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Research Brief

Leader States in Personal Care Aide Training Standards

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Leader States in Personal Care Aide Training Standards

Executive Summary

This report highlights seven “leader states” in training standards for Medicaid-funded personal care aides (PCAs). Although our previous research has demonstrated a paucity of standards in most states, a few have engaged in a rational approach to designing PCA training standards with the goal of better preparing these essential frontline workers to provide care. We showcase these standards and describe, in brief, the approaches several states have taken to address the need for uniform and rigorous PCA training standards across Medicaid programs.

Methods

Based on data collected for prior research, we selected seven states to profile as leaders in the area of PCA training standards: *Alaska, Arizona, Arkansas, Idaho, Minnesota, Virginia, and Washington*. These states were selected because: 1) they have uniform PCA training requirements across all Medicaid-funded programs; and 2) they articulate requirements for one or more of the following: training hours, a state specified/endorsed exam, state-specified competencies, or a state-sponsored training curriculum.

Results

The seven leader states profiled in this report arrived at their PCA training standards through a range of approaches, however the resulting requirements can be grouped into two broad categories: 1) states that outline the competencies and skills but allow training entities the latitude to conduct training using their own curricula and methods, sanctioning a more individualized approach; and 2) states that specify the training curriculum, exams, and methods, and mandate the use of these resources to ensure a level of consistency.

Recommendations

Growing interest in PCA training standards at the federal level have spurred states to think about how to institute, improve, and rationalize their current training systems and requirements. The experiences of the several states that have already engaged in such processes can provide useful insight for the remaining states as they begin to reform or develop PCA training standards and systems.

Leader States in Personal Care Aide Training Standards

This Research Brief examines “leader states” in the area of training standards for personal care aides (PCAs) employed in Medicaid programs. Relying on our extensive prior research,^{1, 2} we highlight here the states that have achieved high levels of rigor and uniformity of training standards across their Medicaid-funded personal care programs.

Background

Personal care aides are the second fastest-growing occupation in the nation, and this sector will lead the creation of new jobs in the coming decade.³ PCAs, nearly 90% of whom are women, provide the essential supports and services that enable older adults and individuals with disabilities to remain in their own homes and to participate in their communities.⁴ Their work is crucial and yet, compared with similar direct-care occupations—certified nursing assistants and home health aides—these workers earn significantly lower wages and are governed by minimal and disparate regulations across the programs in which they operate.^{1, 2, 5}

In particular, there are no federally-required minimum training standards that apply to PCAs employed in Medicaid-funded programs providing personal care services.⁶ As a result, states have wide latitude in outlining and overseeing training standards for PCAs, resulting in extensive variability in the qualifications and preparedness of these workers.

Our prior report, *The National Landscape of Personal Care Aide Training Standards*, established that most states require minimal if any training for PCAs employed in Medicaid-funded programs.¹ In that report, we assessed the level of rigor in state PCA training standards; rigorous standards were defined as those that specify required minimum training hours, required exams or competency evaluations, state-sponsored curriculum, detailed competencies, and/or certification. Additionally we examined the level of uniformity of training standards across Medicaid-funded personal care programs.

A significant number of states either fail to address training within Medicaid regulation or leave it up to the provider agency to determine how *or whether* to prepare their aides and assess competency. In the states that have outlined some form of training requirements for PCAs in Medicaid programs, the vast majority of these requirements lack rigor.¹

Purpose

In this report we highlight “leader states”— those that stand out for having already implemented relatively rigorous training standards that are uniform across all major Medicaid-funded personal care programs (state plan and waivers). In providing real examples, we hope to assist states currently considering reforms to their programs aimed at improving the quality of training standards for PCAs.

The inadequacy of state standards for PCA training is of growing concern and interest, especially at the federal level. Following several high profile reports,^{7, 8, 9} the most significant federal investment in state-led development of PCA training standards has been the Personal and Home Care State Training (PHCAST) program.¹⁰ This six-state demonstration program was funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) to identify core competencies, develop curricula, and implement training and certification programs for PCAs. The national evaluator’s report is expected to be released in the summer of 2015.

Methods

Drawing on our prior research^{1, 2} we used two selection criteria to identify the seven leader states highlighted in this report:

1. PCA training requirements are uniform for agency-employed PCAs across all major Medicaid programs in the state.ⁱ
2. Training requirements include one or more of the following elements, reflecting the rigor of training standards: specified training hours, a state specified/endorsed exam, state-specified detailed competencies, or a state-sponsored training curriculum.

Nineteen states met the first criterion of uniformity. Of those 19 states, seven rose to the top for requiring one or more of the elements of rigor listed in number 2, above. These are the seven leader states profiled in this report.

We provide brief profiles of the seven leader state training requirements, outlining a brief history of the development and implementation of standards. In Table 1 we examine each state’s system along five dimensions: required hours, exam, skills/competencies, curriculum, and certification. The information included in this report is based primarily on information collected from systematic searches of state

ⁱ Research was limited to PCA training standards required in Medicaid State Plan Personal Care Options, and HCBS Waivers for elders and individuals with physical, intellectual, and/or developmental disabilities.

administrative codes (see Reference section), Medicaid provider manuals, and Medicaid waiver documents. In some instances, where we required further clarity, we confirmed or clarified this information via email or telephone inquiries with state Medicaid officials.

Leader State Summaries

Each of the leader states operates its program uniquely. Broadly speaking, states can be categorized into two approaches. The first group consists of states that designate specific competencies but provide latitude for provider agencies or training entities to conduct training using their own approaches (Alaska, Arkansas, Idaho). The second group is composed of states that outline more specifically, and in some cases require, the curriculum, competencies, methods for teaching, and methods for evaluation (Arizona, Minnesota, Virginia, Washington). The benefit to the first approach is that training entities are given greater flexibility in how they deliver training—with the flexibility to customize training based on the learning abilities of the trainees and the populations being served. In the second approach, the state exercises greater control, but can ensure a certain minimum level of preparedness, regardless of the training provider.

Following and in Table 1 are profiles of the leader states' standards and approaches.

Alaska

In 2008, as part of several multi-year workforce development initiatives to improve the recruitment, retention, training, and education of the state's health and human service workforce, the Alaska Mental Health Trust Authority sponsored the development of the Alaskan Core Competencies for Direct Care Workers in Health & Human Services. This was done in collaboration with the University of Alaska and the State of Alaska Department of Health & Social Services.

The core competencies were developed over two years by distilling and integrating shared elements from nationally recognized competency sets. The resulting set of competencies was designed to cut across and be relevant to training for multiple sectors including long-term care, developmental disabilities, addictions, and child development. The process for arriving at consensus around a set of competencies was multi-step. First, the team identified the relevant workforce sectors and job categories. Various nationally recognized competency sets were obtained and compared for common elements, from which broad competency categories were formed. These common elements and individual competencies were reviewed by a diverse set of stakeholders to ensure they reflected the experiences and interests of the relevant groups. The final competencies, published in 2010,¹¹ cover the

following major categories: working with others; assessing strengths and needs; planning services; linking to resources; advocating; individualizing care; documenting; behaving professionally and ethically; and developing professionally.

The Alaska Department of Health and Human Services, which requires that agency-employed PCAs in Medicaid programs complete a state-approved, 40-hour training and testing program, has yet to mandate the use of these competencies. However, the state does endorse their use for updating existing training programs or as a foundational source for new training curricula.

Arizona

The comprehensive training requirements in Arizona evolved from a 2005 report by the Citizens' Workgroup on the Long-Term Care Workforce.¹² The Workgroup was established to address the development of a "committed, stable pool of front line workers who are willing, able, and prepared to provide high caliber care to people with long-term care needs." Several guiding principles informed the group's recommendations including: the promotion of person-centered care practices, parity in wages and benefits for direct-care workers, acknowledgement of the intrinsic value of caregiver and direct-care worker roles, and assurance of access to care and quality of care in long-term care settings.

These recommendations resulted in the development of a model training curriculum for personal care aides: "Principles of Caregiving."¹³ From this curriculum, consensus competencies for personal care aides and other direct-care workers were developed as well as a standardized competency evaluation that all agency-employed personal care aides must pass. While the standards for PCA training do not specify the required number of training hours that an aide must complete—an intentional decision by the writers, who felt that specifying the number of hours could be restrictive—the model curriculum was intended to be taught in about 80 hours. If an agency or training entity desires to use a different curriculum, training must be approved by the Medicaid department and must cover the specified competencies. This training is universal for all Medicaid-funded PCAs, excluding those in the Medicaid program's consumer-directed option.

Arkansas

Arkansas offers personal care services through the Medicaid State Plan and one HCBS waiver program. In both cases, PCAs must complete 40 hours of training—24 hours of classroom training must be completed prior to 16 hours of supervised clinical training conducted on site. The training must cover specific topics outlined in a state-approved curriculum and trainees must pass a competency evaluation and receive a certificate. In 1985, Arkansas became one of the first states to implement

a state plan Personal Care Option program, and these standards have been in place since that time.

Recently, advocates at Arkansas' Schmieding Center for Senior Health and Education successfully lobbied for the extension of these same Medicaid standards to all private pay home care aides in Arkansas. Act 1410 passed in 2013 with the notion that private pay consumers of home care should be guaranteed the same minimum preparedness of their PCAs as those receiving Medicaid-funded services. In this sense, Arkansas is a rare example of a state with uniform training requirements for agency-employed personal care aides, regardless of the payer.

Idaho

In 2000, the Idaho Personal Assistance Oversight (PAO) Committee was created statutorily as a subcommittee of the state's Medical Care Advisory Committee. The purpose of the PAO Committee is to "plan, monitor, and recommend changes to the Medicaid waiver and personal assistance programs." The Committee consists of a mix of stakeholders including providers, advocates, and Medicaid officials, but statutorily, 51% of its members must be participants or their representatives.

The "Idaho Skills Matrix"—a list of necessary competencies and assessment methods for personal care aides—was developed in 2008 by the PAO Committee.¹⁴ The Matrix outlines skills and competencies required for PCAs as well as the person or entity responsible for verification, usually a state-employed RN who is trained to provide assessments. PCAs must pass a written examination or demonstrate proficiency in each task or competency. For some skills, verification of experience is sufficient. Assessors are trained to incorporate feedback on a PCA's competency from the entire care team as well as the participant. While very specific skills are outlined by the state, each employer has leeway in terms of the methods of training and the state encourages agencies to treat the required competencies as a minimum threshold, and to conduct further training to ensure adequate preparedness.

Minnesota

In May of 2009, the governor of Minnesota signed into law comprehensive reform of personal care attendant services. Included in this reform was the establishment of mandatory Department of Health Services-administered training for provider agencies, qualified professionals, and personal care attendants. Starting in July of 2009, it became a requirement for provider agency administrative staff (non-PCAs) to complete training, and for all staff, including PCAs, to undergo federal criminal background checks.

The second wave of this reform occurred in 2010, from which point PCA provider agencies were required to use 72.5% of personal care attendant revenue towards PCA salaries and benefits. The mandatory Department of Health-administered PCA training was also extended to both agency-employed and consumer-directed PCAs. This training and a competency test are available free online in six languages.¹⁵ The online training covers the following topics: emergencies, infection control and standard precautions, body mechanics, understanding behaviors, boundaries and protection, timesheet documentation, fraud, and self-care.

Virginia

Historically, Virginia's Department of Medical Assistance (DMAS) allowed agencies to train personal care aides, either using the state's 120-hour CNA training or through another curriculum, with a recommended minimum of 40 hours. However, on-site reviews at both agencies and in-home settings showed that few workers were actually being trained. This led to the creation of a stakeholder workgroup—including service recipients, advocates, and Medicaid officials—to come up with a 40-hour consensus curriculum.

As of 2002, all agency-employed PCAs who provide Medicaid waiver services must complete a 40-hour curriculum, exam, and skills checklist—all provided by the DMAS.¹⁶ The training must be conducted by an RN. Agencies may adapt these materials to add additional units, but must, at a minimum, teach the curriculum content.

Under the Individual and Family Developmental Disabilities Waiver and the Intellectual Disability/Mental Retardation Waiver, providers must also ensure that PCAs are trained to work with individuals with developmental disabilities. This additional training can be done using the state-sponsored Mental Retardation Staff Orientation Workbook and accompanying exam, or using specified units/tests from the College of Direct Support.

Washington

Unlike many PCAs, the workforce in Washington State is unionized, represented in collective bargaining with the state by the Service Employees International Union (SEIU) Healthcare 775NW. Since 2003, collective bargaining agreements have resulted in higher wages for personal care aides, and benefits like worker's compensation and access to health insurance coverage. In 2007, the Establishing Quality in Long-Term Care Services Act, ESSHB 2284, created a home and community long-term care workforce development workgroup.¹⁷ The workgroup's duties, outlined in this legislation, include evaluation of training requirements for

direct-care workers with respect to quality of care, and recommendations as to appropriate levels of training for direct-care workers, e.g., required hours, content of basic curricula, and criteria for certification of direct-care workers. This legislation also mandates the development of “advanced training” for long-term care workers and the creation of a Training Partnership to provide training and other supports to individual providers represented by the collective bargaining unit.

SEIU Initiative 1029, passed in 2008 was intended to implement the workgroup’s recommendations. The initiative focused primarily on federal criminal background checks for long-term care workers and a formal system of education and experiential qualifications leading to a certification test. As of January 2012, all PCAs, with the exception of parents providing personal care, are required to be “certified home care aides.” They must complete a 75-hour basic training curriculum and pass a Department of Health-approved competency evaluation. Agencies provide this training, with approval from the Department of Health. The SEIU NW Training Partnership provides the training for independent, consumer-directed PCAs, who are then listed on the state’s Referral Registry.

Conclusions

Although the federal government presently neither specifies nor mandates training prerequisites for personal care aides, as is the case for other direct-care workers, the seven states profiled in this report, comprising 16% of the total PCA workforce, have gone the extra mile to bring consistency to standards across programs. They have designed their programs with the goal of ensuring a basic level of PCA preparedness. It is worth noting that uniformity of standards within a state does not alone imply value, as some standards are relatively weak. For inclusion in this report as a leader state, the standards were also required to meet the test for rigor.

We conclude that there is no “one size fits all” strategy or system for PCA training standards, even in the states with the most uniform and rigorous standards. In fact, each of these leader states has traveled a markedly different path to arrive at its current system.

States may wish to consider approaches such as those used in Idaho and Alaska, where stakeholders and advocates from different settings and populations came together to outline the “core competencies,” or those skills and knowledge that are required to provide supports and services across settings or populations. Population-specific knowledge (such as training in specific diseases, dementia, intellectual disabilities, and hospice) can then be added on to core training. This type of structure helps to prevent duplicative training for PCAs and allows them to build upon existing skills and experience with further training. In other states,

especially those with collective bargaining agreements between home care workers and the state, such as Washington, it may be possible to arrive at a uniform system with a mandatory set of competencies or curriculum, or even certification.

It is important to note that viewpoints differ markedly across stakeholders on the need for more oversight and mandatory training for PCAs. What is clear is that there is no single right way to go about rationalizing the currently fragmented system; any reforms that states explore should be undertaken with thorough stakeholder engagement—including input from consumers and their families.

Implications

We determined the states that are leaders in training of personal care aides based on the uniformity of standards and the presence of one or more elements of rigor (hours, exam, competencies, curriculum, and certification). We believe these elements to be important components of high quality training standards, however the existence of standards is not enough to ensure that PCAs are sufficiently prepared to perform their duties. In fact, even in these leader states, there remain unanswered questions about the preparedness of personal care aides to perform an ever evolving and involved array of medical and support tasks for individuals with complex conditions.ⁱⁱ Future research should examine how these standards are operationalized on the ground and the degree to which PCAs who undergo training have the skills they need to provide high quality supports and services.

ⁱⁱ See: Hajishengallis, O. (2013, December 8) States looking to tighten rules on home care aides. *USA Today*, Retrieved from: www.USAToday.com; Serres, C. (2014, August 17) Care aides get little to no training for life-and-death tasks. *The Star-Tribune*, Retrieved from: www.startribune.com.

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Arizona: Arizona Administrative Code, article 5, R9-28-508; Medicaid provider manual.

Arkansas: Arkansas Code 0.16.06.034, Medicaid provider manual; Medicaid waiver applications.

Idaho: Idaho Administrative Procedure Act 16.03.10.300, 16.03.10.320, 16.03.10.700 through 719; Idaho Code 39-5605; Medicaid waiver applications; Idaho Skills Matrix.

Minnesota: Minnesota Statute 2009 Supplement 256B.0659.

Virginia: Virginia Administrative Code: 12-VAC 30-120-900, 950; 12-VAC 30-120-211, 225, 233; 12-VAC 30-120-700, 766, 770.

Washington: Washington Administrative Code 388-106-0200, 388-106-0300, 388-106-0500, 106-1400, 388-845.

Table 1. Leader State Training Standards

State	Hours	Exam/Evaluation	Skills/Competencies	Curriculum	Certification
Alaska	40	Agency-based, must be approved by state	1. Working with others 2. Assessing strengths and needs 3. Planning services 4. Linking to resources 5. Advocating 6. Individualizing care 7. Documenting 8. Behaving professionally and ethically 9. Developing professionally	No state sponsored curriculum, but state must approve the curriculum	No
Arizona	Not specified	Statewide	1. Roles and responsibilities within the agency and/or community 2. Ethical and legal issues 3. Observing, reporting, and documenting 4. Communication and cultural competency 5. Job management skills and self-care 6. Infection control 7. Safety and emergencies 8. Nutrition and food preparation 9. Home environment maintenance 10. Body mechanics and techniques for maintaining back safety 11. Additional competencies outlined in the areas of: aging and physical disabilities, developmental disabilities, and Alzheimer's and related dementias	Yes, sponsored by the state, not mandatory	No

State	Hours	Exam/Evaluation	Skills/Competencies	Curriculum	Certification
Arkansas	40	Agency-based evaluation, must be approved by state	Required skills in the Arkansas Medicaid provider manual §222.120. 1. Correct conduct toward beneficiaries 2. Understanding and following spoken and written instructions 3. Communications skills 4. Record-keeping 5. Recognizing and reporting changes in the beneficiary's condition or status 6. State law regarding delegation of nursing tasks to unlicensed personnel 7. Body functioning 8. Safe transfer techniques and ambulation 9. Normal range of motion and positioning 10. Recognizing emergencies and knowledge of emergency procedures 11. Basic household safety and fire prevention 12. Maintaining a clean, safe and healthy environment 13. Personal hygiene and grooming	No state sponsored curriculum, but state must approve the curriculum	Yes, done by agency or training entity not the state.
Idaho	Not specified	RN must sign off that aide can complete each relevant task, per Idaho Skills Matrix. The methods for training and testing are left to the employer.	Successful completion of the Skills Matrix Competencies (excluding participant specific endorsements) is a pre-employment requirement for all direct-care providers in the State of Idaho. Each employer will determine the methods used to train and assess direct-care staff competencies: 1. Communication ability 2. Confidentiality 3. Personal care, including: meal preparation, feeding, toileting, mobility, hygiene	Agencies provide training on skills listed in skills matrix.	No

State	Hours	Exam/Evaluation	Skills/Competencies	Curriculum	Certification
			4. Medication 5. Supervision 6. Infection control 7. IADLs including: finances, shopping, laundry, and housework 8. Additional participant-specific endorsements are also required		
Minnesota	Not specified	Statewide, online	Modules covered in basic training include: 1. Overview of the Personal Care Assistant (PCA) program and people 2. Emergency preparation 3. Infection control and standard precautions 4. Body mechanics 5. Understanding behaviors 6. Professional boundaries, child and vulnerable adult maltreatment 7. Time cards and documentation 8. Fraud 9. Stress, personal self-care and support for the PCA role 10.	Yes, online statewide	No
Virginia	40	Statewide, provided by Department of Medical Assistance Services	Yes, outlined by state Dept. of Med. Assistance Services: 1. Effective communication 3. Bed-making 4. Mobility and transfer 5. Bathing 6. Skin and hair care, including shaving the male recipient 7. Passive range of motion exercises 8. Oral hygiene	Yes, statewide. Note agencies may add additional units. Also, note that PCAs employed in the IDD waivers must complete additional	No

State	Hours	Exam/Evaluation	Skills/Competencies	Curriculum	Certification
			9. Dressing or assisting with dressing the recipient 10. Assisting recipient with self-administered medications 11. Meal preparation and feeding	training in working with clients with IDD.	
Washington	75	Statewide, Department of Health sponsored.	State specifies curriculum; the 75-hour training includes: orientation, safety training, and 70 hours of basic training, including: 1. Basic skills and information needed to provide hands on personal care 2. Training tailored to a specific group of clients and their unique care needs due to their disease, condition, and/or stage of life Specialty training meets the population-specific requirement when taken with Core Basic training.	Yes, statewide	Yes

Source: Research conducted for Marquand, A., Chapman SA. (2014). The National Landscape of Personal Care Aide Training Standards. San Francisco, CA: UCSF Health Workforce Research Center on Long-Term Care.