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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Diane Allen Tate

has been found to be complete and satisfactory in all respects,
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Review Committee
Dr. Derek Rohde, Committee Chairperson, Psychology Faculty
Dr. Reba Glidewell, Committee Member, Psychology Faculty
Dr. Richard Thompson, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2023

Abstract

Strategies to Reduce Turnover Among Black Home Healthcare Aides

by

Diane Allen Tate

MA, Boston University, 1975

BA, Boston University, 1972

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Psychology in Behavioral Health Leadership

Walden University

February 2023

Abstract

Many individuals prefer to remain in their homes as they age instead of entering a long-term care facility. As the proportion of older Americans rapidly grows, the demand for delivery of nonmedical services by home healthcare aides (HHAs) is expected to increase. However, the national and local supply of HHAs is insufficient and must be rectified to meet a projected increase of older Americans by 2050. This research study involved exploring this problem for one small home healthcare organization in the Maryland suburbs outside of Washington, DC with an HHA workforce that was comprised predominantly of Black/African American and African women. Using a single case qualitative study design, data were collected through semi-structured interviews with the organization's behavioral health leaders and a review of organizational records. The study was grounded in the Baldrige Excellence Framework which describes concepts and behaviors that characterize high-performing organizations. Thematic qualitative analyses were conducted to describe practices the organization used to recruit and retain their HHA workforce and to compare these practices to effective strategies according to scholarly literature. Results showed the organization had a practical foundation upon which it can build successfully to improve its HHA recruitment and retention practices and reduce staff shortages and turnover. The study also addressed a literature gap involving how racial, ethnic, and culturally-based perspectives involving elder caregiving might be used to enhance HHA recruitment and retention. Actionable recommendations are presented to strengthen the organization and contribute to positive social change.

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Dedication

I dedicate this research study to all home healthcare aides who deliver selfless, life-enhancing services to thousands of elderly and disabled Americans daily to help them retain their independence during difficult times. I am especially grateful to my late mother, Gwendolyn, who received home healthcare services for over six years and continually inspired and encouraged me to complete my doctoral studies until her passing five months ago.

Acknowledgments

I want to thank my daughter, Alleson, for accompanying me on an adventurous six-year doctoral journey. Alleson and my mother were my greatest supporters. I thank my classmates at Walden University, doctoral Committee Chair Dr. Derek Rohde, and Second Committee Chair Dr. Reba Glidewell, for their ongoing feedback, guidance, and encouragement. I thank University Research Reviewer Dr. Richard Thompson for his insight. Also, I must thank the late Dr. Freda Gould Rebelsky, former Chair of the graduate developmental psychology program at Boston University. She planted a seed in my mind over 40 years ago that I should pursue a doctorate, and this research study reflects the value of lifelong learning. Finally, I am grateful to the small nonprofit organization that served as the case for this study and whose leaders did everything they could to support a lengthy collaboration.

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Section 1a: The Behavioral Health Organization

Introduction

There is a growing crisis in the United States for older adults and disabled persons needing long-term care (LTC) and support services (Scales, 2018). By 2060, the number of Americans aged 65 and older will more than double from 46 million in 2014 to upwards of 98 million (Mather et al., 2015). During the same timeframe, the number of Americans aged 85 and older will triple from 6 million in 2014 to 20 million by 2060 (Mather et al., 2015). The expected explosion in the population of older Americans by mid-century must be met with a sufficient supply of qualified home healthcare workers to help support the physical, behavioral, and cognitive limitations that often accompany this phase of life (Carpenter et al., 2021). This is particularly true since many older individuals prefer to remain in their own homes and communities to receive care for these challenges (Ahn et al., 2021; Olsen, 2019).

In the State of Maryland, the number of persons aged 65 and over is expected to grow by 75% from 837,496 in 2015 to 1,465,776 in 2045, and the number of people aged 85 and older is anticipated to increase by 179% over the same time period (Scales, 2018). In the Maryland suburbs outside of neighboring Washington, DC, where the organization I studied is located, the number of persons aged 65 and older is expected to grow by 99% from 323, 515 in 2015 to 643,895 in 2045, and the number of individuals aged 85 and older is expected to increase by 242% over the same time period. Given these projections, the demand for LTC and support services within the geographic area served by the organization under study is likely to be substantial.

Despite these projections, there is a disconnect between current and anticipated demand for in-home LTC services in the U.S. and in Maryland, and the supply of direct care workers (DCWs) who are qualified and available to render services. In this study, I examined the crisis involving recruiting and retaining qualified home healthcare aides (HHAs) and focused on one organization's commitment to overcoming these challenges. Throughout Section 1a and Section 1b as well as subsequent sections, I use terms that are relevant to understanding this doctoral study (see Table 1).

Information in Section 1a and Section 1b was obtained through exploratory semi-structured interviews I conducted with the organization's behavioral health leadership and reviews of current and archival documents and publicly available documents. I held initial discussions with the behavioral health leaders (BHLs) to establish the basis for the professional practice problem and study context. As such, many of the topics and findings described in Section 1 are addressed in more detail in Sections 2 through 4.

Table 1

Overview of Selected Key Terms Used in Research Study

Term	Acronym	Working Definition
Behavioral Health Leader(s)	BHL(s)	The study interviewee(s) who are the Executive Director and Nurse Supervisor at the participating organization.
Black or African American	B/AA	Individuals in the U.S. with partial or total ancestry from sub-Saharan Africa (i.e., not North Africa) and who are descendents of Africans who were enslaved in the U.S. The singular descriptor "Black" is used interchangeably in this study to connote B/AA background.

Term	Abbreviation	Definition
Activities of Daily Living	ADL	A person’s usual daily self-care activities such as bathing, dressing, and moving within the home.
Certified Nursing Assistant	CNA	A member of a client’s healthcare team who performs hands-on tasks under the supervision of a Registered Nurse or Licensed Practical Nurse.
Client	n/a	The recipient of healthcare services in their home.
Code of Maryland Regulations	COMAR	The official compilation of administrative regulations issued by agencies within the State of Maryland.
Direct Care Worker	DCW	A person who provides hands-on care services to clients.
Geriatric Nursing Assistant	GNA	A CNA with additional training and competency related to caring for elderly and disabled clients.
Home Healthcare Aide	HHA	A generic term used in this study that refers to CNAs, GNAs, and Unlicensed Aides who provide services in a home care setting.
Instrumental Activities of Daily Living	IADL	More complex daily living activities of clients such as fixing one’s meals, driving, or taking public transportation.
Long-term Care	LTC	A variety of services that are designed to meet a person’s physical and behavioral needs to help them live independently and safely when they can no longer perform everyday activities alone. Services might be performed in a skilled nursing or rehabilitation facility, an assisted living center, an in-home setting, or a related environment.
QRS	QRS	The pseudonym of the organization participating in the study.

Underserved or Marginalized	n/a	Populations or groups that are disadvantaged due to inability to pay, poor access, or other disparities attributed to factors such as race, religion, native language, and socioeconomic status.

Organizational Description

The organization under study is QRS (pseudonym), a nonprofit 501(c)(3) organization located in suburban Maryland outside of Washington, DC. It is considered a nonmedical home healthcare agency. This means that its primary goal is to render physical and behavioral health support in the homes of clients who do not require medical or skilled nursing services such as injections, wound dressings, or intravenous infusions (Carpenter et al., 2021). Traditionally, this includes providing support with activities of daily living (ADLs), instrumental activities of daily living (IADLs), companionship, and socialization (Rossman, 1997). ADLs are normal daily activities a person usually engages in themselves such as bathing, dressing, ambulating within the home, and taking medications. IADLs are more complex routine tasks such as preparing one's own meals, performing household chores, shopping, driving a vehicle, and taking public transportation.

Nonmedical home care—the institutional context for QRS—traditionally provides help with personal care tasks, with routine activities persons would normally engage in themselves if they had no limitations, and with socialization and emotional support (Carpenter et al., 2021). The nonmedical home care model is becoming increasingly popular given the importance of activities like medication adherence, socialization, and

nutritious meal preparation for obtaining positive health outcomes (Carpenter et al., 2021).

Assets and Regulation

As with many small nonprofits, QRS assets are limited. The Executive Director (ED) said non-personnel assets include office desks, tables, computer hardware and software, printers, a training/meeting room, and telecommunications equipment. Personnel assets include two BHLs (ED and Nursing Supervisor), an administrative assistant, and a fluctuating staff of 50 HHAs who work directly with assigned clients in their homes.

As a 501(c)(3) tax-exempt organization, QRS must abide by rules and guidelines established under the Internal Revenue Code for charitable organizations. Specifically, none of its earnings can benefit any private shareholder or individual, and it must not influence legislation or support political campaigns or candidates. As a nonmedical home healthcare agency in Maryland, QRS is licensed by the Office of Health Care Quality (OHCQ) in the State of Maryland Department of Health.

Staff

The ED said QRS currently employs 50 HHAs who provide direct services to a current daily census of 50 in-home patients. HHAs are comprised of Certified Nursing Assistants (CNAs), Geriatric Nursing Assistants (GNAs), and Unlicensed Aides. CNAs and GNAs are certified by the Maryland State Board of Nursing under the Code of Maryland Regulations (COMAR) which is the official compilation of administrative regulations issued by Maryland agencies. CNAs are individuals who are certified to

routinely perform nursing tasks under the supervision of a Registered Nurse or Licensed Practical Nurse (COMAR, 2022). CNAs who intend to work in home care settings undergo an additional home healthcare competency evaluation. A GNA is a CNA with additional required training and competency in working with elderly and disabled persons (COMAR, 2022). GNAs and CNAs often work in nursing homes, but they are also prevalent working in personal homes and assisted living facilities (Black, 2015).

CNAs and GNAs play a vital role in LTC by helping to promote the physical and behavioral health of patients who depend upon their help with ADL and IADL tasks, socialization, and emotional support. QRS also employs Unlicensed Aides who are not certified or licensed by the state because they strictly provide companionship and socialization services for clients. The BHLs also depend on volunteers from the local community to help with fundraisers and other events to meet its mission.

Service Offerings

Services delivered by QRS primarily involve help with ADL and IADL tasks that allow elderly and disabled clients to remain in their homes and maintain daily routines that promote health and wellness. Examples of ADL tasks include help with bathing and dressing, using the bathroom, light meal preparation and housekeeping, and moving from room to room (Osakwe et al., 2019). IADL activities involve higher levels of independence and complex thinking such as taking public transportation, maintaining financial records, and cooking meals (Osakwe et al., 2019). Companionship and socialization services provided by Unlicensed Aides include tasks such as reading to

clients, engaging in crafts, and accompanying clients to medical appointments or events. Services are offered for any amount of time, from an hour to 24-hour coverage.

Clients

Clients of QRS are elderly and/or disabled individuals in need of ADL and IADL services to help them remain in their homes instead of entering a nursing home, rehabilitation center, or an assisted living facility. Clients also include homebound and frail elderly persons who are a special subgroup that is especially vulnerable to institutionalization without quality in-home healthcare (Lubaczewski & Pezzoli, 1998).

Most QRS clients are Black or African American (B/AA) born in the United States, while HHAs at QRS comprise workers who are B/AA, African, Haitian, Hispanic, and non-Hispanic White. The organization currently has only a few African clients. The Nurse Supervisor (NS) who is African attributes this observation mostly to a custom within African culture that family members typically take care of their own elders. QRS has few White clients which may be due to the location of the agency in a county where 64.1% of the population is B/AA and 27.2% is White (U.S. Census Bureau, 2022).

Organizational Structure

In this small nonprofit organization, BHLs have developed an organizational structure that is uncomplicated and practical. Since its inception in 2016, the QRS Board of Directors has grown from five to seven members who have expertise in law, medicine, psychology, social work, education, human services, marketing, and event planning. One member currently serves as the Board Chair and ED. Two Board members occupy the positions of Secretary and Treasurer. All seven individuals are independent voting

members of the Board. Its members govern and provide overall strategic direction to the ED who oversees day-to-day administration and operations. Identification, screening, hiring, assignment, and monitoring of HHAs who deliver direct patient services are collaborative activities involving the ED and NS.

Practice Problem

The practice problem for this research study concerns workforce recruitment and retention of HHAs at QRS. This is an industry-wide problem that has been an ongoing challenge in the LTC sector. Although various strategies have been applied to improve industry retention rates for nurses and HHAs, dramatic improvement has not been achieved (Black, 2015). QRS has experienced problems for three years in terms of hiring and retaining qualified HHAs in order to provide direct services to seniors and disabled individuals. HHA shortages and turnover are occurring at a time when the preference of older Americans for aging-in-place, or growing older in their own homes and communities as an alternative to facility-based care, is increasing (Ahn et al., 2020). Adding to the practice problem is the public health crisis caused by the COVID-19 pandemic which exacerbated HHA shortages at QRS due to issues noted by Bandini et al. (2021). This included safety concerns attributed to client COVID-19 status, inadequate access to personal protective equipment, and unsafe public transportation.

QRS leaders said HHA shortages also occur due to a lack of workplace professionalism and dependability. Although their HHAs pass basic hiring requirements, screenings, and background checks, the on-the-job performance of some caregivers hampers client service delivery due to a lack of workplace courtesy. Examples of this

undesirable behavior include not showing up on time for assignments, last-minute cancellations of scheduled home visits, and quitting without advance notice. Leaders at QRS want to implement strategies and promising practices identified by researchers and other leaders in the home healthcare industry to strengthen their organizational hiring and retention practices and reduce undesirable behaviors.

Since most of the organization's clients are B/AA, learning about effective culturally-based solutions is also of interest. Through this study, I considered whether there are motivators for worker recruitment and retention that appear to be culturally driven. Although researchers have surveyed HHAs of color, I found no information about culturally competent HHA recruitment or retention strategies. Yet, B/AA women are disproportionately represented among HHAs and comprise about 34.9% of the national HHA workforce (Bercovitz et al., 2011).

Research questions that guided this doctoral study are as follows:

RQ1: How do leaders at QRS recruit home healthcare aides?

RQ2: How do leaders at QRS retain home healthcare aides?

RQ3: How do leaders at QRS incorporate cultural considerations into recruitment and retention practices?

Purpose

The study's purpose is to address the practice problem identified by QRS leadership using a single case study methodological approach that involved applying the Baldrige Excellence Framework (NIST, 2021), collecting interview data from QRS leaders, and reviewing public and internal records and the scholarly literature. I chose this

Framework for the study because it focuses on characteristics of high-performing organizations in many areas of leadership and management, including workforce engagement and development. It is applicable to large and small organizations. I used the Framework to develop questions about the organizational environment at QRS (e.g., governance, leadership, workforce profile and engagement, clients and competitors) to explore potential factors that could be positively or negatively impacting the organization's capability and capacity to recruit and retain qualified HHAs. I applied the Baldrige Excellence Framework (NIST, 2021) by taking interview questions directly from the Framework's healthcare criteria, since QRS provides healthcare services, and developing a semi-structured interview guide. I adapted the wording of the questions as warranted to customize it to the QRS environment. I then used the interview guide to collect information from the two BHLs included in the study.

I analyzed the BHL's interview responses to describe current strategies used by QRS for recruiting and retaining HHAs and making potential organizational changes and improvements. I compared the BHL's descriptions of how they currently operate to strategies discussed in the academic literature that were found to promote or hinder HHA recruitment and retention. My goal was to recommend actionable and culturally appropriate strategies for improving QRS hiring and retention of HHAs to help the organization grow and thrive. I examined workforce composition, systems, processes, and practices of QRS and assessed organizational capability and capacity to recruit and retain qualified HHAs. I used primary and secondary data collection techniques in this study to address the research questions.

Primary Data Collection

Primary data collection consisted of semi-structured interviews with two BHLs at QRS. I developed and used an interview guide that consisted of questions and probes adapted from the Baldrige Excellence Framework (NIST, 2021) which is based on characteristics of high-performing healthcare organizations. I conducted the interviews informally and conversationally so that the BHLs would feel at ease in responding. Table 2 reflects interview guide questions on workforce development that I adapted from the Framework.

Table 2

Interview Questions on Workforce Development at QRS

Topic	Interview Questions
Workforce Environment	• How do you build an effective and supportive employment for your HHAs? • How do you assess your workforce capability and capacity for these DCWs? • How do you recruit, hire, and onboard new HHAs? • Do any of these strategies vary depending upon the racial, ethnic, or cultural background of the HHA (e.g., B/AA, African, Haitian, Hispanic)? If so, are you aware of any patterns or customs that we may be able to build upon to improve HHA recruitment and retention at QRS? • How do you ensure workplace health, security, and accessibility for the HHAs? • What are your performance measures and improvement goals for your workplace environmental factors? • How do you support your HHAs via services, benefits, and policies?
Workforce Engagement	• How do you engage your HHAs for retention and high performance? • How do you promote job satisfaction for your HHAs?

	• How do you foster an organizational culture characterized by open communication, high performance, patient safety, and an engaged workforce? • How do you manage career development for your HHAs?

Note. Adapted from *2021-2022 Baldrige Excellence Framework (Health Care): A systems approach to improving your organization's performance* by U.S. Department of Commerce, National Institute of Standards and Technology, 2021. https://www.nist.gov/baldrige/publications/baldrige-excellence-framework/health-care

Secondary Data Collection

Secondary data consisted of QRS current and archival documents that could be used to corroborate or increase understanding of the BHL interview data. I anticipated challenges in terms of receiving some of these materials from this small nonprofit organization. Nonetheless, I requested annual reports for 2019, 2020, and 2021 to examine organizational programs, activities, and accomplishments and strategic plans for 2020 and 2021 to examine stated plans and priorities. I asked for an HHA position description to ascertain employment qualifications, roles, and duties and two completed employee performance evaluations with employee identifiers redacted for anonymity. I also asked for a current employee manual to examine information provided to HHAs on QRS policies, procedures, and benefits. Finally, I requested financial reports for 2020 and 2021 to determine the financial position of the organization.

Significance

The number of persons who will need some form of LTC is projected to nearly double from 46 million in 2014 to over 98 million by 2060 (Mather et al., 2015). A substantial number will prefer to receive LTC in their communities through DCWs, including HHAs (Bercovitz et al., 2011). Thus, it is important that home healthcare

agencies such as QRS find actionable strategies and solutions to the industry-wide problem of recruiting and retaining qualified HHAs and decreasing worker shortages and turnover. Otherwise, a lack of qualified HHAs could negatively impact client physical and behavioral health outcomes and mitigate the viability of in-home healthcare as an effective alternative to entering a LTC facility.

In terms of behavioral health organizational practice and leadership, the study may help fill a gap in terms of understanding how to use effective and culturally competent approaches to improve recruitment and retention of Black HHAs. This is an important endeavor since Black women are disproportionately represented among HHAs in the LTC industry, comprising 34.9% of HHAs nationwide (Bercovitz et al., 2011) and most of the QRS workforce.

DCWs occupy some of the lowest paid positions in the American healthcare system (Bercovitz et al., 2011). Schweid (2021) said those who help preserve the health and independence of older Americans barely make a living wage to take care of themselves. Thus, I examined the extent to which earnings may play a role in terms of recruitment and retention of Black HHAs, and how income inequality is detracting from the creation of a pool of qualified and competent HHAs and leading to expanded numbers of working poor in America.

Summary and Transition

The study involved exploring a practice problem involving BHLs at QRS as well as a prevailing challenge of BHLs in the home healthcare industry. Strategies for recruiting and retaining qualified HHAs and decreasing DCW shortages are needed to

help meet the LTC needs of elderly and disabled individuals who want to age-in-place by remaining in their homes and communities as they get older instead of living in a more restrictive environment. As a small nonprofit home healthcare organization, QRS offers personnel services to help support the physical and behavioral health needs of elderly and disabled individuals in suburban Maryland. However, it is operating within a competitive market of for-profit home healthcare agencies that may be positioned to offer enhanced salaries and benefits, which could impact the stability of the QRS workforce.

Using a single case study qualitative approach, the study involved examining strategies used by QRS and similar organizations that hold promise for resolving the stated practice problem drawing upon the Baldrige Excellence Framework (NIST, 2021). Also, since the QRS workforce is comprised mainly of Black HHAs who are lower wage workers, I expect to gain an understanding of strategies that may lead to positive social change by addressing income inequality among America's working poor.

In Section 1b, I provide an organizational profile of QRS to convey a general overview of the organization in terms of its purpose, organizational structure, staff and stakeholder profiles, regulatory and compliance requirements, and performance improvement efforts.

Section 1b: Organizational Profile

Introduction

The professional practice problem in this study involved strategies to reduce turnover among Black HHAs. The study's purpose was to examine this problem for one home healthcare organization located in suburban Maryland outside of Washington, DC. The research questions involve how leaders within the organization recruit and retain their HHA workforce, and whether they consider and incorporate any culturally-based factors in their staff recruitment and retention practices.

This section includes an organizational profile of QRS and factors of strategic importance. I describe the organization's mission, vision, values, governance, structure, and service offerings. I also provide an institutional context for the study and describe the organization's resource planning strategy and performance improvement system.

Organizational Profile and Key Factors

Factors of Strategic Importance to QRS

Kemper et al. (2005) reported that Americans will need LTC services for an average of three years after they reach age 65, especially those with chronic conditions and/or functional limitations. Yet, most older Americans are unprepared to contend with dramatic changes in their healthcare status that may require supportive services and pose overwhelming financial challenges (Lewin Group, 2010).

It is important to BHLs at QRS that they are well-positioned to maintain a sufficient qualified pool of HHAs to meet the healthcare needs of elderly and disabled persons in their service area who could benefit from the services they offer. The

population of residents in the QRS service area is projected to increase by 99% around mid-century for individuals 65 and older and by 242% for persons 85 and older (see Table 3). Therefore, this organizational strategic goal is both viable and necessary. In stark contrast, only a 7% percent increase is projected in the number of persons in the 20 to 64 age group by 2045.

Table 3

Population Projections by Age Group for the QRS Service Area

Age Group	2015	2025	2035	2045	Change	Percent Change
20-64	1,561,159	1,580,869	1,603,112	1,663,239	102,080	7%
65+	323,515	464,190	597,010	643,895	320,280	99%
85+	42,081	56,423	95,800	143,735	101,654	242%

Note. Adapted from *The Direct Services Workforce in Long-term Services and Supports in Maryland and the District of Columbia* by Scales, K. PHI Research Brief, 2018. https://www.phinational.org/wp-content/uploads/2018/09/DSWorkers-Maryland-2018-PHI.pdf

Not only do BHLs at QRS consider workforce readiness a strategic priority, but service affordability is equally important. QRS was formed to provide underserved elderly and disabled persons with high-quality and affordable home healthcare options. Delivering reasonably priced home care services was of key importance to the Board of Directors at its founding, and this factor continues to drive their activities and initiatives. The ED stated that its nonprofit status allows the organization to offer affordable rates to QRS clients, a sizeable number of whom are paying out-of-pocket.

Mission

McKenzie (2010) described a philosophical difference between for-profit and nonprofit providers of home healthcare and hospice services. For-profits are likely to have organizational missions, visions, and values that focus on their core and highly specialized services. Nonprofits do not only focus on their core service offerings but also on greater public health needs that exist within communities which are addressed via health and wellness programs and immunization campaigns (McKenzie, 2010).

As stated on the QRS website, the mission of QRS is to educate, support, and empower. The mission aligns with the philosophical underpinnings of a nonprofit charitable organization committed to providing quality and affordable nonmedical support to elderly and disabled individuals. Directly related to the mission are its key objectives to promote self-actualization, render instruction to increase awareness, and support the eldest citizens by creating a strong foundation for their long-term stability.

Vision

The QRS Board of Directors and BHLs envision the organization will be able to reach a vast population of elderly and disabled individuals who could benefit from in-home healthcare services but for whom affordability is an issue. The ED said, “We seek to incorporate programs that allow them to remain independent in their homes as an alternative to institutionalization.” At the same time, the ED foresees more exposure of their clients to children and other community members to enhance in-home life quality.

Values

Honesty, transparency, integrity, and trust in service provision are principal values at QRS. These values are reflected in the process used to assign an HHA to a particular client. Once a client assessment is conducted and a plan-of-care is developed, required personnel are matched to clients' needs, and the plan is articulated to the client and family in a clear, honest, and transparent manner. Should a client's plan-of-care not require the skills of a CNA or GNA—and is more oriented toward personal self-care, companionship and socialization—then assignment of an Unlicensed Aide is made, and the plan clearly reflects this determination. Similarly, trust is salient, especially in terms of establishing and maintaining relationships between QRS leaders and staff. Personnel need to feel confident that a competent leader has determined that homes they enter are safe prior to starting an assignment. Similarly, leaders need to know that staff will keep them informed about their status and work environment.

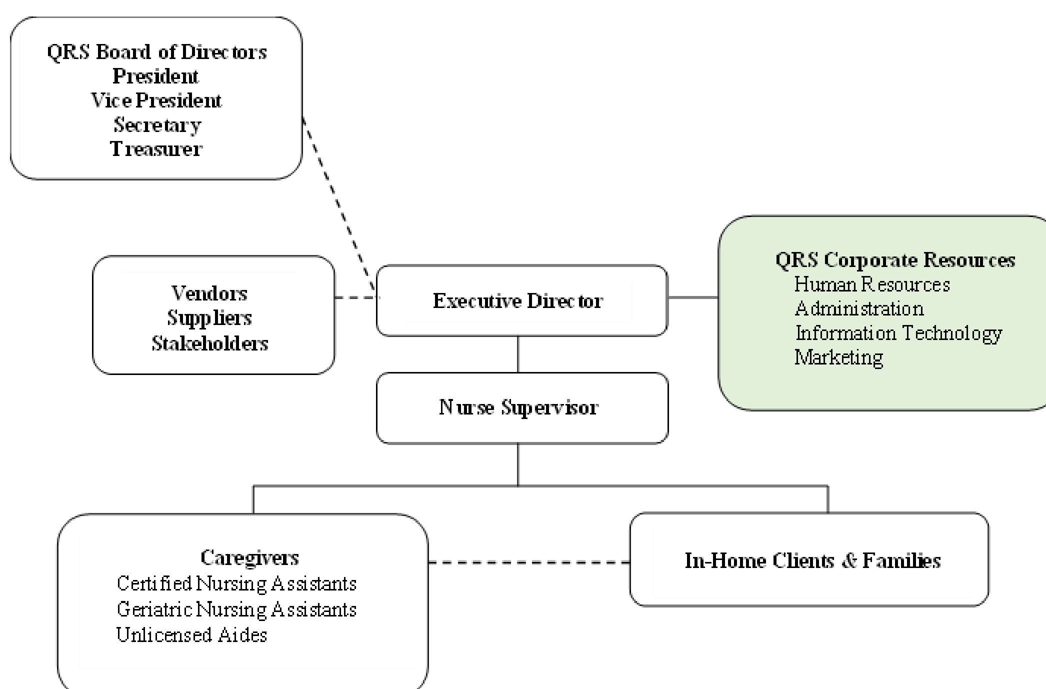
Governance and Organizational Structure

At the small nonprofit organization, BHLs have developed an organizational structure that the ED stated is practical for their purposes (see Figure 1). It is a traditional hierarchical structure through which oversight, decision-making, and communication flows from the top down—from the Board of Directors to the ED to the NS to the office personnel and frontline workers. The ED is the founder and chair of the Board of Directors. The ED oversees day-to-day QRS operations and maintains connections with suppliers, vendors, and other external stakeholders to meet the organization's mission. The ED supervises the activities of the NS. Identification, screening, hiring, assignment,

and monitoring of HHAs who deliver direct patient services is a collaborative activity between the ED and NS. Ultimately, all work is performed to provide quality healthcare services to QRS clients and their families.

Figure 1

QRS Organizational Chart



Strategic Direction

The ED envisions that strategically the role of volunteers in its programs will help the organization grow and meet the needs of increased numbers of underserved elderly and disabled persons over the next few years and beyond. Currently, volunteers assist with organization-sponsored events, such as fundraisers. The BHLs intend to recruit and train additional adult and youth volunteers to help with direct service delivery to patients. They anticipate that volunteers could read and sing with clients and help them write

letters to family members and friends. They also expect to pair volunteers with HHAs as caring community companions. The ED stated the BHLs are currently working on this concept with an intern from a local community college to help actualize these plans.

Another strategic priority communicated by the ED is increasing the presence and visibility of QRS in the community as a nonprofit organization invested in the health and wellness of older Americans and the disabled. Increasing its community presence should help to raise awareness of home care services available to underserved or marginalized individuals who have avoided access due to affordability.

Services

QRS provides nonmedical home healthcare services to its clients and their families who contract for services (QRS website, 2022). This consists primarily of assistance with ADL and IADL tasks that promote independence and normalcy for in-home clients (QRS website, 2022). They offer these services because such activities are essential to experiencing a decent quality of life in the community, and low ADLs are strongly associated with poor health outcomes (Osakwe et al., 2019). This can lead to higher hospitalization rates and costs of healthcare (Chuang et al., 2003; Kumar et al., 2017). Low ADLS can also lead to increased mortality and risk of admission to a nursing or rehabilitation facility (Holup et al., 2017; Stineman et al., 2012). Table 4 includes additional detail on the specific ADL, IADL, companion, and socialization services that HHAs provide to QRS clients as conveyed by the ED and given on the QRS website.

Table 4

Nonmedical Service Offerings by QRS

Type of Service	Description of LTC Support Services
ADL Services	-Ensure medications are taken as directed -Implement exercises prescribed by a physical therapist, an occupational therapist, or another healthcare professional -Help with nutrition planning and grocery shopping -Prepare light healthy meals -Help with eating or being fed -Perform light housekeeping and chores -Help with grooming, personal, oral hygiene and using restroom -Assist with mobility, ambulation, and transfer from bed or chair -Help with dressing and changing clothes
IADL Services	Help client: -Take own medications -Prepare own meals -Use public transportation -Drive own vehicle -Perform light housekeeping and chores -Handle personal finances
Companion and Socialization Services	-Provide fellowship and emotional support -Sit and converse with client -Reduce isolation -Make beds and launder clothing -Plan meals with client input -Run short errands -Escort patients to medical appointments or religious events

Performance Improvement System

The members of the QRS Board of Directors and the BHLs follow a systematic approach to ascertain and manage the performance of the organization and its personnel

in delivering services. It is a basic process which the ED stated they intend to expand to gain more insight into their performance.

At present, the QRS performance improvement system is tied into determining whether the organization is meeting the home healthcare needs of its client population. The ED explained that an initial needs assessment is conducted by one of the BHLs with clients and families prior to commencing services. At that time, goals and services are outlined and incorporated into an individualized client plan-of-care. Then, clients and families are queried periodically to ascertain their satisfaction with services delivered by their HHAs and to learn how services may be improved. Also, the ED stated the HHAs are queried at intervals during their assignments to obtain similar input. This information is used to improve service delivery, make needed changes, and shape internal staff training programs. The root causes of any performance variations are discussed with the appropriate parties, and accountability is established for implementing corrective actions. If any major changes are warranted, the Board of Directors would be brought into the process; but the ED advises this step has not been necessary. Formalizing the QRS performance management system will entail developing a set of performance management reporting tools and indicators that can be easily applied and understood by all QRS personnel.

Organizational Background and Context

Study Need and Context

Economic interest in this burgeoning segment of American's healthcare system is evident given that home healthcare is among the top three fastest-growing employment

sectors in the country (Schweid, 2021). This trend is fueled by steady growth in the percentage of older Americans who want to receive home-based healthcare (Olsen, 2019). Scales (2018) reported Maryland will need 40% more DCWs over current supply from 2014 to 2024. The ED requested participation in the research study because QRS desires to become better positioned to meet increased demand for in-home healthcare within its service area, now and in the future.

Institutional Context

To appreciate the need for the study, it is important to explain the institutional context in which HHAs typically perform their duties (Rossman, 1997). There are two general categories of home healthcare organizations or models—those that provide medical home healthcare services and those that provide nonmedical home care (Carpenter et al., 2021; Rossman, 1997). Medical home care is structured to provide services to patients with medical conditions that can be managed in their homes with assistance. Often such services are rendered to patients recently discharged from a hospital stay (Rossman, 1997).

Nonmedical home care—the institutional context for QRS—traditionally provides help with personal care tasks, with routine activities persons would normally engage in themselves if they had no limitations, and with socialization and emotional support (Carpenter et al., 2021). Nonmedical home health can also include provision of limited medical services such as taking vital signs and implementing orders issued by a licensed clinical professional (e.g., a physical therapist) under the supervision of a Registered Nurse or Licensed Practical Nurse. The nonmedical home care model is becoming

increasingly popular given the importance of activities like medication adherence, socialization, and nutritious meal preparation for obtaining positive health outcomes (Carpenter et al., 2021). The two organizational models co-exist in America's LTC industry because healthcare policy in the United States and other Western countries emphasizes that elderly persons should live at home and maintain quality of life for as long as possible (Olsen, 2019).

Demographic Context

Whether operating in a medical or nonmedical home healthcare environment, the problem of hiring and retaining qualified HHAs is attributed to some degree to the demographic makeup of these DCWs (Rossman, 1997). Nationally, HHAs are overwhelmingly female (87%), and disproportionately persons of color (57.6%), consisting of 29.5% Black, 21% Hispanic, and 7.1% Asian (Osterman, 2018). About 28% are immigrants, and in some areas of the country (e.g., in New York and California) immigrants predominate. Nearly one-half (48%) of HHAs nationally have some college education (Osterman, 2018).

In the geographic area where QRS is located and draws its clients, the demographic profile of HHAs mirrors the national pattern, but it is more pronounced along certain dimensions. About 89% of home care workers in their service area are women while 72% are Black or African American (B/AA), 6% are Latino, and 7.1% are Asian or Pacific Islander (Scales, 2018). Thus, HHAs of color (85.1%) predominate in the QRS service area. About one-third (66%) are U.S. citizens by birth or naturalization. In terms of educational attainment, 10.3% did not graduate from high school while 34%

were high school graduates. Similar to national trends, over one-half (55.7%) had college experience in that 26.5% had some college but held no college degree, while 29.2% earned an associate's degree or higher (Scales, 2018). Nearly two thirds (64.7%) work full-time and 35.3% work part-time. Annual median personal earnings of HHAs in the QRS service are $22,492, and a sizeable proportion live on wages that are at or below the poverty line. Upwards of one-third (36.6%) receive some form of public assistance (e.g., Food Stamps or Medicaid) and only 39% receive employer-provided health insurance (Scales, 2018).

Regulatory Context

The regulatory context of the practice problem has roots in federal and state regulatory environments which have historically and unfavorably impacted the home care industry (ACLU, 2015). The Fair Labor Standards Act (FLSA) is the federal law enacted in 1938 as part of the New Deal that set minimum wage, overtime pay and related standards for workers in the private and public sectors. As enacted, the law excluded home healthcare workers and other domestic workers from guarantees of minimum wages and overtime pay (ACLU, 2015). Some view this exclusion as a legacy of slavery and the Jim Crow era in which Black women who did not labor in the fields were forced to work for unpaid wages in the homes of slave owners or as low-paid domestic workers (ACLU, 2015).

In 1974, Congress amended the FLSA through which most domestic workers were afforded the protections of a minimum wage and overtime pay (ACLU, 2015). However, interpretation of this amendment by the U.S. Department of Labor continued to

exclude most home healthcare workers. Not until 2013, fueled by the Affordable Care Act, did the Department issue rules that granted basic wage protections to home health workers. It required HHAs who worked for third-party agencies—which is the overwhelming majority of HHAs—be paid minimum wage and overtime. Notably, over many decades, the home health industry exploded as businesses thrived in an industry that paid substandard wages under the protection of U.S. jurisprudence (Schweid, 2021). This historical context continues to have an impact on HHAs. Despite being the linchpin of home healthcare, HHAs occupy one of the least respected and poorly paid paraprofessional positions in America's workforce (ACLU, 2015; Rossman, 1997).

Fiscal Resource Planning, Management, and Behavioral Health Policy Compliance

Medical home healthcare agencies and organizations in Maryland are licensed to conduct business and regulated by the OHCQ in the State of Maryland Department of Health. The OHCQ is responsible for oversight of these entities which encompasses initial licensure, recertification, surveys, and complaint investigations (State of Maryland Department of Health OHCQ, 2022). Since QRS is a nonmedical home healthcare organization, state oversight consists of licensure.

The State provides a directory of licensed and regulated medical home healthcare providers by county in which 55 providers are listed, and 18 of these are located in the same county as QRS or a contiguous county (State of Maryland Department of Health OHCQ, 2022). The ED stated that its BHLs are aware of existing competition brought by medical home healthcare agencies for employing qualified CNAs and GNAs. Accordingly, it draws from many of the elements found in COMAR for medical home

health agencies (e.g., patient's rights; duly constituted governing board with written by-laws; licensed CNAs, GNAs, and Nurse Supervisors; patient plan-of-care) to shape its own professional practice.

Summary and Transition

Home healthcare is a multidisciplinary service that supports aging-in-place which is the capacity to live safely and independently on one's own regardless of age, income, or ability level (Ahn et al., 2020). It involves numerous professions, encompasses a range of services provided by paid workers and volunteers to elderly persons in their homes, and involves clients and their families (Genet et al., 2011; Thorne, 2003). Section 1 included the foundation for understanding one organization's experience, capability, and capacity for delivering nonmedical home healthcare services within the context of an industrywide practice problem involving insufficient supply of qualified hands-on workers to meet escalating demand.

In Section 2, QRS governance, leadership strategy, strategy development, and operations are examined. The organization's approach to workforce development and current strategies for hiring and retaining personnel are also explored. Furthermore, the section includes supporting literature and a review of sources including evidence to understand best practices involving HHA hiring and retention as implemented by similar organizations. Finally, details regarding the methodology used for data collection and analytical strategies are described.

Section 2: Background and Approach–Leadership, Strategy, and Clients

Introduction

This study focuses on strategies to reduce turnover among Black HHAs. I aimed to examine this problem for one home healthcare organization in suburban Maryland outside of Washington, DC. The research questions involve how leaders within the organization recruit and retain their HHA workforce and whether they consider and incorporate any culturally-based factors in staff recruitment and retention practices that facilitate workforce development.

This section includes supporting research literature involving the problem as well as approaches researchers and practitioners used to address the problem and sources of evidence. Then, leadership strategies applied by QRS are described, followed by descriptions of clients and populations served, the workforce and its operations, and the analytical approach to data collection in this study.

Supporting Literature

Literature Review Resources

In reviewing supporting academic literature, the following databases and keywords were used:

Table 5

Databases and Keyword Searches

Databases	Keyword Searches
EBSCO Academic Search	Black Home Health Aides
Gale Academic OneFile	Black Home Health Care Workers
ProQuest Central	Certified Nursing Assistant Retention
ProQuest Nursing & Allied Health Database	Certified Nursing Assistant Shortage
ProQuest Dissertation & Theses Global	Direct Care Workers
ProQuest Ebook Central	Direct Care Workers and Race
ProQuest Science Journals	Direct Care Workers and African American
Psychology Databases Combined	Home Care Aides
SAGE Journals	Home Health Caregivers
Science Direct	Home Health Workers
Thoreau APAPsycArticles	Home Care Workforce
Thoreau APAPsycInfo	Home Health Care Aide Retention
	Home Health Care Worker Shortage
	In-home Health Care Workers
	Nonmedical Home Health Care
	Workforce Retention and Home Health Care or Home Care
	Workforce Retention and Direct Care Workers
	Workforce Retention and Home Health

Background on the Problem

Bercovitz et al. (2011)—using data from the first nationally representative 2007 National Home Health Aide Survey (NHHAS)—said there were 160,7000 home health and hospice care aides in the U.S. The overwhelming majority (96%) were female, over one-half (53.3%) were White, and about one-third (34.9%) were Black. More than one-half (51.8%) had ever received public benefits consisting of Temporary Assistance for Needy Families (TANF), Special Supplemental Nutrition Program Assistance for Woman, Infants, and Children (WIC), or Food Stamps. About one-third (31.9%) had employer-provided health insurance coverage, while nearly one-fifth (18.8%) had no

health insurance coverage through their employer, a spouse or other individual, or a governmental program (e.g., Medicaid or Medicare). About 5.4% received housing assistance including public housing, rental subsidies, or lower rent due to government contributions. In terms of education, over one-half (51.9%) had either a GED certificate (14.2%) or high school diploma (37.7%). Over one-third (33.7%) had some college or post-secondary trade school education. Nearly one-half (46.9%) had annual family income of $30,000 or less.

These statistics paint a picture of home healthcare as an occupation that is attracting sizeable and disproportionate numbers of B/AA women of limited education, income, and personal resources to a field that typically exhibits little opportunity for career advancement. Since the workforce at QRS is predominantly B/AA, the study findings pose opportunities for its BHLs to develop more effective recruitment and retention strategies targeted to this demographic segment of the national home healthcare industry that can be shared with other practitioners and leaders who face similar problems with HHA shortages and turnover.

Brady (2016) said CNAs comprise 66% of the healthcare workforce, which makes them the largest group of healthcare workers, with a 20% increase in the need for CNAs expected by 2020. Yet, despite this positive occupational outlook, Brady reported a nationwide turnover rate of 36% which threatens the stability of this vital segment of the healthcare workforce. It makes it critical to better understand what it takes to recruit and retain HHAs.

Brady (2016) studied what constitutes job satisfaction for HHAs by interviewing nine CNAs who participated in a career information session. It was found that job satisfaction for these CNAs involved a culture of teamwork, recognition for good patient care, opportunities to grow and become better, and a voice in work-related matters. Low pay was said to decrease job satisfaction, although it was not the most important factor. It was also reported that when leadership invests in CNAs as a recognized and valued part of the healthcare team, retention rates are likely to improve.

Factors Related to HHA Recruitment and Retention

Training and Mentoring

Feldman et al. (2019) reported on the Homecare Aide Workforce Initiative (HAWI)—an innovative, grant-funded workforce entry-level training program provided to 4,831 HHAs who worked at three home healthcare agencies in the New York, NY area. The program was designed to increase HHA retention through improved skills and job satisfaction and featured a training curriculum customized to the needs of the HHAs, a peer mentoring component, and individual case management.

Feldman et al. (2019) found that 3 months after hire, HHAs enrolled in the HAWI said they were very satisfied or satisfied with their job. Over one-half said they were not at all likely to leave the agency within the coming year. After 365 days, nearly two-thirds of the HHAs were still employed. Job retention after 1 year was significantly higher among aides who graduated from the training program compared to aides who did not participate. Recruitment and retention of Black HHAs at QRS might be improved by considering a similarly innovative and customized entry-level training program.

Kreiser and Gallagher (2010) reported on an HHA peer mentor aide program developed by a home healthcare agency in New York, NY designed to improve retention among newly hired and trained HHAs. A peer mentor aide was defined as an HHA with skills in an area that can help another HHA (the mentee). The peer mentor aides employed for at least 1 year were paired with less experienced HHA mentees to discuss and resolve issues of concern. The peer aide training curriculum included modules on peer mentoring and communications, cultural diversity, servicing the private-pay client, psychiatric and mental health disorders, palliative care, and telehealth. Participation in the program provided a path to career advancement for the peer mentor aides. They were instrumental in helping HHA mentees to address job-related matters such as client care issues or concerns and employer policies and practices. This program resulted in an 87% peer mentor aide retention rate in 2010 up from 49% in 2008 and 57% in 2009. Peer mentors saw it as a means for career advancement and longevity for themselves and mentees. Participants received other benefits, including promotions, hourly wage increases, and cell phones paid for by external grant money. Innovative training programs that include HHA mentoring might be a strategy that QRS should consider.

Relationships with Supervisors and Perceptions of Empowerment

Creapeau et al. (2022) investigated practices to help recruit and retain CNAs who work in skilled nursing facilities, and said while wages are a top concern, numerous nonmonetary factors were equally important. These factors included emotional support, training, relationship-building, communication, and work culture. Perspectives of organizational leaders (i.e., nursing home administrators and directors of nursing) can

vary from those of CNAs in terms of what matters most. Feeling appreciated and recognized for the hard work CNAs endure was a significant factor in retention, along with emotional support, ongoing training, continuing education paths, and mentorship.

Kusmaul et al. (2020) sought to understand how empowerment is defined and experienced by HHAs. The concept of empowerment is an effective strategy to help retain DCWs in nursing homes, but it was not studied for in-home care. Using qualitative semi-structured interviews, four Black workers in one urban area and eight White workers in one rural area in the American northeast participated. Researchers developed a multifaceted definition of empowerment that encompassed structural components such as access to resources, information, and support, and psychological components, including feelings of meaningful work, competence, and autonomy. They found that these DCWs did not always feel structurally or psychologically empowered. These results suggest it is important to explore potential structural and psychological factors within QRS to determine what aspects may be exceptionally empowering and which ones contribute to job dissatisfaction and turnover.

All of the Black workers in this study were immigrants. Since QRS is within a geographic area with sizeable immigrant populations, it will be essential to remember that the Black race is not monolithic and comprises a vast array of different racial, ethnic, and cultural subgroups. Thus, strategies for effective recruitment and retention of Black workers should consider these differences.

Organizational Policies and Practices

Iloabachie (2018) explored strategies used by owners of five different home healthcare agencies in Wake County, NC, known for successfully recruiting and retaining an adequate supply of DCWs to meet their needs. Case study data were collected through semi-structured interviews with the organizational leaders on their hiring practices supplemented by researcher observations. They found that critical factors for attracting and retaining staff included demonstrating a good company reputation, maintaining frequent on-the-job contact between managers and employees, showing appreciation for employee performance, conducting employee orientation and ongoing training, recognizing and responding to employees' personal needs, and advocating for DCW support at state and local governmental levels.

Carpenter et al. (2021) studied factors influencing turnover among nonmedical HHAs who resigned from nonmedical home healthcare agencies. Nonmedical healthcare is a large and growing segment of the home health industry whereby HHAs focus on ADLs and IADLs, socialization, medication adherence, and nutritious meal preparation to improve health outcomes for older adults. A relationship was found between tenure and reasons for leaving. The study is important because it suggests that leaders at QRS might need to understand and develop policies and practices that address the varying needs of newly hired versus longer-term HHAs to improve their job retention rates. Notably, approximately 14% of the sample were B/AA.

Kennedy et al. (2022) studied how wages and employment affect the retention of CNAs through analysis of a sample from the mandated 2015 Ohio Bienniel Survey of

LTC facilities. Facility staff in Ohio completed the survey online with a 95.6% response rate. High CNA nursing home staff rates are critical to delivering consistent quality patient care. It can also favorably impact LTC facilities by lowering the costs of recruiting, hiring, and training new personnel. Kennedy et al. (2022) found that high retention is fostered through high wages and empowerment along with other factors. Facilities in the sample with high wages and high empowerment practices experienced a significantly higher CNA retention rate (73%) than other study providers (63%). In Ohio, this meant paying wages above $13.00 per hour and providing many ways to be valued and appreciated at work. The most commonly reported organizational practices that improved retention included staff working together to cover shifts for each other when someone is unable to come to work, involving CNAs in quality improvement teams, allowing staff teams to collaboratively manage scheduling, including CNAs in the direct hiring of DCWs, and offering advancement opportunities such as a CNA career ladder.

Through a review of the research literature on LTC facilities in Canada, Black (2015) found that drivers of retention for nurses and healthcare aides in the LTC sector included job autonomy (e.g., involvement in patient care planning and decision-making), orientation and ongoing training for growth and development, educational opportunities, caring and meaningful relationships with residents, supportive supervisors, and an appreciative and respectful work culture. Drivers of turnover included inadequate staffing levels and hiring practices, work difficulty (e.g., heavy workloads), insufficient compensation (e.g., wages and benefits do not reflect the value of their contributions), and work and family conflicts.

The federal Office of Family Assistance (ACYF, 2022) provides Health Profession Opportunity Grants to organizations that want to help underserved and marginalized individuals become CNAs and enter or advance in the nursing field. Examples of this type of organizational support include assistance with transportation (e.g., bus passes, gas cards, and help with car repairs), work clothing (e.g., uniforms, scrubs, and shoes), and tutoring. Such supportive programs and practices could be important elements in strategies for improving HHA recruitment and retention at QRS.

Psychosocial Demands

Clare (2011) discusses the psychosocial requirements of caregiving that can impact HHA recruitment and retention. Theirs is a job that requires an intense investment in caring for the health and well-being of others. Caregiving can create stressors that take an emotional toll on some workers because of the daily reality of providing companionship and support to elderly or disabled persons. These stressors can lead to fatigue, burnout, and other deleterious effects such as an overinvestment of the self in the well-being of others. HHAs who care for clients in the end stages of life have the added burden of knowing death is imminent. Moreover, if a client dies, HHAs invested in their care may experience a sense of grief that calls for a mourning period, much like family members experience.

There are family stressors too. When an HHA takes a job in a client's home, having various family members present can hinder or help caregiving depending upon their level of involvement. Further, Clare (2011) views alienation as another psychosocial stressor that can occur due to a perception that HHAs are unappreciated, unfulfilled, or

even demeaned by some client or family behaviors. Demeaning can occur through verbal abuse or assuming the HHA is supposed to perform domestic duties in addition to caring responsibilities.

Howe (2008) explored psychosocial factors that promote retention in a study of 2,260 home healthcare workers employed by an agency in California. It was found that commitment to the client is the most crucial reason HHAs remain on the job.

Racial, Ethnic, and Cultural Considerations

Landes and Weng (2020) used data from the nationally representative 2007 NHHAS to examine racial and ethnic differences in HHA turnover rates. A sample of 3,344 HHAs found that Non-Hispanic Black HHAs and Non-Hispanic Other HHAs had higher turnover rates than Non-Hispanic Whites. Specific reasons for leaving also varied by race. Minority HHAs were likelier to leave their employers due to lower wages and fewer opportunities for educational and career advancement than their White counterparts. Hispanic HHAs were more apt to leave due to perceived disrespect or difficulty with the supervisor or agency.

In contrast, Non-Hispanic White HHAs were likelier to leave due to an upcoming move. These findings suggest that efforts to reduce HHA turnover intent at QRS require an examination of internal business practices that may be hindering HHAs of color from joining and remaining at QRS. Since the workforce at QRS predominantly comprises HHAs of color, insight on worker shortages related to race or ethnicity is of interest to this organization.

Covington-Ward (2017) filled a gap in the literature about HHAs of color by conducting semi-structured interviews with African immigrant HHAs who lived in the Pittsburgh, PA area. Prior studies of African immigrants in the healthcare industry centered on the experiences of physicians and nurses. Although 10% of the U.S. healthcare workers are foreign-born, African immigrants comprise 45% of HHAs in the United States. Salient reasons cited by African immigrants in the study for entering this low-paying profession were a passion for caring for others, a need for quick money, the ease of obtaining work as an HHA, and a foot-in-the-door to better-paying jobs with more prestige.

In assessing job satisfaction using the Likert Scale measurement, a majority indicated they were very satisfied or somewhat satisfied, although most intended to move on to other jobs. The study pointed out several differences between HHAs emigrating from Africa versus those U.S. born. Demographically, the African immigrant group has higher educational attainment levels than most DCWs in that 83% had some college or an advanced degree.

Davis and Smith (2013) studied cultural factors that impact the training of DCWs, including HHAs, personal care aides, and nursing assistants who are not on a licensure track or in an academic, degree-based program. They identified three interconnected factors that figure prominently in caregiver training. These factors are the effects of immigrant culture and language (and language barriers), varying intergenerational cultural constructs (i.e., skills, attributes, or abilities that vary by age and culture), and culturally-based attitudes about aging and dementia.

The study findings of Covington-Ward (2017) and Davis and Smith (2013) suggest that effective strategies for recruiting and retaining the predominantly Black workforce at QRS are likely not to be a one-size-fits-all solution. Instead, the BHLs may need to consider the race, ethnicity, or cultural background (U.S. born or immigrant) among other differentiators to help curb HHA turnover and shortages.

Political and Governmental Influences

Allen (2006) said the plight of HHAs has been publicized by workers themselves in hopes of improving conditions that can favorably impact recruitment and retention. Thousands of unionized HHAs in the Harlem community of New York, NY commemorated the federal Martin Luther King Day holiday in 2006 by marching to demand economic justice through improved wages and benefits. They protested the big gap between what some home care agencies in New York receive from Medicare and Medicaid and what they pay their workers. Specifically, certain agencies received $20 per hour from the Federal Government, but only paid an hourly wage of $7 to their HHAs with no benefits.

Mareschal and Ciorisi (2016) discussed the role of labor unions which is to give workers a voice for improving their work conditions and terms of employment and to fight for economic equality. Through a qualitative case study of home care workers in the State of Washington, researchers found that home care workers provide services that are considered to be naturally occurring (i.e., caring and nurturing tasks), meaning that special skills are not required. Thus, their services have historically been devalued as unskilled and consequentially, underpaid. Since many of the people who receive HHA

services are not in a position to pay for care, wages for those who deliver care is set by political and governmental forces and third-party payors (e.g., Medicare, Medicaid, and private insurers). Consequently, even though demand for home healthcare is rising as the U.S. population ages, hourly wages have not increased in line with market demand. Knowing that external political and governmental influences can impact HHA recruitment and retention as much as organizational policies and other major factors suggests that QRS will need to develop a multifaceted action plan to address its challenges with worker shortages and turnover.

Summary of Supporting Literature

As found in this brief review of the scholarly literature, many of the more promising best practices to reduce turnover among DCWs involve establishing and maintaining rapport and relationships with these essential workers and valuing their input. The relationship between the worker, supervisor, and team members is significant and could benefit from improved communication and understanding. Livingston (2022) said the simple conversation is "one of the most powerful ways to build knowledge, awareness, and empathy, and ultimately affect change" (p. xxi).

The literature review touches briefly on the racial, ethnic, and cultural nuances of HHAs of color who experience additional complications on the job compared to their White counterparts. Differences include discrimination in hiring practices and wages among other factors which can directly affect turnover. As QRS leadership and governance strategies are assessed and described later in this section, it will be necessary to learn how this organization—with its predominantly Black Board of Directors, Black

ED, and nonprofit status—can capitalize on unique opportunities this trifecta may offer to promote a work culture that is fair, equitable, and highly appealing to HHAs of color.

Sources of Evidence

Sources of evidence for the study consisted of primary and secondary data. Primary data collection comprised semi-structured interviews with two BHLs at QRS. Specific main and follow-up questions and probes were noted in a customized interview guide I adapted from the Baldrige Excellence Framework (NIST, 2021). Secondary data were requested from the ED, although the availability of documents from this small organization was limited. Current and archival secondary documents were requested including strategic plans and annual reports, an HHA position description and performance evaluation (redacted to remove personal identifiers), employee manuals or desk guides, and financial performance data. Collection and analysis of this evidence was appropriate for addressing the three research questions and providing insight into different aspects of QRS planning and operations that could have a direct impact on its ability to recruit and retain a stable workforce. Secondary data were used to corroborate and enhance understanding of responses obtained from interviews with the two BHLs.

Leadership Strategy and Assessment

Governance and Leadership

The ED stated QRS has adopted an organizational structure that is uncomplicated, practical, and functional. It allows the Board of Directors to govern and provide overall strategic direction to the organization. The Board of Directors comprises seven members with expertise in law, medicine, psychology, social work, education, human services,

marketing, and event planning. The ED is the founder and chair of the Board of Directors. This configuration facilitates identification, discussion, and resolution of operational matters that warrant Board attention.

QRS leaders govern and lead the organization in a manner that befits their assigned roles for a nonprofit, tax-exempt organization. Like QRS, most organizations with this designation derive their tax-exempt status from Section 501(c)(3) of the U.S. Tax Code (Fishman, 2010). Operating as a public charitable organization, as defined in the Internal Revenue Code, nonprofits are primarily creatures of State law. State nonprofit corporate codes lay the foundation for basic functions and activities of the organization. These include the formation and dissolution, merger or consolidation of the entity; internal governance procedures and maintenance and inspection of corporate records; election and removal of directors; quorum and voting requirements; rules of procedure and members' rights; and obligations and restrictions of directors (Fishman, 2010).

QRS by-laws are consistent with these fundamental requirements. Most state nonprofit statutes, however, do not prescribe specifically how organizations should govern (Fishman, 2010). Such matters are internal organizational decisions which give a nonprofit organization the flexibility to govern in a useful and efficient manner to meet its mission.

Evaluation

The ED said members and activities of the Board of Directors and QRS staff have never been formally evaluated because, "It is hard to look at ourselves when we are

trying to help others." This is a key challenge that interferes with execution of many facets of good governance and leadership as listed in the Baldrige Excellence Framework (NIST, 2021). However, the ED would like to begin identifying areas for improvement throughout the organization, including periodic self-evaluation.

Recently, the ED hired a new NS who is a retired female HHA skilled in office administration and operations management. She spent time shadowing the ED and identifying areas where her assistance would be valuable, such as improving the organization's database capabilities, or engaging effectively with HHAs to obtain their feedback on potential job-related improvements. This determination is a first step in making the types of changes that can facilitate organizational governance, leadership, and operations. It also paves the way for future self-evaluation.

Strategy Development and Implementation

The ED recognized the importance of strategy development and implementation to the growth and success of the organization. However, there was no formal strategic plan or process in place to identify key strategic challenges and formulate an appropriate action strategy. The ED attributed this drawback to the small size of the organization wherein the ED and NS wore multiple hats with little time for strategic planning. These were the only two leaders available to oversee day-to-day home healthcare activities that yield revenues for QRS. They were constantly putting out fires. For example, if an HHA assigned to a particular client called out with little notice, the ED and NS worked to find a suitable replacement on a compressed timetable. This can take up to a full-day of their time and detract from other duties and responsibilities.

Short- and Long-Term Goal Planning

Given that there was no strategic plan, there were also no written short- or long-term goals that could be reviewed for this study. Action planning has not happened. The ED explained that one of the organization's major goals, however, is increasing its fundraising and generating additional revenues. Given the practice problem the study addresses, strategic goals are needed that consider the organization's strengths, weaknesses, opportunities, and threats to increasing revenues.

When asked what it would take to institute any of the organizational changes suggested in the scholarly literature to reduce HHA turnover and shortages, the ED stated that it depends on the type of recommended change. Smaller changes, such as adding new content to the HHA orientation training program, can be implemented fairly easily and quickly without Board input. However, major organizational changes, such as offering signing or merit bonuses or implementing an HHA mentor/mentee program, would require the input, vote and approval of Board members. This thinking is consistent with that of McNamara (2005) who defines organizational change as a significant change-in-direction, such as restructuring the organization or adding a new product or service. He underscores the importance of ensuring that the Board of Directors is highly involved in major projects for change.

The ED acknowledged that strategic planning would have helped execute a recent major change that QRS experienced. Although the Board agreed to transition a sizeable number of clients to QRS from a local home healthcare agency that ceased operations, a viable strategy for this project was not formulated. As a result, the ED characterized the

change as rocky with excessive burden placed on the ED and NS. In hindsight, the organization would have benefitted from a step-wise, methodical plan to transition the caseload with stated goals.

Clients/Population Served

Client Description

The types of clients that receive services from QRS are elderly or disabled persons with varying levels of physical or mental impairment. These are persons who desire nonmedical services in their homes to retain a level of independence and avoid placement in a more restrictive environment (e.g., a nursing home). QRS has clients who require live-in home care whereby HHAs reside in the client's home and provide 24/7 services. The agency also provides client hospice care if required, which is end-of-life comfort care.

Most often, QRS clients need nonmedical assistance with ADL and IADL tasks (see Table 4). This support promotes independence and normalcy for in-home elderly and disabled patients. ADLs and IADLs are essential to experiencing a decent quality of life in the community. Low ADLs are strongly associated with poor health outcomes (Osakwe et al., 2019) and higher hospitalization rates and costs of healthcare (Chuang et al., 2003; Kumar et al., 2017).

Demographically, the clients of QRS are predominantly B/AA. There are also a few African clients and Non-Hispanic White clients. All are age 50 or older. Although the organization accepts clients from any county in Maryland, the majority of clients are from Prince Georges's County (i.e., where QRS is located) and adjacent counties. The

ED was unable to provide precise client demographic data without extensive review of written client records. But, the ED explained the organization is working toward development of an automated client database that will permit easy access to this type of information in the future.

Client Input and Feedback

The ED stated that the BHLs interacted with and obtained information from clients in four ways. Initially, clients are asked a series of questions as part of the assessment and intake process conducted by either the ED or NS. Responses are used as input to the development of the client's plan-of-care based on this data and staff observation.

The second point at which client input is obtained is when payment for services is received. A survey is sent out with each invoice whereby the client can indicate, using a Likert scale, how satisfied they were with the services received in the prior month. The questions address service quality, aide professionalism, and possible areas for improvement.

The third point at which data is collected from the client is through a stated open-door policy wherein clients are provided a number to call if they have a question or complaint at any time. Ideally, this type of information would all be entered into the automated client database. The fourth point of contact occurs when the ED or NS proactively contacts the client to determine how services are progressing.

Client Engagement and Satisfaction

QRS primarily engages and builds relationships with its clients through the input and feedback approach just described. This strategy helps the ED and NS keep their fingers on the pulse of what is occurring in clients' homes. This way, they can track the appropriateness of HHA assignments and services offered by the organization and gauge client satisfaction. The ED indicated that the open-door policy is perhaps the most effective tool for such purposes because clients know they always have recourse to addressing any concern at any time. It has proven to be a key practice for enabling clients to seek the information and support they need in a timely manner. The ED and NS strive to return client calls within 1 business day.

The ED stated that it is important to recognize that there are two types of clients to engage and build relationships with in any given assignment. The first client is the person who needs and receives direct services. The other client is the family of this individual who most likely made the initial contact with QRS and is involved in payment of services. McNamara (2005) noted three types of clients in an engagement—official clients, direct clients, and indirect clients. An official client is usually the person or group (e.g., the family) that makes the decision to hire or contract with an entity. They have the authority to decide if the services rendered meet their expectations and to make payment. Direct clients are the indivduals who receive the contracted services (e.g., the in-home patient). Indirect clients are entities that are affected indirectly and ultimately by the work of the organization (e.g., the Board of Directors or funding grantors). All have a stake or interest in successful client service outcomes and overall satisfaction.

McNamara (2005) further pointed out the importance of keeping all three types of clients in mind in leading organizations. Awareness of client types is also relevant to the practice problem because any recommended change in QRS policies or practices will need to consider how it impacts the organization's internal and external clients.

Analytical Strategy

This section includes details on the study design, researcher reflexivity and ethics, participants, data collection strategy, and efforts to ensure the research is high-quality, trustworthy, and credible.

Research Design

This doctoral study utilized a qualitative, single case study research design. Yin (1999) contended this design is appropriate when we seek intense study of a single phenomenon within a real-life context. Because the research was exploratory in nature, this design permitted collection of data from multiple sources that focused on a professional practice problem for a single organization. A quantitative study design would be inappropriate because such studies commonly have the opposite goal to find answers to stated research questions by controlling the context (Ravitch & Carl, 2016).

Triangulation

Farquhar et al. (2022) said triangulation is a recommended good practice when conducting case study qualitative research. It improves the validity and credibility of qualitative data collection by comparing findings from different sources or methods to allow cross-checking of results. Qualitative studies often involve a small number of participants compared to quantitative studies, and they investigate real-life phenomena

in-depth in naturalistic settings (Yin, 1999). Multiple perspectives on the same topic are important whether comparing the same data from two or more primary data sources (e.g., interviews with more than one BHL), from two or more secondary data sources (e.g., different archival or organizational documents), or from a primary data source and a secondary source (e.g., validating what we are told with what we observe or read). Yin (1999) pointed out the importance of collecting data from different sources for case studies, and that it is inadvisable to use only one data collection method such as a site visit or an interview.

In this study, data triangulation was achieved. Primary data were collected through interviews with two BHLs at QRS. Secondary data were collected from archival and organizational documents to confirm information collected through the primary interviews. Also, certain written documents were compared with each other for validation purposes.

Researcher Reflexivity and Ethics

Effort was made to ensure researcher reflexivity in this case study. Reflexivity addresses the thoughts, feelings, and perspectives of researchers who are involved in a study. It requires an awareness of personal or professional biases that could interfere with study findings (Ravitch & Carl, 2016).

In this study, I was the only researcher. It is important to acknowledge that I used and observed services of both medical and nonmedical home health providers for six years in the care of my own elderly mother. Thus, I was knowledgeable about types of

services and programs offered by such organizations. I was also professionally acquainted with the ED at QRS.

Although I had direct experience with HHAs and issues that could result in DCW attrition and shortages, I adopted a scholar-researcher role on this study by remaining aware of the impact of subjective impressions and presence on data collection, analysis, and presentation of findings. Furthermore, I understood the ethical importance of protecting anonymity of participants, maintaining confidentiality of information as appropriate, and minimizing harm.

Nature of Data Collected and Respondents

For this qualitative single case study, primary and secondary data sources were collected and analyzed. Primary data collection consisted of four semi-structured qualitative interviews conducted with QRS leaders at this small, nonprofit behavioral healthcare organization. The interview participants were the ED, who is also the chair of the Board of Directors, and the NS. The ED participated in three interviews and the NS in one interview. The data collection was structured in this manner because the ED had a longer leadership history with QRS than the NS and was better positioned to address topics related to organizational characteristics, leadership, governance, and strategy. The NS, who had a working relationship with the HHAs as their direct supervisor, was included only in the interview that focused on workforce development and engagement.

Primary Data Collection

As the primary data collection instrument, a comprehensive set of semi-structured interview questions was developed that were in alignment with the following three research questions that comprise the professional practice problem:

RQ1: How do leaders at QRS recruit home health care aides?

RQ2: How do leaders at QRS retain home health care aides?

RQ3: How do leaders at QRS incorporate cultural considerations into their recruitment and retention practices?

Relevance of Data to the QRS Practice Problem

The semi-structured interviews were comprised of a set of questions based upon the Baldrige Excellence Framework (NIST, 2021)—a leadership tool that empowers an organization to assess itself, reach its goals, and improve results. I took interview questions directly from the Framework's healthcare criteria, since QRS provides healthcare services. I adapted the wording of the questions as needed to customize it to the QRS environment and address the study's three research questions on HHA recruitment and retention.

Archival and Organizational Secondary Data Sources

Archival and organizational data, classified as secondary data sources, were important elements of the study analytical strategy. These were data from public sources and internal documents the organization produced and used. The public sources of data consisted of legal forms completed by QRS and submitted to the U.S. Internal Revenue Service (IRS) and the State of Maryland. They provided reputable evidence on the

organizational profile and added validity to the study. Limitations of the public sources were that the information was brief and constituted only a snapshot of organizational status at a certain point in time. Public documents included the QRS Articles of Incorporation for a Tax-Exempt, Non-Stock Corporation from the State of Maryland website; the IRS Determination Letter for a Nonprofit, Tax-Exempt Organization; and federal tax return filings for 2017 through 2021.

The internal organizational documents provided a more in-depth look at current QRS operations. These data too were limited in that certain documents (e.g., financial reports and cost analyses, Board by-laws and meeting summaries, and strategic plans and annual reports) were unavailable for this study. The organizational documents were used to promote an understanding of the QRS work environment, culture, and operations. The documents and forms provided to me that pertain to HHAs were the job application, onboarding checklist, professional employment reference form, documentation of education form, employee compliance/confidentiality form, consent form for criminal background and driver's license check, health security and testing form, QRS policies and procedures manual, employee handbook, code of conduct form, degree and license type form, assurance of client confidentiality and clients' rights information form, staff competency/credential form, and client assessment and plan-of-care forms.

Evidence Generated for the Doctoral Study

Participants

The two study participants purposively selected to be a part of this doctoral study were the organizational leaders most involved in the planning, implementation, and

oversight of the QRS programs, services, and operations. Of the two participants, the ED—a wellspring of historical and current knowledge about QRS—provided most of the information on the practice-focused problem. The NS provided information on the operation and supervision of the HHA workforce, which is their forte and primary responsibility on the QRS team. The ED provided access to internal organizational documents.

Procedures

For primary data collection, a semi-structured interview guide was developed to use for discussions which contained space to make handwritten notes to document key information. The interview timetable was established based on the convenience of the two BHLs to avoid respondent burden and maintain a viable working relationship throughout the data collection period—March, 2022 through August, 2022. Interviews had to be rescheduled several times due to HHA shortages and call-outs which caused last-minute changes in the availability of the ED and NS.

Summary and Transition

In Section 2, I covered sources of evidence for the professional practice problem for this study. This included examination of supporting literature, QRS leadership strategies and assessments, clients and populations served, and analytical strategies. In Section 3, data on workforce operations and engagement strategies are evaluated to determine how QRS leadership creates effective and supportive workforce environments which are conducive to high-performance work. I address how leaders design, manage, and improve critical services and work processes. Additionally, the section includes an

evaluation of how QRS uses knowledge assets, information, and information technology related to recruitment and retention of HHAs.

Section 3: Measurement, Analysis, and Knowledge Management Components of the Organization

This study involved exploring the problem of shortages and turnover of HHAs at QRS, a home healthcare organization in suburban Maryland outside of Washington, DC. The practice-focused research questions involve how the organization recruits and retains HHAs. Since nearly all the organization's HHAs are Black women, racial-ethnic and culturally-based factors that helped or hindered HHA recruitment and retention were also explored.

In Section 3, I conducted an analysis of QRS. I assessed how the organization builds its workforce environment and engages the workforce. I also evaluated how QRS improves its organizational services and processes and ensures effective management of operations.

Analysis of the Organization

The study was based on three key sources of evidence for addressing the professional practice problem. One source was a review of supporting scholarly literature to identify strategies that similar organizations have used to address HHA recruitment and retention challenges. The second source was a series of semi-structured interviews with two BHLs at this small nonprofit organization to obtain their insights and perspectives on the problem. The third source was federal and state public documents, as well as internal archival and organizational documents that QRS developed and shared with me to support information conveyed via interviews.

Workforce and Operations

Building the Workforce Environment

The home healthcare industry depends on the availability of a sufficient supply of DCWs who are qualified and readily available to provide services to clients in their own homes (Carpenter, 2021). At QRS, the mission is to offer affordable nonmedical home care to elderly and disabled patients and their families who contract for services. These services consist primarily of assistance with ADL and IADL tasks that promote independence and normalcy. Poor health outcomes can lead to higher hospitalization and healthcare costs (Chuang et al., 2003; Kumar et al., 2017), as well as increased mortality and risk of admission to a nursing or rehabilitation facility (Holup et al., 2017; Stineman et al., 2012).

HHAs are necessary in terms of the ability of QRS and similar agencies to successfully care for vulnerable patients in their homes. The ED and NS said they must be well-positioned to hire and retain an adequate pool of HHAs to meet current and projected needs. By 2025, a 43.4% increase is anticipated in the number of persons aged 65 and older within the QRS service area compared to 2015 levels, and a 99% increase is expected by 2045 (Scales, 2018). To execute their mission and meet market demand, QRS depends primarily on three types of HHAs in their professional practice: CNAs, GNAs, and Unlicensed Aides. Building a supportive and effective workforce environment that comprises all three groups is essential to being prepared to operate successfully in the short- and long-term.

Creating Workforce Capability and Capacity

The capability and capacity of QRS to recruit, hire, and retain qualified and capable HHAs depends to a large extent on devising an actionable strategy in order to resolve this practice problem. McKenzie (2010) said for-profits are driven by revenues and profits, while nonprofits are more concerned with how their work will add value to the communities they serve. QRS is committed to ensuring that the area's eldest citizens have access to high-quality, affordable, nonmedical healthcare. The ED said, "Ours is a heartfelt mission. We are not in it to make a mint. We're looking to meet people at their financial ability. By reducing prices for services … we can help underserved seniors."

Keeping patient charges affordable places limits on hourly wages QRS is financially able to pay their HHAs, although they try to remain competitive by paying what the market demands. This poses a dilemma for QRS. Typically, HHAs are among the lowest paid DCWs in the healthcare industry (Schweid, 2021). While salary is an important factor used by HHAs in deciding whether to affiliate with a particular home healthcare employer, it is not always the primary consideration (Brady, 2016; Carpenter, 2021; Kennedy et al., 2022). QRS understands this and relies upon relationship building and trust to help enhance worker capability and capacity.

Fostering Relationships. Once a potential candidate responds to ads placed by QRS, the ED or a designee initiates a telephone call to screen the potential applicant to determine their eligibility for hire as an HHA. During this early stage, the HHA candidate is asked to view several videos about QRS before moving forward with the application process.

Videos are important to relationship building early on because they educate the applicant about the QRS mission, vision, values, and activities to help the individual decide if QRS is an organization they desire as an employer. Relationship building at QRS continues throughout an HHA's term of employment as the ED and NS remain in frequent direct contact with HHAs once assigned to a case. The relationship between the NS and HHAs is important to the success of the organization's workforce capability and capacity efforts because it sets the tone for the work culture and how the HHAs perceive the value of their daily contributions. The NS stated that the person in this supervisory position must exhibit honesty, openness, and trust in communicating with HHAs so that they know that they have advocates at all times.

Hiring and Onboarding. After viewing videos and completing a job application, qualified candidates who have continuing interest in QRS are invited to a personal interview with the BHLs and undergo a thorough hiring and onboarding process. An onboarding checklist is used by QRS personnel to standardize the process and ensure all important matters are systematically covered with each applicant.

Staff Training. At QRS, proper training of HHAs is emphasized. However, this training has been limited primarily to an initial orientation and a training session shortly after the point-of-hire, largely due to BHL time constraints. The ED said that if any special training is needed for certain assignments (e.g., how to safely operate a Hoyer lift), then QRS provides it. Various technical and administrative documents are reviewed during staff trainings, and documentation of this step is added into each employee's personnel file. These documents include the QRS policies and procedures manual,

support professional's handbook, employee code of conduct, assurance of client confidentiality and clients' rights information form, clinical supervision goals and agreement form, and client needs assessment and plan-of-care form. In addition to these documents, certain practices are reviewed and implemented during training which pertain more specifically to building a healthcare workforce. This includes HIPPA rules for protecting client health information, CPR/AED training for adults and children, first aid training, bloodborne pathogen training, and NCI restrictive interventions training.

The NS stated the BHLs are especially sensitive to the need for more intensive staff training throughout the course of employment with QRS and envision training as a tool for ongoing engagement of HHAs once they are hired. Because home healthcare is a fast-growing industry, there are always emerging developments and trends (e.g., new research findings for diseases such as Dementia) that can be applied in the home care setting that HHAs and other QRS staff should know.

Staffing Configurations. Workforce capabilities, capacity, and needs are assessed collaboratively by the ED and NS. The ED said the number of HHAs that are needed is directly tied to the number of executed patient contracts. At the time the study was launched, QRS had 50 cases which means that it had 50 HHAs on board. Staff were assigned to cases depending upon the results of the client assessment and plan-of-care conducted by the NS. The required type of HHA (i.e., CNA, GNA, or Unlicensed Aide) is then matched to the client's needs and articulated to the client and family before the HHA is sent into the home.

The pool of HHAs at QRS is comprised of CNAs, GNAs, and Unlicensed Aides (QRS website, 2022). CNAs and GNAs are certified by the Maryland State Board of Nursing (COMAR, 2022). These are paraprofessionals who are certified to perform nursing tasks under the supervision of a Registered Nurse or Licensed Practical Nurse. A GNA is a CNA who has met additional requirements and competencies for working with elderly and disabled individuals. The ED explained that many of the client care plans are implemented at QRS by Unlicensed Aides who do not require state certification because they strictly provide companionship and socialization care.

Establishing Workforce Climate and Engagement

Promoting Safety. Workforce capability and capacity are inextricably linked to workforce climate and engagement. The ED said without a safe and accessible work environment—and internal practices designed to engage the workforce—it is difficult to keep committed and high-performing workers. Disengaged HHAs can foster staff turnover and shortages.

QRS provides a safe and accessible work climate in several ways. The ED stated it begins by ensuring that all staff understand that patient safety is of great concern. This is especially important when delivering services in patients' homes. The HHAs must undergo a series of health-related tests during the job application process before they are assigned to a case. This includes a drug test. However, the NS said they are considering spontaneous drug testing during an HHA's term of employment since personal circumstances could change at any time. Doing so would help increase workplace safety and protect both the worker and patient.

Furthermore, as healthcare workers, HHAs are given Cardiopulmonary Resuscitation and Automated External Defibrillator (CPR/AED) and First Aid training if needed to protect themselves and the clients. The ED stated that creating a safe work climate means that HHAs should feel confident that a competent leader has determined the homes they will enter are safe prior to beginning an assignment, which is why the BHLs conduct initial and periodic home visits. Similarly, the BHLs need to know that staff will keep them informed about the status of caregiving and their work environment. The ED and NS view caregivers as the eyes and ears of in-home healthcare.

Enhancing the Workplace. The scholarly literature reveals numerous effective approaches and practices that home healthcare providers have applied to engage workers and enhance the work environment. Brady (2016) noted that job satisfaction for CNAs is enhanced by an organizational culture that emphasizes teamwork, recognizes valuable contributions to patient care, provides opportunities for personal and professional growth and improvement, and gives CNAs a voice.

Kusmaul et al. (2020) pointed out that the psychological empowerment of CNAs—including access to resources, information, and support for professional and personal matters—is an important enhancement. Iloabachie (2018) stated that critical factors for attracting and retaining staff include a good company reputation, employee orientation and ongoing training, recognizing and responding to employee's personal needs, and advocating for DCWs at governmental levels. Clare (2011) focused on the psychosocial toll that caregiving takes on many HHAs because it requires an intense investment in caring for the health and well-being of others which can lead to fatigue,

burnout, and other deleterious effects. Another factor that can disengage HHAs from the workplace environment is a feeling of alienation if HHAs feel unappreciated, unfulfilled, or even demeaned by some patients or family members.

A key driver of workforce enhancement and engagement at QRS is its practice of exhibiting the type of soft people skills evidenced in the supporting literature, which includes relationship building, communication, empathy, and similar patterns of behavior to interact effectively with employees. The ED said the emphasis is inherent in the organization's principal cultural values for accomplishing the mission which include honesty, transparency, integrity, and trust. The nature of the relationship is one of support for both job-related and personal matters that may arise. For example, the ED explained that sometimes HHAs experience transportation problems that preclude them from travelling to and from a client's home. In such cases, the BHLs have pitched in and given rides to HHAs to the work site demonstrating empathy and concern for the professional and personal well-being of their workers. The ED stated they would like to offer perks such as no-cost sessions with motivational speakers and clinical counselors to help HHAs resolve some of the personal issues they witness and perceive as barriers to worker retention, job satisfaction, and career advancement.

QRS Challenges in HHA Recruitment and Retention

One of the greatest challenges the BHLs have experienced in building workforce capability and capacity and recruiting and retaining qualified HHAs is discerning the various types of caregivers who are drawn to the home healthcare industry. The NS explained there are those who view caregiving as a mission or passion executed out of

love for vulnerable individuals. Others see caregiving as a pathway to related professions (e.g., licensed practical nursing, medical technology, or social work). Still others enter the field primarily because they need a paycheck. A good recruiter of HHAs must be able to discern the motivation and mindset of each candidate. While professional references and background checks are important, the BHLs also look for evidence of honesty, integrity, and mature judgement at this early stage. They find that asking the right questions and posing relevant work-related scenarios is one of the best ways to identify preferred candidates. For example, the NS often asks the following types of interview questions:

> "What is your greatest achievement? What is your goal in life?"
>
> "How long have you worked in the field of caregiving? What type of clients have you worked for? In what settings have you provided care (e.g., in a hospital, nursing home, assisted living facility, or a personal home)?"
>
> "If you go into a client's home, what would you do to ensure that the client and their home environment remain safe?"
>
> "If a family problem arises at the same time you are scheduled to be at a client's home, what would you do?"

The NS noted that this line of inquiry allows the BHLs to determine if the candidate views the job as a profession, a passage, or a paycheck. Sometimes QRS finds it acceptable to hire all three types of candidates, depending upon the needs of the organization. For example, if a client contracts for in-home care that is scheduled to begin immediately on certain days and at times when a candidate is available, it may be advisable to hire them provided they meet all other eligibility requirements.

Career Progression and Advancement of HHAs

The supporting literature provides evidence that when HHAs view their employment as important to their overall career path, retention may be improved (Kennedy et al., 2022). The NS is aware of larger organizations that can afford to pay their HHAs a monetary bonus if they register in external programs to become a licensed practical nurse, medical technician, or another health-related professional. However, with limited revenues at QRS, the NS said the BHLs focus instead on instilling confidence in their Unlicensed Aides that they can succeed in a related career with better compensation, benefits, and prospects once they perform well in their current position. The NS said many of the Unlicensed Aides at QRS are young and immature. For this reason, the ED and NS empower younger workers by enhancing their self esteem and identifying community resources they can access to place them on a viable career path. This practice also enhances relationship building once the HHAs sense that their employer truly cares about them.

HHA Rewards and Recognition

QRS engages and retains its personnel by issuing plaques and other awards to deserving employees. However, the ED acknowledged that certain types of awards they would like to bestow are expensive and currently out-of-reach. One of the biggest drawbacks in their engagement strategy is the organization is not in a financial position to offer important employee benefits such as health insurance. This is also attributed to the fact that the majority of these HHAs are not full-time employees. Financial information

contained in publicly available federal tax returns for QRS confirms that organizational revenues may be insufficient to support these types of benefits (IRS, 2022).

The ED said that QRS also promotes retention and appreciation for a job well done through less expensive methods for deserving staff such as holding periodic job recognition sessions and dinners, issuing letters of appreciation, disseminating pins for exemplary performance, and giving annual hourly wage increases. In addition, they try to keep the HHA hourly pay rate higher than other competitors in their service area by leveraging their status as a nonprofit organization with certain tax advantages and operational savings that for-profit entities do not have.

HHA Retention Through Governmental Changes

Challenges experienced at QRS in worker recruitment and retention have roots in federal and state regulatory environments which have historically and unfavorably impacted the home care industry (ACLU, 2015). The Fair Labor Standards Act (FLSA), enacted in 1938 as part of the New Deal, set minimum wage, overtime pay and related standards for workers in the private and public sectors. As enacted, the law excluded home healthcare and domestic workers from guarantees of minimum wages and overtime pay (ACLU, 2015). In 2013, fueled by the Affordable Care Act, the Federal Government granted basic wage protections to workers in these categories.

The legacy of this governmental context is that QRS and many home healthcare providers throughout the United States are attempting to fill a dire need to attract and retain qualified home healthcare workers without the benefit of an appropriate level of governmental support and assistance. The NS cited changes that could be implemented at

federal or state government levels that would likely improve HHA recruitment and retention. This includes making training certification more affordable and accessible to those who want to enter the caregiving field. There are many Unlicensed Aides at QRS who could become CNAs or GNAs but cannot afford the program fees. Becoming certified could place them on a more promising career path. The NS stated there is a glaring disconnect between the demand for qualified caregivers and the hourly wages they are paid. One way to improve pay is for governments to provide subsidies to elderly and disabled clients. In turn, home healthcare employers can better afford to pay higher hourly rates to their HHAs. Also, subsidies and grants could be given to home healthcare organizations to help improve HHA pay rates.

The NS said that governments should provide pay equity for HHAs that considers the circumstances of the workplace. For example, DCWs in assisted living facilities are often expected to care for many patients—as opposed to a single patient in a home healthcare environment—and should be compensated accordingly. The NS also stated that Maryland should offer government-paid training and refresher courses to HHAs to help them keep pace with the many changes that occur in the home healthcare industry.

Improving Organizational Services, Processes, and Operations Management

The ED said there is a rudimentary performance improvement system at QRS that the BHLs use to track HHA performance and patient satisfaction with services rendered. Initially, clients are asked a series of questions as part of the assessment and intake process for home healthcare services. Their responses are used primarily to develop a customized client plan-of-care. Another way client information is obtained to gauge QRS

performance is through a short survey included with each invoice sent to the client. The questions address service quality, staff professionalism, client satisfaction with services, and areas for possible improvement. Notably, performance information is also gathered through a stated open-door policy at QRS wherein clients are provided a number to call if at any time they have a question or complaint. Finally, the BHLs proactively check-in with each client periodically to see how things are going and to enhance ongoing relationships.

Knowledge Management

Improving Organizational Performance

Performance improvement in home healthcare is gaining widespread attention at a time when greater proportions of persons aged 60 and older are opting to receive medical and nonmedical services in their homes to maintain independence and normalcy (Carpenter et al., 2021). Morahan (1999) reported on the wide application of continuous quality improvement (CQI) processes in home healthcare settings. There is a spectrum of performance improvement approaches ranging from facilities that assemble cross-departmental CQI teams or committees as an integral part of their operations to organizations with less sophisticated programs. The types of data that could be collected in a rigorous CQI program for in-home healthcare include patient clinical records, patient satisfaction surveys, infection control records, incident reports, staff competency assessments, management meeting reports, and reviews of prior CQI activities.

Terry (2013) pointed out a lack of research and evidence-based practice on how total quality management concepts can be incorporated into home healthcare environments. However, for meaningful and sustainable performance improvement, Terry (2013) recommended a 5-step process that can be adapted in most of these environments. This includes examining current practices and systems that are in place, becoming a learning organization through restructuring or re-focusing activities, knowing what tools and best practices are available for such purposes, understanding how to collect and manage relevant data, and training organizational leaders and clinical staff in performance improvement practices and procedures.

As a small nonprofit organization, QRS has a straightforward and uncomplicated process for improving its organizational performance. Although it is not as sophisticated as that described by Morahan (1999), it meets their needs, and could serve as the foundation for a more comprehensive approach in the future to measuring and analyzing performance. The NS at QRS said, “Ongoing monitoring is important. It’s a two-way street. We ask our home health aides for feedback on the client and the home where they work. And we ask the client for feedback on the aide we assign to them.”

It is important to the ED and NS that they receive regular input from both sources. They said they want to know what has been observed in terms of what services or tasks are being carried out properly and which ones have been challenging. Obtaining this knowledge helps the BHLs better understand the effectiveness of QRS’s methodology to providing home healthcare services.

The NS explained that caregivers are the eyes and ears of the organization. They are the ones who observe the details of a client's living situation beyond what is gleaned from a single initial visit by a BHL prior to assigning a case. As such, HHAs are well-positioned to keep the NS and ED informed about the status of the assignment and potential changes that could be implemented to improve service delivery. Schweid (2021) describes how HHAs are sometimes viewed by a client's family as domestic workers or housekeepers in addition to their role as a caregiver. The NS stated that while QRS caregivers are expected to keep the client's personal belongings and living area neat and clean, their role does not extend to general cleaning within the home. Therefore, should a client or family member ask the HHA to perform tasks that are outside the scope of their agency contract, the HHA would be expected to report this situation to the NS or ED who, in turn, would remind the client and family of the contract limitations.

Providing a Safe Operating Environment

To access needed knowledge and to improve performance, there must be a level of trust between the BHLs and the HHAs that facilitates honest communication. The NS stated that the relationship between the HHAs and the NS is of utmost importance at QRS. The NS should bring honesty and openness to the relationship and reassurance to HHAs that someone has their backs. The HHAs trust that the ED or NS is monitoring the home environment to ensure it remains safe and suitable for the HHA to work there. The NS advised they do not send an HHA into a home that one of the BHLs has not visited in advance. These initial visits are conducted to make certain that both the HHA and client

are in a situation that is free from harm and danger. In the words of the NS, “The essence of caregiving is making it a win-win for both the caregiver and the client.”

The NS stated that the BHLs are considering instituting performance improvement activities that involve safety practices based on knowledge received through their feedback mechanisms. Specifically, they are considering instituting stricter enforcement measures—should an HHA break any of the terms of their contract—by entering pertinent details into their performance record. For example, failing to show up at a client’s home without advance notice could leave an elderly or disabled client in an unsafe situation and would warrant a negative notation in the HHA’s employment record. The NS said another possible performance improvement is conducting spontaneous drug testing of HHAs during the term of employment. At present, drug testing is conducted prior to hiring. However, given that personal circumstances are subject to change over time, periodic drug testing would help protect the agency, the HHA, the client, and the family from potential deleterious outcomes.

Managing Organizational Knowledge

As a small nonprofit organization with basic non-personnel assets and limited revenues (IRS, 2022), the BHLs at QRS manage their knowledge assets and data through an information technology infrastructure that is evolving. The ED stated the transition to QRS of a sizeable patient caseload acquired from a former home healthcare provider included the transfer of the technology used by that firm to house and organize patient data and related information. The NS is tasked with learning and utilizing this technology to gain access to required information for personalized, client-centered home healthcare

services, improved client outcomes, and similar purposes. The ED said this technology will also provide for better organization of administrative and human resources data to improve staff and organizational performance, productivity, and efficiency.

Summary and Transition

In Section 3, I conducted an analysis of QRS in terms of how its BHLs build an effective and supportive workforce and engage their HHAs to achieve a high-performance work environment. I also described how they design, manage, and improve key organizational services and work processes and ensure effective management of operations. Lastly, I described how organizational performance is used to make process improvements, as well as how technology will be used to help gauge performance.

Based on evidence collected in this study, Section 4 includes an analysis of study results in terms of implications for QRS. I also discuss strengths and limitations of these findings.

Section 4: Results–Analysis, Implications, and Preparation of Findings

This study involved examining the problem of shortages and turnover of HHAs at QRS, a home healthcare organization located in the Maryland suburbs outside of Washington, DC. The practice-focused research questions involved how the organization recruits and retains HHAs to serve their elderly and disabled clients. Since nearly all the organization's HHAs are women of color (i.e., B/AA, African, Haitian, or Hispanic), I also addressed racial, ethnic, and culturally-based factors that may help or hinder HHA recruitment and retention.

In Section 4, I used evidence to address the following three research questions:

RQ1: How do leaders at QRS recruit their HHAs?

RQ2: How do leaders at QRS retain their HHAs?

RQ3: How do leaders at QRS incorporate cultural sensitivity into their HHA recruitment and retention practices?

Results were based on a series of semi-structured primary interviews with BHLs, an examination of publicly available data, and a review of secondary internal documents. I evaluated the agency's client-focused programs and services, initiatives, workforce, leadership, and governance. Analysis of these findings provided a foundation for study recommendations that I present in Section 5. Study strengths and limitations are described in Section 4.

Analysis, Results, and Implications

Qualitative Coding

Using Delve, a cloud-based tool for coding qualitative data based on interview and focus group transcripts, I coded transcripts that were derived from four interviews conducted with the organization's two BHLs. Interview data initially yielded 33 detailed thematic codes which I analyzed and subsequently recoded into a final set of 10 recurring themes. These themes were applicant engagement; mission, vision, and values; standardized procedures; applicant motivation; supervisor relationship; performance improvement; wages and benefits; governmental assistance; caregiver training; and career advancement.

I then examined the final set of themes to determine which ones related directly to each of the three research questions. Although the 10 themes sometimes overlapped and could be relevant to more than one research question, I took this analytical approach to facilitate presentation of recommendations in Section 5.

Following analyses of findings by research question, I examined the results with a focus on QRS client programs and services, client workforce, leadership and governance, financial and marketplace performance, and social implications and impact. These analyses are important for understanding why the organization may be experiencing certain professional practice problems such as staffing shortages and retention issues. Moreover, such analyses help to construct a realistic framework for presenting and implementing study recommendations with actionable solutions.

Thematic Results by Research Question

Recruitment of HHAs at QRS

Theme: Applicant Engagement

The ED and NS follow a thorough process for recruiting, hiring, and onboarding new HHAs to find and engage their workforce. Potential applicants are identified through several online resources, as well as referrals from past and current clients, and professional associates and networks. The applicants undergo a telephone screening by the ED or NS followed by in-person interviews for promising candidates. The BHLs further engage applicants in interviews by stressing the importance of becoming part of a movement bigger than themselves and caring for others with healthcare needs.

Theme: Organizational Mission, Vision, and Values

During the recruitment stage, the BHLs ask candidates to view videos about QRS before they decide to join the organization. Leaders consider watching videos as an opportunity to acquaint applicants with the QRS mission, vision, values, and activities. The intent is to raise awareness that QRS is a vital and affordable community resource for elderly and disabled persons. Also, it affords the applicant an opportunity to decide if they want to affiliate with this type of organization. The ED said:

> It’s a heartfelt mission. We let them know we’re serving the underserved. You’re part of this vision. You’re out there on the front line. [We] build it up so they know what their role is, and we make it [sound] as important as it really is.

Theme: Standardized Procedures

Recruitment is aided by a set of basic documents and forms that are used during the hiring and onboarding processes. Examples of these internal organizational documents include the QRS Onboarding Checklist, Policies and Procedures Training Manual, Employee Code of Conduct and Compliance/Confidentiality Form, Health Security and Testing Form, and Consent for Criminal Background and Driver's License Check form. Such documents are used to standardize recruitment and hiring approaches and help ensure that all relevant topics are covered systematically with each HHA. This approach also helps to build workforce capacity and confidence in QRS as an ethical employer with well-established policies, practices, and procedures that respects worker and client safety and rights.

Theme: Caregiver Motivation

One of the most important tasks BHLs undertake in terms of recruiting applicants is discerning their motivations for the job. The ED and NS stated that many applicants view caregiving as a mission or passion executed out of love for vulnerable persons. Others see caregiving as a pathway to related professions such as licensed practical nursing, medical technology, and social work. Still others enter the field primarily because they need money. The BHLs said a good recruiter of HHAs must be able to accurately determine the motivation and mindset of each candidate. While qualifications, professional references, and background checks are important, BHLs also look for evidence of honesty, integrity, and mature judgement during this early stage. They said asking the right questions and posing relevant work-related scenarios are among the best

ways to identify preferred candidates. Furthermore, this allows BHLs to determine if the candidate views the job as a profession, a means to find different employment, or a way to make money. Knowing this helps them estimate how long the candidate might be affiliated with the company.

Retention of HHAs at QRS

Theme: Supervisor Relationship

Retaining HHAs involves understanding the nature of the relationship between these DCWs and their immediate supervisors. The relationship should be one built upon trust, honesty, and transparency on the part of the HHA and supervisor. The ED said "They know they are [going to] get some honest feedback and, hopefully, it'll sustain them long enough to retain them for as long as you need them."

Additionally, they believe the relationship must be supportive, encouraging, and trustworthy. The ED stated:

> I have to constantly encourage them to do well and give them the credit where they deserve it when they put the work in without complaining. It's not an easy job … We work out of trust. I trust my caregivers and they trust that where I assign them to [is] a safe place as well … It goes both ways.

Theme: Performance Improvement

BHLs acknowledged there is no formal performance improvement data collection or periodic review of the Board, staff, or employees. However, they obtain helpful information to make operational or other changes through a direct feedback loop upon which they depend. This rudimentary system helps retain employees by empowering

them to provide their insights, perspectives, and ideas on their assignments. Researchers have found that employees who feel psychologically empowered—and a key part of a caregiving team—are more likely to be retained (Creapeau et al., 2022; Kusmaul et al., 2020). The feedback the BHLs obtain from the HHAs, clients, and staff contributes to the improvement of organizational operations, processes, and services as well as HHA job performance.

Clients establish expectations of their healthcare services based on an initial client intake assessment interview and home visit. Subsequently, the BHLs develop a client plan-of-care which guides the services to be provided. They then receive feedback from clients on HHA performance by including a short survey form with monthly invoices to clients and through an open door policy the ED offers by which clients can contact QRS directly by telephone or email as needed. Similarly, the BHLs encourage the HHAs to provide any useful information on what transpires in the home that may help or possibly hinder client caregiving services.

Theme: Wages and Benefits

As a nonprofit organization with a small but growing client base, QRS is limited in terms of the wages and benefits it can offer to prospective HHAs. The organization has been unable to offer health insurance, paid time off, paid family leave, retirement plans, dental or vision insurance, or life insurance. According to the NS, the organization is paying an acceptable wage—one the NS states is higher than many of their for-profit competitors. However, the BHLs are cognizant that these wages are still considered low

although well above the Maryland state-mandated minimum hourly wage rate of $12.50 effective through January 1, 2023. The ED empathizes with their situation:

> They all have bills to get started with [if they] have been looking for a job. We would like to offer some type of signing business and a higher hourly wage, and to support a path to career advancement that could increase retention.

Theme: Governmental Assistance

The BHLs were emphatic that governments need to view home healthcare as a public priority. They consider a lack of assistance from federal or state government to be a significant barrier to improving HHA recruitment and retention. The NS stated that governments can help by providing subsidies and grants that allow home healthcare agencies to pay higher hourly rates to HHAs, provide signing bonuses, or offer other incentives such as pay increases for mentoring less-experienced HHAs. The NS said there should also be more equitable pay to CNAs and GNAs in the LTC industry depending upon the demands of the service delivery setting (e.g., nursing homes, assisted living, or in-home).

The NS said governments should offer training and refresher courses to HHAs to help them keep pace with the many changes and trends that occur in the home healthcare industry. Furthermore, there are many unlicensed personal care aides who could become CNAs or GNAs which, in turn, could lead to a related profession or career that improves the quality of life for themselves and their families. The NS stated, “Many of the home health aides are heads of households and the main source of income to their families.” The ED offered similar sentiments, “You’re … in a Catch 22. You are operating in an

industry where even the government hasn't really helped in terms of allowing you to raise the hourly wage but so much."

Theme: Caregiver Training

The BHLs agree that HHA training is important in a home healthcare environment, especially since it is a field that is relatively easy to enter with limited education and experience. Studies have shown that specialized or ongoing training beyond an initial orientation training offered to HHAs is a significant factor in retaining these workers (Feldman et al., 2019).

QRS has been unable to offer ongoing HHA training due to cost. However, the ED acknowledged that QRS looks favorably upon hiring HHAs who have been formerly employed in demanding healthcare environments–such as nursing homes and assisted living facilities–which often require some degree of additional training. That way, the HHAs are well-trained when they apply to QRS. Since QRS employs CNAs and GNAs, the ED explained that these individuals already have a basic knowledge of important facets of a nonmedical home healthcare environment. Specialized training is provided when needed, such as how to use a Hoyer lift installed in a client's home.

Theme: Career Advancement

The ED said it important to try and connect some of the HHAs with resources within the community for life skills training to improve the quality of their lives as well as employment retention. Many HHA new hires are young people with limited or no work experience who could benefit from training in areas that would improve their chances of success in the world of work. This includes topics such as identifying and

solving problems, communicating effectively, empathizing with others, and coping with life situations. The NS suggested that providing training is also important to retaining HHAs because it signals that their employer is interested in them as a person, and not just a worker. The NS stated, "Programs and training are needed to encourage the young aides to find a career path. We also want to direct them to resources they need to build a career path." The ED expressed that some of the HHAs may benefit from clinical counseling services rendered by certified mental health professionals to help them address personal challenges and behaviors that can hamper their ability to be effective workers and team members such as depression, anxiety, or post-traumatic stress disorder.

Incorporating Cultural Sensitivity into HHA Recruitment and Retention Practices

Theme: Supervisor Relationship

The NS—who was born and raised in Africa—said that HHA recruitment and retention is enhanced when the recruiter or direct supervisor understands how the racial-ethnic or cultural background of an HHA can manifest in the workplace. Regarding African culture, the NS explained, "Caregiving comes naturally to African home health aides. It is engrained in African culture—caring for the generations. Africans who come to the United States have the background they need to care for sick and elderly clients."

Having a recruiter or supervisor from an African culture may facilitate recruitment and retention of African HHAs because an African candidate knows there is someone in the organization who understands their language and culture and is accustomed to their ways. This enables the BHLs to ask relevant questions and pose realistic scenarios to help discern how the applicant will fare as part of the QRS

workforce. The NS added that for B/AA applicants (i.e., American-born descendants of enslaved Africans), "Caregiving for others is part of the Black American way. White home health aides tend to take jobs for the pay. Aides of color tend to take these jobs due to the caring human aspects."

Notably, QRS has fewer White applicants than persons of color for HHA positions. This could be attributed to the geographic location of QRS where 64.1% of residents are B/AA and 27.2% are White.

Theme: Caregiver Motivation

The NS stated that having a basic understanding the racial-ethnic and cultural background of an HHA candidate helps to shape QRS expectations about the type of worker they will be and how long they are likely to remain with the organization. Young B/AAs not bound for college or other post-secondary school placements or opportunities may seek the job because it can be performed successfully with limited education and training.

As for African HHAs, the NS explained, "Although caregiving is a natural aspect of African culture, African HHAs are viewed by us as strong workers but who may not remain with us for long. This is because they may be seeking higher-paying job opportunities elsewhere." Covington-Ward (2017) found that Africans who emigrate to the United States and take DCW positions often have a higher level of education than many B/AA candidates for the same positions. This could help explain why Africans who are hired by QRS to work as HHAs are viewed as continually seeking better job opportunities. It also suggests that creating a pipeline of viable HHA candidates is

warranted to help alleviate both anticipated and unanticipated HHA absences or shortages.

Other Organizational Results

Client Programs and Services

QRS provides nonmedical home healthcare services to elderly and disabled clients and their families who contract for services. This work consists primarily of assistance with ADL and IADL to promote client independence and normalcy. The BHLs explained that engaging successfully in these activities is essential to experiencing a decent quality of life. Scholarly literature corroborates this perspective. Low ADLs are strongly associated with poor health outcomes and higher hospitalization rates and healthcare costs (Chuang et al., 2003; Kumar et al., 2017; Osakwe et al., 2019). Low ADLs can also lead to increased mortality and risk of admission to a nursing or rehabilitation facility (Holup et al., 2017; Stineman et al., 2012). The BHLs stated they would like to offer additional programs and services that include using adult or youth volunteers to perform activities such as reading or singing to clients, writing letters to family and friends, and providing haircare and beauty services.

Client-Centered Workforce

The salient characteristic of the QRS workforce that provides direct services to elderly and disabled clients is their indisputable passion for caregiving. Such dedication allows the HHAs to continue to deliver quality services that vulnerable persons require to remain in their homes despite low wages, few employer benefits, and stressful work in many situations. The ED and NS said they provide a high level of support in appreciation

for the passion the HHAs bring to their jobs. They ensure HHAs are assigned to safe homes, forge trusting and reliable work relationships, and value HHAs as key members of their client services teams by empowering them to voice their feedback and ideas. Presently, there are 50 HHAs working at QRS which is based on a current caseload of 50 clients (i.e., a one-to-one ratio of workers to clients). However, there is no pipeline of HHAs which could result from ongoing recruitment to proactively improve worker availability before an actual need arises. The ED said they utilize their relationships with external resources (e.g., healthcare staffing organizations) to augment the ranks of the QRS client-serving workforce as needed, but this is not done in advance of a stated need.

The ED said that strategically increasing the role of volunteers as a useful adjunct to the HHA workforce could help meet the needs of current and projected numbers of underserved elderly and disabled persons within their market. With this goal in mind, the BHLs are seeking to pair volunteers with HHAs as caring community companions in the months ahead.

Organizational Leadership and Governance

QRS is a small nonprofit organization that has been in business since 2016. They operate with an uncomplicated, practical, and traditional hierarchical structure in which oversight, decision-making, and communication flow from the top down. Governance is provided through a Board of Directors which is comprised of seven professionals. The decisions made by the Board are often those voiced by the ED as the organizational founder and Board chairperson who is on the frontline daily of QRS operations.

Responsibility for the recruitment, retention, and supervision of HHAs, the day-to-day leadership, and the oversight of client programs and services, is shared between the ED and NS. It is clear the BHLs are wearing too many hats and are understaffed. If an HHA calls out or does not show up unexpectantly for duty, either the ED or NS must take action on short notice to find a possible suitable replacement or devise another solution. I was not given access to Board meeting minutes or notes, so it was not possible to discern if such issues were addressed or how the Board could act to assist the ED and NS.

Financial and Marketplace Performance

Adequate staffing and other key areas of organizational operations directly affect an entity's ability to generate sufficient revenues for a favorable financial position. The home healthcare services market is exploding all around the country, and Maryland is no exception. As a nonprofit, nonmedical services home healthcare provider, QRS was formed with the public good in mind. As such, the organization is committed to providing quality, affordable healthcare services to elderly and disabled individuals in their own homes. In so doing, they support the area's most vulnerable citizens by helping to create a strong foundation that fosters a viable alternative to more restrictive placements.

However, given the current and projected demand for home healthcare services within the Washington, DC metropolitan area, QRS revenues from client services are quite low compared to what they could be. Based on publicly available IRS documents, the organization posted a net profit in 2017, a net loss in 2018, and low gross revenues from 2019 through 2021. The ED indicates they have 50 clients; however, that number was considerably lower in prior years. If the HHA shortages and turnover were

alleviated, QRS would potentially be better positioned to significantly increase the number of clients served and improve their financial position and market share.

Social Impact

The ED said that a key priority of QRS is increasing its presence and visibility in the community as a nonprofit organization invested in the health and wellness of older Americans and the disabled. Raising awareness will help increase the number of clients they can serve who are in need of personalized, nonmedical home healthcare which cannot be paid for by a third-party (i.e., private health insurance, a government agency, an employer, or a health maintenance organization). And because affordability fuels their mission, QRS stands to have a positive social impact on the health and wellness of hundreds of individuals and numerous communities as the business grows and thrives.

Strengths and Limitations of the Study

The strengths of the study include its flexible qualitative design, sound working relationship with interviewees, adaptive use of the Baldridge Excellence Framework (NIST, 2021), and the utility of the chosen data analysis tools, tape recordings and transcriptions. The single case study design allowed for in-depth exploration of a realistic and well-recognized challenge within the home healthcare industry through semi-structured interviews with leaders who routinely face these issues. The design permitted guided conversation rather than a search for specific information to be quantified, and it fostered active listening and the ability to direct interviews unobtrusively (Babbie, 2017). The BHLs consistently displayed their willingness to be interviewed and remained available to me despite their small size, ongoing HHA shortages throughout the COVID-

19 pandemic, and operational changes which frequently interfered with interview scheduling. This enabled me to establish a trusted ongoing relationship to explore and clarify responses to improve data accuracy, validity, and understanding.

Another strength was the recorded interviews—transcribed using a subscription service. I printed out the transcripts and stored them in a notebook. This practice facilitated multiple reviews, aided understanding of emerging themes, and yielded meaningful verbatim quotes that I used to substantiate the findings. Furthermore, the analysis was strengthened by use of Delve—an intuitive online qualitative analysis tool that allowed me to develop thematic codes and consider the same responses within multiple contexts. This resulted in 33 initial thematic codes that were whittled down to 10 general themes. Another strength was use of the Baldrige Excellence Framework (NIST, 2021) because it was flexible enough to allow me to select and customize interview questions that I deemed appropriate for the small nonprofit healthcare organization under study.

The salient limitation of the study is data reliability. Although findings on two of the research questions (i.e., how QRS recruits and retains HHAs) are corroborated to a degree in the academic literature, there are few studies on the third research question (i.e., how race/ethnicity or cultural considerations can help or hinder HHA workforce shortages). The research study that I conducted barely scratched the surface on this topic. The interviews constitute the limited though important perspective of only two BHLs of a home healthcare organization. Similar interviews of leaders from other home healthcare

agencies who hire HHAs of color are warranted and would add to the limited knowledge base on this topic.

Another study limitation is the data documentation through secondary sources. The ED did not provide certain types of written records (e.g., financial reports) or they did not exist in written format (e.g., performance improvement data; Board meeting minutes). Most written documents were those associated with HHA recruitment, onboarding, and orientation. While this situation may be common or insurmountable in small organizations with limited resources, it hinders data triangulation and a holistic understanding of the organization as it relates to the research questions.

Summary and Transition

In Section 4, I examined the study results in terms of implications for QRS. I analyzed and synthesized the results of interview data collected from BHLs and findings from review of public and internal organizational documents to address the three study research questions which focus on HHA recruitment and retention practices at QRS. I also discussed strengths and limitations of the study findings.

In Section 5, I discuss recommended solutions to challenges the BHLs at QRS have experienced in the area of HHA recruitment and retention. I also include a plan for disseminating and implementing the study results.

Section 5: Recommendations and Conclusions

In Section 4, I analyzed data collected through semi-structured interviews with two BHLs at QRS and review of public and internal organizational documents to examine a professional practice problem identified by the ED. Specifically, I addressed how BHLs recruit and retain home HHAs with the goal of determining new or enhanced strategies to help them curb challenges involving HHA shortages and turnover. In Section 5, I convey recommended solutions in order to potentially address these challenges and a plan to disseminate and implement the study findings.

Recruitment Recommendations

The following recommendations and ideas should be considered to help QRS strengthen its existing HHA recruitment strategies and practices.

QRS leadership should build upon the comprehensive process that is already established and followed for identifying and hiring new HHAs. I recommend adding an individual to the QRS staff whose functions would include HHA identification and screening, recruitment, and related functions. Doing so should substantially reduce the labor hours currently required by the ED and NS to address such tasks.

QRS leadership should expand the approach they apply to locate individuals who are qualified to care for elderly and disabled persons. In addition to currently used resources such as online staffing sites, referrals from past and current clients, and professional associates and networks, I recommend increasing the candidate pool by collaborating with local nonprofit organizations with large memberships or followers. For example, there are numerous megachurches (i.e., churches with an unusually large

number of congregants) in the QRS service area with thousands of members that reflect the racial, ethnic, and cultural diversity of the QRS workforce and clientele. Many of these churches have ministries that provide services to vulnerable and marginalized groups that would resonate with the QRS mission and vision.

QRS leadership should consider intensifying its branding and visibility to HHAs and other stakeholders within its service area as a nonprofit HHA. By emphasizing its mission to provide affordable in-home healthcare that supports elderly and disabled citizens in the community, it can increase its appeal to like-minded potential HHAs, volunteers, and donors to help pay for many of these recommendations.

QRS leadership should form relationships with staff at local community colleges in and near their service area with courses of study that could yield HHA candidates. For example, Prince George's County Community College (PGCC), located a short distance from QRS offices, offers an associate's degree program in human services (e.g., counseling, social work, nursing, and gerontology). QRS leaders could increase their visibility and raise awareness of potential job opportunities to key stakeholders in this and similar institutions. Other potential resources for viable HHA candidates who may have limited education include state and county unemployment offices and local social services offices.

Retention Recommendations

The following recommendations and ideas should be considered to help QRS strengthen its existing HHA retention strategies and practices.

QRS leadership should consider applying a more formalized approach to their current HHA personal support efforts. The attention BHLs typically give to HHAs to help them address personal matters is likely a significant positive differentiator between QRS and other organizations. With a few enhancements, this support could be strengthened to aid retention. I recommend that BHLs develop and administer a questionnaire to their HHAs to identify areas of personal need (e.g., reliable childcare or transportation, better job skills, or community resources for low-income residents) that may be holding them back from improved job performance and overall quality of life. BHLs would then use this questionnaire as a basis for shaping and monitoring support activities that directly recognize and address their individual needs. This strategy could also help HHAs manage potential psychosocial stressors of the position (e.g., alienation, unfulfilled aspirations, heavy workloads, caregiving in the end phase of a client's life) which can lead to fatigue, burnout, and turnover (Black, 2015; Clare, 2011; Iloabachie, 2018).

QRS leadership should consider instituting an HHA peer mentoring program in which HHAs who have worked for the organization for a year or longer are paired as mentors with new hires or less-experienced HHAs to address and resolve issues of concern. I recommend that mentors receive some type of benefit (e.g., an hourly wage increase, paid time off, monetary bonus, or gift cards) for performing such duties. To fund the mentoring program, the Board could pursue grants or donations from local businesses, host fundraisers, or seek other external financial support.

QRS leadership should increase opportunities for training and career development once HHAs are hired and have worked for the organization for a specified time period.

HHA training initiatives can improve job satisfaction and retention (Feldman, 2019). Since the QRS workforce includes many Unlicensed Aides who, unlike CNAs and GNAs, only provide personal care services, BHLs could encourage and help them become certified caregivers to improve their job status at QRS. Ultimately, this would enhance their chances for a future career in nursing or a related healthcare field, if desired. I recommend that QRS explore federal or state workforce development grants for underserved communities and similar funding opportunities. For example, the Federal Office of Family Assistance provides health profession opportunity grants to organizations that help underserved persons become CNAs or enter or advance in the nursing field.

QRS leadership should consider providing training to newly hired HHAs involving workplace success skills and workplace professionalism for health paraprofessionals. This could be a virtual or live course geared toward QRS work culture to reduce problems expressed by BHLs such as unexpected call-outs, no shows, and other unprofessional behaviors that can disrupt client services. The course could be conducted by one of the BHLs, a Board member, a qualified volunteer, or an external training vendor.

QRS leadership should improve upon how they select, gather, store, and use data, information, and knowledge assets to monitor client service provision and improve organizational performance. Data collection should involve tracking key information including daily operations and progress in terms of achieving strategic objectives and overall organizational performance when meeting measurable targets.

QRS leadership should incorporate strategies that focus on HHA empowerment and caregiver team development. Drawing upon productive working relationships the BHLs have already established with their HHAs, they could add strategies that researchers found to increase worker retention. Examples of such strategies include increasing job autonomy, involving HHAs in patient care planning and decision-making, and ensuring an appreciative and respectful work culture. Instituting regularly scheduled HHA listening sessions—or informal dialogues between groups of HHAs and the ED and NS—may also be helpful. These recommendations would give HHAs a voice in shaping a culture of teamwork that fosters job satisfaction and demonstrates their value as caregivers. Kusmaul et al. (2020) reported on the importance of helping DCWs feel structurally and psychologically empowered as a foundation for retaining them.

Regularly scheduled team check-in meetings between HHAs and their supervisors may also help in this regard. I recommend that consideration be given to allowing HHAs to participate in the initial assessment or interview of clients to which they are assigned. HHA involvement in shaping client care planning has been shown to increase HHA investment in their client's needs and health outcomes (Danilovich et al., 2019).

QRS leadership should increase its cultural sensitivity on how the race/ethnicity and cultural background of its workforce can help strengthen its recruitment and retention efforts. The BHLs sometimes consider such factors to help identify candidates that are the best fit for a particular job opening. Since HHAs of color predominate in the QRS service area (Scales, 2018) and also at QRS, it would be useful for the BHLs to expand their understanding of how culturally-based perceptions, customs, and values about elders

and caregiving can enhance QRS client care practices and HHA recruitment and retention. This topic could be explored at one of the HHA listening session.

Client Programs and Services and Client-Centered Workforce

Although the focus of QRS home healthcare services is on underserved elderly and disabled persons, the ED has worked in the past with at-risk youth. I recommend the BHLs move forward with plans stated by the ED to launch intergenerational strategies to help address HHA shortages and turnover. This includes pairing youth with elderly and disabled clients for purposes such as reading, singing, or engaging in crafts. Doing so would demonstrate to HHAs that QRS is innovative in its approach to client programs and services which, in turn, could foster an appreciation for affiliating and remaining with this home healthcare provider over a competitor. It also reinforces the QRS team approach to client care.

QRS leadership should expand its use of adult volunteers to help with certain office functions and direct service delivery to clients (e.g., reading to clients or assisting with correspondence from clients to friends and family). Their role would be similar to that specified above for at-risk youth. Currently volunteers assist with organization-sponsored events such as fundraisers, but they could also be paired with HHAs as caring community companions.

Organizational Leadership and Governance

QRS leadership should consider implementing a strategic planning process to identify short-term, mid-term, and long-term goals for the organization with a focus on staff recruitment and retention, revenues, and other critical issues that impact

sustainability. Using the Baldrige Excellence Framework (NIST, 2021), the full Board of Directors could focus on developing strategic objectives and action plans and deciding how QRS will implement them, make changes as required, and measure progress.

QRS leadership should develop a Communications and Marketing Plan with the goal of expanding organizational branding as a vital and affordable community resource for elderly and disabled residents in need of home healthcare services. This would include updating the QRS website to convey important information to potential HHAs and clients and bolster staff recruitment and retention goals and organizational revenues. Also, the website could include a link whereby potential HHAs can apply for employment.

Financial and Marketplace Performance

QRS leadership should focus squarely on strategies to increase its revenue base. Although many of the recommendations presented herein could be implemented at low cost, certain factors that are reported to impact HHA recruitment and retention—such as increased hourly wages, health insurance, and performance bonuses—require that QRS is in a substantially improved financial position. This can occur by significantly expanding its customer base from the current caseload of 50 clients to a larger number as projected by an accountant or other financial professional.

QRS leadership should consider adding an individual to its Board who has expertise in finance or accounting to evaluate and report on the financial position of the organization on a regular basis. It is important to track financial performance results using key measures or indicators of financial return, financial viability, and budgetary

performance (NIST, 2021). Additionally, I recommend adding a member to the Board with experience in nonprofit fund development, grant-writing, and research. This person would identify suitable funders and apply for grants to help QRS grow and thrive.

Social Impact

QRS leadership should remain abreast of the status of relevant federal and state legislation and activities that will likely impact QRS operations and the larger community of in-home caregivers. This task could be assigned to a Board member who might also attend state legislative hearings held in Annapolis, MD. QRS leadership should especially monitor governmental activities related to HHA wages and benefits since many researchers have found a connection between higher compensation and better rates of retention among nursing assistants (Black, 2015; Creapeau et al., 2022; Kennedy et al., 2022). However, it is important to be mindful that nonprofit entities are prohibited from influencing legislation or supporting political campaigns or candidates (IRS, 2022).

Implementation and Evaluation Strategies

I include a proposed plan to implement and evaluate the recommendations outlined in Section 5 of this research study. Information is provided in sufficient detail so that the QRS Board of Directors, ED, NS, and other internal and external stakeholders can carry out the plan efficiently and effectively.

Table 6 provides an overview of the proposed implementation strategy which covers five phases in a logical, step-wise manner. Given the limited personnel and financial resources of the organization—and the urgent need to improve HHA

recruitment and retention practices—a simplified but relevant approach is proposed that can be accomplished within a relatively short timeframe.

Table 6

Overview of Implementation Plan for Recommendations

Phase	Description	Timeframe
Phase 1	Conduct Pre-planning	Month 1
Phase 2	Hold Strategic Planning Meetings	Month 2
Phase 3	Develop 2023-2025 Strategic Plan	Month 3
Phase 4	Implement the Strategic Plan	Months 4 to 12
Phase 5	Evaluate and Update Strategic Plan	Month 13

In Phase 1, I will present the research study results initially to the ED to give an overview of the study findings. At that time, I will emphasize the need for holding strategic planning meetings as a key next step. With the ED's approval, I will recommend the findings be shared at these meetings with the full Board of Directors, the NS, and any other key internal or external stakeholders they designate to be part of this planning group. Sharing the findings could be accomplished through use of a PowerPoint presentation that I would develop to highlight the study methods, results, and recommendations. Alternatively, I could summarize this information in a brief written format and provide a copy to these individuals, depending upon the preferences of the ED.

In this initial phase, we will establish the need for strategy development. This refers to an organization's approach to preparing for the future and making decisions on

how it will proceed and allocate resources (NIST, 2021). We will also agree upon a convenient schedule for the strategic planning meetings. I will provide online links to strategic plans developed by other organizations so the end-product of our efforts can be better visualized. Also, I will provide other useful reference materials—such as Census Bureau population projections by age group for the QRS service area—to help inform our planning. Subsquently, Phases 2 through 5 of strategic planning will be implemented.

In Phase 2, the Board will primarily determine its short-, mid-, and long-term goals and objectives that are in alignment with the QRS mission. To formulate strategic objectives, the planning group should focus on specific challenges, advantages, and opportunities that are most important to the ongoing success of QRS and to the strengthening of its overall performance in meeting the mission. It should reach consensus on the key process steps and timeframes for achieving these goals and objectives.

It will be important at this stage to determine how the strategic plan will address the potential need for change, including whether and how to adopt the recommendations presented in this research study. It will also be important to prioritize change initiatives for organizational agility which is the organization’s capacity to accommodate a rapid change in direction based on needs and opportunities (NIST, 2021).

In Phase 3, the QRS 2023-2025 Strategic Plan will be written and a copy provided to each member of the planning group. Since this would be the first time QRS has held strategic planning meetings, I recommend the document cover a 2-year timeframe to allow for multiple mid-course corrections and updating as the group grows more

accustomed to managing change. Also, since QRS is new to this process and organizational funds are limited, I recommend engaging a qualified volunteer with strategic planning expertise to facilitate the planning meetings and co-author the QRS 2023-2025 Strategic Plan along with the ED or another Board member.

In Phase 4, an action plan for implementation of the Strategic Plan should be developed and deployed. The planning group will decide on key short- and longer-term action plans that support and are in alignment with the strategic goals and objectives. It should include a strategy for deploying the action plan to the QRS workforce and to key suppliers, partners, and collaborators. It should also cover resource allocations to ensure that adequate personnel and non-personnel resources are available to meet current obligations and stated targets (NIST, 2021).

In Phase 5, the planning group will re-visit the Strategic Plan to evaluate if it is being implemented in a satisfactory manner and if intended results are being achieved. This will require the review of performance measures or indicators that must be developed in Phase 4 to track achievement and effectiveness of the action plan and its impact in key areas (e.g., HHA recruitment and retention; client programs and services; financial and marketplace positioning). Examples of circumstances that might require shifts in action plans include disruptive internal or external events, changes in local economic conditions or competitive marketplace realities, or changes in client program and service needs or workforce skill levels (NIST, 2021). Any required changes or updates would be made at this point to guide QRS Board and staff operations going forward.

Recommendations for Future Studies

The home healthcare industry is among the top three fastest-growing employment sectors in the United States (Schweid, 2021) and is fueled by steady growth in the percentage of older Americans who want home-based healthcare (Olsen, 2019). For-profit and nonprofit home healthcare agencies of varying sizes comprise the competitive marketplace within the geographic area served by QRS.

This study focused on one small, nonprofit organization that is committed to ensuring that nonmedical home healthcare is an affordable alternative for those who need it. The study reflects the perspectives of the two BHLs within the organization who are most familiar with QRS systems, processes, and practices as related to the research questions. However, limited internal secondary documents were available to corroborate some findings. Since large and small home healthcare providers nationwide struggle with DCW shortages and turnover, additional qualitative case studies are warranted. Such studies may also increase knowledge of how sensitivity to the racial, ethnic, or cultural background of HHAs can improve how they are recruited and retained.

Dissemination Plan

I conducted this research study to benefit two parties—me in my quest to pursue a topic of importance to behavioral health leadership in the home healthcare industry, and BHLs at QRS who are facing ongoing challenges in HHA recruitment and retention. Upon completion of this study, I will meet with the ED to provide an overview of study findings and recommendations and discuss potential plans to disseminate this work to the Board of Directors and any other designated staff members and stakeholders. This may

be accomplished by delivering a PowerPoint presentation or a brief written summary that highlights key methods, findings, and recommendations, depending on the preferences of the QRS leadership. Since many of the recommendations constitute a change-in-direction or an expanded approach to current practices, I will highlight the need for the leaders to undergo a strategic planning process to set the course for taking action and making needed changes to improve future organizational performance.

Conclusion

Given the scholarly literature and U.S. Census Bureau population projections—coupled with my six years of personal experience interfacing with HHAs and home healthcare agencies for a family elder—it is my informed perspective that many Americans will one day either require a caregiver, become a caregiver, or hire a caregiver for a loved one. Services to support the cognitive, physical, and behavioral limitations of this life phase are essential (Carpenter et al., 2021) as most older individuals prefer to remain in their own homes to help retain their self-reliance and independence (Ahn et al.; Olsen, 2019). However, unless the home healthcare industry and federal, state, and local governments work together effectively to seek solutions to continuing challenges in recruiting and retaining HHAs, there stands to be insufficient availability of caregivers when American families will need them the most. This is a looming healthcare workforce crisis that cannot be overstated or overlooked.

The vital services that HHAs provide are still undervalued in today's society and economy as they have been historically, prompting many of these individuals to change employers or leave the profession to improve earnings, psychosocial conditions, work

culture, and quality-of-life for themselves and their families. Collecting and sharing information from studies of workers on the front lines of caregiving—and from those who work closely with them—can help curb worker shortages, turnover, and other disruptions through increased knowledge, understanding, and action that could lead to meaningful social change. This may be especially true for women of color who, despite being the linchpin of home healthcare, continue to occupy one of the less respected and poorly paid paraprofessional positions in the U.S. workforce (ACLU, 2015; Rossman, 1997).

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Appendix A: Semi-Structured Interview Questions

Organizational Environment and Relationships:

- How would you describe the organizational mission? What is the vision? What are the core values?
- What types of services does your organization provide to its clients?
- If you had to weigh the relative importance of the various services to organizational success, are some services emphasized over others?
- How are you set up to deliver home healthcare services?
- What is the organizational structure of the organization?
- What are the reporting relationships among the Board and Senior Leaders? What are their roles? Is there a formal organizational chart?
- What non-personnel assets (e.g., facilities and equipment) does the organization have?
- Is QRS subject to an external regulatory body (e.g., health or safety regulations, certifications at federal or state level) for compliance purposes?

Workforce Profile:

- What are the workforce groups or categories of personnel? What are the education and experience requirements and competencies for each category?
- Who has the most daily contact with the HHAs? What is the nature of these contacts?
- Have you experienced any recent changes in your workforce composition?

- How would you describe the demographic composition of your HHAs? Are there any aspects of the demographic composition that might positively or negatively impact HHA recruitment and retention?

Clients, Suppliers, and Partners:

- What are the organization's key market segments and customer groups? What is the demographic profile?
- What types of suppliers, partners, and collaborators does the organization have?
- What role do they play in the organization's work systems, especially in producing and delivering key health care services and client and other customer support services, and in enhancing competitiveness?
- What are the organization's key mechanisms for two-way communication with suppliers, partners, and collaborators?

Competitive Environment:

- Who are your competitors? How many and what size? Does comparative data exist for your market?
- What is your competitive position in providing home health care in your market?
- What key changes, if any, are affecting your competitive position, including opportunities for innovation?

Leadership, Governance, and Organizational Strategy:

- How do the senior leaders set and deploy the organization's mission and vision?
- How do their personal actions demonstrate commitment to ethical behavior?

- How does senior leadership communicate with and engage their entire organization, including external stakeholders?
- What are the key strategic challenges and advantages for leadership?
- Do you see any potential changes to your market that will impact how you will lead within the next year, including any advocacy occurring at Federal or State levels?
- How are organizational strategies and plans developed and implemented that impact HHAs?
- What is the organization's performance improvement system to evaluate its systems and processes to accomplish the mission?
- What societal contributions to the public health and well-being do the senior leaders ensure the organization makes?

Workforce Environment:

- How do you recruit, hire, and onboard new HHAs to build an effective and supportive workforce?
- How do you organize and manage your workforce? How do you assign HHAs with clients?
- How do you assess your workforce capabilities and capacity and needs?
- How are HHAs introduced to the organization's mission, vision, and values from the application process through hiring and onboarding?
- What type of training is provided to HHAs at the point of hire and/or after they are hired? Who provides/leads the training?

Workforce Engagement:

- Are there any special recognition programs you conduct for a job well done?
- What benefits are offered to HHAs?
- How do you ensure workplace health, security, and accessibility for the HHAs?
- How do you determine the key drivers of workforce engagement in terms of what is important to the HHAs?
- What formal or informal assessment methods and measures do you use to determine workforce satisfaction?
- Is there a way HHAs can share their ideas for performance improvement purposes?
- What factors do you think contribute to challenges you have experienced in engaging, recruiting, and retaining qualified HHAs to meet your needs?
- What type of changes would you like to see your organization or the federal and state governments make that may improve HHA engagement, recruitment, and retention?