

## Building the Skills of Direct Care Workers: The Alaskan Core Competencies Initiative

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A large proportion of the health and social service workforce is comprised of direct care workers who have no formal preservice education and receive a limited amount of on-the-job training. These workers are essential in all geographic areas and are especially critical in rural and frontier regions where access to advanced health care professionals is limited. Driven by stakeholder demand, the State of Alaska launched the multiyear Alaskan Core Competencies initiative to strengthen the training of its direct care workforce. This article details the development of a set of cross-sector core competencies relevant to workers in the fields of mental health, addictions, developmental and physical disabilities, and the long-term care of older adults. Also described are the related assessment tools, curriculum, and train-the-trainer learning communities, which were developed to enable the dissemination of the competencies. The authors conclude by discussing the growing interest nationally in competencies for this workforce, the challenges of adapting one set of competencies for varied jobs in diverse health and social service sectors, and the financial barriers to widespread adoption of competency-based worker training.

*Keywords:* Alaska, assessment, competencies, curriculum, direct care workers

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The Alaskan Core Competencies are available for review on the Trust Training Cooperative website at <http://www.trustrainingcoop.org/training/akcc.html>. For more comprehensive information visit the Annapolis Coalition website at <http://annapoliscoalition.org/?portfolio=471>. For information on permission to use the Alaskan Core Competencies outside of Alaska contact the senior author.

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The direct care workforce is the face of the health and social service system for millions of Americans and their families. Known by many different names (see [Table 1](#)), these workers provide a large percentage of the direct care delivered to persons with mental health and substance use conditions, developmental and physical disabilities, and long-term care needs, whether in community, residential, or hospital settings ([Hewitt et al., 2008](#)). The nature of this direct care is highly varied, involving tasks such as providing assistance with daily living tasks (shopping, cooking, cleaning, personal hygiene), offering emotional support and reassurance, organizing group activities, and ensuring safety.

Direct care workers typically receive low wages and few, if any, benefits. Vacancy rates for these positions are high because of recruitment and retention challenges, with annual turnover ranging between 25–71% across the varied health and social service sectors ([Hewitt et al., 2008](#)). Although they tend to spend more time than other providers in direct contact with individuals and families in need, they have the least preservice education and receive the least preparation for their jobs ([Hewitt et al., 2008](#)). Training may be limited to a day or two at the time of hire and is largely restricted to administrative content, with little opportunity for initial or continuing education on skills in service delivery. The federal government has prescribed the number of required training hours and has specified training topics for groups such as Certified Nursing Assistants ([Requirements for Approval of a Nurse Aide Training & Competency Evaluation Program, 2011](#)). However, there has been no widely recognized

cross-sector set of competencies to guide the skill development of direct care workers or to evaluate their performance. This article describes an effort by the State of Alaska to strengthen this workforce by developing such competencies.

## Background and Significance

Providers, policymakers, and advocates in the State of Alaska have had longstanding concerns about recruitment, retention, training, and overall competence of the direct care workforce. In a meeting of stakeholders in Alaska that occurred in 2005, discussions of shared concerns led to agreement about the need for a set of uniform competencies to guide the training and the assessment of direct care workers ([Hoge et al., 2008](#)). They prioritized the development of a core competency set that was cross-sector in nature, capturing the skills necessary to function effectively in almost any area of health and social services, while excluding those skills that would be relevant to only some sectors. This goal was driven by recognition of the fact that many of the essential skills were common across sectors, that workers often moved between sectors, and that individual provider agencies and their workers frequently served multiple populations ([Hewitt et al., 2008](#)). As the work began to unfold, the many potential benefits of a core competency approach were articulated for employees, employers, and for the State of Alaska and its residents (see [Table 2](#); [Hoge et al., 2008](#)).

Three agencies within Alaska combined forces to lead and financially support the development of the Alaskan Core Competencies and other resources to train and assess worker skill in these competencies. The Alaska Mental Health Trust Authority operates like a foundation with the mission of improving the lives of individuals with mental health and substance use conditions, developmental disabilities, and those in need of home and community based care. The University of Alaska has numerous health-related educational programs and a commitment to strengthening the health care workforce within the state. The Department of Health and Social Services oversees all public health and social services in Alaska and manages the state's Medicaid program.

Table 1  
*Examples of Names for Direct Care Workers*

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Direct service worker
Direct support worker
Direct support professional
Personal care assistant
Personal care attendant
Paraprofessional
Aide
Technician
Peer support specialist
Home health aide

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Table 2  
*Potential Benefits of Core Competencies*

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For workers	
1.	Access to training in the skills essential to perform one's job
2.	Increased sense of professionalism
3.	Increased job satisfaction
4.	Increased competitiveness for jobs
5.	Increased job opportunities in other sectors
For employers	
1.	Access to standardized competencies and training resources
2.	Increased pool of qualified job applicants
3.	More competent employees
4.	More appropriate, effective, and humane care
5.	Decreased critical incidents
6.	Increased retention of workers
For the state and its residents	
1.	A more qualified direct care workforce
2.	A workforce that can be deployed flexibly across sectors
3.	Increased access to care (decreased vacant positions)
4.	Increased quality of care
5.	Increased satisfaction with care

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*Note.* Source: Adapted from Hoge et al., 2008.

The task of developing the competencies and related resources was contracted to two national organizations. The Mental Health Program of the Western Interstate Commission for Higher Education (WICHE), which had extensive knowledge about rural workforce issues and a history of providing technical assistance to the State of Alaska, engaged as an equal partner the Annapolis Coalition on the Behavioral Health Workforce, which had special expertise in competency development.

A statewide committee of Alaska stakeholders was created to oversee the development and ensure broad input into the competencies. Senior leaders in state government selected two state employees to cochair the committee, and the cochairs enlisted 25 others to serve. Members were drawn from geographically diverse areas representing highly varied state and non-profit agencies with interests including mental health, addictions, developmental disabilities, brain injury, children services, senior services, tribal health, and peer services. The committee met in person or by teleconference approximately every 8 to 12 weeks and placed an emphasis on building consensus on key projects decisions.

The sections below describe the development of the competencies and the related resources. It

is worth noting that initial stakeholder concerns regarding the need to develop and effectively train the direct care workforce have been bolstered by the recent industry and occupational forecast released by the [Alaska Department of Labor and Workforce Development \(2014\)](#). The forecast indicates that over the next 10 years, the state's population will grow by 10.8%, while Alaskans over age 65, who as a group use high levels of health and social services, will increase by 79%. The report predicts that health and social service jobs will account for an estimated 33% of all job growth during the next decade and over 70% of new jobs will go to individuals with a high school diploma or less than a high school education. Relevant to this review, the demand in Alaska for personal care aides, which is a type of direct care worker that routinely assists the elderly with daily living activities ([U.S. Department of Labor, 2014](#)), is projected to increase by 26% over 10 years, with more than 1,000 new jobs created and the need to refill 1,100 existing positions ([Alaska Department of Labor and Workforce Development, 2014](#)).

## Development Phases

To address the need for a skilled direct care workforce, the Alaskan Core Competency initiative was organized into five key phases. Each of these is described below and is also described in more detail in project reports available online ([Hoge et al., 2008](#); [Hoge & McFaul, 2009](#)).

### Phase 1: Competency Development

The identification of the competencies was the first stage of the process, which involved the following steps:

1. Consensus was developed by the oversight committee on the health and human sectors to be included in this initiative (mental health, substance abuse, developmental disabilities, aging) and the relevant direct care worker job categories within those sectors.
2. Eleven competency sets in use nationally and within Alaska for these job categories were identified, such as the USpra Role Delineation for mental health rehabilitation and the 15 NADSP Competency Ar-

- as for developmental disabilities (Hoge et al., 2008).
3. Project staff from WICHE and the Annapolis Coalition created a crosswalk comparing the competency categories in the 11 sets. Using a qualitative process, project staff members working individually first identified common competency categories among the 11 sets in use nationally and in Alaska and then compared their independent conclusions. Through discussion they achieved consensus on a recommended set of 10 competency categories for Alaska, which the oversight committee reviewed and subsequently endorsed (see Table 3).
  4. Individual competency items were culled by project staff from the 11 sets, then combined, simplified, and placed within the 10 competency categories, resulting in a draft competency set for Alaska. Behavioral descriptors for each of the competencies were developed at three levels: unsatisfactory, satisfactory, and excellent. The oversight committee, representing diverse health and social service sectors, reviewed and guided changes to the draft to ensure the relevance and clarity of each competency and its descriptors.
  5. In April 2009, 28 Alaskans were selected by the Alaska Mental Health Trust Authority and gathered together by WICHE and Annapolis Coalition staff to systematically review every competency and behavioral descriptor. Each team took a third of the items for group discussion of the relevance of the competency to direct care workers and the clarity of the item con-

tent. Teams included some members of the oversight committee, augmented by service agency directors and managers, educators, and policymakers, as well as eight direct care workers who had been nominated as exceptional performers by their supervisors. Individuals with shared areas of expertise were dispersed across the three teams.

6. With review team recommendations incorporated, the oversight committee conducted a last round of reviews and identified a modest set of changes to finalize the set containing 42 individual competencies. These are available online (Hoge & McFaul, 2010).

The majority of the Alaskan Core Competencies are highly relevant to the practice of direct care workers in any geographic region of the country. However, special attention was given to ensuring the inclusion of competencies relevant to the unique characteristics of Alaska. Competency category #7, for example, places a detailed focus on skills in individualizing care, which is particularly relevant given the diversity within the state with respect to race, ethnicity, culture, religion, and community characteristics. This competency category involves identifying these important individual characteristics, understanding the impact of the characteristics on the person's needs, and adapting services to those needs and the individual's preferences. The rural and frontier nature of Alaska, as well as many other states, often requires direct care workers to function with minimal supervision or support, so the competencies call for a relatively high degree of skill among workers located in these remote regions in terms of assessing treatment needs, delivering services without assistance from others, and intervening in crises. Competency in using technology, such as videoconferencing and online learning software, to deliver services and obtain supervision and continuing education also was considered essential. Skills in collaborating locally with community members and groups to meet the needs of Alaskans were similarly considered important given the scarcity of formal health and social services in rural and frontier areas. For direct care workers functioning alone in these areas, this

Table 3  
*Alaskan Core Competency Categories*

Competency category
1. Working with others
2. Assessing strengths and needs
3. Planning services
4. Providing services
5. Linking to Resources
6. Advocating
7. Individualizing care
8. Documenting
9. Behaving professionally and ethically
10. Developing professionally

Note. Source: Hoge & McFaul, 2010.

involves identifying those in the community who have the resources to be of help to individuals in distress and then coordinating community efforts to respond.

## Phase 2: Competency Assessment Tools

To facilitate the identification of learning needs and the assessment of skills, the second phase of the initiative involved the development of *Assessment Tools for the Alaskan Core Competencies*, which are available online (Hoge & McFaul, 2011). The tools, as a set, are based on a collaborative competency-based approach in which the worker and his or her supervisors work together to assess needs and develop skills. They were distributed to agencies in Alaska to use in promoting the adoption of the competencies within their organizations. The tools, which were developed before any classroom curriculum was available to teach the competencies, are designed to promote skill development in the workplace, as well as formal assessment of competencies through performance evaluations.

There are six steps and tools in this skill building process:

1. The worker completes the Employee Self-Assessment by rating his or her abilities on all 42 competencies using the categories of exceptional, satisfactory, or needs improvement. The worker and the supervisor at the agency in which he or she is employed then discuss these ratings, which serve as one source of information regarding worker competencies that may need further development;
2. The worker and supervisor jointly create a Skill Building Plan using a template in which they identify several learning needs for the worker, outline the steps that they will take to address the learning needs, and document the outcome of these efforts;
3. Both the worker and supervisor track day-to-day examples of the worker's learning needs and areas of strong performance using the Competency Logbook, which provides a template for documenting strengths and learning needs for each Alaskan Core Competency;
4. The supervisor gathers opinions about the worker's performance from coworkers, patients, and/or families using the 360 Degree Feedback Form, which is a template that requests such feedback within each of the 10 competency categories;
5. The supervisor conducts a formal Performance Review using the template in which the worker's abilities are rated overall and for each competency category as exceptional, satisfactory, or unsatisfactory; and
6. Workers use the Portfolio Guide as a template to record information about their learning experiences, such as continuing education events, and the relationship of the learning to the Alaskan Core Competencies.

## Phase 3: Competency Curriculum

The importance of effectively training a large number of workers in the competencies suggested the need for a standardized curriculum. A project team of four from WICHE and the Annapolis Coalition created the curriculum, building an instructional slide for each behavioral descriptor in the competency set. The content was based on the team's knowledge of best practices in direct care and their search of the literature for supporting resources, such as handouts from national organizations and federal agencies on topics such as suicide and substance abuse. The curriculum, which is designed to cover all of the competencies and to be delivered over the equivalent of four full days, has as its core a large set of PowerPoint slides that are annotated with notes that provide guidance to the trainer on how to use each slide. Although many of the slides contain content in outline form, a substantial percentage of the curriculum includes prompts for interactive group discussions or exercises. The educational approach emphasizes workers learning from the trainer, as well as workers sharing best practices and learning from each other. Accompanying the slide set are (a) suggested schedules for organizing the content into training sessions with workers; (b) content summaries and handouts for distribution to workers; (c) the self-assessment tool so that workers can rate their skills after learning each competency; and (d)

guidance on how to adapt the curriculum to specific settings or jobs.

The project staff from WICHE and the Annapolis Coalition piloted portions of the curriculum by delivering it to 27 direct care workers and supervisors in Anchorage, Alaska. The curriculum was revised based on the experience of delivering it and was also shaped by the verbal and written feedback of participants. Prior to finalization, the curriculum was reviewed by the oversight committee and edited based on their feedback (Hoge, McFaul, Paris, & Vogt, 2012). It is currently available within Alaska to individuals who have formally been trained to deliver it, as described below.

#### **Phase 4: The Training of Trainers**

The capacity to teach the competencies to direct care workers throughout Alaska required developing a strategy for preparing a large cadre of qualified trainers. The Trust Training Cooperative, now known as the Alaska Training Cooperative, is a unit within the University of Alaska that organizes and delivers training for the Alaska Mental Health Trust Authority. It coordinated the development of a 2-day educational experience for trainers who were nominated for participation by their service agencies. Delivered in conjunction with WICHE and the Annapolis Coalition, this train-the-trainer program is highly interactive. It is designed to impart the knowledge necessary to deliver the curriculum, while also exploring best practices in teaching approaches that engage direct care workers and create a positive training experience.

The trainers were organized into a learning community, first observing the curriculum developers demonstrating portions of the curriculum, and then practicing curriculum delivery in front of their peers, with opportunities for constructive feedback. Trainers returned to their agencies, developed plans to deliver the curriculum, and reconvened by teleconference with their peer trainers at least three times over the course of a 9- to 12-month period to share successes and discuss challenges.

#### **Phase 5: Dissemination and Adoption**

Early adopters within service agencies in Alaska were quick to enroll their trainers in this initiative and to use the curriculum within their

organizations. A large percentage of these early adopters not only trained their direct care staff, but also asked supervisors and managers to participate in the training in order to foster an organizational culture that embraced the competencies.

Currently underway is an effort to engage a larger percentage of Alaska's health and social services agencies in the adoption of the competencies. Multiple informational communications have been developed to educate senior managers within these agencies about the competencies and to showcase best practices in adoption among agencies that are routinely using these competencies to train their staff. Examples of these practices, which were identified by leaders within Alaska state agencies, WICHE, and the Annapolis Coalition, include finding champions of the competencies within service organizations, obtaining the support of agency senior leaders, training supervisors and middle managers in the competencies, and incorporating the competencies into job descriptions. In terms of dissemination, plans are underway to identify influential champions of the competencies within the state and to inform and engage newly appointed policy leaders in key positions about the work that has been accomplished and the challenges that remain to achieve broad scale adoption.

The Alaska Mental Health Trust Authority has commissioned the development of work-based learning modules for use by supervisors in teaching and reinforcing the competencies during the natural flow of daily work responsibilities and supervisory interactions. This model will enlist supervisors in facilitating the transfer of learning from the classroom to the work setting and in fostering retention of the newly learned competencies (Roberts et al., 2011).

#### **Evaluation**

A total of 27 direct care workers participated in the 2-day curriculum pilot. They were drawn from four service sectors: mental health, substance use disorders, developmental disabilities, and long-term care. Participants were very positive about the experience as evidenced by the ratings reported in Table 4. Many valued the opportunity to participate in training with workers from different service sectors as they reported learning from this experience about the

Table 4  
*Worker Ratings of Curriculum Pilot*

Question	Mean score
The purpose of the training was clearly communicated.	4.6
The training content was relevant to my job.	4.6
Training content was practical and easy to understand.	4.6
I understand what a competency is and can identify at least five of the Alaskan Core Competencies.	4.3
There was adequate opportunity to hear from and learn from others in the training.	4.8
I feel better prepared to do my job.	4.4

*Note.* Rating scale: 5 = *strongly agree*, 4 = *agree*, 3 = *neither agree nor disagree*, 2 = *disagree*, 1 = *strongly disagree*.

broader service system in which they were working.

Three cohorts of trainers have been trained over the past three years. As of May 2015, a total of 55 individuals have been trained as trainers, representing 31 agencies from across the State of Alaska. Thirty of these trainers (55%) have completed their training commitment to deliver the entire curriculum twice. Over the past 3 years, 1,090 direct care workers have received some competency training, of which 730 (67%) received training in some of the Alaskan Core Competencies and 360 (33%) received training in all of the competencies.

Satisfaction among trainers with the train-the-trainer experience has been very high. Data are available for the first two cohorts of trainers, 100% of whom indicated satisfaction with the experience (85% of whom gave the highest possible rating). With respect to knowledge of the core competency training modules, 77.5% strongly agreed and 17.5% agreed that their knowledge had been increased as a result of the training, with just two of 40 participants expressing dissatisfaction.

The assessment of the training experience by direct care workers also has been quite positive. An overall satisfaction rating is captured in the state's learning management system. A total of 3,097 satisfaction surveys were sent out to participants in core competency trainings. This involved invitations to the 1,090 participants to rate multiple training sessions. A total of 2,764 (89%) of the surveys were returned, with 54% indicating strong agreement and 43% indicating agreement that the training in the competencies was valuable to them. Only 3% of the completed surveys indicated disagreement or strong disagreement with the statement that the competency training had value.

## Discussion

The importance of core competencies for direct care workers is gaining national attention. Subsequent to the development of the *Alaskan Core Competencies*, the Centers for Medicare and Medicaid Services funded the development of a cross-sector competency set known as the *Roadmap of Core Competencies for the Direct Service Workforce* (National Direct Service Workforce Resource Center, 2014). Development began with a comparison of competency sets drawn from varied health sectors and included the *Alaskan Core Competencies*. The Centers for Medicare and Medicaid Services does not mandate the use of these or any other competencies. Additionally, the *Road Map* competencies are not accompanied by assessment tools, a curriculum, or methods to train trainers. In a parallel effort by another federal agency, the Substance Abuse and Mental Health Services Administration (2015) recently commissioned and posted for comment "foundational and essential core competencies" for peer workers within behavioral health services.

In any core set of competencies, not all individual competencies are relevant to every direct care worker or direct care position. Competencies that are relevant to 70% to 80% of workers or positions are generally included in core sets (National Direct Service Workforce Resource Center, 2014). In Alaska and nationally, concern among employers about the relevance of core competency sets has primarily emerged in the physical disabilities and long-term care sectors. Through implementation efforts, Alaska has supported and provided guidance on how to adapt the Alaskan Core Competencies curriculum to specific populations and types of direct care workers, while striving to maintain the

integrity of the competencies being taught. The Alaska Mental Health Trust Authority has commissioned work to begin on the development of an adaptation of the competency curriculum for direct care workers who provide long-term care to older adults. Overall, the Alaskan experience suggests that it is quite feasible to develop a core, cross-sector set of competencies, while recognizing the need to tailor the training in those competencies to local agency and population needs.

The major obstacle to building a set of core competencies involved the challenge of developing consensus among representatives of the highly varied health and human service sectors. This was achieved through the involvement of a large number of stakeholders, a transparent development process, and multiple opportunities for their input into the final content of the competencies. Leadership from the Alaska Mental Health Trust Authority in organizing and funding the competency development and in convening the stakeholders was also essential to the project's success.

The major barrier to wide-scale adoption of any training program for direct care workers involves the labor costs to the employer associated with having these workers engage in a nonbillable training activity. Health and social service agencies that have a workforce comprised largely of direct care workers tend to have very small operating margins, with few resources to spend on training. High turnover rates create a constant need to train new workers, which increases costs. No matter how compelling the merit of training workers in a core set of competencies, most state governments, including the government in Alaska, have been reluctant to either directly fund the cost associated with training or to create unfunded mandates that require training, certification, or credentialing. The Alaska Mental Health Trust Authority is grappling with this issue by developing a financial model that identifies the cost to an employer of adopting the Alaskan Core Competencies and exploring with state agencies the various options for incentivizing employers to train their workers in the competencies.

As a nation, the United States places many of its most vulnerable individuals in the hands of direct care workers. These workers are given very little training despite their many responsibilities and tend to stay briefly in these jobs given the low

wages, lack of guaranteed hours, minimal benefits, frequent need to rely on various forms of public assistance, and few prospects of a career path or advancement. Resources, such as the *Alaskan Core Competencies*, are now available to guide the initial training, continuing education, and assessment of workers. The challenge that remains is to devise and implement reforms in the nation's health and social service systems that support the training of direct care workers in the basic competencies necessary to do their jobs and to provide incentives for these workers, once trained, to continue to do this important work. This should be a high priority throughout the country but is especially critical in rural and frontier regions where these workers may be functioning in relative isolation and with minimal oversight and support.

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