



Perspectives On:

Investing in California's Direct Care Workforce by Increasing Geriatric Training Opportunities

August 2009

Acknowledgements

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August 2009

Dear Colleagues,

The direct care workforce which includes nursing aides, home health aides and home makers provides care for Seniors in the community through home health services and residents of long-term care facilities. In California there are more than 150,000 certified nursing assistants (CNAs) and home health aides (HHAs) providing paid care and support for a growing number of older adults and persons with disabilities.

The SCAN Foundation as part of developing its Fall 2009 Request for Proposal (RFP) commissioned a set of issue papers from experts across the nation which focus on understanding the role of CNAs and HHAs in California and the opportunities for developing senior specific curriculum to enhance their skills through continuing education. The papers include:

Direct Care Workers: Essential to Quality Nursing Home and Home Health Care

Author: Sarah Wells, Executive Director and Alice Hedt, Consultant, NCCNHR
(National Citizens' Coalition for Nursing Home Reform)

State of California Certification and Continuing Education Requirements for Certified Nursing Assistants and Home Health Aides

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Effective Strategies and Exemplary Ongoing Training Programs for Direct Care Workers

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Developing Geriatric Curricula

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Supporting Training for Direct Care Staff

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Opportunities for the State of California

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In addition to commissioning these issue papers, The SCAN Foundation has invited experts and key stakeholders for a convening later this month in Sacramento, to gain an in-depth understanding of the continuing education needs of the direct care workforce, and the opportunities to develop pertinent curricula, with the goal of enabling CNAs and HHAs to provide the highest quality of care for California seniors.

We appreciate your interest in this issue and welcome your input.

Sincerely,



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Direct Care Workers: Essential to Quality Nursing Home and Home Health Care

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On any given day, 126,000 Californians in nursing homes receive care from Certified Nursing Assistants (CNAs). An additional number of the State's residents receive care in their own homes from the 54,260 registered Home Health Aides (HHAs). Each of these persons is dependent on Direct Care Workers (DCWs) to address at least some of their most fundamental human needs. The DCW is also a liaison to the nursing staff, reporting the care-receiver's medical and emotional status and she or he may also be the person's key connection to the outside world¹.

Put yourself in this scenario. You are an older adult who needs assistance with almost every aspect of your life. It is early morning and you await the DCW who is assigned to you today and who will spend between 20 and 40 minutes with you. The DCW's actions in this short period of time will directly affect:

- When and whether you get out of bed
- How long you have to lie in wet pants
- If you get to decide what you want to wear
- Whether your teeth are brushed, your nails filed and your body washed
- If the curtains are closed so that no one can see you naked
- If the nurse is notified of the red spot on your heel that could easily become a bedsore
- If you have enough to eat and are positioned correctly so that you will not choke
- Whether the water by the bed can be reached and if there is a straw that you need
- If you are taken to any morning activities
- Whether you start your day hearing a few kind words
- If you are rushed or relaxed
- If you are in a nursing home, whether you are able to call for help the rest of the morning with a call bell or phone in reach

This scene is replayed daily in 1.6 million nursing home resident rooms throughout the country and

in thousands of homes where older adults receive much needed medical care and assistance from HHAs. The bottom line is obvious:

No matter what laws and regulations are in place, no matter if the care is from a for-profit or not-for-profit organization no matter the amount of money being paid by the individual or by the State's Medicaid program -- the experience of the older adult is determined by his or her interactions with the DCW.

A landmark NCCNHR study of residents in 1985 identified the key components of quality from the consumer's perspective. Nursing home residents throughout the country explained that the most important elements of quality in their day-to-day lives were the accessibility and attitude of the DCW². Daily since the study, NCCNHR staff and board members have been in conversation with consumers who consistently reiterate the study's findings – that DCWs in all settings across the continuum of care are the most essential part of the care-receiver experience. These consumers – nursing home residents, individuals receiving care in their homes, family members and advocates – stress that a good long-term care experience is dependent on having enough DCWs who are well trained and have a positive attitude. Judith Mangum, a former NCCNHR board member and nursing home resident for over 20 years explains, "On some days, I am just the recipient of a task that they have to do and record – give me water, wash my face, help me into the wheelchair. On good days, I get what I need as well as a smile, kind words and support so I can do what I can for myself. The worst days are when no one has time to talk to me. I am too often sitting here - alert and wanting human contact - and no one can or will have a conversation because they have to complete their tasks."

As curriculum is developed for those who care for older adults, it is essential that it contain

components that strengthen DCWs' skills (quality of care) and enable the worker to have interactive, respectful relationships (quality of life) with residents with all kinds of needs and disabilities. Poor training about dementia and mental health issues, for example, has been identified as a factor that contributes to neglect and abuse³.

One way of identifying the skills component is to examine what is needed by nursing home residents and individuals receiving home health care in California. For example, equipping CNAs to understand that restraints are not appropriate and helping them understand alternatives could impact the excessive rate of 11 percent of California nursing home residents who are restrained daily⁴. California long-term care ombudsman data from 2008 indicate other problem areas that could be addressed in a geriatric curriculum, including accident prevention and handling, reporting and addressing physical symptoms and care plan implementation⁵. Oral care has also been identified by the ombudsman program as a serious problem in California. Adequate nutrition and hydration practices are essential topics based on the detailed research conducted by Jeanie Kayser-Jones in California⁶. Likewise, nursing home and home health deficiency data could inform the home health curriculum.

The quality of life components sometimes referred to as soft competencies can also be identified through ombudsman data. For example, the third highest complaint in California is about staff attitudes - staff not treating residents with respect and dignity. The number one complaint category handled by California ombudsmen is another important DCW competency - handling roommate and resident conflict⁷. Other important soft competencies that promote quality of life as well as DCW job satisfaction include resident/care-receiver rights, organizing work, empowerment, teamwork, stress management and cultural sensitivities.

One long-time CNA summarized the link between quality of life and quality of care when she addressed a Career Nursing Assistants' meeting

saying, "We have all been taught how to clean up messes. The trick of being a good CNA is how to clean up messes and not make the resident feel bad, how to be supportive in my tone of voice and attitude⁸."

Because the DCW is so important to the consumer as well as to the entire long-term care system in this country, it is essential that any training that is developed be mindful of specific characteristics of both the workforce and of those for whom the workforce provides care. NCCNHR proposes the following considerations to be part of the discussion so that DCWs are more effectively equipped to carry out their important work, thus improving the day-to-day experiences of residents.

Cultural Diversity. The diversity of the population in California needs to be addressed in ways that are affirming of ethnic, cultural, sexual and religious differences. Information on varying communication styles, lifestyle and diet preferences, religious practices and attitudes about end-of-life should be addressed as part of resident/care-receiver rights that maintain that each person should be treated with dignity and respect as an individual⁹.

Individualized Care Plans. Comprehensive person-directed care planning is essential to quality in every setting¹⁰. Equipping DCWs to understand, implement and participate in the care planning process can ultimately improve care for all consumers, particularly since this worker can best recognize physical and emotional changes in the care-receiver that need to be addressed by nursing and other members of the care team.

The Nursing Home Reform Law spells out the goal of care planning: that each person receives services and activities to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care." This is more fully implemented in culture change facilities that focus on the individual and his or her relationship with the worker, rather than on the institution. Consistent assignment and other culture change activities will not be successful without adequate training and empowerment of the DCW.

Systemic Issues. While training is essential to quality, it is important to recognize that DCWs also need adequate compensation, benefits and a work environment that is respectful¹¹. Equally important, there must be adequate numbers of CNAs to perform the care and to interact with the residents. Needed nursing home staffing levels of 4.1 hours per day have been identified by NCCNHR and affirmed by CMS research¹². A study of nurse staffing in California nursing homes found that the most dramatic differences in quality were among facilities with highest levels of nursing assistant care – at least 4.5 hours per resident per day¹³. Likewise, individuals receiving services in their own homes will experience quality if there is adequate training, compensation and time for the worker to complete the needed activities and interactions with the care-receiver. Addressing these systemic issues is ultimately necessary to address the turnover and retention that inhibit quality of care and quality of life.

DCW Supervisor Training. Every effort should be made to make sure that those responsible for supervising and mentoring the DCWs receive the same training and ideally participate with the workers in the training. If not, the workers may eagerly attempt to implement what they learned and be frustrated by a work environment that does not support their active participation or respect their important observations.

Dementia Training. Every DCW needs to be familiar with Alzheimer's disease and other dementias and be comfortable with consumers whose behaviors are affected by these diseases. With 50 percent of those 85 and over expected to develop Alzheimer's disease, DCWs will need extensive training to understand and manage resulting behaviors. Health care reform bills being considered in the House and Senate would require dementia-care training for nursing assistants.

Adult Learning. One way to respect nursing home residents and those receiving home health care is to respect the workers who care for them. This means providing training that is designed for adult learners that is interactive, participative,

stimulating and fun. Effective training will affirm the worker while providing relevant educational information. The involvement of workers themselves in the development and testing of training materials is a useful strategy. In addition, the use of materials developed for consumers is often appropriate for DCW training. NCCNHR's consumer booklet on restraints that was developed in California, and its residents' rights materials, are examples of easy-to-understand tools that enable the worker to better understand the uniqueness of each older adult¹⁴. In addition, materials need to be designed that can be offered in a variety of times and settings so that they can be effectively utilized by providers.

This paper was developed as a "think piece" to stimulate dialogue among stakeholders who are discussing the needed components of training for DCWs. For 35 years, NCCNHR has maintained this kind of dialogue with long-term care consumers including nursing home and board and care residents, their families, and their advocates, and more recently those receiving services in their own homes. As our experience has shown in this paper, DCWs are essential to the quality of life for and quality of care of older adults. Furthermore, there is a critical need to better support DCWs through cultural sensitivity, involvement in care planning, by addressing systemic issues and through comprehensive training opportunities.

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State of California Certification and Continuing Education Requirements for Certified Nursing Assistants and Home Health Aides

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Purpose

The purpose of this paper is to describe the requirements for and process of obtaining continuing and in-service education for CNAs and HHAs in California. The goal is to address how well current continuing education requirements address the needs of the geriatric population and to make recommendations about potential policy changes. The scope of this paper does not include the workforce in other settings such as assisted living or the category of personal care aides who provide assistance to the aged and disabled in the home.

Background and Description of CNAs and HHAs

CNAs are employed by skilled nursing facilities (SNFs) and provide the bulk of direct patient care. This care includes assistance with bathing, dressing, eating, toileting, and ambulation. They also take vital signs and report changes in patient condition to the licensed nursing staff. HHAs are employed by Home Health Agencies and provide similar direct care to patients in their homes^{1,2}. Some of the occupational data used in this paper refers to a category of “nurse aides” inclusive of nursing assistants in all settings; only nursing assistants employed in SNFs are “certified” and can use the CNA designation. Nursing homes and home health agencies must meet all State regulatory requirements including Title XXII, Welfare & Institutes Code, and Health & Safety Codes for training requirements. If organizations accept Medicare and Medicaid they must also meet Omnibus Budget Reconciliation Act (OBRA) requirements.

Wages for CNAs and HHAs are among the lowest in health care. The mean hourly wage for nurse aides in California is \$13.33 and \$11.07 for

HHA³. In California, median age of nurse aides is 42 years; 83 percent are female; and race/ethnicity is comprised of 33 percent Latino, 29 percent White, 19 percent Asian, 14 percent African American, and 5 percent Other⁴. In addition, many workers in these occupations do not receive health insurance benefits. If benefits are offered by the employer, these workers are often not able to afford their share of the health insurance premiums⁵.

According to the California Department of Public Health, Licensing and Certification Program, there are a total of 154,034 CNAs and HHAs in 2009. Of the 150,630 CNAs, about 27 percent (41,234) are dually certified as CNA/HHA. There are 3,395 individuals who hold the HHA only certification⁶. In comparison, licensing and certification data from 2001 indicated about 109,000 CNAs and HHAs in the State. This represents an estimated increase of about 41 percent in the number of certificants over the past 8 years⁷. While the total number of CNAs and HHAs has increased, the retention rates for both categories of workers have decreased⁶. CNA average retention rates are currently 68%, down from 75% in FY 06-07. The HHA average retention rates have decreased from 68% in FY 06-07 to 64% this fiscal year. The decreasing retention rate has important implications for addressing the anticipated demand for more caregivers as our older adult population ages and has a greater need for care.

The California Employment Development Department (EDD) surveys employers and estimates the overall employment of nurse aides including those who are not certified. Coincidentally, the total number of nurse aides and HHAs is very close to

the number certified in the State⁸. EDD projects occupational growth rates of 22 percent for nurse aides and 39 percent for HHA for the period 2006-2016⁹. That translates to about new 3,000 nurse aide jobs and 2,300 home health aide jobs in California per year. In those projections, about one-quarter to one-third are replacement needs due to the high turnover and poor retention rates. Turnover rates for CNAs are estimated at 67 percent in the State of California¹⁰. We were unable to determine turnover rates for HHAs.

CNA/HHA Minimum Initial Training

Minimum federal requirements for training of nurse aides (assistants) were established by the OBRA in 1987¹¹. The minimum federal requirements for CNAs include: 75 hours of state-approved training, a state certification exam, and at least 12 hours per year of continuing education¹². HHAs must meet the same requirements if they work in an agency that receives Medicaid or Medicare reimbursement. The federal requirements include specifications as to content such as basic nursing skills, restorative skills, and caring for the cognitively impaired. Twenty seven states have mandated training requirements beyond

the federal minimum¹³. California is one of four states that mandates 160 hours of initial training for nurse aides and 75 hours of training for HHAs (previously 120 hours for HHAs). The regulations for training CNAs and HHAs in California are spelled out in detail in the Title XXII, Health and Safety codes¹⁴. The regulations are more detailed and specific for CNAs than for HHAs. Table 1 presents an overview of the training requirements for CNAs and HHAs in California as stipulated in those regulations.

Training Providers

Training providers for initial training and continuing and inservice education must be approved by the State's Licensing and Certification program. The list of educational program providers on the State's Department of Public Health (CDPH) website, Licensing and Certification homepage includes non-facility based nurse assistant training programs (community colleges, regional occupational programs (ROPs), and private schools), and facility and agency based training programs and was last updated in June of 2009. Table 2 displays the types of training providers by the type of training they may conduct.

Table 1. Overview of CNA and HHA Training Requirements in California

Requirements	CNAs	HHAs
Initial Preparation for Certification	160 hours *60 hours classroom (H&S code) *100 hours clinical	75 hours
Who is Responsible to Provide Continuing Education	Director of Staff Development	Director of Nursing
Continuing Education Units (2 years) Specialized Training	48 hours every 2 years 5 hours Dementia Training	24 hours every 2 years

Table 2. Types of Training Providers Initial/Continuing

	Initial	Continuing
Community or state colleges	X	X
Adult education regional occupation programs	X	X
General acute care hospitals		X
American Red Cross		X
Home Health Agencies/PACE (ON LOK)	X	X
State long-term care ombudsman		X
Continuing Education providers approved by state nursing boards		X
Online Providers (restricted to 12 hours)		X

A review of the list of providers for initial CNA training indicates that there are a large number of programs located in most counties in the State and that most of the programs are facility based. There are far fewer HHA training programs in the State. This may be due to the fact that there was a significant decrease in the number of Home Health Agencies (40.5% between 1997 and 2001) due to changes and decreases in the federal payments for home health services¹⁵. The list of continuing education providers does not seem to include facility based programs so it is difficult to accurately assess the number of continuing education providers. The website also lists and provides links to 13 approved online continuing education providers.

Cost of Initial Training, Continuing Education (CNAs), and In-Service Education (HHAs)

Although we found little data on cost of CNA and HHA initial and continuing education, it is generally thought that most CNAs and HHAs participate in programs based in long-term care facilities. Thus, individual trainees who participate in facility based programs do not incur out of pocket costs for initial training, continuing education, or in-service education.

Individuals who receive their initial CNA or HHA training in a community college, regional occupational program (ROP), or private school would likely incur out of pocket costs for the training unless the training program was reimbursed by a facility. Generally community college and ROP fees are low; private school fees are often considerably more costly.

Continuing education is generally provided by the SNF or home health agency, again with no out-of-pocket cost to the individual CNA or HHA. The regulations for CNAs allow for 24 of the 48 hours of continuing education to be obtained from approved online computer based training. Those online vendors generally charge a fee for the course, per course or per hour of training. The cost continued training is incurred by the SNFs and home health agencies. They must pay for the instructor, materials, classroom space, and time for the CNAs to obtain training. We were not able to

obtain specific information about how SNFs and home health agencies are reimbursed for these costs.

Continuing Education and Inservice Education Requirements

The State of California (Title XXII) has mandated ongoing continuing education training for both CNAs and HHAs. CNAs are required to have 48 hours of continuing education over two years; at least 12 hours must be taken in any single year. HHAs must have 12 hours annually of in-service education (see Table 1). The California continuing education requirement for CNAs is more stringent than the Federal OBRA requirement of 12 hours per year. California's Health and Safety code (1263) also mandates that CNAs receive a minimum of five hours each year in dementia training in accordance with the Dementia Training Standards Act of 2001¹⁶.

Responsibility for Providing Continuing Education

Nursing homes are responsible for providing at least 24 hours of CNA continuing education annually during the CNAs regular work hours. Continuing education courses may also be taken from California Department of Public Health (CDPH) approved providers. Home health agencies are responsible for providing a minimum of twelve hours of in-service annually to agency HHAs, also during the HHA's work regular work hours. We were unable to find any special requirements for the educator.

Home study courses are not allowed for either CNAs or HHAs because there is no opportunity for questions and answers. It is not clear how this issue is addressed in online education. Individuals or organizations (facilities) who seek approval to be a continuing education provider must complete a California State Application (HS192) and provide:

- 1) One year schedule of courses with the number of CEUs identified
- 2) A sample of lesson plans, course outlines, performance standards, tests for four separate courses offered and demonstrate experience in the topic presented.
- 3) Resumes for all instructors.

Who Conducts Training

The Director of Staff Development (DSD) is a licensed nurse responsible for developing and maintaining the annual CNA training calendar in a nursing home and typically provides a substantial portion of the training. In California, the DSDs must have a minimum of two years of nursing home experience and be approved by the CDPH, Licensing and Certification Division. DSDs that teach nursing assistant initial certification programs must complete a 24 hour course that meets the criteria for the DSD position in accordance with the California Code of Regulations, Title XXII, Division 5, Chapter 2.5, Section 71829 or have collected transcripts showing proof of completion of courses related to teaching. The management of HHA in-service is the responsibility of the Home Health Agency Director of Nursing or designee.

Continuing Education Training Content

Outside of the mandatory requirements, DSDs have wide latitude in determining content. There is no provision for CNAs to have input into the training content. Title XXII states this education must enhance the basic CNA training program, be consistent with resident needs, and address areas of deficiencies from the previous licensing survey. Additionally, the Federal Center for Medicare and Medicaid (CMS) requires that training be sufficient to ensure the continuing competence of the CNA and that it addresses any areas of weakness as determined in the CNA's annual performance reviews. These requirements suggest that the programs be customized for each CNA. We did not find specific content requirements for HHA in-service education.

CNAs or HHAs who are pursuing nursing licensure may receive credit for nursing program courses by submitting the courses on their certification renewal. Semester units = 15 hours of CEU and quarters equal 10 hrs of CEU. If a CNA is also training as a HHA, he or she may count 26 of the 40 hours HHA training program toward continuing education.

How Training is Conducted

Typically, CNA training occurs in a classroom setting at the facility where the CNA is employed.

DSDs are free to use a variety of different methods; however, if videos or tapes are used, the DSD must certify they are present for discussion and/or demonstration. Continuing education for HHAs is similar in that the employer provides regular in-service training specific to the needs of the organization and that training is usually provided by licensed nurses.

Tracking Continuing Education

The nursing home DSD must track the overall programmatic offerings to ensure a minimum of 24 hours are offered annually that meet the specific annual requirements and provide each CNA with a list of the annual education they have received. The facilities must maintain the records for a minimum of four years. For each class, the DSDs must retain 1) student behavioral objectives, 2) descriptive topic content (technique, method, and procedures), 3) method of teaching, and 4) method of evaluation that indicates learning has occurred. Home health agencies similarly are responsible for keeping track of HHA in-service education.

Auditing Recertification

The Licensure and Certification Board conducts random audits of approximately 100 CNAs and HHAs who are renewing their certification each month to verify if the required continuing education or in-service training has been completed. The CNAs or HHAs chosen for the audit submit verification of training (the State provides a form that CNAs and DSDs can use for this purpose). If the CNA or HHA does not respond to the request, the State initiates an investigation. The CNA or HHA can submit verification at any point during the investigation. Failure to provide adequate proof can bring on disciplinary action, included but not limited to revocation or suspension of the certification. If a CNA or HHA cannot meet the continuing education or work requirement to renew their certificate, they are offered the opportunity to reactivate their certificate by passing the State approved competency evaluation. For fiscal year 08-09, there were 3,556 CNA/HHA certificates that were re-activated⁶.

Recommendations for Improvement of CNA/HHA Continuing Education

Poor or inadequate training has been cited by educators, researchers, ombudsmen, and nurse aides themselves as reasons for impediments to quality improvement, neglect and abuse in facilities, and poor staff retention¹⁷. From the perspective of caring for older adults, continuing education needs to focus on geriatric specific content. Currently, the only geriatric related training requirement is for dementia training. CNAs are employed in nursing home settings where the majority of residents are older adults with chronic diseases, geriatric syndromes, and behavioral issues. It is critical that CNAs get the necessary geriatric content in order to properly care for the residents. The recommendations made in this paper are those most relevant and practical for the State of California to consider; some of these recommendations have been addressed in previous literature.

Educator/Trainer Skills

- Educator/Trainers need improved skills and methods as trainers to include effective adult learning techniques. These should extend beyond typical didactic settings and lecture presentations to include case based scenarios and other activities that involve the learner. Training calendars must include variety in content in addition to creative delivery and instructional design. One way to ensure that educators emphasize unique training environments and processes is to require that surveyors observe training programs not just review educational program records.

Patient Centered Training

- Training should be a patient centered approach (seeing it from the resident's eyes) that is infused into all training. For example, when providing clinical training on Activities of Daily Living (ADLs), aides should describe the patient/resident perspective on receiving a bath, being fed when it's difficult to swallow, and having to wait for the call light to be answered.

Expanded Training Content

- Beyond the traditional training tasks, CNA/HHA continuing education should include effective

communication, error reporting and patient safety, address issues related to CNA care that were found to be deficient in previous facility surveys, and cultural competency to include understanding diverse cultural response to health problems.

Geriatric-Specific Content

- Requirements for geriatric specific education should include knowledge about and competence in procedures for all of the geriatric syndromes including, urinary incontinence, falls, restraints, pressure ulcers, unintended weight loss, and end-of-life/palliative care. CNA/HHAs need to understand their responsibility in caring for patients with complex chronic care management including diabetes, congestive heart failure, hypertension, and End Stage Renal Disease. CNA/HHAs also need to understand that special care must be taken with older patients who have catheters, gastrostomy tubes, and intravenous lines because of increased risk of infection and other complications. In addition, they need to understand how to provide ADL care to older patients with behavioral problems.

Recommendations for Policy Changes

- There needs to be more emphasis in allowing CNA/HHA input into their personal educational needs. There should be a mechanism to ensure that CNA/HHAs have a process to inform employers of the continuing education that will help them improve care.
- CNA/HHAs need to be completely freed from resident care during continuing education. Too often, CNAs and HHAs are pulled away for patient care needs and never complete training. The State could require mandatory staff release time for education (after or before regular work hours with no simultaneous patient care responsibilities).
- The State should expand current regulations for dementia training to focus on CNA and HHA tasks in caring for patients with dementia.
- Specific geriatric content has to be more than just a suggestion, the State must ensure that content is an actual requirement.
- The State should consider allowing experienced CNAs to be used as "assistant trainers". This would provide a potential career ladder step for

CNAs that could aid in staff retention. Additionally, it would be important to provide compensation and relief time in association with this position. Similar opportunities should be offered to HHAs.

- HHA specificity in regulations appears to be weak. Enhanced HHA training and training content requirements should be required by regulation.

In summary, we believe that addressing the issues identified in these recommendations will lead to improved resident outcomes and improved CNA/ HHA satisfaction.

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Effective Strategies and Exemplary Ongoing Training Programs for Direct Care Workers

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Overview of Continuing Education and Training

Direct Care Workers (DCWs) provide 80 percent of the paid care for long-term care consumers and are critical to the long-term care system (Stone and Weiner, 2001; DHHS, 2006; Stone and Dawson, 2008). Over the past decade, policymakers and providers have expressed concerns about the quality of this long-term care workforce and the adequacy of their preparation, knowledge and skills to care for residents and clients (IOM, 2008; Harahan and Stone, 2007; Biles, Burke, Stone et al., 2005; IOM, 2004; USDHHS, 2003; Wunderlich and Kohler, 2001). Policymakers, providers, practitioners, and educators are paying particular attention to how the nature, scope and the quality of educational training, including ongoing training, and support of DCWs affects the organization's ability to attract and retain staff and produce quality outcomes for residents and clients (Stone & Weiner, 2001; PHI, 2001). This paper focuses on the factors to consider in the development of ongoing training programs and describes exemplary training programs.

A 2007 Harahan and Stone report states that continuing education requirements are minimal and "typically perceived as book learning without any real link to the reality of tasks that DCWs must perform on a daily basis" (Harahan & Stone, 2007). The goal of continuing education is to build the capacity and knowledge of the staff to create better jobs for staff and better care for the residents and clients. Increasing the number of training hours is not sufficient to improve recruitment, retention and quality of care. The quality and content of the training is crucial to successful continuing education. Successful programs create training that imparts new knowledge and skills and provide opportunities for staff to implement and sustain practice changes (Stone, 2007).

Factors to Consider for Training Programs

Research shows that poor orientation and

continuing education are among the job-related stressors that are significant predictors of job dissatisfaction (Ejaz et al., 2008). Quality training for DCWs may help to increase their job satisfaction (Menne et al., 2007). One critical element is to understand the needs of DCWs to help them perform their jobs. Menne et al. conducted a study with 49 long-term care organizations across a five-county area of Ohio to solicit staff perceptions and recommendations for training, job orientation and continuing education. The study found that over half of the DCWs reported they received helpful continuing education, with a significantly higher percentage of reported adequacies among DCWs in home health agencies. The participants provided several recommendations to improve the content and delivery of continuing education:

- The topic areas reported as very helpful or not provided consistently to DCWs, regardless of setting, were CPR, caring for residents with dementia, communicating with residents, end of life issues/coping with grief, caring for residents with mental illness, resident care skills such as bathing, eating and dressing, teamwork, and work style. These are topics to consider for a continuing education program.
- The majority of nursing assistants want to receive continuing education through interactive sessions with other workers. DCWs in home health agencies also reported a strong preference for printed materials. More workers preferred to learn in frequent, shorter sessions than full-day sessions.

Stone (2007) reported that studies over the past decade have demonstrated that many DCWs need basic soft skills training (e.g., time and money management, interpersonal communication) as well as technical and clinical knowledge. The diversity of staff suggests educational programs should address English literacy and take into

consideration the range of cultures in the workplace. Cultural competence needs to be built into training efforts that focus on both relational skills and clinical issues (Stone, 2007).

Research has shown that only 5 to 40 percent of new knowledge from workplace trainings is actually put into practice, with diminishing returns over time (Aylward et al, 2003; Baldwin and Ford, 1988; Cromwell and Kolb, 2004; Saks & Belcourt, 2006). Ongoing training on its own is not sufficient. Several factors must be considered to increase knowledge transfer into the “real world” environment. Employees need support from peers, supervisors and upper management during all phases of the training. The training should use principles of adult education, properly prepare the employee and the employee’s peers before training, coach and make time for practicing new knowledge post-training, align policies and procedures with information within the training and provide the correct resources for the learner (Broad & Newstrom, 1992; Stolee et al, 2005; Zenger, Folkman & Sherwin, 2005). The organizational commitment and active management support is critical for DCWs to apply their new skills and sustain changes made in practice (Beck et al., 2005; Berkhout et al, 2004; Broad, 2006; Specht & Mass, 2004; Stone et al., 2002).

Two additional key factors for effective learning are the educational material content and the trainer. The content of the educational materials should be as concrete as possible and fit the learner, context and desired result of the educational effort (McConnell et al., 2009; Stolovitch & Keeps, 2003). It is important that the clinical information has an evidence-base and to provide guidance for the trainer on how best to approach and support learning and the transfer of learning to practice (Bostrom et al., 2008; Crites et al., 2009; McConnell et al., 2009; Tagney & Haines, 2009).

Training Program Examples

Several training programs have been created to improve the worker competency as well as incorporate strategies to facilitate practice

change and retain staff. Summarized below are examples of various workforce initiatives and training programs. Training is a key piece of these programs and many of the programs move beyond training to assist the implementation of processes to improve care. Some of the programs have only been tested in one state and a few have been replicated in other states. The programs are funded through a variety of mechanisms. California may not replicate each of these programs in their entirety; however, core elements of and learning from each program can serve as a model in the development of the continuing education for DCWs in California. This list is not exhaustive and there are other available training programs.

WIN A STEP UP

(www.aging.unc.edu/research/winastepup/) WIN A STEP UP is a workforce development program proven to upgrade skills of nursing assistants, increase their career commitment and provide rewards and recognition. The program is a partnership between the North Carolina Department of Health and Human Services and the University of Carolina Institute on Aging. WIN A STEP UP is a 33-hour curriculum that focuses on clinical and interpersonal topics such as infection control, being part of a team, dementia care, fecal impaction and hydration, and person-centered bathing. A key component of the program is that nursing assistants agree to attend the classes and remain employed at the facility for a specified period. The facility agrees to commit staff time to completing the program and distribute a retention bonus or wage increase to nursing assistants who successfully complete the curriculum at the end of the retention contract period. The program provides the curriculum, per module stipends to nursing assistants, and a \$75 retention bonus to participants who complete the program.

Morgan et al. (2009) conducted an evaluation of the program. The researchers identified several factors that influenced the translation of learning into practice—use of adult learning principles, training took place where the worker was employed and on facility time, the modules were clearly written, aimed at the appropriate reading

level and administered in a cohort approach, use of role playing and on-the-floor exercises, and management buy-in and support. The key challenges in the implementation were the literacy and numeracy of the DCWs due to limited formal education and difficulty taking staff off the floor for training. Dill et al (2009) examined the impact of WIN A STEP Up on nursing homes and found that nursing homes participating in the WIN A STEP UP program are 15% more likely to have below-average turnover than nonparticipating nursing homes.

LEAP

(www.matherlifeways.com/re_leap.asp)
Learn, Empower, Achieve, Produce (LEAP) is a workforce initiative designed to develop leadership, mentoring, teamwork and communication skills among nursing staff through a model of person-centered care. Mather LifeWays Institute on Aging developed the program. LEAP has two modules— one designed to train nurse managers and charge nurses and a second module to train certified nursing assistants. The certified nursing assistant module trains workers in person-centered care, communication skills, team building, mentoring and career building. The LEAP program has been successful in reducing turnover, increasing job satisfaction and effectiveness of staff and improving the quality of care and satisfaction among residents and families.

Wellspring Model

(www.lifespan-network.org/beacon_wellspring.asp)
Wellspring is a quality improvement model that began in Wisconsin by an alliance of 11 nursing homes. Life Span Network, a mid-Atlantic senior provider association, now manages the program. The primary focus of the program is to strengthen clinical and managerial skills of staff, empower residents and frontline staff and create a high quality of life for residents. Frontline staff members receive educational training and are coached on how to collect relevant data, critically evaluate information, and implement processes that improve care. Nurse consultants serve as clinical experts to oversee the program and provide implementation guidance and support. The clinical education modules are one of the

key components of the program. The modules are best practices and new developments in clinical practice in areas such as elimination and incontinence care, observing and understanding the older adult, nutrition, restorative care for falls prevention, pressure ulcers, dementia care, holistic palliative care, and infection control. The staff training occurs on cross-disciplinary teams and the training is shared across facilities and gives staff opportunities to collaborate and consult on difficult clinical issues. Staff members are responsible as a team to disseminate new information and ensure that new practices are incorporated into routine care. Research has demonstrated that Wellspring improves quality of care, resident satisfaction, employee satisfaction and more.

SEIU Healthcare NW Training Partnership Program

(www.myseiubenefits.org)
SEIU Healthcare NW Training Partnership (Training Partnership), a nonprofit, labor-management organization, will provide an array of training, including continuing education courses, to all Washington home care aides beginning in 2010. Training Partnership will create the curricula and materials for the training. The courses could include CPR, First Aid, Alzheimer's Disease, diabetes, autism spectrum disorders, stress management, critical communications, healthy cooking, healthy aging, preventing skin breakdown, bi-polar disease, depression, grief and loss, end-of-life support, transfers and body mechanics, and developmental disabilities and sexuality.

Geriatric Resource Specialist Certificate Program

(coa.kumc.edu/cpgec/grs.htm)
The Central Plains Geriatric Education Center (CPGEC), led by the University of Kansas Medical Center, provides interdisciplinary education for nursing facility staff on evidence-based practices and works with interdisciplinary groups from nursing facilities on team-building, communication, documentation, and integration of knowledge and research into practice. The Geriatric Resource Specialist Program is an 80-hour program and incorporates adult learning principle and utilizes multiple modalities in teaching communication, conflict management, team building and evidence-

based care. With mentoring from project staff, each team designs and implements a project using evidence-based processes and protocols to improve a care outcome in their facility.

Creating Solutions: Handling Culturally Complex Situations in a Long-Term Care Setting

(www.bjbc.org/content/docs/Training1.pdf)

Creating Solutions is a training guide that assists nursing home staff in discussing culturally complex and often difficult situations that may arise in the facility. Boston University under the Better Jobs Better Care (BJBC) program developed the program. The guide is organized into two sections. One section is for use during an orientation and the second section is geared toward an in-service. The in-service section includes a video on DCWs talking about their real-life experiences in their jobs, an accompanying discussion guide that provides ideas on how to use the video and provoke dialogue on the issues it raises, and a case study and discussion.

Long-Term Care Registered Apprenticeship Program

The Department of Labor created the Long-Term Care Registered Apprenticeship Program, which supports partnerships among workforce development agencies, long-term care providers, and educational institutions to improve DCWs' formal instruction, on-the-job training, mentoring, and wages. The apprenticeship program is offered in 20 states. The LTC/RAP apprentices undertake a minimum of 2,000 hours of on-the-job training with 144 hours of related instruction. The current model is focused on four long-term care occupations, which include CNAs and home health aides:

- Certified Nursing Assistant is designed for nursing assistants working in nursing homes; apprentices gain skills and advance in several specialty areas: restorative, dementia, geriatric, mentor, hospice and palliative care, disabilities, and medication aide.
- Home Health Aide is for aides who work with consumers in their own homes; apprentices gain skills and advance in several specialty areas: hospice and palliative care, geriatrics, disabilities, mental illness, dementia, and peer mentor.

Beyond Basics in Dementia Care

(www.bjbc.org/tools.asp)

Beyond Basics in Dementia Care is a specialized training to help DCWs develop effective strategies and new skills in providing care for people with dementia. The BJBC Vermont demonstration project developed the program and created the curriculum with input from recognized Vermont trainers in dementia care. The training is a 12-hour, three-session continuing education course for experienced licensed nursing assistants and personal care assistants. The first class builds a foundation of the nature (pathology) of dementia; the second emphasizes managing behaviors; and the third discusses managing the environment for effective caregiving. The training program combines lecture, interactive discussion, learning activities, question/answer periods and on-the-job application of the new skills with self-evaluation and peer feedback.

Beyond Basics in Palliative Care

(www.bjbc.org/tools.asp)

Beyond Basics in Palliative Care is designed to give direct care providers specialized training in understanding the challenges of palliative care and the strategies for improving care for people with chronic and life-threatening illnesses. The training incorporates materials from many sources, but especially from the Hospice and Palliative Care Nurses' Association and the Vermont Ethics Network. It is a 12-hour, three-session continuing education course for experienced licensed nursing assistants and personal care attendants. The course covers issues related to the care of people with chronic illness, pain/symptom management and comfort care at the end of life. The training program combines lecture, interactive discussion, learning activities, question/answer periods and on-the-job application of the new skills with self-evaluation and peer feedback.

Genesis Eldercare: Geriatric Nursing Assistant Specialist (GNAS) Program

(www.directcareclearinghouse.org/practices/r_pp_det.jsp?res_id=47210)

The GNAS training program is a career ladder program for certified nursing assistants designed to prepare them for working with Medicare

patients. The sponsor organization is Genesis Eldercare, a skilled nursing and assisted living division of Genesis Health Ventures. Genesis Health Ventures is a for-profit provider of long-term care and services headquartered in PA. The program enrolls CNAs with at least six months tenure, above-average performance evaluations, and positive attitudes. Interested CNAs must write a one-page essay to apply for the program.

Selected CNAs participate in between 100 and 108 hours of training and receive pay increases upon completion of the program. The format of the training program is flexible. The six modules are: introduction to communication; anatomy and physiology; cognition, death and dying; common disorders of the elderly; care process minimum data set (MDS), therapeutic recreation and rehab skills; and advanced communication.

Conclusion

Continuing education is a critical component in building a quality direct care workforce. DCWs need training to improve clinical as well as the soft skills. Given the diversity of staff, cultural competency should be incorporated into any training program. Successful training programs have support from all levels of staff, including upper management, incorporate principles of adult learning, properly prepare the trainee and their peers, and allow opportunities to practice the new knowledge gained from the training. The training programs described in the paper are designed to improve the skills and competency of the worker and facilitate the transfer of knowledge into the "real world" environment. The programs can serve as models for California as it develops its continuing education program, with a focus on geriatrics, for CNA and HHA.

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Developing Geriatric Curricula

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Objective and Purpose

This paper proposes a structure that can serve as the basis for geriatric curricula for direct care workers (DCWs). It draws on several reports and initiatives designed to improve long term care.

The purpose of this paper is two-fold: First, it is designed to encourage a discussion about how the initial training, orientation, and continuing education of DCWs can be improved. Second, this paper is presented as a starting point for the development of curricula by educational institutions, service providers, or public agencies.

While the ultimate the goal of any educational effort focused on geriatrics in long-term care should be to promote care that supports the well-being of older people, education also has a significant impact on the DCW. Education has been linked to job satisfaction and retention. These in turn affect the quality of care and the quality of relationships with both coworkers and the older people receiving care. The potential synergistic impact on both DCWs and those they care for is the basis for several long term care improvement efforts, such as Better Jobs Better Care².

Background

Geriatrics is the health care specialty that focuses on preventing and treating diseases and conditions that are more common or likely to have symptoms that differ with advancing age. Many health care occupations including medicine, nursing, dentistry, social work and psychology now include geriatric as a specialty. However as a recent report by the Institute of Medicine (2008) underscores, the aging of the population will outpace the numbers of people with specialized training in geriatrics. While increasing the number of specialists is one approach to meeting the needs of older Americans, equally if not more important is the need to “enhance the competence of all individuals in the delivery of geriatric care” (IOM, 2008, p.2).

In considering changes to curricula it is important to acknowledge that direct care work is predominately geriatric care. A recent analyses confirmed that over 85.6% of home health care episodes involve a person 65 years old or older and in 21.7% the patient is 85 or older (Murtaugh et al., 2009). In nursing facilities 88.3% of residents were over 65 years older and 45.2% were aged 85 years and older. (Jones et al., 2009) However, it is not age alone that is important. Older people requiring long term care services are also increasingly challenging to care for due to the complexity of their needs. In home care over 75% of older people have one or more chronic conditions and 46% have some level of cognitive impairment (Murtaugh et al., 2009). In nursing facilities the second most common diagnosis is mental disorders and 51.1% of residents require assistance with five activities of daily living (bathing, dressing, toileting, transferring and eating) (Jones et al., 2009). These facts illustrate that DCWs care for individuals who are medically complex and require significant functional (physical and cognitive) support.

Developing Geriatric Curricula: General Principles

Training for DCWs should be rooted in what we know about how adults learn, how to influence behavior and the characteristics of the learners. Theories of adult learning contend that adults bring more experience and different motivations to learning situations. Effective adult education focuses on learning through experience, viewing education as more than just preparation, (Knowles, 1984) and using methods tailored to adult learning (e.g. role play/simulations, hand-on training, coaching, mentoring, small groups etc.). Another important consideration is that the DCW includes significant and growing numbers of minorities, people who were foreign-born, or people with limited English skills (PHI, 2009). Given this demographic reality, curricula needs to help workers function in English and what may be a new environment while fostering respect and understanding across cultures.

Current training requirements and best practices are covered in other papers. However, in thinking about the specifics for curricula it is important to acknowledge that there are significant barriers to comprehensive education for DCWs. Perhaps the biggest barrier is time – even if the number of mandatory training hours was doubled or even tripled, it will be challenging to include all relevant topics. For this reason, any additions to mandated training requirements or voluntary supplemental education must be carefully constructed, targeted, and highly likely to be effective. Furthermore ongoing education needs to extend beyond the few hours in the classroom or conference room and be incorporated into meetings, supervision, and the daily provision of care. Given these constraints, curricula need to be based on a small number of core components, while allowing the specific content contained within these components to be flexible and responsive to changes in the state of the science as well as variations in needs across long term care settings and populations.

Developing Geriatric Curricula: Proposed Core Components

Curricula and tools are available for direct care work training (Institute for the Future of Aging Services, 2008; National Clearinghouse on the Direct Care Workforce, 2007). Some of these focus on one element (e.g., cultural competence or skills in a specific domain) while others are more comprehensive. New efforts, whether to develop a program for a specific location or to change regulations or management practices should review what exists and ‘steal shamelessly’ rather than risk overwhelming all involved with the prospect of creating something entirely new. The following description and justification of three core components for geriatric curricula is proposed as one possible way to organize and combine existing and new content and approaches.

Foundation for Appreciation and Respect

DCWs are often described as ‘invisible’, ‘undervalued’, and ‘unskilled’. The lack of value placed on this work has many root causes. Assuring that DCWs feel respected is essential to improving the direct care workforce, involves addressing a myriad of factors (e.g.,

communication issues across race, class, and culture; ineffective supervisory relationships, and lack of opportunities for to develop potential) and requires ongoing work at all levels within an organization (McDonald, 2007).

In focusing on the geriatric nature of most direct care work, it is important to acknowledge that the lack of respect is also due to the fact that in our society we devalue age and try to ignore aging. Fostering respect for older people, an understanding of the aging process, and an appreciation of the diversity among older people in both initial and ongoing training can help assure that workers value their contribution and take pride in their work. Respect in the workplace and appreciation outside the field can be more firmly established on a foundation of self-respect and pride among those who work in long term care.

Specifically curricula should:

- Include opportunities for DCWs to learn the life stories of older people who need care and to appreciate what is important to their quality of life. Training needs to constantly reinforce that people are at the center of care and work to overcome the tendency to view the work, and reduce the people, to tasks to be completed (e.g., the bath, feeding assistance or a toileting schedule).
- Explain why age matters. Many people, even professionals in health care, do not fully appreciate that sensory changes (vision, hearing and even smell) and other biological changes mean that even a healthy 85 year old person is likely to recover differently and require different care than a 50 year old with the same illness or injury. Understanding why geriatrics is different from general adult health underscores the importance of long term care work while helping to create an identity distinct both in health care and among other service occupations.
- Discourage assumptions and generalization about older people. One of the hallmarks of geriatrics is diversity. By old age people have

accumulated a wide variety of experiences, including different occupations, family situations, diseases and illnesses, and exposures to numerous environments. These truly do make each individual older person unique. Relying on assumptions and stereotypes of older people (e.g., forgetful, grumpy, slow, complaining) is not only disrespectful, it can result in missing or misinterpreting important symptoms and changes.

Structured Approach to Observation and Communication

DCWs provide the majority of hands on care and have access to the daily lives, living situation, and families of older people who need long term care. No other health personnel have such an intimate view of what patients or residents need and want, or of their functional status and resources. This access means DCWs have the potential to make a significant contribution to high quality, person-centered care planning, implementation and ongoing monitoring.

Maximizing the value of what DCWs can accomplish by watching, talking with patients/residents, and reporting observations, requires the development and implementation of structured tools that standardize and facilitate this essential component of long term care work.

Curricula should build on structured approach to observation and communication:

- That is simple, concrete and easy to remember. Tools have been developed for communications about healthcare team members, such as SBAR for communicating about critical situations and needed actions (IHI, 2009) and are commonly used in other industries. The challenge is developing one that fits this workforce and occupation. Ideally any tool would be functional in a written or verbal format so that literacy and language skills would not be a major barrier.
- In which both the people doing the data collection and reporting and those receiving the data, agree that the information is important. One of the major lessons learned in a partnering collaborative designed to better

integrate professional and paraprofessional services was that everyone involved needs to support the underlying purpose, as well as the use, of the tool (Feldman, et al, 2007).

- Helps DCWs recognize the value in what they may perceive as mundane activities (e.g., watching a person's actions, reactions and expressions and talking to a person during care activities). Just as many clinicians have transformed their interactions with patients by employing motivational interviewing techniques, training and tools could help DCWs turn silence or brief chats with older people into 'monitoring conversations'.

Targeted Geriatric Content

Selecting the topics to be covered is often the first step in developing a curriculum. Some text books and course on geriatrics cover a lengthy list of topics, but fail to prioritize, justify the selection or, most troubling, do not create linkages across the various subject areas. A curriculum for DCWs can not be exhaustive given the limited time available for the education.

Choices must be made and this will be difficult as the scope of geriatrics is broad and many topics are important. Geriatric content in curricula for DCWs needs to strike a balance between what is feasible and what would be ideal. Furthermore the evidence base for best practices is limited and of little help in selecting from the large list of possibilities. Few direct care practices have been evaluated and studies of comparative effectiveness (e.g., comparing managing medications, strength exercise, improving balance, or home modifications in reducing falls) are rare. One way to keep this from derailing projects to expand training is to develop and then apply criteria for the selection of the topics. Changes and additions can be made over time, but it is important to establish and justify the starting point. Targeting geriatric content for DCWs could be based on earlier efforts to establish priorities in quality improvement or on new national or local efforts.

The project, establishing a National Framework for Geriatric Home Care, provides an example.

The expert advisory committee realized that home health agencies could not undertake quality improvement in all areas of care and established selection criteria (1. improvement likely to make a real difference in quality of care and life; 2. sufficient evidence exists to support specific recommendations; 3. experts agree that home care could make a unique contribution in this area; and 4. policy importance). Applying these criteria resulted in a focus on six Practice Areas: Care Coordination, Management and Transitions; Medication Management; Cognitive Function; Physical Function; Chronic Pain; Palliative Care and Advance Illness Management. (VNSNY Center for Home Care Policy & Research, 2009). Similarly, the Advancing Excellence in America's Nursing Home Campaign (2006), selected eight goals (reduce high risk pressure ulcers, reduce use of physical restraints, improve pain management for long and short stay residents [2 goals], establishing individual targets for improving quality, assessing resident and family satisfaction, increasing staff retention and improving consistent assignment) and participating facilities begin by working on three.

Given this curricula developers seeking to add geriatric content should focus on:

- Topics that can be constructed in order to assure that limited training time is maximized. For example, overarching concepts that can be used to organize the material should be prioritized over attention to specific diseases or disabilities. Consideration should also be given to when topics should be covered—in initial training, continuing education, or career ladder or specialization programs.
- Input from key stakeholders. What DCWs themselves want to learn to do a better job caring for older people should be a priority (information is available from existing research or it could involve new data collection). The values and priorities of the older people receiving care should also play an important role in selecting specific content.
- Topics where DCWs are likely to have the biggest impact. Specifically these include:

- Situations that involve a high risk of harm to the older person such as falls, failure to take medications, the misinterpretation of instructions, or potential abuse or neglect.
- Behaviors, symptoms or changes that could be clinically important and are likely to be noticed by a DCW. This essentially means monitoring physical and cognitive function as well as emotional status. DCWs should be trained to both watch and talk to those they care about for:
 - the amount of help needed with ADLs (activities of daily living),
 - pain, weakness, other symptoms such as dizziness and nausea,
 - the ability to remember recent events, recognize people, make decisions and express preferences, and
 - feelings of anxiety, hopelessness or fear.

No curriculum in and of itself will improve direct care jobs and quality of long term care. However, what is taught sends a message about what is important. Increasing geriatric content than can be an important initial step.

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1. A significant portion of the content of this brief is based on the author's recent experience directing a project (Establishing a National Framework for Geriatric Home Care Excellence) for the Center for Home Care Policy & Research at VNSNY with funding from the John A. Hartford Foundation. This paper also draws on the experience of other experts (with special thanks to Janice Foust, PhD, RN) and several projects. Any opinions, conclusions, omissions or errors in representing the source material are the author's alone.
2. Better Jobs Better Care is a national program supported by the Robert Wood Johnson Foundation and The Atlantic Philanthropies and directed by the Institute for the Future of Aging Services, AAHSA in partnership with the Paraprofessional Institute. <http://www.bjbc.org/>

Supporting Training for Direct Care Staff¹

Lee Goldberg, Long Term Care Policy Director, Service Employees, International Union (SEIU)

In California as elsewhere there is broad concern over the capacity to provide the hands-on care needed by an aging population. The state has experienced a chronic shortage of direct care workers caused primarily by low wages, the lack of healthcare benefits and the limited opportunities for career advancement. These problems in the labor market have an impact on not just caregivers but also on those who need the assistance. High turnover and low retention rates among direct care workers create discontinuities of care and may result in authorized care not being delivered.

What direct care workers need to stay in the field is not difficult to discern. Focus groups of direct care workers as far back as 2000 and 2001 found the lack of adequate compensation, the lack of respect and the lack of adequate training to be top issues of concern². Although workers in different settings have different priorities and different interpretations of what those issues mean, similar sentiments were echoed in surveys of direct care workers in states that participated in the Better Jobs Better Care program³ and in the 2004 national nursing home assistant survey⁴.

Current stresses on the direct care workforce raise the question of how can workers address their professional concerns. Many direct care workers have turned to union representation and collective bargaining to address these issues. For certain geographic and functional segments of the direct care work force, this has been a successful strategy. The wages of union certified nurse aides (CNAs) and union home health aides (HHAs) are 15% higher than their non-union colleagues; the percentage that have health insurance and pensions are almost double non-union workers doing the same work⁵. Unions have also carved out a role in the professional and personal development of direct care workers through the creation of Taft-Hartley training funds and non-profit community organizations that draw on public funding to finance and deliver training.

Where employer opposition to unions is strong and the industry is characterized by a large number of small employers that create a fragmented labor force, alternative strategies, such as worker associations, may be needed. This paper is intended to explore vehicles and potential barriers to the professional development of the direct care workforce.

Sectoral Hurdles

The turnover rate for direct care workers is in itself a major barrier to training and to the development of organizations that can provide direct care workers with the professional development they seek. One recent study found turnover rates ranging from 25% – 50% among home health agencies to 99% – 127% in the nursing home sector⁶. Such churn makes it difficult for workers to find a base of support for the creation of any vehicle, whether it is a union or a worker association. Except in geographic markets with high union density and multi-employer training funds, the high turnover also creates a strong disincentive for employers to invest in significant training or other professional development programs because of the “free rider” problem. Employers do not want to pay for training that raises the skill level of staff – only to lose them to a competitor who is not contributing to the cost of training or career development.

A second major problem is the training itself. As one participant in the 2000 and 2001 focus groups commented, direct care workers need better – not simply more – training. Many current training programs fail to teach the less obvious but necessary skills that are so important for the realities of the direct care work place, such as interpersonal communication and problem solving skills⁷. They also fail to provide the broader set of wrap-around services, such as citizenship classes, English as a second language classes, financial literacy classes, career counseling, basic educational classes in reading and mathematics that make the worker a better student and resolve

issues in a worker's personal life that may prevent them from staying on the job. For as important as these kind of classes are, few workers would admit to an employer the need for them.

The Union Model

The most common method of developing a robust program of professional development is through the creation of a Taft-Hartley training fund permitted under the Labor-Management Relations Act of 1947. Taft-Hartley funds are negotiated through collective bargaining and are used to finance a range of benefits including health coverage and training programs. They are funded by a small flat-rate contribution based on the number of hours worked by members of the bargaining unit in covered employment and are managed jointly by unions and employers. Such a funding mechanism creates a significant revenue stream that can support ongoing and regular educational opportunities in union training facilities and in accredited educational institutions in the community like community colleges and even local universities. In addition, such funds are often able to qualify for public funding as part of state efforts to bolster public-private partnerships that are aimed at improving the workforce. The 1999 Training and Upgrade Fund that is jointly governed by SEIU's United Healthcare Workers East and its employers, for example, has been successful in using funding from New York's Health Care Reform Act for CNA training programs. Politically, the use of public funds is often easier if it enhances private-sector contributions and is overseen by a joint labor-management entity.

Taft-Hartley funds can be used for multiple employers, which from a policy perspective, has a number of advantages. In geographic areas or industries where there is significant union density, this reduces free-riders and improves the likelihood that employers will see a return on investment from resources devoted to training. From a worker perspective, Taft-Hartley funds provide portability of benefits since employees can change employers and keep their benefits if the new job is with an employer who participates in the same Taft-Hartley fund. Multi-employer funds can offer an array of training and career advancement programs

that are unaffordable for a single employer. Also, union training programs offer more than just traditional skills enhancement needed by HHAs and CNAs (information on common geriatric health problems or recommendations for clients with particularly difficult diseases like Alzheimers or Parkinsons) but soft skills, particularly communications skills and conflict resolution skills. Again, Taft-Hartley training funds are often best positioned to work with employees and management to determine the skills needed to meet the demands of the work. Taft-Hartley funds work well because they combine private sector funding with a worker perspective on how best to deliver training.

Direct Care Worker Association Model

An alternative model suggested by some is the direct care worker association. Professional associations are becoming an established option for improved training and career development in the health care field and other professions. The direct care worker association started with the Career Nurse Assistants Programs, Inc. founded in Ohio in 1977 to upgrade the status of CNAs and nurses in the field of long-term care. There are now a half-dozen state-based organizations that have been created to bring together direct care workers for mutual support and educational seminars. The Iowa Caregivers Association, the Maine Personal Assistance Services Association, and the Vermont Association of Professional Care Providers are among the best known. Supported by dues and grants from a variety of sources, these entities are fairly small in terms of membership and financial resources but do provide opportunities for networking and political advocacy. They also offer seminars intended to provide direct care workers with the opportunity for professional support and serve as an information clearing house in the state; the idea with many of these associations is to supplement rather than replace training provided by the employers or required by the state and to hone a sense of pride in direct care work.

It is not clear whether these groups can address the resource-intense concerns of direct care workers around training without compromising their independence. Unlike trade associations

for highly paid white collar workers, whose members can afford three-figure annual dues, professional associations for direct care workers cannot survive on dues alone⁸. The Missouri-based National Association of Geriatric Nurse Associations (NAGNGA), for example, is closely tied to the provider community in the state and nationally. Many of NAGNGA's 30,000 members are enrolled in a program where the nursing homes pay the membership fees. This close tie to providers is something that many workers elsewhere have expressed serious concern about, but it is almost inevitable, given the need for financial support outside of dues, the need to get employer support for workers to attend meetings and the need for mailing lists to publicize the groups.

There are groups that were founded by direct care workers (the Connecticut Association of Personal Assistants, the Virginia Association of Professional Nursing Assistants and the National Association for Direct Care Workers of Color) but many appear to be small with ad hoc programming and without the resources necessary for a robust training program. Occasional seminars and informal peer-led opportunities to network may be useful for sharing best practices, but these are no substitutes for the formal educational settings needed to provide workers with career ladders.

A hybrid model, the Virginia Association of Personal Care Attendants (VAPCA), is a direct care workers association that has the financial support of and affiliation with the Service Employees International Union, the largest union representing direct care workers. Although Virginia labor laws make it difficult for VAPCA to use traditional organizing methods to raise wages and provide benefits, it can achieve similar results by influencing the budget and the state's Medicaid policy. The organization has attracted several thousand members and mobilized workers around political campaigns as a way to build support in the state legislature. Effective in terms of political advocacy, the organization does not have the resources to develop a robust training program.

Assessing California

For some HHAs and CNAs, the union model of professional development works well. Approximately 20% of nursing home workers in California are represented by a union, primarily the Service Employees International Union. United Home Care Workers – West and United Long Term Care Workers, the two major SEIU locals in the state with long term care members, have Taft-Hartley training funds that are effective sources of education and skill building for direct care workers. Among home health aides, however, the story is very different, primarily because union representation is much less. SEIU represents workers at Addus Health Care, the second largest home care agency in state measured by number of employees, but they comprise perhaps 1% of the workforce.

Union representation in the state's direct care workforce reflects the nature of the labor market. With over 1,100 skilled nursing facilities in California – many of them small providers – worker affiliation with a union can be a costly and time consuming process without employer willingness to partner with the union. Many workers that believe union affiliation would be beneficial avoid the issue altogether because of employer opposition and the frequency of dismissal among employees that seek to bring a union into the workplace. Hundreds of nursing home workers a year in California join a union, but given turnover rates and changes in corporate ownership, union density is unlikely to reach that found in the New York market for decades. For home health aides, the union model is even more problematic. With many more small employers than the nursing home sector, home health aides face significant structural barriers to joining a union, starting with the fact that they typically have little contact with their colleagues.

The nature of the labor markets in California for direct care workers raises the question of whether policymakers and stakeholders can create new vehicles that effectively allow workers to seek skills training and pursue a path of career enhancement, independent of the needs of their employer. Is there a trade association model that

could work for HHA's? Could the State play the role akin to that of an employer in setting up a training fund for agencies that provide significant amounts of Medicaid-covered services? Is there an analogous role for the federal government with respect to agencies providing Medicare covered services? Are there other entities, such as the public authorities, that could play a constructive role in training? These are just a few of the important questions to explore as we seek to improve the skills and the longevity of today's direct care workforce.

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Opportunities for the State of California

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California has more people who over the age of 65 than any other state, and the number is expected to grow dramatically in the years to come, with most of the growth predicted to occur within the next 20 years. According to the Paraprofessional Healthcare Institute, the rapid growth in the population of older adults is fueling an accelerating need for long-term care services and supports, including the need for an adequately trained workforce of paraprofessionals like Certified Nursing Assistants (CNAs) and Home Health Aides (HHAs). However, our systems for training direct-care workers to provide quality care in skilled and residential settings have not kept pace with demand¹. In response, policymakers will need to develop systems and policies to train individuals to care for the aging population and continue to recruit and retain the existing workforce.

Existing California Law and Requirements

A recent report from the Institute of Medicine found that the content of direct-care worker training does not reflect the current environment for older adults and is lacking geriatric-specific educational content². Aside from general descriptions of skills and training topics, California law does not specify training necessary to meet the unique needs of older adults or adults with disabilities with complex health, social, and environmental needs. The training requirements also fail to require cultural competence for working with ethnically diverse patients and provide only limited discussion of palliative care.

CNAs

California currently requires CNA training programs to include a combination of program orientation, classroom training, and clinical “on-the-job” training. Federal law requires 75 hours of training for CNAs; however, California and many other states exceed the Federal minimum required.

For initial certification, California law requires 60 hours of classroom training; including basic

nursing skills, patient safety and rights, the social and psychological problems of patients, and abuse prevention. In addition to the classroom hours, training programs also include at least 100 hours of supervised and on-the-job training. At least six hours of the overall training includes information on the special needs of persons with disabilities, including developmental disabilities and individuals living with Alzheimer’s disease or dementia. Once certified, CNAs must complete 48 hours of in-service training every two years. California also offers an option for CNAs who wish to become dually certified as HHAs. CNAs can add an additional 40 hours of training for the dual certification.

Home Health Aides

Federal rules require HHAs to pass a competency evaluation if their employer receives Medicare or Medicaid reimbursement. In addition, Federal law suggests, but does not require, aides to have at least 75 hours of training. In 2008, AB 993 (Aghazarian), Chapter 620, Statutes of 2008, aligned the training requirements for HHAs in California to the Federal standard of 75 hours. Prior to AB 993, the basic training program for certification as a HHA in California exceeded the Federal baseline and required a minimum of 120 hours. The training requirements include an overview of home health agencies as well as more in depth training on the medical and social needs of care recipients and personal care services. Once certified HHAs must receive 12-hours of in-service training from their employers. In contrast to CNA training, state regulations only require a minimum of 20 hours of clinical experience.

In comparison to state requirements for healthcare paraprofessionals, careers that arguably require less intimate contact with patients and residents have more extensive training requirements for licensure. For example, a licensed cosmetologist is required to have 1,600 hours of training; and a manicurist needs 350 hours of training prior to licensure.

Training requirements for both CNAs and HHAs (as well as a wide variety of other professions) are set in state statute and further defined through regulations. As evidenced by the recent changes to requirements for HHAs, any increase or decrease in training requirements would require legislation. In addition, changes to training standards or curriculum within the existing required training may require legislation, but in limited cases could be accomplished through the development of regulations by the California Department of Public Health.

Comparison to Other Professions and Promising Practices

Over the course of the last 10 years, California's policymakers have increasingly focused on building competency in elder care among the health professions. Recent legislation, including the California Integrated Elder Care and Involvement Act of 2002, SB 953 (Vasconcellos, Chapter 541, Statutes of 2002) has required physicians, psychologists, marriage and family therapists, and social workers to obtain varying levels of training in the biological social and psychological aspects of aging. Additional legislative efforts have focused on the readiness of the continuing education system to train future workers, including requirements for the California State University, University of California, and community college systems to develop standards and guidelines for including coursework in geriatrics and gerontology in various professional degree programs, and recruiting professionals to work in geriatric care settings.

Although legislation may be required in some areas in order to increase training requirements or make curriculum changes, existing California law does provide some flexibility for industry-led change. The training requirements for certification as a CNA in law are considered a baseline and nursing facilities or training providers can, and in many cases do, expand upon the required classroom or clinical hours in order to provide more specialized training. A report from the Institute for the Future of Aging Services documented that nearly 90 percent of the facilities (skilled nursing facilities, continuing

care retirement communities and assisted living facilities) participating in the study offered education and training beyond the state and Federal requirements³.

In 2005, the Department of Health and Human Services Office of Inspector General issued a report on emerging practices in skilled nursing facilities. The report highlighted industry-driven programs to improve staff training and retention, including the use of mentoring programs. In such programs, nurse aide mentors are experienced aides trained to provide peer leadership to newly hired aides. In return for the additional responsibilities, the mentors are paid more than other aides⁴.

Increasing job responsibilities and wages with additional training through mentoring programs is one method for employers to improve retention of direct care workers, but lateral transitions may not be as successful as programs that allow workers to advance to more skilled positions. A number of research and advocacy organizations recommend the development of career pathways or career ladders that allow workers to advance from entry-level positions to higher levels with additional training and education. However, establishing more formal steps from entry level CNA positions to higher nursing positions such as licensed practical and vocational nursing has been problematic.

While existing California law encourages career ladder opportunities for CNAs, progressing along the career ladder with intermediate steps with enhanced training has been difficult due to perceived scope of practice conflicts with other nursing staff. Several facilities offer incentives for employees to pursue higher positions, including time off for education, however, attempts to establish positions between rungs on the career ladder such as medication technicians have faltered. Existing law is a barrier to expanding the responsibilities of CNAs with additional training. California law prohibits CNAs from performing tasks that must be performed by a licensed health care professional, including the administration of medication.

The Future of Direct Care Worker Training in California

In comparison to other states, California ranks near the top in the number of hours required for CNA training. However additional or more geriatric-specific training will likely improve the quality of care in skilled settings and perhaps increase job stability and reduce turnover among CNA staff. Given the recent reduction in the required training hours for HHAs, policymakers and advocates may need to consider how to ensure that the most essential information is delivered to trainees in the more condensed certification and continuing education process.

Changes in training requirements may also help providers, and their frontline staff, meet the changing needs of older adults and adults with disabilities in long-term care settings. For example, like other states, California has seen a shift from an institutional focus of care to home and community-based services where direct care workers encounter different issues and challenges than in a skilled nursing facility setting. In addition, for CNAs working in skilled settings, curriculum changes may be needed to reflect the current population of residents in skilled nursing facilities and the focus on shorter-term rehabilitation as opposed to longer-term care.

California already has examples of population-specific training requirements. The California Department of Developmental Services established statewide mandatory competency-based training curriculum for paraprofessionals serving consumers with developmental disabilities in licensed community care facilities in 1999. The program is divided into two 35-hour segments to be completed over the course of the first two years of employment. Training topics include medication management, oral health, and person-centered planning.

Any future changes in training requirements for CNAs or HHAs will require an adequate supply of qualified trainers or faculty to provide the enhanced curriculum. Previous efforts, including the California Caregiver Training Initiative, which was part of Governor Davis's Aging with

Dignity Initiative in 2001, have indicated that the shortage of qualified and available instructors can inhibit the success of training programs.

Finally, any changes to training requirements, either through legislation or regulation, that requires additional oversight from the state will be difficult due to the ongoing budget crisis. Advocates have suggested the development of standardized curriculum for the training of direct care workers, however, the development and testing of such curriculum would likely be time consuming and costly if dependent upon state funds. Similarly, replicating the competency-based training curriculum developed for use in the developmental services network would face the same fiscal barriers. Ironically, the State budget crisis will continue to limit the availability of state funds for new or enhanced programs just as the population of older Californians and the related demand for direct care workers with experience in meeting the needs of older adults will increase substantially.

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Debra Bakerjian, PhD, MSN, FNP has been a nurse for 30 years and a nurse practitioner for 20 years. She received her Masters of Nursing and PhD in Gerontology and Health Policy from the University of California, San Francisco, where she is just completing a Claire M. Fagin Post Doctoral Fellow. She is also an Assistant Adjunct Professor at UCSF. Her program of research focuses on nurse practitioners, quality of care, pressure ulcers, and interdisciplinary quality improvement in nursing homes.

Dr. Bakerjian is the Immediate Past Vice-Chair of the Advancing Excellence in America's Nursing Homes Steering Committee and the immediate past president of the Gerontological Advanced Practice Nurses Association (formerly NCGNP). In addition, she serves on the board and is past chair of the education committee for California Long Term Care Medicine (California AMDA Chapter). She is also an active member of the Coalition of Gerontological Nursing Organizations and a variety of national collaborative quality initiatives. In addition to the above mentioned organizations, she is a member of several professional organizations including American Medical Directors Association, American Nurse's Association, American College of Nurse Practitioners, American Association of Nurse Practitioners, American Geriatrics Society, and Gerontological Society of America.

Dr. Bakerjian's current projects are: PI in a study of differences in physician and nurse practitioner hospital transfer practices for nursing homes funded by John A Hartford Foundation and Atlantic Philanthropies; Co-PI on two studies examining how states implement quality improvement in association with Advancing Excellence in America's Nursing Homes funded by The Commonwealth Fund; National Professional Nursing Collaborative funded by Atlantic Philanthropies; Co-Investigator for a study on pain management for National Pain Collaborative for Nursing Homes funded by Mayday Funds. She also leads the Goals Task Force for the Advancing Excellence Campaign, working closely with other

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Dr. Bakerjian is a nationally known speaker having developed and presented well over a two hundred presentations on a number of clinical and quality of care topics affecting older adults, particularly pressure ulcers, wound care, chronic diseases and behavioral issues in nursing homes. She provides consultation to troubled nursing homes and has a business that provides medical administrative support to clinicians with long-term care practices as well as continuing as a practicing clinician.

Dr. Bakerjian has long been an advocate for interdisciplinary team based care as well as improved quality of care and quality of life for frail elders and has written and spoken extensively on the topic in a variety of settings. She has published a book chapter on the role of nurse practitioners in nursing homes and recently published a comprehensive literature review of advanced practice nurses in nursing homes.

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Dr. Chapman's areas of expertise are nursing and allied health workforce policy and research, program development, managed care, and health system administration. Her projects include a multi-year effort to address allied health workforce challenges in California, evaluation of two California workforce initiatives focused on nursing and long-term caregivers, and studies of individual allied professions including research on certified nurse assistants, the clinical laboratory workforce, cancer registrars, EMT/paramedics, respiratory care practitioners, and imaging professionals.

Dr. Chapman was asked to join an interdisciplinary group of researchers at the prestigious Institute of Medicine and was part of the study group that developed the publication "Retooling for an Aging America: Building the Health Care Workforce". She is also a member of the American Public Health Association, AcademyHealth, and the National Association of EMS Physicians for which she has been an invited speaker.

As Director of Allied Health Workforce Studies at the Center for Health Professions, she is often contacted by the press and by policymakers at the local, state, and national level to provide technical assistance and information on the health care workforce. Other state agencies for which she frequently provides data and advice include the California Employment Development Department (EDD), the Office of Statewide Health Planning and Development, and the Senate Legislative Analyst Office.

At the national level, Dr. Chapman continues to offer expertise and technical assistance about

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Lee Goldberg is the Policy Director for the Long Term Care Division of the Service Employees International Union, the largest health care union in the United States. He received a Bachelors degree in economics and political science from the University of California, Davis in 1984, a law degree from the George Washington University in 1992 and a masters in international economics and international relations from the Johns Hopkins School for Advanced International Studies also in 1992. At SEIU, he works with local leaders on a variety of state level issues ranging from rebalancing state Medicaid programs to workforce training issues; he also works closely with executive and legislative branch staff on federal long term care policy and funding, including Medicare/Medicaid integration and federal regulation of nursing homes and homecare providers. Prior to coming to SEIU, he was a Senior Communications Manager and a Senior Legislative Representative with the National Committee to Preserve Social Security and Medicare where he directed the media operations of the political advocacy group through two campaign cycles and lobbied on health care and income security issues through policy position papers and briefings. In addition to his work in the labor movement and in advocacy world, Lee worked on the Hill for Sen. Donald Riegle (D-MI) and Rep. Pete Stark (D-CA).

Allison Ruff is the Chief Consultant for the California Assembly Committee on Aging and Long-Term Care chaired by Assemblywoman Bonnie Lowenthal. Her scope of work includes the development and staffing of legislation for Assemblywoman Lowenthal, bill analysis and tracking for the Committee, the development of the Master Plan on Aging, and health and human services budget issues. In addition, Ms. Ruff serves as a resource for the legislature, advocacy

organizations, and community members on aging and long-term care issues.

Ms. Ruff is an advisor for numerous projects, including the California Elder Economic Security Initiative and the A4AA Aging Boomer Study, and a member of the Health and Human Services Agency Community Choices Advisory Committee and the California Council on Gerontology and Geriatrics Board of Directors.

She holds a Bachelor's degree in Speech Pathology and Audiology from Western Washington University and a Master's degree in Gerontology from the University of Southern California.

Annette Totten, MPA, PhD. has held a variety of policy, research, and management positions in provider and university-based research centers, state government, and private foundations. Her areas of expertise are long term care, research methods, survey research and chronic illness care.

Annette began her career as a nursing assistant and her prior positions include legislative aide in the Ohio House of Representatives, program associate for the John A. Hartford Foundation, and project director for the New York State Department of Health, the New York University Department of Nursing and the Columbia University School of Nursing. She was the founding Director of the Center for the Study of Aging and an Assistant Research Professor at Boise State University and then Director of the Geriatric Frameworks project for the Center for Home Care Policy & Research at VNSNY.

She earned her doctorate in health services research with a minor in gerontology from the University of Minnesota School of Public Health; a Masters of Public Administration from the Robert F. Wagner Graduate School of Public Service at New York University; a Masters of Arts in Modern Languages from Middlebury College; and Bachelors Degree from Allegheny College.

Sarah Wells joined NCCNHR as the new Executive Director in January 2009. She oversees

the daily operations of the organization; leads fundraising efforts; and continues NCCNHR's unique role since 1975 as the only national consumer advocacy organization whose sole mission is improving the quality of care and life of the elderly and people with disabilities in long-term care.

Sarah comes to NCCNHR after nearly a decade at Women in Government (WIG), a national, nonprofit organization providing public policy education for women state legislators, where she most recently served as Vice President. While at WIG, Sarah was instrumental in significantly increasing the organization's operating budget, establishing a public policy department from the ground up and leading numerous policy initiatives that resulted in significant state action.

Sarah took over the position vacated by Alice H. Hedt, who joined the NCCNHR staff in 1998 as Director of the National Long-Term Care Ombudsman Resource Center and had been Executive Director since 2004.

About The SCAN Foundation

The SCAN Foundation is an independent nonprofit foundation dedicated to advancing the development of a sustainable continuum of quality care for seniors that integrates medical treatment and human services in the settings most appropriate to their needs and with the greatest likelihood of a healthy, independent life. The SCAN Foundation supports programs that stimulate public engagement, develop realistic public policy and financing options, and disseminate promising care models and technologies.



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