PHI QUALITY CARE THROUGH QUALITY JOBS

New York State Legislature Joint Public Hearing: Nursing Home, Assisted Living, and Homecare Workforce – Challenges and Solutions
July 27, 2021
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State Policy Advocacy Specialist, PHI

I want to thank the Standing Committees on Aging, Health, and Labor for hosting today's hearing on the nursing home, assisted living, and home care workforce in New York State. My name is Hannah Diamond, and I am the State Advocacy Policy Specialist at PHI, a New-York based national non-profit organization that works to transform eldercare and disability services by promoting quality direct care jobs as the foundation for quality care.

PHI was founded in collaboration with Cooperative Home Care Associates (CHCA), a worker-owned home care agency in the Bronx with which we continue to partner to improve training and job quality for home care workers in New York City. For three decades, PHI has been the nation's leading expert on the direct care workforce through our research, policy analysis, and direct consultation with policymakers, payers, providers, and workers—developing a unique 360-degree perspective on the long-term care system in our state and across the United States.

My testimony focuses on the nearly 530,000 direct care workers—including nursing assistants, home health aides, and personal care aides—who assist New Yorkers living in nursing homes, residential care communities, and private homes across our state.[1] These workers assist older adults and individuals with disabilities with daily personal care, support their social engagement, and help them maintain their health and wellbeing. As these workers spend more time with clients and residents than any other provider, they also offer critical information and insight to inform care planning and delivery.[2]

The essential contribution of these workers has never been more evident. While the COVID-19 virus has devastated our state, direct care workers have risked their health and lives—and the lives of their loved ones—to provide ongoing care. Tragically, in New York nursing homes alone, nearly 39,600 staff (including but not limited to nursing assistants) have contracted COVID-19 and 90 have died—along with a shockingly high number of

[1] PHI. "Workforce Data Center." Last modified September 14, 2020. https://phinational.org/policy-research/workforce-data-center/. Direct care workers are also employed in other settings, including hospitals.
[2] PHI. 2020. *Direct Care Workers in the United States: Key Facts.* Bronx, NY: PHI. https://phinational.org/resource/direct-care-workers-in-the-united-states-key-facts/#:~:text=Key%20Takeaways,to%204.6%20million%20in%202019.

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nursing home residents.[3] Due to data limitations, we unfortunately cannot quantify how many additional direct care workers in home and community-based settings contracted or died from COVID-19; this shortcoming demonstrates the need for more robust data collection on this workforce, which we address below.

Sadly, many of the factors that accelerated the spread of COVID-19 throughout long-term care—including persistent underfunding, insufficient staffing and heavy workloads, inadequate supervision and support, limited ongoing training, and overall poor job quality, among others—are not new. Indeed, these factors have been driving recruitment and retention challenges in the long-term care industry for decades. PHI commends New York State for investing in long-term care providers in a range of ways during the COVID-19 pandemic.

But more action is critically needed—to support the current workforce, recruit new job seekers to strengthen the pipeline into this sector, and help ensure that we never again reach such a crisis point. To that end, I will highlight five opportunities to improve jobs for direct care workers and increase the availability and readiness of this workforce.

Increase Compensation for Direct Care Workers

Median hourly wages for direct care workers in New York State are $14.24, which is over $3.00 less than the median wage for other occupations in the state that have similar entry-level requirements and $0.65 less than occupations with *lower* entry-level requirements.[5] Despite the physically and emotionally demanding nature of their work, nursing assistants in New York make just under $30,000 per year, residential care aides make less than $25,000 per year, and home care workers make the least, earning approximately $19,000 per year.[6] As a result of low wages, often-unpredictable hours, and limited annual earnings, nearly 50 percent of direct care workers in New York live in or near poverty and rely on public assistance—and many are leaving the long-term care sector for higher-paying or more stable employment opportunities elsewhere.

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[3] These data reflect nursing homes that reported data for the week ending on July 4, 2021. Centers for Medicaid and Medicare Services (CMS). 2021b. *COVID-19 Nursing Home Dataset*. https://data.cms.gov/Special-Programs-Initiatives-COVID-19-Nursing-Home/COVID-19-Nursing-Home-Dataset/s2uc-8wxp.

[5] PHI. "Workforce Data Center." Last modified September 14, 2020. https://phinational.org/policy-research/workforce-data-center/; PHI. 2021. *Caring for the Future: The Power and Potential of America's Direct Care Workforce*. Bronx, NY: PHI. http://phinational.org/caringforthefuture/

[6] PHI. "Workforce Data Center." Accessed 7/13/21. https://phinational.org/policy-research/workforce-data-center/.

Especially given that the state's American Rescue Plan Act (ARPA) Implementation Spending Plan[7] does not, disappointingly, allocate wage increases to direct care workers, alternative solutions are immediately needed to improve these jobs. PHI offers the following four recommendations to the New York State legislature to improve compensation for direct care workers:

- **Recommendation 1:** It is important to note that providers have not received adequate funding to compensate for increased costs related to the pandemic. To ensure that there are sufficient funds in the system to meet the growing need for long-term care services and cover the full costs of providing those services, PHI urges the legislature to end the Medicaid Global Spending Cap and to stop making across-the-board Medicaid cuts.
- **Recommendation 2:** The legislature should direct the Department of Health to establish, with stakeholder input, a living and competitive base wage for direct care workers across long-term care settings. As a model, the Fair Pay for Home Care bill proposes 150 percent of the regional minimum wage as home care workers' base wage.[8] The Department of Health should then integrate these base wages into Medicaid rates through a transparent rate-setting process. The Department must also mandate a base rate that managed long-term care plans must pay providers that fully covers base wages as well as all other labor-related costs, including benefits, training, supervision, and other costs.
- **Recommendation 3:** The legislature should enact and fully fund the Fair Pay for Home Care bill.[9] By providing home care workers with a living and competitive wage, this legislation will attract and retain workers and help overcome a worsening workforce shortage. If enacted, this legislation would lower poverty rates among home care workers, reduce expenditure on public benefits, and increase spending within local economies. As specified above, this wage mandate must be matched by an increase in the Medicaid reimbursement rate and included in the base rate that managed care plans must pay to providers.
- **Recommendation 4:** Specific to nursing homes, PHI commends the New York State legislature for requiring that 70 percent of nursing home revenue be spent on direct resident care, of which at least 40 percent must go towards frontline staff.

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[7] Department of Health. 2021. *Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817*. NY: https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/enhanced_funding/docs/2021-07-08_hcbs_spending_plan.pdf

[8] "NY State Senate Bill S5374." New York State Senate. Accessed 07/19/21. https://www.nysenate.gov/legislation/bills/2021/s5374.

[9] Ibid.

Further analysis is needed, however, to determine if this allocation is enough to provide workers with a living and competitive wage, sufficient benefits, and other job quality elements. After the Department of Health has made its base wage determination, the department should assess—in conjunction with all relevant stakeholders—the appropriateness of this revenue allocation before the next budget cycle to allow timely adjustments in the Fiscal Year 2023 budget.

Strengthen Direct Care Training

While better compensation is needed to attract workers to the long-term care industry, adequate training and advancement opportunities are critical for job satisfaction, workforce retention, and high-quality care. Current training standards and programs do not, for the most part, sufficiently prepare nursing assistants, residential care aides, and home care workers for their complex and challenging roles. As one specific example, the January 2021 New York Attorney General's investigation into nursing homes' responses to the pandemic found that insufficient infection control training contributed to the spread of COVID-19.[10]

The recently completed Managed Long Term Care Workforce Investment Program provides an excellent model for building capacity among long-term care providers and the workforce through enhanced and targeted training programs. As a designated Workforce Investment Organization (WIO), PHI has created a range of timely and specialized trainings in response to providers' needs, including value-based payment and pandemic-related trainings. PHI applauds the Department of Health for its recent recognition, via the state's ARPA Implementation Spending Plan, of the critical role that WIOs play in enhancing worker preparedness; with this potential ARPA funding, WIOs will assist providers and workers to achieve value-based payment goals.

To improve training for direct care workers, PHI offers the following recommendations:

- **Recommendation 1:** Once the state's ARPA Implementation Spending Plan has been approved, robust oversight is needed to ensure that it is properly implemented for the benefit of providers, workers, and clients/residents. The New York State legislature should direct the Department of Health to facilitate consistent feedback from all relevant stakeholders, including providers, direct care workers, consumers and their advocates, and others, to monitor implementation and evaluate impact. This oversight is critical for ensuring that all of the provisions within the plan are

[10] "Attorney General James Releases Report on Nursing Homes' Response to COVID-19." New York State Attorney General. Last modified January 28, 2021. https://ag.ny.gov/press-release/2021/attorney-general-james-releases-report-nursing-homes-response-covid-19

appropriately implemented, including but not limited to those related to direct care workforce training.

- **Recommendation 2:** Because the Workforce Investment Program funding ended in March 2021, immediate financial support is needed to ensure that WIOs can continue to meet the training needs of the long-term care workforce. In the event that ARPA funding is not available for this purpose, the legislature must provide bridge funding for WIOs through another timely funding mechanism.
- **Recommendation 3:** Beyond this initial bridge-funding period, the Workforce Investment Program should be reviewed and renewed for an additional four years—with key amendments based on lessons learned specific to engagement, timing, flexibility, measurement, and sustainability.[11]

Create Opportunities for Advancement

Career advancement opportunities within direct care are also critical for retaining workers, amplifying their contribution to client/resident care, and achieving quality outcomes and cost savings for the system. In advanced roles, direct care workers can help new staff develop their competence and confidence; support existing staff in navigating challenging care situations; provide specialized care for residents with complex conditions, such as those living with dementia; assist in entry-level training; play a meaningful role in care planning and assessment as part of the interdisciplinary care team; and more. Examples of advanced roles include "transitions specialists" who assist clients in safely moving between care settings, "peer mentors" who support new hires throughout their onboarding process (and beyond), and "care integration senior aides" who support other direct care workers and family caregivers and serve as a link to the interdisciplinary care team.[12]

Career ladder innovation is already happening at the individual provider level, but there is a need to invest in, evaluate, and scale-up these efforts. To develop advanced roles for direct care workers, PHI offers the following recommendations:

- **Recommendation 1:** The New York State legislature should enact and fully fund the Home Care Jobs Innovation Fund (Senate Bill S4222) to support pilot projects

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[11] PHI. 2021. *PHI Urges New York State to Renew the Medicaid Managed Long Term Care Workforce Investment Program*. Bronx, NY: https://phinational.org/wp-content/uploads/2021/06/Discussion-Paper-April-2021.pdf

[12] Hostetter, Martha, and Sarah Klein. "Placing a Higher Value on Direct Care Workers." Commonwealth Fund. Last modified July 1, 2021. https://www.commonwealthfund.org/publications/2021/jul/placing-higher-value-direct-care-workers; Scales, Kezia. 2017. *Success Across Settings: Six Best Practices in Promoting Quality Care through Quality Jobs*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2017/09/evaluation_brief_final.pdf

aimed at improving recruitment and retention among home care workers, including career advancement innovations.[13] While innovation is needed across long-term care settings, this bill's focus on home care is especially justified, as home care workers represent the largest and lowest paid segment of the direct care workforce.

- **Recommendation 2:** As New York State's new Section 1115 Medicaid Waiver is designed, the Department of Health should consider building in advanced role demonstration projects. The waiver should include provisions for thorough evaluation of these demonstration projects to build the evidence base and facilitate replication and scale-up statewide.

Convene a Direct Care Workforce Taskforce

PHI strongly encourages the New York State legislature to convene a Direct Care Workforce Taskforce to engage diverse stakeholders in developing a coherent and sustainable response to the challenges facing the direct care workforce in long-term care. The Taskforce should be comprised of representatives from the Departments of Health, Education, and Labor, as well as managed care plans, long-term care providers, workforce development experts, direct care workers, long-term care consumers, family caregivers, and other stakeholders. The Taskforce could provide feedback on the state's implementation of the ARPA Implementation Spending Plan, the 1115 Medicaid Waiver redesign, compensation and benefits for workers, training access and quality, and innovative approaches to improving workforce recruitment and retention. We recommend that the Taskforce develop an initial report outlining the current needs of the long-term care workforce and recommendations to address these concerns by the end of the first year. The Taskforce should then produce a follow-up report within two years that evaluates the state's progress toward achieving those recommendations.

Improve Direct Care Workforce Data Collection

Finally, PHI recommends that New York State improve efforts to collect, monitor, and report direct care workforce-related information from across all long-term care settings. The state's current data collection limitations impede policymakers from quantifying workforce shortages and other challenges, monitoring workforce trends over time, and evaluating the impact of policy and practice interventions.

To address these concerns, PHI suggests a two-phase approach. First, the state should survey all relevant departments and agencies, including but not limited to the Departments

[13] Cook, Allison. *The Home Care Jobs Innovation Fund: Investing in Recruitment and Retention of Home Care Workers in New York*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2017/11/Home-Care-Jobs-Innovation-Fund-PHI-Jan-2018.pdf

of Health, Labor, and Education, to catalogue existing workforce-related data collection mechanisms as well as identify gaps and inconsistencies. Second, the state should fund a survey of direct care workers across occupations, care settings, and regions of the state to gather their firsthand experiences, insights, and recommendations for improving job quality. Information from both phases of this data-collection effort could inform the recommendations developed by the Direct Care Workforce Taskforce described above.

Conclusion

To enhance the competitiveness of direct care jobs, strengthen the direct care workforce, and stabilize long-term care for older adults and people with disabilities, the New York State legislature must take action to ensure that direct care workers receive a living and competitive wage, targeted training, and career advancement opportunities. PHI also recommends the creation of a multi-stakeholder Direct Care Workforce Taskforce to develop a coordinated and sustainable response to the state's direct care workforce challenges, complemented by efforts to improve New York's direct care workforce data collection infrastructure. PHI appreciates the opportunity to testify today and looks forward to ongoing conversations about how to best support the direct care workforce in long-term care.

For questions or further discussion, please contact me at hdiamond@PHInational.org or 718-928-2048.

PHI QUALITY CARE THROUGH QUALITY JOBS

NOVEMBER 2018

RESEARCH BRIEF

Best Practices in State-Sponsored Personal Care Aide Training Curricula: Lessons from Six States

BY STEPHEN CAMPBELL

In the absence of widespread training standards, many personal care aides (PCAs) enter the field without adequate preparation, which can lead to anxieties and injuries on the job, among other concerns. Despite their career aspirations, some of these workers end up leaving their jobs because they lack the skills and confidence to provide high-quality care. Recognizing a need to raise the bar on PCA training, six states—Arizona, Maine, Massachusetts, New York, Virginia, and Washington—have developed model curricula for statewide implementation. This report examines these state-sponsored curricula to identify best practices in training methods and content for PCAs and other direct care workers.

HOW DO STATE-SPONSORED CURRICULA PROMOTE HIGH-QUALITY TRAINING?

In the absence of federal training standards for PCAs, states can play a valuable role in establishing and disseminating best practices for preparing these workers to fulfill their complex roles. State-level PCA training requirements tend to be minimal, and lack any specification about training topics or instruction and assessment methods, but there are notable exceptions. This report focuses on six states—Arizona, Maine, Massachusetts, New York, Virginia, and Washington—that have adopted and promoted a comprehensive PCA training curriculum through state regulations.[1] To varying degrees, each of these state-sponsored curricula advance adult learner-centered teaching methods and competency-based content—two widely recognized features of effective entry-level training.

In contrast with traditional, didactic teaching methods, *adult learner-centered methods* are designed to address diverse learning styles and build on the life experience that trainees bring to the classroom. Trainees participate in a mix of dynamic, interactive activities, including hands-on demonstrations that simulate real-world situations—with instructors serving as facilitators rather than experts. An adult learner-centered approach is central to high-quality PCA training, given that many prospective PCAs have limited experience with formal education and may face barriers to success in a traditional classroom.[2]

As well as teaching methods, high-quality training includes competency-based content. With competency-based training, workers develop *knowledge* of key concepts in home care, as well as the *skills* to apply their knowledge in practice. In addition, they develop the *attitudes* that support professional, person-centered care delivery. Moreover, training curricula that are built around core competencies are a critical component of a coordinated training system that facilitates career mobility across settings and populations, which helps ensure a flexible, adaptable workforce.

FIGURE 1: EXCEPTIONAL TRAINING CURRICULUM IMPROVES OUTCOMES FOR PERSONAL CARE AIDES

In 2015, PHI formed the Quality Care through Quality Jobs (QCQJ) Training Collaborative with four training sites to promote a competency-based, adult learner-centered PCA training in the Chicagoland area. Compared to trainees who received their employers' original training, QCQJ trainees:

- Expressed **16 percent** higher overall satisfaction with training;
- Were **17 percent** more likely to "strongly agree" that they felt prepared to support their clients; and
- Reported 11 percent higher intent to stay in their jobs for at least one year.

Source: Campbell, Stephen. 2017. *Training Methods Matter: Results of a Personal Care Aide Training Program in Chicago*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2017/07/training_methods_matter_-_phi_-_july_2017.pdf.

This report examines each state-sponsored curriculum to answer the follow questions: how does the curriculum promote effective instruction? What topics does the curriculum cover? And does the content promote the competency of new workers in the field?

To compare training content, we assigned each subsection of each curriculum to one of 12 competency areas named in the *Direct Service Workforce Core Competencies* set developed by the Centers for Medicare and Medicaid Services (CMS) for all direct care workers (see Appendix A).[3] To avoid double-counting the curricular content, we assigned each subsection to only one competency area (identifying the primary competency in subsections that touched on more than one).

THREE REASONS PCAs NEED HIGH-QUALITY TRAINING

1. **Explosive Demand:** More than **600,000** new home care workers will be needed nationwide within the next decade.[4] Better training is needed to help improve job satisfaction, reduce turnover, and ensure an adequate supply of workers now and in the future.[5]

2. **Higher Care Needs:** More people with intensive support needs are now receiving services in their homes and communities. Training standards for PCAs have not kept pace with this trend, however, leaving many workers unprepared to provide the type or level of services required.

3. **Dangerous Work:** Compared to the average U.S. worker, PCAs face a **44 percent** higher likelihood of experiencing injuries on the job.[6] As part of a comprehensive safety program, better training for PCAs can help reduce the risk of accidents and injuries.[7]

Arizona: 'The Principles of Caregiving'

SUMMARY

DESCRIPTION: Arizona's *Principles of Caregiving* curriculum was funded and developed by state-organized workgroups from 2004 to 2012.[8] It includes a basic core module and population-specific modules. Home care agencies must ensure that PCAs ("direct care workers" in Arizona) complete the core module and a module on caring for older adults and people with disabilities within 90 days of hire.

CUSTOMIZATION: With state approval, training providers may use their own training curricula as long as they cover the same competencies featured in the *Principles of Caregiving*.

TRANSFERABILITY: PCA training is not transferable to other settings in Arizona.

INSTRUCTION METHODS

The *Principles of Caregiving* specifies skill demonstration activities to assess trainees' competencies in assisting consumers with activities of daily living. Otherwise, instruction methods are largely left to trainers, although the curriculum does suggest a small number of interactive activities. For example, one exercise asks trainees to discuss in small groups how they would handle emergencies.

APPROACH TO COMPETENCY

Each section of the curriculum lists learning objectives. These objectives focus primarily on knowledge attainment, except for objectives related to technical skills, which require skill demonstrations. For example, one learning objective is to describe effective communication and conflict resolution, but the curriculum does not specify how trainees should demonstrate competency on this topic.

CONTENT

UNIQUE CONTENT: The curriculum delineates the principles of independent living and includes anecdotes from consumers on why they value these principles, as well as providing content on supporting consumers' sexualities.

Maine: ‘Introduction to Health Care and Human Services’

SUMMARY

DESCRIPTION: Since 2003, all PCAs (“personal support service workers” in Maine) must receive training using the *Introduction to Health Care and Human Services* curriculum within six months of starting employment.[9]

CUSTOMIZATION: Trainers may not develop their own curricula.

TRANSFERABILITY: The state acknowledges the applicability of the curriculum’s content to other settings—the PCA curriculum also serves as an introductory course for nursing assistants.[10]

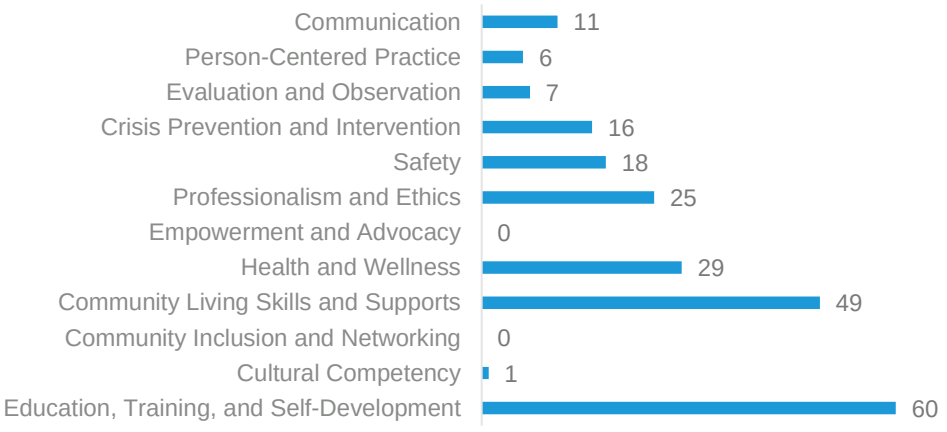
INSTRUCTION METHODS

Maine’s curriculum primarily relies on didactic instruction methods but does suggest opportunities for trainees to practice technical skills in front of a trainer.

APPROACH TO COMPETENCY

For technical aspects of personal care, the curriculum includes a few competency-based learning objectives, such as “demonstrate the ability to break a fall.” However, for other topics, such as communication and a person-centered demeanor, the curriculum does not specify how trainees should demonstrate competence.

CONTENT



UNIQUE CONTENT: The curriculum includes a section focused exclusively on personal and career development, encouraging trainees to advance their education and pursue other careers in health and human services.

Massachusetts: 'The ABCs of Direct Care'

SUMMARY

DESCRIPTION: In 2012, the Executive Offices of Health and Human Services and Elder Affairs in Massachusetts received a federal Personal & Home Care Aide State Training (PHCAST) demonstration grant to develop the 60-hour *ABCs of Direct Care*. The state partners with advocacy groups and educational institutions to update and disseminate the training.[11]

CUSTOMIZATION: Agencies may use their own curricula. In the state's Medicaid contracting standards, home care agencies are encouraged, but not required, to use the curriculum.[12]

TRANSFERABILITY: After completing the training, workers may take an abbreviated training to become home health aides or nursing assistants.

INSTRUCTION METHODS

The *ABCs of Direct Care* provides background content for trainers on adult learning concepts and their application in training. It also reinforces these concepts through a range of suggested classroom activities, including hands-on practice.

APPROACH TO COMPETENCY

The curriculum includes skills-based learning objectives for each section and provides guidance to trainers on how to assess trainees' knowledge, skills, and attitudes through a combination of observation and testing.

CONTENT

UNIQUE CONTENT: The section on communication mirrors PHI's Coaching Approach® to Communication, which stresses paraphrasing, active listening, and open-ended questions.

New York: 'Home Care Curriculum'

SUMMARY

DESCRIPTION: The 40-hour *Home Care Curriculum* was originally developed in 1992 by the State University of New York at Buffalo and revised by a state workgroup in 2002.[13] All PCAs must receive training that follows the *Home Care Curriculum* within 60 days of hire.[14]

CUSTOMIZATION: Home care agencies must follow the framework of the *Home Care Curriculum* in developing their own training programs, which must then be approved by the Department of Health.

TRANSFERABILITY: The curriculum forms the basis for a lengthier home health aide training, and the "basic core" of the curriculum is transferable to nursing assistant training.

INSTRUCTION METHODS

Although the curriculum does not offer detailed guidance on adult learner-centered methods, each section of the curriculum provides broad suggestions for classroom activities (e.g,. role plays, case scenarios, and hands-on demonstrations). More specifically, the curriculum requires trainees to demonstrate competency in certain tasks, such as assisting with activities of daily living.

APPROACH TO COMPETENCY

Learning objectives are based on a mix of knowledge and skills. For some sections, knowledge-based objectives are paired with "measurable performance criteria." For example, trainees are asked to discuss cultural sensitivity *and* demonstrate how cultural difference affects communication.

CONTENT

UNIQUE CONTENT: The curriculum frames personal care delivery according to the principles of basic human needs, which include: physical needs, safety and security, belonging, self-worth, and self-fulfillment.

Virginia: ‘Personal Care Aide Training Curriculum’

SUMMARY

DESCRIPTION: Since 2002, all home care agencies are required to follow the 40-hour *Personal Care Aide Training Curriculum*. According to the Department of Medical Assistance Services (DMAS) regulations, PCAs must complete the training before providing personal assistance services under any Medicaid waiver program.[15]

CUSTOMIZATION: Trainers must include content from the *Personal Care Aide Training Curriculum* in their own trainings but are encouraged to include additional topics as needed.

TRANSFERABILITY: PCA training does not apply toward training requirements in other direct care occupations.

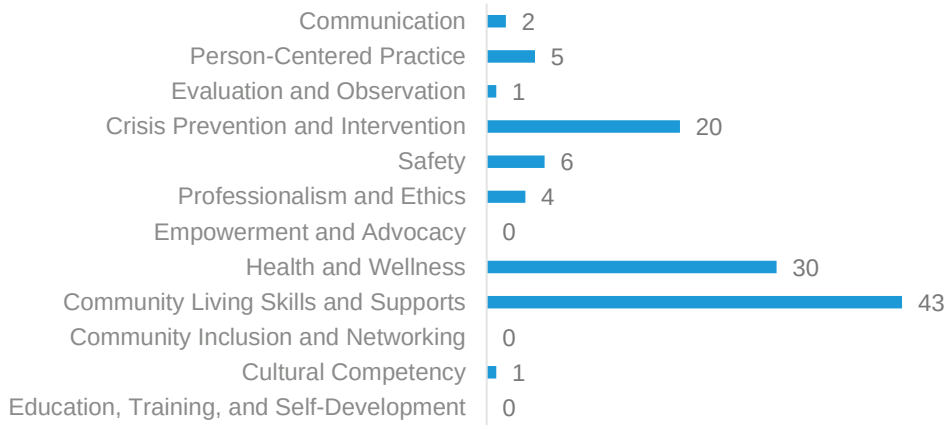
INSTRUCTION METHODS

The curriculum does not prescribe teaching methods. Trainers must develop their own methods for assessing their trainees’ skills, although a sample skills assessment is provided.

APPROACH TO COMPETENCY

The *Personal Care Aide Training Curriculum* broadly outlines training topics and briefly prescribes how workers should perform tasks, but trainers are responsible for populating most of the training content. For example, in the section on infection prevention, the curriculum encourages instructors to demonstrate proper glove removal, but does not specifically describe how trainers should demonstrate or evaluate this task.

CONTENT



UNIQUE CONTENT: The curriculum encourages training providers to partner with local police and fire departments to speak about personal and environmental safety in the home.

Washington: Department of Social and Health Services (DSHS) Curricula

SUMMARY

DESCRIPTION: The Washington Department of Social and Health Services (DSHS) provides three curricula: a three-hour safety training, a two-hour orientation, and a lengthier basic training called the *Revised Fundamentals of Caregiving*.[16] The state developed these curricula from 2002 to 2004, with input from leaders in home care. PCAs must complete 75 hours of training following a state-approved curriculum within 120 days of their start date.

CUSTOMIZATION: Trainers may develop their own curricula, but unlike in other states that allow this flexibility, they must align training content *and* instruction methods with the state-sponsored curriculum.

TRANSFERABILITY: After obtaining certification, PCAs may take an abbreviated training to gain certification as home health aides or nursing assistants.

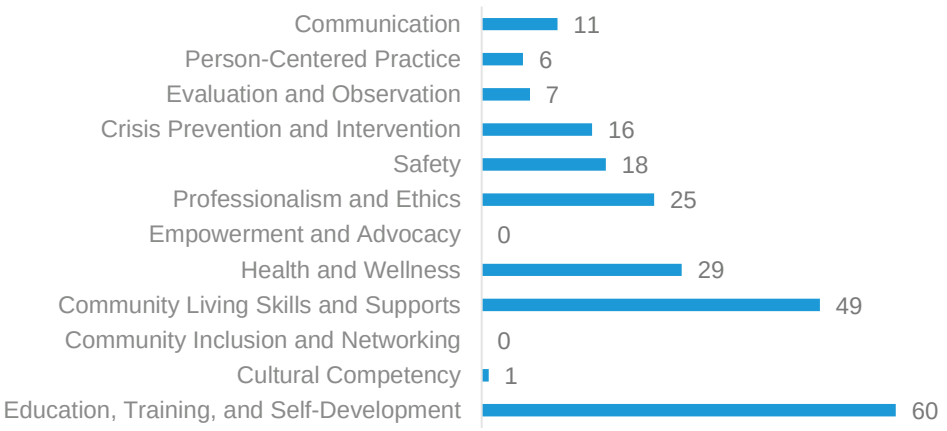
INSTRUCTION METHODS

The curricula explicitly endorse adult learner-centered teaching methods, providing a range of activities designed to meet a variety of learning styles—including brainstorming, guided discussions, and skill demonstrations.

APPROACH TO COMPETENCY

Each module of the curricula specifies competency-based learning objectives and provides a range of ways for trainers to assess trainees' knowledge, skills, and attitudes. Trainees are also required to demonstrate competency through a certification exam, which includes a written portion and skill demonstrations.

CONTENT



UNIQUE CONTENT: The curricula encourage trainees to expand their knowledge by providing extensive resources on common conditions that affect older adults and people with disabilities.

DISCUSSION

This report has examined six state-sponsored PCA curricula to draw out similarities, differences, and best practices in standardization, content, and teaching methods.

Maine stands out as the only state that requires training providers to exclusively use the state-sponsored curriculum. In the other five states, training providers can develop their own curricula, but those curricula must align with the content established in the state-sponsored curricula.

The review found a range of requirements for teaching methods in state-sponsored PCA curricula. For example, Washington training providers must adhere to the adult learner-centered methods laid out in the state-sponsored curricula. The same is true for Massachusetts trainers who opt to use the state's *ABCs of Direct Care* curriculum. The other state-sponsored curricula also require or recommend that trainers incorporate diverse learning activities into their curricula, such as skill demonstrations, group discussions, and case studies—but specification of these activities varies widely across the curricula.

In assessing the extent to which each state-sponsored curriculum follows a competency-based approach, we found that most curricula encourage or require trainers to assess trainees' mastery of technical competencies, such as lifts and transfers (see Appendix B). By comparison, the curricula tend to under-emphasize relational competencies, such as communication and person-centered care. There are exceptions: Arizona requires trainees to learn the principles of independent living, and in New York's curriculum, trainees learn to apply a basic human needs framework to their daily work. New York, Massachusetts, and Washington also cover skills in communication, like open-ended questions, active listening, and paraphrasing.

As well as enhancing individual trainees' job preparedness, a competency-based approach enhances career mobility and workforce flexibility in direct care—as workers are able transfer and build on recognized competencies from one role or setting to another. Reflecting this idea, Maine, Massachusetts, New York, and Washington allow PCAs to complete an abbreviated training program to become home health aides or nursing assistants.

CONCLUSION

By standardizing best practices in PCA training content and instructional methods through state-sponsored curricula, states can help ensure that new workers are prepared to provide skillful, professional, and person-centered care when they enter the field. In the training classroom, competency can be honed through various activities that engage trainees regardless of their educational background or learning style.

This approach to training deserves consideration by other states. In an era characterized by high turnover, a limited supply of workers, and growing demand for services, state-sponsored training—when paired with ongoing support from supervisors and peers—can help workers feel safe, confident, and competent in doing the work that they love.

NOTES

[1] A seventh state, Idaho, specifies detailed training topics for direct care workers, including PCAs, through regulations, but has not adopted a specific curriculum.

[2] PHI. 2018. *U.S. Home Care Workers: Key Facts*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2018/08/U.S.-Home-Care-Workers-2018-PHI.pdf

[3] Centers for Medicare and Medicaid Services (CMS). 2014. *CMS Direct Service Workforce Core Competencies*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/ltss/downloads/workforce/dsw-core-competencies-final-set-2014.pdf. The *Professionalism and Ethics* competency area emphasizes workers' respect for the rights of consumers and family members in delivering services, whereas *Empowerment and Advocacy* covers the role of workers in communicating those rights to the people they support. *Safety* relates to environmental hazards, like fires and natural disasters, as well as abuse and neglect, while *Crisis Prevention and Intervention* comprises all content related to personal crises among consumers. In this report, *Crisis Prevention and Intervention* also includes content on workers' personal safety.

[4] Campbell, Stephen. 2017. *Here's How We Achieve a Strong Economy: Invest in Direct Care Workers*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2017/11/LTC-and-the-Economy-PHI-2017.pdf

[5] Swedberg, Lena, Hans Michelsen, Eva Hammar Chiriac and Ingrid Hylander, 2015. "On-The-Job Training Makes the Difference: Healthcare Assistants Perceived Competence and Responsibility in the Care of Patients with Home Mechanical Ventilation." *Scandinavian Journal of Caring Sciences* (29(2): 369-378. http://dx.doi.org/10.1111/scs.12173.

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

[7] Sherman, Martin F., Robyn R.M. Gershon, Stephanie M. Samar, Julie M. Pearson, Allison N. Canton, and Marc R. Damsky. 2008. "Safety Factors Predictive of Job Satisfaction and Job Retention Among Home Healthcare Aides." *Journal of Occupational and Environmental Medicine* 50(12): 1430-1441. doi: 10.1097/JOM.0b013e31818a388e; Stone, Robyn, Jess Wilhelm, Christine E Bishop, Natasha S Bryant, Linda Hermer, and Marie R Squillace. 2017. "Predictors of Intent to Leave the Job Among Home Health Workers: Analysis of the National Home Health Aide Survey." *The Gerontologist* 57(5): Pages 890-899. https://doi.org/10.1093/geront/gnw075; McCaughey, Deirdre, Gwen McGhan, Jungyoon Kim, Diane Brannon, Hannes Leroy, and Rita Jablonski. 2012. "Workforce Implications of Injury Among Home Health Workers: Evidence from the National Home Health Aide Survey." *The Gerontologist* 52(4): 493-505. https://doi.org/10.1093/geront/gnr133; Faucett, J., T Kang, and Robert Newcomer. 2013. "Personal Service Assistance: Musculoskeletal Disorders and Injuries in Consumer-Directed Home Care." *American Journal of Industrial Medicine* 56(4). https://doi.org/10.1002/ajim.22133.

[8] Campbell, Stephen. 2017. *Training Standards for Personal Care Aides: Spotlight on Arizona*. Bronx, NY: PHI. https://phinational.org/resource/training-standards-for-personal-care-aides-spotlight-on-arizona/

[9] Code of Maine. 2003. *Rule Chapters for the Department of Health and Human Services*. 10-149 CMR Ch. 5, 63.10 Personal Support Services. https://www.maine.gov/sos/cec/rules/10/chaps10.htm#149; Maine Department of Health and Human Services, Division of Licensing and Regulatory Affairs. 2005. "Personal Support Specialist (PSS) – Overview." https://gateway.maine.gov/dhhs-apps/assisted/pss_overview.asp.

[10] Maine Department of Human Services, Bureau of Elder and Adult Services. 2003. *Introduction to Health Care and Human Services*. Augusta, ME: Maine Department of Human Services. https://www.maine.gov/dhhs/dlc/licensing/pss/PSS_Student_Manual.pdf.

[11] Massachusetts Direct Care Workforce. 2018. "About the Personal and Home Care Aide State Training Program." https://madirectcare.com/abcs-for-direct-care/about-us/

[12] Massachusetts Executive Office of Elder Affairs (EOEA). 2017. *Homemaker Notification of Intent (NOI) Instructions for Current Providers and Prospective Bidders*. Boston, MA: EOEA. https://noi.800ageinfo.com/Common/GetPubDocument?DocId=17.

[13] New York State Department of Health (DOH). 2007. *Home Care Curriculum*. Albany: NY: DOH. https://www.health.ny.gov/professionals/home_care/curriculum/docs/home_care_curriculum.pdf.

[14] DOH. 2012. "Home Health Aide Training Program Frequently Asked Questions and Answers." https://www.health.ny.gov/professionals/home_care/hhtap_training_program_faq.htm

[15] Virginia Department of Medical Assistance Services (DMAS). 2003. *Personal Care Aide Training Curriculum*. Richmond, VA: DMAS. http://leg5.state.va.us/reg_agent/frmView.aspx?Viewid=3a946000964~1&typ=40&actno=000964&mime=application/pdf

[16] Campbell, Stephen. 2017. *Training Standards for Personal Care Aides: Spotlight on Washington*. Bronx, NY: PHI. https://phinational.org/wp-content/uploads/2017/11/wa_case_study_pca_training_standards_2017.pdf

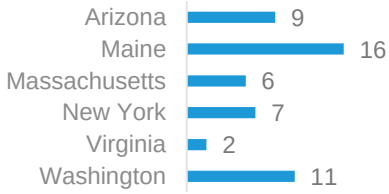
APPENDIX A: CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) DIRECT SERVICE WORKFORCE CORE COMPETENCIES

CMS generated an initial list of direct care competencies through a comprehensive inventory of common competency lists from across settings in long-term care. Next, CMS solicited input from consumers, family members, direct service workers, state representatives, provider agencies, and training development experts to develop the following set of core competencies.

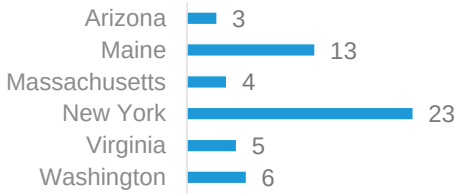
- **COMMUNICATION:** Use strong communication to build relationships with consumers and team members.
- **PERSON-CENTERED PRACTICES:** Assist consumers to make choices and plan goals and support them in achieving those goals.
- **EVALUATION AND OBSERVATION:** Gather information on a consumer's physical and emotional health and communicate observations to care teams and supervisors.
- **CRISIS PREVENTION AND INTERVENTION:** Identify factors that can lead to a crisis and use effective strategies to prevent or intervene in the crisis.
- **SAFETY:** Prevent and respond to signs of abuse, neglect or exploitation and help consumers avoid unsafe situations and keep them safe during emergencies.
- **PROFESSIONALISM AND ETHICS:** Provide supports professionally and ethically, maintaining confidentiality and respecting consumer and family rights.
- **EMPOWERMENT AND ADVOCACY:** Assist consumers in advocating for themselves and achieving their goals.
- **HEALTH AND WELLNESS:** Support consumers in achieving and maintaining good mental and physical health.
- **COMMUNITY LIVING SKILLS AND SUPPORTS:** Help consumers manage the day-to-day tasks that form the basis of independence in the community.
- **COMMUNITY INCLUSION AND NETWORKING:** Help consumers maintain and expand their roles and relationships in the community and assist individuals with major transitions that occur in community life.
- **CULTURAL COMPETENCY:** Respect cultural differences and provide services and supports in line with consumer preferences.
- **EDUCATION, TRAINING AND SELF-DEVELOPMENT:** Obtain necessary training, and seek opportunities to improve skills and work practices through ongoing learning opportunities.

APPENDIX B: CURRICULUM MODULES BY STATE AND COMPETENCY AREA

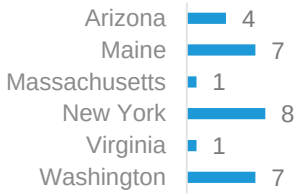
COMMUNICATION



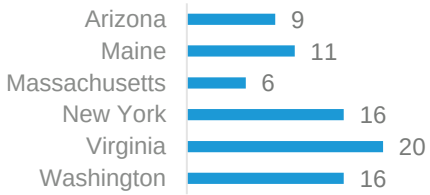
PERSON-CENTERED PRACTICE



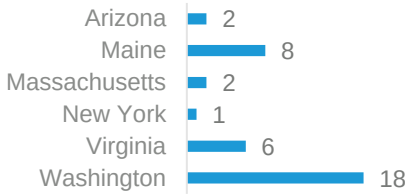
EVALUATION AND OBSERVATION



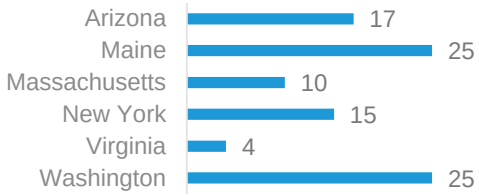
CRISIS PREVENTION AND INTERVENTION



SAFETY

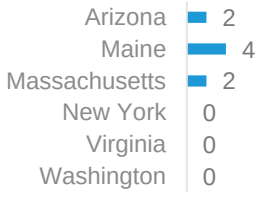


PROFESSIONALISM AND ETHICS

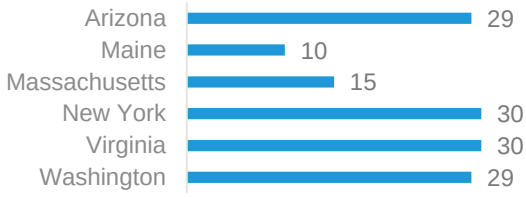


APPENDIX B: CURRICULUM MODULES BY STATE AND COMPETENCY AREA (CONT.)

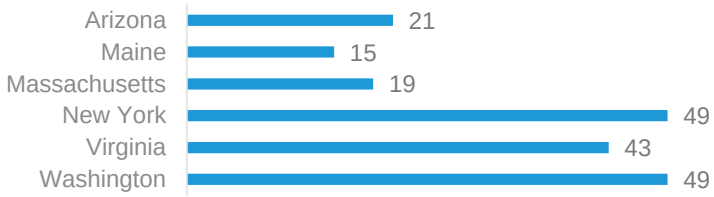
EMPOWERMENT AND ADVOCACY



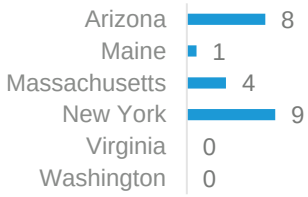
HEALTH AND WELLNESS



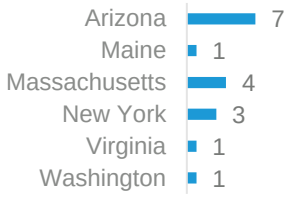
COMMUNITY LIVING SKILLS AND SUPPORTS



COMMUNITY INCLUSION AND NETWORKING



CULTURAL COMPETENCY



EDUCATION, TRAINING, AND SELF-DEVELOPMENT

About PHI

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

Drawing on 25 years of experience working side-by-side with direct care workers and their clients in cities, suburbs, and small towns across America, PHI offers all the tools necessary to create quality jobs and provide quality care. PHI's trainers, researchers, and policy experts work together to:

- Learn what works and what doesn't in meeting the needs of direct care workers and their clients,
  in a variety of long-term care settings;
- Implement best practices through hands-on coaching, training, and consulting, to help long-term
  care providers deliver high-quality care;
- Support policymakers and advocates in crafting evidence-based policies to advance quality care.

For more information, visit our website at PHInational.org or 60CaregiverIssues.org.

PHI Urges New York State to Renew the Medicaid Managed Long Term Care Workforce Investment Program

Summary

Building from lessons learned from the Medicaid Managed Long Term Care Workforce Investment Program, New York State should fund a renewal program ("WIP 2.0") that retains foundational elements of the original program while introducing improvements related to engagement, timing, flexibility, measurement, and sustainability.

Introduction

More than half a million direct care workers, including personal care aides, home health aides, and nursing assistants, provide critical daily supports to older adults and individuals with disabilities across New York.[1] By pledging up to $245 million over the past three years to recruit, train, and deploy direct care workers (and other long-term care workers) through the Medicaid Managed Long Term Care Workforce Investment Program, New York State recognized the importance of providing these essential workers with the tools they need to provide quality care in a rapidly evolving field.[2] Given the imminent conclusion of the Workforce Investment Program (March 31, 2021), this discussion paper recommends that New York State develop a renewed workforce development program as soon as possible, and provides input about how the program should be designed and implemented.[3]

The Value of the Medicaid Managed Long Term Care Workforce Investment Program

New York's Workforce Investment Program was designed to improve the recruitment and retention of direct care workers, improve client health outcomes, address changing training and employment needs, support home and community-based services, and reduce the Medicaid costs of long-term care, among other goals.[4] To achieve these goals, the Workforce Investment Program has supported entry-level and incumbent worker training and career advancement through approved Long Term Care Workforce Investment Organizations (WIOs).

PHI, which is a Bronx-based research, consulting, and advocacy organization, serves as a WIO for the New York City region. As one example of impact, PHI worked with over 15 providers as a WIO, reaching over 1,000 long-term care workers. In our role as a WIO and through engagement with other WIOs and long-term care providers across the state, PHI has seen firsthand the value of the Workforce Investment Program and the critical need for additional funding to continue meeting long-term care workforce development needs. Prior to the COVID-19 pandemic, long-term care providers reported that WIOs provided critical support in addressing their workforce development needs, particularly with regards to meeting value-based payment goals—enabling providers to offer training programs that they

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[1] Cook, Allison. 2020. *New York's Direct Care Workforce.* Bronx, NY: PHI. https://phinational.org/resource/new-york-states-direct-care-workforce/.
[2] New York State Department of Health. "Managed Long Term Care Workforce Investment Program." Accessed March 1, 2021. https://www.health.ny.gov/health_care/medicaid/redesign/2017/mltc_invest.htm.
[3] The Workforce Investment Program was implemented through New York's Medicaid Section 1115 Medicaid Redesign Team (MRT) Waiver. Although this program will expire in March 2021, Governor Cuomo indicated in February 2021 that the state will likely submit a future Section 1115 Waiver State Plan Amendment to address workforce development needs. Cuomo, Andrew. 2021. "FY 2022 Executive Budget Briefing Book." Cuomo, Andrew. 2021. *FY 2022 Executive Budget Briefing Book.* Albany, NY: New York State Governor. https://dingo.telicon.com/NY/library/2021/20210119ZY.PDF.
[4] New York State Department of Health, 2020.

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did not have sufficient funding, capacity, or expertise to offer otherwise.[5] In the context of the pandemic, WIOs provided timely training on COVID-related topics as well as on adapting training programs to meet COVID-related safety considerations (for example, by offering instructor-led remote options or smaller in-person classes).

PHI's experience has revealed several shortcomings in the design of the current Workforce Investment Program. Most notably, the short timeframe of the program, single-year funding cycles, and delayed funding disbursements hindered WIOs and providers from planning longer-term or more innovative workforce interventions. Further, these year-by-year funding uncertainties and delays combined with COVID-related barriers have made it challenging for WIOs to complete their proposed interventions within the program's deadlines. Additionally, although the most effective workforce interventions funded through the Workforce Investment Program have involved close partnerships between Managed Long Term Care plans ("MLTC plans"), WIOs, and providers, this level of partnership was rare because it was neither required nor sufficiently incentivized. Finally, while training for advanced roles for direct care workers has been covered by the Workforce Investment Program, the implementation of such roles has been limited by the lack of sustained funding and support (particularly for enhanced wages).

Guidance for Renewing the Workforce Investment Program ("WIP 2.0")

Given the preliminary success of the Workforce Investment Program in building and strengthening New York's long-term care training infrastructure, PHI recommends that the program be renewed as soon as possible. We suggest that the foundational elements of the program remain the same: designated WIOs should continue to serve as training providers, and WIO training programs should be offered for all long-term care roles and across care-delivery settings. However, based on the lessons learned from the current program, adjustments should be made to improve MLTC plan engagement, expand the timeframe of the program, increase flexibility, effectively measure impact, and ensure sustainability. These amendments are described in turn below.

Improve MLTC Plan Engagement

New York's renewed and revised Workforce Investment Program ("WIP 2.0") should require the meaningful engagement of MLTC plans alongside WIOs and providers. Stricter requirements for all MLTC plans to actively participate in identifying, implementing, and sustaining interventions—rather than some plans opting out of the program, and others simply passing through funding to the WIOs—would expand the reach of the program, allow for better program planning and coordination, and facilitate the implementation of more impactful and sustainable interventions.

Expand the Timeframe

WIP 2.0 should be at least five years long, with WIOs notified of their full five-year awards at the beginning of the program and granted flexibility in how to spend the funds during that timeframe. Relatedly, the timing of funding disbursements should be clearly articulated at the outset, and WIOs should be permitted to roll unused funding over to subsequent fiscal years. These revisions would allow WIOs, in collaboration with MLTC plans and providers, to focus proactively on planning and program design as well as program implementation.

Increase Flexibility

As well as building in more flexibility related to timing, WIP 2.0 should allow greater flexibility in the expenditure of funds. Specifically, the program should cover a greater range of costs related to in-service

[5] Cook, Allison. 2020. *Value-Based Payment in New York: Assessing Progress on Integrating the Home Care Workforce.* Bronx, NY: PHI. https://phinational.org/resource/value-based-payment-in-new-york-assessing-progress-on-integrating-the-home-care-workforce/.

training programs, the development and implementation of advanced direct care worker roles (including enhanced wages), the introduction of new technologies to support workforce development and care delivery, building provider capacity to address workforce development needs, and other interventions. Greater flexibility in the program will allow WIOs to respond to the sector's workforce development needs in more targeted, innovative, and comprehensive ways—toward the goal of improving access to and the quality of long-term services and supports in New York.

Effectively Measure Impact

To demonstrate the impact of interventions and support their sustainability, outcomes data collection and reporting requirements should also be built into the WIP 2.0 program design. As active and accountable partners in the program, MLTC plans should be required to share data on care outcomes that are relevant to value-based payment and related WIO training interventions, such as potentially avoidable hospitalizations, falls, and other outcomes. Additionally, beyond the training-related data that are already collected (i.e., the number of workers trained, and trainees' employment and compensation outcomes), WIOs and providers should also be required to collect and report data on related training and workforce outcomes such as training satisfaction, job preparedness, turnover, and retention.

Ensure Sustainability

The WIP 2.0 program should be structured to promote sustainability—to ensure that workforce development interventions have an impact on the sector beyond the end of the funding period. The recommendations made above can help facilitate sustainability, namely: requiring MLTC plans to engage in planning, implementing, and sustaining interventions; allowing flexibility in the design and implementation of interventions; and measuring the impact of interventions in order to build the case for their continuation. However, additional supports for sustainability should be built into the program design as well. As one specific recommendation, the program should include a mechanism to incentivize the continued utilization and scale-up of advanced roles beyond the funding period. This could be achieved through a separate funding pool that rewards MLTC plans and long-term care providers for continuing to fund advanced roles with proven quality outcomes.[6]

Conclusion

The success of the Medicaid Managed Long Term Care Workforce Investment Program has underscored the importance of having a dedicated long-term care workforce development program in New York. PHI strongly recommends that the state continue this program in an amended form as soon as possible. The WIP 2.0 program would bolster the capacity of the workforce to successfully meet the needs of older adults and people with disabilities in New York. Further, by improving direct care and other long-term care jobs, this improved program would help stabilize the workforce and drive economic growth in the state.

[6] As an example, this pool could be built around a similar model as the Quality Incentive Vital Access Provider Pool, which rewards quality employers who meet wage parity requirements with additional funding. NYS Department of Health. "MRT 61 - Home Care Worker Wage Parity." Updated February 2020. https://www.health.ny.gov/health_care/medicaid/redesign/mrt_61.htm.