Secretary Jeffrey R. Beckham
Office of Policy & Management

CONNECTICUT

December 30, 2024

Senator Jan Hochadel,
Co-Chair of the Aging Committee
State Capitol Building, Room 011
Hartford, CT 06106

Representative Jane Garibay,
Co-Chair of the Aging Committee
State Capitol Building, Room 011
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Senator James Maroney,
Co-Chair of the General Law Committee
Legislative Office Building, Room 3500
Hartford, CT 06106

Representative Michael D'Agostino,
Co-Chair of the General Law Committee
Legislative Office Building, Room 3500
Hartford, CT 06106

Senator Saud Anwar,
Co-Chair of the Public Health Committee
Legislative Office Building, Room 3000
Hartford, CT 06106

Representative Cristin McCarthy Vahey,
Co-Chair of the Public Health Committee
Legislative Office Building, Room 3000
Hartford, CT 06106

Dear Honorable Leaders of the Aging, General Law, and Public Health Committees:

Pursuant to Section 11 of Public Act 23-48 as amended by Section 36 of Public Act 24-68, please find enclosed the Plan to transfer the responsibility for registration and oversight of homemaker-companion agencies, as defined in section 20-670 of the general statutes, from the Department of Consumer Protection (DCP) to the Department of Public Health (DPH).

The act requires the Secretary of the Office of Policy and Management (OPM), in consultation with the Commissioners of Consumer Protection and Public Health, to "(1) provide a timeline for the proposed transition, and (2) include recommendations on appropriate training standards that (A) exemplify best practices for providing homemaker and companion services, as defined in section 20-670 of the general statutes, (B) provide instruction and specialized training benchmarks for the care of clients with Alzheimer's disease, dementia and other related conditions, and (C) ensure a high quality of care for homemaker-companion agency clients and may evaluate and make recommendations on the appropriate use of the term "care" in describing the services provided by homemaker-companion agencies and any limitations on the use of such term to ensure consumer clarity."

OPM contracted with Corcoran Consulting Group, LLC, to conduct research and to assist with the development of a Plan as described above. Multiple stakeholders were engaged as part of this process, including state agencies, homemaker and companion agency (HCA) owners, administrators, staff and clients, national and state industry associations, and national home care leaders.

Based on the findings of this research, OPM developed a four-year plan that outlines the key process steps, estimates the resource needs, and provides a timeline for making such a transition of oversight and regulatory authority of HCAs from DCP to DPH.

Industry best practices identified through research and stakeholder engagement were also considered in formulating the following recommendations:

(1) Require all HCA staff to complete initial and continuing trainings (which should include, in part, content specific to dementia-related conditions), pass a written examination, and submit attestation of completed trainings and examinations to the state.

(2) Require HCAs which advertise care for clients with dementia-related conditions to employ staff with state-approved Alzheimer's care or dementia care certifications to provide these services.

(3) Permit HCAs to include the term "care" in their advertisements and continue requiring that these businesses disclose to clients that their services are "nonmedical".

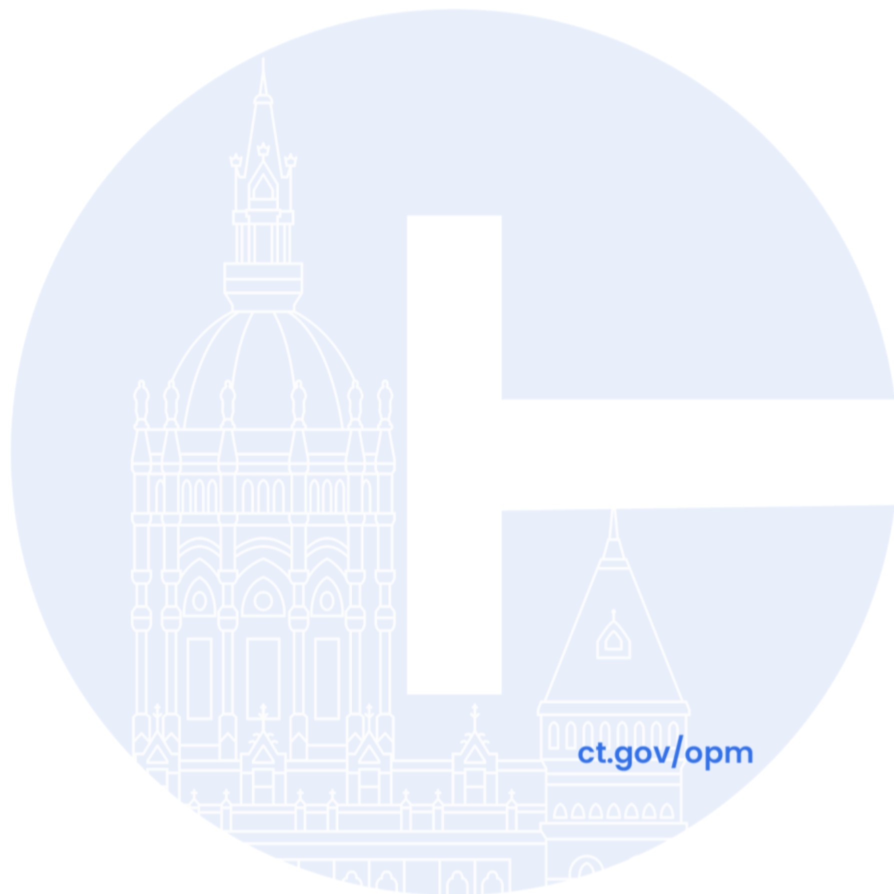
Additional requirements or regulations for HCAs beyond these recommendations may require further analysis of potential impacts on consumers and the HCA industry. OPM looks forward to its continued work with the Connecticut General Assembly on strategies to ensure high quality services for Connecticut residents who utilize HCAs.

If you have any questions, please contact Melissa Morton at melissa.morton@ct.gov.

Sincerely,

Jeffrey Beckham
Secretary

CC: Senator Lisa Seminara
Representative Mitch Bolinsky
Senator Paul Cicarella
Representative David Rutigliano
Senator Heather Somers
Representative Nicole Klarides-Ditria
Legislative Library
Beverley Henry
Nick Neely



Plan and Timeline for the Transition of Oversight from the Department of Consumer Protection to the Department of Public Health

Submitted to the Committees with Cognizance over Aging, General Law, and Public Health in Accordance with Public Act 23-48, Section 11

December 30, 2024

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Executive Summary

Public Act 23-48 § 11 directed the Office of Policy and Management (OPM) to develop a plan and timeline for the transfer of responsibility for registration and oversight of homemaker-companion agencies (HCAs) from the Department of Consumer Protection (DCP) to the Department of Public Health (DPH), as well as present recommendations that:

(A) Exemplify best practices for providing homemaker and companion services
(B) Provide instruction and specialized training benchmarks for the care of clients with Alzheimer's disease, dementia, and other related conditions, and
(C) Ensure a high quality of care for homemaker-companion agency clients.

OPM was also tasked with evaluating the use of the term "care" by HCAs and making recommendations on the appropriate use of the term to ensure consumer clarity regarding the services that these agencies may provide.

Throughout the development of this report, OPM and the Corcoran Consulting Group conducted interviews, hosted focus groups, and administered surveys to solicit feedback from national and state industry associations, HCA owners and administrators, and relevant state agencies, including DCP and DPH. Information obtained throughout the stakeholder engagement process, as well as findings from research into the current home care regulatory structure in Connecticut, home care regulations in other states, and best practices for regulating and overseeing HCAs and staff were considered during the formulation of the oversight transition plan and recommendations issued pursuant to PA 23-48, §11.

Based on the findings from these investigations, OPM developed a four-year plan for transitioning oversight and regulatory authority of HCAs from DCP to DPH, that includes (1) designing and enacting the regulatory framework necessary for DPH to enforce standards for nonmedical home care agencies; (2) preparing DPH and the agency's staff to adopt new responsibilities related to HCA oversight and regulation; (3) informing the homemaker-companion industry of changes made during the transition process and training these entities on new regulatory compliance requirements; (4) implementing required IT system changes at DPH; and (5) establishing operations within DPH to receive, review, and resolve HCA applications and monitor compliance on an ongoing basis. OPM's analysis suggests, however, that because this transition would span several years and require extensive operational and regulatory changes, this plan may result in additional costs on the state and consumers in the long term.

Industry best practices identified through research and stakeholder engagement were also considered during the formulation of the following recommendations: (1) require all HCA staff to complete initial and continuing trainings, which should include but not be limited to information specific to dementia-related conditions, pass a written examination, and submit attestation of completed trainings and examinations to the state; (2) require HCAs advertising care for clients with dementia or related conditions to employ staff with state-approved Alzheimer's care or dementia care certifications who can provide these services; and (3) permit HCAs to include the term "care" in their advertisements but continue requiring these businesses to disclose that their services are "nonmedical" to clients. Additional requirements or regulations for HCAs beyond these recommendations may require further analysis of potential impacts on consumers and the HCA industry.

Plan and Timeline for the Transition of Oversight from the Department of Consumer Protection to the Department of Public Health

I. Purpose

During the 2023 legislative session, the Connecticut legislature passed Public Act 23-48, Section 11[1] requiring the Office of Policy and Management (OPM) to "develop a plan to transfer the responsibility for registration and oversight of homemaker-companion agencies, as defined in section 20-670 of the general statutes from the Department of Consumer Protection (DCP) to the Department of Public Health (DPH). Such plan shall (1) provide a timeline for the proposed transition, and (2) include recommendations on appropriate training standards that (A) exemplify best practices for providing homemaker and companion services, as defined in section 20-670 of the general statutes, (B) provide instruction and specialized training benchmarks for the care of clients with Alzheimer's disease, dementia and other related conditions, and (C) ensure a high quality of care for homemaker-companion agency clients and may evaluate and make recommendations on the appropriate use of the term "care" in describing the services provided by homemaker-companion agencies and any limitations on the use of such term to ensure consumer clarity."[2]

As the result of a competitive bid process, OPM contracted with Corcoran Consulting Group, LLC to conduct research and to assist with development of a Plan responsive to the statutory mandate.[3] The following Plan is the result of research, interviews, surveys, and focus groups with stakeholders including Connecticut state agencies (DCP, DPH, and the Department of Aging & Disability Services (ADS), as well as the Long Term Care Ombudsman Program (LTCOP), national and state industry associations, homemaker-companion agency (HCA) owners and administrators, national home care leaders, HCA employees who interact with HCA clients (Caregivers), clients (Care Recipients) and their family members.

II. Background

A. Definition of an HCA

"Homemaker-Companion Agency" <u>is</u> *"any (i) public or private organization that employs one or more persons and is engaged in the business of providing companion services or homemaker services, or (ii) registry. (b) "homemaker-companion agency"* ***<u>does not include</u>*** *(i) a home health care agency, as defined in subsection (d) of section 19a-490, or (ii) a home health aide agency, as defined in subsection (e) of section 19a-490"*

Source: C.G.S., §20-670(7)

To put the recommendations set forth in this Plan into context it is necessary to understand what HCAs are and are not, the services they can legally provide and where they fit in the continuum of home and community-based services available to Connecticut residents.

HCAs are non-medical providers that either are (1) public or private organizations that provide companion services (non-medical, basic supervision services to ensure the safety and well-being of a person in the person's home) or homemaker services (non-medical and supportive services, including assistance with cooking, household cleaning, laundry, personal hygiene and other household

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[1] Subsequently amended by Public Act 24-68, § 36, Section to expend report submission deadline. See Appendix A

[2] "An Act Concerning Notice of a Proposed Involuntary Transfer or Discharge of a Nursing Facility Resident, Family Councils in Managed Residential Communities, Coordination of Dementia Services, Nursing Home Transparency and Homemaker-Companion Agencies," Public Act No. 23-48 § 11 (2023), 18, https://www.cga.ct.gov/2023/ACT/PA/PDF/2023PA-00048-R00HB-05781-PA.PDF.

[3] Contract for Corcoran Consulting Group can be found on CTsource https://webprocure.proactiscloud.com/wp-web-public/en/#/contractboard/contracts/7631?customerid=51

chores, that ensure a healthy and safe environment for a person in the person's home), or (2) registries (any person or entity engaged in the business of supplying or referring an individual to, or placing an individual with, a consumer for the purpose of enabling the individual to provide to the consumer companion services or homemaker services, provided such individual is (A) directly compensated, in whole or in part, by the consumer, or (B) considered, referred to or treated by such person or entity as an independent contractor) as defined in CGS §20-670.[4] Unlike home health workers providing services under a medical home care model HCA Caregivers do not have any formal minimum requirements for training or education.[5]

Due to their non-medical nature, HCAs in Connecticut are currently not required to be licensed by DPH but are required to register with DCP and to renew that registration annually.[6] Entities seeking to operate as an HCA must apply to DCP to receive a certificate of registration as a homemaker-companion agency. Applications can be obtained on the DCP Homemaker Companion Agency Registration website[7] or by applying online via the State of Connecticut's eLicense website.[8] The simple two-page application may be submitted online or through electronic mail. To be approved, applicants must maintain a surety bond or an insurance policy of at least $10,000, have an active Certificate of Good Standing with the Connecticut Secretary of State, provide a comprehensive state and national criminal history records check for owners, and pay a $375 registration fee.[9]All HCA registrations expire on October 31st of each year and must be renewed annually with a $375 registration renewal fee. Once an application is approved, HCAs receive a certificate of registration and must comply with all statutory and regulatory requirements, which include (1) comprehensive background investigations of prospective employees as defined in CGS §20-678, (2) creation and content of individualized service plans, (3) a complaint filing process, (4) inclusion of the HCA registration number on all marketing materials, and (5) notices to clients that the agency solely provides non-medical care.[10]

According to DCP, as of October 2024, there were 1,048 active HCAs registered with the agency, employing over 30,800 individuals in total. This is an increase of 176% (668 agencies) since 2012 when there were 380 registered HCAs operating in the state. Of these HCAs, 343 provide registry services and 705 agencies provide homemaker companion services only. An HCA that is a registry service provides a list of caregivers from which the consumer can choose to employ one or more to provide homemaker or companion services. The 343 registries do not provide care services directly to consumers. Therefore, the vast majority of regulatory oversight is limited to the 705 agencies that provide care services to consumers. HCAs range in size from employing 0 caregivers (registries who only make referrals or use independent contractors) to 167 caregivers, with the majority of HCAs (46%) employing 1-9 caregivers, followed by 33% employing 10 – 50 caregivers.[11]

[4] "Homemaker-Companion Agencies - Definitions," Chapter 400o Connecticut General Statutes § 20-670 (2019), https://www.cga.ct.gov/2021/pub/chap_400o.htm.
[5] "Homemaker-Companion Agencies 2024 Supplement," Chapter 400o Connecticut General Statutes § § 20-675 - 20-684 (2023), https://www.cga.ct.gov/2024/sup/chap_400o.htm#sec_20-675.;
"Registration of Homemaker-Companion Agencies," Subtitle 20-670 Regulations of Connecticut State Agencies, accessed November 1, 2024, https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/Title_20Subtitle_20-670/.
[6] "Registration of Homemaker-Companion Agencies Required," Chapter 400o Connecticut General Statutes § 20-671 (2006), https://www.cga.ct.gov/2021/pub/chap_400o.htm.
[7] *DCP Homemaker Companion Agency Registration Website may be found here:* https://portal.ct.gov/dcp/license-services-division/license-division/homemaker-companion-agency-registration?language=en_US
[8] *CT's eLicense website may be found here:* https://www.elicense.ct.gov/
[9] "Homemaker-Companion Agencies - Application for registration. Fees. Failure to register," Chapter 400o Connecticut General Statutes § 20-672 - https://www.cga.ct.gov/2023/pub/chap_400o.htm#sec_20-672..
[10] "Homemaker-Companion Agencies 2024 Supplement," Chapter 400o Connecticut General Statutes §§ 20-675 - 20-684 (2023), https://www.cga.ct.gov/2024/sup/chap_400o.htm#sec_20-675.
[11] *Department of Consumer Protection, HCA report October 2024.*

Notably, HCAs often refer to themselves as "home care agencies," and many states default to this term for non-medical home care provider entities. In addition to housekeeping and companionship tasks, home care workers in other states are often responsible for providing "personal care services" to clients, which typically include assistance with *activities of daily living* (ADLs), such as dressing, bathing, eating, toileting, transferring and continence. Personal care services may also include assistance with *instrumental activities of daily living* (IADLs), such as managing finances, communicating on behalf of clients, arranging transportation, and managing medications (i.e., understanding medication instructions and ensuring that the client takes medications as prescribed).[12] However, unlike "home care agencies" in many other states, HCAs in Connecticut are only permitted to offer Personal Care Attendant (PCA) services to clients through the Medicaid Home and Community-Based Waiver programs and only those PCAs are permitted to assist clients with the full range of ADLs and IADLS (all HCA staff may provide assistance with toileting and bathing under the DCP guidance issued related to the provision of "personal hygiene"). Personal Care Aide/Assistant, Direct Care Worker, or Home Care Aide are also common titles for this position across the country.[13]

B. HCAs Versus Home Health Care and Home Health Aide Agencies

Non-medical HCAs are different and distinct from the medical model Home Health Care Agencies (HHCA) and Home Health Aide Agencies (HHA) defined in DPH statutes CGS §§19a-490(d) and (e) as follows:

Home Health Care Agency CGS §19a-490(d): *"a public or private organization, or a subdivision thereof, engaged in providing professional nursing services and the following services, available twenty-four hours per day, in the patient's home or a substantially equivalent environment: Home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy or medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four hours per day.*"

Home Health Aide Agency CGS §19a-490(e): "*a public or private organization, except a home health care agency, which provides in the patient's home or a substantially equivalent environment supportive services which may include, but are not limited to, assistance with personal hygiene, dressing, feeding and incidental household tasks essential to achieving adequate household and family management. Such supportive services shall be provided under the supervision of a registered nurse and, if such nurse determines appropriate, shall be provided by a social worker, physical therapist, speech therapist or occupational therapist. Such supervision may be provided directly or through contract."*

Home Health Aide Services provided by HHCAs are defined in C.G.S Sec 19a-490(f) by what they are not: "*Home health aide services as defined in this section shall not include services provided to assist individuals with activities of daily living when such individuals have a disease or condition that is chronic and stable as determined by a physician licensed in the state."*

Due to the medical nature of services provided, HHCAs and HHAs are licensed though DPH and must adhere to more stringent regulation and oversight that focuses on health and safety and quality of care. Although both DPH and DCP utilize the State's eLicense system to manage registration or licensing, DCP

[12] "Activities of Daily Living," Cleveland Clinic, accessed November 1, 2024, https://my.clevelandclinic.org/health/articles/activities-of-daily-living-adls.
[13] Anita Bercovitz et al., "An Overview of Home Health Aides; United States, 2007," *National Health Statistics Reports*, no. 34 (May 19, 2011), https://stacks.cdc.gov/view/cdc/13188.

also utilizes it for complaints and enforcement case management, while DPH employs other systems for complaint management and enforcement.

The distinction between what is a medical service requiring provision by a licensed HHCA or HHA entity versus a non-medical unlicensed HCA is not always clear, especially when it comes to the provision of "personal hygiene," which term appears in both HHA or HCA statutes, but is not defined.[14] Since the term is undefined, it is unclear what differences, if any, exist between assistance with personal hygiene provided by the two distinct classes of agencies.

Because these entity types share similar names despite offering different services, stakeholders have expressed concerns that clients may not understand the distinction between "homemaker companion agencies" and "home health care agencies".[15] Individuals seeking services at home may be unaware that there is a statutory distinction between the medical services that HHCAs and HHAs licensed by DPH can provide versus the non-medical services that can be provided by HCAs registered with DCP. As a result, clients may risk hiring an HCA agency with a service level expectation for the HCA caregiver that does not align with what they are allowed to provide under statute. The chart below demonstrates the differences between licensed HHAs and registered HCAs.

Table 1 – Differences Between HCAs, HHCAs and HHAs

	Homemaker-Companion Agency	Home Health Care Agency	Home Health Aide Agency
Required to be licensed Y/N	N (but are required to be registered with DCP)	Y	Y
Oversight entity	DCP	DPH	DPH
Authorized to provide medical care	N	Y	Y
Authorized to provide assistance with Activities of Daily Living	Y with the following conditions: (1) All HCA caregivers may provide assistance with bathing and toileting under the DCP guidance provided for the provision of "personal hygiene" (2) Personal Care Attendants who serve clients on the Medicaid home and community-based waiver programs may assist with the full array of ADLs.	Y	Y
Medical model that requires nursing supervision	N	Y	Y
Requires referral from a physician/physician order	N	Y	Y

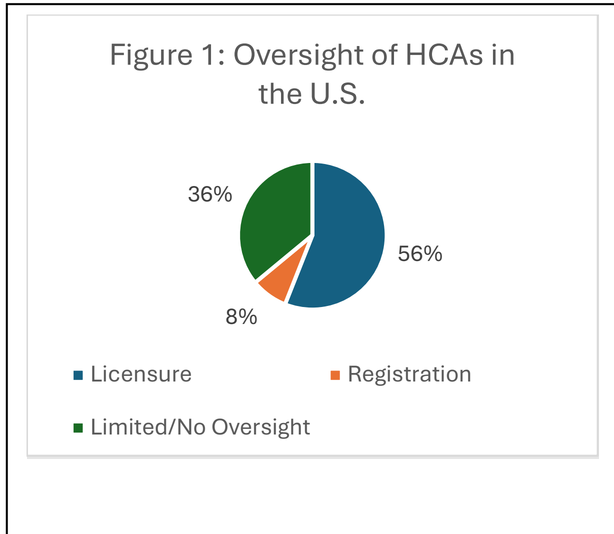
[14] "Licensing of Institutions. Definitions.," Chapter 368v Connecticut General Statutes § 19a-490(e) (2022), https://www.cga.ct.gov/current/pub/chap_368v.htm#sec_19a-490.;
Homemaker-Companion Agencies - Definitions.
[15] *Feedback from Consumer Focus Groups held by Corcoran Consulting Group July 7, 2024 and September 19, 2024*

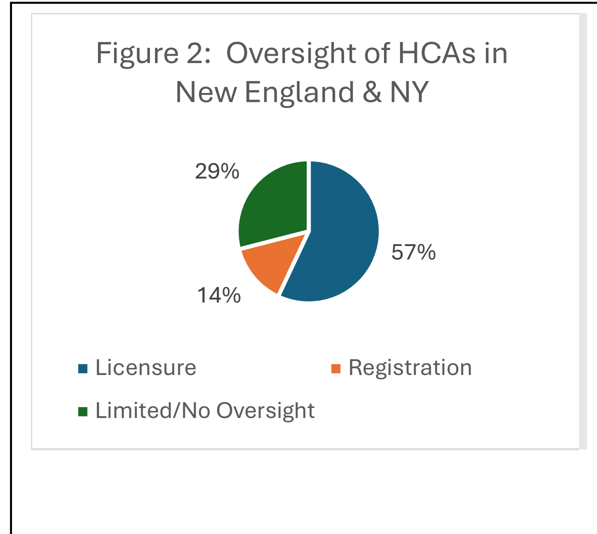
	Homemaker-Companion Agency	Home Health Care Agency	Home Health Aide Agency
Requires skilled nursing services	N	Y	Y
Requires certain levels of training for care staff	N (Except when HCA is advertising their memory care services, which needs to be supported by evidence of training provided to DCP.)	Y (upon hire and annually thereafter)	Y (upon hire and annually thereafter)
Covered by private medical insurance or Medicare	Sometimes (Coverage depends on certain variables. Private pay is primary payer source).	Y	Y
Covered by private Long-Term Care Insurance or Medicaid	Sometimes (Coverage depends on certain variables Private pay is primary payer source.)	Y (for LTC policy if policy covers home care)	Y (for LTC policy if policy covers home care)

C. Current HCA Landscape and Oversight Structure

DCP is statutorily charged with regulatory oversight of HCAs in Connecticut.[16] DCP's mission is "to ensure a fair, equitable, and safe marketplace for businesses and consumers in the industries we regulate by: managing licenses, permits, and registrations across many regulated industries, enforcing regulations in the industries we oversee without overburdening businesses that follow the law, monitoring the marketplace to protect consumers from unfair business practices and unsafe products, investigating consumer complaints."[17] As HCAs provide non-medical services (such as housekeeping, cooking, laundry, personal hygiene, and companionship), and are legally prohibited from providing health care services (including, but not limited to, dispensing of medications, wound care, and nursing care), the regulations and oversight pertaining to this industry are focused on ensuring a fair, equitable, and safe marketplace for clients. In the case of HCAs, the protection of consumer interests has the downstream effect of promoting the clients financial and physical well-being through the regulation of general business practices, such as appropriate advertising, employment practices, transparency in services that can be legally provided and contractual agreements that fall under the expertise of DCP. DCP is not authorized, nor does it have the agency and staff expertise to regulate the administration and quality of the nonmedical services being provided to clients. Conversely, DPH is charged with regulating the provision of health care services and ensuring that medical care is provided in a manner that guarantees the health and safety of recipients and it does not have the authority or agency/staff expertise to regulate the HCA activities currently overseen by DCP.[18] To aid in guaranteeing consumer clarity regarding the non-medical nature of HCA services, the legislature passed Public Act 23-48 which among other things (1) requires HCAs to provide consumers with and obtain their signature on a written "nonmedical care notice" that explicitly states that the agency only provides nonmedical care; and (2) institutes advertising rules including the requirement that HCAs include in contrasting colors at the top of all advertising materials "(agency name) solely provides nonmedical care"

[16] Registration of Homemaker-Companion Agencies Required.
[17] "Department of Consumer Protection," State of Connecticut, accessed November 1, 2024, https://portal.ct.gov/dcp.
[18] "About Us," Connecticut State Department of Public Health, accessed November 1, 2024, https://portal.ct.gov/dph/communications/about-us/about-us.





and audibly convey these words in any audio advertising. Additionally, HCAs must create a consumer brochure and website that explains what nonmedical services the agency provides.[19]

The oversight structure of HCAs across the country varies, with 56% of states (28) requiring HCAs to be licensed and 8% of states (4), including Connecticut, requiring registration while 36% (18) do not require licensure and have limited or no oversight of the HCA private-pay industry (See Figure 1).[20] Looking closer at the seven states (New England plus New York) surrounding Connecticut, oversight variability tracks along the national breakdown (See Figure 2). Of these seven states, those requiring licensure are all regulated by the Department of Public Health or Department of Health and Human Services (See Table 2).

Table 2: Oversight Structure New England and New York

State	Oversight Mechanism	Agency with Oversight
Connecticut	Registration	Department of Consumer Protection
Rhode Island	Licensure	State Department of Health
New York	Licensure	State Department of Public Health
Massachusetts	None	N/A
New Hampshire	Licensure	Department of Health & Human Services
Maine	Licensure	Department of Health & Human Services
Vermont	None	N/A

[19] An Act Concerning Notice of a Proposed Involuntary Transfer or Discharge of a Nursing Facility Resident, Family Councils in Managed Residential Communities, Coordination of Dementia Services, Nursing Home Transparency and Homemaker-Companion Agencies.
[20] Paraprofessional Healthcare Institute (PHI), "Personal Care Aide Training Requirements," PHI, accessed November 1, 2024, https://www.phinational.org/advocacy/personal-care-aide-training-requirements/.;
"Non-Medical Home Health Services License Application" (Ohio Department of Health), accessed November 18, 2024, https://odh.ohio.gov/wps/wcm/connect/gov/e52da572-efd9-46c0-bd03-1e3507f777a9/Non-medical+home+health+services+license+application+HEA0622.pdf?MOD=AJPERES.;
"Home Care Provider and Home Care Services," 2024 Minnesota Statutes § 144A.471, accessed November 18, 2024, https://www.revisor.mn.gov/statutes/cite/144A.471.;
"ARChoices Provider Services Requirements" (Arkansas Department of Human Services), accessed November 18, 2024, https://humanservices.arkansas.gov/wp-content/uploads/ARChoices_Provider_Certification_Requirements.pdf.

DCP employs two full-time Special Investigators and three other staff at half-time or less (processing technician, staff attorney and paralegal) a staffing pattern that has not changed significantly since 2012 despite the 176% (668 agencies) increase in the number of registered HCAs operating in the state. The two investigators can conduct approximately four routine HCA audits per week, depending on the number of violations found at a specific location. In 2023, DCP completed 208 audits. The typical audit includes, but is not limited to, the following activities: reviewing service contracts, verifying ownership is the same entity that holds the registration, verifying the HCA is conducting background checks on their employees, ensuring the HCA insurance policy or surety bond is active and provides badges for all employees. Special Investigators are also responsible for investigating complaints filed against HCAs. The rapidly increasing number of HCAs operating in the state has also resulted in an increase in filed complaints from 41 in 2021 to 64 in 2023. According to DCP, most complaints (49 of 64) filed are related to operations of the HCA which are geared toward protecting the interests of consumers through ensuring the delivery of safe services and may indirectly promote positive health outcomes. For example, inappropriate conduct of an HCA employee or lack of supervision of an HCA client, and billing or other business issues. Of the 64 complaints received in 2023, 55 of the cases were investigated and closed by DCP and nine cases remain open and pending investigation. Fifteen of the complaints were business practice infractions such as advertising medical services, failure to register/renew with DCP, failure to maintain insurance or surety bond, and billing disputes.[21] The time it takes to investigate a complaint varies based on the nature and complexity of the violation. However, on average it takes approximately 35 hours to complete an investigation.[22] The Special Investigators responsible for conducting routine agency audits and complaint investigations are required, by general state job classification, to possess five years of investigatory experience in health care, insurance claims, law enforcement, or a regulatory field. College training (bachelor's degree) in consumer protection, health care, law enforcement or a closely related field may be substituted for four years of the General Experience and a master's degree in a closely related field may be substituted for one additional year of the General Experience. The annual salary range for this position is $72,758.00-$91,881.00.[23]

In comparison, DPH has 75 surveyors/investigators on staff to provide oversight of over 2,000 health care facilities including over 88 HHCAs (excluding hospice). Currently, there are no HHA agencies licensed, however, that fluctuates based on industry trends and as of December 2024, there were eight licensure applications pending. There are no staff assigned to only inspect HHCAs and HHAs. The team that typically surveys HHAs and HHCAs also surveys other facility types including assisted living service agencies and long-term care facilities when necessary. According to DPH, each HHCA inspection requires one to three surveyors and takes an average of 70 hours to complete. In 2023, DPH conducted 21 relicensure/recertification visits. DPH also conducted six initial licensure visits of HHCAs requiring hours of staff time. Of note, some HHAs are certified, and some are not, which adds another layer to the survey visit process. Complaints handled by DPH surveyors/investigators are predominantly related to patient health and safety and the provision of licensed medical services, with the most prevalent being timely initiation for start of care, implementation of plan of care, change in condition/revising plan of care, misappropriation of medications, and condition changes.

In 2023, DPH received 8 complaints related to HHCAs and HHAs. This was lower than in previous years, as complaints averaged 50 per year and have decreased post COVID. These complaints varied in complexity, but on average an individual investigation took 35 hours to complete.[24] DPH surveyor resources

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[21] Interviews with DCP staff. See appendix B for list of informants for this Plan.

[22] See Appendix C for a detailed description of the DCP investigation process.

[23] "Special Investigator (General) (7804AR)," Job Board, State of Connecticut Executive Branch, accessed November 1, 2024, https://www.jobapscloud.com/CT/specs/classspecdisplay.asp?ClassNumber=7804AR&R1=undefined&R3=undefined.

[24] See Appendix D for information on the DPH investigation process.

are also utilized for onsite visits to investigate reports of unlicensed entities. Due to the medical nature of DPH surveys and complaints, surveyors/investigators for DPH teams are comprised of credentialed and experienced staff with different areas of expertise than the DCP investigators. DPH surveyors/investigators are housed within the Facilities Licensing and Investigations Section (FLIS) and include Health Program Associates and Supervisor, Nurse Consultants and a Supervising Nurse Consultant. See Table 3 for a comparison of DCP and DPH Surveyor/Investigator roles and qualifications.

Table 3: DCP and DPH Surveyor/Investigator Roles and Qualifications

	DCP Special Investigator	**DPH Surveyor/Investigator**
Oversight agency mission	Ensure fair, equitable, and safe marketplace for businesses and consumers and manage licenses, permits, and registrations across many regulated industries, enforce regulations, monitor the marketplace to protect consumers from unfair business practices and unsafe products, investigate consumer complaints.	Ensure the health and safety of CT residents – medical facility and service licensure and oversight, conduct health care facility surveillance and investigate complaints. To ensure compliance with all applicable state and federal laws and regulations.
Type of entity/services regulated	Registered, nonmedical HCAs	Licensed health care facilities and HHCAs/HHAs among other licensed health care entities (28 types in total). Also act as agent for CMS certification when required.
Required Surveyor/Investigator experience	Five (5) years of investigatory experience in health care, insurance claims, law enforcement or a regulatory field. Per DAS/OLR job classification.	Four (4) years of experience as a professional nurse in a position involving administration, consultation, education or supervision. Two (2) years of the General Experience must have been in a public health nursing program, home health care agency, community health care setting, or in a hospital. After hire, each surveyor must complete 6 months of training before taking the SMQT (surveyor minimum qualifications test) and then train and have mentorship for another 6 months -1 year before being fully independent. Before any state or federal surveyor may serve on an HHA survey team (except as a trainee), he/she must complete the HHA Basic Surveyor Training course located in QSEP. Additionally,

	DCP Special Investigator	DPH Surveyor/Investigator
		prior to finalizing the survey team, Sas must ensure that no conflicts of interest are present between surveyors and the HHA being surveyed
Number of entities responsible to oversee	1,048	Over 2,000 health care facilities and over 88 HHCA/HHAs
Frequency & number of staff conducting routine surveillance/audits per year (not related to a complaint)	DCP completed an average of four routine audits per week in 2023, for a total of 208 audits, which were conducted by two special investigators.	HHAs are licensed and recertified by FLIS staff every two to three years based on deemed status. Allotted resources to conduct HHA surveys can fluctuate depending on the agency's past history of compliance, the unduplicated admission count (number of patient admissions to the agency over a 12-month period) as this dictates the number of home visits (surveyor travels to the patient's home) and clinical records that need to be reviewed. If the HHA provides hospice services under their license, the survey team will review additional clinical records to ensure the agency is meeting hospice standards and the patient's needs. If the HHA has multiple patient service offices, this will require members of the survey team to visit each office to ensure the agency is meeting federal and state regulations. In addition, the survey team conducts revisits to determine if the agency is in compliance with the federal and state regulations.
Most common nature of complaints	Unregistered business, deceptive advertising, service contract violations	Licensed, medical health and safety matters, including timeliness for start of care, plan of care, condition changes and medication misappropriation

D. Considerations Prior to Transitioning Oversight from DCP to DPH

A change in oversight of HCAs would not be a straightforward statutory transfer of responsibility. It would constitute a significant shift in how the industry is regulated and how clients would use HCA services. The existing oversight structure could not simply be transferred intact from DCP to DPH, as their current regulatory authorities, operational structures and areas of expertise are entirely different. DPH would require a significant number of additional staff and fiscal resources, and would have to implement a multi-year process, including changes in statute, regulations and agency functions. Therefore, before a transition to DPH could be implemented, there are several threshold issues that should be carefully considered and evaluated.

- Clearly Defining the Scope of HCA Services

First, the state must clearly define the specific services that are covered when an agency is providing "homemaker companion" and "personal care" services. Currently, ambiguity in DCP and DPH's statutory terminology for HCAs (i.e. lack of definition of "personal hygiene") has resulted in a regulatory gray area that makes it difficult for HCAs and their employees to know when a specific service or the manner in which a service is provided is within the permitted scope for an unlicensed agency or if they are providing care that should be delivered by a licensed agency. Clear boundaries are needed between medical and non-medical care to avoid any confusion over what type of licenses are required for companies and workers, what kinds of services the workforce can offer, and what kind of regulatory oversight DPH can enforce. Any overlap, real or perceived, between homemaker-companion (non-medical) and home care (medical care) definitions will continue to cause confusion among the industry and clients using their services.

- Clearly Defining the Appropriate Oversight Structure

The current function of DCP registration of HCAs is to assess compliance with the goal of protecting the interests and safety of the consumer. The current function of DPH licensure is to ensure the health and safety of Connecticut residents. If oversight of HCAs were moved to DPH, existing regulations of business practices would not be within the purview of DPH's licensure oversight and may be left unregulated. Alternatively, HCAs would have to become subject to separate oversight by both DCP and DPH, or DPH would need to be granted regulatory authority to change its scope of oversight to include business practices. DPH staff would need to be trained by DCP on current HCA industry practices, and how to regulate a business entity, as this has never been under DPH's purview.

This study examined the possibility of bifurcating agency responsibilities, given that each agency has expertise in two relevant components of HCA regulatory oversight (health and safety vs business practice). Careful examination revealed that it would be impractical and ineffective to adopt a structure that separates the regulatory oversight of business practices (keeping at DCP) from those of ensuring health and safety (assigning to DPH), as it would result in regulatory compliance oversight complexity and difficulty for DPH and DCP, as they each regulate different components of the same business entities. It would create a system that is burdensome for the HCAs and confusing for clients and their families.

Additionally, transitioning oversight from DCP to DPH and retaining the current registration procedure has practical limitations that should be considered. DPH currently registers two programs, Managed Residential Communities (MRC) and Temporary Nursing Service Agencies. In this role, DPH collects certain operational information but does not have the enforcement authority to do anything beyond simple collection of paperwork. Should DPH assume responsibility for registering HCAs as well, this level of oversight would be more limited than what DCP currently provides. DPH also currently licenses

Residential Care Homes (RCH), which provide a social model of care, as opposed to a medical one. However, DPH does not license or credential RCH staff (although DPH does participate in the medication certification program for RCH staff), rather it oversees the physical plant and three types of services: medical, dietary and recreational. DPH's current oversight practices and authorities are significantly different than the current business practice oversight DCP has over HCAs, and, therefore, a process would need to be undertaken to determine the details of an appropriate oversight structure and the corresponding necessary statutory and regulatory revisions.

- Identifying Necessary Training and Staffing Needs

Once the oversight structure is determined, DPH would need to ascertain the staffing pattern needed to implement it effectively both initially and in the outyears, accommodating for industry growth (176% over the last 12 years. It should be noted that there has not been a grant of additional staff to DCP in this area over that same 12-year period). New and existing staff would require extensive training in this new oversight model, encompassing both business practices and health and safety standards. DPH would need to oversee licensure/registration and ongoing investigations and enforcement. Comprehensive outreach to the HCA industry would also need to take place, including information with details about the new regulatory structure. Such outreach would need to be coordinated with community partners, and be offered in multiple formats, including workshops, agency websites, and ongoing support as needed. Resources would also need to be allocated for outreach to clients and families, who would need be kept apprised of these changes, and for providing clients support in navigating the new mechanisms for filing complaints.

This process would require a significant staffing increase at DPH, entailing recruiting, hiring and training personnel in a variety of clinical, legal and administrative roles.

Table 4: Projected DPH staffing needs for assuming oversight of HCAs

Includes Fringe			
Job Classification	**FTEs**	**Cost per FTE**	**Total cost**
Health Program Associate	10	$151,448.14	$1,514,481.39
Nurse Consultant	9	$182,577.09	$1,643,193.79
Supervising nurse consultant	2	$201,083.60	$402,167.20
Health program supervisor	3	$182,577.09	$547,731.26
Attorney 1	3	$175,159.52	$525,478.55
Paralegal	1	$152,482.78	$152,482.78
Processing Technician	3	$112,154.30	$336,462.89
Administrative assistant	1	$128,753.17	$128,753.17
TOTAL	**32**	**N/A**	**$5,250,751.04***

For the Licensure and Renewal fees to offset the cost of DPH regulating this industry, assuming renewals every 3 years and 1,100 HCAs (assuming growth), the licensure/renewal fee would have to be $14,320, paid every 3 years ***compared to the current $375 fee for registration/annual renewal.***

The associated ongoing costs, plus those required for community education and outreach, would be significant. There would also be increased costs to HCAs, including, but not limited to, more extensive background checks, training, and undertaking compliance measures. These costs would most likely be passed along to clients. As this would be a multi-year transition process, a mitigation strategy would need

to be developed, including an interagency mechanism to ensure client concerns and complaints are directed to the correct regulatory agency at any point in that process.

DPH expressed concern that without additional staff for the oversight of HCAs, the current backlog of approximately 2,500 complaints regarding nursing homes and hospitals will be negatively impacted and affect the overall healthcare quality and safety of the public, as resources would be over stretched, and the agency would be unable to meet demands.

Taking into account the above considerations, the following section presents a four-year plan detailing the necessary tasks and timeline involved in a transfer in oversight of HCAs from DCP to DPH.

III. Transition Plan and Timeline

Year 1: DPH Staff Education, HCA Regulatory Analysis, and DPH Staffing Level Determination

Goal: to conclude the year with (1) DPH staff understanding the current HCA regulatory framework and nature of the industry, (2) a determination made on the appropriate level of oversight for the non-medical HCA industry and the statutory and regulatory action required to enact it; and (3) the required DPH staffing pattern to meet the anticipated regulatory obligations.

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	Key Tasks	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
1.Train DPH staff on the HCA service industry and existing oversight structure	DPH and DCP staff develop a transition team to lead the transition efforts and set meeting cadence.	X											
	DCP staff orient DPH staff on the HCA industry (services provided and trade associations etc.), current regulatory oversight structure in CT, strengths and challenges of the HCA industry and existing regulatory framework and DCP organizational structure and operational protocols.	X	X	X	X								
	Transition team reviews all pertinent statutes and regulations and identifies areas where additional clarity is needed to ensure a clear distinction between medical home health care agencies and nonmedical HCAs to provide greater understanding within the industries, for clients, and to aid in state oversight. This exercise will also serve to determine what current regulatory criteria are within DPH scope and expertise to regulate.	X	X	X	X								

Major Objectives	Key Tasks	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
2. Determine appropriate oversight structure (registration or licensure) and corresponding initial/renewal fee.	DPH staff determines what level of regulatory oversight is indicated for the nonmedical HCA industry that will provide the necessary authority for them to enforce regulatory standards and enact penalties as needed to ensure high quality service provision and HCA compliance with all laws and regulations (i.e. registration or licensure). Such regulatory oversight structure must also align with DPH mission and scope.					X	X	X	X	X			
	DPH staff draft legislative proposals and begin process of designing an appropriate regulatory framework. Coordinate with DCP on legislative proposals as needed.										X	X	X
3. Determine required staffing levels	DPH determines staffing pattern required to implement the oversight structure determined necessary for HCAs and laid out in revised statute and regulation. Based on approximately 1,048 HCAs currently in operation and a growth rate of 176% over 12 years – DPH estimates needing 32 new staff to investigate complaints and surveys if the state moves to licensure vs. registration. If state continues with registration only one new staff person would be required to investigate care related complaints. DPH does not currently have the statutory authority nor is it within the agency's core mission to investigate business practices.										X	X	X
4.Engage the HCA Industry	Transition team determines timeline and methods of informing HCA industry of upcoming transition and how to effectively engage the industry in the transition process (such as sharing concerns and feedback to inform the process) and identify and mitigate any unintended consequences that could negatively impact access to HCA services.												X

Year 2: Statutory and Regulatory Revisions

Goals: to conclude the year with (1) the General Assembly having passed legislation that establishes the regulatory structure for HCAs at DPH including setting initial/renewal registration or licensure fee to assist with offsetting new costs; (2) the General Assembly having appropriated the necessary funds to support the transition including DPH infrastructure and staffing; (3) DPH having finalized policies and procedures and regulations; (4) DPH having begun ongoing outreach and education efforts to HCAs, state agencies and stakeholders; (5) DPH having begun IT systems changes; and (6) DPH having initiated staff recruitment.

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	Key Tasks	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
1. Make necessary statutory and regulatory revisions	DPH staff determine statutory and regulatory revisions that are needed to allow for appropriate oversight of the HCA industry. Such revisions should also include fees, required notification of change in oversight to clients and/or legal representatives, minimum training standards for HCA staff, and reflect the required change to the HCA industry regarding use of the Applicant Background Check Management System that DPH is required to utilize per 10a-491c). The extent of statutory and regulatory revision required will depend on the oversight structure DPH believes is necessary (continued registration or require licensure).	X	X	X									
	NOTE: Legislative action required for a transition of oversight to occur. General Assembly passes legislation establishing the regulatory structure at DPH and providing DPH (1) the necessary statutory authority to enact the regulatory authority, and (2) approve required appropriations to staff HCA oversight at DPH and build the necessary infrastructure; and (3) establish in statute the initial and renewal registration or licensure fee at a level that assists with offsetting the new costs.					X	X	X	X				

Major Objectives	Key Tasks	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
2. Formulate Policies and Procedures and promulgate regulations to implement new statutory oversight at DPH	DPH to (a) draft policies and procedures and begin drafting regulations; and (b) submit policies and procedures to OPM for formal review and approval. Note: This is step one in the lengthy regulatory approval process that will likely take at least one year from passage of authorizing statute, starting end of year two and going through at a minimum, the first half of year three. **The General Assembly could grant legislative authority to DPH providing the agency with the ability to implement policies and procedures pending approval of formal regulations that would allow the agency to begin program operations while the formal approval process is underway.**								X	X	X	X	X
3. Begin educational outreach to industry, impacted state agency and key stakeholders	DPH to begin hosting workshops and forums with HCA industry representatives engage them in the regulatory change process and gather feedback. Additional workshops and public outreach needed to help inform clients, Area Agencies on Aging, municipal agents and other navigator resources that individuals and families use to find and connect with home and community-based services.											X	X
4. Identify and begin efforts to implement IT system changes at DPH	DPH IT will need to create pathways for regulatory reporting/survey upload, complaint intake/tracking, incident event reporting. E Licensure will require addition of this licensure group for tracking.								X	X	X	X	X

Major Objectives	Key Tasks	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
5. Establish required staffing structure based on outcome of statutory mandates and allocated resources	DPH to design surveyor team structure and management; determine what skills, classifications and expertise are needed to implement DPH oversight of HCAs within allocated resources.								X	X	X	X	X
6. Initiate Staff Recruitment	DPH to establish surveyor and other positions as identified in staffing structure. This multi-step lengthy process includes: (a) drafting minimum qualifications, core duties, job descriptions for new DPH staff, (b) obtaining DAS and OPM approvals; (c) engaging in the recruitment process including advertising positions, reviewing applications, conducting interviews, making hiring offers. Note: Should licensure be the required mode of oversight, 32 new DPH staff will need to be hired at a total cost of $5.3 million to license and survey 1,048 HCAs in a rapidly growing industry.									X	X	X	X

Year 3: Regulatory Finalization, Staff Onboarding, and Industry Training

Goals: to conclude the year with (1) approval of regulations by the Legislative Regulation Review Committee; (2) completion of system updates; (3) HCAs formally noticed of upcoming oversight transition and trained on new regulatory oversight procedure to remain operational; and (4) HCA clients and/or legal representatives noticed about the oversight transition and what that means to them.

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	**Key Tasks**	**1***	**2***	**3***	**4***	**5***	**6***	**7***	**8***	**9***	**10***	**11***	**12***
1.Continue staff recruitment and onboard staff as Hired	Onboarding requires 6 months to 1 year of training. Surveyors start with general orientation (which includes: prerequisites to federal and state laws, CMS modules) and then begin SMQT prep training which includes how to investigate, how to apply the laws and field training specific to that level of care. Additionally, complete the HHCA basic surveyor training course. There will also be mentoring with experienced surveyors for up to 1 year post hire.	X	X	X	X	X	X	X	X				
2. Receive approval of **regulations from the Legislative Regulation Review Committee**	DPH to (a) finalize regulations; (b) go through internal legal review; (b) go through notice and comment period; (c) submit to OPM for review and approval; and (d) submit regulations to the **Legislative Regulation Review Committee for approval.**	X	X	X	X	X	X						
3. Conduct a series of focused training sessions for HCAs resulting in industry understanding of new regulatory requirements	DPH to conduct a series of focused training sessions for HCAs on the new oversight process and associated fee, regulatory compliance requirements, and a detailed written timetable for HCAs to remain operational after a certain date.										X	X	X

Major Objectives	Key Tasks	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
4. Issue formal written notice to all HCAs about deadline to achieve regulatory compliance to remain in business	DPH to issue a written notice to all HCAs operational in the state informing them at a minimum of the following: (1) requirement to attend one of the regulatory compliance trainings l; (2) method of oversight (registration or licensure); (3) date new regulations become effective; (4) actions with timeline specifying what HCAs must do to remain operational; (5) specific date by which failure to comply with new regulation will result in notice to cease operations; (6) technical assistance available to aid in transition; (7) deadline to notify DPH of intent to cease operations as an HCA and HCA plan to notify clients.										X	X	X
5. Develop technical assistance resources to aid HCAs with the transition to the new oversight structure	DPH to develop technical assistance resources to aid HCAs with the transition to the new oversight structure and update as needed based on industry need and feedback.	X	X	X	X	X	X	X	X	X	X	X	X
6. Notify all HCA clients and/or legal representatives of the impending oversight transition and what that means for them.	HCAs to draft and file with DPH notices to clients and/or legal representatives that include at a minimum the components specified in statute or regulation.							X	X	X	X	X	X
7. Finalize systems updates	DPH to complete all required IT updates.						X	X	X				

Year 4: Transition Regulatory Oversight from DCP to DPH

Goal: to have successfully transitioned 100% of HCAs currently registered with DCP and who wish to remain in business, from DCP to DPH under the revised oversight authority.

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	**Key Tasks**	**1***	**2***	**3***	**4***	**5***	**6***	**7***	**8***	**9***	**10***	**11***	**12***
1. Begin accepting new registration or license applications from HCAs	DPH to begin accepting new registration or license applications from HCAs have 6 months to file with DPH and come into compliance with new regulations. During this time DPH staff will provide intensive technical assistance to help HCAs come into compliance to continue operations without service disruption.							X	X	X	X	X	X
2. Reviews and dispatch decisions on HCA applications for continued operations under new oversight authority	DPH staff conducts reviews of applications for continued operations (registration or licensure) and dispatches decision on a rolling basis with goal to get through all by end of month 12. Should licensure be the new oversight mechanism this activity will include the following: review applications, ensure HCA meets established requirements, plan licensure onsite visits, ABCMS background checks if applicable.							X	X	X	X	X	X

IV. Training Standards and Benchmarks – Best Practices

In addition to tasks and timeline, Public Act 23-48, Section 11 requires the that plan include: *"recommendations on appropriate training standards that (A) exemplify best practices for providing homemaker and companion services, as defined in section 20-670 of the general statutes, (B) provide instruction and specialized training benchmarks for the care of clients with Alzheimer's disease, dementia and other related conditions, and (C) ensure a high quality of care for homemaker-companion agency clients."*[25] Therefore, when setting minimum training requirements for homemaker-companion staff (heretofore referred to as "caregivers") as suggested in Section E, Transition Plan and Timeline, the following HCA training recommendations should be considered.

A. Best Practices for Agencies Providing Homemaker-Companion Services:

1. Key Findings

Impacts of Standardized HCA Training Requirements

A 2022 study published in *The Journal of Clinical Nursing* found that providing training to family and professional caregivers yields a variety of benefits for both the populations receiving and delivering the care. The study found that training caregivers to incorporate cognitive intervention strategies into their regular caregiving tasks improves clients' health-related quality of life (i.e., the clients' perceptions of their physical, psychological, and social well-being),[26] cognitive abilities, and autonomy and independence.[27] The National Council of Certified Dementia Practitioners has also reported that training home care workers improves caregivers' confidence, allows them to more effectively observe and respond to changes in their client's condition, and develops their ability to respond to emergencies or control otherwise stressful situations.[28] Developing these competencies reportedly improves caregivers' job satisfaction, especially among family caregivers who may not have extensive prior experience caring for aging individuals with complex needs.[29]

Researchers have also found that in addition to initial training, continuous education for direct care workers can have additional advantages for further reducing worker turnover and job dissatisfaction. Notably, continuing education allows home care workers to ensure that they are adequately prepared to meet the various needs of the many different clients they may serve. Continuing education also develops caregivers' communication and client-relations skills beyond their initial training and helps workers remain abreast of changes in culture or in the home care field, improving their ability to deliver care in the long run.[30] Another study published by the Gerontological Society of America reported similar benefits, but also suggested that continuing professional development for long-term care workers may improve their ability to understand

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[25] An Act Concerning Notice of a Proposed Involuntary Transfer or Discharge of a Nursing Facility Resident, Family Councils in Managed Residential Communities, Coordination of Dementia Services, Nursing Home Transparency and Homemaker-Companion Agencies.
[26] "What Is Health Related Quality of Life," Johns Hopkins Arthritis Center, accessed November 15, 2024, https://www.hopkinsarthritis.org/arthritis-research/patient-centered-outcomes-research/what-is-health-related-quality-of-life/.
[27] Miriam Sanjuán, Elena Navarro, and María Dolores Calero, "Caregiver Training: Evidence of Its Effectiveness for Cognitive and Functional Improvement in Older Adults," *Journal of Clinical Nursing* 32, no. 5–6 (2023): 736–48, https://doi.org/10.1111/jocn.16301.
[28] National Council of Certified Dementia Practitioners, "3 Benefits of Home Care Training for Caregivers," accessed November 15, 2024, https://www.nccdp.org/3-benefits-of-home-care-training-for-caregivers/.
[29] Sanjuán, Navarro, and Calero, "Caregiver Training."
[30] Heather L. Menne et al., "Direct Care Workers' Recommendations for Training and Continuing Education," *Gerontology & Geriatrics Education* 28, no. 2 (October 24, 2007): 91–108, https://doi.org/10.1300/J021v28n02_07.

and recognize cognitive changes in their clients, which is essential for adapting their care for clients with developing health needs, such as dementia.[31]

Findings from State Agencies

As part of the research for this Plan, the establishment of HCA training requirements in Connecticut was discussed in interviews with the DCP, DPH, ADS, and the Connecticut Long-Term Care Ombudsman Program. There was broad agreement that there is a need for caregiver training standards in the state. DCP specifically mentioned the importance of caregivers receiving training for client and caregiver boundaries, CPR, first aid, fall prevention and emergency response. Additionally, DCP suggested that HCA caregivers training should include the ability to identify when an escalated level of care is needed for a client (e.g. transitioning from non-medical services to home health or skilled nursing care). Lastly, it was recommended that caregivers complete some competency training that aligns with the level of services being provided, such as cooking, laundry, and communication. In discussions with ADS, agency staff recommended aligning requirements across public payer sources to ensure that caregivers do not have to repeat training to provide the same level of services.

General Training Requirements for HCA Caregivers

Training requirements for agency caregivers providing homemaker companion services vary widely depending upon the state. Notably, several states, including Connecticut, have no formal training requirements for homemaker and companion services. Washington state, however, requires 75 hours of training for "companion home providers."[32] Additionally, Washington requires companion home providers to complete 70 hours community and residential services training, 5 hours of orientation and safety training, and 12 hours of continuing education annually. The community and residential services curriculum include 40 hours of CORE residential services training and 30 hours of population specific training.[33]

An absence of standardized training requirements at the national level for non-medical home care providers has created a complex system where there are numerous inconsistencies in training requirements across states. Due to the lack of federal standards, states develop their own training mandates for HCAs and workers. There is a significant amount of variation between state policies, however, as some definitions and qualifications for HCA employees and standards are also applied inconsistently within states. For example, some states apply their training requirements only to caregivers employed by agencies serving clients of public programs. Others require standardized training of private-pay homecare agency workers, as well, but do not impose these standards on workers hired directly by the client. This bears out in the data, as only fourteen states have consistent training requirements for agency-employed caregivers providing PCA services, seven do not regulate training at all,[34]

Nationally, the inconsistencies for training standards are also present when examining other specific requirements such as training duration, competency assessments, training transferability/portability,

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[31] Sienna Caspar et al., "Nonpharmacological Management of Behavioral and Psychological Symptoms of Dementia: What Works, in What Circumstances, and Why?," *Innovation in Aging* 1, no. 3 (November 1, 2017): igy001, https://doi.org/10.1093/geroni/igy001.
[32] Washington State Department of Social and Health Services, "Mandatory Training Requirements for Companion Home Providers," accessed November 1, 2024, https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/DDAProvider/Mandatory%20Training%20for%20CH%20Providers.pdf.
[33] Ibid.
[34] Paraprofessional Healthcare Institute (PHI), "Personal Care Aide Training Requirements."

continuing education, and instruction methods. Twenty-six states have a minimum number of training hours for PCAs in at least one competency area. Fifteen of these require PCAs to complete forty or more hours of training. Thirty-four states require completion of a competence assessment for PCAs, but there are several variations to this requirement as well, and seventeen have specific regulations related to instruction methods, eleven of which require the use of a state-sponsored curriculum.[35]

Training standards for non-medical home care services in the northeastern United States show the same level of inconsistency as on the national level. In Connecticut, there are no formal training requirements for services provided by non-medical HCA caregivers other than what has been instituted by DSS for PCAs serving clients of certain Medicaid waiver programs, including the Connecticut Home Care Program for Elders, Connecticut Home Care Program for Disabled Adults, and the Acquired Brain Injury Waiver. Some states in the northeast, such as Maine, Massachusetts, and New Jersey, also only have training requirements for PCA services paid for by public programs. While New Hampshire, New York, and Rhode Island impose training requirements for caregivers employed by private-pay agencies, New Jersey, Rhode Island, and Vermont have established home health agency minimum standards when personal care services (assistance with ADLs and IADLs) are provided to clients of Medicaid programs.[36]

Connecticut's curriculum for PCAs, issued by the DSS Community Options Unit, is comprised of seventeen training modules and includes demonstration videos of certain key tasks. PCAs are given ninety days from hire to complete the training and must complete quizzes and pass a certification test with a score of 70 or higher, but there is no instituted duration requirement. Massachusetts, Maine, New Jersey and Rhode Island all require between 40 (NY) and 120 hours (RI) of training for personal care services. However, these duration requirements do not apply consistently across payer sources, and Rhode Island is a minority, requiring a Nursing Assistant certification for personal care services.[37]

Table 5: Summary of Northeastern States Personal Care Services Training Requirements

PERSONAL CARE SERVICES TRAINING REQUIREMENTS BY STATE								
Payer Source/Employer Type	**State**							
Training Required for Personal Care Provided By:	***CT***	***MA***	***ME***	***NH***	***NJ***	***NY***	***RI***	***VT***
Home Care Agency Caregivers: Medicaid Programs	Y	Y	Y	Y	Y	Y	Y	N/A
Home Care Agency Caregivers: Private-Pay	N	N	N	Y	N	Y	Y	N
Consumer Directed Workers: Private Pay	N	N	N	N	N	N	N	N
Consumer Directed Workers: Public Programs	N	Y	N	N	N	N	N	N/A
Home Health Agencies for Medicaid Programs (PCA services are only provided by Home Health Agencies for Medicaid Programs)	N	N	N	N	Y	N	Y	Y

[35] Paraprofessional Healthcare Institute (PHI).
[36] Ibid.
[37] Ibid.

Table 6: Summary of Specific Training Requirements in Northeastern States

State	Private Pay HC Agcy.	Position Title	Hourly Mandate	Proof of Competency Req.
CT	N	Personal Care Assistant	N/A	Y
MA	N	Personal Care Homemaker	60 Hours	Y
ME	N	Personal Support Specialist	50 Hours	Y
NH	Y	Personal Care Services Provider	N/A	N
NJ	N/A	Homemaker-Home Health Aide	76 Hours	Y
NY	Y	Personal Care Aide	40 Hours	Y
RI	Y	Nursing Assistant	120 Hours	Y
VT	N	N/A	N/A	N/A

As of 2019, 22 states had established training requirements for personal care services workers specific to private-pay home care agency caregivers, according to data curated by the Paraprofessional Healthcare Institute (PHI). Of these states, thirteen had instituted a minimum training duration requirement. Moreover, eight states required more than forty hours of training while nine states did not specify a minimum required number of hours.[38] Seventeen states also require annual continuing education for caregivers. Competency assessments are mandatory in seventeen states, ten of which only require a written or oral test, nine require a skills demonstration, and eight require both a written or oral test and a skills demonstration. Eleven states specify instructor qualifications, six specify the instruction methods and three require the use of state-sponsored curriculum.[39] Of the states that require training for private pay home care agency workers, all but one require home care agencies to be licensed in their state.

Training Curriculum & Competencies

In interviews, focus groups, and surveys, Home Care Association executives, HCA owners in Connecticut and other states, caregivers, clients, and clients' family members commonly expressed interest in the establishment of standardized training requirements for caregivers to improve the quality of services provided to clients. Clear training themes were also identified during this process.

Based on the results of the above outreach, it is recommended that a statewide training in the following eight key competencies be considered: (1) Communication Skills; (2) Understanding HIPAA for Caregivers; (3) Understanding and Reporting Elder Abuse and Neglect; (4) Nutrition and Meal Preparation for Older Adults; (5) CPR and First Aid; (6) Maintenance of a Clean and Safe Environment; (7) Basic Infection Control; and (8) Safe Transferring and Lifting (applicable to PCAs only). Additionally, trade association leaders and agency owners expressed support for the state to require eight hours of initial training before a caregiver can provide services, as well as ongoing continuing education programs.

[38] Paraprofessional Healthcare Institute (PHI), "Personal Care Aide Training Requirements."
[39] Ibid.

Training Best Practices and Benchmarks

> *HCA trade association leaders and agency owners expressed support for the state to require 8 hours of initial training before a caregiver can provide services and some level of on-going continuing education programs.*

The recommended eight core competencies largely align with skills and competencies have been identified as best practices by national organizations in the HCA industry. The LeadingAge Center for Applied Research created a development guide for PCAs which covers the following technical skills core competencies: (i) Assistance with ADLs and IADLs, (ii) Evaluation and Observation, (iii) Infection Control, (iv) Nutrition and Meal Preparation, (v) Providing Services and Supports, (vi) Roles of the Direct Care Worker, and (vii) Safety and Emergency. Each core competency contains an associated evaluation checklist. The training guide outlines applied understanding core competencies with topics such as abuse, neglect, professionalism, and ethics. Additionally, the guide features training topics related to interpersonal skills core competencies, including communication, empathy, advocacy, and relationship building.[40] The interpersonal skills core competencies steadily focus on traits and behaviors associated with person-centered care. The DSW Core Competency Project, an initiative launched by the Center for Medicare and Medicaid Services (CMS), also identified similar key training components for direct care workers. In 2014, CMS released a training toolkit organized around twelve broadly identified competency areas that principally are in line with those identified by the industry and LeadingAge.[41]

Most of the topics mentioned above are also covered in caregiver training in states with established training requirements. For instance, Virginia's homemaker-companion initial training course includes material on housekeeping, safety and emergencies, meal preparation, patient rights, and elder abuse.[42] Several surrounding states, including Massachusetts,[43] Maine,[44] and New York,[45] have also developed or required trainings containing similar content that is centered around some of the same core skills and competencies.

2. Analysis

Although there is variation in general training requirements for caregivers across states, CareAcademy's Executive Summary Training Report reported an average initial training requirement of 29.3 hours for non-medical home care provided by agencies offering Medicaid waiver services across the country (in Connecticut these would be the HCAs that provide PCA services under the Medicaid home and community-based waivers).[46] CareAcademy's analysis also found the lowest state-imposed training requirement to be

[40] "Personal Care Attendant Competency Development Guide" (LeadingAge Center for Applied Research), accessed November 15, 2024, https://leadingage.org/wp-content/uploads/drupal/Personal%20Care%20Attendant%20Competency%20Development%20Guide_Final_0.pdf.
[41] "Direct Service Workforce Training Resources Toolkit: A Companion Resource" (Centers for Medicare & Medicaid Services, December 2014), https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/dsw-core-competencies-training-toolkit-december-2014.pdf.
[42] "Virginia Homemaker/Companion Initial Training," CareCourses, accessed November 2, 2024, https://www.care-courses.com/collections/virginia-homemaker-companion-initial-training.
[43] Leanne Winchester and Kate Russell, "Massachusetts Personal and Home Care Aide State Training (PHCAST) Program," accessed November 2, 2014, https://mahealthyagingcollaborative.org/wp-content/uploads/2014/03/UMass-MEdical-Home-Care-State-Training.pdf.
[44] "Personal Support Specialist (PSS) Student Training Program" (Maine: Department of Health and Human Services, February 1, 2019), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/dlc/9-PSS-Training-Curriculum-2019.pdf.
[45] "Home Care Curriculum" (New York State Department of Health, January 2007), https://www.health.ny.gov/professionals/home_care/curriculum/docs/home_care_curriculum.pdf.
[46] Erika Sessions, "Executive Summary Training Report" (CareAcademy, September 6, 2024).

two hours, with the highest being 144 hours of training. Specifically, for homemaker-companions in this grouping, there is an average initial training requirement of 23.5 hours across 13 states.[47] The hourly mandate ranges from eight to forty hours of training depending upon the state.[48] Research suggests that caregivers providing hands-on assistance with activities of daily living often receive a greater number of skill-specific training hours than those who do not. While evidence suggests that 40 hours may be the ideal duration of training for workers providing personal care services, homemaker-companion agencies in Connecticut are not permitted to provide assistance with ADLs, with the exception of bathing and toileting, unless it is through a Medicaid waiver program. Therefore, if Connecticut adopts a minimum required number of training hours for caregivers, a lower requirement may be more appropriate for the scope of services provided by these workers.

Recommendations on appropriate training standards that exemplify best practices for providing homemaker and companion services

(1) Introductory/Orientation Training Requirements

(2) Written Examination and Proof of Competency

(3) Continuing Education

(4) Training Curriculum and Approval Criteria

(5) Training Portability and Uniformity

Among states that regulate training for caregivers of non-medical home care agencies, there is significant commonality in the topics, skills, and competencies included in their curricula. Some of the skills, competencies, and subjects most commonly identified as best practices include Communication skills; Infection Control; Health & Safety; Emergency Preparedness; Client Rights; Reporting Elder Abuse & Neglect; Monitoring & Documentation of Care; Nutrition & Meal Preparation; Housekeeping; Activities of Daily Living and Dementia & Alzheimer's. Furthermore, industry leaders, advocates, state regulators, and other stakeholders appear to offer broad endorsements of portability of training and adoption of some form of competency assessment for non-medical in-home caregivers. Lastly, there is substantial support for uniformity when adopting training requirements. Consistent requirements across programs is one of the key positive indicators in PHI's state index for direct care workers and is associated with positive outcomes for caregivers and clients.[49]

3. Recommendations

The following recommendations include the training standards that, research suggests, promote best practices for providing homemaker and companion services:

(1) **Introductory/Orientation Training Requirements**

In line with state and national best practices identified in this Plan, HCAs registered with the state should be required to provide their caregivers eight (8) hours of initial introductory training instruction before they are permitted to serve clients. This requirement should be established for

[47] Ibid.

[48] Paraprofessional Healthcare Institute (PHI), "Personal Care Aide Training Requirements."

[49] "State Index Tool Methodology & FAQ," PHI, accessed November 2, 2024, https://www.phinational.org/state-index-tool/methodology-faq/.

HCAs providing services through public programs as well as for private-pay clients. To ensure compliance with this mandate, HCAs should be required to submit documentation to DPH attesting that each caregiver employed by the agency is satisfactorily trained according to the established requirements.

While this recommended duration is likely sufficient for homemakers and companions, more training hours would be warranted if this plan is expanded to include personal care services to accommodate the broader scope of services (i.e., assistance with all ADLs and IADLs). Skills competencies related to ADL assistance should also be added to the training curriculum.

(2) **Written Examination and Proof of Competency**

HCAs should be required to provide proof of competency for their caregivers by attesting that each employed caregiver has met all state requirements, including the completion of training and receipt of a passing grade on a written examination. If the scope of services is expanded to include personal care services, then a skills demonstration should be included as well as a written exam.

(3) **Continuing Education**

HCAs should be required to ensure that caregivers who have completed their initial 8-hour training course also complete 8-hours of continuing education training made available by the HCAs on an annual basis. Records documenting course completion should be retained by the HCAs and available for audit by DPH.

(4) **Training Curriculum and Approval Criteria**

DPH should require HCAs operating in the state to provide training to their caregivers that, based on identified best practices, covers at a minimum the following broad topics: (1) Communication; (2) Person-Centered Care Practices; (3) Understanding and Reporting Elder Abuse and Neglect; (4) Nutrition and Meal Preparation for Older Adults; (5) CPR and First Aid; (6) Maintenance of a Clean and Safe Environment; (7) Basic Infection Control; and (8) Professionalism and Ethics. DPH may evaluate the possibility of including additional topics in the initial training and developing their own training platform, materials, and evaluation criteria.

DPH should identify a minimum set of continuing education training topics to be offered by HCAs to their caregivers that may include topics such as: Client Rights, ADLs and IADLs, HIPAA for Caregivers, Evaluation and Observation, Advocacy, and Cultural Competency.

(5) **Training Portability and Uniformity**

DPH should establish training requirements that allow for portability and better career advancement opportunities for caregivers. DPH should also work with other relevant state agencies such as DSS, ADS, and DDS, to better align training requirements across programs where appropriate and allow for the development of stackable credentials where additional specialty training is needed.

B. Specialized Training Benchmarks for Clients with Alzheimer's Disease and Dementia

1. Key Findings

Impacts of Dementia Care Training

Although homemaker companion services are frequently utilized by older adults, the most common demographic to receive a diagnosis for Alzheimer's disease,[50] HCAs in Connecticut are explicitly precluded from advertising their ability to provide "dementia care" as to prevent the misconception that caregivers can provide medical care services to these clients.[51] Dementia is a term used to describe a range of neurological conditions that affect the brain and worsen over time. Some diseases that can cause symptoms of dementia include Alzheimer's disease, and Frontotemporal, Lewy Body or Vascular dementia.[52] Due to the prevalence of Alzheimer's disease in Connecticut, stakeholders have begun to call for specialized trainings based on best practices for caregivers serving clients with Alzheimer's disease and other forms of dementia alongside general training standards for homemakers and companions.

While homemaker companions in Connecticut are not permitted to provide medical dementia care services, evidence suggests that caregivers who understand the disease and its associated impacts are able to anticipate the needs of their clients more effectively and provide better quality care. According to the National Council of Certified Dementia Practitioners, providing a baseline of dementia training to home care staff improves communication between caregivers and clients with cognitive impairments, enables staff to more effectively manage challenging behaviors as they arise, gives caregivers the skills to provide more compassionate care to this population, and enriches the emotional wellbeing of clients, as caregivers are better equipped to accommodate their unique needs.[53] Workforce dementia training requirements have also shown correlation with the reduction of the health, economic, and social burdens of people with dementia and their families, as well as improvement in clients' independence and overall quality of life.[54]

Other experts have identified basic dementia care training for homemaker companions as a potential means of lessening the burden of the ongoing healthcare specialist shortage, particularly for individuals in the early stages of dementia who do not necessarily require skilled nursing or institutional care. The American Public Health Association has reported that a training a workforce that is better prepared to support individuals with dementia at all levels of care, including social care (e.g., homemaker companionship), may improve service coordination, reduce the incidence of unnecessary hospitalization, and delay nursing home placement for individuals with dementia.[55] Such trainings have also been shown to reduce the incidence of caregiver burnout when working with this population, as well as create opportunities for the workers to grow in their professional careers.[56]

[50] "Alzheimer's Disease Facts and Figures," Alzheimer's Association, accessed November 1, 2024, https://www.alz.org/alzheimers-dementia/facts-figures.
[51] "Advertising Guidelines: Homemaker Companion Agencies," Fact Sheet (Connecticut Department of Consumer Protection (DCP)), accessed November 15, 2024, https://web.hcaoa.org/External/WCPages/WCWebContent/webcontentpage.aspx?ContentID=4982.
[52] "Types of Dementia," Alzheimer's Society, accessed November 15, 2024, https://www.alzheimers.org.uk/about-dementia/types-dementia.
[53] National Council of Certified Dementia Practitioners, "The Empowering Benefits of Dementia Training for Caregivers," July 16, 2024, https://www.nccdp.org/the-empowering-benefits-of-dementia-training-for-caregivers/.
[54] "Strengthening the Dementia Care Workforce: A Public Health Priority" (American Public Health Association, October 24, 2020), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2021/01/13/strengthening-the-dementia-care-workforce.
[55] Ibid.
[56] National Council of Certified Dementia Practitioners, "The Empowering Benefits of Dementia Training for Caregivers."

State & National Landscape for Alzheimer's and Dementia Care Training

Despite increased nationwide attention to developing standards for Alzheimer’s and dementia specialized trainings for caregivers, Kentucky, Washington State, Arkansas, and Florida are the only states to develop or approve standardized Alzheimer’s curricula. However, a rise in the number of state policy proposals related to dementia care training initiatives has been observed across the country in recent years. CareAcademy’s *Executive Summary Training Report* identified 22 legislative and regulatory proposals specifically addressing caregiver training for Alzheimer’s disease and dementia in 2024.[57] Federal policy includes but is not limited to the National Plan to Address Alzheimer’s Disease,[58] the Biden Administration’s Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers,[59] and the GUIDE Model.[60]

Rhode Island, Colorado, and Washington are among the states that have established dementia-related training requirements for caregivers employed by non-medical home care agencies.

- Rhode Island: Mandates that home care agencies providing services for individuals with Alzheimer's and other dementia-related conditions must meet specific training requirements to ensure appropriate care standards. Caregivers in Alzheimer’s- and dementia-specific care settings are required to complete at least twelve hours of specialized orientation and training.[61] This training covers essential topics such as understanding various forms of dementia, effective communication strategies with those with dementia, and techniques for managing behavioral challenges associated with these conditions. Ongoing education for caregivers is required annually, including two additional hours specifically focused on dementia care, to allow caregivers to stay up-to-date with best practices.
- Colorado: Specifies that all personal care staff employed by a licensed home care agency shall be provided initial training within 45 days of their hire date, which must include “communication skills with consumers such as those who have a hearing deficit, dementia, or other special needs.”[62]
- Washington: Requires all paid in-home caregivers, including non-medical workers, to obtain a state home care aide certification, which entails completing 70 hours of home care aide basic training. As part of the 70-hour basic training requirement, prospective home care aides must complete population-specific training in either dementia, mental health, or developmental disability.[63]

[57] Sessions, “Executive Summary Training Report.”
[58] “National Plan to Address Alzheimer’s Disease: 2023 Update” (U.S. Department of Health and Human Services), accessed November 2, 2024, https://aspe.hhs.gov/sites/default/files/documents/3c45034aec6cf63414b8ed7351ce7d95/napa-national-plan-2023-update.pdf.
[59] Joseph R. Biden Jr., “Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers,” Executive Order, Presidential Actions (The White House, April 18, 2023), https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/.
[60] “Guiding an Improved Dementia Experience (GUIDE) Model,” Centers for Medicare & Medicaid Services (CMS), July 2024, https://www.cms.gov/priorities/innovation/innovation-models/guide.
[61] “Licensing Home Nursing Care Providers and Home Care Providers,” Rhode Island Code of Regulations: 216-RICR-40-10-17, accessed November 2, 2024, https://rules.sos.ri.gov/regulations/part/216-40-10-17.
[62] “Personal Care Worker Training,” 6 CCR 1011-1 Chapter 26 Code of Colorado Regulations § 8.6, accessed December 3, 2024, https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8507&fileName=6%20CCR%201011-1%20Chapter%2026.
[63] Washington State Department of Social and Health Services, “Home Care Aide Certification and 75 Hour Training Overview,” https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTC%20Worker%20Training%20Requirements.pdf.

Nonexempt home care aides must also complete 12 hours of continuing education each year[64] on a variety of topics, which may include dementia care.[65]

Findings from State Agencies

DCP recommended that homemaker-companion agencies advertising their expertise in "dementia care" should be required to certify caregivers in dementia care. Public Act 23-48 allowed HCAs to advertise services for people experiencing memory issues. However, a specific amount of training was not required. The recommendation that caregivers become certified in dementia care was also supported by the Connecticut LTCOP. Additionally, ADS recommended that outside-certified dementia and Alzheimer's trainers be part of instruction requirements, and that training should be encouraged for all family caregivers.

Specialized Training Criteria and Best Practices

While there are numerous examples of training standards established across the United States, the Alzheimer's Association has been in the forefront of developing education which is widely recognized throughout the county. The Alzheimer's Association provides online no-cost training modules that cover topics to consider when developing a training curriculum, including understanding Alzheimer's and dementia risk factors, causes, symptoms, and progression; responding to dementia-related behavior and effective communication strategies; providing early-stage care following a diagnosis; late-stage care adjustments; and more.[66] Additionally, training components specific to Alzheimer's and dementia were included in the Direct Care Worker and Personal Care Aide introductory training core competencies that were developed by LeadingAge[67] and The DSW Core Competency Project.[68]

In focus groups conducted for this plan, which included HCA clients and caregivers, participants commonly expressed the opinion that caregivers should be trained to better understand the clients' ADL-related needs, as well as receive training in Alzheimer's and dementia, specifically, and in proper nutrition. Moreover, the National Association for Home Care and Hospice suggested that best practices would include requiring dementia care training for HCAs as part of the general training requirements for caregivers, rather than as a specialized optional credential. The Connecticut Alzheimer's Association also recommended that Connecticut establish defined training benchmarks for Alzheimer's and dementia care and that all HCA direct care staff receive such training upon hire. It was further recommended that these staff be subject to annual retraining requirements and that these trainings be provided by certified Alzheimer's Association trainers.[69]

2. Analysis

On average, the need for long term care manifests 3.9 years after an individual is diagnosed with Alzheimer's disease, and the average life expectancy following a diagnosis is 5 years.[70] In 2024, 76,800

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[64] "Continuing Education Requirements," Washington State Department of Social and Health Services, accessed December 3, 2024, https://manuals.dshs.wa.gov/altsa/training/continuing-education-requirements.

[65] "What Is Continuing Education and What Topics May Be Covered in Continuing Education?," Chapter 388-71 Washington Administrative Code § 0985, accessed December 3, 2024, https://app.leg.wa.gov/WAC/default.aspx?cite=388-71-0985.

[66] "Alzheimer's and Dementia," Alzheimer's Association, accessed November 2, 2024, https://alz.org/alzheimer_s_dementia.

[67] "Personal Care Attendant Competency Development Guide."

[68] "The DSW Core Competency Project," Centers for Medicare & Medicaid Services (CMS), accessed November 3, 2024, https://www.medicaid.gov/medicaid/long-term-services-supports/direct-care-workforce/dsw-core-competency-project/index.html.

[69] Information provided during interviews and focus groups conducted by the Corcoran Consulting Group.

[70] "Dementia," American Brain Foundation, accessed November 2, 2024, https://www.americanbrainfoundation.org/diseases/dementia/.

adults over 65 years of age had an Alzheimer's disease diagnosis in Connecticut, according to the Alzheimer's Association. This represents 11.9% of individuals aged 65 and older in the state.[71] The American Brain Foundation found that 33% of all people 85 or older may have some form of dementia. Individuals aged 65 and older are the most likely demographic to receive an Alzheimer's diagnosis, and this group currently makes up 17.4% of the population of Connecticut. Because the population of individuals over the age of 65 is expected to grow to at least 20% of the total state population by 2030,[72] demand for qualified in-home caregivers is projected to continue to rise in the coming years. Evidence suggests that the most effective way to address the projected rise in complex care needs for Connecticut's aging population may be to ensure that caregivers are provided a base of understanding of the needs and functional behaviors of clients with dementia. On average, the need for long term care manifests 3.9 years after an individual is diagnosed with Alzheimer's disease, and the average life expectancy following a diagnosis is 5 years.[73]

Caring for chronic conditions like Alzheimer's, dementia and other related conditions necessitates a multi-faceted approach, which includes ensuring that the client maintains a healthy lifestyle with proper diet and exercise, attends regular medical checkups, has their emotional needs met, and is able to access additional supports from healthcare professionals and community resources as needed.[74] In addition, care for clients with Alzheimer's disease often involves creating a safe and supportive environment, utilizing memory aids, and providing consistent routines to help the client manage daily activities.[75] Supporting clients with chronic conditions in their homes requires caregivers be trained to understand the client's condition and appropriately assist with the management of symptoms. Most clients receiving services from HCAs have at least one chronic condition.[76] As a result, care for individuals with Alzheimer's and dementia has been identified as a critical regulatory priority, as evidenced in the various policies and training mandates enacted and proposed at the federal level and across states.

3. Recommendations

Based on the research conducted, the following instruction and specialized training benchmarks for the care of clients with Alzheimer's disease, dementia and other related conditions are recommended:

(1) Include Basic Alzheimer's and Dementia Education in Introductory Training Curriculum

DPH should require HCAs to include educational material specific to Alzheimer's and dementia in the introductory training curriculum for caregivers. DPH may also consider including subsections specific to Alzheimer's and dementia in the Communication and Person-Centered Care sections of the introductory training curriculum proposed in Section III(A) of

[71] "2024 Connecticut Alzheimer's Statistics," Fact Sheet (Alzheimer's Association, 2024), https://www.alz.org/media/Documents/connecticut-alzheimers-facts-figures-2024.pdf.
[72] "Connecticut's State Plan on Aging" (Connecticut Department of Aging and Disability Services, 2024), https://portal.ct.gov/-/media/aginganddisability/agingservices/state-plans/state-plan-on-aging-2024_2027_final_-for-public-comments_06_01_2024.pdf?rev=1cd995f624e84e30ad1d395ab060f3e8&hash=A6FB7DA1C79FCD70CCB6123228E30EA3.
[73] Karlijn J. Joling et al., "Time from Diagnosis to Institutionalization and Death in People with Dementia," *Alzheimer's & Dementia* 16, no. 4 (April 2020): 662–71, https://doi.org/10.1002/alz.12063.
[74] "Taking Care of Yourself," Alzheimer's Association, accessed November 2, 2024, https://alz.org/help-support/i-have-alz/live-well/taking-care-of-yourself.
[75] "What Equipment Can Improve the Home of a Person with Dementia?" Alzheimer's Society, accessed November 15, 2024, https://www.alzheimers.org.uk/get-support/staying-independent/what-equipment-improve-adapt-home-person-dementia.
[76] Naoko Muramatsu et al., "Perceived Stress and Health among Home Care Aides: Caring for Older Clients in a Medicaid-Funded Home Care Program," *Journal of Health Care for the Poor and Underserved* 30, no. 2 (May 2019): 721–38, https://doi.org/10.1353/hpu.2019.0052.

this report. Similarly, the Department may evaluate other sections of the introductory training to include Alzheimer's and dementia-related best practices and require HCAs to submit an attestation to DPH ensuring compliance with established minimum training regulations for each newly employed caregiver.

(2) **Prohibition of Advertising "Dementia Care" Services Without Appropriate Credentials**

DPH should require HCAs advertising "dementia care", "Alzheimer's care", "memory care", or assistance with "memory loss", "senility", or other cognitive impairments as provided services to have Alzheimer's- and dementia-certified caregivers.

(3) **Training Curriculum & Dementia Care Certification**

DPH should explore the possibility of making recommendations for operationalizing training curriculum standards for a dementia care specialty certification. Based on identified best practices, the adopted training curriculum should cover, at a minimum, the following topics: Understanding Alzheimer's and Dementia, Effective Communication Strategies for Caregivers; Living with Alzheimer's for Caregivers; and Understanding and Responding to Dementia-Related Behavior. The Department may evaluate the possibility of including additional topics in the initial training. The Department should publish the list of approved trainings on their website and may assess developing their own training platform, materials, and evaluation criteria. To monitor compliance with this mandate, the regulatory agency may also require HCAs to submit documentation demonstrating that each caregiver who provides dementia care has satisfactorily completed the established trainings and earned a dementia care specialty certification.

DPH should identify a minimum set of continuing education training topics for Alzheimer's and dementia specialized trainings and may evaluate the need for requiring regular annual continuing education for dementia certified caregivers.

C. Quality Assurance and Appropriate Use of the Term "Care"

1. Key Findings

Regulatory Structure & Landscape

Currently, Connecticut HCAs are required to comply with certain DCP quality assurance standards. HCAs registered with the Department must: (1) conduct comprehensive background checks for their employees, (2) provide a written individualized service plan to their clients, (3) maintain a surety bond or insurance policy of at least $10,000, and (4) maintain client and business records open for inspection and audit by the commissioner. In addition, at the discretion of the Commissioner they may employ disciplinary actions for: agencies or employees engaging in deceptive or fraudulent practices, and HCAs engaging in untruthful or misleading advertising.[77] Amid confusion regarding the scope of services provided by HCAs, DCP has also added language to their statutes requiring HCAs to provide a written non-medical home care notice to their

[77] "Disciplinary Actions Against Homemaker-Companion Agency. Grounds. Notice and Hearing.," Chapter 400o Connecticut General Statutes § 20-675 (2011), https://www.cga.ct.gov/2024/sup/chap_400o.htm#sec_20-675.

clients and obtain the client's signature acknowledging receipt and understanding of such notice.[78] This has called into question the appropriate use of the term "care" in HCAs' advertisements and communications in Connecticut.

Findings from State Agencies

DCP and DPH both expressed the need for clarification regarding the scope of services permitted to be provided by HCAs. It would be difficult to develop or make recommendations on specific training standards and best practices without first clearly defining the scope of services permitted. Along these lines, DPH expressed concerns over the "scope creep" of HCAs, which has been reported to be impacting service delivery by some HCAs. DPH acknowledged that the industry appears to be trending in a more medically-focused direction. This shift presents challenges in determining whether the workforce is adequately prepared and trained to be aligned with an increase in scope. Although there are concerns over some HCAs blurring the lines between the medical and non-medical home care space, it is not believed to currently be a widespread issue.

2. Training Best Practices for Quality Assurance & Appropriate Use of the Term "Care"

The importance of establishing coherence in the definitions, scope of services and consistent requirements for HCAs was echoed in feedback received from industry leaders, HCA owners, clients, caregivers, and other stakeholders. Additionally, in focus groups with clients it was found that quality assurance and consumer confidence would be improved by establishing a minimal certification for caregivers employed by HCAs.[79] This would help to reassure clients that the caregiver has had some level of formal training in the services being provided. Formal credentialing could further provide caregivers with opportunities for growth and career development in their field, which was one of their main priorities.[80] Clients also specifically noted the need for better clarity concerning the level of care provided, and the need for better communication between agencies, caregivers and clients.

The National Association for Home Care & Hospice recommended standards for HCAs implementing a Quality Assurance program. Specific to training requirements they mentioned metrics such as: (1) implementing and tracking client outcome measures or improvements: having caregivers report and measure the improved quality of life of the client; (2) tracking incident rates, as many agencies don't track client falls, because such tracking is not currently required; and (3) education for caregivers and clients on the differences between Home Care and Home Health.[81] Nationally, states with established training requirements include many of these same elements of measuring quality and outcomes in their curricula.[82]

In interviews with Home Care Association executives and Home Care Agency CEOs in Connecticut and across the country, there were shared concerns surrounding further prohibitions or restrictions on the use of the term "care" when describing services provided by HCAs. As previously mentioned, DCP currently requires HCAs to provide a non-medical care notice to their clients and in advertisements.[83] The Home Care Association of America Connecticut Chapter (HCAOA CT), also previously provided testimony to the Aging Committee on the subject in 2023. The testimony was on the original draft of Senate Bill 1025, *An*

[78] Disciplinary Actions Against Homemaker-Companion Agency. Grounds. Notice and Hearing.
[79] Information provided during interviews and focus groups conducted by the Corcoran Consulting Group.
[80] Ibid.
[81] Ibid.
[82] Paraprofessional Healthcare Institute (PHI), "Personal Care Aide Training Requirements."
[83] Information provided during interviews and focus groups conducted by the Corcoran Consulting Group.

Act Implementing the Recommendations of the Homemaker-Companion Task Force. In their testimony, HCAOA CT notes the universality of the terms used in the non-medical home care space, by clients, families, and workers and emphasized that further prohibition or restriction would be disruptive to business practices.[84]

3. Analysis

Following comprehensive review of state and national best practices, information and feedback received from state and national industry stakeholders, Connecticut caregivers, clients and state agencies, key best practices for improving and promoting quality assurance in training standards for HCAs in Connecticut have been identified. The commonly identified best practices from the research conducted are (1) creating formal caregiver credentialing, (2) clarifying the scope of services that can be provided by homemaker companions, (3) aligning regulations with training standards, (4) providing education and disclaimers to caregivers and clients on the differences between non-medical and medical models of care, and (5) establishing training requirements for safety and falls prevention, workplace violence prevention, sexual harassment prevention, and tracking client outcome measures and improvements.

In addition to quality assurance expansion, stakeholders have called for the prohibition of use of the term "care" in marketing for HCA services out of concern that clients may specifically associate the word with medical services. However, a review of federal definitions, as well as descriptions of non-medical in-home services provided in other states demonstrates that the term "care" is universally used by the industry nationwide. The federal Administration for Community Living (ACL), for example, defines "personal care" as "non-skilled service or care, such as help with bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom," which is distinct from other forms of care that require medical expertise.[85] The U.S. Department of Labor similarly defines "companionship services" as "the provision of care … [that] is provided to and in conjunction with the provision of fellowship and connection … [and that] is limited to assistance with activities of daily living."[86] Rather, many entities use the term "health" to distinguish between non-medical in-home services and licensed home medical care, as in the usage of the terms "home care" and "home health care" by the ACL,[87] or directly incorporate the terms "medical" and "non-medical" to differentiate between service types. These findings suggest that the word "care" in this context denotes the personal and attentive characteristics of these services, the usage of which is comparable to the terms for such non-medical services as "childcare" and "day care," as opposed to the provision of medical assistance.

An evaluation of state regulations also revealed that the word "care" is commonly featured in states' homemaker companion provider definitions. In Oregon, for example, "in-home care agency" is defined as "an agency primarily engaged in providing in-home care services (including personal grooming, mobility assistance, nutrition/hydration assistance and others) for compensation to a client in the client's place of residence," and the state specifies that, because in-home care agencies do not provide home health services,

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[84] Home Care Association of America, "Senate Bill 1025, An Act Implementing the Recommendations of the Homemaker-Companion Task Force," Testimony, February 21, 2023, https://www.cga.ct.gov/2023/agedata/TMY/2023SB-01025-R000223-Chickerella,%20Marlene,%20Chair-HCAOA-Supports-TMY.PDF.

[85] "Glossary," Administration for Community Living (ACL), accessed November 15, 2024, http://acl.gov/ltc/glossary.

[86] "Domestic Service Final Rule Frequently Asked Questions (FAQs)," U.S. Department of Labor, Wage and Hour Division, accessed November 15, 2024, https://www.dol.gov/agencies/whd/direct-care/faq.

[87] Administration for Community Living (ACL) and Administration on Aging (AoA), "Home Health Care," Fact Sheet, accessed November 15, 2024, https://acl.gov/sites/default/files/news%202017-03/Home_Health_Care.pdf.

they are not statutorily recognized as "home health agencies."[88] Maine defines "personal care agency" as "a [licensed] business entity or subsidiary of a business entity that … hires and employs direct access personnel or individuals who work in direct contact with clients, patients or residents to provide home care services to individuals in the places in which they reside, either permanently or temporarily" and similarly specifies in statute that "personal care agencies" do not include "home health care providers."[89]

Rhode Island is the only state confirmed through this analysis to explicitly limit the inclusion of the word "care" in some capacity through restrictions on homemaker companion business names, though the term "care" is only prohibited when it directly follows the word "health." HCAs are also prohibited from including in their names the words "nurse" and "nursing" to avoid confusion among prospective clients.[90] This study did not identify a trend in states prohibiting the use of the term "care" within the context of non-medical in-home services.

This investigation found, though, that while stakeholders oppose broad restrictions against the use of the word "care," they generally support the establishment clear guidelines on its inclusion in marketing and service agreements. Therefore, agencies should continue to be required to clearly state that they provide non-medical services, with a detailed listing of what those services include (e.g., companionship, cooking, light housekeeping) and do not include (e.g., medical treatments, nursing care).[91]

4. Recommendations

(1) HCA Certification & Caregiver Certification

DPH shall explore the possibility of and make recommendations for operationalizing a caregiver certification for HCA employees who have completed the training course(s) and met all state requirements. DPH may also evaluate the creation of additional certifications and the establishment of prohibitions on HCAs advertising certified caregivers that have not received a state approved caregiver certification. This requirement may be implemented in combination with the "Written Examination and Proof of Competency" recommendation presented in Section III (A) of this report.

(2) Clarify Scope of Services for HCAs & Align Training Requirements

DPH should clarify the definitions of services permitted to be provided by HCAs in Connecticut and ensure that any subsequent training requirements established are within scope.

(3) HCA Quality Assurance Training Standards

DPH should require HCAs operating in the state to provide training to their caregivers that at a minimum includes the following broad topics: (1) tracking client outcome and improvement measures; (2) tracking and reporting incidents; (3) fall prevention; and (4) education for caregivers

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[88] "In-Home Care (IHC) Agency Initial Licensure Frequently Asked Questions," Fact Sheet (Oregon Health Authority, September 2023), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/HEALTHCAREHEALTHCAREREGULATIONQUALITYIMPROVEMENT/Documents/IHCFactSheet.pdf.
[89] "Licensing of Personal Care Agencies," Title 22 Chapter 401 Maine Revised Statutes § 1717, accessed November 18, 2024, https://www.mainelegislature.org/legis/statutes/22/title22sec1717.html.
[90] "Homemaker Companion Agency (HCA) Registration," Department of Consumer Protection, accessed November 1, 2024, https://portal.ct.gov/dcp/license-services-division/license-division/homemaker-companion-agency-registration.
[91] Information provided during interviews and focus groups conducted by the Corcoran Consulting Group.

and clients on the differences between home care and home health to ensure clarity for caregivers on the scope of their responsibilities. HCAs should provide documentation attesting to their compliance with all established training requirements or maintain proof of completion that is available upon audit.

(4) **Disclosures and Advertisements on Medical vs. Non-Medical Care**

DPH should continue to uphold DCP's current standard of providing a "non-medical" care notice to clients and in advertisements. The Department should implement improvements to these disclosures by developing a guide describing the differences between home care and home health that must be delivered to the client and included with their service plan. The "non-medical" disclosure should also be included with the service plan. DPH may also consider developing a template service plan for HCAs to use for their clients.

D. Discussion

The following challenges and obstacles are worth considering when evaluating recommendations related to (a) HCA caregiver training requirements, (b) standardized training specific to "dementia care", and (c) best practices for quality assurance and the appropriate use of the term "care."

1. Administrative and Regulatory Considerations

DPH has cited that they may be unable to enforce training requirements under a registration system. According to DPH, licensure would provide the regulatory framework and enforcement mechanisms necessary to impose training requirements on HCA caregivers, but the agency noted that this would require additional resources to establish the program. However, mandating that the industry be responsible for providing required minimum training to home care staff and submitting documentation to the regulatory agency, as well as tasking the oversight entity with auditing compliance with these requirements may address some of these resource concerns.

2. Access and Affordability

A growing aging population has increased the demand for non-medical supportive services. The increase in demand is heightened by a nationwide shortage of caregivers. Many have argued that the lack of training and opportunities for career advancement available to caregivers contributes to the existing workforce shortage problem. Others have argued, however, that over-professionalizing the field will increase business costs that will be passed on to the client, further limiting access to these services.[92] Additional evidence regarding the impact that this measure would have on training costs and accessibility may be needed to support the recommendations provided. As many HCAs in Connecticut are small businesses, there is concern regarding the impact that adoption of excessively stringent standards may have on these agencies and their ability to provide services to their communities.[93]

[92] Information provided in surveys, interviews, and focus groups conducted by the Corcoran Consulting Group.
[93] Information provided by DCP.

3. Quality

Although HCAs are already required to comply with various quality assurance standards, opacity regarding the scope of services provided by homemaker companions and the training that they receive may negatively impact clients' confidence in their caregivers. Training caregivers more comprehensively is suggested to improve workers' confidence and job satisfaction, reduce employee turnover rates, and produce greater quality of care for clients.[94] Additionally, required credentialling and more comprehensive training for non-medical caregivers provides greater opportunities for workers to progress in their careers and facilitates better communication and stronger relationships between workers and care recipients.

While some experts have argued that credentialling and training requirements over-professionalize the field,[95] research presented in Sections III(A) and III(B) suggests that minimum training standards may reduce confusion among prospective clients, as well as administrative burden for providers. Moreover, a broader base of professionals equipped to care for individuals with long-term chronic conditions may provide more equitable access to in-home care for this population, delay the need for institutional care, and save clients money by reducing their incidence of avoidable hospitalizations.[96]

The term "care" is used universally by governments, caregivers, and clients to refer to services of a generally personal or attentive nature, though stakeholders have expressed their approval of continuing to require that HCAs explicitly disclose that their care services are "non-medical" in all advertisements and communications. Stakeholders have also argued that prohibiting the use of the term "care" may contribute to further client confusion and impose significant administrative burden on HCAs. Further, requiring established entities to change their company names may suggest a more material change in service offerings for clients who are already familiar with the business and the services that they provide. The financial impact that this change may have on HCAs that feature the term "care" in their trademarked company name, rather than solely within the agencies' service descriptions, may also warrant further investigation.

V. Conclusion

Transferring responsibility of registration and oversight of HCAs from DCP to DPH is not a simple administrative change. Rather, it is a lengthy and potentially costly action for both the state and the HCA industry, which would likely get passed onto consumers paying for these services. Currently, DCP administers the registration and annual renewal processes for HCAs and regulates their business practices in pursuit of protecting the interests of the consumer. DCP's agency mission and staff expertise supports this regulatory framework. Should oversight be transitioned to DPH, an agency responsible for the oversight of health care service delivery, the scope and method of regulation would likely change focus and resemble a medical model of oversight concentrated on the services provided by HCAs. Any such transition would require legislative action from the General Assembly that contemplates the recommendations and considerations provided in this plan and ensures the avoidance of unintended negative consequences on the HCA industry, especially smaller HCAs, and the clients who count on these services (both in terms of cost and access).

[94] "7 Reasons Why Caregiver Training Matters," AxisCare, accessed November 18, 2024, https://axiscare.com/tip-sheets/reasons-why-caregiver-training-matters/.
[95] Information provided in surveys, interviews, and focus groups conducted by the Corcoran Consulting Group.
[96] "Strengthening the Dementia Care Workforce."

Additionally, Connecticut appears to be unique in the country by both separating homemaker-companion services from the provision of assistance with activities of daily living (except for allowing this under Medicaid home and community-based waivers) and with focusing on limiting use of the term “care”. Nationally, HCAs are typically referred to as “home care agencies” and provide a range of nonmedical services from companionship up to and including assistance with ADLs. To the degree that the few states who do address restrictions on terminology characterizing the distinction between a medical and nonmedical service model, the limitation is not on use of the term “care” alone but use of the phrase “health care”. Prior to enacting additional limitations on the use of the term “care” it is recommended that lawmakers carefully consider the implications of such action on the HCA industry. Finally, there are numerous examples across the HCA industry of quality assurance and training best practices, including those regarding Alzheimer’s disease and related dementias. Connecticut should consider how to implement these best practices to ensure HCA caregivers understand their roles and responsibilities, feel qualified to best serve their clients and for clients to receive quality nonmedical services in their homes.

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Appendices

Appendix A – Statutory Authority

Appendix B – Stakeholders Interviewed or Surveyed to Inform this Plan

Appendix C – DCP Complaint Investigation Process

Appendix D – DPH Complaint Investigation Process

Appendix A

Statutory Authority

Public Act No. 24-68

AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES

Sec. 36. Section 11 of public act 23-48 is repealed and the following is substituted in lieu thereof (Effective from passage): The Secretary of the Office of Policy and Management, in consultation with the Commissioners of Consumer Protection and Public Health, shall develop a plan to transfer the responsibility for registration and oversight of homemaker-companion agencies, as defined in section 20-670 of the general statutes from the Department of Consumer Protection to the Department of Public Health. Such plan shall (1) provide a timeline for the proposed transition, and (2) include recommendations on appropriate training standards that (A) exemplify best practices for providing homemaker and companion services, as defined in section 20-670 of the general statutes, (B) provide instruction and specialized training benchmarks for the care of clients with Alzheimer's disease, dementia and other related conditions, and (C) ensure a high quality of care for homemaker-companion agency clients and may evaluate and make recommendations on the appropriate use of the term "care" in describing the services provided by homemaker companion agencies and any limitations on the use of such term to Substitute House Bill No. 5290 Public Act No. 24-68 51 of 66 ensure consumer clarity. Not later than [August] December 1, 2024, the secretary shall report, in accordance with section 11-4a of the general statutes, on such plan to the joint standing committees of the General Assembly having cognizance of matters relating to aging, general law and public health.

Appendix B

Stakeholders Interviewed or Surveyed to Inform this Plan

State Agencies
CT Department of Consumer Protection
CT Department of Consumer Protection
CT Dept of Aging & Disability Services including the Office of the State Long Term Care Ombudsman
Alzheimer's Association of America – CT Chapter

Trade Associations and Strategy Groups
CT Association for Health Care at Home
Home Care Association of America – CT Chapter
National Association for Home Care & Hospice
Leading Home Care

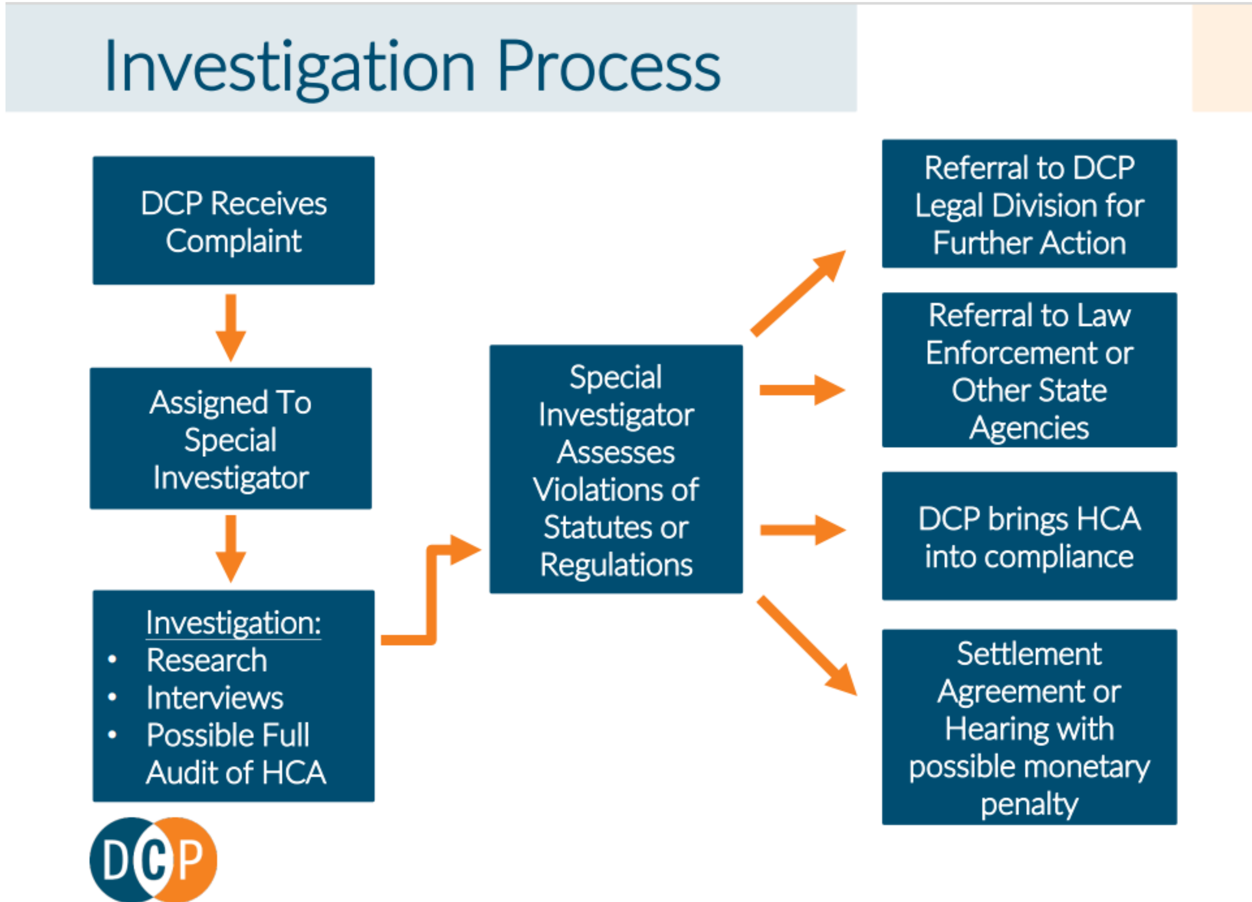
Home Care Agencies, Client and Family Members in Connecticut
Over 150 HCA leadership and caregiving staff provided information through survey or focus groups
Clients and caregivers provided information through individual interviews and focus groups

Home Care Agencies in Other States
California Association of Health Care at Home
Home Care Association of Florida
Pennsylvania Home Care Association
Illinois Home Care Counsel
Indiana Association for Home Care & Hospice
Trinity In-Home Care, Cincinnati, OH, also HCAOA Board
Home Care Providers (California)
Open Arms Solutions, (Illinois)
Family Caregivers Network, Pennsburg (Pennsylvania)
All the Comforts of Home (Colorado)
Home Care Franchise

National Home Care Training Leaders and IT solutions
Activated Insights
CareAcademy
Empowermentia
Nevvon
Relias
Community Health Accreditation Partner

Appendix C

DCP Complaint Investigation Process



Appendix D

DPH Complaint Investigation Process

Complaint-Facility Reported Incidents (FRI)
(The process is consistent across the healthcare sector in all 28 licensed institutions)