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:

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

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<td>1</td>
<td>Implement an umbrella system for credentialing DCWs that incorporates new and existing training options.</td>
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<td>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.</td>
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<td>2</td>
<td>Adopt common core competencies for all direct care workers.</td>
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<td>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.</td>
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<td>3</td>
<td>Ensure training is accessible for all workers, including paid training time.</td>
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<td>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.</td>
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<td>4</td>
<td>Develop infrastructure for the administration and oversight of credentialing.</td>
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<td>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.</td>
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<td>5</td>
<td>Connect competency attainment with wage and rate differentials.</td>
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<td>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.</td>
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<tr>
<td>6</td>
<td>Provide additional wraparound support services to direct care workers.</td>
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<td>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.</td>
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North Carolina Facts

Direct Care Workers

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

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

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.

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 initiative 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.

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 programs⁴), 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.

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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:

1. Implement an umbrella system incorporating new & existing training options.
2. Adopt common core competencies for all direct care workers.
3. Ensure the accessibility of training for all direct care workers.
4. Develop infrastructure for administration & oversight of credentialing.
5. Connect competency attainment with wage & rate differentials.
6. Provide additional supports to direct care workers.

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.

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\(^5\) 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, to support individuals with physical, cognitive, and intellectual/developmental disabilities 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, 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.

While the work that DCWs provide is often referred to as “low-skilled” or even “unskilled,” 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.

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.\textsuperscript{12}

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,\textsuperscript{13} and those with low educational attainment. In 2021, of the estimated 112,630 DCWs\textsuperscript{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.\textsuperscript{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.\textsuperscript{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:\textsuperscript{17}

\begin{itemize}
  \item \textsuperscript{12} Direct Care Workforce State Index | North Carolina, 2023
  \item \textsuperscript{13} Hostetter and Klein, 2021
  \item \textsuperscript{14} Defined in this section as personal care aides, home health aides, and nursing assistants.
  \item \textsuperscript{15} Essential Jobs, Essential Care, 2023
  \item \textsuperscript{16} North Carolina – PHI, 2023
  \item \textsuperscript{17} AARP, 2020
\end{itemize}
• 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.”

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. 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].”

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.”

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.”

The shortage in direct care workers has resulted in decreased access to care and decreased quality of care with 66% of providers turning away new referrals, 34% discontinuing services, and 40% seeing higher frequencies of reportable incidents.

References:

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.”

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. 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.

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. 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 and a positive correlation with patient-reported quality of life as well as DCW job retention and satisfaction. 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 expressed concerns over the lack of staff training:

“When they can make more at a fast-food restaurant, it’s hard to keep them interested.”

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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 but may also contribute to retaining this workforce, though studies often measure worker perception of training satisfaction rather than measures of effectiveness of training. One study demonstrated that training and more flexibility in shifts increased DCW retention even without raising wages. 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.

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.”

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).

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).

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.

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.

| 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 |

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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.\textsuperscript{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).”\textsuperscript{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.\textsuperscript{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.\textsuperscript{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).\textsuperscript{48}
- The number of people with I/DD is growing and their life expectancy is increasing.\textsuperscript{49}
- The incidence of co-morbidities across all patient populations require enhanced skillsets that are already highly valued in the DSP workforce.\textsuperscript{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

\textsuperscript{44} Standard Occupational Classification, n.d. 
\textsuperscript{45} “The Medicaid Glossary: Long-Term Services and Supports Glossary,” 2021
\textsuperscript{46} Direct Care Workers in the United States, 2023
\textsuperscript{47} Bradley, 2021
\textsuperscript{48} Barkoff, 2023
\textsuperscript{49} Videlefsky et al., 2019
\textsuperscript{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.

**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

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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.\textsuperscript{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.\textsuperscript{56} Low compensation is often cited as the top cause of DCW turnover and contributes to movement between organizations and settings.\textsuperscript{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.\textsuperscript{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,

\begin{itemize}
\item \textsuperscript{55} Results of The Direct Support Workforce and COVID-19 National Survey, 2020
\item \textsuperscript{56} Scales and Stepick, n.d.
\item \textsuperscript{57} President’s Committee for People with Intellectual Disabilities, 2012
\item \textsuperscript{58} Espinoza, 2020
\end{itemize}
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

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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. 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.

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.

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.

Competencies are “the knowledge, skills, abilities, and behaviors that contribute to individual and organizational performance.”

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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.\textsuperscript{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.\textsuperscript{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.

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.

\begin{table}[h]
\centering
\begin{tabular}{|c|}
\hline
\textbf{Core Competencies for DCWs:} \\
\hline
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 \\
\hline
\end{tabular}
\end{table}

\textsuperscript{63} Lewis et al., 2022
\textsuperscript{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

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.” Or more simply, they are “building blocks where each short-term credential that a person earns builds into a higher-level credential.” 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

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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. 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. 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

Vogels, 2021
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. 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, 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

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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.

WE CARE: 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.” 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. WE CARE, currently in its second year of five, is one of four partnerships selected by UNC Cares to receive grant funding from the NC DHHS Money Follows the Person (MFP) project.

In developing this plan, we worked closely with the WE CARE 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.

WE CARE 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

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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 and explains how this implementation plan will address those factors.

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

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.

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\(^\text{81}\) and the NC Center on the Workforce for Health\(^\text{82}\) 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,\(^\text{83}\) and additional relevant information.

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\(^{81}\) 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
<table>
<thead>
<tr>
<th>State</th>
<th>Rank</th>
<th>Coordinating Entity</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>13</td>
<td>Department of Aging</td>
<td>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.</td>
</tr>
<tr>
<td>New York(^*)</td>
<td>14</td>
<td>NY State Office for People with Developmental Disabilities (OPWDD)</td>
<td>OPWDD entered into a 3-year contract with NADSP to offer credentialing for DCWs through its E-Badge Academy.(^85)</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>2</td>
<td>Executive Office of Health and Human Services (EOHHS)</td>
<td>HCBS Workforce Recruitment &amp; Retention initiative(^86)</td>
</tr>
<tr>
<td>Tennessee(^*)</td>
<td>45</td>
<td>Tennessee’s Medicaid program</td>
<td>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.</td>
</tr>
<tr>
<td>Vermont</td>
<td>12</td>
<td>Department of Disabilities, Aging &amp; Independent Living (DAIL); VT Money Follows the Person; HireAbility Vermont</td>
<td>Vermont Direct Care Initiative(^88) aims to improve recruitment and retention and to promote the healthcare career ladder.</td>
</tr>
<tr>
<td>Washington</td>
<td>1</td>
<td>Aging and Long-Term Support Administration (ALTSA)</td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>25</td>
<td>WI Department of Health Services; WI Health Care Association; LeadingAge Wisconsin</td>
<td>WisCaregiver Careers(^89) coordinates training, job connections, and incentives for DCWs in nursing homes</td>
</tr>
</tbody>
</table>

\(^*\)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.

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\(^{84}\) California GROW's - 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 TeamSTEPPS92 or other team training framework would likely be valuable, but implementation must consider specific organizational characteristics as well.

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**

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...

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\(^ {93}\) *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

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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,\textsuperscript{101} unreliable childcare,\textsuperscript{102} and costly housing.\textsuperscript{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.

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.\textsuperscript{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,\textsuperscript{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

\textsuperscript{101} The Direct Care Workforce, 2022
\textsuperscript{102} Caring for Care Workers, 2023
\textsuperscript{103} Direct Care Workers in the United States, 2021
\textsuperscript{104} About NCCARE360, n.d.
\textsuperscript{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.

**Recommendations for Implementing a Credentialing System for Direct Care Workers in North Carolina**

1. Implement an umbrella system for credentialing direct care workers that incorporates new and existing training options.
2. Adopt common core competencies for all direct care workers.
3. Ensure training is accessible for all workers, including paid training time.
4. Develop infrastructure for the administration and oversight of credentialing.
5. Connect competency attainment with wage and rate differentials.
6. Provide additional wraparound support to direct care workers.
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.\(^\text{106}\) 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:

\(^{106}\text{NC Medicaid Obtains Approval of the 1915(i) State Plan Amendment, 2023}\)
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. 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

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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


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://ncnr.ncdhhs.gov/gloss.html#M.


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%20Factors%20to%20be%20Considered%20in%20Determining%20Rate%20Sufficiency%20for%201915%28c%29%20HCBS%20Waivers.pdf.


# Appendix A: Direct Care Worker Definitions & Profiles

## Nurse Aide I

<table>
<thead>
<tr>
<th>Alt. Name(s):</th>
<th>Est. # in NC*</th>
<th>Part of HCBS Workforce?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Aide, CNA, NAI, Certified Nursing Assistant, Certified Nursing Aide, Nursing Attendant, Nursing Aide, Nursing Care Attendant, Medication Aide</td>
<td>000,000</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Alt. Name(s)</th>
<th>Est. # in NC*</th>
<th>Part of HCBS Workforce?</th>
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</thead>
<tbody>
<tr>
<td>NAI+4, Nurse Aide, CNA, NAI, Certified Nursing Assistant, Certified Nursing Aide, Nursing Attendant, Nursing Aide, Nursing Care Attendant, Medication Aide</td>
<td>000,000</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 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
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*

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### Nurse Aide II

<table>
<thead>
<tr>
<th>Alt. Name(s)</th>
<th>Est. # in NC</th>
<th>Part of HCBS Workforce?</th>
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<tr>
<td>NAI, Nurse Aide, CNA, Certified Nursing Assistant, Certified Nursing Aide, Nursing Attendant, Nursing Aide, Nursing Care Attendant, Medication Aide</td>
<td>10,548 (as of 8/22/2023. Updated daily at <a href="http://www.ncbon.com">www.ncbon.com</a>)</td>
<td>Yes</td>
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<table>
<thead>
<tr>
<th>Setting &amp; Care Population</th>
<th>Description</th>
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<tr>
<td>Acute care facilities, nursing facilities, primary care/outpatient setting, home care</td>
<td>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.</td>
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<table>
<thead>
<tr>
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<th>Credentialing</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>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.</td>
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</table>

<table>
<thead>
<tr>
<th>Expiration/Renewal</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
</tr>
</tbody>
</table>
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.  
Verify a License, 2023 |

### Medication Aide (Skilled Nursing Facility, Nursing Home)

<table>
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<tr>
<th>Alt. Name(s)</th>
<th>Est. # in NC*</th>
<th>Part of HCBS Workforce?</th>
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</thead>
<tbody>
<tr>
<td>Med Aide</td>
<td>000,000</td>
<td>No, but tangential</td>
</tr>
</tbody>
</table>

**Setting & Care Population**  
Medication Aide (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**  
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)

<table>
<thead>
<tr>
<th>Alt. Name(s)</th>
<th>Est. # in NC*</th>
<th>Part of HCBS Workforce?</th>
</tr>
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<tbody>
<tr>
<td>Med Tech</td>
<td>000,000</td>
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**Setting & Care Population**  
Adult Care Home
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<thead>
<tr>
<th>Description</th>
<th>Unlicensed assistive personnel who will perform medication aide duties in Adult Care Homes.</th>
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<tr>
<td>Training</td>
<td>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.</td>
</tr>
<tr>
<td>Credentialing Expiration/Renewal</td>
<td>A listing on the NC Medication Aide Registry for Adult Care Homes does not expire and does not need to be renewed.</td>
</tr>
<tr>
<td>Tracking</td>
<td>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.</td>
</tr>
<tr>
<td>Other Info</td>
<td>$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.</td>
</tr>
</tbody>
</table>

### In-Home Aide

<table>
<thead>
<tr>
<th>Alt. Name(s)</th>
<th>Personal Care Assistant/Aide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Est. # in NC*</td>
<td>000,000</td>
</tr>
<tr>
<td>Part of HCBS Workforce?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting &amp; Care Population</th>
<th>Home care, community based setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>“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</td>
</tr>
</tbody>
</table>
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 retraining/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 conducting 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**

## Personal Care Aide

<table>
<thead>
<tr>
<th><strong>Alt. Name(s)</strong></th>
<th>Residential Aide, Caregiver, Home Care Aide, Personal Care Assistant, Personal Care Attendant, Resident Care Assistant</th>
<th><strong>Est. # in NC</strong></th>
<th>000,000</th>
<th><strong>Part of HCBS Workforce?</strong></th>
<th>Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Setting &amp; Care Population</strong></th>
<th>Adult Care Home; comparable requirements in family care homes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Description</strong></th>
<th>Unlicensed assistive personnel who provide or directly supervise staff who provide personal care to residents in Adult Care Homes.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Training</strong></th>
<th>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.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Credentialing Expiration/Renewal</strong></th>
<th>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 retraining/competency evaluation with each new employer.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Tracking</strong></th>
<th>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.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Other Info</strong></th>
<th>It is the responsibility of the employer to assure the ongoing competency of the Personal Care Aide.</th>
</tr>
</thead>
</table>

|-----------------|------------------------------------------------------------------------------------------------------------------|
### Geriatric Aide

<table>
<thead>
<tr>
<th>Alt. Name(s)</th>
<th>Est. # in NC*</th>
<th>Part of HCBS Workforce?</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a</td>
<td>000,000</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Alt. Name(s)</th>
<th>Est. # in NC*</th>
<th>Part of HCBS Workforce?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraprofessional/Habilitation Assistant, Habilitation Technician, DSP</td>
<td>000,000</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**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


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### Home Care Aide

<table>
<thead>
<tr>
<th>Alt. Name(s)</th>
<th>Est. # in NC</th>
<th>Part of HCBS Workforce?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNA, NAI, In-Home Aide</td>
<td>Approximately 215 listed on the NC Home Care Aide Specialty Training Registry</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting &amp; Care Population</th>
<th>Description</th>
<th>Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td>A Nurse Aide I who successfully completes the North Carolina state-approved Home Care Aide specialty training program.</td>
<td>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</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Credentialing Expiration/Renewal</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracking</td>
<td>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: <a href="https://info.ncdhhs.gov/dhsr/hcpr/pdf/HCA-Training-Programs.pdf">https://info.ncdhhs.gov/dhsr/hcpr/pdf/HCA-Training-Programs.pdf</a></td>
</tr>
<tr>
<td>Other Info</td>
<td>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.</td>
</tr>
</tbody>
</table>

---

**Paid Feeding Assistant**

<table>
<thead>
<tr>
<th>Alt. Name(s)</th>
<th>Est. # in NC*</th>
<th>Part of HCBS Workforce?</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td>No, but tangential</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Setting &amp; Care Population</th>
<th>Nursing facilities</th>
</tr>
</thead>
</table>

**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.
<table>
<thead>
<tr>
<th>Credentialing Expiration/ Renewal</th>
<th>Largely employer-driven</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracking</td>
<td>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.</td>
</tr>
<tr>
<td>Other Info</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*Attempts to obtain estimated numbers were unsuccessful.*
<table>
<thead>
<tr>
<th></th>
<th>DirectCourse</th>
<th>Open Future Learning</th>
<th>Relias</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stackability</strong></td>
<td>Yes - via the NADSP E-Badge Academy</td>
<td>Yes - via the NADSP E-Badge Academy</td>
<td>Yes - via the NADSP E-Badge Academy</td>
</tr>
<tr>
<td><strong>Portability</strong></td>
<td>Yes - via the NADSP E-Badge Academy</td>
<td>Yes - via the NADSP E-Badge Academy</td>
<td>Yes - via the NADSP E-Badge Academy</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>Accessible on phone via web browser</td>
<td>Accessible on phone via web browser</td>
<td>Accessible on phone via web browser or via Relias Learner Mobile App Features SMS text notifications for upcoming or overdue training</td>
</tr>
<tr>
<td><strong>Ability to Annotate</strong></td>
<td>Yes - can be annotated at state or organization level; annotation privileges can be controlled by admin</td>
<td>Yes - can create own modules for platform or can customize modules in collaboration with OFL staff</td>
<td>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</td>
</tr>
<tr>
<td><strong>Tracking</strong></td>
<td>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</td>
<td>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</td>
<td>Learner transcripts can be transferred to new employer upon request Can run reports on individual portals (more granular) or entire network</td>
</tr>
</tbody>
</table>
| **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 crosswalked 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

<table>
<thead>
<tr>
<th><strong>Contact(s)</strong></th>
<th><strong>Bill Waibel</strong></th>
<th><strong>Ben Drew</strong></th>
<th><strong>Nellie Galindo</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em><a href="mailto:b.waibel@elsevier.com">b.waibel@elsevier.com</a></em></td>
<td><em><a href="mailto:hello@openfuturelearning.org">hello@openfuturelearning.org</a></em></td>
<td><em><a href="mailto:ngalindo@relias.com">ngalindo@relias.com</a></em></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td><em>Tanner Melton</em></td>
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<td></td>
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<td></td>
<td><em><a href="mailto:tmelton@relias.com">tmelton@relias.com</a></em></td>
</tr>
</tbody>
</table>

and long-term care, home health and home care, individual health care workers, health and human services, public sector, payers and public safety
Appendix C: Additional DCW Efforts in NC

<table>
<thead>
<tr>
<th>Workforce Engagement with Care Workers to Assist, Recognize and Educate (WECARE)</th>
</tr>
</thead>
</table>
| **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]

<table>
<thead>
<tr>
<th>Timing</th>
<th>In development/ongoing</th>
</tr>
</thead>
</table>
| **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

<table>
<thead>
<tr>
<th>Timing</th>
<th>Ongoing Courses offered multiple times annually</th>
</tr>
</thead>
</table>
| 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)

<table>
<thead>
<tr>
<th>Timing</th>
<th>Ended (HRSA-funded initiative)</th>
</tr>
</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>Timing</th>
<th>Ended</th>
</tr>
</thead>
</table>
| 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

**Addition Information**
Funded by NC Council on Developmental Disabilities
https://nccdd.org/nc-alliance-of-direct-support-professionals.html

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### 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/

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### 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
### 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**  
NC CareGivers 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/](https://nchealthworkforce.unc.edu/)

### Direct Care Workforce Capacity Building Center

<table>
<thead>
<tr>
<th><strong>Timing</strong></th>
<th>5-year grant; awarded October 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outputs</strong></td>
<td>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</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam Sholar</td>
<td>NC Health Care Facilities Association</td>
<td>President &amp; CEO; Vice Chair NC Coalition on Aging</td>
</tr>
<tr>
<td>Akan Iyamu</td>
<td>Trillium (LME-MCO)</td>
<td>Associate Vice President of Population Health Clinical Operations</td>
</tr>
<tr>
<td>Amanda Outlaw</td>
<td>Eastpointe (LME-MCO)</td>
<td>Director of Provider Monitoring</td>
</tr>
<tr>
<td>Amber Byrum</td>
<td>Trillium (LME-MCO)</td>
<td>Network Coordinator</td>
</tr>
<tr>
<td>Barbara Burt</td>
<td>NC Department of Public Instruction</td>
<td>Education Program Specialist; Health Science Consultant</td>
</tr>
<tr>
<td>Benita Hathaway</td>
<td>Trillium (LME-MCO)</td>
<td>Vice President, Care Management</td>
</tr>
<tr>
<td>Bertina Parkins</td>
<td>Sandhills (LME-MCO)</td>
<td>Training Coordinator</td>
</tr>
<tr>
<td>Betty Jenkins</td>
<td>Trillium (LME-MCO)</td>
<td>Accounting Manager</td>
</tr>
<tr>
<td>Brieanne Lyda-McDonald</td>
<td>NC Institute of Medicine/NC Task Force on the Future of Nursing</td>
<td>Project Director</td>
</tr>
<tr>
<td>Brooke Mickelson</td>
<td>Eastpointe (LME-MCO)</td>
<td>Director of Training and Community Relations</td>
</tr>
<tr>
<td>Catherine Moore</td>
<td>NC Board of Nursing</td>
<td>Chief Legislative and Quality Officer</td>
</tr>
<tr>
<td>Catherine Sevier</td>
<td>NC American Association of Retired Persons (AARP)/NC Future of Nursing Action Coalition</td>
<td>Past President/Co-Chair</td>
</tr>
<tr>
<td>Chris Egan</td>
<td>NC Department of Health and Human Services</td>
<td>Assistant Secretary for Employment and Inclusion</td>
</tr>
<tr>
<td>Christina Dupuch</td>
<td>CCR Consulting</td>
<td>Senior Consultant</td>
</tr>
<tr>
<td>Christopher White</td>
<td>LifeSpan</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>Colleen Tapan</td>
<td>NC DHHS</td>
<td>Senior Director of Strategy and Operations</td>
</tr>
<tr>
<td>Crystal Tillman</td>
<td>NC Board of Nursing</td>
<td>Chief Executive Director</td>
</tr>
<tr>
<td>Dave Peterson</td>
<td>Trillium (LME-MCO)</td>
<td>Central Regional Director</td>
</tr>
<tr>
<td>Dave Richard</td>
<td>McGuire Woods Consulting</td>
<td>Sr. Vice President Government Relations/Retired NC Medicaid Director</td>
</tr>
<tr>
<td>Emma Sandoe</td>
<td>NC Department of Health Benefits</td>
<td>Associate Director of Strategy and Planning</td>
</tr>
<tr>
<td>Erin Carson</td>
<td>National Domestic Workers Alliance-NC, WECARE</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Organization and Department</td>
<td>Current Role</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Erin Fraher</td>
<td>Carolina Health Workforce Research Center Sheps Center for Health Services Research</td>
<td>Director</td>
</tr>
<tr>
<td>Ginger Yarbrough</td>
<td>NC Division of Mental Health, Development Disabilities, and Substance Use Services</td>
<td>Intellectual and/or Developmental Disabilities and Traumatic Brain Injury Section Chief</td>
</tr>
<tr>
<td>Heather Burkhardt</td>
<td>NC Coalition on Aging, WECARE</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Holly Richard</td>
<td>The Arc of NC</td>
<td>Special Projects Advisor</td>
</tr>
<tr>
<td>Holly Riddle</td>
<td>Office of the Secretary, NCDHHS</td>
<td>Assistant Director for Olmstead Implementation</td>
</tr>
<tr>
<td>Jack McGlynn</td>
<td>Deloitte; Caregiving Workforce Strategic Leadership Council Direct Care Worker Workstream</td>
<td>Human Capital Consultant</td>
</tr>
<tr>
<td>Jessica Foster</td>
<td>NC Healthcare Association</td>
<td></td>
</tr>
<tr>
<td>Jennifer Mackethan</td>
<td>Trillium (LME-MCO)</td>
<td>Communications and Marketing Director</td>
</tr>
<tr>
<td>John Nash</td>
<td>The Arc of NC</td>
<td>Executive Director</td>
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<tr>
<td>Jon D'Angelo</td>
<td>Advocate, Self-Directing CAP DA</td>
<td></td>
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<tr>
<td>Julie Brinson</td>
<td>Trillium (LME-MCO)</td>
<td>Network Operations Manager</td>
</tr>
<tr>
<td>Julie Kokocha</td>
<td>Trillium (LME-MCO)</td>
<td>Head of Network Accountability</td>
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<tr>
<td>Karen Wade</td>
<td>NC Department of Health and Human Services</td>
<td>Policy Advisor</td>
</tr>
<tr>
<td>Kathy Colville</td>
<td>NC Institute of Medicine</td>
<td>President and CEO</td>
</tr>
<tr>
<td>Kathy Colville</td>
<td>NC Institute of Medicine</td>
<td>President and CEO</td>
</tr>
<tr>
<td>Kellie Baker</td>
<td>Trillium (LME-MCO)</td>
<td>Finance Director</td>
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<tr>
<td>Kelly Crosbie</td>
<td>NC Division of Mental Health, Development Disabilities, and Substance Use Services</td>
<td>Director</td>
</tr>
<tr>
<td>Kenneth Bausell</td>
<td>NC Department of Health Benefits</td>
<td>Senior Director of Employment and Inclusion</td>
</tr>
<tr>
<td>Kevin Coughlin</td>
<td>Wisconsin Certified Direct Care Professional Program, Wisconsin Department of Health Services</td>
<td>Policy Initiatives Advisor</td>
</tr>
<tr>
<td>Kevin FitzGerald</td>
<td>NC Center on the Workforce for Health</td>
<td></td>
</tr>
<tr>
<td>Kezia Scales</td>
<td>Paraprofessional Healthcare Institute (PHI), WECARE</td>
<td>Vice President of Research and Evaluation</td>
</tr>
<tr>
<td>Kimberly Huneycutt</td>
<td>Trillium (LME-MCO)</td>
<td>Internal Compliance and Medicaid Contract Manager</td>
</tr>
<tr>
<td>Kristy Myers</td>
<td>The Arc of NC</td>
<td>Director of Long Term Services and Supports Care Coordination</td>
</tr>
<tr>
<td>Name</td>
<td>Organization</td>
<td>Position/Title</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LaCosta Parker</td>
<td>NC Department of Health Benefits</td>
<td>Intellectual and/or Development Disability Policy Consultant</td>
</tr>
<tr>
<td>Lisa Poteat</td>
<td>The Arc of NC</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>Lori Byrd</td>
<td>NC Community College System</td>
<td>Associate Director, Academic Programs - Health Sciences</td>
</tr>
<tr>
<td>Luz Terry</td>
<td>Trillium (LME-MCO)</td>
<td>Director of Contracts and Provider Support Services</td>
</tr>
<tr>
<td>Mary Bethel</td>
<td>Retired (prev. Associate State Director for Advocacy with AARP NC)</td>
<td>Chair, NC Coalition on Aging</td>
</tr>
<tr>
<td>Matt Potter</td>
<td>Disabled Youth Advocate and Public Speaker</td>
<td></td>
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<tr>
<td>Melissa Leeds</td>
<td>NC Department of Public Instruction</td>
<td>Health Science Consultant</td>
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<tr>
<td>Melissa Swartz</td>
<td>NC Council on Developmental Disabilities</td>
<td>Planner Evaluator/Staff for Advocacy Development Committee</td>
</tr>
<tr>
<td>Michael Ganley</td>
<td>NC Department of State Operated Healthcare Facilities</td>
<td>Program Manager, Developmental Center Team</td>
</tr>
<tr>
<td>Michelle Merritt</td>
<td>NC Department of Health Benefits</td>
<td>Intellectual and/or Development Disability Policy Consultant</td>
</tr>
<tr>
<td>Nathan Boucher</td>
<td>Duke Sanford School of Public Policy, WECARE</td>
<td>Associate Research Professor of Public Policy, Principle Investigator WECARE</td>
</tr>
<tr>
<td>Pam Edwards</td>
<td>Duke University Health System</td>
<td>Assistant Vice President for Education, Practice &amp; Research</td>
</tr>
<tr>
<td>Richard Anderson</td>
<td>Horizons Residential Care Center</td>
<td>President &amp; Chief Executive Officer</td>
</tr>
<tr>
<td>Russell Bailey</td>
<td>Deloitte/Caregiving Workforce Strategic Leadership Council Direct Care Worker Workstream</td>
<td>Physician Consultant</td>
</tr>
<tr>
<td>Sabrena Lea</td>
<td>NC Medicaid, Long Term Services and Supports</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>Sandi Lane</td>
<td>Appalachian State University, WECARE</td>
<td>Associate Professor, Masters of Health Administration Program</td>
</tr>
<tr>
<td>Sarah Griffith</td>
<td>NC Board of Nursing</td>
<td>Chief Nursing Officer</td>
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<tr>
<td>Sheryl Deal</td>
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<td>Claims Director</td>
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<tr>
<td>Stacy Thompson</td>
<td>NC Board of Nursing</td>
<td>Practice Consultant</td>
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<tr>
<td>Steve Strom</td>
<td>NC Department of Health and Human Services</td>
<td>Director, Money Follows the Person</td>
</tr>
<tr>
<td>Talley Wells</td>
<td>NC Council on Developmental Disabilities</td>
<td>Executive Director</td>
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<tr>
<td>Tara Heasley</td>
<td>NC Department of Health Benefits</td>
<td>Intellectual and/or Development Disability Policy Consultant</td>
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<tr>
<td>Joyce Winstead</td>
<td>NC Board of Nursing</td>
<td>Director of Practice</td>
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<tr>
<td>Ted Goins</td>
<td>Lutheran Services Carolinas</td>
<td>President &amp; Chief Executive Officer</td>
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<tr>
<td>Trish Farnham</td>
<td>NC Coalition on Aging, WECARE</td>
<td>Project Coordinator</td>
</tr>
<tr>
<td>Valerie Howard</td>
<td>NC Future of Nursing Action Coalition</td>
<td>Co-Chair</td>
</tr>
</tbody>
</table>
Appendix E: Example Proposal for NCCARE 360 Wraparound Support Services

NC AHEC
Proposal Valid Until September 29th, 2023

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

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

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.