long-term supports and services system and develop metrics to measure systems outcomes. Michigan was one of the first states to include a description and analysis of the HCBS workforce in its State Profile Report. To expand this analysis, Michigan decided to conduct surveys of workers in two of the state's Medicaid-funded self-determination programs.

The purpose of these surveys was to collect basic data on the workforce supporting participants in self-determination programs in order to assure the viability of this delivery option for current and future participants. Due to changes in federal priorities, the two surveys were conducted at different times. OSA engaged PHI to develop and implement the two surveys and to analyze the findings.

The survey of the MI Choice workforce serving elders and people living with physical disabilities—Individual Workers in Self-Determination Survey (IWSD)—was conducted in November 2010. The survey of the workers serving self-directing individuals with intellectual and developmental disabilities and mental illness in the community mental health system (CMH)—CMH Self-Directed Workers Survey (CMH-SD)—was conducted in June 2012.

These surveys represent the first attempt by state agencies in Michigan to quantify the direct-care workforce specific to the self-determination option in Medicaid-funded HCBS

1 Claypool, H. and O'Malley, M. (March 2008). Consumer Direction of Personal Assistance Services in Medicaid: A Review of Four State Programs. Kaiser Family Foundation. Available online: **http://www.kff.org/medicaid/upload/7757.pdf**

waiver programs. Recognizing that friends and family members make up a sizeable part of the workforce for self-directing participants, the surveys also allowed for analysis based on the relationship of the worker to the participant. This data is valuable, given that many family members and friends are paid to support self-directing participants in Michigan and in most self-determination programs across the country.

This federal and state survey effort was based largely on guidance provided by the National Direct Service Workforce Resource Center (DSW-RC)[2] in the development and creation of a minimum data set (MDS) of workforce measures for home and community-based programs. In the white paper, *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection*, the DSW-RC provided recommendations to states on how to develop an MDS based on three key pieces of workforce data:

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

Workforce Stability—Turnover rates and job vacancies

Workforce Compensation—Average hourly wages and availability of benefits

For the workforce supporting self-directing participants, most of the MDS information related to workforce volume and stability is available through state program and financial records. However, other valuable data on this segment of the workforce can and should be obtained through survey efforts. This includes:

- Demographic characteristics
- Employment characteristics
- Worker satisfaction
- Training needs and interests

The MDS and other workforce data can help a state achieve the following goals and outcomes:

- Identify and set priorities for LTSS reform and systems change.
- Inform policy development regarding direct service workforce improvement initiatives, including efforts to improve workforce recruitment and retention.
- Promote integrated planning and coordinated approaches for LTSS.
- Create a baseline against which the progress of workforce improvement initiatives can be measured.
- Compare workforce outcomes for various programs and populations to better evaluate the impact of policy initiatives.
- Compare state progress with the progress of other states and with overall national performance (where data from other states are available).

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

Demographic and Employment Characteristics

Basic information and data at the state and national level on the workers providing services and supports to participants in Medicaid self-determination programs is scarce. Although labor market data (size, wage rates, projections for need) for Michigan's direct-care workforce exist, it covers only workers employed by LTSS agencies. Workers employed by self-directing participants are not represented in most general labor reports and forecasts. There are several reasons for this. First, workforce occupational and industry data collected by the federal and state governments only track workers employed by traditional employer organizations. Workers for self-directing individuals tend to be "independent providers"; considered "self-employed," they are excluded from many traditional labor or occupational analyses. Additionally, state agencies and Medicaid program administrators do not regularly collect the level of detailed information solicited in these surveys.

Table 1 provides an overview of some of the demographic and MDS data collected from both the MI Choice and CMH self-directed workers surveys.

Table 1 – Characteristics of the Workforce for Medicaid-Funded Self-Determination Home and Community-Based Services (HCBS)[3]

	MI Choice Self-Determination Workers (November 2010)	CMH Self-Determination Workers (June 2012)
Survey Population	1,500	1,530
Survey Response Rate	42% (642 responses)	38% (578 responses)
Demographic Data		
Gender	Female – 82% Male – 18%	Female – 80% Male – 18%
Race and Ethnicity	White – 69% Black/African-American – 28% Latino or Hispanic – 2% Native American – 4% Other – 3%	White – 83% Black/African-American – 13% Latino or Hispanic – 3% Native American – 2% Other – 2%
Average Age	44 years old	44 years old
Household Income Less than 200% of Federal Poverty Level[4]	82%	63%
Wages and Benefits		
Current Average Hourly Wage	$9.72 per hour	$9.95 per hour
Health Insurance Status	Uninsured – 38% Medicaid beneficiary – 29% Covered by spouse's – 24% Medicare beneficiary – 18% Buy my own insurance – 15% Another job – 11%	Uninsured – 31% Medicaid beneficiary – 9% Covered by spouse's – 19% Medicare beneficiary – 10% Buy my own insurance – 16% Another job – 8%

Table 1 continued on page 4

3 Data elements may not total 100% due to missing data or the survey allowing for multiple answers.

4 For 2012, 200% of FPL for a family of three is $38,180.

	MI Choice Self-Determination Workers (November 2010)	CMH Self-Determination Workers (June 2012)
Employment Characteristics		
Motivating Factor	Friend or family needed care – 78% Gives me personal satisfaction – 55% I can work a flexible schedule – 48%	Gives me personal satisfaction – 66% Friend or family needed care – 58% Need the income – 36%
Relationship between worker and participant	Family member – 49% Friend or neighbor – 24% No prior relationship – 18%	Family member – 27% Friend or neighbor – 23% No prior relationship – 44%
Live with participant	27%	28%
Intend to stay on the job over the next 12 months	51%	59%
Provide services and supports for which they are not paid	60%	40%
Provide transportation for participant	63%	74%
Are reimbursed for mileage and/or gas	21%	51%
Satisfaction[5]		
I am satisfied with my job	87%	86%
My job uses my skills well	86%	84%
I am satisfied with my wages	69%	46%
I am satisfied with the number of hours I work	56%	65%

In addition to these workforce measures, both surveys also collected information on training. The training questions differed markedly between surveys, with the CMH-SD survey asking clearer, more in-depth questions on how workers are trained and their interest in receiving further training. These findings are highlighted below, and presented in more detail in the accompanying full reports for each survey (see **www.PHInational.org/michigan**).

5 Figures reported are of those respondents who agreed or strongly agreed with the survey statement.

Summary of Findings on the Workforce Supporting Self-Determination Programs

Workers supporting self-directing participants are, overall, satisfied with their jobs.

Survey responses indicate that workers in the Medicaid-funded MI Choice and CMH self-determination waiver programs are satisfied with their jobs, find the work rewarding, and believe that the work uses their skills well. They understand the vital role that they play in maintaining the independence and lives of the participants they support. This high level of satisfaction may be attributed to a large number of workers being drawn to this work because it gives them a sense of personal satisfaction. In addition, many respondents (58 percent of friends and family members in MI Choice and 63 percent of all workers in CMH self-determination programs) express an interest in working for another self-directing participant when the one they currently support no longer needs them. Pursuing the expressed willingness of the majority of the current workforce to serve others is a good strategy to recruit and retain a future workforce to serve self-directing participants.

Even with these high levels of overall personal satisfaction, worker satisfaction falters regarding wage rates. The average hourly wages for workers in the CMH and MI Choice self-determination programs—$9.95 in 2012 and $9.72 in 2010, respectively—are higher than the average current wage rate in the Medicaid Home Help program ($8.00 per hour).[6] The CMH hourly wage for workers supporting self-directing participants is slightly higher than the wage for agency-based workers in Michigan's home and community-based services programs.[7] And, yet, less than half of the respondents to the CMH-SD worker survey—those with the highest wages—indicate satisfaction with their wages.

One way of predicting turnover among the direct-care workforce is to measure "intent to stay" or "intent to leave." On average, 19 percent of respondents to both surveys indicated they are very or somewhat likely to leave employment in the next 12 months. This figure is substantially higher than a comparable workforce in California. In a survey of workers in California's In-Home Supportive Services (IHSS) program, only 5 percent of workers supporting self-directing individuals reported they were unlikely to continue working.[8] IHSS is the largest self-determination programs in the country. Most IHSS participants and workers have greater infrastructure and resources to support them, including matching registry services, training, higher wages, and access to health care coverage.

6 The hourly wage floor for Home Help independent providers is set at $8.00, but varies by county, with a few counties paying as much as $11.00. For more information, see MSA Bulletin, MSA 09-59: http://www.michigan.gov/documents/mdch/MSA-09-59_305871_7.pdf.

7 Findings from surveys of Michigan's LTSS-waiver programs show an average hourly wage of $9.76.

8 Vandenberg, R.J., & Barnes, J.B. (1999). "Disaggregating the Motives Underlying Turnover Intentions: When Do Intentions Predict Turnover Behavior?" *Human Relations*, 52:1313-1336.

CMH workers supporting self-directing participants believe that training in certain core competencies should be mandatory.

Michigan Department of Community Health (MDCH) policies outline modest competency and training requirements for the direct-care workforce in the CMH and MI Choice self-determination programs. MI Choice workers are only required to be trained in universal precautions and blood-borne pathogens.[9] Beyond that, the waiver agent and the participant together determine the training needs of selected workers. It is the responsibility of the MI Choice participant to assure that the worker receives appropriate training. The participant also is responsible for training the worker on issues specific to their unique needs or conditions. There is currently no uniform, regional, or state-based training resources or system to ensure that MI Choice workers have met any training requirements or are competent to serve an individual participant.

Table 2 – Training Received by Workers in CMH-Waiver and MI Choice Self-Determination Programs[11]

MI Choice Survey Training Topics	CMH Survey Training Topics
Care skills – bathing, toileting, eating, dressing	Behavior management
Communicating with consumers	Care skills such as bathing, toileting, eating, and dressing
First aid, CPR, and universal precautions	Communicating with individuals receiving self-directed services
Health conditions (e.g. caring for bed sores, handling incontinence)	First aid, CPR, universal precautions
Home skills – cleaning, meal preparation, and shopping	Health conditions (e.g. caring for bed sores, handling incontinence, etc.)
Principles of person-centered planning	Home skills, such as cleaning, meal prep, and shopping
Reducing pain	Principles of person-centered planning
Stress management	Rights and responsibilities for individuals receiving services and supports
Understanding dementia	Stress management/personal safety and wellness
Understanding the disease/condition specific to the consumer	Understanding condition specific to the individual you work for
Understanding social needs	Understanding mental illness
Using technology to support the consumer	Understanding social needs

In the CMH self-determination program, modest training requirements are outlined for all workers funded by the Bureau on Behavioral Health and Substance Abuse programs.[10] Direct support staff serving adults are to be trained in first aid, recipient rights, universal precautions, person-centered planning, and "in the beneficiary's plan of service, as applicable." Pre-Paid Inpatient Health Plans (PIHPs) and Community Mental Health Service Providers (CMHSPs), the entities that administer the CMH-waiver programs, are required to

9 Michigan Department of Community Health, Minimum Operating Standards for MI Choice Waiver Program Services, October 1, 2012.

10 Medicaid Provider Manual, Mental Health/Substance Abuse section and Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services and HCPCS/CPT Codes, March 12, 2012; Recipient Rights—Mental Health Code Section 330.1755; Person Centered Planning—MDCH contract with PIHPs and CMHSPs—PCP Policy and Practice Guideline; Self Determination—MDCH Contract with PIHPs and CMHSPs—SD Policy and Practice Guideline.

11 Training topics are listed in alphabetical order. Ranking of training topics is provided in the individual report for each program with detailed explanation. Download at **www.PHInational.org/michigan**

develop and support "methods that lead to consistency and success" in selection and retention of direct support staff.

Both surveys asked respondents to select from a list of topics that reflect the needs of the populations served and the goals of each program those for which they had received training (**Table 2**).[12]

The CMH survey did not seek information on how best to deliver the needed trainings—whether through the individual employers or participants conducting/arranging classes, or from larger classes taught by others. Before moving on to policy decisions, it is important to consider these worker training needs and preferences in a way that respects the needs and preferences of individuals receiving supports and the skills needed by workers. The survey did not gather information about paticipants' thoughts on important or necessary training topics. Prior to any training, a needs assessment of both the participant and individual worker will increase the efficacy of the training effort.

Common assumptions about family members and friends working in the Medicaid self-determination programs are not reflected in the survey findings.

As mentioned earlier, these surveys are unique because they provide a way to understand workers based on their relationship to the self-directing participant they support. Often, assumptions are made about this workforce based on the large number of friends and family members that work for participants. However, findings in both surveys point to areas where these common assumptions are not consistent with the data.

Two common assumptions not supported by survey findings are that most family member workers live with the participant and that most family members do this work to reap substantial financial rewards from the program. These assumptions are based on the notion or fear that family members and participants are attracted to this type of working arrangement to "game the system" and increase family income.

Table 3 – SD Worker Wages, Relationship to CMH Self-Determination Waiver Participant

Relationship to Participant	CMH Self-Determination Worker Survey
Family Member	$9.37 per hour
Friend or Neighbor	$9.83 per hour
No Prior Relationship	$10.35 per hour

Table 4 – SD Worker Wage Ranges, Relationship to MI Choice Waiver Participant[13]

Hourly Wage Level	Family Members	Friend or Neighbor	No Prior Relationship
Less than $10.00	28%	28%	17%
$10.00	58%	58%	44%
$10.01 – $12.00	9%	9%	24%
More than $12.00	2%	2%	13%

Survey results show that only one-third (35%) of family workers live with the participant they are paid to support. In both the CMH and MI Choice surveys, direct-care workers with no prior relationship to the participant earned higher wages. Among

12 The CMH-SD survey also asked workers to identify whether they received training on the listed topics from a class or from the participant they support. More in-depth discussion on the source of training is available in the CMH-SD Workers Survey Report.

13 Average hourly wage by relationship to the participant is not available for the MI Choice Self-Determination Survey.

CMH respondents, those with no prior relationship commanded a wage $1.00/hour higher than family members (**Table 3**). MI Choice workers with no prior relationship were more likely than either family members or friends/neighbors to earn more than $10/hour (**Table 4**).

More self-directed workers are family members in MI Choice than in CMH-waiver programs.

Almost half (49%) of workers in MI Choice are family members, compared to just over a quarter (27%) of the workers in the CMH self-determination programs. Family members have very different opinions and experiences than other types of workers in two critical areas—interest in continuing work with self-directing participants and the source of received training.

Continuing work with self-directing participants—Family members who work in Medicaid CMH waiver programs supporting self-directing participants are less likely to want to continue working in this field than those who are not related to the participant. Just over one-third (41%) of surveyed CMH workers who are family members wish to continue in this work after the person they support no longer needs support. Of CMH workers in the self-determination programs who are friends, 63 percent report they would be willing to continue in this work; of those with no previous relationship, 78 percent report a similar interest in continuing this work after their current client no longer needs support. This is important to note as the self-determination option continues to grow and the need to attract new workers to serve more participants increases.

Training—CMH workers with no prior relationship to the participant are more likely to have received training in a class or program on all training topics. Conversely, family members are more likely to report that they received training from the individual they support. Balancing the source and, possibly, timing of training as well as the needs and interests of workers, which depends on their relationship to the participant, will be important in developing training options for workers in self-determination programs.

Similarities across the Surveyed Workforces

Transportation reimbursement—Most workers in the self-determination waiver programs are providing transportation to self-directing participants, yet large numbers of workers are not reimbursed for gas and/or mileage. Medical-related transportation (doctor's appointments, lab work, etc.) are covered Medicaid services in MDCH policies. Transportation to and from a participant's home for non-medical services is a covered service in both MI Choice and CMH self-determination waiver programs as either a distinct service or included as part of the bundled service, Community Living Supports.

While Medicaid self-directing participants have flexibility in choosing services and supports within their individual budget, we do not know the extent to which that extends to the reimbursement of mileage and/or gas when workers provide transportation. As a result, it is difficult to understand why workers report such a high rate of transportation services without payment. The lack of payment for transportation services is likely feeding the high dissatisfaction rates with wages. A closer look at this to identify best practices and provide clarity on transportation in the context of self-determination would be beneficial to participants, MI Choice waiver agents, PIHPs, and CMHSPs.

Health care coverage—In keeping with other direct-care workers in Michigan, roughly one-third of the workforce supporting self-directing participants is uninsured. With more provisions of the federal Affordable Care Act becoming effective in January 2014, and enrollment in coverage available through the Exchange slated to begin in October 2013, direct-support workers will be making critical decisions regarding health care coverage over the next year. Based on the income levels reported by workers in this survey, many will be able to receive health care coverage through Medicaid if the state chooses to expand eligibility to 133 percent of the federal poverty level (annual income of $25,390 for a family of three).

Conclusion

Findings from these surveys of workers in the MI Choice and CMH self-determination programs provide baseline data on workforce volume, stability, and compensation, as well as other demographic, training, and satisfaction data that is important for understanding this workforce. For a number of years, the Michigan Legislature has requested a report from MDCH on a wide array of CMH and PIHP services including an "estimated number of direct support workers."[14] The legislative call reflects the importance of data-driven decision making. Only by having reliable program-specific information on the needs and preferences of workers and employers, including self-directing participants, can Michigan adequately meet the growing demand and shifting preferences for LTSS in home and community-based settings.

Continued collection of this data can inform policymakers and self-directing participants who are competing for workers. These survey tools can be adapted and improved to more clearly measure specific issues or to evaluate specific interventions. Program decisions based on timely, specific workforce data and other information can ensure the actualization of participant-driven long-term supports and services for all those who want them.

14 This request for basic direct support workforce data regularly appears in Section 404 of the MDCH annual appropriations legislation.