Home Care Workers: Interstate Differences in Training Requirements and Their Implications for Quality

Christopher M. Kelly, Jennifer Craft Morgan and Kendra Jeanel Jason

Journal of Applied Gerontology 2013 32: 804 originally published online 22 March 2012
DOI: 10.1177/0733464812437371

Article

SGS SOUTHERN GERONTOLOGICAL SOCIETY

Journal of Applied Gerontology
32(7) 804–832

DOI: 10.1177/0733464812437371
jag.sagepub.com
SAGE

Home Care Workers: Interstate Differences in Training Requirements and Their Implications for Quality

Christopher M. Kelly[1], Jennifer Craft Morgan[2], and Kendra Jeanel Jason[2]

Abstract

Home care workers, the fastest growing segment of the U.S. direct care workforce, provide nonmedical services that are not reimbursed by Medicare; consequently, requirements for training and supervision are left to the states. The purposes of this study are to compare these state requirements and to identify core competencies for home care workers. Our content analysis of relevant state laws determined that 29 states require a license for home care providers. Of these 29 states, 26 require orientation and 15 require in-service training for home care workers; the duration and content of these programs vary widely across the states. Fifteen states require on-site supervision of home care workers. We believe that in addition to current state training requirements (e.g., activities of daily living (ADLs) and instrumental activities of daily living (IADL) assistance; infection control), other core competencies (e.g., basic medication information; behavioral management) should also be mandatory. More frequent on-site supervision is also necessary to improve home care quality.

Manuscript received: April 28, 2011; **final revision received:** November 28, 2011; **accepted:** January 4, 2012.

[1]University of Nebraska at Omaha, Lincoln, NE, USA
[2]University of North Carolina at Chapel Hill, NC, USA

Corresponding Author:
Christopher M. Kelly, University of Nebraska at Omaha, 310 Nebraska Hall, 901 North 17th Street, Lincoln, NE 68588-0562, USA.
Email: cmkelly@unomaha.edu

Keywords

home care, state policy, direct care workers, workforce development, home- and community-based services

In the United States, the scope of home care is expanding. In 2000, 16% of the U.S. population over 65 received long-term care (LTC), with the majority receiving home- and community-based services (HCBS; Smith & Baughman, 2007). Home care clients include permanently homebound seniors, a population that is expected to increase to more than 2 million Americans in 20 years (Smith, Soriano, & Boal, 2007). Home care is the fastest growing segment in the LTC workforce and the third fastest growing health care profession overall. The fastest growth within home care is among personal and home care aides who provide nonmedical services; more than 1.3 million of these workers are projected by 2018 (Deichert, Kosloski, & Holley, 2010; Lacey & Wright, 2009).

The need for workforce development in this segment for both trainees and incumbent workers is clear. Training standards are low across the LTC workforce but are particularly variable among the home care workforce. Training requirements for home care workers are determined by the states with no national guidelines. Home care stands out as the least regulated environment in LTC; typically, its workers "require and receive little or no training" (Stone & Harahan, 2010). There is some evidence to suggest that increasing skill-enhancing practices, like training and realistic job previewing, would lower aggregate turnover rates as new entrants to the field are better prepared for the realities of the job (Crow, Hartman, & McLendon 2009; Lopina, Rogelberg, & Howell 2011). For incumbent workers, employers are also likely to improve collective commitment and organizational performance outcomes by increasing such skill-enhancing practices (Subramony, 2009). These practices are particularly important in direct care jobs where low job quality (e.g., low wages, few benefits, and heavy workloads) is the norm. Furthermore, many LTC work environments typically do not support frontline supervisors and workers with input into care and decision making leading to a perceived lack of respect (Ejaz, Noelker, Menne, & Bagaka, 2008; Institute of Medicine, 2008; Stone & Harahan, 2010).

Identification of competencies and associated training standards is one of the first steps to a successful workforce development effort that has the potential to lead to the recognition of these positions as "worthy careers" (Stone & Harahan, 2010). Minimum standards for home care workers, whether employed by agencies or by their clients themselves, vary from state to state. A related concern is whether these various state standards provide clear guidelines for the skills needed to provide quality care. Finally, a third issue, from a regulatory perspective, is whether

minimum core competencies can be identified within the home care profession itself, and whether these skill sets may form the basis for national baseline standards for personal and home care aides. The purposes of this study are to analyze state training requirements for home care workers and to lay a foundation for understanding how these standards may be enhanced to identify the core competencies and ultimately help improve the preparation of the home care workforce.

What is Home Care?

Home care services are focused on postacute care (Levine, Boal, & Boling, 2003) as well as on individuals with functional limitations (Piercy & Dunkley, 2004). Home care can serve as an intermediary care setting between hospitals and LTC facilities (Hirdes et al., 2004), enabling many older Americans to continue to live in their own homes (Potter, Churilla, & Smith, 2006). Home care services are primarily provided by paraprofessionals working either for agencies or for client-employers (Benjamin & Matthias, 2004; Hirdes et al., 2004; Montgomery, Holley, Deichert, & Kosloski, 2005). Home care workers provide the majority of hands-on care, supervision, and emotional support for older adults and persons with disabilities living at home in the United States (Smith & Baughman, 2007).

The primary tasks for home care workers (e.g., personal and home care aides as defined by the Bureau of Labor Statistics) are to assist clients with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Home care workers, by definition, do not assist in medical procedures (Levine et al., 2003). ADLs include personal care tasks such as bathing, dressing, feeding, and toileting. IADLs include chores such as shopping, preparing meals, and housework. These workers are an important and growing part of the total U.S. direct care workforce which includes *psychiatric aides* who assist mentally impaired or emotionally disturbed patients, working under the direction of nursing and medical staff, *nursing aides*, *orderlies*, and *attendants* who provide basic patient care under the direction of nursing staff, *home health aides* who provide routine medical care, and, our focus, *personal and home care aides* who provide nonmedical services, such as ADL and IADL assistance (Montgomery et al., 2005). Home care workers are frequently employed by health care providers, such as hospitals, outpatient care centers, and home health agencies; others work for private households. However, the fastest growing employers are home care agencies, with a workforce that increased 212.9% from 2000 to 2008 (Deichert et al., 2010).

Home care is expanding, a consequence of both increased consumer preference for noninstitutional care and public policy efforts to develop a more balanced service delivery system, particularly in the wake of the Supreme Court's

Olmstead decision in 1999, which requires states to provide LTC alternatives in the community (Wiener, Tilly, & Alecxih, 2002). Many states chose to address this need by developing two Medicaid programs: the Title XIX Personal Care Services (PCS) optional state plan benefit and the 1915(c) HCBS waiver program (Harrington, LeBlanc, Wood, Satten, & Tonner, 2002; Kitchener, Ng, & Harrington, 2007). Both home care agencies and client-employed providers receive Medicaid reimbursement through these programs, which has contributed to the expansion of personal care services (Benjamin, Matthias, & Franke, 2000; LeBlanc, Tonner, & Harrington, 2001). Between 2000 and 2008 there was a 60.8% increase in the number of home care aides in the United States, the largest increase in the direct care workforce (Deichert et al., 2010). The home care industry is expected to expand further under current federal and state initiatives designed to slow the growth in Medicare and Medicaid spending on institutional LTC. One example is the Money Follows the Person (MFP) rebalancing demonstration program, which was designed to assist states in transitioning Medicaid enrollees from LTC facilities to the community (Centers for Medicare and Medicaid Services [CMS], 2011a).

Characteristics of Home Care Workers

Demographic and employment characteristics of the home care workforce are shown in Table 1. This workforce is predominantly female, as is true of the overall U.S. direct care workforce. In other respects, however, home care workers are unique. Nearly a quarter are divorced or separated, a higher proportion than among other types of LTC workers (Montgomery et al., 2005). This pattern suggests that home care may provide newly single workers greater flexibility than jobs in an institutional setting. Home care workers are also more likely to be older adults (Montgomery et al., 2005; Yamada, 2002), with more than 10% of this workforce age 65 or older (see Table 1). This age-related pattern suggests that home care has been more likely than other areas of employment in LTC to attract workers who are exiting rather than entering the work force, again due largely to the flexibility unique to this type of direct care job (Montgomery et al., 2005).

The home care workforce has a lower proportion of African American workers than other direct care professions and a higher proportion of Latino workers. In addition, home care workers are more likely to be noncitizens and non-English speaking; nearly a third of these aides speak a language other than English at home (see Table 1). Furthermore, home care workers have lower levels of education than hospital or nursing home aides (Montgomery et al., 2005; Yamada, 2002). These trends suggest that although home care attracts an older workforce,

Table 1. Demographic and Employment Characteristics of Personal and Home Care Aides: 2008 American Community Survey.

Number of aides	592,979
Age	
Under 25	10.4%
25-34	15.3%
35-44	19.6%
45-54	24.6%
55-64	19.9%
65 or older	10.3%
Median age	47.0
Mean age	45.6
Gender	
Male	12.5%
Female	87.5%
Language spoken at home	
English only	31.4%
Other language	68.6%
Race	
White, not Hispanic/Latino	48.0%
African American, not Hispanic/Latino	21.5%
Other, not Hispanic/Latino	10.6%
Hispanic/Latino	20.0%
Marital status	
Married	40.4%
Widowed	7.6%
Divorced/separated	24.4%
Never married	27.6%
Education	
Not high school graduate	23.2%
High school graduate	35.6%
Some college	31.8%
4+ years of college	9.5%
Citizenship	
Native-born U.S. citizen	72.0%
Native-born U.S.-outlying area	0.8%
Native-born abroad U.S. parent	0.8%
Foreign born (naturalized)	12.3%
Not a U.S. citizen	14.1%

(*continued*)

Table 1. (continued)

Number of aides	592,979
Labor force participation	
Year-round, full-time	39.0%
Year-round, part-time	12.6%
Part-year, full-time	26.5%
Part-year, part-time	21.9%
Class of employment	
For profit company	60.2%
Not for profit company	9.5%
Government	14.6%
Self-employed	15.1%
Unpaid family worker	0.6%
Weeks worked per year	
Median	35.0
Mean	33.3
Total annual earnings	
Median	US$12,000
Mean	US$14,165

Source: Deichert, Kosloski, and Holley (2010).

it may still represent an entry-level job for workers of all ages who experience barriers to employment such as language, education, and citizenship (or legal residence) status.

Like other direct care occupations, home care is often viewed as an entry-level job in the health care field. Home care workers, like most direct care workers, labor under challenging conditions in jobs that exact a high physical and emotional toll with low hourly wages, few benefits, and limited opportunities for career advancement (Dill, Morgan, & Konrad, 2010). Some home care workers have a higher mean per hour salary, but most are much less likely to work year-round than hospital aides and nursing home aides, resulting in fewer weeks of employment, fewer hours of employment per week, and much lower annual earnings. They are also much more likely than hospital aides and nursing home aides to be self-employed or to be hired directly by the client (see Table 1). Home care workers are more likely to be relatives, friends, or acquaintances of the clients they serve. These are all characteristics of what has been described as a casual labor force; for example, home care workers are more likely than other members of the direct care workforce to be employed on a part-time and/or short-term basis (Montgomery et al., 2005; Yamada, 2002).

Home Care Workers and the Role of the States

Despite the overall increased oversight of LTC and its workforce in the United States, consistent standards for home care quality across the states remain undeveloped. In fact, less is known about home care quality across the states than other LTC services. There are several reasons for this inconsistency. First, the use of quality indicators, such as the minimum data set (MDS), in LTC facilities has only recently been made available for use in home care (Hirdes et al., 2004). Second, home care has less agency oversight and therefore has limited effective utilization of these quality indicators (Hirdes et al., 2004; Wiener et al., 2002). Third, the nature of home care is often unique to the state in which these services are provided. The states are given wide latitude in designing their Medicaid PCS and HCBS waiver programs, for example, in the supply and organization of home care services, as well as financial and functional eligibility criteria for home care clients (Harrington et al., 2002; Wiener et al., 2002).

These fundamental differences make comparisons in home care quality between the states difficult. Assessing the qualifications of the home care workforce is similarly complex. Compared with other LTC providers, home care agencies are largely unaffected by formalized training requirements. Nursing homes employ workers under consistent national guidelines for participation in the Medicare and Medicaid programs, guidelines which include 75 hr of federally mandated training for direct care workers who provide medical care (Tyler, Jung, Feng, & Mor, 2010). Medicare-certified home health agencies must conform to similar training standards for workforce training (Jette, Smith, & McDermott, 1996). Assisted living facilities, licensed by the states, conform to the training requirements specified in these licensing standards. Training requirements vary across states, with most preservice training or orientation programs lasting between 1hr and 16 hr (Mollica & Sims-Kastelein, 2007).

Home care workers receive less formalized training than other members of the direct care workforce, which can be attributed to three factors. First, unlike medical services provided by nursing homes and home health agencies, personal care services (typically nonmedical care such as ADL and IADL assistance) are not reimbursed by Medicare and are not subject to federal Medicare requirements (such as training) for employers to participate in this program. Second, although Medicaid can (and often does) pay for personal care, this reimbursement does not provide federal oversight in areas such as training. Under Medicaid guidelines, the decision whether to require formalized training of personal care workers is left to the states, and few states exercise this authority. LeBlanc et al. reported in 2001 that only 8% of states with Medicaid PCS plans and only 13% of states that offered personal care under Medicaid HCBS waivers required workers to undergo

training. Third, home care workers are more likely than other members of the direct care workforce to work for employers and/or in settings that are not licensed by the state. For example, they are more likely to work in private homes, employed directly by the client (Montgomery et al., 2005). Furthermore, many states do not require a license for home care agencies that provide nonmedical care.

As a result of these factors, home care workers today receive less oversight than other direct care workers in areas such as *orientation, in-service training*, and *on-site supervision*. This exacerbates the growing concern that many home care workers in the United States may lack the initial training and the ongoing skills assessment and evaluation necessary to provide quality home care (Harrington et al., 2002; Levine et al., 2003; Piercy & Dunkley, 2004). This is particularly true of home care agencies, the fastest growing and least regulated of these organizations (Deichert et al., 2010; LeBlanc et al., 2001). The impact of this problem is not limited to workers. Without baseline standards, agencies are limited in their ability to compare the qualifications of new hires with current workers. Consumers lack the information necessary to make informed decisions about the workers coming into their homes. In short, the existing policy framework is bad for workers, bad for employers, and bad for families.

This lack of information presents a problem as well for policy makers and researchers. To our knowledge, no previous studies have compared licensure standards, including training requirements, for home care providers across all 50 states. In the present study, we analyze state-mandated training requirements for home care workers in each state, using the most recent and comprehensive data available. Our data come from state policies pertaining to home care, as written in each state's code of law. We assess (a) whether states have established a separate licensure category for home care; (b) whether states have instituted training and supervision requirements for home care workers specifically, orientation training, in-service training, and on-site supervision; and (c) whether states have identified specific skills (or *core competencies*) that these aides must master before they can visit clients. Finally, we discuss how core competencies may serve not only as the basis for new regulatory standards but also as a resource for workforce development for home care workers and their employers.

Method

Sample and Analysis

Our sample consists of the 50 states, and our data are the current laws pertaining to home care providers in the 50 states. The data were found in each state's code of laws, where licensing requirements for home care agencies and client-employed

providers are described. We also consulted, where necessary, information from the administrative rules of state government agencies responsible for regulating home care providers, as well as official state reports on these services. We obtained these materials from each state's official government website between February 1, 2011 and March 15, 2011. An estimated 80 hr during this 45-day period were devoted to data collection from these 50 state websites and the analysis of these data.

Content analysis has previously been used to compare state laws that affect older adults in areas such as managed care plans (Rolph et al., 1986), advance directives (Glick & Hays, 1991; Gunter-Hunt, Mahoney, & Sieger, 2002; Sabatino, 1999), and dementia-specific services (Kaskie, Knight, & Liebig, 2001). In recent years, e-government has expedited this type of analysis. Although state governments have had varied success in implementing the available technology (West, 2000), due to factors such as institutional capacity and economic development (Tolbert, Mossberger, & McNeal, 2008), a broad range of basic services is available through each state's official government website (Gant & Gant, 2002). One example is the code of laws, which is accessible online for each of the 50 states.

In the current study, we performed a content analysis of the state laws specific to home care providers. First, we determined whether each state had established a separate licensure category for home care providers. This information was found in each state's code of laws, in which state licensing requirements for all health care providers (e.g., hospitals, nursing homes, and home health agencies) were found. We identified states with a separate licensure category for home care providers as those states that required a license for providers to deliver nonmedical (or personal care) services, such as ADL and/or IADL assistance. Home care providers were identified in these states as "home care agencies" (or their equivalent) and/or as client-employed providers.

Second, we assessed the minimum training requirements for employees in each state that has established a separate licensure category for home care agencies. We addressed the following activities: (a) orientation of new home care workers; (b) annual in-service training for all home care workers; and (c) periodic on-site supervision of home care workers. We were interested in the duration of orientation and in-service programs, whether states required specific training course content for all home care workers (or instead set training requirements on a client-by-client basis), and the required time frame for on-site supervision of these aides by managers and health care professionals. Minimum requirements for orientation and in-service training programs were found in the code of laws of those states with a separate licensure category for nonmedical (personal and home care) providers.

Third, we compared the specific training requirements for home care workers in the states with a separate licensure category for home care agencies. In so doing, we identified what each of these states determined to be core competencies, the specific skill sets that these aides are required to demonstrate before they are allowed in the homes of clients. We also assessed whether states required a competency evaluation for home care workers during or following their initial training. Specific training requirements such as these were found in the code of laws, supplemented (where necessary) by the administrative rules of the state government agencies responsible for regulating home care providers. For example, in Connecticut, required content areas for orientation and in-service training for home care workers were described in the administrative rules of that state's Department of Public Health (2006).

Results

Licensure Categories for Home Care Agencies

In the United States, 29 states required a license for agencies providing nonmedical personal care services in 2011. In 11 of these states (Massachusetts, Minnesota, New Hampshire, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Virginia, and Washington), these providers are defined as *home care agencies*. Alternatively, nonmedical personal care services in other states are defined as *home services* (Illinois), *homemaker and companion services* (Connecticut and Florida), *residential services* (Maryland), *personal care* (Nevada and Ohio), *personal services* (Indiana), *personal care/homemaker services* (Colorado), *personal care attendant services* (Louisiana), *personal assistance services* (Alaska, Delaware, and Texas), *health care service firms* (New Jersey), *in-home personal care* (Maine and Nebraska), *in-home respite services* (Georgia), and *community-based in-home services* (Wyoming). In addition, four states (Alaska, Maine, Ohio, and Oregon) have licensure requirements for both home care agencies and client-employed providers. Finally, in the remaining 21 states, home care is not a separate licensure category (see Table 2); providers of services in these states are not subject to licensure requirements such as employee training and on-site supervision.

Training Requirements for Home Care

Orientation. In the United States, 26 states required home care providers to provide training for new home care workers in 2011. Of these states, eight (Georgia, Illinois, Louisiana, Nevada, New Hampshire, Ohio, Rhode Island, and Wyoming)

Table 2. Licensure for Home Care/Name of Category.

State	Separate licensure category for home care
Alabama	No
Alaska	Yes; personal care assistance (agency or consumer directed)
Arizona	No
Arkansas	No
California	No
Colorado	Yes; home care: personal care/homemaker services
Connecticut	Yes; homemaker-companion
Delaware	Yes; personal assistance services
Florida	Yes; homemaker/companion services
Georgia	Yes; in-home respite services
Hawaii	No
Idaho	No
Illinois	Yes; home services
Indiana	Yes; personal services
Iowa	No
Kansas	No
Kentucky	No
Louisiana	Yes; personal care attendant services
Maine	Yes; personal care agencies and consumer-directed services
Maryland	Yes; residential service
Massachusetts	Yes; home care
Michigan	No
Minnesota	Yes; home care Class B: paraprofessional agency
Mississippi	No
Missouri	No
Montana	No
Nebraska	Yes; in-home personal services
Nevada	Yes; personal care services through provider agency or intermediary service organization
New Hampshire	Yes; home care
New Jersey	Yes; health care services firms
New Mexico	No
New York	Yes; home care
North Carolina	Yes; home care
North Dakota	No
Ohio	Yes; personal care service (agency, nonagency, or consumer directed)

(*continued*)

Table 2. (continued)

State	Separate licensure category for home care
Oklahoma	Yes; home care
Oregon	Yes; in-home care agencies and client-employed providers
Pennsylvania	Yes; home care
Rhode Island	Yes; home care
South Carolina	No
South Dakota	No
Tennessee	Yes; home care
Texas	Yes; personal assistance services
Utah	No
Vermont	No
Virginia	Yes; home care
Washington	Yes; home care
West Virginia	No
Wisconsin	No
Wyoming	Yes; community-based in-home services

specified a minimum number of hours for this orientation; the average among these 8 states was 22.5 hr. Ohio required the greatest number of hours (60) of orientation among these 8 states; in contrast, Illinois, New Hampshire, and Wyoming required 8 hr each (see Table 3). Eighteen states required orientation training but did not specify the duration of these programs. For example, Nebraska required these aides to have "training sufficient to provide the requisite level of in-home personal services offered" (In-Home Personal Services Act, NE LB 236, § 40, 2007).

The states also varied widely in the required content of these orientation programs. Of the 26 states that required orientation for home care workers, 16 states detailed specific course content that is required for all home care workers, whereas 10 states did not (see Table 2). Among the latter group of states, the training necessary for each aide was typically determined by a health care professional, based on the tasks needed by an individual client. For example, in New Jersey, a homemaker employed by a health care service firm "shall only perform tasks that have been delegated to him or her by the health care practitioner supervisor or which the health care practitioner supervisor has directed the homemaker-home health aide to perform" (Homemaker-Home Health Aides and Agencies Act, NJ AC, § 13:45B-14.7).

Among the 16 states with specific training requirements, the breadth of these requirements varied. An average of 13.9 separate training criteria were found

Table 3. Orientation Requirements for Home Care Workers.

State	Orientation required	Durations	Specific course content required
Alaska	Yes	Not specified	No
Colorado	Yes	Not specified	Yes
Connecticut	No[a]	NA	No
Delaware	Yes	Not specified	Yes
Florida	No[a]	NA	No
Georgia	Yes	40 hours	Yes
Illinois	Yes	8 hours	Yes
Indiana	Yes	Not specified	No
Louisiana	Yes	16 hours	Yes
Maine	No[a]	NA	NA
Maryland	Yes	Not specified	No
Massachusetts	Yes	Not specified	Yes
Minnesota	Yes	24 hours	Yes
Nebraska	Yes	Not specified	No
Nevada	Yes	16 hours	Yes
New Hampshire	Yes	8 hours	Yes
New Jersey	Yes	Not specified	No
New York	Yes	Not specified	No
North Carolina	Yes	Not specified	Yes
Ohio	Yes	60 hours	Yes
Oklahoma	Yes	Not specified	No
Oregon	Yes	Not specified	No
Pennsylvania	Yes	Not specified	Yes
Rhode Island	Yes	Not specified	Yes
Tennessee	Yes	Not specified	Yes
Texas	Yes	Not specified	No
Virginia	Yes	Not specified	Yes
Washington	Yes	Not specified	No
Wyoming	Yes	8 hours	Yes

Note: NA = not applicable.
[a]Connecticut, Florida, and Maine license home care providers, but do not require orientation for home care workers.

among these states, ranging from the single requirement in Massachusetts for orientation programs to provide training on abuse prevention (Massachusetts Department of Health and Human Services, 2012) to the 32 specific criteria in

Colorado. In terms of particular standards, a number of patterns emerged (see Table 4). Training that specified knowledge of the home care agency was required in 11 states. In Delaware, to give one example, this training included the organizational structure of the agency, its consumer care policies and procedures, and its philosophy of consumer care (Personal Assistance Services Agencies, DE AC 16, § 4.5.2). Six states required training in basic ADL requirements, whereas four states required training in both ADL and IADL assistance. Five states required training in occupational principles outside of ADL/IADL tasks. For example, basic training for home care workers in Nevada included an overview of aging and disability "regarding changes related to the aging process, sensitivity training toward aged and disabled individuals, recognition of cultural diversity, and insights into dealing with behavioral issues" (Medicaid Service Manual, § 3503.18). Ten states required training of home care workers in state reporting requirements for abuse and neglect; four states required training in additional regulatory policies. In the latter category, for example, was Virginia, where orientation included knowledge of applicable laws, regulations, and other policies and procedures that apply to home care (VA AC 5, § 381-200).

Finally, 8 of the 16 states with specific course content for orientation of home care workers required a competency assessment at the conclusion of this training. These were Colorado, Delaware, Georgia, Illinois, Minnesota, Nevada, Pennsylvania, and Rhode Island. Illinois, for example, prohibited agencies from assigning a home care worker until the aide had first passed a competency evaluation (Home Health, Home Services, and Home Nursing Agency Code, IL AC 77, § 245.71). In the remaining eight states (Louisiana, Massachusetts, New Hampshire, North Carolina, Ohio, Tennessee, Virginia, and Wyoming), trainees were not required to pass an examination before their first assignment (see Table 4).

In-service training. In the United States, 15 states required annual in-service training for home care workers in 2011. Seven states (Georgia, Illinois, Louisiana, Minnesota, Nevada, Ohio, and Virginia) specified the duration of in-service programs. The average among these 7 states was 7.9 hr, ranging from 6 hr (Minnesota) to 40 hr (Louisiana). In Colorado, the annual in-service training requirement was prorated in accordance with the number of hours the employee actively worked with the agency (Home Care Agencies Act, 6 CCR 1011-1, § 8.6). In the remaining seven states (Massachusetts, New Hampshire, Oklahoma, Rhode Island, Tennessee, Texas, and Washington), the required duration of in-service programs for home care workers was not specified (see Table 5).

Seven states required specific content for in-service training programs. These were Colorado, Illinois, Massachusetts, Minnesota, New Hampshire, Rhode Island, and Tennessee. In general, these states required fewer content areas for in-service training than for orientation training. The most common

Table 4. Specific State Requirements for Orientation of Home Care Workers.

State	Training specifies agency knowledge, basic rights, documentation	Training specifies only basic ADL requirements	Training specifies basic ADL and IADL requirements	Training specifies occupational principles and processes knowledge	Training specifies abuse and neglect reporting requirements	Training specifies regulatory knowledge	Depth of requirements (measured by no. of criteria)	Distinctive measures required by state	Training includes required competency assessment
Colorado	Yes	No	Yes	No	Yes	No	32	Role of coordination with other community providers	Yes
Delaware	Yes	No	Yes	Yes	No	Yes	26	Philosophy of consumer care	Yes
Georgia	Yes	Yes	No	No	Yes	No	19	Code of conduct	Yes
Illinois	Yes	Yes	No	No	Yes	No	16	Use of specific adaptive equipment	Yes
Louisiana	No	No	No	No	Yes	Yes	2	Emergency and safety procedures; client abuse	No
Massachusetts	No	No	No	No	Yes	No	1	All content related to patient and resident abuse	No
Minnesota	Yes	Yes	No	No	Yes	Yes	19	Physical, emotional, and developmental needs of clients	Yes
Nevada	Yes	Yes	No	Yes	No	No	19	On-the-job annual training as needed	Yes
New Hampshire	Yes	No	No	No	Yes	No	10	NA	No
North Carolina	No	Yes	No	No	No	No	6	Competencies applicable only to aides hired after January 4, 2009	No

(*continued*)

Table 4. (continued)

State	Training specifies agency knowledge, basic rights, documentation	Training specifies only basic ADL requirements	Training specifies basic ADL and IADL requirements	Training specifies occupational principles and processes knowledge	Training specifies abuse and neglect reporting requirements	Training specifies regulatory knowledge	Depth of requirements (measured by no. of criteria)	Distinctive measures required by state	Training includes required competency assessment
Ohio	Yes	No	Yes	Yes	No	No	23	Previous experience recognized in competency measure	No
Pennsylvania	Yes	Yes	No	No	Yes	No	16	No timeline required for competencies	Yes
Rhode Island	No	No	Yes	No	No	No	7	Only IADL criteria listed	Yes
Tennessee	No	No	No	Yes	No	No	6	All criteria concerning infection control	No
Virginia	Yes	No	No	No	Yes	Yes	9	Cultural awareness; job duties and performance criteria are discretionary	No
Wyoming	Yes	No	No	Yes	Yes	No	12	NA	No

Note: ADL = activities of daily living; IADL = instrumental activities of daily living.

Table 5. In-Service Requirements for Home Care Workers.

State	In-service required	duration	Specific course content required
Alaska	No	NA	NA
Colorado	Yes	Varies[a]	Yes
Connecticut	No	NA	NA
Delaware	No[b]	NA	NA
Florida	No	NA	NA
Georgia	Yes	8 hours	No
Illinois	Yes	8 hours	Yes
Indiana	No	NA	NA
Louisiana	Yes	40 hours	No
Maine	No	NA	NA
Maryland	No	NA	NA
Massachusetts	Yes	Not specified	Yes
Minnesota	Yes	6 hours	Yes
Nebraska	No	NA	NA
Nevada	Yes	8 hours	No[c]
New Hampshire	Yes	Not specified	Yes
New Jersey	No	NA	NA
New York	No	NA	NA
North Carolina	No	NA	NA
Ohio	Yes	8 hours	No
Oklahoma	Yes	Not specified	No
Oregon	No	NA	NA
Pennsylvania	No	NA	NA
Rhode Island	Yes	Not specified	Yes
Tennessee	Yes	Not specified	Yes
Texas	Yes	Not specified	No
Virginia	Yes	12 hours	No
Washington	Yes	Not specified	No
Wyoming	No	NA	NA

Note: NA = not applicable.
[a]In Colorado, number of required in service is prorated with length of service.
[b]Delaware requires annual competency test for home care workers.
[c]In Nevada, consideration must be given to in-service topics suggested by home care workers.

elements of in-service programs in these seven states were infection control, abuse and neglect prevention, client rights and responsibilities, and emergency procedures (see Table 6). In some cases, the in-service training topics were unique to the particular state. For example, Colorado required in-service training to also

Table 6. Specific State Requirements for In-Service Training of Home Care Workers.

State	Behavior management	Disaster and emergency procedures	Infection control	Basic first aid and home safety	Client rights	Abuse and neglect reporting requirements
Colorado	×	×	×	×		
Illinois		×	×		×	×
Massachusetts						×
Minnesota			×			
New Hampshire		×	×		×	
Rhode Island						×
Tennessee			×			

measure communications skills with consumers who have special needs, such as a hearing deficit or dementia (Home Care Agencies Act, 6 CCR 1011-1, § 8.6).

Finally, eight states required in-service training for home care workers but did not specify the content of these training programs. Virginia, for example, allowed the in-service training topics to be determined by the on-site supervisor (Home Care Organization Licensing, Virginia Annotated Code 5, § 381-200). Nevada (see Table 5) allowed consideration to be given to topics suggested by the home care worker (Personal Care Services Program, Nevada Medicaid Services Manual, § 3503.18).

On-site supervision of home care workers. In 2011, 15 states required on-site supervision of home care workers after they had been hired (see Table 7). For example, Tennessee required a registered nurse to make a monthly visit, either when the aide was present or absent, "to assess the aide's competence in providing care and determine whether goals are being met" (Standards for Homecare Organizations Providing Home Health Services, § 1200-08-26). Thirteen states specified a time frame for this on-site supervision. These periods ranged from 1 month (Colorado and Tennessee) to 6 months (Oklahoma). In Georgia, the required time frame for on-site supervisory and monitoring visits varied, based on the level of care provided by home care workers (In-Home Respite Service Requirements, § 310.10 [E]). In Minnesota, scheduling of on-site supervision of home care providers was determined by the home care agency and the client (Minnesota Department of Health, 2008). In the 15 states with required on-site supervision, visits were primarily provided by professional nurses or agency personnel (see Table 7). In Wyoming, for example, on-site monitoring was one of the duties of the case manager assigned to each home care client (Rules for Community Based In-Home Services 1, § 10 [b]).

Table 7. On-Site Supervision of Home Care Workers.

State	On-site supervision required	Time frame	Professional providing supervision
Alaska	Yes	6 months	RN
Colorado	Yes	1 month	Qualified agency employee
Connecticut	No	NA	NA
Delaware	Yes	3 months	Agency director
Florida	No	NA	NA
Georgia	Yes	Varies[a]	Supervisor
Illinois	No	NA	NA
Indiana	No	NA	NA
Louisiana	No	NA	NA
Maine	No	NA	NA
Maryland	No	NA	NA
Massachusetts	No	NA	NA
Minnesota	Yes	Varies[b]	RN or therapist
Nebraska	No	NA	NA
Nevada	No	NA	NA
New Hampshire	Yes	3 months	Coordinator of client services
New Jersey	Yes	2 months	Health practitioner supervisor
New York	No	NA	NA
North Carolina	Yes	3 months	Supervisor
Ohio	Yes	2 months	Supervisor
Oklahoma	Yes	6 months	RN/LPN
Oregon	Yes	3 months	Manager
Pennsylvania	No	NA	NA
Rhode Island	Yes	3 months	Supervisor
Tennessee	Yes	1 month	RN
Texas	No	NA	NA
Virginia	Yes	3 months	RN
Washington	No	NA	NA
Wyoming	Yes	3 months	Case manager

Note: RN = registered nurse; LPN = licensed practical nurse; NA = not applicable.
[a]In Georgia, timing on on-site supervision based on level of care received.
[b]In Minnesota, on-site supervision scheduled by agency and client.

Discussion

The home care workforce in the United States comprises two categories of aides: those who provide medical services (such as nursing aides, psychiatric aides, and home health aides) and personal and home care aides, who provide nonmedical

services (Montgomery et al., 2005). While the former are primarily employed by agencies regulated under consistent national standards for participation in the Medicare program, the latter are not (Hirdes et al., 2004; Wiener et al., 2002). Personal and home care aides, the focus of our study, whether employed by agencies or clients (or self-employed), are subject to state requirements in areas such as training and supervision, but only in those 29 states in which a separate licensure category exists for home care providers. The purposes of this study were to analyze state requirements for orientation, in-service training, and on-site supervision of home care workers, and from these requirements, identify core competencies for these aides. These competencies could then serve not only as a model for legislation in other states but also as the foundation for preparing the home care workforce.

The importance of identifying core competencies for this workforce is clear; personal and home care services are the fastest growing in LTC, yet the quality of these services is often difficult to predict, in part because the skills necessary to provide these services are not clearly defined. Establishing a set of core competencies for home care would provide clients, employers, and workers a baseline of information comparable to that which already exists in other areas of LTC (e.g., nursing homes). Core competencies would help clients and their families judge the preparation of potential home care workers. They would help employers (home care agencies and client-employers) assess job candidates and help agencies develop career lattices for workers. Career lattices provide maps of organizations such that workers can identify both upward and lateral mobility options within their field. These career lattices can be meaningfully tied to educational and training plans for workers. Finally, core competencies would help home care workers understand their role and feel pride and achievement in attaining the necessary skills and knowledge. The skills currently required by some of the states provide a foundation from which to start.

Our analysis of state training requirements identifies several key components that orientation and in-service training programs must have to adequately prepare home care workers, even at the nonmedical level. This leads us to make the following recommendations in regards to this training (see Table 8). First, core competencies should include basic skills such as agency policy, including client rights and documentation; assistance with ADLs (e.g., grooming) and/or IADLs (e.g., housekeeping); maintenance of a clean, safe, and healthy environment (e.g., infection control); awareness of abuse and neglect reporting requirements; and communication. These skills are common elements in the training programs in most of the states in which required content is specified. Second, we believe core competencies should also include certain advanced skills, currently required in only one or two states, which also reflect the needs of potential clients. These

Table 8. Recommendations for State Training Programs for Home Care Workers.

Components of most current training programs	Components of some current training programs	Training components that are still needed
Agency knowledge, basic rights, documentation	Introduction to use of common assistive technology or adaptive equipment (e.g., mechanical lifts)	Basic medication information (e.g., usage, adverse reactions, drug interactions)
ADL assistance (e.g., bathing, feeding, grooming)	Emergency preparedness and accident prevention	Awareness of self-neglect
IADL assistance (e.g., housekeeping, food preparation, transportation)	Coordination with other community providers (e.g., area agencies on aging, Medicaid waiver HCBS providers, emergency medical services)	Caring for clients with dementia and other cognitive problems
Maintenance of a clean, safe, and healthy environment (e.g., infection control)	Understanding physical, emotional, and developmental needs of clients	Knowledge of legal and ethical issues (e.g., advance directives, guardianship)
Awareness of abuse and neglect reporting requirements	Behavioral management	
Basic communication skills	Cultural awareness	

Note: ADL = activities of daily living; IADL = instrumental activities of daily living; HCBS = home- and community-based services.

include use of assistive technology or adaptive equipment (e.g., mechanical lifts); emergency preparedness and accident prevention; coordination with other community providers (e.g. Medicaid waiver HCBS providers); understanding of the physical, emotional, and developmental needs of clients; behavioral management; and cultural awareness. Third, our analysis suggests the need for additional core competencies not currently required by the states. These include basic medication information; awareness of self-neglect; caring for clients with dementia

and other cognitive issues (e.g., Alzheimer's disease); and knowledge of legal and ethical issues, such as advance directives. Training programs that emphasize advanced clinical and interpersonal skills such as these have been particularly effective across LTC settings in reducing turnover and improving performance of direct care workers, creating a safer living environment for clients (Dill et al., 2010; Morgan & Konrad, 2008; Piercy & Dunkley, 2004).

Our analysis also reveals current trends among the states in requirements for on-site supervision. We found that roughly half (15 of 29) of the states that licensed home care providers also mandated on-site supervision of home care workers, with most (11) of these states requiring this professional supervision to occur within 3 months. This suggests to us a growing consensus among these states that nonmedical service providers should bear responsibility for ongoing quality assurance akin to that required of medical service providers (e.g., home health agencies) under federal law. That is, although federal Medicare rules require an on-site reassessment within 30 days for medical services (CMS, 2011b), several states have taken the initiative to require an on-site reassessment within 90 days (or less) for nonmedical services. We recommend that this 90-day requirement be the benchmark for other states that have yet to codify the required time frame for on-site supervision of home care workers.

In sum, our study has identified several states in which model home care policy potentially exists in areas such as training and supervision. Seven states (Colorado, Illinois, Massachusetts, Minnesota, New Hampshire, Rhode Island, and Tennessee) have established a separate licensure category for home care providers and require specific course content in the orientation and in-service training. Five of these states (Colorado, Minnesota New Hampshire, Rhode Island, and Tennessee) also require regularly scheduled on-site supervision of home care workers. The progress made in areas such as training and oversight suggest that these states may serve as regional and national leaders in efforts to improve the quality of home care. Previous research has established that certain states emerge as leaders in different areas of public policy (Gerber & Teske, 2000; Gray, 1973; Savage, 1978; Walker, 1969); for example, state policymaking in LTC has been particularly active in New England states (Kelly, Liebig, & Edwards, 2008; Wiener & Stevenson, 1998), a trend also reflected in the results of the present study. Home care is an area for future state policy growth, as reflected in the growing number of home care consumers and the relatively low number of states today with specific requirements for training and oversight. Future research should examine whether innovative home care policies in states such as Colorado, New Hampshire, and Tennessee are adopted by neighboring states and ultimately become national standards.

Although our analysis identifies potential core competencies, and states in which model efforts are already underway, we recommend that several considerations be made before adopting changes to existing state-mandated training programs. First, home care is often an entry-level job that provides economic opportunities to some of our most disenfranchised workers. The need for standard competencies, such as those recommended in this study, must be balanced with barrier reduction for entry into such jobs, as well as multiple entry points for workers. Multiple entry points into career lattices should allow for workers to enter at different levels depending on their prior education, direct care experiences, and prior paid care work. High-quality competency examination has the potential to acknowledge prior learning and allow those with higher levels of education, and work experience to enter at appropriate points without having to "retake" known content. Competency examinations must also accommodate multiple learning styles (i.e., oral, written, and performance), so as not to exclude well-qualified workers with other educational or employment barriers, such as low literacy levels, undiagnosed learning disabilities, poor educational experiences, and test anxiety. Training must also be accelerated so that individuals in need of jobs can self-pace learning and meet criteria as quickly as desired. Furthermore, realistic job previewing and active experiential learning strategies are essential training components necessary to transition displaced workers into these jobs. Finally, core competencies should be established with an eye to developing career lattices for home care workers, so that states and employers can best use the skills of these workers to meet the multiple and complex needs of older adults who want to age in place.

Developing state-level training systems will require collaboration between state agencies, educational institutions (particularly community colleges), employers and other key stakeholders depending on the state context (e.g., workforce investment boards, Boards of Nursing, community-based organizations). Six states, funded by the U.S. Department Health and Human Services Health Resources and Services Administration, have recently (September 2010) begun to develop comprehensive training programs for home care workers. The Personal and Home Care Aide State Training Program (PHCAST) was created in 2010 as part of national health care policy reform under the Affordable Care Act to fund a 3-year demonstration program in 6 states (California, Iowa, Maine, Massachusetts, Michigan, and North Carolina) to develop core competencies, pilot training curricula, and develop certification programs for personal and home care aides.[1] Implementation of these state-based programs should provide valuable information for states interested in reforming their legislation and implementing systemic change in standardizing the training requirements for entry, improving the continuing education and systematizing the assessment and potential credentialing process for home care workers

(Paraprofessional Healthcare Institute [PHI], 2010). The call for proposals that shapes the work of these six state grantees identified several evidence-based core competencies needed to provide person-directed personal care (e.g. self care, safety and emergency training, consumer rights, ethics and confidentiality; PHI, 2009). These core competencies are expected to inform the work of these states in developing comprehensive training programs (PHI, 2010).

The challenge for policymakers will then lie in translating strategies, lessons learned and curricula that emerge at the end of the PHCAST demonstration period in 2013 into coherent national training standards for home care. One particular challenge will be in integrating these new requirements into existing federal and state LTC programs (e.g., Medicaid HCBS waiver programs). If new evidence-based training standards for home care workers can be incorporated into the existing federal and state bureaucratic framework, improving the quality of home care (which is one of the objectives of national health care policy reform) can be achieved. Our study, particularly in its recommendations for the core competencies needed by this workforce, will hopefully provide another catalyst toward this ultimate goal.

Finally, there was an important limitation to our study, that is, our reliance on information currently available on state government websites. Although there is no evidence that the information necessary for this study was intentionally restricted by state mandate (as stated above, the code of laws in each state is available online), previous researchers have noted varying degrees of success among the states in their overall implementation of e-government (Gant & Gant, 2002; Tolbert et al., 2008; West, 2000). For our purposes, this may limit the reliability and validity of some of our interstate comparisons. Online resources outside the code of laws (such as administrative rules for regulatory agencies) we found helpful in some states may not yet be available in others. Fortunately, the states continue to improve in their utilization of the available technology (Tolbert et al., 2008), and as they do, it is essential for future studies to monitor where, when, and how the information available on state websites changes.

In conclusion, our analysis of state requirements for the training and supervision of home care workers lays a foundation for policy reform across the country to support these aides, the organizations that employ them and perhaps, most importantly, the clients that need these services. By focusing on the core competencies identified in this study, the states can potentially standardize the educational preparation of home care workers and integrate these competencies with career lattices across the direct care workforce. These state policy efforts are both necessary and timely, given the vulnerability of both the workforce and the clients they serve, and the projected expansion of home care services in the coming years. Flexibility in entry and exit points are vital to matching clients and workers in ways that support employment for workers, standards for organizations and quality of care for clients.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Note

1. Author two, Jennifer Craft Morgan, PhD, is involved as the principal evaluator of the North Carolina PHCAST grant through a subcontract with the North Carolina Foundation for Advanced Health Programs, Inc.

References

Benjamin, A. E., & Matthias, R. E. (2004). Work-life differences and outcomes for agency and consumer-directed home-care workers. *The Gerontologist, 44*, 479-488.

Benjamin, A. E., Matthias, R. E., & Franke, T. M. (2000). Comparing consumer-directed and agency models for providing supportive services at home. *Health Services Research, 35*, 351-366.

Centers for Medicare and Medicaid Services. (2011a). *Community services and long-term supports: Money follows the person*. Retrieved from https://www.cms.gov/CommunityServices/20_MFP.asp

Centers for Medicare and Medicaid Services. (2011b). Home health services. In *Medicare benefit policy manual*. Retrieved from https://www.cms.gov/manuals/downloads/bp102c07.pdf

Connecticut Department of Public Health. (2006). *Licensure of home health care agencies*. Retrieved from http://www.ct.gov/dph/lib/dph/agency_regulations/sections/pdfs/title_19._health_and_safety/phc/chapter_iv/19-33._home_health.pdf

Crow, S. M., Hartman, S. J., & McLendon, C. L. (2009). The realistic job preview as a partial remedy for nursing attrition and shortages: The role of nursing schools. *Journal of Continuing Education in Nursing, 40*, 318-323.

Deichert, J., Kosloski, K., & Holley, L. (2010). *A profile of direct care workers from the American Community Survey: Changes from 2000 through 2008*. Poster presentation at the annual meeting of the Gerontological Society of America in New Orleans, LA.

Dill, J. S., Morgan, J. C., & Konrad, T. R. (2010). Strengthening the long-term care workforce: The influence of win a step up workplace intervention on the turnover of direct care workers. *Journal of Applied Gerontology, 29*, 196-204.

Ejaz, F. K., Noelker, L. S., Menne, H. L., & Bagaka, J. G. (2008). The impact of stress and support on direct care workers' job satisfaction [Special issue]. *The Gerontologist, 48*, 60-70.

Gant, J. P., & Gant, D. B. (2002). *Web portal functionality and state government e-service*. Proceedings of the 35th Hawaii International Conference on System Sciences. Retrieved from http://www.computer.org/comp/proceedings/hicss/2002/1435/05/14350123.pdf

Gerber, B. J., & Teske, P. (2000). Regulatory policymaking in the American states: A review of theories and evidence. *Political Research Quarterly, 53*, 849-886.

Glick, H. R., & Hays, S. P. (1991). Innovation and reinvention in state policymaking: Theory and the evolution of living will laws. *Journal of Politics, 53*, 835-850.

Gray, V. (1973). Innovation in the states: A diffusion study. *American Political Science Review,* 67, 1174-1185.

Gunter-Hunt, G., Mahoney, J. E., & Sieger, C. E. (2002). A comparison of state advance directive documents. *The Gerontologist, 42*, 51-60.

Harmuth, S., & Dyson, D. (2002). *Results of the 2002 National Survey of State Initiatives on the long-term direct care workforce*. Raleigh: North Carolina Department of Health and Human Services, Office of Long Term Care.

Harrington, C., LeBlanc, A. J., Wood, J., Satten, N. F., & Tonner, N. C. (2002). Met and unmet need for Medicaid home- and community-based services in the states. *Journal of Applied Gerontology, 21*, 484-510.

Hirdes, J. P., Fries, B. E., Morris, J. M., Ikegami, N., Zimmerman, D., Dalby, D. M., . . . Jones, R. (2004). Home care quality indicators (HCQIs) based on the MDS-HC. *The Gerontologist, 44*, 665-679.

Home Care Agencies Act, Colorado Annotated Code, 6 CCR 1011-1, § 8.6 (2009).

Home Care Organization Licensing, Virginia Annotated Code 5, § 381-200 (2003).

Home Health, Home Services, and Home Nursing Agency Code, Illinois Administrative Code 77, § 245.71 (2010).

Homemaker-Home Health Aides and Agencies Act, New Jersey Annotated Code, § 13:45B-14.7 (2008).

In-Home Personal Services Act, Nebraska Annotated Code, NE LB 236, § 40 (2007).

In-Home Respite Service Requirements, Georgia Department of Human Resources Division of Aging Services, § 310.10 (E) (2010).

Institute of Medicine. (2008). *Retooling for an aging America: Building the health care workforce*. Washington, DC: National Academies Press.

Jette, A. M., Smith, K. W., & McDermott, S. M. (1996). Quality of Medicare-reimbursed home health care. *The Gerontologist, 36*, 492-501.

Kaskie, B., Knight, B. G., & Liebig, P. S. (2001). State legislation concerning individuals with dementia: An evaluation of three theoretical models of policy formation. *The Gerontologist, 41*, 383-393.

Kelly, C. M., Liebig, P. S., & Edwards, L. J. (2008). Nursing home deficiencies: An exploratory study of interstate variations in regulatory activity. *Journal of Aging & Social Policy, 20*, 398-413.

Kitchener, M., Ng, T., & Harrington, C. (2007). Medicaid home and community-based services for the elderly: Trends in programs and policies. *Journal of Applied Gerontology, 26*, 305-324.

Lacey, T. A., & Wright, B. (2009). Occupational employment projections to 2018. *Monthly Labor Review*. Retrieved from www.bls.gov/opub/mlr/2009/11/art5full.pdf

LeBlanc, L. J., Tonner, M. C., & Harrington, C. (2001). State Medicaid programs offering personal care services. *Health Care Financing Review, 22*, 155-173.

Levine, S., Boal, J., & Boling, P. A. (2003). Home care. *JAMA, 290*, 1203-1207.

Lopina, E. C., Rogelberg, S. G., & Howell, B. (2011). Turnover in dirty work occupations: A focus on pre-entry individual characteristics. *Journal of Occupational and Organizational Psychology*. Advance online publication. doi:10.1111/j.2044-8325.2011.02037.x

Massachusetts Department of Health and Human Services (2012). *Home Care Assistance Program Handbook*. Retrieved from: http://www.mass.gov/eohhs/consumer/disability-services/living-supports/home-care/under-60/hcap-handbook.html

Minnesota Department of Health. (2008). *A guide to home care services*. Retrieved from http://www.health.state.mn.us/divs/fpc/profinfo/lic/newguide.pdf

Mollica, R., & Sims-Kastelein, K. (2007). *Residential care and assisted living compendium 2007*. Washington, DC: U.S. Department of Health and Human Services.

Montgomery, R. J. V., Holley, L., Deichert, J., & Kosloski, K. (2005). A profile of home care workers from the 2000 Census: How it changes what we know. *The Gerontologist, 45*, 593-600.

Morgan, J. C., & Konrad, T. R. (2008). A mixed-method evaluation of a workforce development intervention for nursing assistants in nursing homes: The case of win a step up [Special issue]. *The Gerontologist, 48*, 71-79.

Personal Assistance Services Agencies, Delaware Administrative Code, Title 16, § 4.5.2 (2007).

Personal Care Services Program, Nevada Medicaid Services Manual, § 3503.18 (2010).

Paraprofessional Healthcare Institute. (2009). *Providing personal care services to elders and people with disabilities: A model curriculum for direct-care workers*. Retrieved from http://phinational.org/training/resources/pcsc/

Paraprofessional Healthcare Institute. (2010, October 7). *PHCAST awards announced*. Retrieved from http://phinational.org/archives/phcast-awards-announced/

Piercy, K. W., & Dunkley, G. J. (2004). What quality paid home caregivers means to family caregivers. *Journal of Applied Gerontology, 23*, 175-192.

Potter, S. J., Churilla, A., & Smith, K. (2006). An examination of full-time employment in the direct-care workforce. *Journal of Applied Gerontology, 25*, 356-374.

Rolph, E. S., Ginsburg, P. B., Hosek, S. D., Rich, J., Keenan, K. M., & Gertler, G. B. (1986). *State laws and regulations governing preferred provider organizations*. Santa Monica, CA: RAND.

Rules for Community Based In-Home Services, Wyoming Department of Health, Aging Division, Chap. 1, § 10 (b) (2005).

Sabatino, C. P. (1999). Survey of state EMS-DNR laws and protocols. *Journal of Law, Medicine & Ethics, 27*, 297-315.

Savage, R. L. (1978). Policy innovativeness as a trait of American states. *Journal of Politics, 40*, 212-219.

Smith, K., & Baughman, R. (2007). Caring for America's aging population: A profile of the direct-care workforce. *Monthly Labor Review,* 130, 20-26.

Smith, K. L., Soriano, T. S., & Boal, J. (2007). Brief communication: National quality-of-care standards in home-based primary care. *Annals of Internal Medicine, 146*, 188-192.

Standards for Homecare Organizations Providing Home Health Services, Rules of the Tennessee Department of Health, Board for Licensing Health Care Facilities, § 1200-08-26 (2010).

Stone, R., & Harahan, M. F. (2010). Improving the long-term care workforce serving older adults. *Health Affairs, 29*, 109-115.

Subramony, M. (2011). A meta-analytic investigation of the relationship between HRM bundles and firm performance. *Human Resource Management, 48*, 745-768. doi:10.1002/hrm.20315

Tolbert, C. J., Mossberger, K., & McNeal, R. (2008). Institutions, policy innovation, and e-government in the American states. *Public Administration Review, 68*, 549-563.

Tyler, D. A., Jung, H.-Y., Feng, Z., & Mor, V. (2010). Prevalence of nursing assistant training and certification programs within nursing homes, 1997-2007. *The Gerontologist, 50*, 550-555.

Walker, J. L. (1969). The diffusion of innovations among the American states. *American Political Science Review, 63*, 880-889.

West, D. (2000). *Assessing e-government: The Internet, Democracy, and service delivery by state and federal governments*. Washington, DC: World Bank.

Wiener, J. M., & Stevenson, D. G. (1998). State policy on long-term care for the elderly. *Health Affairs, 17*, 81-100.

Wiener, J. M., Tilly, J., & Alecxih, L. M. B. (2002). Home and community-based services in seven states. *Health Care Financing Review, 23*, 89-114.

Yamada, Y. (2002). Profile of home care aides, nursing home aides, and hospital aides: Historic changes and data recommendations. *The Gerontologist, 42*, 199-206.

Author Biographies

Christopher M. Kelly is an assistant professor in the Department of Gerontology at the University of Nebraska at Omaha. His research explores indicators of nursing home quality, as well as innovative long-term care alternatives at the state and local levels. The latter efforts include working with public and private stakeholders to develop home and community-based services; for example, through the state of Nebraska's newly created Aging and Disability Resource Center (ADRC). In addition to home care services, his current research also includes rural and minority caregiving and end-of-life decision making.

Jennifer Craft Morgan is a scientist at the Institute on Aging and a research assistant professor in the Department of Allied Health Sciences in the School of Medicine at the University of North Carolina at Chapel Hill. Her interests include medical sociology, gender stratification, evaluation research, health care/long-term care workforce, and the sociological study of work and careers over the life course. She is currently working on projects studying the work and careers of three feminized occupational groups: frontline health care workers, library and information professionals, and nurse faculty.

Kendra Jeanel Jason is a PhD candidate at North Carolina State University and a graduate research assistant at UNC-Chapel *Hill's* Institute on Aging. Her interests include research methods, inequality, organizations, and workforce development. Her dissertation is on frontline health care supervisors and job-training programs.