

**Enhancing Competency, Increasing  
Mobility, Improving Care:  
The Value of Statewide Home Care  
Training and Credentialing Systems**



**2023 Home and Community-Based  
Services Conference**

# Introductions

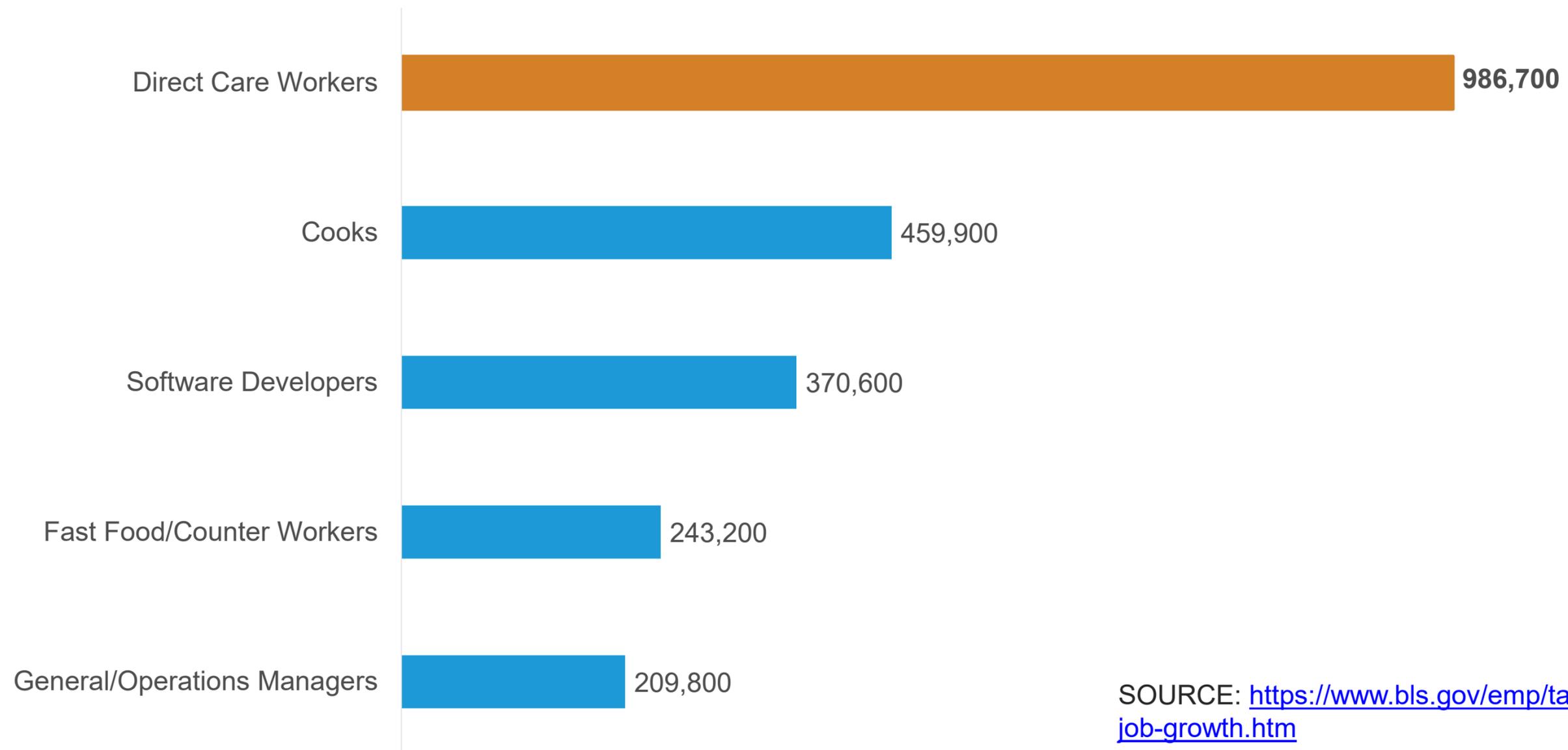
## Moderator:

- Kezia Scales, PHI

## Panelists:

- Kevin Coughlin, Wisconsin Department of Health Services
- Trish Farnham, North Carolina Coalition on Aging
- Jake McDonald, PHI (with Clare Luz, IMPART Alliance and Michigan State University)

# The direct care workforce will add more new jobs than any other occupation within the next decade (2021-2031).



SOURCE: <https://www.bls.gov/emp/tables/occupations-most-job-growth.htm>

# Long-Standing Workforce Challenges

- Median hourly wage = \$15.43; median annual earnings = \$23,688
- Two in five direct care workers live in or near poverty (39%); 46% rely on public assistance
- Limited benefits: 13% without health insurance; very limited access to paid leave, retirement savings
- Limited training and few career development opportunities, often inadequate support and supervision on the job

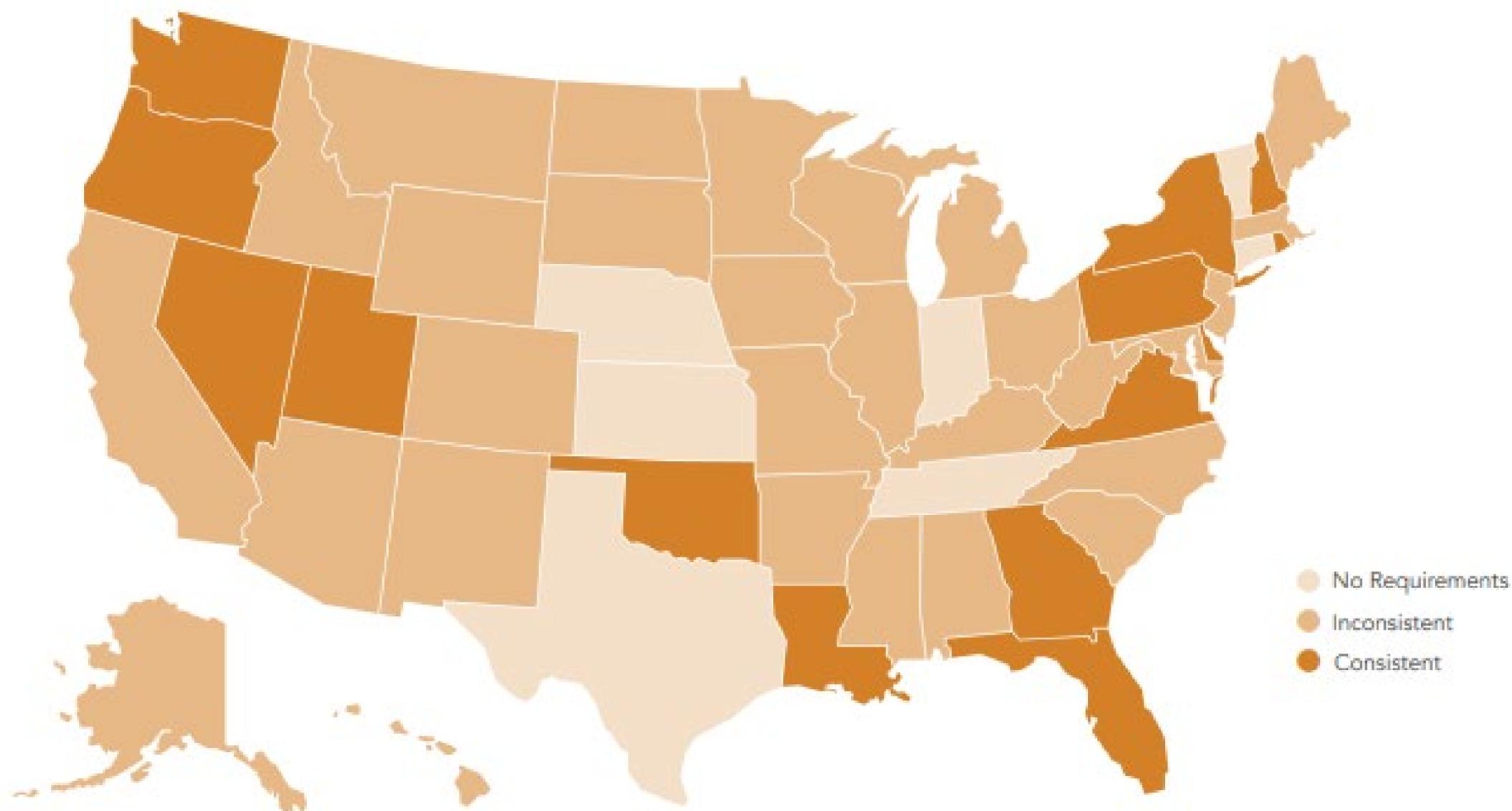


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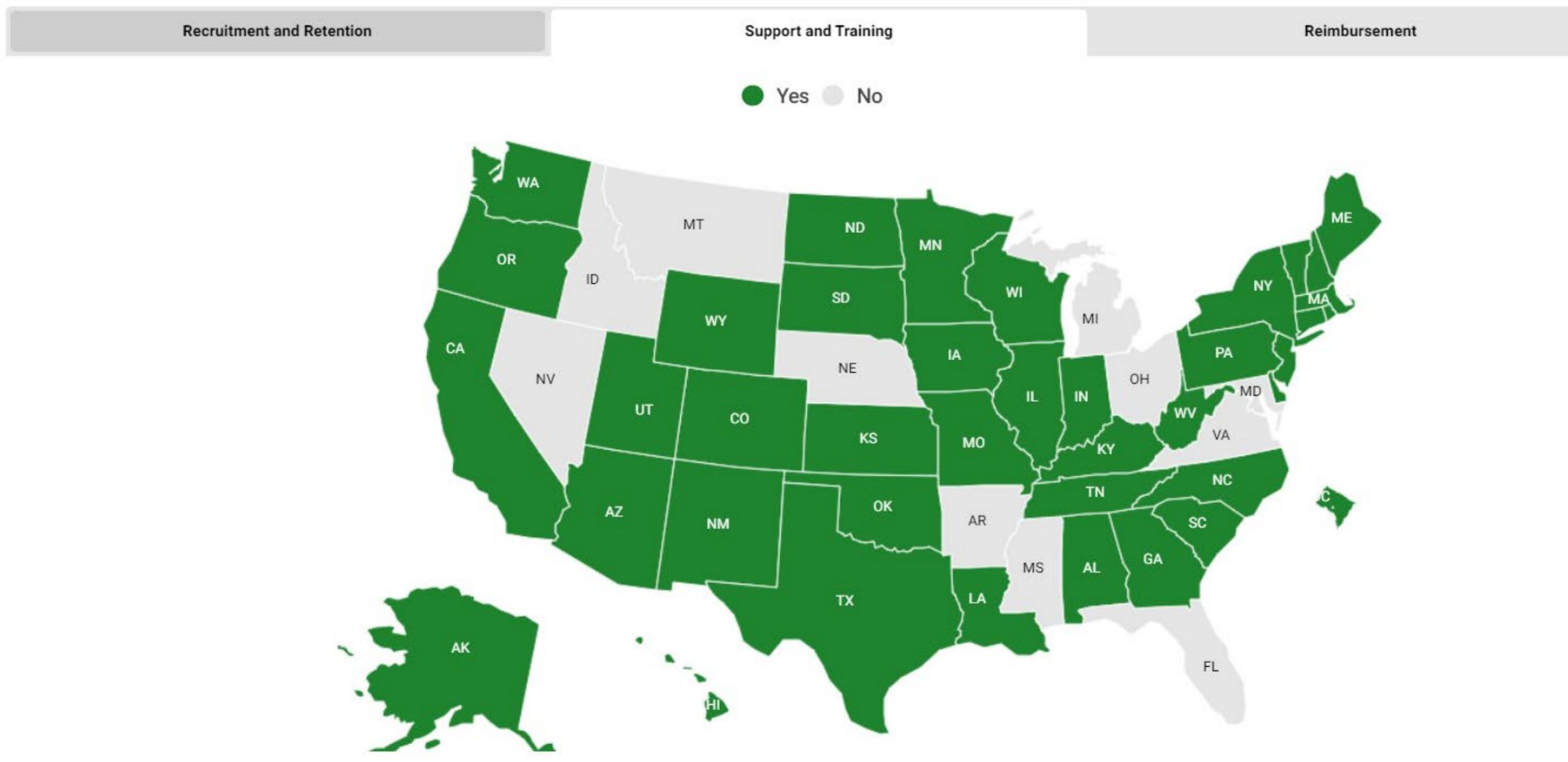


## Training standards for personal care aides vary widely across and within states.



SOURCE: <https://phinational.org/advocacy/personal-care-aide-training-requirements/>

# Momentum for Change: American Rescue Plan Act HCBS Spending Plans



SOURCE: <https://nashp.org/states-use-american-rescue-plan-act-funds-to-strengthen-home-and-community-based-service-workforce/>



# WisCaregiver Careers

A professional workforce advancement program.



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# Background

## Direct Care Workforce Crisis

**1 in 4 direct caregiver positions**  
**are vacant**

**20,000 additional home**  
**care workers needed by 2024**

**>50% Wisconsin's**  
**annual caregiver turnover**



# Components of the Direct Care Workforce Project



- MFP Supplemental and ARPA HCBS
- State of the Workforce (SoTW) Surveys
- Certified Direct Care Professional (CDCP) program
- WisCaregiver Connections, a platform connecting job seekers with employers
- Innovation Grants

- Online self-paced - FREE
- Estimated 30 total hours
- 14 competencies



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# Caregiver Recruitment

- ARPA funded vouchers to cover training for ~10,000 Certified Direct Care Professionals
- ARPA funded sign-on and stay-on bonus (\$250) and retention bonus (\$250)



# Ladders and Lattices

- Wisconsin DQA – Approved CNA training, Crosswalks to Assisted Living, Personal Care.
- [Wisconsin HOSA](#)
- [Regional Career Pathways](#)
- [Youth Apprenticeship](#)



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# Work Settings

Various HCBS options:

- Non-medical home care
- IRIS (self-directed) - One-on-One Care
- Adult family homes
- Community-based residential care facilities
- Residential care apartment complexes



# WisCaregiver Connections - Workforce IT Platform

- One stop workforce portal
  - Job postings
  - Auto-match employers with job seekers
  - Candidate profiles
  - Credentialing details
  - Training opportunities
  - Employer and other key stakeholder resources
  - Educator and student resources
  - Resource library, and more.

# Caregiver Recruitment – Marketing Campaign

- Branding WisCaregiver Careers

- Dedicated website
- Social Media
- Videos
- Print ads
- Radio
- Listserv
- And more .....



- Green Bay Packer Partnership



# National Recognition

- [PHI - Will Wisconsin's Direct Care Program Change the Field?](#)
- [Badger State aims to recruit 10,000 home care workers with on-line training program](#)
- [Real Problems, Real Solutions to the Long-Term Care Crisis](#)
- [As Worker Shortages Loom, Some States Move to Train Paid Caregivers](#)
- [Free program offers streamlined path to direct care professional certification](#)



# Resources

- Website: <https://www.dhs.wisconsin.gov/caregiver-career/index.htm>
- Student/Provider recruitment website: <https://www.wiscaregivercdcp.com/>
- Competencies: <https://dhs.wisconsin.gov/publications/p03320.pdf>
- Program fact sheet: [English](#)(PDF) | [Hmong](#)(PDF) | [Spanish](#)(PDF)
- Innovation Grants: <https://www.dhs.wisconsin.gov/arpa/hcbs-grantsopportunities.htm>



## Kevin Coughlin, DHS

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Division of Medicaid Services

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# *Enhancing Competency, Increasing Mobility, Improving Care: The Value of Statewide Home Care Training and Credentialing Systems*

Insights from North Carolina: The WECARE Project



# WECARE's Origin Story

## Essential Jobs, Essential Care-NC



Essential Jobs, Essential Care™™ is PHI's signature multi-state advocacy initiative that works closely with state leaders to advance policy reforms on the direct care workforce. From 2020-2022, PHI worked closely with the NC Coalition on Aging to design and co-lead a 3-year advocacy initiative focused on improving these essential jobs

Continued support is thanks to the Z. Smith Reynolds Foundation.



# WECARE: Workforce Engagement with Care Workers to Assist, Recognize, and Educate

- Partners: Duke University (project lead), NC Coalition on Aging, National Domestic Workers Alliance-NC, PHI, and Appalachian State University (evaluation)
- Funding: *Money Follows the Person* funds awarded and administered by the Center for Aging Research and Educational Services (Cares) at the UNC-Chapel Hill School of Social Work
- Main aim: Use a collective impact framework to develop and test a **training, credentialing, and job quality model** for improving direct care jobs in NC (focusing on HCBS)

Duke | SANFORD SCHOOL of  
**PUBLIC POLICY**



Additional Partners and  
Community Members

# WECARE Project Goals

**1** Identify direct care core competencies and curricula reflecting competencies

**2** Optimize a training and credentialing approach for direct care workers in NC

**3** Identify high-road HCBS employers and tools to support direct care workers

**4** Implement an awareness and community outreach effort

**5** Pilot the training, credentialing, and support model from # 1 and # 2

# The WECARE Training Crosswalk Analysis

Working with partners and subject matter experts to analyze and compare training content, format and regulatory requirements for comparable but distinct direct care workforce categories through a person-centered training lens:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
					Note: In Home Care Licensing rule (15A NCAC 132), In-Home Aide & In-Home Companion/Other also considered under Umbrella Title of "In-Home Caregiver" (see Definition (14))						DSP (See 15A NCAC 270, Innovations Waiver COP)			DSP State Funded (Is there any federal, state or private funding?)	DSP FIC/DED	
Direct Care/Support Worker Description	(Added 4/30/22): NA	(Added 4/30/22): NA+H	Nurse Aide I (for facility-based services)	Home Health Aide/In-Home Aide (Substitute Hands On Assistance)	In-Home Aide (Limited Hands On Assistance)	PHCAST Level 1	In-Home Companion/Other (under Home Care Licensing Rule)	Personal Care Aide for Adult Care Homes (and Family Care Homes)	DSP Innovations (In-home service Community Living and Supports as essential)	DSP Innovations (In-home service Supported Living as essential)	DSP Innovations Residential	Self-Directed-Innovative	Self-Directed-CAPDA			
Person-Specific Training Requirement?	No, although NC BCN strongly advises competencies be demonstrated in a clinical setting for a simulated environment.	No	General training is not typically tailored to person but agencies may require person-specific training (like Hoyer 10 day). Also, Provider RN sign-off required to validate NA's competency to perform any delegated task. Agency has flexibility in how to evaluate competencies (sometimes simulated, sometimes client-specific). RN/PLN Supervision is usually. Nurse Practice Act does not specify physical demonstration. Note: accreditation may also have impact. Note: check CMS admin re additional to CPR reqs.	NA has to sign off on competencies but can do so with other client specifically or in simulated setting THROUGH PHYSICAL DEMONSTRATION. To a mix of agencies evaluating competency in simulated and others doing person-specific competency no set standard. And agencies may offer to train. Both simulated and both 11. Agency practice determined by agency policy. Home care agencies required to conduct supervisory visit every 90-days and at least 1 x a year (1 of the 90 day visits) that are needs to be present at supervisory visit. NOTE: CAPC requires 90 day supervision and 2x for aide present.	NA has to sign off on competencies but can do so with other client specifically or in simulated setting, as determined by agency policy. Conducts supervisory visit every 90 days. Aligned with in-home interdisciplinary experience requirements.	88 hours is standard but additional trainings may be required if aide will be supporting person with specific needs outside what is covered in the PCA training. (eg LHPD skills-let in rule)	88 hours is standard but additional trainings may be required if aide will be supporting person with specific needs outside what is covered in the PCA training. (eg LHPD skills-let in rule)	88 hours is standard but additional trainings may be required if aide will be supporting person with specific needs outside what is covered in the PCA training. (eg LHPD skills-let in rule)	Service definition requires that DSP be "Qualified in the customized needs of the beneficiary as described in the DSP". Provider is responsible for ensuring DSP is trained on person's specific supports and trained in the specific dimensions of the person's support needs. Different providers do it differently.	Confers to this is typically accomplished (service definition: staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the DSP)	Qualified in the customized needs of the beneficiary as described in the DSP? Provider is responsible for ensuring DSP is trained on person's specific supports and trained in the specific dimensions of the person's support needs. Different providers do it differently. In licensed setting, must show evidence of training and understanding of DSP before supporting person (Monitoring tools outlined). Required documentation of supervision plan and ongoing supervision by QP (Rule just says "ongoing," but DHR typically expects monthly). No target (?) a required amount of time for supervision.					Yes, it's all person-specific.
Training Requirements Authority Source(s)	Managed Under 21 NCAC 38 (Occupational Licensing Boards and Commissioners, Board of Nursing). Chapter 21 NCAC 38-0322 (Qualifications)	21 NCAC 24M. See NC BCN Rules Aide + 1 Process	Nursing Facility Requirement to Employ Nurse Aides (15A NCAC 130-2300) NOTE: include 15A NCAC 130-2300-CP. See also: 42 CFR 483.101. State review and approval of nurse aide program and necessary criteria regarding to 28A3-604.102 Requirements for approval of a nurse aide program (28A3-604.102) 483.104 Nurse aide competencies (28A3-604.104) 483.105 Nurse aide supervision (28A3-604.105) Authority to set training requirements and evaluation within the parameters established in federal rule. NC's training requirements exceed federally mandated 75 hours. There are no separate, state specific training requirements established in NCAC or NCOS. Higher state hour requirement required to be submitted to DHR (has consistently required higher level-relevant and/or. See also 21 NCAC 38-0322. Qualifications for NA1 and NA 2)	Home Care Licensing Rules, generally (15A NCAC 132), In-Home Aide/Personal Training Requirements see (15A NCAC 132-1001). See also In-Home Aide Services (15A NCAC 132-1101). See also In-Home Companion/Other (15A NCAC 132-1102). See also 42 CFR 483.101. See also 28A3-604.102. See also 28A3-604.104. See also 28A3-604.105.	Home Care Licensing Rules, generally (15A NCAC 132), In-Home Aide/Personal Training Requirements see (15A NCAC 132-1001). See also In-Home Aide Services (15A NCAC 132-1101). See also In-Home Companion/Other (15A NCAC 132-1102). See also 42 CFR 483.101. See also 28A3-604.102. See also 28A3-604.104. See also 28A3-604.105.	Home Care Licensing Rules, generally (15A NCAC 132), In-Home Aide/Personal Training Requirements see (15A NCAC 132-1001). See also In-Home Aide Services (15A NCAC 132-1101). See also In-Home Companion/Other (15A NCAC 132-1102). See also 42 CFR 483.101. See also 28A3-604.102. See also 28A3-604.104. See also 28A3-604.105.	Home Care Licensing Rules, generally (15A NCAC 132), In-Home Aide/Personal Training Requirements see (15A NCAC 132-1001). See also In-Home Aide Services (15A NCAC 132-1101). See also In-Home Companion/Other (15A NCAC 132-1102). See also 42 CFR 483.101. See also 28A3-604.102. See also 28A3-604.104. See also 28A3-604.105.	NOTE: Comparable rules govern Adult Care Homes and Family Care Homes. For simplicity, Adult Care Home rules are listed here. See NCAC 130-0202, SNAF, CROGNATION, TRAINING, COMPETENCY AND CONTINUING EDUCATION (see specifically 2021-0827, and 15A NCAC 130-0202 LICENSED HEALTH PROFESSIONAL SUPPORT)	See Innovations Clinical Coverage Policy BP. Not subject to 15A NCAC 270, per DHR, MCI XI	See Innovations Clinical Coverage Policy BP, MCI XI	See 15A NCAC 270.800 (SUPERVISORY/PROF DEVELOPMENT OF ALL DISABILITY GROUPS) See Innovations Clinical Coverage Policy BP, MCI XI			See CAP DA, COP (v.2) specifically Personal Assistance Services (2.4.12) 2.4.12.1.1.1.1.2 + Service Definition in Appendix B) From Service Definition for Personal Assistance Services (COP Appendix B, pg. 128 (g)) Consumer-directed providers must: a. complete a clinical background and registry check prior to hire and payment of payroll; and b. demonstrate competencies and skill sets to care for the CAPDA beneficiary as documented by the consumer-directed beneficiary or responsible party. (The competency documentation is updated in the case file using the CAP Business System to inform the financial management agency of the readiness to hire and pay the selected employee (personnel assistance). Documentation must be provided when training and education services are needed and documentation is available to support training needs were met. To clarify with Jon In-Home Aide Provider requirements (pg 98, 6.4.7) has reference to self-directed services- is this if a self-directed person chooses to hire staff through an agency (before triggering home care rule)?		
Are they impacted by a public registry?	Yes-NA 1 Registry created by NC BCN, but compliance tied to NC DHR. Must also be on NA 1 Registry managed by DHR. Subject to Health Care Personnel Registry.	Yes	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry, CDP-908. If an individual is a Medication Aide, must be on the NC Medication Aide Registry. This NA registry is distinct from the Medication Aide Registry in Adult Care Homes.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.	Yes-NA 1 Registry managed by DHR; being carried on umbrella may be impacted but not explicitly required to be on Registry. NA 1 also subject to Health Care Personnel Registry.
General Description of How Training is Conducted/Credentialed (Second if applicable)	Managed by NC BCN approved Course. Training programs must receive formal NCBCN approval to provide NA 1 training. Three types of NA 1 Training programs: Community College including HS "Career and College Program", not associated with CPE Licensed Care Agencies (e.g. Health Services, Proprietary Schools. Most facilities are LTC facilities for clinical site (if clinical facility established, moving to "out of the box" settings like specialty clinics).	Person must be NA1. Provider organization may select to teach up to 4 NA 1 skills to provide NA 1. Training must be based on NA 1 training modules + skills competency validation. Providers are not required to seek prior approval. May be subject to track back review to ensure compliance with requirements. Provider may be authorized to track the 4 selected skills. If used to teach a different skill, they may substitute out one of the selected 4.	Must receive state-endorsed training from training entity and pass competency exam with program AND state-endorsed state exam. Note: the training does not fully align with what is being asked on the written exam. State offers training programs to develop own (selected) skills or skills existing (but state exam has very specific "step by step" process checklist of all NA 1 candidates are evaluated based on criteria set forth in NC Nurse Aide Candidate Handbook. NA candidates are required to demonstrate competency, general competency, 5 selected of 28 (7) tasks, and 11 functional skills. Other candidates are competent to perform client care tasks or activities designated by agency policy for the vendor and current vendor. Confirms New North provincial alternative skills.	From 15A NCAC 132-1102 "Each agency shall document that its caregiver and other are competent to perform client care tasks or activities designated by agency policy for the services assigned." 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NC: Not subject to training/evaluation of skills by RN.
Added 4/30/22: Typical payers for required training	Depends on pathway. May get tuition reimbursement. Under 2 approving provider agency pays for staff time to return to school to receive their NA 1.	Confirms: providers for the additional 4 tasks, under NA 1, would depend on provider and NA history.	Prayer for training depends on why person is being trained. If provided at high school, training/instruction is covered by school. States do not require to pay. For courses (other state requires), that there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.	Not yet consistently standard practice. But there are providers who pay the tuition to get to NA 1. More and more are doing that. (Requis, Post Light, Right at Home), but as clear that they are paying for staff's train.
Is Resulting Credential Portable (e.g. recognized by another employer under same training/credentialing)	Would still need to be on NC's NA 1 registry and NA 1 not provided in LIS - possibly NC is only one? (NOTE: in other states train activities in NA 1)		Yes, NA 1 credential ports to any other provider/setting/person which requires NA 1 for services. Whether NC has reciprocity for NA 1 credential is for other states is variable. Interstate reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.	Yes, DHR/NCOS is long as well through state approval. Reciprocity a little sketchy-allowed under COVID flexibility, but reciprocity appears to only be allowed if the training is provided in a state that has reciprocity with NC.

- Nurse Aide I and II
- In-home Aide (NA 1)
- In-Home Aide—Limited
- Personal Care Assistant (Adult Care Home)
- Direct Support Professionals under Innovations waiver
- Support under Self-Directed Supports
- Does not include all direct care worker categories in NC

# The WECARE Core Competency Analysis

COMPETENCY THEMES IDENTIFIED ACROSS ALL COMPETENCIES REVIEWED IN ENVIRONMENTAL SCAN	CMS DSW Core Competencies	Nurse Aide I (for facility-based services)	Home Health Aide/In-Home Aide (Extensive Hands On Assistance)	In-Home Aide (Limited Hands On Assistance)	PHCAST Level II	Personal Care Aide for Adult Care Homes (and Family Care Homes)	DSP-Innovations [in-home service Community Living and Supports as example]	DSP-Innovations--[i n-home service Supported Living as example]	DSP-Innovations Residential	Self Directed-CAP DA	Listening Sessions to Date-- Direc Care Workers: Identified Themes
Communication	x	x	x		x	x	x	x	x		X
Job duties	x	x	x	x	x	x	x	x	x		X
Person centered services	x	x	x		x	x	x	x	x		X
Background	x	x	x		x	x	CONFIRM (Behavioral Support Trainings)				X
Cultural competency	x						x	x	x		
Safety	x	x	x		x	x	x	x	x		
Ethics	x	x	x		x	x	x	x	x		X
Consumer growth and wellbeing	x	x	x		Confirm	x	x	x	x		X
Professional development	x				x		x	x	x		X
Professionalism	x	x	x		Confirm (Finding and Keeping DCW Job?)		x	x	x		
Consumer and FCG role										[Must] demonstrate competencies and skill sets to care for the CAP/DA beneficiary as documented by the consumer-directed beneficiary or responsible party.	X
Self care					x (Coping Skills)						X
Planning											

Working with partners and subject matter experts to examine training requirements through the lens of established core competency sets, including CMS' HCBS Core Competency Set.

## A Few Things the WECARE Team Has Heard...

"I didn't feel prepared at all, I felt thrown in with the client."

-direct care/support worker

"I was looked at as a housekeeper and I wasn't expecting that as a Home Health Aide."

-direct care/support worker

"We often build our 'core competencies' from our regulatory system requirements. We should start with the relationship between person using services and the direct support worker."

-provider and trainer

"We want a personality fit over a service delivery fit."

-person using direct support services

"There is a disconnect between the level of expectations and the level of compensation."

-family member

"People sometimes start doing the work and they realize it's a lot more challenging than what they thought it was going to be—that it's not just caregiving or babysitting. I think that's why we lose a lot of people---they're not trained and they don't know what to expect. People look at the online ads for a "caring person" and they think that's the extent of the job—that you're going to just sit with the person for a while."

-direct support worker/manager

# Preliminary Observations

- > Crosswalk is first comprehensive resource on training and credentialing requirements for direct care workers in North Carolina.
- > Findings have been immeasurably strengthened through ongoing and in-depth community partner engagement and input.
- > Strong training models exist in our state, thanks to previous demonstration projects and current standards/practice (e.g. 120 hours for NAI role, home care aide specialty role).
- > Training and credentialing requirements for direct care workers are exceedingly complex, overall: numerous roles/programs, multiple authorities and oversight, several different registries.
- > There is very little portability of credentials across settings/programs.
- > There are limited incentives for employers or workers to pursue additional training/credentials (e.g., geriatric aide), because no additional funding.

## Preliminary Observations, cont'd.

- > Lack of flexibility in training requirements: relevant experience cannot count toward training/credential.
- > There is inconsistent application of training requirements; staff supporting the same person may be subject to different requirements depending on service.
- > There is uneven integration of person-centered/person-specific training.
- > Core competencies re: cultural competency, role determinations, self-care and planning appear least represented in current training landscape.
- > In-home aides providing limited assistance appear to be the area with the most opportunity for support.
- > From listening sessions: "Relational" core competencies (communication, respect, etc.) were identified as high priorities.

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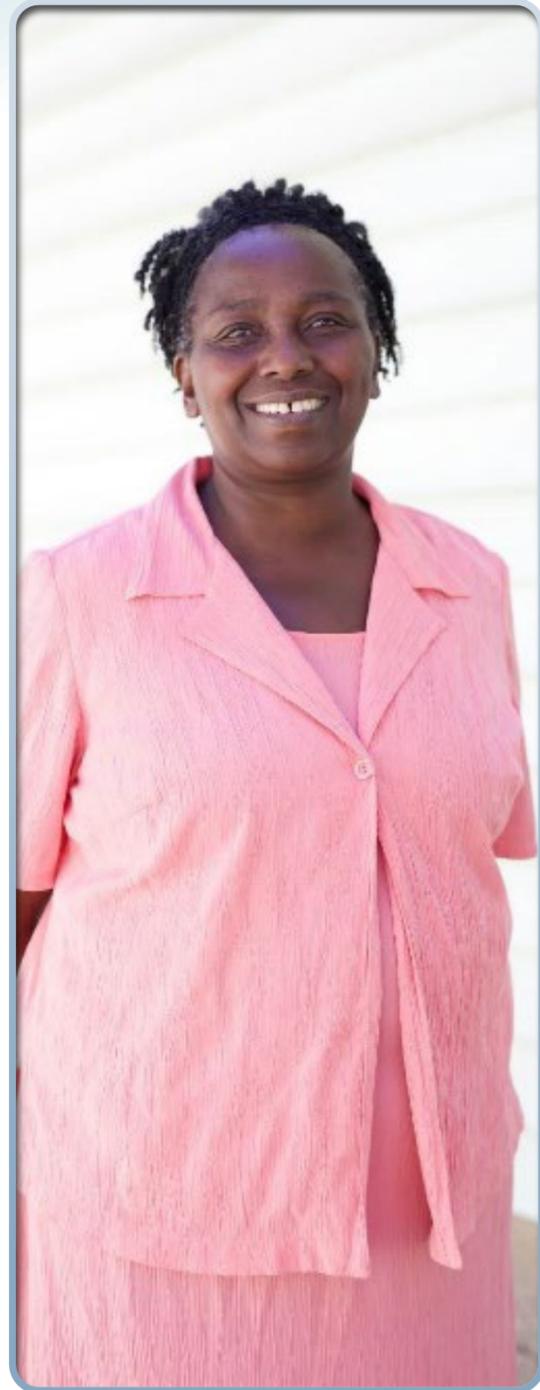


# Statewide Home Care Training & Credentialing: Michigan

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# Guiding Principles: Requirements for Success



- Coordinated, strategic, inclusive, statewide leadership and a plan to address a statewide problem rooted in historical and systemic structures. Ultimately, the plan needs to lead to economic security and respect for DCWs.
- Strong relationships across all stakeholders, built on ongoing communication, respect, and trust
- A Common Definition of DCW
- Agreement to advocate for all DCWs on joint initiatives vs. one segment of DCWs
- Understanding that the reasons, and the solutions, for the DCW shortage are interrelated and therefore need to be addressed simultaneously.

# Who are Direct Care Workers (DCWs)?

- Provide essential services through behavioral health, community mental health and long-term care systems to support older adults and individuals with long-term disabilities or post-acute care needs in a range of settings including private homes, group homes, assisted living facilities, nursing homes, and community living supports settings.
- Go by many titles including, but not limited to, certified nursing assistants, home health aides, Home Help providers, hospice aides, personal care assistants, direct support professionals, self-directed home care workers, and home care companions.
- Distinguished by core tasks shared by most DCWs that generally include assisting with hands-on personal care, activities of daily living, instrumental activities of daily living, vocational assistance, rehabilitation, and community living supports.
- Are paid primarily through Medicaid but may also be covered by private insurance, Older Americans Act funds, Medicare, directly by individuals, or other funding sources.

# Why is there a DCW Shortage?

## *Lack of economic security* due to:

- Low wages & benefits
- Lack of guaranteed hours versus high caseloads
- Lack of training
- Lack of career advancement options
- Lack of societal value placed on direct care work
- Institutional & historical racism, sexism, agism, and discrimination against immigrants and persons with disabilities

## Three Primary Strategies to raise economic security, equity, and respect

- Increase Wages & Benefits
- Professionalize the DCW Workforce by establishing:
  - Competencies, Professional, and Ethical Standards
  - Training Guidelines & make training accessible and affordable
  - Credentials
  - Career Pathways
- Cultural Change - Increase the value placed on direct care work



# MDHHS DCW Advisory Committee

## Competency, Education & Credentialing Workgroup

### GOALS

Competency Guidelines for skills needed to work across all settings, payors, programs and populations served

- Professional and Ethical Standards
- Education and Training Guidelines
- Career Pathways including 3 new, stackable categories of DCWs each with their own credential
- Credentials that are competency based – not tied to training.
- Career success models



# Three New Categories of DCWs under Consideration

**Stackable Levels** each with associated competencies & credentials

- Direct Care Associate
- Home and Direct Care Specialist
- Certified Direct Care Worker

## **Value Added**

- Are based on person-centered principles
- Identify baseline competencies that all DCWs should have
- Establish a credential that recognizes the important skills and work of DCWs who are often referred to as “Companions”, as well as for those who provide invaluable IADL support in home settings. Neither of these currently exist
- Establish credentials that align with all the state supported DCW Competency Guidelines



# New DCW Categories and how each level maps to the State-Supported Competencies

	State-Supported Competencies	Level 1: <i>Direct Care Associate</i>	Level 2: <i>Home &amp; Direct Care Specialist</i>	Level 3: <i>Certified Direct Care Worker</i>	Possible Specialty Certificates
1	Role of a DCW	Introduction to DCW	Specific Client Populations		→ End of Life
2	Professionalism	DCW Ethical Code Client and Worker Rights Privacy/Confidentiality/HIPAA	Case examples related to IADLs	More advanced case examples related to ADLs and practicum	→ Advanced Dementia → Autism
3	Person-Centered Thinking and Practice	Intro to Person Centered Thinking (PCT) & Relationships Importance of trust and feeling safe	Person Centered IADL Support Case examples. Demonstrating ability to build trust	PCT ADL Support Advanced cases examples and practicum	→ Mental Health → Limited English Proficiency
4	Communication	Effective communication strategies; Professional boundaries; Communicates with supervisor & team as needed	More advanced case examples, client population specific, IADL related; specialty communication; use of technology	More advanced case examples, ADL related, practicum	→ CPR, Emergency Response → Mental Health Crisis
5	Evaluation and Observation	Reporting changes in physical, mental, or behavioral condition	Reporting changes, advanced, population specific	Reporting change, advanced, ADL specific, practicum	→ Medication Administrator → Vital Signs
6	Crisis Prevention and Intervention	Mandatory reporting, Critical thinking; Emergency situations, Introduction to Trauma	Responding to urgent problems, mental status & behavior changes	Crisis Intervention Trauma II	→ Medication Administration → Job Coaching
7	Safety	Infection Control & Bloodborne Pathogens I; Abuse & Neglect; Risks & Safety Promotion, Knows when to call 911	Body Mechanics; Infection Control II. Knows how to respond to different risks. PPE Use.	Advanced critical thinking Dementia II Mental Illness II Substance use	→ Transfer Lifts → Advanced Intellectual & Developmental Disabilities (I/DD)
8	Participant Empowerment	Focus on abilities, provides choice. Understands Dignity of Risk	Caring for diverse populations. PCT IADL support	Person-centered ADL support; I/DD II, Mental Illness II	→ Advanced Mental Illness
9	Health and Wellness	Intro to Dementia, Intro to Mental Illness, Intro to I/DD, Meaningful Activities	IADLs – cleaning, shopping, meal planning. Medication support	Body Systems Skin and wound care	→ Advanced Trauma
10	Independent Living Skills	Works in partnership with person & team	IADLs - Home Care, Meals; assess for environmental challenges	ADL Skills – bathing, transfers, dressing, etc.	→ Self-Determination
11	Family & Interpersonal Relationships; Community	Therapeutic Relationships Grief, Loss & End of Life	IADLs to support participation in family and community	ADLs to support participation in family and community; Habilitation	
12	Cultural Competency	Diversity & Cultural Awareness Understanding own biases	Cultural Competency, case examples, IADL related	Advanced Cultural Competency	
13	Education, Training, and Self-Development	Stress Management Self-care	Use of technology; career options; seeking feedback	Leadership roles/options	
14	Documentation	HIPAA, Documentation	Reporting change in condition	Reporting ADL changes, Practicum	
15	Organizational Participation	Knows policies; team player	Participates in agency meetings	Leadership roles/opportunities	

# Measurable Tasks under each Competency

<i>Competency</i>	<i>Knowledge</i>	<i>Recommended Measures</i>	<i>Skills</i>	<i>Recommended Measures</i>
1. Understanding the Role of a DCW (CMS requirement: respecting residents' rights)	1.a. Define DCW 1.b. Identify work settings 1.c. Describe effective teamwork performance by the DCW 1.d. Identify participant rights 1.e. Identify DCW rights and responsibilities	1.a-e. Post-quiz (For example: multiple choice, matching, true and false)  1.a-e. Explain each concept verbally or in writing	1.1. Blend participant rights into DCW supports 1.2. Blend DCW rights and responsibilities into supports	1.1-1.2 Respond to relevant scenario (For example: role play or written response to the prompt, "Give 2 examples of blending participant rights into supporting the person with a personal care activity")  1.1-2. Ongoing inclusion of these skills in performance of supports and services
2. Professionalism & Ethics	2.a. Define terms: professionalism, ethics, legal, HIPAA, confidentiality 2.b. Describe professional and ethical standards 2.c. Describe professional boundaries when working with individuals and families 2.d. Identify need for stress management and personal wellness approaches.	2.a-d. Post-quiz 2. a-d. Explain each concept verbally or in writing	2.1 Apply legal and ethical standards to supports 2.2. Identifies, communicates, and adheres to professional boundaries with individuals and families	2.1-2. Respond to relevant scenario  2.1-2. Ongoing inclusion of these skills in performance of supports and services

# Concrete and Hopeful Progress

1. **Widen the Pipeline:** Identify talent sources including underserved and underutilized populations and strategies to successfully recruit from these pools.
2. **Increase Affordable DCW & Trainer training opportunities** for new and incumbent DCWs that can be delivered virtually and align with the 15 competencies adopted by the MI DCW Advisory committee. Develop and pilot related Master Trainer and Train-the-Trainer programs
3. **Sound Competency Assessments:** Develop and Pilot
4. **Competency-based Credentials** for new DCW levels under consideration
5. **Well-articulated career pathways and success models** that provide advancement opportunities within DCW and to other specialties.
6. **A DCW credentialing system** that:
  - Ensures DCWs are competent to perform their assigned asks.
  - Is recognized by all payors and programs across all settings and populations for maximum portability, reciprocity, continuity and quality of care, administrative efficiencies, and cost containment.

# The Main, Long-Term Objectives

- Competencies that are relevant to the job
- Competency-based credentials that are recognized by all payors and programs across all settings and populations for maximum portability, reciprocity, continuity and quality of care, administrative efficiencies, and cost containment.



# Short-Term Objectives & Next Steps

- Focus first on the new categories of DCWs and their associated competencies and credentials
- Establish a process for determining competency assessments
- Establish at least one credential during the grant period that can be tested
- Determine the best place to house new credentialing system
- Make recommendations related to best practices, including those that affect training and hiring requirements
- Meet remaining project goals including those unrelated to competencies and credentialing such as marketing for culture change, and
- Continue advocacy on all other fronts – wages/benefits, culture change, etc.

# Contact Information



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# Panel Discussion

# Thank you!



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