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The Direct Care Workforce in Long-Term Care Settings:

Recommendations for Recruitment and Retention

South Carolina Institute of Medicine & Public Health

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Introduction

The direct care workforce provides necessary services to nearly twenty million adults in the United States who require assistance completing daily living tasks (typically aging adults and people with disabilities).[1] The Bureau of Labor Statistics classifies the direct care workforce as personal care aides, home health aides and nursing assistants. Family caregivers are also necessary and valuable direct care providers but will not be discussed in this report due to the distinct needs of an unpaid workforce. The roles discussed in this report are defined below using language from United States Bureau of Labor Statistics.[2]

Personal Care Aides

Also referred to as caregivers or personal attendants, personal care aides are generally limited to providing nonmedical services including companionship, cleaning, cooking and driving. Some of these aides work specifically with people who have developmental or intellectual disabilities to help create a behavior plan and teach self-care skills, such as doing laundry or cooking meals.[3] Personal care aides are often unlicensed professionals.

Home Health Aides

Home health aides in South Carolina may provide some basic health services such as checking a client's pulse, temperature and respiration rate. They also help with simple prescribed exercises and give medications. Occasionally, they change bandages or dressings, give massages, care for skin or help with braces and artificial limbs. With special training, experienced home health aides also may help with medical equipment such as ventilators.

Home health aides are supervised by medical practitioners, usually nurses, and may work with therapists and other medical staff. These aides keep records on the client such as services received, condition and progress. They report changes in the client's condition to a supervisor or case manager.[4] Home health aides in South Carolina may be licensed or unlicensed professionals.

Nursing Assistants

Nursing assistants are often the principal caregivers in nursing and residential care facilities. The term "residential care facilities" refers to independent living residences, hospitals, nursing homes or skilled nursing facilities, home health agencies, hospice agencies, adult day services centers and subacute or rehabilitation service centers. Nursing assistants are employed in diverse settings, and the nature of their role varies depending on their specific occupation and the employer.

Nursing assistants provide basic care and help with activities of daily living. They typically perform duties to support the clinical workforce such as bathing and cleaning patients, helping patients dress, repositioning patients, transferring patients between beds and wheelchairs, recording health concerns and reporting them to nurses, measuring vital signs and serving meals and helping patients eat.

Nursing assistants in South Carolina may also administer medication if they have completed the necessary training.[5] Nursing assistants, also referred to as nurse aides, are often licensed professionals but in some instances are only required to receive a certification. In South Carolina they must be registered with the South Carolina Department of Health and Human Services (SCDHHS) to work in a nursing home and must recertify every two years to remain in compliance.

Direct Care Workers and the Pandemic

The Institute for the Future of Aging Services describes the direct care workforce as the "hands, voice and face of long-term care."[6] This became increasingly evident throughout the coronavirus pandemic, when direct care workers were faced with increased work-related hazards, declining staffing levels and corresponding decreases in morale concurrent with a heightened need for their services.

In a recent article published in the Journal of the American Medical Directors Association, researchers described increased fear, burnout and demoralization among direct care workers because of the pandemic.[7] The authors explain that the increased fear of infection has affected employees across the spectrum of direct care occupations.[8] By February 6, 2022, a total of 1,024,219 nursing home workers across the United States were infected with COVID-19 and 2,290 of those infected have died as a result of the virus.[9]

Demoralization resulting from the impact of public scrutiny focused on long-term care facilities during the pandemic was a regularly cited complaint among direct care workers.[10] One staff member cited exorbitant amounts of "negative media" focused on long-term care facilities as a source of emotional distress.[11] Additionally, widespread burnout across the spectrum of direct care occupations has exacerbated already existing challenges recruiting and retaining talented direct care workers across the country.

Burnout is characterized as a prolonged feeling of energy depletion or exhaustion resulting from chronic workplace stress.[12] The coronavirus pandemic intensified work-related stress among direct care workers leading to burnout, high turnover and difficulties recruiting new staff.[13,14] According to the Bureau of Labor Statistics, nursing homes across the country lost 380,000 workers between February 2020 and July 2021.[15]

Nursing assistants have suffered the most significant increase in turnover throughout the pandemic, rising from 39.4% in 2020 to 60% in 2021.[16] In 2020, 41% of nursing homes across the country hired temporary nursing assistants from staffing agencies to meet the demand, despite the higher costs associated with subcontracting.[17]

High turnover rates and the resulting decrease in staffing levels threaten quality of care, result in diminished health outcomes and negatively influence the viability of infection control measures.[18] A study from the University of Rochester Medical Center identified a correlation between lower staffing levels in a sample of Connecticut long-term care facilities and higher rates of confirmed COVID-19 cases and deaths.[19]

Maintaining and supporting the direct care workforce is a necessary component of providing quality care to older adults and people with intellectual or developmental disabilities. Without a robust direct care workforce, people living in residential care facilities and people receiving in-home support services are at an increased risk of receiving suboptimal support. It is important to note that improving retention and recruitment efforts can help prevent burnout, improve continuity of care and improve health outcomes among residents in long-term care facilities and individuals receiving home- and community-based services.[20,21]

This policy brief surveys the challenges associated with direct care worker recruitment and retention throughout South Carolina and best practices and recommendations for expanding recruitment and retention efforts across the state.

Direct Care Workforce in South Carolina: Data and Trends

The direct care workforce employed as home and personal care aides or in residential care facilities across South Carolina provide critical services while often working under demanding conditions. The National Governors Association (NGA) explains that the intense physical demands inherent in these jobs coupled with low wages and sustained workforce shortages have led to growing concerns among policy makers, administrators and other stakeholders.[22]

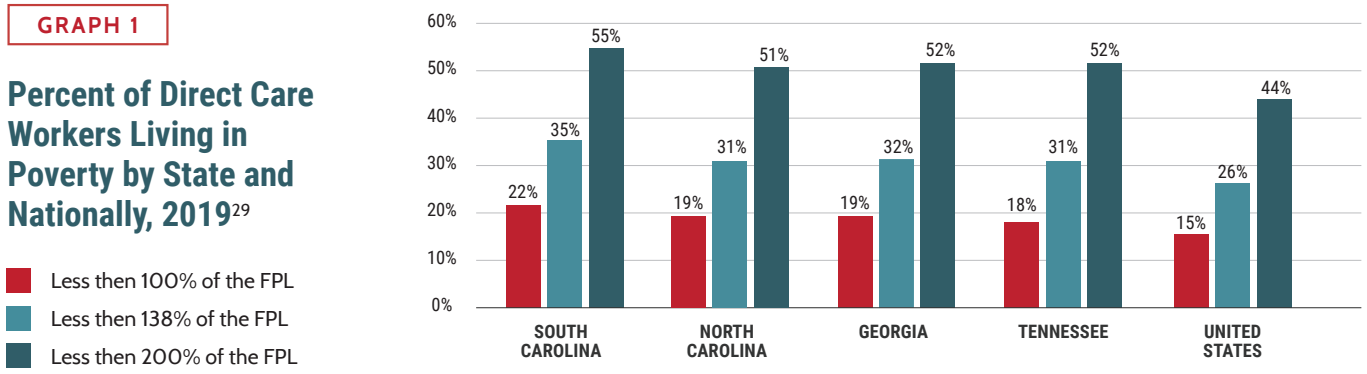
The home health and personal care aide workforce in South Carolina has grown approximately 52% between 2010 and 2020, while the number of nursing assistants has decreased 11% in the same period.[23] In 2020, South Carolina had 551 home health and personal care aides per 100,000 residents and 344 nursing assistants per 100,000 residents.[24,25] Similar trends exist in neighboring states, which are discussed in more detail in later sections.

Despite the well-known demand for direct care workers, their pay and benefits remain uncompetitive.[26] This fact leads many existing direct care workers and potential workers to seek alternative careers in less physically and emotionally demanding positions and introduces significant challenges in retention, which has only been exacerbated by the coronavirus pandemic.[27] The PHI explains that "minimum wage increases and Medicaid policy changes in some states have marginally increased wages for home care workers in recent years. However, these raises have not translated into improvements to their financial wellbeing, as a large proportion [of direct care workers] still live in low-income households and rely on public assistance."[28] This quote refers to the fact that the marginal wage increases are not enough to keep up with inflation in many areas, leading to negligible improvements in financial stability among direct care workers.

The charts below illustrate the percentage of direct care workers who live in poverty and the percentage of direct care workers without affordable housing[a] in South Carolina, North Carolina, Georgia and Tennessee. The data indicate that South Carolina has the highest percent of direct care workers living in poverty compared to neighboring states and the second highest percent of direct care workers living in unaffordable housing compared to neighboring states.

GRAPH 1

Percent of Direct Care Workers Living in Poverty by State and Nationally, 2019[29]

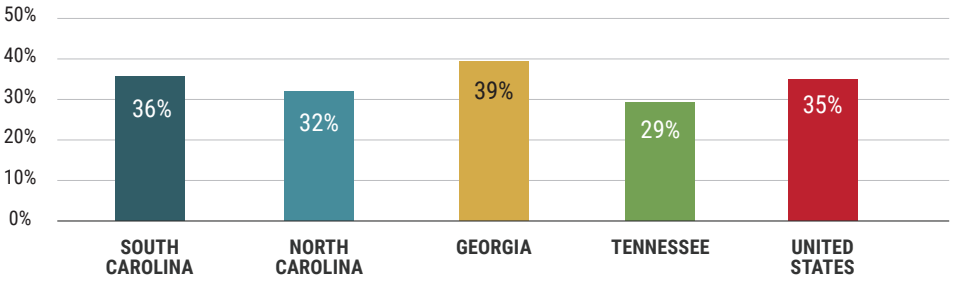


Source: PHI, 2020

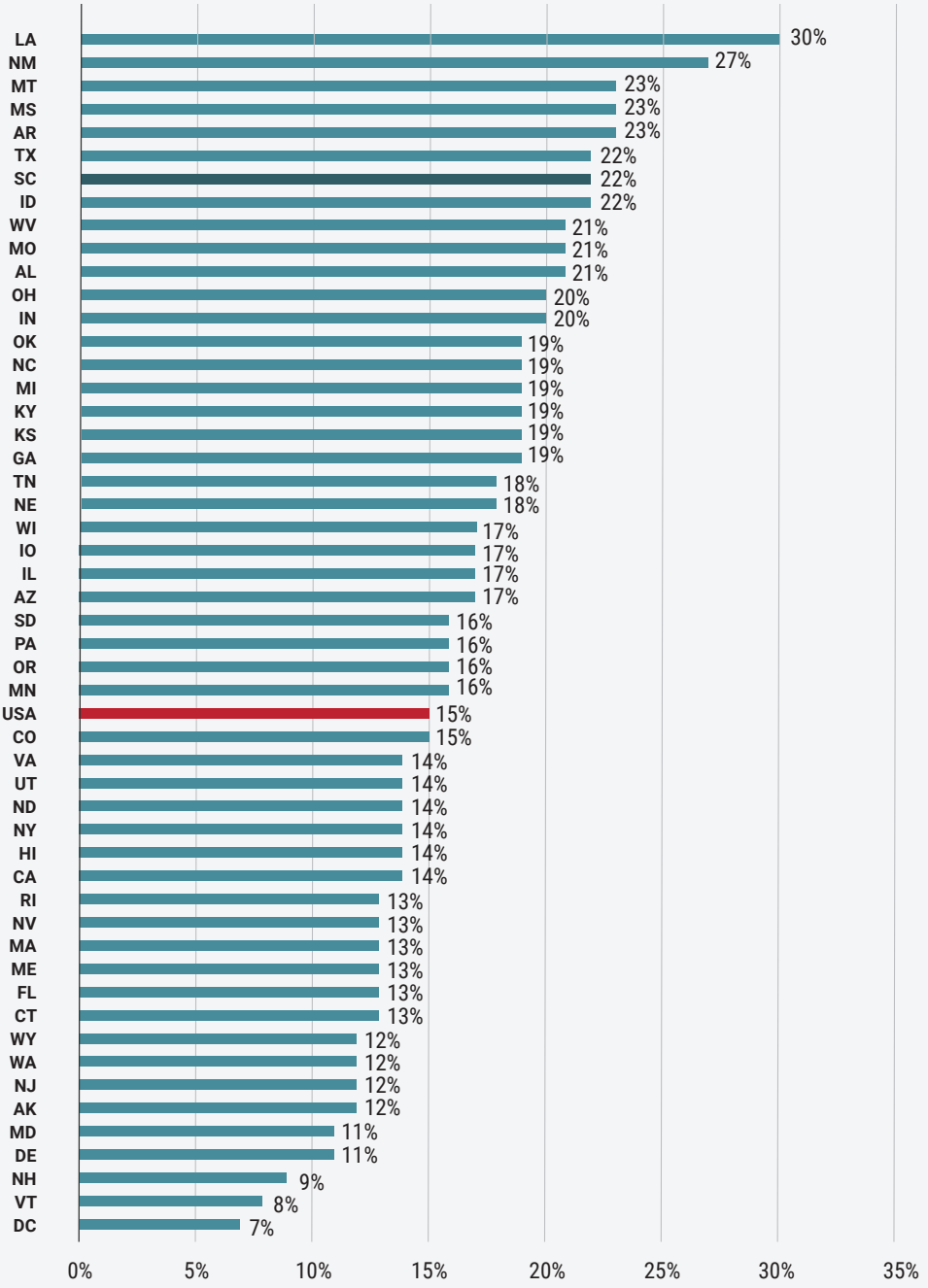
[a] Affordable housing is defined by the United States Department of Housing and Urban Development (HUD) as housing which the occupant is paying no more than thirty percent of their gross income for housing costs including utilities. For an individual making $30,000 annually, this translates to roughly $750 a month.

GRAPH 2

Percent of Direct Care Workers Living in Unaffordable Housing by State and Nationally, 2019[30]



Source: PHI, 2021



GRAPH 3

Percent of Direct Care Workers Living Below 100% of FPL by State, 2019[32]

Source: PHI, 2021

Nationally, South Carolina is tied with Texas and Idaho for fourth out of 50 states and the District of Columbia in the percent of direct care workers living below 100% of the federal poverty level. The national rankings are shown in graph 3.[31]

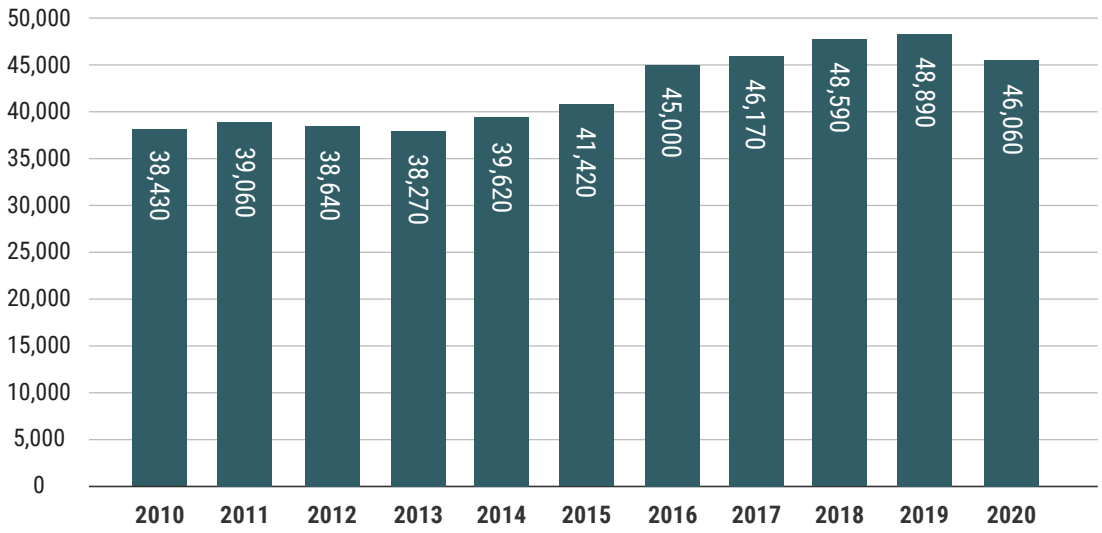
In the decade between 2010 and 2020, direct care worker's median annual salaries have only increased twenty cents across South Carolina, averaging $11.73 an hour as of 2020.[33] For context, economists at MIT have determined that a living wage for a single adult without dependents in South Carolina is $14.58 hourly or $23,974.00 a year.[34] For a person with one dependent, that number increases to $29.81 hourly or $49,020 a year.[b,35]

In the absence of a significant change leading to increased recruitment and retention, the pervasive effects of the workforce shortage will only escalate throughout the next decade as the population ages and the need for direct care workers' services increases. According to the South Carolina Department on Aging, the number of adults aged 60 and above is projected to increase to 1,450,487 by 2030.[36] Compounding the issue, the number of seniors aged 65 and above with at least one disability exceeded 295,000 in 2020 and is expected to increase.[37]

The growing number of people living with disabilities and chronic conditions emphasizes the need for long-term care services.[38] However, the supply of direct care workers remains misaligned with the demand. In the chart below, the number of direct care workers across the state is demonstrated by year, illustrating the recent decline in the available workforce between 2019 and 2020.

GRAPH 4

Direct Care Worker Employment, Raw Numbers, South Carolina, 2010 – 2020[39]



Source: PHI, 2021

[a] Living wage is defined by the Massachusetts Institute of Technology as "the hourly rate that an individual in a household must earn to support his or herself and their family with the assumption that the provider is working full-time for a total of 2,080 hours a year." MIT explains that their living wage calculator tool is "an alternative measure of basic needs. It is a market-based approach that draws upon geographically specific expenditure data related to a family's likely minimum food, childcare, health insurance, housing, transportation, and other necessities (e.g., clothing, personal care items, etc.) costs. The living wage draws on these cost elements and the rough effects of income and payroll taxes to determine the minimum employment earnings necessary to meet a family's basic needs while also maintaining self-sufficiency. The living wage model exceeds the poverty level as measured by the poverty thresholds, but it is a modest 'step up,' which accounts for individual and family needs. The living wage model does not include funds for what the public considers the necessities enjoyed by many Americans. It does not incorporate funds for pre-prepared meals or those eaten in restaurants. It does not contain money for leisure time or unpaid vacations or holidays."

In addition to low wages, direct care workers are also tasked with emotionally and physically demanding responsibilities. Many are asked to care for vulnerable residents with a variety of complex conditions. Research indicates that direct care workers employed in long-term care facilities frequently experience grief over patient death and illness, leading to emotional distress and burnout.[40] A 2017 study conducted by RTI International for the Centers for Disease Control and Prevention (CDC) found the following across residential care facilities in South Carolina:

52.6%
of residents were aged 85 years and above

42.8%
of residents have been diagnosed with Alzheimer's disease or dementia

29.7%
of residents have been diagnosed with depression

58%
of residents need assistance with bathing

42.3%
of residents need assistance with walking

44.3%
of residents needed assistance with dressing[41]

These figures indicate that caregivers are regularly tasked with caring for extremely vulnerable adults across residential care facilities. Generally, residents in assisted living facilities require less specialized care than nursing homes. While nursing homes offer a wider range of health services focusing on medical care, assisted living facilities often offer residents more independent living and personal care services.[42] These differences account for variations in responsibilities between sites. Many direct care workers also provide in-home services for aged adults and adults with intellectual and developmental disabilities. Similarly, there are variations in responsibilities and compensation by role, discussed in more depth in the following sections.

Personal Care and Home Health Aides in South Carolina

Both personal care and home health aides work with older adults and people with disabilities to accomplish activities of daily living such as eating, dressing, bathing and household chores.[43] Their contributions allow many people to age in place, which has been shown to contribute to a variety of psychological, emotional, social and financial benefits.[44] Services in home are often less expensive than residential care and are the preferred option among many older adults and people with intellectual and developmental disabilities.[45,46]

In their *2021 South Carolina State on Aging* report, the Department of Aging discussed their goal to increase the number of clients across the state receiving "home care" annually by 5%.[47] They explain that:

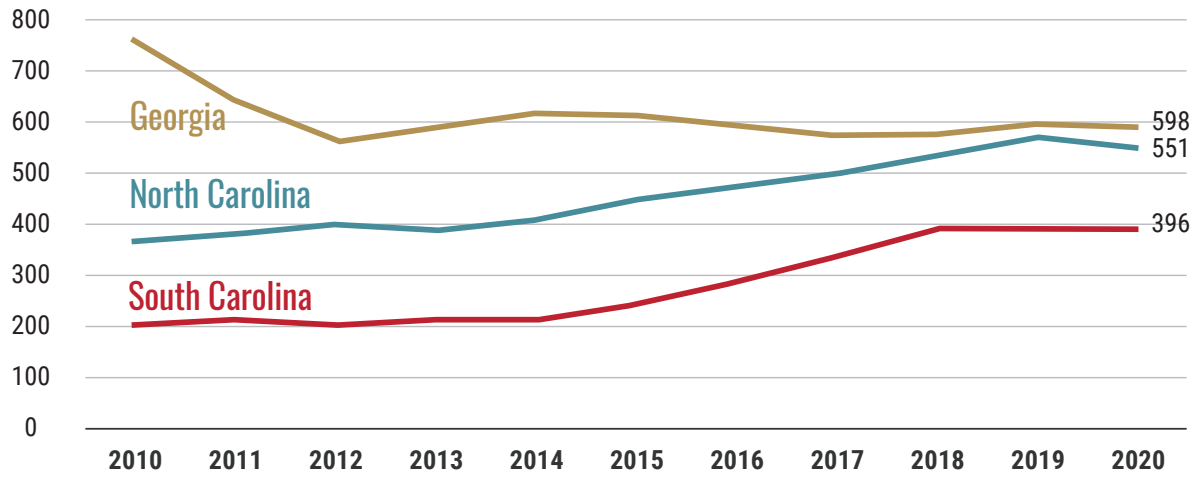
> The goal of home care is to address a progressive level of need that a program beneficiary usually experiences when dealing with a condition that requires assistance with instrumental or routine activities of daily living. Home care services assist older individuals, families and/or caregivers to overcome specific barriers to maintain, strengthen, and safeguard independent functioning in the home. These services are designed to prevent or delay institutionalization and improve the individual's or caregiver's quality of life and include personal care, homemaker and chore assistance.[48]

Personal care and home health aides make up the largest segment of the direct care workforce.[49] In 2019, the United States Bureau of Labor Statistics estimated that there were approximately 95 home health workers per 1,000 adults aged 65 and older with a disability in South Carolina. The national rate is nearly double – in 2019, there were an estimated 179 home health workers per 1,000 adults aged 65 and older with a disability in the United States.[50]

These estimates are calculated by the United States Bureau of Labor Statistics. They rely on employer reporting and do not include self-employed workers. As a result, they may not reflect the full workforce. Future initiatives focused on developing a comprehensive method to track the home health and personal care workforce in South Carolina would be beneficial. The following figure illustrates home and personal care aide workforce composition in North Carolina, South Carolina and Georgia.

GRAPH 5

Number of Home and Personal Care Aides per 100,000 Residents in South Carolina, North Carolina and Georgia, 2010-2020[51,52]



Source: PHI, 2021

These estimates suggest that the home health and personal care aide workforce in South Carolina has grown approximately 52% between 2010 and 2020. It is estimated that at least 1.2 million independent providers across the country are employed as a home health aide through a Medicaid-funded, consumer-directed program.[53,54]

Home health and personal care aides in South Carolina are not licensed professionals; however, they are employed by in-home care provider agencies which must be licensed. In South Carolina, an "in-home care provider" is legally defined as:

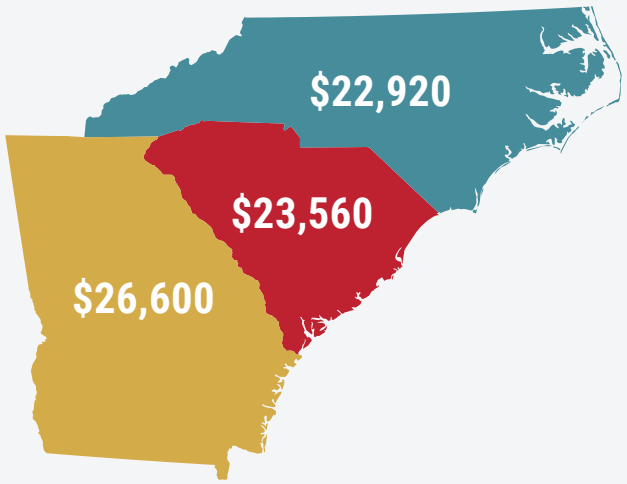
> A business entity, corporation, or association, whether operated for profit or not for profit, that for compensation directly provides or makes provision for in-home care services through its own employees or agents or through contractual arrangements with independent contractors or through referral of other persons to render in-home care services when the individual making the referral has a financial interest in the delivery of those services by those other persons who would deliver those services.[55]

As of March 2022, there are an estimated 838 licensed in-home care providers in South Carolina who contract and employ individuals to aid in activities of daily living.[56] Although these workers are not licensed individually, home health aides in South Carolina must complete at least 75 hours of training, including sixteen hours of practical experience, and must meet competency evaluation requirements to receive a home health aide certificate. Home and personal care aides are also able to pursue advanced training in their field. For example, the Arnold School of Public Health at the University of South Carolina offers advanced trainings for existing home and personal care aides online at no cost to the participant.[57]

Notwithstanding the fact that the home health care market was a $400 billion dollar enterprise in 2021, high levels of financial insecurity among workers persist.[58] Across the country, one in six home health aides lives in poverty, more than half of home health aides receive some form of public assistance and 17% of home health aides lack health insurance.[59] The Bureau of Labor Statistics estimates that the median annual wage for home health and personal care aides nationally was $27,080 in 2020, but South Carolina, North Carolina and Georgia wages are lower.[60,61] Map 1 illustrates the median annual wage for home health and personal care aides in North Carolina, South Carolina and Georgia.

MAP 1

Home Health and Personal Care Aides Mean Annual Wage by State, 2020[62,63,64]



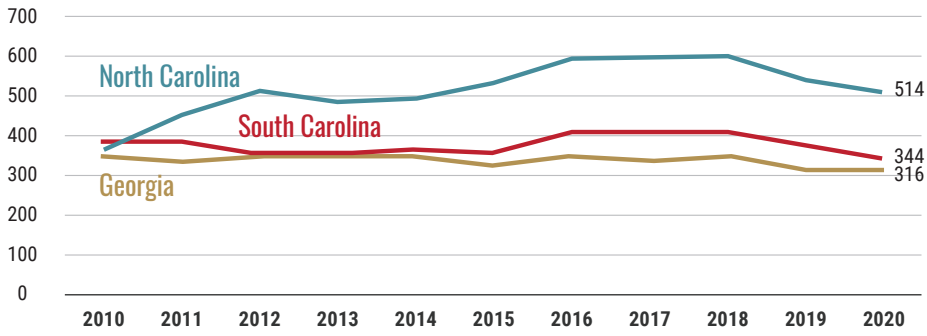
Source: Bureau of Labor Statistics, 2021

Nursing Assistants in South Carolina

In South Carolina, new nursing assistants must typically complete a 100-hour state-approved nursing assistant training program, 40 hours of clinical training and pass the National Nurse Aide Assessment Program (NNAAP) to become certified within four months of being hired.[65] These requirements exceed the federal minimum guidelines requiring the completion of a 75-hour nursing assistant program, which was implemented to ensure consistent and quality care in nursing homes.[66,67] Similar to trends in Georgia the number of nursing assistants per 100,000 residents in South Carolina has decreased 11% between 2010 and 2020, as illustrated below in Graph 6.

GRAPH 6

Number of Nursing Assistants per 100,000 Residents in South Carolina, North Carolina and Georgia, 2010-2020[68,69]

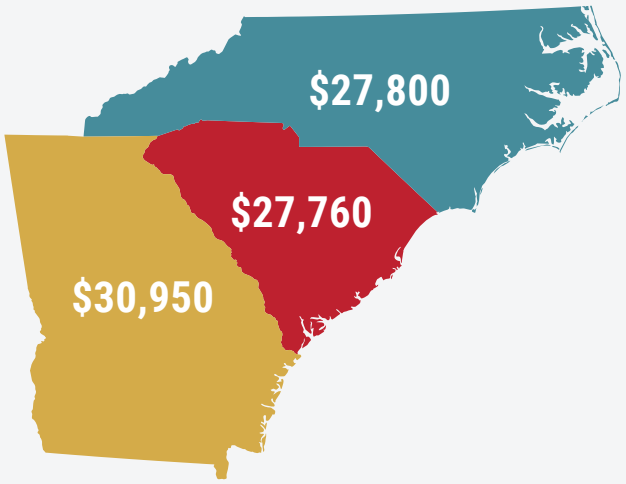


Source: PHI, 2021

The shrinking workforce in South Carolina is charged with taking care of thousands of older adults. Preliminary data indicate that in 2020, 22,638 people resided in nursing homes or skilled nursing facilities across South Carolina.[70] Nursing assistants are also more than three times more likely to experience workplace injuries than the typical worker in the United States.[71] A 2017 literature review focused on workplace hazards in the United States found that many nursing assistants suffer from physical injuries and workplace violence while employed.[72]

MAP 2

Nursing Assistant Median Annual Wage by State, 2020[77,78,79]



Source: Bureau of Labor Statistics, 2021

One of the surveys cited in the literature review reported that 65% of respondents experienced workplace violence, and another found that 59% of 138 survey participants reported being assaulted at least once per week while at work.[73,74]

A 2012 analysis of the National Nursing Assessment Service (NNAS) and the National Nursing Home Survey (NNHS) data found that 44.6% of nursing aides reported scratches, open wounds or cuts occurring due to workplace injury while 16.2% reported black eyes and bruising and 11.5% reported human bites. The authors suggest that it is likely that these incidents are underreported.[75] Despite the significant hazards associated with the role, nursing aides in South Carolina are still compensated significantly below the median annual wage across all occupations in the state, which was $46,230 as of 2020.[76] Map 2 illustrates the median annual wage for nursing assistants in North Carolina, South Carolina and Georgia.

Moving Forward

Recognizing the dire need to improve recruitment and retention of direct care workers across South Carolina, the South Carolina Institute of Medicine and Public Health's Long-Term Care Leadership Council convened to examine these issues and to steer the development of this policy brief and the corresponding recommendations. Utilizing the expertise of the committee and existing literature, the council chose to focus on recommendations that fall into the following themes:

1. Reimbursement and incentives

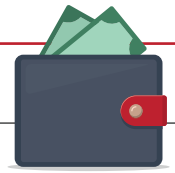
2. Workforce development

3. Training and scope

4. Supporting, empowering and acknowledging the direct care workforce

Recommendations

The following recommendations focus on recruiting and retaining direct care workers across South Carolina. The expected increase in demand for direct care workers in the coming years necessitates that the state proactively implement policies that incentivize recruitment and retention to maintain standards of care and to save on costs. The following objectives list potential recommendations to cut costs and improve quality of care in long-term care settings.



1. Reimbursement and Incentives

1.1 Increase and Effectively Utilize Medicaid and Medicare Reimbursement Rates

Health Affairs explains that increasing Medicaid reimbursement rates to a level that allows employers to pay the direct care staff a living wage is critical to improving recruitment and retention efforts.[80] Recognizing the importance, SCDHHS has, and continues to, incorporate rate increases in upcoming home- and community-based services waiver renewals and amendments.[81,82]

To ensure that Medicaid reimbursement results in increased compensation, the authors suggest adopting a "wage pass-through" measure that requires providers use new Medicaid payments to increase staff wages. They also suggest that policy makers work together to guarantee that a living wage is built into Medicaid payment rates on a continuing basis and that a suitable amount of provider reimbursement goes to direct care worker compensation.[83]

Examples of wage pass-through measures introduced in other states include:

ARIZONA

2017[84]

Arizona implemented wage pass-through legislation that applies to direct care workers employed in both residential- and community-based services. This law designates that a specified percentage of the reimbursement rate increases must be used for direct care worker wages to meet the increased minimum wage. Provider participation is mandatory.

MONTANA

2000, 2017[85]

Originally introduced in 2000 and updated in 2017, Montana implemented wage pass-through legislation to increase direct care worker compensation through MT HB 618 and MT SB 261. The legislation designates that a specific dollar amount be added to direct care worker wages; however, provider participation is voluntary.

MAINE

2000, 2015, 2018[86]

Maine has passed a variety of wage pass through laws to improve retention among direct care workers. These laws have been created through several appropriation bills and regulations requiring that a certain percentage of the reimbursement rate increase be used for wages and benefits. Provider participation is mandatory.

1.2 Increase Direct Care Worker Compensation to Offer Competitive Wages

One in eight direct care workers across the country currently lives in poverty.[87] The National Governors Association (NGA) writes that "examining and developing targeted strategies for addressing wage issues is part of a comprehensive approach to enhancing workforce development in the direct care sector."[88] In the absence of increased Medicaid reimbursement, several states have implemented creative solutions to increase compensation for their direct care workforce.

1 in 8

direct care workers currently lives in poverty.

For example, Massachusetts implemented a Direct Care Cost Quotient which requires that nursing facilities invest at least 75% of their revenue toward direct care staff costs.[89] Similarly, during the pandemic, Minnesota required that 72.5% of revenue generated by the medical assistance rates must be used for direct care worker salary and benefits.[90]

New Hampshire established the COVID-19 Long-Term Care Stabilization Program which provided weekly $300 stipends to full-time direct care workers between April 16, 2020, and June 30, 2020.[91] Although these short-term solutions must be refined to provide sustainable wage increases to direct care workers, they offer insights on how to address this complex issue.[92]

Additionally, at least thirty-nine states resolved to use American Rescue Plan Act (ARPA) funding to increase direct care worker compensation.[93] For example, Indiana has proposed implementing a Workforce Stabilization Grant program to distribute funds directly to frontline workers affected by the coronavirus pandemic, and Wisconsin has proposed using ARPA funds to increase rates for all direct care workers by 5%.[94] Likewise, Colorado, Iowa, Minnesota, Nevada, New Jersey and Washington have each resolved to use ARPA funds to increase wages for direct care employees and provide retention or hiring bonuses.[95] Similarly, Idaho plans to spend all the increased Federal Medical Assistance Percentages (FMAP) appropriations outlined in ARPA for pay increases and bonuses for direct care workers.[96]

In South Carolina, SC DHHS has dedicated more than 40% of its ARPA funds to increasing pay for direct care workers and incentivizing staff retention. In addition to dedicating additional funding to increase direct care workers' pay, SC DHHS has formed a workgroup to gather further input on activities to ensure funding incentivizes staff retention and promotes the stability of the provider network.

1.3 Offer Subsidies to Direct Care Workers

Many direct care workers experience challenges accessing and affording childcare, transportation, housing, healthy food and health care.[97] Partnering with state agencies, non-profits and social service organizations to provide housing vouchers, childcare vouchers, transportation vouchers and food subsidies could mitigate these challenges and encourage retention within the existing workforce. The Long-Term Services and Supports Center at the University of Massachusetts suggests that more should be done to provide wrap-around services to direct care workers such as groceries, childcare services and other benefits to support the existing workforce and entice others to become direct care workers.[98]

This concept has been integrated into proposed ARPA funding in other states including Colorado, where policymakers have incorporated childcare, housing and education subsidies in their proposed spending plan

for the implementation of the American Rescue Plan Act.[99] Their proposal pledges to "research innovative opportunities for increasing compensation for the HCBS workforce, including direct care workers and case managers, by addressing issues related to the benefit cliff as well as the social factors that most impact low-income workers' ability to thrive such as child care, housing and education."[100]

1.4 Provide Health Insurance

Nearly one in four direct care workers in South Carolina live below the poverty line, leaving them unable to access necessary health benefits through private insurance or to qualify for subsidized health insurance through the Healthcare Marketplace.[101] In 2019, less than half of direct care workers in South Carolina received coverage through their employer, 27% were insured through Medicaid, Medicare or other public insurance and 18% (approximately 8,290 direct care workers) were uninsured.[102] The elevated risk of workplace injury compared to other positions further reflects the need for health insurance. This objective builds on objectives listed in the 2019 South Carolina Institute of Medicine and Public Health report *The Evolving Workforce: Redefining Health Care Delivery in South Carolina.* The report recommended that "employers of direct care workers should provide health insurance to their employees."[103]

2. Workforce Development

2.1 Increase the Availability of Workforce Pipelines

Offering workforce pipelines to direct care workers who are interested in higher education or pursuing specialized skills is a valuable incentive to retain dedicated workers. Limited advancement opportunities have been tied to high turnover rates among home health workers, suggesting that improving access to training can help decrease resignation rates.[104] Offering a path towards advancement can create meaningful career pathways for direct care workers and increase employee satisfaction.[105]

Partnering with universities and apprenticeship programs to create formal conduits in which entry-level direct care workers can pursue advanced skills is a viable option for retaining current staff and recruiting additional workers.[106] The NGA suggests providing apprenticeship programs, approved college credits earned through on-the-job training and defined career pathways from nursing assistant to licensed practical nurse.[107] Alabama, Colorado, Illinois Indiana, Iowa, Massachusetts, Minnesota, Missouri, Tennessee, Washington and Wisconsin currently offer formal workforce pipelines for entry-level direct care workers.[108,109] For example, the Tennessee Direct Support Professionals (DSP) Apprenticeship Program is a "work-based learning model where individuals are compensated for on-the-job training and guarantees wage increases of $3.50 or more per hour upon completion of this one-year program."[110]

Policymakers could encourage local technical colleges, universities and long-term care facilities to partner to offer formalized career trajectories for students, allowing them to begin working as a certified nursing assistant (CNA) while studying to become a licensed practical nurse and then a registered nurse. Professional and social organizations across the state such as the South Carolina Nursing Association, the Black Nurses Association and sororities and fraternities could be valuable partners and could offer mentorship programs for individuals entering early career programs. Stakeholders should be prepared to identify ways to continue to attract people to the career as existing CNAs advance, leaving that position to be filled.

SC DHHS' ARPA spending plan includes activities to increase the state's HCBS provider capacity by using time-limited funding to provide funding for providers and their workforce to pursue additional education and certification opportunities.

3. Training and Scope

3.1 Standardize Roles and Regulatory Requirements for Direct Care Workers

The American Healthcare Association recommends that "all licensure, certification and maintenance of certification for healthcare professionals should include demonstration of competence in care of older adults as a criterion."[111] With the exception of nursing assistants and some home health aides, many direct care workers are not required to meet set standards in terms of their training, roles and responsibilities. Instead, standards are set at the employers discretion.[112] These discrepancies lead to variations in competencies among workers. Standardizing roles and regulatory requirements for direct care workers is a component of professionalizing the workforce.[113,114]

This objective builds on objectives listed in the 2019 South Carolina Institute of Medicine and Public Health report *The Evolving Workforce: Redefining Health Care Delivery in South Carolina.* The report recommended that "training standardization for direct care workers is essential. Implementation of a statewide training program would ensure that all direct care workers in South Carolina are prepared for the new challenges of their roles in the health care ecosystem."[115]

3.2 Refine Direct Care Worker Training to Reflect the Full Set of Skills Required

Although the pandemic introduced a need for extended flexibilities among direct care workers, there are benefits to expanding the training for direct care workers, specifically those who work with people living with dementia, people living with intellectual and developmental disabilities and other vulnerable populations.[116] Research suggests that expanded training can result in better health outcomes and lower costs associated with care.[117] SC DHHS has recognized the importance of expanding training programs to include specific emphases to address the needs of vulnerable populations. The agency's ARPA spending plan will support the development and implementation of expanded training resources and curriculum in support of these distinct emphasis areas.

The South Carolina Institute of Medicine and Public Health has previously released recommendations describing this need, specifically that direct care workers must be given the necessary specialized training to provide person-centered dementia care.[118] Likewise, Iowa proposed allocating ARPA funds to deliver Crisis Response training to direct care workers beginning July 1, 2022, in order to increase workforce capacity and to effectively serve clients with behavioral health concerns and intellectual or developmental disabilities.[119]

3.3 Strengthen Training Infrastructure to Support Adult Learners

Based on existing knowledge of the demographic composition of the direct care workforce, PHI suggests that stakeholders develop training programs that incorporate best practices for adult learners.[120] Trainings that are tailored to adult learners often emphasize experiential learning, peer mentoring and skills

development.[121] Tailoring the education to the learner addresses challenges in recruiting and retaining entry-level workers, ensuring that they are adequately prepared for the job.[122] Additionally, these trainings should be accessible to adult learners - meaning that evening and remote courses should be incorporated into standard programs to accommodate working professionals and parents of small children.

4. Support and Acknowledge the Direct Care Workforce

4.1 Develop Peer-to-Peer Support Groups for Direct Care Workers

A study conducted by the Long-Term Care Services and Support Center at the University of Massachusetts found that employees who resigned during the pandemic reported higher levels of stress while employed than their peers who remained in the direct care workforce.[123] Offering mental health support to direct care workers, specifically those who have experienced trauma as a result of the pandemic, can build capacity and increase retention.[124] Peer-to-peer support services are particularly important in this context to create an environment where participants feel validated, understood and safe to share their emotions and experiences.

4.2 Acknowledge and Assess the Direct Care Workforce through Improved Data Collection

Improved evaluation efforts would increase awareness of the direct care workforce. Improving evaluation metrics in skilled nursing facilities and incorporating data collection requirements in home- and community-based waivers could allow South Carolina to measure the impact of the direct care workforce across the state.[125] Additionally, a more comprehensive understanding of the trends and composition would allow the state to better identify, respond to and anticipate the needs of the workforce.

This data would allow the state to better understand the impact direct care workers have on long-term care services and could support future efforts to increase investment in the workforce. Additionally, this data could also be used to provide insight on the trajectory of direct care workers to develop targeted career pathways based on data-driven insights on the typical career pathway.[126] Using ARPA funds, Colorado has proposed expanding data infrastructure to better understand the current supply and demand for direct care workers.[127]

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