HMA

HEALTH MANAGEMENT ASSOCIATES

Developing Sustainable Workforce Solutions in Behavioral Health and Direct Care

FINAL REPORT

PREPARED FOR

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

BY

HEALTH MANAGEMENT ASSOCIATES
IN PARTNERSHIP WITH
PUBLIC SECTOR CONSULTANTS

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Preface

The Michigan Department of Health and Human Services (MDHHS) contracted with Health Management Associates (HMA) to conduct a behavioral health workforce analysis for the state, and Public Sector Consultants (PSC) partnered with HMA to facilitate stakeholder engagement for this analysis. Based on initial conversations, it was clear that MDHHS wanted to include the direct care workforce (DCW) in this analysis as well. The statement of work was amended to include an analysis and interim report addressing DCW for both behavioral health and long-term care, with a final report including an analysis of the behavioral health professions as well.

This is the final report on this analysis and includes a review of the research design and summary of findings. It also includes recommendations on potential metrics to measure the impact of implementation. HMA and PSC have been committed to coordinating with multiple other workforce related initiatives and groups within MDHHS. This report and its recommendations should be considered collectively with the recommendations of these other groups and initiatives.

Executive Summary

This project was intended to assess reasons and potential solutions for workforce shortages in Michigan, specifically among direct care workers (DCWs) and behavioral health practitioners. This report follows an interim report submitted in March that primarily focused on the research and recommendations regarding DCWs. This report advances the interim recommendations and includes data and discussion regarding behavioral health practitioners.

Health Management Associates (HMA) reviewed the literature and data pertaining to Michigan and the nation, and engaged Public Sector Consultants (PSC), a public policy research firm, to gather qualitative information from people with a role in Michigan's behavioral health and direct care workforces, as well as community members across the state. This combined approach, coupled with our knowledge and expertise related to meaningful planning and implementation of systemic change, is described in this report.

The challenges facing people in the direct care workforce in Michigan and, indeed, all other Michigan healthcare providers, are consistent with those across the nation. Traditional hiring approaches are no longer working in this tight labor market. Low-wage workers have more options than ever—many of which provide more flexible schedules and attractive benefits. Reimbursement for services that direct care workers (DCWs), and many behavioral health professionals is misaligned with needed wage increases. The administrative work associated with understanding and navigating the programs and systems for direct care patients and clients is burdensome. This is equally true for behavioral health professionals such as licensed psychologists, social workers, counselors, physicians, and nurses. Training and skill development is neither consistent nor readily accessible. Low workplace morale and burnout are significant among all healthcare workers, and DCWs and behavioral health professionals are especially at risk. Given the complexity of this challenge, no single solution is available.

HMA recommends that Michigan leaders consider a systemic and holistic approach that uses a worker-centric model which keeps places the worker at the center of all new and improved strategies and acknowledges that categories of effort may overlap and often have an interdependent relationship see figure at right. A statewide DCW and behavioral health professional recruitment and retention strategy, with all strategic focus areas—policy, wages and benefits, worker skills, barriers, flexibility, technology, and wellness— and the worker at the center, will likely result in stronger, more cohesive, meaningful, and more sustainable workforce.

This model should be implemented with a commitment to collaboration among agencies and system stakeholders with a focus on equity.

To ensure equity, Michigan must lead and authentically partner with diverse stakeholders to create a system in which people want to work in the healthcare sector because they have support and are valued for their commitment to providing quality care. **Successful navigation of the current and emerging workforce market requires an ongoing partnership capable of addressing change at the environmental, system, policy, and employee levels.** The state should review Medicaid rates, support reducing costs associated with entering the profession, develop and expand low-cost or free training programs, create a visible and meaningful campaign to support the well-being of workers, and find new and creative mechanisms for sharing the burden of barriers to this work, including access to affordable childcare. **All these strategies must be developed with a focus on health equity and with the worker at the center**. Participants in the focus groups and interviews held statewide have made many suggestions for action, and their views should be taken seriously.

Data Approach

The project involved a quantitative data approach, including review and analysis of relevant state and national data, literature, and studies. It also comprised a qualitative component, which was based on findings drawn from focus groups and interviews with people representing Michigan's direct care and behavioral health workforce.

Data and Literature Review

HMA reviewed and analyzed national and state DCW and behavioral health data from publicly available sources. When possible, we compared Michigan data with national data to highlight similarities and differences. We retrieved and reviewed data factors including demographics, race and ethnicity, wages, education, and turnover.

In addition, we conducted a literature review of recent studies centered on recruitment and retention barriers. Results of these efforts are provided throughout this report. See Appendix A for key data points and Appendix B for a summary of literature reviewed.

Workforce Demographics

The direct care workforce is predominantly female (86 percent), with some variation by setting: 92 percent of nursing assistants in nursing facilities are female, compared with 87 percent of home health workers and 84 percent of residential care aides.[1] The median age of the direct care workforce is 41 years old, but the distribution of DCWs by age varies by setting, with older workers (ages 55 and older)

[1] Scales K. (2020). "It's Time to Care: A Detailed Profile of America's Direct Care Workforce."

representing the largest share of home health workers at 30 percent.[2] Residential facilities and nursing homes have much younger workers, with workers ages 16-34 comprising 47 percent and 45 percent of the workforce, respectively.[3] Generational differences in the workforce are having an impact. Younger workers are increasingly challenging and questioning previously set expectations and pushing for leaders to evolve alongside their workforce and implement changes that better support the needs of DCWs. Recruitment and retention challenges discussed during the Michigan focus groups often mirror what we found in the data and literature.

In 2021, most (67%–75%) of behavioral health workers in Michigan were 25-54 years old. However, 24–31 percent of behavioral health workers were age 55 or older. Psychiatrists made up the largest percentage (31%) of behavioral health professionals ages 55 and older.[4] Of the 40,872 individuals working in behavioral health in 2020, 79 percent were female. Most were White (69%), 23 percent were African American or Black, and 2 percent were Asian.[5]

Stakeholder Engagement

HMA engaged Public Sector Consultants (PSC), a public policy research firm, to gather qualitative information from the behavioral health and direct care workforces. PSC led seven regional sessions (four in-person and three virtual), one statewide session (virtual), and 11 small group discussions (all virtual). Participants from throughout the state engaged in these programs. Participants included employers and managers, association representatives, community, and advocacy representatives, DCWs such as personal care aides and certified nursing assistants (CNAs), and behavioral health professionals. PSC partnered with the following community organizations to recruit participants and promote sessions:

- Community Mental Health Association of Michigan (behavioral health)
- Area Agencies on Aging Association of Michigan (aging services)
- LeadingAge Michigan (aging services)
- The Health Care Association of Michigan (long term care facilities)
- Michigan Health and Hospital Association (long term care facilities)
- Michigan Behavioral Health and Wellness Collaborative (behavioral health)

To reach as many direct care and behavioral health professionals as possible in a short period of time, PSC developed and distributed a brief questionnaire (see Appendix D). The questionnaire was distributed through members of the Michigan Department of Health and Human Services Direct Care Worker Advisory Committee—54 individuals who either represent the direct care and behavioral health workforces or who implement related policies. PSC encouraged members of the advisory committee to distribute the invitation through their networks. In 13 days, 765 DCWs and behavioral health professionals in 66 counties across Michigan completed the form. With the information provided, PSC

[2] Id.
[3] Id.
[4] Michigan Health Council. Q3 2021 HealthSights: Behavioral Health.
[5] Ibid.

extended invitations to a diverse set of stakeholders based on several factors, including role, demographics, and location in Michigan (see Table 1).

Table 1. Focus Group Details

Activity	Month(s)	Participants	Groups (number of participants)
Employer Small Group Discussions (6)	January–March	30	• Aging services • Behavioral health providers • Hospitals • Mental health providers • Nursing and long-term care facilities
Employee Small Group Discussions (5)	February	31	• Behavioral health professionals • Caregivers • Certified nursing assistants • Personal care aides • Residential care aides
Regional Sessions (7) and Statewide Session (1)	May–June	149	• Flint/Saginaw (9) • Mid-Michigan (15) • Northern Michigan (14) • Southeast Michigan (2 groups, 36) • Upper Peninsula (14) • West Michigan (23) • Statewide (38)
Community and Advocacy Small Group Discussions (4)	June	103	• Consumer-focused (40) • Behavioral health-focused (31) • DCW-focused (25) • Tribal health administrators (7)

Analysis and Findings

Traditional hiring approaches are archaic in this tight labor market. Low-wage workers have more options than ever. Providers in states across the country are struggling to fill openings and retain talent. The power dynamic has shifted. Employers can still hire and fire, but their employees can find other employment immediately. This situation is complex and void of a specific, single solution. HMA recommends that Michigan leaders consider a systemic and holistic approach that adheres to a worker-centric model that is constantly focused on the worker to collaboratively creates strategies that meet relevant objectives and that can meaningfully address recruitment and retention challenges. The worker-centric model is a thoughtful and strategic approach to the many challenges state leaders and other stakeholders identified.

Common Challenges

The challenges DCWs and behavioral professionals face in Michigan are consistent with those across the country. The DCW and behavioral health workforce shortage is a complex issue, affected by systemic

factors, such as educational opportunities, career development and progression, federal and state policy, wages, payment, worker scope and capacity, historical disparities, stigma, and social determinants of health. Further exacerbating the crisis is the increased need for and heighted threat of overburdening behavioral health providers recovering from the pandemic and its aftershocks.

Labor shortages and fewer workers entering the fields, low wages, limited training and professional development, low workplace morale, and burnout all contribute to recruitment and retention. For people from racial and ethnic minority populations, some of the same themes emerge regarding issues and needs that affect turnover, including burnout, pay, and benefits. For people of color (BIPOC), additional themes emerge regarding the primary issues that affect their desire to enter or remain in the field, including work-life balance, limited career growth opportunities, and personal safety concerns.[6]

Widespread Labor Shortages and Pipeline Concerns

At present, that nation has more jobs than people to fill them. This shift is creating significant staffing shortages for high demand but less desirable occupations, including direct care and behavioral health. Demand for DCWs and behavioral health practitioners is high. Key contributing factors include the fact that Michigan's aging population is experiencing more chronic health conditions than ever,[7] most older adults wanting to age in place, and mental health issues being exacerbated during the pandemic. Workforce shortages often are worse in underserved areas, where recruitment and retention are particularly challenging.

The direct care workforce added nearly 1.5 million new jobs in 2011−2021, and this growth trend is projected to continue with an additional 1.2 million new jobs in 2020−2030.[8] The demand for DCWs is anticipated to increase sharply, mainly because of the rapid aging of the population. In the United States, population growth among people ages 65 and older is projected to spike 92 percent by 2060, and the population ages 85 and older is projected to grow by 198 percent. At the same time, the population ages 18 to 64 (the age group working as DCWs) is projected to remain relatively flat, with only a 15 percent projected growth rate.[9]

Approximately 40 percent of Michigan is classified as a mental health professional shortage area.[10] The Health Resources and Services Administration estimates large shortages of behavioral health providers will persist for at least a decade in the state. The shortage is especially significant for psychiatrists, psychologists, substance use disorder (SUD) counselors, and mental health counselors.[11] At present, 27 counties in Michigan have no psychiatrists or addiction medicine physicians.[12] (See Appendix A, for details.) According to a 2023 Community Mental Health Association survey, average vacancy rates

[6] Miu AS, Moore JR. (March 3, 2021). "Behind the Masks: Experiences of Mental Health Practitioners of Color during the COVID-19 Pandemic - Academic Psychiatry."

[7] National Council on Aging. (April 2021). "The Top 10 Most Common Chronic Conditions in Older Adults."

[8] PHI National. (September 6, 2022). "Direct Care Workers in the United States: Key Facts."

[9] Colby, Sandra L., and Jennifer M. Ortman. "Projections of the Size and Composition of the U.S. Population: 2014 to 2060." Current Population Reports, P25-1143, U.S. Census Bureau, Washington D.C.

[10] Health Resources and Services Administration. Quick Maps - Mental Health Professional Shortage Areas (HPSA).

[11] Health Resources and Services Administration. (2019). Supply and Demand.

[12] The George Washington University. Behavioral Health Workforce Tracker.

among Michigan mental health employers overall was 19 percent and, for some, as high as 63 percent. For direct care behavioral health professionals, the average vacancy rate was 27 percent and more than 85 percent for the respondents most challenged to fill positions.[13]

Labor Shortages

In focus groups, some employers said their vacancy rates have doubled or tripled from pre-pandemic rates. Many employers and DCWs highlighted the challenges associated with employers competing for workers outside of the healthcare industry. Food service, shipping fulfillment, or retail industries were frequently mentioned as local competitors for similarly skilled workers. Most employers and DCWs acknowledged that for similar or higher pay, it is relatively easy to find a job that is less stressful or physically demanding than direct care work. Participants in employer discussion groups mentioned, and participants in employee groups sensed, a near-desperation to fill direct care roles. In many situations, licensing requirements drive employers to hire less-than-ideal candidates.

The scarcity of DCWs can sometimes lead employers and supervisors to avoid being honest with a job candidate about the responsibilities of the job and how much training is provided. There is a concern that if a person is exposed to the reality of the job too soon, they won't give the job a chance, but the paradox is those workers probably aren't a good fit anyway.

Likewise, employers of behavioral health clinicians are competing with the appeal of transitioning into private practice, taking one of the many higher paying jobs in school systems, or transitioning out of clinical work altogether.

Pipeline Concerns

Employers of DCWs and behavioral health clinicians, as well as the employees, raised concerns about the lack of interested and qualified people interested in entering these workforces.

Many employers of DCWs and seasoned DCWs noted shifts skills that people with a high school diploma or equivalent have when entering the workforce. One example of this came from focus groups related to in-home care providers and people who provide homemaking services. In the past, employers could assume most everyone would know how to help a client cook or do basic household tasks, but many new hires need significant training and support to provide high-quality care. In addition to household tasks, employers and seasoned DCWs highlighted poor verbal and written communication skills and problem-solving skills among new workers. Consequently, employers need to provide high-touch training and mentoring, which was uncommon in the past.

DCWs and employers had some perspectives on why younger people are avoiding direct care professions. First, fewer young people are raised around older adults and people with disabilities than in the past. They have significant fear of what direct care jobs would be like and low expectations for what

[13] Sheehan R. (March 19, 2023). "Opinion: Michigan public mental health care is seriously understaffed. We can change that".

they are capable of doing. One employer of in-home care workers in a rural area found promise in paying high school students to job shadow teams and see what the work is like. Often tasks people think they could never do are easier when they have a connection to a client and have coworker support. This gives them a way to see the rewards of direct care work. This informal program offers an opportunity for young people in her community who might be good long-term fits for direct care work and may not be on a path to a four-year degree.

Many focus group participants remarked that despite any pay-related solutions (e.g., sign-on bonuses) recruitment remains a challenge because clear pathways for people to advance within and beyond direct care work are lacking. They shared a frustration that direct care is undervalued, and the people doing this work are underappreciated. Many feel direct care is rarely promoted as a valuable, viable career path, as evidenced by the lack of credentialing opportunities. The stigma that direct care work is equivalent to working at fast food establishments, combined with low wages, hinders the ability to hire and retain new talent.

Employers of behavioral health care workers identified the challenge of finding job candidates who are qualified to meet licensing and other administrative requirements. Fewer people pursue social work degrees than in previous decades, but many people who complete degrees in liberal arts or public policy for example, could still be a good fit for jobs that require social work degrees.

In some situations, especially in less populated parts of the state, employers flagged that some public policies make it harder to find qualified candidates to fill non-clinician direct care worker roles. Many believed the state's legalization of marijuana for recreational use has made it more difficult to find candidates who can pass an initial drug test. Some felt policies prohibiting people with criminal records from working in their facilities prevented them from considering a pool of candidates who could have skills aligned with the needs.

Though most of these challenges were broad and applicable to the entire state, specific regional issues affect Upper Peninsula and other northern areas of Michigan. For example, the lack of colleges and programs in the Upper Peninsula and northern region of the state hinders the ability to feed into career pipelines. The affordability and availability of housing also make these regions less attractive and results in fewer job seekers. Individuals in these locations have greater difficulty finding and securing transportation, and longer travel times increase the overall cost of services.

Many focus group participants acknowledged workforce shortages are not solely related to healthcare, noting different sectors statewide are struggling to hire and retain personnel, especially in Michigan's rural areas. Participants shared that it is difficult to draw potential employees to more rural areas where childcare and housing options are more limited than in more densely populated regions of the state. Others said the lack of space and inpatient beds is both a symptom and a result of the DCW and behavioral health workforce shortage, adding that the stigma driven by the difficulties inherent in direct care and behavioral health is exacerbated because the lack of available staff makes the work that much more demanding.

Clients and caregivers also described feeling the burdens of the workforce shortage. Family members of people receiving services explained the overall lack of job shadowing through colleges and universities prevents exposing potential employees, like college students, to direct care work. Family members shared their frustration with colleges and universities prohibiting individuals from advertising for direct care support on campuses via physical or virtual message boards.

Wages and Benefits

Many DCWs, other than behavioral health clinicians, earn around the estimated living wage estimate for Michigan, which is $16.27 per hour for a single adult. For a single adult plus one child in Michigan, the living wage is $36.81 per hour,[14] far more than most direct care workers earn. With most DCWs being female heads of household, it matters greatly whether wages and benefits will meet their family's needs.

As of 2020, the average hourly wage for CNAs has been $15.40, for personal care and home health aides $12.60, and for all other occupations in Michigan $25.67.[15] These wages are significantly lower than what the average American earns on a weekly basis. According to the Bureau of Labor Statistics, the median weekly earnings of full-time wage and salary workers in the fourth quarter of 2022 was $1,085.[16] With the median hourly wage of CNAs at $15.18, their weekly earnings would total $607.20, assuming they are at an FTE status, which suggests that take home roughly 45 percent less than the national FTE average.

The direct care workforce is failing to keep pace with the trends of increased compensation across the country and rising inflation rates. These data reveal the drastic difference in compensation across occupations and speaks to the lack of financial incentives to pursue direct care roles. Individuals can earn more money elsewhere and are leaving their jobs to do so, as reflected in the high rates of turnover among DCWs. Wage disparities also affect DCWs, with women of color earning the least among home care and nursing home employees and men of color earning the least among residential care workers, based on 2017 data.[17]

Depending on the applicable standard occupational classification that the Bureau of Labor and Statistics uses, in May 2021 mental health and SUD social workers and counselors earned an annual mean wage of approximately $52,700 ($25.34 hourly). Rehabilitation counselors earned less ($45,380 annual/ $21.82 hourly mean wage), and all other social workers earned an average $62,290 annual mean wage ($29.95 hourly mean wage).[18]

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[14] Massachusetts Institute of Technology. (2023). "Living Wage Calculation for Michigan."

[15] Public Sector Consultants. (August 2021). Rep. "Michigan's Direct Care Workforce Living Wage and Turnover Cost Analysis".

[16] U.S. Bureau of Labor Statistics. (January 2023). "Usual Weekly Earnings of Wage and Salary Workers Fourth Quarter 2022."

[17] Scales K. (2020). "It's Time to Care: A Detailed Profile of America's Direct Care Workforce."

[18] Bureau of Labor and Statistics. (May 2022). "Occupational Employment and Wage Statistics". (https://www.bls.gov/oes/current/oes_mi.htm)

Focus Group

Participants shared that DCWs in Michigan are living at or below the federal poverty line, struggling with some of the same social determinants of health as the people they serve. Employee costs of working are high, with inflation, groceries, travel (vehicle maintenance, gas mileage), and daycare costs among the contributing factors. Wages simply are not providing meaningful compensation for the work done and the cost of doing the work.

Though employers and DCWs expressed appreciation for the direct care worker wage pass-throughs that the pandemic spurred, workers and employers agreed incremental or temporary wage increases are a weak driver for recruitment in light of rising inflation and cost of living increases. These types of wage increases are, however, helpful in retaining staff.

Benefits for direct care and behavioral healthcare workers vary depending on their job and employer. However, all agreed that for DCWs such as CNAs, personal care assistants, and similar roles, benefits like paid time off, retirement savings plans, and flexible schedules are not strong enough to recruit and retain employees in the workforce long-term. Participants also noted that employee health insurance premiums are especially high for the kinds of insurance most small businesses offer. Paid sick leave is fully dependent on an employer's policy, making this benefit inconsistent across the workforce.

> *"We're always working sick because if we don't get work, we don't get paid; paid sick leave has to happen for anyone in healthcare, especially people working with vulnerable populations."*
> – DCW focus group participant

In general, employers and DCWs (except for behavioral health clinicians and their employers) were skeptical about the benefits of double pay, bonuses for retention or sign-on, and the like. Because of the other complexities facing DCWs, one-time or token financial incentives don't lead to good long-term hires. In one case, an employer shared a story of an employee incentive offered for referring new hires to have gone terribly wrong. It led to short-term candidates, sometimes linked to each other in ways that created disturbances in team morale. Not only have these tools had mixed results, but all employers agreed they are unsustainable.

Many employers acknowledged the benefits and the drawbacks of agencies offering DCW services. The costs to employers and wages for employees are higher, so it may appeal to workers but prove costly for meeting staffing needs. Agencies also sometimes provide more dependable workers, while also offering their staff some flexibility.

All the focus groups agreed DCW, and behavioral health, wages are lower than they should be. Pay was the top concern heard in every regional session, regardless of location in the state or stakeholder type. Multiple participants indicated pay is still a significant issue that shouldn't be understated, as it drives many of the other issues in direct care and behavioral health work like high turnover, high burnout and low morale, and ultimately lower quality of care. Participants explained the gap between minimum

wage and DCW pay continues to lessen, and as a result, prospective or existing DCWs choose careers in other fields with more competitive wages and benefits.

Focus group participants explained that locating affordable, available housing is a significant barrier in drawing outsiders to northern Michigan, noting the popularity of vacation rental sites like Airbnb and VRBO has drastically decreased available housing.

Others noted for prospective direct care and mobile behavioral health workers, finding reliable transportation can make keeping a job, showing up on time, and traveling to consumers' homes difficult. For current workers, the travel time to clients' homes is a significant hurdle because it is a non-reimbursable expense. This issue is exacerbated in rural areas because clients are more spread out, with fewer workers available between locations. Moreover, vehicle wear and time spent traveling can result in workers effectively losing money to do their jobs.

Training and Credentialing

Training requirements are inconsistent across the different types of DCWs and often lead to insufficient support and structure for workers and patients.

In Michigan, CNAs have considerable oversight. They must have 75 hours of training, pass a written exam, and demonstrate specific skills under the supervision of a registered nurse. Personal care aides (PCAs), however, have little state and federal oversight, often without any certification or training required.[19]

Mentoring is an evidence-based practice in staff career development. Mentoring can be a crucial recruitment, retention, and development tool. Employees, regardless of career stage, often appreciate the opportunity to work with or shadow people who are more experienced in their field with the explicit goal of learning, and **79 percent of Millennials believe mentoring is crucial to their success**.[20]

Best Practices for Mentorship Program Design

- Involve top management in the development of the program, as well as someone who can champion the program on the ground.
- Create space for the mentor to provide appropriate mentorship beyond any required clinical supervision.
- Provide tools and resources to both mentor and mentee, including templates that articulate individual professional development goals or areas of need or support.
- Reward employees for building skills as well as mentoring others.

Focus Group

Workforce development, especially for DCWs, includes establishing quality standards, comprehensive training and credentialing programs, and clear career pathways. DCWs and employers agreed that training and credentialing needs to work for both. It needs to be affordable, effective, minimize how much time is required, and occur on site.

[19] Public Sector Consultants. (August 2021). Rep. "Michigan's Direct Care Workforce Living Wage and Turnover Cost Analysis".
[20] Wallack M. (July 2, 2019). "Mentorships Are the Key to Long-Term Employee Retention."

Employers and DCWs, including behavioral health crisis workers, said they found variations in employer training needs and opportunities and that many hard skills cannot be carried from one job to another. Employer-sponsored training varies in duration, verification of comprehension, and topic. Statewide-coordinated trainings for DCWs that all employers and CMHs will accept are scant, and existing opportunities are inadequate. These programs should be standardized and more accessible statewide.

Participants indicated inadequate training and nonexistent or non-standardized credentialing opportunities were a significant barrier to setting up DCWs and behavioral health professionals for success. Everyone agreed dedicated, well-trained employees are key to providing high-quality care; however, in addressing the shortage, many organizations are hiring less qualified workers than in the past. Without the funding or additional personnel to ensure comprehensive training is conducted, employees and employers alike said training may be rushed. New hires are left feeling overwhelmed, and many organizations reported high turnover rates because people are thrust into new responsibilities too quickly. Participants also noted workplace violence has increased since the COVID-19 pandemic, and training for DCWs who care for people with complex/high needs, such as individuals with Alzheimer's disease, schizophrenia, and violent behaviors, is limited.

There was tension identified between DCWs expressed needs for more paid training (frequency and range of topics) and employers' attention to the cost of training. With a shortage of workers, it is difficult to justify taking people off a shift to do training, but employees will not participate if it requires time outside of normal work hours. Employers and DCWs also agreed training alone does not draw workers to specific employers, especially given that the skills learned often are non-transferrable.

New Workforce Expectations of Remote and Flexible Work

Across the country, employers are experiencing a shift in employee expectations based on the generational diversity. Individuals from different generations often have different work-related values; Baby Boomers (people born in 1946−1964) are often seen as competitive and dedicated to their employers. Gen Xers (people born in 1965−1980), are generally viewed as flexible, independent, and informal, and will outnumber Baby Boomers by 2028.[21] Millennials (people born in 1981−2000) are often viewed as open-minded and tend to value diversity and embrace change.[22] According to an article published in *Purdue Global*, Millennials will account for 75 percent of the global workforce by 2025.[23] The diversity and changing demographics of the workforce reinforce the need for adaptability among employers, including in the healthcare industry. One-way employers are adapting to these generational shifts is to offer more flexibility in working styles. As Millennials and members of Gen Z come to dominate the workforce, the level of comfort with new technology and remote work will only increase across employees. To remain competitive, employers must embrace the increasing desire for flexibility and shift away from some of the traditional approaches to workforce norms and culture.

[21] Purdue Global. (2023). "Generational Differences in the Workplace [Infographic]."
[22] Ibid.
[23] Ibid.

The COVID-19 pandemic enabled a shift toward a more remote workforce. It also resulted in more workers evaluating work-life balance and reconsidering the weight they place on job flexibility. Though some jobs must be performed on site, more workers in Michigan and across the country are actively seeking opportunities that afford them more flexible scheduling. Employers said they are having trouble competing with some remote work opportunities and jobs in the direct care workforce tend to require rigid scheduling and, in some situations, payers only will cover in-person services.

The pandemic prompted expansion of telehealth coverage, which created more opportunities to provide some direct care and behavioral health services remotely. Though some situations require in-person contact (e.g., remote applied behavior analysis services for children with autism), most behavioral health workers agreed telehealth has led to more flexibility in scheduling. DCWs who provide services of companionship or training or education on home-based tasks would like their employers or payers to consider allowing these responsibilities to be completed remotely. In some cases, clients who are unable to receive care regularly because of their location could at least have a check-in virtually if it were billable.

Especially in rural parts of the state, direct care and behavioral health workers and their employers acknowledged the costs of traveling to reach clients, both in terms of real travel expenses well as the costs serving fewer clients.

Public Benefits Reimbursement and Administrative Burden

Administrative burdens are the costs and barriers Medicaid imposes on provider organizations, workers, and individuals. These encumbrances include time spent filling out forms, contacting eligibility staff, documenting required information, researching, and learning about the Medicaid program, and stresses associated with navigating the processes.[24] Because people of color are disproportionately likely to rely on Medicaid coverage, these administrative burdens can reflect and perpetuate systemic racism and racial inequity.[25]

Employers believe Medicare and Medicaid reimbursement rates for many DCW services are a primary driver of low wages. The Medicare and Medicaid payment rates are lagging behind the real costs of care and inflation.

In addition, the administrative burden of public benefits is taking DCWs and behavioral health clinicians away from their client-facing work. Many employers identified situations where paperwork requirements for Medicare or Medicaid coverage was required under state regulations but never through a common tool.

Employers identified the differences in the administrative burden for direct care work compared with behavioral health services. Therapists and other behavioral health professionals who counsel Medicare

[24] Herd, P., Moynihan, D., and Ray, V. (January 2022). "Racialized Burdens: Applying Racialized Organization Theory to the Administrative State."
[25] Wikle, S., Wagner, J., Erzouki, F. and Sullivan, J. (July 2022). "States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity."

and Medicaid clients must complete significant amounts of paperwork. Contracted community mental health providers acknowledged their client intake process (i.e., consents, notices, client history) can take up to two hours to complete. This situation can cause significant inequities in access to care as private pay clients have the same protections, but their rights are mirrored across different entities with smoother intake. The burden to the provider and the client is much lower for private pay clients despite getting the same level of services. This element of high administrative burden for clients who rely on Medicare and Medicaid can drive some clinicians to go into private practice, provide school-based services, or seek other positions that allow them to interact more with clients and perform fewer administrative tasks.

Every focus group discussed the effects of increasing administrative requirements. Many participants shared that entities that don't accept another agency's documentation of administrative tasks, even though they want the same information (e.g., payers and licensing). Some employers have different compliance requirements depending on the employees they hire and the communities they serve. For example, a northeast Michigan employer reported having to run monthly background checks on staff. In this instance, turnover is low, and in the small community served, background checks provide little unknown information. Several groups talked about having to chart both on paper and electronically, depending on the employer. In many cases, the paperwork that must be done to comply with payer or licensing expectations cause DCWs, already worn thin, to stay at work past the end of their shift.

Childcare

Finding and affording quality childcare is a challenge facing many employees nationwide. Only 39 percent of respondents to McKinsey's 2020 American Opportunity Survey who have incomes of less than $50,000 and children at home said they could afford childcare. (The online survey polled 25,109 people ages 18 and older throughout the nation).[26]

More employers are starting to consider everything from babysitting stipends to childcare subsidies for employees with children. In addition to the tax credit, numerous studies show that childcare is often a barrier to work. An August 2020 Care@Work survey of 1,000 working parents with children younger than 15 years old showed 73 percent were considering making major work-related changes, such as revising their schedules (44%), looking for a different job (21%), or leaving the workforce entirely (15%).[27]

When it comes to DCWs specifically, a major barrier to supporting their children at home is the unpredictable nature of their role. DCWs often have inflexible work schedules that inhibit their ability to take a day off if they don't have childcare. Even if they do coordinate a replacement caregiver to cover their shift, they cannot leave the client alone in the case the replacement fails to show up.

Focus Group

These challenges affect DCWs in specific ways. First, childcare continues to be a statewide obstacle to building the direct care and behavioral health workforces. Many said DCWs' wages are too low to access full-time, quality childcare but too

[26] McKinsey & Company. (2020). "American Opportunity Survey."
[27] Lobell, Kylie Ora. (July 7, 2021). "Employers Consider Child Care Subsidies."

high to qualify for public assistance. The lack of affordable, available childcare is a significant barrier to workers entering and remaining in the field, especially for women, and more so for women of color, who comprise a disproportionate share of Michigan DCWs.

Many childcare services don't offer the schedules needed to meet employer needs. Some of these challenges include programs offering only full-time or part-time care, most programs only meeting the needs of traditional daytime workhours, and very few offering care for sick children or the ability to accommodate unexpected schedule changes. Childcare services have become increasingly less reliable for working families because services have developed policies related to waiting periods for recovery from common childhood diseases.

Employers of DCWs and behavioral health clinicians shared the impact of their employees' childcare challenges on their ability to reliably ensure they can meet their clients' needs. With a mostly female workforce, employers are regularly having to manage staff availability and expect higher rates of call outs than before the pandemic. Employers and DCWs agreed this situation has negatively affected morale.

Burnout and Low Workplace Morale

A significant amount of published research relates to burnout and low workplace morale among healthcare practitioners, especially tied to the magnitude of hardship, trauma, and stress that the pandemic created. Factors contributing to DCW and behavioral health worker burnout existed before the pandemic but grew more intense during the public health emergency.

The challenges discussed in this report all contribute to low morale and burnout, especially when workers experience more than one challenge over a period of time. DCWs work in a variety of positions and settings and must manage a range of clients. Factors contributing to burnout and low workplace morale may vary according to those categories (e.g., challenging client behavior may be cited more frequently as a contributor to burnout for DCWs working in institutional settings with clients with intellectual disabilities). Themes of underlying factors associated with burnout among all DCWs are highlighted here.[28,29,30]

Contributing Factors to DCW Burnout and Low Workplace Morale

- Challenging client or patient behavior
- Lack of coping skills for dealing with stress
- Care settings are neither welcoming nor conducive to whole-person care and healing
- Unfair treatment
- Heavy workloads and unreasonable time frames
- Poor communication from management

DCWs and behavioral health professionals have demanding jobs, and the combination of burnout, low workplace morale, and low wages leads to high

[28] Ryan C, Bergin M, Wells JSG. (March 27, 2019). "Work-related stress and well-being of direct care workers in intellectual disability services: a scoping review of the literature."
[29] Yeatts DE, Seckin G, Shen Y, Thompson M, Auden D, Cready CM. (2018). "Burnout among direct-care workers in nursing homes: Influences of organizational, workplace, interpersonal and personal characteristics."
[30] O'Flynn, C. (May 2020). "The challenge of burnout in nursing home care workers during COVID-19."

turnover. In the United States, the turnover rate for home healthcare workers is 65 percent, and for caregivers in nursing homes it is 90 percent.[31] Michigan turnover rates are comparable: 68 percent for CNAs, 89 percent for personal care aides, and 89 percent for home health aides.[32]

Nationally, 2022 turnover rates for behavioral health facilities averaged 31 percent overall. Client-facing staff had much higher turnover rates: 37 percent for mental health workers and psychiatric aides, 29 percent for registered nurses, and 23 percent for clinical professionals.[33] In Michigan, the average turnover for direct behavioral healthcare workers is 40 percent.[34]

COVID-19 exacerbated the challenges many DCWs already were facing. Some said personal protective equipment (PPE) and protocols, though necessary, made it harder for them to do their job. Taking on the risk of exposure without PPE was stressful for many individuals and affected their families as many stayed outside the home to avoid exposing their families. As is widely known, many people left the workforce because these sacrifices were too costly emotionally and financially.

Simply not having enough workers contributes to burnout. Depending on the employer, many DCWs are taking on extra shifts, and not always by choice. They are sometimes working with colleagues who are inadequately trained or ill-suited for direct care work, and colleagues' callouts can lead to in-fighting and a retaliatory culture.

In many cases, dedicated DCWs with experience and who are well-suited to the work, struggle to train colleagues who are disinterested in the work feel compelled to compensate for a colleague's poor work to ensure their client is receiving the appropriate quality of care. As a result, some DCWs essentially working for free because they cannot bill for the same task as one of their colleagues. Behavioral health clinicians did not experience these challenges but said they were familiar with these kinds of challenges in long-term care facilities and among in-home care workers.

In some cases, DCWs build meaningful relationships with their clients. For instance, if a client's family or guardian is uninvolved in caregiving, DCWs may feel responsible for advocating for patient. This emotional element of the work can be draining and difficult to compartmentalize.

Providing tools and resources to support workers is necessary these days. Tools and resources can be offered to demonstrate that the state and employers care about the well-being of the individuals who do this work.

[31] Rollison, Julia, et.al. (2022). "An Evaluation of a Multisite, Health Systems–Based Direct Care Worker Retention Program: Key Findings and Recommendations."
[32] Public Sector Consultants. (August 2021). "Michigan's Direct Care Workforce - Living Wage and Turnover Cost Analysis".
[33] Hospital & Healthcare Compensation Service. (May 2023). "Behavioral Health Salary & Benefits Report".
[34] Community Mental Health Association of Michigan

Low Workplace Morale

Closely tied to burnout, declining workplace morale commonly contributes to turnover and DCW retention issues. The sources of low morale in some situations are societal; others are interpersonal or professional in nature.

Focus Group

Members of nearly every focus group shared that DCWs (other than behavioral health clinicians) are underappreciated. Though some people may believe DCWs are responsible only for their clients' hygiene and nutrition, seasoned DCWs and those who are suited to this work are confident they are "helping people on personal level." DCWs who support older adults or people with disabilities recognized they provide structure to their clients' days and are often their only personal connection to the outside world. Though some DCWs recognize the importance of their role, it can be demeaning to hear what other people think about their work.

DCWs across the state in many kinds of settings expressed low commitment to their employers if they retain poor performers. Because people who ill-suited to this kind of work are hired, DCWs with more experience and pride in their role sometimes work past their scheduled shifts, unpaid, to fix their colleagues' poor work to protect the rights and dignity of the people they are serve.

DCWs and behavioral health clinicians alike expressed their frustration with not being able to serve everyone who needs their care. Social workers, psychologists, and behavioral health technicians feel like they can never do enough, constantly mindful of long wait lists for behavioral health services. Many of them worry about the costs of delayed care for people with identified mental health needs and shared that this issue affects their morale and causes them to consider pursuing other roles.

Many DCWs who have been in the field since before the pandemic felt cooperation between team members treating the same individuals has declined. Some attributed this situation to certain new hires receiving cash incentives when longer-term employees received only wage pass throughs. Similarly, some DCWs in the behavioral health field sensed an occasional disconnect between clinicians' treatment plans or goals for clients. Many DCWs believe they should be included in treatment planning and goal setting to ensure care coordination.

Challenges Facing Employers and Managers

Focus Group

Following are some of challenges employers of the direct care and/or behavioral health workforce face on carer setting or populations served.

Hospitals and Long-Term Care Facilities

Representatives from hospital and long-term care facilities raised a few unique concerns, including competition for hiring direct care and behavioral health workers, decreasing workplace safety since the beginning of the pandemic, and increasingly complex health needs among clients.

As stated previously, employers are competing for workers with other industries, and hospitals and long-term care facilities are competing with staffing agencies. Hospital and long-term care facility

managers shared that while agency DCWs can be an important resource, they are more expensive and inconsistent workplace knowledge among teams can affect continuity of care.

Hospitals and long-term care facilities also highlighted how dependent they are on the local community colleges to provide a pipeline of workers. One northern Michigan hospital administrator said the facility has been struggling to recruit and retain nurse aides, ultrasound technicians, and surgical technicians since the regional community college stopped offering programs in these fields.

The aging population and increased complexity of individuals' medical needs was raised as a contributing factor to rising costs. Long-term care facilities all agreed peoples' desires to age in place and to avoid nursing homes increases the demand for DCWs. The desire to avoid nursing homes as long as possible shifts costs from Medicare and Medicaid toward the private market. One assisted living facility administrator shared that that the facility previously needed one nurse on call overnight and now needs to have three nurses on call 24/7.

Participants from hospitals and long-term care facilities had some insights into why they are having trouble recruiting new DCWs, including:

- Workplace violence increased during the pandemic with members of the public or patients being belligerent about vaccination or masking policies.
- Rural areas lose high school graduates to larger cities.
- Housing shortages, especially in some seasonal vacation communities, keep DCWs from being able to afford the rental market.
- Training as a standalone incentive does not always work; people don't feel committed to an employer even if the employer invests in their professional development.

Aging Services Providers

Aging services providers shared clear, unanimous feedback about the consequences of many workers not qualifying for the DCW wage increases. Overall, this group agreed DCWs in assisted living facilities are doing sometimes identical work to nursing home staff but were ineligible for the pass-through. Most of these facilities employ traditional DCWs, as well as staff who are not always considered DCWs, such as housekeepers, food service workers, and so on. These individuals did not qualify for the temporary wage increases despite personal risk during the pandemic. In facilities with nursing home and assisted living staff, creating disunification at a time when they needed to be brought together.

One long-term care facility offers its staff interest-free loans as a benefit, which has helped build some loyalty between low-wage DCWs and their employer.

Aging service providers also communicated the challenges they are facing delivering services. These facilities provide housing, hospitality, and healthcare services simultaneously, while balancing the many sometimes competing needs of clients and staff.

Challenges Facing Employees in the Direct Care or Behavioral Health Workforce

In-home Caregivers

During the pandemic, in-home caregivers accepted significant risk and responsibility. Before PPE was widely accessible, many of them took on risk by going into clients' homes. They also accepted the responsibility of communicating about the pandemic to clients who didn't understand the pandemic and were combatting isolation.

Even now that the public emergency has ended, in-home caregivers have more responsibility for cleaning and disinfecting their clients' residences. Workers who serve clients with disabilities face the added challenges of planning around COVID-related risks.

This group also communicated concerns about a lack of growth opportunities for in-home caregivers. Some acknowledged they knew of colleagues who had been promoted into management roles in their field, but if a management role is unappealing, it is unclear how they could advance in the field.

Residential Nursing Aides

Residential nursing aides identified significant ranges of pay depending on the employer. Some employers offered more financial incentives, some pay hourly wages, and others pay a flat daily rate.

One independent provider cited the complexity of the licensing process as a barrier to more people entering the workforce and creating the flexible schedules many of these individuals want or need.

This group identified the challenges of keeping medications straight for clients with changing needs and various providers. Medication management for most clients has become more complicated, and that complexity increases the risk of error. Many focus group participants were aware of technologies and resources that could be supportive but said their employers have yet to use the resources.

Some residential nursing aides shared frustrations with scheduling. Many perceived staffing ratio guidelines to be causing them to have to work harder during a shift and to have fewer people on a shift, raising concerns about patient safety and quality of care.

Residential nursing aides in general become attached to their clients. Though this connection has many benefits, for some it also comes with the challenges of feeling excluded from client care planning and goal setting. Some felt that case managers are patronizing or dismissive, which prevents them obtaining information that might be helpful in providing patient care. One residential nursing aide said, "Case managers don't know them like we do: we're with consumers all day, almost every day. We can help them achieve goals, and we know what's not realistic for them. We'd rather see them succeed. They don't appreciate our expertise."

Personal Care Aides and Community Living Support Staff

Personal care aides and community living support staff reported several challenges. Many would like to have part-time or flexible schedules, but their employers are unable to accommodate them because of workforce shortages. Many must work undesirable shifts, such as evenings, weekends, holidays.

Personal care aides said it can be difficult for them to budget because their income is variable. Some of them spoke about performance-based bonuses or what they perceive to be pay cuts. These swings can be hard to manage and have negatively affect morale.

Some of these workers were frustrated about the frequency with which long-term employees train new staff without additional pay and without being relieved of any of their own responsibilities during training. They feel their dedication goes unrewarded.

Certified Nursing Assistants

CNAs provided feedback that was consistent with that of other DCWs, expressing significant concern about staffing ratios. They shared that some employers overlook clients' needs when assigning them to a CNA. For example, if a CNA always has 10 clients, no one is considering how many will require a great deal of time and attention and whether clients will receive care that is appropriate for them. CNAs it would go a long way for morale and quality of care if acuity were considered when determining assignments on a shift.

Behavioral Healthcare Providers

Behavioral healthcare providers shared several concerns related to their direct care and clinician workforces.

- Expanded coverage for telehealth during the pandemic has improved access to mental health care for many Michiganders but has also created more comfort for providers with virtual platforms. Some employers believe this transformation has made it easier for clinicians to transition into private practice.
- In general, the hardest DCW and clinician roles to fill are those requiring bachelor's, master's, and registered nursing degrees. It also is difficult for behavioral healthcare providers to hire teachers.
- Clinicians who serve Medicare and Medicaid populations are paid well below market rates, causing more people to consider transitioning into private practice.
- Some community mental health (CMH) administrators shared how their healthcare centers pay disproportionately to serve the behavioral health workforce. They frequently hire early-career professionals, invest in their training, provide quality professional opportunities and mentorship, but ultimately, these employees often leave for career advancement, higher salaries in hospital systems, or to go into private practice.
- In order for Medicare or Medicaid to reimburse for behavioral health services, these services must be provided by individuals with a limited set of degrees. It is more difficult to find qualified individuals with these degrees despite many people being considered trainable and otherwise suited to the work.
- Behavioral health employers appreciate the recent policy change that allows recent graduates to bill to Medicare and Medicaid.

Children's Behavioral Health Providers

Focus group participants reported that regulations for adults who receive supported in-home or skilled nursing facility care overlook the differences in providing care to children with behavioral health needs. Focus group participants believe the MDHHS requirements exceed CMS mandates, creating barriers to care.

Credentialing requirements to work with children can be a barrier to bringing more workers into the field. For example, someone may have 20 years of experience working with adults, but unless they have two years of experience working with children, they are not considered to qualified to work with children. Often, the only way to gain required experience is to work outside of the CMH system and bill third-party payers. Further, 20+ hours in continuing education is required to work with children, which can be a barrier if employers do not cover training costs.

Community Mental Health Professionals

Many behavioral health professionals and administrators described inconsistencies between CMHs' operations across the state. Differences in reporting requirements for providers result in administrative burdens for DCWs and behavioral health professionals, which can be time-consuming and require additional training to complete and input properly. Some records must be handwritten, while other must be electronically entered, and some institutions require both, resulting duplicative records. Participants shared that reimbursement rates are inadequate to cover the increasing workloads of DCWs and behavioral health professionals.

Behavioral health participants also noted differences in rates of pay between HH services directly authorized by MDHHS compared with pay rates for community living supports (CLS). Despite the comparable nature and actual crossover of these tasks, the differences in pay rates and which entities authorize them (HH through MDHHS and CLS through CMHs) creates further confusion for administrators when coding and billing. In addition, the Medicaid provider manual definitions of services are often too broad for agencies to make medical necessity determinations for CLS services, making statewide parity difficult to achieve.

Some administrators noted the wage pass-through CMHs receive doesn't cover the time it takes to complete the additional paperwork required. In addition, the wage pass-through also does not reach and benefit DCWs and the services they provide. Providers described some of the administrative challenges with wage pass-throughs, including the barriers to ensuring the funds reach DCWs as intended, including:

- Delays with state reimbursement and funding
- Administrative challenges calculating DCW hours
- Bonuses paid as lump sums to DCWs result in the loss of other work supports
- Varying pay rates between CMHs

Behavior Technicians

Behavior technicians voiced challenges related to certification, regulatory policies, and work-related expenses.

- Some behavior technicians said it was difficult to complete their certifications while working. Classes were often only offered during work hours.
- Some said top-down regulations have increased over the last few years, creating additional stress in an already challenging work environment. They feel that Medicare and Medicaid regulations without accounting for whether it is possible for DCWs to meet the proposed requirements.
- Some behavioral health technicians had ideas for ways to improve treatments, systems, and procedures, but they felt like they were always short staffed and putting out fires and unable to devote time to trying new things.
- Some behavioral health technicians shared it often costs them personally to do their jobs. Often travel between clients is unpaid, as is the time spent planning or preparing for client visits.

Focus Group Suggestions and Potential Actions

Focus group participants suggested many solutions and actions to address recruitment and retention of the DCW workforce. We have assembled these suggestions to align with the worker-centric model components (enhance wages and benefits, invest in worker skills, remove barriers, increase flexibility, use technology to simplify, wellness support, and change policy).

Enhancing Wages and Benefits

Increase access to childcare resources. Childcare often is a limiting factor in workforce development. DCWs need access to high-quality, affordable childcare to improve their reliability, availability, timeliness, and job satisfaction.

Implement/simplify loan forgiveness. School loans can be a significant deterrent from DCWs seeking additional education. DCWs and employers alike championed the need for school healthcare programs to implement loan forgiveness structures to attract additional workforce members, such as increasing the number of nurses in rural areas to meet the demand.

- Most **repayment assistance programs** are designed so that employees must continue making minimum monthly payments, and then the employer contribution acts as an additional payment. The employer contribution helps employees pay off their debt quicker and save on interest.

- A court hold is in place on federal student loan forgiveness; however, you may choose to provide information to employees and monitor this opportunity for them to receive some relief.

- Memorial Hermann Health System, based in Texas, is an example of a successful program. The system introduced a **student loan repayment benefit** in 2016, to attract top talent and address a shortage in nurses, according to John Eshleman, director of benefits. The program was a quick success. Memorial Hermann found first-year retention with registered nurses went up 12 percent in the first two years of the program. For details, go to: https://studentaid.gov/manage-loans/forgiveness-cancellation/debt-relief-info.

Prioritize professional development opportunities. Employers recommended connecting staff with additional education and skill training opportunities. The Michigan Reconnect program, which supports applicants older than 25 years of age to return to school and finish their educational program through community colleges at no cost is an example of such an opportunity. Employers proposed reducing the age limit to promote entice younger adults to consider careers and skill building in healthcare-related fields. Some employers expressed that program such as Futures for Frontliners, offering higher education opportunities at no cost to frontline workers, would be an opportunity for continuing education support.

Revamp retirement savings program. Currently, DCW retirement savings programs limit employees' ability to retain/build the savings portfolio available to them. Employers advocated for changing vesting rules.

Investing in Worker Skills	**Support a healthcare pipeline.** Participants acknowledged that hiring high-quality, well-trained, dedicated healthcare staff has flagged since the pandemic. Employers suggested building partnerships with educational institutions (both K-12 and community colleges), especially for high school students and recent graduates, to inspire career awareness and interest at an earlier stage. This type of program could also attract students not currently college-bound to consider entry-level positions.
	Implement volunteer/intern program. In conjunction with a career pipeline, many DCWs and employers agreed that exposing teens and young adults to direct care work while in high school would help garner interest and build credibility in the healthcare field.
	Establish job shadowing and mentorship opportunities. Offering job shadowing opportunities beyond the internship phase allows DCWs and employers to test whether they are a good fit for each other. The mentorship aspect would help aspiring DCWs to understand the benefits, reality, and magnitude of direct care work.
	Offer trainings for basic life skills. DCWs and employers both agreed that expectations for recent high school graduates are different now than several decades ago. Many young adults may not know how to cook, clean, or care for someone, and participants advocated for related life skills training for new hires. DCWs stated it would be helpful to standardize those trainings and to prioritize other soft skills, such as gentle teaching and reacting to difficult emotional situations.
	Expand/formalize career pathways. A lateral transition to a different field of work with similar compensation but less responsibility, like food service or retail, doesn't come with the same advancement opportunities that healthcare does. Employers suggested highlighting the additional opportunities beyond entry-level jobs, including within business offices (admissions, accounts receivable, human resources, payroll) and specific medical expertise (technical experience with tracheal tubes, ventilators, IVs) to attract new talent and promote and retain existing workers.
	Require DCW experience for nurses. In an effort to improve quality of care and foster a shared appreciation for care giving, some DCWs suggested that nurses should be required to work in DCW positions during their training to better understand the challenges (clinical requirement).

Removing Barriers	**Make it easier for new providers to enter the field.** Some independent providers noted the licensing policies and registration system is difficult and burdensome to independent providers. Lowering these barriers to entry could bring more DCWs into the field.
Increasing Flexibility	**Create a centralized pool of DCWs.** Greater regional connectivity could ensure more flexibility for DCWs and allow them to take existing paid time off without worrying about coverage. Many DCWs shared that they experienced ongoing work periods (for some, days or weeks in a row) without time off because they did not have relief workers to support clients while they took needed time away.
	Consider flexible scheduling. DCWs and employers supported worker-requested scheduling such as four 10-hour workdays instead of five eight-hour workdays to attract and retain new hires. Many see this as an opportunity to empower workers to meet scheduling needs within the confines of regulatory/licensing requirements.
Use Technology to Simplify	**Simplify work through technology.** Some DCWs felt that all healthcare employers should be required to transition to electronic tracking/medication/reporting systems. They shared that on-paper reporting takes more time, is slower, and creates more room for error.
Supporting Wellness	**Offer on-site lunch and learn activities.** DCWs recommended establishing professional development opportunities outside of mandatory work training, such as lunch-hour educational speakers.
	Limit required additional shifts. DCWs often work grueling hours, working overtime on a regular basis, often required by their supervisor. Limiting required additional shifts can help contribute to better work-life balance.
	Provide wellness programming/training requirements. Many resources are needed to support the mental health and well-being of DCWs. This components should be built into the culture and continuing education of every direct care employer.
	Champion supportive management. Employee appreciation levels often correspond with commitment to the employer. DCWs feel appreciated when their employers acknowledge the difficult aspects of their job and celebrate staff victories. Employers and DCWs agreed that supervisory relationships should be helpful, nurturing, and inspire a feeling of wanting to go to work.
	Support team building. Some DCWs felt that staff celebrations activities, like team outings, demonstrate a positive company culture and build team trust. Similarly, rewards like gift cards and lunches help staff feel that their accomplishments are appreciated.

Changing Policy

Increase reimbursement rates. Medicare and Medicaid reimbursement rates should be updated to drive wage and benefit increases. Employers shared that reimbursement rates should keep pace with inflation and the real costs of providing services to support the ancillary costs DCWs incur, such as gasoline, childcare, and other costs to work.

Consider promoting changes to federal immigration policy to provide an influx of qualified DCWs. Some employers advocated for changes to immigration policy to better leverage an underutilized sector of the workforce, foster advancement opportunities for those workers, and bolster credentialing processes.

Amend state-required ratio of staff to consumers. Some DCWs feel that employers, management (and to some extent, the state) establish staffing ratios only to ensure compliance with care requirements instead of supporting ratios that would provide better care for the consumer and meet the high demands on DCW's time.

Incorporate mentorship. Many DCWs stated their support for training and ongoing education. Some suggested the addition of mentoring or additional supervision by qualified professionals would empower DCWs to continue growing in their chosen career path.

Allow family members to qualify as caregivers and reimburse at equal rates to other caregivers. Families and parents of consumers recommended state allow family members to qualify as caregivers. Michigan has a shortage of DCWs, which particularly acute in rural areas. Currently family caregivers are reimbursed at a low rate that is more of a token than additional compensation. Without other care available, some family members have had to leave the workforce to care for their family members at home.

Simplify licensing and credentialing. Employers of behavioral health clinicians proposed extending limited licenses and other types of credentials to address the increased demand and workforce shortage. Some employers noted that it was common for professionals to have master's degrees but not yet completed requirements for licensing. They advocated for the state to either provide more time to complete additional licensing requirements or simplify the process to ensure people get the credentialing they need to meet current demands.

Develop career paths. Both employers and employees explained that greater professionalization and progressive career paths would attract and retain DCWs in and behavioral health practitioners. They suggested the state explore career pathways to help defray costs and encourage commitment to a professional and progressing career direct care. Some highlighted that other states have paths for non-degreed individuals to become social workers and explained that on-the-job training can benefit both consumers and DCWs.

Reduce administrative burden for staff. DCWs and employers alike expressed frustration with excessive reporting requirements that take away from service time. Though most administrative burdens are related to licensing requirements, reporting can result in working (sometimes unpaid) overtime to input important consumer data when a DCW is over capacity because of understaffing.

Aligning common standards: When standards are clear and consistent, providers can spend more time delivering the full range of services they care deliver and less time at their desks navigating confusing and ambiguous compliance requirements.

Refocusing standards: When the timelines for completing or approving treatment documents are realistic, providers are better able to focus on developing trusting therapeutic relationships and delivering high-quality services.

Strategies from Other States

Many states have conducted DCW and behavioral health workforce studies and analyses leading to the identification of various strategies that can be leveraged to strengthen financing, compensation, training standards, recruitment, and retention across the workforce. The following examples are from states that have implemented policies and initiatives aimed at improving key aspects of their direct care and behavioral health workforce.[35]

Direct Care Workforce

Strategic investments in Medicaid: North Carolina is dedicating American Rescue Plan Act (ARPA) funds to increasing wages across the workforce, creating a Direct Care Jobs Innovation Fund that will support recruitment initiatives, as well as adding new waiver slots. At least 30 states are leveraging ARPA funds for initiatives and programs designed to improve Medicaid payment policies related to improving recruitment and retention of DCWs.[36]

Increasing reimbursement rates for LTSS: Wisconsin's ARPA spending plan includes a 5 percent reimbursement increase to all home- and community-based (HCBS) providers to offset any urgent financial challenges. Additionally, Wisconsin has created a Direct Care Workforce Funding Initiative that directs funding to LTSS providers for compensation-related expenses, such as wage increases.

Enacting wage reforms: Colorado implemented a standard minimum wage of $15 per hour for DCWs who provide care to Medicaid-funded HCBS care recipients. This amount is close to $2.50 more than the statewide minimum wage. Rhode Island is enhancing provider reimbursement based on achieving set criteria, such as high scores on quality metrics.[37] In Kansas, nursing and intermediate care facilities can apply for additional dollars per resident day to support DCW wages or benefits.[38] In Massachusetts, nursing facility providers are required to spend at least 75 percent of the total facility revenue on DCW-related expenditures.[39] Similar wage pass-through laws have been enacted in several states.

Improving employee benefits: Virginia Home Health Workers who provide specific types of care under Virginia's Medicaid state plan are eligible to receive up to 40 hours of paid sick leave per year. This leave can be used for preventive or diagnostic care, either for themselves or their family members.

Addressing additional barriers to work: Additional recommendations and strategies related to supporting employees with innovative benefits and perks such as childcare credits or assistance, transportation needs, lifestyle needs (e.g., pet insurance), flexible scheduling, establishing protections around equity, etc. are increasingly present in the literature. Washington and Tennessee have developed training programs that link to advancement and/or wage increases. Wisconsin launched a marketing campaign, using videos to illustrate the rewards of being a CNA.[40] As previously mentioned in

[35] Scales K. (2022). "State Policy Strategies for Strengthening the Direct Care Workforce."
[36] MACPAC Issue Brief. (March 2022). "State Efforts to Address Medicaid Home-and Community-Based Services Workforce Shortages."
[37] Block, L., et.al. (October 2022). "Addressing Wages of the Direct Care Workforce through Medicaid Policies."
[38] Ibid.
[39] Ibid.
[40] Hostetter M, Klein S. (2021). "Placing a Higher Value on Direct Care Workers."

this report, many DCWs are immigrants. While the percentage of DCWs who are immigrants is smaller in Michigan, implementing protections for immigrants to obtain work is a means of recruiting them into direct care roles and address workforce shortages. For example, Illinois allows undocumented immigrants to get a driver's license, relieving a huge barrier for individuals who would otherwise be prohibited from legally transporting themselves to and from work.[41]

Establishing workforce innovation funds: Maryland's Senate Bill 307 establishes a direct care workforce innovation program that provides matching grants to eligible groups with the intention of improving and expanding recruitment and retention initiatives.

Behavioral Health Workforce

Regional collaborative approach: Many regional employers, high schools, post-secondary education institutions, community-based organizations and public health agencies collaboratively identify gaps and opportunities to promote behavioral health professions, providing students a glide-path into education programs and shadowing experiences that create incentives to enter the field. Regional approaches allow for geographic-specific nuances in gaps, needs, and opportunities and tend to promote innovation. Public-private partnerships are used to fund loan repayment programs, create scholarships, sponsor conferences, and fund pathway programs.

Increase Medicaid reimbursement rates: A total of 19 states that responded to a Kaiser Family Foundation survey in 2022 reported increases in behavioral health provider reimbursement rates that year; another 23 states reported plans to increase rates in fiscal year 2023. Many states are leveraging ARPA funds for this strategy.[42]

Extend the workforce: Adding peer recovery specialists or family specialists is a common strategy for many states. New Jersey allows licensed clinical social workers to bill independently. Many states also reimburse services delivered by individuals who are license-eligible and practicing under supervision.[43] Several states are establishing programs to train and hire peer support and addiction counselors.[44]

Expand loan repayment programs: States are expanding existing loan repayment programs to include behavioral health professionals, creating standalone behavioral health professional loan repayment programs, and entering into public-private partnerships to supplement funding of loan repayment programs. Pennsylvania allocated $5 million for behavioral health professionals working in areas with high opioid use and workforce shortages.[45]

Prioritize emergency federal funding for behavioral health recruitment and retention: Oregon Health Authority leveraged ARPA funding for incentives and assistance to recruit and retain BIPOC, tribal, and rural behavioral health providers and to encourage practice in underserved areas. Includes financial incentives, including sign-on bonuses, tuition assistance and scholarships for undergraduate and

[41] Scales, K. (2022). "State Policy Strategies for Strengthening the Direct Care Workforce."
[42] Saunders, Heather, et. al. (January 2023). "A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs". Kaiser Family Foundation
[43] Ibid.
[44] National Council of State Legislators. (May 2022). "State Strategies to Recruit and Retain the Behavioral Health Workforce".
[45] Pennsylvania Department of Health. "Substance Use Disorder Loan Repayment Program Fact Sheet".

graduate students. Loan forgiveness, housing assistance, childcare and tax subsidies, bonuses, and stipends for supervising.[46] Virginia appropriated $110 million in part for direct care staff bonuses, expansion of community-based crisis services, and personal protective equipment.[47]

Strengthen resiliency within the workforce: Florida contracts with nonprofit organizations and the Professionals Resource Network to promote health professional wellness.[48] Minnesota created a health professionals' services program to promote early intervention, diagnosis, treatment, and monitoring for health professionals with potentially impairing conditions before clinical skills are compromised. The program provides peer counseling and monitoring.[49]

Enhance career pathways and tailor pipeline programs to support communities historically underrepresented: Washington appropriated $1.5 million in 2021 to establish apprenticeship programs, compensate providers and apprentices, develop on-the-job training, and provide incentives for providers serving rural communities and communities of color.[50]

Recommendations for Michigan's Department of Health & Human Services

Most recommendations affecting the direct care and behavioral health professionals will require employer involvement. However, it is critical these initiatives be supported by funding and policy at the state level. The recommendations below will require additional review with key stakeholders to develop discrete steps and plans.

[46] National Academy for State Health Policy. (December 2021). "State Strategies to Increase Diversity in the Behavioral Health Workforce".
[47] Hughes K. (January 2022). National Conference of State Legislators. "ARPA is Helping States Tend an Ailing Health System".
[48] Ibid.
[49] Ibid.
[50] National Council of State Legislators. (May 2022). "State Strategies to Recruit and Retain the Behavioral Health Workforce".

Worker-Centric Growth Model

Many factors have affected the direct care and behavioral health workforce, including COVID-19, technology, and demographic shifts. Michigan, like many states, is struggling to care for people who need or would benefit from direct care or behavioral health services. This problem is complex, and MDHHS will need to apply a systemic approach to address the worker shortage in direct care, behavior health, and across human services. We recommend an approach that supports providers and collaboration at the systems and environmental levels to implement strategies centered on the worker.

This model requires the state to consider many changes to address the workforce shortage. It is critical that the state build a model providers can embrace, is focused on health equity, and that the state can support. The worker-centric growth model includes strategies to enhance wages and benefits, invest in worker skills, remove cumbersome administrative barriers, increase flexibility in the work, improve use of technology, develop policy changes, and focus on workers' well-being.

The worker-centric growth model is not a simple fix. The state, providers, and all stakeholders must lean in to create multiple solutions to this complex issue impacting caregivers across Michigan and across the country.

A worker-centric model drives a systemic approach to addressing recruitment and retention challenges in healthcare. Each component (policy, wages and benefits, worker skills, barriers, flexibility in and complications of the work, and worker wellness) must be addressed in a collaborative way among the systems and institutions with a role in its issues and ability to effect positive change. This model will require the state to consider rate increases to enhance pay and benefits and create a supportive environment for providers to be competitive in the market for the workforce. The state must remove barriers, partner to build better training and career pathways, develop and share wellness tools for workers with system partners, and find mechanisms to address the barriers that childcare and transportation costs present as well as the shortage of affordable housing.

Worker-centric strategies are intended to encourage employers to shift the organizational mindset toward thinking more like a potential employee, balanced against the needs of the agency, in developing a recruitment and retention strategy. Regardless of which strategy or strategies are assessed to be most impactful, Michigan leadership should begin thinking more about how to enable, empower, and tap workers' strengths, passions, and goals. Workers want experiences that interest them, and the

state and employers must think creatively about how to develop pipelines that feed not only internal recruitment goals, but also cultivate and sustain employee enthusiasm and compassion.

Michigan leaders should develop a comprehensive plan that includes changes to policies such as rate increases to support enhanced wages and benefits, training programs that are accessible, administrative simplification and application of technology to enhance efficiencies, and implementation of a wellness and equity-oriented support system for workers. Attention should be given to geographic locations where recruitment and retention is especially challenging. Additionally, as noted previously, consideration should also be given to the broader needs and context of the workforce, including worker, system, and environmental factors and levers.

The state must lead and **authentically partner** to create a system people want to work in because they have support and are valued for the commitment and care they provide. To achieve this vision, the state will need to review Medicaid rates, support reducing the costs associated with entering the profession, develop and expand low-cost or free training programs, create a visible and meaningful campaign that supports the wellness of workers, and find new and creative mechanisms for sharing the burden of barriers to this work. **All these strategies must be developed with a focus on health equity and with the worker at the center**. The recommendations below represent initial steps in addressing workforce challenges. Several of these recommendations are geared toward gathering more specific, regionalized input to inform and drive future actions. **It is imperative that the state continue to engage employers, workers, and other stakeholders on a continual and consistent basis to resolve workforce challenges. It is important that MDHHS continue to provide the leadership that has been in place with the Health Care and Human Services Workforce Capacity Steering Committee, either though the continuation of the current committee or a similar structure.**

Making the Worker-Centric Model Work

PSC heard from stakeholders that the worker-centric wheel cannot stand alone without broader considerations related to the systems in which DCWs and behavioral health professionals are educated, trained, recruited and work, and the broader environment including perception and understanding of the value and nature of direct care and behavioral health work.

Well-coordinated systemic change leads to overall improvement in workforce quality, sustainability, and scale. Participants repeatedly discussed the need to acknowledge the system in which the workforce is operating, how the system itself affects the workers, and how any changes will be implemented and exist in the current environment.

A broader conversation in support of a sustainable workforce is needed. Attendees discussed the need to improve the external perception of direct care workers, address the stereotype of DCWs being unskilled, and move toward professionalizing the work as a career, potentially through credentialing and a public awareness campaign that promotes the value of the work. Participants suggested these changes would also improve DCWs' self-perception and cultivate pride in their work.

Participants also noted the need to acknowledge and consider consumers and caregivers as a part of the direct care ecosystem. Attendees reflected a desire for consumer service and caregiver needs to be included in the context of the worker-centric model.

A note on metrics: Appropriate metrics to assess the impact of these implemented recommendations will evolve with time. This report recommends outcomes for assessment, but the specific metrics should, to the extent possible, be developed using data currently collected, to avoid increasing administrative burden on workers. Development of these metrics is critical to assessing the impact of actions and to making appropriate adjustments as needed. It will be essential that the same partnership between state leadership and the service delivery system support the development of these metrics. This should be an integral part of the implementation plan.

Recommendation #1: Develop a Collaborative, Worker-Centric Approach Focused on Equitable Worker Experiences and Client Outcomes

The worker-centric collaborative approach to address workforce challenges is largely based on the ability to truly engage diverse stakeholders in a meaningful process to identify challenges and co-design solutions. The approach must be sensible and accessible to all stakeholders and designed and organized based on their collective input, with equity embedded throughout. **Consider supporting localized (based on shared barriers and challenges) communities of practice with state-level support to enable regional-specific articulation of problems and solution designs that inform statewide policy changes and investments.** A community of practice (CoP) has three primary elements:

- A common identity, meaning, purpose, or value that inspires participation and mutual exploration,
- A social fabric of learning and willingness to share, ask, and listen,
- Collectively developed, shared, and maintained frameworks, tools, and ideas that are tested and used.[51]

A well-established CoP engages participants meaningfully in a cohesive process to bring about change and advance common goals. It requires a shift in the ways in which members of the community and those most affected by a particular problem are united to explore root issues and design effective solutions. Adopting a CoP approach will likely require a shift from traditional stakeholder engagement approaches toward approaches that are community-centric and culturally responsive. Using the worker-centric model, this recommendation includes establishing a mechanism to engage DCWs and the professional behavioral health workforce, particularly people from historically marginalized backgrounds, to understand their unique challenges and needs and co-design solutions.

Recommendation 1.1

Establish CoPs will require the following:

- A communications plan to educate participants,

[51] Wenger E, McDermott R, and Snyder W. (2002). "Cultivating Communities of Practice: A Guide to Managing Knowledge – Seven Principles for Cultivating Communities of Practice".

- Stakeholder engagement to identify appropriate communities and priorities,
- A plan to establish and support CoPs where there is sufficient interest and participation.

Key Outcome Measures

- Number of CoPs developed.
- Percentage of the state and workforce represented in a CoP.

Recommendation #2: Enhanced Pay/Pay Differential

Wages for DCWs are intricately connected to provider reimbursement rates. MDHHS has done much over the past several budget cycles to support DCW wage passthroughs. This has been done before, during and after the COVID-19 pandemic. Though these pay increases have been important, they are insufficient. Various options could enhance the value of rate increases. **MDHHS should consider models for enacting an enhanced payment rate based on set criteria**, **such as achieving high scores on quality metrics, or a required percentage of total facility revenue providers must spend on direct care wages and benefits**.

Wage strategies implemented through proposed state statute are most successful when they are also prioritized in the governor's proposed budget. Fee for service offers some flexibility for providers increase DCW wages. Directing managed care organizations to pay providers according to a specific rate or method to increase DCW wages is obtained through an 1115 waiver or state-directed payment authority.[52]

Shift differential is not required under the Fair Labor Standards Act, but it is common in the healthcare industry. It can be used as a recruitment strategy, with a premium pay rate for evenings and weekends, as it is usually required to be competitive in the current employment market. Pay differential options often include a shift differential for non-standard hours, call-back premiums, weekend and holiday premiums, and hazard pay.[53]

Recommendation 2.1

Wage efforts must be based on specific, regional data rather than on state average pay for workers. Gather additional wage information for workers in Michigan based on real wages and identified trends, establish a plan to move DCW wages to the point of being and remaining competitive. Any actions relating to increasing wages also should consider the impact of wages on eligibility for various benefits. It is known that at a certain income level, employees hit what is known as the "benefits cliff"—the point at which they earn too much to qualify for certain public benefits (food or housing supports) but still earn less than a living wage. This regional analysis of real pay should also include an analysis of the criteria for public benefits and the related challenges within this part of the state.

[52] Medicaid and CHIP Payment and Access Commission. (March 22, 2022). "State Efforts to Address Medicaid Home-and Community-Based Services Workforce Shortages."
[53] Broyles, David. (February 15, 2023). "What Employers Should Know about Shift Differential Pay."

Key Outcome Measure

This recommendation provides actual, actionable information regarding pay and pay adequacy specific to areas of the state rather than statewide data. Measurable outcomes include availability of locally specific, actionable data as well as local action plans with measures of change related to the actions taken, such increasing wages, reduced incidents of lost benefits, and improved employee retention.

- Actual change in wages by CoP or rural/urban location
- Actual incidence of loss of benefits or employees because of wage losses by CoP or rural/urban location

Recommendation 2.2

Evaluate potential value-based payment (VBP) options for those services DCWs provide. Identify potential metrics and pilot a VBP structure. (Note: Recent proposed rules regarding HCBS adequate pay will impact any decisions in this area.) It also is important to standardize and simplify reporting related to funding directed to wages.

Key Outcome Measure

This recommendation would support the development of a sustainable payment method that supports increased wages and improved outcomes. Measures include service volume in value-based contracts and an increase in wages. Outcomes to consider in development of VBP may include client satisfaction, payments in value-based contracts, rate of staff turnover, and wages as a percent of reimbursement.

Recommendation #3: Support Innovative Benefits and Perks

Benefits and perks beyond those traditionally available to DCWs could have a positive effect on recruitment and retention. **MDHHS should support innovative and nontraditional benefits providers need to offer in their strategic recruitment and retention practices**. Support could be wrapped into changes in policies impacting wages and benefits or additional grant programs. Additional support could be demonstrated by partnering with organizations to provide information and training on building nontraditional benefit programs tailored to the diverse needs of DCWs. Frequently mentioned challenges include childcare, transportation, and affordable housing. Sign-on bonuses and pet insurance also are offered increasingly.

Recommendation 3.1

Address policy changes to support flexible benefits for employees as allowable expenses. This should include identifying policies that may be barriers, potentially gathering input from the CoPs.

Key Outcome Measure

Employee retention

Recommendation 3.2

Increase access to various benefits, such as childcare, housing, transportation. Employers can take several possible approaches, including offering financial support to the worker, providing a childcare center, or coordinating services. Each CoP should collaborate with employers to determine effective ways to reduce the barriers of housing, transportation, and childcare.

Key Outcome Measure
Employee retention

Recommendation 3.3
Implement and simplify loan forgiveness. Some programs are structured so that employees continue to make normal payments and employers make additional payments, which ends the obligation sooner, but for some people, more immediate relief is needed. One example of a successful loan repayment program can be found at Memorial Hermann Health System discussed previously. MDHHS is addressing this issue, and CoPs may be able to assist in nuancing the program to better meet the needs of DCWs and behavioral health practitioners.

Key Outcome Measure
Employee retention, improved recruitment in targeted areas

Recommendation 3.4
Consider, implement, and support flexible scheduling. While acknowledging that this scenario works better with adequate staff, potential options for schedules of three 12-hour days, four 10-hour days, or five eight-hour days may remove certain barriers for employees with transportation, childcare, or other challenges.

Key Outcome Measures
Employee retention, improved recruitment

Bonuses
A **referral bonus** compensates or rewards employees who successfully recruit new employees. Employees submit referrals and if the agency hires the individual, then the employee receives a bonus. Note: Because referral bonuses rely on employee networks, organizations lacking diversity may unintendedly maintain workforce homogeneity by implementing such programs. Monitoring workforce demographics will be critical to implementing this approach.

An agency can separate itself from another when hiring by offering a **sign-on bonus**, without having to disrupt the pay scale or incurring more long-term costs.

Pet Insurance
Generally, pet insurance plans cover unexpected injuries or accidents, including surgery, illness, medication, non-preventive tests or diagnostics, and emergency care and related exam fees.

Almost one in five American households acquired a pet during the pandemic. Close to 70 percent of American households have pets.[1] While only 15 percent of employers offer it, many employers are adding pet insurance to their flexible benefit plans to attract talent. Millennials are the dominant generation in the workforce, and they will represent 75 percent of the workforce by 2025, and 76 percent of Millennials have pets.

Recommendation # 4: Support Childcare Incentives and Caregiver Benefits
Often, workers have childcare needs and are responsible for aging or disabled loved ones. Affordable childcare, especially, is a significant concern for many workers. **MDHHS should consider supporting**

childcare and other caregiver incentives and programs agencies and employers can use as part of their strategic recruitment and retention strategy.

The Employer-Provided Child Care Credit, under the Internal Revenue Code Section 45F,[54] offers employers a tax credit of up to 25 percent of qualified childcare expenditures and 10 percent of qualified childcare resource and referral expenditures. The credit is capped at $150,000, meaning employers would have to spend around $430,000 to receive the full credit. Even if the tax credit does not apply to an agency, this idea makes sense as a recruiting strategy.

Recommendation 4.1

MDHHS, with stakeholder input, should review policies to identify policy/regulatory/contractual restraints on employers' ability to support their employees' childcare and caregiver needs. Based on this review, MDHHS will identify those restraints that can be changed and take appropriate action to initiate change.

Key Outcome Measure

Actual policy/statutory/regulatory changes and employee recruitment and retention.

Recommendation # 5: Invest in Training and Professional Development

Similar to the Improving MI Practices initiative to advance training for BEHAVIORAL HEALTH professionals, MDHHS and Michigan providers should invest in DCWs and their careers and explore ideas with workers on career development needs. **MDHHS should provide support to ensure a cohesive and collaborative multi-system approach exists across the state for a responsive, accessible training program**. Building a successful team and workforce requires a commitment to training, mentoring, and experiential learning that is focused on evidence-based practices and settings in which practitioners are likely to work during their careers. Training should address the needs of the modern learner, be engaging, and include tools *t*o address the pressing issues of understanding and responding to the needs of their clients and patients. Communication skills training is also critically important yet often overlooked. DCWs should receive training that will help them be better at their jobs, alleviate their stress and empower them with skills that will make a positive difference in the lives of their clients and patients and themselves. Consideration also should be given to developing career ladders that include a defined step-up plan that workers can embrace. Pay increases, certificates, titles, additional responsibilities, and coaching/mentoring roles are some of the ways that DCWs can feel rewarded and valued by their employers, while offering them opportunities to move into other positions.

Recommendation 5.1

Explore options for expanding the Improving MI Practices website to include DCW training. Leverage the current evidence-based practice training uses of websites for behavioral health staff.

[54] Internal Revenue Service. (September 2022). "About Form 8882, Credit for Employer-Provided Child Care Facilities and Services."

Recommendation 5.2

Establish central database of trainings and trainers with dates training is offered to be easily used by providers, potentially building on to the Improving MI Practices site.

Key Outcome Measure

- Increased training opportunities
- Improved training compliance
- Reduction in citations (licensing or site review) related to training

Recommendation 5.3

Support the development of a healthcare pipeline through a focused effort to support current workers and expose potential workers to the field. Options include:

- Implementing volunteer/intern programs for various levels of workers
- Developing and implementing "job shadowing" and "mentorship" programs that may expose high school or undergraduate student to direct care and behavioral health work,
- Establish a direct care worker conference to provide skill development and celebration of the DCW workforce,
- Develop a credentialing process for DCWs that provides verification of training and competency, which may include training in certain basic life skills such as cooking, cleaning, and personal hygiene.

Key Outcome Measure

Increase in qualified applicants for positions

Recommendation 5.4

Explore benefits of creating a centralized pool of DCWs at the CoP level to support recruitment open shift coverage.

Recommendation # 6: Support Improvement in Administrative Processes

Through continuous improvement, administrative simplification allows systems to become a support rather than a barrier for workers. Agencies and providers must make a systemic commitment to determining essential administrative work and using modern approaches to identify and eliminate system requirements that are of little value and that distract from the team's vision and mission.

DCWs want less paperwork and more time with clients. Duplicative and complex documentation requirements divert attention from providing quality care to the people who need their services. Listen to the workers. They know where the system has issues. Not everything may get fixed, but continuous improvement and tangible incremental gains matter. **Support efforts to redesign and improve administrative processes to reduce the burden imposed at the state and provider level.** (For example, recent changes in time reporting requirements for DCWs in behavioral health have created additional burden.)

Recommendation 6.1

Behavioral Physical Health and Aging Services Administration (BPHASA) should establish a workgroup with appropriate staff and stakeholder participants to develop a list of potential policy/reporting changes to reduce the amount of time required to meet current documentation and reporting requirements.

Key Outcome Measure

The group will produce a proposed list of policy/reporting changes, along with a work plan that includes assignments to the individuals/entities responsible for achieving these modifications.

Recommendation 6.2

BPHASA should convene a workgroup of appropriate staff and stakeholders, including vendor representatives from electronic health record (EHR) vendors, to determine how to standardize certain reporting and ensure effective health information exchange (HIE) to reduce the need for DCWs to enter information into multiple EHRs with differing requirements.

> *NOTE: Stakeholders recommend using technology to simplify work, suggesting standardized EHRs and medication reporting. Include employee input in the stakeholder group discussions.*

Key Outcome Measure

The group will produce a list of recommended changes that will reduce complexity and burden while improving interoperability and standardization. The group will identify key persons/organizations and develop a workplan for all stakeholders to review.

Recommendation 6.3

Consider options to reduce, streamline, and simplify supervisory requirements degreed professionals need before achieving full licensure. Review should consider length of time for supervision, required frequency of supervisor and supervisee meetings, and how to potentially streamline documentation requirements. Consider potential to incorporate in centralized credentialling process.

Key Outcome Measure

Increased number of licensed professionals (MSW, LLP, LPC) completing licensing requirements

Recommendation 6.4

Create a statewide, centralized training database that includes both trainings/trainers/dates and training records.

Key Outcome Measure

Reduced training costs, real training reciprocity, reduced turnover costs

Recommendation 6.5

MDHHS should develop a system for identifying which administrations or bureaus issue various regulations and instructions to which provider systems to ensure coordination for consistency before

issuing instructions. (Examples may include implementation and reporting for DCW wage pass-throughs, HCBS compliance monitoring, and data collection.)

Key Outcome Measure

Reduction of inconsistent/redundant/conflicting requirements, reduced administrative cost, improved employee retention.

Established structure (division or section) within MDHHS, with staff and responsibility for this function.

Recommendation #7: Provide Tools and Guidance Addressing Wellness Support

Well-being should be a focus of every agency interested in recruiting and retaining a workforce, especially in fields like healthcare and behavioral health where the emotional toll of the work is pronounced. **MDHHS should be an active supporter in ensuring reliable resources are available, promote shared learning, and make wellness initiatives eligible for grant programs.** Developing staff capabilities and wellness goes beyond required training and focuses on the individual to support their overall career growth and well-being. Many tools and resources are available to support the workforce.

The Office of the Surgeon General published the Framework for Workplace Mental Health and Wellbeing in 2022. It highlights five essential components, centered on the worker and equity that support workplaces as engines of well-being: Protection from Harm, Connection and Community, Work-Life Harmony, Mattering at Work, Opportunity for Growth.[55] This framework dovetails well with the worker-centric model.

MDHHS has an opportunity to lead in developing and making available well-being resources and tools for employers and employees within the service delivery system.

Recommendation 7.1

Establish a group, including MDHHS staff, employers, employees, and stakeholders to review and evaluate the Surgeon General's Framework for Workplace Mental Health and Wellbeing. Based on review of document, develop plan inclusive of appropriate communications, surveys/input, and recommendations.

Key Outcome Measure

Improved employee retention and employee engagement measures

Recommendation 7.2

Implement programs to develop supportive management and team building coordinated through the CoPs and supported by necessary funding mechanisms and policies. From the state perspective, review ways of incentivizing activities. From the employer perspective, consider options for management training, team-building activities, and training.

[55] Office of the Surgeon General. (2022). "The U.S. Surgeon General's Framework for Workplace Mental Health & Well-Being."

Key Outcome Measures

- Increase in numbers of trainings available
- Increase the number of people completing trainings
- Improved employee retention. Increased employee advancement

Recommendation #8: Implement Strategies to Expand the Workforce Pool

Understanding Michigan's changing demographics and exploring opportunities to engage new workers provides an opportunity to expand the pool of potential DCWs and behavioral health workers. The state may need to support the regular collection and reporting of regional demographic data. These approaches should be coordinated through the CoPs as demographic differences across Michigan regions require unique and customized approaches.

Recommendation 8.1

Implement a data-driven approach to identify new or growing demographics in regions across the state (through CoPs) and develop targeted strategies to engage these emerging populations in understanding potential opportunities to work in the healthcare sector. As with many states, Michigan has experiences shifts in demographics in certain pockets of the state, in part due to resettlement efforts of new immigrants as well as the increasingly more transient nature of the US population. This recommendation requires annual monitoring of demographic shifts across the state to identify early on any new populations to engage. This approach also has the mutual benefit of addressing both workforce and health equity challenges as it results in building a workforce that reflects the community and client demographics.

Key Outcome Measure

Demographic dashboards by regions. Improved diversity within the workforce.

Recommendation 8.2

Evaluate state requirements for DCWs and behavioral health licensure to determine whether there are any requirements that deter candidates from considering the field or that go beyond what is necessary to perform the role safely and satisfactorily. For example, consider extending the "ban the box" requirement to providers. This approach would not dilute the requirements for background checks but may increase the pool of qualified candidates as some candidates with unrelated criminal histories may be deterred from applying for DCW or behavioral health jobs.

Summary Table of Recommendations and Needs

Recommendation	Priority	Legislative/Policy	Funding needed	Partners	Timeline
1.1 Establish Communities of Practice. This will require: • A communication plan to educate participants • Stakeholder engagement to identify appropriate "communities" and priorities • Developing and implementing a plan to establish and support Communities of Practice where there is sufficient interest and participation.	Highest	No	Potential	Yes	First
2.1 Wage efforts must be based on specific, regional data rather than on state average pay for workers. Gather additional wage information for workers in Michigan and based on real wages and identified trends, establish a plan to move DCW wages to the point of being and remaining competitive. Any actions relating to increasing wages must also consider the impact of wages on eligibility for various benefits. It is clear that at a certain income level, employees hit what is referred to as the "benefits cliff." This is the point at which they earn too much to qualify for certain public benefits (food or housing supports) but still earn less than a living wage. This regional analysis of real pay should also include an analysis of the criteria for public benefits and the related challenges within this part of the state.	High	Not initially but future actions likely will	Potential	Yes	Early
2.2 Evaluate potential Value-Based Payment options for those services provided by DCWs. Identify potential metrics and pilot a VBP structure. (NOTE: Recent proposed rules regarding HCBS Adequate Pay will impact any decisions in this area.) It is also important to standardize and simplify reporting related to funding directed to wages.	High	Policy Likely	Yes to implement	Yes	Early
3.1 Address policy changes to support flexible benefits for employees as allowable expenses. This should include identifying those policies that may be barriers, potentially gathering input form the Communities of Practice.	Second	Likely	Yes	Yes	Second

Recommendation	Priority	Legislative/Policy	Funding needed	Partners	Timeline
3.2 Increase access to various benefits, such as childcare, housing, transportation. There are several possible approaches to this, including financial support to the worker, providing services such as a childcare center/service, or coordinating services. Each CoP should collaborate with employers in the area to determine effective ways to reduce the barriers of housing, transportation, and childcare.	Second	Likely	Yes	Yes	Second
3.3 Implement/simplify Loan Forgiveness. Some programs are structured such that employee continues to make normal payments and employer makes additional payment. This ends the obligation sooner, but for some positions more immediate relief is needed. Examples of successful loan repayment programs, including the one at Memorial Hermann Health System. *MDHHS is currently addressing this issue, and it may be appropriate to simply defer to that. This is also an area that the Communities of Practice may be able to assist in nuancing the program to better meet needs.*	Moderate	Yes	Likely	No	Build on current work
3.4 Consider, implement/support flexible scheduling. While acknowledging that this works better with adequate staff, potential options for schedules of 3 twelve-hour days, 4 ten-hour days, or 5 eight-hour days may remove certain barriers for employees with transportation, childcare, or other challenges.	Low	No	Should not	Yes	Second or third
4.1 MDHHS, with stakeholder input, will review policies to identify policy/regulatory/contractual restraints on employer ability support employees' childcare and caregiver need. Based upon this review, MDHHS will identify those restraints that can be changed and take appropriate action to initiate change.	Hight	Yes	No	No	Early
5.1 Explore options for expanding the Improving MI Practices website to include DCW training. Leverage the current EBP training uses of website for behavioral health professional staff.	Moderate	No	Yes	Likely	Early
5.2 Establish central database of trainings and trainers with dates training is offered to be easily used by providers (potentially building on Improving MI Practices site.)	Moderate	No	Yes	Yes	Early

Recommendation	Priority	Legislative/Policy	Funding needed	Partners	Timeline
5.3 Support the development of Healthcare Pipeline through a focused effort to support current workers and expose potential workers to the field. This should include options such as: • Implementing volunteer/intern programs for various levels of workers • Developing and implementing "job shadowing" and "mentorship" programs that may expose high school or undergraduate student to direct care and behavioral health work • Establish a "direct care worker" conference to provide skill development and celebration of the DCW workforce. Develop a credentialling process for Direct Care workers that provides verification of training and competency. This may include a training in certain basic life skills such as cooking, cleaning, and personal hygiene. (This connects to Recommendation 6.4 and 5.1)	High	Perhaps	Likely	Yes	Start soon, will take time
5.4 Explore benefits of feasibility of creating a "centralized pool" of Direct Care workers. This would be at the Community of Practice level and could potentially support recruiting and be a valuable tool for covering open shifts.	Low	No	No	Yes	Second or third
6.1 BPHASA will establish a workgroup with appropriate staff and stakeholder participants to develop a list of potential policy/reporting changes to reduce the amount of time required to meet current documentation and reporting requirements.	High	Yes	Perhaps	Yes	Hight
6.2 BPHASA will convene a workgroup of appropriate staff and stakeholders, including vendor representatives from EHR vendors, to determine how to standardize certain reporting and ensure effective HIE to reduce the need for DCW to enter information into multiple EHRs with differing requirements.	High	No	Yes	Yes	High

Recommendation	Priority	Legislative/Policy	Funding needed	Partners	Timeline
6.3 Consider options to reduce, streamline, simplify supervisory requirements degreed professionals before achieving full licensure. Review should consider length of time for supervision, required frequency of supervisor and supervisee meetings, and how to potentially streamline documentation requirements. Consider potential to incorporate in centralized credentialling process.	Moderate	Yes	No	Yes	Second
6.4 Create a statewide, centralized training database. Training database should include both trainings/trainers/dates and training records for all trainees.	High	Maybe	Yes	Yes	High
6.5 MDHHS will develop a system for identifying which administrations or bureaus issue various regulations/instructions to which provider systems to ensure coordination for consistency prior to issuance of instructions. (Examples may include implementation and reporting for DCW wage passthroughs, HCBS compliance monitoring, and data collection.)	High	Yes	Yes	Yes	Early
7.1 Establish a group, including MDHHS staff, employers, employees, and stakeholders to review and evaluate Surgeon General's Framework for Workplace Mental Health and Wellbeing. Based on review of document, develop plan inclusive of appropriate: communications, surveys/input, recommendations.	Moderate	Perhaps	Perhaps	Yes	Second or third
7.2 Implement programs to develop supportive management and team building. This should be coordinated through the Communities of Practice and supported by necessary funding mechanisms and policies. From the state perspective, review ways of incentivizing activities. From the employer perspective, consider options for management training, team building activities and training.	Moderate	No	Yes	Yes	Second or third

Recommendation	Priority	Legislative/Policy	Funding needed	Partners	Timeline
8.1 Implement a data-driven approach to identify new or growing demographics in regions across the state (through Communities of Practice) and develop targeted strategies to engage these emerging populations in understanding potential opportunities to work in the healthcare sector. As with many states, Michigan has experiences shifts in demographics in certain pockets of the state, in part due to resettlement efforts of new immigrants as well as the increasingly more transient nature of the U.S. population. This recommendation requires annual monitoring of demographic shifts across the state to identify early on any new populations to engage. This approach also has the mutual benefit of addressing both workforce and health equity challenges as it results in building a workforce that reflects the community and client demographics.	High	No	Yes	Yes	Early, it will take time to build
8.2 Evaluate state requirements for DCWs and behavioral health licensure to determine whether there are any requirements that deter candidates from considering the field or that go beyond what is necessary to perform the role safely and satisfactorily. For example, consider extending the "ban the box" requirement to providers. This approach would not dilute the requirements for background checks but may increase the pool of qualified candidates as some candidates with unrelated criminal histories may currently be deterred from applying for DCW or behavioral health jobs.	Moderate	Yes	Yes	Yes	Second

Appendices

Appendix A: Key DCW and BEHAVIORAL HEALTH Data Points

Summary of Key DCW Data Points

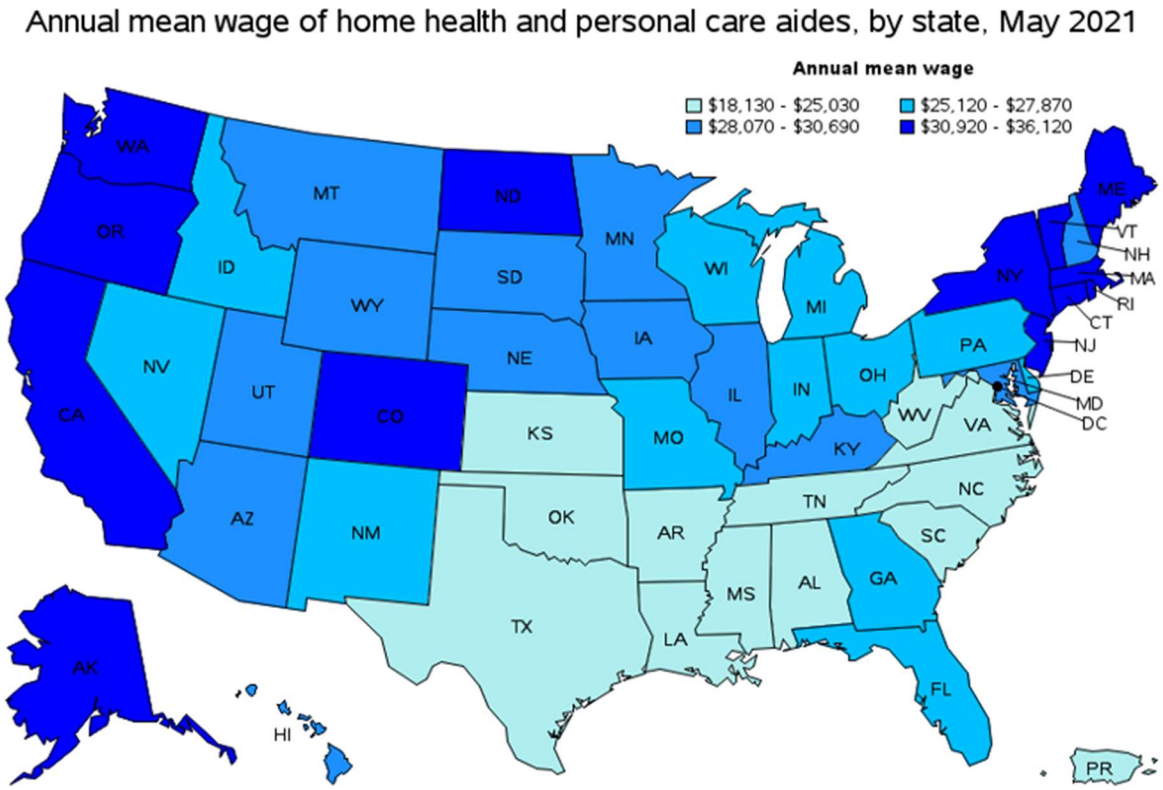
Data Measure	In Michigan	In the U.S.
Median Wage (hourly	$11.85 - $15.18	$13.34
Median Wage (annually)	$24,640 - $31,570	$20,200
% of DCWs that are women	89%	87%
% of DCWs that are people of color	40%	59%
% of DCWs that are immigrants	5%	26%
Turnover Rate	68% for CNAs 89% for PCAs 89% for HHAs *Average across all roles: 75.5%*	35% for CNAs in hospitals 65% for home care workers 90% for caregivers in nursing homes
# of DCW Vacancies	203,900 job openings by 2026 36,000 more needed now	7.4 million from 2019 – 2029

Michigan Direct Care Workforce Demographics*

	All DCWs	CNAs	PCAs	HHAs
Gender				
Female	87%	89%	84%	90%
Male	13%	11%	16%	10%
Race/Ethnicity				
White	63%	62%	63%	62%
Black or African American	29%	29%	29%	30%
Latino or Hispanic	4%	4%	4%	3%
Asian American	2%	2%	1%	1%
Two or more races	2%	2%	2%	3%
Other	1%	1%	1%	0%
Education				
Less than high school	9%	7%	11%	8%
High school diploma or equivalent	34%	31%	36%	34%
Some college	39%	44%	33%	41%
Associate Degree or higher	18%	18%	19%	16%

Source: US Census Bureau. 2019 American Community Survey five-year estimates. *Table adapted from *Rep. Michigan's Direct Care Workforce Living Wage and Turnover Cost Analysis. Public Sector Consultants, August 2021. https://www.chcs.org/media/Michigans-Direct-Care-Workforce-Living-Wage-and-Turnover-Cost-Analysis.pdf.*

DCW Wages and Earnings in the U.S.*



Map created by U.S. Bureau of Labor Statistics. Retrieved from https://www.bls.gov/oes/current/oes311120.htm

DCW Turnover in Michigan (2020) *

	CNAs	PCAs	HHAs	All Direct Care Workers
Turnover Rate	68%	89%	89%	N/A
Jobs	48,610	41,106	27,404	164,712
Turnover occurrences	33,055	36,584	24,390	101,305

Source: EMSI census and proprietary employment data. *Table adapted from *Rep. Michigan's Direct Care Workforce Living Wage and Turnover Cost Analysis. Public Sector Consultants, August 2021. https://www.chcs.org/media/Michigans-Direct-Care-Workforce-Living-Wage-and-Turnover-Cost-Analysis.pdf.*

Behavior Health Workforce Supply and Demand

Behavioral Health Care Provider Supply and Demand in Michigan by Provider Type, 2016 and 2030

Provider Type	Supply (2016)	Demand (2016)	Adequacy (2016)	Supply (2030)	Demand (2030)	Adequacy (2030)
Psychiatrists	1,130	2,020	(890)	940	1,880	(940)
Psychiatric Nurse Practitioners	260	420	(160)	450	440	10
Psychiatric Physician Assistants	70	60	10	90	60	30
Psychologists	2,390	3,790	(1,400)	2,350	3,570	(1,220)
*Social Workers**	*10,280*	*9,210*	*1,070*	*18,590*	*9,370*	*9,220*
Addiction Counselors	1,770	3,370	(1,600)	1,880	3,670	(1,790)
Mental Health Counselors	2,600	5,370	(2,780)	2,890	5,670	(2,780)
Marriage & Family Therapists	1,270	2,020	(750)	1,590	2,040	(450)

Source: HRSA, 2019

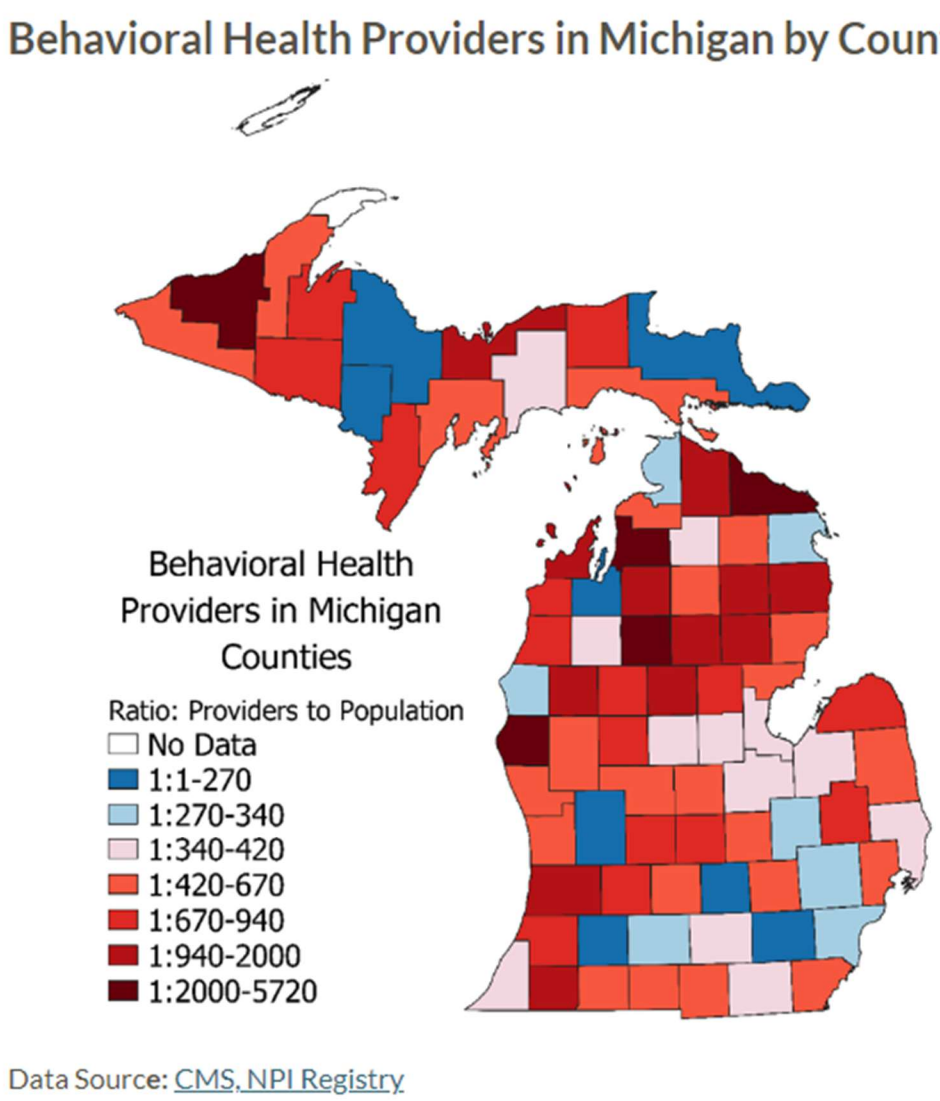
BEHAVIORAL HEALTH Workforce: Employment Numbers and Wages in Michigan (2021)

Occupation	Employment	Hourly Mean Wage	Annual Mean Wage
Clinical and Counseling Psychologists	2,040	$39.40	$81,940
School Psychologists	1,190	$37.72	$78,460
Psychologists, All Other	400	$35.97	$74,810
Marriage and Family Therapists	-	$27.07	$56,300
Rehabilitation Counselors	2,680	$21.82	$45,380
Substance abuse, behavioral disorder, and mental health counselors	8,560	$25.32	$52670
Counselors, All Other	160	$20.80	$43,260
Child, Family, and School Social Workers	13,530	$24.95	$51,900
Healthcare Social Workers	5,530	$28.55	$59,390

Mental Health and Substance Abuse Social Workers	4,070	$25.34	$52,700
Social Workers, All Other	1,130	$29.95	$62,290
Community Health Workers	1,630	$23.04	$47,920
Psychiatrists	500	$120.47	$250,570
Psychiatric Aides	1,260	$19.54	$40,640

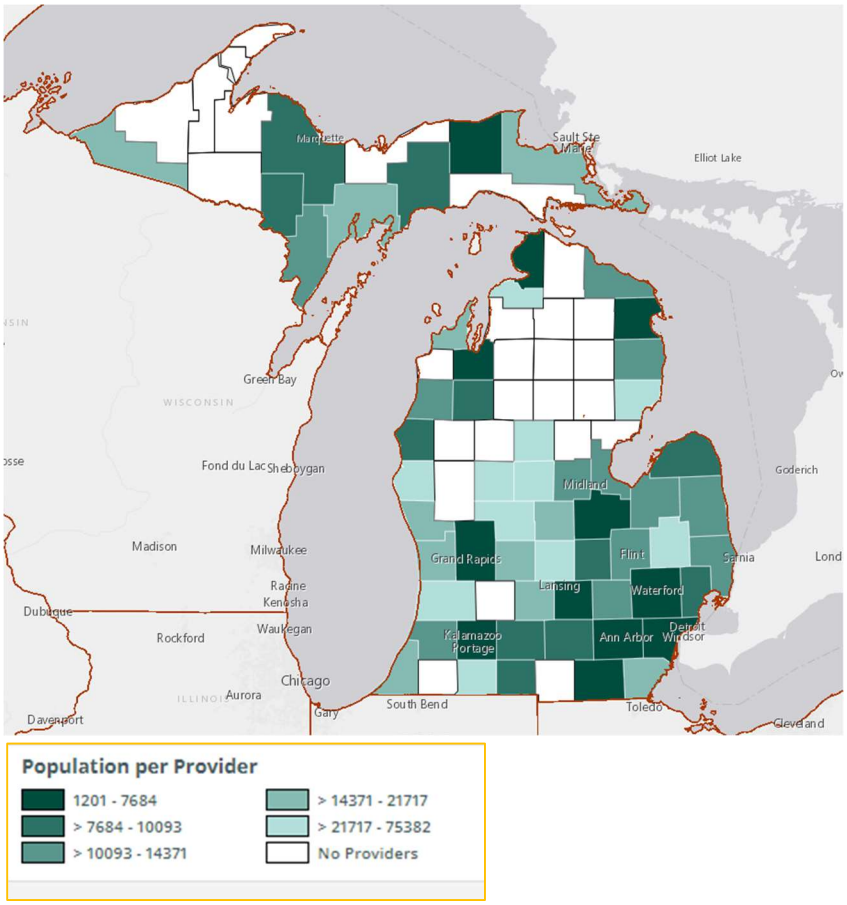
Table adapted from BLS data: https://www.bls.gov/oes/current/oes_mi.htm

Behavioral Health Providers in Michigan by County, 2019



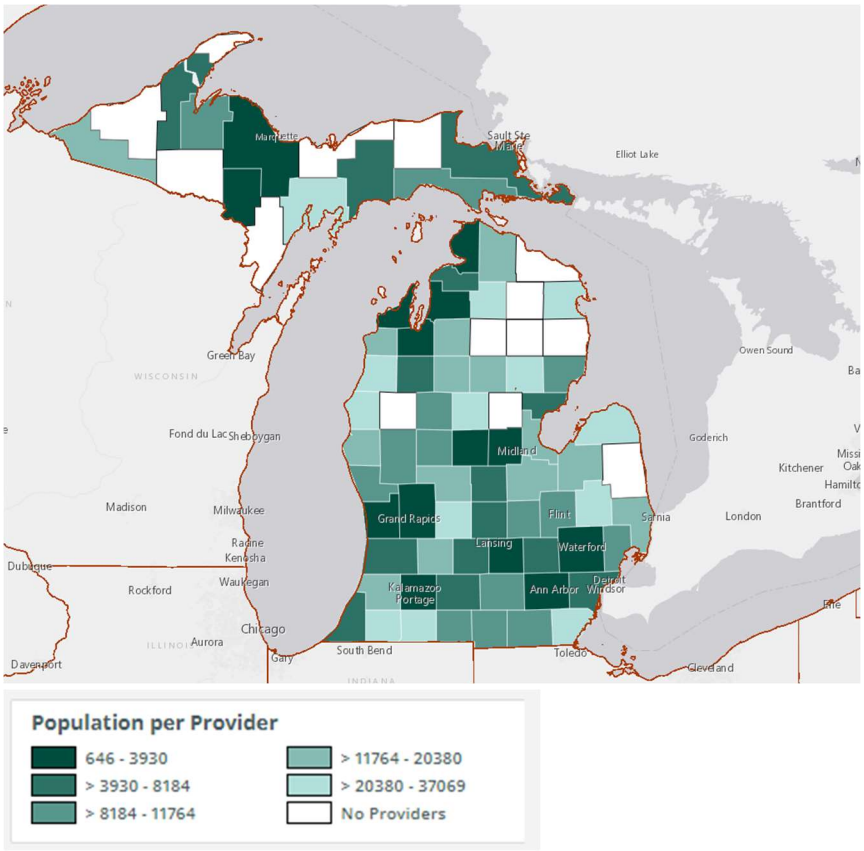
Source: Citizens Research Council of Michigan (https://crcmich.org/michigan-still-falls-short-on-mental-health-services)

Psychiatrists and Addiction Medicine Specialists in MI



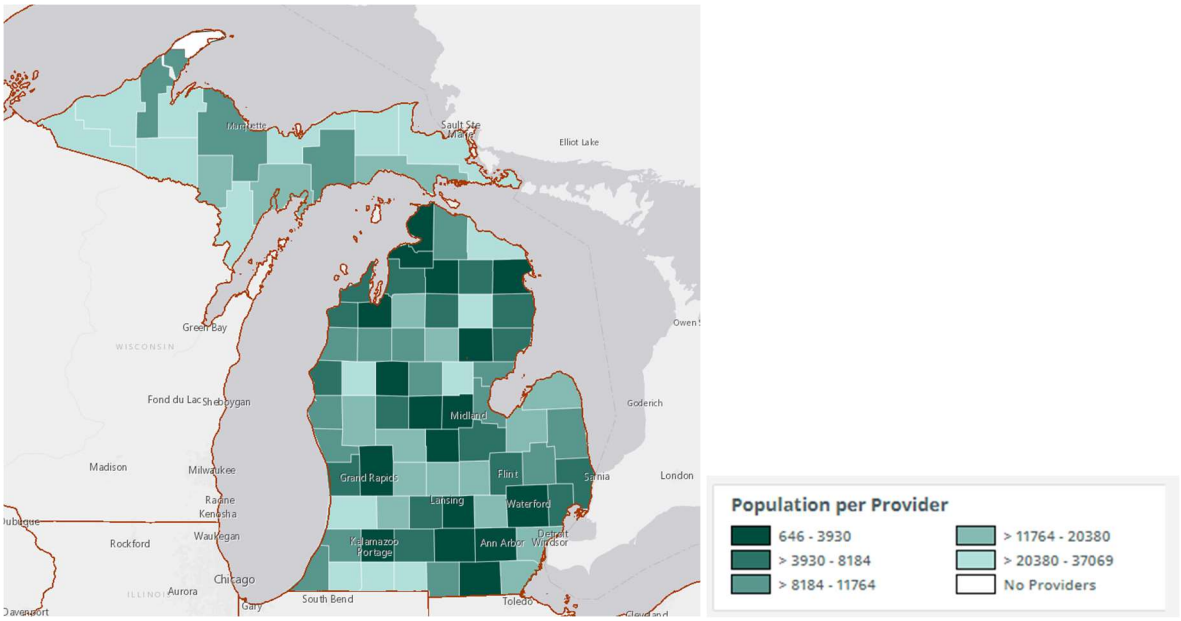
Source: Behavioral Health Workforce Tracker, The George Washington University

Psychologists in MI



Source: Behavioral Health Workforce Tracker. George Washington University

Counselors and Therapists in MI



Source: Behavioral Health Workforce Tracker. George Washington University.

Appendix B: Literature Review Summary

Literature Reviewed	Description	Population of Focus
Altarum and PHI. (2020). Michigan's Long-Term Care Workforce: Needs, Strengths, and Challenges.	Demographic data specific to Michigan's direct care workforce. Provides breakdowns of information based on role.	DCW
Baum, N., King J. (February 2020). The Behavioral Health Workforce in Rural America: Developing a National Recruitment Strategy.	Study on recruitment approaches for rural health and behavioral health providers.	Behavioral Health
Behavioral Health + Economics Network. (2019). Addressing Illinois' Behavioral Health Workforce Shortage.	Fact sheet on behavioral health workforce shortages in Illinois.	Behavioral Health
Bowen Center for Health Workforce Research and Policy. (2020, June). Indiana's Behavioral Health Workforce Report Series - Psychiatrists and Psychiatric APRNs.	Component of the Behavioral Health Data Report Series; highlights key insights and data on behavioral health professionals in Indiana.	Behavioral Health
Brandon, P. (n.d.). Creating Career Paths for Direct Care Workers.	Provides recommendations for investing in direct care worker training and professional development.	DCW
Children and Youth Committee of the Wisconsin Council on Mental Health. (2020, August 6). Mental Health Workforce Principles and Policy Recommendations.	Recommendations on enhancing the mental health workforce serving children in Wisconsin.	Behavioral Health
Citizens Research Council of Michigan. (2022, August). Making Telehealth a Viable Long-Term Option for Mental HealthCare Services in Michigan.	Discusses the use of telehealth when providing behavioral health services.	Behavioral Health
Citizens Research Council of Michigan. (2022, August). Michigan (Still) Falls Short on Mental Health Services.	Highlights challenges and strategies to address behavioral health provider shortages.	Behavioral Health

Colorado Behavioral Health Administration. (September 2022). Strengthening the Behavioral Health Workforce in Colorado: An Approach to Community Partnership.	Strategic plan focused on improving access to care, strengthening the career pipeline for behavioral health providers, removing barriers and reducing administrative burdens.	Behavioral Health
Cunningham, J., Keating, S., Finnegan, D., & Holmes, J. (2022, July 20). Behavioral Health Comparison Rate Development: SFY 2023.	Report for Michigan DHHS on their fee schedule for the state's Medicaid behavioral health managed care program.	Behavioral Health
Fastiggi, B. (2019, January). State of Vermont Workforce Report Fiscal Year 2018.	Report compiled by the Department of Human Resources on the demographics and characteristics of the Vermont workforce during FY 2018.	General Workforce
Frazier, E. R., Sanderson, B., & Loy, J. K. (2021, May). South Carolina Behavioral Health 2021 Progress Report: Successes and Opportunities in Transforming Behavioral Health Care Systems across South Carolina.	Report that highlights specific communities that have come together to address local behavioral health challenges.	Behavioral Health
Green, R. (2022). The Direct Care Workforce Crisis: Factors Affecting Employee Retention and Turnover Amidst a Pandemic.	Provides turnover and demographic data for DCW's across the country. Included recommendations for states to address workforce barriers.	DCW
Goldsby, S., Mount, J., & Sox, H. (2022, June). South Carolina's Guide to Approved Uses for Investing Opioid Settlement Funds.	Resource for state policymakers when addressing opioid settlement funds in South Carolina.	Behavioral Health
Hall, A., Boyd, K., Enemark, D., & Connolly, K. (2022, August). Addressing San Diego's Behavioral Health Worker Shortage.	A needs assessment on behavioral health workforce shortages in San Diego.	Behavioral Health
Health Management Associates and National Council for Mental Wellbeing. (2021, October). Behavioral Health	Brief that offers ways to address the BEHAVIORAL HEALTH workforce shortage at a state policy level.	Behavioral Health

Workforce is a National Crisis: Immediate Policy Actions for States.		
Health Management Associates and National Council for Mental Wellbeing. (2022). Immediate Policy Actions to Address the National Workforce Shortage and Improve Care.	Recommended actions regarding burnout, CCBEHAVIORAL HEALTHC model, measuring causes and the impact of workforce shortages, building a pipeline, and leveraging telehealth.	Behavioral Health
Health Resources and Services Administration. (2020). Behavioral Health Workforce Projections, 2017-2030.	Workforce projections on behavioral health practitioners.	Behavioral Health
Health Resources and Services Administration of the U.S. Department of Health and Human Services. (2022). State Strategies to Recruit and Retain the Behavioral Health Workforce. National Conference of State Legislatures.	Summary of state strategies and policy considerations.	Behavioral Health
Herd, P., Moynihan, D., and Ray, V. (2022, January). Racialized Burdens: Applying Racialized Organization Theory to the Administrative State.	Article that provides a perspective on administrative burden using racialized organization theory. Provided context around equity.	General Workforce
Hostetter, M., Klein, S. (2021). Placing a Higher Value on Direct Care Workers.	Highlights the issues, innovative approaches and policy implications of recruitment and retention practices.	DCW
Hubble, S. (2022). Opinion: Michigan's direct care worker shortage is an emergency.	Article specific to Michigan, discusses the lack of funding allocated to DCWs by the state legislature.	DCW
Hunt, B. (2020, November). Increasing Access to Behavioral Health Care Providers in South Carolina.	High-level overview of the various provider roles within behavioral health and credentialing implications in South Carolina.	Behavioral Health
Impart Alliance. (2021). Some Facts about Direct Care Workers in MI.	Fact sheet on DCW demographics in Michigan, as well as supply and demand, wages, and turnover.	DCW

Koch B, Coates S, Brady B, Peters J, and Derksen D. (2020). The Arizona Behavioral Health Workforce.	A review of the behavioral health landscape in Arizona.	Behavioral Health
MACPAC. (2022). State Efforts to Address Medicaid Home- and Community-Based Service Workforce Shortages.	Issue brief describes DCW issues and the Medicaid levers available to address them.	DCW
McCall, S., Scales, K. (2022). Direct Care Worker Disparities: Key Trends and Challenges.	Speaks to DCWs as a whole across the country, highlights demographic, wage, and turnover data as well as policy recommendations.	DCW
Mercer. (2021). U.S. Healthcare Labor Market Whitepaper.	A study on healthcare labor shortages across the nation and how to address them.	General Workforce
Mette, E., Townley, C., & Purington, K. (2019, November). 50-State Scan: How Medicaid Agencies Leverage their Non-Licensed Substance Use Disorder Workforce.	Analysis on how Medicaid agencies reimburse for SUD services provided by non-licensed workers, training/supervisory requirements for non-licensed staff, and what services they provide and in what settings.	Behavioral Health
Michigan Department of Health and Human Services. (2021, May 31). Report on CMHSPs, PIHPs, and Regional Entities (FY2021 Appropriation Act - Public Act 166 of 2020).	Legislative report that outlines Community Mental Health Service Programs Demographic and Cost Data, along with other required analysis.	Behavioral Health
Michigan Department of Health and Human Services. (2021c, June). Michigan Treatment Workforce Development Report 2021.	Information gathered from a survey of Michigan's SUD treatment workforce.	Behavioral Health
Michigan Health Council. (2021). Health Sights: Behavioral Health July 2021 - September 2021.	Data compiled from online job postings and the Bureau of Labor and Statistics.	Behavioral Health
Milbank Memorial Fund. (2022). Direct Care Workforce Policy and Action Guide.	Offers state strategies at addressing workforce barriers through administrative, funding and policy avenues.	DCW
Minnesota Department of Health Office of Rural Health and Primary Care.	Recommendations provided by the MN Rural Health Advisory Committee	Behavioral Health

(2021). Recommendations on Strengthening Mental Health Care in Rural Minnesota.	on ways to strengthen the behavioral health workforce.	
National Academy of Medicine. (2022). National Plan for Health Workforce Well-Being.	Provides high level recommendations to combat healthcare workforce burnout and turnover.	DCW and Behavioral Health
National Governors Association. (2022). Addressing Wages of The Direct Care Workforce Through Medicaid Policies.	Medicaid State policy approaches to addressing DCW wages.	DCW
The Ohio Council of Behavioral Health & Family Services Providers. (2021, December 20). Breaking Point: Ohio's Behavioral Health Workforce Crisis.	White paper on the causes of the behavioral health workforce shortage in Ohio, with potential solutions and recommendations.	Behavioral Health
Ohio Department of Mental Health and Addiction Services. (2021). Strategic Plan 2021-2024.	OhioMHAS' strategic plan for 2021-2024.	Behavioral Health
Office of the Surgeon General. (2022). The U.S. Surgeon General's Framework for Workplace Mental Health & Well-Being.	Provides a detailed framework for creating workplaces that drive and support well-being for healthcare workers.	General Workforce
O'Connor, J. G., Dunlap, B., Gattman , N. E., & Skillman, S. M. (2020, December). Washington's Behavioral Health Workforce: Barriers and Solutions.	Report that provides background information and recommendations on specific topic areas related to the behavioral health workforce in Washington.	Behavioral Health
Public Sector Consultants. (2021). Michigan's Direct Care Workforce: Living Wage and Turnover Cost Analysis.	Demographic, wage, turnover, and demand data for all DCWs in Michigan.	DCW
Ryan, C., Turner, A., Ehrlich, E., & Stanik, C. (2019, July). Access to Behavioral Health Care in Michigan.	Report that includes methods and analyses to improve BEHAVIORAL HEALTH access in Michigan.	Behavioral Health
Rollison, J. et. al. (2022). An Evaluation of a Multi-Site Health Systems-Based	Data focuses on turnover and retention for DCWs nationwide.	DCW

Direct Care Workforce Retention Program.		
Ryan C, Bergin M, Wells JSG. (2019, March). Work-related stress and well-being of direct care workers in intellectual disability services: a scoping review of the literature.	Literature review synthesizing findings of research related to burnout among DCWs working with intellectually disabled clients.	DCW
Scales, K. (2022). State Policy Strategies for Strengthening the Direct Care Workforce.	Outlines state strategies that are focused on policy.	DCW
Scales, K. (2021). Transforming Direct Care Jobs, Reimagining Long-Term Services and Supports.	Provides a national perspective on wages and demographics.	DCW
Scheyer K, Gilchrist E, Muther J, Hemeida S, Wong SL. (2019, April). Recruitment and Retention Recommendations for Oregon's Behavioral Health Workforce.	Provides evidence-based recommendations on improving the behavioral workforce in Oregon.	Behavioral Health
Substance Abuse and Mental Health Services Administration. (2022). Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies.	Offers interventions to address employee burnout in behavioral health workers.	Behavioral Health
Substance Abuse and Mental Health Services Administration. Behavioral Health Workforce Report.	Report that highlights evidence-based models of care, various healthcare models and the number of providers needed for the models, and supply and demand for each BEHAVIORAL HEALTH occupation.	Behavioral Health
SHRM. (2022, March). Supporting Employee Caregivers.	Provides data on employee caregivers and potential benefits and supports employers can provide to employee caregivers.	DCW
U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation, Disability, Aging and Long-	Examines billing eligibility and reimbursement for SUD treatment services across Medicaid, Medicare, and commercial insurance plans.	Behavioral Health

Term Care Policy. (2019, November). Credentialing, Licensing, and Reimbursement of the SUD Workforce: A Review of Policies and Practices Across the Nation.		
Vigna, A. (2020, August). 2019 Wisconsin Behavioral Health System Gaps and Report.	Report with data gathered from key informant interviews, surveys, and consumer focus groups on gaps that exist in Wisconsin's current behavioral health system.	Behavioral Health
Wenger, E., McDermott, R., and Snyder, W. (2002). Cultivating Communities of Practice: A Guide to Managing Knowledge – Seven Principles for Cultivating Communities of Practice.	Highlights expertise and guidance authors offer in the book of the same name.	General Workforce
Werner, M., Shunkweiler, T., Rutherford Self, T. (February 2023). Identifying bottlenecks and roadblocks in the rural mental health career pipeline.	Discusses the behavioral health landscape in rural MN.	Behavioral Health
Wikle, S., Wagner, J., Erzouki, F., Sullivan, J. (2022, July). States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity.	Article articulating how administrative burden exacerbates inequity, and steps states have and can take to reduce those burdens.	General Workforce
Wisconsin Hospital Association. (2022, March). Wisconsin 2022 Health Care Workforce Report.	Annual report from the Wisconsin Hospital Association that provides analysis and recommendations on the current workforce.	General Healthcare Workforce
Wisconsin Office of Children's Mental Health. (2021, February). Supporting Child Well-Being Through Addressing Shortages in the Mental Health Workforce.	Factsheet on mental health workforce shortages in Wisconsin.	Behavioral Health

Yeatts, DE., Seckin, G., Shen, Y., Thompson, M., Auden, D., Cready, CM. (2018). Burnout among direct-care workers in nursing homes: Influences of organizational, workplace, interpersonal and personal characteristics.	Journal article detailing a study of 410 direct care workers in 11 Texas nursing homes and reported factors associated with workplace burnout.	DCW
Zhu, J. M. et. al. (2022, February 1). Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature.	Findings and recommendations on improving outcomes for populations needing behavioral health care.	Behavioral Health
Zivin, K. et. al. (2022, March 1). Relationships between work–environment characteristics and behavioral health provider burnout in the Veterans Health Administration. Wiley Online Library.	Examines burnout and work-environments specifically related to the Veterans Health Administration.	Behavioral Health

Appendix C: Small Group Discussion Guide (Employers/Employees)

Topical Questions

To start, can you tell us about your position/role as part of the direct care workforce?

How long have you been in this role?

What drew you to the healthcare field and your position?

What observations have you made about the landscape/conditions of Michigan's direct care workforce over past few years? Let's create a list of what you've seen.

What is keeping you at your current position in the direct care workforce?

If you held previous positions, what did you like/what worked well in those positions you've held?

Have you considered making a job change? If so, why?

Would you stay in direct care work, look for a job more widely in healthcare, or leave healthcare altogether?

Key Questions

What would you need to feel supported by your employer in a direct care position? What are some of the biggest challenges the sector has faced in meeting DCWs' needs?

How have workforce shortages impacted your role?

What staffing shifts have you noticed in your direct care peers?

Have you observed some positions experiencing more shortages than others? What are those positions and why do you think this might be the case?

What do you think might attract new talent to the direct care positions? Let's create a list of those ideas. Is there anything that could be done with:

- Regional recruitment initiatives?
- Telehealth?
- Training/mentoring to create job paths (i.e., pipeline)?
- Cultural/linguistic training?
- Additional benefits – PTO, childcare stipends, transportation, etc.?
- Creative scheduling solutions?
- Anything to address burnout?

Of the ideas listed, which should decision makers prioritize? Which ones will be easier to accomplish?

Wind Down

Is there anything MDHHS could do to better support direct care workforce needs?

Is there anything else you would like to share that you didn't have a chance to?

Is there anything else we didn't bring up that we should be aware of?

Appendix D: Behavioral Health and Direct Care Workforce Questionnaire

Prescreen Email Invitation

The Michigan Department of Health and Human Services is conducting an analysis of Michigan's behavioral health and direct care workforces. If you are interested in participating in a small-group discussion via Zoom, please take this brief questionnaire to help us plan the most effective discussion.

If selected to participate, you will then receive a calendar invitation with the Zoom call details. In the meantime, please reach out to Erin Lammers at elammers@publicsectorconsultants.com with any questions you may have.

Employees: Small-group Discussion Prescreen Survey

The Michigan Department of Health and Human Services has engaged Public Sector Consultants (PSC), a nonpartisan public policy firm based in Lansing, to conduct an analysis of Michigan's behavioral health and direct care workforces.

PSC is conducting small-group discussions with behavioral health or direct care professionals as well as leadership at places that employ these professionals, such as hospitals, health centers, nursing homes, aging service providers, and more. Please complete this brief questionnaire and, if you qualify, you will be invited to join a 90-minute group discussion. If you are selected, you will be invited via email to participate. If you participate in one of these focus groups, you may qualify for a stipend.

Survey Questions

1. Do you have access to a stable internet connection and a device you can use to participate in a virtual video call?

    a. Yes
    b. No [If no, end the survey]

2. First name
3. Last name
4. Email address

    a. Confirm email address

5. Select which of the following options best describes your current role in the healthcare or direct care workforce.

    a. In-home caregiver or respite staff
    b. Residential nursing care aide
    c. Personal care aide or community-living support staff
    d. Certified nursing assistant
    e. Behavioral health technician or clinician

f. I am not currently employed

6. If you have worked in other roles in the past, select as many of the following options that best apply to your experience:

   a. In-home caregiver or respite staff
   b. Residential nursing care aide
   c. Personal care aide or community-living support staff
   d. Certified nursing assistant
   e. Behavioral health technician or clinician

7. Which of the following types of employers best describes your current or most recent employer?

   a. Behavioral health service provider
   b. Hospital
   c. Health center
   d. Nursing home
   e. Aging services provider
   f. Other

8. The video call will take place on:

   a. [If they answered a to question 5] Monday, February 6 from 7:00–8:30 PM
   b. [If they answered b to question 5] Tuesday, February 14 from 7:00–8:30 PM
   c. [If they answered c to question 5] Thursday, February 16 from 7:00–8:30 PM
   d. [If they answered d to question 5] Wednesday, February 8 from 7:00–8:30 PM
   e. [If they answered e to question 5] Thursday, February 9 from 9:00–10:30 AM

9. Are you able to participate during the scheduled time?

   a. Yes
   b. No

10. [If 9b] Select which days of the week work best for you to join a virtual video call.

    a. Monday
    b. Tuesday
    c. Wednesday
    d. Thursday
    e. Friday
    f. Saturday
    g. Sunday

11. [If 9b] Select which times of the day work best for you to join a virtual video call.

    a. 8:00 AM–12:00 PM
    b. 12:01–5:00 PM
    c. 5:01–9:00 PM

Demographic Information

12. What county do you live in?
13. [13–15 are optional] Gender

    a. Female
    b. Male
    c. Transgender male

d. Transgender female
e. Gender variant/nonconforming
f. Prefer to self-describe: ____
g. Prefer not to answer

14. Age

a. 0–17
b. 18–24
c. 25–34
d. 35–44
e. 45–54
f. 55–64
g. 65 or older

15. Race

What is your race? Select all that apply.

a. American Indian or Alaska Native
b. Arab American
c. Asian
d. Black or African American
e. Native Hawaiian or Other Pacific Islander
f. White
g. Some other race

16. Ethnicity

Are you of Hispanic or Latino origin?

a. Yes
b. No
c. Prefer not to answer

Survey Complete/Thank You

Thank you for completing the survey! Your response was successfully submitted.

Appendix E: Email Language from Partners to DCW Contacts

Subject: MDHHS Wants to Hear from DCWs

Direct care workers, we want your input!

To help improve working conditions for direct care workers (DCWs), the Michigan Department of Health and Human Services (MDHHS) has partnered with Public Sector Consultants (PSC) to figure out what DCWs need, how DCWs are affected by workforce shortages, and ways to fix these challenges.

PSC is hosting 90-minute small group discussions on Zoom where you can share your ideas and experiences. If you want to participate, please fill out this questionnaire to help us plan the most effective discussion. The questionnaire may take around five minutes to finish.

If you qualify to participate, you will receive an email with the Zoom call details. In the meantime, please reach out to Erin Lammers at elammers@publicsectorconsultants.com with any questions you may have.

Sincerely,

[Organizational partner signature]