

Strengthening the Direct Care Workforce for Long-Term Services and Supports

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Suggested Approaches From a National Panel of Experts



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SUGGESTED APPROACHES FROM A NATIONAL PANEL OF EXPERTS

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INTRODUCTION

In 2008, the ad hoc Committee on the Future Health Care Workforce for Older Americans, under direction from the Institute of Medicine (IoM), published its report concluding that the definition of this workforce must be expanded. According to the report, the definition should encompass everyone involved in a patient's care, including direct care workers (DCWs) such as nursing assistants and home care aides, and informal caregivers, referring to family and friends (IoM, 2008). The expansion of the definition is essential because DCWs and family caregivers deliver most of the hands-on care to chronically ill and impaired adults, and are regarded as the backbone of the long-term care workforce (Noelker, 2001). Hence, any efforts to improve the health care workforce must give thoughtful attention to strategies that address the needs and interests of DCWs and family caregivers. The IoM Committee proposed a three-fold approach for retooling the health care workforce aimed at the following: increasing recruitment and retention; enhancing competency through education and training; and, improving care delivery to ensure better outcomes for care receivers.

For more than 40 years, the Aging Network has helped to grow the long-term-care workforce in order to expand home- and community-based services (HCBS), thereby affording choice in long-term-care arrangements and supporting the independence of older Americans. The U.S. Administration on Aging (AoA) has led the Aging Network in these efforts. Over the years, it has taken a central role through Older Americans Act (OAA) Title IV training initiatives to improve the workforce. It also has overseen the expansion of services for family caregivers through the National Family Caregiver Support Program, funded under Title III of the OAA.

EXPERT PANEL ON THE LONG-TERM-CARE WORKFORCE

Under a Cooperative Agreement with AoA, the Benjamin Rose Institute on Aging convened a national panel of experts on the long-term-care workforce, specifically DCWs and family caregivers, to examine ways to enhance their capacity. One basis for the AoA request was that DCWs and family caregivers are critical to the delivery of long-term services and supports for older adults and adults with disabilities. As such, they are a vital part of the health care workforce in this nation, which was acknowledged in the recent IoM report (2008) that focused on the urgent need to "retool" or strengthen this workforce.

The second basis was health care reform legislation, including the CLASS Act, that presaged a new emphasis on and expansion of health promotion, chronic

disease prevention and management, and HCBS. In anticipation of the legislation's passage, AoA was seeking input from recognized experts in the field on the implications of this legislation for the long-term-care workforce, as well as possible strategies and initiatives for AoA to consider in its effort to strengthen both the direct care workforce and family caregivers.

The third basis was the pending reauthorization of the Older Americans Act and the work being done through public forums and other events to gather information from various constituencies and stakeholders related to the reauthorization. The panel was asked to consider workforce-related initiatives that AoA could carry out independently, as well as those it might do in partnership with federal and state agencies, national associations, labor unions, and other organizations. Panelists were cognizant that some long-standing and seemingly intractable workforce issues, such as low wages and the lack of health insurance for direct care workers, were not under AoA's authority or control. However, the panel did consider the extent to which AoA and the Aging Network could use their stature and experience in the long-term-care arena to explore the development of new workforce initiatives.

The expert panel was asked to address five areas of concern: 1) the supply of DCWs and family caregivers, 2) the retention of these helpers, 3) the readiness or capacity of these helpers to provide care, 4) the quality of care they provide in terms of outcomes for those in their care, and 5) the impact of the Patient Protection and Affordable Care Act, including the CLASS Act, on DCWs and family caregivers. The panel was also asked to reflect on some of the challenges regarding defining DCWs and the blurring between DCWs and family caregivers when the latter are paid to provide care to their impaired relatives.

THE PANEL'S WORK

Eleven panelists, selected in consultation with AoA staff, attended meetings of the panel with Benjamin Rose and AoA staff and/or submitted written recommendations. In advance of the first meeting, members were sent informational materials and a matrix laying out potential areas for new initiatives to strengthen the workforce. The purpose was to generate preliminary thoughts about how education and training initiatives, new or amended public policies, AoA program initiatives and demonstrations, labor pools, and potential partnerships could strengthen the supply, retention, readiness, and quality of care the workforce provides.

When the first meeting in February 2010 was canceled due to inclement weather, panel members were sent an expanded matrix and asked to submit written comments and recommendations. These were compiled by Benjamin

Rose staff and distributed along with a summary document in advance of the rescheduled meeting, which was held in March 2010 in conjunction with the ASA/NCOA Aging in America conference. The discussion of the 12 persons in attendance at this meeting, including AoA and Benjamin Rose staff, was audio-taped and subsequently transcribed, analyzed, and compiled into a report incorporating all of the participants' comments and suggested approaches to date. A second meeting was held in April in Washington, DC, with 15 participants, several of whom had not been able to attend the March meeting. The discussion at this meeting was also audio-taped, transcribed, analyzed, and integrated with previous findings. The results of all the panel's deliberations are included in this report.

CHALLENGES DEFINING DCWs AND PAID FAMILY CAREGIVERS

The panel was confronted with several challenges, including different perspectives on which types of workers are included in the direct-care workforce. This challenge exists because there is little consistency or consensus across the states on the nomenclature used for classes of direct-care workers. For example, personal care attendant is a term used in federal classifications but with many different meanings across the states, where such workers may be designated as a mental health aide, respite worker, or a service aide (U.S. Department of Health and Human Services, 2004). Other nomenclatures for direct-care workers include nurse aides, orderlies and attendants; home health aides; and personal and home care aides (Harmuth & Dyson, 2005). Nursing aides are also known as nurse aides, nursing assistants, certified nursing assistants, geriatric aides, unlicensed assistive personnel, orderlies, or hospital attendants, according to the Bureau of Labor Statistics, which considers home health aides and personal/home care aides (the latter are also called homemakers, caregivers, companions, and personal attendants) to be separate occupations (U.S. Department of Labor, 2010). For these reasons, panelists had to clarify when their recommendations pertained to specific types of DCWs, such as home care workers as distinct from certified nursing assistants.

A further complication was that distinctions between family caregivers and direct-care workers have become blurred; for example, family members can become paid helpers under consumer-directed care programs and some family members perform functions that were formerly the sole responsibility of professional providers. Furthermore, a Rosalynn Carter Institute caregiver study indicates that 31% of DCWs also have family care responsibilities and function as caregivers both at work and at home (Nottingham, Haigler, Smith, & Davis, 1993). In addition, there have been attempts to enlarge the direct-care work-

force by engaging former family caregivers in paid employment as direct-care workers (U.S. Department of Health and Human Services, 2009). In brief, the complexities and subtleties of caregiver designations pose challenges for their identification and categorization, which have implications when considering various strategies to enhance their recruitment, retention, training, and quality.

1. INCREASING THE SUPPLY AND RETENTION OF DCWS

Panelists discussed the importance of a variety of methods to improve both the supply and retention of DCWs.

With respect to increasing the supply of DCWs, panelists recommended drawing upon immigrant populations, displaced workers over 55 years old whose jobs were lost in the current recession, and persons with developmental disabilities who could be trained as DCWs. Separately, it was widely acknowledged that the wages and benefits paid for direct-care work are a deterrent to recruitment and retention efforts. For example, home care work is among the fastest-growing occupations in the nation; however, home care workers earn on average less than ten dollars an hour (Dawson, 2010). One panelist noted that DCWs frequently are not paid minimum wage. Under the Fair Labor Standards Act, those working in the home, even if employed by third parties, are designated as “companions to the elderly and infirm” and are excluded from these protections (PHI, 2010). The latest Department of Labor semiannual regulatory agenda indicates that there are plans to review the companionship exemption. This is especially important in light of a recent investigation into violations of employment and labor laws in America’s cities, which showed that home care workers were frequent victims of overtime violations, off-the-clock violations, and meal break violations (Bernhardt et al., 2009). Consequently, a number of panelists suggested advocating for the enforcement of existing employment and labor laws to ensure protection for these workers.

State workforce registries, generally regarded as effective systems for collecting, organizing, and disseminating information on the available pool of DCWs, were mentioned by several panelists. According to CMS’s National Direct Service Workforce Resource Center, 23 states have worker registry websites that match persons needing direct support or personal assistance at home or in the community with caregivers looking for work. These computerized registries have the capability to match home care workers’ qualifications with consumers’ needs, generate lists of potential workers for consumers to interview, and provide access to training for both consumers and workers. It was also suggested that the Aging and Disability Resource Centers (ADRCs), in cooperation with

State Units on Aging (SUAs) and Area Agencies on Aging (AAAs), could house statewide registries because they serve as information portals for consumers. This would require federal agencies to provide funding for information technology to create a user-friendly, easily accessible system. Private agencies could also partner to create a database of available DCWs.

Chief among the incentives discussed for retaining DCWs were: a) adequate wages, b) benefits, c) career advancement opportunities and career pathways, d) effective supervision and leadership, e) mentorship programs including peer-to-peer mentoring, and f) recognition of the intrinsic benefits of the job such as compassionate care, which are critical components of this type of work. Panelists discussed several challenges to implementing increases in pay and benefits. For example, federal agencies such as AoA are likely to find it difficult to try to promote changes at the state and local levels and in the private market. Another barrier to increasing DCW wages related to the prevalence of small- and mid-size home care agencies and their flat organizational structure that limited opportunities to implement career ladders and consequently improve compensation. Another panelist mentioned the possibility of working with unions in order to improve compensation packages. Increases in pay and benefits packages would, in turn, help attract and retain workers, thereby increasing the supply of DCWs.

With respect to increasing worker benefits, particularly health insurance, panelists suggested that smaller agencies could pool together to buy into a larger government or private health care plan. Health care reform and the prospect of health insurance availability for those without it now may also have an impact on this issue. Currently, many low-paid home health aides do not want to work more hours for fear of losing their Medicaid benefits.

One panelist mentioned an intervention study in Ohio where career ladder opportunities were created for nurse assistants in nursing homes so that they could become Dementia Care Specialists (Noelker & Ejaz, 2001). However, when the nurse assistants completed the course, they received a change in title but not a wage increase.

Another suggested avenue to pursue for better retention is improved supervision of DCWs. There is, in fact, a substantial body of research on the importance of good supervision for retention of DCWs (Noelker, Ejaz, Menne, & Bagaka's, 2009). Thus, several panelists referred to the need for improved management training programs for providers of long-term-care services and supports. One panelist suggested that standards should be developed for the Aging Network related to creating supportive work environments and effective

worker retention practices. Moreover, these same standards should be used as performance standards for provider organizations under contract with Area Agencies on Aging.

APPROACHES TO INCREASE THE SUPPLY AND RETENTION OF DCWS

- 1.1 Collaborate with the Department of Labor to extend Fair Labor Standards Act laws to home care workers, and explore funding implications of requiring provider organizations to offer living wage salaries and benefits to DCWs.
- 1.2 Provide incentives and technical assistance to the states that currently do not have worker registries to develop and implement them, possibly through grants to ADRCs, SUAs and AAAs, so that persons needing direct support are matched with caregivers seeking work.
- 1.3 Through ADRC grants, support the establishment of linkages between ADRCs and existing worker registries in states that have them.
- 1.4 In collaboration with CMS, launch a public service campaign that would elevate the public's image of DCWs and the importance of their role in the nation's health care workforce.
- 1.5 Collaborate with boards of nursing and other associations to promote the use of existing training protocols, and implement and test supervisory training programs for nurses in long-term care focused on team leadership skills, person-centered care, empowerment, and mentoring and coaching DCWs.

2. INCREASING THE SUPPLY AND RETENTION OF FAMILY CAREGIVERS

In this regard, panelists discussed the importance of continuing to expand consumer-directed care programs in which persons requiring long-term care in the community can directly hire and pay their helpers, including family members. This approach gives consumers more control over their care arrangements. Being "hired" also provides family caregivers with much needed financial compensation, especially when their earnings in the paid workforce are diminished because of caregiving responsibilities or when they make financial expenditures related to the care recipient's needs. Following a discussion about various options under consumer-directed care, it was suggested that the most attractive option for some family members was getting direct cash benefits under a flexible individual budget. In fact, a recent national survey of family caregivers

reported that their top preferences for programs or policies were tax credits and payment for the care they give (National Alliance for Caregiving, 2009). These could include providing refundable tax credits to help cover families' long-term-care costs as well as broadening the applicability of the Dependent Care Tax Credit to care recipients who do not live with the taxpayer.

Programs and incentives that transition former family caregivers into the direct care workforce were also suggested by panelists. Yet, some panelists felt this was a limited pool because former caregivers are often “burned out” and, if they are looking for employment, are likely to be seeking more lucrative opportunities. Another consideration related to the potential supply of family caregivers is the increase in informal caregiving by peers, non-kin, and fictive kin, especially in light of recent demographic changes, such as the entry of more women into the workforce, decreased birth rates, increased life expectancy, and the geographic dispersion of families. Informal caregivers could also be supported and encouraged through mechanisms such as caregiving cooperatives, community caregiver associations that mentor individuals new to caregiving, and easily accessible sources of caregiving information provided by ADRCs.

With respect to improving the recruitment and retention of family caregivers, panelists discussed approaches such as providing funds for home and environmental modifications to accommodate disabled relatives more easily in their own homes. Similarly, it was suggested that funds be made available for families to purchase assistive devices and associated training to facilitate bathing, lifting, transferring, and other care tasks, which make the work less physically demanding and safer for both the caregiver and care receiver. In addition, panelists recommended an increase in funding for services specifically directed toward caregivers, particularly respite services with 24-hour availability. Major increases in funding for the National Family Caregiver Support Program were also called for and seen as critical to supporting and retaining family caregivers.

Some panelists' suggested approaches for supporting employed caregivers included the following: having geriatric care managers help caregivers develop strategies to support care receivers while caregivers are at work; educating employers about caregiving issues such as the importance of flexible work schedules; and expanding the Family and Medical Leave Act (FMLA) and other paid leave policies at the federal and state level to promote wage replacement. For example, those caring for siblings, in-laws, domestic partners, and/or grandparents could become eligible under FMLA, and the threshold for coverage of private employers could be reduced from the current 50 employ-

ees to 15-25. Also with respect to the FMLA, ADRCs, SUAs, and AAAs could play a role in education about individuals' rights under the Act.

APPROACHES TO INCREASE THE SUPPLY AND RETENTION OF FAMILY CAREGIVERS

- 2.1 Continue supporting expansion of consumer-directed care programs; promote peer-to-peer care and allow spouses, non-kin, and fictive kin to qualify as paid caregivers.
- 2.2 Identify ways, in partnership with the construction trades, home remodelers, HUD, and technology companies, to fund home remodeling, home additions, and installation of assistive technologies that enable informal caregivers to house and care for persons with disabilities.
- 2.3 Pursue strategies to expand the Family and Medical Leave Act that will better accommodate the needs of family caregivers and support the development and implementation of training programs for ADRC, SUA, and AAA staff so they can better educate persons about their rights under the Act.
- 2.4 Pursue strategies to amend the tax code to include Caregiver Tax Credits to ease the financial burdens of caregiving by offsetting both direct care expenses (e.g., food, clothing) and indirect expenses (e.g., lost wages).
- 2.5 Conduct demonstration and evaluation studies of new care models in which persons can serve as unpaid caregivers and bank their work hours for later use when they or their family members require care.
- 2.6 Encourage the Aging Network to foster and support community caregiver associations that mentor those new to caregiving and take advantage of the latest technologies to supply on-going information and support to family caregivers, possibly through ADRCs.
- 2.7 Increase funding for the National Family Caregiver Support Program to enhance all service components, including respite services with 24-hour availability.

3. IMPROVING THE READINESS OF DCWs

There were divergent opinions among panelists regarding the advisability of increased training requirements for DCWs. Acknowledging the various types of DCWs and the corresponding range of skills, knowledge, and expertise re-

quired, some panelists expressed the belief that increased training requirements could be a barrier or deterrent to increasing the supply of DCWs. They also pointed out that associated training costs for providers would increase, although their reimbursement would not. Much of this discussion centered on whether DCWs actually required additional training to perform home-related chores and basic personal care tasks. The argument was made that adding “clinical” hours would lead to “medicalizing” home care and would work against the delivery of person-centered care.

Other panelists were of the opinion that home care workers are increasingly serving individuals who suffer from multiple chronic conditions and have complex medical needs requiring additional training, especially given consumers’ preferences for home care over institutional care. According to these panelists, requiring additional training and licensing would lead to higher standards and wages. These panelists maintained that special attention and advocacy efforts are needed to raise the federal and state training requirements for DCWs, specifically, certified nursing assistants and home care workers. These requirements have not been amended since the passage of OBRA in 1987 (§ 1891(a)(3)). As of 2009, there were 20 states that had not increased the entry-level training requirements from the OBRA-mandated 75 hours, while 13 other states and the District of Columbia changed them to require 120 hours or more (PHI, 2009). In the state of Washington, legislation has been passed to update requirements for training hours and curriculum content, combined with requirements that home care aides have certification.

Panelists also noted that entry-level training for these workers should include more clinical experience to develop their skills and to have a fuller understanding of the nature of the work. Peer-to-peer and mentoring programs were viewed as a valuable component of entry-level training programs. Regarding DCWs’ continuing education requirements, there have been calls issued over the past decade for increases in the annual requirement of 12 hours and mandates for specific training content such as skills and techniques for person-centered care (U.S. Department of Health and Human Services, 2002).

One recommendation by the panel was to have evidence-based training curricula and programs designed around the core competencies necessary for the job, including interpersonal and team skills to foster the care recipient’s independence. These core competencies should be aligned with those specified in Title V of the Patient Protection and Affordable Care Act of 2010. Students for whom English is not their first language were seen as requiring special attention and adjustments to training curricula and programs, as were low-income persons and those with cultural backgrounds that influence delivery of care.

Some panelists endorsed the development of a set of core competencies that cut across age and disability groups as a method of helping to enhance the skills of DCWs and their employability in a wider variety of care settings. One program mentioned by a panelist as exemplifying a successful approach to training DCWs to serve older adults and adults with disabilities was SPEAK (Support Providing Employees' Association of Kentuckiana), a network of provider organizations guided by two lead agencies – The Council on Mental Retardation and Seven Counties Services, Inc. SPEAK provides networking opportunities to “Direct Support Professionals” who serve a wide range of individuals, such as those with developmental disabilities, mental illness, and emotional disturbances, and the elderly. SPEAK also provides pre-service orientation to give job applicants a realistic preview of the work before they are hired, a mentorship/apprenticeship program to help new hires adjust and learn best practices from a peer, and training and recognition opportunities (SPEAK, 2010).

In the wake of health care reform, there may be new opportunities for specialized training for DCWs. For example, the “medical home” model of care delivery includes comprehensive training to coordinate care, along with an ongoing relationship between a provider and patient, 24-hour access to medical consultation, and patient-centered care. DCW specialists specifically trained in post-hospital care could work within a care receiver’s medical home to facilitate smooth care transitions that help prevent unnecessary emergency department use and acute care hospital readmissions.

Panelists also noted that in decades past, AoA has historically supported specialized training programs in aging using Older Americans Act Title IV funds to better educate professionals in gerontology and long-term care. Future investment in these types of training programs for DCWs can both attract new people to the field of long-term care and ensure that those working in the field are properly prepared to perform their jobs. Paying trainees during training was also mentioned as a necessity by one panelist.

Partnerships were viewed as central to expanded and improved training programs, as were demonstration grant initiatives to implement workforce innovations and evidence-based best practices in various programs and states. Such partnerships could include high schools, community colleges, universities/centers of excellence, boards of nursing, Alzheimer’s Association chapters, AARP, disability advocates, immigrant advocates, labor unions, United Way, ADRCs, and coalitions such as the Long-Term Care Working Group in Washington, D.C. Among state and federal government entities, partnerships between AoA and Workforce Investment Boards, Departments of Labor and Education, Centers for Medicare and Medicaid Services, Veterans Affairs, Assistant Secre-

tary for Planning and Evaluation (ASPE), Health Resources and Services Administration (HRSA), and Housing and Urban Development (HUD) offices could result in coordinated and sustained attention to training program initiatives that will ensure ongoing advances in the quality of the long-term-care workforce.

APPROACHES TO IMPROVE THE READINESS OF DCWs

- 3.1 Include a proposal in the Administration's recommendations for the OAA reauthorization for DCW training programs that are focused on the core competencies needed by specific types of DCWs, as specified in Title V of the Patient Protection and Affordable Care Act, along with career advancement programs, career ladders, and standardized certification that transfers to different locations.
- 3.2 Make greater use of OAA Title IV funds for demonstrations, training and education programs, including train-the-trainer programs for DCWs, and ensure these are evidence-based training programs directed to core competencies, aligned with the provisions of the Patient Protection and Affordable Care Act.
- 3.3 Promote training programs for DCWs that are designed to accommodate the needs of low-income persons, immigrant persons for whom English is a second language and those with cultural backgrounds that influence their approach to and delivery of care.
- 3.4 Consider a variety of partners to develop and implement recruitment and training programs for DCWs, including special apprenticeship programs targeted to HCBS; some of these may include Workforce Investment Boards, community colleges, Department of Labor, Department of Education, labor unions, boards of nursing, senior and disability advocates, advocates for immigrants, universities/centers of excellence, ADRCs, and United Way.
- 3.5 Explore possible mechanisms for funding child care and other expenses while persons are receiving DCW training.
- 3.6 Ensure that training programs include a pre-training component which provides applicants with actual experience of what the job is like and include more on-the-job training and peer mentoring for skill development.

4. IMPROVING THE READINESS OF FAMILY CAREGIVERS

Panelists expressed the opinion that in order to meet the training needs of family caregivers, substantial attention and a plan of action will be required. As evidence of the need for family caregiver education, findings from a national survey showed that fewer than one in five caregivers reported receiving formal training for their role, and 78% said they needed more information on a variety of topics related to caregiving (National Alliance for Caregiving, 2009).

In this regard, training in the use of assistive technology could be leveraged to address projected increases in the number of older adults with disabilities and shortages of DCWs, especially in rural areas. In recent national surveys about assistive technology use and the home environment, funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services, investigators found that about 25% of adults age 50+ were able to manage their personal care using devices, and another 25% could benefit from home modification (Freedman, Agree, & Cornman, 2006). Thus assistive technology could benefit both caregivers and care recipients.

Panelists stated that families could benefit from hands-on training to gain skills in areas such as body mechanics, lifting, transferring, bathing, using assistive devices, managing medications, and recognizing signs and symptoms for common diseases, including dementia and Alzheimer's disease. Training for family caregivers could take place either in a formal setting like a classroom or on-site, such as in senior housing units. In the latter case, a panelist noted that conducting training in this type of setting could benefit family members who do not self-identify as caregivers. Another panelist described a program in Baltimore County that trains family members caring for older adults age 60+ and grandparents who are the primary caregivers of grandchildren, through a grant from the National Family Caregiver Support Program. Mention was also made of the District of Columbia's Caregivers' Institute, a centralized training, education and support resource for caregivers experiencing financial burden due to caregiving for an older adult with low to moderate income.

In addition, it was suggested that on-demand (as opposed to scheduled) training for family caregivers would be useful, perhaps in the form of 24-hour hotlines operated by ADRCs, SUAs and/or AAAs offering information, consultation and counseling on care-related problems. In this context, it would be important to develop core competencies for professionals in the Aging Network who work with and support family caregivers. AAAs and ADRCs could also promote the use of validated caregiver assessment tools aimed at identifying training, ser-

vice, and support needs, and their administration at critical points when the assistance needs of care recipients increase or change (e.g., prior to discharge from hospital, rehabilitation unit, or nursing home).

For family caregivers and care receivers involved in consumer-directed programs, it would be helpful to offer training in fiscal management and effective supervision of DCWs. For example, family members, especially adult children and spouses, might be called upon to act as a “case manager” in a medical home model of care delivery. Because the medical home is a comprehensive approach to coordination of care, a family caregiver could play an important role by reinforcing the focus on disease prevention, disease management and patient-centered care.

A toolkit of evidence-based training programs for family caregivers was seen as having substantial benefits. Although some panelists said that the selection criteria for scientific evidence were not very stringent, they noted that a list of such tools is maintained by the Rosalynn Carter Institute for Caregiving. The development of innovative training programs and evidence-based programs could be supported by AoA using a variety of funding mechanisms and partnerships, including Older Americans Act Title III funds from the National Family Caregiver Support Program.

APPROACHES TO IMPROVE THE READINESS OF FAMILY CAREGIVERS

- 4.1 Support demonstrations and evaluations of hands-on training programs for family caregivers that include training on skills such as body mechanics, lifting, transferring, bathing, and use of assistive devices, and include them in AoA’s toolkit of evidence-based training programs.
- 4.2 Determine the capacity of ADRCs, SUAs and AAAs to provide 24/7 hot lines for caregivers to receive information, consultation and counseling on care-related problems they encounter.
- 4.3 Through the AAAs and/or ADRCs, promote the use of validated caregiver assessment tools aimed at identifying training, service, and support needs and their administration at critical points when the assistance needs of care recipients increase or change (e.g., prior to discharge from hospital, rehabilitation unit, nursing home).
- 4.4 Develop core competencies for professionals in the Aging Network to implement in their work with and support of family caregivers.

5. IMPROVING THE READINESS OF BOTH DCWs AND FAMILY CAREGIVERS

In addition to joint training programs for DCWs and family caregivers, another suggestion from panelists was to develop and test training models in which DCWs are prepared to educate and train family caregivers. For example, new training programs for DCWs could enable them to educate family caregivers about safe and effective care techniques (e.g., lifting, transferring) and other core competencies. Conversely, family caregivers were seen as having a role in training DCWs because family members can provide workers with insight into the values, preferences, and unique interests of those receiving care, thereby helping to foster person-centered care. Thus, creating synergy in the training of DCWs and family caregivers was seen as an effective way to improve training outcomes for both.

APPROACHES TO IMPROVE THE READINESS OF BOTH DCWs AND FAMILY CAREGIVERS

- 5.1 Support demonstration-evaluation programs that build on core competencies to train family caregivers and DCWs jointly in order to promote shared understanding of their roles and new training programs for DCWs that enable them to educate family caregivers about safe and effective care techniques (e.g., lifting, transferring), possibly in collaboration with the Department of Labor.

6. IMPROVING OUTCOMES FOR CARE RECIPIENTS AND CAREGIVERS

DCWs: Turnover among DCWs was seen by panelists as detrimental to the continuity and quality of care for recipients. Panelists were clear that the development and implementation of standard approaches for tracking DCW turnover and retention rates by AAAs and employers in the Aging Network are necessary to determine the actual extent of turnover and to identify the workplace and management practices associated with lower turnover rates. These practices should be publicized and disseminated throughout the Aging Network for replication purposes. Further, provider organizations could be incentivized to implement workforce improvement practices, using OAA and/or Medicaid funding, and include measures of workforce improvement (e.g., decreased turnover, increased number of job advancements, fewer unfilled positions) in their reports to AoA.

Regarding the role of education and training programs for DCWs in fostering quality care, the panelists again underscored a focus on desired outcomes for care recipients which directly link to core job competencies that are instilled through enhanced training programs. These core competencies should be broadened to include training to achieve quality of life outcomes for care receivers, such as sustained independent living, empowerment, choice and control over their care arrangements, and engagement in the management of chronic conditions.

Several panelists pointed to the potential role of the Aging Network in achieving better health care outcomes for care recipients. Specifically, they called for demonstration and evaluation research initiatives that address the Network's role in preventing unnecessary hospitalizations and emergency room use (i.e., improved service system outcomes) through partnerships and collaborative programs linking AAAs with primary care physician practices and hospital systems.

The issue of the variable quality of home care provider organizations was raised in discussing care outcomes, along with the suggestion to implement a voluntary system of accountability related to service reliability, consistency in workers, worker training requirements, and consumer satisfaction. High-performing provider organizations should be recognized for their successful efforts and consumers and family caregivers made aware of those with records of high performance. Another suggestion was to involve the AAAs in evaluating how DCWs can influence client outcomes. In addition, AAAs could influence provider organizations to raise the standards for delivering effective care by rewarding providers that achieve desired outcomes for DCWs (e.g., job retention, job satisfaction) and for consumers (e.g., increased length of stay in HBCS settings, reduced hospital and nursing home (re)admissions among waiver participants, fewer emergency department visits). In addition, AAA and ADRC staff could benefit from training and support that promotes their understanding of and preparation for undertaking legal and liability issues as they develop and maintain registries of providers that meet quality outcome criteria.

Family Caregivers: Regarding outcomes for family caregivers, several panelists recommended the implementation of a standardized caregiver assessment process and its application throughout the Aging Network to ensure that the service and support needs of caregivers are addressed. Other panelists expressed divergent opinions and cautioned that the content and administration of caregiver assessments could have adverse effects on caregivers and on the quality of care and outcomes for elders. There were also concerns that assessment of family caregivers would have a negative impact on supply, could lead

to accusations of elder abuse, and should not be linked with training. One panelist pointed out that in the United Kingdom, caregiver assessment is a right under the Carers (Equal Opportunitites) Act of 2004, but many eligible caregivers are unaware of that fact and few have availed themselves of it. Similarly, panelists cautioned against trying to be prescriptive with family caregivers because they make their own decisions about what type of help they want and when to seek help.

Other panelists asserted that caregiver assessment would help to ensure service quality and appropriate training of family members. Proponents of this approach recommended that assessment of family caregivers could occur at the time care recipients are discharged from the hospital to determine the caregiver's ability to manage new or expanded care tasks related to the care recipient's post-hospital care. As a critical agent in a family member's care, the caregiver's capacity at time of discharge has a direct bearing on the relative's successful transition back to and continued functioning in the home setting.

APPROACHES TO IMPROVE OUTCOMES FOR DCWs AND FAMILY CAREGIVERS

- 6.1 Support demonstrations and evaluations of specialized DCW training programs that enable them to assist older adults' in managing chronic conditions and determine the impact on clients' health outcomes.
- 6.2 Have AAAs raise the standards for the workforce by rewarding providers that achieve desired outcomes for DCWs and consumers (e.g., increased length of stay in HCBS settings, reduced nursing home admissions among waiver participants, fewer emergency department visits, and reduced re-admissions to hospitals).
- 6.3 Provide training and support to AAA and ADRC staff that promote their understanding of and preparation for undertaking legal and liability issues as they develop and maintain registries of providers that meet quality outcome criteria.
- 6.4 Incentivize provider organizations to implement workforce improvement practices, using OAA and/or Medicaid funding, and include measures of workforce improvement (e.g., decreased turnover, increased number of job advancements, fewer unfilled positions) in their reports to AoA.

7. IMPLICATIONS OF HEALTH CARE REFORM AND THE CLASS ACT

Title V of the Patient Protection and Affordable Care Act (2010) is intended to encourage innovations in health workforce training, recruitment, and retention. One area of focus is direct-care workers who provide long-term-care services and supports, as exemplified by the enumeration of a core set of 10 competencies for personal or home care aides. Six states will be awarded funds totaling up to \$5 million a year from 2010-2012 to demonstrate approaches to training that will advance these core competencies and to develop training protocols (Justice, 2010). The latter will include a certification test for home care aides who complete this training, and the impact of the training on aides' job skills will be evaluated.

A National Health Care Workforce Commission is going to be established in the latter part of 2010, and it will serve as a resource for Congress and the President. Panelists suggested that, upon request, AoA should provide information to the Commission regarding development, dissemination, and application of evidence-based, best-practice programs designed to advance the training, support and retention of DCWs and informal caregivers. If the Commission makes recommendations regarding the establishment of a national credentialing program for personal care workers, those could be considered by AoA.

Demand for HCBS and the direct-care workers who provide such services is expected to increase as a result of the CLASS Act, the purpose of which is to facilitate community living services and supports. It establishes a new public-private approach to financing long-term services and supports, and gives enrollees flexibility in how to use their cash benefits. In such an environment, the growth of consumer-directed care programs is also likely, which again has implications for family caregivers. For example, there is potential for paid family caregivers to be unionized. In addition, one panelist noted that increased demand in the market for these services could create upward pressure on DCW compensation. Others suggested that AoA could collaborate with CMS on infrastructure grants designed to build the capacity of AAAs for the expansion of HCBS, for serving a private pay market and administering managed care programs.

Patient-centered medical homes, as described earlier, will be established under a federal grant program, and must contract with primary care providers for support services, including care coordination, chronic disease management and care planning. Panelists also suggested that AoA could take a leadership role in promoting evidence-based practices and the involvement of family caregivers in the care of older adults served by medical homes. In addition,

AoA could collaborate with CMS to continue investing in ADRCs and/or AAAs; they could play a significant role in care coordination and care transition models in which family involvement and education around anticipated changes in caregiving tasks and demands are critical. They could also provide counseling and education about the use of the benefits under the CLASS Act, although there are still many unanswered questions remaining about the specifics of its implementation.

APPROACHES RELATED TO HEALTH CARE REFORM AND THE CLASS ACT

- 7.1 Provide information upon request to the National Health Care Workforce Commission regarding development, dissemination, and application of evidence-based, best-practice programs designed to advance the training, support and retention of DCWs and informal caregivers.
- 7.2 Consider recommendations made by the National Health Care Workforce Commission regarding the establishment of a national credentialing program for personal care workers.
- 7.3 Have AoA take a leadership role in promoting the involvement of family caregivers in the care of older adults served by medical homes and evidence-based practices that medical homes should use to communicate, educate and coordinate care with family caregivers.
- 7.4 Collaborate with CMS on investing in ADRCs and/or AAAs so that they have a significant role in care transition and care coordination models that emphasize family involvement and education around anticipated changes in caregiving tasks and demands.
- 7.5 Collaborate with CMS on investing in ADRCs and/or AAAs to provide counseling and education about use of benefits under the CLASS Act.
- 7.6 Collaborate with CMS on infrastructure grants designed to build the capacity of AAAs for the expansion of HCBS and for serving a private pay market and administering managed care programs.

SUGGESTED PRIORITIES

After all recommended approaches were compiled into a matrix, panelists were asked to rank them in relation to their perceived priority. In all, six out of the eleven panelists completed the task of ranking the top priorities among the

total of 33 suggested approaches noted in this document. The results in Table 1 show approaches that at least two panelists considered a priority.

The approaches that were most frequently endorsed (by four panelists) were:

- 2.4—Pursue strategies to amend the tax code to include Caregiver Tax Credits to ease the financial burdens of caregiving by offsetting both direct care expenses (e.g., food, clothing) and indirect expenses (e.g., lost wages).
- 6.1—Support demonstrations and evaluations of specialized DCW training programs that enable them to assist older adults' in managing chronic conditions and determine the impact on clients' health outcomes.

The next most frequently endorsed priorities (three panelists each) were:

- 7.1—Provide information upon request to the National Health Care Workforce Commission regarding development, dissemination, and application of evidence-based, best-practice programs designed to advance the training, support, and retention of DCWs and informal caregivers.
- 7.6—Collaborate with CMS on infrastructure grants designed to build the capacity of AAAs for the expansion of HCBS and for serving a private pay market and administering managed care programs.

It is interesting to note that these four priorities speak to support for family caregivers, both financially as well as through education and training; specialized and evidence-based training programs for direct-care workers; and the Aging Network's ability to evolve in response to new developments in the arena of home- and community-based services programs. In combination, these approaches have significant potential to enhance the capacity and performance of the long-term-care workforce.

CONCLUSION

The panelists set forth a wide variety of programmatic, advocacy, and policy suggestions for the Aging Network's consideration as it works to improve the supply, readiness, retention, and outcomes for DCWs and family caregivers. The responses summarized in this report are indicative of the work that needs to be planned and implemented in order to fully equip the Aging Network as it expands home- and community-based long-term-care programs, and continues to build and support the direct-care workforce that delivers the bulk of long-term care.

Table 1. Suggested Approaches Endorsed as Top Priorities by Panelists

Suggested Approaches		Number of Panelists' Endorsements
2.	APPROACHES TO INCREASE THE SUPPLY AND RETENTION OF FAMILY CAREGIVERS	
2.1	Continue supporting expansion of consumer-directed care programs; promote peer-to-peer care and allow spouses, non-kin, and fictive kin to qualify as paid caregivers.	2
2.4	Pursue strategies to amend the tax code to include Caregiver Tax Credits to ease the financial burdens of caregiving by offsetting both direct care expenses (e.g., food, clothing) and indirect expenses (e.g., lost wages).	4
2.7	Increase funding for the National Family Caregiver Support Program to enhance all service components, including respite services with 24-hour availability.	2
3.	APPROACHES TO IMPROVE THE READINESS OF DCWS	
3.4	Consider a variety of partners to develop and implement recruitment and training programs for DCWs, including special apprenticeship programs targeted to HCBS; some of these may include Workforce Investment Boards, community colleges, Department of Labor, Department of Education, labor unions, boards of nursing, senior and disability advocates, advocates for immigrants, universities/centers of excellence, ADRCs, and United Way.	2
4.	APPROACHES TO IMPROVE THE READINESS OF FAMILY CAREGIVERS	
4.1	Support demonstrations and evaluations of hands-on training programs for family caregivers that include training on skills such as body mechanics, lifting, transferring, bathing, and use of assistive devices, and include them in AoA's toolkit of evidence-based training programs.	2
5.	APPROACHES TO IMPROVE THE READINESS OF BOTH	
5.1	Support demonstration-evaluation programs that build on core competencies to train family caregivers and DCWs jointly in order to promote shared understanding of their roles and new training programs for DCWs that enable them to educate family caregivers about safe and effective care techniques (e.g., lifting, transferring), possibly in collaboration with the Department of Labor.	2
6.	APPROACHES TO IMPROVE OUTCOMES FOR DCWS AND FAMILY CAREGIVERS	
6.1	Support demonstrations and evaluations of specialized DCW training programs that enable them to assist older adults' in managing chronic conditions and determine the impact on clients' health outcomes.	4
6.4	Incentivize provider organizations to implement workforce improvement practices, using OAA and/or Medicaid funding, and include measures of workforce improvement (e.g., decreased turnover, increased number of job advancements, fewer unfilled positions) in their reports to AoA.	2
7.	HEALTH CARE REFORM AND THE CLASS ACT	
7.1	Provide information upon request to the National Health Care Workforce Commission regarding development, dissemination, and application of evidence-based, best-practice programs designed to advance the training, support, and retention of DCWs and informal caregivers.	3
7.4	Collaborate with CMS on investing in ADRCs and/or AAAs so that they have a significant role in care transition and care coordination models that emphasize family involvement and education around anticipated changes in caregiving tasks and demands.	2
7.5	Collaborate with CMS on investing in ADRCs and/or AAAs to provide counseling and education about use of benefits under the CLASS Act.	2
7.6	Collaborate with CMS on infrastructure grants designed to build the capacity of AAAs for the expansion of HCBS and for serving a private pay market and administering managed care programs.	3

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