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**LTCSS Commission Workforce Development Workgroup  
MWA Issue Committee Conference Call Meeting**

**Wednesday, August 6, 2008**

**9 am to 11 a.m.**

**Conference call-in numbers:**

**Passcode: 245156**

**Toll: 1-719-234-7853**

**I. Welcome and Introductions**

**II. Overview of current MWA programs at state and local levels, particularly in the context of Medicaid LTC Task Force recommendations 1-6 below. A representative of the Michigan Works! Association will discuss current association and local activities.**

1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers and job seekers.
2. Recast the state's Work First program to recruit, screen, train, and support individuals who demonstrate the desire, abilities, and commitment to work in LTC settings.
3. Develop recruitment campaigns to attract men, older workers, people of diverse cultural backgrounds, and people with disabilities to long-term care careers.
4. Mobilize state agencies' activities to include the research, exploration, explanation, and promotion of career opportunities in long-term care.
5. Improve and increase training opportunities for direct care workers to allow for enhanced skill development and employability.
6. Increase training opportunities for employers to improve supervision and create a positive work environment.

**III. Next steps for the issue committee, next meeting**

## Side by Side Comparison of Federal CNA and Hospice Aide Requirements

Federal Minimum Requirements	Medicare/Medicaid Nursing Home Law Written by Congress in 1987	CNA Federal Regulations (42 C.F.R. 483) Written by CMS in 1990s	Hospice Aide Federal Regulations (42 C.F.R. 418) Written by CMS in 2008	MDCWI/ Commission Recommendations
<i>Total Classroom and Supervised Technical Training</i>	75 hours	75 hours	75 hours  A minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours (no specific areas required). <i>See, 42 CFR §418.76(b)(2)</i>	
<i>16 hours of classroom training must precede any technical training/direct contact</i>		<i>At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:</i> <ul style="list-style-type: none"> <li>• Communication and interpersonal skills;</li> <li>• Infection control;</li> <li>• Safety/emergency procedures, including the Heimlich maneuver;</li> <li>• Promoting residents' independence; and</li> <li>• Respecting residents' rights.</li> </ul> <i>See, 42 C.F.R. § 483.152(b)(1)</i>	A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact and an initial orientation for each employee that addresses the employee's specific job duties. <i>See, 42 C.F.R. 483.100(vii)</i>	
<i>Pre-requisites for acceptance into training program</i>	None	None-left to state and individual programs	None-left to state and individual programs	
<i>Training program curriculum:</i>	Secretary shall establish requirements for the approval of nurse aide training and competency evaluation programs,	<ul style="list-style-type: none"> <li>• Communication and interpersonal skills;</li> </ul>	<ul style="list-style-type: none"> <li>• Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff.</li> <li>• Observation, reporting, and documentation of patient status</li> </ul>	

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<p><i>Training program curriculum:</i></p>	<p>including requirements relating to the areas to be covered in such a training program.</p> <ul style="list-style-type: none"> <li>• Must include at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights</li> </ul>	<ul style="list-style-type: none"> <li>• Taking and recording vital signs;</li> <li>• Measuring and recording height and weight;</li> <li>• Infection control;</li> <li>• Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor;</li> <li>• Caring for residents when death is imminent;</li> <li>• Caring for the residents' environment;</li> <li>• Safety/emergency procedures, including the Heimlich maneuver;</li> <li>• Promoting residents' independence;</li> <li>• Respecting residents' rights.</li> <li>• Personal care skills, including, but not limited to:</li> <li>• Bathing;</li> </ul>	<p>and the care or service furnished.</p> <ul style="list-style-type: none"> <li>• Reading and recording temperature, pulse, and respiration.</li> <li>• Basic infection control procedures.</li> <li>• Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.</li> <li>• Maintenance of a clean, safe, and healthy environment.</li> <li>• Recognizing emergencies and the knowledge of emergency procedures and their application.</li> <li>• The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property.</li> <li>• Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist: <ul style="list-style-type: none"> <li>• Bed bath.</li> <li>• Sponge, tub, and shower bath.</li> <li>• Hair shampoo (sink, tub, and bed).</li> </ul> </li> </ul>	

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<p><i>Training program curriculum:</i></p>		<ul style="list-style-type: none"> <li>• Skin care; and</li> <li>• Grooming, including mouth care;</li> <li>• Toileting;</li> <li>• Dressing;</li> <li>• Proper feeding techniques;</li> <li>• Proper feeding techniques;</li> </ul> <ul style="list-style-type: none"> <li>• Transfers, positioning, and turning</li> </ul> <ul style="list-style-type: none"> <li>• Maintenance of range of motion;</li> </ul> <ul style="list-style-type: none"> <li>• Assisting with eating and hydration;</li> </ul> <p><i>Mental health and social service needs:</i></p> <ul style="list-style-type: none"> <li>• Modifying aide’s behavior in response to residents’ behavior;</li> <li>• Awareness of developmental tasks associated with the aging process;</li> <li>• How to respond to resident behavior;</li> <li>• Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident’s dignity; and</li> <li>• Using the resident’s family as a source of emotional support.</li> </ul> <p><i>Care of cognitively impaired residents:</i></p> <ul style="list-style-type: none"> <li>• Techniques for addressing the unique needs and behaviors of individual with</li> </ul>	<ul style="list-style-type: none"> <li>• Nail and skin care.</li> <li>• Oral hygiene.</li> <li>• Toileting and elimination.</li> </ul> <ul style="list-style-type: none"> <li>• Safe transfer techniques and ambulation.</li> <li>• Normal range of motion and positioning.</li> <li>• Adequate nutrition and fluid intake.</li> </ul> <ul style="list-style-type: none"> <li>• Any other task that the hospice may choose to have an aide perform.</li> </ul> <p><i>See, 42 CFR §418.76(3)</i></p>	

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<p><i>Training program curriculum:</i></p>		<p>dementia (Alzheimer’s and others);</p> <ul style="list-style-type: none"> <li>• Communicating with cognitively impaired residents;</li> <li>• Understanding the behavior of cognitively impaired residents;</li> <li>• Appropriate responses to the behavior of cognitively impaired residents; and</li> <li>• Methods of reducing the effects of cognitive impairments.</li> </ul> <p><i>Basic restorative services:</i></p> <ul style="list-style-type: none"> <li>• Training the resident in self care according to the resident’s abilities;</li> <li>• Use of assistive devices in transferring, ambulation, eating, and dressing;</li> <li>• Maintenance of range of motion;</li> <li>• Proper turning and positioning in bed and chair;</li> <li>• Bowel and bladder training; and</li> <li>• Care and use of prosthetic and orthotic devices.</li> </ul> <p><i>Residents’ Rights.</i></p> <ul style="list-style-type: none"> <li>• Providing privacy and maintenance of confidentiality;</li> <li>• Promoting the residents’ right to make personal choices to accommodate their needs;</li> <li>• Giving assistance in resolving grievances and disputes;</li> <li>• Providing needed assistance in getting to and participating in resident and family</li> </ul>		

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<i>Training program curriculum:</i>		<p>groups and other activities;</p> <ul style="list-style-type: none"> <li>• Maintaining care and security of residents’ personal possessions;</li> <li>• Promoting the resident’s right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff;</li> <li>• Avoiding the need for restraints in accordance with current professional standards</li> </ul> <p><i>See, 42 C.F.R. §483.152(b)(1-7)</i></p>		
<i>Approved Programs</i>		<p>The State—</p> <ul style="list-style-type: none"> <li>• Must specify any nurse aide training and competency evaluation programs that the State approves as meeting the requirements of § 483.152 and/or competency evaluations programs that the State approves as meeting the requirements of § 483.154; and</li> <li>• May choose to offer a nurse aide training and competency evaluation program that meets the requirements of § 483.152 and/or a competency evaluation program that meets the requirements of § 483.154.</li> <li>• If the State does not choose to offer a nurse aide training and competency evaluation program or competency evaluation program, the State must review and approve or disapprove nurse aide training and competency evaluation programs and nurse aide competency evaluation programs upon request.</li> <li>• The State survey agency must in the</li> </ul>	<p>Hospice aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse, or a licensed practical nurse, who is under the supervision of a registered nurse.</p> <p><i>See, 42 CFR 418.76(b)(1)</i></p> <p>A qualified hospice aide is a person who has successfully completed <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• A training program and competency evaluation</li> <li>• A competency evaluation program that meets the applicable requirements</li> <li>• A nurse aide training and</li> </ul>	

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		<p>course of all surveys, determine whether the nurse aide training and competency evaluation requirements of § 483.75(e) are met.</p> <p><i>See, 42 C.F.R. § 483.151(a)</i></p>	<p>competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry.</p> <ul style="list-style-type: none"> <li>• A State licensure program that meets the applicable requirements</li> </ul> <p><i>See, 42 CFR 418.76(a)(1)</i></p>	
<i>Location of Clinical Sites</i>	None	Left to states	Left to states	Upon application and Department approval, “locked-out” nursing homes can serve as clinical sites for approved CNA training programs.
<i>Class size, student-to-instructor ratios</i>	None	Left to states	Left to states	Maximum class/lecture size 24. Lab 1 to 12. Clinical placement 1 to 8.
<i>Qualifications for instructors</i>		<p>The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long term care facility services;</p> <ul style="list-style-type: none"> <li>• Instructors must have completed a course in teaching adults or have experience in</li> </ul>	Classroom and supervised practical training must be performed by a registered nurse who possesses a minimum of 2 years nursing experience, at least 1 year of which must be in home care, or a licensed practical nurse under supervision of an RN, or by other individuals under	

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		<p>teaching adults or supervising nurse aides;</p> <ul style="list-style-type: none"> <li>• In a facility-based program, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility who is prohibited from performing the actual training; and</li> <li>• Other personnel from the health professions may supplement the instructor, including, but not limited to, registered nurses, licensed practical/vocational nurses, pharmacists, dietitians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physical and occupational therapists, activities specialists, speech/language/ hearing therapists, and resident rights experts. Supplemental personnel must have at least 1 year of experience in their fields</li> </ul> <p><i>See, 42 C.F.R. § 483.152(A)(5)(i-iv)</i></p>	<p>the general supervision of a registered nurse. <i>See, 42 CFR 42 CFR 418.76(b), (e)</i></p>	
<i>In-service training</i>	<p>The skilled nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for</p>	<p>The facility must complete a performance review of every nurse aide <b>at least once every 12 months</b>, and must provide regular in-service education based on the outcome of these reviews. The in-service training must—</p> <ul style="list-style-type: none"> <li>• Be sufficient to ensure the continuing competence of nurse aides, but must be <b>no less than 12 hours per year</b>;</li> <li>• Address areas of weakness as determined in nurse aides’ performance reviews and may address the special needs of residents</li> </ul>	<p>A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the inservice</p>	

Federal Minimum Requirements	Medicare/Medicaid Nursing Home Law Written by Congress in 1987	CNA Federal Regulations (42 C.F.R. 483) Written by CMS in 1990s	Hospice Aide Federal Regulations (42 C.F.R. 418) Written by CMS in 2008	MDCWI/ Commission Recommendations
	individuals providing nursing and nursing-related services to residents with cognitive impairments.	<p>as determined by the facility staff; and</p> <ul style="list-style-type: none"> <li>For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</li> </ul> <p><i>See, 42 C.F.R. § 483.75(e)(8)(i-iii)</i></p>	<p>training provided during the previous 12 months. 42 CFR 417.100 (vii)</p> <p>At least 12 hours of in-service training during each 12-month period</p> <ul style="list-style-type: none"> <li>Training may be offered by any organization, and must be supervised by a registered nurse.</li> <li>The hospice must maintain documentation that demonstrates the requirements of this standard are met.</li> </ul> <p><i>See, 42 CFR §418.76(d)</i></p>	
<i>State Nurse Aide Registry</i>		<p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless:</p> <ul style="list-style-type: none"> <li>The individual is a full-time employee in a training and competency evaluation program approved by the State; or</li> <li>The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual becomes registered.</li> </ul> <p><i>See, 42 C.F.R. § 483.75(e)(5)</i></p> <p>A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—</p>	<p>A qualified hospice aide is a person who has successfully completed <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>A training program and competency evaluation</li> <li>A competency evaluation program that meets the applicable requirements</li> <li>A nurse aide training and competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry.</li> <li>A State licensure program that meets the applicable requirements</li> </ul> <p><i>See, 42 CFR §418.76(a)(1)</i></p>	

Federal Minimum Requirements	Medicare/Medicaid Nursing Home Law Written by Congress in 1987	CNA Federal Regulations (42 C.F.R. 483) Written by CMS in 1990s	Hospice Aide Federal Regulations (42 C.F.R. 418) Written by CMS in 2008	MDCWI/ Commission Recommendations
		<ul style="list-style-type: none"> <li>• Is a full-time employee in a State approved training and competency evaluation program;</li> <li>• Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or</li> <li>• Has been deemed or determined competent as provided in Sec. 483.150 (a) and (b). <i>See, 42 C.F.R. § 483.75(e)(4)</i></li> </ul>		
<i>Abuse, Neglect Reporting, and Requirements</i>		<p>The facility must:</p> <ul style="list-style-type: none"> <li>• Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. <i>See, 42 C.F.R. § 483.75(c)(1)(iii)</i></li> </ul> <p>The facility must not:</p> <ul style="list-style-type: none"> <li>• Employ individuals who have been: <ul style="list-style-type: none"> <li>(a) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or</li> <li>(b) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. <i>See, 42 C.F.R. § 483.75(c)(1)(i-ii)</i></li> </ul> </li> </ul>	<p>The hospice must:</p> <ul style="list-style-type: none"> <li>(i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator;</li> <li>(ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all</li> </ul>	

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			<p>alleged violations must be conducted in accordance with established procedures;</p> <p>(iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and</p> <p>(iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation.</p> <p><i>See, 42 CFR §418.52(4)</i></p>	
<i>Complaint and Discipline Process</i>	None	Left to states	Left to states	Same process as used with other health care occupations; article 15 of the Public Health Code.
<i>Renewal Process</i>		If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency	If there has been a 24-month lapse in furnishing services, the individual must complete another program before providing services.	

Federal Minimum Requirements	Medicare/Medicaid Nursing Home Law Written by Congress in 1987	CNA Federal Regulations (42 C.F.R. 483) Written by CMS in 1990s	Hospice Aide Federal Regulations (42 C.F.R. 418) Written by CMS in 2008	MDCWI/ Commission Recommendations
		evaluation program or a new competency evaluation program. <i>See, 42 C.F.R. § 483.75(e)(7)</i>	<i>See, 42 CFR §418.76(a)(2)</i>	
<i>Competency Evaluation: Content</i>		<p>The competency evaluation must—</p> <ul style="list-style-type: none"> <li>(1) Allow an aide to choose between a written and an oral examination;</li> <li>(2) Address each course requirement specified in § 483.152(b);</li> <li>(3) Be developed from a pool of test questions, only a portion of which is used in any one examination;</li> <li>(4) Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations;</li> </ul> <p>and</p> <ul style="list-style-type: none"> <li>(5) If oral, must be read from a prepared text in a neutral manner.</li> </ul> <p>The skills demonstration must consist of a demonstration of randomly selected items drawn from a pool consisting of the tasks generally performed by nurse aides. This pool of skills must include all of the personal care skills listed in § 483.152(b)(3) (see above). <i>See, 42 C.F.R. § 483.154(b)(1-2)</i></p>	<p>Must address: (1) Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff; (2) Observation, reporting, and documentation of patient status and the care or service furnished; (3) Reading and recording temperature, pulse, and respiration; (4) Basic infection control procedures; (5) Basic elements of body functioning and changes in body function that must be reported to an aide’s supervisor; (6) Maintenance of a clean, safe, and healthy environment; (7) Recognizing emergencies and the knowledge of emergency procedures and their application; (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property; (9) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist: Bed bath; Sponge, tub, and shower bath;</p>	

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			Hair shampoo (sink, tub, and bed); Nail and skin care; Oral hygiene; Toileting and elimination; (10) Safe transfer techniques and ambulation; (11) Normal range of motion and positioning; (12) Adequate nutrition and fluid intake; (13) Any other task that the hospice may choose to have an aide perform. <i>See, 42 CFR §418.76(c)(1)</i>	
<i>Competency Evaluation: Administration</i>		The competency examination must be administered and evaluated only by— <ul style="list-style-type: none"> <li>• The State directly; or</li> <li>• A State approved entity which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.</li> </ul> The skills demonstration part of the evaluation must be— <ul style="list-style-type: none"> <li>• Performed in a facility or laboratory setting comparable to the setting in which the individual will function as a nurse aide; and</li> <li>• Administered and evaluated by a registered nurse with at least one year’s experience in providing care for the elderly or the chronically ill of any age.</li> </ul> <i>See, 42 C.F.R. § 483.154(c)</i>	<ul style="list-style-type: none"> <li>• Numbers 1, 3, 9, 10, and 11 above must be evaluated by observing the aide’s performance of a task with a patient; the remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient.</li> <li>• Evaluation must be completed by a registered nurse in consultation with other skilled professionals, as appropriate</li> </ul> <i>See, 42 CFR §418.76(c)(1-3)</i>  A long list of conditions that disqualify a home health agency from doing the competency evaluation program for 2 years. <i>See, 42 CFR 418.76(f)</i>	
<i>Costs/charges to students for training</i>		No nurse aide who is employed by a nursing facility or offered employment may be charged for the training program or textbooks		

Federal Minimum Requirements	Medicare/Medicaid Nursing Home Law Written by Congress in 1987	CNA Federal Regulations (42 C.F.R. 483) Written by CMS in 1990s	Hospice Aide Federal Regulations (42 C.F.R. 418) Written by CMS in 2008	MDCWI/ Commission Recommendations
		or other required course materials. <i>See, 42 CFR 483.152(c)(1)</i>		
<i>Provider's allowable costs and Medicaid reimbursement for training costs</i>		The State must provide for reimbursement of an individual's training costs for anyone who, within 12 months, completes training and the evaluation process and then goes to work in a certified nursing home. <i>See, 42 CFR 483.152(c)(2)</i>  [In MI, the aide is reimbursed by the home up to \$675 (?) and then home's expense is reported in their annual cost report.]		
<i>Aide provides only Medicaid personal care services</i>	None	None	Before the individual (aide) may furnish personal care services, the individual must be found competent by the State (if regulated by the State) to furnish those services. The individual only needs to demonstrate competency in the services the individual is required to furnish. <i>See, 42 CFR 418.76 (i)</i>	

## Workforce Development Workgroup

Michigan Long-Term Care Supports and Services Commission  
Meeting Notes  
May 14, 2008

Attendees: John King, Craig Nobbelin, Michelle Munson-McCorry, Dave Jackson, Jules Isenberg-Wedel, Jean Peters, Lauren Swanson, Rosemary Ziemba, Jillian Rainwater, Chris Hennesey

### 1. Welcome, Introductions, Review of Agenda, Review of March Notes

Attendees introduced themselves and shared their favorite sight, sound, or smell of Spring. Minutes from March meeting were accepted without revision.

### 2. Next steps for CNA training and program administration legislation and changes

Hollis presented a one page summary memo that will be presented to the full Commission at their Monday meeting. Since the last workgroup meeting, endorsements from Michigan County Medical Care Facilities Council, Center on Frail and Vulnerable Elders, U of MI School of Nursing, The Alzheimer's Association, Hospice of Michigan, Area Agency on Aging 1-B, Tri-County Office on Aging, AARP/Michigan, Citizens for Better Care, Michigan Long Term Care Ombudsman Program, Healthcare Regional Skills Alliance, NW MI Council of Governments, Michigan Dementia Coalition, TEACH, Olmstead Coalition, Area Agencies on Aging of Michigan, Campaign for Quality Care, UAW, Michigan Home Health Association, Cassie Stern Healthcare Workers Training and Education Center, SEIU, Healthcare Michigan, and Michigan Office on Services to the Aging have been received. Indications thus far from HCAM are positive and a letter of endorsement is expected as long as allowable costs are considered. **UPDATE SINCE MEETING-- The workforce recommendations were unanimously approved at the 5/19/08 LTCSS Commission meeting!**

Next steps for the CNA Issue Committee will be to meet and begin the process of mapping out work and developing legislative concepts. To assist in the process, Hollis distributed a state by state comparison of CNA training requirements compiled by PHI. Hollis, Chris, Rosemary, Jillian, and Michelle volunteered to follow-up with colleagues to see if a law/health care graduate student might be interested in conducting a more thorough analysis of the data. Others present agreed to solicit additional letters of endorsement and forward them to Hollis ASAP. **UPDATE SINCE MEETING – Alison Hirschel of the MI Poverty Law Center and an instructor at the University of Michigan's Law School, has a law student who can begin work in June on examining and analyzing the laws and rules from those 25+ states that do not rely on the federal CNA training standards.**

### 3. Review of the recommendations of the MDCH Task Force on Nursing Regulations

John King presented an overview of the Task Force recommendations to the MDCH Director regarding changes needed to improve the regulation of nursing in Michigan. The Task Force was asked to look at three issues: Nursing Regulation, Nursing Education, and the Practice of Nursing itself. The Task Force has recommended the formation of additional task forces to examine Nursing Education and Nursing Practice, and has focused on the Nursing Regulation piece.

The recommendations made for Nursing Regulation address the following:

- Increase funding to and flexibility of utilization of the Nurse Professional Fund.
- Encourage retired nurses who wish to practice nursing as volunteers to do so, and allow Public Health Code Provisions for Special Volunteer Licenses and liability exemptions.
- Support a change in the Public Health Code that adds definitions for certain Advance Practice Nursing specialties – Certified Nurse Midwives and Certified Nurse Practitioners.
- Exempt Bureau of Health Professional regulatory staff positions from current and future hiring freezes.
- Resolve inconsistencies among the Public Health Code, the School Code, and MIOSHA Statutes that affect the provision of in-school healthcare for children.

The recommendation for the MDCH Director to convene the two additional Task Forces on Nursing Education and Nursing Practice will impact long term care, and members of the LTCSSC Workforce Development Workgroup may wish to seek representation on both. It is expected that the additional Task Forces will be appointed this year, with work completed by early next year. Hollis will follow up with Andy Farmer at the full Commission meeting and request to have the Workforce Workgroup be involved in the two additional Task Forces.

Issues brainstormed by the workgroup for possible consideration by the additional Task Forces included:

- Looking at the relevance of required obstetric and pediatric clinicals for LPNs interested in long term care ( not eliminating the education piece, but eliminating the clinicals requirement)
- Having a standard review of curriculum of LPN and Associate Degree Nursing programs, and examining ways to eliminate credit differences between community colleges – there is a desire to create a career ladder, but inconsistencies in programs prevent this.
- Establish a state uniform curriculum for nursing.
- Create better clinical placement systems.
- Look at student to faculty ratios – may need to be adjusted for specialty areas.
- Have a uniform definition of terms defined in the Public Health Code – eliminate “nurse speak.”

#### 4. **Review of “The Need for Monitoring the Direct Care Workforce and Recommendations for Data Collection”**

Rosemary presented an overview of the recommendations from the DSW Resource Center’s “white paper” on the recommendations for states for basis data collection. PHI played a huge role in the creation of the document, and Medicaid agencies can apply to the Resource Center for to receive technical assistance. The goal was to look at a minimum data set and ask two questions -- What could we glean from DLEG and other national databases? and Is there a potential to look at workforce volume and compensation data?

So far, the results indicate that the data is skewed. The over representation of public vs. private entities is probably an artifact of the public funding stream and the efficiency of data collection. In addition, turnover appears to be calculated in many different ways across databases, so

comparisons are difficult. There is a need to look at additional collection methods (like North Carolina's model of voluntary reporting with license renewals) that have definitions to standardize the calculation of turnover. The paper argues that each state needs to plan a statewide tracking by common measures, establish their own data set, and have a commitment to wanting the data.

Jean reported that she has been using an extensive database for collecting workforce data, suggested that the group look to work with such state databases that are already in existence. Next steps for the Data Issue Committee will be to examine what can be gleaned from existing state systems.

#### **5. Updates from Other Issue Committees**

No updates at this time.

#### **6. Other**

Hollis distributed a press release on the MDCH initiative and grant to the Detroit AAA to improve Detroit nursing home, and will make sure that the CNA curriculum enhancement recommendations are circulated to the Detroit group.

Lauren reported that information from the 2008 DSW Resource Center Symposium is now available to download from their website ([dswresourcecenter.org](http://dswresourcecenter.org)). One of the presentations included data from a national survey of Nursing Homes and over 3000 CNAs working in the field with results parallel to those from Michigan's *Voices From the Front*. Similar data was also presented from a survey of Home Health Aides that included a lot of data from private employers. The group is planning a survey of other types of residential care settings (licensed and non-licensed AFCs, Assisted Living, etc), but this survey has yet to be funded.

#### **7. Next Meeting: July, 23<sup>rd</sup>, 9:30-11:30, PHI's Offices at 1325 S. Washington in Lansing. Telephone conferencing information TBA.**

## Agenda – July 23, 2006

### CNA Training Enhancement Project

**1-3 p.m.**

PHI Offices/The Arc Michigan  
1325 S. Washington  
Lansing, MI 48910  
517.372.8310

**Directions:** Get to Lansing and I-496. If coming from the west, take the Pine street exit and stay on the frontage road to S. Washington, turn right. If coming from the east, take the Grand exit [even though Grand Avenue is closed], stay on the frontage to S. Washington, turn left. Just passed the RR tracks, turn left to 1325 S. Washington. **Remember that this section of S. Washington is a speed trap, thanks to the Lansing PD. Do not exceed 27 mph.**

**Conference call in numbers:** Toll: 1-719-234-7853 **passcode** 245156

1 p.m.	Welcome and introductions
1:10 p.m.	Review of draft Team Charter document, attached
2:00 p.m.	Review of federal requirements for CNA and Hospice Health Aide created by Lindsey Kaczmarek, law student
2:50 p.m.	Next Steps, next meeting

## **Workforce Development Workgroup of the LTCSS Advisory Commission**

### **Memorandum**

**To:** Andrew Farmer, Chair LTCSS Advisory Commission and LTCSS Commissioners

**From:** LTCSS Workforce Development Workgroup by Hollis Turnham

**Date:** May 15, 2008

**Re: Improving Michigan's CNA training program**

As of July 7, the following organizations formally support the initiative in enhance Michigan's CNA training program:

Michigan County Medical Care Facilities Council (MCMCFC)  
Center on Frail and Vulnerable Elders, U of MI School of Nursing  
The Alzheimer's Association  
Hospice of Michigan  
Area Agency on Aging 1-B  
Tri-County Office on Aging (TCOA)  
AARP/Michigan  
Citizens for Better Care (CBC)  
Michigan Long Term Care Ombudsman Program  
Healthcare Regional Skills Alliance, NW MI Council of Governments  
Michigan Dementia Coalition  
TEACH, association of facility staff development directors  
Olmstead Coalition  
Area Agencies on Aging Association of Michigan (AAAAM)  
Campaign for Quality Care  
United Automobile Workers (UAW)  
Michigan Home Health Association (MHHA)  
Cassie Stern Healthcare Workers Training and Education Center, SEIU Healthcare Michigan  
Michigan Office on Services to the Aging (OSA)  
PHI Michigan  
West Central Michigan Health Care Regional Skills Alliance  
Aging Issues Forum of Kalamazoo County  
Upper Peninsula Health Care Round Table (UPHCRT)

### **The LTCSS Commission's Workforce Workgroup asks to the Commission:**

1. Recommend that the state Legislature authorize the Michigan Department of Community Health to create a CNA training and registration program that is responsive to the state's long-term care needs and stop relying on federal minimum standards.
2. Authorize its Workforce Development Workgroup, with assistance from the Office of LTCSS, to convene a collaborative process of supportive and interested organizations and stakeholders to fashion the needed legislative concepts, based on the recommendations proposed by MDCWI and other issues as they arise and to recruit and work with legislative champions for passage of the legislation.
3. Review those legislative concepts as soon as they are developed for adoption and support for their enactment by the state Legislature and implementation by the Department of Community Health.

# CNA Training Enhancement Project

## DRAFT Team CHARTER

July 11, 2008

**Name of Project:** CNA Training Enhancement Project

**Project Sponsor:** LTCSS Advisory Commission, now. Initially, MI Direct Care Workforce Initiative

**Team members:** Organizations that have formal support the concept of seeking state legislation to define and enhance Michigan's CNA training process beyond the current federal minimum training standards. See attached list. [Roles to be discussed]

**Project Leaders:** Jules Isenberg-Widel, Hollis Turnham [Roles to be discussed]

### **Decision (s) requested from the LTCSS Commission regarding:**

1. Recommend that the state Legislature authorize the Michigan Department of Community Health to create a CNA training and registration program that is responsive to the state's long-term care needs and stop relying on federal minimum standards.
2. Authorize its Workforce Development Workgroup, with assistance from the Office of LTCSS, to convene a collaborative process of supportive and interested organizations and stakeholders **to fashion the needed legislative concepts, based on the recommendations proposed by MDCWI and other issues as they arise and to recruit and work with legislative champions for passage of the legislation.**
3. Review those legislative concepts as soon as they are developed for adoption and support for their enactment by the state Legislature and implementation by the Department of Community Health

**Criteria to Support Decision Making** (Known factors that must be taken into account, as well as others agreed upon by people involved in the decision.)

- The state legislation will not contain all necessary details but will authorize DCH to complete all details (model curricula, registry operations, etc.) through a collaborative process with stakeholders.

- While not the deciding factors, cost and the length of training must be considered in designing a new MI CNA training program.
- Others.....

**Working agreements/ground rules:** Proposal – use those developed by MDWCI and the LTCSS Commission’s definition of consensus.

**Objectives:** To be discussed

**Decision making authority:** Recommendation to full Workforce Development Workgroup and then to LTCSS Commission.

**Decision making process:** Consensus as defined by the LTCSS Commission. Attached.

**Frequency and length of meeting:** Monthly with conference calling abilities.

## **CONSENSUS DEFINED**

Excerpted from *True Consensus, False Consensus* by Bea Briggs  
Published in the Journal of Cooperative Living, Winter, 2001

The consensus process is a decision-making method based on values such as cooperation, trust, honesty, creativity, equality, and respect. Consensus goes beyond majority rule. It replaces traditional styles of top-down leadership with a model of shared power and responsibility.

The consensus process rests on the fundamental belief that each person/organization has a piece of the truth. Each member of the group must be listened to with respect. On the other hand, individuals/organizations cannot be permitted to dominate the group.

This is not to suggest that the consensus process presupposes or automatically confers complete peace and harmony within a group. In fact, in groups that are truly diverse, differences are both a sign of health and an invitation to creativity.

Consensus is not a panacea. It will not work in every situation. In order to invoke the power and magic of consensus, these main elements must be in place:

- Willingness to share power
- Informed commitment to the consensus process
- Common purpose
- Strong agendas
- Effective facilitation.

### **Procedure for Determining Consensus**

In the consensus process, no votes are taken. Ideas or proposals are introduced, discussed, and eventually arrive at the point of decision. In making a decision, a participant in a consensus group has three options.

- To give consent. When everyone in the group (except those standing aside), says “yes” to a proposal, consensus is achieved. To give one’s consent does not necessarily mean that one loves every aspect of the proposal, but it does mean that one is willing to support the decision and stand in solidarity with the group, despite one’s disagreements.
- To stand aside. An individual stands aside when he or she cannot personally support a proposal, but feels it would be all right for the rest of the group to adopt it. Standing aside is a stance of principled non-participation, which absolves the individual from any responsibility for implementing the decision in question. Stand asides are recorded in the minutes of the meeting. If there are more than a few stand-asides on an issue, consensus has not been reached.
- To block. This step prevents the decision from going forward, at least for the time being. Blocking is a serious matter, to be done only when one truly believes that the pending proposal, if adopted, would violate the morals, ethics, or safety of the whole group. One probably has a lifetime limit of three to four blocks, so this right should be exercised with great care. If you frequently find yourself wanting to block, you may be in the wrong group.

Consensus decisions can only be changed by reaching another consensus.

## 5

# The Direct-Care Workforce

### CHAPTER SUMMARY

*This chapter describes the direct-care workforce—nurse aides, home health aides, and personal and home-care aides—which is in many respects the linchpin of the formal health care delivery system for older adults. This collection of workers supplies a major portion of the direct care provided to older adults, including the provision of some clinical services plus assistance with bathing, dressing, housekeeping, and food preparation. Direct-care workers have rewarding but difficult jobs, and they are typically very poorly paid and receive little or no training for their duties. As a result, turnover rates are high, and recruitment and retention of these workers is a persistent challenge. In the context of rapidly increasing demand for direct-care services, the need for these workers is beginning to reach a crisis stage. This chapter discusses a range of approaches to improve the quality of direct-care occupations, including needed increases in pay and benefits. In addition, improvements in the education and training of these workers are needed to ensure that they have the knowledge and skills required to meet the care needs of older patients.*

Direct-care workers, also referred to as paraprofessionals, are the primary providers of paid hands-on care, supervision, and emotional support for older adults in the United States. While not all direct-care workers care for older patients, they work primarily in settings important in the care of older adults, such as nursing homes, assisted living facilities, and home-care settings. According to the Bureau of Labor Statistics (BLS), about three million workers were employed in direct-care occupations in 2006<sup>1</sup> (BLS, 2008c, 2008d). Still, the current number of direct-care workers is insufficient to meet demand (GAO, 2001a, 2001b; Stone, 2004). The need for direct-care workers is expected to increase in the coming decades, mainly because of the aging of the population but also because the number of females aged 25 to 54—the typical direct-care worker demographic—is projected to remain flat (PHI, 2001).

A further trend that may exacerbate this unfulfilled need, especially for personal and home-care aides, is a shift away from institutional care to home- and community-based care. Policy makers and payers are increasingly implementing home- and community-based care programs in response to consumer preferences and legal mandates and with the hope that costs will be lower for at least some types of services. However, caring for older adults in these settings may require proportionately more direct care-level staff than in institutional facilities (National Center for

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<sup>1</sup> It is important to note that this figure does not include the many workers who are hired privately by patients and their families.

Health Workforce Analysis, 2004). The workforce providing non-institutional personal assistance and home health services tripled between 1989 and 2004, and Medicaid spending for these services also increased significantly during that time (Kaye et al., 2006). Over that same time period, the workforce providing similar services in institutional settings remained relatively stable. In fact, the BLS predicts that personal and home-care aides and home health aides will represent the second- and third-fastest growing occupations between 2006 and 2016 (BLS, 2007b). This trend will not only lead to an increase in demand for services in non-institutional settings but will also require home-based workers to deliver more skilled care to patients with more complex needs (Seavey, 2007b). In home- and community-based care settings, carers work more independently and rely on personal skill and judgment; however, many direct-care workers do not receive the education or training they need in order to be prepared for the care of older patients with complex care needs.

A major factor in the deficit of direct-care workers is the poor quality of these types of jobs. Direct-care workers typically receive very low salaries, garner few benefits, and work under high levels of physical and emotional stress. In 2005 the median hourly wage for all direct-care workers was \$9.56, about one-third less than the median wage for all U.S. workers (Dawson, 2007). Direct-care workers are more likely to live in poverty, to lack health insurance, and to rely on food stamps than other workers (GAO, 2001b). Additionally, these workers have high rates of job-related injury, most often due to overexertion in the care of a patient (BLS, 2007a). All of these factors contribute to the unacceptably high rates of vacancies and turnover among these occupations, which can, in turn, lead to poor quality of care for patients.

Much of this chapter focuses on issues concerning direct-care workers in general because there is relatively little data on just the group of direct-care workers involved in the care of older adult; whenever possible, however, issues related specifically to the care of older adults will be highlighted. The chapter begins with descriptions of direct-care occupations and the basic demographics of the current workforce, followed by an overview of the current state of education and training of these workers. The chapter then discusses challenges to the recruitment and retention of direct-care workers, including financial disincentives and difficulties in work environment. The chapter concludes with an examination of strategies to improve the recruitment and retention of direct-care workers, including enhancing the quality and quantity of basic education and training, increasing overall job satisfaction (including expanding roles and responsibilities), improving economic incentives, and broadening the labor pool. Overall, in order to create a more effective and efficient direct-care workforce, much more needs to be done to educate and train these workers to care for older adults, and much more needs to be done to enhance the quality of these jobs.

## DIRECT-CARE OCCUPATIONS

Direct-care workers are often grouped into three categories: nurse aides (also known as nursing assistants); home health aides; and personal and home-care aides (Harmuth and Dyson, 2005). Forty-two percent of direct-care workers care for patients in the home setting, 41 percent work in nursing homes, and the remaining 17 percent are employed in hospitals (Smith and Baughman, 2007). Table 5-1 provides details about the various types of direct-care workers, including their most common employers, the types of services they provide, and typical supervision requirements.

**TABLE 5-1** Comparison of Direct-Care Occupations

	Nurse Aides (Assistants), Orderlies, and Attendants	Home Health Aides	Personal and Home Care Aides
Common employers	Nursing and residential-care facilities; hospitals	Home healthcare agencies; social assistance agencies; nursing and residential-care facilities	Home care agencies; individual and family services; private households
Examples of typical services provided	Answer patients' call lights; deliver messages; serve meals; make beds; help patients eat, dress, and bathe; escort patients to medical appointments; take vital signs; observe patients' physical and mental conditions	Administer oral medications; take vital signs; help patients bathe, groom, and dress; assist with prescribed exercises	Help clients get out of bed, bathe, dress, and groom; assist with housekeeping, grocery shopping and cooking; accompany clients to doctors' appointments or on other errands
Supervision	On-site nursing and medical staff	Periodic check-ins/ visits by supervisors (e.g., nurses, physical therapists, social workers, case managers)	Periodic check-ins/visits by supervisors (e.g., case managers, patients' families, nurses)

SOURCE: BLS, 2008c, 2008d; Fishman et al., 2004.

### Nurse Aides and Home Health Aides

The occupation of nurse aide goes by a number of job titles which vary by state, setting, and situation; these titles include certified nursing assistant (CNA), geriatric aide, orderly, and hospital attendant (BLS, 2008c). Nurse aides are employed primarily in nursing homes but also work in other institutional settings, such as hospitals and assisted-living facilities. They assist residents with activities of daily living (ADLs), including bathing, dressing, eating, and toileting, and they can perform such clinical tasks as taking blood-pressure readings and, in some states, administering oral medications (Reinhard et al., 2003). These workers have a major role in institutional settings, providing 70 percent to 80 percent of direct-care hours to those older Americans who receive long-term care (Harmuth and Dyson, 2005).

Home health aides (HHAs) are generally hired through a home health agency and assist individuals with ADLs in their homes. They may also assist with food preparation and housekeeping. Both nurse aides and home health aides provide a degree of clinical services (e.g., wound care) and work under the supervision of a registered nurse (RN).

### Personal and Home-Care Aides

Personal and home-care aides may work in group or individual home settings and are somewhat more difficult to classify. These aides may be referred to as personal care attendants, personal assistants, or direct support professionals, and they may be employed through an agency or hired directly by an individual (BLS, 2008d; Harmuth and Dyson, 2005). They help older adults maintain their independence and remain in their homes and communities by providing assistance with both ADLs and instrumental activities of daily living (IADLs), such as meal preparation and transportation. Personal care services have been growing and all states now have

waiver programs through Medicaid that provide these services to seniors and people with disabilities (Kitchener et al., 2007; Seavey and Salter, 2006).

Whereas home health aides who provide Medicare-certified home care perform their jobs under the supervision of a registered nurse (RN), personal and home care workers frequently have no supervision, even though they may perform many of the same services. Furthermore, many personal and home care workers may be hired privately by patients, without the involvement of an agency. Because of these hiring practices, little can be done to track the workers in this “grey market,” which makes it difficult to create a demographic profile of the workers or to regulate their work practices (Seavey, 2007b).

As patients move rapidly away from institutional long-term care and toward home- and community-based settings, they are increasingly relying on direct-care workers to provide needed care, including more complex services than previously provided in these settings. Assisted-living facilities, which are community-based facilities that provide more services than a typical home setting but less than a nursing home, are a rapidly growing option for the residential care of older adults (Lyketsos et al., 2007), and the workers serving patients in these settings (including the patients with more complex needs) are typically personal and home-care aides rather than home health or nurse aides. There is little to no federal regulation regarding the training or staffing requirements for assisted-living facilities; instead, each state regulates workers in these settings.

### WORKFORCE DEMOGRAPHICS

Direct-care workers are overwhelmingly female (89 percent) and are typically between the ages of 25 and 55, unmarried (including those who are widowed, divorced, or separated), without college degrees, and citizens of the United States (Montgomery et al., 2005; Smith and Baughman, 2007; Yamada, 2002). Approximately 30 percent of direct-care workers are African American and 15 percent are of Hispanic or Latino origin (BLS, 2008a), although this can vary by setting and job title.

In 2005 Montgomery and colleagues examined data from the 2000 Census to create a profile of home care aides who provide direct long-term care services, including those who are hired privately (Montgomery et al., 2005). The study revealed that as compared to hospital aides and nursing home aides, home care aides are on average older, more likely to be of Hispanic or Latino origin, more likely to be self-employed, and less likely to have steady year-round employment (Table 5-2).

**TABLE 5-2** Characteristics of Direct-Care Workers, 1999

Characteristic	Hospital Aides	Nursing Home Aides	Home-Care Aides
<b>DEMOGRAPHIC CHARACTERISTICS</b>			
Gender (% female)	81.2	91.3	91.8
Average age (years)	40.5	38.0	46.2
White, non-Hispanic (%)	48.4	55.6	50.3
Hispanic or Latino (%)	10.7	7.8	15.9
U.S., native-born (%)	81.5	85.5	75.1
Marital status (% married)	46.2	42.7	44.2
Education – less than high school (%)	17.6	26.3	30.9

EMPLOYMENT CHARACTERISTICS			
Year-round, full-time employment (%)	52.4	48.3	34.3
Part-year, part-time employment (%)	13.0	14.8	24.3
Self-employed (%)	0.0	0.3	16.8

SOURCE: Montgomery et al., 2005

A recent study found notable differences between female direct-care workers and the female workforce overall (Table 5-3) (Smith and Baughman, 2007). Black women, for example, make up a disproportionately large percentage of the female direct-care workforce relative to their presence in the female workforce overall (29 percent versus 13 percent). A second difference is that female direct-care workers are more likely to be single mothers than are female workers in general (24 percent versus 14 percent); of those who are single parents, 35 percent to 40 percent are below the poverty line (GAO, 2001b).

**TABLE 5-3** Demographic Characteristics of Female Direct-Care Workers Versus All Female Workers, 2006

Characteristic	All Female Workers	All Female Direct-Care Workers	Female Hospital Aides	Female Nursing Home Aides	Female Home Health Aides
Average age (years)	42	41	40	38	45
<b>RACE AND ETHNICITY (%)</b>					
White, non-Hispanic	70	51	55	51	49
Black, non-Hispanic	13	29	30	35	24
Other, non-Hispanic	6	5	5	4	7
Hispanic	11	15	11	10	21
Foreign-born	13	20	19	17	22
<b>MARITAL STATUS (%)</b>					
Married	54	38	35	38	39
Previously married	21	31	27	27	37
Never married	25	31	38	36	24
Children under 18 years	41	43	32	50	40
Single mothers	14	24	17	28	22

NOTE: The direct-care worker category consists of the three types listed in the last three columns (hospital aides, nursing-home aides, and home health aides). The table excludes the 11 percent of the direct care workforce that is men. Percentages listed are based on weighted data for female workers aged 19 years and older. Percentages may not sum to 100 because of rounding.

SOURCE: Smith and Baughman, 2007.

### EDUCATION AND TRAINING REQUIREMENTS

The education and training of the direct-care workforce is insufficient to prepare these workers to provide quality care to older adults. Although there are a number of state and federal requirements for the education and training of nurse aides, home health aides, and personal and home-care aides, these requirements are minimal (Table 5-4). Many direct-care workers have no more than a high school education, and some have even less (Montgomery et al., 2005; Smith and Baughman, 2007). Minimum training requirements for these workers are often inadequate or non-existent, and they vary across occupational categories and settings of care as well as among states. A number of other training-program characteristics vary among states as well, including

the specific qualifications that instructors are expected to have, maximum student/instructor ratios, and the required program approval and oversight processes (AARP, 2006).

This section describes the current requirements for education and training of direct-care workers. Where possible, direct-care education and training issues that are particularly relevant to the older patient population are highlighted.

**TABLE 5-4** Education and Training Requirements for Direct-Care Occupations

Nurse Aides, Orderlies, and Attendants	Home Health Aides	Personal and Home-Care Aides
Federal requirements of 75 hours of training (for nurse aides); competency evaluation results in state certification; high school diploma and previous work experience not always required	Per federal rules, if employer receives Medicare/Medicaid reimbursement, workers must pass competency test (75 hours of classroom and practical training suggested); high school diploma and previous work experience not always required	Dependent on state, with some requiring no formal training; high school diploma and previous work experience not always required

SOURCES: BLS, 2008c, 2008d; Fishman et al., 2004.

### Nurse Aides

The Omnibus Budget Reconciliation Act of 1987<sup>2</sup> established the Nurse Aide Training and Competency Evaluation Program, which created minimum federal requirements for the education and training of nurse aides (OIG, 2002). Nurse aides working in Medicare- or Medicaid-certified nursing homes or home health agencies are required to successfully complete the following:

- at least 75 hours of state-approved training by, or under the general supervision of, an RN with at least two years of experience in nursing and at least one year of experience in a long-term care environment (or in home health care for training of home health aides);
- a competency evaluation (state certificate exam to become a certified nursing assistant); and,
- at least 12 hours per year of continuing education; for nursing homes, this must include training on providing services to individuals with cognitive impairments and on aide-specific areas of weakness identified in performance reviews.

Many states have established additional requirements beyond the federally mandated minimums. For example, 27 states and the District of Columbia require more than 75 hours of initial training and 12 states plus the District require 120 hours or more (Seavey, 2007a). Under federal rules the initial 75 hours of nurse aide training must cover a number of specific subject areas (Box 5-1). That time must include 16 hours of supervised practical, or “hands on,” training in a clinical setting, and the trainee must demonstrate the ability to perform specific tasks, such as taking vital signs. The 75-hour training requirement is low compared to other service professions. For example, California requires significantly more hours of training for manicurists (350 hours), skin-care specialists (600 hours), and hair stylists (1,500 hours) (Harrington, 2007a).

<sup>2</sup> *Omnibus Budget Reconciliation Act of 1987*. Public Law 100-203. 100th Congress. (1987).

**BOX 5-1**

**Federal Requirements for Nurse Aide Training, by Subject Area**

- Basic nursing skills, such as monitoring vital signs and height/weight; reporting abnormal changes in body functioning; and caring for the dying resident.
- Personal care skills, including activities of daily living such as bathing, grooming, dressing, toileting, and skin care; feeding and hydration; and transferring, positioning, and turning.
- Mental health and social service skills, such as responding to a resident's behavior; allowing the resident to make personal choices; and drawing upon the resident's family to be a source of emotional support.
- Caring for cognitively impaired residents, such as addressing the behaviors of dementia patients and responding to residents with other cognitive impairments.
- Basic restorative skills, such as training the resident in self-care; use of assistive devices; maintaining range of motion; eating, dressing, and ambulation; and bowel and bladder training.
- Residents' rights, such as maintenance of privacy and confidentiality; promoting residents' rights to make personal choices; helping to resolve grievances and disputes; reporting any instances of abuse, mistreatment, and neglect.

SOURCE: OIG, 2002.

States are responsible for ensuring compliance with educational requirements and administering (or contracting with someone who administers) competency exams. Subject to the 75-hour minimum, states have flexibility in developing training programs. These training programs can be offered by vocational schools, nursing homes, or home health agencies as long as the institution maintains its certification requirements. Instructional facilities that are judged to be providing substandard care can lose their right to offer a nurse-aide training program, which generally makes it more difficult and more costly to recruit new aides.

**Home Health Aides**

Home health aides must meet federal requirements only if their employer receives Medicare or Medicaid reimbursement. Specifically, home health aides in such institutions must pass a competency test that covers 12 subject areas (Box 5-2). Federal law suggests that home health aides be provided at least 75 hours of classroom and practical training that is supervised by an RN. These training programs vary by state.

**BOX 5-2**

**Subject Areas Covered in Home Health Aide Competency Tests**

- Communication skills;
- Observation, reporting, and documentation of patient status and the care or services furnished;
- Reading and recording vital signs;
- Basic infection-control procedures;

- Basic elements of body function and changes;
- Maintenance of a clean, safe, and healthy environment;
- Recognition of, and procedures for, emergencies;
- The physical, emotional, and developmental characteristics of the patients served;
- Personal hygiene and grooming;
- Safe transfer techniques;
- Normal range of motion and positioning; and
- Basic nutrition.

SOURCE: *Home Health Aide Training*. 2006. 42 C.F.R. § 484.36.

### **Personal and Home-Care Aides**

Since residential-care services, such as those provided in assisted-living facilities, are not paid for under the Medicare and Medicaid programs (except under some state Medicaid waivers), there are no federal requirements for residential-care personnel, and states have the primary responsibility for regulating residential-care facilities (IOM, 2001). When aides are hired directly by individuals (i.e. through consumer-directed programs), the patient or the patient's family member assumes responsibility for deciding what the worker needs to know and for providing training for those tasks, most often through direct observation (PHI and Medstat, 2004). In turn, patients may need to learn training and supervisory skills (as was discussed in Chapter 4 for the case of professionals), including effective communication and problem-solving.

While no federal requirements exist for personal-care attendants who work outside a nursing home or home health agency, states may conduct checks on the background, training, supervision, age, health, and literacy of these service providers if they receive Medicaid reimbursements (OIG, 2006). Training checks may include verification of instruction in topics such as first aid, assistance with ADLs, and basic health and hygiene. In 2006 the Office of Inspector General (OIG) found that the median number of training hours required of personal-care attendants was 28, but state requirements ranged from 2 to 120. As more personal-care attendants are hired privately by patients, making sure that these workers have the appropriate abilities will become an even more complex task.

### **RECRUITMENT AND RETENTION CHALLENGES**

Health care workers serving older patients have high rates of turnover, and maintaining adequate levels of staffing within the industry overall is a persistent challenge. This challenge is especially pronounced among direct-care workers, who have a number of immediate, less stressful job alternatives, such as those offered by the food and hospitality industries. In 2006, for example, personal and home care aides had median wages of \$8.54 per hour while counter attendants in cafeterias, food concessions, and coffee shops had median wage-and-salary earnings of \$7.76 per hour (including tips) (BLS, 2008b).

One study found that 40 percent to 60 percent of home health aides leave after less than one year on a job, and 80 percent to 90 percent leave within the first two years (PHI, 2005). Staff turnover in assisted-living settings ranges from 21 percent to 135 percent, with an average of 42

percent (Maas and Buckwalter, 2006). In nursing homes CNA turnover averages 71 percent per year, and the turnover rate in many states is much higher (Decker et al., 2003). Turnover may have negative effects on the quality of patient care and may also increase employer costs because of the need for continuous recruitment and training. A study of direct-care workers in Pennsylvania estimated annual recurring training costs due to turnover to be almost \$24 million for nursing homes and almost \$5 million for home health and home care agencies (Leon et al., 2001). It has been estimated that turnover among direct-care workers in the United States costs providers a total of \$4.1 billion per year (Seavey, 2004).

While many direct-care workers find the work of caring for frail older individuals to be rewarding, the appeal of these professions is weakened by a number of other factors including low wages, few (if any) benefits, high physical and emotional demands, and a significant potential for on-the-job injury (Newcomer and Scherzer, 2006; Pennington et al., 2003). Job dissatisfaction among these workers can also result from factors related to the work environment including poor relationships with supervisors, a lack of respect from other health professionals, and few opportunities for advancement (Fleming et al., 2003; Stone, 2000). Not surprisingly, high job dissatisfaction has been associated with increased turnover (Castle et al., 2007). Conversely, improved job satisfaction can result in a greater intent to stay.

Researchers examining the predictors of high turnover in nursing homes have identified a number of key variables, including: low staffing ratios, for-profit ownership, and higher numbers of beds (Castle and Engberg, 2006); low reimbursement rates, a high Medicaid census, low wages, and low administrative expenses (Kash et al., 2006); and inadequate benefits and not having a good social environment at work (Grau et al., 1991). One study examining predictors of turnover in a residential-care setting found that the physical condition of the neighborhood<sup>3</sup> in which the facility was located was by far the strongest predictor of turnover, outweighing other factors such as starting wages, availability of health insurance, Medicaid census, and average case mix (Konetzka et al., 2005).

In the following sections, several of these challenges are discussed in more detail, along with the effect that these factors have on patient outcomes. Initiatives to overcome these barriers are also discussed later in this chapter. It is important to note that the chapter provides only a general discussion of challenges to the recruitment and retention of direct-care workers and that, depending on the type of direct-care worker, the setting, and the source of dissatisfaction, these various factors may weigh more or less heavily in a particular situation.

### Financial Disincentives

Direct-care workers receive low hourly wages, which contributes to the lower appeal of these jobs. In fact, in 2007 *Forbes* magazine profiled personal and home care aides as one of the top 25 worst-paying jobs in America (Maidment, 2007). Table 5-5 shows the median wages for direct-care occupations in a variety of settings that are important in the care of older adults.

The average annual earnings of female direct-care workers are significantly lower than the average annual earnings of female workers in general (\$17,228 versus \$30,441), and 19 percent of female direct-care workers have incomes below the poverty level versus 8 percent of female workers in general (Smith and Baughman, 2007). The low incomes of direct-care workers are due in part to the fact that many direct-care workers do not have predictable hours or the opportunity to work more hours if desired (Dawson, 2007).

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<sup>3</sup> The condition of the neighborhood was likely a proxy for many of the resource issues that cannot be measured well and typically cannot be included in these studies.

**TABLE 5-5** Median hourly wages for direct-care occupations by setting, 2006

	Nurse Aides	Home Health Aides	Personal and Home-Care Aides
All settings	\$10.67	\$9.34	\$8.54
Community care facilities for older persons	\$10.07	\$8.87	NA
Services for older or disabled persons	NA	\$9.26	\$9.18
Home health care	NA	\$9.14	\$7.19
Nursing care facilities	\$10.37	\$9.76	NA

NOTE: NA = not available.  
 SOURCE: BLS, 2008c, 2008d.

Direct-care workers have limited access to employee benefits, including health insurance coverage, sick leave, and retirement benefits (Brady et al., 2002; Dawson, 2007; GAO, 2001b; Smith and Baughman, 2007). Approximately one-quarter of direct-care workers lack health insurance coverage (Lipson and Regan, 2004; Hams et al., 2002). Often these workers are unable to afford their share of the health insurance premiums or they are ineligible for coverage because they work part time or they work independently of an agency. As can be seen in Table 5-6, female direct-care workers are considerably less likely to have health insurance coverage than are female workers in general. This situation can vary dramatically by occupation and region, however. A study of home care workers in Los Angeles, for instance, found that about 45 percent of them were uninsured (Cousineau, 2000). And health insurance is not the only benefit that direct-care workers are less likely to receive. For example, approximately three-fourths of nurse aides in nursing homes and home health settings have no pension benefits (GAO, 2001b).

**TABLE 5-6** Health Insurance Coverage of Female Workers and Direct-Care Workers, 2005

Type of Coverage	All Female Workers	All Female Direct-Care Workers	Female Hospital Aides	Female Nursing-Home Aides	Female Home Health Aides
All private	78	60	84	63	49
Employer-based	51	38	63	44	23
Public	12	22	10	19	29
None	16	25	13	24	30

NOTE: Percentages are based on weighted data for female workers aged 19 years and older. Columns may sum to more than 100 percent because some workers are covered by more than one type of health insurance.

SOURCE: Smith and Baughman, 2007.

### Non-Financial Factors

While concerns about poor wages and lack of benefits are significant, non-financial job characteristics also play a major role in the job satisfaction of direct-care workers (Bowers et al., 2003). Factors that influence job satisfaction include professional growth opportunities, adequate training, rewards for performance, and manageable workloads (Castle et al., 2007; Parsons et al., 2003). Direct-care workers often report that they do not receive enough respect for their knowledge and skills, that they have little discretion or input into care planning (despite being responsible for most of the patient care hours), and that they sense a lack of trust by management (Bowers et al., 2003). Other factors contributing to worker dissatisfaction include excessive paperwork, frequent patient deaths, combative and uncooperative patients, and inadequate

staffing (Cherry et al., 2007). Aides who work in understaffed facilities feel extra time pressure, which contributes to burnout and absenteeism (Bowers et al., 2000). Research has shown that job satisfaction and organizational culture are strong predictors of worker commitment to an organization (Sikorska-Simmons, 2005), and, as discussed in Chapter 4, poor supervisory relationships are a key driver of turnover (Tellis-Nayak, 2007).

Caring for older patients can be emotionally draining, especially when patients are at the end of life (Haley et al., 2003; Holland and Neimeyer, 2005; Jezuit, 2000; Viles, 2000). Moreover, the work can be physically taxing. Direct-care staff in nursing homes have one of the highest rates of workplace injury among all occupations. In 2006, according to the BLS, the rate of non-fatal occupational injury and illness involving days away from work was 526 incidents per 10,000 workers among nursing aides, orderlies, and attendants (BLS, 2007a). This was four times the average rate among all occupations and was a higher rate than found among either construction workers (488) or truck drivers (411). Fifty-six percent of injuries and illnesses among direct-care workers were directly related to patient interaction, and 86 percent of these injuries and illnesses were due to overexertion. Nursing aides, orderlies, and attendants also had the highest rate of musculoskeletal disorders among all occupations examined.

Among personal care aides, the documentation and treatment of on-the-job injuries is impeded when aides change employers, which can affect an individual worker's ability to access worker's compensation benefits (Scherzer, 2005, 2006b). In addition, the rate of injury to personal care aides may be severely underestimated, largely because independent providers are generally ignored by current surveillance mechanisms.

In 1996 the IOM recommended that all personnel who provide direct care (especially in nursing homes) should receive annual training in lifting and transferring patients. The committee also concluded that hospitals and nursing homes should develop effective programs to reduce work-related injuries (IOM, 1996). Chapter 6 of this report identifies a number of technologies that have been developed to assist both direct-care workers and informal caregivers in performing some of the physically demanding tasks that are involved in caring for older adults.

Finally, trends in the care of older adults, such as the movement toward more home-based care, can affect the job environment for these home- and community-based workers. For example, as more workers are hired directly by patients under consumer-directed models of care, home care workers may have to contend with a more ambiguous situation in terms of their lack of supervisory management. This in turn can make it less likely that these workers will have someone to deal with regarding such concerns as on-the-job injury and access to workers' compensation. One study of injured home care workers found that individually hired workers faced greater obstacles (e.g. barriers to creating a safe working environment, receiving appropriate care for injuries, or receiving compensation benefits) than did agency-hired workers (Scherzer, 2006a).

### **Impact on the Quality of Patient Care**

Several issues related to the difficulties of recruiting and retaining direct-care workers may have direct effects on the quality of care provided to older patients. Studies have shown, for example, that a significant relationship exists between staffing levels and the quality of patient care (Harrington, 2007b; Harrington and Swan, 2003; IOM 1996, 2001). Research has also linked turnover rates with quality of care, although the details of that relationship remain equivocal (Bostick et al., 2006; Castle and Engberg, 2005, 2006; Cohen-Mansfield, 1997). Most of the studies simply demonstrate associations, for instance, so it is not possible to estimate the

magnitude of a potential causal effect. Furthermore, most studies of turnover to date have suffered from inconsistencies in the way that turnover is calculated, both in terms of its definition and its use as a linear measure.

Although historically it has been difficult for researchers to prove direct causal links between recruitment and retention challenges and the quality of care delivered to patients, there is some evidence that the two are related. In a series of research publications, Castle and Engberg concluded that, in general, high turnover is associated with poor quality and that staff characteristics such as turnover, staffing levels, and worker stability all affect the quality of care of nursing homes (Castle and Engberg, 2007). The researchers also found that increases in nurse aide turnover, especially those from moderate to high levels, result in decreases in quality as measured by rates of physical restraint use, catheter use, contractures, pressure ulcers, psychoactive drug use, and quality of care deficiencies reported on certification surveys (Castle and Engberg, 2005). Castle and Engberg found evidence of a nonlinear relationship between turnover and quality in their examination of one-year turnover rates among nurse aides and licensed practical nurses (LPNs) in nursing homes (Castle and Engberg, 2006). While there was no significant relationship between turnover and the quality of care at lower levels of turnover, they found that when turnover rates were greater than 50 percent, there was a significant negative relationship between turnover rates and quality.

In nursing homes, nurse aides often have to manage heavy patient loads, which not only increases the burden placed on them but can also decrease the quality of care that they provide (Schnelle et al., 2004). A report released in 2001 by the Centers for Medicare and Medicaid Services (CMS), which investigated the appropriateness of minimum nurse staffing ratios in nursing homes, noted:

“[W]ith one nursing assistant commonly responsible for nine or more residents on the day shift and twice as many at night, time management often degenerates into triage. Baths and meals are given on a tight schedule and at the convenience of the home’s routine rather than the residents, leading to things like waking residents in the middle of the night for showers. Call lights are left unanswered, nonessential tasks such as nail care are neglected, and practices are often adopted that endanger either residents or staff” (CMS, 2001).

Conversely, improving some aspects of job quality (e.g. reducing turnover) may lead to improvements in the quality of patient care. For example, allowing nurse aides to have greater responsibility in care decisions is associated with higher social-engagement scores among patients, and lower rates of turnover and higher rates of retention have been associated with lower incidence of pressure ulcers (Barry et al., 2005). One study of residents and staff at assisted-living facilities found that a high-quality work environment, including an organizational culture that emphasizes teamwork and participatory decision-making, is associated with greater satisfaction among the residents (Sikorska-Simmons, 2006). Another study examined a skilled nursing facility that had created a staffing program that emphasized consistent scheduling, with staff permanently assigned to specific residents. The facility reported that the program had positive effects both on worker satisfaction (including a 10 percent decrease in turnover and a 50 percent decrease in injuries) and on patient outcomes (including a 40 percent decrease in pressure ulcers and an 83 percent decrease in complaints) (ASA, 2008). Again, however, it is difficult to prove a causal relationship between job satisfaction and turnover and the consequent

effects on patient care. Strategies to improve the quality of direct-care jobs and the effects of these strategies on reducing turnover and increasing intent to stay are discussed in the next section.

### **IMPROVING RECRUITMENT AND RETENTION**

In order to overcome the challenges to recruitment and retention of direct-care workers, more needs to be done to improve the overall quality and, therefore, desirability of these jobs. Strategies to do this can be grouped into three broad categories:

- enhancing the quality and quantity of basic education and training;
- increasing economic incentives (i.e., increased wages and benefits); and
- improving the work environment (e.g., empowerment strategies and culture change).

These strategies not only are important for developing a robust health care workforce but also have direct implications for the quality of care provided to older adults. In addition to improving the quality of these jobs, the sheer number of workers needed to care for the future population of older adults makes it imperative that new sources of workers be considered. The following sections outline strategies both to improve job quality and to broaden the potential labor pool, and they include examinations of several large-scale efforts to improve the recruitment and retention of direct-care workers.

#### **Enhancing Basic Education and Training**

There are a number of indications that the current training requirements for direct-care workers are insufficient, both in terms of quality of content and quantity of training hours. Most nurse aide educators, as well as nurse aides themselves, agree that current levels of education and training for initial certification is inadequate (CMS, 2001). Moreover, 58 percent of ombudsmen identified inadequate training as a major impediment to quality care in nursing homes, and CNAs rank inadequate training among the top three problems that they face (Hawes, 2002). Poor training has also been identified as one of the factors that contributes to occurrences of neglect and abuse in nursing homes, especially for patients with behavioral difficulties associated with dementia (Hawes, 2002; IOM, 2002).

Very little is known about the quality of training for home health aides or personal and home care aides. Moreover, little is known about how training translates into practice. Some have suggested that these home- and community-based workers need to receive more training than workers in nursing-home settings because of the breadth of their responsibilities and their relative lack of supervision (Benjamin and Matthias, 2004; PHI and Medstat, 2004). Others have criticized attempts to standardize the training of these workers. As consumer-directed care has become more important, for example, some patients have expressed fears that personal and home care aides hired directly by patients or their families may not respond to the consumers' personal preferences if training standards are made too rigid. (See Chapter 6 for a fuller discussion of issues related to the trend of consumer-directed care.) However, most agree that certain basic skills and aptitudes are needed for the delivery of personal assistance.

Both the initial training and the continuing education of direct-care workers appear to be inadequate. In a survey of direct-care workers across multiple settings, only a little more than half said that their initial training was adequate, while 40 percent to 50 percent said that they

could benefit from further training; 45 percent said continuing education was only somewhat useful (Menne et al., 2007). These workers identified a number of areas where their knowledge and skills needed further development, including dementia, end-of-life care, teamwork, and problem solving.

Much more research is needed to determine the competencies that direct-care workers need in order to provide high-quality care to older patients. Unfortunately, as is also the case with the professional health care workforce, expansion of training opportunities for direct-care workers is limited both by the availability of qualified trainers and by the funding available to pay for additional training.

While there is limited research on how different levels and types of training affect the quality of care provided, there is some evidence that a relationship does exist (IOM, 2001). For example, studies have shown that dementia, a common geriatric syndrome, is inadequately diagnosed and treated in assisted-living facilities, which can contribute to a quicker discharge to a nursing home (Lyketsos et al., 2007; Rosenblatt et al., 2004). In fact, in residential settings such as assisted-living facilities, the level of staff training is a key factor in determining whether residents will need to be relocated to nursing homes as their needs become more acute (Maas and Buckwalter, 2006).

Adequate training also has an effect on recruitment and retention. High levels of training have been positively associated with recruitment of home health workers (Leon et al., 2001). Increasing the skills of personal care aides through a geriatric case-management program has shown strong influence on the workers' intent to stay and also some effect on job satisfaction (Coogler et al., 2007). Similarly, nurse aides who have received adequate training have been found to provide higher-quality patient care (Goldman et al., 2004) and to be less likely to want to leave their jobs (Castle et al., 2007).

In 2001 the IOM recommended that "all long-term care settings, federal and state governments, and providers, in consultation with consumers, develop training, education, and competency standards and training programs for staff based on better knowledge of the time, skills, education, and competency levels needed to provide acceptable consumer-centered long-term care" (IOM, 2001). This still holds true.

### *Content of Training*

One area in which the content of direct-care worker training does not reflect the current environment is its relative lack of geriatric-specific educational content. A 2002 OIG study found that more than half (63 percent) of nursing-home supervisors interviewed believed that training had not kept pace with the care demands imposed by the increasing complexity of resident diagnoses, including Alzheimer's disease and other behavioral and cognitive disorders. Some of the specific skills for which additional training was found to be needed were related to catheter and colostomy care, lifting, skin care, feeding, hydration, and infusion therapies (OIG, 2002).

*The committee concluded that direct-care workers who attend to older adults, especially frail older patients with complex health care needs, need to have specific training that will prepare them for these patients.*

In addition to instruction that applies to older patients generally, staff may also need specific training in cultural competence for working with ethnically diverse patients and co-workers (Fuller, 1995; Minore and Boone, 2002). This type of training is not currently specified in federal

requirements. Another area where training is inadequate is in palliative care; workers in both nursing homes and home-care settings are typically not well trained in the care of patients at the end of life (Ersek, et al., 2006; Ferrell et al., 1998). Additionally, many direct-care workers need soft skills training, such as communication skills.

### *Quantity of Training Hours*

In recent years there have been calls to increase the number of hours required for direct-care worker training. In 1998 the National Citizen's Coalition for Nursing Home Reform called for nursing assistants to be given a minimum of 160 hours of training (NCCNHR, 1998). Also in the late 1990s a panel of experts convened by the Hartford Institute for Geriatric Nursing recommended that training requirements for nursing aides be doubled, from 75 hours to 150 hours (Harrington et al., 2000). In 2002 an OIG survey of state-level directors of the Nurse Aide Training and Competency Exam Program found that 40 of the 49 respondents believed that the 75-hour federal minimum was insufficient to ensure adequate preparation for the job (OIG, 2002). In 2006 AARP examined nurse aide training programs in 10 states and found that the majority of officials interviewed believed that federal minimums need to be increased to between 100 and 120 hours (Hernandez-Medina et al., 2006).

Curricula are often overloaded, and there are challenges in covering all of the included ground in just two weeks (CMS, 2001). It may also be unrealistic to expect students to assimilate all of the necessary material in so little time (OIG, 2002). Moreover, the educational content for direct-care worker training has not kept pace with changes in the patient population, such as the increased prevalence of dementia and other cognitive disorders. As a result, more geriatric-specific educational content is needed. Additional hours will be required to cover this added material.

**Recommendation 5.1: States and the federal government should increase minimum training standards for all direct-care workers. Federal requirements for the minimum training of CNAs and home health aides should be raised to at least 120 hours and should include demonstration of competence in the care of older adults as a criterion for certification. States should also establish minimum training requirements for personal care aides.**

As described previously, more than half of states currently require more than the 75-hour federal minimum for nurse aide training, and about one-quarter require at least 120 hours (Table 5-7). This minimum should be raised in order to provide direct-care workers with the enhanced preparation they need to do their work. The committee ultimately decided to recommend 120 hours in order to raise the entire nation to the minimum standards of the top quartile of states. While data on the exact competencies needed by different types of direct-care workers when caring for older adults are minimal, the committee concluded that there is an immediate need to increase current federal minimum requirements to a higher standard. The committee recommends this new 120 hour minimum anticipating that even higher levels of required training hours may be needed to adequately cover additional knowledge and skill areas as more evidence is accumulated concerning the specific competencies that these workers need when caring for older adults. States, individual disciplines, regulators, patients, and others will need to work together to determine these competencies. This will be especially important as direct-care

workers assume increasingly complex responsibilities and work more often in alternative sites of care. As data are gathered on the competencies needed for these additional and changing responsibilities, the minimum number of training hours needs to be raised accordingly.

The committee’s recommendation does not offer any detail on the composition of those hours with respect to clinical training. At this time the states differ substantially in terms of how much training comes in the form of classroom instruction and how much is covered through practical training (Table 5-7). For example, North Carolina and Wyoming both require a minimum of 75 hours of nurse aide training, but North Carolina requires only 16 of those hours to be devoted to clinical training (the federal minimum), while Wyoming requires 48 hours of clinical training.

While there is already an established system for training and certifying home health aides and certified nursing assistants—a system that the committee is proposing to strengthen—the methods for training and certifying personal and home care aides are much more inconsistent from state to state, with no formal system in existence. The committee’s recommendation with regards to these workers is intended to create a basic framework for further requirements that may be implemented by states and the federal government in the future, especially as the knowledge base about the education and training of all types of direct-care workers develops.

**TABLE 5-7 Nurse Aide Training Requirements (by State), 2007**

Hours	State	Minimum Training Hours/(Minimum Clinical Hours)
120+ hours (12 states +DC)	Missouri	175 (100)
	California	150 (100)
	Delaware	150 (75)
	Maine	150 (50)
	Oregon	150 (75)
	Alaska	140 (80)
	Arizona	120 (16)
	District of Columbia	120 (n/a)
	Florida	120 (40)
	Idaho	120 (40)
	Illinois	120 (40)
	Virginia	120 (40)
	West Virginia	120 (55)
	76 – 119 hours (15 states)	Indiana
Connecticut		100 (50)
Hawaii		100 (70)
Maryland		100 (40)
New Hampshire		100 (60)
New York		100 (30)
Rhode Island		100 (20)
Kansas		90 (45)
New Jersey		90 (40)
Georgia		85 (16)
Washington		85 (50)
Louisiana		80 (40)
South Carolina		80 (40)
Utah		80 (16)
Nebraska		76 (n/a)

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75 hours	Alabama	75 (16)
(23 states)	Arkansas	75 (16)
	Colorado	75 (16)
	Iowa	75 (30)
	Kentucky	75 (16)
	Michigan	75 (16)
	Massachusetts	75 (16)
	Minnesota	75 (37.5)
	Mississippi	75 (16)
	Montana	75 (25-30)
	North Carolina	75 (16)
	North Dakota	75 (16)
	New Mexico	75 (n/a)
	Nevada	75 (n/a)
	Ohio	75 (16)
	Oklahoma	75 (16)
	Pennsylvania	75 (37.5)
	South Dakota	75 (16)
	Tennessee	75 (35)
	Texas	75 (24)
	Vermont	75 (16)
	Wisconsin	75 (16)
	Wyoming	75 (48)

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SOURCE: Seavey, 2007a.

### Increasing Economic Incentives

As described previously, wages for direct-care workers are low and do not appear to adequately support the recruitment and retention of these workers. In a classic economic model of a labor shortage, wages, benefits, and other job attributes would simply improve until enough workers were willing to fill the positions, and the shortage would no longer exist. However, given that Medicaid and Medicare are responsible for about 70 percent of all long-term care dollars spent (Komisar and Thompson, 2007), there is little room for the market to adjust without the government's being willing to commit additional funds.

Evidence shows that higher wages do in fact lead to lower rates of turnover among all types of direct-care workers (Howes, 2005, 2006; Sherard, 2002). In seeking to find ways to increase wages for direct care workers in this environment, several mechanisms have been employed, including: setting a minimum service rate percentage that must be passed through to direct-care labor costs; creating rate enhancements for providers that compensate their workers at a higher level; establishing automatic cost-of-living-adjustments to be passed through to direct-care labor costs; and establishing procurement and contracting standards that specify minimum staffing standards that providers must meet, such as worker compensation.

By far the most prevalent mechanism for stimulating increased direct-care worker pay is the wage pass-through, a state-level allocation of Medicaid funds that are added to reimbursement rates for the specific purpose of increasing direct-care staff wages. A review and evaluation of state wage pass-through laws conducted in 2003 found that 21 states had implemented such programs; nine of those programs were for skilled nursing facilities only, while the others also included home health or personal care (PHI, 2003b). Most of these programs were mandatory,

but participation was voluntary in at least six of the states, and some states allowed flexibility in exactly how the funds were to be used to improve staffing.

Evaluation data for wage pass-throughs are limited and show mixed results, especially in terms of the effect on recruitment and retention. The effects on actual wages were also unclear. One reason for the lack of clarity is that Medicaid is only one payer among several and workers are not payer-specific, so facilities with different proportions of Medicaid residents received different total amounts to be spent on wage increments. A variety of other obstacles to analyzing these programs also exist, including the use of differing measures of recruitment and retention, an inability to monitor how wages are actually transferred to the employees, and difficulty in separating the effects of the wage pass-through from other interventions. The lack of data suggests the need for careful monitoring and auditing of wage pass-through programs. The evidence that is available, however, indicates that the wage increases were often too small, were unreliable year to year, lacked accountability mechanisms, and were time consuming and expensive to implement. However, some states, such as Wyoming, have implemented programs that have been deemed successful by assessors (Seavey and Salter, 2006).

Increasing wages is only one step toward improving the recruitment and retention of direct-care workers; benefits also need to be improved. This is especially true of direct-care workers in home settings, who typically have very limited benefits (Howes, 2006). According to a 2005 study, nine states had developed or were in the process of developing programs that would address the lack of health insurance among health care workers (Harmuth and Dyson, 2005). State strategies for expanding access to coverage for these workers include subsidizing employer-sponsored insurance, designing innovative employer-based insurance packages, and, in the case of Massachusetts, including the workers in a near-universal state health coverage plan (Seavey and Salter, 2006). In states such as Wisconsin, wage pass-throughs have also been considered as an option for funding the health care benefits of direct-care employees (PHI, 2006).

**Recommendation 5.2: State Medicaid programs should increase pay and fringe benefits for direct-care workers through such measures as wage pass-throughs, setting wage floors, establishing minimum percentages of service rates directed to direct-care labor costs, and other means.**

The committee also supports efforts to address the issue of variable hours and unstable income among direct-care workers. For example, the Guaranteed Hours Program implemented by Cooperative Home Care Associates (a home-care staffing agency in New York City) aims to reduce turnover and vacancy rates (PHI, 2007). Under this program, home health workers are considered full-time employees, are guaranteed full-time wages, and effectively serve on an “on call” basis during work hours when no client visit is scheduled. Although it has not been evaluated in isolation, it is part of a set of workforce interventions that have been documented to reduce turnover to nearly half the industry average (PHI, 2007).

### **Improving the Work Environment**

Besides pay and benefits, a number of other factors may increase job satisfaction among direct-care workers, such as participation in decisions related to care planning and workplace improvement, the availability of career advancement opportunities, and high-quality supervision. Research has shown that job satisfaction and changes in organizational culture are strong

predictors of commitment to an organization (Sikorska-Simmons, 2005) and that improved job satisfaction can result in a greater intent to stay (Castle et al., 2007). A variety of approaches, including mentoring (Hegeman, 2005), use of self-directed work teams (Yeatts et al., 2004), and career ladders (Maier, 2002), have all been closely linked to employee satisfaction.

### *Improving Relationships with Supervisors*

As discussed in Chapter 4, the relationship between nursing supervisors and direct-care staff plays a significant role in the development of a hospitable work environment that leads to increased job satisfaction (Tellis-Nayak, 2007; Bishop et al., 2006). Positive supervision (as opposed to more punitive approaches) can greatly increase the direct-care worker's sense of value and ultimately can increase his or her level of job satisfaction and intent to stay. Evidence shows that perceived support by supervisors is also an important determinant in decreasing job-related stress (McGilton et al., 2007). A strengthening of the relationship between supervisors and staff may also enhance the practice of job delegation, as members of a workforce develop better and more interactive relationships, including improved recognition by supervisors of each worker's skills.

### *Increasing Recognition*

Direct-care workers often feel that they do not receive adequate recognition for their work or for the contributions that they make toward quality patient care. Studies looking at the implementation of empowered CNA teams at skilled nursing facilities found that giving CNAs added decision-making responsibilities led them to become more competent and also to develop better attitudes about their jobs. This approach also takes advantage of the fact that CNAs have the most direct knowledge about the preferences of nursing home residents and as a result are often in the best position to make decisions relating to day-to-day care (Yeatts, 2007). Efforts to increase the involvement of direct-care workers in decision-making have also been linked to increased overall job satisfaction and, ultimately, decreased turnover. One study, for example, found that turnover among nursing home aides was significantly reduced when they were involved in interdisciplinary care-plan meetings (Banaszak-Holl and Hines, 1996). In a study of Pennsylvania's direct-care workforce, increased involvement of direct-care workers in care planning was associated with decreased rates of staff shortages and fewer job vacancies (Leon et al., 2001).

The Wellspring nursing home quality improvement model is one example of an effort to improve the recognition of CNAs as important members of the care team by enabling them to become leaders in continuous quality improvement. The program encourages individual staff members to acquire knowledge and skills in particular clinical areas (e.g., incontinence and pressure ulcers) so that they can lead care-resource teams in the care-planning and decision-making processes for residents (Wellspring Institute, 2005). (See the next section on career lattices for more on the development of specialty areas among direct-care workers.) These areas of training are based on best practices determined by the guidelines of both the Agency for Healthcare Research and Quality and the American Medical Directors' Association as well as on other national standards of best practices (Wellspring Institute, 2005).

Evaluation of the program has shown that its training and organizational change methods have had measureable impact on retention and job satisfaction among its staff, as well as on resident satisfaction. Turnover rates were lower than at comparable facilities in the area; staff

was more actively involved in assessing resident needs and providing care; and there was observational evidence of improved quality of life and interactions with staff among residents (Stone et al., 2002).

### *Creating Career Lattices*

Another approach to increasing overall job satisfaction among direct-care workers is to expand their roles and responsibilities and to enhance their ability to develop new skills. The term “lattice” refers to how some workers move laterally in their careers (i.e. through the development of specialized skill areas) while others move linearly up the career “ladder” (e.g., advancement from CNA to LPN to RN) (CAEL, 2005). There have been many efforts to encourage the development of lattices for direct-care workers, sometimes in concert with the ability to move up a career ladder. For example, the Office of Apprenticeship in the U.S. Department of Labor (DOL) awarded grants to the Council for Adult and Experiential Learning (CAEL) and PHI with the goal of creating apprenticeship opportunities for direct-care workers to develop special skills through on-the-job training, related instruction, and mentoring (DOL, 2008c). The increased skill development associated with apprenticeships often leads to increases in wages as well (CAEL, 2005).

**Council for Adult and Experiential Learning (CAEL)** The CAEL has implemented the nursing career lattice program in nine sites (including both acute and long-term care settings) to develop more CNAs, LPNs, and RNs (CAEL, 2008; DOL, 2008c). As a first step, many apprentices are recruited from auxiliary areas such as housekeeping, clerical staff, and food service to be trained for CNA certification. Next, CNAs are encouraged to develop enhanced skills in specific areas including geriatrics, dementia care, and peer mentoring. CNAs are given flexible training schedules and wage increases in alignment with their increased responsibility. In this manner, the program prepares CNAs to take the required examination to become LPNs. LPNs also receive additional training based on specific competencies. For the next step on the career ladder, LPNs receive online education along with clinical training at local community colleges that prepares them to take the required examination to become RNs. This program has resulted in increased retention, reduced recruitment costs, and decreased worker shortages (CAEL, 2005, 2008).

**PHI** Under its grant, PHI developed the Home Health Aide Registered Apprenticeship at five sites to help home health aides gain basic skills and develop skills for specialty areas, such as hospice and palliative care, geriatrics, dementia, and peer mentoring (DOL, 2008c). As in the CAEL program, the training programs are based on specific competencies. Apprentices are required to demonstrate competence in basic skills as well as the skills needed for two specialty areas. They also receive mentoring from experienced home health aides.

### *Creating New Jobs and Delegating Responsibilities*

As discussed in previous chapters, efficient use of the workforce will require more delegation of job duties in the coming years. This delegation has a cascading effect, with specific tasks being handed off to people in various professions and occupations, depending on the situation, which allows each worker to be used at his or her highest level of skill. The combination of the need to delegate additional duties and the desire of some direct-care workers to assume more

responsibilities creates opportunities to restructure workforce assignments in ways that are potentially more satisfying for direct-care workers.

In some new models, direct-care worker roles may become much broader. For example, the Green House model described in Chapter 3 gives a more expansive role to direct-care workers. Under that model, frontline caregivers take responsibility for a broader range of tasks that include personal care, cooking, housekeeping, and making sure that residents spend time according to their preferences.

In other cases, direct-care workers take on specific tasks that require a higher level of skill than is usually expected of them. One example of this is the delegation of medication administration duties from RNs, as discussed in Chapter 4. Although there have been some concerns raised regarding patient safety, some RNs who have assessed the delegation of these responsibilities to CNAs have argued that CNAs may be able to deliver medications with greater accuracy because they face fewer distractions than RNs (Reinhard et al., 2003). If so, giving this responsibility to CNAs has the potential to increase efficiency, benefit patients, and facilitate the recruitment and retention of direct-care workers. Similarly, having home health aides assume responsibility for medication administration from RNs could help decrease the need for RN visits to homes.

If direct-care workers are to assume these increased responsibilities, they may in turn need to delegate certain of their own tasks. One example of this is the use of feeding assistants in the long-term care setting. Nurse aide training includes instruction in how to assist older adults with eating and hydration, and this is one of the primary responsibilities of CNAs. In 2003, however, CMS issued regulations allowing states to permit long-term care facilities participating in Medicare or Medicaid to use paid feeding assistants to supplement CNA services under certain conditions. Requirements for feeding assistants include the successful completion of a minimum of 8 hours of training in a state-approved course. The use of the feeding assistant has been controversial, but a preliminary analysis found that the quality of feeding done by feeding assistants was comparable to the quality of feeding by CNAs and, furthermore, that facilities did not decrease CNA hours in response (Kasprak, 2007; Simmons et al., 2007).

### *Using Technology*

New technologies will make possible the more efficient use of the direct-care workforce in a variety of ways. As was discussed in previous chapters, the development and use of health information technologies will likely improve the coordination of patient care and enhance communication among caregivers. The development and use of assistive technologies may help patients be more independent, thereby reducing their need for assistance, especially personal care assistance (see Chapter 6). Furthermore, the use of these technologies can reduce the physical demands of many tasks, perhaps leading to a reduction in the rate of injury among direct-care workers. One such example would be technologies that can assist with tasks that often result in muscle strain on the part of workers, such as lateral transfers, repositioning patients up or side-to-side in bed, and bed-to-chair or bed-to-wheelchair transfers (Baptiste, 2007).

### *Improving Safety*

In addition to the use of these assistive technologies, a number of other efforts have been undertaken to prevent injuries among direct-care workers. For example, the Occupational Safety and Health Administration (OSHA) has developed ergonomic guidelines aimed at preventing

musculoskeletal disorders among nursing home workers (OSHA, 2008). These guidelines offer safe methods for lifting and repositioning patients and help meet the training needs of workers in nursing home settings. Additionally, in 2002 OSHA announced a new National Emphasis Program for nursing and personal care facilities, which aims to address ergonomics, exposures to health risks, and slip-and-fall injuries (OSHA, 2002).

OSHA also awards Safety and Health Achievement Recognition Program (SHARP) designations to small employers who exemplify high standards of safety and health management. In 1998 one such recipient, the Good Shepherd Nursing Home of Wheeling, West Virginia, analyzed its injury reports and determined that most of the injuries were the result of heavy lifting (OSHA, 2007). Subsequently, the nursing home procured a mechanical lifting device to assist with transfers and also implemented a safety program which included training, workplace analysis, and hazard prevention. In its first year the program led to a 62 percent decrease in worker injuries at the nursing home, and, thanks to the improved safety, between 2000 and 2005 the nursing home reduced its workers' compensation insurance premiums by over \$800,000. The nursing home's administrator commented that "a highly efficient and highly skilled workforce makes fewer mistakes, reduces exposure to liability, and keeps insurance premiums low" (OSHA, 2007).

### **Broadening the Labor Pool**

While improving the quality of direct-care occupations is important to the recruitment and retention of this workforce, sources for new workers also need to be considered, especially the possibility of recruiting workers from other, currently underutilized sources. A number of options exist for broadening the pool of direct-care workers (Hussein and Manthorpe, 2005; National Center for Health Workforce Analysis, 2004; Stone, 2004; Stone and Wiener, 2001). Some of the groups of people who might be recruited to enter the direct-care workforce are described below.

#### *Men*

As described previously, the population of direct-care workers is overwhelmingly female (Montgomery et al., 2005; Smith and Baughman, 2007). As a result, men represent a potential source of new workers that has so far remained essentially untapped. Given that the number of women in the United States between the ages of 25 and 54 is expected to remain level in the coming years and will not provide a labor pool sufficient to meet projected demand, more men will be needed to fill these roles. However, special consideration may be needed for male workers, including a culture change to accept male workers in an occupation that is currently dominated by females (PHI, 2003a).

#### *Immigrants*

Immigrants are already a significant part of the direct-care workforce, especially in major cities (Wilner and Wyatt, 1998), and they are frequently pointed to as a potential source of new workers in long-term care (Priester and Reinardy, 2003). However, few programs exist to train and place immigrants for careers as direct-care workers. Preparing immigrants for these roles will require instruction not only in technical skills but also in language skills and in the cultural competence needed to work with patients. Successful training models also need to help trainees to navigate immigration systems, seek housing, and prepare for higher education. Limited

experience shows that with the proper training and support, immigrant workers may be an effective source of direct-care workers; without proper support, however, their presence may exacerbate existing cycles of low pay and high turnover (Leutz, 2007).

Many countries in the industrialized world have modified their immigration laws to allow an influx of low-wage workers to fill vacancies for direct-care positions (AARP, 2005). The advantage of this approach is that the number of new workers in the labor pool can potentially be increased without drawing workers away from other industries. On the other hand, this approach could have potentially serious side effects. Specifically, costs for public services and government supports could increase (National Center for Health Workforce Analysis, 2004), there may be undesirable competition for other low-wage jobs (Stone, 2004), and the difficulties that can arise when caregivers and patients are from different cultures could become more common. (See Chapter 4 for more on ethnogeriatrics.) More research is needed on the appropriate use of immigrants, including information on both the benefits and the unintended consequences.

### *Older Workers*

As discussed in Chapter 4, as the population of older patients grows, the workforce itself will be aging. As current health care workers approach retirement age, there will be a need to recruit new health care workers as well as to find ways to retain older workers. This issue will also affect the informal workforce, particularly since spousal caregivers are becoming increasingly older themselves. From 1989 to 1999, for example, the proportion of spouse primary caregivers ages 75 or older increased from 38.2 percent to 47.4 percent (Wolff and Kasper, 2006), and by 1999, 11.1 percent of spouse caregivers (both primary and secondary) were 85 years or older (Spillman and Black, 2005). (See Chapter 6 for more on informal caregivers.)

Because of this aging of the workforce, in recent years there has been an increasing emphasis on strategies to recruit and retain older workers. These strategies include giving older workers greater access to education and training, providing them with additional tax deductions for continuing to work, and offering them opportunities for phased retirement and flexible schedules. For example, AARP has helped older workers obtain federally subsidized training through a local community college in order for them to gain needed technology skills (Taylor, 2007). Retaining older workers has a number of potential benefits aside from increasing the size of the workforce. These benefits include preventing the loss of the older workers' acquired expertise and avoiding the various costs associated with replacing these workers, such as recruitment expenses, paying for temporary replacements (per diem workers), and paying to retrain other workers.

The idea of recruiting older, non-health care professionals into new health-related careers has received increased attention. In a survey of low-income workers over the age of 55, a significant percentage (43 percent) expressed interest in direct-care work (Kosniewski and Hwalek, 2006). Additionally, more than half of employers for nursing homes and home health agencies said that older workers were more likely to be loyal employees and have desirable skills and less likely to leave the position. On the other hand, employers also thought that older workers would be more averse to using technology, and the wage expectations of the older workers who were surveyed were higher than the average for these positions. Furthermore, the older workers expressed more interest in the emotional support of patients than in hands-on tasks.

The recruitment and retention of older workers may require the creation of positions with fewer physical demands. Parsing CNA responsibilities might enable the productive use of older adults in the workforce who lack the strength to do all CNA tasks. In one example of such an

approach, McKesson, a health care services company, has recruited older workers for their call centers to advise patients on medication use (Taylor, 2007). Similarly, strategies to retain existing older workers in clinical positions will likely demand the creation of health care delivery processes that are more ergonomically oriented (Buerhaus et al., 2000). Emerging technologies may assist in this regard (see Chapter 6).

### *Volunteers*

In addition to recruiting new paid workers, workforce needs could be partially satisfied by using volunteers, both in clinical and in academic settings. Older adults themselves would seem to be a likely target group from which to recruit such volunteers, given that baby boomers have the highest volunteerism rate of any age group—they volunteer more often than past generations did at the same ages—and they constitute a very large pool of potential volunteers (Foster-Bey et al., 2007).

Members of younger generations may also be willing to provide needed services, especially community-based personal and home care services that would allow fellow community members to remain in their homes. Community-based models such as Beacon Hill Village in Boston have been developed to allow older adults to “age in place” (Gross, 2006). In these models older adults within a narrow community pay dues to receive support, such as accompaniment to medical appointments, delivery of meals, exercise classes, lectures on aging-related topics, and assistance with daily errands. Volunteers provide many of these services, such as transportation. Other more advanced services, such as home health aide services and home repairs, are often available for a discounted fee. These options may become more appealing as more older adults prefer to stay in their home settings and trends toward consumer-directed care continue (see Chapter 6).

### **Examples of Efforts to Improve Recruitment and Retention**

While some efforts to improve the recruitment and retention of direct-care workers focus on a single strategy, other programs and organizations have developed a mixture of policy- and provider-based interventions. Some large-scale efforts, including those of the federal government, are detailed below. In addition, there have been several large-scale efforts to build an evidence base for the best practices in the recruitment and retention of direct-care workers. These efforts are also described below.

### *Better Jobs Better Care*

The Better Jobs Better Care national program, which was completed in 2007, supported five state-based coalitions (in Iowa, North Carolina, Oregon, Pennsylvania, and Vermont) that designed and tested practice-based interventions and policy changes over a four-year period. These coalitions attempted to reduce turnover and vacancy rates and improve the working environment of direct-care staff in long-term care (BJBC, 2007). Since each state used different approaches to reach these goals, no single method can be fairly highlighted over the others. All of the participating states demonstrated a range of positive results from this effort, including improvement in worker satisfaction and increased recruitment (BJBC, 2008). To accomplish this, the program improved employee pay and also pushed employers to demonstrate respect for direct-care workers in a variety of ways: by providing supervision, peer mentoring, and team

building; by offering opportunities for educational advancement; and by encouraging greater communication and understanding (McDonald, 2007).

### *Employment and Training Administration Programs*

A number of efforts to bolster the direct-care workforce have been undertaken by the Employment and Training Administration (ETA) within the DOL, which has invested hundreds of millions of dollars in grants aimed at strengthening the pipeline of needed workers. The ETA's efforts to improve career lattices through the programs of its Office of Apprenticeship were discussed above. Many of the ETA's grants focus on long-term care workers (Freking, 2007). For example, since 2004 the Community-Based Job Training Grants have funded a number of programs to prepare students for careers in high-growth industries (DOL, 2008b). In March 2008 the DOL awarded \$125 million to 69 community colleges, and 24 of these grants (totaling almost \$40 million) were for developing workers for the health care industry (DOL, 2008a, 2008d).

The ETA's High Growth Job Training Initiative is aimed at giving workers the skills necessary to build a career in one of several different industries, including health care. Under this initiative, the ETA is investing more than \$46 million to address health care workforce shortages, particularly among long-term care workers (DOL, 2007). The initiative will focus on such things as increasing the number of younger workers entering the market, identifying alternative labor pools, developing new educational tools and curricula, increasing faculty, and improving recruitment and retention. The initiative intends to develop approaches that can be replicated across the country.

### *Centers for Medicare and Medicaid Programs*

CMS has also funded several initiatives to strengthen the quality of direct-care work and its services. In 2003, for instance, CMS initiated the Direct Service Workforce Demonstration, which provided grants to 10 states to test the effectiveness of various workforce interventions on the recruitment and retention of direct-care workers in the communities. According to an assessment of this program, the grants were shown to decrease worker turnover and increase retention rates. For example, over a two-year period Kentucky reported a decrease in turnover rates from 43 percent to 29 percent and an average increase in retention rates of five months (University of Minnesota and The Lewin Group, 2006). Such improvements were primarily achieved by increasing the visibility of available positions and by using more accurate selection strategies to hire well-matched workers to those positions.

Later, in 2006, the National Direct Service Workforce Resource Center was created by CMS, and it continues to address the recruitment and retention challenges of direct-care workers by providing information, resources, and assistance to all relevant stakeholders (e.g. policy makers, researchers, employers, workers and patients) involved in the provision of quality care to older adults at the state and local levels (CMS, 2008a).

Another effort by CMS to improve health services to older populations in all 50 states is its Real Choice Systems Change Grants. Since 2001 CMS has provided a total of approximately \$270 million in these grants to provide support for community living (CMS, 2008b). This funding has helped build effective foundational improvements in community-integrated services and long-term care systems by allowing states to address issues regarding personal assistance services, direct-care worker shortages, and respite service for caregivers and family members,

along with many other issues. Several states improved their support of the direct-care workforce by targeting the areas of recruitment, training and career development, and administrative activities (CMS, 2005). Some of the more common or effective strategies used by states to achieve better recruitment and retention of this workforce were altering training strategies, allowing for more flexibility in worker responsibilities, and broadening the definition of who can serve as a personal assistant (CMS, 2007). The funding provided to the states by this grant program has been put to use effectively, CMS reports, and “the infrastructure that has been developed enables individuals of all ages to live in the most integrated community setting suited to their medical needs, have meaningful choices about their living arrangements, and exercise more control over the services they receive” (CMS, 2008b).

### *The PAS Workforce Project*

The five-year PAS Workforce Project, run through the Center for Personal Assistance Services, has the goal of building and disseminating an evidence base for best practices concerning the personal assistance workforce. The information collected includes data on individual interventions as well as related legislation and policy efforts. The project pays particular attention to strategies to improve worker retention in consumer-directed programs, including issues related to wages, training, safety, and supervision, as well as to the development of infrastructures that facilitate consumer-directed programs (CPAS, 2008). To be included, a program must have documented operational experience as well as evidence of program success and replicability.

### *National Clearinghouse on the Direct-Care Workforce*

PHI’s National Clearinghouse on the Direct-Care Workforce is a national, online library of information regarding the direct-care workforce for long-term care. The clearinghouse collects government and research reports, fact sheets, briefs, and other information on issues such as career advancement, education and training, recruitment and retention, job environment, and best practices (National Clearinghouse for the Direct-Care Workforce, 2008). The clearinghouse also produces original research and analysis, including monitoring of state-based initiatives.

## CONCLUSION

Because direct-care workers provide the bulk of paid direct-care services for older patients in nursing homes and other settings, it is vitally important that the capacity of this segment of the workforce be enhanced in both size and ability to meet the health care needs of older Americans. However, the recruitment and retention of sufficient numbers of these workers is challenging due to serious financial disincentives and job dissatisfaction as well as high rates of turnover and severe shortages of available workers.

As it exists today, the education and training of direct-care workers is inadequate to impart the necessary knowledge, skills, and abilities to these workers, especially as the complexity and severity of older adults’ needs increase and as more adults are cared for in home- and community-based settings. The government should raise the federal minimum training requirement for nurse aides and home health aides to 120 hours and states should establish minimum standards for personal care aides if they have not already done so. All direct-care workers should be required to demonstrate that they possess the competencies necessary to

engage in this type of work. More research is needed to determine the appropriate content of training programs, which needs to be individualized for the needs of workers based on their responsibilities and the settings in which they provide care.

Improving the quality of these jobs will demand significant effort. Direct-care workers typically receive low wages and have limited access to other benefits, including health insurance. Economic incentives should be bolstered to improve the desirability of these jobs. Additionally, much more needs to be done to improve the workforce environment. Evidence shows that increased job satisfaction and decreased job turnover rates may be associated with increasing worker responsibilities (including the development of new roles or career lattices), increasing the recognition of the workers' current contributions, improving safety, and improving supervisory relationships. Given all these factors, it is clear that a change in culture is needed—that both health care workers and health care organizations need to change the way they think about direct-care workers and, in particular, that the direct-care workers need to be seen as a vital part of the health care team.

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## **MEETING GROUND RULES**

- **Check personal agendas at the door**
- **One meeting conversation at a time - no sidebars**
- **Stay focused and committed to the purpose of the meeting**
- **Listen for understanding before reacting**
- **Strive for consensus**
- **Keep within agreed time frames**
- **Everyone is responsible for keeping the meeting on track**
- **All ideas are valued**
- **Be committed to being action/outcomes oriented and expedient**
- **Be patient, sensitive and respectful to the diversity of the meeting participants**