NC AHEC | RECRUIT TRAIN RETAIN

Recommendations for HCBS Worker Certification

to the North Carolina Department of Health Benefits

Per contract # 30-2023-007-DHB

The demand for direct care across all caregiving settings, including home- and community-based settings, is on the rise in North Carolina. However, the direct care workforce shortage is reaching crisis levels.

Recognizing this, the North Carolina Department of Health Benefits directed the NC Area Health Education Centers Program (AHEC) to investigate worker certification of direct care workers as a means of addressing the recruitment and retention of home- and community-based care workers.

This report completes the AHEC response to Section D of Contract Number 30-2023-007-DHB, which requested the following:

1) Preliminary Certification Research that was performed to determine the scope and impact of worker certification, including the plan's target audience, benefits and concerns, and potential areas for alignment with existing efforts across the state.

2) Implementation Support Plan that addresses worker certification as part of the recruitment and retention of the HCBS and broader DCW workforce, including addressing questions and concerns, incorporating relevant workforce initiatives; identifying potential tracking methods; and providing direction for next steps.

With this report, AHEC offers a comprehensive plan for implementing DCW worker certification across the state that includes concrete recommendations for policy and practice as well as an understanding of the challenges facing direct care workers both in and outside of home- and community-based settings.

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The Direct Care Worker Credentialing Plan

Objective:

Develop a plan to address certification of direct care workers as a means of increasing the recruitment and retention of the Home- and Community-Based Services (HCBS) workforce.

Additionally, in creating this plan we wanted to:

- Ensure training and career advancement opportunities are accessible to all.
- Ensure nothing in the plan created any primary or secondary barriers to working in direct care.
- Obtain buy-in from both employers and employees by recognizing existing curricula and training accomplishments and ensuring flexibility.

Through our preliminary research, we identified the following four premises to serve as a framework for the implementation support plan:

1. Reliable funding must be made available to invest in the recommended activities.
2. Direct care workers move between settings, specialties, and populations.
3. Existing DCW training curricula and platforms can be leveraged.
4. The solution to the direct care worker crisis is not unilateral.

Why Direct Care Workers?

Direct Care Workers (DCWs) assist older adults and people with disabilities, chronic health conditions, and/or acute illnesses in various settings, including private homes, residential care facilities, nursing homes, and hospitals.

Focusing solely on improving DCW roles in home- and community-based services (HCBS) could lead to DCWs leaving other settings instead of attracting new talent. Further, improving the conditions of DCWs would include improving the lot of HCBS workers, but the opposite would not hold true.

To address the DCW workforce crisis effectively, we must acknowledge the interdependence of DCWs across different settings and consider the healthcare system as a whole. Therefore, we have developed an inclusive implementation support plan for DCWs in all settings, including home- and community-based services.

This plan, which may take up to three years to fully implement, initially prioritizes DCWs providing services in Medicaid-funded home and community-based settings under the 1915(i) State Plan Amendment, prior to expanding to other types and settings. This initial focus includes individuals with intellectual and/or developmental disabilities (I/DD), traumatic brain injury (TBI), and behavioral health conditions.

Implementation Plan

Using our 4 premises as a framework, NC AHEC developed an implementation support plan for developing a credentialing system for direct care workers in all settings, including home- and community-based services, that contains 6 elements:

1 Implement an umbrella system for credentialing DCWs that incorporates new and existing training options.

The credentialing system entails a tiered competency framework that embraces and streamlines existing experience, training, and on-the-job learning within a comprehensive system of buildable skills and qualifications. Employers should have the freedom to determine training needs for their workers, and the status quo must be considered the entry-level direct care position.

2 Adopt common core competencies for all direct care workers.

With a foundation of core competencies -- the essential knowledge, skills, and behaviors needed for effective performance -- additional competencies can be added to address specific needs in various contexts. Core competencies for DCWs include communication, person-centered practices, evaluation and observation, crisis prevention, workplace safety, professionalism, cultural competency, and education.

3 Ensure training is accessible for all workers, including paid training time.

The credentialing plan should prioritize worker accessibility. Employers should provide paid time for worker training and development. And the chosen learning management system (LMS) for worker training and certification should support stackable certifications, be portable, offer annotation capabilities and effective tracking, cater to adult learning, be available in multiple languages, and be compatible with assistive devices.

4 Develop infrastructure for the administration and oversight of credentialing.

Infrastructure is essential for plan execution, outcome assessment, workforce planning, and credentialing system management. This involves designating a lead organization and forming an advisory committee of stakeholders and experts. Employers should receive resources like a consultant group and a handbook for clear implementation guidelines and best practices.

5 Connect competency attainment with wage and rate differentials.

Linking competency achievement to rate differences for employers and wage increases for workers encourages participation. Training costs and time do not burden workers, and employers are adequately compensated to support worker training and advancement. Integrating pay differences promotes higher wages for direct care workers, encourages employer buy-in, and incentivizes workers' professional growth.

6 Provide additional wraparound support services to direct care workers.

Providing wraparound support for workers is essential for their training and advancement. Supports can range widely, from fulfillment of basic human needs to creating hope for the future. Recognizing that direct care workers are underpaid and often marginalized, comprehensive social services can enhance workplace success. Key areas requiring support include childcare, transportation, and access to safe, affordable housing.

North Carolina Facts

Direct care workers provide long-term services and supports (LTSS), including home- and community-based services (HCBS), in a variety of settings.

Direct Care Workers

Low Pay for High Skills

$12.59

the median hourly wage of direct care workers in North Carolina

47%

of direct care workers in North Carolina live in low-income households.

DCW Workforce Crisis

By 2030, North Carolina will have a total of

182,400

direct care job openings.

99%

national turnover rate for nursing home staff

64%

national turnover rate for home care workers

Long-Term Services & Supports

North Carolina ranked

39th

in the overall category

Affordability & Access but

50th

in the subcategory of

No Wrong Door Functions

which is an initiaitve to simplify and streamline access to long-term care services and support.

North Carolina ranked

28th

in the overall category

Quality of Life & Care but

50th

in the subcategory of

Nursing Home Residents with Pressure Sores

which is an indicator that often reflects workforce resources and training.

The shortage in direct care workers has resulted in **decreased access** to care and **decreased quality** of care among LTSS, with providers reporting that

66%

have turned away new referrals,

34%

discontinued some services, and

40%

have seen higher frequencies of reportable incidents.

Please refer to main report, NC AHEC's Recommendations for HCBS Worker Certification, *for citations.*

INTRODUCTION

In the midst of a direct care workforce crisis, North Carolina (NC) is one of the lowest ranking states for direct care workers (DCWs) in terms of compensation, training, and policies related to labor support.[1] In response, Section D of Contract Number 30-2023-007-DHB tasked the NC Area Health Education Centers (AHEC) Program with developing a plan that addresses certification as part of the recruitment and retention of the Home and Community Based Services (HCBS) workforce.

Medicaid covers long-term services and supports (LTSS) through a range of programs and settings. Through Home- and Community-Based Services, people receive care in their own homes and communities rather than in a hospital or other institutional settings. These services include support such as personal care assistance, home-delivered meals, transportation, home modifications, financial services, and more.[2]

Those providing services are called direct care workers (DCWs).[3] These workers are skilled professionals who provide care services to individuals who require assistance due to age or disability in both home- and community-based settings as well as in hospitals and facilities. DCWs include federal occupation codes of personal care aides, home health aides, and nursing assistants/aides.

Common Terms

Home and community-based services (HCBS) is a broad set of health and human services delivered in the home and community, designed to ensure older adults and people with disabilities have an alternative to institutional placement. Eligible individuals such as older adults and people with intellectual and/or developmental disabilities (I/DD), physical disabilities, and/or mental health conditions receive HCBS support through a variety of funding streams.

Direct Care Workers (DCWs) assist older adults and people with disabilities, chronic health conditions, and/or acute illnesses in various settings, including private homes, residential care facilities, nursing homes, and hospitals.

Direct Support Professionals (DSPs) constitute a distinct group within the DCW workforce that provides habilitation services, employment assistance, and other supports to people specifically to with intellectual and/or developmental disabilities (I/DD) in HCBS settings.

[1] *Home- and Community-Based Services*, 2023
[2] "The Medicaid Glossary: Long-Term Services and Supports Glossary," 2021
[3] *Direct Care Workers in the United States: Key Facts 2023*, 2023

Our preliminary research in the development of the implementation support plan indicated the following four assumptions, or premises:

Premise 1: Reliable funding must be made available to invest in the recommended activities. Any plan to address recruitment and retention of the DCW workforce requires a significant investment from state government, insurers, and/or employers. Unfunded, unsupported, and uncoordinated mandates will result in weak, inefficient, and ineffective initiatives – potentially with unintended consequences.

Premise 2: Direct care workers move between settings, specialties, and populations. High job turnover rates among DCWs indicate that they often switch practice settings, either juggling multiple jobs simultaneously or progressing quickly from one role to another. Focusing solely on enhancing DCW roles in home- and community-based care may draw DCWs away from other settings rather than attracting new talent. Addressing the DCW workforce crisis in one area at the expense of another is an ineffective solution. To tackle this issue comprehensively, it is essential to recognize the interconnectedness of DCWs across settings and view the healthcare landscape as an integrated framework. Consequently, this report predominantly discusses all DCWs rather than focusing on specific types or settings.

Premise 3: Existing DCW training curricula and platforms can be leveraged. Existing training programs are often inadequate and inconsistent, rather than comprehensive and competency-based. An essential aspect of formulating a certification plan is to avoid creating further obstacles for DCWs. Instead, the approach should enhance existing comprehensive and competency-based efforts, including those required by federal law (for example, nurse aid certification training and competency evaluation programs[4]), optimizing them to foster professional advancement.

Premise 4: The development and implementation of a certification program will not solve the DCW crisis independently. We can recruit and train DCWs, but the problem will not be solved without efforts to recruit and retain these workers through work culture change, wage increases, and wrap-around supports.

Under these assumptions, we searched the literature with the assistance of the NC AHEC librarians, explored the efforts of other states, and consulted with over 50 advocates, experts, partners, and employers from organizations, agencies, and workgroups across the state.

[4] 42 CFR 483.152

We developed an implementation support plan for direct care workers in all settings, including home- and community-based services, that contains six core elements:

The plan, which we estimate could take 3 years to fully implement, is deliberately inclusive of DCWs in all settings. However, we recommend a scaffolded approach that starts with DCWs who provide services for people with intellectual and/or developmental disabilities (I/DD), traumatic brain injury (TBI), and behavioral health conditions in Medicaid-funded home and community-based settings under the 1915(i) State Plan Amendment.[5]

In developing this report, the NC Area Health Education Centers (NC AHEC) program performed an extensive literature review to understand the current status of the Home- and Community-Based Services (HCBS) workforce as well as what credentialing programs for this dynamic workforce already exist. To ensure the ensuing plan aligned with the current landscape of existing efforts and met needs specific to North Carolina, we consulted subject matter experts from the Department of Health and Human Services, providers, workers, Local Management Entity-Managed Care Organizations (LME/MCOs), family members and individuals with lived experience and other individuals and organizations working in this field. We researched a nationally utilized system for tracking worker competencies as well as multiple training platforms that have training designed specifically for the direct care workforce.

The recommended plan provides a high-quality, flexible framework for credentialing – and thus strengthening – the state's direct care workforce that can be applied across a variety of settings, most notably home- and community-based care settings.

[5] *NC Medicaid Obtains Approval of the 1915(I) State Plan Amendment*, 2023

BACKGROUND

The demand for direct care across all caregiving settings, including home- and community-based settings, is on the rise in North Carolina (NC). However, the direct care workforce shortage is reaching crisis levels.

A Direct Care Worker (DCW) provides essential services, such as bathing, dressing, and other activities of daily living,[6] to support individuals with physical, cognitive, and intellectual/developmental disabilities[7] across a broad variety of employment settings such as nursing homes, residential care, hospitals, and home care sites.

These individuals are formally classified by the United States Bureau of Labor Statistics as nursing assistants/aides, home health aides, and personal care aides,[8] but their specific job titles and duties vary by individual person, population, service definitions, and settings. All three of these federally classified occupations can provide services and supports in HCBS. Direct Support Professionals (DPSs) and independent providers are two other common DCW titles in HCBS that do not have their own federal occupation codes or fit neatly into existing codes.[9]

While the work that DCWs provide is often referred to as "low-skilled" or even "unskilled,"[10] these workers must excel in technical person-centered care as well as interpersonal communication, conflict resolution, and decision-making skills. And, particularly in the current tumultuous service care environment, DCWs must also be competent in wellness, resilience, and self-care.[11]

Direct care workers are highly mobile, moving frequently between settings and specialties. Addressing the workforce crisis in only one area could come at the expense of another by drawing workers away from other settings rather than attracting new workers. Therefore, a comprehensive approach recognizing the interconnectedness of workers across settings is crucial, and this report addresses all direct care workers rather than only those in home- and community-based settings.

[6] Who Are Direct-care Workers?, 2011
[7] Roman et al., 2022
[8] NCHWA, 2018
[9] Direct Care Workers in the United States, 2019
[10] Devine, 2020a
[11] NADSP, 2022; Direct Support Professionals (DSPs), n.d.

Low Pay for High Skills

Direct care work has been historically devalued and misperceived as low-skill work. Due to this misconception of direct care work being low-skilled, DCWs have historically been poorly compensated, with 47 percent of North Carolina's DCWs categorized as living in low-income households. The current median wage of DCWs in North Carolina is $12.59 per hour, which is $2.75 less than the median hourly wage of occupations with similar Standard Occupation Classifications, such as animal caretakers, childcare workers, and pharmacy aides.[12]

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per hour.

Such poor compensation inevitably exacerbates societal inequities, and the direct care workforce has higher representation from historically marginalized or minoritized populations, such as women, people of color, immigrants,[13] and those with low educational attainment. In 2021, of the estimated 112,630 DCWs[14] working across the state, most were people of color (60%), and the vast majority were women (91%). Ironically, as a profession that provides health care support to people in their own homes, almost one out of five (17%) DCWs in North Carolina lack health insurance and nearly a third (31%) lack affordable housing.[15]

These on-the-ground realities in NC are reinforced by PHI's DCW State Index Ranking, which ranks states based on the public policies and financial compensation supporting workers. North Carolina is ranked 47 out of 51 states (including the District of Columbia), placing it as one of the five states with the most opportunity for improvement.[16]

North Carolina also ranked low in the 2020 Long-Term Services and Supports State Scorecard, a performance measurement system that assesses multiple indicators to compare state systems of care and support for older adults, people with disabilities, and family caregivers. Out of 50 states, North Carolina ranked:[17]

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[12] Direct Care Workforce State Index | North Carolina, 2023
[13] Hostetter and Klein, 2021
[14] Defined in this section as personal care aides, home health aides, and nursing assistants.
[15] *Essential Jobs, Essential Care*, 2023
[16] North Carolina – PHI, 2023
[17] AARP, 2020

- 39th in the overall category *Affordability and Access*.
  - However, NC ranked 50th in the subcategory of *No Wrong Door (NWD) Functions*, an initiative designed to simplify and streamline access to long-term care services and support.
- 34th in the overall category *Choice of Setting and Provider*.
  - However, NC ranked 44th in the subcategory of *Self-Direction*, the ability of patients to decide how services are provided and by whom.
- 28th in the overall category *Quality of Life and Quality of Care*.
  - However, NC ranked 50th in the subcategory for *Nursing Home Residents with Pressure Sores*, an indicator that typically reflects workforce resources and training.

High Turnover, Workplace Safety, & Other Retention Issues

PHI projects that by 2030, North Carolina will have a total of 182,400 direct care job openings. But with only about 13 percent (22,900) of those being *new* jobs needed to meet rising demand, the other 87 percent (159,500) of jobs points to a deeper issue: persistent employee turnover.[18]

The employee turnover rate for nearly all types of DCWs across nearly all settings is remarkably high. The annual turnover rate for nursing home staff is an astounding 99 percent, and the annual turnover rate for home care workers is 64 percent.[19] Among DSPs in 2021, the turnover rate ranged from 29 to 59 percent, with a weighted average rate of 43 percent.[20] And in the NC Pandemic Health Workforce Study,[21] more than half (52%) of employer respondents indicated that the types of workers in shortest supply both before and after the pandemic were nursing assistants.

The DCW turnover rate negatively affects the quality of life of those receiving direct care services.[22] And DCWs are

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[18] *Workforce Data Center – PHI*, 2023
[19] Powell and Scales, n.d.
[20] *2021 State of the Workforce Survey Report*, 2021
[21] Tilson et al., 2021
[22] Friedman, 2018

invaluable not only to the individual clients and communities they serve, but also to the "care infrastructure."[23]

In the care system for people with Intellectual and/or Developmental Disabilities (I/DD), the DCW shortage has resulted in 66 percent of providers turning away new referrals, 34 percent discontinuing services, and 40 percent seeing higher frequencies of reportable incidents.[24] These alarming statistics demonstrate not only decreased *access* to care but also decreased *quality* of care.

North Carolina employers further recognize that the inability to recruit and retain DCWs has a spillover effect on the stability of other health professions, such as Registered Nurses. One employer shared, "Simply having a more adequate workforce available with a sufficient supply of trained, direct care employees would help. This would eliminate the overtime demands [on other health care positions]."[25]

The turnover rate is affected by both movement between employers and movement in and out of the profession. Results of the Sentinel Network survey in North Carolina show that employers of DCWs struggle to compete with each other. An acute care employer noted, "Pay rates are rising in the local competitive market, making it difficult to attract and retain talent in rural healthcare."[26]

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This problem extends not just to different service care delivery settings but also to different specialties within health care. An employer in the home care and health services facility setting stated, "We are primarily reimbursed via Medicaid for our services, and the state reimbursement rates are not competitive with the hospitals.... Pediatric nursing home care needs are growing, and the [DCW] supply is low."[27]

[23] Hellmann, 2021
[24] Bradley, 2021
[25] Tilson et al., 2021
[26] North Carolina Health Workforce Sentinel Network, 2022
[27] North Carolina Health Workforce Sentinel Network, 2022

Employers note that the competition from employers outside of health care must also be considered. An employer of personal care aides stated, "We are finding it difficult to keep all aides for more than 3 months.... When they can make more at a fast-food restaurant, it's hard to keep them interested."[28]

> "When they can make more at a fast-food restaurant, it's hard to keep them interested."

Job turnover is further impacted by poor and unsafe working conditions. According to PHI, the injury rate among personal care aides and home health aides was slightly elevated compared to the average injury rate across all occupations, but the injury rate among nursing assistants was over three times that of the average.[29] The most common injuries are those related to the physical demands of DCW jobs, but workers in direct care are also more likely than other occupations to experience violence on the job. One literature review showed that nearly one-third of home care workers (30%) reported experiencing physical violence; additionally, 4% reported sexual abuse and 12% reported experiencing sexual harassment over the course of their career.[30]

These findings emphasize the need to not only evolve as a healthcare and HCBS ecosystem but also to recognize the larger system of employment options. Attempts to address the entire direct care workforce must accurately represent the value that these workers have for both the people they serve and for the other health care professionals they support across the healthcare system.

Training Needs

One method of improving job safety is through direct training and support for DCWs.[31] In addition to reducing the risk of workplace injury, DCW training has a statistically significant negative correlation with COVID mortality, falls, emergency department visits, and re-hospitalizations[32] and a positive correlation with patient-reported quality of life as well as DCW job retention and satisfaction.[33] Unfortunately, client needs are becoming increasingly complex, and DCW training in North Carolina remains inconsistent at best. Employer respondents to the NC Sentinel Network survey[34] expressed concerns over the lack of staff training:

[28] North Carolina Health Workforce Sentinel Network, 2022
[29] Campbell, 2018
[30] Phoo and Reid, 2022
[31] McCaughey, et al., 2012; Walton and Rogers, 2017
[32] Luz et al., 2017; Gallup et al., 2018; Scales, 2017; Levy-Storms & Mueller-Williams, 2022
[33] Russell et al., 2017; Lopez et al., 2012
[34] North Carolina Health Workforce Sentinel Network, 2022

- "Staff are providing care for residents that have a higher acuity. Staff are working longer hours and providing more skilled care to the residents."
- "These are the hardest positions to fill, and people don't stay long when working conditions are so difficult with little back-up, training, or support."

In addition, a common theme among these respondents was concerns over the "lack of qualified candidates," noting that applicants "don't have the needed skills."

Among both empirical and anecdotal evidence, DCWs themselves want increased access to training. Providing training to DCWs not only improves quality of care[35] but may also contribute to retaining this workforce, though studies often measure worker perception of training satisfaction rather than measures of effectiveness of training.[36] One study demonstrated that training and more flexibility in shifts increased DCW retention even without raising wages.[37] In the 2023 Relias survey of Direct Support Professionals (DSPs), a subset of DCWs who generally work for I/DD service providers in HCBS, 61 percent of DSPs who wanted to increase their confidence in their skills wanted to have access to more educational opportunities.[38]

The Direct Care Workers' Perspective

The Relias survey gives insight into factors driving the attitudes of direct support professionals (DSPs), a subset of DCWs, toward their own work supporting people with I/DD. The report summarized these DSPs as having "a desire for workplace wellness, a thirst for learning opportunities, and a yearning for career growth options."[39]

DSPs who were *satisfied* in their jobs reported high levels of satisfaction around available training opportunities, career advancement programs, and how their organization promotes well-being. They were also more likely to feel well prepared for their work, to remain at their current organization, to be satisfied with their supervisor, and to continue working as a DSP.

Of those DSPs who reported feeling *dissatisfied* with their job, the main reasons for dissatisfaction were not feeling fairly compensated (38 percent), not feeling appreciated for their work (25 percent), and not receiving enough support for their work (21 percent).[40]

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[35] Wech, 2001
[36] Brannon et al., 2007; Castle et al., 2007; Wiener et al., 2009
[37] Kishida, 2022
[38] Baker et al., 2023
[39] Baker et al., 2023
[40] Baker et al., 2023

It is worth noting the potential impact of COVID-19 emergency funding on care workers and their retention, as described by the Relias survey:

> While compensation continues to be the largest concern among DSPs, the percentage of respondents who reported not feeling fairly compensated has decreased considerably [from 62% in 2019 to 38% in 2023]. This decrease could be the result of temporary funding received through legislation passed during the COVID-19 public emergency, which allowed DSPs to receive their first meaningful pay increase in quite some time. Without additional funding after the end of the COVID-19 public health emergency, IDD organizations may come to a "fiscal cliff" at some point in the near future, leaving them unable to maintain the increase in wages they've been able to offer their DSPs (and thus negatively affecting their retention rates).[41]

Workers who felt **satisfied** in their jobs also reported feeling satisfied with

- Available training opportunities and career advancement programs
- How their organization promotes well-being
- Their supervisor

They were also more likely to report feeling well-prepared for their work, to remain at their current organization, and to continue working as direct support professional.

Workers who felt **dissatisfied** reported feeling that they were

- Not fairly compensated
- Not appreciated
- Not receiving enough support for their work

While the Relias survey focused on DSPs, our research and expert contributions suggest that its findings can be broadly extrapolated to all direct care workers. We can conclude that DCWs also face the challenges of low wages, lack of benefits, inadequate training, few opportunities for professional advancement, and poor recognition of their contributions.[42]

Increasing DCW pay and benefits is necessary for improving workforce stability but will not be successful if implemented alone. In addition to higher compensation, other factors that support recruitment and retention of DCWs include skilled and supportive supervision, a positive organizational culture that fosters respect for DCWs, opportunities for upskilling and professional advancement, and competency-based training and credentialing.[43]

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[41] Baker et al., 2023
[42] Hess & Hegewisch, 2019; Devine, 2020b
[43] Bradley, 2021

PRELIMINARY CERTIFICATION RESEARCH

In this section, we will describe the scope and impact of worker certification by defining the target audience, describing a training process that addresses the benefits and mitigates potential concerns of a statewide certification plan, and identifying other organizations doing relevant work in NC.

Target Audience

The US Bureau of Labor Statistics recognizes three categories of direct care workers (DCWs): nursing assistants or nurse aides, home health aide, and personal care aides.[44] However, depending on the scope of responsibilities, the setting, and the population served, these workers may have different titles within each of these categories.

Direct support professionals (DSPs) are a subset of DCWs who "offer support and services to individuals with complex health needs who are unable to live independently, either due to age or intellectual and/or developmental disabilities (I/DD)."[45] The evidence behind our plan is primarily rooted in the DSP experience, for a few reasons:

- DCWs in HCBS settings comprise the majority (58 percent) of the DCW workforce.[46]
- DCWs working in the home earn lower wages than categories of equivalent skill within the direct care workforce, such as Certified Nurse Aides in nursing facilities.[47]
- The home care workforce is critical, as it enables people with I/DD to exercise their rights protected by the American Disabilities Act (ADA).[48]
- The number of people with I/DD is growing and their life expectancy is increasing.[49]
- The incidence of co-morbidities across all patient populations require enhanced skillsets that are already highly valued in the DSP workforce.[50]

For these reasons, the DSP workforce in HCBS is at the center of our inquiry. However, considering the interconnectedness of the healthcare ecosystem and the mobility of the direct care

[44] *Standard Occupational Classification*, n.d.
[45] "The Medicaid Glossary: Long-Term Services and Supports Glossary," 2021
[46] *Direct Care Workers in the United States*, 2023
[47] Bradley, 2021
[48] Barkoff, 2023
[49] Videlefsky et al., 2019
[50] Kemp et al., 2022

workforce, a plan focused exclusively on this population or another fragment of the DCW and/or HCBS workforce could result in setting- or sector-specific crises.

Therefore, we considered the needs of DCWs working across *all settings*, such as home-based care, community-based care, nursing facilities, hospitals, and independent providers, as well as *all care populations*, both acute and chronic, including older adults and people with physical disabilities, I/DD, mental illness, substance use disorders, and traumatic brain injury. We primarily use the broader term *direct care worker (DCW)* with occasional reference to more specific DCWs, such as DSP or Nurse Aide (NA).

Implementing this plan across the entire direct care workforce will create a network of invested workers, employers, and communities. Appendix A lists the wide range of titles that these workers hold in North Carolina, along with a description of their role, in what settings and with which populations they work, the training that is currently required (if applicable), and how worker training is currently tracked (if applicable).

Premises

In the course of our preliminary research, we identified multiple areas that would require certain assumptions or prerequisites in order to design a plan. Those assumptions coalesced into the following four premises to serve as a framework for the implementation support plan.

Premise 1: Reliable funding must be made available to invest in the recommended activities.

Any plan to train DCWs requires a significant investment from state government, insurers, and/or employers that is ultimately reflected in direct care worker wages and supports. *Unfunded, unsupported, and uncoordinated mandates will result in weak, inefficient, and ineffective initiatives* – potentially with unintended negative consequences.

According to the Administration for Community Living, "... employer-paid job-related training, financial assistance with pursuing post-secondary education, and support with obtaining credentials were each significantly associated with lower turnover."[51] This plan requires substantial buy-in from employers and from DCWs themselves. Establishing Medicaid reimbursement rate differentials for higher skilled workers will encourage buy-in from employers and will ensure that employers are adequately compensated to support DCW training and advancement so that the cost of the training (both money and time) does not negatively impact the worker. Promoting

[51] Bradley, 2021

accessible training and linking training completion to pay differentials will promote DCW motivation for career development and job retention.

A commitment to oversight and ongoing evaluation is also needed to ensure sustainability and collaboration. Other states that have invested resources in strengthening the DCW workforce – both via increasing wages and non-wage benefits – conduct regular monitoring and evaluation. Strategies include determining trends in turnover, vacancy rates, and compensation via state-administered surveys (Wisconsin, Minnesota, and Michigan); calculating return on investment if DCW wages were raised (Minnesota and New York); measuring impact of requiring LME-MCOs to implement interventions (Arizona); and commissioning studies with workforce components (Michigan).[52]

In its August 2023 Section 1115 Demonstration Renewal Request, NC Department of Health and Human Services requested funding to "provide recruitment and retention payments for direct support professionals and other behavioral health professionals who serve Medicaid beneficiaries."[53] Regular evaluation of these interventions will assess impact and will inform if changes need to be made.

Four premises provide a framework for the Implementation Plan:

Premise 2: Direct care workers move between settings, specialties, and populations.

Due to the breadth and depth of the direct care workforce, a comprehensive study of job patterns, to our knowledge, has never been conducted. However, as high as 40% of long-term care workers, many of which work in direct care, reported holding a second job in a 2022 study.[54]

[52] Roman et al., 2022
[53] North Carolina Medicaid Reform, 2023; Sandoe et al., 2023
[54] Dill et al., 2022

A national survey conducted in 2020 with 9,000 DSP responses concluded 29% of respondents indicated that they worked in different settings because of the pandemic.[55] In addition, our anecdotal conversations and the DCW turnover evidence suggest that these workers likely cross practice settings either by holding multiple jobs simultaneously or through movement from one position to the next.[56] Low compensation is often cited as the top cause of DCW turnover and contributes to movement between organizations and settings.[57] Therefore, the plan herein acknowledges that these workers can – and likely do – move between settings.

In considering the status and future of HCBS workers, it would be detrimental to consider DCWs in home and community settings as separate from DCWs in hospital and facility settings. A comprehensive perspective is therefore crucial, recognizing both the interconnectedness of DCWs across settings as well as the healthcare landscape as an integrated framework. Our strategic course must account for any secondary consequences that may cascade from our proposed plan.

Premise 3: Existing DCW training curricula and platforms can be leveraged.

There are many training opportunities available for direct care workers in North Carolina. However, a major challenge for DCWs is that this training is often inadequate, inconsistent and does not lead to professional advancement.

> The training landscape for direct care workers (i.e., training requirements, delivery systems, content, and methods) leaves many of them without the skills, knowledge, and confidence to succeed in their roles... Furthermore, many training programs in this sector are topic-based and duration-based, instead of taking a competency-based approach that emphasizes workers' acquisition of the right knowledge, skills, and abilities. These programs are also rarely rooted in adult learner-centered instruction, which works best in the direct care context, where many workers have limited formal education. Further... best practice in direct care training – which focuses on core competencies, incorporates the (informal) learning experiences of participants, and assumes active not passive (or didactic) learning and skills demonstration – is unfortunately not the norm in this field.[58]

It is thus clear that North Carolina needs to take steps to improve and streamline training and credentialing requirements for DCWs. However, an essential consideration in developing credentialing recommendations was to create a solution that does *not* create an additional barrier to obtaining work as a DCW. Rather, the solution must leverage efforts that already exist,

[55] Results of The Direct Support Workforce and COVID-19 National Survey, 2020
[56] Scales and Stepick, n.d.
[57] President's Committee for People with Intellectual Disabilities, 2012
[58] Espinoza, 2020

improving them to ensure that they lead to opportunities for career development. North Carolina already has an infrastructure in place for tracking and recruiting into certain credential programs: NC Workforce Credentials, which is a partnership of the NC Office of the Governor, NC Community College System, NC Department of Public Instruction, NC Department of Commerce, NC Association of Workforce Development Boards, and myFutureNC.

NC Workforce Credentials defines credentials as "[indicating] documented mastery of a set of defined skills and competencies… through success in a cumulative assessment" and specifies that non-degree credentials include certificate, industry-recognized certification, and/or license that is below the Associate's level.[59]

Because certifications are considered a type of credentialing,[60] we use the term "credentialing" throughout this report unless referring to a specific type of credential.

Premise 4: The solution to the DCW crisis is not unilateral.

Initiatives to recruit and train DCWs will not be successful without correlating efforts to retain these workers through wage increases, work culture change, and wrap-around supports.

The proposed plan includes elements that seek to:

- Equip DCWs with the skills needed for team-based care, effective communication, self-care and wellness, and workplace safety.
- Incentivize the credentialing achievements of DCWs through employer recognition, advancement, and compensation.
- Foster an environment that encourages employers to connect with their community, motivates communities to invest in their workforce, and provides DCWs with the resources needed – such as safe housing, reliable transportation, affordable childcare, and food security – for them to reliably get to and stay at work.

A multi-faceted approach is necessary to address the multiple challenges DCWs face on the job.

Incorporating Current Requirements into a Training System

The goals of a statewide credentialing program for DCWs are to improve the recruitment, training, and retention of the workforce needed to care for the growing population of North Carolinians

[59] NC Workforce Credentials, n.d.
[60] Mariscal, 2021

in need of direct care services. A statewide credentialing program will garner attention toward and insight into the role of the DCW in promoting meaningful lives for those receiving services.

Currently, a wide range of required and recommended training for DCWs across both the United States and North Carolina persist; but nursing assistants/aides and home health aides who work in Medicare- and Medicaid- certified nursing homes and home health agencies are the only categories with federally required training.[61] A statewide credentialing program should establish a training system for all subsets of DCWs and seamlessly integrate with training that is already required as well as other valuable training that exists in the state. It must supplement but not replace any direct training and orientation that already exists to ensure a quality, supportive caregiving relationship, including both the tactical skills of physical care and the unique needs of the person relying on the DCW.

In terms of benefits, credentialing DCWs in North Carolina would:

- Enhance recognition of workers' value by enhancing professional credibility, recognizing achievement, and fostering respect for direct care workers.
- Support direct care workers by clarifying professional roles and responsibilities, increasing understanding of job expectations, and providing clear pathways for professional advancement.
- Improve the quality of care by ensuring the attainment of necessary skills and competencies.
- Allow a mechanism for tracking and coordinating workforce trends, labor statistics, and outcomes related to professional practices.

By standardizing competencies and allowing data tracking, credentialing programs also create an opportunity to investigate, promote, and ensure equitable care across practice settings and populations.

These benefits of implementing a statewide program for credentialing DCWs were recognized across all advocacy, government, and expert groups that were consulted during this process (Appendix D). But while a generalized consensus on the direction is palpable, substantial concerns also exist. Most notably, a statewide credentialing plan must consider the critical and fragile condition of the direct care workforce. If existing workers perceive a credentialing plan as too difficult or costly to achieve, they may simply leave the direct care workforce altogether.

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[61] *Who Are Direct Care Workers?*, 2011

Therefore, our first recommendation is to implement an umbrella system for credentialing direct care workers that incorporates new and existing training options. By incorporating existing training, experience, and on-the-job training, the plan *recognizes the status quo as entry-level direct care workers*, thus ensuring that current workers retain their ability to work.

> Recommendation #1:
>
> Implement an umbrella system for credentialing direct care workers that incorporates new and existing training options.

To further ameliorate the primary concern of a credentialing program being a barrier to workers, we incorporated the following parameters into our plan:

- Increase training accessibility by ensuring training is available and training time is paid for by employers.
- Incorporate flexibility by embracing DCW core competencies while allowing for training customization and by creating a mechanism for training to follow the DCW between employer settings as well as across a lifelong learning and professional development continuum via credentials that build upon each other.
- Ensuring the retention and integration of current DCWs by recognizing existing training accomplishments.

This umbrella credentialing system should be structured for the attainment of a tiered set of competencies that allow workers to progress through education and certification.

Recognizing DCW Competencies

North Carolina does not currently have the capability to ensure or track the attainment of competencies in the direct care workforce. Within the credentialing system, our second recommendation is for North Carolina to adopt common core competencies for all DCWs across all settings and care populations.

> Recommendation #2:
>
> Adopt common core competencies for all direct care workers across all settings and care populations.

Competencies are "the knowledge, skills, abilities, and behaviors that contribute to individual and organizational performance."[62] Focusing on

[62] What Are Competencies?, 2017

competencies ensures that the knowledge, skills, abilities, and behaviors learned in the classroom space are successfully translated and applied into the practice setting through contextualization. Competency-based education has been gaining traction in the education field over the past 70 years, and in that time, several health care professions – medicine, social work, and nursing, for example – have transitioned to competency-based education.[63]

Competencies also provide common ground. Though job titles and descriptions for DCWs are variable and dependent on population served and/or setting, the foundational competencies required to complete the work are the same. The Direct Service Workforce Resource Center (DSW RC) has adopted the following set of core competencies for workers providing direct care services in long term services and supports (LTSS): communication; person-centered practices; evaluation and observation, crisis prevention and intervention; safety; professionalism and ethics; empowerment and advocacy; health and wellness; community living skills and support; community inclusion and networking; cultural competency; and education, training, and self-development.[64]

Each competency includes skill statements that reflect observable actions and subsets of categories (such as infection control and first aid procedures). After identifying common core competencies for all direct care workers, other competencies can be identified for advanced or specialized skills.

Core Competencies for DCWs:

1. Communication
2. Person-Centered Practices
3. Evaluation & Observation
4. Crisis Prevention & Intervention
5. Safety
6. Professionalism & Ethics
7. Empowerment & Advocacy
8. Health & Wellness
9. Community Living Skills & Support
10. Community Inclusion & Networking
11. Cultural Competency
12. Education, Training & Self-Development

An example of an umbrella system that incorporates a common set of competencies for a subset of DCWs is the National Alliance for Direct Support Professionals (NADSP) E-Badge Academy.

[63] Lewis et al., 2022
[64] The DSW Core Competency Project, 2014

The E-Badge Academy provides a model structure for national credentialing of DSPs and Frontline Supervisors (FLS) by tracking and stacking competencies. It was designed to help DSPs be more aware of and empowered by their unique skill sets, and utilizes stackable electronic badges that demonstrate knowledge, skills, and values utilized by DSPs that go towards DSP-I, DSP-II, DSP-III and FLS certifications.

E-Badges are broken into two categories – hours of NADSP Accredited Education (Knowledge E-Badges) and CMS Core Competency Areas (Skills and Values Badges) – and users must earn badges from each category to meet each level of certification. Knowledge badges are earned when applicants upload training records from a NADSP-accredited training program; these badges are earned in intervals of hours of education completed (e.g., 10 hours education). Skills and Values badges are tied to skill statements from the CMS Core Competencies and the 2014 DSW Core Competencies.[65]

Applicants may earn these badges via testimonials that address two prompts: an example of the applicant applying skills to provide quality support and an explanation of how the values of the profession are shown in their example.[66] NADSP employs a team of reviewers to evaluate testimonials and give feedback when appropriate – these reviewers include people with lived experience and professionals working in the direct care field.

The inclusion of the NADSP FLS badge, which allows for supervisors to also receive a certification to demonstrate their competence in the knowledge, skills, and values required for their work, is an important component of the umbrella system. In a 2023 survey of DSPs working in the I/DD field,[67] findings indicated that positive workplace culture, job satisfaction, and worker retention were dependent on workers having competent and supportive supervisors. In fact, half of DSPs reported that they had left their jobs because of a supervisor.[68] DSPs report an increasing desire for their supervisors to act as mentors. Additionally, they seek supervisors that demonstrate respect, communicate transparently, hold staff accountable equally, show appreciation for a good job, have a positive attitude, and provide professional and emotional support,[69] all of which require upskilling. Similar findings have been reported for other types of DCWs.[70]

Considering the direct care workforce is already in critical shortage, any efforts to credential DCWs must be done in a way that does not create barriers to workforce entry nor negatively

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[65] *Long-Term Services and Supports Care Management,* n.d.
[66] Baer & Hermreck, 2023
[67] Baker et al., 2023
[68] Baker et al., 2023
[69] Baker et al., 2023
[70] Espinoza, 2020

affects retention of the current supply. In the umbrella system that we are recommending, employers and people who hire DCWs under the self-directed models have flexibility in choosing the appropriate level of training that is required for the job, and *the status quo must be considered the entry level DCW position*.

For example, an employer or regulator may determine that the NA-I certification fulfills the requirements for a specific DCW position. The employer could identify the need for and recognize the benefit of additional training in the North Carolina credentialing umbrella and require a DSP-II (or other umbrella) certification in addition to an NA-I for a specific position. These decisions should remain employer-based, with state-level incentives for participation, and should be reflected in rate and wage increases for each additional credential.

In another example, a person with an I/DD can choose to hire a college student and provide on-the-job training that will meet that persons' needs. The DSP (or other umbrella) certification offers individuals who self-direct their care opportunities to support the professional development of their DCW, in addition to the individualized training they provide directly. These decisions should remain in the hands of the person receiving the care, with incentives for DCWs to pursue certification, including wage increases.

On the other hand, existing training such as the NA-I certification curriculum could be reviewed and approved to count towards the NADSP Knowledge E-badges (or other umbrella system) that are required for certain tiers of DSP (or other umbrella) certifications. Accrediting existing training mechanisms through NADSP (or other umbrella system) reduces the amount of training needed for positions that require certifications in addition to the statewide credentialing and provides motivation for direct care workers to pursue certification. In addition, incorporating existing training into the umbrella could create opportunities for augmentation of the skills and developing competencies that are not fully addressed in current NAI training.

Choosing an Accessible Learning Management System

Many of these core competencies are addressed in existing training. However, preliminary analysis conducted by Workforce Engagement with Care Workers to Assist, Recognize and Educate (WECARE) in North Carolina reveals that the existing requirements for many types of DCWs are not meeting all of these core competencies, and most current DCWs will need further training. Therefore, our third recommendation is to ensure training is accessible for all DCWs, including ensuring paid training time.

> Recommendation #3:
>
> Ensure training is accessible for all direct care workers, including ensuring paid training time.

North Carolina's DCWs have various training requirements, depending on the service provided, the population served, and the location of that service. Further, these trainings are implemented in a variety of ways, depending on the training itself--employer-sponsored, trainings and credentialing available through high schools and community colleges and independent educators. However, not all DCWs have access to high-quality, comprehensive training. For this reason, we recommend that the state invest in a learning management system (LMS) that makes high-quality training accessible to DCWs in all settings, regardless of employer. Additionally, accessibility must include *compensated time* for DCWs to complete both required and advancement training.

The LMS should be available for employers to lean on to train their DCWs, but not required if they have a training mechanism that will prepare DCWs to meet the required competencies for each level of DCW training already in place. In seeking a potential LMS for North Carolina's DCWs, a number of platforms and their curricula were vetted for how well they would meet needs and mitigate concerns around feasibility and effectiveness.

Characteristics of the ideal LMS platform:

- Stackable
- Portable
- Accessible
- Able to be annotated
- Trackable
- Caters to adult learning
- Multilingual
- Compatible with assistive devices
- For both workers and supervisors
- Developed by or in partnership with people with lived experience

Stackability: The ideal LMS platform will allow for tracking stackable modules and certifications from multiple sources. Stackable credentials are "part of a sequence of credentials that can be accumulated over time to build up an individual's qualifications and help them move along a career pathway or up a career ladder to different and potentially higher-paying jobs."[71] Or more simply, they are "building blocks where each short-term credential that a person earns builds into a higher-level credential."[72] The primary benefit of stackable credentials is flexibility. When well-organized into a system, workers get credit for all training and do not have to re-take courses, trainings, or competency evaluations simply because they switch jobs, move locations, or need to take a break from advancement efforts. Stackable credentials are intended to represent exit and entry points designed to maximize skill acquisition, employability, and seamless transition to careers. Ideally, learners can exit a program for full-time employment and resume where they left off when they are ready to pursue the next level of credential or degree attainment, or they can leverage their

[71] Oates, 2010
[72] Heckstall, 2020

newly earned credential to secure an entry-level position in their chosen career field while continuing their education part-time.

The best example of stackable credentials in the direct care workforce right now is the Nurse Aide I (NAI). Appendix A shows that the NAI can gain additional training that leads to a specialty in home care (Home Care Aide) and geriatrics (Geriatric Aide), as well as additional responsibilities such as Nurse Aide II skills and medication administration (Medication Aide for Nursing Homes). However, there is not one source for tracking these credentials nor is there any standardization of tiers, compensation, or recognition for additional training.

Portability: Credentialing should not be a mandated or promoted training program that lives with the employer, but rather should follow the worker. When training is employer-based, it is often piecemeal and overlapping. When workers move to a new employer, they may be missing needed skills. And without a clear understanding of previous training, the new employer may disregard any prior training and require the new employee to start over with their own training – and perhaps also start at a beginner level position and pay rate. Tying training to the worker recognizes their competency and skill attainment while allowing for mobility.

An example of a stackable but not portable credential is the NAI+4. The NAI can perform additional skills, but those additional skills are employer-specific and will not follow the NAI to a new employer – instead, the employee must be re-trained on those skills.

Accessibility: Accessibility includes device accessibility. Not only are mobile devices often more convenient, but low-income people are also less likely to have access to a computer or broadband internet service.[73] Additionally, home- and community-based workers may not have access to office space with employer-provided computer equipment. The ability to access training on a mobile device – is therefore a crucial characteristic for an LMS platform.

Ability to annotate: Some consulted individuals were concerned that a standardized LMS would occlude training flexibility.[74] Though the foundational competencies of DCWs are shared across all contexts, we recognize that additional competencies may vary depending on the employer, setting, community, population being served, and more. Having the ability to annotate records, customize existing modules, and/or create new modules allows the flexibility needed to train workers across such a wide variety of work settings. For example, an employer may wish to include

[73] Vogels, 2021
[74] Grierson et al., 2021

training specific to their organization (e.g., an online HIPAA module) which could be added to the LMS platform to be incorporated into the employee's training.

Trackability: Any system chosen to manage training for direct care workers must include a rigorous tracking component that allows credentials to be tied to the user/worker rather than the employer. This allows the credential to move with the user if they work in multiple settings or change employers. By establishing and tracking formal credentials, employers can be assured that a potential employee has a foundation of competencies. This allows employers to shorten onboarding and training of new employees and to integrate wage differentials for workers with advanced training.[75] Additionally, it provides the data tracking that the state needs for more efficient workforce planning. The chosen LMS should make it easy to track internal and external worker training, to create and share both individual and aggregate reports, to move worker records to new employers, and more.

Other distinguishing features: Other accessibility considerations for selecting an LMS include whether content is offered in multiple languages (particularly Spanish); presented at an appropriate reading level and with adult learner-centered instruction; formatted for use with screen readers, closed captioning, or other functions supporting people with disabilities; available for both workers and front-line supervisors; and developed by or with consideration from people with lived experience.

Three learning management systems (LMSs) meeting our criteria and containing pre-populated DCW curricula emerged from our research as potential training platforms for our state: DirectCourse, Open Future Learning, and Relias. Appendix B describes their stackability, portability, ability to annotate, tracking components, language accessibility, and other distinguishing features. In addition, we recognize that content in each of these LMSs is targeted to DSPs and not the more general DCW. However, the curricula are based on the competencies identified by the DCW Core Competency Project,[76] which implies relevance to all DCW. Two of the LMS platforms we researched have curriculums that encompass other direct care specialties. Further, the ability to customize training will ensure applicability to all DCWs.

Coordination and Alignment

Our research included efforts to identify other organizations doing relevant work in North Carolina in order to determine potential opportunities for alignment or integration. Based on conversations with experts referred by the Department, a landscape analysis, and snowball

[75] See more under Incorporating Wage & Rate Differentials.
[76] *The DSW Core Competency Project*, 2014

referrals, we identified many individuals and organizations working to support the recruitment, training, and retention of the HCBS workforce across the state.

WECARE: Workforce Engagement with Care Workers to Assist, Recognize and Educate is an initiative that is "using a 'collective impact' framework to engage community members across disciplines and agencies in this five-year project resulting in a pilot for improved direct care worker training, credentialing, and employer conditions in home- and community-based services."[77] Key partners include Duke Sanford School of Public Policy, NC Coalition on Aging, PHI, Appalachian State University, and the National Domestic Workers Alliance-NC Chapter. WECARE, currently in its second year of five, is one of four partnerships selected by UNC Cares[78] to receive grant funding from the NC DHHS Money Follows the Person (MFP) project.[79]

In developing this plan, we worked closely with the WECARE leadership team to ensure alignment between our recommendations and their continued work over the next several years. Their objectives include:

- Develop and establish a unified entry-level training and credentialing framework.
- Optimize a training and credentialing approach for direct care professionals.
- Identify best practices for supporting direct care professionals as well as high-performing employers implementing such practices.
- Implement an awareness and community outreach effort.
- Pilot the training, credentialing, and support model.

WECARE has exceptional expertise within their core leadership team and taps into subject matter expert and advocate expertise through their workgroups. This group is poised to gather continued feedback and buy-in from a variety of professionals and people with lived experience and should be closely included in moving these recommendations forward.

The Arc of NC is another organization involved in providing a training framework for the DSP workforce. In partnership with Mt. Eagle College, the Arc of NC has developed a 2,000-hour employee apprenticeship program in which successful participants complete the program with the NADSP DSP-I certification. The apprenticeship includes employer-specific training from the Arc of NC, an NADSP-accredited curriculum delivered by an instructor from Mt. Eagle College, and on-the-job learning. Mt. Eagle College's nine-week program utilizes the Open Future Learning

[77] Sanford School of Public Policy, 2022
[78] *UNC Cares*, n.d.
[79] *Money Follows the Person*, 2023)

management system and module-based curriculum paired with additional virtual live education and discussion facilitated by an instructor with lived I/DD experience.

This apprenticeship model directly aligns with our recommendation for an umbrella system. The Arc of NC is currently seeking funding to bring the apprenticeship program to fruition and will first pilot test the apprenticeship program with their employees with the potential to expand to workers outside their organization in the future. The Arc of NC should be looked to for expertise as an employer as well as an organization implementing a credentialing framework that directly aligns with our plan.

The Personal Home Care Aide State Training (PHCAST) model, developed with grant funding from the Health Resources and Services Administration (HRSA), may be used as a reference and possible model for future home care curriculum design and lessons learned. Though it is no longer funded, the PHCAST curriculum is currently available for open use. The four-phase framework integrates training pathways for DCWs across long-term care settings and provides career ladder advancement opportunities for the NA I certification.

Other partners engaged in important work around advocacy, professional development, network, and resources pertaining to the HCBS workforce include:

- *Caregiving Workforce Strategic Leadership Council* uses data and expert input to identify strengths and challenges facing the workforce and develop coordinated action. They plan to release a Future Workforce Development Report in December 2023.
- *NC Council on Developmental Disabilities (NCCDD)* carries out provisions of the Developmental Disabilities Assistance and Bill of Rights Act, and their goals include increasing community living and advocacy for individuals with I/DD.
- *NC Providers Council* promotes overall improvement of community support services across the state, including encouraging professional growth and training opportunities for DCWs.
- *Essential Jobs, Essential Care (EJEC) NC* is a multisector direct care workforce advocacy initiative managed by the NC Coalition on Aging.

A full description of each organization can be found in Appendix C, which includes timing, outputs, and potential areas of alignment. There should be ongoing coordination between these groups to ensure that efforts to recruit, train, and retain are mutually beneficial and not duplicative.

In addition to these organizations/groups, we consulted over 50 subject matter experts representing the Department, employers, direct care workers, Local Management Entity-Managed Care Organizations (LME-MCOs), and representatives from other states doing similar work. Appendix D provides the names and roles of these subject matter experts.

IMPLEMENTATION SUPPORT PLAN

After extensive preliminary research, our team created an implementation support plan for developing a credentialing program for direct care workers in North Carolina. The plan includes recommendations for the incorporation of current direct care workforce initiatives across the state, a potential method of tracking, wraparound support measures, and future direction.

The following figure shows the key factors necessary to support DCW recruitment and retention[80] and explains how this implementation plan will address those factors.

Key Factors that Support DCW Recruitment and Retention	*How the Factor Is Addressed by this Plan*
Increased wages and benefits	Indirectly, by connecting increased training with increased rate differentials that flow into increased wage differentials
Realistic job previews	Directly, by incorporating training that effectively describes the role of the DCW and offering implementation resources to employers
Match between individual skills and the person's need for support	Indirectly, by offering implementation resources to employers
Skilled and supportive supervision	Directly, by including training for front-line supervisors in the training and credentialing program
Positive organizational culture that fosters respect for DCWs	Indirectly, by improving competencies of workers and offering wrap around supports
Opportunities for professional advancement	Directly, by ensuring the credentialing program is stackable and follows the worker
Opportunities for self-direction	Indirectly, by ensuring the credentialing program is stackable and follows the worker, by creating career pathways, and by offering wraparound support services.
Competency-based training and credentialing	Directly, by establishing an umbrella training and credentialing program

[80] Bradley, 2021

Developing Infrastructure

Given the sheer complexity of implementing a statewide credentialing plan of this magnitude, our fourth recommendation is to develop infrastructure for administration and oversight of credentialing that operationalizes this plan, evaluates outcomes, and leads workforce planning.

> Recommendation #4:
>
> Develop infrastructure for administration and oversight of credentialing.

Successful implementation includes the following objectives:

1) Identify a lead organization (department, outside organization, or other agency) to carry these plans to fruition.
2) Form one or more advisory committees to draw on the knowledge and experience of experts, advocates, and invested partners in the direct care workforce space.
3) Develop implementation resources for employers, including a consultant group and implementation handbook.

Identifying a Lead Organization

The training system recommended in this report requires extensive oversight and coordination from an appointed department, agency, or outside organization. The NC Caregiving Workforce Strategic Leadership Council[81] and the NC Center on the Workforce for Health[82] include members from government, regulatory bodies, academic organizations, employers, and professional and trade organizations and could serve as thought leaders for developing an appropriate leadership structure.

In our research, we looked to successful models in other states for insight into their administrative and oversight structures.

The following table shows potential models for North Carolina, listing the coordinating entity or entities for select states, the state's ranking in PHI's Direct Care Workforce State Index,[83] and additional relevant information.

[81] NC Department of Health and Human Services, 2023
[82] *NC Center on the Workforce for Health*, n.d.
[83] *The Direct Care Workforce State Index*, 2023

State	*Rank*	*Coordinating Entity*	*Additional Information*
California	13	Department of Aging	California GROWS[84] (Growing a Resilient and Outstanding Workforce in the Home and Community) is a DCW training and stipends program focusing on skills, recruitment, and retention
New York*	14	NY State Office for People with Developmental Disabilities (OPWDD)	OPWDD entered into a 3-year contract with NADSP to offer credentialing for DCWs through its E-Badge Academy.[85]
Rhode Island	2	Executive Office of Health and Human Services (EOHHS)	HCBS Workforce Recruitment & Retention initiative[86]
Tennessee*	45	Tennessee's Medicaid program	TennCare[87] works with the Department of I/DD, MCOs, and other organizations to address workforce challenges through value-based purchasing, quality improvement support for providers, and competency-based training and professional development for workers.
Vermont	12	Department of Disabilities, Aging & Independent Living (DAIL); VT Money Follows the Person; HireAbility Vermont	Vermont Direct Care Initiative[88] aims to improve recruitment and retention and to promote the healthcare career ladder.
Washington	1	Aging and Long-Term Support Administration (ALTSA)	
Wisconsin	25	WI Department of Health Services; WI Health Care Association; LeadingAge Wisconsin	WisCaregiver Careers[89] coordinates training, job connections, and incentives for DCWs in nursing homes

*Contact information for these states (and others not listed here) are available upon request.

While these structures work for these states, additional research is needed to explore the possibilities for an effective structure that meets the unique needs of North Carolina.

[84] *California GROWS – CDA's Direct Care Workforce Initiative*, n.d.
[85] Dama, 2022
[86] *HCBS Workforce Recruitment and Retention*, 2022
[87] *System Transformation*, n.d.
[88] *Vermont Direct Care Initiative*, n.d.
[89] *About Us*, n.d.

Forming an Advisory Committee

One of the key recommendations from PHI is to "establish a statewide workgroup to create recommendations for advancing policies that improve direct care jobs."[90] A direct care workforce advisory committee for North Carolina should include staff from relevant state departments and divisions, employers, LME-MCOs, standard Prepaid Health Plans, subject matter experts (SMEs), family members and individuals with lived experience, and, crucially, direct care workers themselves. The WECARE committee, the NC Caregiving Workforce Strategic Leadership Council, and the NC Center on the Workforce for Health may be a helpful starting point. This advisory team of subject matter experts will offer a critical understanding of the workforce's needs as well as expert guidance for implementation.

In addition to other tasks that will become apparent in the course of implementation, the advisory committee's work should include the following activities:

- Provide a thorough peer review of this plan.
- Coordinate ongoing governance of the HCBS workforce credentialing structure.
- Review (and, if applicable, revise) the curriculum.
- Develop recommendations for DCW training time compensation.
- Give insight into program success criteria.
- Serve as experts in implementation strategies.
- Understand and provide guidance around systems changes.
- Promote the new system among their own spheres of influence.
- Serve as stewards/champions of this credentialing structure.
- Develop a comprehensive recruitment plan that capitalizes on the effort made to improve job satisfaction, compensation, and professional development opportunities.

Appendices C and D include lists of active subject matter experts in the state who have contributed to this report and could potentially serve on the advisory committee. Additionally, gaining buy-in from a few major employers across North Carolina to serve on the advisory committee and/or to assist with a pilot could create champions and demonstrate early value.

[90] Altman and Espinoza, n.d.

Developing Implementation Resources

Rather than put responsibility solely on workers, this credentialing plan asks employers to implement changes as well. We recommend the development of two primary resources for employers to use in implementing this plan: an implementation handbook and an implementation consultant group.

An implementation handbook can serve as a reference for employers. In addition to explaining the credentialing system, it would offer guidance and best practices for incorporating other elements that enhance retention, such as paying employees for training time, allowing the use of work hours for training, providing recognition for accomplishments, ensuring candidates have appropriate job expectations, matching an employee's skills with a client's needs, promoting connection and reducing isolation of DCWs through peer mentor supports, and establishing employee wellness programs.[91]

A consultant group can support employers in developing and implementing a plan specific to their workplaces, which is especially useful where workplaces need a cultural shift in addition to a policy change. As the saying goes, "Culture eats strategy for breakfast." A strategy is only good if it can be implemented, and organizational culture can make or break the implementation process.

A strong implementation plan will include the consideration of organizational theory, with reflection on internal and external constraints, human behavior and relationships, communication, and other sociological constructs. A standardized approach through TeamSTEPPS[92] or other team training framework would likely be valuable, but implementation must consider specific organizational characteristics as well.

Core Teamwork Skills by TeamSTEPPS

[91] Baker et al., 2023; Kreiser et al., 2010; Bradley, 2021
[92] *Topic: TeamSTEPPS*, n.d.

An implementation consultant group – either separate or as part of the advisory committee – can help to ensure implementation is successful in a meaningful way, thereby safeguarding the state's return on investment. Direct Support Workforce Solutions is a national consulting group that provides a helpful model for how experts in workforce development can support organizations with training and technical assistance.[93]

Incorporating Wage & Rate Differentials

> Recommendation #5:
>
> Connect competency attainment with wage differentials for workers and rate differentials for employers.

Allowing the entry-level DCW position to continue as the status quo is necessary for seamless integration and to avoid a worsening crisis; however, it also emphasizes the critical need to provide incentives for employer participation. In a 2023 survey of DSPs,[94] not feeling fairly compensated was the top reason for reporting dissatisfaction with their job. To address the need for increased compensation, our fifth recommendation is to set wage differentials for workers and rate differentials for employers that are tied to the attainment of tiered credentials**.** Ideally, each subset of DCW would have their own Standardized Occupational Classification (SOC). However, that level of change would need to occur at the federal level and would take years. At present, the Recognizing the Role of Direct Support Professionals Act has proposed to "direct the Office of Management and Budget to revise the Standard Occupational Classification system to establish a separate code for Direct Support Professionals."[95]

An umbrella system – such as the NADSP DSP-I, II, III and FLS tier system - provides an alternative standardized framework for attaching wages and rates to credentials. In pay-for-performance or similar models used by many other states,[96] rate differentials to employers can be connected to the number of each credentialing tier of DCWs employed, and a portion of that rate differential needs to be passed to employed DCWs in the form of wage differentials that are tied to that worker's credentialing tier. Some states have used supplemental funding under 1915(c) waivers to advance workforce development; for example, one state provides competency payments for homemaker providers with experience and specified training, and another state

[93] *Direct Support Workforce Solutions*, n.d.
[94] Baker et al., 2023
[95] *Recognizing the Role of Direct Support Professionals Act, S. 1437*, 2021
[96] Twomey, 2019

makes supplemental payment to providers who serve individuals with the goal of preventing institutionalization.[97]

Human services organizations such as NC DHHS can create an administrative account with NADSP,[98] but more examination is needed to develop a mechanism in which the formal credentials are tied to employers so that rate differentials can be integrated. This will require coordination among multiple state offices and balance among multiple state priorities:

> ... [W]ages for direct care workers have remained flat. This is in large part because payment for direct care providers is mainly determined by states through their Medicaid long-term services and supports (LTSS) programs, which offer a range of benefits for those with disabilities and other conditions.... 'And as the largest payer, Medicaid sets the industry standard for direct care wages.[99]

The integration of rate differentials will support crucial wage increases for direct care workers. Further, it will incentivize employers to expand beyond the status quo to require the credentials in their job descriptions and to support DCW professional development through paid training time and financial support. Employers should bear some responsibility for employee training; in this case, that takes the form of both release time and compensation for training. Rate differentials should take into account the need for onboarding so that training requirements do not lead to a delay in employment. These differentials will allow employers to shoulder the cost and time of employee training.

More examination is needed to address the training of workers who are in the self-directed service role, such as independent providers, and how this tracking mechanism could lead to future developments, such as a matching system that connects people with care needs to those who have demonstrated competence in addressing those needs.

Providing Wraparound Support Services

Our research both in the literature and with employers emphasized the role that socio-economic issues play in the lives of direct care workers. DCWs in North Carolina are low-income wage earners, mostly women, and many with children.[100] As such, many face challenges such as lack of

[97] "Factors to Be Considered in Determining Rate Sufficiency for 1915(C) HCBS Waivers," 2021
[98] NADSP, n.d.
[99] Hostetter & Klein, 2021
[100] *Direct Care Workers in the United States*, 2021

transportation,[101] unreliable childcare,[102] and costly housing.[103] Our sixth recommendation is to provide additional wraparound support services to direct care workers.

Wraparound services for workers will ensure they are able to engage in training and advancement opportunities. Support can range widely, from fulfillment of basic human needs to creating hope for the future. By acknowledging the current status of direct care workers as underpaid and under-resourced, whole-person social services can augment success in the workplace. Major areas where DCWs may need support include transportation, childcare, and safe and affordable housing.

> Recommendation #6:
>
> Provide additional wraparound support services to direct care workers.

NCCARE360 is an existing coordinated care network across all 100 counties that connects individuals and families with identified needs to local services and resources that can fulfill those needs.[104] In this model, a screened individual is referred into a shared technology platform of more than 13,000 service listings and 26,000 service locations to address unmet needs. A team of navigators is available to assist with more complex resource needs, and referrals can be tracked for closure. The integration of this platform into the DCW credentialing plan can be done in multiple ways:

1. Targeted marketing and training to DCWs and employers for referrals.
2. Investment into additional navigators specifically focused on the needs of DCWs in NC.
3. Community investment to ensure the availability of resources.

One study found that access to a coach in a resource network significantly lowered turnover rates among direct support professionals,[105] suggesting that a care network like NC CARE 360 can have significant positive impact on North Carolina's DCWs.

Initial discussions with UniteUs – the organization that provides the care coordination and hosts the NCCARE360 platform – conclude that there is a precedent for applying a population-focused model, and an investment into this network for DCWs could potentially yield a high return on investment. More discussions are needed to explore how other states are implementing their

[101] The Direct Care Workforce, 2022
[102] Caring for Care Workers, 2023
[103] *Direct Care Workers in the United States*, 2021
[104] *About NCCARE360*, n.d.
[105] Bradley, 2021

coordinated care networks for direct care or similar workers and what options NC has for similar efforts. Appendix E provides an example proposal from UniteUs for a population-focused model.

The following image provides a visual for the NC AHEC recommendations for HCBS worker certification. The six recommendations include an umbrella system that incorporates new and existing training options, is supported by a robust infrastructure, and encompasses common core competencies, accessibility of training, connection to wage and rate differentials, and wraparound support services.

MOVING FORWARD

The NC DCW credentialing plan described in this report is a large undertaking and will require considerable resources. Appendix A lists several types of DCWs. We recommend prioritizing a subset of these workers as an initial step. Because the identified LMS systems and the NADSP umbrella system have traditionally targeted DSPs, and because DSPs are part of the largest and arguably the least regulated type of DCW at the present time, we recommend starting with DSPs in home- and community-based settings with a deliberate, time-sensitive plan to scaffold to other types of DCWs in other settings.

Next Steps & Suggested Timeline

To move forward, the following next steps should be considered:

Conduct a peer review. The timeframe in which this report was completed did not allow for a thorough peer review. Organizations, advocates, and experts listed in Appendix B and C should be engaged to provide feedback, identify barriers and opportunities, and get buy-in for one or more of the LMSs listed in Appendix B. The peer review should be intentional about including direct care workers as well as people who receive services from DCWs and their families.

Convene workgroups. The following workgroups should be established:

- The NC Caregiving Workforce Strategic Leadership Council and/or the NC Center on the Workforce for Health to determine the structure for plan administration and oversight.
- A workgroup should be convened immediately to plan implementation steps for DCWs who provide services for people with intellectual and/or developmental disabilities (I/DD), traumatic brain injury (TBI), and behavioral health conditions in Medicaid-funded home and community-based settings under the 1915(i) State Plan Amendment.[106] The implementation plan should include all 6 recommendations contained in this report, including connection to reimbursement rates and wages, incorporation of paid training time, and wraparound support services.
- The advisory group, with potential members listed in Appendix D, should be convened to determine steps for scaffolding in other subsets of DCWs and additional settings. The advisory group should include individuals with lived experience and family members as well. This group may need to develop additional work groups such as:

[106] *NC Medicaid Obtains Approval of the 1915(I) State Plan Amendment*, 2023

    - Determining how to implement a plan for nurse aides, including but not limited to the specific steps required to accredit the existing NA curriculum with NADSP (or other chosen system) and how employers will determine and then incorporate the need for workers to have both an NA and the statewide DCW credential.
    - Exploring the incorporation of self-employed DCWs and peer extenders.
    - Examining the value of an employment matching system.
- NC AHEC should convene the NC Community College System (NCCCS), the NC Department of Public Instruction (DPI), and other partners to explore credentialing pathways for DCWs.

Determine the budget and the structure for administration and oversight. A comprehensive budget will include lines for administration such as leadership, administrative support, evaluation, and tracking; for a statewide LMS system that considers the estimated employer need, participation, and cost share for an LMS; for NADSP or other organization to provide the umbrella structure and tracking; and for regulatory wage and rate differentials. The budget will likely cross government departments and should consider program growth beyond the initial pilot.

Outline next steps for direct support professionals (DSPs) in home- and community-based care settings. The pilot phase should target DSPs and then expand to workers who provide care to people with traumatic brain injury (TBI) and behavioral health conditions in Medicaid-funded HCBS settings.[107] The relevant advisory group should have a plan for how to recruit employers, market to DSPs and people receiving care, connect training to rates and wages, implement wrap around supports, create tracking mechanisms that follow the DSP but are accessible to employers and regulatory bodies, and offer consultation and support to onboarding employers and employees. This phase should proactively include formative evaluation, such as ongoing participation and curriculum review, and summative evaluation, including recruitment, retention, and patient outcomes.

Identify, prioritize, and implement career pathways. The relevant advisory group should prioritize the possibilities for career pathways based on the workforce needs. A crosswalk with the tiers of the statewide DSP certification competencies with community college credit towards other health professional careers, such as nursing, lab technicians, and surgical technicians, for example, is needed to determine which pathways offer the least resistance for implementation.

Work with Unite Us to determine how to incorporate NCCARE360. We have had encouraging preliminary discussions about the feasibility of using the NCCARE360 platform to offer support for DCWs. Appendix E is an example contract; the details of this contract such as how many

[107] *NC Medicaid Obtains Approval of the 1915(I) State Plan Amendment*, 2023

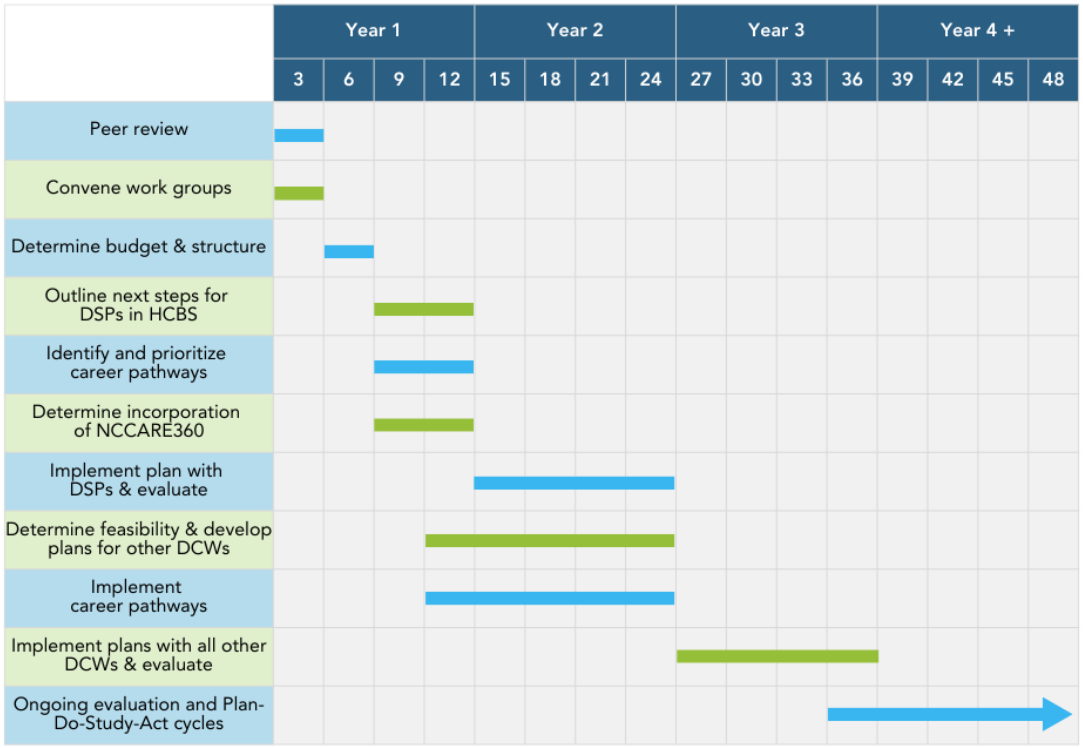
navigators are needed, what regions to pilot in (if needed), what outcomes the state wants to track, and how to connect the assistance back to retention in the workforce will need to be flushed out.

Implement credentialing plan with DSPs and conduct formative and summative evaluations. Determine feasibility for scaffolding to other subsets of DCWs. Using data and lessons learned from the pilot phase, relevant advisory groups – under the administrative leadership of the plan – should prioritize implementation plans for additional subsets of DCWs.

Implement credentialing plan with other subsets of DCWs and conduct formative and summative evaluations. The implementation strategy includes piloting with DSPs in HCBS, but this plan is meant to inclusively scaffold to target all of the DCWs listed in Appendix A. Because each of those subsets of DCWs are trained and tracked in silos, they may each require their own implementation plan that addresses unique characteristics or challenges of the role. This step will need to be repeated until all types of DCWs are under the statewide credentialing umbrella.

Conduct ongoing evaluations and implement Plan-Do-Study-Act cycles. This plan requires more than a one-time implementation strategy. No other state that we know of has a plan that crosses such diverse government, organizational, and regulatory sectors and involves rate and wage differentials, tracking, training, wrap around services, and career pathways for direct care workers. Ongoing evaluation of what is working and what is not – evaluation that can be shared with other states - is essential to the sustainability of this comprehensive, inclusive plan.

The following figure provides a suggested timeline for implementing these activities.



Future Direction

Our research suggests a number of areas for additional exploration. Beyond the implementation plan and initial steps described above, further research is needed to ascertain the role of care extenders, the possibility of establishing partnerships across the state, and additional opportunities to improve the recruitment and retention of direct care workers.

Care Extenders

Care extenders, such as peer support specialists and paid family caregivers, have become increasingly valued members of the direct care workforce. The care extender role includes identifying short-term and long-term needs, connecting community resources, and tracking outcomes.

By sharing their lived experience, peer support specialists can offer hope, empowerment, and navigation aid to people living with chronic, mental health, and/or substance use conditions, as well as people living with I/DD.[108]

Family members can also play a critical role in caregiving – they manage medications, assist with activities of daily living, navigate appointments, and provide emotional support.

While the foundational competencies needed by care extenders likely align with the foundational competencies of DCWs, the literature on specialty training for care extenders is limited. Though our plan does not explicitly include care extenders, they should be included as valuable members of a whole person health team. Future activities could include (1) further cross-walking of the foundational training needs of care extenders and those recommended for DCWs and (2) integrating current specialized training programs for care extenders in NC such as Community Bridges,[109] Second Chance Peer Support Training,[110] and Area Agencies on Aging.[111]

Potential Partnerships

This training plan should continue to evolve and may do so through strategic partnerships. To boost recruitment and retention of direct care workers, the state should explore the potential for partnerships with:

- *NC Community College System* to create pathways into other healthcare fields.

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[108] Community Bridges, 2022
[109] *IDD Peer Mentoring*, n.d.
[110] *Second Chance Peer Support Training*, n.d.
[111] *Family Caregiver Support Program*, n.d.

- *myfutureNC* to market the DSP credential with pathways to employment.
- *NC Business Committee for Education* to create opportunities for on-the-job training.
- *NC Career and College Promise* to recruit efficiently from high school into the direct care workforce.
- *NC Department of Public Instruction* to create pathways for high school students to learn about the role of DCWs and earn DSP credentials.

Hope for the Future

One of the themes that emerged from our discussions with employers is the need to create hope for the future for direct care workers. The recommendations contained in this report are only the first steps to developing a comprehensive and effective strategy to support this valuable workforce.

In addition to providing holistic wraparound support for workers, future efforts around DCW credentialing should explore career pathways for direct care workers who achieve advanced and/or supervisory credentials. Constructing a vision for career development will enable DCWs to foresee a long-lasting career that offers opportunities for lifelong learning and advancement.

Implementing these recommendations as a system – as interconnected, dependent recruitment, training, and retention strategies – and with an eye towards the future will strengthen the direct care workforce, positively impact the health care ecosystem in our state, and ultimately improve the quality of care for the people of North Carolina.

REFERENCES & APPENDICES

References

2021 State of the Workforce Survey Report. (2021). National Core Indicators Intellectual and Developmental Disabilities. https://idd.nationalcoreindicators.org/wp-content/uploads/2023/02/2021StateoftheWorkforceReport-20230209.pdf.

AARP. (2020). *2020 Scorecard Report*. Long-Term Services & Supports State Scorecard: North Carolina. https://www.longtermscorecard.org/databystate/state?state=NC.

About NCCARE360. (n.d.). NCCARE360. Retrieved September 25, 2023, from https://nccare360.org/about/.

About Us. (n.d.). WisCaregiver Careers. https://wiscaregivercna.com/about/.

Altman, A., & Espinoza, R. (n.d.). *Center Direct Care Workers in Leadership Roles and Public Policy*. PHI. Retrieved September 16, 2023, from https://www.phinational.org/issue/direct-care-workers/.

Baer, D. L., & Hermreck, D. (2023, June). *NADSP E-Badge Academy Discussion* [Virtual meeting].

Baker, J., Kruse, L., Bridges, A., & Galindo, N. (2023). *DSP Survey Report*. Relias. https://www.relias.com/wp-content/uploads/2023/05/23-HHS-IDD-4165-Report-DSP.pdf.

Barkoff, A. (2023, July 26). Continuing the Fight to Fulfill the Promise of the ADA. *Administration for Community Living*. https://acl.gov/news-and-events/acl-blog/continuing-fight-fulfill-promise-ada.

BoardSource. (2010). The handbook of nonprofit governance. In *Jossey-Bass eBooks*. http://ci.nii.ac.jp/ncid/BB0903890X.

Bradley, V. (2021, September). *Promising Recruitment and Retention Strategies*. NCAPPS. https://ncapps.acl.gov/docs/Resources/DSP%20Promising%20Recruitment%20and%20Retention%20Strategies.pdf.

Brannon, D., Barry, T., Kemper, P., Schreiner, A., & Vasey, J. (2007). Job perceptions and intent to leave among direct care workers: Evidence from the Better Jobs Better Care Demonstrations. *Gerontologist*, *47*(6), 820–829. https://doi.org/10.1093/geront/47.6.820.

California GROWs – CDA's Direct Care Workforce Initiative. (n.d.). California Department of Aging. Retrieved September 25, 2023, from https://www.aging.ca.gov/Providers_and_Partners/Cal_Grows/.

Campbell, S. (2018, April). *Workplace Injuries and the Direct Care Workforce*. PHI. https://www.phinational.org/wp-content/uploads/2018/04/Workplace-Injuries-and-DCW-PHI-2018.pdf.

Caring for Care Workers: Post-COVID Labor Shortages in the Direct Care Industry. (2023, March 21). Kenan Institute of Private Enterprise. https://kenaninstitute.unc.edu/kenan-insight/caring-for-care-workers-post-covid-labor-shortages-in-the-direct-care-industry/.

Castle, N. G., Engberg, J., & Men, A. N. (2007). Nursing home staff turnover: Impact on nursing home compare quality measures. *Gerontologist*, *47*(5), 650–661. https://doi.org/10.1093/geront/47.5.650.

Community Bridges. (2022). Mission Possible: Advancing Whole Person Care by Employing People with I/DD & Family Members as Care Extenders. In *NC Council on Developmental Disabilities*. https://nccdd.org/images/2023/Blogs/NEW-Care_Extender_White_Paper_-_Final.pdf.

Dama, N. (2022, August 15). News: New York State Partners with NADSP to Provide NADSP Certification to 2400 Direct Support Professionals. *National Alliance for Direct Support Professionals*. https://nadsp.org/nadsp-news-nadsp-certification-in-nys/.

Devine, M. (2020a, February 10). Let's call home care work what it is: skilled work. *PHI*. https://www.phinational.org/lets-call-home-care-work-what-it-is-skilled-work/.

Devine, M. (2020b, September 29). *PHI Launches State Advocacy Initiative to Strengthen the Direct Care Workforce* [Press release]. https://www.phinational.org/news/phi-launches-state-advocacy-initiative-to-strengthen-the-direct-care-workforce/.

DHSR Glossary of Terms. (n.d.). NC Department of Health and Human Services, Division of Health Service Regulation, Health Care Personnel Education and Credentialing Section. Retrieved May 1, 2023, from https://ncnar.ncdhhs.gov/gloss.html#M.

Dill, J., Frogner, B. K., & Travers, J. (2022). Taking the long view: understanding the rate of second job holding among Long-Term care workers. *Medical Care Research and Review*, *79*(6), 844–850. https://doi.org/10.1177/10775587221089414.

Direct Care Workers in the United States. (2019). PHI. https://www.phinational.org/wp-content/uploads/2023/09/PHI-Key-Facts-Report-2023.pdf.

Direct Care Workers in the United States: Key Facts 2021. (2021). PHI. https://www.phinational.org/wp-content/uploads/2021/09/Direct-Care-Workers-in-the-US-2021-PHI.pdf.

Direct Care Workers in the United States: Key Facts 2023. (2023, September 11). PHI. https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2023/.

Direct Care Workforce State Index | North Carolina. (2023, January). PHI. https://www.phinational.org/state/north-carolina/.

Direct Support Professionals (DSPs). (n.d.). US Department of Labor, Office of Disability Employment Policy. Retrieved September 27, 2023, from https://www.dol.gov/agencies/odep/program-areas/individuals/DSP.

Direct Support Workforce Solutions. (n.d.). University of Minnesota, University Center on Excellence in Developmental Disability, Institute on Community Integration. Retrieved September 20, 2023, from https://dsws.umn.edu/.

Espinoza, R. (2020). Would You Stay?: Rethinking Direct Care Job Quality. In *PHI*. https://www.phinational.org/wp-content/uploads/2020/10/Would-You-Stay-2020-PHI.pdf.

Essential Jobs, Essential Care. (2023, March). North Carolina Coalition on Aging. https://medicaid.ncdhhs.gov/mar-17-2023-mcac-meeting-nc-coalition-aging-workforce-update/download?attachment.

Factors to be Considered in Determining Rate Sufficiency for 1915(c) HCBS Waivers. (December, 2021). In *ADvancing States* [Conference session slides]. HCBS Conference, Baltimore, Maryland, United States of America. http://www.advancingstates.org/sites/nasuad/files/u34008/CMS%20Track%20-Factors%20to%20be%20Considered%20in%20Determining%20Rate%20Sufficiency%20for%201915%28c%29%20HCBS%20Waivers.pdf.

Family Caregiver Support Program. (n.d.). NC Department of Health and Human Services, Family Caregiver Support. Retrieved September 27, 2023, from https://www.ncdhhs.gov/divisions/aging-and-adult-services/family-caregiver-support-program.

Frequently Asked Questions: Nurse Aide II. (n.d.). NC Board of Nursing. Retrieved May 4, 2023, from https://www.ncbon.com/news-publications-statistics-frequently-asked-questions-nurse-aide-ii.

Friedman, C. (2018). Direct Support Professionals and Quality of Life of People With Intellectual and Developmental Disabilities. *Intellectual and Developmental Disabilities*, *56*(4), 234–250. https://doi.org/10.1352/1934-9556-56.5.234.

Gallup, A., Tomasson, J. B., & Svihla, V. (2018). Empowerment and Constraint: Design of a homecare worker training program. *International Journal of Designs for Learning*, *9*(1), 149–157. https://doi.org/10.14434/ijdl.v9i1.23459.

Glossary. (n.d.). NC Department of Health and Human Services, NC Division of Health Service Regulation. Retrieved May 1, 2023, from https://info.ncdhhs.gov/dhsr/glossary.htm.

Grierson, L., Allice, I., Baker, A., Farag, A., Guscott, J., Howard, M., Mountjoy, M., Siu, H., Tong, X. C., & Vanstone, M. (2021). Impacts of the Certificates of Added Competence credentialling program: a qualitative case study of enhanced-skill family medicine practice across Canada. *CMAJ Open*, *9*(4), E966–E972. https://doi.org/10.9778/cmajo.20200278.

HCBS Workforce Recruitment and Retention. (2022, April 27). The Executive Office of Health and Human Services, State of Rhode Island. https://eohhs.ri.gov/initiatives/hcbs-workforce-recruitment-and-retention.

Health Care Personnel Education and Credentialing Section. (n.d.). NC Department of Health and Human Services, NC Division of Health Service Regulation. Retrieved May 4, 2023, from https://info.ncdhhs.gov/dhsr/hcpr/floaide.html.

Heckstall, I. (2020, February 10). *Stackable Credentials Backgrounder*. Higher Learning Advocates. https://higherlearningadvocates.org/resource/stackable-credentials-backgrounder.

Hellmann, J. (2021, January 24). *Democrats propose $400 billion Medicaid boost for home care*. Modern Healthcare. https://www.modernhealthcare.com/medicaid/democrats-propose-400-billion-medicaid-boost-home-care.

Hess, C., & Hegewisch, A. (2019). The Future of Care Work: Improving the Quality of America's Fastest-Growing Jobs. In *Institute for Women's Policy Research*. https://iwpr.org/wp-content/uploads/2020/07/C486_Future-of-Care-Work_final.pdf.

Home- and Community-Based Services. (2023, September 6). Centers for Medicare & Medicaid Services. https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services.

Hostetter, M., & Klein, S. (2021, July 1). *Placing a Higher Value on Direct Care Workers*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/2021/jul/placing-higher-value-direct-care-workers#infocus.

IDD Peer Mentoring. (n.d.). Community Bridges Consulting Group. Retrieved September 27, 2023, from https://www.cb-cg.com/idd-peer-mentoring.html.

Introducing TeamSTEPPS. (n.d.). [Slide show; Online]. Agency for Healthcare Research and Quality. Retrieved September 26, 2023, from https://www.ahrq.gov/teamstepps-program/curriculum/intro/teach.html.

Kemp, A. H., Tree, J. J., Gracey, F., & Fisher, Z. (2022). Editorial: Improving Wellbeing in Patients with Chronic Conditions: Theory, Evidence, and opportunities. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.868810.

Key Message and Tips for Providers: Home and Community-Based Services. (2015, September). Centers for Medicare & Medicaid Services. https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/key-messages-hcbs-%5Bfebruary-2016%5D.pdf.

Kishida, K. (2022). The effects of wages and training on intent to switch or leave among direct care workers. *Innovation in Aging*, *6*(4). https://doi.org/10.1093/geroni/igac035.

Kreiser, A. L., Adamski, T., & Gallagher, B. (2010). Building a Peer Mentor Home Health Aide program. *Home Healthcare Nurse: The Journal for the Home Care and Hospice Professional*, *28*(8), 480–486. https://doi.org/10.1097/nhh.0b013e3181ed7456.

Levy-Storms, L., & Mueller-Williams, A. C. (2022). Certified nursing aides' training hours and COVID case and mortality rates across states in the U.S.: Implications for infection prevention and control and relationships with nursing home residents. *Frontiers in Public Health*, *10*. https://doi.org/10.3389/fpubh.2022.798779.

Lewis, L. S., Rebeschi, L. M., & Hunt, E. (2022). Nursing Education Practice Update 2022: Competency-Based Education in Nursing. *SAGE Open Nursing*, *8*, 237796082211407. https://doi.org/10.1177/23779608221140774.

Long-Term Services and Supports Care Management. (n.d.). NC Department of Health and Human Services, NC Medicaid. Retrieved September 24, 2023, from https://medicaid.ncdhhs.gov/care-management/long-term-services-and-supports-care-management.

Lopez, C., White, D. L., & Carder, P. (2012). Direct care worker's perceptions of job satisfaction following implementation of Work-Based learning. *Journal of Applied Gerontology*, *33*(1), 97–120. https://doi.org/10.1177/0733464812463982.

Luz, C., Hanson, K., Hao, Y., & Spurgeon, E. (2017). Improving patient experiences and outcomes through personal care aide training. *Journal of Patient Experience*, *5*(1), 56–62. https://doi.org/10.1177/2374373517724349.

Mariscal, P. (2021, January 21). The difference between certification and certificate. *The ANSI Blog*. https://blog.ansi.org/anab/certification-certificate-difference-credential/.

Money Follows the Person. (2023, June 20). U.S Department of Health and Human Services, Centers for Medicare Medicaid Services. https://medicaid.ncdhhs.gov/providers/programs-and-services/long-term-care/money-follows-person.

NADSP. (n.d.). *The NADSP E-Badge Academy*. National Alliance for Direct Support Professionals. Retrieved September 27, 2023, from https://nadsp.org/services/the-nadsp-e-badge-academy/.

NADSP. (2022, May 25). *The NADSP Competency Areas - NADSP*. NADSP - Making a World of Difference in People's Lives. https://nadsp.org/resources/the-nadsp-competency-areas/.

NC Center on the Workforce for Health. (n.d.). NC Institute of Medicine. Retrieved September 23, 2023, from https://nciom.org/nc-center-workforce-for-health/.

NC Department of Health and Human Services. (2023, March 7). *North Carolina launches Caregiving Workforce Strategic Leadership Council* [Press release]. https://www.ncdhhs.gov/news/press-releases/2023/03/07/north-carolina-launches-caregiving-workforce-strategic-leadership-council.

NC Medicaid Obtains Approval of the 1915(i) State Plan Amendment. (2023, June 30). NC Medicaid. https://medicaid.ncdhhs.gov/blog/2023/06/30/nc-medicaid-obtains-approval-1915i-state-plan-amendment.

NC Workforce Credentials. (n.d.). NC Careers. Retrieved September 27, 2023, from https://nccareers.org/credentials.

NCHWA. (2018, March). *Long-Term Services and Supports: Direct Care Worker Demand Projections 2015-2030*. U.S. Department of Health And Human Services, Health Resources And Services Administration, National Center For Health Workforce Analysis. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/hrsa-ltts-direct-care-worker-report.pdf.

North Carolina Health Workforce Sentinel Network. (2022). https://nc.sentinelnetwork.org/findings/overview/.

North Carolina Medicaid Reform: Section 1115 Demonstration Renewal Request. (2023, August). NC Department of Health and Human Services. https://medicaid.ncdhhs.gov/nc-1115-waiver-renewal-fact-sheet/download?attachment.

Nurse Aide I Tasks. (2022, June). NC Board of Nursing. https://www.ncbon.com/myfiles/downloads/nurse-aide/nurse-aide-i-tasks.pdf.

Nurse Aides. (2023, May 8). NC Board of Nursing. https://www.ncbon.com/practice-nurse-aides.

Oates, J. (2010, December 15). *Training and Employment Guidance Letter No. 15-10*. US Department of Labor, Employment and Training Administration. https://www.dol.gov/sites/dolgov/files/ETA/advisories/TEGL/2010/TEGL15-10.pdf.

Phoo, N. N. N., & Reid, A. (2022). Determinants of violence towards care workers working in the home setting: A systematic review. *American Journal of Industrial Medicine*, *65*(6), 447–467. https://doi.org/10.1002/ajim.23351.

Powell, P., & Scales, K. (n.d.). *Fund, Implement, and Evaluate Direct Care Workforce Interventions*. PHI. Retrieved September 25, 2023, from https://www.phinational.org/issue/workforce-interventions/.

President's Committee for People with Intellectual Disabilities. (2012). Report to the President 2017: America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy. In *US Department of Health and Human Services, Administration for Community Living*. https://acl.gov/sites/default/files/programs/2018-02/2017%20PCPID%20Full%20Report_0.PDF.

QuickFacts North Carolina. (2021). [Dataset]. In *US Census Bureau*. https://www.census.gov/quickfacts/fact/table/NC/COM100221.

Recognizing the Role of Direct Support Professionals Act, S. 1437, 117th Cong. (2021). https://www.congress.gov/bill/117th-congress/senate-bill/1437/text.

Requirements for approval of a nurse aide training and competency evaluation program. (n.d.). 42 CFR 483.152. https://www.ecfr.gov/current/title-42/section-483.152.

Results of The Direct Support Workforce and COVID-19 National Survey 2020. (2020). University of Minnesota, Institute on Community Integration. https://ici-s.umn.edu/files/iJphkG6fcN/dsp-covid-survey-results.

Roman, C., Luz, C., Graham, C., Joseph, N., & McEvoy, K. (2022). *Direct Care Workforce Policy and Action Guide*. Milbank Memorial Fund. https://www.milbank.org/wp-content/uploads/2022/05/DirectCareWorker_Toolkit_final.pdf.

Russell, D., Mola, A., Onorato, N., Johnson, S., Williams, J., Andaya, M., & Flannery, M. (2017). Preparing home health aides to serve as health coaches for home care patients with chronic illness: Findings and Lessons learned from a Mixed-Method Evaluation of two pilot programs. *Home Health Care Management & Practice*, *29*(3), 191–198. https://doi.org/10.1177/1084822317706080.

Sandoe, E., Lerche, J., Ramirez Perez, M., & Brown, C. (2023, September 15). *North Carolina Medicaid Reform Section 1115 Demonstration Renewal Public Hearing* [Slide show]. Medical Care Advisory Committee (MCAC) Meeting, United States of America. NC Medicaid. https://medicaid.ncdhhs.gov/nc-medicaid-1115-demonstration-waiver-renewal-update-mcac15sept2023/download?attachment.

Sanford School of Public Policy. (2022, December 8). UPDATE: Boucher, Sanford School's WECARE Initiative Receives Grant. *Duke University, Sanford School of Public Policy*. https://sanford.duke.edu/blog-post/update-boucher-sanford-schools-wecare-initiative-receives-grant/.

Scales, K. (2017, August 21). *Success Across Settings: Six Best Practices in Promoting Quality Care through Quality Jobs*. PHI. https://www.phinational.org/wp-content/uploads/2017/09/evaluation_brief_final.pdf.

Scales, K., & Stepick, L. (n.d.). *Understanding the Direct Care Workforce*. PHI. Retrieved September 25, 2023, from https://www.phinational.org/policy-research/key-facts-faq/.

Second Chance Peer Support Training. (n.d.). NC Department of Health and Human Services, NC Division of Mental Health, NC Certified Peer Support Specialist Program. Retrieved September 24, 2023, from https://pss.unc.edu/second-chance-peer-support-training.

Standard Occupational Classification. (n.d.). US Department of Labor, US Bureau of Labor Statistics. Retrieved September 18, 2023, from https://www.bls.gov/soc/.

System Transformation. (n.d.). TennCare. Retrieved September 27, 2023, from https://www.tn.gov/tenncare/long-term-services-supports/systems-transformation.html.

The Direct Care Workforce. (2022, March 28). National Academy for State Health Policy. https://nashp.org/the-direct-care-workforce/.

The Direct Care Workforce State Index. (2023, January 10). PHI. https://www.phinational.org/state-index-tool/,

The DSW Core Competency Project. (2014, December). Centers for Medicare & Medicaid Services, National Direct Service Workforce Resource Center. https://www.medicaid.gov/medicaid/long-term-services-supports/direct-care-workforce/dsw-core-competency-project/index.html.

The Medicaid Glossary: Long-Term Services and Supports glossary. (2021). *www.uhccommunityandstate.com*. https://www.uhccommunityandstate.com/medicaid-glossary/long-term-services-and-supports.

Tilson, H. H., Jones, C., Forcina, J., & Tran, A. (2021, March 26). *Pandemic Health Care Workforce Study*. North Carolina AHEC. https://www.ncahec.net/wp-content/uploads/2021/04/NC-AHEC-Pandemic-Health-Care-Workforce-Study-2021_FINAL.pdf.

Topic: TeamSTEPPS. (n.d.). US Department of Health and Human Services, Agency for Healthcare Research and Quality. Retrieved September 22, 2023, from https://www.ahrq.gov/topics/teamstepps.html.

Twomey, M. (2019, April 10). State Options for Making Wise Investments in the Direct Care Workforce. *Center for American Progress*. https://www.americanprogress.org/article/state-options-making-wise-investments-direct-care-workforce/.

UNC Cares. (n.d.). Retrieved September 27, 2023, from https://cares.unc.edu/.

Verify a License. (2023, September 1). NC Board of Nursing. https://www.ncbon.com/licensure-listing-verify-a-license.

Vermont Direct Care Initiative. (n.d.). Vermont Agency of Human Services, Disabilities Aging and Independent Living. Retrieved September 19, 2023, from https://dail.vermont.gov/services/programs/vermont-direct-care-initiative-scholarship-program.

Videlefsky, A., Reznik, J. M., Nodvin, J., & Heiman, H. J. (2019). Addressing Health Disparities in Adults with Developmental Disabilities. *Ethnicity & Disease*, *29*(Supp2), 355–358. https://doi.org/10.18865/ed.29.s2.355.

Vogels, E. (2021, June 22). Digital divide persists even as Americans with lower incomes make gains in tech adoption. *Pew Research Center*. https://www.pewresearch.org/short-reads/2021/06/22/digital-divide-persists-even-as-americans-with-lower-incomes-make-gains-in-tech-adoption/.

Walton, A. L., & Rogers, B. (2017). Workplace hazards faced by nursing assistants in the United States: A focused literature review. *International Journal of Environmental Research and Public Health*, *14*(5), 544. https://doi.org/10.3390/ijerph14050544.

Wech, D. (2001). Improving the quality of Long-Term care. In *National Academies Press eBooks*. https://doi.org/10.17226/9611.

What are competencies? (2017, August 9). National Institutes of Health, Office of Human Resources. https://hr.nih.gov/about/faq/working-nih/competencies/what-are-competencies.

Who are direct-care workers? (2011, February). PHI. https://www.phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf.

Wiener, J. M., Squillace, M. R., Anderson, W., & Khatutsky, G. (2009). Why do they stay? Job tenure among certified nursing assistants in nursing homes. *Gerontologist*, *49*(2), 198–210. https://doi.org/10.1093/geront/gnp027.

Workforce Data Center - PHI. (2023, September 1). PHI. https://www.phinational.org/policy-research/workforce-data-center/#states=37&var=Employment+Projections.

Appendix A: Direct Care Worker Definitions & Profiles

Nurse Aide I		
Alt. Name(s): Nurse Aide, CNA, NAI, Certified Nursing Assistant, Certified Nursing Aide, Nursing Attendant, Nursing Aide, Nursing Care Attendant, Medication Aide	*Est. # in NC** 000,000	*Part of HCBS Workforce?* Yes
Setting & Care Population	Home care, nursing facilities, acute care, skilled and long-term care, clinics, ambulatory care settings, schools, public health	
Description	Any unlicensed individual, regardless of title, who has successfully completed a state-approved nurse aide training and competency evaluation program and is listed on the Nurse Aide I Registry maintained by the Division of Health Service Regulation. The individual performs nursing care activities, defined by the N.C. Board of Nursing, under the supervision of a licensed nurse.	
Training	State approved Nurse Aide I training and competency evaluation program or state approved competency evaluation program or comparable program approved by the department.	
Credentialing Expiration/ Renewal	Listing on the Division of Health Service Regulation Nurse Aide I Registry is valid for two years. To maintain registry listing, the individual must work as a nurse aide under Registered Nurse supervision for pay for at least 8 hours within the two-year period.	
Tracking	The NC Division of Health Service Regulation provides the Nurse Aide I Registry, which is a listing of all nurse aides who have successfully completed a state-approved Nurse Aide I Training and Competency Evaluation Program (NAT/CEP) or a state-approved Competency Evaluation Program (CEP) or an approved Reciprocity application.	
Sources	*NC Division of Health Service Regulation Glossary*, n.d. *Health Care Personnel Education and Credentialing Section*, n.d. *Nurse Aide I Tasks*, 2022	

Nurse Aide I + 4		
Alt. Name(s) NAI+4, Nurse Aide, CNA, NAI, Certified Nursing Assistant, Certified Nursing Aide, Nursing Attendant, Nursing Aide, Nursing Care Attendant, Medication Aide	*Est. # in NC** 000,000	*Part of HCBS Workforce?* Yes
Setting & Care Population	Acute care facilities, nursing facilities, skilled and long-term care, ambulatory care, clinics, schools, public health	
Description	Same as Nurse Aide I, with training in an additional agency-chosen and designated Nurse Aide II skills (up to 4 skills).	

Training	Additional training for Nurse Aide I: Up to 4 Nurse Aide II nursing skills can be selected by an agency as designated NAI+4 skills for that agency. Nurse Aide I's in the agency must be taught using the designated NCBON required modules. The NAI+4 skills, education, and competency validation must be performed by a Registered Nurse and documented/retained at the agency. A Nurse Aide I is not approved for Nurse Aide II skills except the approved NAI+4 skills within the agency. Those skills can only be performed in that agency. Additional skills performance requires education and credentialing as a Nurse Aide II.
Credentialing Expiration/ Renewal	Listing on the Division of Health Service Regulation Nurse Aide I Registry is valid for two years. To maintain registry listing, the individual must work as a nurse aide under Registered Nurse supervision for pay for at least 8 hours within the two-year period.
Tracking	There is no listing process for NAI+4; must hold current Nurse Aide I listing on the NC Division of Health Service Regulation Nurse Aide I Registry. A Nurse Aide I with training in 1-4 additional skills may only perform those skills at that specific employer and need re-training/competency evaluation with each new employer.
Sources	*Nurse Aides*, 2023

Nurse Aide II

Alt. Name(s)	*Est. # in NC*	*Part of HCBS Workforce?*
NAII, Nurse Aide, CNA, Certified Nursing Assistant, Certified Nursing Aide, Nursing Attendant, Nursing Aide, Nursing Care Attendant, Medication Aide	10,548 (as of 8/22/2023. Updated daily at www.ncbon.com	Yes

Setting & Care Population	Acute care facilities, nursing facilities, primary care/outpatient setting, home care
Description	Any unlicensed individual, regardless of title, who has completed a N.C. Board of Nursing-approved Level II nurse aide program, and who in addition to being listed on the Nurse Aide I Registry, is listed on the Nurse Aide II Registry maintained by the Board. The individual performs nursing care activities, defined by the Board, under the supervision of a licensed nurse.
Training	Must first obtain NAI credential then successfully complete NC BON-approved Level II nurse aide program. Training includes a minimum of 80 hours of theory and 80 hours of direct patient care supervised by a NC BON approved NAII instructor. A NC Board of Nursing-maintained registry containing the names of health care personnel who have successfully completed a Level II nurse aide training program.
Credentialing Expiration/ Renewal	Nurse Aide II with a listing expired in the past 24 months must successfully complete a NC Board of Nursing approved competency assessment to be eligible for renewal. Nurse Aide II with a listing expired in excess of 24 months are required to successfully complete a Nurse Aide II Program to be eligible for renewal.
Tracking	Must have current listing on the NC Division of Health Service Regulation Nurse Aide I Registry. The Nurse Aide II must have performed nursing care activities for monetary compensation within the past 24 months for at least 8 hours under the

	direct supervision of a Registered Nurse to maintain the Nurse Aide II listing. The NC Board of Nursing Licensure and Listing Verification database tracks Nurse Aide II listings.
Other Info	$24 for initial listing and renewal of Nurse Aide II
Sources	*NC Division of Health Service Regulation Glossary*, n.d. *Frequently Asked Questions: Nurse Aide II*, n.d. *Verify a License*, 2023

Medication Aide (Skilled Nursing Facility, Nursing Home)

Alt. Name(s)	*Est. # in NC**	*Part of HCBS Workforce?*
Med Aide	000,000	No, but tangential
Setting & Care Population	Skilled Nursing Facility, nursing homes	
Description	Nurse Aide I who will perform medication aide duties in nursing homes.	
Training	High School Diploma or GED required; successful completion of a 24-hour medication aide training program approved by the NC BON and a state-approved competency evaluation program. Skilled nursing facilities also require Nurse Aide I credentials.	
Credentialing Expiration/ Renewal	Renewal every 2 years if the individual has worked a minimum of 8 hours in each consecutive 24-month period	
Tracking	To work as a medication aide in a nursing home, a person must be listed on the NC Medication Aide Registry for Nursing Homes, which operates under state nursing home rules and statutes. NC does not have reciprocity with other states for NC Medication Aides. Listing on the NC Medication Aide Registry does not qualify a person to administer drugs in an adult care home. A Medication Aide in a nursing home must also be listed on the NC Division of Health Service Regulation Nurse Aide I Registry.	
Sources	*DHSR Glossary of Terms*, n.d.	

Medication Aide (Adult Care Home)

Alt. Name(s)	*Est. # in NC**	*Part of HCBS Workforce?*
Med Tech	*000,000*	Yes
Setting & Care Population	Adult Care Home	

Description	Unlicensed assistive personnel who will perform medication aide duties in Adult Care Homes.
Training	The 5-hour, 10-hour, and 15-hour competency-based curriculums provide unlicensed staff with basic knowledge and skills needed to ensure that medication administration is performed in a safe and effective manner. Successful completion of the 5-hour plus 10-hour training courses or the 15-hour training course will prepare individuals to take the state written medication exam for adult care home staff and for competency validation using the Medication Administration Skills Validation Form (DHSR/AC 4605 NCDHHS) required at the employing facility. There is an exception for individuals who passed the state written medication exam for medication staff in adult care homes on or before 9/30/13. A clinical skills validation must be conducted by a Registered Nurse before medication administration tasks are performed in an Adult Care Home.
Credentialing Expiration/ Renewal	A listing on the NC Medication Aide Registry for Adult Care Homes does not expire and does not need to be renewed.
Tracking	To work as a medication aide in an adult care home, a person must be listed on the NC Medication Aide Registry for Adult Care Homes, managed by the NC Division of Health Service Regulation. Listing on the NC Medication Aide Registry does not qualify a person to administer drugs in an adult care home.
Other Info	$25 to take the written examination; $25 to re-test the written examination. NC does not have reciprocity with other states for NC Medication Aides.
Sources	State Approved Medication Administration Courses for Adult Care Homes. Accessed online on 5/4/2023 from https://info.ncdhhs.gov/dhsr/acls/training/medaide.html; DHHS DHSR Medication Aide- Adult Care Home (January 30, 2023). Accessed online on 5/4/2023 from https://ncnar.ncdhhs.gov/pdf/MedicationAideAdultCareGeneralInformation.pdf

In-Home Aide

Alt. Name(s)	*Est. # in NC**	*Part of HCBS Workforce?*
Personal Care Assistant/Aide	000,000	Yes

Setting & Care Population	Home care, community based setting
Description	"In-home aide services" are hands-on services that assist individuals, their family, or both with home management tasks, personal care tasks, or supervision of the client's activities to enable the individual, their family, or both to remain and function at home. Multiple levels exist: Level I – Home Management provides assistance with basic home management tasks, such as housekeeping, cooking, shopping, and bill paying. Individuals are self-directing and medically stable; Level II – Home Management/Personal Care provides assistance with basic activities of daily living (eating, dressing, bathing, etc.) and home management tasks; Level III – Home Management provides intensive education and support to clients/families

	with home management tasks and improving family functioning skills; Level IV – Personal Care provides substantial ADL support with health/personal care tasks; Respite Care provides respite for a primary caregiver. For this purpose, In-Home Aide Services may be provided to an individual in his/her own home or in the home of his/her primary caregiver. Respite Care consists of any level of home management or personal care tasks.
Training	Aides who provide In-Home Aide Services must meet the competency requirements for the level of service they are regularly required to perform. Training is the primary mechanism for preparing aides to gain the knowledge and skills to perform their work and to meet competency requirements. Training can be carried out through a variety of methods such as: classroom instruction, on-the-job training, and individual instruction/coaching. Experienced aides, whose abilities have not been documented, may be able to meet competency test requirements without further training. *An aide performing any task in Level III Personal Care must meet the competency requirements for that level and be registered as a Nurse Aide I with the NC Division of Facility Services. Meeting competency requirements include a correct demonstration of the tasks to an appropriate professional and must be documented before allowing the aide to perform task(s) independently.
Credentialing Expiration/ Renewal	Listing on the Division of Health Service Regulation Nurse Aide I Registry is valid for two years. To maintain registry listing, the individual must work as a nurse aide under Registered Nurse supervision for pay for at least 8 hours within the two-year period. In-Home Aides that are not listed on the Nurse Aide I Registry need re-training/competency evaluation with each new employer.
Tracking	In-Home Aides who perform Level III Personal Care must be listed on the NC Division of Health Service Regulation Nurse Aide I Registry. In-Home Aides who perform Level I, II, or IV services are tracked by their employers.
Other Info	It is the responsibility of the agency providing In-Home Aide Services to assure the supervision is given to all aides, including conucting and arranging for necessary training and observing and evaluating the aide's performance. Regardless of the level of tasks performed, supervisory home visits must be made at least twice during the first month of the aide's employment. Otherwise, the frequency of required supervisory visits for aide supervision correlated to the level of the tasks performed by the In-Home Aide. Some funding sources may also require more frequent visits to receive reimbursement for services.
Sources	https://www.ncdhhs.gov/divisions/aging-and-adult-services/home-aide; NC DHHS Division of Aging and Adult Services. In-Home Aides. Accessed 5/5/2023 from: https://www.ncdhhs.gov/divisions/aging-and-adult-services/home-aide#:~:text=In%2Dhome%20aide%20services%20are,self%2Ddirecting%20and%20medically%20stable; NC Division of Aging In-Home Aide Services - Policies and Procedures (July 1, 1992). Accessed online on 5/5/2023 from: https://www.ncdhhs.gov/daas-homeaide-policies-and-procedures/open

Personal Care Aide			
Alt. Name(s) Residential Aide, Caregiver, Home Care Aide, Personal Care Assistant, Personal Care Attendant, Resident Care Assistant		*Est. # in NC** 000,000	*Part of HCBS Workforce?* Yes
Setting & Care Population	Adult Care Home; comparable requirements in family care homes		
Description	Unlicensed assistive personnel who provide or directly supervise staff who provide personal care to residents in Adult Care Homes.		
Training	Within 6 months of hiring, an employer must assure and document the successful completion of the 80-hour training and competency evaluation program established by the Division of Health Service Regulation. The 80-hour personal care training and competency evaluation program curriculum includes: (1) observation and documentation skills; (2) basic nursing skills, including special health-related tasks; (3) activities of daily living and personal care skills; (4) cognitive, behavioral, and social care; (5) basic restorative services; and (6) residents' rights as established by G.S. 131D-21. Personal Care Aides are exempt from the 80-hour training and competency evaluation program if they are licensed health professionals, listed on the Nurse Aide Registry, or documented as having completed a previously approved training program.		
Credentialing Expiration/ Renewal	Listing on the Division of Health Service Regulation Nurse Aide I Registry is valid for two years. To maintain registry listing, the individual must work as a nurse aide under Registered Nurse supervision for pay for at least 8 hours within the two-year period. Personal Care Aides that are not listed on the Nurse Aide I Registry need re-training/competency evaluation with each new employer.		
Tracking	Personal Care Aides who are Nurse Aide I's must be listed on the NC Division of Health Service Regulation Nurse Aide I Registry. Other Personal Care Aides are tracked by their employers.		
Other Info	It is the responsibility of the employer to assure the ongoing competency of the Personal Care Aide.		
Sources	Section .0500 Staff Orientation, Training, Competency and Continuing Education. 10ANCAC13F .0501 Personal Care Training and Competency. Accessed online 5/5/2023 from: https://info.ncdhhs.gov/dhsr/rules/2022/adult-family-carehomerules/10A-NCAC-13F.0501-final.pdf PHI-Key-Facts-Report-2023.pdf (phinational.org)		

Geriatric Aide		
Alt. Name(s) n/a	*Est. # in NC** 000,000	*Part of HCBS Workforce?* Yes
Setting & Care Population	Geriatrics	
Description	Geriatric Aide, in NC, means a Nurse Aide I who has passed a state-approved geriatric aide training course and who has a record of the training entered on the N.C. Geriatric Aide Registry.	
Training	Geriatric Aides must be listed as a Nurse Aide I and must pass a state-approved Geriatric Aide Training Program, taught at participating community colleges. In the training, the aides learn new concepts to help the older adult. They learn about topics such as dementia/challenging behaviors, mental health issues and death and dying. Aides also learn self-care and ways to manage stress. Concepts build on their Nurse Aide I knowledge.	
Credentialing Expiration/ Renewal	Listing on the NC Geriatric Aide Registry does not expire and does not need to be renewed. Listing on the Division of Health Service Regulation Nurse Aide I Registry is valid for two years. To maintain registry listing, the individual must work as a nurse aide under Registered Nurse supervision for pay for at least 8 hours within the two-year period.	
Tracking	Geriatric Aides must be listed on the N.C. Geriatric Aide Registry. Geriatric Aides must also be listed on the NC Division of Health Service Regulation Nurse Aide I Registry.	
Other Info	n/a	
Sources	NC DHHS DHSR Health Care Personnel Education and Credentialing Section. NC Geriatric Aide Registry. Accessed online 5/4/2023 from: https://ncnar.ncdhhs.gov/ncga.html#:~:text=Geriatric%20Aides%20are%20individuals%20who,to%20help%20the%20older%20adult.	

Direct Support Professional		
Alt. Name(s) Paraprofessional/Habilitation Assistant, Habilitation Technician, DSP	*Est. # in NC** 000,000	*Part of HCBS Workforce?* Yes
Setting & Care Population	Mental Health, Substance Use, Traumatic Brain Injury, and Intellectual and Developmental Disability Settings, including in home and community-based setting.	
Description	Unlicensed assistive personnel who assist adults aged 18 and older with intellectual and/or developmental disabilities so they can remain in the communities of their choice. Services include 1) Personal care; 2) Habilitation; 3) Supported employment; 4) Residential services; and 6) Education and supportive services for families. Services are accessed through Local Management Entities-Managed Care Organizations (LME-MCOs).	

Training	Be at least 18 years of age; Have a valid driver's and a safe driving record, and an acceptable level of automobile liability insurance, if providing transportation; Not be listed in the North Carolina Health Care Abuse Registry; Become qualified in CPR and First Aid; Become qualified in the customized needs of the beneficiary as described in the Individual Service Plan (ISP); Have a high school diploma or high school equivalency (GED); Be absent of a history of abuse, neglect, exploitation or violent crimes against children or vulnerable adults; Have a criminal background check that presents no health and safety risk to beneficiary; comply with all trainings and competency checks required by the employer of record. DSPs must be trained in the Core Competencies established in 10A NCAC 27G or those Core Competencies covered in Innovations services.
Credentialing Expiration/ Renewal	Varies from employer to employer
Tracking	Largely employer driven
Other Info	The National Alliance for Director Support Professionals launched an e-Badge Academy, which offers a national certification through stackable electronic badges, but right now in NC this is mostly individual driven. Several NC and national organizations have developed other training for DSPs (see partners list).
Sources	NC DHHS Division of Mental Health, Developmental Disabilities, and Substance Abuse Disorders. Accessed online 5/5/2023 from https://openwindow.ncdhhs.gov/index.aspx?pid=rep_servicereport&ServiceID=a8c87d03-4970-499f-b5e9-b9fb0be0a126&itemsource=Service&primaryid=eb2f89cb-f0cf-408a-99d7-77d325c2e3bf ; 10A NCAC 27G, http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health,%20community%20facilities%20and%20services/subchapter%20g/subchapter%20g%20rules.pdf

Home Care Aide

Alt. Name(s)	*Est. # in NC*	*Part of HCBS Workforce?*
CNA, NAI, In-Home Aide	*Approximately 215 listed on the* NC Home Care Aide Specialty Training Registry	Yes
Setting & Care Population	Home Care	
Description	A Nurse Aide I who successfully completes the North Carolina state-approved Home Care Aide specialty training program.	
Training	NC has a list of State-approved Home Care Training Programs offered at Community Colleges across the state. The 25 module, 96+ hour curriculum is designed to teach nurse aides how to deliver care in the client's home environment, build on concepts/skills from Nurse Aide I training and competencies, focus specifically on	

	the unique care delivery challenges associated with providing care in an individual's home, encompass more in-depth knowledge and more advanced soft skill development, provide a pathway for advancement in career ladder for the Nurse Aide I, provide opportunities for community agencies to partner with high schools and community colleges. There is no NC state-approved HomeCare Aide specialty competency exam and it is not a required credential.
Credentialing Expiration/ Renewal	Listing on the NC Home Care Aide Specialty Training Registry does not expire and does not need to be renewed. Listing on the Division of Health Service Regulation Nurse Aide I Registry is valid for two years. To maintain registry listing, the individual must work as a nurse aide under Registered Nurse supervision for pay for at least 8 hours within the two-year period.
Tracking	Home Care Aides are individuals who are listed on the NC Division of Health Service Regulation Nurse Aide I Registry and who have completed the North Carolina state-approved Home Care Aide specialty training program for listing on the NC Home Care Aide Specialty Training Registry: https://info.ncdhhs.gov/dhsr/hcpr/pdf/HCA-Training-Programs.pdf
Other Info	This is not a required credential in any setting. Fees for training vary per program. There are no registry fees. North Carolina is not a Home Care Aide Specialty Training reciprocity state.
Sources	NC DHHS DHSR Health Care Personnel Education and Credentialing Section. Home Care Aide FAQ. Accessed 05/05/2023 from: https://ncnar.ncdhhs.gov/hcafaq.html#:~:text=Answers%3A-,Is%20training%20required%3F,Care%20Aide%20specialty%20training%20program; NC DHHS DHSR Health Care Personnel Education and Credentialing Section. Accessed online 5/5/2023 from: https://ncnar.ncdhhs.gov/pdf/HomeCareAideTrainingProgramList.pdf; Home Health Curriculum. Accessed online 5/5/2023 from https://info.ncdhhs.gov/dhsr/hcpr/curriculum/homecareaidecurriculum.html

Paid Feeding Assistant

Alt. Name(s)	*Est. # in NC**	*Part of HCBS Workforce?*
N/A		No, but tangential

Setting & Care Population	Nursing facilities
Description	A feeding assistant is a single-task worker used to feed residents in nursing homes. Nursing homes may only use paid feeding assistants after they pass state-approved training.
Training	Paid Feeding Assistants must successfully complete the NC state-approved Feeding Assistant curriculum. Topics include the role of the feeding assistant, communication and interpersonal skills, resident rights, safety and emergency procedures, infection prevention, and nutrition and hydration. The curriculum is available online and documentation of mastery is employer-based.

Credentialing Expiration/ Renewal	Largely employer-driven
Tracking	Paid Feeding Assistant who are Nurse Aide I's are listed on the NC Division of Health Service Regulation Nurse Aide I Registry. Otherwise, tracking is employer-driven.
Other Info	n/a
Sources	NC DHHS DHSR State-Approved Curriculum Feeding Assistant (June 2020). Accessed online 5/5/2023 from https://info.ncdhhs.gov/dhsr/hcpr/pdf/approved_fed_curr.pdf

**Attempts to obtain estimated numbers were unsuccessful.*

Appendix B: Direct Care Worker Learning Management Systems Comparison Table

	DirectCourse	Open Future Learning	Relias
Stackability	Yes - via the NADSP E-Badge Academy	Yes - via the NADSP E-Badge Academy	Yes - via the NADSP E-Badge Academy
Portability	Yes - via the NADSP E-Badge Academy	Yes - via the NADSP E-Badge Academy	Yes - via the NADSP E-Badge Academy
Accessibility	Accessible on phone via web browser	Accessible on phone via web browser	Accessible on phone via web browser or via Relias Learner Mobile App Features SMS text notifications for upcoming or overdue training
Ability to Annotate	Yes - can be annotated at state or organization level; annotation privileges can be controlled by admin	Yes - can create own modules for platform or can customize modules in collaboration with OFL staff	Yes - can be annotated at state or organization level; annotation privileges can be controlled by admin; cannot alter existing modules Subportals allow for passing information down to agencies in network Possible to have hundreds of portals within a network - allows to operate at organizational level with individual agency additions
Tracking	Learner transcripts can be transferred to new employer upon request Outside classes/events (e.g., org. CPR training) can be tracked within system Standardized reporting options available; can look at completion rate statewide or at org level	Learner transcripts cannot be transferred from one employer to another; learner can print transcript Administrators also have access to user certificates Ability to issue bulk transcripts for group learning Administrators would oversee accounts and would have to report to the state	Learner transcripts can be transferred to new employer upon request Can run reports on individual portals (more granular) or entire network

Capturing Lived Experienced	Curriculum developed by people with lived experience	100% dedication to intellectual and developmental disabilities	Course imagery (including simulations) includes people with lived experience Business partnerships with orgs that serve IDD community Neurodiverse content developer
Language Accessibility	Content geared toward 6th grade reading proficiency Closed captioning available Content formatted to function with screen readers	Focus on plain language and storytelling - avoid jargon, acronyms Modules being translated into Spanish	Courses in both English and Spanish In early stages of exploring opportunity to add more languages to IDD content Home Care/Home Health library includes 6 languages
Accreditation	Yes - via the National Alliance of Direct Support Professionals	Yes - via the National Alliance of Direct Support Professionals	Yes - via the National Alliance of Direct Support Professionals
Modules for Front-Line Supervisors	Yes	Yes	Yes
Additional Information	DirectCourse has curriculum including College of Direct Support; College of Employment Services; College of Personal Assistance and Caregiving; College of Recovery and Community Inclusion; College of Frontline Supervision and Management; College of Person-Centered Counseling Announcements, surveys, discussion boards, skills checklists 88 standardized reports (e.g., completion rates, knowledge gaps, etc.)	Variety of module types: staff learning modules, mini modules, side-by-side modules (participate alongside person with I/DD and both earn certificates), audio learning modules Video library includes videos from modules as well as additional resources Interactive notes for strategic application of learning; account administrator can see notes Billed by active users in 30-day period	Variety of module types: standard, pro on the go (5-7 minute, mobile optimized), simulations "Seat model" - buy a number of seats at once (protects against turnover) Can buy specific course libraries to meet need Can create training plan that includes custom modules (non-Relias trainings) All solution packages include employee wellness course library They serve hospitals and health systems, post-acute

	Best practice would be for state to purchase "open license" so employers don't have to pay support fee Curricula can be cross walked with community college system for 9-12 hours credit (ICI-MN did this) Previously offered at no cost to 9 providers in NC as a 3-year pilot; needed a payor to maintain		and long-term care, home health and home care, individual health care workers, health and human services, public sector, payers and public safety
Contact(s)	Bill Waibel b.waibel@elsevier.com	Ben Drew hello@openfuturelearning.org	Nellie Galindo ngalindo@relias.com Tanner Melton tmelton@relias.com

Appendix C: Additional DCW Efforts in NC

Workforce Engagement with Care Workers to Assist, Recognize and Educate (WECARE)	
Timing	Four years, with possibility of 5th: Y1 - convene community partners, gather community inputs, complete landscape analysis Y2 - using landscape analysis to guide further community inquiry, early formation of pilot elements with a consideration of "high road" employers and direct care worker champions as part of pilot Y3 - pilot development with community partner input Y4 - pilot execution with evaluation, dissemination plans Y5 - dissemination of model
Outputs	The overarching goal of WECARE is to create a strong, HCBS entry-level training and career pathway options for Direct Care Workers/Direct Support Professionals that are portable and tied to wage increases. - Develop/establish a unified entry level training and credentialing framework, based on previous and existing efforts in NC and nationally. Based on identified core competencies. - Optimize a training and credentialing approach for direct care professionals - Identify high-road HCBS employers and tools to support direct care professionals - Implement an awareness and community outreach effort - Pilot the training, credentialing and support model
Additional Information	Partners: Duke Sanford School of Public Policy (Nathan Boucher; nathan.boucher@duke.edu), Appalachian State University (Sandi Lane), National Domestic Workers Alliance-NC (Erin Carson), NC Coalition on Aging (Heather Burkhardt, Trish Farnham), PHI (Kezia Scales)

The Arc of NC [Employee Apprenticeship]	
Timing	In development/ongoing
Outputs	Arc of NC employee apprenticeship: The Arc of NC training, Mt. Eagle curriculum, and on the job learning (total 2,000 hours) Pilot with The Arc of NC employees with potential to expand Apprenticeship was approved in January 2023
Additional Information	Currently seeking funding support for apprenticeship program The Arc of NC could possibly become a sponsor of the apprenticeship model in the future so it can be more widely shared

Mt. Eagle	
Timing	Ongoing Courses offered multiple times annually
Outputs	Disability Support Professional course resulting in NADSP's DSP-I credential - 9-week program - Access to NADSP e-badge academy - Access to Open Future Learning curriculum - Access to instructor with lived experience to supplement modules, guide discussion - IDD focus
Additional Information	Employers or students pay for training (~$700) - decline in enrollees now that ARPA funding phasing out This curriculum will be paired with The Arc of NC supplements to form the DSP apprenticeship

Personal and Home Care Aide State Training (PHCAST)	
Timing	Ended (HRSA-funded initiative)
Outputs	Home Care Aide Curriculum (4 phase framework that integrates training pathways for DCWs across LTC settings) - Phase I - Job readiness, literacy/numeracy, keyboarding and realistic job previewing skills - Phase II - Non-NAI personal care task and soft skill development - Phase III - Enhanced NAI content/delivery - Phase IV - Advanced NAI knowledge and skills; new Home Care Nurse Aide focuses on specific care environment (this phase will also create a track parallel to Geriatric or Med Aide career path options for NAs in NC) Curriculum is available for use but is not current required or funded; curriculum is still used as a reference and possible model for future home care curriculum design
Additional Information	Planning to review materials for updates Ability/opportunity to add to training if needed DPI offers Home Care Aide and Geriatric Aide courses – students receive the endorsement on their Nurse Aide listing

NC Alliance of Direct Support Professionals	
Timing	Ended
Outputs	Establish NC chapter of National Alliance of DSPs to engage and empower DSPs and providers in greater collaboration - Increase access to educational experiences (training, continuing/higher ed)

	- Build connections and collaboration among DSP community statewide - Promote value in DSP line of work; work toward professional standards
Additional Information	Funded by NC Council on Developmental Disabilities https://nccdd.org/nc-alliance-of-direct-support-professionals.html

Caregiving Workforce Strategic Leadership Council

Timing	Through December 2023 with possibility of continuation
Outputs	Use data and expert input to identify strengths and challenges facing workforce and develop coordinated action - 4 convenings of caregiver leaders (completed by November 2023) - Future Workforce Development Report (December 2023) First three focus areas include: direct care, nursing, behavioral health

NC Center on the Workforce for Health

Timing	In formation/ongoing
Outputs	The NC Center on the Workforce for Health will provide a forum for health employers, workers, educators, regulators, policymakers, and others throughout North Carolina to convene, discuss challenges and opportunities, share best practices and lessons learned, identify potential solutions and metrics for success, and monitor progress toward addressing these challenges. North Carolina's historic, persistent, and worsening health workforce shortages can best be addressed through intentional, transparent, and collaborative engagement by the communities interested in solving those problems. Although many organizations focus on health workforce development, that work typically is focused on a specific profession, geography, or institution.
Additional Information	https://nciom.org/nc-center-workforce-for-health/

NC Council on Developmental Disabilities

Timing	2022-2026 (5-year state plan)
Outputs	Carry out provisions of the Developmental Disabilities Assistance and Bill of Rights Act; Ensure the Council is a member-driven, effective, efficient, and accountable organization - Increase financial security through asset development for individuals with I/DD - Increase community living for individuals with IDD - Increase advocacy for individuals with IDD

Additional Information	60% membership is people with IDD or family members

Career and College Promise

Timing	Ongoing
Outputs	CCP provides three pathways to help advance eligible students' post-high school success: - College Transfer – College transfer pathways (CTP) provide tuition-free course credits toward the AA, AS, AATP, ASTP, AE, ADN, AFA- Music, AFA-Theatre, or AFA-Visual Arts that will transfer seamlessly to any UNC System or participating private college or university. - Career and Technical Education – Career and Technical Education (CTE) pathways provide tuition-free course credits toward a certificate, diploma, or state or industry-recognized workforce credential. Workforce Continuing Education (WCE) credentials are offered via state or locally developed WCE CCP pathways. - Cooperative Innovative High Schools – Begin earning tuition-free college credits as a high school student by attending an approved Cooperative Innovative High School.

NC Providers Council

Timing	Ongoing
Outputs	Promote overall improvement of community support services for individuals who require those supports to live in their communities across NC. - Encourage professional growth and training opportunities - Advocate for governmental policies, compensation, and other supports - Support members through consultation and networking - Foster development of appropriate resources and services
Additional Information	Important group to engage to get employer buy-in

Essential Jobs, Essential Care NC

Timing	Ongoing
Outputs	Multi-sector direct care workforce advocacy initiative managed by the NC Coalition on Aging. Works in collaboration with other workforce development initiatives but has broader advocacy scope.
Additional Information	Via PHI

National Domestic Workers Alliance	
Timing	Ongoing
Outputs	NC chapter of nationally affiliated grassroots advocacy initiative. The National Domestic Workers Alliance (NDWA) is social movement organization that "works to win respect, recognition, and labor rights and protections for the nearly 2.5 million nannies, housecleaners, and homecare workers who do the essential work of caring for our loved ones and our homes."

NC CareGivers	
Timing	Ongoing
Outputs	NCCaregivers initiative is managed by NC Health Care Facilities Association in partnerships with community college network. Provides CNA credential training reimbursement.
Additional Information	Erik Kivisto and Rebekka Cheek at NCHCFA are points of contact. https://www.nccaregivers.org/

NC Division of Aging and Adult Services State Aging Plan	
Timing	2023-2027
Outputs	OBJECTIVE 4.1: Strengthen, support, expand, and diversify the direct care workforce to meet the growing care needs in NC. *Strategy 1:* Explore recruitment of older workers to provide direct care using Title V training funding to pay for Personal Care Aide or Certified Nursing Assistant (CNA) training. *Strategy 2:* To enhance best practices, encourage home care agencies and educational institutions to partner with state agencies to support a ready and well-qualified direct care workforce. *Strategy 3:* In collaboration with DMH/DD/SAS, provide support to providers on trauma-informed care. *Strategy 4:* Expand opportunities for community involvement and volunteerism to increase the availability of services to older adults, people with disabilities, and family caregivers.
Additional Information	AdvaNCing Equity in Aging: A Collaborative Strategy for NC (2023-27) (ncdhhs.gov)

Sheps Health Workforce NC	
Timing	Ongoing
Outputs	Sheps Health Workforce NC provides timely, objective data and analysis to inform health workforce policy in North Carolina and across the United States. We are based at

	the Cecil G. Sheps Center for Health Services at UNC-Chapel Hill, but our mission is statewide, a collaboration between the Sheps Center, the North Carolina Area Health Education Centers Program (AHEC), and the health professions licensing boards.
Additional Information	https://nchealthworkforce.unc.edu/

Direct Care Workforce Capacity Building Center	
Timing	5-year grant; awarded October 2022
Outputs	Provide technical assistance to states and service providers and facilitate collaboration with stakeholders to improve recruitment, retention, training, and professional development of the direct care workers who provide the critical services that make it possible for people with disabilities and older adults to live in their own homes and communities
Additional Information	Grant funding awarded by the Administration for Community Living Initiative led by the National Council on Aging

Appendix D: Consulting Organizations, Individuals, and Groups

Name	*Organization*	*Title*
Adam Sholar	NC Health Care Facilities Association	President & CEO; Vice Chair NC Coalition on Aging
Akan Iyamu	Trillium (LME-MCO)	Associate Vice President of Population Health Clinical Operations
Amanda Outlaw	Eastpointe (LME-MCO)	Director of Provider Monitoring
Amber Byrum	Trillium (LME-MCO)	Network Coordinator
Barbara Burt	NC Department of Public Instruction	Education Program Specialist; Health Science Consultant
Benita Hathaway	Trillium (LME-MCO)	Vice President, Care Management
Bertina Parkins	Sandhills (LME-MCO)	Training Coordinator
Betty Jenkins	Trillium (LME-MCO)	Accounting Manager
Brieanne Lyda-McDonald	NC Institute of Medicine/NC Task Force on the Future of Nursing	Project Director
Brooke Mickelson	Eastpointe (LME-MCO)	Director of Training and Community Relations
Catherine Moore	NC Board of Nursing	Chief Legislative and Quality Officer
Catherine Sevier	NC American Association of Retired Persons (AARP)/NC Future of Nursing Action Coalition	Past President/Co-Chair
Chris Egan	NC Department of Health and Human Services	Assistant Secretary for Employment and Inclusion
Christina Dupuch	CCR Consulting	Senior Consultant
Christopher White	LifeSpan	Chief Operating Officer
Colleen Tapan	NC DHHS	Senior Director of Strategy and Operations
Crystal Tillman	NC Board of Nursing	Chief Executive Director
Dave Peterson	Trillium (LME-MCO)	Central Regional Director
Dave Richard	McGuire Woods Consulting	Sr. Vice President Government Relations/Retired NC Medicaid Director
Emma Sandoe	NC Department of Health Benefits	Associate Director of Strategy and Planning
Erin Carson	National Domestic Workers Alliance-NC, WECARE	

Erin Fraher	Carolina Health Workforce Research Center Sheps Center for Health Services Research	Director
Ginger Yarbrough	NC Division of Mental Health, Development Disabilities, and Substance Use Services	Intellectual and/or Developmental Disabilities and Traumatic Brain Injury Section Chief
Heather Burkhardt	NC Coalition on Aging, WECARE	Executive Director
Holly Richard	The Arc of NC	Special Projects Advisor
Holly Riddle	Office of the Secretary, NCDHHS	Assistant Director for Olmstead Implementation
Jack McGlynn	Deloitte; Caregiving Workforce Strategic Leadership Council Direct Care Worker Workstream	Human Capital Consultant
Jessica Foster	NC Healthcare Association	
Jennifer Mackethan	Trillium (LME-MCO)	Communications and Marketing Director
John Nash	The Arc of NC	Executive Director
Jon D'Angelo	Advocate, Self-Directing CAP DA	
Julie Brinson	Trillium (LME-MCO)	Network Operations Manager
Julie Kokocha	Trillium (LME-MCO)	Head of Network Accountability
Karen Wade	NC Department of Health and Human Services	Policy Advisor
Kathy Colville	NC Institute of Medicine	President and CEO
Kellie Baker	Trillium (LME-MCO)	Finance Director
Kelly Crosbie	NC Division of Mental Health, Development Disabilities, and Substance Use Services	Director
Kenneth Bausell	NC Department of Health Benefits	Senior Director of Employment and Inclusion
Kevin Coughlin	Wisconsin Certified Direct Care Professional Program, Wisconsin Department of Health Services	Policy Initiatives Advisor
Kevin FitzGerald	NC Center on the Workforce for Health	
Kezia Scales	Paraprofessional Healthcare Institute (PHI), WECARE	Vice President of Research and Evaluation
Kimberly Huneycutt	Trillium (LME-MCO)	Internal Compliance and Medicaid Contract Manager
Kristy Myers	The Arc of NC	Director of Long Term Services and Supports Care Coordination

LaCosta Parker	NC Department of Health Benefits	Intellectual and/or Development Disability Policy Consultant
Lisa Poteat	The Arc of NC	Deputy Director
Lori Byrd	NC Community College System	Associate Director, Academic Programs - Health Sciences
Luz Terry	Trillium (LME-MCO)	Director of Contracts and Provider Support Services
Mary Bethel	Retired (prev. Associate State Director for Advocacy with AARP NC)	Chair, NC Coalition on Aging
Matt Potter	Disabled Youth Advocate and Public Speaker	
Melissa Leeds	NC Department of Public Instruction	Health Science Consultant
Melissa Swartz	NC Council on Developmental Disabilities	Planner Evaluator/Staff for Advocacy Development Committee
Michael Ganley	NC Department of State Operated Healthcare Facilities	Program Manager, Developmental Center Team
Michelle Merritt	NC Department of Health Benefits	Intellectual and/or Developmental Disability Policy Consultant
Nathan Boucher	Duke Sanford School of Public Policy, WECARE	Associate Research Professor of Public Policy, Principle Investigator WECARE
Pam Edwards	Duke University Health System	Assistant Vice President for Education, Practice & Research
Richard Anderson	Horizons Residential Care Center	President & Chief Executive Officer
Russell Bailey	Deloitte/Caregiving Workforce Strategic Leadership Council Direct Care Worker Workstream	Physician Consultant
Sabrena Lea	NC Medicaid, Long Term Services and Supports	Deputy Director
Sandi Lane	Appalachain State University, WECARE	Associate Professor, Masters of Health Administration Program
Sarah Griffith	NC Board of Nursing	Chief Nursing Officer
Sheryl Deal	Trillium (LME-MCO)	Claims Director
Stacy Thompson	NC Board of Nursing	Practice Consultant
Steve Strom	NC Department of Health and Human Services	Director, Money Follows the Person
Talley Wells	NC Council on Developmental Disabilities	Executive Director
Tara Heasley	NC Department of Health Benefits	Intellectual and/or Developmental Disabilities Policy Consultant

Joyce Winstead	NC Board of Nursing	Director of Practice
Ted Goins	Lutheran Services Carolinas	President & Chief Executive Officer
Trish Farnham	NC Coalition on Aging, WECARE	Project Coordinator
Valerie Howard	NC Future of Nursing Action Coalition	Co-Chair

Appendix E: Example Proposal for NCCARE 360 Wraparound Support Services

NC AHEC

Proposal Valid Until September 29th, 2023

UNITE US

Proposal

Proposal Summary

When you partner with Unite Us, you are choosing a leader revolutionizing health and social care delivery. We have measurably impacted the lives of thousands of people by better connecting them to the housing, employment, food, behavioral health, and other services they need. Our networks empower individuals through a deep focus on results across their entire care journey.

What we build

Robust, interconnected networks of health and social service providers. With the Unite Us Platform, you and your community get access to a simple yet comprehensive tool to address the needs of the people you serve. Unite Us works closely with community organizations to develop network standards around response times for referrals and documenting outcomes, enabling you to conveniently monitor the progress of those you serve in real-time. Creating an accountable ecosystem alleviates the navigation, scheduling, and attendance burden on the individual. Our platform turns providers from passive recipients to active participants, ensuring that underserved populations can focus on themselves and their families.

What you get

Public health infrastructure 2.0. With Unite Us you are getting a solution to address social determinants of health at scale. You also get a strategic thought partner that will innovate with you to drive impact. We all know that the healthcare landscape is changing, and while we have built a product that scales, we are no strangers to change. We will help you navigate regulatory changes, payment model innovations, and more.

Our provider-agnostic solution lets you scale across care settings, whether that is care management, primary care, or even home health. Our web-based platform supports configurable screeners, assessments, and workflows to direct members to the most appropriate care setting to meet their needs. We collect structured service episode data at the individual level as well as network level data on program availability, capacity, and service type mix. Whether you are looking to improve individual member health outcomes and well-being or drive community transformation, Unite Us has the data and insights to support your vision.

But we aren't just a technology vendor. We are active members of your team and your community. Between our customer success team and data infrastructure, the answer to your question is never far away.

What you pay

Investment	Year 1	Year 2+
Unite Us Network Social Care Coordination, 50 referrals per week *Supports coordination center functions by identifying and executing on appropriate client referrals, taking the onus off of individual organization administrators.*	**$120,000**	**$120,000**
Assistance Request Form	$2,500	$2,500
Total, Net	**$122,500**	**$122,500**

Assistance Request Form

Unite Us will embed an Assistance Request Form on a customer-designated website and enable individuals to directly request services via the form. Submitted assistance request forms will be routed to the Unite Us Network Hub Support to follow-up and connect the individual with an organization that can service their needs.

Premium Support

Social Care Coordination

Social Care Coordination is a premium network support feature to help ensure clients receive the services they need. Unite Us deploys Network Hub Support specialists to identify client needs, engage with clients to gather any information required for referrals, and determine the right community partner to address needs.

Assistance Request Fulfillment

Submitted assistance request forms will be routed to Unite Us Network Hub Support to follow-up and connect the individual with an organization that can service their needs.

NC AHEC | RECRUIT TRAIN RETAIN

North Carolina Area Health Education Centers Program
145 N. Medical Drive, CB 7165
The University of North Carolina at Chapel Hill
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