

The Role of Training in Improving the Recruitment and Retention of Direct-Care Workers in Long-Term Care

To combat high vacancy and turnover rates of direct-care workers in long-term care, state officials, providers, and consumer groups are exploring a broad range of strategies. One theory is that improving pre-employment training and continuing education reduces turnover by giving workers the competence and confidence they need to do the job well.

The purpose of this issue brief is to:

- Describe federal and state pre-employment and on-the-job training requirements for direct-care workers;
- Examine the costs involved in training workers and how to pay for it;
- Summarize the research on the impact of training programs on worker recruitment and retention and care quality; and
- Identify key questions and options for the consideration of policymakers, educators, and other parties interested in developing pre-employment and training initiatives to improve workforce recruitment and retention.

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Types of Workers

Direct-care workers in long-term care go by many titles, but they can be divided into three main categories: **certified nursing assistants (CNAs)**, **home health aides**, and **personal assistants**. While their responsibilities vary, all provide personal assistance and emotional support to older adults and/or younger people with chronic illness and mental or physical disabilities.

CNAs generally work in nursing homes at the direction of a nurse, where they provide the great majority of the hands-on care. They help residents perform activities of daily living (ADLs) such as eating, bathing, dressing, toileting, skin and mouth care and ambulation or repositioning. Under the direction of nursing or medical staff, they provide health-related services such as administering oral medications; checking pulse, temperature, and respiration; helping with simple prescribed exercises; and assisting with medical equipment such as ventilators. They also make beds and help clean residents'

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rooms, although housekeeping staff do the bulk of the cleaning in nursing homes. Some states use their own titles for these workers. For instance, New Hampshire calls them licensed nurse aides (LNAs) and Ohio calls them state-tested nurse aides (STNAs).

Home health aides provide personal care as well as some clinical care for people in their own homes or other community settings. Like CNAs, they provide health-related services under the direction of nurses or other licensed medical staff. They may also perform light housekeeping tasks, such as helping to prepare food or changing bed linens.

Personal assistance workers generally work in group homes, assisted living facilities, or private homes. They provide help with ADLs, but by law they cannot perform the clinical care that CNAs and home health aides provide.¹ However, they often help with instrumental activities of daily living (IADLs) such as housekeeping, meal preparation, medication management, shopping, and bill paying. These workers are known by a variety of names, including home care aide, personal assistance worker, personal care attendant, personal attendant, and personal assistant. Those who work with people with mental retardation or other developmental disabilities are often known as direct support professionals.

Federal and State Training Requirements

Pre-employment Training

The federal government requires initial and on-going training for two types of direct-care workers in long-term care: home health aides who work in certified home health agencies and certified nursing assistants (CNAs) who work in Medicare- and/or Medicaid-certified nursing homes. These workers must demonstrate competency in specific areas. The requirements for both types of workers, which are basically the same, were implemented after a 1986 Institute of Medicine (IOM) study found that nursing assistants were generally inadequately trained to perform their duties. That study resulted in the Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), which put into law federal requirements for CNA and home health aide training.

Training must include at least 75 hours of instruction, 16 of which involve practicing hands-on “clinical tasks” under the direct supervision of a registered nurse or a licensed practical nurse. These clinical tasks may be practiced on nursing home residents or home health clients or in a classroom lab. Instruction must cover a broad range of topics, including:

- Communication and interpersonal skills;
- Basic infection control procedures;
- Promoting the independence and respecting the rights of residents and patients;

¹ For consumers who direct their own care, there are exemptions to this rule. Almost all states exempt family members, while others provide specific exemptions for Medicaid-waiver consumer-directed programs.

- Basic nursing skills, such as taking and recording vital signs and observing and reporting abnormal changes in functioning;
- Personal care skills, including assistance with ADLs;
- Mental health and social service needs, such as how to modify one's own behavior in response to the behavior of the person being served and allowing residents and patients to make personal choices;
- Basic restorative services, including the use of assistive devices, proper methods of turning and positioning, and bowel and bladder care; and
- Basic safety and emergency procedures.

In addition to these basics, federal regulations require that nursing assistants learn about caring for people with Alzheimer's disease and other cognitive impairments, while home health aides must learn about maintaining a clean, safe, and healthy environment. To demonstrate that they have the needed skills, CNAs and home health aides must either complete a state-approved training and competency evaluation program or pass a competency evaluation that meets federal standards (Social Security Act, Title 19, Sections 1819(b)(5) and 1891(a)(3)). Nine states permit home health agencies to hire home health aides if they can pass the competency evaluation without attending training (NAHC 1996). Only 17 states require CNA candidates to complete a state-approved training program before taking the test, but some have other requirements for candidates who "test out" without undergoing training. For example, they may require that they previously held a certificate, worked as a nursing assistant for a certain amount of time, or are currently certified in another state.

Regardless of the law, few CNA candidates can pass the test without taking the class, so nearly all go through CNA training. So do a great many home health aides, in part because the required content for both is so similar and in part because many states require home health aides to be certified as CNAs (some require candidates to supplement CNA training with in-service sessions on topics specific to home care). Furthermore, free CNA classes are often easier to find than free classes tailored for home health aides, since nursing homes are reimbursed for training costs and home health agencies are not.

States are free to decide how to implement the federal training requirements and whether to expand on them.

Continuing Education Requirements

The federal government requires both CNAs and home health aides to have at least 12 hours of continuing education a year, but the regulations offer little guidance as to what must be taught. For CNAs, the regulations stipulate only that ongoing education must be "sufficient to ensure the continuing competence" of workers, and that topics should address areas of weakness as determined by performance reviews or special needs of the consumers served (Code of Federal Regulations, Title 42, Part 483, Section 483.75). For home health aides, the only stipulations are that training must "generally" be supervised by a registered nurse with at least two years of nursing experience, including one year in home health care (Code of Federal Regulations, Title 42, Part 484, Section 484.36).

State and Local Variations

About half the states mandate more than 75 hours of pre-employment training for CNAs and some require as much as 120 hours of training for home health aides (IOM 2000). In addition, over half the states require more than 16 hours of clinical training for CNAs. Pennsylvania, for instance, calls for only 75 hours of training but requires that half be hands-on clinical training, while California mandates 150 hours, of which 100 must be clinical (US DHHS OIG August 2002).

Individual schools or employers may also require more than the federal minimums. A CNA educator in Texas, which requires just 75 hours of training, teaches a 210-hour CNA course in a community college. The extra hours in her program, she says, allow her to explain the reasons behind things like hand-washing rather than just teaching the skills, and understanding those reasons makes students far more likely to maintain proper procedures on the job. Extra hours also make it easier to teach critical-thinking skills and the principles of resident-centered care. “Instead of just giving a bath, we’re really looking at the individual,” she explains (Abt 2002).

All CNA curricula must be state-approved, but there is no limit as to how many a state may approve. About half the states have established a single approved curriculum; others have approved more than 100 (US DHHS OIG August 2002). Typically, classes are taught in a variety of locations, including nursing homes, Red Cross centers, community colleges, and private schools. While the regulations require that an RN with some familiarity with long-term care (or a team headed by an RN) teach the course, there is no requirement that instructors have any background in adult education, leading to considerable variation in quality of instruction.

Continuing education requirements also vary. Four states mandate more than 12 hours of in-service training a year for CNAs, and 16 identify specific topics that must be taught every year (US DHHS OIG August 2002).

Training Requirements for Other Workers

Training requirements for all other workers vary widely depending on job title, state requirements, and the preferences of individual employers. In general, however, requirements are limited.

Personal Assistance Workers

Many states require some training for personal assistance workers. California, for instance, has a classification called “personal home care aide” for home care agency workers who are providing privately paid support services in the home. These workers must pass a competency test in 12 areas and complete 75 hours of classroom and practical training under the supervision of a registered nurse. Minnesota requires home care aides to attend the same 75-hour training course as home health aides. By contrast, home care workers at agencies providing private-pay services in Pennsylvania are not required to have any training.

All but nine of the 50 states and the District of Columbia require some training for personal assistants who work in licensed assisted living facilities, but the range of skills required varies widely. In some states, these workers must be trained as CNAs or demonstrate competency in a detailed list of skills. In others, they are required only to attend a few hours of annual in-service education or to obtain “appropriate orientation and training” (Bentley et al. 2003). According to the IOM (2000), this is too much variation; it recommends that states “work to bring about more standardization and consistency” in their education and training requirements for assisted living.

Personal assistants in other areas of long-term care operate under different rules. For instance, a growing trend in offering consumer-directed care for Medicaid beneficiaries has led some states to develop curricula for personal assistants who deliver services under that model. San Francisco’s In-Home Supportive Services (IHSS) public authority, for example, offers a free, voluntary 25-hour initial training through San Francisco Community College for personal assistants serving self-directing consumers. The curriculum addresses communication, health, safety, nutrition, and job readiness (Calderon 2002).

Direct Support Professionals

Most states require some training for direct support professionals (Hewitt et al. 1995). As in assisted living, however, mandates vary widely. Training typically consists of between one and five days of classroom training in topics such as an introduction to developmental disabilities, emergency procedures, blood borne pathogens, consumer rights, CPR, and first aid. “Despite its importance, there is currently little consistency in the training that direct support workers receive across the United States and within the individual states,” conclude the authors of one report (Hewitt et al. 1995).

Some states name topics to be covered in direct support professional training, others require a certain number of hours (typically less than 40), and still others stipulate only that workers must be trained within a certain amount of time after their start dates. Only a handful, including California, Kansas, New Mexico, North Dakota, and Oklahoma, have statewide training curricula (Hewitt and Lakin 2001).²

Some experts advocate credentialing as a way of establishing consistent professional standards. The National Alliance of Direct Support Professionals has developed a national credentialing program based on the Community Support Skills Standards (available on-line at www.cshse.org/community.html), a group of 12 broad knowledge and skill sets needed by workers. By completing courses through the Internet-based College of Direct Support (www.collegeofdirectsupport.com), workers can advance through several stages, becoming a support professional assistant, licensed support professional, certified direct support professional and then supervisor while earning first an associate’s and then a bachelor’s degree.

² Information about California’s curriculum may be found at http://www.dds.ca.gov/dspt/dspt_main.cfm.

A few states have credentialing programs of their own. The Massachusetts Department of Mental Retardation, for instance, offers a 21-credit Direct Support Certificate Program, which is taught at community colleges. Workers who complete the course get an increase in pay.

Who Pays for Training and What Does It Cost?

Little data is available on the cost of training direct-care workers. According to one study published more than a decade ago, it cost an average of \$1,859 to certify and train a home health worker (Zahrt 1992). A more recent study reported average CNA training costs of \$1,066 at privately operated facilities and \$1,604 at government-operated nursing homes, which generally provide substantially more hours of training per student (Pennsylvania Intra-Governmental Council 2001). An informal questionnaire sent to affiliates of the American Health Care Association (2001) found estimated costs ranging from as low as \$150 per trainee to \$2000, with the majority of states reporting costs ranging from \$500 to \$1000 per trainee. Those costs are borne primarily by the Medicaid program, the facilities and agencies that employ workers, and the workers themselves.

CNA training is funded through the Medicaid program. However, nursing facilities that train CNAs are not always reimbursed in full, since states may impose caps on training costs. In addition, in some states nursing homes are reimbursed only for a percentage of their training costs, based on the percentage of their residents whose care is covered by the Medicaid program (AHCA 2001).

CNAs who pay for their own training at a private school or community college are supposed to be reimbursed for their costs if they start work or receive an offer of employment at a nursing home within a year of being certified (Code of Federal Regulations, Title 42, Part 483, Section 483.152 (c)(1)). Federal law says the state should reimburse the CNA, usually through the nursing home that hires him or her. Facilities are allowed to stipulate that workers must remain for a certain amount of time in order to be reimbursed and many do, usually requiring a period of six months to a year.

Many CNAs who meet the qualifications, however, are never repaid (Abt 2002),³ and even when they are, the payment may not cover all their costs. In Florida, for instance, Medicaid repays a portion of a CNA's training costs based on the facility's Medicaid occupancy. One report found that the state reimbursed 750 CNAs an average of \$187 each for the cost of their training during the 18-month period from January 1997 through June 1998, although the cost of training had averaged \$292 per CNA. Not only were those CNAs paid for less than two-

³ This topic has been largely ignored in the literature on direct-care workers, but three of the experts on nursing assistant education who were interviewed for the training chapter of the Abt report, all of who are in regular contact with hundreds of nursing assistants nationwide, said they had heard of numerous instances in which new workers who had paid for their own training were not repaid, usually because they were unaware that they were entitled to the reimbursement and the facility where they worked did not inform them of it.

thirds of their costs, but they probably represent only a small portion of the workers eligible for refunds. Approximately 15,000 people take Florida's CNA test every year, although it is not known how many end up working for nursing homes (Florida Department of Elder Affairs 2000).

Agencies that employ home health aides are not reimbursed for training costs as there is no similar federal regulation to that requiring reimbursement for certified nursing assistant training. Many hire aides who have graduated from CNA training. Some train their own, covering the cost themselves or cobbling together grants to help pay for it. Assistance is also available through federal programs (see **Key Questions** below.)

Some states provide funding to train other kinds of workers. For example, Washington state, which requires training for personal care assistants in its Medicaid-funded consumer-directed care program, covers the cost of that training for all workers who complete it within 120 days, and Kansas and Oklahoma build the cost of training direct support professionals into their per-diem rates for providers.

Community colleges or other training consortia sometimes partner with providers to offer free or subsidized training. The Massachusetts Extended Care Career Ladder Initiative, for instance, has promoted collaboration between workforce development agencies, community colleges, and long-term care providers to educate direct-care workers (Eaton et al. 2001; Wilson et al. 2002).

The Research: The Impact of Training on Recruitment, Retention and Quality Care

Recruitment and Retention

Researchers do not have a clear understanding of the connection between the amount of or quality of nurse assistant training and its impact on worker recruitment and retention. Some in the field believe that inadequate training leads to higher turnover, and a growing body of research supports that hypothesis (IOM 2000). This is especially salient given the annual turnover rates among direct-care workers. Turnover was estimated at more than 71 percent among nursing home CNAs in 2002 (AHCA 2003), while a study of home health aides found that 40 to 60 percent leave after one year or less on the job and 80 to 90 percent during the first two years (NYAHS 2000).

One researcher found that 40 to 50 percent of all nursing assistants leave within their first six months on the job, often because they have not learned how to prioritize competing demands. "The new CNA graduates generally have not had enough experience to gain good organizational, prioritizing, and time management skills" (Pillemer 1996).

Trainees may also resign out of frustration or disillusionment if what they are taught in class does not prepare them for what they face on the job (Atchley 1996; Schirm and Garland 1997). As one expert notes, direct-care workers "are put in situations that require unusually sophisticated interpersonal and communication skills. They are called upon to manage conflict, set limits, make ethical decisions, grieve and help others grieve, and

support other members of the caregiving team. There is little in their training that addresses such complex psychosocial problems” (Hoffman 1995).

Conversely, more and better training may decrease turnover. One national review of literature on the impact of training on recruitment and retention found that, in general, higher levels of training for direct-care workers helped employers both find and keep employees. The connection held across provider types but was stronger for home health agencies than for nursing homes (Pennsylvania Intra-Governmental Council 2001). The study also found that training had “a more positive effect on retention rates and a much weaker effect on recruitment.”

Effective training may reduce turnover rates by giving new workers the confidence that they are doing the job right. One study of nursing assistants in two nursing facilities found that those assigned at random to an educational program on dementia care had lower turnover rates three months and six months after the training than their peers in a control group. The researchers posited that the CNAs who attended the classes may have felt more empowered and better able to communicate with the residents they cared for (McCallion et al. 1999). Another study found that extra training, especially when accompanied by additional compensation and responsibility, can make direct-care workers feel more valued and stay longer on the job (Taylor 2001), while a third found that CNA turnover rates dropped, in one case dramatically, in two nursing homes that instituted an enhanced educational program. The latter study included a control facility, which offered no additional training and saw no reduction in CNA turnover (Noel et al. 2000).

Quality of Care and Quality of Life

To date, research has not provided much evidence linking quality of patient care with staff training, and most of what is known is limited to nursing home settings.

In one study comparing quality of care in nursing homes before and after OBRA '87, professionals who evaluated quality of care in Pennsylvania's nursing facilities rated 15 areas of CNA care as having improved after the law's training mandate went into effect (Gross 1995). Focus groups with practitioners bear out that impression: One survey of nursing facility administrators, directors of nursing, nursing assistants, social workers, family members and surveyors found that “training, orientation or education” was tied for first place as a means of improving quality of care, mentioned by more respondents than anything else other than “improve communication” (Deutschmann 2001). In other studies, nursing assistants have reported that formal training was necessary for learning how to provide good care (Schirm et al. 2000; Bell 1998).

A recent IOM study reported “some agreement among experts ... that there is a relationship between the level and type of training and the quality of care that nursing assistants provide.” However, the report notes, there is little definitive data to prove that belief (IOM 2000). Three experts argue that more research in this area is essential (Stone, Dawson, and Harahan 2003). They note that improved training and job quality decreases turnover, which in turn, impacts both quality of care and quality of life of residents.

Key Questions

The following questions can be used by state agencies and providers in assessing pre-employment and in-service training available in their states and communities and exploring how to improve educational opportunities for all direct-care workers.

- Do entry-level training and continuing education requirements adequately prepare new workers for the specific demands they will encounter in their jobs?
- What are the most promising approaches to providing training for direct-care workers?
- How can training teach responsiveness to the preferences of individual consumers while providing workers with the basics they need to stay safe and follow clinical protocols?
- How can federal, state, and local resources be maximized to support the training of direct-care workers?

Do entry-level and continuing education requirements adequately prepare new workers for the specific demands they will encounter in their jobs?

Entry-Level Training

Though research suggesting that training positively impacts retention and quality of care is limited, most providers, consumers, and direct-care workers would argue that there is a direct connection. These groups often advocate for increasing training opportunities for CNAs and home health aides—especially in the areas of clinical and psycho-social skills.

Several consumer advocates have already issued calls for higher or different training standards. The National Citizens' Coalition for Nursing Home Reform recommends at least 160 hours of pre-employment training for CNAs, including “training in appropriate feeding techniques” (NCCNHR 1998). The Alzheimer's Association (www.alz.org) calls for more training in dementia care, cultural sensitivity, and how to report elder abuse and neglect. The World Institute on Disability advocates that workers be required to demonstrate certain competencies rather than calling for a certain amount or type of training (Glazier 2001).

Consumers who direct their own care sometimes reject formal training, saying that it often fosters paternalism, a tendency to treat people with disabilities as if they were ill, or an insistence on doing things the way the worker was taught rather than the way the consumer prefers (Dautel and Frieden 1999; Moseley 1999; Saviola 2002; New Jersey Cash and Counseling Program 2002, DeGraff 2002). These consumers prefer to train their own workers; however, it is worth noting that their objections are based on the way training is currently conducted, not on a belief that no training is needed. Some self-directing consumers welcome formal training, particularly if it is taught in a resident- or consumer-focused way. Clients of Washington State's Home Care Quality Authority, for example, have generally supported the required 28-hour training for their assistants, with

some advocating for additional hours to ensure their workers have the skills needed to provide quality care.⁴

A number of studies have recorded what direct-care workers and their supervisors have to say about pre-employment training. Many focus on the gap between the skills taught in the classroom and what workers are required to do on the job. As one researcher observes, classroom education “is often negatively evaluated by frontline workers in long-term care, often because it is either ‘above their heads’ or has no obvious application in their everyday work” (Atchley 1996).

Nursing home administrators and nursing assistants surveyed for an OIG report on CNA training concluded: “Nurse aides need more skill training on behavioral and cognitive disorders, catheter care, colostomy care, lifting, feeding, hydration, and infusion therapies. They also need more training in interpersonal skills, including communication, teamwork, coping with death and dying, time management, and new technologies” (US DHHS OIG November 2002). Nurses surveyed about their perceptions of nursing assistants for another study said: “Nurse assistants often do not receive enough practical experience in their training and are therefore too frequently ill-prepared for ‘real world’ conditions” (Schirm and Garland 1997).

CNAs interviewed in New York said training failed to cover a number of necessary skills, such as dealing with multicultural staff, working as part of a team, and caring for people who use supplemental oxygen or feeding tubes. They also recommended allowing more time for pre-certification training and incorporating more hands-on practice with residents in a facility (NHCC 2003). In Pennsylvania, direct-care workers employed in a variety of long-term care settings said they wanted training that is “relevant, practical, and consistent,” criticizing the status quo for lacking depth and breadth and failing to prepare them for the day-to-day realities of the work (Pennsylvania Intra-Governmental Council 2002). And more than a third of the nursing assistants interviewed for an Iowa study said their training had not prepared them to do the job well. As one put it: “I figure a lot out on my own because of my background, but I feel all of us would benefit from timely and complete training at the beginning of our employment” (Bell 1998).

Though stakeholders and researchers have identified many of the weaknesses in current entry-level training programs, there is little definitive research to guide decisions as to how many hours of training or what courses are needed to provide optimal entry-level training. One approach might be to follow the Institute of Medicine recommendation that federal and state governments, providers, and consumers work together to develop training programs, along with training, education, and competency standards, for staff in all long-term care settings. These standards and programs, the IOM believes, should be “based on better knowledge of the time, skills, education, and competency levels needed to provide acceptable consumer-centered long-term care” (IOM 2000).

⁴ Home Care Quality Authority, personal communication, June 2004. State training requirements can be found at www.aasa.dshs.wa.gov or by ordering the Individual Provider Handbook from the Washington State Department of Social and Health Services.

BOX**Addressing Employment Barriers**

In many parts of the country, a significant portion of the candidates for direct-care work are new immigrants, women transitioning from welfare to work, and others facing significant barriers to employment, according to a 2001 US General Accounting Office report (Scanlon 2001). That study, for example, found that a little over 20 percent of direct-care workers have less than a high school education, over one-quarter are single parents with children, and among home health aides, 20 percent are immigrants. Limited literacy skills and lack of workforce experience are major employment obstacles for new immigrants as well as those who have little formal education. As a result, successful recruitment and retention of direct-care workers may require that increased attention be paid to the following:

- *Job Readiness.* In order to qualify for direct-care work, candidates may need some pre-employment training in basic life skills or employment skills such as goal setting, time and money management, and how to balance home and work responsibilities.
- *Literacy.* Because they need to communicate with the people they care for and other members of the care team, direct-care workers usually need to be able to speak English. In addition, because they often need to read instructions or document the care they have provided, they usually need to be able to read and write in English. Basic education programs are available in most states, but they are often hard to access (see the section below on federal, state, and local resources). What's more, coupling literacy and basic education training with vocational education and work has been shown to be the most effective way to boost needed skills (Martinson and Strawn 2002), but such programs are in short supply.
- *Cultural Competence and Diversity Training.* Cultural, ethnic, religious, and class differences can all create tensions or lead to misunderstandings between direct-care workers and their supervisors or the people they assist. While it is not clear that educational programs can change people's attitudes or behavior, many long-term care experts believe that workers would benefit from basic training in cultural differences (Bonder et al. 2001).

In-Service Education

Federal law states that continuing education for CNAs must address weaknesses uncovered in annual performance reviews and provide specialized knowledge needed to care for a particular client or resident population (Code Federal Regulations, Title 42, Part 483, Section 483.75). A study of state CNA training requirements, however, could

not determine whether in-service trainings usually meet the federal requirement of addressing areas of weakness for individual workers. What was clear was that CNAs, ombudsmen, and other experts consulted had a low opinion of most in-service training, saying the content was often repetitious, not directly relevant, or signed off on without being absorbed (US DHHS OIG November 2002). In one California survey, workers criticized their in-service training because most was done through videos or books even though, they said, they learned best through hands-on training (Harahan et al. 2003).

A typical in-service training session lasts about an hour and is conducted by lecture or videotape. When states specify topics to be covered—such things as OSHA standards, residents’ rights and fire and safety procedures—the same presentations tend to be repeated each year. Providers also rely on medical equipment and supply representatives, who do presentations on how to use their equipment and other products.⁵

Weak in-services may undermine the potential of continuing education, which could provide significant opportunities for professional development. Where providers have strengthened their in-service training—for example, the Wellspring Quality Improvement Program (Stone et al. 2002)—the evidence suggests nurse assistants become more valued members of the care team and are more likely to stay longer in their jobs.⁶

What are the most promising approaches to providing training for direct-care workers?

There are two parts to this question: What are the most promising teaching methods? And, considering the limits of classroom training, how can training be reinforced on the job?

- *Teaching methods:* As noted above, direct-care workers are typically educated through a combination of lectures, readings, and videotapes, with a limited amount of supervised hands-on practice. But both education experts and direct-care workers agree that traditional teaching methods that rely heavily on lecture and videotape often fail learners, who often don’t absorb the information being conveyed.

Education researchers have learned a great deal about teaching and learning over the last several decades (Weimer 2002). We now know that people have different learning strengths—some learn by seeing, others by hearing, and still others by doing. The more participatory the classroom, the more likely learners will integrate new knowledge into their understanding of their work and the world

⁵ Personal communications with nurse educators suggest this is a relatively common practice. Such presentations are described as “professional” and “useful” and “not overly commercial.” This type of presentation, however, is not likely to embrace the kind of learner-centered practices that educators recommend as the most effective way to engage learners (see p. tk).

⁶ For additional examples of effective in-service programs, see the Practice Profile Database, www.directcareclearinghouse.org

around them and be able to call on that information when confronted with a new or challenging situation.

Many adult educators today are shifting toward more learner-centered classrooms, in which content is taught through a variety of problem-solving activities that involve role-plays, case studies, small group discussions, or any number of interactive exchanges (Stage et al. 1998; Paraprofessional Healthcare Institute and MEDSTAT, 2004). These activities help learners remember specific content while also building life-long learning skills, analytic capacity, and communication skills, all of which strengthen the ability of direct-care workers to do their jobs well. Building the capacity of long-term care educators to incorporate learner-centered teaching practices into both entry-level and in-service training could greatly increase the effectiveness of direct-care worker training programs.

- *Reinforcing training on the job.* Even the most well-trained direct-care workers have trained a maximum of four weeks prior to beginning employment. These workers, many of whom may have limited literacy skills and/or work histories, may not be able to acquire all the skills needed to care for people with a variety of complex physical, social, and spiritual needs in such a short period. In a series of focus groups with nurses and nursing assistants in Ohio nursing homes, participants recommended an extended orientation period to allow time to develop “technical, observational, and interpersonal skills” under the supervision of a licensed nurse (Schirm et al. 2000). Robert Atchley (Abt 2002) suggests that senior CNAs can play a key role in this kind of on-the-job training, modeling job performance and introducing new skills as needed. He notes that this training may be more effective than classroom models as “material is introduced when it is most relevant and is not disconnected from the activities of the job.”

Along with on-the-job training programs, on-the-job orientation, supervision, and peer mentoring may also provide opportunities to strengthen skills and instill confidence. For example, Cooperative Home Care Associates of the South Bronx provides three months of on-the-job support that includes frequent check-ins by supervisors and peer mentors, monthly in-services, and peer support groups, which make the transition from training to employment more successful for workers and clients. At the Masonic Home of New Jersey, peer mentors work side by side with new employees during their first two to four weeks on the job, orienting them to workplace practices and providing feedback until the mentors judge that the new employees are ready for their own workload.

How can training teach responsiveness to consumer preferences while providing workers with the basics they need to stay safe and follow clinical protocols?

Most pre-employment training programs include a section on residents’ or patients’ rights, which are a mandated part of CNA and home health aide training. But consumers and providers are increasingly embracing consumer-centered practices, enhancing consumer choices, and altering how support services are delivered to support autonomy

and self-determination (Dautel & Frieden 1999; Misiorski 2004). Consumers and their family members want care and support services to be delivered in ways that respect their individual needs and desires, not just their need for “privacy” or “consent.”

This expanded concept of consumer rights and resident or client-centered practice is increasingly being integrated into training curricula. To deliver “person-centered” care—i.e., care and support that enhances the individual’s ability make choices and live as fully as possible—direct-care workers need to learn not only *how* to do the tasks required of them but *why*. They need to know when there is one right way to do things, as in washing hands to control the spread of infections, and when flexibility is called for, as in responding to a consumer’s preference regarding when he or she would like to bathe or shower.⁷ Under the Wellspring model of quality improvement, for example, workers discuss why care practices are done a certain way and how new practices will affect residents (Stone et al. 2002).

Person-centered care also requires healthy, strong relationships between caregivers and those they support. Curricula that stress problem-solving and interpersonal skills, particularly honest, open, and effective communication, help direct-care workers balance consumer preferences with health and safety concerns (Paraprofessional Healthcare Institute 2003b, 2004).

How can federal, state, and local resources be maximized to support the training of direct-care workers?

A number of federal and state training programs provide English language, GED, or other classes for people transitioning into the job market or laid off from declining industries. However, providers and workers are often unaware of how to access available resources. A recent symposium sponsored by the Department of Labor and the Department of Health and Human Services (Pathway to the Future: How Workforce Development and Quality Jobs Can Promote Quality Care, May 23-25, 2004) was an effort to improve collaboration between workforce development programs and long-term care providers.

Some state human services departments underwrite training for direct-care workers. While their contributions are usually modest, there are exceptions. In New York, for instance, the New York State Department of Health has allocated \$100 million in surplus TANF funds to educate nursing home workers and certain home care aides.

Federal programs such as the Workforce Investment Act (WIA), Temporary Assistance to Needy Families (TANF), and the Perkins Act include workforce development funds that can be tapped to train direct-care workers (Raynor 2003). California, for example, used \$25 million in combined WIA and TANF funds to improve training and retention of frontline workers in long-term care.

⁷ To learn more about how care can be redesigned to honor consumer preferences, even in cases where consumers may have difficulty communicating, see Barrick et al, *Bathing without a Battle* (Springer Publishing Co., 2001).

The Administration on Aging occasionally pays for training or curriculum development for direct-care workers through the Older Americans Act (OAA). For example, the National Council on the Aging used OAA funds between September 2002 and May 2003 to train home health aides and CNAs in several sites in Florida and California (NCOA 2003).

The Department of Labor's new High-Growth Job Training Initiative, which targets health services as one of nine fast-growing sectors, is a promising new source of support for long-term care training programs.

Next Steps

While research has not yet determined the direct link between the amount or type of training and recruitment and retention of direct-care workers, most providers and workers would agree that quality training that adequately prepares workers for their job is important to providing quality care. Additional research, however, is needed to determine the impact of the content and structure of training programs on workforce stability and the quality of care and services received by consumers. Areas of research might include:

- Empirical studies of entry-level training programs to evaluate the effectiveness of existing models, as measured by retention and quality of care outcomes. For instance:
 - Comparisons of 75-hour CNA and home health aide training programs with programs that provide additional training hours.
 - Studies of the appropriate balance between clinical skills training and training in communication and problem solving.
 - Comparisons of programs that provide a relatively large amount of pre-employment training and a relatively small amount of formal on-the-job training with programs that reverse that ratio, in an effort to learn which kinds of skills are best taught in preparatory training and which are best taught on the job.
 - Comparisons of employer-based and community-based training programs.
 - Side-by-side evaluations of different ways of teaching the same material, to determine whether certain methods tend to be most effective (e.g., hands-on practice for clinical skills).
 - Comparisons of training programs for direct-care workers who work in different long-term care settings (and, therefore, are subject to different training requirements), but provide the same basic services, to determine whether these variations in training affect quality of care.
- Evaluation of specialized training programs, to assess whether they influence worker retention and/or quality of care.
- The design and testing of various model core curricula to determine whether there is a core set of skills and knowledge needed by direct-care workers in all long-term care settings.

Conclusion

Though more research is needed, there is evidence to suggest that some direct-care workers may not be receiving the training they need to serve effectively a growing population of elders and people with disabilities.

As noted above, direct-care workers in different settings, many of whom have similar responsibilities, receive different educational opportunities, with some entering the field with no training at all and others receiving three to four weeks of clinical and soft-skill development. Identifying critical competencies for direct-care workers continues to be challenging, in large part because few studies have analyzed the overlapping, but sometimes different, skill sets workers need to support consumers living with a range of disabling conditions in a variety of settings.

The most promising approaches to improving training for direct-care workers appears to involve a combination of improvements in content and teaching methods. In the future, additional studies could help determine what content and teaching methods best prepare direct-care workers for the complex emotional work of caregiving, and in turn, help shape training requirements for direct-care workers as well as their instructors.

Training is, of course, only one of several key elements in the creation of a stable and well-qualified workforce (IOM 2000). But linked to effective orientation, supervision, and supportive workplace cultures, sound training can lead to improvement in retention for workers and quality of care and life for consumers.

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The nonprofit **Paraprofessional Healthcare Institute** (PHI) works to strengthen the direct-care workforce within our nation's long-term care system through developing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy. PHI's work is guided by the belief that creating quality jobs for direct-care workers is essential to providing high-quality, cost-effective services to long-term care consumers. Web: www.paraprofessional.org

The Institute for the Future of Aging Services (IFAS) has a two-fold mission: 1) To create a bridge between the policy, practice and research communities to advance the development of high-quality aging services; and 2) To provide a forum for the health, supportive services, and housing communities to explore and develop policies and programs to meet the needs of an aging society. Web: www.futureofaging.org.

