Evaluation of Interventions to Improve Recruitment and Retention: Summary of Results

For the Washington State Home Care Quality Authority

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About SESRC

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INTRODUCTION

INTRODUCTION

In 2004, the Home Care Quality Authority (HCQA) received funding to improve the recruitment and retention of in-home care service workers participating in Washington's "individual provider" program. Several initiatives were eventually implemented, drawing on both federal and state funding. The single most expensive new initiative was the availability of subsidized health insurance to individual providers who meet eligibility criteria. Several other initiatives were also implemented, some in only specific regions of the state. At the same time, wage levels were also increased.

HCQA contracted with Washington State University's Social and Economic Sciences Research Center (WSU-SESRC) to conduct an evaluation of the initiatives. At the time the evaluation was designed, health care was viewed as the most significant intervention; therefore, the evaluation design focused on assessing the effects of health care coverage.

This was a multi-pronged evaluation, encompassing multiple components:

- A telephone survey of individual providers who joined the program after health insurance coverage became available
- Baseline and follow-up web surveys of case managers
- Analysis of data from the Social Service Payment System (SSPS) and wages and hours from the Unemployment Insurance files

During the same timeframe, WSU-SESRC analyzed data from HCQA's periodic surveys, which provided further context for this study's research questions.[1] These surveys were:

- A mail survey of individual providers (IP's)
- A mail survey of in-home care service recipients (consumer/employers)

This report summarizes the evaluation results in an attempt to answer the question: Did the availability of health care benefits improve recruitment and retention of IP's in Washington State?

BACKGROUND

The prevailing method for public provision of in-home personal care for aged and persons with disabilities in the US has been through state agency contracting with local home care agencies. Starting in 1983 with Medicaid waiver programs, Washington State has developed an alternative system in which the recipients of care, or their guardians, contract directly with individual providers, using public funds. The state has standardized many features of the process so that the administrative burden for care recipients who become employers is not excessive. In Washington State, the individual provider option

[1] The execution and analysis of biennial mail surveys were funded through separate, state funds. Each of the surveys is also covered in its entirety in a separate report.

coexists with a continuation of the traditional agency care model. Recipients of services have both options: they can contract directly with an IP or receive care through an agency which contracts with a state or regional public agency.

Because a relative of a care recipient can serve as an individual provider to that recipient, the individual provider workforce can be viewed as consisting of two separate components: IP's providing services for family members ("family providers") and IP's providing services for non-family members ("non-family providers"). Family providers comprise about 65 percent of the individual provider workforce.[2]

While HCQA is responsible for managing some aspects of the individual provider program, the state's Office of Financial Management is ultimately responsible for the collective bargaining agreement for IP workers. In addition, the public programs under which IP's are paid are operated by the Department of Social and Health Services (DSHS), through its Aging & Disability Services (ADSA), the Developmental Disabilities Division (DDD), a division of ADSA, and the Children's Services Administration (CSA)..

Changes in IP Employment Benefits

During this study, there were several important changes in the employment benefits offered to IP's. While they were not all funded through the grant, they occurred in a similar timeframe and are all included in the discussion of interventions in the Results section of this report. These included changes not only in health insurance coverage but also in worker's compensation coverage, paid leave, and wage levels.

Health Insurance Coverage

Prior to 2005, health insurance coverage was available to a relatively small number of IP's through the Basic Health Plan (BHP). This program provides insurance coverage to low-income persons throughout the state. Eligibility was based on income level, and the program has frequently had caps on the number of enrollees. While some IP's could qualify for the BHP, many were not eligible. The program features small monthly premiums, patient co-payments and a modest deductible. It includes family coverage but does not provide vision or dental benefits.

Starting in January 2005, health insurance coverage became available to all IP's under a Taft-Hartley Trust established through collective bargaining – the SEIU 775 MultiEmployer Health Benefits Trust (hereinafter "Trust"). The Trust is a comprehensive medical plan that includes dental and vision benefits. It features small enrollee premiums, some patient co-payments and no deductible. It does not include family coverage. To be eligible, the IP must have been working for at least three months, must work at least 86 hours per month, and with limited exceptions under the law, must not be eligible for other sources of health insurance.

[2] Family and non-family providers can differ in their reasons for joining and remaining in the field so they are discussed separately, as appropriate throughout this report.

Worker's Compensation Insurance
Through collective bargaining, all individual providers received workers compensation insurance coverage which provides medical and time-loss benefits for on-the-job injuries, starting October 1, 2004.

Paid Leave
Paid leave was also negotiated in the bargaining agreement, with accrual of leave credit starting in the summer of 2006.

Wage Increases
In the 4th quarter of 2004, IP wages increased from $8.43 per hour to $8.93 per hour. Further wage increases were implemented in the 3rd quarter of 2006 and again in the 3rd quarter of 2007. Those later increases were not considered in this report because they occurred after the data collection phase of the evaluation.

Home Care Referral Registry of Washington State[3]

Another initiative that started during the timeframe of this study was the Home Care Referral Registry of Washington State (hereafter referred to as "Referral Registry"). The Referral Registry was implemented through a phased geographic roll-out, from January 2005 to September 2006. Therefore, some counties had access to the Referral Registry for longer than others.

The Referral Registry provides a service for matching consumer/employers with IP's. It can be accessed via telephone or the internet. The goal of the Referral Registry is to ease the process of matching IP's with consumer/employers and to facilitate better quality matches that will be long-lasting, positive experiences for both parties.

[3] The Home Care Referral Registry of Washington State was previously referred to as "Referral and Workforce Resource Centers".

METHODOLOGY

This evaluation included multiple components. An overview of each is provided below. More detailed information on each of the surveys is available in separate reports.

Telephone Survey of New Individual Providers

The main purpose of surveying new providers was to determine the role employment benefits played in individual providers' decisions to join the field (recruitment), and to remain in the field (retention). The survey protocol was designed in collaboration with HCQA management, with review by the Washington State Department of Social and Health Services (DSHS).

The survey focused on individuals who were issued their first paycheck as an IP between October of 2005 and March of 2006 and were still being paid as an individual provider in March of 2006. The survey was offered in English, Spanish, and Russian.

The interviews were conducted from the Public Opinion Laboratory of WSU-SESRC between the dates of June 21st and July 9th, 2006. Out of a pool of 698 randomly-selected individual providers, 286 surveys were completed and one survey was partially-completed, for a response rate of 42 percent (287/688).[4]

Web Surveys of Case Managers

This was a series of two web surveys: a baseline survey conducted in March-April of 2005 and a post-implementation survey conducted in April-May of 2006. The main goal of these surveys was to determine if case managers were aware of any difference in the ease of finding individual providers and if they saw an increase in the pool of available individual providers in the follow-up survey. The case manager survey was developed in conjunction with HCQA and incorporated input from managers at Home and Community Services (HCS), Division of Developmental Disabilities (DDD), and Area Agencies on Aging (AAA).

In both rounds of the survey, case managers were invited to participate via an email distributed by the administration of each agency. Respondents could either complete the survey over the Internet (via a link in the email) or request a printed survey. Response rates were 14 percent (N=144) for the first survey and 15 percent (N=153) for the second survey.

Analysis of Social Service Payment System (SSPS) and Employment Security Department (ESD) Data

SSPS is the central DSHS system for authorizing and issuing vendor payments for a wide range of non-medical services to clients.

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[4] . Ten respondents were removed from the sample because they were no longer working as individual providers.

The SSPS data was provided in a monthly format, covering November 2003 to March 2006, and the ESD data was in a quarterly format, covering Q3 2003 to Q2 2006. Since the health insurance coverage became available in January 2005, the pre-intervention and post-intervention periods were assigned as follows:

- SSPS: Pre-period, January-December 2004. Post-period, February 2005-January 2006.
- ESD: Pre-period, Q1-4 2004. Post-period, Q2 2005-Q1 2006.
- Each period was a full year in order to minimize any seasonal effects.

The data analysis examined the following indicators:

- Average monthly turnover rates
- Average monthly percentage of IP's who also maintain employment outside their individual provider work
  - The distribution of industries in which providers maintain outside employment concurrent with their IP work
- Average monthly percentage of IP's leaving work as individual providers
  - The distribution of industries in which providers chose to work after leaving the industry

Unfortunately, some obvious measures of recruitment and retention were impossible to run due to limitations in the data. For instance, the datasets did not include an indicator of consumer/employer authorizations to receive services, only whether or not they actually received services. This means that there was no way to measure unmet demand (consumer/employers who were authorized for services but were unable to find an IP.) Likewise, IP's who were eligible and searching for work were not included. IP's do not become a part of the reporting system until they have a contract with a consumer/employer and have begun to provide services. Therefore, there was no way to measure the size of the pool of available IP's. Similarly, there is no way to differentiate between an IP voluntarily taking a break and one actively looking for work.

Mail Surveys

As mentioned above, the mail surveys of IP's and consumer/employers were not conducted specifically as part of this evaluation. They are conducted regularly on two to three-year cycles, which happened to coincide with the data collection for this evaluation. While they do not have pre-post data to contribute to the discussion of the efficacy of the interventions, they do provide interesting context.

Individual Provider Mail Survey

The survey protocol was developed in close collaboration with HCQA managers and with review and input from the Washington State Department of Social and Health Services (DSHS) and the Service Employees International Union (SEIU).

HCQA coordinated with DSHS in randomly selecting a sample of 3,000 individual providers. On September 18th, 2006, the surveys were mailed, and reminder postcards

were sent out two weeks later. The survey closed on October 30th, with 793 returned surveys and a response rate of 26 percent.

Consumer/Employer Mail Survey

The survey protocol was developed in close collaboration with HCQA managers and with review and input from DSHS. The cover letter was signed by both HCQA and DSHS.

In addition, the survey protocol included questions drawn from a nationwide survey of in-home care consumers sponsored by RAND as part of the national-level grant evaluation. In order to avoid confusion and possible survey fatigue among the Washington state personal care consumers, the necessity of a separate survey by RAND was avoided by incorporating many of their questions in this survey and sharing those survey results with them.

HCQA coordinated with DSHS in randomly selecting a sample of 3,000 consumer/employers who were receiving services under the state's Medicaid waiver funded through DSHS. On August 14th, 2006, the surveys were mailed, and reminder postcards were sent out two weeks later. The survey closed on September 25th, with 672 returned surveys, a response rate of 22 percent.

EVALUATION RESULTS

A major purpose of the program initiatives was to improve recruitment and retention of IP's in Washington State. The data collection process for this evaluation amassed an extensive knowledgebase of input from IP's, consumer/employers, and case managers as well as analysis of employment and payment data. The goal of this report is to provide a summary of the evaluation results as they relate to changes in recruitment and retention before and after the implementation of the initiatives. For a broader view of the in-home health care system in Washington State, please see the separate reports of each survey component.[5]

This report will first address how the initiatives affected the likelihood that IP's who were already in the field would remain (retention). Next, it will explore how the initiatives affected the recruitment of new IP's to the field.

Previous research has shown substantive differences between family and non-family IP's, such as differing motivations for joining and remaining in the field. Therefore, many of the research results are presented separately for these two populations.

RETENTION

Overall, it appears that the stability of the workforce has improved and that IP's are less likely to leave the industry following the implementation of several initiatives during the study timeframe. There are many different ways to measure workforce stability and retention rates. The factors considered in this report include the following:

- Turnover rates
- Percentage of IP's leaving the industry
- Percentage of IP's who also maintain employment outside their IP work
- Among IP's new to the field, if they perceive that the interventions would make them more likely to remain in the field.
- Among a sample of all IP's, if they plan on remaining in the field

One way to measure workforce stability is turnover rates: the percentage of consumer/employers experiencing a change in IP. Average monthly turnover declined after the interventions, from 1.53 percent to 1.27 percent. This decline was statistically significant for consumer/employers with family providers as well as those with non-family providers.[6] As expected, turnover was higher among those with non-family providers.

Another measure indicating that retention has improved is the annual percentage of IP's leaving the industry. After the interventions were implemented, the percentage of IP's

[5] Please note that the analysis of employment and payment data is only presented in this summary report. Detailed tables of the employment and payment data analysis are included in Appendix B.
[6] Two-sample test: data were insufficient for a time series test. Please see the Appendix for details on this and other measures.

exiting the industry declined from 10.36 percent to 8.90 percent. This decline was statistically significant.

Among the IP's who left the field, there was interest in their employment after they stopped working as an IP. The most common field to which exiting IP's transferred was health care (21%), followed by social assistance (13%), retail trade (11%), education services (9%), administrative, support, remediation, and waste management services (9%), and accommodation and food services (8%).

It appears that most of the exiting IP's who moved into the health care and social assistance sectors continued to work with the same population (the elderly and persons with disabilities). In the industry codes used in Unemployment Insurance records (NAICS), the health care sector is narrowly defined to include employees with specific health care credentials and those working in medical offices. [7] The most common NAICS codes within health care were "home health care services", "nursing care facilities", and "homes for the elderly." In the social assistance sector, the most common NAICS code was "services for the elderly and persons with disabilities".

One hypothesis tested in this study was whether transfers to other positions in the health care field would decline after health insurance became available. The assumption behind this hypothesis is that before the interventions, IP's who wanted to stay in the health care field but needed health insurance coverage would transfer to other positions in the health care field. After health insurance coverage became available, these transfers would decline because IP's would not need to move to another position solely to obtain health insurance.

There was a decline in the percentage of IP's transferring to other positions in the health care field. While this change was in the expected direction (a decline), it was not statistically significant.

Nevertheless, there were statistically significant changes in the percentages of exiting IP's transferring to two different career fields: an increase in transfers to jobs in social assistance and a decrease in transfers to agriculture, forestry, fishing and hunting (hereafter referred to as "agriculture"). The percentage of exiters transferring to positions in the social assistance field increased from 12.57 to 12.90 percent.[8] The percentage of exiting IP's transferring to professions in agriculture declined from 2.81 to 2.15 percent.[9]

The decline in transfers to agriculture may be because most entry-level positions in the agriculture field do not offer health insurance so these positions became less attractive

[7] The health care and social assistance fields are grouped in the same North American Industry Classification System (NAICS) sector. For the purposes of this study, health care fields were designated by NAICS codes beginning with 620, 621, 622, and 623, and social assistance NAICS were assigned to codes beginning with 624.

[8] The change in the percentage of exiting IP's transferring to social assistance professions was significant at the .05 level.

[9] The reduction in the percentage of IP's shifting to employment in agriculture was significant at the .01 level.

after health insurance coverage became available to IP's. It is unclear why there was an increase in the proportion of exiting IP's transferring to the social assistance field.

In addition to reviewing IP transfers to other fields, the analysis also explored whether IP's combined their work as an IP with outside employment. Before this study began, anecdotal evidence suggested that some IP's were combining their employment as an IP with outside employment in order to receive health insurance coverage. It was hypothesized that once health insurance coverage was available to IP's, there would be a decline in the number of IP's who were simultaneously employed outside the IP field.[10] For instance, if an IP held a second job in order to obtain health insurance, they would no longer need the second job after health insurance became available through their position as an IP.

In fact, the percentage of IP's with outside employment *increased* after the interventions, and this increase was statistically significant.[11] In the pre-period, an average of 37.84 percent of the IP's who provided IP services in all three months of each quarter were simultaneously employed outside of the IP field. This rose to 39.16 percent in the post-period.

The increase in outside employment was seen in both family and non-family providers, though only the changes in the rates of the non-family providers were statistically significant. In general, non-family providers were more likely to have outside employment than family providers, both before and after the health insurance benefit was added.

It is unclear why the rates of concurrent outside employment rose between the pre and post periods. This finding suggests that health insurance coverage is not the primary reason that some IP's combine their jobs with outside employment.

Among IP's with outside employment, the largest share of them found their other employment in the health care sector (19%). Most often, this consisted of jobs where they continued working with the same population (elderly and persons with disabilities). Other sectors accounting for at least 5 percent of the IP's with outside employment included education services (12%), social assistance (8%), manufacturing (8%), accommodation and food services (8%), and administrative, support, remediation, and waste management services (8%).

In addition to reviewing employment data, data was also gathered directly from the IP's, through telephone and mail surveys. The telephone survey asked IP's who were new to the field how the availability of health insurance and worker's compensation insurance would affect their decisions to continue working as an IP. About one in three respondents (32%) reported that the availability of health insurance would make them more likely to

[10] The number of IP's with multiple employers was calculated as the number of IP's who provided IP services in all three months of the quarter and also had employment outside of class code 119 in that same quarter divided by the number of IP's providing services in all three months of the quarter.
[11] The increase in IP's with outside employers was significant at the .01 level.

stay in their line of work. About one in five respondents (21%) stated that the availability of worker's compensation insurance would influence them to continue working as an IP.

The availability of these employment benefits had a stronger positive influence on the retention of non-family providers than family providers. Thirty-seven percent of the non-family providers and 29 percent of the family providers reported that the availability of health insurance would make them more likely to stay in their line of work. About one-quarter (24%) of the non-family providers and 19 percent of the family providers reported that the availability of worker's compensation insurance would positively influence their decision to continue working as an individual provider.

The mail survey of IP's was not conducted specifically to be a part of this evaluation. (It is administered on a two- to three-year cycle, which coincided with this study.) Though it was not designed to measure the efficacy of the interventions, it offers interesting context for the discussion on retention.

Overall, 8 percent of the mail survey respondents indicated that it is likely they will actively look for a non-individual provider job in the next year. The most common factors that IP's reported would influence them to stay in the field were higher wages, more paid hours, or a friend/family member needing care. Hourly wages for IP's did increase in 2004, but apparently IP's still viewed the wage level as a barrier to remaining in the field.

RECRUITMENT

Recruitment was harder to measure than retention, due to limitations in the data, so the effects of the initiatives weren't as clear. Nevertheless, there are indications that the initiatives had a positive effect on recruitment.

The evaluation component bearing most directly on recruitment issues was the telephone survey of new providers.[12] For each employment benefit, the respondent was asked…

- if they were aware of the benefit before joining the field,
- if so, to what extent the availability of the benefit affected their decision to join the field

In order for the employment benefits to affect individual providers' decisions to join the field, they would have to be aware of the benefits before joining the field. Overall, respondents had low awareness of the benefits before they started to work as an IP. Health insurance had the highest level of awareness (16%), followed by workers' compensation insurance (9%).

Of the respondents who were aware of the employment benefits before joining the field, health insurance positively influenced over one-third of the group (35%) in their decision to become an individual provider. Workers' compensation positively influenced one-quarter (24%) of the group. There were no strong differences between family and non-family providers in the recruitment effect of the benefits.

Although wage increases for IP's were not explicitly part of the state's package of interventions discussed in the federal grant application, hourly wages have increased through collective bargaining during the same time period as the implementation of the other employment benefits. Therefore, hourly wages were included in some questions regarding perceived incentives to join the profession. Respondents were asked how the hourly wages affected their decision to become an individual provider. The response options were "a very positive factor", "a somewhat positive factor", "a somewhat negative factor", "a very negative factor", or "not a factor at all".

The most common responses were that the wage level was "a somewhat positive factor" for about one-third of the respondents (34%) and "not a factor at all" for another third of the respondents (32%). The family providers were slightly more likely to state that the level of wages was not a factor in their decision to become an IP (family providers: 34%, non-family providers: 28%). The non-family providers were more likely to indicate that the hourly wages were a negative factor (non-family providers: 28%, family providers: 11%).

[12] The phone survey respondents had been employed as individual providers for six months or less at the time of the survey.

While some of the IP's perceived the employment benefits as having positively influenced them to join the field, employment benefits were not generally cited as being the *main* reason for joining the field. In the 2006 IP mail survey, the respondents delineated their motivations for joining the field. The most common reasons were that a friend or family member needed care (family providers: 97%, non-family providers: 77%), it gave them personal satisfaction (family providers: 86%, non-family providers: 90%), and they could work a flexible schedule (family providers: 78%, non-family providers: 87%). About two-thirds of the family providers indicated that they would do the work whether they were paid or not (family providers: 66%, non-family providers: 42%). It appears that while employment benefits have a role in recruiting new IP's to the field, other factors play a much bigger role.

When the evaluation process began, it was assumed that the main reason for consumer/employers having difficulty in finding an IP was the lack of a sufficient pool of available IP's. Thus, improved recruitment incentives were expected to make finding an IP easier. Case manager survey responses provided some insight into the process of finding an IP. This process of consumer/employers and IP's finding each other is much more complex than a simple economics problem of balancing supply and demand.

Factors that can make finding an IP difficult include the following: scheduling, transportation, trust issues, consumer/employer expectations, consumer/employer confusion over the search process or willingness to participate in the search process, consumer/employer family dynamics, IP confusion over DSHS bureaucracy, finding IP's with specialized skills, difficulties with the background check and contracting process, language barriers, consumer/employers' preferences for an IP of a certain gender/ethnicity/religion/culture, individual providers' preference for a certain type of consumer/employer, and a lack of IP's in rural areas. In addition, it appeared that there was confusion in the administering DSHS agencies regarding the appropriate role of program staff in supporting matching between IP's and consumer/employers .

It was hypothesized that the Referral Registry would improve the process of matching consumer/employers and IP's and thereby decrease turnover rates through facilitating better quality matches. Survey questions regarding the Referral Registry were included in all of the evaluation components.

Generally, awareness of the Referral Registry was fairly low among consumer/employers (22%) and IP's (21%). Due to the geographic roll-out of the Referral Registry, there was some confusion about whether the Referral Registry was available in the respondents' county at the time of each survey. Responses to the open-ended questions indicated that interest in using the Referral Registry was high, especially among non-family providers and consumer/employers with non-family providers.

However, while interest was high, actual usage of the Referral Registry was so low among survey respondents (IP's: 5%, consumer/employers: 8%) that the Registry did not have any detectable effect on the overall retention rates. It appears that the data collection

phase of this research occurred too close to the initiation of the Referral Registry to measure effects on retention.

One unexpected anecdotal finding from a number of sources was that the Registry was being used as a "last resort" when the IP, consumer/employer, or case manager was unable to find an appropriate match through other sources. This has interesting implications for future research because it means that the population of consumer/employers and IP's using the Referral Registry may not be representative of the general population; these may be "hard to place" cases with special needs. The role and effectiveness of the Referral Registry deserve future research.

The mail survey of consumer/employers in 2006 suggested that finding a new IP was still a difficult process for most consumer/employers. Roughly one-third of the survey respondents indicated that they had changed their IP in the previous year (31%). Within this group, over half (56%) reported that it was "very" or "somewhat" difficult to find someone new. About one-quarter (26%) indicated that it was "very" or "somewhat" easy to find a new IP, and the remainder were neutral or didn't know.

Consumer/employers with a family provider were more likely to be at the extremes of the scale, reporting that finding a new IP was "very difficult" (family providers: 44%, non-family providers: 34%) or "very easy" (family providers: 23%, non-family providers: 19%). A possible explanation is that there may be two subgroups among the respondents with family providers: those who have a family provider because they were unable to find a non-family provider who met their needs, and those whose first choice was a family provider.

Previous research demonstrated that an area of concern was how often consumer/employers were going without services for a period of time because of the inability to find an IP. Analyzing these gaps in service was another approach selected to look at the efficiency of the IP marketplace: are consumer/employers able to find an IP when they need one?

Attempting to measure gaps in services is a challenging topic because it touches on the interaction between regular IP services, respite (short-term) IP services, and agency services. Comments from surveyed caseworkers suggested that in many cases, when a consumer/employer is unable to find a replacement IP, either respite or agency services fill the gap. However, no empirical research had been done on this phenomenon.

We examined gaps in services in several ways in order to explore whether consumer/employers were without any paid services or whether those gaps were filled by a respite or agency provider. Due to limitations in the data, gaps were defined as a consumer/employer not receiving paid services for between 30 and 60 consecutive days. Gaps shorter than 30 days or longer than 60 days were not included in this analysis.[13]

[13] The limitations of the monthly administrative data made it difficult to accurately determine when gaps on care shorter than 30 days had occurred, and many gaps longer than 60 days could easily have reflected changes in service authorizations.

Overall, gaps in service declined from a monthly average of 2.58 percent to 2.16 percent between the pre and post periods, a statistically significant decline of 0.42 percent. Including respite services in the analysis reduced the percentage of consumer/employers experiencing gaps by only a few hundredths of a percent (pre-period: 2.52%, post-period: 2.14%). It is not surprising that including respite services had a minimal effect on this analysis since respite services are primarily intended for relatively short-term use, and this study examined gaps of at least 30 days.

In order to explore the role of agency services, the analysis was further limited to a population of consumer/employers receiving services funded through AAA or DDD (removing HCS).[14] For this limited population, the decline in gaps in service was even more pronounced, from 3.27 percent in the pre-period to 2.51 percent in the post-period, a statistically significant decline of 0.76 percent.

Based on this limited population (AAA and DDD), agency services filled approximately one-third of the gaps in the pre-period, bringing the average monthly percentage of consumers with gaps from 3.27 percent to 2.16 percent. Agency services filled roughly one-fifth of these gaps in the post-period, reducing the post-period gaps from 2.51 percent to 1.91 percent. It is not clear why the proportion of gaps filled by agency services declined from 1.11 percent to 0.60 percent between the pre and post periods. In all variations of the analysis, there were statistically significant declines between the pre and post-periods in the percentage of consumer/employers experiencing a gap in service of 30 to 60 days. This was the case even when including agency services in the analysis.

[14] Children receiving IP care had access to a relatively wide range of other placements and alternative sources of in-home care, making any accurate estimate of the non-IP substitutes unmanageably complicated.

RESEARCH SUMMARY

Overall, this evaluation demonstrated that workforce stability and retention among IP's in Washington State improved during the timeframe in which the initiatives were implemented. The effects of the initiatives on IP recruitment are not as clear, though there are indications that the initiatives played a part in some individual providers' decisions to join the profession.

There were statistically significant improvements in many measures of IP retention. Turnover rates declined, as did the percentage of IP's leaving the profession. About one-third of the IP's new to the field reported that the initiatives would make them more likely to remain in their line of work.

The only retention indicator that did not move in the expected direction was the rising percentage of IP's who maintained outside employment at the same time that they were paid as an IP. Nevertheless, the overall analysis suggests that IP retention improved after the introduction of the initiatives, such as health insurance coverage, during this timeframe. IP survey responses also indicate that the improved employment benefits will continue to positively affect retention rates in the future.

Given the absence of a formal measure of the supply "pool" of available IP's, recruitment was more difficult to measure than retention. However, it appears that – among the IP's who were aware of the employment benefits prior to becoming IP's – the employment benefits had a positive effect on their decision to join the profession. The reductions in gaps in service also suggest that there was an improvement in recruitment to the field.

In general, evaluation results suggest that the hypothesis that improved recruitment would ease the major difficulties of finding an IP was not supported by evidence. Improved employment incentives may increase the overall size of the pool of potential IP's, producing a modest reduction in the difficulty of finding an IP. However, finding an appropriate IP for a particular consumer/employer is a complex process in which the sheer size of the potential provider pool may often be a negligible factor. More research is needed on this issue.

Beyond the effects on recruitment and retention, this research illuminated other complexities of the field. Overall, it appears that this workforce is strongly motivated by non-economic factors. The most common reason for joining the field was that a friend or family member needed care (cited by 97 percent of family providers and 77 percent of non-family providers). Likewise, the most common reason for leaving the field was that a friend or family member no longer needed services.[15] And among providers who had left the field, one of the most common reasons that they would consider returning to the field was if another friend or family member needed services.

[15] About two-thirds of the non-family providers (68%) and one-third of the family providers (36%) who entered the field because a friend/family member needed care said that they'd consider continuing to work as an IP after their current consumer/employer no longer needed their services.

When individual providers were asked which employment benefit was the most important, the three most popular benefits were wages (35%), health insurance (26%), and "something else" (26%). This order of priority was true for both family and non-family providers, though health insurance appeared to be more important to the non-family providers. The response "something else" primarily involved the emotional rewards of helping others or taking care of a loved one. Respondents named benefits such as "the joy of helping other people", "being able to help our daughter", and "to make life a little better for someone else."

While it is clear that wages and employment benefits are important to individual providers, it appears that the emotional connection with the consumer/employer plays a very large role in individual providers' decisions to join or remain in the field. This finding suggests that initiatives aimed at improving wages and employment benefits are not likely to have a dramatic effect on recruitment and retention.[16] In general, it appears that the initiatives affected retention much more than recruitment.

One other complexity in the field in Washington State is that the IP service delivery model coexists with the agency model. These two models seem to interact in a couple of ways. From the consumer/employer's perspective, they have the option to receive service from either an IP or an agency worker. This decision may be based on factors beyond the availability of IP's. From the IP's standpoint, they have the option to work as an IP or as an agency provider.[17] With both models competing for workers, this could also affect the recruitment and retention of IP's.

Case managers reported that in the vast majority of cases, consumer/employers are acquainted with their IP before the IP is hired. This finding is supported by the fact that the majority of IP's report originally being motivated to join the field to help a friend or family member. If the consumer/employer is not able to identify an IP, case managers often direct the consumer/employer to agency services (81%) rather than an IP (38%) or the Referral Registry (44%).[18]

Case managers identified advantages and disadvantages with each system. An IP may offer a closer emotional tie and more personalized services. Agencies were viewed as offering faster contracting and background checks, more supervision, and easier access to back-up/respite services. The relationship between these two service delivery models deserves further research.

In summary, the in-home care services field in Washington State is very complex, and many factors impact the recruitment and retention of IP's. The initiatives put into place

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[16] Unfortunately, this research did not include contact with potential IP's who decided not to join the field. The input by this group could provide valuable insights into the recruitment decision-making process.
[17] Close to one-third of non-family providers also worked for an agency (31%). Only 14 percent of the family providers combined their individual provider work with employment at an in-home health agency.
[18] This was a survey question where the case manager could mark more than one response; therefore, the responses add to more then 100 percent.

during the timeframe of this evaluation – the availability of health care coverage, worker's compensation coverage, and increased wages – are just part of the picture. Nonetheless, the evaluation showed significant improvements in the stability and retention of the IP workforce during the timeframe that the initiatives were implemented. There are indications that recruitment also improved, though this was harder to measure conclusively.

APPENDIX A: RESEARCH QUESTIONS

Figure 1
Summary Table of Research Questions and Conclusions

Research Question	Conclusion
Retention	
1. Has there been a decline in the rate at which recipients experience a change in providers?	Yes, there has been a slight decline in average monthly turnover rates. The decrease in the average monthly turnover rate from 1.53% to 1.27% was statistically significant.
2. 2a. Has there been a decline in the number of providers leaving the industry?	Yes, a slight decline. The decrease from 10.36% to 8.90% in the average annual percentage of individual providers who exit the field was statistically significant.
2b. Among those leaving the industry, to what industry (health vs. non-health) and wage level are they transferring?	Most exiting IP's moved into other positions in the health care (21%) and social assistance (13%) sectors where they continued to work with the same population (the elderly and persons with disabilities.)
3. Has there been a decline in the percentage of providers who have concurrent employment outside of the IP field?	No, there has been a slight increase, from 37.84 to 39.16%. This increase is statistically significant at the .01 level.
Recruitment	
4. Do new providers entering the industry perceive the health care benefits as an incentive to become a provider?	Only 16% of the respondents were aware that health insurance was available to IP's before they joined the field. Of those, over one-third (35%) said that it positively affected their decision to join the field.
5. Do caseworkers perceive an increase in the number of providers?	It was incorrect to assume that caseworkers would be aware of an increase in the general pool of available IP's. This research question was not appropriate for measuring the effect of the interventions, primarily because few caseworkers maintain an informal pool or are systematically involved in recruitment.
6. Are more providers working in the industry?	It was determined that this research question does not measure the effect of the interventions; therefore, this data was not analyzed.

APPENDIX B: SUPPORTING TABLES

Figure 2
Average Monthly Turnover Rates
(Consumer/Employers Experiencing a Change of IP)

	Pre-Period	**Post-Period**	**Difference**
Overall Turnover	1.53%	1.27%	-0.26%***
Family providers	0.48%	0.27%	-0.21%***
Non-family providers	1.63%	1.42%	-0.21%***
IP's providing services to both family & non-family	2.90%	2.13%	-0.78%

**Significant at the .05 level
***Significant at the .01 level

Figure 3
Average Monthly Percentage of Consumer/Employers with Gaps in Services of 30 to 60 Days

	Pre-Period	**Post-Period**	**Difference**
All consumer/employers…			
Receiving services from an IP	2.58%	2.16%	-0.42%***
Receiving services from an IP and a Respite Provider	2.52%	2.14%	-0.38%***
Consumer/employers receiving services funded through DDD or AAA…			
Receiving services from an IP	3.27%	2.51%	-0.76%***
Receiving services from an IP and a Respite Provider	3.24%	2.51%	-0.73%***
Receiving services from an IP and a Respite Provider or Agency	2.16%	1.91%	-0.25%***

**Significant at the .05 level
***Significant at the .01 level

Figure 4
Percentage of Exiting IP's Transferring to Each NAICS Sector

NAICS Sector	Pre-Period (Column %)	Post-Period (Column %)	Difference
Health care	22.27%	21.11%	-1.15%
Social assistance	12.57%	12.90%	0.32%**
Retail trade	10.11%	10.75%	0.64%
Accommodation and food services	8.96%	8.41%	-0.54%
Education services	8.95%	8.85%	-0.11%
Administrative and support and waste management and remediation services	8.45%	9.36%	0.91%
Manufacturing	4.97%	5.53%	0.57%
Other services, except public administration	4.07%	3.80%	-0.26%
Public administration	3.27%	2.66%	-0.61%
Agriculture, forestry, fishing and hunting	2.81%	2.15%	-0.66%***
Arts, entertainment, and recreation	2.18%	2.23%	0.05%
Transportation and warehousing	2.09%	1.75%	-0.33%
Professional, scientific, and technical services	1.81%	1.95%	0.14%
Construction	1.76%	2.35%	0.59%
Wholesale trade	1.62%	1.73%	0.11%
Finance and insurance	1.56%	1.99%	0.43%
Real estate and rental and leasing	1.49%	1.41%	-0.08%
Information	0.81%	0.90%	0.09%
Utilities	0.16%	0.07%	-0.09%
Mining	0.08%	0.05%	-0.02%
Management of companies and enterprises	0.02%	0.02%	0.00%
Total	100%	100%	

**Significant at the .05 level
***Significant at the .01 level

Figure 5
Average Quarterly Rates of Concurrent Employment (outside the IP Field)

	Pre-Period	Post-Period	Difference
Overall rate of concurrent employment	37.84%	39.16%	1.32%***
Family providers	31.73%	34.09%	2.36%
Non-family providers	38.62%	40.41%	1.79%***
IP's providing services to both family and non-family	28.04%	28.08%	0.05%

**Significant at the .05 level
***Significant at the .01 level

Figure 6
Percentage of IP's with Concurrent Employment outside the IP Field in Each NAICS Sector

NAICS Sector	Pre-Period (Column %)	Post-Period (Column %)	Difference
Health care	19.27%	19.35%	0.07%
Education services	12.42%	12.52%	0.10%
Retail trade	10.66%	10.95%	0.29%
Social Assistance	8.29%	8.34%	0.05%
Accommodation and food services	7.93%	7.21%	-0.72%
Administrative and support and waste management and remediation services	7.59%	7.35%	-0.25%
Manufacturing	7.54%	7.98%	0.44%
Other services, except public administration	4.82%	4.55%	-0.27%
Public administration	3.24%	3.37%	0.13%
Arts, entertainment, and recreation	2.63%	2.61%	-0.01%
Finance and insurance	2.43%	2.61%	0.18%
Transportation and warehousing	2.32%	2.26%	-0.06%
Professional, scientific, and technical services	2.09%	2.22%	0.12%
Agriculture, forestry, fishing and hunting	1.96%	1.54%	-0.42%
Wholesale trade	1.80%	1.91%	0.11%

NAICS Sector	Pre-Period (Column %)	Post-Period (Column %)	Difference
Real estate and rental and leasing	1.77%	1.88%	0.11%
Construction	1.63%	1.83%	0.20%
Information	1.39%	1.32%	-0.07%
Utilities	0.12%	0.11%	-0.01%
Management of companies and enterprises	0.05%	0.05%	0.00%
Mining	0.04%	0.03%	-0.01%
Total	100%	100%	