Best Practices and Innovative Models for Stabilizing Colorado Direct Care Brief

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Colorado faces a workforce crisis with difficulties to recruit and retain personal care aides (PCA) at a time of increasing demand for these workers. PCAs provide the majority of hands-on care to individuals requiring long-term services and supports (LTSS) in their own homes or in the community. Key contributors to PCA workforce recruitment and retention problems are lack of training and preparation of these workers to care for people with increasingly complex health and chronic conditions, limited advancement potential and fewer opportunities to grow professionally, and low wages and benefits. These factors have been linked to high turnover and difficulties to attract people into this occupation (Luo et al., 2012; Morris, 2009; Stone et al., 2017; Butler et al., 2012). Personal care aides do not have federal requirements governing their training and certification; that role is primarily with state Medicaid agencies. The wide range and scope of training requirements for personal care aides makes it difficult to prepare, hire and continue to educate this workforce since they impede the development of the job as a clearly defined professional occupation with a standard set of training requirements and competencies. Colorado currently requires agency-employed PCAs to receive an orientation in six broad topics within 45 days of hire. Those under Medicaid programs must complete 20 hours of training in 19 broad topics before providing services. Proof of competency is not required and PCAs are exempt from the training by passing a skills validation test (PHI, 2019).

In 2018, Colorado passed legislation to build the capacity and stability of the personal care aide workforce to meet the needs of individuals requiring LTSS. This included wage increases and establishing a workgroup to review and recommend initial and ongoing training requirements for agency-based PCAs (Government Performance Solution, Inc., 2019). Colorado Department of Health Care Policy and Financing, in collaboration with other state agencies, is building on this work to continue examining the challenges facing Colorado's direct care workforce and the solutions to meet the challenges. As part of this effort, the LeadingAge LTSS Center @UMass Boston conducted a study to identify and describe potential strategies that address the goal to develop a stable and high-quality PCA workforce to prepare and plan for the growing demand of LTSS.[1] The brief summarizes the findings of promising practices in state-sponsored entry-level training programs, nurse delegation, and advanced roles that can serve as potential approaches and models to address the PCA workforce crisis in Colorado.

[1] The focus of the report is on personal care aides employed by home care organizations, home health agencies, hospice agencies or other organizations as this was the target workgroup for the legislative bills. It does not include nursing assistants in nursing homes or independent personal care aides, unregistered personal care aides, or providers who are hired by the consumer or the consumer's representative.

Definitions of Terms

Long-term services and supports or LTSS, refers to a range of health and social services that support older adults and persons with disabilities who have a reduced degree of physical or cognitive functioning and need help with daily living tasks. The major goal of LTSS is to minimize, rehabilitate or compensate for the loss of independent physical or mental functioning, and to maximize quality of life for older people with chronic disabilities. LTSS can be received in a residential care setting or at home.

Direct care workers assist older adults and people with disabilities to carry out basic activities of daily living across LTSS settings (i.e., individual homes, assisted living communities, and nursing homes). Direct care workers include personal care aides, home health aides, and certified nursing assistants. We refer to direct care workers in the report when the study or data represents direct care workers across settings and is not specific to personal care aides.

Personal care aides (also called home care aides or personal care assistants; referred to as personal care aides in this brief) assist older adults and people with disabilities to carry out basic activities of daily living in their own home or in the community. Personal care aides are not licensed, and do not have any recognized qualifications or certification in nursing.

Distinction between home health aide and personal care aide: Personal care aides and home health aides comprise the home care workforce. There is significant overlap in the roles of these two job categories but also some differences in their training, certification requirements, and employment. Home care aides deliver non-medical personal care and supports. These aides are hired directly by their clients or through a home care agency. Home health aides care for individuals who require short-term care to manage a medical condition or to rehabilitate after an acute condition such as a heart attack or stroke. Home health aides provide personal care and some medically-oriented services on a time-limited basis under nurse supervision as part of a physician-ordered care plan to support recovery after illness or injury (MedPAC, 2019). Colorado does not technically use the designation home health aide. Direct care workers providing home health care in Colorado are required to be CNAs and are subject to the training requirements described under CNAs.

Key Findings and Recommendations for Colorado Policymakers

Training

Standardized training can help to ensure a basic level of personal care aide (PCA) preparedness. Designating specific competencies instead of prescribing curriculum, competency testing and instructor methods allows training providers to customize and accommodate the training based on the abilities of the trainees and populations being served. Develop and deliver training in multiple languages.

Engage a diverse group of stakeholders across different settings and populations in the development and implementation of the training program. It provides varying perspectives on the core competencies and can help with buy-in.

Core competencies that cut across different settings and populations for the basic training can break down the silos, prevent duplicative training for PCAs and allow them to build upon existing skills with further training. Population-specific knowledge can be added to the core training.

Incorporate the use of an adult learner-centered approach in delivery of the training and focus on the competencies the trainees need to perform well. Develop criteria for instructors, such as teaching and clinical experience as well as understanding of the work of PCAs. Provide guidelines or training for the instructors in the delivery of the training to help with fidelity to the model.

Assess competencies of learners through knowledge exams and in-person skills demonstration. Create alternative options to written exams, ensure they account for cultural diversity, and make them available in multiple languages.

Require personal care aides to have continuing education on topics relevant to the responsibilities of the PCAs and are condition-specific.

Enhanced or Advanced Roles

Review the scope of practice laws and regulations that might affect implementation of the enhanced role model(s) for any limitations on the role of PCAs.

The advanced roles need to be acknowledged as a different job category with more advanced tasks and responsibilities. Understand how it gets implemented at the agency and receives buy-in from the end users or employers. Engage employers when developing these roles or models to integrate PCAs into home-based care teams: Supervision, training on advanced skills, ability to pay increased wages for the PCA and supervisor, performance evaluations, and employer's assessment of using a PCA in an advanced role and having the clientele requiring an advanced PCA.

Educate healthcare team members on the value and role of PCAs for more successful integration and use of PCAs' knowledge and skills in home-based care teams.

Scale up and test the promising models of advanced or enhanced roles for PCAs to make an evidence-based case for sustained investment.

Funding

Incentives to invest in this workforce and fund training programs and advanced roles beyond demonstration programs can support the implementation and sustainability. Funding options include:

- Build the program costs into Medicaid or managed care programs so there is continued funding for training, support for the aide, and increased compensation for the enhanced position.

- Explore how to use Medicaid reimbursement strategies to incentive providers to create more professional development opportunities for their PCAs.

- Build on pay-for-performance to target dollars towards successful programs in home settings that specifically provide advancement opportunities for PCAs.

- Build reimbursement for additional services provided by PCAs when they are part of a coordinated care system. This can help with the additional employer costs for training, support and supervision, and increased wages.

Colorado Personal Care Aide Workforce

Personal care aides (PCA) provide most of the paid personal assistance and health care support to seriously ill, functionally impaired individuals in their homes and in community-based settings. The personal care aide workforce is growing due to increasing demand from an aging population and the increasing shift of providing long-term services and supports (LTSS) from nursing homes into home and community-based settings. Federal and state policies also are providing incentives for hospitals and health systems to rapidly move people with serious illness from acute care settings into the home (Enquist et al., 2010; Landers et al., 2016).

Supply and Demand

The Colorado older adult population is increasing and growing faster than most other states. In 2017, approximately 714,000 people in Colorado were 65 and older and the number is expected to double to 1.7 million older adults by 2050, representing approximately 20 percent of the population (Gomez, 2019). Colorado will have a more ethnically and racially diverse older adult population: The non-white population will increase from 16 percent of older adults in 2015 to 28 percent by 2040 (Colorado Department of Public Health and Environment, 2015).

In 2013, 91% of adults 65 and older in Colorado had at least one chronic condition and 70% had two or more chronic conditions (Colorado Department of Public Health and Environment, 2015). Additionally, 18.5% had a physical disability, 12.5% reported challenges to live independently and 12.5% reported moderate or major problems with performing regular activities or maintaining their home (Colorado Health Institute, 2020). Estimates suggest that nearly 70 percent of U.S. adults aged 65 and older will need some level of long term services and supports (at home with paid or informal caregivers or at nursing homes or assisted living facilities) due to physical,

cognitive, developmental, and/or behavioral conditions. They will use these services for an average of three years (LongTermCare.gov, 2017). Adults 85 and older are four times more likely to need LTSS compared to people 65 to 84. Among individuals receiving services, most live in the community (Scales, 2020).

As Colorado ages and there is an increasing demand for services, the state will experience a shortage of workers and vacancies among the PCA workforce (Table 1). Between 2016 and 2026, the projected job growth due to demand in industry and employment trends is 11,760 jobs or 45% growth (Kuwik, 2020; PHI, 2020). The anticipated number of separations during the same period is 44,740 due to workers leaving the labor force through retirement, disability or other reasons or moving into a new occupation. The result is a total of 56,500 job openings for PCAs due to occupational growth and separation (PHI, 2020). Colorado currently has one direct care worker for every 13.6 adults 65 and older. This ratio is expected to decrease to one direct care worker for every 14.3 older adults by 2030 (Colorado Health Institute, 2020).

Demographics of Colorado Direct Care Workforce

Colorado's direct care workforce (which includes PCAs and other workers who assist across LTSS settings) is primarily women (85%) and disproportionately Black (10%) and Hispanic (25%) compared to the overall Colorado workforce (Kuwik, 2020). The Colorado direct care workforce is slightly older and more educated than the state's workforce as a whole. Forty-five percent of direct care workers in Colorado is 45 years and older and 64% has some college or an associate's/bachelor's degree or higher. One in seven direct care workers in Colorado is a U.S. citizen by naturalization or not a U.S. citizen.

Table 1: Demographics of Colorado Direct Care Workforce

	Colorado Direct Care Workforce	**Percentage Point Difference between Colorado's Overall Workforce**
Gender		
Women	85%	+3%
Race/Ethnicity		
Black	10%	+6%
Hispanic	25%	+4%
White	58%	-11%
Nativity		
Foreign-born	14%	+1%
Age		
45 and older	45%	+9%
Educational Attainment		
Some College or Association/Bachelor's Degree	60%	+14%

Economics of Colorado Personal Care Aide Workforce

Wages: In 2018, PCAs in Colorado earned low wages, a median hourly wage of $11.68 (Kuwik, 2020; PHI, 2020). Half worked full-time, while 45% worked part-time for non-economic reasons (personal or family obligations and health problems) and six percent were part-time for economic reasons (business conditions at the organization or in the broader labor market).

Poverty Level and Public Assistance: In 2017, 17% of the PCA workforce lived in households below the federal poverty line and 44% were low-income, living below 200 percent of the poverty level. More than half required some form of public assistance, including food and nutrition assistance (22%) and Medicaid (34%), and 16% were uninsured.

Table 2: Economics of PCA Workforce

	Colorado Direct Care Workforce	**Percentage Point Difference between Colorado's Overall Workforce**
Wages		
Median hourly wage	$11.68	-$8.66
Poverty Level		
At or below 100% of the Federal Poverty Level	17%	+11%
At or below 200% of the Federal Poverty Level	44%	+27%
Public Assistance		
Any public assistance	52%	
Food and nutrition assistance	22%	
Medicaid	34%	
Health Insurance		
Uninsured	16%	
Medicaid, Medicare or other public health insurance	46%	

Given the increasing demand for LTSS and the limited supply of workers, it is important to understand how to recruit and retain PCAs to provide care to older adults and younger people with disabilities.

Personal Care Aide Landscape

PHI examined the personal care aide training requirements across the country to collect information about PCA training standards in Medicaid programs (PHI, 2019).[2] The study found the training requirements regarding hours of training, competencies or skills required, curriculum content, and testing vary widely across and within states, where they exist at all.

- 14 states have consistent training requirements for all agency-employed PCAs, meaning that training on a uniform list of topics is required for all personal care aides employed by home care agencies participating in public programs and those who offer services to private-pay clients. Seven states do not require training and the remaining 29 states have different requirements depending on whether the PCA works in specific Medicaid programs or for private-pay home care agencies.
- 26 of the 43 states that have at least one set of training requirements established a minimum number of training hours.
- 34 states and the District of Columbia require PCAs to complete a competency assessment after training. This can be written or oral, skills demonstration, or both written or oral and skills demonstration. Fourteen of the states and District of Columbia have a state-sponsored standardized test.
- 17 states delineate the instructor methods to teach PCAs.

These disparities can potentially lead to significant differences in the skill level and preparedness of these workers across the country and their ability to provide high-quality care.

Table 3: State training requirements of agency-employed personal care aides (2019)

Training Requirements	**Number of states**
Consistency of Training	
Consistent training requirements: All agency-employed PCAs are subject to the same training requirements	14
Inconsistent: PCAs are subject to varying requirements, depending on whether they work in specific Medicaid programs or for private-pay home care agencies	29 and District of Columbia
No requirement	7
Training Hours	
Minimum number of training hours	26 and District of Columbia
40 or more hours of training (of states with minimum number of training hours)	15 and District of Columbia
Competency Assessment	
Any competency assessment after training	34 and District of Columbia

[2] A large proportion of the PCA workforce serves consumers in state Medicaid programs — Medicaid State Plan Personal Care Options, Medicaid Home and Community-Based Services (HCBS) waiver programs, and under Medicaid 1116 Demonstration waiver programs.

Competency assessment includes both written and oral test and skills demonstration	16 and District of Columbia
Standardized test required	14 and District of Columbia
Instruction Method	
Instruction methods specified	16 and District of Columbia

State-Sponsored Training Curricula for Personal Care Aides: Promising Practices

States can play a valuable role in establishing and disseminating best practices for preparing PCAs to provide complex care for older adults and younger people with disabilities. Ten states and the District of Columbia have a state-sponsored curriculum where at least one set of the regulations require trainers to use a state-sponsored curriculum or submit an equivalent curriculum for approval by the state (PHI, 2019). The brief summarizes the key components of seven state programs that have adopted and promoted comprehensive PCA training curriculum through state regulations that have consistency and some level of rigor in the training—Alaska, Arizona, Maine, Massachusetts, New York, Virginia, and Washington.[3,4] The curricula share similarities in terms of content but can differ in how the content is organized, delivery of the training, and robustness of the training. The training programs have not been evaluated to determine the preparation of the workforce and the impact on worker or client outcomes. Lessons learned from the state programs can inform Colorado policymakers as they consider standardized training for PCAs.

Stakeholder coalition to inform curriculum development and training program implementation

The states established a stakeholder coalition of representatives across settings and populations served to assist with development of the curriculum and buy-in to implement and sustain the training program. The coalition members recommended key competencies and topics, training hours, and/or certification requirements for PCAs through a consensus-building process. Partners included consumer groups, state agencies, educational institutions, home care provider associations, home care agencies, and workers. In addition to the advisory board,

[3] Sources for state training programs: Alaska Administrative Code, 2018; Alaska Department of Health and Social Services, 2019; Arizona Department of Economic Security, 2007; Arizona Direct are Initiative, 2011; Arizona Health Care Cost Containment System, 2014; Maine Department of Health and Human Services, 2019; Maine Direct Service Worker Training Program, 2017; MassAHEC Network-UMass Medical School, 2016; New York State Department of Health, n.d.; New York State Department of Health, 2007; New York State Department of Health, 2017; Ordway et al., 2019; Virginia Administrative Code, 2017; Virginia Department of Medical Assistance Services, 2003; Washington Administrative Code, 2019; Washing State Department of Social and Health Services, 2015; Campbell, 2018; Campbell, 2017a; Campbell, 2017b

[4] It is not clear whether Virginia continues to mandate training for personal care aides and the use of the personal care aide curriculum/manual developed by the Virginia Medicaid office. The interviewees indicated the regulations changed and there is no longer a state-sponsored curriculum. However, they were not able to provide specifics and we attempted to follow-up with the Medicaid office to get clarity but have not been able to talk with them to get more information.

subject-matter experts in some states provided guidance on training design and course development.

Develop Competency-Based Curriculum

To varying degrees, the state-sponsored training programs advanced learner-centered teaching methods and competency-based content. A basic training of core competencies across different settings and populations breaks down silos, prevents duplicative training and allows PCAs to build upon existing skills with further training. Existing competency models—Centers for Medicare and Medicaid Services Direct Service Workforce Core Competencies, PHI Competencies for Direct Care Worker, LeadingAge Personal Care Attendant Competency Model—can be used to define the competencies. In addition, The Personal and Home Care Aide State Training (PHCAST) program also can serve as a starting point for developing the competency standards to define the personal care aide profession. PHCAST was a national demonstration program, funded by the Affordable Care Act in FY 2010, and provided grants to six states to develop, implement and evaluated competency-based curricula and aide certification. The grantees covered 10 core competencies in their curriculum and each state developed its own training program and modes of delivery.

Population-specific knowledge can be added to the core training. Training providers can customize the training based on the abilities of the trainees and population being served. Several states provide the curriculum and trainings in multiple languages.

The training hours in the state programs varied from 40 to 75 hours. The number of training hours should be based on the competencies defined for the workers and the time needed to train the workers in the knowledge and skills required to demonstrate each competency.

Assessment of competencies through knowledge exams and in-person skills demonstrations is important for learners to demonstrate their understanding and ability to apply the knowledge learned in the training. It also is important to accommodate all learners by providing alternative options to written exams and having exams available in multiple languages.

Multiple options for training delivery

Colorado can offer PCA training through various types of organizations such as home care agencies, vocational schools, and educational institutions. This provides options for the trainees. The advantage of the home care agency for the worker is the training is often paid through the employer, while vocational schools and educational institutions typically charge a fee determined by the school.

While several of the states required the instructor to be a registered nurse, not all states had this condition. Licensed practical nurses (LVN)/licensed practical nurses (LPN) and certified nursing assistants (CNA) may be well-positioned to teach the curriculum. Many of the state training regulations specified criteria for the instructors, such as teaching and clinical experience as well as an understanding of the work of PCAs, and required demonstration of

competence in the skills they would be teaching. Guidelines or training for the instructors support fidelity to the model. The quality of instructors and training providers should be assessed at the onset and monitored to ensure they are equipped to provide the training.

States used varying methods to deliver the training: In-person, online and hybrid. In-person training is interpersonal and has a high-level of hands-on activities that are conducive to the personal care aide population. Hybrid training models can augment in-person instruction and hands-on learning opportunities with classroom-based technologies, and are preferable to online learning methods.

Advanced Roles for PCAs[5]

Career paths for PCAs through advanced roles, such as specialized or senior aide positions, peer mentors, and health coaches can improve retention in the long term and allow employees to grow and progress in their careers. These opportunities enable PCAs to take on more expansive and satisfying roles, which can reduce turnover and make the job more competitive. The PCAs in these advanced roles require additional training and extensive supervision.

PCAs also can be part of interdisciplinary healthcare teams either as full members or through regular reporting structures to allow for more informed decision making about client care. Given PCA engagement with clients they develop familiarity, trust and understanding of a person's health and well-being. They are well-positioned to contribute their observations from the home to other practitioners on a care team, improve understanding of a client's health condition, navigate transition in care, support health-promoting behavior, identify signs and symptoms of emerging or worsening conditions among clients, track clients' medical appointments, assist with medication adherence and management, understand and report social and environmental conditions that shape a person's health, and help other providers connect clients with community supports (Drake, 2019).

Most state initiatives have been funded through one-time grants to local providers and educational entities. Several states have created statewide career advancement initiatives. The state initiatives and pilot programs have demonstrated promising outcomes for advanced roles or the integration of PCAs into team-based care. Highlighted below are examples of advanced roles and team-based programs that include personal care aides and may serve as models for Colorado.

New York Advanced Home Health Aide: New York State through its legislative process created the Advanced Home Health Aide (AHHA) position, allowing home health aides to perform advanced tasks under nurse delegation and supervision to clients who are medically stable (New York State Department of Health, 2019; Advanced Home Health Aide Advisory Group, 2015). RNs who work for the same employer as the AHHA assign the AHHA to the advanced tasks for the

[5] We included models and programs that target independent providers and home health aides since the training topics or responsibilities of the aides overlap with the potential tasks for a personal care aide.

client, train the aide on performing the advanced tasks appropriate to the client, provide written instructions to the AHHA on how to perform the advanced task and criteria for identifying, responding and reporting problems, and supervises the aide. New York State had to amend its nurse practice acts to permit delegation of the tasks to home health aides who receive appropriate training and supervision (Breslin, 2018). The AHHA training includes 80 hours of didactic classroom training and skills laboratory training and at least 45 hours of RN supervised practical training in a home care setting.

The workgroup that informed the development of the AHHA role expressed concerns about the legislation because it did not include funding to support curriculum development, training program costs, increased wages for AHHAs, increased nurse supervision costs, and other expenses (Breslin, 2018). This may impact the uptake among workers and employers given the lack of designated funding for the position and increased wages. The final rule was implemented in 2019, and to date there have been no reports on how this program has been implemented.

Massachusetts' Supportive Home Care Aides: Massachusetts created an advanced position— Supportive Home Care Aide— who specializes in mental health or Alzheimer's disease (Gleason & Coyle, 2016). Home health aides serve the personal care needs as well as the emotional and behavioral needs of clients who have difficult and complex conditions. In addition to the 75 hours of required training for home health aides, Supportive Home Care Aides complete 12 hours of training on their specialty topic and 12 hours of in-service training per year (Home Care Aide Council, 2016; Gleason & Coyle, 2016). The aides receive weekly support training and in-services, attend team meetings and interdisciplinary case conferences, have weekly contact with supervisors, and supervision once every three months. The supervisors receive three hours of supervisory training to develop the complementary competencies.

St. John's Enhanced Home Care Pilot: The pilot program trained in-home support services (IHSS) providers, PCAs who are hired by the consumer or consumer's representative and paid by the county Medi-Cal program, to improve integration of care and health outcomes for older adults and younger people with disabilities (St. John's Well Child and Family Center, ULTCS SEIU, & United Long-Term Care Workers, 2014). The program tied coordination of care with IHSS providers and enhanced role for the workers. In the advanced role, IHSS providers were integrated into care coordination teams via communication, coordination, and delivery of enhanced services. They received 25 hours of training on team-based communication with the client's care coordinator and medical providers, coordinating health care and related services, and supplemental skills relating to paramedical tasks and chronic disease management. A care coordinator served as the primary contact for the IHSS worker and supported the coordination of clinic services and integration of the services with home-based care. An evaluation showed improvements in clients' perceived quality of life and overall quality of care, increase in the number of "health days'" and decreased hospitalization and emergency department visits.

Extended Care Career Ladder Initiative: In 2000, the Massachusetts legislature enacted the Extended Care Career Ladder Initiative (ECCLI) as part of a broader Nursing Home Quality Initiative. This legislation was in response to high turnover and vacancies among home health aides and certified nursing assistants in LTSS. ECCLI's primary goal was to enhance resident/client care quality and outcomes while simultaneously addressing the problems of recruiting and retaining skilled HHS and CNA workers. This was one of the first state-initiated efforts in the United States to address the issue of frontline workforce quality improvement in LTSS (Heineman et al., 2008). ECCLI required all participating nursing homes and home health organizations to create career ladders and lattices for CNAs and HHAs with modest hourly wage increases tied to the advancement ($.25 to $1.00 per hour wage increase). Career ladder steps focused on clinical (e.g. nutrition, skin assessment, transferring) and soft skills training. However, multiple-step career ladders were less common among home health agencies than nursing homes. The home health agencies trained HHAs in advanced clinical skills without developing a hierarchy of aides so their job titles and responsibilities remained essentially the same.

A positive program evaluation found improved communication among co-workers and upper management, increased competence in clinical skills, improved teamwork, greater self-esteem and self-confidence among aides, recognition, respect and trust from supervisors and management, and reductions in turnover (Heineman et al., 2008). Despite the positive results, the program was not sustained after the state funding ended.

Care Connections Pilot: A partnership between PHI, a training advocacy organization for direct care workers, and Independent Care System, a Medicaid managed care plan in New York City, created an advanced role and enhanced training for PCAs (Misiorski, 2018). The senior aides provided coaching and support for other PCAs and family caregivers, and served on an interdisciplinary team. The aides received classroom and on-the-job training on observation, documentation and reporting skills, chronic condition, and how to educate and mentor other PCAs. An internal evaluation found an eight percent reduction of emergency department visits among the clients and improvements on caregiver strain. Workers also benefitted from the program through a 60% wage increase, improvements in job satisfaction, greater inclusion in care team activities, better relationships with families and clients, and improved communication with clinical managers.

Care Team Integration of the Home-Based Workforce Pilot: The California Long-Term Care Education Center integrated IHSS providers into clients' care teams and assisted workers to identify a problem and communicate with the care team (Coffman & Chapman, 2012; California Long-Term Care Education Center, 2016). The California Long-Term Care Education Center trained IHSS providers to serve in an enhanced caregiving role and to be members of clients' care teams by bridging quality in-home care with the health care delivery system. The providers helped implement care plans, monitored and communicated changes in clients' conditions, and assisted clients to navigate the system. They completed a 75-hour training on chronic disease

management, care coordination, communicating with clients and team members, coaching and navigating the health system, providing care for common and specific diseases, nutrition, caregiver safety and medication adherence. An evaluation found trainees reported increased knowledge and skills, increased confidence, and improved communication with clients and primary care physicians. In addition, the study found a decline in emergency department visits and rehospitalizations and cost savings of $12,000 per trainees due to these declines.

Peer Mentors: PCAs can serve as peer mentors to support both new workers and incumbent workers who need special assistance or have received disciplinary action. This can provide an advancement opportunity for experienced PCAs and higher wages. Mentors are paired with the aides and support the person with client care issues and ensure they understand the policies and procedures at the organization. The mentor receives training on topics covering peer mentoring, communication, cultural diversity, psychiatric and mental health disorders, and palliative care.

Health Coach: Health coaches "assist clients with setting goals and gaining the knowledge, skills, tools and confidence they need to participate in their own care" (Russell, et al., 2017). PCAs are well-positioned for this role as their intimate and frequent interactions with the client allow them to understand their needs, preferences and barriers to disease self-management. PCAs can be trained on symptom identification, self-management, readiness to change, goal setting, and motivational interviewing.

The pilot demonstrations struggle to continue beyond the grant funding and lack formal evaluations to provide an evidence-base on the effectiveness. The advanced role models and demonstration programs need to be scaled up and tested to make an evidence-based case for sustained investment.

Apprenticeships

The Department of Labor's (DOL) Registered Apprenticeship Program (RA) supports job development by providing a career pathway where individuals receive the knowledge and skills necessary for an occupation through paid-work and a simultaneous education or instructional component. RA programs are proven models of apprenticeship to help develop worker pipelines that have been validated by DOL or a state apprenticeship agency (Lerman et al., 2014). While RAs have long been associated with trades such as construction, electrician and plumbing, DOL and its state counterparts have begun to pay increasing attention to jobs in the health care sector, including the personal care aide workforce.

Despite modest attempts to implement these programs over the past decade, home care RAs have faced major challenges. A study of five defunct RA programs for direct care workers (Koeh et al., 2011) and another based on key informant interviews (Bates et al., 2018) identified barriers to successful RA programs in home care including lack of awareness of and skepticism about the RA approach among home care agencies, lack of a clear career advancement path

from personal care aide to other professions, failure of employers to offer increased wages for increased skills, lack of sustainable government funding, and challenges in program development and administration. Washington's Advanced Home Care Aide RA Program, developed in 2012, is one exception. It has overcome many of the challenges typically faced by RAs in home care. Originally DOL-funded, this program is now sustained by employer contributions. Employers began paying workers for their time spent in training in 2015, earning a 25 cent per hour raise after completing the first 75-hour training, and another 25 cent raise after completing the advanced training (Choitz et al., 2015).

Nurse Delegation

One impediment to the expansion of the PCA role is the degree states are willing to modify their nurse practice regulations and allow aides to perform paramedical tasks. Nurse practice acts vary by state and the regulations determine which nursing services, including health maintenance tasks, can only be performed by or under the direct supervision of a licensed nurse (Reinhard, 2010). Responding to growing pressure from states with more liberal nurse delegation acts, the National Council of State Boards of Nurses and the American Nurses Association have developed principles and competencies to facilitate and standardize the process for safe delegation of nursing responsibilities (American Nurses Association, 2012; National Council of State Boards of Nursing, 2016). The groups have outlined the responsibilities of the employer/nurse leader, licensed nurse, and the worker to whom the task is delegated and created delegation decision trees for RNs to decide on whether and to whom to delegate a task(s) and what to delegate based on the client's needs and conditions.

There is little research on the impact of nurse delegation regulations on quality of care or its effect on the ability of people to live in the community instead of relying on institutional care (Corazzini, et al., 2010). Some evidence indicates that the expansion of home health and personal care aide scope of practice, particularly in the administration of medication and other treatment plans, would allow them to provide a more well-rounded care while reducing the workload of nurses (Hewko, et al, 2015). There is no research that demonstrates restrictive regulations improve client safety or outcomes.

Funding

One challenge is how to fund standardized training programs for entry-level PCAs and advanced roles. Few states were able to estimate their costs to develop and implement the training programs. Some estimated one full-time equivalent staff person to write the curriculum or facilitate a stakeholder process to develop the competencies and training modules and work with a consultant to write the content. The state incurs implementation costs if they have a role in the oversight and monitoring, maintaining a database of approved instructors or training providers, and/or certification.

One option to fund the programs is to build training and advanced role costs into Medicaid or managed care programs so there is continued funding for training, support for the aide, and increased compensation for the enhanced position. Medicaid reimbursement strategies can incentive providers to create more professional development opportunities for their PCAs (Spetz et al., 2019). Building on pay-for-performance targets dollars to successful programs in home settings that specifically provide advancement opportunities for PCAs. Colorado also can build reimbursement for additional services provided by PCAs when they are part of a coordinated care system. This can help with the additional employer costs for training, support and supervision, and increased wages. These advanced roles potentially result in savings associated with reductions in emergency department visits and hospitalizations that would be realized by Medicare and Medicaid programs. Studies are needed to test whether these advanced roles are associated with these savings, including reduced turnover that is related to quality outcomes and potential savings.

Conclusion

Promising practices exist on developing and implementing entry-level, competency-based training. Partnerships with key stakeholder groups—educational institutions, home care employers, industry associations, labor organizations, and government agencies—can support the development and implementation of standardized training. The brief summarized state efforts and recommendations to develop curriculum and a training program that can serve as a starting point to developing core competencies and training standards. Considerations on the cost and who pays for training will be important factors for the sustainability and access to the training. Medicaid and other funding sources should be leveraged to support this approach and to not place the training costs on the potential workers or employers.

Promising models of enhanced roles for aides need to be scaled-up and tested to make an evidence-based case for sustained investment. Considerations on the training, supervision, new role and responsibilities, removing barriers to fulfilling health maintenance responsibilities, and increased compensation all need to be taken into account for implementing these models and uptake among providers to offer these opportunities.

References

Advanced Home Health Aides Advisory Workgroup. (2015). *Guidance*. Albany, NY: New York State Department of Health. https://health.ny.gov/facilities/home_care/advanced_home_health_aides/

Alaska Administrative Code. (2018). *Agency-Based Personal Care Services Program; Personal Care Assistant Education and Training Requirements*. 7 AAC §125.160. http://www.akleg.gov/basis/aac.asp#7.125.160

Alaska Department of Health and Social Services. (2019). *Personal care services program.* http://dhss.alaska.gov/dsds/Pages/pca/default.aspx

American Nurses Association. 2013. *ANA's Principles for delegation by registered nurses to unlicensed assistive personnel (UAP).* Silver Spring, MD: American Nurses Association. https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principlesofdelegation.pdf

Arizona Department of Economic Security. (2007). *Core curriculum and expansions committee: Summary of Strategic Planning Meeting.* https://web.archive.org/web/20101228231923/https://www.azdes.gov/main.aspx?menu=28&id=702

Arizona Direct Care Initiative. (2011). *Principles of Caregiving.* Retrieved from http://www.azdirectcare.org/Training--DCW_Curriculum.html

Arizona Health Care Cost Containment System. (2014). *Direct care worker training and testing program*. https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/429.pdf

Bates, T., Chapman, S., & Spetz, J. (2018). *Expanding registered apprenticeships in healthcare.* https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/hcap_report_final_111318.pdf

Breslin, M.L. (2018). *Improving support for health maintenance in home and community-based services: How states adopt nursing rules for the Community First Choice Program*. San Francisco, CA: Community Living Policy Center, University of California San Francisco. https://dredf.org/healthcare-access/improving-support-health-maintenance-hcbs/.

California Long-Term Care Education Center. (2016). *Care team integration and training of home care workers*. http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CLTCECHomecareIntegrationTrainingProgram.pdf

Campbell, S. (2018). *Best practices in state-sponsored personal care aide training curricula: Lessons from six states*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2018/11/State-Sponsored-PCA-Curricula-2018-PHI.pdf

Campbell, S. (2017a). *Training standards for personal care aides: Spotlight on Arizona*. Bronx, NY: PHI. Retrieved from https://phinational.org/resource/training-standards-for-personal-care-aides-spotlight-on-arizona/

Campbell, S. (2017b). *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

Choitz, V., Helmer, M., & Conway, M. (2015). *Improving jobs to improve care: The SEIU Healthcare NW Training Partnership.* Washington, DC: The Aspen Institute.

https://assets.aspeninstitute.org/content/uploads/2017/05/SEIU-CaseStudy.pdf?_ga=2.192212586.1168692654.1596639402-2090877988.1596639402

Coffman, J.M.& Chapman, S.A. (2012). *Envisioning enhanced roles for In-Home Supportive Services workers in care coordination for consumers with chronic condition: A concept paper*. California: Philip R. Lee Institute for Health Policy Studies and the Center for Personal Assistance Services, University of California, San Francisco, and the Center for Labor Research and Education, University of California, Berkley.

Colorado Department of Public Health and Environment. (2015). *The health of Colorado's older adult population: Data infographic*. https://www.cohealthdata.dphe.state.co.us/chd/Age/Healthy-Aging-in-Colorado-Infographic.html.

Colorado Health Institute. 2020. *Closing the care gap: Opportunities for employers to support and grow Colorado's direct care workforce*. Denver, CO: Colorado Health Institute. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/Closing%20the%20Care%20Gap%20FINAL.pdf

Corazzini, K.N., Anderson, R.A., Rapp, C.G., Mueller, C., McConnel, E.S., & Lekan, D. (2010). Delegation in long-term care: Scope of practice or job description? *Online J Issues Nurs*., *15*(2), Manuscript 4.

Drake, A. (2019). How 'upskilling' can maximize home care workers' contributions and improve serious illness care. *Health Affairs Blog.*

Enquist, G., Johnson, C., Lind, A., & Barnette, LP. (2010). *Medicaid-funded long-term care: Toward more home- and community-based options*. Hamilton, NJ: Center for Health Care Strategies, Inc. https://www.chcs.org/resource/medicaid-funded-long-term-care-toward-more-home-and-community-based-options/.

Gomez, A. (2019). *Aging in communities in COLORado*. Denver, CO: Colorado Health Institute. Retrieved from https://www.coloradohealthinstitute.org/blog/aging-communities-colorado

Gleason, H. & Coyle, C. (2016). *Mental health supportive home care aide training*. Home Care Aide Council. http://commcorp.org/wp-content/uploads/2016/07/hcwtf-planning-grants_home-care-aide-council-report.pdf

Government Performance Solutions, Inc. (2019). Senate Bill 19-238: Improve Wages and Accountability for Home Care Workers: Recommendations regarding home care worker training and notification of compensation and wage changes. Denver, CO: Department of Health Care Policy & Financing.

Heineman, J.M., Washko, M., Gottlieb, A., & Wilson, K. (2008). *The qualitative evaluation of ECCLI: Research and evaluation brief*. Boston, MA: Commonwealth Corporation.

Hewko, S. J. et al. (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.

Home Care Aide Council. (2016). *Mental health supportive home care aide training*. https://cdn.ymaws.com/www.hcacouncil.org/resource/resmgr/Grants/Fact_Sheet-_Mental_Health_SH.pdf

Koeh, D., Lerman, R., Eyster, L., Anderson, W., Khatutsky, G., & Wiener, J. (2011). *Characteristics of long-term care registered apprenticeship programs: Implications for evaluation design.* Washington, DC: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation.

https://aspe.hhs.gov/execsum/characteristics-long-term-care-registered-apprenticeship-programs-implications-evaluation-design

Kuwik, A. (2020). *Colorado's direct care workforce*. Denver, CO: The Bell Policy Center. https://www.bellpolicy.org/2020/01/21/colorado-direct-care-workforce/

Landers, S., Madigan, E., Lee, B., et al. (2016). The future of home care: A strategic framework for optimizing value. *Home Health Care Management Practice*, *28*(4), 262-278.

Lerman, R., Eyster, L., and Kuehn, D. (2014). Can we upgrade low-skill, low-wage occupations? The case of apprenticeships in the long-term care occupations. *Journal of Women,Politics & Policy, 35*(2):110–132. https://doi.org/10.1080/1554477X.2014.890835

LongTermCare.gov. (2017). *How much care will you need?* Washington, DC: U.S. Department of Health and Administration on Aging. Retrieved from https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html.

Luo, H., Lin, M., and Castle, N. (2012). The correlates of nursing staff turnover in home and hospice agencies: 2007 national home and hospice survey. *Research on Aging*, *35*(4), 375-392. https://doi:10.1177/0164027512443072

Maine Department of Health and Human Services. (2019). *Personal support specialist student training program.* https://www11.maine.gov/dhhs/dlc/licensing/pss/documents/9-PSS-Training-Curriculum-2019.pdf

Maine Direct Service Worker Training Program. (2017). *Maine direct service workers: A guide to job titles.* http://mainedirectserviceworker.org/files/docs/MDSWAGuidetoJobTitles.pdf

MedPAC. (2019). *Home health care services*. http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch9_sec.pdf?sfvrsn=0

Misiorski S. (2018). "Creating career paths for nursing and home health workers." PowerPoint presented at LeadingAge Annual Meeting, Philadelphia, PA, October 29, 2018.

Morris L. (2009). Quits and job changes among home care workers in Maine: The role of wages, hours, and benefits. *The Gerontologist*. *49*(5): 635–650.

National Council of State Boards of Nursing. 2016. National guidelines for nursing delegation. *Journal of Nursing Regulation, 7*(1), 5-14.

New York State Department of Health. (n.d). *Advanced home health aides: Chapter 471 of the laws of 2016*. https://www.health.ny.gov/facilities/home_care/advanced_home_health_aides/

New York State Department of Health. (2007). *Home care health related tasks curriculum.* https://www.health.ny.gov/professionals/home_care/curriculum/docs/health_related_tasks_curriculum.pdf

New York State Department of Health. (2017, May 9). *In-service requirements for Home Health Aides and Personal Care Aides. [Letter to administrators]*. http://leadingageny.org/home/assets/File/4F173E21B75300A8E053C0A80FB100A8(1).pdf

New York State Department of Health. (2019). *Advanced home health aide agency requirements*. https://www.health.ny.gov/facilities/home_care/dal/docs/19-02.pdf

Ordway, A., Johnson, K., Kneale, L., Amtmann, D., & Deniris, G. (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. Doi.org/10.1177/0898264319860298

PHI. (2019). *Personal care aide training requirements*. https://phinational.org/advocacy/personal-care-aide-training-requirements/

PHI. (2020). *Workforce Data Center*. Last modified August 30, 2019. https://phinational.org/policy-research/workforce-data-center/

Reinhard, S. (2010). A case for nurse delegation explores a new frontier in consumer-directed patient care. *Generation*, *4*(7), 75-81.

Scales, K., Sturgeon, J.M., Espinoza, R., Campbell, S., & Cook, A. (2018). *Envisioning the future of home care: Trends and opportunities in workforce policy and practice*. Report to Gordon and Betty Moore Foundation. California: Gordon and Betty Moore Foundation.

Scales, K. (2020). *It's time to care: A detailed profile of America's direct care workforce*. https://phinational.org/resource/its-time-to-care-a-detailed-profile-of-americas-direct-care-workforce/

St. John's Well Child & Family Center, ULTCW SEIU, & United Long-Term Care Workers. (2014). *St. John's enhanced home care pilot program. California: St. John's Well Child & Family Center, ULTCW SEIU, & United Long-Term Care Workers.*

Stone, R. (2017). Developing a quality direct care workforce: Searching for solutions. *Public Policy & Aging Report, 27*(3)*,* 96-100. https://doi.org/10.1093/ppqr/prx015

Virginia Administrative Code. (2017). *12VAC30-120-930 General requirements for home and community-based participating providers*. https://law.lis.virginia.gov/admincode/title12/agency30/chapter120/section930/

Virginia Department of Medical Assistance Services. (2003). *Personal care aide training curriculum.* http://leg5.state.va.us/reg_agent/frmView.aspx?Viewid=3a946000964~1&typ=40&actno=000964&mime=application/pdf

Washington Administrative Code. (2019). *Home and community services and programs. 388 WAC §71.* https://app.leg.wa.gov/wac/default.aspx?cite=388-71

Washington State Department of Social & Health Services. (2015). *Revised fundamentals of caregiving: Learner's guide, second edition*. https://www.dshs.wa.gov/sites/default/files/ALTSA/training/DSHSCurriculum/RFOC.pdf