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A MORE CERTAIN FUTURE: CERTIFICATION FOR PERSONAL CARE ASSISTANTS/AIDES

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4887-7250-3167.1

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Prepared for the Minnesota Metropolitan Center for Independent Living (MCIL)

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FORWARD

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Throughout the United States of America, our healthcare platform consists on one side the medical model with clinics, hospitals, ambulatory-related services. On the other side of our healthcare platform is home and community-based services, with long-term care facilities in the middle between the medical model and home and community-based services. Homecare services is among the fastest growing area in the healthcare platform, notably in direct care services for children, individuals, and families with disabilities and for older adults.

We recognize the role of the Certified Nursing Assistant in context of the medical model and its related educational curriculum requirements leading to the credential of a Certified Nursing Assistant. While in the homecare sector there is the Personal Care Assistant, and also its related role of a Direct Support Professional. Yet today there exists no similar curriculum opportunity as a next-level career lattice for PCA's or DSPs to pursue whereby they are also able to receive a credential and an increase of pay. Until now.

Throughout Minnesota and the United States, we are at a dangerous threshold of a rapidly growing direct care workforce shortage crisis that is leading to peril and death for people with disabilities and older adults who rely upon PCAs for daily living and find themselves with major gaps in PCA/DSP support.

Metropolitan Center for Independent Living (MCIL) has been working for many years on advancing recommendations and, now solutions to solve the direct care workforce shortage crisis. As Executive Director for MCIL, we are most honored to share with you, that our team of faculty have now produced the first-ever curriculum for PCA's and DSPs that provide the essential tools, skills and ultimately whereby successful completion of the curriculum leads to the credential of a "Certified PCA/DSP." This work was made possible by a Community Innovation grant from The Bush Foundation.

Thanks to passage of a PCA rate framework in the 2021 Minnesota legislative session, MCIL also has identified how the new PCA/DSP career lattice of a Certified PCA/DSP, can lead to a wage differential that is equal to the median wage of a Certified Nursing Assistant. Our work will focus on passage of both the curriculum leading to the credential of a Certified PCA/DSP and also passage of statutory language that will identify competitive workforce factors and their related component values resulting in the Certified PCA/DSP having an hourly wage that is egal to the median wage of a Certified Nursing Assistant based upon its associated Standard Occupational Classification.

There are over 100,000 PCAs and DSPs in Minnesota and over 4 million throughout the United States. To bring forward this curriculum and also the rate framework will be to not only transform the quality of life for millions of PCAs and DSPs, but to also reduce the direct care workforce shortage gap, to assure

that people with disabilities and older adults have the daily support needed for daily living and as importantly to enhance our culture and democracy in advancing the ability of people to care for one another based upon the two foundational principles of who we are a democracy namely: 1. The Inalienable Rights of all People and 2. It is self-evident that Human Dignity is equally endowed in all Humanity, that means every person throughout the world and throughout all time.

Furthermore, the Certified PCA curriculum prepared for Minnesota is for a voluntary, not required, Tier 3 PCA career training. It assumes that participants/students in the training will have previously completed the Tier 1 and Tier 2 PCA training requirements. While there is some overlap with those trainings, this Tier 3 training expands on knowledge and skill building and includes competencies in areas not included in the other training requirements. As comprehensive as this training is, it does not replace in-the-home training in the presence of the person directing and receiving care and a qualified professional. This training includes exposure to and requires some practice and student demonstration of safety, crisis intervention, and health care practice skills, but it is not a substitute for specific training based on personal needs within the home.

This training was developed by three instructors with combined experience in training at the Tier 1 and 2 levels, curriculum development and university-level teaching experience in disability studies and other human services areas, direct-service and crisis intervention work, nursing, and personal experience with disability. The curriculum is based on the direct strategic work of Metropolitan Center for Independent Living through a Community Innovation grant from The Bush Foundation in which a PCA Community Innovation Project Committee worked over three years in identifying the formal training programs from throughout all 50 of the United States and also through input by key stakeholders through the Skills Engine system called Calibrate.

The leadership of this work at MCIL determined best to align the work of the curriculum development in accordance with the twelve PCA competencies determined by the Federal government's CMS, so that the curriculum has relevancy and alignment with CMS throughout the United States of America for purposes of scalability for America's homecare sector. The time is now to transform direct care services for the Homecare sector for the United States of America. We welcome you to join this transformative era for who we are as a democracy and as a civil society. This work is part of a larger framework to transform the direct care sector for the United States of America through: *The National Declaration for Strengthening Direct Care Services and Benefits for People with Disabilities and Older Adults* (Bethke Gomez, 2023).

Jesse Bethke Gomez, MMA
Executive Director
Metropolitan Center for Independent Living

INTRODUCTION

For over twenty years, the United States has faced a direct care workforce crisis that has only been exacerbated by the COVID-19 pandemic. The Metropolitan Center for Independent Living (MCIL) is resolute in solving this direct care worker shortage crisis and is leading efforts to focus on scalability across the United States. Advances in medical technology, the greying of the population, and a shift towards home and community-based services (HCBS) has led to increasing demand for direct care (Litvak, Bruckner, & Berrol, 2000). However, we lack the care infrastructure to meet this demand, particularly as regards the wages and standards of direct care workers (DCW) (Kalipeni & Kashen, 2021). Approximately 17 million people with disabilities require personal assistance services (PAS) with activities of daily living (e.g., eating, personal hygiene, mobility – ADL) and instrumental activities of daily living (e.g., cooking, transportation, housekeeping, paying bills – IADL). Of these, 13% receive assistance from paid family members or a DCW (Sage, Standley, & Ipsen, 2022). By 2030 older adults are expected to outnumber children for the first time in U.S. history (Vespa, Armstrong, & Medina, 2018). Currently, the direct care workforce is comprised of DCWs who are certified (e.g., certified nursing assistants (CNA)) and those who are not (e.g., personal care assistants/aides (PCA)) (Christopher Kelly, Craft Morgan, Kemp, & Deichert, 2020). Moreover, any solutions to the direct care crisis must attend to the growing need for HCBS among the aging and disabled Veteran population (Harrison, 2023). In 2021, Minnesota had 134,330 DCWs. The State ranks 24 out of 51 on the PHI *Direct Care Workforce State Index*, landing it near the bottom of Tier 2.[1] This was due in part to having scored a 6/10 on Personal Care Aide Training Standards Key Provisions, consistent with other Tier 2 States and below all Tier 1 States.

In general, care has been critically undervalued and underfunded in the U.S. (Kalipeni & Kashen, 2021). Most care is provided by unpaid caregivers, which is estimated to cost as much as $522 billion annually. When it comes to Veterans, research found that family caregivers provided $14 billion in uncompensated care each year, a number which is expected to be much higher today (Harrison, 2023). Somewhere between 18 million and 38 million Americans act as unpaid caregivers for older adults and adults living with disabilities (Dawson, Boucher, Stone, & Van Houtven, 2021). Increased investment in HCBS has been associated with lower rates of informal caregiving (Ko et al., 2014). DCWs are a precarious workforce given their low wages, high turnover rates, and low levels of health insurance (Smith & Baughman, 2007). On average, DCW turnover is 44% across the States. High turnover rates and long-term job vacancies are costly for providers, consumers, their families, and DCWs alike (Stone, 2004).

The pandemic revealed systemic problems with the U.S. long-term services and supports (LTSS) system, resulting from a failure to coordinate public health at the Federal level, and disinvestment and neglect at the State and Local levels (Dawson et al., 2021). The PAS worker shortages that were seen before the pandemic have only intensified over the past three years. With demand for home health and personal assistance services already expected to grow by 33% between 2020 and 2030, compared to a projected growth of 8% for all occupations (Sage et al., 2022), we may see even greater demand given the impact

[1] https://www.phinational.org/state/minnesota/

of COVID as a mass disabling event. Our society is in the midst of a period of transformation in the advent of the Certified PCA curriculum transforming the PCA sector – in part to meet this accelerated demand.

In 2022, the National Survey on Health and Disability asked about the impact of the pandemic on PAS and found that approximately 29% of adults with disabilities who use PAS have unmet needs. This number rises to nearly 50% for individuals who live alone (Sage et al., 2022). Causes of unmet need include systemic problems, worker shortages, personal choice, and trust. The consequences of needs going unmet affect housekeeping, meals and food preparation, personal care, health management, mental health, and emotional well-being. Adjustments made to substitute for the loss of PAS drew heavily on informal supports yet again (Sage et al., 2022).

Disability advocates have pushed for care to be included as part of Federal COVID-19 economic recovery policies. The #CareCantWait Coalition argues that care is a critical part of our nation's infrastructure as "care jobs make all other work possible" (Kalipeni & Kashen, 2021, p. 5). Home health aides and personal care assistance are the third and fourth fastest growing occupations in the U.S. In fact, the care sector generates twice as many jobs per dollar as construction and, as such, care is key to equitable economic recovery. The #CareCantWait movement is calling for a national care agenda, which requires raising wages and standards to ensure dignity for domestic and all care workers (Kalipeni & Kashen, 2021). The process of certification for PCAs MCIL has created is central to accomplishing this agenda.

Despite the mounting pressure of the direct care workforce crisis, we have failed to make substantive programmatic and policy changes. Further, more research needs to be done to understand the impact of investing in PCAs, especially pertaining to the implementation and evaluation of PCA certification. We have long known that there has been a lack of training to adequately prepare DCWs and few opportunities for career development and advancement (Stone, 2004); however, PCAs have been relatively overlooked in these efforts. Providing the option for certification of the PCA role[2], following three core tenets below, will allow for equity with similarly skilled levels of direct care work, such as CNAs. Each tenet goes hand-in-hand with research and policy recommendations contained in this report.

1. Certification for PCAs can establish a clear, standardized level of expertise. The training for certification, utilizing an apprenticeship approach, should give rise to improved levels of professionalism, performance, and quality of service.

2. Certified PCAs should be compensated commensurate with CNAs having similar levels of experience. Certification and improved comparability of compensation (pay equity) should lead to improved retention with reduced employee turnover, hiring expenses, and training costs. Overall productivity should accompany greater expertise and workforce stability; these improvements will be highly cost effective.

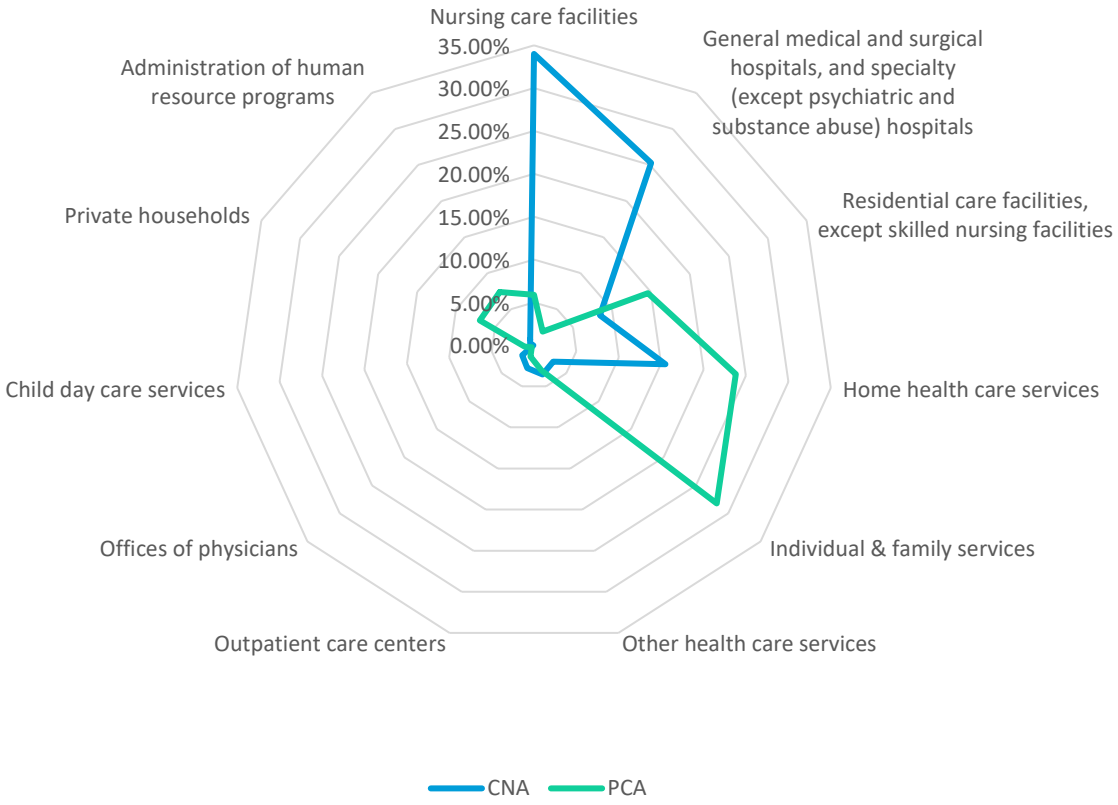
[2] The creation of a formal PCA certification would not make it a requirement, as it is understood that many friends and family members often become PCAs to help compensate for what would otherwise be unpaid labor. Rather, it would provide an option for those seeking more training and career development opportunities.

3. An established accrediting body can and should develop ongoing, longitudinal data collection and evaluation to secure further improvements in PAS and cost efficiencies. It may also offer or require ongoing education for certified PCAs and may offer advanced certification levels in the future.

BACKGROUND

It can be difficult to distinguish between the direct care work that CNAs do and the work that PCAs do, as both provide LTSS. Some believe that the distinction between the two is that one has certification, and is therefore doing more technical work, while the other isn't certified. However, this is not the key distinction between the two roles. Whereas CNAs may provide assistance with ADLs and IADLs, their primary focus is a medical one while the focus of PCAs is on independent living that is specifically not medical. To be clear, CNAs and PCAs are different jobs, requiring different skills, and serving different populations.

Figure 1: Industries by Share



2020 U.S. Census Bureau American Community Survey (ACS) Public Use Microdata Sample (PUMS)

For example, PAS also provides support in the workplace (Misra, Orslene, & Walls, 2007; Turner, Barkus, West, & Revell, 2003). Subsequently, training specific to PAS in work settings is needed that focuses on the differences in providing support in a business environment versus a home environment and

methods for PCAs to remain unobtrusive while providing the necessary level of support (Turner et al., 2003). Overall, there are six components to PAS provision: (1) attendant services, including personal services, paramedical services, and household tasks; (2) communication services; (3) cognitive/emotional support services; (4) PAS management services; (5) transportation services; and (6) work related services (Litvak et al., 2000).

However, PCAs are being paid less because they are seen as not having training or certification, leading to more precarious employment. Inevitably, employment disparities such as these will affect not only the quality of services being provided, but also the quality of life of people with disabilities that rely upon PAS to live independently.

One of the biggest differences between CNAs and PCAs is that the latter is primarily paid via Medicaid reimbursement. Further, the highest wages appear to be paid in institutional medical settings, whereas PCAs are primarily working in home and community-based settings. This discrepancy reflects what is known as the "institutional bias" in Medicaid. The institutional bias means that when States receive Federal dollars for Medicaid to provide LTSS they are required to cover services received in institutional settings. Conversely, HCBS is an optional waiver program to provide non-medical services in community-based settings for those that do not want or need institutional care (Dawson et al., 2021; Miller & Beauregard, 2022; Ryan & Edwards, 2015; Sowers, Claypool, & Musumeci, 2016). Across the U.S. we are seeing a surge of "rebalancing" policies aimed at addressing this institutional bias and providing more community-based care (Dawson et al., 2021; Miller & Beauregard, 2022; Ryan & Edwards, 2015).

The demographics for CNAs and PCAs are strikingly similar, making them an apt comparison group. However, it also raises the question of why these two groups are being treated differently. It appears to come down to certification and the value it ascribes to one's work.

DEMOGRAPHIC PROFILE

According to the U. S. Bureau of Labor Statistics Occupational Employment and Wage Statistics, In May of 2022 nursing assistants earned a mean hourly wage of $17.41 and annual wage of $36,220; whereas PCAs earned a mean hourly wage of $14.87 and annual wage of $30,930. This indicates a possible annual pay gap of $5,290 per year on average. Table 1 shows hourly and annual wages broken down by percentile:

Table 1: Wages by Percentile

Percentile		10%	25%	50% (Median)	75%	90%
Nursing Assistant	Hourly Wage	$ 13.48	$ 14.79	$ 17.19	$ 18.87	$ 22.09
	Annual Wage	$ 28,030	$ 30,770	$ 35,760	$ 39,260	$ 45,940
Personal Care Aide	Hourly Wage	$ 10.82	$ 13.03	$ 14.51	$ 16.40	$ 18.44
	Annual Wage	$ 22,500	$ 27,100	$ 30,180	$ 34,110	$ 38,350

Percentile		10%	25%	50% (Median)	75%	90%
Pay Gap	Hourly Gap	$2.66	$1.76	$2.68	$2.47	$3.65
	Annual Gap	$5,530	$3,670	$5,580	$5,150	$7,590

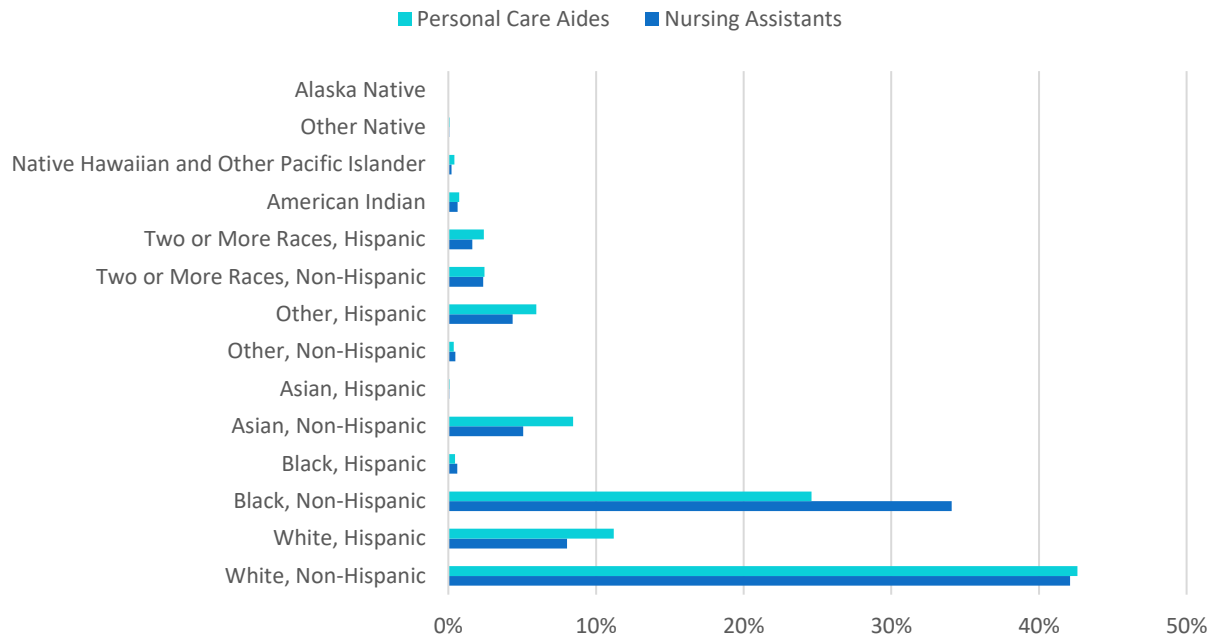
U. S. Bureau of Labor Statistics Occupational Employment and Wage Statistics, May 2022

Accordingly, the pay gap between CNA and PCA ranges from as low as $3,670 to as high as $7,590 per year. However, calculations of annual wage here assume that DCWs are working full-time when in fact the majority are not. Over half of all CNAs in the U.S. are employed part-time, 40% rely upon public assistance, and there are increased levels of poverty among them (McMullen & Travers, 2023). On average, 44% of all long-term care workers live below 200% of the Federal poverty level, 42% receive public assistance, and one in six hold a second job (Dawson et al., 2021). In Minnesota, in 2021, the median wage for DCWs was $14.77 and wage competitiveness was -$3.64. In 2020, median personal earnings were $21,600, 41% lived in a low-income household, 29% lacked affordable housing, and 8% were uninsured.[1] In 2022, according to the Minnesota HCBS Labor Market Report, 63% of PCAs worked part-time and only 57% were offered health insurance by their employer. On a national scale, providing a living wage to DCWs across LTSS settings has been projected to raise employment by 9.1%. It would have an economic impact via the additional spending of workers somewhere between $17 billion and $22 billion by 2030, and would reduce reliance on public assistance programs by between $912 million and $1.6 billion per year (Dawson et al., 2021).

DCWs have also been found to spend more time on housework, unpaid caregiving, and commuting than do other care workers (Dawson et al., 2021). This is unsurprising given that, according to the U.S. Department of Labor Employment and Earnings by Occupation 2021 data, the majority of CNAs (88.1%) and PCAs (80.3%) are women, compared to all occupations (43.7%). Women's earnings as a percentage of men's for CNAs are 88.1% and for PCAs they are 93.6%, compared to 81.5% for all occupations. The average age, according to the 2020 U.S. Census Bureau American Community Survey (ACS) Public Use Microdata Sample (PUMS), for CNAs is 40.4 years and 45.5 years for PCAs. Further, CNAs work an average of 31.9 hours per week, while PCAs work an average of 29.8 hours per week.

When it comes to looking at the race and ethnicity of DCWs, the claim is frequently made that the majority are people of color (POC). This is not entirely accurate. According to PUMS data, 42.1% of CNAs and 42.6% of PCAs were white, non-Hispanic as can be seen in Table 2:

Table 2: Race & Ethnicity



2020 U.S. Census Bureau American Community Survey (ACS) Public Use Microdata Sample (PUMS)

However, when adding the number of DCWs who are white and identify their ethnicity as Hispanic, then the majority of CNAs (50.1%) and PCAs (53.1%) identify as white. The second most common category is black for 34.7% of CNAs and 25% of PCAs. Across all race categories, individuals who identify as Hispanic appears to account for 14.7% of CNAs and 20.1% of PCAs. In Minnesota in 2020, 38% of DCWs were POC and 23% were immigrants.[1] It is clear that a significant portion of CNAs and PCAs are POC nationally and across the State of Minnesota.

Unfortunately, we do not have data on incidence of disability among DCWs, despite knowing that there exist nurses with a variety of disabilities (Marks & Sisirak, 2022) and that people with disabilities are both caregivers as well as recipients of care. Moreover, people gravitate towards jobs in areas where they have experience. Due to their experience with the care industry, it is not uncommon for people with disabilities to seek out jobs in direct care in one form or another. We do not have data regarding whether or to what extent people with disabilities may be seeking out and/or experiencing barriers to care work, including starting businesses and consulting in this area (Caldwell, Parker Harris, & Renko, 2016, 2019).

It is important to appreciate that there is considerable variation in demographics presented on the topic of “personal assistance” depending upon how the group is being defined by the researchers the term being used varies among the States and the data available for analysis. In the disability community it is common for family members and friends to be paid as personal assistants, but it remains unclear how they are included in Federal and State data sets and whether this information is disaggregated for analysis. In Minnesota, the 2022 HCBS Labor Market Report shows that 60% of consumer-directed community supports (CDCS) is personal assistance, and 69% of “self-direction workers” are paid family

members. There also appears to be discrepancies because either there is no distinction between PCAs paid through public versus private funds or those paid independently through private means are not captured in data collection efforts. Data indicates[1] that jobs in the private sector pay more than those reimbursed via Medicaid.

EFFECT OF STIGMA

Jobs in personal care services, regardless of whether they are in institutional or home-based settings, are typically seen as being poor quality jobs with low wages, limited flexibility, little advancement opportunity, and high rates of disability (Ko et al., 2014). In the direct care workforce, there is a negative public image of PCAs, who are viewed as being poorly trained with few skills and little to no chance for advancement. This lack of training is used as justification for paying PCAs less than DCWs who have had training (Christopher Kelly et al., 2020). Many PCAs do not feel valued by employers or immediate supervisors and the negative stigma towards them can discourage individuals from seeking out or remaining in a job that is already physically and emotionally demanding. These pressures are exacerbated by worker shortages (Stone, 2004). A national study of the Better Jobs Better Care demonstration project looked at what changes DCWs thought management needed to make to make their jobs better. Findings included, first and foremost, more pay. Findings also included better work relationships when it comes to improving communication, supervision, being appreciated, listened to, and treated with respect. Specific changes needed differ between settings, however. Workers in home care and assisted living facilities were significantly more likely to say increasing wages was the single most important issue. Home care workers were then more likely to ask for improved fringe benefits and the opportunity to work more hours (Kemper et al., 2008).

PCA certification can help lessen stigma by raising awareness about the work that PCAs do as well as adding a level of professionalization and subsequent validation to the field as a whole.

TURNOVER & RETENTION

Wages, benefits, and training are key issues affecting one's decision to accept a position as a community-based DCW (Claypool, 2008). Higher annual earnings are associated with a higher likelihood of remaining in the direct care occupation (Smith & Baughman, 2007). Low wage rates for PCAs have been found to correlate with job dissatisfaction and high turnover, subsequently leading to a shortage of high quality providers (Ko et al., 2014). Compensation and benefits have a direct link to worker satisfaction, motivation, hiring, and retention (McMullen & Travers, 2023), other job qualities appear to be critically important as well. Workers are more satisfied and likely to remain in their job when they feel personally responsible for their work, receive ongoing feedback from supervisors, and have organizational support. Good personal relationships among management, workers, and consumers are essential for retention. Workers that feel they have more decision-making authority over their schedule and how care is provided report less stress and greater job satisfaction (Stone, 2004).

One Pennsylvania study found that the estimated annual recurring cost of training due to turnover among LTSS providers was at least $35 million. The total financial cost of each employee turnover for a DCW was $3,362. This includes the costs of recruiting, orienting, and training new home care workers

and cost related to terminating the worker being replaced (e.g., exit interview, administrative functions, separation pay, and unemployment taxes). There are also costs associated with lost productivity. This includes the time it takes to recruit and train new hires, more so when you factor in the rate of attrition between each stage. Finally, there is a loss of independence when consumers don't have someone to help provide personal assistance in the home as well as in the workplace. High turnover can lead to poor quality of care and/or unsafe care, disruption in continuity of care, and reduced access to care. Having a reduced pool of worker places pressures on family caregivers, and places pressure on individuals to accept poorer quality care (Stone, 2004).

In looking at dual eligible Medicare and Medicaid beneficiaries using LTSS, higher payment rates for PCAs appear to increase utilization of HCBS, while low reimbursement rates become a barrier to HCBS access as the number of providers willing to provide services at those rates are inadequate. Research indicates that raising payment rates for PCAs in Medicaid should increase HCBS utilization/access by creating more stability in the personal care workforce and by a combination of offsetting lost wages due to informal caregiving and "boosting" the supply of formal providers, including both relatives and non-relatives (Ko et al., 2014).

Training is a mechanism of both recruitment and retention (Christopher Kelly et al., 2020). Inadequate training has been found to be a major contributor to high turnover rates among DCWs, while greater training is correlated with improved recruitment and retention rates (McMullen & Travers, 2023) and improves job quality, satisfaction, career growth opportunity, as well as the quality of life for those receiving services (Christopher Kelly et al., 2020).

In 2016, Minnesota convened a Direct Care/Support Workforce Summit attended by MCIL, which concluded that direct care/support jobs are low paying and rarely offered employer-based benefits. Also, turnover is high as workers can easily find better pay in other low wage work. The Summit report identified five major themes, in order of priority: (1) increasing workers' wages and benefits; (2) expand the worker pool by partnering with professional programs or with the Department of Education; (3) enhance direct care/support worker training; (4) increase job satisfaction; and (5) build public awareness. A PCA training and certification program that responds directly to these concerns can thereby lessen the impact and import of turnover and retention. The recommendations from this report were approved by Minnesota's Olmstead Subcabinet and served as the basis for both the MCIL Certified PCA curriculum, the PCA Rate Framework that passed into law in 2021, and also the PCA College Service Corps that MCIL has been working on.

IMPACT OF COVID-19

The COVID-19 pandemic has disproportionately impacted the disability community (Sabatello, Burke, McDonald, & Appelbaum, 2020; Sabatello, Landes, & McDonald, 2020). In fact, researchers have identified four distinct waves of discrimination in the pandemic response: (1) healthcare rationing and disability inclusion; (2) access to resources, supplies, and accommodations; (3) vaccine access; and (4) long COVID and disability identity (Lund & Ayers, 2022). Each wave has affected the provision of PAS. The first wave alone brought about enhanced institutionalization, breakdown of essential community-

based services, multiplication of intersectional harms, and denial of access to healthcare (Mladenov & Brennan, 2021).

COVID-19 put people with disabilities in the position of having to effectively gamble to access the care they need, assessing risk when making care decisions. For example, weighing concerns about whether a PCA would be allowed to accompany them when receiving medical care and possible neglect if their PCA is not allowed. Further, one may feel it necessary to postpone needed care due to these concerns (Reber, Kreschmer, DeShong, & Meade, 2022). People with disabilities have also expressed having concerns about PCAs not following necessary COVID-19 guidance and putting their health and the health of their loved ones at risk (Reber et al., 2022).

Roughly 27% of workers in personal caregiving occupations were displaced from their occupations due to the pandemic and, of these, 36% had not returned to the field in early 2021 (Sage et al., 2022). People with disabilities report having difficulty finding PCAs due to lack of availability or workers refusing to come (Reber et al., 2022). There were several reasons why it was difficult to find PAS workers during the pandemic, such as poor working conditions and low wages, low reimbursement rates, lack of benefits, and drive and travel time to reach locations. Further, PCAs may leave because they can easily find better paying work elsewhere, including working for nursing homes (Sage et al., 2022). COVID-specific reasons for worker shortages were reported to include fear affecting willingness to work as frontline professionals; time off due to awaiting testing results, symptoms, or because they or their family members/close contacts were sick, or they decided to stop/delay working as frontline professionals; when consumers contracted COVID; and finally due to COVID-related deaths reducing the PCA workforce (Sage et al., 2022).

The COVID-19 pandemic certainly highlighted a need for education and training that had existed previously in a workforce that has been put under immense pressure among a population that has been the hardest hit. This is a problem we can no longer afford to ignore, as we have seen the devastation that occurs when we do.

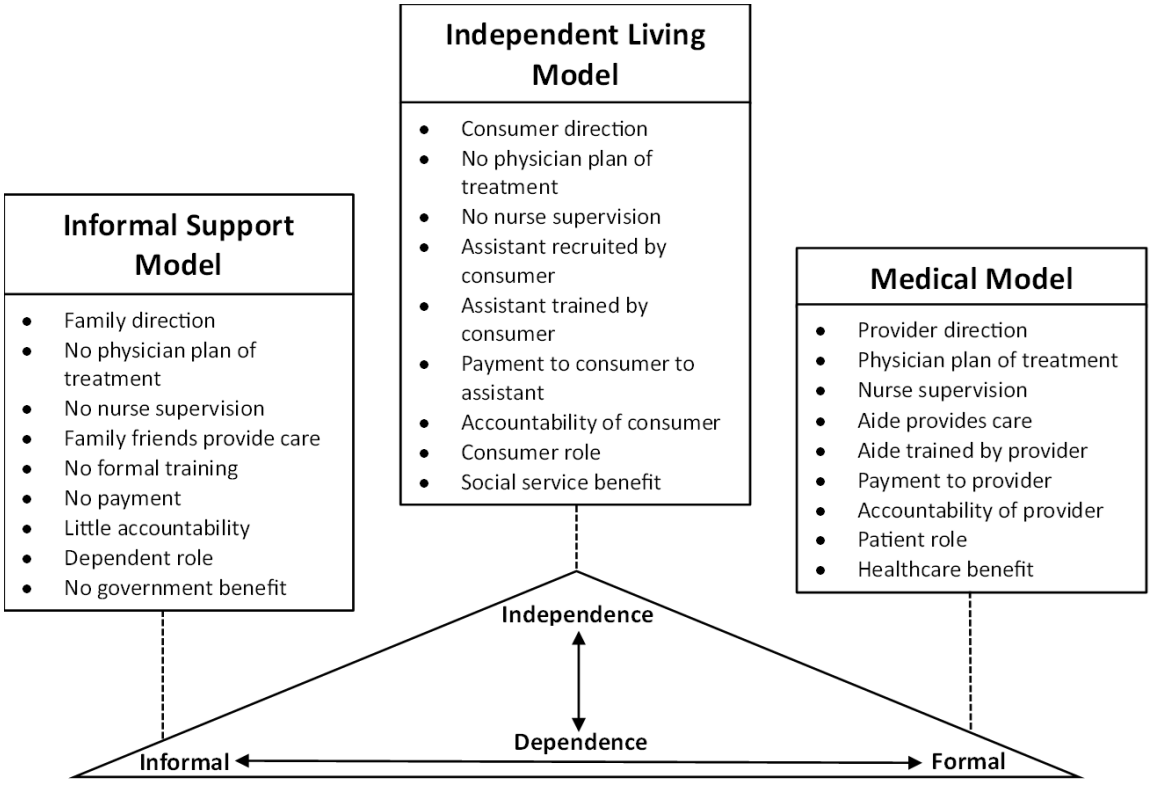
INDEPENDENT LIVING MODEL

Personal care assistance “evolved as a non-medical solution to a problem that had initially been conceived as a medical need, but one that had proven too costly to be served within the healthcare system to which 20th century Americans increasingly turned for help with the age-old matters of illness, disability, and death” (Glazier, 2001, p. 2). Indeed, our approach to personal assistance as we know it today in the U.S. has been largely driven by the disability rights and independent living (IL) movement of the 1960s and 70s (Heller, Harris, Gill, & Gould, 2018). Going back to the 1980s, research found that it was more efficient for consumers to train their own attendants, and that it was significantly more cost effective to provide care at home rather than in a hospital/institutional setting (Glazier, 2001). In the 1990s a set of ten values were developed at a World Institute on Disability (WID) conference of stakeholders that were intended to drive a national program of PAS (Turner et al., 2003, p. 158):

1. No medical supervision is required.
2. The services provided include personal maintenance and hygiene including catheterization, mobility, and household assistance.
3. The maximum service limit should exceed 20 hours per week.
4. Service is available 24 hours a day, seven days a week.
5. The income limit for eligibility is greater than 150% of the poverty level. Further, individuals who are severely disabled whose income exceeds that established for eligibility should be allowed to buy into an insurance policy that would provide attendant care. Marital status and consequent financial circumstances should not govern access to personal care assistance.
6. Individual providers can be utilized by the consumer.
7. The consumer hires and fires the assistant.
8. The consumer pays the assistant.
9. The consumer trains the assistant.
10. The consumer participates in deciding on the number of hours and type of service he/she requires.

While certain facets have been put into effect, this vision for a national program of PAS services has never fully been realized. Over time, WID identified three models of PAS for people with disabilities that had emerged, including among them the *Independent Living Model of Personal Assistance* (Batavia, DeJong, & McKnew, 1991; DeJong, Batavia, & McKnew, 1992; Litvak et al., 2000; Misra et al., 2007):

Figure 2: Three Models of Long-Term Care for Persons with Disabilities



Under the medical model, an individual's needs are assessed by a medical professional and directed via a provider agency. In this model, people with disabilities are seen as dependent and service provision is highly formalized. This approach aligns with the medical model of disability, which sees disability as a problem, defect, or deficiency that somehow needs to be fixed or cured. Disability scholars and activists have pushed back against this medical model and advocated for more advanced models of understanding disability. The disability rights movement (DRM) drew upon the civil rights movement to develop the minority group (sociopolitical) model of disability. This model sees disability as a minority group, similar to other minority groups, that have been disenfranchised and wherein members with shared experiences must advocate for their civil rights. Proponents of the minority model distrusted the medical model and medical professionals who controlled decision making, while people with disabilities had little voice in the process (Evans, Broido, Brown, & Wilke, 2017). Disability Studies scholars also pushed back against the medical model of disability with a social model of disability, which posits that disability is not a problem inherent in any one individual, but rather that while an individual may have an impairment it is instead society that is disabling by not being able to meet that individuals' needs and instead having created social and environmental barriers. The social model of disability thereby removes "blame" for one's disability from the individual and places it on society, emphasizing barriers that can be addressed through program and policy change.

Neither the minority nor social model of disability are mutually exclusive and, in fact, complement and hold the potential to build on each other in powerful ways to meet the changing needs of a diverse disability community. In particular, recent years have seen a shift towards disability justice to address the concerns of, as Vilissa Thompson coined it, #DisabilityTooWhite (Mulderink, 2020). While the DRM has long been critiqued for centering white men and people with physical disabilities, so too have decades passed since Chris Bell questioned whether Disability Studies was actually just White Disability Studies. Scholars and activists continue to call for critical intersectionality in the field that "centers the needs, perspectives, and interests of marginalized people with disabilities and enables the advancement of disability justice" (Miles, Nishida, & Forber-Pratt, 2017). Disability justice is a framework, a movement, and a set of ten principles[3] that were created to shift the center to focus instead on non-normative people living at intersecting junctures of oppression (Berne, 2015). The need for a disability justice approach is echoed by the #CareCantWait Coalition, recognizing the confluence of multiple systems of oppression that have shaped the care industry in America, relying on programs that were built on racism, ableism, sexism, and exclusion (Kalipeni & Kashen, 2021).

Under the informal support model (e.g., family model), an individual's needs are assessed and directed by family members. In this model, people with disabilities are seen as dependent and service provision is highly informal and typically unpaid labor. This is the most common form of PAS as approximately 79% of people with disabilities rely upon volunteer/unpaid support from family and friends to live in the community (Batavia et al., 1991). In both the medical and informal support model, people with disabilities little, if any, control over their own care (Heller et al., 2018). The independent living model of personal assistance puts people with disabilities (i.e., consumers) in control when it comes to the management and direction of their PAS. As a result, independence is high in this model, which employs

[3] https://www.sinsinvalid.org/blog/10-principles-of-disability-justice

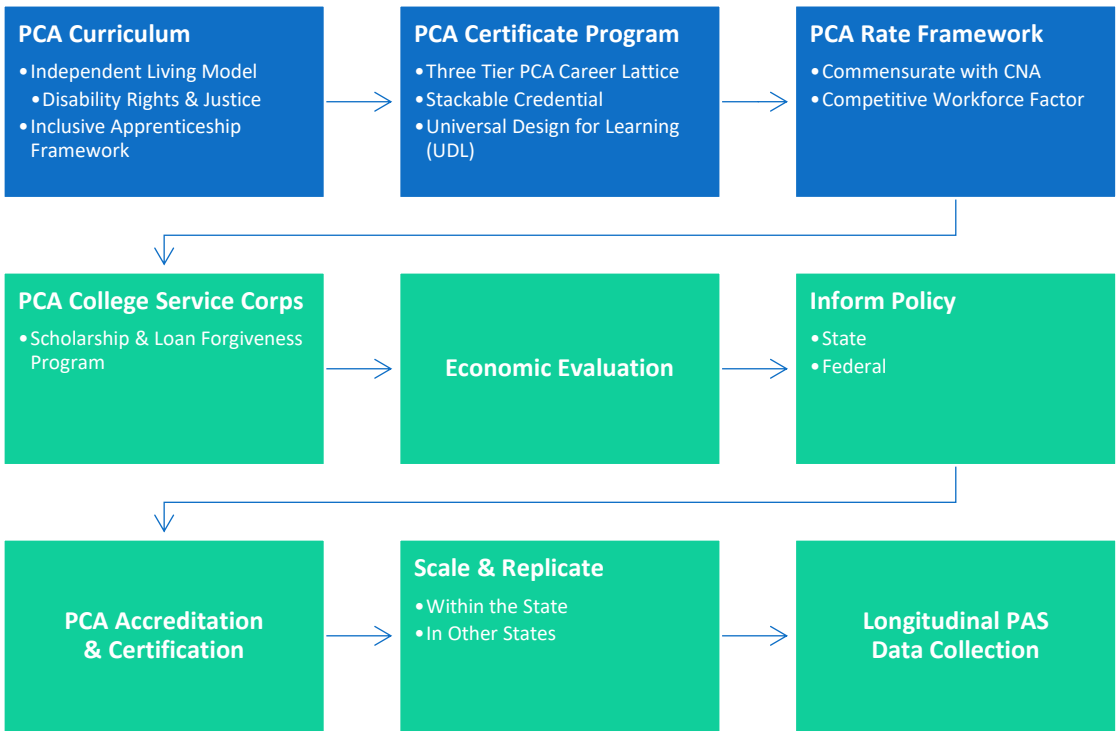
a mixture of formal and informal support. The influence of the WID values is evident in the independent living model. Longitudinal research has shown that consumer-directed PAS (CD-PAS) has beneficial effects, such as increased satisfaction and safety and fewer unmet needs (Clark, Hagglund, & Sherman, 2008).

Looking at the three models it becomes clear that CNAs follow a medical model approach whereas PCAs follow an independent living model approach, indicating different skill sets, knowledge bases, and training needs. A review of four State programs looking at CD-PAS in Medicaid found that while consumer direction of PAS is becoming more available, the majority of consumers use agency directed services in the community. This could be due to lack of awareness of the option or it could be due to reluctance to assume responsibility for hiring, scheduling, and paying PCAs (Claypool, 2008). Certification for PCAs would alleviate the pressure on consumers by establishing a baseline standard of care, informed by an independent living model and disability rights and justice principles, upon which they can focus on providing individualized training specific to their needs.

INCLUSIVE APPRENTICESHIP FRAMEWORK

The Metropolitan Center for Independent Living (MCIL) received a Bush Foundation Community Innovation grant in support of a project to solve the PCA worker shortage crisis. The focus of this grant was to build upon the current PCA career lattice as a means to recruit and retain PCAs to support people with disabilities and older adults who utilize PCA services throughout Minnesota. MCIL has worked collaboratively with many stakeholders across State, government, public, private, higher education and non-profit sectors, PCAs, PCA Provider Agencies, the SEIU Union and importantly people with disabilities and representatives of the older adult provider communities on this project. MCIL has been working with HealthForce Minnesota and four Minnesota State Faculty on developing a certificate program leading to the credential of a Certified PCA along with program design and considerations for engaging the Centers for Medicare & Medicaid Services (CMS) with such a three-tiered PCA Career Lattice in design and delivery of Minnesota PCA services. Economic evaluation is still needed to learn of the return on investment (ROI) that can result from PCA's becoming Certified PCA's with the PCA Rate Framework passed into law with component values that account for competitive workforce factors of compensation of similar positions, such as a CNA. Figure 3 shows the stages of the PCA project that have been completed (blue) and those to be taken on in future work (green):

Figure 3: PCA Initiative Progress



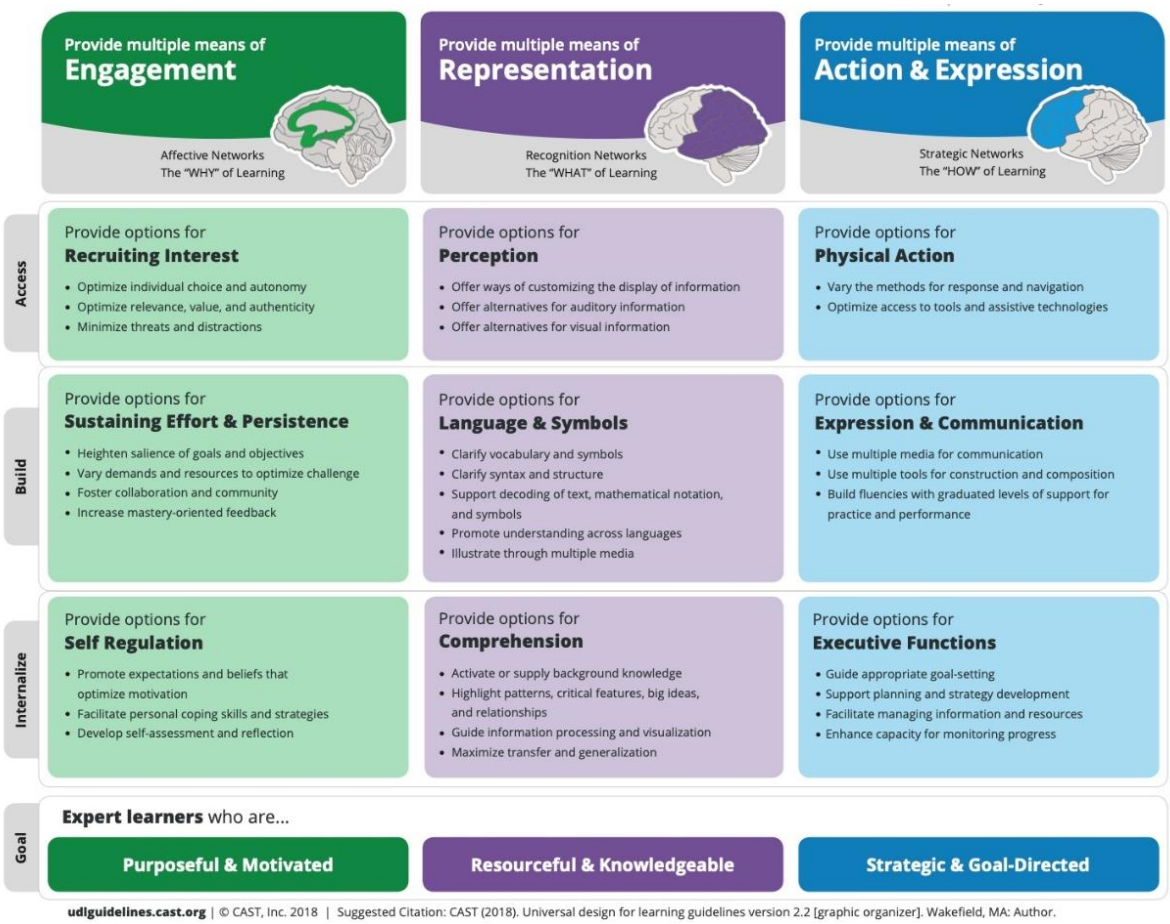
The PCA certificate program utilizes an inclusive apprenticeship approach, which combines classroom-based learning with structured on-the-job training as apprentices work toward a nationally recognized occupational credential. The emphasis in inclusive apprenticeship is on not discriminating on the basis of disability in apprenticeship programs and ensuring that everyone, including people with disabilities, can access apprenticeship opportunities. There has been growing interest in inclusive apprenticeship among State legislatures, as evidenced in a recent report from the Council of State Governments (CSG) and the State Exchange on Employment & Disability (SEED), an initiative of the U.S. Department of Labor's Office of Disability Employment Policy (ODEP).

> *"In Minnesota, for example, about ninety six percent of individuals actively enrolled in apprenticeships between 2015 and 2017 were working in skilled construction trades. While apprenticeship advocates would like to see state initiatives broaden apprenticeship opportunities into fields like health care, information technology, agriculture, and manufacturing, Minnesota's construction industry is the only one to fully embrace apprenticeships, according to a study by the Midwest Economic Policy Institute." (CSG, 2021, p. 18)*

Inclusive apprenticeship recommends bringing together a framework of Work-Based Learning (WBL) and Universal Design for Learning (UDL) in its program and curriculum design. Doing so has the benefit of offering alternative ways to perceive information, providing "mastery-oriented" feedback, optimizing the relevance and delivery of training, optimizing individual choice and autonomy, optimizing access to accessible tools and assistive technologies, and accounting for learner perspective and context (ODEP, 2020). The UDL framework can be found in Figure 4 below, indicating three core foci: engagement,

representation, and action and expression. These foci are used to activate different networks (affective, recognition, strategic) and develop areas of mastery in learners. Additionally, the Minnesota Department of Education has developed a framework for WBL[4] that should be valuable in program and curriculum design. In Minnesota, approved WBL programs must include school-based components (licensed instructor, advisory committee, career seminar course, work experience course) and work-based components (individual training agreement, individual training plan, performance evaluation).

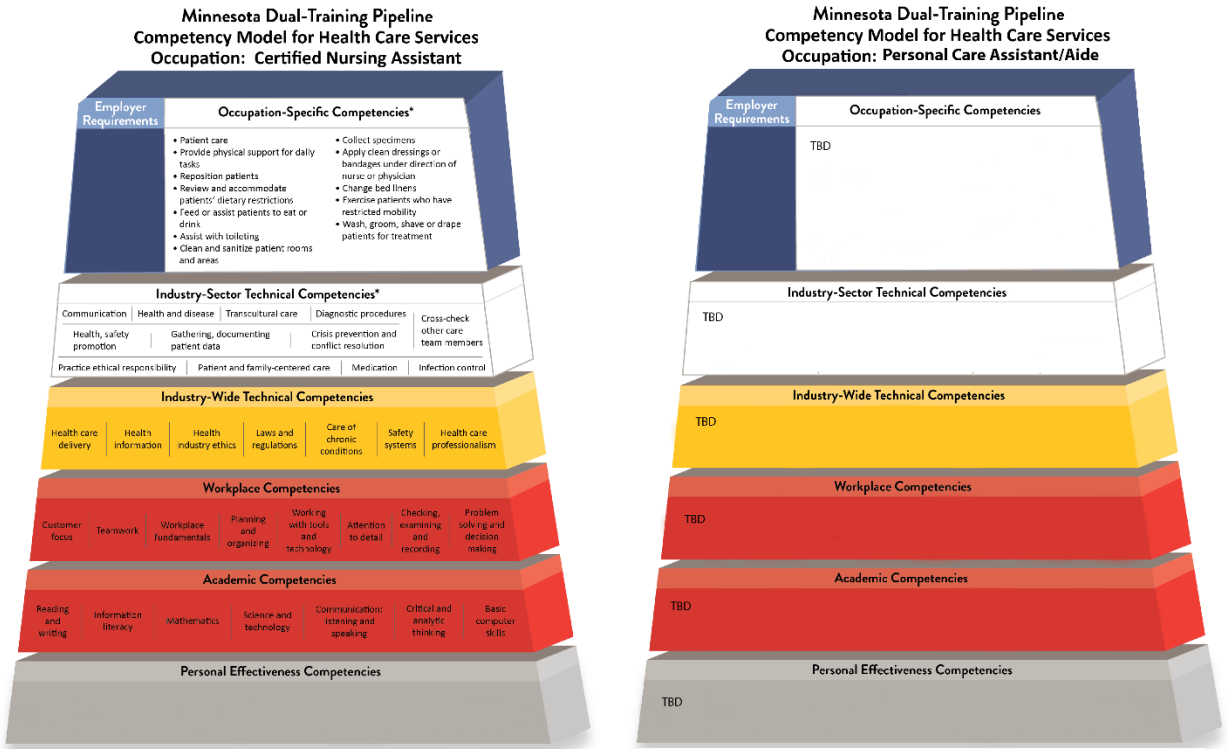
Figure 4: Universal Design for Learning Framework



Minnesota has developed the Dual-Training Pipeline (DTP) to support competency-based apprenticeships to meet workforce needs in the industries of advanced manufacturing, information technology, agriculture, and health care services. Already, CNAs have been included in the Pipeline under health care services, which is where PCAs would be included as well:

[4] https://education.mn.gov/MDE/dse/cte/prog/wbl/

Figure 5: Minnesota DTP Competency Model for Health Care Services



The DTP programs focus on assessing a hierarchy of competencies in six areas: starting at the bottom (1) personal effectiveness competencies; (2) academic competencies; (3) workplace competencies; (4) industry-wide technical competencies; (5) industry-sector technical competencies; and finally (6) employer requirements alongside occupation-specific competencies.

PCA CURRICULUM

We can look to Canada as a prime example of established curriculum in this area. For over a decade they have had "personal support worker" (PSW) certificate training programs and standards of practice[5] (Grant, 2016; Christine Kelly & Bourgeault, 2015). There have been efforts in the U.S. to develop similar training programs over the years, but they did not lead to a certificate. Moreover, the most critical piece to this puzzle is the passing of PCA rate framework legislation and ensuring that PCA certification is commensurate with CNAs under that rate framework. This came as a result of Minnesota's Olmstead Subcabinet Direct Care Workforce Recommendations Report, of which MCIL's Executive Director, Jesse Bethke Gomez, served as one of three technical writers. The Certified PCA education and role, tied to a PCA rate framework that transforms our economy based upon wage differentials are among the most essential components in solving our nation's direct care worker shortage crisis.

The report pinpointed three promising solutions that MCIL has been working to address: (1) adding a voluntary third tier to Minnesota's PCA Career Lattice – that of Certified PCA; (2) passing the PCA rate framework whereby PCA position and compensation become linked by workforce factors; and (3)

[5] https://files.ontario.ca/mcu-personal-support-worker-jan2022-41469-en-2022-03-31.pdf

establishing the PCA College Service Corps. The Certified PCA curriculum is based upon a 50-State review of all PCA training programs conducted by the MCIL Community Innovations PCA Project Committee alongside a review of the CMS 12 competencies of a PCA. The curriculum utilizes the CMS framework more so, as to create interoperability of curriculum implementation throughout the U.S., since States have to seek approval from CMS for the inclusion of this additional PCA career lattice.

The curriculum was created through a strategic alliance with the Minnesota State HealthForce Center of Excellence and Winona State University. A PCA Pilot Project Committee was formed that had a broad scope of participation. Four Minnesota State University faculty are currently developing the curriculum. The curriculum follows the Minnesota statute on the role of PCA's and the 12 Competencies of PCAs by CMS for the homecare sector.

According to the 2016 Minnesota Direct Care/Support Workforce Summit report, areas that DCWs identified as beneficial training opportunities included: training specific to a type of disability or disease; responsibilities or skills related to job; working with people with difficult behaviors; career advancement; medical; creating a better workplace; policy and systems; communication or relationship building; training method (in person, hands on/on the job, online); self-care; other; person centered training; more training in general; community resources; cultural; training for general public about people receiving services; and best practices or research. The curriculum that MCIL is developing will fundamentally incorporate content addressing models of disability, the independent living model, disability rights and justice, as well as contemporary topics such as PAS in the workplace.

ACCREDITATION & CERTIFICATION

The PCA program holds potential to change the landscape for PCAs not just in Minnesota, but across the country. The approach to PCA certification herein described provides a model, framework, and curriculum that is both scalable and replicable – leveraging advancements in disability employment policy in a way that can strengthen our national network of Centers for Independent Living (CIL). However, doing so will require passing legislation similar to the PCA rate framework at the State and/or Federal level if the certificate is to be a meaningful credential. Further, an accrediting body will need to be created to ensure that as more PCA certificate programs are created, they are meeting the same standards. Similar to other professional organizations, the *PCA Certificate Accreditation Organization* (PCAO) will be responsible for administering the certificate exam and may offer continuing education for certified PCAs as well as potentially advanced certification levels in the future as the field grows. The creation of an accreditation body for certified PCA's should lead to improved longitudinal data collection around PCA demographics and earnings at the State level and nationally, which is currently very much missing. The curriculum learning objectives will align with what candidates will be tested on in their certification exam, and with the competencies they will be assessed on in the field (DTP) to ensure mastery. The PCA certificate will be a stackable credential that incorporates into the career lattice structure to allow versatility in career mobility for individuals interested in pursuing care work.

RESEARCH RECOMMENDATIONS

Given the severity of the crisis that we are facing with the direct care workforce, the lack of research that has been done in this area is alarming, especially when it comes to PAS. A comprehensive research agenda on PAS needs to be implemented that extends beyond the scope of this current work. However, research that can be recommended based on the PCA certificate initiative includes economic evaluations to assess the ROI and social benefit of PCA certification (tenets 1 & 2), and longitudinal data collection to assess the impact of PCA certification over time (tenet 3).

ECONOMIC EVALUATION

COMPARATIVE ANALYSIS

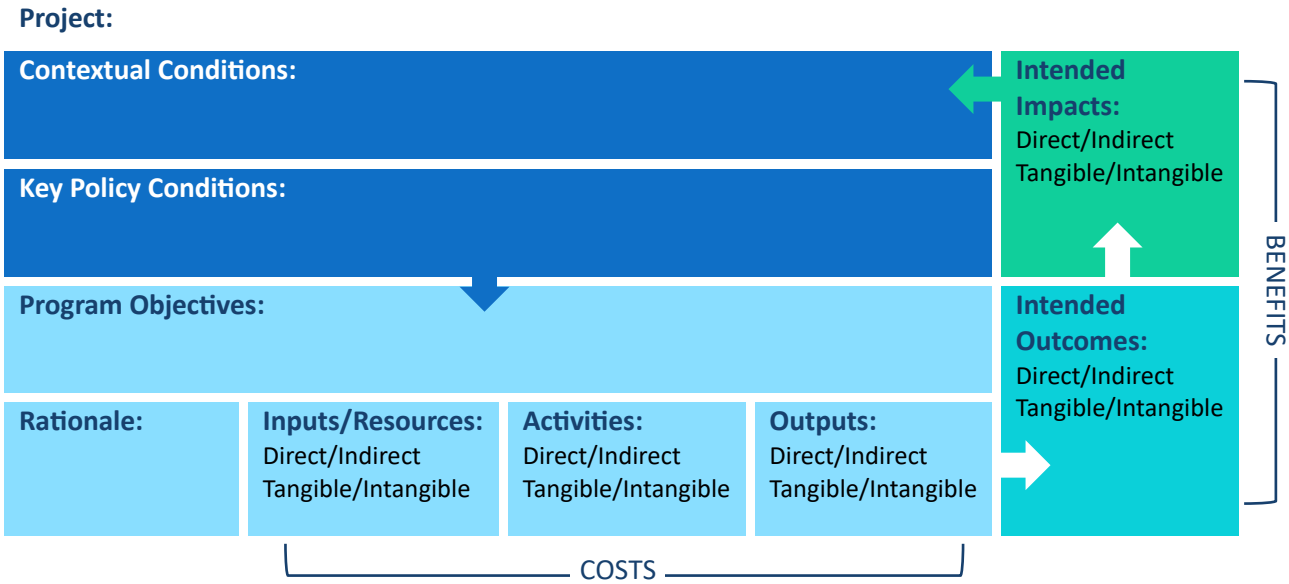
There are two methods of comparative analysis that could be used to evaluate improvement in professionalism, performance, and quality of service (tenet 1): within-group comparison versus between-group comparison. A within-group comparison would involve a pretest-posttest evaluation that conducts a baseline survey of PCAs before they begin the certificate program and pairs responses to those collected after completing the certificate program. The items needed for this survey would appear to align with an assessment of PCA DTP competencies (Figure 5), and as such could be integrated into the DTP evaluation.

A between-group comparison would involve conducting a cross-sectional self-report survey with three groups: (1) certified PCAs, (2) PCAs that do not have their certificate, and (3) family member PCAs. Given the limitations of self-report data, it could also be informative to conduct a cross-sectional consumer survey with three additional groups where the items on the survey would pair with the self-report survey. The three groups to sample for this survey would include (4) consumers using certified PCAs, (5) consumers using PCAs that are not certified, and (6) consumers using family members as PCAs.

COST-BENEFIT ANALYSIS

A cost-benefit analysis (CBA) is a methodology for evaluating the feasibility of applying an economic approach to complex social intervention, which is needed to evaluate program progress towards equity, productivity, and workforce stability (tenet 2). A CBA is more comprehensive than a simple ROI analysis in that it quantifies costs and benefits that are direct/indirect and tangible/intangible. A logic model should be developed to identify and classify the costs and benefits, such as in the template provided below:

Table 3: Template for CBA Logic Model



In this logic model, intended outcomes comprise both short-term and medium-term outcomes, while intended impacts covers long-term outcomes.

The Minnesota Disability Waiver Rates System (DWRS) collects data annually that can be useful for this analysis. The DWRS calculates a regional variance factor (RVF) to adjust rate calculations regionally. A competitive workforce factor (CWF) is also calculated using day and residential services as its base and categorized by education needed for entry as well as on the job training needed for competency. Accordingly, going forward the CWF should incorporate the PCA certificate. Data collected for annual HCBS labor market reporting includes:

- Number of direct-care staff
- Wages of direct-care staff
- Hours worked by direct care staff
- Overtime wages of direct-care staff
- Overtime hours worked by direct care staff
- Benefits paid & accrued by direct care staff
- Direct-care staff retention rates
- Direct-care staff job vacancies
- Amount of travel time paid
- Program vacancy rates
- Other related data requested by the commissioner

Some data, however, will need to be valuated and quantified, based on the findings of the logic model. This may involve the use of existing data as proxy variables or may require the collection of additional data. For this reason, the logic model needs to be completed first and foremost, then assess what data is being collected already, and finally consider administering a data supplement to collect additional data if necessary. It is also possible that this CBA identifies additional factors that are worthwhile in continuing to monitor. If so, the supplement may become a useful part of annual data collection.

There are five methods of valuation. The *human capital approach* views people as an investment whose purpose is to be economically productive. This is the approach most people are familiar with when they think about CBA and it measures livelihood not value of living. However, this approach assumes a fair

labor market and subsequently tends to devalue low-wage workers as well as intangible consequences. In this method value is determined by looking at earnings generated and productivity. The *friction cost approach* values productivity loss during a period of friction. For example, during the time it takes to recruit and train new employees. The *revealed preference method* determines value based on consumer behavior. However, this method assumes that consumers are rational. The *stated preference method* determines value based on what people would be willing to pay. Finally, the *life satisfaction approach* determines value based on the impact on people's reported well-being.

LONGITUDINAL PAS DATA COLLECTION

Currently, consumer satisfaction is the only measure for quality of service, and more and better measures for PAS quality are needed (Claypool, 2008). Due to the paucity of data being collected on PAS, one of the most significant contributions to the evidence-base will be made possible by establishing an accrediting body, the PCAO, which will be in the ideal position to collect longitudinal data from PCAs that have completed their certification on an annual basis. In addition to collecting data on the state of the field over time, there is also a potential to use this as an opportunity to collect data on employment outcomes for PCA certificate holders. If so, it then becomes possible to assess outcomes at yearly intervals after having completed the certificate. Data being collected should include demographic information, information on wages and work climate, consumer satisfaction and quality of life. Additional measures of PAS quality should align with certification goals and requirements; effectively what PCAs are tested on in the exam to become certified. This should also include DTP competencies to some extent.

POLICY RECOMMENDATIONS

NATIONAL DECLARATION FOR STRENGTHENING DIRECT CARE SERVICES AND BENEFITS FOR PEOPLE WITH DISABILITIES AND OLDER ADULTS

First and foremost, adopt the guiding principles of the *National Declaration for Strengthening Direct Care Services and Benefits for People with Disabilities and Older Adults*, which puts forward three objectives. First, to solve the direct care workforce shortage crisis whereby the solutions create an arc that meets the needs of all who rely upon the direct care workforce well into the future. The solution to this problem can be found in the PCA initiative described in the current document. Second, assure Federally mandated direct care technologies do not infringe upon the civil rights and fundamental rights of individuals who rely upon direct care services and upon worker rights of personal care assistants. In particular, revisiting the development of Electronic Visit Verification (EVV) in a manner that is consistent with all other development protocols for electronic health records and related health technologies defined in the 21st Century Cures Act. Third, remove the unfair 40-year frozen asset limitation for people with disabilities and older adults with a cost-of-living framework that provides continual fairness in asset adjustment thresholds. Specifically, Congress should seek to adjust the asset limitations to $10,000 per individual and $20,000 for couples, along with cost-of-living increases henceforth each year thereafter. Further, Congress should seek Federal-related health and human services that work in concert with State programs, the necessity by the States on conformance with the asset limitations of

$10,000 per individual and $20,000 for couples along with cost-of-living increases henceforth each year thusly thereafter.

POLICY THROUGH PARTNERSHIPS

PARALYZED VETERANS OF AMERICA

MCIL and Paralyzed Veterans of America (PVA) together can advance advocacy for addressing our nation's direct care worker shortage crisis for our country's Veterans who rely upon PCAs for daily living. MCIL and PVA together can work together with the Veteran's Administration on instituting the Certified PCA Curriculum and rate framework (competitive compensation for PCAs, sustainable PCA rates and adjusted budget models for Veterans) as a new career and voluntary career lattice for VA in support of Veterans who rely upon PCAs/DSPs for living independently.

NATIONAL COUNCIL FOR INDEPENDENT LIVING & AREA AGENCIES ON AGING

When it comes to partnerships for our nation's people with disabilities and older adults who rely upon PCAs for daily living, MCIL and the National Council for Independent Living (NCIL) can advance advocacy that will address the direct care worker shortage crisis for people with disabilities while MCIL and Area Agencies on Aging (AAA) can advance advocacy to address the crisis for older adult populations. MCIL along with advocacy by NCIL and AAA can seek the commitment by the Administration for Community Living (ACL) and CMS on identifying the selection of two States to receive demonstration grants to conduct research and evaluation on the implementation of the Certified PCA Curriculum and rate framework (competitive compensation for PCAs, sustainable PCA rates and adjusted budget models for PCA Participants) as a new career and voluntary career lattice in support of people with disabilities and older adults who rely upon PCAs/DSPs for living independently. The purpose of this grant being to analyze the scalability of the new career lattice for the direct care portion of the homecare sector of our nation's healthcare platform.

STATE EXCHANGE ON EMPLOYMENT AND DISABILITY

MCIL recognizes the vitally important role of the U.S. Department of Labor's Office of Disability Employment Policy, State Exchange on Employment and Disability (SEED), "a unique State-Federal collaboration that supports State and local governments in adopting and implementing inclusive policies and best practices that lead to increased employment opportunities for disabled people, and a stronger, more inclusive American workforce and economy."[6] The PCA career lattice recognizes the interdependent nature of CMS in each State as it pertains to the delivery of PCA/DSP services for people with disabilities and older adults. The role of CMS requires rigorous requirements be met in the utilization of Federal funds to support a State's direct care plan.

It is pivotal for MCIL to collaborate with SEED in sharing resources and information with Federal and State legislators and policymakers about the PCA certification model, program, and legislative efforts. In particular, advocating with CMS and State legislatures to provide for: 1) Certified PCA curriculum leading

[6] https://www.dol.gov/agencies/odep/state-policy

to the credential of a "Certified PCA"; and 2) advancing PCA/DSP rate frameworks that address competitive workforce factors, component values that result in competitive compensation for PCAs, sustainable PCA rates, and adjusted budget models for people who utilize Certified PCAs.

THE STATE OF MINNESOTA

Partnership with Minnesota's Governor's Office, the Minnesota State Legislature, Minnesota State University and the University of Minnesota in bringing forth the *Minnesota Model* for the rest of the nation to follow. A new third tier career lattice for the PCA/DSP workforce, the implementation of the Certificate PCA/DSP curriculum leads to the credential of a "Certified PCA." Along with legislation that includes component values, this new role of "Certified PCA" has the same median wage as the Standard Occupational Code for a "Certified Nursing Assistant." Both Minnesota State University and the University of Minnesota have the opportunity to implement the new PCA/DSP curriculum leading to the credential of a "Certified PCA." This new third tier needs to be universal across the DWRS, PCA/CFSS and Older Adults statutory Service lines of the direct care field.

MCIL along with the Minnesota Office of Governor and the Minnesota State Legislature have the opportunity to build upon recent legislative gains. This should begin with working together to introduce across the many statutory rate frameworks (i.e., DWRS rate Framework, PCA/CFSS Rate Structure) that this new third-tier Certified PCA has the universal component values at the median wage of the standard occupational code of a CNA in optimizing the role for the direct care workforce of the homecare sector. Doing so creates the necessary balance for pursuing moonshot advancements for both Certified PCAs and CNAs. Minnesota's overall healthcare platform includes both the medical model on one end, where CNAs are currently employed, and the homecare/direct care sector on the other end whereby this new third tier "Certified PCA" role is very much needed.

THE WHITE HOUSE

MCIL and a Coalition of Concerned Institutions and People can work with The White House on advocating for a Presidential Executive Order addressing the direct care worker shortage crisis across the United States, whereby millions of people with disabilities and older adults lack PCA/DSP support for living independently and are being re-institutionalized. MCIL and the Coalition can work with The White House on identifying actionable and scalable tools, policies, and commitments as identified in the *National Declaration for Strengthening Direct Care Services and Benefits for People with Disabilities and Older Adults*. The executive oversight of The White House can catalyze many of initiatives integral to addressing the direct care crisis for millions of people who rely upon PCAs and, in doing so, has potential to further transform our economy and advance the most noble of values we hold as sacred as a democracy – the ability of people to care for one another.

TENET-SPECIFIC POLICY

To meet the goals of tenet 1, we recommend that at the State level the program receive approval of the certificate program from the relevant State board of higher education. In Minnesota this would be the Office of Higher Education. Approval of the program will also be needed from the Minnesota

Department of Labor and Industry as a DTP program. The equivalent will be needed for other States to recognize the program within their State-supported apprenticeship structures.

At the nexus of the State and Federal level, ensure that certified PCAs benefit from State and Federal apprenticeship legislation going forward. For example, the National Apprenticeship Act of 2023[7] (H.R. 2851), which will expand the national apprenticeship system to create nearly 1 million opportunities for new apprenticeships, youth apprenticeships, and pre-apprenticeships and to promote the furtherance of labor standards necessary to safeguard the welfare of apprentices, and for other purposes. Additionally, the American Apprenticeship Act[8] (S.83) was introduced in the Senate in early 2023. This bill proposes to assist States in, and pay for the Federal share of the cost of, defraying the cost of pre-apprenticeships or related instruction associated with qualified apprenticeship programs, and for other purposes.

To meet the goals of tenet 2, we recommend paying PCAs a living wage, which begins with establishing a PCA rate framework. Other States can look to what Minnesota has accomplished with the PCA rate framework legislation that was passed into law in 2021. This approach links the certificate program with a statutory rate framework and competitive workforce factor as component values to create a market rate for the Certified PCA.

Federal policy efforts in this vein should begin with the White House establishing an Executive Order for strengthening the direct care services and benefits in response to the expanding workforce and infrastructure crisis we face. One substantive effort is a recently released CMS notice of proposed rulemaking called the Ensuring Access to Medicaid Services, or "Access" Rule, which has the goal of improving access to and quality of HCBS.[9,10] The Access Rule seeks to:

- Establish a new strategy for oversight, monitoring, quality assurance, and quality improvement for HCBS programs.
- Strengthen person-centered service planning and incident management systems in HCBS.
- Require States to establish grievance systems in FFS HCBS programs.
- Require that at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for the direct care workforce (as opposed to administrative overhead or profit).
- Require States to publish the average hourly rate paid to direct care workers delivering personal care, home health aide, and homemaker services.
- Require States to establish an advisory group for interested parties to advise and consult on provider payment rates and direct compensation for direct care workers.

[7] https://www.congress.gov/bill/118th-congress/house-bill/2851
[8] https://www.congress.gov/bill/118th-congress/senate-bill/83
[9] https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking
[10] https://www.federalregister.gov/d/2023-08959

- Require States to report on waiting lists in section 1915(c) waiver programs; service delivery timeliness for personal care, homemaker and home health aide services; and a standardized set of HCBS quality measures.
- Promote public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliance measures.

If finalized, the HCBS requirements in this proposed rule are intended to supersede and fully replace the reporting and performance expectations described in March 2014 guidance for section 1915(c) waiver programs. To ensure consistency and alignment across HCBS authorities, CMS proposes to apply the new HCBS requirements to section 1915(c) waiver programs and to section 1915(i), (j), and (k) state plan services, except where it is noted that a proposed requirement would only apply to certain services. In addition, except where noted, the proposed requirements would apply to services delivered through both FFS and managed care delivery services. Further, we clarify in the rule that, consistent with the applicability of other HCBS regulatory requirements to section 1115 demonstration projects, the proposed requirements for section 1915(c) waiver programs and section 1915(i), (j), and (k) state plan services would apply to these same services included in demonstration projects, unless we explicitly waive or make not applicable one or more of the requirements as part of the approval of the demonstration project.[8]

To meet the goals of tenet 3, we recommend establishing the PCAO through a combination of Federal and State funds intended to support the direct care workforce and apprenticeship programs. Advocate for ongoing funding from both grants and fees for services to support the development and administration of certification education, monitoring, and examination. Support the creation and development of continuing education opportunities for certificate holders and consider the development of levels of enhanced certification. Support data collection, analysis, and research to ensure that PAS may continue to follow evolving best practices and methodologies.

Provide for participation of a PCAO stakeholder in Federal advisory bodies such as the Federal Advisory Committee on Apprenticeship (ACA) to help advise the committee on inclusive apprenticeships and provide disability inclusive recommendations to the Secretary of Labor. Provide for participation of PCAO stakeholders in corresponding State bodies, such as the Minnesota Apprenticeship Advisory Board.

ACRONYMS

- Activities of Daily Living (ADL)
- Administration for Community Living (ACL)
- American Community Survey (ACS)
- Area Agencies on Aging (AAA)
- Centers for Independent Living (CIL)
- Centers for Medicare & Medicaid Services (CMS)
- Competitive Workforce Factor (CWF)
- Consumer-Directed Community Supports (CDCS)
- Consumer Directed Personal Assistance Services (CD-PAS)
- Council of State Governments (CSG)
- Direct Care Worker (DCW)
- Direct Service Professional (DSP)
- Disability Rights Movement (DRM)
- Disability Waiver Rates System (DWRS)

- Dual-Training Pipeline (DTP)
- Federal Medical Assistance Percentage (FMAP)
- Home and Community-Based Services (HCBS)
- Independent Living (IL)
- Instrumental Activities of Daily Living (IADL)
- Long Term Services and Supports (LTSS)
- Metropolitan Center for Independent Living (MCIL)
- National Council for Independent Living (NCIL)
- National Academies of Sciences, Engineering, and Medicine (NASEM)
- Notice of Proposed Rulemaking (NPRM)
- Office of Disability Employment Policy (ODEP)
- Paralyzed Veterans of America (PVA)
- People of Color (POC)
- Personal Assistant (PA)
- Personal Assistant Services (PAS)
- Personal Care Assistant/Aide (PCA)
- PCA Certificate Accreditation Organization (PCAO)
- Personal Support Worker (PSW)
- Public Use Microdata Sample (PUMS)
- Regional Variance Factor (RVF)
- Return on Investment (ROI)
- State Exchange on Employment & Disability (SEED)
- Universal Design for Learning (UDL)
- Work-Based Learning (WBL)

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