DIRECT SERVICE workforce

INDIANA DIRECT SERVICE WORKFORCE REPORT

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

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SCHOOL OF MEDICINE
BOWEN CENTER FOR HEALTH
WORKFORCE RESEARCH & POLICY

Developed by the Bowen Center for Health Workforce Research & Policy in partnership with the Family and Social Services Administration

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INTRODUCTION/BACKGROUND

In late 2020, Indiana's Family and Social Services Administration (FSSA) launched a multi-prong effort to enhance the provision of long-term services and supports (LTSS). One key component of this work is the development of a person-centered and statewide Direct Service Workforce Plan (Plan) to improve the recruitment, training, support, and retention of direct service workers in home and community-based services (a sub-sector of long-term services and supports).

The LTSS sector is a critical component of the health system that includes an array of health, health-related and social services focused on assisting and supporting the needs of individuals with disabilities or conditions of aging. LTSS are provided in a continuum of settings ranging from institutional to home and community-based[1] settings. Medicaid is the largest payer of LTSS, with more than $200 billion Medicaid dollars spent on LTSS in 2020 nationally (out of the total $400 billion spent).[2]

The backbone of the LTSS sector is a diverse workforce comprised of professionals, formal caregivers, and informal caregivers (family members and friends, many of whom are unpaid) who provide services and supports to their patients, clients, and loved ones. While much of LTSS are provided by informal caregivers, the formal paid workforce is crucial to ensuring the availability of services for many people. The foundation of this workforce comprises Direct Service Workers (DSWs; also frequently referred to as Direct Care Workers, Direct Support Professionals/DSPs, or Personal Care Aides), who are paid individuals that provide personal care and supportive services for people of all ages in institutional and community-based LTSS settings.[3] In one particular setting category, home and community-based settings, DSWs provide supportive services which enable people to live in their homes and communities as long as they may desire.

THE NATIONAL LANDSCAPE

Did You Know?

The population 65 years of age and above is projected to nearly double by 2060.

Demand for LTSS in the United States is expected to increase significantly in the coming years and decades as the population ages and a greater number of people require support for everyday personal care tasks.[4,5] The population 65 years of age and above is projected to nearly double by 2060, and the population over the age of 85 is projected to triple within that same time frame.[1,2] As the demand for LTSS increases, so too will the demand for DSWs. Between 2011 and 2021, the total number of healthcare support workers nearly doubled, and between 2021 and 2031 this workforce is projected to have the greatest number of new jobs compared to all other occupational groupings.[6,7] Increased demand for LTSS and Direct Service Workers is happening at a time where the number of working age adults is projected to be stagnate.[2] These demographic projections signal a looming crisis in which the growth of the aging population will outpace the growth of the Direct Service Workforce. The competition for the limited supply of Direct Service Workers is challenging today. In the future, it will be fierce.

Unfortunately, the United States LTSS sector has historically been plagued with workforce challenges, the foremost of which is the chronic shortage of Direct Service Workers.[8] Direct Service Worker jobs are relatively low wage as compared to other jobs of similar skill levels in other sectors.[9] Turnover of Direct Service Workers has been estimated to range from 40 to 60% nationally.[10] The factors contributing to these high turnover rates are long-documented, and include low wages, high physical demand, and limited opportunities for upward economic mobility. Additionally, the majority of these workers are women of color, many of whom serve as primary

1. Centers for Medicare and Medicaid Services. LTSS Overview. Available at: https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/ltss-ta-center/info/ltss-overview

2. 10 Things About Long-Term Services and Supports (LTSS). Kaiser Family Foundation. 2022. Available at: https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/#:~:text=Figure%203-,The%20U.S.%20Spent%20Over%20%24400%20Billion%20On%20LTSS%20In%202020,of%20all%20spending%20on%20LTSS.

3. U.S. Department of Labor definition of Direct Care Workers: https://www.dol.gov/agencies/whd/direct-care/workers#:~:text=Direct%20care%20workers%20are%20workers,aides%2C%20caregivers%2C%20and%20companions

4. Projected population growth by age group, 2015-2050 figure, accessible at https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf.

5. Projections of the Size and Composition of the U.S. Population: 2014 to 2060, accessible at: https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf

6. U.S. Bureau of Labor Statistics (BLS), Occupational Employment and Wage Statistics, OEWS Data. May 2011 & May 2021 National Level Data https://www.bls.gov/oes/tables.htm

7. News Release U.S. Bureau of Labor Statistics (BLS), Employment Projections- 2021-2031 (September 8, 2022). https://www.bls.gov/news.release/pdf/ecopro.pdf

8. Stone, Robyn, and Mary F. Harahan. "Improving the long-term care workforce serving older adults." Health Affairs 29.1 (2010): 109-115.

9. Competitive Disadvantage: Direct Care Wages are Lagging Behind. PHI. Available at: https://www.phinational.org/wp-content/uploads/2020/10/Competitive-Disadvantage-2020-PHI.pdf

10. PHI. Understanding the Direct Care Workforce. Available at: http://www.phinational.org/policy-research/key-facts-faq/#:~:text=PHI%27s%20literature%20reviews%20on%20this,this%20segment%20of%20home%20care.

breadwinners for their families.[11] According to the 2020 Staff Stability Survey, LTSS provider agencies in Indiana reported 42.2% of direct service workers being non-white. Comparatively, around 16% of Indiana's population identifies as non-white. At this stage of the COVID-19 public health emergency, workers who are reentering or relocating in the workforce are moving to similar skilled professions with higher wages than the Direct Service Workforce. [12]

Meeting LTSS needs, both now and in the future, demands strengthening the Direct Service Workforce. Strengthening this workforce requires the development of solutions focused on mitigating historical challenges and demands a transformation in the way society values these critical workers. While LTSS are delivered to individuals within communities by the hand of DSWs and other providers, states have a critical role in the LTSS sector through influencing related policies and programs such as Medicaid HCBS waivers and other programs. Like Indiana, states across the nation are currently refining their LTSS game plans, and the Direct Service Workforce is front and center in these initiatives.[13]

An Indiana LTSS Reform Key Result

"Create and implement a person-centered, statewide plan – the Indiana Direct Service Workforce Plan – to improve the recruitment, training, support, and retention of direct service workers in home and community-based settings."

INDIANA LEADING THE WAY

Anticipating increased demand for LTSS and recognizing the desire among Hoosiers to age in place with independence and dignity for as long as possible, Indiana is the first state that has prioritized the development of a Direct Service Workforce Plan for HCBS.[14] The purpose of this report and the associated Plan is to inform and align related policies and investments in a manner that encourages workforce recruitment and retention, ensures quality and safety of LTSS, and supports the well-being of the workforce and the individuals they serve. The development of the Plan and this report is in alignment with a FSSA Key Result (see above) developed as a part of related LTSS Reform initiatives.[15] The Plan was informed through assessment of the current state of the workforce, best practices research for state workforce strategies, and ongoing stakeholder engagement. The following document outlines additional information, research, and context to accompany the Indiana Direct Service Workforce Plan; however, it should be recognized that planning is a process not an end point. Ongoing evaluation and refinement of this Plan will be required to ensure the strategies remain relevant within a dynamic environment. At the time of publication of the Report and associated strategies, a number of strategies were already underway, including the following:

- **HCBS Spend Plan:** Over the last year, FSSA received input from a diverse array of stakeholders on the best ways to optimize one-time enhanced Federal Medical Assistance Percentage funds from the federal American Rescue Plan to improve Medicaid HCBS. Building on feedback from more than 660 stakeholders and in alignment with guidance from the federal Centers for Medicaid & Medicare Services, FSSA's HCBS Spend Plan outlines how FSSA is investing an estimated $817 million into the HCBS landscape, including workforce development, through March 2025.

11. https://www.phinational.org/wp-content/uploads/2020/01/Its-Time-to-Care-2020-PHI.pdf
12. https://www.phinational.org/resource/workforce-displacement-and-re-employment-during-the-covid-19-pandemic/
13. National Association of State Directors of Developmental Disabilities Services. State Workforce Initiatives, ARPA Spending Plan Topical Analysis. 2021. Available at: https://www.nasddds.org/wp-content/uploads/2021/09/NASDDDS-ARPA-Workforce-Topical-Analysis_September2021-publish.pdf
14. Other states have pursued strategic planning for some portion of the Direct Service Workforce, such as the Texas Community Attendant Workforce Development Strategic Plan. Available at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/rider-157-ca-workforce-dev-strat-plan-nov-2020.pdf
15. LTSS Reform Update MAC Meeting. Available at: https://www.in.gov/fssa/ompp/files/LTSS-Overview-MAC-Aug-22.pdf

- **HCBS Stabilization Grants**:[16] In January 2022, FSSA launched its HCBS Stabilization Grant initiative to recognize the critical efforts of frontline Medicaid HCBS staff and retroactively address COVID-19-related expenses including costs related to compensation and benefits, testing, personal protective equipment, and other COVID-19 related expenses incurred by Medicaid HCBS providers. FSSA awarded grants to 1,195 providers across the state. Due to the grant requirement that providers must pass through at least 75% of their grant award to DSWs, no less than $132 million in grant funds were directed to the HCBS workforce.

- **Direct Service Workforce Investment Grants**:[17] In November 2022, FSSA announced a Direct Service Workforce Investment Grant initiative to help eligible Medicaid HCBS providers invest in their DSWs through financial compensation (i.e., bonuses, hourly wage increases), wraparound benefits (e.g., financial support for transportation, child care, housing support, and tuition reimbursement or assistance) FSSA allocated $130 million for statewide investment with a requirement that 95% of grant awards pass through directly to DSWs. Grant awards will be a flat percentage of qualifying SFY 2022 claims expenditures for each provider and may not be used toward retroactive costs or replace existing funding or programs.

- **Other FSSA Investments**: FSSA is focused on targeted investments that promote provider capacity, enhancing HCBS and caregiver supports. Recent examples of these investments include the following:

  - *Division of Disability and Rehabilitative Innovation Pilot Grant*[18] – the Division of Disability and Rehabilitative Services will issue $50,000 Phase 1 development grants to HCBS waiver services providers, non-provider community entities, self-advocates and families interested in exploring innovative approaches to inform HCBS waiver redesign, among other topics. Phase 2 implementation funds will be based on providers' estimated implementation costs in their Innovation Pilot Plan

  - *HCBS Provider Readiness Grant*[19] – the Office of Medicaid Policy and Planning issued one-time $20,000 grants to Indiana Health Coverage Programs-approved LTSS providers to invest in HCBS provider preparations (e.g., trainings, readiness planning) and success in a managed care system in 2024.

  - *988/Crisis Response System Development*[20] – the national 988 Crisis and Suicide Lifeline went live in July 2022, providing FSSA with an opportunity to invest in a broader, statewide crisis response system using various federal funding sources, including American Rescue Plan Act dollars. Under the Division of Mental Health and Addiction, pilot projects are underway to inform the development of the full crisis response system over the next 7 to 10 years.

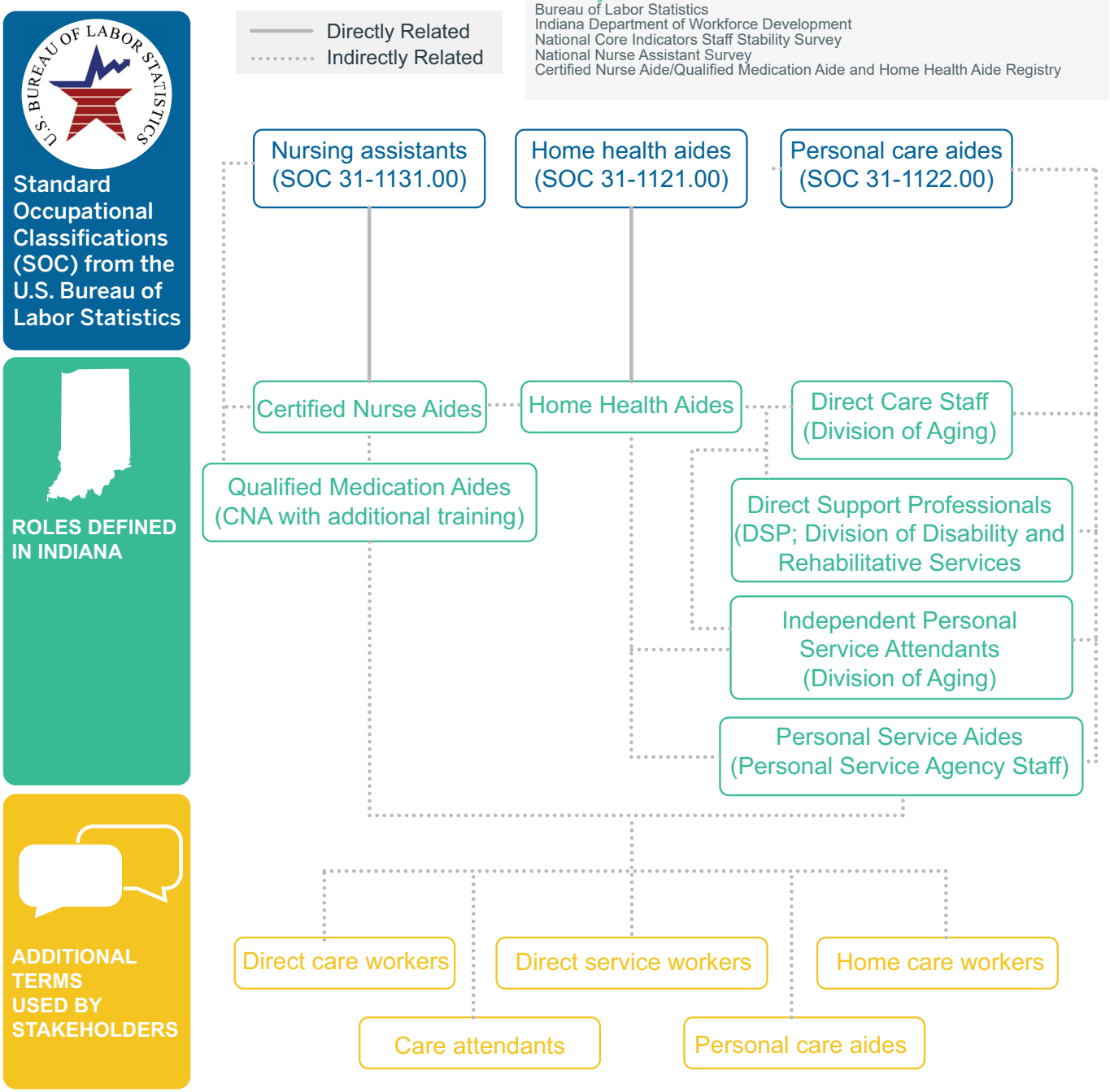
16. https://www.in.gov/fssa/ompp/files/HCBS-Stabilization-Impact-One-Pager.pdf
17. https://www.in.gov/fssa/ompp/files/Direct-Service-Workforce-Investment-Grant-FAQs-11.17.22v2.pdf
18. https://www.in.gov/fssa/ddrs/files/HCBS-Innovation-Pilot-Projects-application-period-now-open.pdf
19. https://www.in.gov/fssa/ompp/files/HCBS-Provider-Readiness-Grant-FAQ.pdf
20. https://secure.in.gov/fssa/dmha/update-on-988-in-indiana/

THE STATE OF INDIANA'S DIRECT SERVICE WORKFORCE

WHO ARE DIRECT SERVICE WORKERS?

At the time this Plan was developed, Indiana did not have a formal definition for Direct Service Workers. The specific occupations, roles, and titles that are to be considered part of this workforce vary based on the reference source. The federal Bureau of Labor Statistics (BLS) reports three occupations as Direct Service: Nursing Assistants (referred to in Indiana as Certified Nurse Aides, or CNAs), Home Health Aides (HHAs), and Personal Care Aides (PCAs). An in-depth investigation into Indiana's direct service workforce regulations identified seven distinct roles each with its own title. (Details of each of these roles and their sources/ references is presented in the Appendix). Review of research and discussions with stakeholders, both nationally and in Indiana, identified other terms used to reference this workforce. This plethora of terms contributes to lack of clarity and inconsistencies across HCBS initiatives and within the workforce itself. The lack of a standard definition and clear professional title(s) is a top tier challenge. Absent national guidance, it falls to states to clearly define this workforce and differentiate between professional roles in regulation and in practice.

Inventory of Indiana Direct Service Workforce Data Sources
Bureau of Labor Statistics
Indiana Department of Workforce Development
National Core Indicators Staff Stability Survey
National Nurse Assistant Survey
Certified Nurse Aide/Qualified Medication Aide and Home Health Aide Registry



Identification and exploration of the seven Direct Service Workforce roles in Indiana highlighted key differences among them, most notably is that regulations and related provisions are divided between two state agencies. FSSA has provisions related to DSPs, Direct Care Staff, and Independent Personal Services Attendants. The Indiana Department of Health (IDOH) has provisions related to Certified Nurse Aide, Qualified Medication Aides, Home Health Aides, and Personal Services Aides.

Another notable difference between roles is that some are governed by federal regulations. Certified Nurse Aides and Home Health Aides are federally defined with clear provisions regarding training, regulation, and scope of services for these roles[21] While there are federal standards for these aides, states have flexibility to develop and implement provisions related to training, regulation, and scope of services for the remaining roles.[22] A review of state regulations associated with these roles identified significant variations in the provisions related to training and scope of services. These variations likely stem from the siloed development of individual LTSS policies to address emerging, unique needs of Hoosiers , which evolved as separate but important initiatives over many years. Unfortunately, a lack of coordination between these initiatives has resulted in inconsistencies across Indiana's Direct Service Workforce. **A strategic opportunity exists to consider coordination and streamlining across direct service roles, especially those that are not federally defined, through the development of a standardized definition for direct service roles alongside standardized training.**

WHAT DO WE KNOW ABOUT THE DIRECT SERVICE WORKFORCE?

Information on the labor dynamics and characteristics of Indiana's Direct Service Workforce is critical to identify gaps and allocate resources. A workforce assessment was prepared as part of Indiana's Direct Service Workforce State Plan.[23] This assessment explored existing sources of information on Indiana's direct service workforce, as well as targeted information on Indiana's population and other LTSS data and developed a working strategy for ranking Indiana counties based on current demand for Direct Service workers and resources (such as total bed capacity in residential care facility).

An inventory of existing data sources was developed as part of the workforce assessment (see text box to the right). This inventory identified several sources of information, each varying in the type, completeness, and representation. Unfortunately, none of the existing sources of data are inclusive of all Indiana Direct Service Worker roles, nor do any of the sources provide a complete view of the demographic, socioeconomic, and employment characteristics of this workforce. Based on the data available through the Indiana Department of Workforce Development, as of 2020 there were approximately 68,000 individuals employed in jobs classified as Direct Service with 5,532 unfilled positions.[24] Between 2020 and 2030, the state projects at least 14,000 new Direct Service jobs will be required to meet the growing demand described above. This means Indiana is anticipating a 20% increase in the total number of Direct Service jobs needed to support LTSS in the state.

Inventory of Indiana Direct Service Workforce Data Sources

Bureau of Labor Statistics

Indiana Department of Workforce Development

National Core Indicators Staff Stability Survey

National Nurse Assistant Survey

Certified Nurse Aide/Qualified Medication Aide and Home Health Aide Registry

Unfortunately, there is little to no information available on the demographic, social, and professional characteristics of Indiana's Direct Service Workforce. Based on national reports, this workforce is largely comprised of women and people of color. National data also suggest relatively high utilization rates of public benefits (such as Medicaid or the Supplemental Nutrition Assistance Program)among these workers. State level survey data, collected from LTSS provider respondents that serve adults with intellectual and developmental disabilities through the National Core Indicators Intellectual and Developmental Disabilities 2020 Staff Stability Survey Report, sheds some light on the demographic and employment characteristics of Indiana's Direct Service Workforce.[25] The most recently reported data (2020), cites that approximately 58% of direct service workers employed by

21. It is important to note that these provisions set the regulatory "floor." States have flexibility to build upon federal requirements. Indiana has done so with the state's training provisions for Certified Nurse Aides/Qualified Medication Aides.
22. Indiana Direct Service Workforce Regulatory Review available upon request.
23. Complete Indiana Direct Service Workforce Needs Assessment available upon request.
24. https://www.indianacareerready.com/Indemandjobs
25. 2019 National Core Indictors Staff Stability Survey accessible at: https://www.in.gov/fssa/ddrs/files/2019-Staff-Stability-Survey-Report.pdf

respondent providers identified as white.[26] Indiana's overall population is approximately 84% white. While it is not clear whether these data are representative of the state's overall workforce, this information indicates likely overrepresentation of non-white individuals in Indiana's Direct Service Workforce. As of 2019, 71.4% of these providers reported offering health insurance for full-time workers, but these same providers reported that only 57% of their workers are employed full-time. These data are limited in representation but highlight the dearth of workforce data beyond wage and employment rates. Moving forward, to understand and support development of direct service workers, Indiana will employ a cohesive approach to collecting and reporting more robust information.

Knowing the workforce also requires an adequate understanding of the populations that rely on their person-centered service and support. Unfortunately, little information is available on the populations that utilize LTSS outside of individuals that are Medicaid-enrolled. After exploring the existing data sources and their limitations, the workforce needs assessment framework designed for this Plan utilized employment data and information on other LTSS resources that were available at the county-level. Population data included general counts of working age and older adults, as well as those with disabilities as a proxy for need for assistance with activities of daily living (e.g., eating, bathing, dressing). These data sources were sufficient for calculating workforce capacity and demand. However, no evaluation of providers or populations participating in specific LTSS programs could be conducted.

As Indiana prepares to implement its Direct Service Workforce Plan, measurable information that is comprehensive and timely will be required to inform and guide initiatives. Existing data sources on the Direct Service Workforce shed light on the current state of the Direct Service Workforce, but strategies are needed to ensure Indiana has more robustinformation that is needed to keep a finger on the pulse of the workforce moving forward.

Direct Service Workforce Strategies

To support the development of the Indiana Direct Service Workforce Plan, a compendium of state strategies to support the Direct Service Workforce was prepared.[27] This compendium included more than 20 strategies, identified through review and research into state-level approaches/initiatives and organized into six "bucket areas:" Recruitment, Training & Regulation, Wages & Benefits, Retention & Career Development, Workforce Data & Tracking, Social & Other Supports.

Stakeholders were engaged to review these strategies and provide insight and guidance on other strategies that may be needed for Indiana's Direct Service Workforce. Stakeholder engagement occurred in multiple forms and forums. Stakeholders included Direct Service Workers, LTSS providers, consumers, consumer advocates, and state government entities. Stakeholders provided fedback and input on the benefits and challenges of specific strategies. Ultimately, stakeholders assisted in prioritization of the areas to be addressed in Indiana's Direct Service Workforce Plan.[28]

The Indiana Direct Service Workforce Plan has been informed by findings on the state of workforce, results from the research and review of state strategies, and, most importantly, the input of stakeholders. The Plan includes three primary Action Areas, each with associated recommendations:

- **Wages and Benefits**
- **Training and Pathways**
- **Promotion and Planning**

Background, rationale, potential solutions, associated state examples, and Indiana-specific recommendations are presented below for each of the Action Areas. As mentioned previously, planning is a process, not an end state. The contents of this document serve as an important first step.

26. 2020 National Core Indicators Staff Stability Survey accessible at: https://www.ncilegacy.com/upload/core-indicators/2020StaffStabilitySurveyReport_FINAL.pdf
27. State Strategies for Direct Service Workforce Compendium available upon request.
28. A summary of the Indiana Direct Service Workforce Plan Strategy Session is available upon request.

Table 1. Stategies to Support Indiana Direct Service Workers

Strategies to Support Indiana Direct Service Workers	
Activities	**Goals**
Action Area: Wages & Benefits Short-term: Provide HCBS grant opportunities to support DSWs. Mid-term: Monitor direct service workforce measures through implementation of the Staff Stability Survey. Initiate new rate setting methodologies for LTSS in 2023. Long-term: Establish a Wages and Benefits Action Group. Develop expanded self-directed service options across HCBS programs. Address benefits cliffs.	Increase the number of DSW by providing support through enhanced wages and benefits through strategic investment in Medicaid reimbursement.
Action Area: Training & Pathways Short-term: Explore development and implementation of a standard definition of “direct service worker” and related responsibilities and requirements. Mid-term: Form career and education ladders for DSWs. Explore development of a web-based registry of DSW credentials. Long-term: Design training opportunities that included minimum curriculum for DSWs as well as more specialized trainings.	Help guide the establishment of a minimum statewide standard training that would allow for portability for workers who move between providers or for those who hold several part-time positions. A training standard would create efficiencies, uniform values, principles and quality standards, and reduce the administration and financial burden for providers.
Action Area: Promotion & Planning Short-term: Capture information that is critical to direct service workforce planning from DSWs that maintain a state certification. Mid-term: Form a Data Action Group to gain a better understanding of the Direct Service Workforce. Form a Marketing Action Group to explore opportunities to raise awareness of direct service opportunities. Long-term: Develop a DSW Hub website to house information on Indiana’s Direct Service Workforce.	Increase general awareness of the DSW career paths and increase available data to understand the composition of the workforce.

ACTION AREA: WAGES AND BENEFITS

The Challenge

Low wages and poor benefits are consistently among the top issues impacting direct service workers in Indiana and nationally,[29] and, with stiff competition from higher paying jobs at similar training levels, wage issues are arguably the greatest barrier to workforce recruitment and retention. Stakeholders prioritized wages and benefits strategies as the most important strategies to outline in the Indiana Direct Service Workforce Plan.

As of 2021, Indiana median wages for CNAs ($14.28 per hour[30]) and HHAs/PCAs ($11.57 per hour[31],[32]) are less than the national median wages for these occupations ($14.57 and $14.15 respectively) and less than Indiana living wage estimates[33] (or the calculated hourly rate that an individual must earn to support themself and their family). In addition to relatively low wages, these workers are less likely to have access to employer-offered benefits in comparison to other occupation types and are more likely to qualify for and utilize public assistance.[34,35]

Direct Service Workforce Wages & Benefits FACTS

- **Median hourly wage for nursing assistants is $14.28 and $11.57 for HHAs and PCAs in Indiana [30, 32]**
- **Nationally, over half (56.5%) receive some form of public assistance[1]**
- **Nationally, 84.4% of workers report having no employer-sponsored retirement benefit[1]**

https://www.onetonline.org/link/localwages/31-1122.00?st=IN

1. LeadingAge. Making Care Work Pay: How Paying at Least a Living Wage to Direct Care Workers Could Benefit Care Recipients, Workers, and Communities. 2020. https://www.ltsscenter.org/wp-content/uploads/2020/09/Making-Care-Work-Pay-Report-FINAL.pdf

Recent data has shown that while benefits are available to direct service workers in Indiana, accessing them from their employers can have several obstacles. For instance, the 2020 National Core Indicator-Intellectual/Developmental Disabilities Staff Stability Survey[36] results found that while 85.9% of Indiana provider agencies offer paid time off benefits to their workers, only 74.7% offer health insurance (compared to 79% of workers overall in health care and social assistance jobs[37]). Among those providers offering health insurance, most (71.4%) only offer health insurance to full-time employees and over half (60.3%) require direct service professionals to have been employed a minimum amount of time in order to access health insurance. Additionally, strategies focused on recruitment may have an unintended adverse impact on worker retention. For example, in an environment with pervasive workforce shortages and employers competing for existing workforce supply, recruitment bonuses can contribute to job hopping. Another contributing factor is that although the majority of Indiana direct service provider agencies offer health insurance (74.7%), most also report requiring employment associated waiting periods prior to eligibility to access health insurance benefit (60.3%).[38] With waiting periods for benefits, workers may prefer to transition between employers to obtain pay increases through bonuses. It is important to note the limitations of the Staff Stability Survey findings when seeking to understand the Direct Service Workforce as a whole; current survey results are only available for workers serving populations with intellectual or developmental disabilities and are skewed toward representing workers employed by provider agencies though representation of provider agencies is likely limited.

29. PHI. Direct Care Worker Disparities: Key Trends and Challenges. 2022. http://www.phinational.org/wp-content/uploads/2022/02/Direct-Care-Worker-Disparities-2022-PHI.pdf
30. https://www.onetonline.org/link/localwages/31-1131.00?st=IN
31. https://www.onetonline.org/link/localwages/31-1121.00?st=IN
32. https://www.onetonline.org/link/localwages/31-1122.00?st=IN
33. MIT Living Wage Calculator, Indiana. Available at: https://livingwage.mit.edu/states/18
34. PHI. Direct Care Worker Disparities: Key Trends and Challenges. 2022. http://www.phinational.org/wp-content/uploads/2022/02/Direct-Care-Worker-Disparities-2022-PHI.pdf
35. https://leadingage.org/sites/default/files/Making%20Care%20Work%20Pay%20Report.pdf
36. 2020 Staff Stability Survey Report. Available at: https://www.ncilegacy.com/upload/core-indicators/2020StaffStabilitySurveyReport_FINAL.pdf
37. U.S. Department of Labor, Bureau of Labor Statistics. Employee Benefits in the United States, Table 2. March 2022. Available at: https://www.bls.gov/news.release/pdf/ebs2.pdf
38. 2020 Staff Stability Survey Report. Available at: https://www.ncilegacy.com/upload/core-indicators/2020StaffStabilitySurveyReport_FINAL.pdf

Possible Solutions

Low wages and poor benefits for direct service workers are national challenges, not just in Indiana This is an issue that has been identified broadly across all states and all are seeking to find suitable, sustainable solutions. In fact, 47 states planned to implement some form of action to address worker wages or provide incentives in state American Rescue Plan Act (ARPA) spend plans.[39] In general, wage/benefit support for workers followed one of two approaches: 1) temporary or one-time supplemental payments to direct service workers or 2) kickstart investments in longer-term solutions such as rate studies or adjustments to better support direct service worker wages and benefits.

Temporary or One-time Supplemental Payments

Persistent Direct Service Workforce challenges have been underscored during the COVID-19 public health emergency. Many facilities and providers needed quick acting compensation solutions to support recruitment and retention of workers. The most common use of federal ARPA funds to support direct service workers was temporary wage strategies in the form of one-time wage or benefit pass-throughs to workers. Such strategies were implemented in 46 states.[40] Implementation of these strategies varied significantly by state. Some states, such as Maine[41] and Kansas[42] implemented a one-time bonus per direct care worker. Other states, such as Illinois and Colorado, used ARPA funds to support a rate increase that was directed to direct service workers. For example, Illinois[43] increased the hourly rate for DSPs by $1.50 and Colorado[44] increased rates to providers to support implementation of a minimum wage for home care workers of $15 per hour. Other states, such as Nevada[45], structured some portion of one-time payments as a retention bonus or hazard payments, directed only to home care workers. Different still, Utah[46] implemented a value-based strategy whereby providers received a 5% rate increase of the total amount each provider was reimbursed for claims paid in the previous quarter (excluding any denied claims).

Indiana used a portion of ARPA funding to implement a temporary payment strategy to providers to support direct service workers in the form of two rounds of payments, known as the Home & Community-Based Services Provider Stabilization Grants.[47] Providers were required to pass on 75% of these funds directly to the workforce, resulting in $73 million of funds being directed to the workforce. Providers were required to submit attestation forms in order to qualify for the payments. In total, $176 million was allocated through the Provider Stabilization Grants, $132 million of which was to be passed on directly to frontline HCBS staff.[48] Surveys were conducted to determine the impact of these Grants, and 80,000 to 100,000 individuals are estimated to have been impacted by the funding. Providers had substantial flexibility on implementation to allocate funding on workforce in the manner they saw fit (in compliance with requirements that 75% of the funding be used for this purpose). As noted through qualitative feedback provided by the Indiana Direct Service Worker Advisory Board, the specific implementation approach for the use of these funds varied significantly, making it challenging to assess the impact it had on the Direct Service Workforce as a whole. FSSA noted that concerns and questions were shared by Direct Service Workforce Advisory Board members. For example, one Direct Service Worker reported that they did not receive any of the bonus payments, as they were a full-time weekday worker and funds were spent incentivizing staff to pick up weekend night shifts.

Long-term Wage or Other Compensation Solutions

While one-time payment strategies may be used to respond to an acute crisis, due to the nature of these strategies and associated funding (term-limited), additional strategies will be required to meet longer-term wage and benefit issues for direct service workers. Recognizing this, some states, such as North Carolina,[49] used ARPA funds as a capital investment in direct care worker wage

39. National Association of State Directors of Developmental Disabilities Services. State Workforce Initiatives, ARPA Spending Plan Topical Analysis. 2021. Available at: https://www.nasddds.org/wp-content/uploads/2021/09/NASDDDS-ARPA-Workforce-Topical-Analysis_September2021-publish.pdf
40. The American Rescue Plan and the Need to Strengthen Home Care: How States Are Using ARPA. Available at: https://www.newamerica.org/new-practice-lab/reports/the-american-rescue-plan-and-the-need-to-strengthen-the-home-care-workforce/iv-how-states-are-using-arpa/
41. State of Maine Initial Plan for Implementation of American Rescue Plan Act of 2021, Section 9817
42. Kansas Workforce Incentive Program
43. Illinois Initial Spending Plan and Narrative for Enhanced Funding under the American Rescue Plan Act of 2021
44. COLORADO HOME AND COMMUNITY-BASED SERVICES (HCBS) AMERICAN RESCUE PLAN ACT BASE WAGE RATE INCREASE
45. Nevada Initial ARPA Enhanced Spending Plan
46. Utah Enhanced Spending Plan
47. Indiana Family and Social Services Administration. Home & Community-Based Services Stabilization Grant. 2022. Available at: https://www.in.gov/fssa/ompp/files/HCBS-Stabil-Grants-MAC-Feb.22.pdf
48. https://www.in.gov/fssa/ompp/hcbs-enhanced-fmap-spending-plan/
49. https://medicaid.ncdhhs.gov/media/9910/open

increases, while working with the state Legislature on long-term strategies for sustainability. Other states have used ARPA funds to support conducting a rate study to inform modified rates for LTSS to support and sustain increases in direct service worker compensation. For example, Arizona[50] dedicated ARPA funds to complete a rate study for HCBS and behavioral health outpatient services, with plans to conduct an annual scan on reimbursement rates throughout the APRA funding period. Similarly, Kentucky is conducting a comprehensive study of the services and rates within all HCBS waiver programming to support equality across all services and populations.[51]

With respect to reimbursement rates methodology, some states have codified the various components that are used to update rates. For some LTSS, the direct service worker labor rate is the core element and largest funding requirement for service provision. In Minnesota, calculation components of the LTSS payment rate are codified.[52]

Some of Indiana's fee schedule rates for LTSS have been updated more recently (such as Medicaid HCBS waivers under the Division of Aging which were updated in early 2020). However, other LTSS fee schedules have only seen temporary recent rate actions which were approved by the Legislature to respond acutely to the post-COVID wage environment. In recent meetings with stakeholders, it was identified that there are variations in labor rates (and therefore wages and benefits) across service types despite similar experiences, credentials, and skills among the workers providing the various services.[53] For example, within the Assisted Living Rate (Level 2), attendant care services are based on a $4.40 labor cost whereas homemaker services are based on a $3.66 labor cost. Additionally, current rates for the Division of Aging Medicaid HCBS waiver were set using wage data for personal care aides and home health aides with provisions for 4% inflation.[54] Unfortunately this methodology did not account for the significant inflation that was experienced as a result of the COVID-19 public health emergency, and, due to the use of a single data point of median wage, this methodology does not allow for any competitive factor associated with wages of occupations in other sectors, settings, or occupations with similar levels of training.

In an effort to address direct service worker wage issues, in the 2021 Budget Bill, the Indiana legislature included a code modification to account for a 14% rate increase for DSPs providing services for Division of Disability and Rehabilitative Services' Family Supports Waiver (FSW) and Community Integration and Habilitation (CIH) Medicaid waivers. The Bill mandated that 95% of the increase be used to cover payroll tax liabilities and increase wages and benefits paid to hourly direct care staff.[55] The language also included a requirement for providers to submit their spend plan for use of the rate increase, and to maintain documentation of the use of funds for audit (and potential fund recoupment if non-compliance occurs). While important, this strategy may not have impacted all direct service workers in all settings, as some facility-based settings were excluded (such as skilled nursing facilities) and only workers providing FSW and CIH waiver services were included. (Relatedly, to minimize impact on individuals and families that could unintentionally result from the rate increase, the annual cap on the FSW annual budgets was also increased from $17,300 to $19,614[56]). As the demand for workers increases in the LTSS sector and the economy overall, it will be critical for rates to be structured in a way that supports a competitive wage for direct service workers.

50. https://www.medicaid.gov/media/file/az-arpa-hcbs-spending-plan.pdf

51. Kentucky Division of Long-term Services and Supports. Improving Home- and Community-Based Services. Available at: https://www.chfs.ky.gov/agencies/dms/dca/Pages/arpa.aspx
https://www.chfs.ky.gov/agencies/dms/dca/Documents/ARPAupdate1.pdf
https://www.chfs.ky.gov/agencies/dms/dca/Documents/RateStudyProviderBrief.pdf https://www.youtube.com/playlist?list=PLKd8Ibu6xnqHPwjkoyz9XpEHYIOUb1FbA

52. https://www.revisor.mn.gov/statutes/cite/256R/full#stat.256R.23

53. Medicaid Home Health and HCBS Reimbursement Stakeholder Meeting #2, Slide 11 and 20. July 2021. Available at: https://www.in.gov/fssa/long-term-services-and-supports-reform/files/070121-HH-HCBS-LTSS-Stakeholder-Presentation-vF-1-FINAL-ua.pdf

54. Medicaid Home Health and HCBS Reimbursement Stakeholder Meeting #2, Slide 25. July 2021. Available at: https://www.in.gov/fssa/long-term-services-and-supports-reform/files/070121-HH-HCBS-LTSS-Stakeholder-Presentation-vF-1-FINAL-ua.pdf

55. Indiana State Budget Bill 2021. Available at: https://www.in.gov/sba/files/HB1001-Final.pdf (p.168-170)
IC 12-15-1.3-18. Available at: http://iga.in.gov/legislative/laws/2022/ic/titles/012#12-15-1.3-18
https://www.in.gov/fssa/ddrs/files/Rate-Increase-Implementation-RequirementsCORRECTION.pdf https://www.in.gov/fssa/ddrs/files/Provider-Rate-Increase-Implementation-Plan-FAQs-11.17.21.pdf https://www.in.gov/fssa/ddrs/files/DSP-wage-verification-schedule-spreadsheet-directions.pdf

56. https://www.in.gov/fssa/ddrs/files/Pro-direct-sup-prof-rate-increase-FSW-cap-increase.pdf

Table 2 Wages and Benefits: Challenges & Opprotunity

The Challenge	The Opportunity
• Low hourly wage • No competitive advantage over other sectors • Less likelihood of employer-sponsored benefits or benefits with stipulations • Reimbursement rates not coordinated across LTSS programs	• HCBS grant opportunities • Staff Stability Survey • HCBS Rate Methodology • Wages and Benefits Action Group • Self-Directed Options • Addressing Benefits Cliffs

What Can Be Done in Indiana?

Short-term Strategies

HCBS grant opportunities. As a bridge to completion and implementation of HCBS rate-setting work, FSSA announced Workforce Investment Grants in November 2022. This $130 million grant opportunity is available only to HCBS providers that employ DSWs. In response to feedback received from DSW during focus groups, 95% of the funding must go directly to the DSWs. The purpose of the grant is to support HCBS providers to invest in their Direct Service Workforce through recruitment and retention efforts, financial compensation, and wraparound benefits. At least 95 percent of the funding will be required to go directly to the DSWs. Three rounds of Workforce Investment Grants will be issued beginning in January 2023. This builds from $176 million in HCBS Provider Stabilization Grants awarded in February 2022 that impacted an estimated 80,000 to 100,000 individuals employed by HCBS providers.

Considerations:

- Meets intended purpose. Ensure funding is provided directly to direct service workers, in a format that is valued by the worker.
- Implementation enables evaluation. Structure funding allocations in a manner that enables state assessment of the direct impact of funding.
- Advancing equity. Ensure funding is distributed in a manner that is equitable to direct service workers.
- Reduce unintended consequences. Ensure care is taken to minimize any unintended consequences that might be associated with increased wages, such as loss of income-based public benefits.

Mid-term Strategies

Staff Stability Survey. To collect data on the workforce that is providing direct service to individuals enrolled in the Medicaid Aged and Disabled Waiver, FSSA participated as one in five states in the pilot National Core Indicators Staff Stability Survey. The findings, expected in early 2023, will help to inform LTSS policy and innovation across the state. This initiative follows and builds on the longstanding participation of the Division of Disability and Rehabilitative Services in the National Core Indicators Intellectual and Developmental Disabilities Survey in its efforts to understand the landscape in Indiana regarding turnover, wages, and benefits as compared to other states and to inform future policy and plans. The LTSS rate study is advancing with stakeholders to initiate new rate setting methodologies in 2023 that comply with the Centers for Medicare and Medicaid Services rules and achieve alignment, sustainability, promote person-centeredness and value-based purchasing and reduce disparities.

HCBS Rate Methodology. FSSA continues to build on the work from the 2021 state budget bill that provided a 14% rate increase for professionals providing services through the Medicaid Family Supports Waiver and the Community Integration Habilitation Waiver. The LTSS rate study is advancing with stakeholders to initiate new rate setting methodologies in 2023 that comply with the federal Centers for Medicare and Medicaid Services rules and achieve alignment, sustainability, promote person-centeredness and value-based purchasing, and reduce disparities.

Considerations:

- Competitive advantage. It is recognized that direct service worker wages are currently insufficient to offer direct service employers with a market advantage compared to competition from other sectors. Therefore, labor market factors incorporated within rates should not simply reflect current wages, but rather should be structured to ensure wages are competitive with other employers or sectors.
- Alignment across Medicaid programming. Direct service workers commonly serve various clients across various settings. To support economic opportunity of these professionals and sector retention, rate modifications should be aligned across payer types and between services.
- Consider tiered rate structuring. To support workforce development opportunities for direct service workers within LTSS, tiered reimbursement structures should be explored and perhaps developed in alignment with micro- and macro-credential pathway studies conducted by the “Training & Pathways” Action Group.
- Determine appropriate rate study frequency. Although major changes are currently required for rate adjustments, a mechanism for routine rate adjustments should be considered to ensure rates continue to remain relevant.
- Transparency for rate calculations. Rate calculations should be transparent to encourage understanding and confidence in the process and methodology, potentially considering opportunities to include rate calculations in publicly accessible formats such as through state code, rules, or other public-facing governmental documents.
- Consider potential unintended consequences. Labor rates for direct service workers should take into consideration the “Benefits Cliff” that may exist within various accessible benefits.
- Explore transportation support. Reimbursements related to transportation (or services that may require transportation) should be structured in a manner that support clients’ needs (including medical and social needs), ensures reasonable reimbursements are provided directly to transporters (in many cases, direct service workers), and ensures rates are dynamic and sufficient to account for changes or flexibility required for transportation-related costs (e.g. gas costs, distances for rural clients or long-distance trips, public transportation, etc.).

Long-term Strategies

Wages and Benefits Action Group. FSSA will establish a Wages and Benefits Action Group to explore strategies to address employment-related costs, benefits and value-based incentives.

Considerations:

- Miscellaneous employment-related costs. Exploring strategies to address other miscellaneous job-related expenses borne by direct service workers (such as use of personal mobile devices and other social supports such as transportation and childcare)
- Value-based incentives. Determining what, if any, value-based incentives could or should be provided to respond to workforce measures that support network adequacy, quality, and worker satisfaction.
- Addressing benefits. Exploring strategies to support direct service workers' access to health insurance and other benefits
- Including DSWs. As the workers themselves are one of the primary audiences of strategies within this action area, engaging DSWs in the conversation will be critical to the development and implementation of effective strategies.

Self-Directed Options. FSSA will develop expanded self-directed service options across FSSA's Medicaid HCBS programs to expand the pool of qualified DSWs and diversify opportunities.

Addressing Benefits Cliffs. To address the high prevalence of DSWs who must rely on public benefits, FSSA would like to better understand where "cliffs" exist. Simply stated, FSSA wants to learn more about how wage increases may impact financial eligibility criteria for certain benefits.

The Challenge

The Direct Service Workforce in Indiana includes a variety of role types, working in various settings, and providing numerous different services. For some direct service roles, such as CNAs as well as HHAs working for federally-licensed agencies, the roles and associated training requirements are clearly outlined by federal provisions, which are then enforced by state authorities. For other direct service roles, such as DSPs and direct care staff, role definition and training requirements are less clear. In fact, training requirements are often left to the interpretation and implementation responsibility of the employer. (Review the regulatory review findings in the Introduction and Appendix A to learn more about the current variations in direct service roles, entry/training requirements, and allowable tasks presented by direct service worker type). Stakeholders reported a lack of clarity or role definition for direct service workers as one of the top issues impacting the Direct Service Workforce and likely one of the issues impacting both worker recruitment and worker satisfaction.

Variations in entry requirements for direct service worker roles means there is no standard portable credential that can be achieved by most workers. This contributes to a lack of mobility of workers between employers or roles. For example, in Indiana, a DSP providing care to an individual who is covered under a Medicaid HCBS waiver likely receives direct training from their agency employer to provide assistance with activities of daily living and other services as well as for certain health-related services (health-related training is conducted by a registered nurse or health care professional). However, if that worker chooses to seek employment providing similar services through non-waiver provider agency, they will first need to complete Core A and B training.

In addition to wide variations in training requirements across direct service roles or perhaps because of these variations, there is a lack of clear opportunity for growth or advancement within direct service roles or in other roles in the LTSS sector. Currently, there are no formally defined relationships between the direct service roles. Additionally, outside of a bridge program developed by Ivy Tech Community College to provide CNAs with credit hours toward a pre-nursing certificate, no known bridge program exists from direct service roles to other education or training.

Key Terms

Training Requirement: Defined by PHI as "A set of regulations that specifies training content and/or duration mandated for certification or employment in a specified occupation. In addition to content and duration, requirements may include instructor qualifications, competency assessment, portability of credentials, continuing education, and additional elements."

Portability: Defined by PHI as "The degree to which a training experience, credential, or certification in one occupation or role, care setting, or geographic region can be applied toward qualification and employment in the same role in another care setting or geographic region."

Mobility: The application of portable credentials to minimize additional training or onboarding necessary to move between similar roles.

Stackable Credentials: (Modified from PHI definition) Training experience, credential, or certification in one occupation or role can be applied toward training requirements, qualification, and employment in a different—typically higher-level—occupation or role. Both micro- and macro-credentials can be made stackable.

Micro-credentials: Targeted education or training that is generally short in duration and is focused on a specific topic. Micro-credentials generally result in digital badges or certifications.

Macro-credentials: Broad based qualifications that can be shown through a degree or a certification, typically from one level of education or training to another. In contrast to micro-credentials, macro-credentials are typically credit-yielding in higher education settings, or represent large "rungs" on a career ladder.

Certain key terms referenced above are presented as or modified from definitions outlined in the PHI report "Caring for the Future: The Power and Potential of America's Direct Care Workforce" available at: https://www.phinational.org/resource/caring-for-the-future-the-power-and-potential-of-americas-direct-care-workforce/

These direct service workforce issues are not unique to Indiana. It is widely known that training requirements vary across the nation among direct service roles, both federally regulated and those left to the discretion of the state. For example, although federal minimum training requirements are established for CNAs, many states choose to go above and beyond those federal minimums (Indiana included).[57] The state-by-state variation is even more substantial among non-federally regulated roles such as personal care aides (or similar roles). Most commonly among these roles, states either do not have training requirements or the requirements are inconsistent across payer programs, settings, or employers.[58] However, more commonly than not, states have siloed requirements for direct service workers under some types of Medicaid programs or in some settings, and frequently a lack of coordination across the training requirements in place across all direct service worker roles. States are grappling with the balance between ensuring training is aligned to meet minimum state standards while accounting for person-centered training, addressing a severe direct service workforce shortage, and responding to researchers' recommendations to increase entry training requirements.[59]

Although data directly from Indiana's direct service workers are limited, we can look to other national sources and feedback from stakeholders to better understand workers' needs. Related to education and training, workers report desiring more training[60] and the general public believes workers would benefit from more training.[61]

Training represents only one of the entry requirements to become a direct service worker. Other entry requirements may include minimum age and a criminal background check to ensure no criminal prohibitions exist. Similar to the variations found among direct service worker training requirements, there are wide variations in other entry requirements across the direct service roles. Additionally, although criminal background checks are important, they only cite certain civil or criminal findings. There may be other employment-related incidents that have occurred that should be considered prior to employment that would not be identified on a criminal background check. Some direct service worker roles have a process for reporting, investigation, and making a final determination of alleged incidents and the impact on the individual worker, such as CNAs working in long-term care facilities.[62] However, most direct service workers in other roles or settings do not have a formal process that can be easily linked to an individual and queried. The FSSA Intellectual & Developmental Disabilities Task Force (the "1102 Task Force") convened a sub-committee in June 2022 to explore opportunities related to incident reporting and develop recommendations, which were adopted by the Task Force in August 2022 and shared with legislative council (more details on this Task Force are available in subsequent sections).

Types of Registries for Direct Service Workers

Qualified Worker Registry: A registry that only contains workers that have met certain criteria (generally training, background check, etc.). These registries support the public by "vetting" workers qualifications and eligibility.

Adverse Action Registry: A registry that contains only those workers that have been involved in a substantiated negative incident. These registries protect the public from "bad actors."

Combination Registry: These registries both require certain entry requirements (such as training or background check) and have processes in place to add a negative "Finding" or other indication of adverse actions if appropriate.

Possible Solutions

Clear Definition of Direct Service Roles

It is well known that direct service workers provide a variety of services and serve in many settings. Without resulting in a reduction of services provided, some states have organized their direct service workforce efforts to provide clarity on who direct service workers are, how to become one, and what they do. In an effort to align state conversations and initiatives related to the direct service workforce, some states have adopted a standardized definition. For

57. PHI. Nursing Assistant Training Requirements by State. Available at: http://www.phinational.org/advocacy/nurse-aide-training-requirements-state-2016/
58. PHI. Personal Care Aide Training Requirements. Available at: http://www.phinational.org/advocacy/personal-care-aide-training-requirements/
59. PHI. Direct Care Workers Need Stronger Training Standards and Systems. 2021. Available at: http://www.phinational.org/direct-care-workers-need-stronger-training-standards-and-systems/
60. Peter Kemper, PhD, Brigitt Heier, MS, Teta Barry, PhD, Diane Brannon, PhD, Joe Angelelli, PhD, Joe Vasey, PhD, Mindy Anderson-Knott, PhD, What Do Direct Care Workers Say Would Improve Their Jobs? Differences Across Settings, The Gerontologist, Volume 48, Issue suppl_1, July 2008, Pages 17–25, https://doi.org/10.1093/geront/48.Supplement_1.17
61. John A. Hartford Foundation. Age-Friendly Insights Poll: Direct Care Workers Are Underpaid, Lack Support and Oversight. 2022. Available at: https://www.johnahartford.org/dissemination-center/view/age-friendly-insights-poll-direct-care-workers-are-underpaid-lack-support-and-oversight
62. Indiana Incident Reporting by Long Term Care Facilities. Available at: https://www.in.gov/health/long-term-carenursing-homes/incident-reporting-by-long-term-care-facilities/

example, Maine has established a definition of "direct care workers" in state statute ("'Direct care worker' means an individual who by virtue of employment generally provides to individuals direct contact assistance with personal care or activities of daily living or has direct access to provide care and services to clients, patients or residents regardless of setting. 'Direct care worker' does not include a certified nursing assistant employed in that person's capacity as a certified nursing assistant.").[63] Similarly, Delaware has developed a definition of direct care worker within state administrative code: "'Direct care worker' means an individual employed by or under contract to a personal assistance services agency to provide a consumer with personal care services, companion services, homemaker services, transportation services, and those services authorized by this paragraph."[64] Delaware administrative code further defines direct care workers to be "those individuals (aide, assistant, caregiver, technician or other designation used) employed by or under contract to a personal assistance services agency to provide personal care services, companion services, homemaker services, transportation services and those services as permitted in [code] to consumers. The direct care worker provides these services to an individual primarily in their place of residence."[65]

Direct Service Worker Registry

Put simply, a registry is a list of workers that meet certain criteria. States' implementation strategies for registries of direct service workers vary widely. Some states implement registries that house only qualified workers; some states implement registries that contain only workers with adverse actions; other states have registries that serve both functions.

Qualified Worker Registry: Qualified worker registries are processes whereby workers who meet certain qualifications (such as training or background checks) can be reviewed by the State (or another entity) and included on an accessible list of qualified workers. An example of implementation of this registry category is defined by PHI as a "matching service registry", or an online platform to help consumers and direct service workers get connected.[66] Three states (Oregon, Pennsylvania, and Washington[67]) have established requirements (training or other) for direct service workers before they can be added to the matching service registry. This process serves as a "vetting" process on behalf of consumers to ensure their worker has met certain state requirements (such as background check and related training) to provide related services.

Adverse Action Registry: These registries are those that do not include any process for reviewing an individual's credentials or entry requirements. These registries are lists of workers that have been determined to be "bad actors" through a "Finding," substantiated incident, or adverse action. Using these registries, consumers or employers could query a prospective worker/employee's adverse actions history to determine if the individual has previous adverse actions against them. Massachusetts[68] and New Mexico[69] have implemented this registry type.

Combination Registry: These registries are those that serve dual purposes: they identify workers who have met certain qualifications to serve in a role and there is a process in place to remove their "good standing" through the addition of a "Finding" or other indicator of adverse actions. These registries are implemented in all states for nursing assistants (as required through federal regulations), including Indiana. A similar process is in place for other licensed health professions in Indiana (who may meet qualifications to receive a license, but their license may be put on probation or revoked if certain adverse actions are taken). Illinois also has a combination registry process in place for a combination registry for their direct care workers, as a part of the Illinois Health Care Worker Registry.[70]

Indiana has conducted some work toward an incident reporting registry for DSPs, through the work of the 1102 Task Force,[71] which was established in 2019 but re-authorized by the Legislature in 2022 with the following:

> *"Not later than September 1, 2022, the task force shall make recommendations to the legislative council regarding*

63. Maine Revised Statutes 22 §1812-G. Available at: https://www.mainelegislature.org/legis/statutes/22/title22sec1812-G.html
64. 24 DE Code § 1921. (2020). Available at: https://delcode.delaware.gov/title24/c019/index.html#1921
65. 16 DAC 3345. Available at: https://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Health%20Care%20Quality/3345.shtml
66. PHI. Matching Service Registries. Available at: http://www.phinational.org/advocacy/matching-service-registries/
67. http://www.phinational.org/advocacy/matching-service-registries/
68. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter19C
69. https://nmonesource.com/nmos/nmsa/en/item/4371/index.do#!b/a47
70. Illinois Health Care Worker Registry. Available at: https://dph.illinois.gov/topics-services/health-care-regulation/health-care-worker-registry.html
71. Intellectual & Developmental Disabilities Task Force. Available at: https://www.in.gov/fssa/ddrs/intellectual-and-developmental-disabilities-task-force/

the creation of a report:

to be distributed by the bureau of developmental disabilities services to each authorized service provider; and

to provide to the authorized service provider the name of each direct support professional who has been the subject of a substantiated incident report."[72]

The 1102 Task Force established study committees in Summer 2022 to make related recommendations, which were approved by the Task Force in the August meeting and submitted to the legislative council in September 2022.[73] Although these recommendations were specific to incident reporting processes and a potential registry for DSPs, this context is important for any future related work.

Minimum Training Standardization

Many states have begun the process of standardization of direct service worker training. State approaches vary significantly in terms of 1) who is required to complete training (i.e. worker type, self-directed vs. agency employed, setting/program), 2) content of training, and 3) length of training (among many other variables). Some states, such as Ohio,[74] Minnesota,[75] Tennessee,[76] and Virginia[77] have developed state minimum training requirements for direct service workers. For each of these states, the scope, depth, and approaches to providing standardized training to direct service workers has varied significantly. Ohio, for example, has implemented standardized training by provider type;[78] waiver service providers have different training than those DSPs working in licensed residential facilities. In this case, a DSP's licensed residential facility training would be portable to any licensed residential facility employer. Virginia, on the other hand, has developed training for DSPs employed by providers and serving in Medicaid HCBS settings. Indiana has conducted some work toward a standard minimum curriculum for one direct service worker role, direct support professionals, through the work of the 1102 Task Force,[79] which was reauthorized by the Legislature in 2022 with the following:

"Not later than September 1, 2022, the task force shall make recommendations to the legislative council regarding the:

establishment of a statewide training curriculum for individuals who provide services to individuals with an intellectual or other developmental disability;

feasibility of establishing training certification;

establishment of a statewide training registry; and

feasibility of a pilot project to implement any recommendations made under this section."[80]

The study committees' recommendations were approved by the Task Force in the August meeting and submitted to the legislative council in September 2022.[81] Although these recommendations were specific to training standards for DSPs, this context is important for any future related work.

Opportunities Beyond Entry-level Direct Service Roles – Add-on Training Options (Micro-credentials)

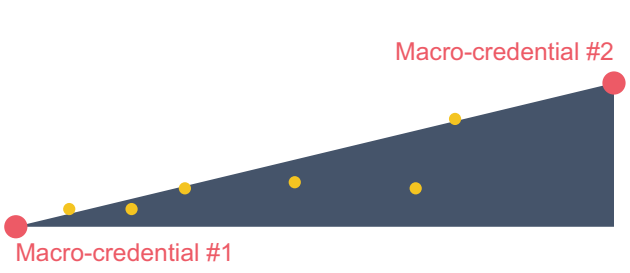
72. 2022 Indiana House Enrolled Act 1075. Available at: http://iga.in.gov/legislative/2022/bills/house/1075#document-95caf6d3
73. Available at: https://iga.in.gov/legislative/2022/publications/agency/reports/tfidd/
74. Ohio Training Requirements for Direct Support Professional. Available at: https://bit.ly/3BWyPOA
75. Minnesota Statute – 245D.09 Staffing Standards. Available at: https://www.revisor.mn.gov/statutes/cite/245D.09
76. State of Tennessee Department of Intellectual and Developmental Disabilities Provider Manual. Available at: https://www.tn.gov/content/dam/tn/didd/documents/providers/provider-manual/Provider_Manual.pdf
77. Virginia Department of Behavioral Health & Developmental Services - Required Training. Available at: https://dbhds.virginia.gov/developmental-services/provider-development/ctp-pd/ctp-required-training/
78. Ohio Department of Developmental Disabilities MyLearning. Available at: https://mylearning.dodd.ohio.gov/
79. Intellectual & Developmental Disabilities Task Force. Available at: https://www.in.gov/fssa/ddrs/intellectual-and-developmental-disabilities-task-force/ ; https://iga.in.gov/legislative/2019/bills/house/1488#digest-heading ; https://www.in.gov/fssa/ddrs/intellectual-and-developmental-disabilities-task-force/
80. 2022 Indiana House Enrolled Act 1075. Available at: http://iga.in.gov/legislative/2022/bills/house/1075#document-95caf6d3
81. Available at: https://iga.in.gov/legislative/2022/publications/agency/reports/tfidd/

Micro-credentials are small trainings that provide an individual with new skills, typically in a targeted topic area. Micro-credentials generally support professional development of workers and support growth within a general role, similar to a low-elevation ramp. Micro-credentials in the Direct Service Workforce space could be tied to a topical area, population, setting, or role. Micro-credentials are also commonly referred to as E-badges or digital credentials, as is the case with the National Alliance for Direct Support Professionals' E-Badge Academy.[82]

Some states, such as Ohio[83], have developed micro-credentials, or add-on training options, for direct service workers that can be accessed within the state learning management system. In the case of Ohio, providers can direct their staff to complete certain courses that would be relevant to their role. For example, providers could direct staff to complete a course called "Orientation to Supported Employment" for DSPs providing employment services. Virginia's model has a similar approach whereby advanced trainings are available for certain modules such as "Choking Risk" or "Changes in Mental Status",[84] and health competencies checklists are available and required for any DSP serving health-related intensive supports to individuals (who have been assigned a certain level on the Supports Intensity Scale).[85] Virginia also has required standardized training for DSP supervisors.[86] Additionally, Oregon has mapped micro-credentials among the home care workforce sector which includes entry-level homecare roles to more advanced homecare roles.[87]

Opportunities Beyond Direct Service Roles – Macro-credentials

Macro-credentials are large achievements in training or education that result in a new certification, degree, or license. Whereas micro-credentials may be thought of as a low-elevation ramp, macro-credentials would be more synonymous with stair steps (as shown in the figure below). To contextualize macro-credentials related to the direct service workforce, a macro-credential might be moving from a CNA to obtain a pre-nursing vocational certificate, then licensed practical nurse certificate or associate degree in nursing. Some states have developed pathways to support macro-credential opportunity and achievement by direct service workers. For example, Maine has developed a healthcare career pathways guide that identifies potential career paths organized by education level and health care setting or sub-sector.[88] In the Maine example, CNA is a step on the career path to higher positions in Long-Term Care as well as Hospitals, and DSP is a step on the career path in Adult Mental Health roles.



Depiction of Micro-credentials

Depiction of Macro-credentials

82. NADSP E-Badge Academy. Available at: https://nadsp.org/services/the-nadsp-e-badge-academy/

83. Ohio Department of Developmental Disabilities MyLearning. Available at: https://mylearning.dodd.ohio.gov/

84. Virginia Direct Support Professionals Orientation - Supplemental Training & Competencies. Available at: https://dsporientation.partnership.vcu.edu/supplemental-training--competencies/

85. Health Competencies Checklist (rev. 1.19.17) DMAS #P244a. Available at: https://dsporientation.partnership.vcu.edu/media/direct-support-professionals-orientation/DBHDSHealthCompetenciesChecklistP244a1.19.17_final_rev.pdf

86. Virginia Department of Behavioral Health and Developmental Services. Direct Support Professional (DSP) and DSP Supervisor DD Waiver Orientation and Competencies Protocol. Available at: https://www.townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\720\GDoc_DBHDS_6823_v1.pdf

87. Oregon Home Care Commission. Career Lattice. Available at: https://ohccworkforce.org/career-lattice/page-2/personal-support-worker/

88. https://www.maine.gov/labor/docs/2022/htr/HealthcareCareerpathways.pdf

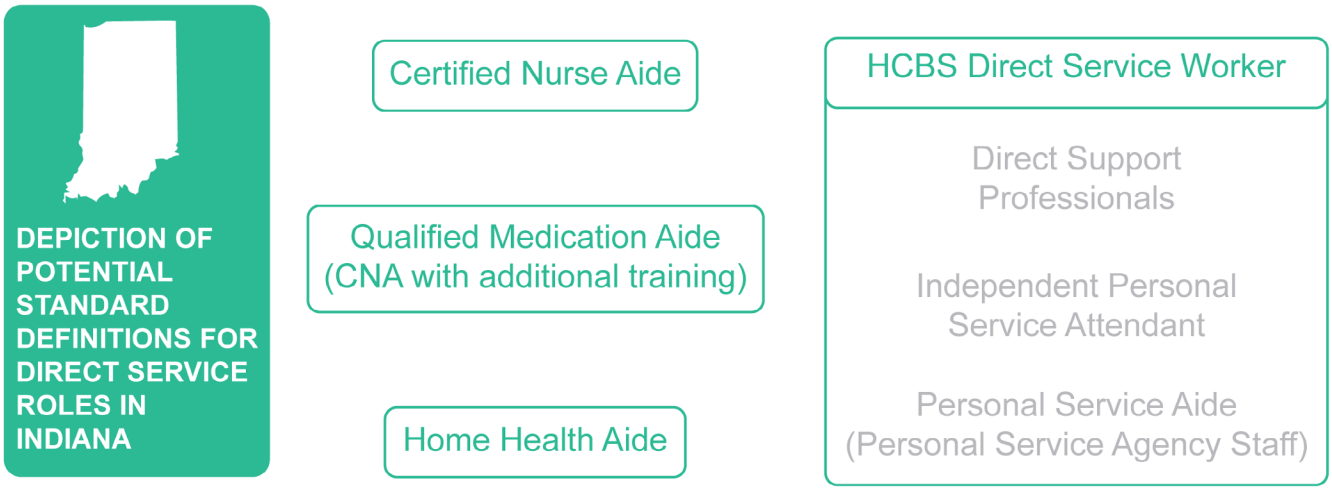
Table 3 Training & Pathways: Challenges & Opportunities

The Problem	The Opportunity
• Lack of clarity of direct service roles and associated requirements and regulations • Lack of standardized training for many direct service worker roles • Desire from direct service workers to have more training • Lack of mobility between direct service roles, resulting in potentially duplicative trainings required for the workers • No defined advancement opportunities for direct service workers, both within direct service roles and to other roles	• New identification • Career pathways • DSW registry • Training opportunities

What Can Be Done in Indiana?

Short-term strategies

A new identification. FSSA will explore options for developing and implementing a standard definition of "direct service worker" as well as all the work-related responsibilities and requirements. A standard definition will promote parity in training/credentialing requirements, service delivery and reimbursement as well as clarity for consumers and their family caregivers.



Mid-term strategies

Career pathways.

FSSA will form a career and education ladder that outlines pathways from entry-level positions to more advanced roles within the workforce. FSSA will also determine with stakeholder input how to tie training, achievement and credentialing to wage increases. In 2022, FSSA awarded a two-year grant to Ivy Tech Community College's Department of Human Services to develop a continuing education curriculum technical certificate program for DSPs. Those who complete the program can go on to earn an associate degree or transfer to any Indiana four-year college to pursue a bachelor's degree in social work.

Considerations

- **Opportunities to translate state credentials into academic credits.** Consider how experience may be coupled with academic achievement in bridge programming.
- **Supporting sector retention.** Macro-credentials for direct service workers could be developed in both human service and health care sub-sectors.
- **Building on previous work.** Consider existing Ivy Tech Community College program for DSPs and how bridge programming might be developed into additional careers, such as nursing, behavioral health, human services, and other health related opportunities.

DSW Registry.

FSSA will explore the development of a web-based registry, a key tool in transparency and portability of DSW credentials, to track completed trainings and pertinent information, reducing duplicative training and administrative tasks for providers.

Considerations:

- Determining desirability between the various registry types. Determine which, if any, registry type should be pursued for Indiana direct service workers
- Minimizing barrier to entry. Ensure any regulatory requirements are minimum necessary to promote public safety and service quality
- Maximizing success and adoption. Explicit processes and clearly defined roles and expectations will be critical for success

Long-term strategies

Training opportunities. A comprehensive minimum curriculum will require input from individuals with lived experiences, DSWs, provider agencies and member associations, advocates and training professionals, among others. As the population of older adults and people with disabilities who use HCBS continues to become more diverse, more specialized trainings for DSWs will be required to reduce unmet needs and health disparities. Individuals with lived experiences will be instrumental in informing the design of training requirements. As FSSA expands self-directed options for HCBS, requirements must provide for person-specific training needs.

Considerations for minimum curriculum:

Leveraging momentum. Activities of this Action Group should build upon the work of the 1102 Task Force. Centers for Medicare and Medicaid Services' Direct Service Workforce Core Competencies Set should be reviewed.[89]

- Consideration of Future Phases. As state standardized minimum training is being developed, consider opportunities to align with post-secondary/higher education credit requirements to support build-out of bridge and pathway programs.
- Consideration of Various Audiences and Implementation Models. Develop programming to support both high school students and adult learners. For high school students, work with Indiana Department of Education to determine how experiential and classroom opportunities could be provided to satisfy diploma requirements or provide supplemental opportunities to students seeking meaningful internship experiences. Leverage individuals with lived experience, as well as professionals, in the identification of state standardized minimum training standards.

Considerations for specialized curriculum:

89. Centers for Medicare and Medicaid Services. The DSW Core Competency Project. Available at: https://www.medicaid.gov/medicaid/long-term-services-supports/workforce-initiative/dsw-core-competency-project/index.html

- Opportunities for alignment with services. Care should be taken to ensure alignment of add-on trainings in alignment with higher level services or reimbursement rates, where appropriate.
- Maximizing retention within direct service roles in the LTSS sector. Opportunities for worker growth within direct service roles should be considered. Pathways and guidance documents should be developed for workers and employers.
- Consideration of Career Pathways. As micro-credential curriculum is being developed, consider opportunities to align with post-secondary/higher education credit requirements to support build-out of bridge and pathway programs.
- Training for direct service supervisors. Consider including direct service supervisor roles within micro-credential pathways and training opportunities.
- Designing a training to meet dynamic population needs. Micro-credential opportunities should include dynamic and responsive curriculum to address new and emerging best practices and be developed within a platform that is nimble to changing state needs.

The Challenge

Although some data were available to support development of the workforce needs assessment, significant data limitations were identified. Data that are ideal to inform workforce planning of the Direct Service Workforce include: supply data (including counts of workers, full-time equivalency, demographics, educational characteristics, practice setting, geographic location, wage/benefits, etc.) and demand data (including unfilled positions, turnover, occupancy, population projections, and geographic need).

Supply Data: Supply data sources that are commonly used for Direct Service Workforce planning includes the following:[90]

Department of Labor Bureau of Labor Statistics (BLS) Estimates for Indiana Direct Service Workers. This source contains information on three direct service worker roles: Nursing Assistants, Home Health Aides (HHAs), and Personal Care Aides (PCAs). These data sources contain counts of these workers in the categories listed, offer wage variables, and provide county-level estimates, but are limited beyond that. Additionally, HHA and PCAs are presented in a single grouping, resulting in limitations for reporting by role.

Indiana Nurse Aide Registry. This data source is currently maintained by the IDOH and administratively housed at the Indiana Professional Licensing Agency. Similar to the BLS data, data from the registry includes basic counts of individuals with active certifications (CNA, QMA, or HHA) and have an associated license address, but no other information is available through this source.

Indiana Results from 2020 National Core Indicator-Intellectual/Developmental Disabilities Staff Stability Survey (SSS). The SSS is focused on employer (provider) reported information. The SSS contains the following information on direct service workers: demographics, employment characteristics (tenure, benefits, services provided, wage), as well as employer-related characteristics (turnover, vacancy, demand, etc.). Currently, findings from the SSS are only available for providers and associated direct service workers serving individuals with intellectual or developmental disabilities under the FSSA Division of Disability and Rehabilitative Services HCBS Waivers. There are future efforts to expand SSS respondents to include those serving consumers under the Division of Aging's Aging & Disabled Waiver, and Indiana participated in the pilot iteration of this survey. The full SSS survey for the aging and disability population will be launched in 2023, with efforts currently underway by the stewards and stakeholders to provide a single SSS survey that addresses both the intellectual or developmental disability and aging and disability populations.

Other National Data Sources with State-level Components. In addition to the above data sources, the U.S. Census Bureau's American Community Survey does have some information on direct service workers, which are able to be attributed to states. However, limitations also exist with this source, including the manner in which direct service workers are categorized; although personal care aides are reported separately, HHAs and nursing assistants are grouped (along with psychiatric aides), which prevents separate reporting on these roles.

Demand Data: Demand information generally provides insights into the workforce that will be needed in the future.

Department of Labor Bureau of Labor Statistics Estimates for Indiana Direct Service Workers. At the state and national level, the BLS provides estimates of current and projected job openings. The source also catalogs state-level sources of demand projections. In the case of Indiana, users are redirected to an interactive occupational demand and workforce projections dashboard maintained by the Indiana Department of Workforce Development.[91]

Job Posting Data Available through the Indiana Department of Workforce Development. The Indiana Department of Workforce Development utilizes data maintained by Lightcast, a newly formed conglomerate of Burning Glass and Emsi which conducts labor market analysis. The analytics performed by Lightcast provide workforce projections based on trends in job openings for and

90. https://www.gao.gov/assets/gao-16-718.pdf

91. Indiana Department of Workforce Development Occupational Projections Interactive Dashboard: https://datavizpublic.in.gov/views/EMSIOccupationSnapshot/SourcesandDataNotes?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no

growth in the direct service worker workforce. These data and outcomes can also be used for comparison of small communities or counties to the national average. Because data are based on SOC codes, analytics group HHAs and PCA together while CNAs are analyzed separately.

It is important to note that there may also be data available at the national level to support direct service workforce planning, such as the National Nursing Assistant Survey and the National Home Health Aide Survey.

Table 4 DSW Data Sources

	Supply	Demand
Current Accessible Data for Indiana	Bureau of Labor Statistics Staff Stability Survey* Nurse Aide Registry† Other National Data Sources (ACS)	Bureau of Labor Statistics Lightcast
Additional Data Used by Other States	Direct Service Worker Registry Supplemental Data on Direct Service Workers (captured during license/certification renewal)	Provider reporting
*For ID/D-serving employer-providers and associated direct service workers only. † Available for certified nurse aides, qualified medication aides, and home health aides only.		

Despite the data limitations, it is widely known through qualitative feedback provided by stakeholders that Indiana is experiencing a shortage of direct service workers in all roles and in all settings. When stakeholders reported on the top issues impacting the direct service workforce, many reported a lack of knowledge among the general public about direct service roles and a lack of coordinated marketing or recruitment strategies within the LTSS sector.[92] Additionally, although it is likely that providers are communicating information about how to become a direct service worker and what to expect in a direct service role, this information is not easily accessed or available on state government sources, likely due to complexities associated with current role confusion, variations in training requirements, and inconsistencies in allowable tasks across the direct service role types.

Possible Solutions

Additional Data Used by States to Assess Direct Service Worker Supply: Data on Direct Service Workers (captured during license/certification renewal).

State credentialing registries offer an excellent opportunity to monitor basic supply data on a workforce. Using a registry, states can export counts of individuals holding a specific credential to monitor licensing trends over time. Registries sometime also contain other variables, such as age or demographic characteristics which are helpful for workforce assessment. In fact, a 2004 report found that 34 states (excluding Indiana) reported collecting and having access to demographic data on nurse aides through tracking these variables using their nurse aide registry.[93] Some basic supply reporting can be done for all licensed or certified occupations in Indiana (including some direct service roles such as CNA, QMA, HHA). Depending on determinations made by the Definition, Training, and Pathways Action Group related to a direct service worker registry, this may be possible to report on direct service workers as well.

In addition to registries providing basic supply data, the registry renewal process can be leveraged to collect supplemental information, such as demographic, practice, employment, and other characteristics, from licensed and certified health professionals. The Indiana Professional Licensing Agency (IPLA) currently captures supplemental information from licensed health

92. Summary of the Indiana Direct Service Workforce Plan Strategy Session available upon request.

93. Iowa Care Givers Association, Survey of Nurse Aide Registries (Direct Care Worker) in the United States. (2004). http://www.advancingstates.org/sites/nasuad/files/hcbs/files/66/3254/state_nurse_aide_registries.pdf, p. 20-23

professional during license renewal. The integration of supplemental questions into the license renewal process has ensured regular and timely data are available on Indiana's health professionals. Such a process could be utilized for collecting information on any direct service role with an associated registry.

Few states actively collect and report on Direct Service Workforce demographic, practice, employment, and other characteristics during license/certification renewal. Virginia is one of few states that has reported on CNA characteristics bi-annually. The Virginia Department of Health Professions collects information from CNAs during their license/certificate renewal period, such as: demographic, educational, professional, geographic, and wage/benefits-related characteristics.[94] Other states such as New Mexico have recognized the importance of this strategy and have called for similar data collection initiatives for their direct service roles.[95]

Additional Data Used by States to Assess Direct Service Worker Supply and Demand: Provider Reporting.

Provider reporting has proven to be crucial for collecting information on direct service workers with regards to compensation, services provided, capacity, and demographics. According to a 2016 report published by the United States Government Accountability Office, several states have implemented direct service worker data collection initiatives through provider surveys. In 2012, these efforts were organized across seven states through a Centers for Medicare & Medicaid Services initiative: the National Balancing Indicators Project.[96] Through this project, states collected information on standardized data variables, including many workforce variables outlined in Table 4. The specific provider survey tools are available on the resource website.[97]

In addition to this one-time organized effort, other states have developed recurring provider reporting strategies. For example, Texas recently began to include certain workforce-related topics (e.g., turnover, retention, and compensation) within their existing provider surveys to better monitor the Direct Service Workforce (modeled after the State of Washington's strategy). The findings are published in a Community Attendant Recruitment and Retention Strategies report.[98]

When it comes to implementation of provider reporting strategies, some states have integrated reporting of certain Direct Service Workforce measures with other reporting initiatives. For example, Kansas requires reporting of certain workforce measures associated with various facility types as a part of their regular facility reporting.[99] Kansas nursing facilities must report detailed staffing, turnover, retention, and vacancy for direct service roles;[100] intermediate care facilities must report total hours and salaries/wages of various direct care staff roles.[101] With these reports available, the Kansas Department for Aging and Disability Services can easily monitor these measures throughout the state. In fact, LeadingAge Kansas developed a Cost Report Navigator tool that enables nursing homes to access the publicly reported data and compare their measures to other nursing homes throughout the state.[102] Similarly, the Connecticut Department of Social Services requires nursing facilities to report quarterly the number of aide hours and associated fees (among many other measures reported). These reports are aggregated and made publicly accessible on the website.[103] Indiana nurse facility reports are submitted through IDOH's Survey Report System[104] and findings are made available on the Centers for Medicare & Medicaid Services' Nursing Home Compare website, including the Direct Service Workforce measure of nurse aide hours per resident day.[105,106] It is unclear whether reporting is done and made available for Indiana residential care facilities.

94. Virginia Department of Health Professions. Healthcare Workforce Data Center, https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/NursingReports/

95. Strengthening New Mexico's Direct Support Workforce through Improved Compensation and Stronger Data Collection (2020). https://www.arcnm.org/wp-content/uploads/Wage-and-Data-Collection-Position-Paper.pdf

96. U.S. Government Accountability Office. Long-term Care Workforce: Better Information Needed on Nursing Assistants, Home Health Aides, and Other Direct Care Workers. 2016. Available at: https://www.gao.gov/assets/gao-16-718.pdf

97. https://omb.report/icr/201111-0938-010/doc/30517401

98. https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/community-attendant-recruitmt-retention-strat-aug-2019.pdf

99. Kansas Nursing Facility and Adult Care Home Programs. Available at: https://kdads.ks.gov/kdads-commissions/long-term-services-supports/nursing-facility-and-adult-care-home-programs

100. Kansas Nursing Facility Cost Report Form. Available at: https://kdads.ks.gov/docs/librariesprovider17/ltss/nursing-facility-(nf)-and-nursing-facility-for-mental-health-(nfmh)-rates-cost-reports/nursing-facility-(nf)-and-nursing-facility-for-mental-health-(nfmh)/ms-2004-nf-cost-report.xls?sfvrsn=b09405ee_2

101. Kansas ICF IID Cost Report Form. Available at: https://kdads.ks.gov/docs/librariesprovider17/ltss/nursing-facility-(nf)-and-nursing-facility-for-mental-health-(nfmh)-rates-cost-reports/intermediate-care-facilities-for-individuals-with-intellectual-disabilities-(icf-iid)/icf-iid-cost-report-form.xls?sfvrsn=bc2607ee_2

102. Of note, LeadingAge Kansas membership is required to access this tool. Available at: https://www.leadingagekansas.org/workforce-resources-and-data

103. Connecticut Nursing Facility Cost Reports. Available at: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Facility-Cost-Reports/Quarterly-Cost-Report-Data ; https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Facility-Cost-Reports/Cost-Report

104. Long Term Care/Nursing Homes. Available at: https://www.in.gov/health/long-term-carenursing-homes/

105. CMS Medicare Nursing Home Compare. Available at: https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true#search

106. "Total nursing staff turnover" is also a publicly reported measure. However, this figure presumably includes registered nursing, practical nursing, and nurse aide turnover. Therefore it has limited utility for Direct Service Workforce assessment.

Table 5. Provider-reported Data Variables Used in National Balancing Indicators Project

	Employer organization survey variables (workforce-related)	Independent provider survey variables (workforce-related)
Required variables	• Number of direct care workers working full time and part time • Number of direct care workers by setting • Number of consumers by setting • Average starting wage paid • Average wage paid • Benefits provided • Turnover rate • Vacancy rate	• Number of hours worked per week • Hourly wage rate paid • Health insurance and other benefits • Tenure in field • Tenure with current employer • Intent to stay in field
Optional variables	• Worker demographics • Additional turnover measures • Training required and provided • Recruitment and retention challenges	• Reason for entering field • Training received • Training desired • Training recommended • Workforce challenges • Worker demographics

Coordinated Statewide Marketing Campaign

In an effort to promote career opportunities within direct service roles and support recruitment, many states across the country have implemented marketing campaigns. For example, Rhode Island[107] is using ARPA funds to implement marketing and outreach initiatives focused on marginalized communities and persons of color with the goal to both increase and diversify the direct service worker workforce. Additionally, in 2018, Wisconsin[108] implemented "WisCaregiver Careers" a recruitment program supported by a statewide marking campaign that used nursing assistant testimony to recruit other nursing assistants. The campaign was considered a major success, resulting in an additional 3,500 trained CNAs since the program's launch.

Following Wisconsin, three additional states (Idaho, New Hampshire, and North Carolina) launched their own statewide marketing campaigns to bolster their direct service workforces.[109] Most recently, Maine launched their "Care For ME"[110] campaign to attract new direct service workers and match them with a place of employment. In the marketing campaign, Maine used video, quotes and testimonials from workers as well as combinations of traditional and social media.

107. https://rtc.umn.edu/docs/DSWPromisingPracticesFINAL.pdf
108. https://www.dhs.wisconsin.gov/gtfc/direct-support-pros.pdf
109. https://www.phinational.org/wp-content/uploads/2022/04/DCW-State-Strategies-2022-PHI.pdf
110. https://ccids.umaine.edu/2022/05/09/caring-for-me-campaign-to-recruit-behavioral-health-and-direct-care-workers/

Development of a State Landing Page (Website) for Direct Service Workers

In an effort to organize information available related to the direct service workforce, some states have invested in the development and maintenance of a state website landing page with relevant information. For example, Maine maintains the "Maine Direct Service Worker Information" webpage,[111] which contains details about what a direct service worker is, career pathways, training and hiring requirements, and guidance documents for direct service worker employers[112] to support standardized job titles. The Maine Direct Service Worker Information website is an off-shoot of the Caring for ME (Maine) initiative and website,[113] that houses additional information for caregiving careers, such as job openings, links to training, caregiver storytelling, and additional employment-related resources. Similarly, Massachusetts has established the Resource Center for the Direct Care Workforce, which serves as a resource center for both job seekers and direct care workers alike, including facilitating employment opportunities to support self-directed consumers.[114] The Massachusetts Resource Center includes links to initial training, continuing education opportunities, and other resources (flyers, job descriptions, storytelling) for both workers and employers (providers and self-directed consumers).

Table 6. Promotion & Planning: Challenges & Opportunities

The Problem	The Opportunity
• Limited supply and demand data on the direct service workforce which threatens detailed state planning efforts • Lack of general public knowledge about direct service worker opportunities • Lack of recognition of the value of direct service workers • Inaccessible information about who direct service workers are, what they do, and how to become one	• Data Collection • Data Action Group • Marketing Action Group • DSW Hub

What can be done in Indiana?

Short-term Strategies

Data Collection. FSSA will partner with the Indiana Professional Licensing Agency and the IDOH to include additional questions during the certification process of certified nurse assistants, home health aides and qualified medication assistants in order to build needed data about the workforce.

Considerations:

- Granularity. To the extent possible, data should be collected in a manner that information is distinguishable on the individual direct service worker level, allowing for detailed state assessments across individuals that may be employed by various employers and may hold various direct service worker credentials. This individual-level data also ensuring greater accuracy in measuring workforce capacity and other characteristics. Similar to the approach taken on individual level licensee data that is reported in technical reports, data privacy should be maintained.
- Coordination of Direct Service Worker Data with Other State-maintained Data. Information on the direct service workforce will be meaningful for state assessments as a standalone. However, to the extent possible, it would be ideal to coordinate individual-level direct service worker information with other data sources that could speak to demand for workers, such as populations served by direct service workers (enrollment count by program type) and wait times or waiting lists. Centralizing this information in a way that data are accessible will be crucial for timely workforce assessments.

111. Maine Direct Service Worker Information. Available at: https://mainedirectserviceworker.org/
112. Maine Direct Service Workers: A Guide to Job Titles. 2022. Available at: https://mainedirectserviceworker.org/wp-content/uploads/2022/07/Job-Title-booklet-final-draft-June-30.pdf
113. Maine Caring for ME. Available at: https://caringforme.org/
114. Massachusetts Resource Center for the Direct Care Workforce. 2022. Available at: https://madirectcare.com/

Mid-term Strategies

Data Action Group. FSSA will form a Data Action Group led by the FSSA Data and Analytics Team that will include representation from persons with lived experiences, DSW Advisory Board members, multiple state agencies, and providers and/or their representative organizations that will help provide a better understanding of the Direct Service Workforce, their roles in the healthcare and social supports systems and what is needed to empower them in their roles. This foundational knowledge will be used to inform the provider network's retention and recruitment efforts and provide a system-level view of strategies, including Indiana's experience relative to other states.

Marketing Action Group. FSSA will form a Marketing Action Group led by the FSSA Director of Communications and Media, and include individuals with lived experience, DSW Advisory Board members, other state agencies, providers/and or their representative organizations. One result could be a marketing campaign to help raise awareness for these essential workers and to recruit and retain DSWs to meet the anticipated demand in Indiana.

Considerations:

- Marketing modalities. Marketing campaigns can be implemented through a variety of mediums, such as radio and television commercials, billboards, internet advertisements, social media, and more. Consideration should be taken as to which strategies would be most effective to recruit workers from various audiences.
- Various audiences. It was noted that there are many "untapped" pools of potential workers, including men, retirees, stay-at-home parents, high school students, individuals with disabilities, and more. Marketing strategies should be developed to target various audience types.
- Storytelling through engagement of current direct service workers and clients. Stakeholders noted that the marketing campaign would be most impactful if it included storytelling about what direct service workers do and that the value of their contributions are recognized (perhaps by highlighting the impact on the clients they serve).

Long-term Strategies

DSW Hub. FSSA will create a website to serve as a hub for information on Indiana's Direct Service Workforce. This will include at a minimum information on career pathways, training and hiring requirements, and guidance documents.

Considerations:

- Scope. A critical first step will be determining a purpose statement for the virtual "hub" and relatedly determining what types of information should and should not be incorporated. Care should be taken to ensure the information is additive and helpful, as opposed to duplication of efforts or information available in other centralized sources.
- Types of resources to be made available. Stakeholders had numerous ideas as to what information could be included on a "hub." Some ideas included: peer-to-peer socialization/networking resources, training modules/materials, and information about career pathways.
- Alignment with marketing strategies. To support coordination and information-sharing, the marketing campaigns should direct audiences to a centralized location (ideally the "hub") whereby users can obtain more information.
- Inclusion of all direct service roles. Direct service workers are known to be mobile across employers and settings (including transitioning between community-based settings and facility-based settings). As such, it is recommended that any hub provide information on all types of direct service roles.

NEXT STEPS AND COMMITMENT TO STAKEHOLDER ENGAGEMENT

FSSA has already started implementing the goals and strategies pertaining to the three areas:

1. **Wages and benefits**;
2. **Training and pathways**; and
3. **Promotion and planning**.

In some cases, critical short-term strategies have been completed, such as with the HCBS stabilization grants. As FSSA works towards the goals set forth in this report, it will measure, monitor, and share progress.

As the work continues, engagement across our diverse stakeholders remains a priority. FSSA is committed to first and foremost hear the voice of individuals with lived experiences about their needs and desires of the Direct Service Workforce. Additionally, FSSA will maintain its DSW Advisory Board to continue to hear directly from individuals serving in these critical roles across Indiana. And finally, engagement with our broader stakeholders—providers, advocacy organizations and other state partners—will continue, particularly as we work to form the action groups outlined throughout the three strategy areas of this report.

These robust efforts will continue throughout 2023 and beyond so that a well-trained, empowered Direct Service Workforce is ready to meet the demand that exists today and will grow in the future as the Hoosier population ages in place. This workforce is critical, and FSSA will work with its existing and new partners, such as the managed care entities who will implement FSSA's managed LTSS program, to ensure that Indiana is prepared to come alongside Hoosiers as they live lives of their own design.

APPENDIX

INDIANA'S DIRECT SERVICE WORKFORCE ROLES

Direct Support Professionals

WHO ARE THEY?

Direct Support Professionals (DSPs) fall under the purview of the FSSA's Division of Disability and Rehabilitative Services (DDRS) and play an integral part in the lives of people with intellectual and developmental disabilities. DSPs provide hands-on, supportive care in multiple aspects of daily living for consumers under the Medicaid Section 1915(c) Community Integration and Habilitation (CIH) and Family Supports (FSW) waivers. They can be found supporting individuals in a variety of home and community-based settings including personal residencies, waiver (group) homes, adult day centers, and furnishing vocational support at a consumer's place of employment.

TRAINING AND CREDENTIALING

There is currently no certification or registration requirement to work as a DSP. To date, a state standardized curriculum or competency exam for DSPs working in home and community-based settings has not been developed (but is notably prioritized for development by the HEA 1102/HEA 1488 Task Force for the Assessment of Services and Supports for People with Intellectual and Developmental Disabilities[115]). DDRS has developed a set of core competencies and licensed provider agencies are responsible for conducting and documenting training based on them. In addition, DSPs must be familiar with each consumer's Individual Support Plan (ISP) and be trained on the specific needs, treatments, and interventions necessary to support their health and wellbeing. Agencies must also ensure continued competency of their staff through annual in-service competency evaluations and training

Direct support professionals in home and community-based settings are responsible for a wide variety of supportive and health-related tasks, which they are able to perform independently after their initial training. There is no specified requirement that these tasks be performed under nurse delegation or with ongoing supervision by a licensed healthcare professional. Instead, provider agencies must decide what supervision, training, in-service, and evaluations are necessary to maintain a DSP's skills and to meet the health and safety needs of their consumers. Provider agencies are responsible for maintaining all personnel training and in-service records, which are subject to review by the DDRS Bureau of Developmental Disabilities Services (BDDS) during the periodic provider licensing reverification process.

ADDITIONAL CONSIDERATIONS

The rules and regulations outlined in the table below only apply to DSPs in home and community-based settings under a Medicaid Section 1915(c) waiver. It is important to acknowledge that in Indiana, there are distinct regulatory policies which were deemed to be outside the scope of this review. For example, community residential facilities, also referred to as non-waiver group homes or supported living facilities, are small residential facilities that operate similarly to traditional institutional care by providing residents with room & board and all needed support services. While allowable tasks between DSPs working in home and community-based and these facility-based settings are similar, non-waiver homes have a well-developed medication administration curriculum, Core A & Core B, along with a competency checklist and exam. Successful completion of Core A and Core B is required of DSPs in non-waiver homes but is only recommended for DSPs in home and community-based settings.

SOURCES

DDRS Home and Community Based Services Waivers - Provider Module

DDRS Policy - Behavioral Support Plan (2011)

DDRS Policy - Employment of Persons with Convictions of Prohibited Offenses or Non-Residency Status (2011)

DDRS Policy - Requirements & Training of Direct Support Professional Staff (2011)

115. https://iga.in.gov/legislative/2022/publications/agency/reports/tfidd/

Indiana Direct Support Professional Training – Core A

Indiana Direct Support Professional Training - Core A and Core B: Introduction

460 IAC Article 6 - Supported Living Services and Supports

IC Title 12 Article 7 – General Provisions and Definitions

Direct Care Staff

Who are they?

The FSSA Division of Aging (DA), with some oversight by Indiana Department of Health (IDOH), governs direct care staff working in home and community-based settings under both the Medicaid Section 1915(c) Aged & Disabled (A&D) and Traumatic Brain Injury (TBI) waivers. Direct care staff provide essential hands-on care to older adults and persons with disabilities who have physical needs, allowing them to stay in their homes for as long as possible. They can be employed in a consumer's personal residence, in assisted living facilities, in adult day centers and other community settings.

Training and Credentialing

Similar to DSPs, direct care staff do not have a state certification or registration process. However, differences exist between these roles in other areas. The DA's Administrative Code does not offer guidance on training, curriculum, or scope of practice. As such, standards outlined in the regulatory review were taken largely from Medicaid Section 1915(c) waiver program requirements. Duties can vary depending on the service being delivered, but direct care staff are generally limited to assisting with Activities of Daily Living (ADLs), Instrumental ADLs, and other personal care tasks like, attendant care, respite care, adult day services, and supported employment.

Additional Considerations

The DA does not have complete regulatory autonomy over their direct care staff, and must instead defer to the higher authority of IDOH regarding certain services and settings. For example, in most instances, due to IDOH licensure requirements, direct care staff are explicitly prohibited from administering medication or providing healthcare services, however, staff employed through Adult Family Care (AFC) providers, who do not operate under IDOH licensure, may provide medication oversight if properly trained. A similar convolution is found in IDOH-licensed Assisted Living Facilities (ALF). In most service settings, direct care staff are required to maintain CPR certification but the DA does not specify any other training or continuing education requirements, leaving content and rigor to the discretion of the provider agency. There is, however, an exception for ALF-employed direct care staff who must receive training in individual rights, incident reporting, emergency procedures, and if applicable, six (6) hours of dementia-specific training, along with four (4) hours of annual in-service training and, when applicable, an additional three (3) hours of dementia-specific training.

SOURCES

DA Home and Community Based Waivers - Provider Module

455 IAC Article 2 - Home and Community Based Services

HCBS Statewide Transition Plan - 2016 Presentation

Independent Personal Services Attendant

Who are they?

The Independent Personal Service Attendant (IPSA) is a unique role designed to benefit LTSS consumers who choose to direct their own care. Also known as Consumer-Directed Attendant Care (CDAC), these workers do not work for a provider agency but are instead directly hired, trained, and managed by the consumer in need of assistance with basic day-to-day tasks in their home and out in the community. Of note, Indiana has contracted with a third-party vendor, Public Partnerships, LLC, which provides customer service support and fiscal intermediary services consumer such as payroll and budget management.

TRAINING AND CREDENTIALING

According to Indiana statute, the primary job function of an IPSA is to provide attendant care, which is defined in Title 12 of the Indiana Code as including both ADLs and IADLs along with any physician-approved “health related services” that can safely be performed in the consumer’s home. Other than training for health-related tasks, which may be done by a licensed health professional within their scope of practice, consumers are responsible for training their IPSA employee, although Public Partnerships, LLC does maintain a CDAC Toolkit which offers guidance to consumers on recruiting, hiring, and training workers under a Medicaid Section 1915(c) HCBS waiver. It is important to note that there is some discrepancy in allowable tasks for IPSAs that work under a Medicaid Section 1915(c) HCBS waiver and those that are paid through another mechanism (such as the CHOICE program, private pay, etc.). The Medicaid Section 1915(c) HCBS waivers will not reimburse services that include health-related tasks.

Additional Considerations

According to Indiana statute, IPSAs are required to register with the State before providing services and every two (2) years after that. In turn, the State should maintain the registry and provide a list of registered IPSAs within a specified geographic area, upon request. The State has contracted with Public Partnerships, LLC, which serves as a third-party fiscal intermediary, to maintain information on current IPSAs. However, there does not appear to be any geographic database to support consumer inquiries.

SOURCES

Consumer-Directed Attendant Care (CDAC): Toolkit

Indiana Consumer Directed Attendant Care Program

455 IAC Article 1 - Aging

Consumer Directed Attendant Care (CDAC): The Guide

IC Title 12 Article 10 - Aging Services

Public Partnership LLC., - Fiscal Intermediary Service, Employee Instructions

Self-Directed Care Training For The Provider

Personal Services Aide

Who are They?

The IDOH regulates Personal Services Aides (PSAide) who are employed by state-licensed personal services agencies to provide assistance with ADLs and IADLs to eligible consumers in their homes and in the community under Medicaid Section 1915(c) HCBS waiver. Personal Service Aides are explicitly prohibited from providing healthcare-related tasks beyond offering medication reminders and cues.

Training and Credentialing

The State provides minimal direct oversight regarding supervision and training beyond a general requirement that employing agencies evaluate and reevaluate the competency of their staff on any task the agency chooses to have that employee perform. In fact, agencies are given wide authority over training. According to Indiana Code, the “agency has the sole discretion to determine if an employee or agent is competent to perform a task.” Indiana does not directly certify or require registration for PSAides. However, personal care agencies are required to renew their license annually with IDOH, and, as part of this process, agencies must submit their staff competency evaluation and training procedures.

Additional Considerations

Indiana Code defines the services that a PSAide may provide as “attendant care” and outlines a general scope of practice which includes assistance with ADLs and IADLs, while restricting the provision of any health-related tasks. Of note, “attendant care” has a different set of standards for independent personal service attendants (IPSAs) in a different section of Indiana Code, which does allow attendants to perform certain physician-approved health-related activities.

SOURCES

405 IAC Article 1 - Medicaid Providers and Services

IC Title 16 Article 18 - General Provisions and Definitions

Personal Services Agency Application Instructions

Home Health Aide

Who are they?

Home Health Aides (HHAs) work for a licensed home health agency. HHAs are considered healthcare paraprofessionals who provide assistance with ADLs and IADLs in a consumer's residence and have received additional training in some basic health supportive tasks, such as measuring vitals, monitoring health conditions, assisting with medication, infection control, and emergency procedures. HHAs serve older adults and individuals with disabilities who require LTSS in order to maintain their independence and are supervised by a healthcare professional who makes periodic visits to consumers' residences.

Training and Credentialing

HHAs employed by federally licensed agencies are required to undergo 75 hours of training on 15 broad topics. Training must be taught by a registered nurse or other qualified healthcare professional. Before an HHA can work independently with a consumer, they must demonstrate competency and be included on the State's nurse aide registry. Home health agencies are responsible for creating, administering, and assessing the competency exam. Not all home health agencies in Indiana are federally licensed; some are state-only licensed. For HHAs working in state-licensed agencies, the number of required hours for initial HHA training are not specified by IDOH. However, HHAs in either agency type are required to have twelve (12) hours of continuing education each year and work at least eight (8) hours in twenty-four (24) months in order to remain on the registry.

Additional Considerations

The State of Indiana does not allow for portability of HHA credentials from another state.

While all direct service worker roles have a provision for TB testing and a criminal background check as part of the hiring process, home health agencies face an additional requirement (and expense), i.e., agencies are required annually to randomly test at least 50% of employees with direct patient contact for the illegal use of controlled substances. Any staff who refuses the drug test or has a positive test result must be either suspended for a minimum of six (6) months or discharged.

While successful completion of a training and competency evaluation program (including sixteen (16) hours of classroom training in federally licensed agencies) is required of an HHA before direct patient contact, approved training programs/vendors are not easily identifiable.

SOURCES

Home Health Aide Registry Renewal Form

Senate Enrolled Act No. 353 - 2022

410 IAC Article 17 - Home Health Agencies

42 CFR 409 - Hospital Insurance Benefits

42 CFR 484 - Home Health Services

IC Title 10 Article 13 - State Police Data and Information Programs

IC Title 16 Article 27 - Home Health Agencies

IC Title 20 Article 26 - School Corporations: General Administrative Provisions

State Operations Manual: Home Health Agencies

Certified Nurse Aide

Who are they?

Certified Nurse Aides (CNAs) generally focus less on ADLs and IADLs and more on healthcare support, although they may not provide procedures or medication administration. Certified Nurse Aides work under the direct supervision of a RN or LPN and serve primarily in nursing and LTSS facilities. While their services are not referenced under any of Indiana's four (4) Section 1915(c) Medicaid HCBS waivers, federal regulations stipulate that CNAs in good standing meet the requirement for HHAs employed in federally licensed facilities.

Training and Credentialing

CNAs are subject to both federal and state regulations. Traditional certification training for CNAs is more rigorous than for other direct service worker roles, combining both classroom and practical training for a total of one hundred and five (105) hours, followed by both a written and a skills competency exam. Certification is valid for two (2) years and can be renewed by CNAs who have remained active in the field and obtained twelve (12) in-service hours each year. IDOH developed the required nurse aide training curriculum, vets and oversees CNA training programs, and partnered with Ivy Tech Community College to administer both the written and skills portion of the required competency evaluation.

The path to CNA certification in Indiana offers some flexibility for both in-state workers with relevant training/experience and out-of-state CNAs in good standing. Qualified student nurses and recent nursing school graduates, along with CNAs from other states may bypass the training requirements and qualify for certification by successfully completing one or both competency exams. CNAs in good standing in other states are permitted to work in Indiana for one hundred and twenty (120) days while applying for the nurse aide registry.

SOURCES

CNA Frequently Asked Questions – Ivy Tech

410 IAC Article 16.2 - Health Facilities; Licensing and Operational Standards

Certified Nurse Aide (CNA) Renewal Form

Certified Nurse Aide: Certification and Recertification – IDOH Webpage

Indiana Nurse Aide Curriculum – Revised in 2015

Standard 14: Nurse Aide Scope of Practice

42 CFR 483 - Requirements for States and Long Term Care Facilities

Administrative Standards for IDOH Nurse Aide Training Program

Aides Registry: FAQS

How do I Become a CNA? – IDOH Webpage

IC Title 16 Article 28 - Health Facilities

Qualified Medication Aide

Who are they?

Qualified Medication Aides (QMAs) are CNAs who have obtained additional training in dispensing and passing medications and applying/administrating treatments. QMAs medication administration. Qualified Medication Aides can provide all the functions of a CNA with the additional ability to administer non-injectable medications and perform health-related tasks. A QMA also has the option to take the insulin administration education module that would qualify them to assist consumers in managing their diabetes and to administer insulin subcutaneously. Much like CNAs, QMAs work with the aging and disabled population under the direct supervision of a RN or LPN, primarily in nursing homes and other residential care facilities.

Training and Credentialing

In order to be eligible for a QMA training program, a worker must be a CNA in good standing with over a thousand (1,000) hours of experience. The QMA training and the QMA-Insulin training programs are overseen by IDOH. These trainings adhere to State-developed curriculum and culminates in the passage of a competency evaluation administered by Ivy Tech Community College. To remain active on the registry, QMAs must renew their certification every two (2) years and meet all requirements to maintain their CNA status. In addition, the QMA should complete six (6) hours of medication-related in-service, one (1) hour of insulin in-service training (if applicable, for QMA-Insulin only) each year, and work in a position which includes medication administration for at least eight (8) hours in a twelve (12)-month period.

Additional Considerations

Of note, the Indiana statutes governing the QMA program expired in 2015. According to IDOH officials, this authorizing language is currently being reviewed.

Like CNAs, qualified nursing students, recent nursing school graduates, Indiana-trained psychiatric attendants, and out-of-state QMAs in good standing can pursue an expedited certification process.

SOURCES

Insulin Administration for QMA - Competency Checklist

QMA Insulin Administration - IDOH Webpage

QMA Insulin Administration Education Module - Information

QMA Insulin Administration Education Module - Student Manual

QMA Program Director - Train the Trainer

QMA Testing FAQ – Ivy Tech Community College of Indiana

Qualified Medication Aide - Scope of Practice

412 IAC Article 2 - Qualified Medication Aides (expired)