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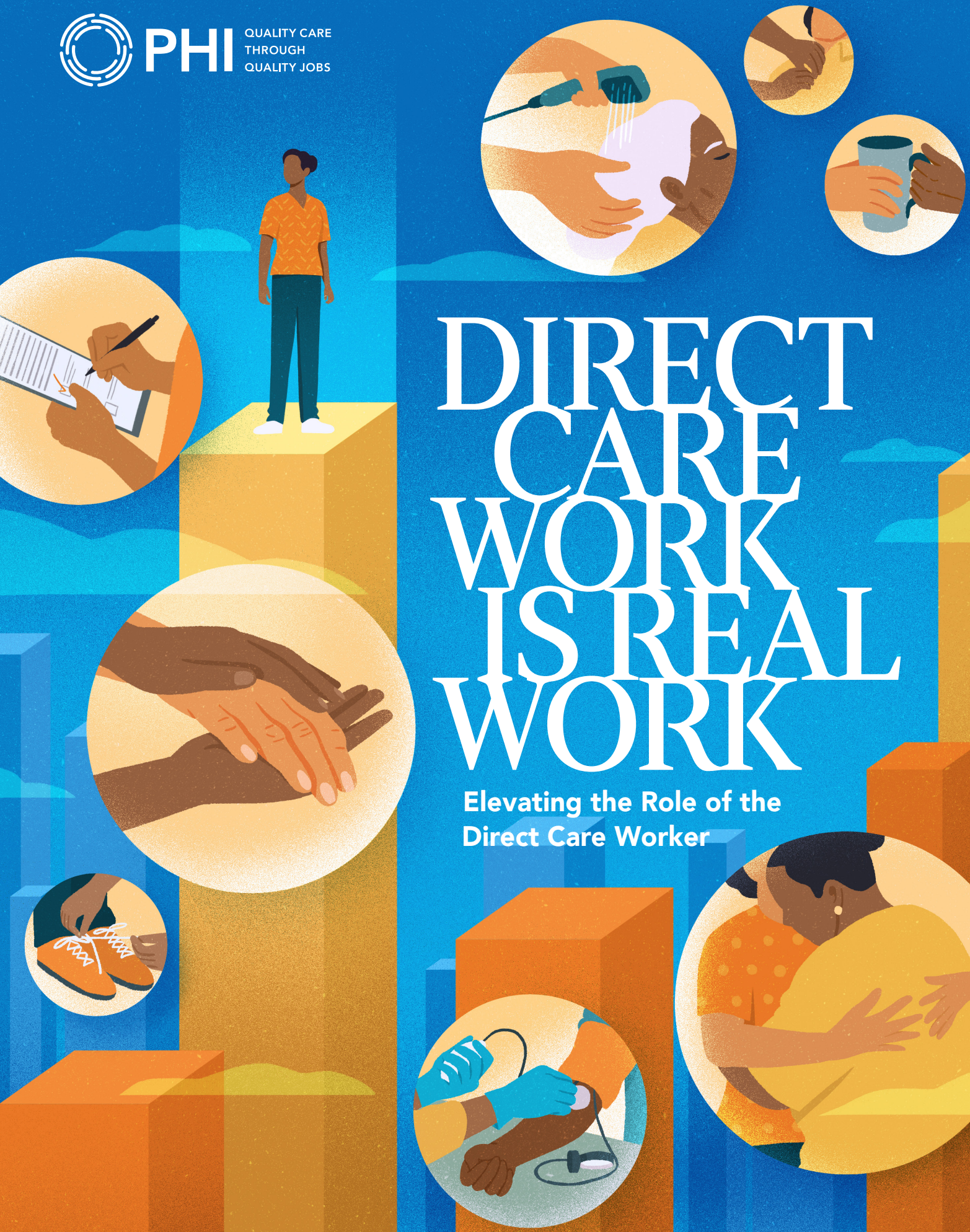
QUALITY CARE THROUGH QUALITY JOBS



DIRECT CARE WORK IS REAL WORK

Elevating the Role of the Direct Care Worker

This report is the third in a year-long series that provides a comprehensive, current-day analysis of the direct care workforce and its critical role in the long-term care system in the United States. *Caring for the Future: The Power and Potential of America's Direct Care Workforce*—which will be released throughout 2020 in four parts, and in its entirety in early 2021—includes a detailed profile of these workers; a segmented look at the long-term care industry; a discussion on the evolving role of the direct care worker; a proposed framework for creating quality jobs in direct care; and a look forward at where this workforce and industry are heading. The report series also offers concrete recommendations for policy and practice, and features stories of direct care workers from around the country, sharing their wisdom and ideas. **In releasing these reports, our goal is to strengthen the national dialogue on the direct care workforce, including what needs to change in policy and in practice.**

PHI would like to thank the **W.K. Kellogg Foundation** and the **Woodcock Foundation** for their generous support of this report.

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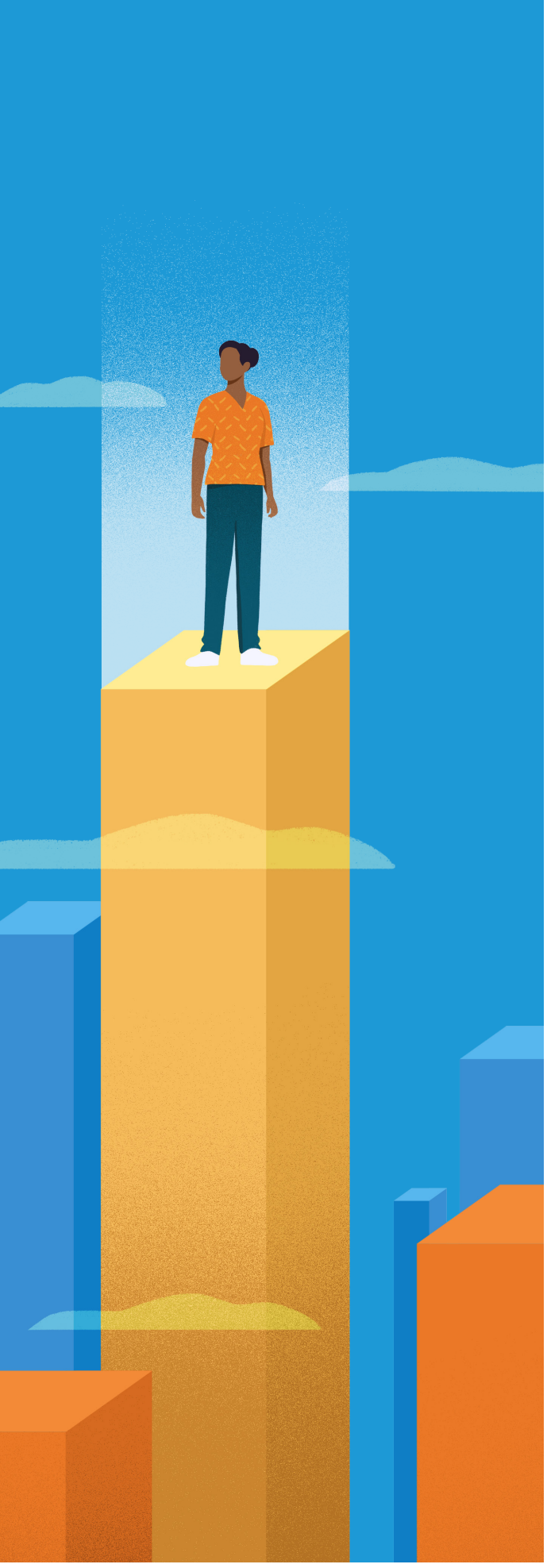

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Chances are that we each know someone—a family member, a friend, ourselves—who receives support from a direct care worker. Direct care is the largest job sector in the United States, employing 4.5 million nursing assistants, home health aides, and personal care aides who deliver services and supports to older adults and people with disabilities across care settings. With strenuous occupational demands and median wages of just $12.27 per hour, direct care jobs are paradoxically considered poor quality jobs and essential jobs. But as demand escalates across the country, these are jobs we can no longer afford to underestimate.

Because direct care work is real work.

This report is the third in a year-long series, culminating in a comprehensive final report in January 2021, that examines the importance and impact of the direct care workforce. Each report in the series provides original data, in-depth analyses, and policy and practice recommendations, along with stories from direct care workers around the country. It's critical that we include workers' voices, experiences, and insights in efforts to shape and improve this sector. The final report will compile all four individual reports, synthesize the key issues, articulate future challenges and opportunities, and provide a full set of policy and practice recommendations.

This report, *Direct Care Work Is Real Work: Elevating the Role of the Direct Care Worker*, examines how existing training standards for direct care occupations fail to capture the full range of skills required for these roles—and raises opportunities to better leverage direct care workers in care coordination. It begins with a look at the current federal and state regulations that govern training in direct care. The training landscape for this workforce is fragmented and outdated, with inconsistent rules and regulations across states, occupational categories and job titles, and payment programs.

Insufficient training standards make it difficult to prepare workers to deliver quality care for consumers. And some of the fastest-growing direct care occupations require little or no training at all.

This report considers the labor involved in direct care work, zeroing in on aspects that are frequently overlooked, including its physical demands, social and emotional complexity, and growing contributions to consumers' health management. Direct care workers have largely been left to fill the gap between the training they receive, if any, and the evolving, increasingly complex care needs of consumers—without additional support, compensation, or professional recognition. The persistently poor quality of direct care training and jobs is rooted in structural discrimination. Political and social decisions have assigned low value to work performed by women, people of color, and immigrants—the majority of the direct care workforce—over time.

Yet because direct care workers spend more time with long-term care consumers than any other health care or social service worker, they hold tremendous potential to help improve quality of care. This report concludes with a review of opportunities to build a stronger, more equitable, and wide-reaching entry-level training system for direct care occupations. We also examine innovative strategies that maximize the role of the direct care worker in care delivery through upskilling, advanced roles, and integration into care teams.

Finally measuring the impact of well-trained and supported direct care workers on consumer outcomes, payers' bottom lines, and public health will help us better appreciate direct care work for what it is: **valuable**.

Terminology

ACTIVITIES OF DAILY LIVING (ADLS)
Essential activities performed every day, including bathing, dressing, eating, toilet care, and transferring/mobility.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare and partners with state governments to administer Medicaid, among other responsibilities.

CONSUMER
An individual who receives paid LTSS due to physical, cognitive, developmental, and/or behavioral conditions. Also referred to as a *client*.

CONSUMER-DIRECTED SERVICES
Publicly funded service delivery model that enables consumers to manage their own LTSS, including by hiring, scheduling, supervising, and dismissing their own workers. Also known as *participant-directed* or *self-directed* services.

CORE COMPETENCIES
A set of competencies—broadly, the knowledge, skills, and abilities applied to complete one's role—that are considered foundational to successful performance of an occupation or set of occupations. Other components of workforce preparation, such as training design, delivery, and assessment, can be developed from a set of core competencies.

DIRECT CARE WORKER
Assists older adults and people with disabilities with daily tasks and activities across LTSS settings (and in hospitals and other settings, though these other settings are not the focus of this report). Direct care workers are formally classified as personal care aides, home health aides, and nursing assistants, but their specific job titles vary according to where they work and the populations they serve.

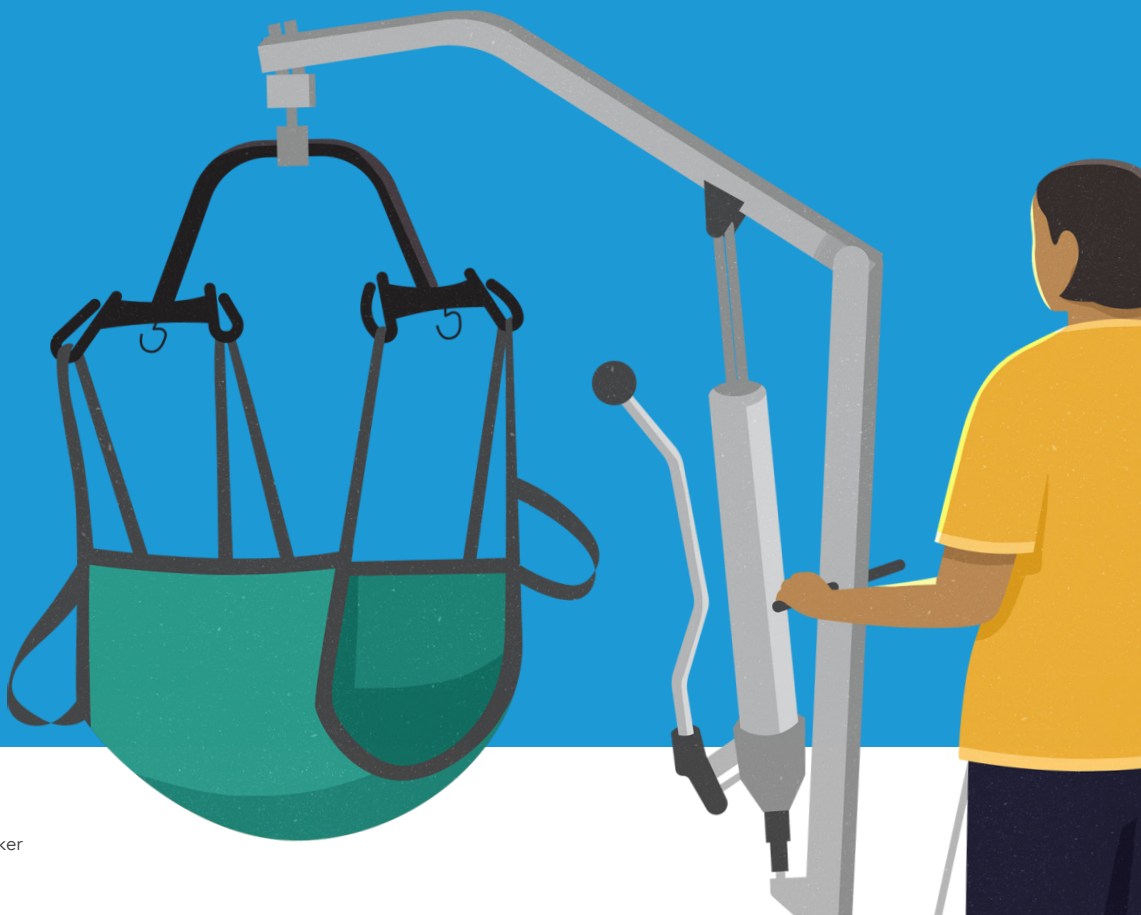
INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)
Tasks associated with living independently, such as preparing meals, shopping, housekeeping, managing medications, and attending appointments.

LONG-TERM SERVICES AND SUPPORTS (LTSS)
A range of health and social services provided to individuals who require assistance with ADLs and IADLs. Also described as *long-term care*.

PORTABILITY
The degree to which a training experience, credential, or certification in one occupation or role, care setting, or geographic region can be applied toward qualification and employment in the same role in another care setting or geographic region.

STACKABILITY
The degree to which a training experience, credential, or certification in one occupation or role can be applied toward training requirements, qualification, and employment in a different—typically higher-level—occupation or role.

TRAINING REQUIREMENT
A set of regulations that specifies training content and/or duration mandated for certification or employment in a specified occupation. In addition to content and duration, requirements may include instructor qualifications, competency assessment, portability of credentials, continuing education, and additional elements.



Introduction

Systemic under-investment in LTSS and disrespect of its workforce run deep in our society. How can these barriers be overcome?

In the *Caring for the Future* report series so far, we've taken an in-depth look at the direct care workforce and the complex, fractured long-term services and supports (LTSS) industry. In the first report (*It's Time to Care: A Detailed Profile of America's Direct Care Workforce*), we described the characteristics of the direct care workforce, underscored the need to bring more workers to this sector to meet escalating demand, and identified opportunities to elevate compensation and develop a more robust recruitment pipeline. In the second report *(We Can Do Better: How Our Broken Long-Term Care System Undermines Care)*, we examined the LTSS financing system and how its fragmented organization and competing priorities often leave both workers and consumers at an economic disadvantage, pointing to the need for systemic reforms.

As these reports have shown, efforts to generate the commitment needed to address workforce shortages and improve jobs for direct care workers confront an array of challenges. Direct care work is less publicly visible than other occupations, taking place primarily in private homes, nursing homes, and residential care communities. The work performed by direct care workers and the regulatory systems that shape it remain poorly understood by most people. Systemic under-investment in LTSS and disrespect of its workforce run deep in our society. How can these barriers be overcome?

We need to better understand the work of delivering LTSS to the 20 million adults in the United States who require assistance carrying out daily activities, engaging with their communities, and managing an increasingly intricate set of health conditions.[1] The demands on nursing assistants and home care workers have evolved significantly in recent decades—and particularly intensified in the midst of the 2020 coronavirus pandemic—but training standards and regulations for these roles have not kept up.

The patchwork nature of the current training infrastructure for direct care occupations undermines both the potential and perceptions of these workers. But improving training and career opportunities in the long-term care sector also holds promise for demonstrating the value of direct care work and driving greater investment in its workforce.

In this report, we survey the regulatory landscape that governs training of direct care workers in the U.S. and compare existing training standards against the challenges workers face on the job. In accounting for the aspects of direct care work that frequently go unrecognized, we argue for a deeper appreciation of the skills needed to deliver quality LTSS. This concept of appreciation directly informs the next report in this series, which will cover strategies for improving job quality for the direct care workforce.

Direct Care Training Regulations

Direct care is the largest job sector in the U.S., with nearly 4.5 million people employed as nursing assistants, home care workers, and residential care aides across care settings. Their work benefits millions more LTSS consumers and family members. But the requirements underlying training for direct care occupations are uneven, with federal mandates applicable only to those providing care in Medicare-certified agencies and state training regulations varying widely across long-term settings and job titles. In this section, we review these regulations and their implications for different segments of the long-term care workforce.

FEDERAL TRAINING REGULATIONS

Federal regulations govern training for two occupations within the direct care workforce. **Nursing assistants** employed in nursing homes that participate in Medicaid and Medicare are federally mandated to complete a state-approved training program and pass a standardized assessment to become certified nursing assistants before beginning work.[2] The rules require that these trainings include at least 75 hours of instruction, including 16 hours of supervised practical training. They further specify which competencies should be covered and under what circumstances training and evaluation can take place. Nursing assistant training topics include assisting residents with activities of daily living (ADLs, like bathing, feeding, and mobility); responding to residents' behavior, which may be affected by physical and/or mental health conditions; and providing social support. They also cover basic nursing tasks like observing and reporting changes in residents' health conditions and recording vital signs. Training may cover other clinical tasks that are specified at the state level and must be conducted under the supervision of a licensed nurse. Some but not all states allow for reciprocity of nursing assistant credentials, meaning workers trained and certified in this occupation in one state can apply for their certifications to be accepted in another state without requiring additional training.

Home health agencies participating in Medicare are also subject to a federal requirement to employ **home health aides** who have completed at least 75 hours of instruction, including 16 hours of supervised practical training, through a state-approved program that follows federal regulations on content, delivery, and evaluation.[3] Topics specified include providing assistance with ADLs, instrumental activities of daily living (IADLs, such as food preparation and maintaining a safe environment), and health-related tasks, such as observing and reporting changes in residents' health conditions and recording vital signs. As with nursing assistant training programs, home health aide training may cover other health-related tasks that are specified at the state level and must be conducted under the supervision of a licensed nurse. These home health aides are also federally mandated to receive 12 hours of in-service training per year.[4] Medicare-funded home health aide services are usually time-limited, for example to periods when Medicare beneficiaries have transitioned home from an acute care setting and require short-term assistance during recovery.

The requirements underlying training for direct care occupations are uneven, with federal mandates applicable only to those providing care in Medicare-certified agencies and state training regulations varying widely across long-term settings and job titles.

Personal care services are not reimbursed by traditional Medicare, and there are no federal training standards for personal care aides.

While federal standards make nursing assistants and home health aides the only segments of the direct care workforce whose training hours are consistently regulated across the U.S., these standards have been criticized as insufficient for preparing workers to meet the needs of long-term care consumers in the current era. In 2008, the National Academy of Medicine recommended that the minimum standards for nursing assistants and home health aides be increased from 75 to 120 hours of instruction, to better prepare workers for the increasingly complex care requirements of an aging population.[5] In the years since, the 120-hour standard has been endorsed by numerous long-term care stakeholder groups but only adopted by a handful of states.[6]

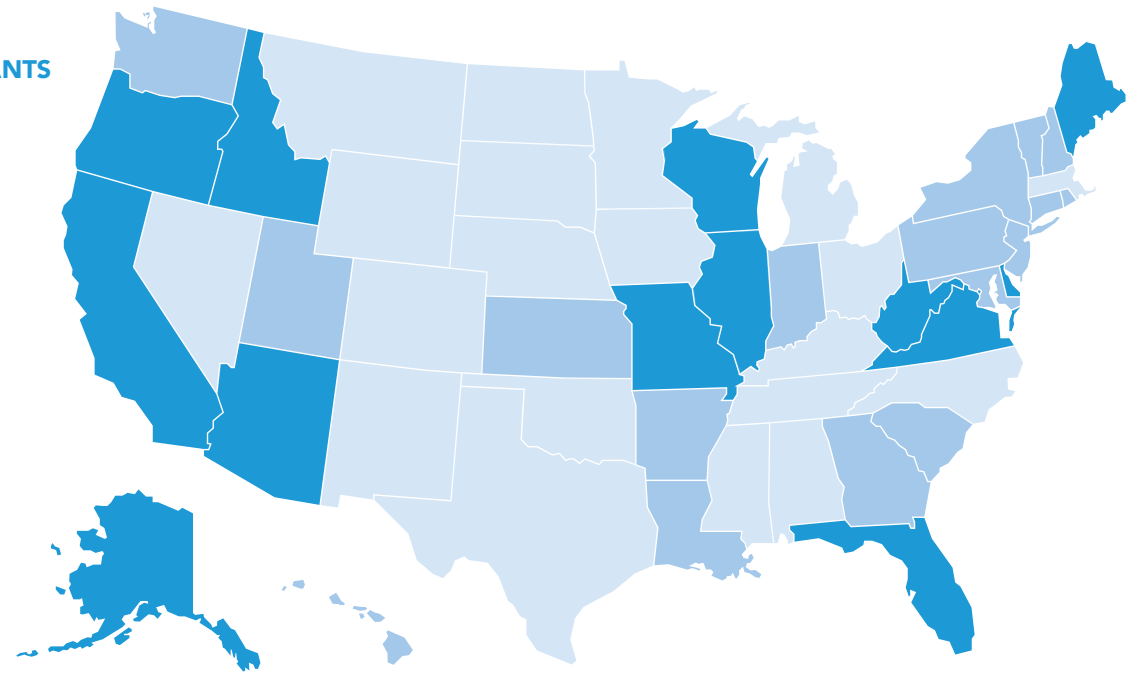
There are no federal requirements for training home care workers employed by agencies that do not participate in Medicare. Personal care services (explored below) are not reimbursed by traditional Medicare, and there are no federal training standards for personal care aides. When personal care services are funded through Medicaid programs, training regulations are decided at the state, program, or payer level.

STATE TRAINING REGULATIONS

Many states have chosen to expand training requirements for direct care workers beyond the federal minimum. Thirty-one states and the District of Columbia require more than 75 hours of training for nursing assistants, and 32 states exceed the 16-hour minimum for supervised practical training. Seventeen states and D.C. require more than 75 hours of training for home health aides, and 11 of these states also require home health aides to first be certified as nursing assistants. The 16-hour minimum for supervised practical training for home health aides has been expanded by 15 states and D.C.[7] Home health aides also care for Medicaid beneficiaries requiring long-term care; as discussed in the second report of this series, such Medicaid funding is primarily disbursed through waiver programs.

TRAINING STANDARDS FOR NURSING ASSISTANTS ACROSS U.S. STATES

- 75 Hours
- 76-119 Hours
- 120+ Hours



Source: PHI. *Nursing Assistant Training Requirements by State*. Bronx, NY: PHI. https://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/

Michelle Godwin

CERTIFIED NURSING ASSISTANT (CNA) AT VILLAS AT KILLEARN LAKES IN TALLAHASSEE, FL
23 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A CNA:

"Ever since I was teenager, I've always loved to be around older adults. I would befriend elderly neighbors, sit with them, and help them with anything they need. We would even sit down and eat dinner together.

After I graduated high school, I went to college for a little bit, but then decided to become a CNA. As soon as I passed my certification, I went right into working in this field. That was more than 20 years ago, and I've been working in it ever since—in nursing homes, hospitals, mental health facilities, home health care, and in a 'small house' neighborhood setting. I just love helping people and am very compassionate for people who can't always help themselves. I also know that one day I will get older and will want to be treated well and have the best care too."

ON HER RELATIONSHIP WITH HER CLIENTS:

"We are very close, and that's what I love most about my job. They see my smiling face, and they can tell through my character and sense of humor that I really care about them. They know that I'm here to do anything to make them feel better. I just enjoy them, and I can tell they enjoy me, too, because we make each other laugh all of the time."

ON WHAT SHE FINDS MOST CHALLENGING IN HER ROLE:

"If you last in this work for more than a year or two, it's because you're not in it for the paycheck—you're in it because you really care. I love what I do, yet I still have bills and responsibilities, and sometimes I don't feel we get paid our worth. That's why I think there is so much turnover in this field. I've worked in nursing homes and other places before where we were really short on help. In some of these places, I was assigned up to 20 residents, and there was no possible way to physically give each of them the care they needed. We are battling to do whatever needs to get done because we care. But if they were paying us more, that high turnover might stop and they'd be more likely to keep staff."

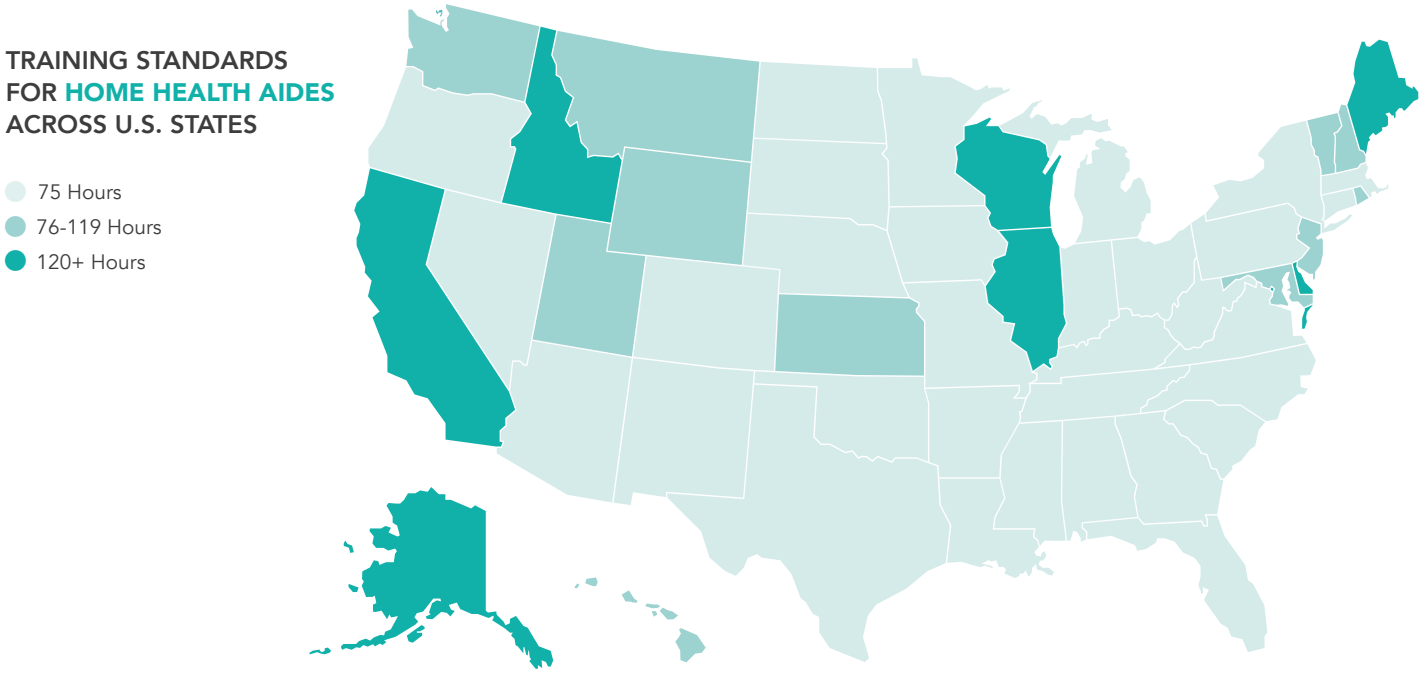
IF SHE COULD CHANGE ANYTHING ABOUT THE FIELD:

"If I could make a change, it would be for this field to show more appreciation for what we do because we are the main backbone of this work. We're the most hands-on with clients and spend more time with them than anyone else. Some days I completely forget to even take a break because the work is constant, and I want to make sure residents get enough time engaging with me. It can get overwhelming.

This can also be back-breaking work. It is very tiresome and can really take a toll on your body. We are lifting residents out of bed, helping them up if they need support walking, running around to get this test and that test done, and making sure they have everything else they need. Sometimes, I go home and my body is still in pain. But I do it over and over again because I really do care."

A CNA with more than two decades of experience working across a variety of care settings, Michelle's commitment to the wellbeing and happiness of older adults started early in life.

TRAINING STANDARDS FOR HOME HEALTH AIDES ACROSS U.S. STATES



Training requirements for direct care workers in residential care settings vary, as these agencies are licensed and for the most part regulated at the state level. Some states license multiple categories of residential care facilities, each of which may have distinct training requirements. All but three states require some form of entry-level training for **residential care aides** employed in assisted living communities. In most cases, these requirements are limited to an orientation on a uniform set of topics.[8] Only 17 states and D.C. require a minimum number of entry-level training hours for residential care aides in assisted living, ranging from 1 to 90 hours. Thirty-eight states require some form of continuing education for these workers. Direct care workers supporting residents with distinct needs within residential care communities, including those with dementia, are often required to complete additional training, as are workers approved to administer medication in these settings.

State variations in training regulations are most pronounced for home care workers who exclusively provide non-medical personal care services, usually in consumers' own homes and communities. Formally classified as **personal care aides** by the U.S. Bureau of Labor Statistics, these workers are known in the field by a range of job titles that vary by state and program—including *personal care aide, personal care assistant, home attendant,* and *home care aide.* Only 14 states have established consistent training standards for this occupation, meaning that training on a uniform list of topics is required for all personal care aides employed by home care agencies in those states. Standards for personal care aide training differ between payment programs within another 29 states and D.C. Among the 43 states (and D.C.) that have at least one set of training requirements for personal care aides, 27 have established a minimum number of hours for personal care aide training, only 16 of which exceed 40 hours. The remaining seven states do not regulate personal care aide training at all.[9]

Source: PHI. *Home Health Aide Training Requirements by State.* Bronx, NY: PHI. https://phinational.org/advocacy/home-health-aide-training-requirements-state-2016/

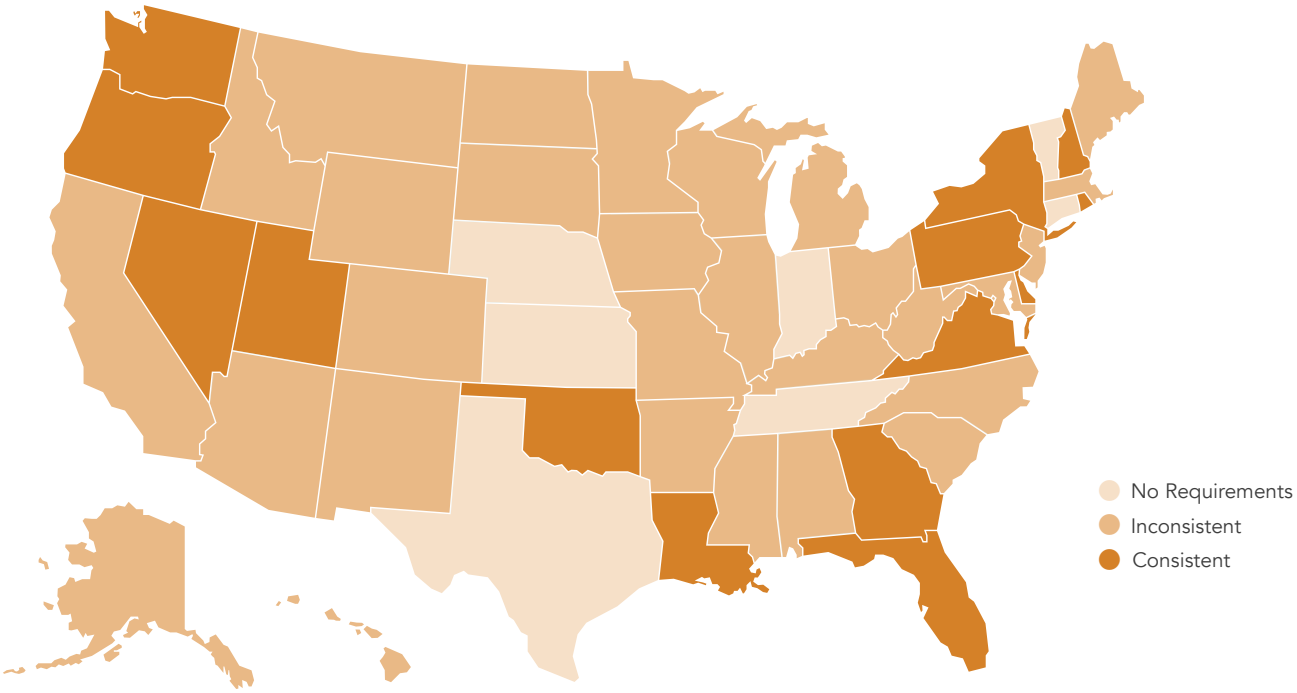
The considerable disparities in whether and how agency-employed personal care aides are trained across states, programs, and job titles suggest that many do their jobs with little formal preparation—with negative implications for variation in the quality of services delivered.[10] Researchers and long-term care stakeholders have for many years called for better training for this segment of the workforce. Along with recommendations for nursing assistants and home health aides, the National Academy of Medicine's 2008 report recommends that all states establish minimum training standards for personal care aides. With demand for this occupation driving the majority of job growth in long-term care, strengthening training standards for personal care aides has been identified as an important factor in meeting consumer need for LTSS in the coming decades.[11]

The considerable differences in training requirements among direct care occupations at the state level make it difficult for workers in this field to translate their experiences across settings. In general, training and credentialing achievements in home care and residential care are not portable: a worker certified in one LTSS setting is rarely eligible for employment in another without additional training, and home care and residential care credentials are not recognized across state lines. Workers must satisfy the unique training requirements of a new setting or state when they switch LTSS fields or move out of state. Further, regulations for direct care titles rarely permit training completed for one role to be applied toward certification in another, whether or not training content overlaps. This inflexibility challenges workforce development in long-term care and has made it more difficult to mobilize direct care workers from one LTSS environment to address workforce shortages or emergency needs in another, such as to stem understaffing in nursing homes during the COVID-19 outbreak.

State Policy Spotlight

Through its **Quality Improvement in LTSS (QuILTSS)** program, Tennessee is redesigning the state's training infrastructure for direct care to create greater consistency, portability, and stackability across direct care occupations.[12] QuILTSS includes competency-based training with required competency demonstrations, as well as micro-credentials and mentorship to support trainees' progress. Credentials earned through the program are logged in a state registry to foster their portability across LTSS settings. The program also aims to give trainees opportunities to earn college credits and connect to career pathways.

TRAINING STANDARDS FOR AGENCY-EMPLOYED PERSONAL CARE AIDES IN THE U.S.



Source: PHI. *Personal Care Aide Training Requirements.* Bronx, NY: PHI. https://phinational.org/advocacy/personal-care-aide-training-requirements/.

A Closer Look at Data Collection

In 2017, Massachusetts passed a law requiring **a public registry for home care workers** in its State Home Care Program.[22] The registry verifies the type of training received and credentials earned by these workers, allowing employers to make hires without duplicating training. Worker registries also offer opportunities for states to assess the size and competency levels of their workforces—addressing a key data gap in long-term care—though few have such databases in place. Advocates have raised concerns that the Massachusetts registry threatens workers' privacy and safety, prompting exemptions for people with heightened safety needs, such as domestic violence survivors.[23] Challenges in the registry's rollout demonstrate the need to incorporate workers' perspectives and privacy into data collection.

REGULATIONS FOR INDEPENDENT PROVIDERS

In consumer-directed models of home care, most or all of the responsibilities for employing a direct care worker, often known as an **independent provider**, are held by the consumer—including training. Among consumer-directed programs that are publicly funded, few require independent providers to receive any standardized training.[13] When consumers directly hire and pay workers privately through what is known as the *gray market*, these workers are not generally subject to any training requirements either.[14]

Allowing consumers to determine whether and how training for their independent providers takes place accords with the principles of autonomy and independent living that helped drive the initial creation and proliferation of consumer-directed LTSS programs.[15] Proponents of these models believe consumers are best able to understand their own needs for in-home LTSS and direct others to deliver them. For many, this appears true: consumer direction has been found effective in supporting consumers' independence, customized needs for support, and satisfaction with care.[16]

The primary training gap identified in consumer-directed programs relates to preparing consumers to understand their respective roles and responsibilities, such as what it means for a consumer to simultaneously occupy the roles of employer, care recipient, and, in many cases, family member or friend.[17] There is little support for establishing training standards for independent providers, as many consumers worry this would affect workers' ability to deliver services that are fully aligned with their preferences.[18] Certain advocates, however, believe that some level of training requirement for consumer-directed workers could help establish greater consistency, safety and quality assurance, and workforce opportunities in these programs.

A NOTE ON TRAINING DELIVERY AND QUALITY

The infrastructure for delivering training for each of the main direct care occupational categories in the U.S.—nursing assistant, home health aide, and personal care aide—is disorganized and underfunded. While some evidence suggests a majority of direct care workers receive training through their employers, not all employers offer this option.[19] Cost is a significant barrier to employer-based training, as entry-level training costs are not generally reimbursable through the Medicare and Medicaid funding many long-term care employers rely on. The availability of direct care training programs varies per region and, in addition to employer sites, may be spread across colleges, proprietary training schools, community-based organizations, vocational high school training programs, and labor organizations.[20] States regulate nursing assistant and home health aide certification programs according to federal standards, and some states regulate aspects of personal care aide training.

Little is known about quality enforcement for these programs overall, but it is likely that the quality of direct care instruction differs significantly across regions and training providers.[21]

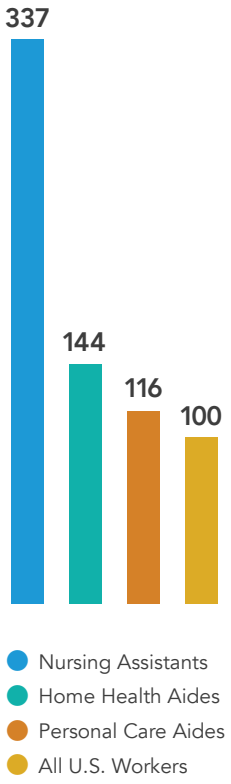
TRAINING STANDARDS FOR DIRECT CARE WORKERS: OCCUPATIONAL CATEGORIES IN SUMMARY

Occupation	Federal Training Standards?	Federal Training Minimum	State Training Requirements: Federal Minimum 75 Hours	State Training Requirements: 76-119 Hours	State Training Requirements: 120+ Hours
NURSING ASSISTANT	✓	**75** hours total, including **16** hours clinical	AL, CO, IA, KY, MA, MI, MN, MS, MT, NE, NV, NM, NC, ND, OH, OK, SD, TN, WY	AR, CT, GA, HI, IN, KS, LA, MD, NH, NJ, NY, PA, RI, SC, TX, UT, VT, WA	AK, AZ, CA, DE, D.C., FL, ID, IL, ME, MO, OR, VA, WV, WI
HOME HEALTH AIDE	✓	**75** hours total, including **16** hours clinical	AL, AZ, AR, CO, CT, DE, FL, GA, IN, IA, KY, LA, MA, MI, MN, MS, MO, NE, NV, NM, NY, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, VA, WV	HI, KS, MD, MT, NH, NJ, RI, UT, VT, WA, WY	AK, CA, D.C., ID, IL, ME, WI
PERSONAL CARE AIDE	✗	None	Requirements exist in 43 states and D.C., varying per job title and program		

Source: PHI. *Nursing Assistant Training Requirements by State.* Bronx, NY: PHI. https://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/; PHI. *Home Health Aide Training Requirements by State.* Bronx, NY: PHI. https://phinational.org/advocacy/home-health-aide-training-requirements-state-2016/; PHI. *Personal Care Aide Training Requirements.* Bronx, NY: PHI. https://phinational.org/advocacy/personal-care-aide-training-requirements/.

The Real Demands of Direct Care Work

DIRECT CARE WORFORCE INJURIES PER 10,000 WORKERS



Much of the discourse that shapes direct care training policies and delivery systems fails to capture the full complexity and scope of the demands faced by this workforce. Training requirements, curricula and assessments, job descriptions, and care plans that describe expectations for direct care workers' preparation and performance tend to focus on basic tasks associated with assisting consumers with ADLs and IADLs.[24] There is often inadequate attention to the physical demands posed by this work, the significant social and emotional aspects of its delivery, and the extent to which direct care workers, regardless of title, are now assisting consumers in managing complex health conditions.

PHYSICAL STRAIN

Direct care workers provide the majority of paid, hands-on care delivered to long-term care consumers, yet the physical demands of their work are frequently undervalued. Helping people to transfer safely between locations, such as in and out of a bathing chair—manually or using an assistive device like a Hoyer lift—requires technical skill, but also physical strength and stamina. Care tasks that require intimate or weight-bearing assistance can also cause stress, fear, or agitation for consumers, and attending to these emotional needs at the same time can compound direct care workers' strain.[25] The limited practical training hours required for most nursing assistants and home health aides, and the dearth of these requirements in personal care aide training, mean that most direct care workers do not adequately practice a range of physically intensive caregiving tasks before beginning work.

It is unsurprising, then, that the direct care workforce has some of the highest rates of occupational injury and on-the-job violence in the U.S.[26] Nursing assistants face the highest rates of injury, at 337 injuries per 10,000 workers (compared with 100 per 10,000 among U.S. workers overall according to 2016 data). These workers perform the majority of physically demanding tasks in nursing homes, assisting multiple residents each shift. Injuries commonly reported by nursing assistants include back injuries, strained or sore muscles, slips, and skin wounds. Home health aides and personal care aides experience injuries on the job at rates of 144 and 116 per 10,000 workers, respectively. It is expected that the rates among home care workers are lower in part due to under-reporting. While home care workers generally carry out fewer physically demanding maneuvers per shift than nursing assistants, implementing these tasks in isolation has been found to elevate their physical risks.[27] Having less training and experiencing low-quality training are factors that have been associated with a higher likelihood of injury among direct care workers across settings.[28]

Further, because much of the essential support provided by direct care workers requires physical assistance, these workers cannot observe the social distancing practices advised during outbreaks of infectious disease. The 2020 coronavirus pandemic brought new attention to the health risks that direct care workers and consumers face in the delivery of LTSS. In the months following the first COVID-19 outbreak in a U.S. nursing home in Kirkland, Washington, direct care employers across the country struggled to provide personal protective equipment and clear guidance on managing infection risk to their workers. The in-person nature of direct care work—in addition to the precarity created by its low wages, lack of paid leave, and limited training—placed personal care aides, home health aides, and nursing assistants among the workforces facing the highest risk due to the coronavirus.[29]

SOCIAL AND EMOTIONAL LABOR

While much of the training and regulation of direct care focuses on visible, measurable tasks, a significant component of what direct care workers do remains

invisible. Developing relationships with consumers to support their emotional wellbeing has been identified as an instrumental component of quality care.[30] Strong caregiving relationships can also facilitate the successful delivery of other, more technical or health-related direct care services.[31] To develop these relationships, direct care workers draw on a range of relational skills. The ability to listen and communicate effectively allows workers to understand consumers' conditions and better fulfill their needs and preferences. Perceiving and interpreting consumers' verbal and nonverbal communication is particularly critical to the delivery of quality care for individuals with speech impairments, behavioral health conditions, and dementias.

Direct care workers must also frequently manage relationships with clients' family members, which adds to their relational workload. In both home and facility-based care settings, family members can misunderstand the role of the direct care worker and place additional demands on workers' time.[32] Leveraging communication skills when managing these dynamics can engender trust and reduce opportunities for miscommunication and conflict. Additionally, as described in the first report of this series, the population of adults over 65 in the U.S. is becoming more racially and ethnically diverse, with a growing number of individuals in this population identifying as lesbian, gay, bisexual, and/or transgender, driving demand for more culturally and linguistically competent care. Yet despite the importance of communication and cultural sensitivity to the delivery of LTSS, such competencies are rarely included in training standards for direct care workers.

Coping with high levels of job-related stress is another under-recognized requirement of direct care work. Caring for individuals experiencing functional disabilities or serious physical and mental health conditions requires sustained emotional engagement, especially when care recipients are experiencing negative emotions such as anger, fear, paranoia, or depression. Placing consumers' emotional needs before one's own is fundamental to the delivery of LTSS. Doing so effectively requires the exertion of emotional labor, such as maintaining sensitivity to others' emotions, suppressing emotions that are not appropriate to the workplace, and adopting or performing emotions that provide comfort or reassurance.[33] These activities can be highly rewarding for direct care workers, who often cite their abilities to express compassion and observe its impact as key drivers of job satisfaction. However, this emotional labor is psychologically taxing and over time can contribute to stress and burnout among direct care workers.[34]

The general lack of attention to relational and self-management skills in direct care training programs—combined with the low-levels of compensation and professional recognition afforded to this workforce—suggests that much of these workers' social and emotional labor goes unseen.

MANAGING COMPLEX HEALTH CONDITIONS

As discussed in the first report in this series, adults in the U.S. now experience a higher prevalence of chronic conditions and functional disability than previous generations. These trends are exacerbated among older adults. Further, in recent decades health care policies have increasingly shifted the provision of post-acute care and LTSS to home and community-based settings. Together, these factors have heightened the complexity of service delivery in long-term care, where the work of supporting individuals in managing chronic and serious health conditions primarily falls to direct care workers.

Yet, the training most direct care workers receive fails to cover the range of topics and skills needed to meet consumers' evolving needs. Consistent among the gaps identified in direct care worker training is in-depth education on complex health conditions commonly presented by long-term care clients. These include Alzheimer's disease and other forms of dementia, which are becoming more prevalent among older adults and require knowledge about disease progression and communication strategies to manage

The general lack of attention to relational and self-management skills in direct care training programs—combined with the low-levels of compensation and professional recognition afforded to this workforce—suggests that much of these workers' social and emotional labor goes unseen.

Industry Feature

In 2017, physician-researcher Madeline Sterling, MD led a first-of-its-kind study into the perspectives of **home care workers caring for consumers with heart failure**, one of the leading causes of hospitalization for adults over 65.[44] Through focus groups with 46 home care workers from 1199SEIU in New York, Sterling and her team found that home care workers are regularly involved in their clients' self-care surrounding heart failure, even though most have not received training in the condition. Workers also reported feeling overworked and left out of care team communication. Still, they expressed passion for their jobs and interest in additional training on heart failure.

effectively.[35] Other chronic diseases needing special instruction include diabetes, heart failure, chronic obstructive pulmonary disease, and asthma. General skill areas that are critical to supporting health maintenance among long-term care clients, but have been flagged as receiving too little attention in training programs, include cultural competence, geriatric care, behavioral health, use of assistive and medical devices, and infection prevention and control—the latter topic has taken on added urgency due to the coronavirus pandemic.[36]

Another barrier to direct care workers' ability to support consumers with complex care needs pertains to the restricted rules on task delegation affecting this workforce. The range of activities that direct care workers are allowed to perform varies by state, LTSS program, and direct care title. For example, some states allow direct care workers to carry out nurse-delegated tasks, like administering specific medications or performing catheterization. A recent analysis showed that 28 states allow nurse delegation of at least 14 out of 16 named health-related tasks to agency-employed home health aides or personal care aides, whereas four states do not allow delegation of any of those 16 tasks.[37] The degree to which home care workers perform activities that are outside their allowable scope or otherwise considered medical in nature is largely unknown.[38] Home care workers employed in consumer-directed programs do not for the most part face restrictions on the health-related services they can provide their consumers.

Regardless of delegation rules, direct care workers perform a wide range of tasks that support consumers' health and prevent declines in serious conditions. These tasks include observing changes in consumers' health and reporting them to ensure the consumer's timely access to primary or acute care as needed. Those serving individuals with chronic conditions provide them with encouragement and assistance in engaging in health-supporting behaviors such as healthy eating, physical activity, and adherence to condition-specific lifestyle guidance or treatments.[39]

In home care settings, direct care workers may also conduct activities like tracking consumers' medical appointments and supporting appointment attendance.

A Note on Skill Level Classifications

Inconsistent attention to the real work involved in direct care has contributed to poor understanding of direct care workers' roles among the public and even among health care officials whose decisions affect this field.[40] These jobs are often erroneously termed as "unskilled" or "low-skilled," which may contribute to the limited enforcement and expansion of training standards in direct care.

Most classification systems that determine whether and to what extent an occupation is "skilled" are based not on the amount of skill required to perform a given job but on the training and formal education required to begin employment. Poor training standards, then, reinforce beliefs that direct care work is not skilled work.

Occupational skill-level categorizations have also been criticized as proxies for wage levels, contributing to the incorrect perception that low-paying work requires little or no skill.[41] The low wages afforded to direct care are fundamentally tied to systems of discrimination that have assigned low value to work traditionally performed by women, people of color, and immigrants—who still today comprise the majority of the direct care workforce.[42] Policy decisions to repeatedly exclude home care workers in particular from pay and labor protections in the U.S. date back to efforts to maintain domestic work arrangements that originated in slavery. The intersection of sexism, racism, and xenophobia compounds the overall underestimation of the demands, and value, of direct care work.

As this report section has examined, delivering LTSS to consumers in nursing home, home care, and residential care settings is complex. It is work that requires skills extending far beyond what the field's training standards provide—and is worth far more than its workers are paid.[43]

Janet Folsom

HOME HEALTH AIDE, CERTIFIED NURSING ASSISTANT (CNA), AND PEER MENTOR AT KNUTE NELSON IN ALEXANDRIA, MN
5 YEARS AS A DIRECT CARE WORKER

ON WHY SHE DECIDED TO BECOME A HOME HEALTH AIDE:

"I decided to go back to school to become a CNA at the age of 50 and am going on five years as a home health aide. Before that, I worked at a day care for 20 years and then spent a little time working at a high school. Direct care work was always something that I wanted to do in my younger years—to work with older people and take care of people that needed help. Even though I took a big pay cut, I absolutely love my job. I know I'm making a difference in the lives of the people I am helping, and that means a lot to me."

ON HER RELATIONSHIP WITH HER CLIENTS:

"I've created quite a bond with each and every one of my clients. We talk, I listen to them, and I pay attention to their wants and needs so they feel safe and can trust me. When I can walk into a home and make somebody happy, that means more to me than anything. And I can usually take a person who is pretty down in the dumps and end up having them smile and laugh. So it can be a very rewarding job."

ON WHAT IT TAKES TO SUCCEED IN HER JOB:

"Caregiving in general is a lovely thing. You need to be a person who has patience and a kind, caring heart. I always think: how would I want to be approached? Or: how would I want somebody approaching my parents or my loved ones? And you need to understand that being a home health aide is work. It's a challenging job, both physically and mentally."

ON TAKING ON AN ADVANCED ROLE IN HOME CARE:

"As a peer mentor, I train new home health aides and make myself available to support a group of five aides. They can come to me with any questions or concerns they have, or to simply talk about their day. When the position was posted, I was encouraged to apply by my coworkers. I felt very honored knowing that they see me as a role model and proudly accepted. I really enjoy connecting with new staff. In my role, I help them feel comfortable and confident when they go out into the field on their own, and I get to share some of my experiences with them."

ON THE IMPACT OF COVID-19:

"Since the start of the coronavirus, my job is more mentally and physically draining than before. Knute Nelson continuously informs us of guidelines from the health department on how to stay safe, and we have access to all the protective gear we need. So we've been very fortunate. But it's really hard for everyone. My clients are scared, and they're getting depressed and lonely. I try and switch off the news if they've been watching 24/7 and to pick them back up and get them to a better mental place, which can be emotionally draining.

Working in the field, we are exposing ourselves to so much risk. We are wearing masks 99.9 percent of our day. We're sanitizing equipment and taking so many precautions. I just wish we had more acknowledgement, or some kind of extra incentive, to help keep us going on the really tough days so we know we're not forgotten."

After a career in childcare and education, Janet became a direct care worker. She enjoys seeing the impact of her work as a CNA and home health aide in the lives of those she serves. Janet also supports other aides in the field in her advanced role as a peer mentor.

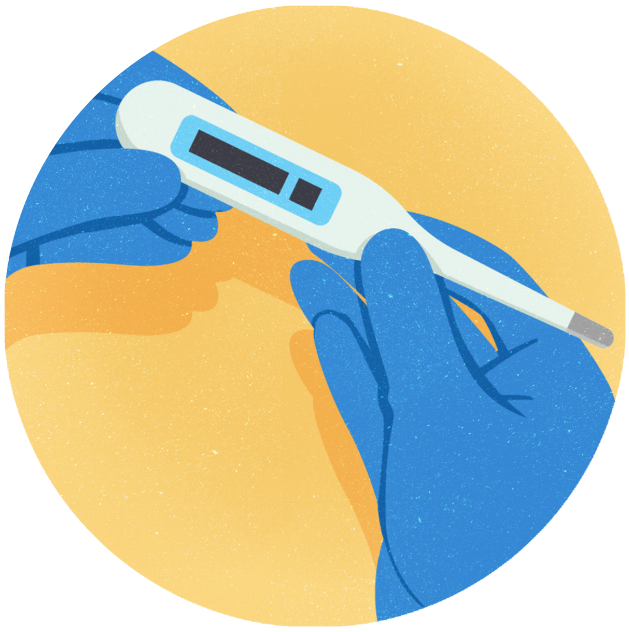
Opportunities for Improving Direct Care Training

While the need for improved training requirements is most evident among personal care aides, experts believe all direct care workers could benefit from the development of core competencies and elevated standards for their enforcement.

Improving standards for training will be a key step toward building the workforce needed to care for our future. Better training not only supports the delivery of high-quality LTSS, it offers professional recognition to direct care work and can help attract more people to this field.

CORE COMPETENCIES FOR ALL DIRECT CARE WORKERS

Recognizing that much of the knowledge and skill applied by direct care workers is transferrable across occupational categories and care settings, several competency sets have been developed to guide training in long-term care. A competency-based approach prioritizes trainees' successful demonstration of competencies as the key indicator of program completion, rather than the number of hours spent receiving instruction. While the need for improved training requirements is most evident among personal care aides, experts believe all direct care workers could benefit from the development of core competencies and elevated standards for their enforcement.[45]



The existing competency sets for direct care workers emphasize interpersonal competencies that are limited in formal training standards, such as communication and relationship development, alongside the ADL assistance traditionally included in training. Several sets include person-centered care practices—like consumer empowerment, advocacy, and direction—along with support for consumers' engagement in the community through social, educational, and professional activities. Some include infection control and supports for consumer wellness, but there is less attention to condition management and other topics that could be considered health-related. Only a few competency sets include a self-care competency area for workers, which speaks to skills like managing stress on the job. (See Appendix 1 for a summary of existing LTSS core competency sets.)

In this section, we review a selection of programs that have developed and implemented core competency standards for various segments of the direct care workforce, distilling lessons learned for future model development.

Personal and Home Care Aide State Training Demonstration Program (PHCAST)

As part of the 2010 Patient Protection and Affordable Care Act, PHCAST supported six states in adapting and scaling a competency-based personal care aide training. The curricula used in this program were based on PHI's 10-part Competencies for Direct Care Workers, from which the participating states—California, Iowa, Maine, Massachusetts, Michigan, and North Carolina—developed training programs ranging from 50 to 120 hours in length.[46] The curricula were designed to be applicable across LTSS settings, not just in home care. More than 4,500 new and incumbent direct care workers were trained through PHCAST over a three-year period. Though evaluation methods differed among the states, trainees overall reported high levels of satisfaction with the program and increased knowledge as a result of the training.

While training infrastructure varied across states prior to the program's implementation, each state reported that PHCAST strengthened their training capacity in some way, including by developing a cadre of trainers, centralizing information about training, and prompting the development of career ladders. These outcomes suggest that a standardized core competency model holds promise for use across multiple states. That knowledge gains were reported among PHCAST participants regardless of job tenure or credentials also indicates the applicability of core competency training across the direct care workforce.[47]

Washington State's Training Model

In 2012, Washington State began implementing Ballot Initiative 1163, which mandates that all long-term care workers providing personal care services to adults in the state complete a 75-hour, competency-based training to achieve certification as a home care aide, along with 12 hours of continuing education annually—more than doubling the prior standard. Notably, this mandate includes the independent provider population (home care workers hired directly by consumers). Curriculum topics include responsibilities within the home care environment, working on a care team, infection control, stress management and other aspects of self-care, as well as specific competencies for dementia care and supporting people with disabilities. The Washington State curriculum is designed to be transferrable across care settings, and its program has also established infrastructure to support stackability, meaning that trainees can leverage their existing training toward additional certifications, such as becoming a nursing assistant.

Trainees have reported high satisfaction with Washington State's training model.[48] The program has also experienced challenges, including: barriers to access for some trainees; a relatively low certification rate of approximately 60 percent, leading to concerns about workforce supply; and difficulties in preparing home care aides to balance the mandated training content with individual consumers' needs and preferences, which has drawn concern among members of the consumer-directed community. The program's continued evolution will help inform future efforts to mandate cross-setting training standards for direct care workers.

National Alliance for Direct Support Professionals (NADSP) Direct Support Professionals Competencies

For more than a decade, the national nonprofit advocacy group NADSP has promoted a set of core competencies for direct support professionals, a subset of the personal care aide workforce that supports people with intellectual and developmental disabilities. Each of the 15 NADSP Competency Areas is associated with three or more skill statements that must be satisfied to demonstrate competency.[49] The competencies focus on direct support professionals' abilities to empower and develop strong relationships with consumers, including assessing their needs and preferences in a given context; supporting their participation in professional, social, and personal activities; and completing tasks in service of consumers' goals. The NADSP competencies form the basis for the organization's voluntary credentialing programs for direct support professionals, which span multiple career ladder tiers, as well as for certification programs in several states and a national apprenticeship program administered by the U.S. Department of Labor.[50] Training and certification for NADSP credentials is now offered through e-learning methods.

BETTER TRAINING METHODS AND DELIVERY

In addition to updated and expanded curricula, programs seeking to improve training for direct care workers have implemented best practices in training methods and program delivery to maximize trainees' access and engagement. Traditional didactic education methods, which are found in many direct care training programs, may be less effective for adult learners, particularly those with limited formal or recent education experience or whose classroom experiences have

Industry Feature

The San Francisco-based nonprofit home care agency, **Homebridge**, runs an award-winning adult learner-centered training program for independent providers in California's consumer-directed In-Home Supportive Services program. The 48-hour entry-level training covers the essentials of personal care, including general safety, recognizing abuse and neglect, and caring for people with dementias or other cognitive disorders.[52] Homebridge also offers shorter, specialized trainings in 24 physical and social determinants of health topics. Caregivers at the agency receive full benefits and have opportunities, through its STEPS Program, to move up through an internal career ladder, with additional training and compensation associated with each new role.

In Focus: PHI's Workforce Innovations

In 2013, PHI launched the **Homecare Aide Workforce Initiative (HAWI)** with the UJA Federation of New York, which piloted a 120-hour, adult learner-centered home health aide training curriculum with 531 trainees across three home care agencies in New York City, along with other workforce interventions. Specialty training programs were also conducted at additional employer sites. The home health aide certification curriculum included core competencies for home care delivery including communication, patient-centered care, and cultural competence. An independent evaluation found that 90 percent of participants completed the course and HAWI trainees were more than twice as likely to be on the job at three months—and 64 percent more likely to be on the job at six months—compared to home health aides hired before the project.[58]

been negative. In contrast, other direct care training programs implement adult learner-centered training principles, utilizing a range of dynamic training methods to promote participation and accommodate multiple learning styles.[51] These methods include group demonstrations, paired work, call-and-response, and role play activities. Adult learner-centered training methods are also designed to break down traditional hierarchical classroom dynamics by centering trainees' expertise and building on the life experiences they bring to the classroom.

Including or strengthening hands-on learning activities, job previews, and field practice in entry-level direct care training is associated with higher levels of satisfaction with training and, in some cases, better outcomes for consumers.[53] These practical learning methods are particularly important for home care workers, whose isolated work structure provides few additional opportunities for on-the-job demonstration. Experts also recommend that direct care training assessments accommodate different test-taking styles, with options to self-pace during examination and demonstrate competency through written, spoken, or performative means.[54]

Training providers should also consider whether their programs are accessible to individuals seeking jobs in direct care. Most prospective and active direct care workers are low-income, and some may be working multiple jobs. Further, workers in this sector are likely to have their own family care commitments. Both the PHCAST demonstrations and Washington State's expanded competency programs faced accessibility challenges because trainings were initially scheduled during weekday working hours when many trainees had competing job commitments they could not afford to break. The PHCAST programs also experienced trainee attrition because training sites were difficult or expensive to access. Acknowledging these challenges, PHCAST organizers retooled their training structures, implementing more flexible make-up policies, moving training to locations that were easily accessible by public transit or subsidizing workers' transportation costs, and offering food, and in some cases, training stipends. These efforts were considered a success; at the end of the program, PHCAST attrition rates were lower than most job training programs, ranging from 1 to 12 percent across sites.[55] Washington State has also addressed its training barriers by boosting the number of home care aide training sites, implementing more flexible training schedules, and offering training in multiple languages.[56]

In-person training remains the best practice and industry standard for direct care occupations. The intensely interpersonal nature of this work and high level of hands-on activities it requires are well-served by in-person training formats. Use of online, asynchronous e-learning technologies to train direct care workers is often posited as a solution for the workforce shortages in this field. E-learning has also been identified as a solution for disseminating training to address emergent needs in direct care, such as recommendations for preventing and treating infections of the novel coronavirus. However, there is limited research on the effectiveness of virtual training methods for this workforce, and field experts have raised concerns about the accessibility and adoptability of such technology. Low-income trainees may lack access to the personal computers and Internet/data plans that make e-learning programs effective and/or may have limited comfort or familiarity with online learning. Blended or hybrid training models, which augment engaging in-person instruction and hands-on learning opportunities with classroom-based technologies, are considered preferable to fully online learning methods for direct care training programs.[57]

Maximizing the Direct Care Role

In addition to being underprepared by most entry-level training programs, direct care workers are underutilized in the delivery of LTSS. These workers have limited opportunities to access quality, condition-specific training as they progress in their jobs. Staff development initiatives are most likely to exist in nursing homes, though studies show they are rarely sustained over time.[59] The isolated and mobile nature of home care work makes it more difficult for direct care workers in these settings to receive formalized on-the-job training, such as orientation and on-site supervision, than for those working in nursing homes or residential care.[60] Many learn from experience, figuring out how to best navigate new challenges in the moment.[61]

While direct care workers' close relationships and sustained contact with consumers can provide an intimate understanding of their health conditions, this workforce is rarely guided to communicate what they know to other members of consumers' health care and social service teams.[62] Interventions that upskill existing direct care workers, particularly those that develop workers' health-related knowledge and team-based communication skills, could significantly augment these workers' contributions to quality care.

UPSKILLING

Upskilling recognizes that the minimum standards of training for most direct care workers are insufficient. Through additional training, upskilling is intended to bridge the gap between workers' entry-level preparation and the competencies required to meet the complex needs of today's long-term care consumers. Upskilling typically focuses on bolstering training in topics within direct care workers' existing scope of responsibilities and is not necessarily associated with pay increases or title promotions. However, many advocates see these training upgrades as key to demonstrating direct care workers' real value: data that links upskilling to improvements in consumer health outcomes and health care spending can be leveraged to bolster the business case for investing more in direct care workers' training and compensation.

Home care and nursing home workers consistently report interest in continuing to develop their skills and contributing more to their consumers' health outcomes.[63] Skill enhancement can elevate workers' job satisfaction and also confer benefits to long-term care employers in the form of increased commitment and performance.[64] Beginning in 2012, an upskilling program through the Schmieding Center for Senior Health and Education trained 3,447 home care workers across four states to better support consumer health maintenance and outcomes. Results from the program showed significant improvements in workers' reported satisfaction, caregiving knowledge, earnings, and retention.[65]

Opportunities for upskilling include a focus on enhancing skills around conditions that are widespread among long-term care consumers, including asthma and dementia, and on providing unbiased, culturally relevant care to specific communities. The 2020 coronavirus pandemic offers an example of an emergent upskilling need: while additional training in infection control procedures had previously been called for among direct care workers, the rapid escalation of the COVID-19 crisis created an urgent need to build infection control skills among this workforce that were contextualized to the pathology of a novel and rapidly spreading virus.[66]

To drive the investment needed to improve direct care training, stakeholders will need to make the case that better training for this workforce contributes to cost savings and quality care outcomes. This can be achieved by designing upskilling demonstrations that speak to the benefits of additional worker training for long-term care payers, which include managed care plans, private insurance providers, health systems, and public payers.[67] Calls to strengthen the direct care workforce increasingly focus on maximizing these workers' contributions to care coordination and the prevention

Data that links upskilling to improvements in consumer health outcomes and health care spending can be leveraged to bolster the business case for investing more in direct care workers' training and compensation.

Opportunities for upskilling include a focus on enhancing skills around conditions that are widespread among long-term care consumers, including asthma and dementia, and on providing unbiased, culturally relevant care to specific communities.

of avoidable, costly health outcomes among LTSS consumers—which have become key priorities in the era of value-based purchasing and payment.[68]

As one example of upskilling training that aligned the interests of workforce development with its impact on consumer health outcomes, in 2014, the New York home care agency Partners in Care implemented a one-week intensive training program on health coaching skills for home health aides. Topics included how to identify symptoms of a deteriorating health condition, promote consumers' medication adherence, and adopt health-supporting behaviors. Consumers served by participating workers showed improvement in self-care maintenance practices, and high-risk heart failure patients who had transitioned home from the hospital experienced improved health-related quality of life.[69]

COMBINING UPSKILLING WITH CARE TEAM INTEGRATION

Through upskilling, direct care workers can cultivate a deeper understanding of their consumers' health and how to manage it in a long-term care environment. But the utility of that information is limited if it is not shared with, and valued, by other members of the consumer's care team.[70]

In some long-term care settings, interdisciplinary care teams already include direct care workers, to varying extents. Several decades ago, nursing homes began adopting models of self-directed care teams that embodied the nonhierarchical tenets of the organizational culture change movement. These teams represent a cross-section of staff and intentionally include nursing assistants. Members receive training on collaborative problem-solving and developing shared accountability for resident outcomes. These team-based care models have been associated with higher job satisfaction and self-esteem for all workers, the development of new skills among nursing assistants, and improved efficiency and turnover overall.[71] In part due to the success of such programs, federal regulations for nursing homes now require nursing assistants to be included in comprehensive person-centered care planning processes.[72] In nursing homes, the "small home" model of custom-built residences designed to provide a home-like experience—most often identified with the Green House Project—centers its care team on the role of the direct care worker, known as a Shahbaz, who receives more training and exercises more autonomy than a traditional nursing assistant. Models for Programs of All-Inclusive Care for the Elderly (PACE), which centralize the coordination of a range of services for older adults, have also included direct care workers on interdisciplinary care teams.[73]

Direct Care Work Is Real Work

A growing body of research supports the formal inclusion of home care workers in care teams, so that they can both share observations from consumers' home environments to inform decisions about care and transmit relevant information back to consumers and family members.[74] Successful integration into the care team requires enhanced training for home care workers on observing, recording, and reporting changes in consumers' physical and environmental health conditions, as well as training on team-based problem-solving. Advocates note that other members of the care team, such as nurses and social workers, will also benefit from training on how to listen to home care workers' observations and understand their contributions to consumer health.[75]

Research on care team integration in home care is limited, but the success of several pilot demonstrations suggests that training and supporting home care workers to contribute to care coordination can produce valuable health outcomes. Between 2012 and 2015, the California Long-Term Care Education Center implemented a 60-hour competency-based training for 6,375 home care workers in the state's consumer-directed In-Home Supportive Services (IHSS) program and supported these workers' integration into care teams. The project showed improved recruitment and retention among home care workers, a 41 percent decline in the average rate of repeat emergency department visits among consumers, a 43 percent decline in the average rate of rehospitalization, and cost savings of as much as $12,000 per trainee.[76]

Another intervention with IHSS consumers from the St. John's Well Child and Family Center in 2012 provided six weeks of upskilling training, covering health-supporting and disease management competencies, to 97 home care workers and integrated them into care teams. The intervention generated improvements in consumers' health-related quality of life (67 percent), satisfaction with care (13 percent), and medication adherence (40 percent), as well as reductions in monthly rates of admission to hospitals (-53 percent) and emergency room visits (-54 percent).[77]

BUILDING THE DIRECT CARE CAREER LADDER

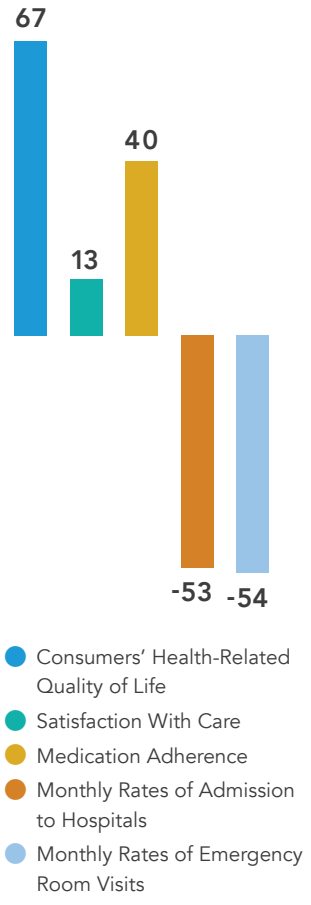
The failure to understand direct care workers' value and integrate their work with other segments of LTSS and health care delivery has hindered the development of a meaningful career ladder for this workforce. In most settings, the next formally recognized health care title above home health aide and nursing assistant positions is a licensed practical nurse (LPN). But while the former certifications can be obtained in a matter of weeks or months with few educational prerequisites, LPN credentials require a year or more of training in addition to a high school diploma or equivalency. The time, financial resources, and educational experience required to pursue an LPN career are out of reach for many direct care workers, particularly those balancing multiple jobs and family caregiving responsibilities. Further, while these workers consistently express interest in acquiring new skills and fairer rates of pay, many also see the work they do at the direct care level as a career and are not interested in leaving the field.

And yet, a lack of career growth opportunities contributes to poor job quality in direct care. It has been identified as a barrier to attracting new workers and to retaining workers over time. There is a significant need to develop rungs in the career ladder that are accessible to direct care workers and that build from their existing experience. Meaningful advancement for this workforce should represent an elevation in title, function, and compensation. Advanced roles for direct care workers have also shown promise for increasing the quality and efficiency of care delivered to consumers.

A number of long-term care employers have recognized the potential for their direct care workers to do more within their existing scopes of work and have created customized advanced roles. The following subsections review the types of advanced roles that have been developed and piloted for direct care workers across the country, with specific examples.

RESULTS OF CARE TEAM INTERVENTION WITH IHSS CONSUMERS FROM THE ST. JOHN'S WELL CHILD AND FAMILY CENTER

(In Percentages of Change)



There is a significant need to develop rungs in the career ladder that are accessible to direct care workers and that build from their existing experience.

Peer Mentors

Retention among direct care workers, particularly in their first months in the field, is a persistent challenge in long-term care.[78] The peer mentorship model trains experienced direct care workers in coaching and problem-solving competencies so they can serve as Peer Mentors who support new workers, helping them navigate caregiving challenges and other issues that arise during the transition into direct care work. Peer Mentors may even go into the field to support their mentees on the job. In some programs, workers serve as Peer Mentors full time, and in others they blend hours worked in this advanced role with their existing work as home care workers or nursing assistants.[79] In the late 2000s, an initiative to improve retention at the long-term care organization Loretto's Program of All-inclusive Care for the Elderly in Central New York centered on the creation of Peer Mentor roles to support home health aides. The project was associated with annual retention rates between 84 and 90 percent among Loretto's home care workforce, compared to a rate of 52 percent before the program.[80]

Care Coordination Roles

The integration of direct care workers into consumer care teams and as key players in care coordination, as described above, also presents opportunities to create advanced positions.

In 2015, PHI created the Care Connections Senior Aide role. Following 240 hours of training in chronic disease knowledge; communication skills; enhanced observe, record, and report skills; and care team participation, eight home health aides were elevated to salaried Care Connections Senior Aide roles. These Senior Aides made home visits to support the upskilling of hundreds of entry-level home care workers. They also helped improve care transitions, solved caregiving challenges in the home, and served as members of consumers' care teams. Outcomes from the initial 18-month demonstration project included an 8 percent reduction in the rate of emergency room admission among the 1,400 consumers impacted, reduced caregiving strain among family members, and improved job satisfaction among home care workers.[81] Following the demonstration period, a majority of the Care Connections Senior Aide roles were sustained at the participating home care agencies.

As another example, PHI has supported the design and development of a Transition Specialist role at Trinity Senior Health Communities in Michigan, applying learnings from the Care Connections Project to nursing homes. Nursing assistants promoted to Transition Specialists are trained in common chronic conditions and how to observe, record, and report changes in their residents' health. The role, which is currently being pilot tested, is structured to improve residents' transitions from acute care settings to the home or nursing home and to prevent avoidable hospital readmissions.[82]

Other Advancement Opportunities

Employers may also promote direct care workers to internal, administrative positions based on their experience in the field. The home care agency Cooperative Home Care Associates (CHCA) in New York estimates that as much as 40 percent of its administrative staff has been recruited from the agency's home care workforce. In addition to a robust Peer Mentor program, CHCA regularly promotes home health aides into positions including Assistant Trainer and Clinical Coordinator. As another example, Community Living Alliance in Wisconsin offers additional training and compensation to prepare experienced home care workers to serve as on-call aides for a range of clients when their regular workers are not available.[83]

Although documented examples are rare, there are also opportunities for employers to promote direct care workers to condition-specific specialty roles, like Dementia Care Specialist or Diabetes Specialist.

Marisol Rivera

CARE COORDINATOR AT COOPERATIVE HOME CARE ASSOCIATES (CHCA) IN THE BRONX, NY
22 YEARS AS A DIRECT CARE WORKER

ON ADVANCING TO NEW ROLES IN HOME CARE:

"I trained to become a Care Connections Senior Aide over three months, which was wonderful. This role built on what I had been doing every day for years.

In the beginning, I was nervous because aides saw me as a supervisor. I would assure them, 'I am a home health aide just like you, but because I've been in the field so long, I'm here to give you support.' As time went on, I felt more comfortable. Now as Care Coordinator, I help triage clients and assist workers over the phone. It's all about delivering better services to clients and keeping them home in the community where they want to stay."

ON WHY ADDITIONAL SUPPORT HELPS WORKERS DELIVER QUALITY CARE:

"I know from my years as a home health aide how difficult that job can be, and I don't think that's something anyone who hasn't been in the field can fully understand. For example, a lot of workers get their initial training in how to use one type of Hoyer lift, but when they get to the home and see a lift they haven't worked with, they worry they might be judged if they call for assistance. But the moment aides heard I was there to provide support and additional training, I could see their tension fade. I'd always speak calmly and tell them, 'It's okay. We'll do this together.'

I know how overwhelmed workers can feel when they're on their own, but when they know they have someone to support them, it helps them to do their job and follow up on client issues. I think every agency should have these roles. They will prevent a lot of hospitalizations."

IF SHE COULD CHANGE ANYTHING ABOUT THE FIELD:

"I think the role of the home health aide should be considered just as important as any other health care role. When an aide reports something, it should be listened to and not disregarded because of her title. Sometimes the aide knows more about the client's health than a physician or family member. We know that we are not a doctor or a nurse, but the home care role can be just as important in supporting the client.

One of the main challenges in a client's home is that family members can misunderstand the home health aide's role. Some people think we are a maid or that we have to care for everyone in the home. During my visits as a Senior Aide, I'd show the client and family the plan of care and what responsibilities it specified. This would help reduce complaints and keep aides with clients longer. Yes, an aide may help clean the client's environment and help them with toileting, but they're also there taking care of your loved one in ways that relieve some caregiving stress otherwise placed on the family."

WHAT HER CAREER PATH HAS MEANT TO HER:

"Working in these advanced roles has given me a lot of confidence in what I do. I feel good about being able to help more clients, more workers, and more family members. I continue to learn, which is also good for me. And I am proud of the example I have set for my daughters.

When home health aides ask me how I got this role, I tell them my story and to look for openings. I tell them, 'You're qualified, so apply for it!'"

With a desire to help others in her community and gain steady employment while she raised children, Marisol was drawn to home care. After 16 years as a home health aide, she trained for an advanced role coaching aides and helping reduce hospitalizations for high-risk consumers. She was later promoted again.

Washington State operates an Advanced Home Care Aide Specialist program that offers additional training to home care workers to support consumers with complex care needs.

Some states have also taken steps to formalize advanced roles for direct care workers. Since 1995, Massachusetts has offered additional training to home health aides to obtain a Supportive Home Care Aide (SHCA) title specializing in care for individuals with either mental health conditions or Alzheimer's disease and other forms of dementia. The program also integrates SHCAs into care teams and provides them with additional supervision.[84] Washington State operates an Advanced Home Care Aide Specialist program that offers additional training to home care workers to support consumers with complex care needs. Workers promoted to the Advanced Home Care Aide Specialist role make an additional $0.75 per hour.[85] In 2016, the New York legislature passed a bill to create an advanced role known as the Advanced Home Health Aide (AHHA), which would permit home health aides with this title to administer certain pre-measured or pre-filled medications, such as insulin. Other advanced tasks, as well as employment and compensation structures for this role, are still being defined. The state has not allocated funding to the implementation of the AHHA, which has stalled its rollout.[86]

Considerations for Nurse Delegation

Many efforts to maximize the role of direct care workers through upskilling and advanced role development cover topics and functions that fall within workers' state-specific job descriptions. However, in some cases, as with New York's AHHA program, amendments to nurse practice acts are required to allow advanced aides to complete previously restricted tasks through nurse delegation. These amendments can be challenging to pass given concerns among certain stakeholders about changes in direct care workers' roles impacting nurses' scopes of practice or consumers' quality of care. Studies on the impact of expanded nurse delegation are rare, but a pilot in New Jersey in which home health aides received enhanced delegation to administer medication found no adverse outcomes and documented a range of positive impacts on consumers and workers.[87] Advocates of expanding nurse delegation to direct care workers argue that if these changes are implemented thoughtfully with appropriate training and supervision, they can safely address unmet care needs and help maximize nursing assistants' and home care workers' contributions to care quality outcomes.[88]

Conclusion and Implications

In reviewing the current regulations and infrastructure for direct care training programs in the U.S., this report finds the landscape for training nursing assistants, home health aides, and personal care aides to be irregular and under-resourced. There is a need to understand the considerable skill level required of direct care workers and the value their work offers to consumers, employers, and society at large. The gap between existing training regulations and programs and the demands workers face on the job is significant. It is in all stakeholders' best interests to address this gap and elevate minimum standards for direct care training across care settings and geographies. A stronger training system will both improve quality of care for people receiving LTSS and afford overdue recognition to the important role of direct care workers. Drawing on lessons learned from programs that have elevated training quality and infrastructure, we conclude with two opportunities to strengthen training in long-term care.

Invest in and Enforce Competency-Based Training

The most widely proposed recommendation for transforming direct care training in the U.S. is to establish a set of core competencies for the delivery of LTSS and require its adoption across states, drawing on existing competency models and involving diverse stakeholders in a consensus process.[89] Numerous groups have defined the core competencies that are needed to prepare direct care workers to be effective in their jobs supporting LTSS consumers. However, the recommendation of these competencies alone has not been enough to spur their widespread adoption. With adults receiving long-term care presenting increasingly complex health and social conditions, we need a workforce that is better prepared and empowered to provide high-quality services.

Building on the input of consumers, workers, and public health professionals, long-term care authorities should establish a standard for direct care competencies at the national level that draws from core competency sets that have already been developed. Ideally, these core competencies should apply to all direct care workers, regardless of payment source, with opportunities for workers to attain additional competency-based credentials to fulfill setting- and consumer population-specific direct care roles, such as home health aide or nursing aide certifications. Further, the core competencies should be accompanied by regulation that mandates their adoption by states—allowing states to then tailor their training programs, based on these universal competency standards, to meet state-specific requirements and regulations. To better serve the career development of direct care workers, states should also receive guidance on how to recognize the core competencies across care settings and integrate them with credentialing programs so that they can be applied toward other health care training.

Evaluate the Impact of Upskilling, Advanced Roles, and Care Team Integration Interventions

Efforts to increase training and compensation for this essential workforce will require better valuing the real work of direct care—and the people who provide it. Greater research attention to what direct care workers can do will help to show the complex system of LTSS payers that investing in these jobs yields a meaningful return. Upskilling, advanced roles, and care team integration are key to this aim. The failure to appropriately recognize direct care work has been aided by a lack of research on the impact of the direct care workforce on the outcomes frequently sought by LTSS payers—primarily positive client health outcomes and reductions in health care spending.[91]

State Policy Spotlight

In 2005, public and nonprofit agencies in Alaska launched a program to strengthen training for the state's direct care workforce. Through a consensus process led by 27 stakeholders from across the state, the initiative established the **Alaskan Core Competencies for Direct Care Workers in Health and Human Services** in 2010 and developed a cohort of trainers using a train-the-trainer model.[90] The competencies are designed to meet Alaska's unique needs for delivering individualized direct care across LTSS settings in frontier areas. However, regulatory requirements and funding at the state level are still needed to spur widespread implementation of the Core Competencies.

Highlighting training and workflow interventions that have multiple layers of benefit (for consumers, families, workers, employers, and health systems) is important for driving needed social and economic investment in the direct care workforce.

Making this case must start with demonstrations that elevate the role of the direct care worker within health care and social service delivery. We know that direct care workers can with training contribute more meaningfully to the management of chronic and serious conditions, reductions in adverse health outcomes, and improvement in consumers' social determinants of health—in most cases while staying within states' nurse delegation rules.[92] But quality studies on such upskilling interventions are lacking, especially beyond the pilot-testing phase. With research attention and investment from public and private funders, more promising models can be developed, evaluated, and potentially scaled for greater impact.

Understanding the power of direct care work—emboldened with data from upskilling, advanced role, and care team integration demonstrations—can help change the conversation about direct care to be one of opportunity, rather than one of low-quality jobs and intractable challenges.

Highlighting training and workflow interventions that have multiple layers of benefit (for consumers, families, workers, employers, and health systems) is important for driving needed social and economic investment in the direct care workforce. Training and career pathways, however, are only part of what constitutes a quality direct care job. The next report in this series will examine all aspects of the jobs held by nursing assistants, home health aides, and personal care aides and bring attention to strategies that have been successful in improving job quality.

Notes

1. Harris-Kojetin, Lauren, Manisha Sengupta, Jessica Penn Lendon, Vincent Rome, Roberto Valverde, and Christine Caffrey. 2019. "Long-Term Care Providers and Services Users in the United States, 2015–2016." National Center for Health Statistics, Vital Health Stat 3(43). https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf; Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). 2017. "Disability and Functioning (Noninstitutionalized Adults Aged 18 and Over)." https://www.cdc.gov/nchs/fastats/disability.htm; U.S. Census Bureau. 2018. American Community Survey (ACS) 2017 1-year Estimates, Characteristics of the Group Quarters Population by Group Quarters Type (3 Types). https://factfinder.census.gov/bkmk/table/1.0/en/ACS/17_1YR/S2602; analysis by PHI (July 18, 2019).

2. Centers for Medicare & Medicaid Services (CMS). 1991. *Standards and Certification; Requirements for States and Long-Term Care Facilities; Requirements That Must Be Met by States and State Agencies: Nurse Aide Training and Competency Evaluation, and Paid Feeding Assistants; Requirements for Approval of a Nurse Aide Training and Competency Evaluation Program.* 42 CFR § 483.152. [Note: Nearly all nursing homes in the U.S. participate in Medicare and Medicaid and are therefore subject to these regulations.]

3. CMS. 2017. *Standards and Certification; Home Health Services; Patient Care; Condition of Participation: Home Health Services.* 42 CFR § 484.80.

4. PHI. *Home Health Aide Training Requirements by State.* Bronx, NY: PHI. https://phinational.org/advocacy/home-health-aide-training-requirements-state-2016/. Accessed April 3, 2020.

5. Institute of Medicine (IOM). 2008. *Retooling for an Aging America: Building the Health Care Workforce.* Washington, DC: The National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK215401/.

6. Prince, Martin, Matthew Prina, and Maëlenn Guerchet. 2013. *World Alzheimer Report 2013. London, England: Alzheimer's Disease International.* https://www.alz.co.uk/research/WorldAlzheimerReport2013.pdf.

7. PHI. *Nursing Assistant Training Requirements by State.* Bronx, NY: PHI. https://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/. Accessed April 3, 2020.

8. National Center for Assisted Living (NCAL). 2019. *2019 Assisted Living State Regulatory Review.* Washington, DC: NCAL. https://www.ahcancal.org/ncal/advocacy/regs/Documents/2019_reg_review.pdf.

9. PHI. *Personal Care Aide Training Requirements.* Bronx, NY: PHI. https://phinational.org/advocacy/personal-care-aide-training-requirements/. Accessed April 3, 2020.

10. Marquand, Abby and Susan A. Chapman. 2014. *The National Landscape of Personal Care Aide Training Standards.* San Francisco, CA: University of California San Francisco, Health Workforce Research Center on Long-Term Care. https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/Report-The_National_Landscape_of_Personal_Care_Aide_Training_Standards.pdf.

11. PHI. *Workforce Data Center: Direct Care Worker Projected Job Openings, 2018 to 2028.* Bronx, NY: PHI. https://phinational.org/policy-research/workforce-data-center/#var=Employment+Trends&tab=National+Data; Kelly, Christopher, Jennifer Craft Morgan, and Kendra Jeanel Jason. 2012, "Home Care Workers: Interstate Differences in Training Requirements and Their Implications for Quality." *Journal of Applied Gerontology* 32(7): 804–832; Leadership Council of Aging Organizations. 2012. *The Direct Care Workforce: A Report on Practices to Promote Quality Long-Term Care.* Washington, DC: LCAO. https://www.lcao.org/files/2012/12/LCAO-LTSS-REPORT.pdf; Bipartisan Policy Center. 2018. *Improving Care for Patients with Serious Illness: Part Two.* Washington, DC: Bipartisan Policy Center. https://bipartisanpolicy.org/wp-content/uploads/2019/03/Improving-Care-for-Patients-with-Serious-Illness-Part-Two.pdf.

12. Long, Charla. "QuILTSS Workforce Development Forum," YouTube video, May 12, 2016. https://www.youtube.com/watch?v=BjVFRwWM36E&feature=youtu.be; Scales, Kezia. 2019. *Envisioning the Future of Home Care: Trends and Opportunities in Workforce Policy and Practice.* Bronx, NY: PHI. https://phinational.org/resource/envisioning-the-future-of-home-care-trends-and-opportunities-in-workforce-policy-and-practice/.

13. PHI. *Personal Care Aide Training Requirements.* Bronx, NY: PHI. https://phinational.org/advocacy/personal-care-aide-training-requirements/. Accessed April 3, 2020.

14. Arkansas Department of Health. 2014. *Rules and Regulations for Home Caregiver Training in Arkansas.* Little Rock, AR: Arkansas Department of Health: Agency #007.05. https://www.sos.arkansas.gov/uploads/rulesRegs/Arkansas%20Register/2014/may14Reg/007.05.13-008.pdf.

15. Scales, 2019.

16. Kodner, Dennis L. 2003. "Consumer-directed services: lessons and implications for integrated systems of care." *International Journal of Integrated Care* 3(12). doi:10.5334/ijic.80.

17. Scales, 2019.

18. IOM, 2008.

19. Hewko, Sarah J., Sarah Cooper, Hanhmi Huynh, Trish L. Spiwek, Heather L. Carleton, Shawna Reid, and Greta G. Cummings. 2015. "Invisible No More: A Scoping Review of the Health Care Aide Workforce Literature." BMC Nursing 14(38). https://doi.org/10.1186/s12912-015-0090-x; Khatutsky, Galina, Joshua Wiener, Wayne Anderson, Valentina Akhmerova, E. Andrew Jessup, and Marie R. Squillace. 2011. *Understanding Direct Care Workers: A Snapshot of Two of America's Most Important Jobs: Certified Nursing Assistants and Home Health Aides.* Washington, DC: U.S. Department of Health and Human Services. https://aspe.hhs.gov/basic-report/understanding-direct-care-workers-snapshot-two-americas-most-important-jobs-certified-nursing-assistants-and-home-health-aides#train.

20. Scales, 2019; Spetz, Joanne, Robin I. Stone, and Natasha Bryant. 2019. "Home and Community-Based Workforce for Patients with Serious Illness Requires Support to Meet Growing Needs." *Health Affairs* 38(6). https://doi.org/10.1377/hlthaff.2019.00021.

21. Stone, Robyn I. 2007. "Introduction: The Role of Training and Education in Solving the Direct Care Workforce Crisis." *Gerontology & Geriatrics Education* 28(2): 5 – 16; IOM, 2008; Reckrey, Jennifer M., Emma K. Tsui, R. Sean Morrison, Emma T. Geduling, Robyn I. Stone, Katherine A. Ornstein, and Alex D. Federman. 2019. "Beyond Functional Support: The Range of Health-Related Tasks Performed in the Home by Paid Caregivers in New York." Health Affairs 38(6). https://doi.org/10.1377/hlthaff.2019.00004.

22. Executive Office of Elder Affairs. *Home Care Worker Registry.* Boston, MA: Commonwealth of Massachusetts. https://www.mass.gov/service-details/home-care-worker-registry. Accessed May 21, 2020.

23. Campbell, Stephen. 2018. "Massachusetts Establishes Home Care Worker Registry." *PHI Blog*, May 18, 2018. Accessed May 21, 2020. https://phinational.org/news/12995/.

24. Franzosa, Emily, Emma K. Tsui, and Sherry Baron. 2018. "Home Health Aides' Perceptions of Quality Care: Goals, Challenges, and Implications for a Rapidly Changing Industry." *New Solutions: A Journal of Environmental and Occupational Health Policy* 27(4): 629-647.

25. Beer, Jenay M., Sara E. McBride, Tracy L. Mitzner, and Wendy A. Rogers. 2014. "Understanding Challenges in the Front Lines of Home Health Care: A Human-Systems Approach." *Applied Ergonomics* 45(6): 1687-99. doi:10.1016/j.apergo.2014.05.019.

26. Campbell, Stephen. 2018. *Workplace Injuries and the Direct Care Workforce.* Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2018/04/Workplace-Injuries-and-DCW-PHI-2018.pdf.

27. Campbell, 2018; Beer et al., 2014.

28. Walton, AnnMarie Lee and Bonnie Rogers. 2017. "Workplace Hazards Faced by Nursing Assistants in the United States: A Focused Literature Review." *International Journal of Environmental Research and Public Health* 14 (544).

29. Jin, Beatrice and Andrew McGill. "Who is most at risk in the coronavirus crisis: 24 million of the lowest-income workers." *Politico,* 21 March 2020, https://www.politico.com/interactives/2020/coronavirus-impact-on-low-income-jobs-by-occupation-chart/. Accessed 11 April 2020; Hewko et al., 2015.

30. Ordway, Anne, Kurt L. Johnson, Laura Kneale, Dagmar Amtmann, and George Demiris. 2019. "The Experience of Home Care Providers and Beneficiaries with Enhanced Training Requirements in Washington State." *Journal of Aging and Health* 31(10): 124S-144S.

31. Reblin, Maija and Bert N. Uchino. 2008. "Social and emotional support and its implication for health." *Current Opinion in Psychiatry* 21(2): 201-5. doi:10.1097/YCO.0b013e3282f3ad89; Franzosa, Emily, Emma K. Tsui, and Sherry Baron. 2019. "'Who's Caring for Us?': Understanding and Addressing the Effects of Emotional Labor on Home Health Aides' Well-being." *The Gerontologist* 59(6).

32. Beer, 2014; Drake, Angelina Del Rio. 2019. "An Advanced Home Care Role Benefits Workers — and Clients." *PHI Blog*, August 19, 2019. https://phinational.org/an-advanced-home-care-role-benefits-workers-and-clients/. Accessed April 11, 2020; Abrahamson, Kathleen, J. Jill Suitor, and Karl Pillemer. 2009. "Conflict Between Nursing Home Staff and Residents' Families." *Journal of Aging and Health* 21(6): 895-912.

33. Hochschild, Arlie Russell. 1983. *The Managed Heart: Commercialization of Human Feeling*. Berkeley, CA: University of California Press.

34. Franzosa et al., 2019; Stacey, Clare. 2005. "Finding Dignity in Dirty Work: The Constraints and Rewards of Low-Wage Home Care Labour." *Sociology of Health & Illness* 27: 831-854. doi:10.1111/j.1467-9566.2005.00476.x.

35. Peterson, Diane, Marla Berg-Weger, Janis McGillick, and Lorelei Schwartz. 2002. "Basic Care I: The Effect of Dementia-Specific Training on Certified Nursing Assistants and Other Staff." *American Journal of Alzheimer's Disease and Other Dementias* 17(3): 154-164; Polacsek, Meg et al. 2020. "'I Know They Are Not Trained in Dementia': Addressing the Need for Specialist Dementia Training for Home Care Workers." *Health & Social Care in the Community* 28(2): 475-484.

36. Bryant and Stone, 2011; Beer et al., 2014; Luz, Clare and Katherine Hanson. 2015. "Filling the Care Gap." Home Health *Care Management & Practice* 27(4): 230-237.

37. Spetz et al., 2019.

38. Hewko et al., 2015.

39. Reckrey et al., 2019; Sterling, Madeline et al. 2018. "'It's Like They Forget That the Word 'Health' Is in 'Home Health Aide'": Understanding the Perspectives of Home Care Workers Who Care for Adults with Heart Failure." *Journal of the American Heart Association* 7(10.1161).

40. Osterman. Paul. 2017. *Who Will Care for Us? Long-Term Care and the Long-Term Workforce*. New York, NY: Russell Sage Foundation.

41. Brooks Olsen, Hannah. 2017. "Service Work Is Skilled Work. Get Over It." *Everyday Feminism* [originally published on *Medium*], January 6, 2017. https://everydayfeminism.com/2017/01/service-work-is-skilled-work/; Auguste, Byron. 2019. "Low Wage, Not Low Skill: Why Devaluing Our Workers Matters." Forbes, February 7, 2019. Accessed April 12, 2020. https://www.forbes.com/sites/byronauguste/2019/02/07/low-wage-not-low-skill-why-devaluing-our-workers-matters/#3917a2c8716d.

42. Burrowes, Jennifer, Alexis Young, Dan Restuccia, Joseph Fuller, and Manjari Raman. 2014. *Bridge the Gap: Rebuilding America's Skills. Boston, MA: Harvard Business School*. https://www.hbs.edu/competitiveness/research/Pages/research-details.aspx?rid=66.

43. Drake, Angelina Del Rio. 2020. *PHI Blog*, February 10, 2020. "Let's Call Home Care Work What It Is: Skilled Work." Accessed April 12, 2020. https://phinational.org/lets-call-home-care-work-what-it-is-skilled-work/.

44. Sterling et al., 2018.

45. IOM, 2008; Scales, 2019.

46. Department of Health and Human Services Health Resources and Services Administration. 2015. *Report to Congress: Personal and Home Care Aide State Training (PHCAST) Demonstration Program Evaluation*. Washington, DC: Department of Health and Human Services. https://www.hrsa.gov/sites/default/files/about/organization/bureaus/bhw/reportstocongress/phcastreport.pdf.

47. Luz, 2015.

48. Campbell, Stephen. 2017. *Training Standards for Personal Care Aides: Spotlight on Washington*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2017/11/wa_case_study_pca_training_standards_2017.pdf; Ordway, Anne, Kurt L. Johnson, Laura Kneale, Dagmar Amtmann, and George Demiris. 2019. "The Experience of Home Care Providers and Beneficiaries with Enhanced Training Requirements in Washington State." *Journal of Aging and Health* 31(10 suppl.): 124S-144S.

49. National Alliance for Direct Support Professionals, Inc. (NADSP). *15 NADSP Competency Areas*. Albany, NY: NADSP. Accessed April 19, 2020. https://nadsp.org/competency-areas-text/.

50. Scales, 2019.

51. PHI. 2008. *Adult Learner-Centered Training: An Introduction for Educators in Home and Residential Care*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/legacy/clearinghouse/PHI-386%20ALCT%20Guide%20(small).pdf.

52. Stewart, Andrew. 2016. *San Francisco County's Partnership with the Homebridge Training Program: Training the Fragile Workforce*. Berkeley, CA: Mack Center on Nonprofit & Public Sector Management, School of School of Social Welfare, Berkeley University of California. https://mackcenter.berkeley.edu/sites/default/files/aas-2016-05-06/AAS/TOC-AAS-38.pdf; Homebridge. *Becoming a Caregiver*. San Francisco, CA: HomeBridge, Inc. https://www.homebridgeca.org/caregiver.

53. Khatutsky et al., 2011; Trinkoff, Alison M., Carla L. Storr, Nancy B. Lerner, Bo Kyum Yang, and Kihye Han. 2017. "CNA Training Requirements and Resident Care Outcomes in Nursing Homes." *The Gerontologist* 57(3): 501-508.

54. Kelly, 2012.

55. Department of Health and Human Services Health Resources and Services Administration, 2015.

56. Washington State Auditor's Office. 2016. *Barriers to Home Care Aide Certification*. Olympia, WA: Washington State Auditor's Office. https://portal.sao.wa.gov/ReportSearch/Home/ViewReportFile?arn=1018059&isFinding=false&sp=false.

57. Ochylski, Daniel P., Clare C. Luz, and Xiaoxi Shen. 2017. "Direct Care Workforce Training: Internet Accessibility and Acceptance." *Journal of Gerontological Nursing* 43(6): 46-52; Scales, 2019.

58. Feldman, Penny H., Miriam Ryvicker, Lauren M. Evans, and Yolanda Barrón. 2019. "The Homecare Aide Workforce Initiative: Implementation and Outcomes." *Journal of Applied Gerontology* 38(2): 253-276.

59. Aylward, Sandra, Paul Stolee, Nancy Keat, and Van Johncox. 2003. "Effectiveness of Continuing Education in Long-Term Care: A Literature Review." *The Gerontologist* 43(2): 259-271; Stolee, Paul, Jacquelin Esbaugh, Sandra Aylward Tamzin Cathers, David P. Harvey, Loretta M. Hillier, Nancy Keat, and John W. Feightner. 2005 "Factors Associated with the Effectiveness of Continuing Education in Long-Term Care." *The Gerontologist* 45(3): 399-405.

60. Kelly et al., 2012; Reckrey et al., 2019.

61. Janes, Nadine, Souraya Sidani, Cheryl Cott, and Susan Rappolt. 2008. "Figuring it Out in the Moment: A Theory of Unregulated Care Providers' Knowledge Utilization in Dementia Care Settings." *Worldviews on Evidence Based Nursing* 5:13-24. doi:10.1111/j.1741-6787.2008.00114.x; Sterling, Madeline R., Nicola Dell, Benedetta Piantella, Jacklyn Cho, Harveen Kaur, Emily Tseng, Fabian Okeke, Mikaela Brown, Peggy B. K. Leung, Ariel F. Silva, Amy L. Shaw, and Lisa M. Kern. 2020. "Understanding the Workflow of Home Health Care for Patients with Heart Failure: Challenges and Opportunities." *Journal of General Internal Medicine* OnlineFirst: 1-9.

62. Sterling et al., 2018; Reckrey, Jennifer, Emma T. Geduldig, Lee A. Lindquist, Sean Morrison, Kathrin Boerner, Alex D. Federman, and Abraham A. Brody. 2019. "Paid Caregiver Communication with Homebound Older Adults, Their Families, and the Health Care Team." *The Gerontologist* 60(4): 745-753.

63. Connolly, Caitlin and Anastasia Christman. 2017. *Surveying the Home Care Workforce: Their Challenges & the Positive Impact of Unionization*. New York, NY: NELP. https://www.nelp.org/publication/surveying-the-home-care-workforce/; Luz, Clare C., Katherine V. Hanson, Yuning Hao, and Elizabeth Spurgeon. 2017. "Improving Patient Experiences and Outcomes Through Personal Care Aide Training." *Journal of Patient Experience* 5(1): 56-62; Sterling et al., 2018.

64. Kelly, 2013.

65. Ahn, Roy. 2017. *HCIA Complex/High-Risk Patient Targeting: Third Annual Report*. Bethesda, MD: NORC at the University of Chicago. https://downloads.cms.gov/files/cmmi/hcia-chspt-thirdannualrpt.pdf.

66. Stone, Patricia W., Carolyn T.A. Herzig, Monika Pogorzelska-Maziarz, Eileen Carter, Ragnhildur I. Bjarnadottir, Patricia K. Semeraro, Catherine C. Cohen, Jasmine Travers, and Steven Schweon. 2015. "Understanding infection prevention and control in nursing homes: A qualitative study." *Geriatric Nursing* 36(4): 267-272.

67. Spetz et al., 2019; Reckrey et al, 2019.

68. Reckrey et al, 2019; Luz and Hanson, 2015.

69. Russell, David, Ana Mola, Nicole Onorato, Sheniqua Johnson, Jessica Williams, Mark Andaya, and Marki Flannery. 2017. "Preparing Home Health Aides to Serve as Health Coaches for Home Care Patients with Chronic Illness: Findings and Lessons Learned from a Mixed-Method Evaluation of Two Pilot Programs." *Home Health Care Management and Practice* 29(3): 191-198.

70. Drake, Angelina. 2019. "How 'Upskilling' Can Maximize Home Care Workers' Contributions and Improve Serious Illness Care." *Health Affairs Blog*, March 4, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190227.420595/full/.

71. White-Chu, E. Foy, William J. Graves, Sandra M. Godfrey, Alice Bonner, and Philip Sloane. 2009. "Beyond the Medical Model: The Culture Change Revolution in Long-Term Care." *Journal of the American Medical Directors Association* 10: 370-378; Stone, Robyn I. et al., 2002. *Evaluation of the Wellspring Model for Improving Nursing Home Quality.* Washington, DC: LeadingAge. http://globalag.igc.org/health/us/evaluation.pdf.

72. CMS. 2016. *Standards and Certification; Requirements for States and Long-Term Care Facilities; Requirements for Long-Term Care Facilities; Comprehensive Person-Centered Care Planning.* 42 CFR § 483.21.

73. IOM, 2008.

74. Osterman, 2017; Stone, 2019; Reckrey, 2019.

75. Drake, 2019.

76. Gallup, Amber, Jusith Balazs Tomasson, and Vanessa Svihla. 2018. "Empowerment and Constraint: Design of a Homecare Worker Training Program." *International Journal of Designs for Learning* 9(1): 149-157.

77. Austin-Oser, Kimberly, Andrea Edmiston, and Rebecca Sussman. No date. *St. John's Enhanced Home Care Pilot Program.* Los Angeles, CA: SEIU Local 2015. https://www.finance.senate.gov/imo/media/doc/Service%20Employees%20International%20Union%20SEIU%20%20Innovations%20in%20Home%20Care%203.pdf.

78. Spetz, Stone, and Bryant, 2019; Barry, Theresa "Teta," Peter Kemper, and S. Diane Brannon. 2008. "Measuring Worker Turnover in Long-Term Care: Lessons From the Better Jobs Better Care Demonstration: Kathleen Walsh Piercy, PhD, Editor." *The Gerontologist* 48(3): 394–400; Stone, Robin I. 2004. "The Direct Care Worker: The Third Rail of Home Care Policy." *Annual Review of Public Health* 25: 521-537.

79. PHI. 2003. *Workforce Strategies No.2: Introducing Peer Mentoring in Long-Term Care Settings.* Bronx, NY: PHI. https://www.ahcancal.org/ncal/quality/qualityinitiative/Documents/Peer%20Mentoring%20Program.pdf.

80. Escandón, Ines and Marcia Mayfield. 2010. *The Business of Caregiving: Loretto's PACE Central New York Proactively Tackling Retention.* Bronx, NY. PHI. https://gcgj.mit.edu/sites/default/files/imce/resource-uploads/Lorettos.pdf.

81. Scales, Kezia. 2017. *Success Across Settings: Six Best Practices in Promoting Quality Care through Quality Jobs.* Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2017/09/evaluation_brief_final.pdf.

82. Dieppa, Emily. 2019. "PHI Helps Design "Transition Specialist" Program." *PHI Blog*, June 10, 2019. https://phinational.org/phi-helps-design-transition-specialist-program/.

83. Campbell, Stephen. 2017. *State of Care: Wisconsin's Home Care Landscape.* Bronx, NY: PHI. https://phinational.org/resource/state-of-care-wisconsins-home-care-landscape/.

84. Massachusetts Executive Office of Elder Affairs. 2014. *Homemaker Standards and Personal Care Guidelines, Attachment* A. Boston, MA: Massachusetts Executive Office of Elder Affairs. https://noi.800ageinfo.com/Common/GetPubDocument?DocId=28.

85. SEIU 775 Benefits Group. "Advanced Home Care Aide Specialist." Seattle, WA: SEIU 775 Benefits Group. https://www.myseiubenefits.org/training/learn-about-classes/advanced-registration/#Learn-More.

86. Cook, Allison. 2016. "New York Legislature Passes Advanced Home Health Aide Legislation." *PHI Blog,* June 21, 2016. https://phinational.org/new-york-legislature-passes-advanced-home-health-aide-legislation/.

87. Hernandez-Sherwood, Colleen. "Home health aides take on more tasks." *AARP Bulletin*, July 1, 2016. https://states.aarp.org/nj-nurses.

88. Stone, 2017; Bryant and Stone, 2019; Scales, 2019.

89. Harhan, Mary F. and Robyn I. Stone. 2009. *Defining Core Competencies for the Professional Long-Term Care Workforce: A Status Report and Next Steps.* Washington, DC: LeadingAge. http://www.ltsscenter.org/resource-library/Defining_Core_Competencies.pdf; Raynor, Charissa. 2014. "Innovations in Training and Promoting the Direct Care Workforce." *Public Policy & Aging Report* 24(2): 70-72; Stone, Robyn and Natasha Bryant. 2019. "The Future of the Home Care Workforce: Training and Supporting Aides as Members of Home-Based Care Teams." *Journal of American Geriatrics Society* 67(S2): S444-S448; Wilson, Daniel and Anne Montgomery. 2016. "PHCAST: Final Evaluation Underscores Urgency of Building Out Comprehensive, Competency-Based Training for Direct Care Workers." *PHI Blog*, July 14, 2016. https://phinational.org/phcast-final-evaluation-underscores-urgency-of-building-out-comprehensive-competency-based-training-for-direct-care-workers/.

90. Hoge, Michael A., Mimi McFaul, Lisa L. Cauble, Kathryn L. Craft, Manuel Paris, and Rick M. Calcote. 2016. "Building the Skills of Direct Care Workers: The Alaskan Core Competencies Initiative." *Journal of Rural Mental Health* 40(1): 31-39.

91. Newquist, Deborah D., Marguerite DeLiema, and Kathleen H. Wilber. 2015. "Beware of Data Gaps in Home Care Research: The Streetlight Effect and Its Implications for Policy Making on Long-Term Services and Supports." *Medical Care Research and Review* 72(5): 622-40; Spetz et al., 2015.

92. Drake, 2019.

93. Bureau of Labor Statistics (BLS). 2010. "Standard Occupational Classification." Accessed September 6, 2019. https://www.bls.gov/soc/2010/.

94. U.S. Census Bureau. 2017. *North American Industry Classification System.* Washington, D.C.: U.S. Census Bureau. https://www.census.gov/eos/www/naics/2017NAICS/2017_NAICS_Manual.pdf.

95. DirectCourse Online Curricula for Life in Community. "College of Direct Support." Accessed September 16, 2018. http://www.directcourseonline.com/direct-support/.

96. National Alliance for Direct Support Professionals, Inc. (NADSP). "15 NADSP Competency Areas." Accessed September 16, 2018. https://www.nadsp.org/15-competency-areas/; NADSP. 2017. *Direct Support Professional Certification Program Guidebook.* Albany, NY: NADSP. https://nadsp.org/wp-content/uploads/2017/06/NADSP-2017-Certification-Guidebook-Final-2017.pdf.

97. U.S. Department of Labor, Employment and Training Administration Competency Model Clearinghouse. 2010. "Long-term Care, Supports, and Services Competency Model." https://www.careeronestop.org/competencymodel/competency-models/long-term-care.aspx.

98. Hoge, Michael A. and Mimi McFaul (eds). 2010. *Alaskan Core Competencies for Direct Care Workers in Health and Human Services.* Anchorage, AK: The Alaska Mental Health Trust Authority. Accessed April 29, 2020. http://annapoliscoalition.org/wp-content/uploads/2013/11/alaskan-core-competencies-jan-2010.pdf.

99. National Resource Center for Participant-Directed Services. 2012. *Administration for Community Living's Long-Term Services and Supports (LTSS) Workforce Competency Model Webinette.* Chestnut Hill, MA: National Resource Center for Participant-Directed Services. http://www.appliedselfdirection.com/sites/default/files/Long-Term%20Services%20%26%20Supports%20Workforce%20Competency%20Model%20Webinette%20-%20Presentation.pdf.

100. National Direct Service Workforce Resource Center. 2014. Final Competency Set. Washington, DC: Centers for Medicaid & Medicare Services. https://www.medicaid.gov/sites/default/files/2019-12/dsw-core-competencies-final-set-2014.pdf.

101. LeadingAge Center for Applied Research. 2015. *Personal Care Attendant Competency Development Guide.* Washington, DC: LeadingAge Center for Applied Research. http://www.leadingage.org/sites/default/files/Personal%20Care%20Attendant%20Competency%20Development%20Guide_Final_0.pdf.

Appendix 1: Data Sources and Methods

The direct care workforce comprises three occupations as defined by the Standard Occupational Classification system developed by the Bureau of Labor Statistics at the U.S. Department of Labor: nursing assistants, home health aides, and personal care aides.[93] Workers are classified based on their on-the-job responsibilities, skills, education, and training.

The industries that are described in this report are defined by the North American Industry Classification System.[94] "Home Care" includes two industries: (1) Services for the Elderly and Persons with Disabilities and (2) Home Health Care Services. "Residential Care Homes" also comprise two industries: (1) Residential Intellectual and Developmental Disability Facilities and (2) Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly. "Nursing Homes" refers to the Nursing Care Facilities (Skilled Nursing Homes) industry.

To summarize nursing assistant and home health aide training requirements, PHI reviewed licensure requirements, state and federal regulations, state-sponsored curricula, and official guidance from state agencies. To summarize personal care aide training requirements, PHI reviewed Medicaid regulations, Medicaid waiver documents, Medicaid provider policy manuals, and state licensure regulations, focusing on personal care aides who provide services to older adults and people with disabilities. We excluded direct support professionals, who assist people with intellectual and developmental disabilities, as they have different on-the-job responsibilities and therefore distinct training needs.

Appendix 2: Training Requirements for Direct Care Workers

Table 1: **Nursing Assistant Training Requirements, December 2016**

	Minimum Total Training Hours	Minimum Clinical Training Hours
120+ Hours (13 States + D.C.)		
Maine	180	70
Missouri	175	100
Oregon	155	75
California	150	100
Delaware	150	75
Alaska	140	80
District of Columbia (D.C.)	120	75
West Virginia	120	55
Arizona	120	40
Florida	120	40
Illinois	120	40
Virginia	120	40
Idaho	120	32
Wisconsin	120	32
76 – 119 Hours (18 States)		
Indiana	105	75
Hawaii	100	70
New Hampshire	100	60
Connecticut	100	50
Maryland	100	40
South Carolina	100	40
Texas	100	40
New York	100	30
Utah	100	24
Rhode Island	100	20
Kansas	90	45
New Jersey	90	40
Arkansas	90	16
Washington	85	50

Table 1: **Nursing Assistant Training Requirements, December 2016** (Cont.)

	Minimum Total Training Hours	Minimum Clinical Training Hours
Georgia	85	24
Louisiana	80	40
Pennsylvania	80	37.5
Vermont	80	30
75 Hours (19 States)		
Iowa	75	30
Montana	75	25
Alabama	75	16
Colorado	75	16
Kentucky	75	16
Massachusetts	75	16
Michigan	75	16
Minnesota	75	16
Mississippi	75	16
Nebraska	75	16
Nevada	75	16
New Mexico	75	16
North Carolina	75	16
North Dakota	75	16
Ohio	75	16
Oklahoma	75	16
South Dakota	75	16
Tennessee	75	16
Wyoming	75	16

Source: PHI. *Nursing Assistant Training Requirements by State.* Bronx, NY: PHI. https://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/. Accessed April 3, 2020.

Table 2: **Home Health Aide Training Requirements, December 2016**

	Minimum Total Training Hours	Minimum Clinical Training Hours
120+ Hours (6 States + D.C.)		
Maine*	180	70
Alaska*	140	80
District of Columbia (D.C.)	125	40
California**	120	20
Idaho*	120	40
Illinois	120	40
Wisconsin*	120	32
76 – 119 Hours (11 States)		
Kansas**	110	45
Utah*	100	24
Rhode Island*	100	20
New Hampshire*	100	60
Hawaii*	100	70
Maryland*	100	40
Montana**	91	25
Wyoming**	91	16
Washington*	85	50
Vermont*	80	30
New Jersey	76	16
75 Hours (33 States)		
Alabama	75	16
Arizona	75	16
Arkansas***	75	16
Connecticut	75	16
Colorado	75	16
Delaware	75	16
Florida	75	16
Georgia	75	16
Iowa	75	16
Indiana	75	16
Kentucky	75	16

Table 2: **Home Health Aide Training Requirements, December 2016** (Cont.)

	Minimum Total Training Hours	Minimum Clinical Training Hours
Louisiana	75	16
Massachusetts	75	16
Michigan	75	16
Minnesota	75	16
Mississippi	75	16
Missouri	75	16
Nebraska	75	16
Nevada	75	16
New Mexico	75	16
New York	75	16
North Carolina*	75	16
North Dakota	75	16
Ohio	75	16
Oklahoma	75	16
Oregon	75	16
Pennsylvania	75	16
South Carolina	75	16
South Dakota	75	16
Tennessee	75	16
Texas	75	16
Virginia	75	16
West Virginia	75	16

* State requires that home health aides be certified as nursing assistants

** State allows certified nursing assistants to be dual certified as home health aides with additional training

*** State allows home health aides to become certified nursing assistants with no additional training provided through successful completion of the nursing assistant competency evaluation

Source: PHI. *Home Health Aide Training Requirements by State*. Bronx, NY: PHI. https://phinational.org/advocacy/home-health-aide-training-requirements-state-2016. Accessed April 3, 2020.

Table 3: **Training Requirements For Agency-Employed Personal Care Aides, 2019**

State	Training Requirement Consistency	Any Training Hours	Any Competency Assessment	Instructor Requirements	Portable Credentials
Alabama	Inconsistent	No	No	No	No
Alaska	Inconsistent	Yes	Yes	Yes	Yes
Arizona	Inconsistent	No	Yes	Yes	Yes
Arkansas	Inconsistent	Yes	Yes	Yes	Yes
California	Inconsistent	Yes	No	No	No
Colorado	Inconsistent	Yes	No	No	No
Connecticut	No Requirements	No	No	No	No
Delaware	Consistent	No	Yes	No	No
District of Columbia (D.C.)	Inconsistent	Yes	Yes	Yes	Yes
Florida	Consistent	Yes	Yes	Yes	Yes
Georgia	Consistent	Yes	No	Yes	No
Hawaii	Inconsistent	Yes	Yes	Yes	Yes
Idaho	Inconsistent	No	Yes	Yes	No
Illinois	Inconsistent	Yes	Yes	No	Yes
Indiana	No Requirements	No	No	No	No
Iowa	Inconsistent	Yes	Yes	No	No
Kansas	No Requirements	No	No	No	No
Kentucky	Inconsistent	No	Yes	No	No
Louisiana	Consistent	Yes	Yes	No	Yes
Maine	Inconsistent	Yes	Yes	No	Yes
Maryland	Inconsistent	No	No	No	Yes
Massachusetts	Inconsistent	Yes	Yes	No	Yes
Michigan	Inconsistent	No	No	No	No
Minnesota	Inconsistent	No	Yes	No	Yes
Mississippi	Inconsistent	Yes	Yes	Yes	No
Missouri	Inconsistent	Yes	Yes	Yes	Yes
Montana	Inconsistent	Yes	Yes	Yes	Yes
Nebraska	No Requirements	No	No	No	No
Nevada	Consistent	Yes	Yes	No	No
New Hampshire	Consistent	No	No	No	No
New Jersey	Inconsistent	Yes	Yes	Yes	Yes

Table 3: **Training Requirements For Agency-Employed Personal Care Aides, 2019** (Cont.)

State	Training Requirement Consistency	Any Training Hours	Any Competency Assessment	Instructor Requirements	Portable Credentials
New Mexico	Inconsistent	Yes	Yes	No	Yes
New York	Consistent	Yes	Yes	Yes	*Yes*
North Carolina	Inconsistent	No	Yes	Yes	*Yes*
North Dakota	Inconsistent	No	Yes	No	*Yes*
Ohio	Inconsistent	Yes	Yes	Yes	*Yes*
Oklahoma	Consistent	No	Yes	Yes	*Yes*
Oregon	Consistent	No	Yes	No	*No*
Pennsylvania	Consistent	No	Yes	No	*Yes*
Rhode Island	Consistent	Yes	Yes	Yes	*Yes*
South Carolina	Inconsistent	No	Yes	Yes	*Yes*
South Dakota	Inconsistent	No	No	No	*No*
Tennessee	No Requirements	No	No	No	*No*
Texas	No Requirements	No	No	No	*No*
Utah	Consistent	No	Yes	No	*No*
Vermont	No Requirements	No	No	No	*No*
Virginia	Consistent	Yes	Yes	Yes	*Yes*
Washington	Consistent	Yes	Yes	Yes	*Yes*
West Virginia	Inconsistent	No	No	Yes	*No*
Wisconsin	Inconsistent	No	Yes	Yes	*No*
Wyoming	Inconsistent	Yes	Yes	Yes	*Yes*

Note: Categories refer to at least one set of training requirements per state

Source: PHI. *Personal Care Aide Training Requirements.* Bronx, NY: PHI. https://phinational.org/advocacy/personal-care-aide-training-requirements. Accessed April 3, 2020.

Appendix 3: Competency Sets for Direct Care Workers in LTSS

Table 4: **Competency Sets for Direct Care Workers in LTSS, by Date of Publication**

Competency Set	Description	Core Competencies
Community Support Skill Standards (CSSS): Tools for Managing Change and Achieving Outcomes[95]	The CSSS represent practice standards for direct service workers in a wide variety of human service program settings, regardless of specific job title or population served. Development and validation of the CSSS, which involved a national coalition of key stakeholders, was led by the Human Services Research Institute with support from the Departments of Labor and Education.	1. Participant Empowerment 2. Communication 3. Assessment 4. Community and Service Networking 5. Facilitation of Services 6. Community Living Skills and Support 7. Education, Training, and Self-Development 8. Advocacy 9. Vocational, Educational, and Career Support 10. Crisis Intervention 11. Organizational Participation 12. Documentation
PHI Competencies for Direct Care Workers	PHI's Competencies for Direct Care Workers, which apply to personal care aides, home health aides, and nursing assistants, are the basis of the organization's flagship entry-level training programs. This competency set was included in the development of the Department of Labor's Long-Term Care and Supports Competency Model and has informed numerous other training models and curricula, including the curricula that were implemented in the PHCAST program.	1. Role of the Direct Care Worker 2. Consumer Rights, Ethics, and Confidentiality 3. Communication, Problem-Solving, and Relationship Skills 4. Personal Care Skills 5. Health Care Support 6. In-Home and Nutritional Support 7. Infection Control 8. Safety and Emergencies 9. Apply Knowledge to Needs of Specific Consumers 10. Self-Care
National Alliance for Direct Support Professionals' (NADSP) Direct Support Professionals Competencies[96]	This set of 15 competencies, which is based on the CSSS, underpins the NADSP voluntary credentialing program for direct support professionals (DSPs) working in community human services. There are four levels of the credentialing program: • DSP-Registered (DSP-R) • DSP-Certified (DSP-C) • DSP-Specialist (DSP-S) • Frontline Supervisor (FLS) The NADSP competency set is used in a number of competency-based training programs and statewide certification programs, including in Georgia, Ohio, New Jersey, and Indiana, and is the basis of the national DSP Apprenticeship Program through the Department of Labor.	1. Participant Empowerment 2. Communication 3. Assessment 4. Community and Service Networking 5. Facilitation of Services 6. Community Living Skills and Supports 7. Education, Training, and Self-Development 8. Advocacy 9. Vocational, Educational, and Career Support 10. Crisis Prevention and Intervention 11. Organizational Participation 12. Documentation 13. Building and Maintaining Friendships and Relationships 14. Provide Person-Centered Supports 15. Supporting Health and Wellness

Table 4: **Competency Sets for Direct Care Workers in LTSS, by Date of Publication** (Cont.)

Competency Set	Description	Core Competencies
Department of Labor Employment and Training Administration's Long-Term Care, Supports, and Services Competency Model[97]	The Employment and Training Administration worked with technical and subject matter experts from education, business, and industry to develop this competency model for LTSS. The model is designed as a resource for workforce development activities such as writing job descriptions and developing curricula. Presented as a pyramid (with competencies within each tier), the model depicts the increasing specialization and specificity in the application of skills as workers progress in their roles.	1. Personal Effectiveness Competencies *e.g., interpersonal skills, dependability* 2. Academic Competencies *e.g., reading, writing, critical and analytical thinking, communication* 3. Workplace Competencies *e.g., teamwork, problem-solving* 4. Industry-Wide Technical Competencies *e.g., supporting daily living, documentation* 5. Industry-Sector Technical Competencies *NADSP competency areas* 6. Management Competencies/Occupation-Specific Competence *No competencies specified*
Alaskan Core Competencies for Direct Care Workers in Health and Human Services[98]	The Alaskan Core Competencies were developed by a consensus group of long-term care stakeholders from different regions of the state. The set draws from pre-existing, nationally recognized competency models, whose components were reviewed and modified for practice in Alaska's unique needs, which include delivering LTSS in frontier areas to a diverse consumer population. The Alaskan model is designed to be "skill oriented" and includes metrics to assess performance of its competencies.	1. Working with Others 2. Assessing Strengths and Needs 3. Planning Services 4. Providing Services 5. Linking to Resources 6. Advocating 7. Individualizing Care 8. Documenting 9. Behaving Professionally and Ethically 10. Developing Professionally
Administration for Community Living's (ACL) Long-Term Services and Supports Workforce Competency Model[99]	The ACL developed the Long-Term Services and Supports Workforce Competency Model from the Department of Labor model described above. In the ACL model, the first through fourth foundational tiers apply to the full long-term care workforce, including direct care workers but also care managers, counselors, administrators, directors, etc. The fifth tier encompasses competencies required for the specific setting, such as a home health agency or Area Agency on Aging, and the top tier covers occupation-specific competencies.	1. Personal Effectiveness Competencies *e.g., interpersonal skills, dependability* 2. Basic Education Competencies *e.g., reading, writing, critical and analytical thinking, communication* 3. Workplace Competencies *e.g., teamwork, problem-solving, and decision making* 4. Industry-Wide Technical Competencies *e.g., supporting daily living, documentation* 5. Industry-Sector Technical Competencies *No competencies specified* 6. Occupation-Specific Requirements *No competencies specified*

Table 4: **Competency Sets for Direct Care Workers in LTSS, by Date of Publication** (Cont.)

Competency Set	Description	Core Competencies
Centers for Medicare and Medicaid Services Direct Service Workforce Core Competencies[100]	Led by the National Direct Service Workforce Resource Center, the Direct Service Workforce Core Competencies were developed through a rigorous process involving a literature review and content analysis with expert input. With applicability across community-based LTSS settings, the competency set is designed to serve as resource for training development and performance improvement and to serve as foundation for career ladders and lattices.	1. Communication 2. Person-Centered Practice 3. Evaluation and Observation 4. Crisis Prevention and Intervention 5. Safety 6. Professionalism and Ethics 7. Empowerment and Advocacy 8. Health and Wellness 9. Community Living Skills and Supports 10. Community Inclusion and Networking 11. Cultural Competency 12. Education, Training, and Self-Development
LeadingAge's Personal Care Attendant Competency Model[101]	LeadingAge's Personal Care Attendant Competency Model is designed to specify the skills, knowledge, and behaviors that will help personal care aides deliver effective supports and services across a variety of positions and LTSS settings, including HCBS, residential, and institutional settings. The model is built around four broad competency areas.	1. Technical Skills *e.g., ADL and IADL care, infection control, role of the direct care worker* 2. Applied Understanding *e.g., dementia, end-of-life care, professionalism and ethics* 3. Interpersonal Skills *e.g., relationship skills, teamwork, communication, accountability* 4. Self-Directed Care *e.g., cultural competency, individualizing care*

Note: This table was originally published in 2019 within PHI's *Envisioning the Future of Home Care: Trends and Opportunities in Workforce Policy and Practice* report authored by PHI Director of Policy Research Kezia Scales. It has been adapted for this report

About PHI

PHI works to transform eldercare and disability services. We foster dignity, respect, and independence for all who receive care, and all who provide it. As the nation's leading authority on the direct care workforce, PHI promotes quality direct care jobs as the foundation for quality care.

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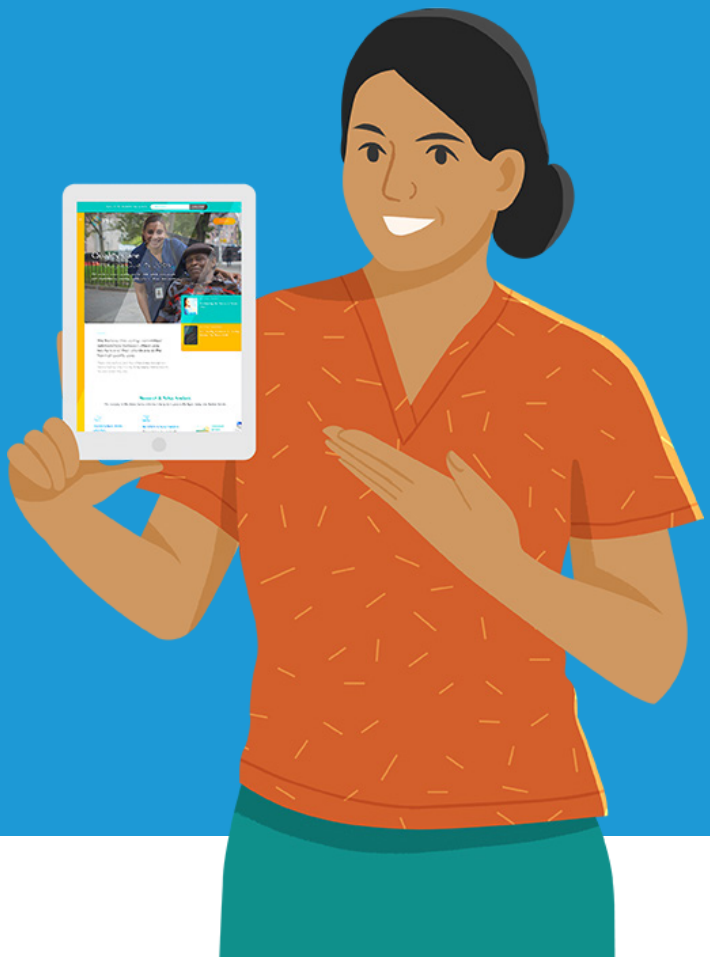

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