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Research Report

The National Landscape of Personal Care Aide Training Standards

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Table of Tables

Table of Figures

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Executive Summary

This report presents research findings on the national landscape of personal care aide (PCA) training requirements across state Medicaid-funded programs. These programs enable older adults and individuals with disabilities to reside safely in their homes and participate in their communities. In the absence of federal standards, there exists wide variation in minimum training requirements between states and between programs within states. Most of the existing state training requirements are relatively undeveloped compared with standards for home health aides and certified nursing assistants.

Methods

We analyzed state regulation, Medicaid provider manuals, and Medicaid's Home and Community-Based Services waiver documents to inventory state-level training standards for Medicaid-funded personal care aides. To evaluate and catalog these requirements, we developed two conceptual frameworks, or "lenses" examining: 1) the rigor of training elements; and 2) the uniformity of training standards across programs, as a measure of the degree to which each state ensures a consistent level of preparation for aides performing the same types of services.

Results

Our findings indicate a paucity of state training standards for personal care aides. Only four states have implemented rigorous PCA training standards that are uniform across the various types of Medicaid-funded programs. The remaining 46 states have weaker and/or disparate training requirements across training programs, with 45% of states having one or more programs with no training requirements, and 22% of states having no training requirements in any of their programs.

Conclusions

Despite strong evidence that training for direct-care workers, such as PCAs, is a key component of job quality—with strong associations with job satisfaction, retention, and the quality of care—there are no federal training requirements for PCAs. Furthermore, few states have developed rigorous PCA training standards that are

uniform across Medicaid-funded programs. In this way PCAs differ from workers in other direct-care occupations, i.e., certified nurse aides and home health aides, who perform similar tasks and are required to complete training and certification according to a federal minimum standard.

The findings from this study highlight the wide national variation in training standards—variation that could lead to significant disparities in PCA preparedness and skills. With demand for PCAs expected to exceed that of nearly every other occupation over the coming decade and many states facing workforce shortages, promulgating rational training standards and the necessary infrastructure to support the training of this essential workforce will need to be prioritized by states and the federal government.

The National Landscape of Personal Care Aide Training Standards

Background

Introduction

Personal care aides (PCAs) provide essential supports and services that enable older adults and individuals with disabilities to reside safely in their homes and participate in their communities.[1] These essential care providers are known by many titles, including home care aides, personal assistants, direct support professionals, and in-home care providers.[2] These aides, together with home health aides (HHAs) and certified nursing assistants (CNAs)—workers who also provide hands-on care in long-term care settings, are known as direct-care workers. In this report, we focus on the workers who provide personal care services, and adopt the official U.S. occupational codes nomenclature of Personal Care Aides (SOC 39-9021).[3] According to the U.S. Bureau of Labor Statistics, these workers constitute the second fastest-growing occupation in the nation, and the profession is expected to lead the creation of new jobs between 2012 and 2022.[4]

Disparate Regulatory Schemes Governing Personal Care Services Training

Other direct-care workers, particularly CNAs and HHAs, both of whom provide care services reimbursable by Medicare, have training standards mandated by federal regulation.[5, 6] Personal care services, on the other hand, are not reimbursable by Medicare because they are not defined as medical services. Most personal care services are instead paid for by a wide variety and non-uniform set of state Medicaid programs – Medicaid State Plan Personal Care Options, Medicaid Home and Community-Based Services (HCBS) waiver programs, and under Medicaid 1115 demonstration waiver programs.[7] Within each program, PCAs may be either agency-employed or employed directly by a consumer in a consumer- or participant-directed program.[8] Little uniformity in job titles, job descriptions, or employment requirements exists between states or even between programs within a state.[1,8]

Furthermore, states enjoy a great deal of latitude in structuring their Medicaid programs; this extends to the degree to which they mandate training requirements for personal care aides. Additionally, unlike Medicare-certified home health agencies, nearly half of agencies providing personal care are not licensed.[9] This translates to even less government oversight as to the training—not to mention

other employment conditions such as pay and supervision—for workers providing personal care services in the home setting.

Consequently, training standards for PCAs, where they exist at all, vary by state and also by program and population served within a given state. This leads to potentially significant regional differences in the skill level and preparedness of these workers.

Purpose of this Report

Given the wide variation in state standards for PCA training, and the paucity of centralized information on the national landscape for PCA training standards, we set three objectives for this report. First, we provide an overview of the demographics, tasks, and drivers of demand for and supply of the PCA workforce. Next, we present an inventory of each state's existing training requirements. Finally, we offer a conceptual framework with which to evaluate each state's standards and make cross-state comparisons of the rigor and uniformity of training standards to be used in future investigations.

National Landscape of the Personal Care Aide Workforce

Current estimates report that more than a million PCAs are employed in the U.S, with demand for these workers expected to increase by nearly 50% between 2012 and 2022.[4, 10] Long-term care industries are growing, with greatest growth expected to occur in the area of non-medical home care—the industry called "Services for the Elderly and Persons with Disabilities." The number of people needing personal assistance services is expected to grow from 13 million in 2000 to 27 million by 2050. Demand for a skilled and stable workforce to provide these services will grow in parallel.[11]

Demographics and Employment Characteristics

The vast majority of PCAs are women, and most are Hispanic or African American. Nearly a quarter are foreign-born although in some regions of the country, e.g., New York and California, this percentage is considerably higher.[12] The average age of this workforce is 44 years.[12] More than half have completed a high school education or less.[12]

Personal care aides are most often employed by home care agencies or employed directly by the client.[13] They are also more likely than other direct-care workers to be employed part-time, or for only part of the year.[13, 14] Personal care work is often appealing to jobseekers because of the low barriers to entry to the occupation and

the flexibility associated with part-time work. However, this flexibility has its drawbacks, and the high incidence of part-time work combined with low hourly wages—the national median wage is under $10/hour—results in annual earnings of less than $15,000.[10, 12] Of the more than half of personal care aides who report working part-time, only 40% do so voluntarily. An additional 40% report being unable to find full-time employment because of slack labor conditions.[12] Unsurprisingly, more than half of this workforce lives in households that rely on public assistance (e.g., Medicaid, food stamps) to subsidize their low earnings.[12] Additionally, unreliable work schedules and irregular hours are associated with lower rates of job satisfaction and greater intent to leave the profession.[15]

Job Responsibilities

Generally, the services provided by PCAs fall into three broad categories: [2]

- Paramedical tasks (e.g., catheter care, oral medication, and dressing changes)
- Assistance with self-care tasks (Activities of Daily Living [ADLs]), e.g., bathing, dressing, and toileting) and with everyday tasks (Instrumental Activities of Daily Living [IADLs] e.g., cooking, shopping, or transportation)
- Social supports to enable full participation in the community and avoid social isolation; and supervision for individuals with cognitive impairments

The role of the personal care aide has evolved dramatically over the past two decades reflecting increases both in the numbers of individuals needing services, and the severity and complexity of their functional limitations.[11] Personal care aides are now providing care to more nursing-home eligible individuals in home settings than ever before.[2] Unlike their counterparts in institutional settings, personal care aides in home settings must perform their duties with minimal direct supervision and little or no access to professional consultation.[2, 9]

Demand for Home and Community-Based Services

Several factors drive increased demand for long-term care services and supports in home and community-based settings: 1) the growing number of adults in need of such care due to the demographic aging of the population; 2) the strong preference of older adults and younger individuals with disabilities and functional limitations to receive supports and services in their homes, [16. 17, 18] and 3) a shift on the part of state governments, supported by federal programs, to provide services away from institutional service delivery systems in favor of home and community delivery systems in response to the relative cost savings of such "rebalancing."[19-23]

While 15 years ago 75% of Medicaid spending on long-term care supports and

services was directed to institutional care, now nearly half is spent on home and community-based services and this percentage is growing.[23] Nationally, the number of home and community-based workers will outnumber facility-based workers by more than 2:1 by 2022.[4] In many states, this ratio is even more dramatic: in California, three-quarters of the direct-care workforce is employed in home care settings.[24] The increasing reliance on home and community-based delivery systems is reflected in the projected demand for personal care aides, who provide the majority of non-medical home and community-based long-term care services and supports. By 2022 more than 1.75 million PCAs will be employed in the U.S.[4]

Workforce Supply and Instability

Although demand for health care and long-term care workers is increasing, especially in the area of home and community-based services, paradoxically, the supply of these workers is stagnating in many geographic areas. This is particularly apparent in the fields of eldercare and disability services, where maintaining adequate staffing is a "persistent challenge."[25] Several states are already experiencing shortages in their home care workforces, which are likely to worsen as demand for home and community-based services grows.[26-28]

One consistent measure of instability is turnover. Studies examining home care aide turnover have shown a range from 44% to 65%. Such levels pose a significant threat to the quality and supply of these services.[15, 29, 30] Turnover is associated with poor continuity of care for consumers and potential unmet need for services and supports.[8, 31] Additionally, the long-term care industry pays an estimated $6.4 billion dollars annually in costs associated with staff turnover.[31] These problematic characteristics of the labor market for personal care aides underscore the importance of improving job quality, which in turn would be expected to: 1) decrease turnover and its associated costs, 2) increase retention, and 3) result in improved outcomes for consumers.[32-35]

Value of Training to Build and Stabilize Workforce

States face significant barriers in building and stabilizing their direct-care workforce. Identifying specific means to improve job quality and satisfaction is of paramount interest to policy makers and employers. Research has shown that one of the key variables affecting satisfaction is training, the absence of which is associated with higher injury rates, higher turnover intent, and poorer job satisfaction.[36-40] In sum, the principal goal of training direct-care workers is to improve job skills and ready the workforce for care tasks.[15, 25, 36, 41-52]

Almost no research has examined the impact of training of home and community-based PCAs. However, reasonable inferences about the essential need for training may be drawn from the existing literature on residential and institutional settings given the increased acuity of the population now served in home care settings, and the fact that PCAs in home settings now carry out similar tasks to their institutional counterparts.[2] Some researchers contend that the increased scope and complexity of responsibilities, coupled with the minimal supervision associated with the provision of personal care services, argues for even more training for these workers than direct-care workers in institutional settings.[25, 53-56]

Policy Investments

The inadequacy and inconsistency in standards governing PCA training has garnered recent and growing federal interest.

A 2006 report by the Office of the Inspector General identified 301 different sets of requirements for personal care aides in Medicaid programs. Extraordinary variation across these programs makes it difficult for states to ensure compliance with existing training and pre-employment requirements. The report concluded with the recommendation that states develop consistent standards for PCA training and employment within Medicaid programs.[8] A 2012 follow-up report added recommendations to CMS to establish federal training standards for PCAs as a more direct means of reducing variation in state standards.[57]

Retooling for an Aging America, a 2008 report issued by the Institute of Medicine, emphasized the need for improved training standards for all direct-care workers, recommending that "*all long-term settings, federal and state governments, and providers, in consultation with consumers, develop training, education, and competency standards and training programs for staff based on better knowledge of the time, skills, education, and competency levels needed to provide acceptable consumer-centered long-term care.*"[25] While the committee endorsed specific increases in the minimum training hours for CNAs and HHAs, in recognition of the relative paucity of standards for personal care aides, the recommendation for these workers was that states create a framework of minimum training requirements upon which further improvements could be made.[25]

The most significant federal investment in this area is the Personal and Home Care Aide State Training grants (PHCAST), created as part of the Patient Protection and Affordable Care Act of 2010. These three-year demonstration programs were funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration in six states (California, Iowa, Maine, Massachusetts, Michigan, and North Carolina) to identify core competencies, develop curricula, and

implement training and certification programs for personal care aides. Findings from these demonstrations, which will conclude in late 2014, will result in state evaluation reports and a national evaluation that will combine lessons and make recommendations for national standards. While the efficacy of these demonstrations remains to be seen, the significant investment made by the federal government for this initiative signals a strong interest in the development of more intentional approaches to PCA training.

Finally, with the advent of Medicaid managed care in many states, health plans have an increased interest in the care received at home for persons with disabilities, especially in terms of coordinating acute and long-term care services.[58] The associated changes in payment mechanisms may help highlight the need for PCA training as health plans begin to value the potential contribution of those workers. PCAs are often the "eyes and ears" on the ground—best suited to report changes in clients' health status and to promote healthy behaviors.[28]

State-by-State Inventory of Existing Training Standards and Conceptual Framework for Comparisons within and across States

Methods

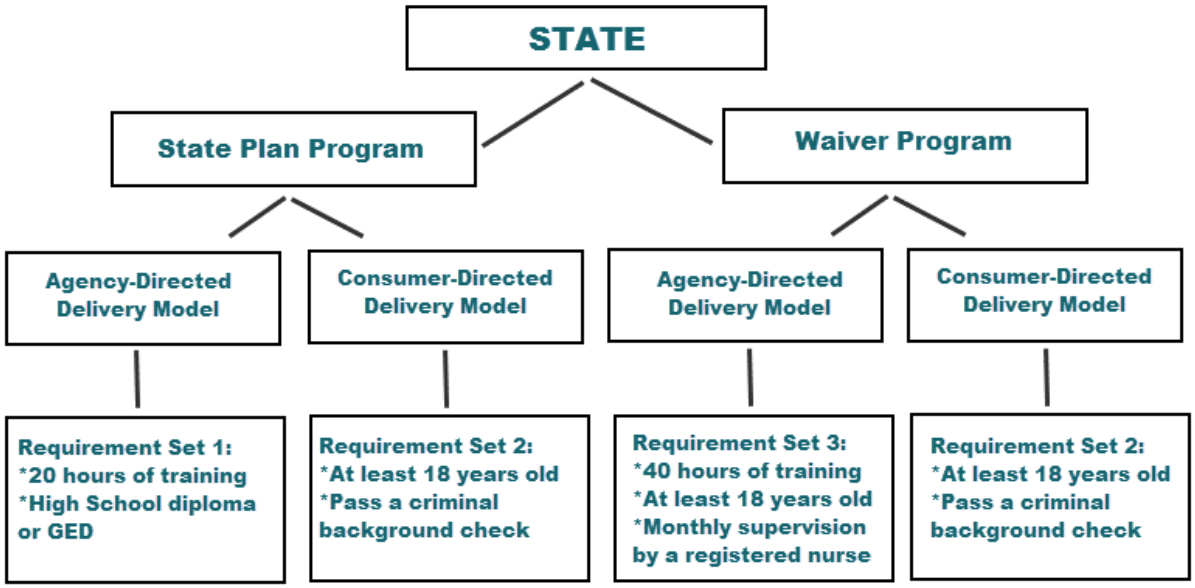
Sample and Analysis

To ensure a minimum level of training for personal care aides, states have the authority to set requirements for participation in the state's Medicaid State Plan Personal Care Option or Home and Community-based waiver programs. These requirements could potentially impact a significant number of the states' personal care aides, given that a large proportion of personal care services are funded by Medicaid.[59] Our report examined requirements for participation in Medicaid-funded personal care programs in each state.

We examined training requirements for PCAs in programs in all 50 states and the District of Columbia, encompassing those programs that provide personal assistance services under Medicaid State Plans and HCBS (1915c) waiver programs for elders and individuals with physical, intellectual, and/or developmental disabilities. Within these programs, systematic searches were conducted of state administrative codes (including departmental regulations and licensing laws both for businesses and individuals), Medicaid provider manuals, and Medicaid waiver documents.

In our research, we also collected information about training requirements in Medicaid programs offering participant-directed personal assistance services. In these programs, consumers have the authority to select and hire the worker of their choosing and oversee many employment functions, including consumer-specific training and supervision.[60-62]

Figure 1. Office of the Inspector General Schematic: One State, Two Programs, Two Delivery Models, and Three Requirement Sets



Source: U.S. Department of Health and Human Services (December 2006) *States' Requirements for Medicaid-Funded Personal Service Attendants*, Office of the Inspector General, OEI-07-05-00250, Fig. 1.

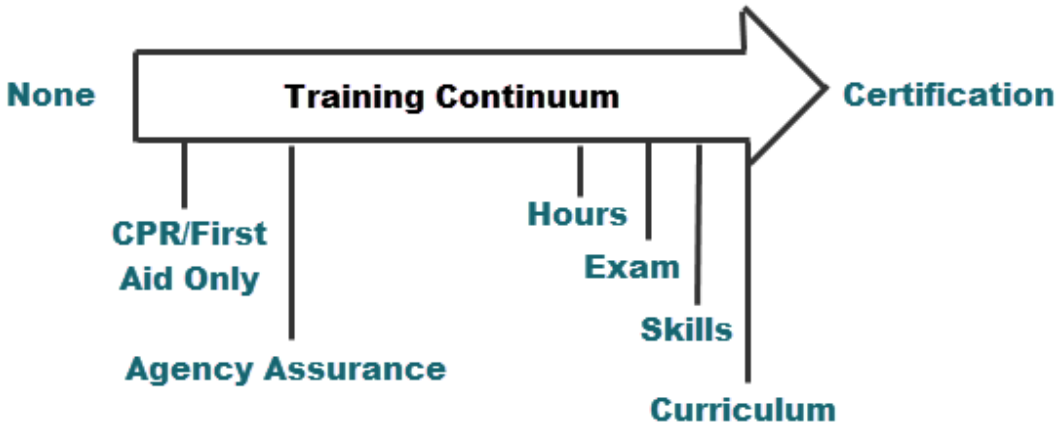
Figure 1 presents an example of a state with two Medicaid-funded personal care programs (State Plan and waiver), two delivery models (agency-directed and consumer-directed), and three sets of requirements. This schematic demonstrates the variation in training standards that often exists within states.[8] Because of this variation, no discrete metric by which to make direct comparisons between states is obvious. Therefore, in order to evaluate and catalogue state training requirements, we developed two conceptual frameworks or "lenses": **Rigor of Training Standards** and **Uniformity of Training Standards**.

Lens 1: Rigor of Training Standards

The first lens allows us to examine the required components of each state's training standards in order to assess the rigor and depth of these requirements. For

example, do these standards specify skills or competencies for aides? Must aides complete a minimum number of training hours? Is there a standard curriculum, a competency exam, or a certification process?

Figure 2. Training Elements Continuum



Source: Research conducted for PHI Project on *PCA Training across the States,* with funding from the National Institute on Disability and Rehabilitation Research (Grant No. H133B080002) through the Center for Personal Assistant Services at UCSF.

These elements may be arrayed on a continuum of least to most stringent, with programs having no requirements for PCAs on one end, and those requiring certification on the other (Figure 2). Between these two extremes, states have outlined various elements of PCA training standards, including: state-specified minimum training hours, state-specified competencies, state-sponsored curricula, and exams or competency evaluations.

Table 1. Elements of Training Standards Definitions

Element	Definition
None	The state does not outline any training requirements for PCAs in regulatory text or provider manuals. If the state requires CPR and/or first aid training but nothing else, it would meet this definition.
Agency Assurance	The regulatory text or provider manual assigns responsibility to the agency to ensure that the personal care aide has sufficient training to carry out the necessary tasks with little or no further guidance. For the purposes of this study, programs meeting only this criterion are considered to have no formal training requirements.
Hours	The state outlines a specific hour requirement for PCA training. Some states require a state-endorsed curriculum of the specified duration; other states may require training of a minimum duration and may or may not require state approval of the curricula.
Exam	The state requires that the PCA complete a competency evaluation or exam before providing services. The exam may be designed/administrated by the agency, or may be standardized and implemented state-wide.
Skills/Competencies	The state lists the specific skills or competencies required of personal care aides. A training curriculum or exam must cover these areas and test these skills.
Curriculum	The state has a state-sponsored or endorsed curriculum for PCA training that may be mandatory or optional/adaptable by providers, providing it meets department standards.
Certification	States have formally described, state-required PCA credentials as "certification." In most of these cases PCAs must complete and pass a state-wide exam in order to meet this qualification. Some states require that PCAs be certified as home health aides, or certified nursing assistants, both of which require completion of state-specified training and competency evaluation programs under federal law.

Source: Research conducted for PHI Project on *PCA Training across the States,* with funding from the National Institute on Disability and Rehabilitation Research (Grant No. H133B080002) through the Center for Personal Assistant Services at UCSF

Lens 2: Uniformity of Training Standards

We also examined PCA training requirements in terms of their uniformity across a state's personal assistance programs. This lens allows us to understand how

"rational" a state's system is—meaning how universal the PCA training requirements are across programs and populations.

In theory, more uniform requirements would enable PCAs who do similar work to move between programs and across populations providing services and supports to people with similar functional limitations. Disparate requirements between programs within a state, by contrast, may lead to sizeable differences in the level of qualification of aides within a state, or may make certain training redundant for PCAs who wish to switch jobs.

We measure uniformity of standards according to four training elements:

- specified training hours
- specified skills/competencies
- state-endorsed curriculum
- required exam or competency evaluation

We then categorized states into four possible groups:

- states that have no training requirements for any programs
- states that have requirements, but only for some programs
- states that have requirements for all programs, but no uniform requirements
- states that have uniform requirements for PCAs across all programs

It should be noted that "uniformity" is not inherently superior to variation in training standards within a state. For example, a state that has strong requirements for PCAs in one large program (e.g., a competency-based, 40-hour training curriculum) but not others, may, on net, have a stronger training foundation than a state with uniform but weak requirements across all programs.

Results

In the absence of federal standards, we found that 45% of states lack training requirements for PCAs employed in one or more Medicaid-funded programs. One in five states (22%) have not articulated training requirements in *any* such program. In states where PCA training standards have been defined, we found wide variation between programs, with most lacking rigor in their training requirements.

Findings – Lens 1: Rigor of Training Standards

Table 2 presents our findings related to the aforementioned "Rigor of Training Standards" lens. One state or program may satisfy more than one criterion, thus

categories are not mutually exclusive and percentages do not total 100%. For example, for a particular program, a state may specify both the number of required hours of training as well as specific skills or competencies that the training must cover. In a second program, the same state may only require "agency assurance" of an aide's competency. In such a case, the state would satisfy the following three categories: "agency assurance," "skills/competencies," and "curriculum."

Table 2. Lens 1: Rigor of Training Standards Findings

PCA Training	No. of States*	Percentage
None	12	23.5%
Agency Assurance	11	21.6%
Hours	18	35.3%
Exam	21	41.2%
Skills/Competencies	20	39.2%
Curriculum	9	17.7%
Certification	4	7.8%
Other Certification		
Home Health Aide	5	9.8%
Certified Nurse Aide	2	3.9%

*Requirements apply to one or more programs in a state, but not necessarily all programs. The only exclusive categories are "none" and "agency assurance." One state or program may satisfy more than one of the remaining criteria, as they are not mutually exclusive; percentages will not total 100%.

Using the Training Elements Continuum (Figure 2), which assesses the depth and rigor of state training standards, we found that in one or more personal assistance program (excluding participant-directed programs):

- 22 states (42%) have no formal training requirements- 11 of these states have programs that require only that the employer-agency be responsible for ensuring the competency of PCAs, without any further specification for training or evaluation
- 18 states (35%) specify required training hours for PCAs; however, of these, only 5 require more than 40 hours of entry-level training; required training ranges from 8-120 hours, with an average of 39 hours
- Approximately 25% of states have a state-sponsored or endorsed PCA curriculum and/or require certification
- 7 states require that PCAs complete other training and certification programs, i.e., certified home health aide training or certified nurse aide training; within these programs, states specify the number of minimum training hours, equal to or surpassing the federally required minimum of 75 hours; these programs also specify necessary competencies, and require competency evaluation prior to certification

Findings – Lens 2: Uniformity of Training Standard

Table 3 presents our findings related to the aforementioned "Uniformity of Training Standards" lens. For all states, because these categories are mutually exclusive, the percentages total 100%.

Table 3. Lens 2: Uniformity of Training Standards Findings

	No. of States*	Percentage
No training requirements in any program	11	21.6%
Requirements for some programs	11	21.6%
Requirements in all programs	10	19.6%
Uniform requirements across all programs	19	37.3%

*Categories are mutually exclusive, and percentages total 100%

Source: Research conducted for PHI Project on *PCA Training across the States,* with funding from the National Institute on Disability and Rehabilitation Research (Grant No. H133B080002) through the Center for Personal Assistant Services at UCSF

We assessed the extent to which training requirements are aligned across programs within a given state and found that (excluding participant-directed programs):

- 11 states (22%) have no training requirements for PCAs in any of their programs
- 11 states (22%) have training requirements in only some of their PCA programs
- 10 states (20%) have training requirements for PCAs in all of their programs, but these requirements are not uniform across programs
- While 19 states (37%) have uniform training requirements for PCAs across all programs:
    - only 4 of the 19 specify a state-endorsed training curriculum for PCAs
    - 3 of the 19 require PCAs to complete home health aide training, and 1 requires CNA training
    - the remaining 12 of 19 have far less rigorous standards

Findings for Participant-Directed Services

A growing number of PCAs are employed directly by program participants within Medicaid programs, and not solely by agency providers. We examined whether or not states required training.

We found that:

- 11 states (22%) articulate specific training for participant-directed PCAs in some or all of their participant-directed programs; of these, 4 require the same training for both agency-directed and participant-directed aides
- 29 states (57%) leave training to the discretion of the participant, and the remaining 11 states (22%) make no mention of training for participant-directed PCAs

In sum, the vast majority of states either leave training up to the program participant or do not address training for participant-directed aides.

Conclusions

This report presents our examination of state-level standards for personal care aide training within Medicaid-funded personal care programs. Our findings reveal that, in the absence of federal requirements, few states have established well-defined training standards for PCAs providing these services, only four[1] have rigorous and uniform standards by our definitions, and a significant percentage—nearly 20%—have no standards at all.

We also find that in states that offer personal care services in multiple programs (e.g., the State Plan Personal Care Option and more than one HCBS waiver), it is common for different standards to apply to essentially the same services. In the nearly 40% of states that do have uniform standards across all Medicaid-funded PCA programs, the vast majority of these standards lack rigor, by our definition. Only four of these states require a state-sponsored training curriculum specific to PCAs. Several states require that PCAs meet state-certified home health aide or nurse aide requirements for training and certification. However, for these occupations, federal regulations do not articulate competencies specific to the provision of person-centered, non-medical long-term care supports and services—the services typically provided by PCAs.

[1] Arizona, Minnesota, Virginia, and Washington require training *and* provide a state-sponsored curriculum and/or certification. These standards are uniform across Medicaid programs in each of these states. Training standards among such "leader states" will be explored in a forthcoming research brief.

To our knowledge, this is the only study surveying state training standards for personal care aides in Medicaid-funded programs. The findings reported here measure the degree to which a state regulates and standardizes training for its personal care aides. We did not evaluate states and programs in terms of the competencies and skills required for PCA training, nor the content of each curriculum.

Further, we do not examine how these training standards are being implemented on the ground—whether employers and workers actually comply with these regulations, nor the degree to which PCAs in states with more rigorous standards are more knowledgeable about the competencies required to provide high quality services.

The articulation of PCA training standards through Medicaid regulation is one major mechanism for states to ensure uniform and rigorous training for a large swath of the workforce. Another approach would be to include worker training standards in home care agency licensing requirements. Craft-Morgan and colleagues found that, of the 29 states that require a license for agencies providing non-medical personal care services, 26 required some training for new home care workers. Of these 26 states, the level of rigor of training requirements varied, although most were generally weak—only eight states specified the number of training hours, and only six required training in provision of ADLs.[9]

At a time of unprecedented demand for personal care services, the relatively undeveloped condition of state training requirements for personal care aides is of concern. Calls to define universal core competencies for PCAs at the national level, which would help to confer status as a "worthy career," have yet to be answered. Many argue that this is an essential step toward mitigating the inequity between direct-care workers in long-term care and those in acute care settings. Unless addressed, difficulties in recruitment and retention of PCAs will likely persist.[63] Of additional concern, variation in training standards for PCAs opens the potential for significant differences in their level of preparedness between states and programs. This raises the question of whether these workers are adequately equipped to perform their job duties safely, effectively, and in the most person-centered way possible.

However, the policy climate is changing. With states facing potential workforce shortages in the area of long-term care, more are exploring the possibility of defining minimum training standards and considering additional investments to improve the job quality of personal care aides.

Limitations

Our research was confined to publicly available documents pertaining to training standards, including state administrative code, provider manuals, and waiver documents. While state administrative codes are available online, other resources such as provider manuals were not always available for all states or all programs. In these cases we made inferences based on available documents. Additionally, we may have missed more recent developments, such as new legislation, if they had not yet been captured in the administrative code or manuals. Additional inferences were made due to the complex level of information and potential inconsistences when triangulating across regulation, provider manuals, and other documents. Terminology is often inconsistent even within states, and thus we were required to interpret the information, which introduces the possibility of error.

Levers for Intervention

Federal Oversight of PCA Training Standards

Our research findings—high levels of variation and a relative lack of rigor in PCA training standards across the country—underscore the consequences of the absence of federal training standards for personal care aides. The need for better standards was articulated by the OIG in 2006 and echoed by the Institute of Medicine in 2008. More recently, Congress established the PHCAST program to encourage states to define competency-based training programs that could inform national standards for these workers. The development of such a federal "gold standard" for PCA training could help guide states in rationalizing and improving their training requirements for this workforce. In the meantime, states could be held accountable for their current training requirements through greater attention to training from CMS within the review process for Medicaid State Plans and waiver services. Short of federal recommendations, states with well-articulated PCA training standards could serve as important models for other states looking to advance their current requirements and rationalize standards across programs. A subsequent report will examine in more detail PCA training standards in several "leader states."

Payment Policies

The dearth of rigorous and uniform PCA training standards in state Medicaid programs is also likely tied to the lack of incentives in payment policies for developing such standards. The success of federal and state initiatives to encourage the development of stronger standards hinges, in large part, on who will pay for this training. Currently, pre-service training of CNAs is a reimbursable Medicaid expense, whereas PCA training is not. CMS could act to change this, and to develop

mechanisms by which states could build pre-service training for PCAs into Medicaid reimbursement rates. CMS could also encourage states to explore other incentives to support training, such as differential reimbursement for providers who train their workers and wage pass-throughs for workers who complete training.

State Training Infrastructure

While developing well-informed and consistent competency-based training standards for PCAs is an essential first step, government support will be required to build and support the necessary infrastructure to provide this training. Funding directed to a range of training entities could help recruit a larger, more varied pool of potential workers and support the delivery of high-quality training across a wide array of settings. These entities could include community colleges, employer-based programs, employer consortia, labor/management partnerships, and regional private-public partnerships.

Additionally, ensuring sufficient preparation of this workforce will require a thoughtful approach to curriculum design and training implementation. For many potential PCAs, the majority of whom have a high school diploma or less, traditional, more passive approaches to learning are not the most effective. These workers could benefit from an adult-learner centered approach, in which competencies are conveyed through interactive techniques and build on the knowledge, attitudes, and skills that trainees have gained through their life experiences. Curriculum content should have a focus on communication and interpersonal problem-solving skills in order to strengthen caregiving relationships and to ensure delivery of services in the manner the consumer prefers.[64, 65] Such training can help PCAs better coordinate with family caregivers and to more effectively interact with the other members of a care team. Implementing training and evaluation programs in a number of languages is also important for this workforce, as many personal care aides speak a native language other than English.

Among certain groups of advocates, especially those who receive services in consumer- or participant-directed programs, there is significant disagreement on the role of formal training for direct-care workers, with some consumers preferring to train their own workers.[66] However, three-fifths of consumers report wanting their workers to be better trained[19] and there is recognition that training in injury prevention and basic skills, while emphasizing person-centered care and the practices of self-determination, could promote improved career development, retention, and mobility for workers, and improve the level of safety for both

workers and consumers. All of these would potentiate more opportunities for consumers to find workers who match their unique needs and preferences.[66]

In conclusion, our analysis of PCA training standards for Medicaid-funded programs across the country shows that, without federal guidance, states have developed a wide range of standards, most lacking rigor and uniformity across programs. Given the projected demand for personal care aides over the coming decade and shortages many states are already facing, investments aimed at professionalizing this workforce through better developed competency-based training requirements would be well timed. Such efforts could assist workforce recruitment and ensure a sufficient, high-quality workforce, ready to provide essential supports and services to individuals in home- and community-based settings.

Acronyms Used in this Report

ADLs: activities of daily living

IADLs: instrumental activities of daily living

PCA: personal care aide

HCBS: home- and community-based services

CNA: certified nursing assistant

HHA: home health aide

CMS: Center for Medicare and Medicaid Services

PHCAST: Personal and Home Care Aide State Training Program

DOL: Department of Labor

OIG: Office of the Inspector General

IOM: Institute of Medicine

Terminology Used in this Report:

Activities of Daily Living (ADLs): The basic personal tasks of everyday life including getting in and out of bed, dressing, bathing, eating, and using the bathroom.

Certified Nursing Assistant (CNAs): CNAs are trained and certified to help nurses by providing non-medical assistance to patients, such as help with bathing, dressing, and using the bathroom. They are direct-care workers who provide basic patient care under direction of nursing staff. They perform duties such as feed, bathe, dress, groom, or move patients, or change linens. CNAs may transfer or transport patients to areas such as operating rooms or x-ray rooms using wheelchairs, stretchers, or moveable beds. They may also maintain stocks of supplies or clean and transport equipment.

Direct-Care Worker: Paraprofessional workers who provide hands-on care: nurse aides, home health aides, and personal care aides. They assist individuals with a broad range of support including preparing meals, helping with medications,

bathing, dressing, getting about (mobility), and getting to planned activities on a daily basis. They make it possible for individuals to live meaningful lives in their homes and communities as well as in long-term care facilities and hospitals.

Home- and community-based services: services and other supports to help people with disabilities of all ages to live in the community. Each state has a mix of programs and funding sources. The Medicaid program pays for many of these services in all states. There are also other federal, state and local dollars that fund home- and community-based services, including the Social Services Block Grant (SSBG), Older Americans Act (OAA), education and rehabilitation funds and state general funds. Various types of services may be provided in the home or in the community to enable individuals to remain in their own home. Assistance is generally provided with Activities of Daily Living and Instrumental Activities of Daily Living.

Home Health Aides: Direct-care workers who assist with personal care related home care support to individuals who are recovering from a hospitalization or related acute medical crisis. Home health aide services are primarily a "medical service" authorized for rehabilitation rather than long-term support. However, home health aides assist with many of the same activities that are conducted by personal care attendants, and they are also able to assist with some homemaking activities as long as these are an adjunct to personal, hands-on care.

Instrumental Activities of Daily Living (IADLs): Everyday tasks including housekeeping, cooking, shopping, laundry, medication management, money management, and communication.

Medicaid State Plan: A State Plan is a contract between a state and the federal Government describing how that state administers its Medicaid program. It gives an assurance that a state abides by Federal rules and may claim federal matching funds for its Medicaid program activities. The State Plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative requirements that states must meet to participate. Optional benefits for personal care services can be included under the Medicaid State Plan.

Home- and Community-Based Waiver Programs (HCBS): The HCBS programs offer different choices to some people with Medicaid. Those that qualify receive care in their home and community to stay independent and close to family and friends. HCBS programs help the elderly and disabled, mentally retarded, developmentally

disabled, and certain other disabled adults. These programs give quality and low-cost services. These waivers include: 1915(c), 1915(i), 1929(b), and 1115 demonstration waiver.

Consumer direction (participant direction): Consumer direction is a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices about the services they receive. They can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services they received. Consumer direction may exist in differing degrees and may span many types of services. It ranges from the individual independently making all decisions and managing services directly, to an individual using a representative to manage needed services. The unifying force in the range of consumer-directed and consumer choice models is that individuals have the primary authority to make choices that work best for them, regardless of the nature or extent of their disability or the source of payment for services (National Institute of Consumer-Directed Long-Term Care Services 1996).

Personal care aides: These direct-care workers assist the elderly, convalescents, or persons with disabilities with daily living activities at the person's home or in a care facility. Their duties are performed most often at place of residence and may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. Some PCAs are employed at non-residential care facilities. PCAs may advise families, the elderly, convalescents, and persons with disabilities regarding such things as nutrition, cleanliness, and household activities.

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