



Caregiver Training in America and Southern California: Results of a National Review

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The Caregiving Project for Older Americans is an action-oriented collaboration that aims to improve the nation's caregiving workforce through training, the establishment of standards, and the creation of a career ladder. Bolstering support for family caregivers is another major goal of the project. A joint venture of the International Longevity Center-USA (ILC-USA) and the Schmieding Center for Senior Health & Education (SCSHE), the effort combines the talents of a policy research center with a clinical outpatient and health education program.

The Schmieding Center for Senior Health and Education of Northwest Arkansas, located in Springdale, Arkansas, provides older adults and their families with education, health care, information resources and other services for more positive aging. Education services include unique in-home caregiver training programs, public programs on positive aging, and professional programs to improve the geriatric expertise of health care professionals and students. Health care services include comprehensive clinical care and rehabilitation by an interdisciplinary team of geriatric professionals. The Schmieding Center is a partnership of the University of Arkansas for Medical Sciences Donald W. Reynolds Institute on Aging, the Area Health Education Center-Northwest, and Northwest Health System.

The International Longevity Center-USA is a not-for-profit, nonpartisan research, education, and policy organization whose mission is to help individuals and societies address longevity and population aging in positive and productive ways, and to highlight older peoples' productivity and contributions to their families and society as a whole. The organization is part of a multinational research and education consortium, which includes centers in the United States, Japan, Great Britain, France, the Dominican Republic, India, South Africa, Argentina, the Netherlands and Israel. These centers work both autonomously and collaboratively to study how greater life expectancy and increased proportions of older people impact nations around the world.

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Numerous individuals and organizations responded to our questionnaire to supply information about their curricula or training programs (listed in Appendix 11), several of whom supplied additional information through lengthy telephone interviews. This report is dedicated to their hard work and to their ongoing efforts to train America's professional caregivers.

Introduction

This report presents findings of a national review—or environmental scan—of caregiver training programs and curricula, conducted by the International Longevity Center (ILC) as an initiative of the Caregiving Project for Older Americans, a joint project of the ILC and the Schmieding Center for Senior Health and Education.¹ The environmental scan, this report and a related conference held this spring in Los Angeles were made possible by generous support from UniHealth Foundation.

It is well documented that the caregiving profession is experiencing a severe and worsening shortage of paid caregivers, at the same time that demographic changes are decreasing the supply of family caregivers. Meanwhile, the number of older people needing care will continue to rise with the aging of the Baby Boom generation. Education, training, and career development of professional caregivers are recognized by experts as crucial underpinnings to a sustainable solution to the caregiving crisis.²

More than 12 million people in the United States, about 80 percent of whom are age 50 or older and about half of whom are age 65 or older, need some kind of long-term care. Many of those in need of care simply go without it—about 20 percent of adults needing assistance are unable to find someone to help, either paid or voluntary. Unfortunately, among those who find help, appropriate care is not always provided.³

More, and more effective, education and training and support for direct-care workers was one of the major recommendations made by the Institute of Medicine in its 2008 report, *Retooling for an Aging America: Building the Health Care Workforce*. The caregiving crisis and the important role of education and training of professional caregivers have motivated this report. Our study is national in scope, with a special emphasis on Southern California. Our primary interest is in-home care of older adults, although curricula and training programs with emphases on other settings of care or on other populations are also included in the review. The purpose of the report is to provide a systematic representation of how in-home care workers are trained—in what settings, what content is provided, presence of special modules, hours of training, types of caregivers trained, whether “best practices” are used, and delivery methods.

A consensus among experts in geriatrics and allied fields confirms the importance of national standards for training of in-home caregivers, and the need for certification for people who successfully complete training that meets those standards.⁴ Yet there is no true national standard for caregiver training.

¹ The professional advisors, expert panel and project staff for the Caregiving Project are listed in Appendix 1.

² Caregiving Project for Older Americans (2006).

³ Caregiving Project for Older Americans (2006).

⁴ Caregiving Project for Older Americans (2007).

Achieving a better understanding of what happens in the absence of standards is one reason studies such as this on caregiver training can be valuable. Another compelling reason to be interested in caregiver training is that many experts believe based upon anecdotal evidence and limited research that quality training leads to improved recruitment and retention of direct care workers. More research in this area would be worthwhile.

Most consumers assume caregivers are trained, despite strong anecdotal evidence provided by experts in the field that many in-home caregivers have little or no training. The Caregiving Project for Older Americans conducted pilot surveys in 2006 and 2007 with Harris Interactive that found that about 8 in 10 consumers think their care providers are trained. Helping consumers to stay informed, and to make informed decisions, is one excellent reason studies on caregiver training are so important.

Studies on caregiver training can help answer important questions such as: What are recognized best practices? Are there some useful programs that do not meet this definition of best practice? What are innovative practices? Why do programs offer what they offer? Are programs evaluated? Are consumers happy? What are opportunities for replication across localities and states? Our hope is that this report contributes to what is known about the answers to such questions, and serves as a springboard to further research.

As discussed in a later section, federal regulations on caregiver training are limited to certain types of workers and do not apply to thousands of people providing paid care. In addition, the required 75-hours of training under the federal regulations are considered inadequate not only by industry experts but also by the majority of states who have adopted more stringent laws. Lastly, federal regulations offer very general guidelines in terms of topics that should be covered in caregiver training; as a result, the quality of the content and of the delivery of training are not assured from agency to agency. The absence of national standards and the presence of 50 states and the District of Columbia with their own ideas about whether or not training should be mandated, and for what kinds of caregiving occupations, has resulted in great variation in all aspects of caregiver training across the country—variation in content, hours, delivery methods, populations served, types of caregivers trained, and quality of instructors. Even job titles used to differentiate levels of expertise among caregivers vary from state to state.

Preliminary findings of the environmental scan of caregiver curricula and training programs detailed in this report were presented for discussion among distinguished members of a Caregiver Training Task Force that convened in Los Angeles May 8, 2008 (Appendix 2.) Several members of the Task Force and special guest Dr. Laura Mosqueda gave presentations at this meeting. The presentations and subsequent discussion among the assembled participants have been instrumental in shaping this report.

After a discussion of the purpose, methods and findings of the environmental scan, we discuss two best practice models that were presented at the May meeting: PHI's Direct-Care Worker Training and Credentialing Model, which was presented by Dr. Vera Salter; and the Schmieding Certified Home Caregiver Training Model, which was presented by Dr. Beth Vaughan-Wrobel. A later section is devoted to special topics related to caregiver training based on the experiences in Southern California. Presentations on special topics were made during the May conference by Dr. Donna Benton (family caregivers and whether or not they need training) and Dr. Cordula Dick-Muehlke (dementia care), both members of the Task Force, and by Dr. Laura Mosqueda (elder mistreatment), who presented as a special guest. The concluding section summarizes the findings of the environmental scan and describes areas where further research is needed.

Environmental Scan: Purpose, Methods and Findings

In this section, the purpose, methods and findings of our national review of caregiver curricula and training programs are discussed. Examples of programs are provided in part to highlight how federal and state regulations shape caregiver training. Besides the influence of regulations, other themes that emerge in the discussion are:

- There is an immense variety of programs in the country
- The *absence* of required hours/content of training does not necessarily lead to inadequate training
- The *presence* of required hours/content of training does not necessarily lead to quality training
- Best practices are not always practical
- National standards are needed to ensure quality care

The socio-demographic and other information about paid, in-home caregivers of older adults that is provided in Appendix 3 provides contextual background to the environmental scan, and discusses the variety of in-home care workers—nursing assistants, home care aides, personal care workers, and others—and their work environments, as well as wages, job growth, and other occupational features.

Purpose of Environmental Scan

The environmental scan presented in this report is intended to provide a systematic overview of the settings of training for in-home care workers, as well as the variety in content, special modules, hours of training, delivery techniques, and types of caregivers trained. Identification of best practices models is another aim of our review.

An exhaustive accounting of all training programs provided everywhere in the United States would not be practical. Even aside from community colleges and all the other venues of caregiver training, there are thousands of home health and home care agencies in the country. There are about 12,000 Medicare-certified home health agencies in the United States, 736 in California. (See Appendix 4, which also provides numbers for all 50 states and the District of Columbia.) Hundreds of certified agencies can serve large metropolitan areas; for example, 454 Medicare-certified agencies serve Los Angeles County.

The number of *non-certified* home care agencies is difficult to know because of interstate variation in licensing and oversight, but there are about 2,700 listed in an on-line directory maintained by CarePathways.com (Appendix 5). Agencies pay a fee to be listed by CarePathways.com; about 8,800 or 75 percent of all Medicare-certified agencies have done so. Extrapolating this 75 percent yields an estimated 3,500 non-certified home care agencies, for a combined total of about 15,000 home health and home care agencies in the United States.

Our aim in this report is to provide a systematic representation of the immense variety of caregiver training programs and curricula in the country. Notwithstanding every diligence on our part to collect information (as described in the “Methods” section below), the immense variety and number of training programs in the country means that it is impossible to include all pertinent programs. *In no way should inclusion of a program in this report be taken to mean that it is necessarily more meritorious than a program that is not included.* Another danger is that a single report such as this on caregiver training will over-generalize and miss important aspects of the caregiving profession due to the multilayered federal, state, and local character of the caregiving profession, and to the complexity and diversity of the issues. We have made every effort to minimize the effect of these limitations.

Methods of Environmental Scan

The environmental scan is an expansion of a review of curricula conducted by the Caregiving Project for Older Americans in 2007, led by the Schmieding Center for Senior Health and Education, which was presented at a conference in New York City March 2007.⁵ The present report is an expansion in the sense that for purposes of the 2007 review, programs were included only if they met a specific definition of “curriculum.”⁶ Another difference is that the present report considers any program that addresses care of older consumers, even if they are not the main focus, whereas the 2007 curricula review considered only those with a very strong focus on older consumers.

An extensive literature review and online search was conducted to identify caregiver training programs and curricula as well as major themes relating to caregiver training. The literature consulted for the review is provided in Appendix 6. Our online search involved visits to websites of several major caregiving stakeholders, which are listed in Appendix 7.

We also obtained input from the Caregiver Training Task Force that was convened for this UniHealth-sponsored initiative, as well as from the influential panel of Experts and Advisors affiliated with our national Caregiving Project.

Lastly, we designed and disseminated a “Call for Caregiver Curricula and Training Programs” to hundreds of organizations throughout the country. The Call for Programs and an example response to the survey that went out with it is provided in Appendix 8. The example survey was completed by the IHSS Consortium of San Francisco.

⁵ A report presenting the 2007 review, *Training Caregivers for Older Adults in the Home: A Search for Curricula*, is available on the Schmieding Center website: www.schmiedingcenter.org.

⁶ As defined in the 2007 review’s report, a curriculum is an education plan with: 1. goals and objectives to be achieved; 2. topics and content to be covered; 3. teaching and learning strategies; and 4. specific evaluation methods to determine learner competency.

The Call for Programs was posted on ILC website, and directly distributed to about 650 individuals and organizations. Appendix 9 lists major organizations that were contacted, including: Administration on Aging, Alzheimer's Association, American Association for Homecare, American Association of Community Colleges, Family Caregiver Alliance, National Alliance for Caregiving, National Association for Home Care and Hospice, National Association of Geriatric Nursing Assistants, PHI, and many others. Specific contacts developed through other initiatives of our national Caregiving Project, such as our Community College Caregiver Training Initiative (sponsored by MetLife Foundation), were also targeted for distribution.

Second attempts were made with about 150 of the non-responses by phone and by email to get answers to the Call for Programs. Follow-up phone interviews were conducted with selected programs among the 71 full responses to our survey for further details. Nine of the 71 responses are from California-based organizations, more than any other state. This is partly the result of California being the most populous state, and partly due to the fact that we intensified our search for programs in California in accordance with UniHealth's interests and with one of the goals of this report.

Findings of Environmental Scan

A detailed summary of the 71 responses to our survey is provided in Appendix 10. The summary is sorted by type of organization: community college or other two-year institution, home care agency, area agency on aging, and so on. Respondents were asked "What type of organization is this?", and given 15 choices. This question proved problematic, in that several respondents did not fit any one category; this partly explains why 11 of 71 respondents chose the "other" category. For each type of organization, those that are not-for-profit are listed separately from for-profit organizations in Appendix 10. About three-fourths of the respondents are not-for-profit.

The survey was designed to take approximately five minutes to complete. Members of the Caregiver Training Task Force provided valuable input regarding the questions asked in the survey. There are thousands of training programs in the country, many of which are known at the local level but not beyond. Our goal was to capture the variety of programs offered, rather than to focus narrowly on known programs and to assess only them. The respondents to our survey should not be taken as representing a scientifically obtained sample of the universe of curricula and training programs. Nevertheless, the results of our survey, in combination with our literature review, online search for programs, and input from the Task Force and members of our Caregiving Project's panel of experts and advisors, provide an accurate view of the great diversity of programs in the United States.

The Call for Programs welcomed responses from organizations that provide curricula or training for *in-home care of older adults*. Twenty-three respondents

(about one-third of the total) said that their program has an exclusive focus on older people, and 40 said that while their main focus is the care of older people, they also address the care of other populations. Only eight of the 71 respondents said that the main focus of their program is the care of populations other than older people (although care for older people is included).

Only about 20 percent of the respondents directly hire the direct-care workers they train; most responding organizations find employment opportunities for trainees via relationships with local workforce development agencies, home care and home health agencies, hospitals, and other employers. In contrast to this general finding, all but one of the for-profit home care and home health agencies directly hire their trainees, as do five of seven not-for-profit home health and home care agencies.

Respondents were asked which of the following types of caregivers they trained:

- Home health aide (skilled/medical)
- Personal care aide or home care aide (non-skilled/non-medical)
- Certified nursing aide (skilled/medical)
- Other

Nearly 70 percent of the responding organizations provide training for personal care aides or home care aides. The next largest category was home health aide, about 50 percent. Training for two or more types of caregivers is provided by about 40% of respondents. Some organizations that provide training for two or more types of caregivers reported that one level builds successively upon the other, consistent with the Schmieding Model discussed in a later section.

Hours of training offered by the respondents varies immensely. Some programs provide as little as two or three hours of continuing education, while others provide 100-200 hours or even more. With so many different types of caregivers being trained at the different organizations, the variation in hours of training is to be expected.

The vast majority of programs include components that address the needs of family caregivers through training, resources and support, or otherwise. Career development of training is also a feature widely offered by the programs. About one-third of respondents who answered the question offer job placement services, one-third offer job or career counseling, nearly 70 percent offer continuing education or retraining courses, and more than half provide training for jobs up the “career ladder”. More than half of the programs offer two or more career development features.

Appendix 11 summarizes the types of organizations who replied to our Call for Programs. The percent of replies from any one type should not be taken as representative of the population of caregiver training programs. For example, the high number of replies from community colleges is almost certainly the result of interest in our Community College Caregiver Training Initiative, and the funding to colleges that is possible from that initiative.

The incredible variation in content, hours, delivery methods, populations served, types of caregivers trained, quality of instructors and other aspects of caregiver training in the U.S. is largely the result of the absence of national standards. States (and the District of Columbia) have great latitude in choosing whether or not to mandate training, and if so, then for what kinds of caregiving occupations.

Federal regulations stipulate that both certified nurse aides (CNAs) and home health aides working through Medicare-certified agencies receive 75 hours of training.⁷ Federal regulations are silent about training of care workers employed by non-certified, private pay agencies—although some states have adopted their own regulations.

For CNAs and home health aides working through Medicare-certified agencies, besides hours, topics of training are also stipulated, although there is considerable leeway in terms of how those topics are taught in practice. Interestingly, required topics for certified nurse aides and home health aides differ.⁸ For certified nurse aides, federal regulations explicitly list training in

- dementia care and cognitive impairment
- elder abuse and mistreatment
- to a lesser extent, socialization and interaction with family members (as part of mental health and social service needs of patient)

These topics are discussed in the “Special Topics” section later in this report. None of these topics are even mentioned in the regulations for home health aides—which may be surprising given that home health aides provide care in people’s homes unsupervised, whereas most certified nurse aides work in institutional settings. If anyone needs training on these three modules, then there is good reason to argue that it should be home health aides.

Many programs address these special modules even in the absence of regulatory requirements. One example is New York City’s Department for the Aging (DFTA), and their training program for personal care aides. The DFTA program includes a 10-hour dementia care module and a 4-hour module on elder abuse. In the state of New York, personal care aides working through certified agencies are required to get 40 hours of training. DFTA provides 105, much of it devoted to job readiness skills. Trainees are largely from unprivileged backgrounds, including those in the City’s welfare-to-work program. Training is provided in English, Spanish, and Mandarin, and DFTA is considering adding Russian. DFTA partners with a couple home care agencies, one of whom provides additional training to bring the DFTA-trained personal care aides up to the level of home health aides.⁹

⁷ 42 CFR Ch. IV (10-1-05 Edition) § 483.152, § 484.34, and § 484.36.

⁸ 42 CFR Ch. IV (10-1-05 Edition) § 483.152, § 484.34, and § 484.36.

⁹ Information about DFTA’s program was obtained in interview with and materials supplied by Robin Fenley, Director of the Alzheimer’s and Caregivers Resource Center, Dept. for the Aging, New York City, and Rebecca Rodriguez of DFTA.

On the other side of the continent in Southern California, San Diego's George G. Glenner School of Dementia Care has a very ambitious program for dementia training, and is widely noted as a "best practices" program.¹⁰ The Glenner School's program involves a total 332 total hours of training. The total equals 184 hours of training for certified nurse aide, plus 40 hours for a student to be recognized by Glenner as a home health aide, and another 108 hours for those wishing to become dementia care specialists. Graduates of the Glenner School are in high demand among agencies. Ten percent of graduates eventually become licensed vocational nurses or registered nurses.

States are free to require training on certain topics or for more hours than is required by federal regulations. *More than half of the states (and the District of Columbia) require more than the 75-hour minimum training for certified nurse aides.* Twelve states and the District of Columbia require 120 or more hours for certified nurse aides, 15 states require 76-119 hours, and 23 states require no more than the federal minimum.¹¹

Missouri's minimum training hours of 175 for certified nurse aides is the most by any state. California has passed recent legislation to increase required hours from 150 to 160, more than any state except Missouri. In California, 100 hours of CNA training must be clinical, which is more than any other state except Missouri, which also requires 100 clinical hours. Three states require 150 hours of overall training for nurse aides: Delaware, Maine and Oregon.

The state requirement for hours of training for home health aides in California is also high compared to other states—120 hours. Although required hours for certified nurse aides (160) is greater than it is home health aides (120), content required to be covered for the training of CNAs does not cover topics deemed necessary for home health aides by state regulators; thus, additional hours are required. In California, CNAs can become home health aides with 40 additional hours of training. In contrast, a home health aide cannot simply take additional hours of training to become a CNA, but has to start from scratch and obtain all 160 hours required for CNAs.

As is true of most states, in California there are no requirements for the training of non-medical personal or home care aides. One private-pay home care agency located in Orange County, California that answered our Call for Programs reported that it provides *four hours* of training for its personal care aides. While this is stated as the "minimum" training provided for a worker by the agency, and although the agency says that training is tailored to the needs of the consumer, it does represent how the lack of standards for private pay, in-home care workers can result in little or no training.

In fact, criminal background checks are not required in most county-based Public Authorities (PAs) in California under the In-Home Supportive Services (IHSS)

¹⁰ PHI National Clearinghouse on the Direct Care Workforce, www.directcareclearinghouse.org.

¹¹ PHI National Clearinghouse on the Direct Care Workforce, "State Nurse Aide Training Requirements, 2007," www.directcareclearinghouse.org.

program. IHSS is a state option under Medicaid, so it's for low-income consumers, although there is a "share the cost" feature that allows other consumers access to services.¹²

There are two modes of service provision under the IHSS, the Independent Provider (IP) mode and the contract mode. IPs are individual home care workers hired directly by the consumer. The IP mode, then, is consumer directed: hiring and training are the responsibility of consumer. About one-half of IPs are family members. Under the contract mode, a home care provider is an employee of an agency that has a contract with the Department of Aging and Adult Services in California.

The creation of the PAs in California has led to greater empowerment of in-home care workers through better wages and benefits, and by serving as employers of record for purposes of labor negotiations. By law, consumers comprise majorities of PA boards, and so have a significant voice in the activities of the PAs. The PAs also maintain registries of home care workers, but the quality of the screening for these workers varies from county to county. There is no state requirement that a criminal background check is done of workers listed in the registry, and most counties do not conduct background checks. Although Los Angeles County nominally conducts background checks, how thorough this is in practice is uncertain given that 129,000 care providers serve the County.¹³ One person with intimate knowledge of the IHSS-PA system interviewed for this report said that the vast majority of consumers do not use the registries, but hire IPs on their own—only 3 percent of non-family IPs in San Francisco, for example, are listed on the registry.

San Francisco's IHSS Consortium is a provider of home care under the IHSS contract mode, and is an excellent example of how, in the absence of training requirements, an excellent program can still be created. In this case, forward-thinking leadership has combined with consumer and employer demand to create a successful program.

The Consortium trains 200-250 personal care aides annually.¹⁴ While no training is required in either the IHSS IP or contract mode, the San Francisco Consortium currently provides 64 of hours training, which soon will be increased to 75 hours. Annual training on elder abuse is mandatory for the Consortium's personal care assistants, program managers, case managers, supervisors and peer mentors. The Consortium is in the process of developing a Home Care Training Institute to

¹² Information on the IHSS-PAs was obtained in an interview with Margaret Baran, Executive Director of the In-Home Supportive Services Consortium of San Francisco, from California Association of Public Authorities for IHSS website, <http://www.capaihss.org/>, and from individual websites of selected county-based Public Authorities.

¹³ Personal Assistance Services Council of Los Angeles County, www.pascla.org.

¹⁴ Much of the Information in this section about the San Francisco IHSS Consortium was obtained in an interview with and materials supplied by Margaret Baran, Executive Director of the In-Home Supportive Services Consortium of San Francisco.

centralize efforts of other agencies in the city to screen and recruit in-home caregivers, to train them and to develop a career ladder.

A model that influenced the San Francisco Consortium is the Direct CareGiver Association (DCA) in Tucson, which is another example of how individual programs can go above and beyond federal or state requirements.¹⁵ The DCA is a non-profit membership organization, comprised of 15 employer agencies (home care agencies, hospitals, nursing homes, etc.) that pay membership dues.

The DCA provides 200 hours of training for certified nurse aides, nearly twice the state requirement in Arizona, which at 120 hours is relatively high compared to other states. The DCA has a stringent screening process for students prior to acceptance into training, and very strong recruitment efforts.

DCA also trains people to become “certified caregivers,” equivalent to what is commonly referred to as personal care aides. For these workers, the state requires 36 hours of training *if* they work in assisted living facilities. If the work setting is a home, then no training is required. Judy Clinco, president and CEO of DCA, said in an interview for this report that Arizona is currently struggling with a phenomenon of “mom and pop” training agencies—it is very easy for anyone to set up a training program to train “certified caregivers” in Arizona. Someone interested in setting up such a program does not have to be a registered nurse or have any related professional experience. Arizona is considering new regulations to address this issue. Also, in Arizona there currently are no regulations for personal care aides working in the home. According to Ms. Clinco, the state will likely develop standards in the near future for Medicare-certified home care agencies employing personal care aides.

Joe Hafkenshiel, president of the California Association for Health Services at Home based in Sacramento, discussed their web-based, multi-level training program for home care aides in an interview for this report. Those who complete all levels of the program are eligible to become home health aides. Mr. Hafkenshiel said that to handle the 16-hour supervised clinical requirement for home health aides, CAHSH is currently in discussions with American River College, a community college in Sacramento.

Community colleges are fertile ground for partnering activities among employers, workforce development agencies, area agencies on aging and service providers. Community colleges can promote the career development of caregivers, and are laboratories of innovation. Sometimes the programs that are offered may be modest, but serve a real need.

For example, Gateway Technical College in Wisconsin provided curriculum expertise as part of a partnership of providers (home health and home care agencies) and the local workforce development agency to develop a program to

¹⁵ Information for DCA obtained in interview with and materials supplied by Judy Clinco, president and CEO of DCA.

train caregivers with fewer than the mandated 40-hours required under the state's Medicaid personal care option. Gateway and its partners wanted to address the needs of consumers by providing custom-made training. This example might serve as a caution against policymakers considering strict adherence to required hours of training—the result could be that consumers do not get the care they want, or cannot afford it because the only caregivers available are “over-trained” for their needs. Gateway reported to us that approval from the state for credentialing was easier to obtain through the partnership with an educational institution than it would have been for a home care agency alone.

Lackawanna College in Pennsylvania has partnered with a company called Rural Opportunities, which seeks employment opportunities for people age 55 and over. All 11 students enrolled earlier this year in the 75-hour program were referrals of Rural Opportunities. Several of the students were motivated to enter the training because of caregiving responsibilities at home.

As a way of ensuring sustainability of its program, Peninsula College in Washington State offers its course on a for-credit basis. This has two benefits. First, it allows the program to leverage the community college's general funds to pay instructional costs. Second, it enables students in the program, most of whom are low-income—to be eligible for various types of financial assistance.

These examples from community colleges may fall short of some best practices model or some idealized national standard, but perhaps it would be beneficial to consider how a national model can accept a legitimate role for more modest programs such as these.

Best Practices Models—Two Examples

It is generally recognized that best practice programs combine several key elements, such as: adequate hours to teach content; adequate content; skilled instructors; on-the-job support; and the existence of special modules—such as dementia care, elder abuse, interpersonal communications and problem solving, language and cultural sensitivity.¹⁶

Informed people may disagree about what is “adequate” in terms of hours and content, about what kinds of modules of training are crucial, or other features of caregiver training, but there are many recognized best practice programs in the U.S., some of which were discussed above.¹⁷ The next section draws upon presentations of two best practice models that were presented at the May 2008 convening of the Caregiver Training Task Force: PHI’s Direct-Care Worker Training and Credentialing Model, which was presented by Dr. Vera Salter; and the Schmieding Certified Home Caregiver Training Model, which was presented by Dr. Beth Vaughan-Wrobel.

PHI Model

The key premises of PHI’s Direct-Care Worker Training and Credentialing Model¹⁸ presented by Dr. Salter are that the model should:

- Be based on consumer self-determination and person-directed care.
- Be competency based, and so recognize the worker’s ability to apply a set of related skills in performing “critical work functions” across a range of situations and settings.
- Use adult learner-centered methods in training programs and curricula to maximize the trainees’ chances of success.

PHI is developing a multi-level curricula based upon these premises:

- Personal Assistance Worker—77 hour model
 - Basic core direct-care competencies required for all direct care workers
- Certified Nursing Assistant / Home Health Aide—175 hours
 - 77 Core hours + 58 hours of health-related skills and assorted labs + 40 hours clinical experience
- Specialty Credentials

¹⁶ Paraprofessional Healthcare Institute (2004).

¹⁷ A list and description of many best practice caregiver training programs is available from PHI’s National Clearinghouse on the Direct Care Workforce at <http://www.directcareclearinghouse.org/index.jsp>. The PHI Clearinghouse is an incredible resource for anyone interested curricula development, training, recruitment, wage support and any of the major issues affecting direct-care workers.

¹⁸ The PHI curriculum presented in this report is the version presented by Dr. Salter at the conference. Revisions made to the curriculum since that time are not reflected. For information about subsequent revisions, interested persons may contact Steven C. Edelstein, national policy director at PHI, sedelstein@PHInational.org.

- Wound care, dementia support, chronic disease management, disability support, peer mentoring, hospice and palliative care

The PHI Model curriculum for personal assistance workers is described below. The text that follows borrows heavily from a draft circulated by Dr. Salter at the May 2008 meeting.¹⁹

PHI's curriculum is based on a set of competencies that define the skills necessary to provide personal care and health-related services in the full range of long-term care settings. Table A provides a list of competencies for personal care workers. The competencies in Table A are necessary for personal care workers to provide quality, person-centered care to consumers in need of assistance with the activities of daily living. This assistance may be provided in any appropriate setting: home care, assisted living residences, personal care homes, or adult day centers.

PHI has developed an additional set of competencies for certified nursing assistants and home health aides which, when added to the personal care competencies listed in Table A, encompass all the competencies that direct-care workers need to provide services to elders and consumers with disabilities in whatever setting they reside.

PHI believes that demonstration of the entire set of competencies (Table A plus competencies for certified nurse assistants and home health aides) will provide a portable certification that will enable a direct-care worker to work in all long-term care settings, providing personal care services as well as performing specific health-related tasks for nursing home residents and Medicare-certified home health clients.

The 77-hour Personal Care Services curriculum was designed to meet three major goals:

- To help participants develop the core competencies needed to provide personal care in a range of long-term care settings;
- To introduce potential workers to all the different settings; and
- To lay the foundation for further training as nurse assistants or home health aides.

Both consumer preferences and government policy have been forces behind a change in care delivery from institutional to home settings. PHI curriculum was designed in consideration of this shift and the subsequent need for home care workers to provide services to people with more complex health conditions. As mentioned earlier in this report, current state requirements for the training of personal care aides are generally limited, and there is great variation from state to state. Home health aides and CNAs, while included in federal law mandating minimum hours of training, are not prepared to work in people's homes.

¹⁹ More information about PHI's Model Curriculum for Direct-Care Workers may be obtained from Steve Edelstein, Director of National Policy at PHI, at sedelstein@PHInational.org.

PHI notes that state policymakers are considering a variety of strategies to promote flexibility and versatility in the direct-care workforce, such as requiring that workers in all settings are trained in the skills necessary to provide safe, effective care that addresses consumer preference; familiarizing workers with all the possible settings of care; and offering standardized credentialing for training that would be recognized in all settings of care. The competency-based curriculum developed by PHI was designed with these ideas in mind.

Table A. Definition of Competencies for Personal Care Workers.

1	Role of the Direct-Care Worker
1.1	Explain the importance of the relationship between the consumer and the direct-care worker for quality of care
1.2	Define the role of the direct-care worker in relation to other members of the service team in various long-term care settings
1.3	Explain the role of the direct-care worker in relation to the consumer receiving services in various long-term care settings
1.4	Demonstrate professionalism and responsibility, including timeliness and professional appearance
1.5	Explain the purpose of the service or care plan
1.6	Explain the role of the direct-care worker in supporting the consumer's engagement in community activities

2	Consumer Rights, Ethics and Confidentiality
2.1	Listen to and observe the preferences of the consumer
2.2	Respect the consumer's right to privacy, respect and dignity
2.3	Demonstrate ways of promoting the consumer's independence
2.4	Explain the philosophies of consumer-direction and independent living
2.5	Facilitate the consumer's desire to express their personal faith and observe religious practice as requested
2.6	Respect the confidentiality of consumer information and adhere to Health Insurance Portability and Accountability Act of 1996 (HIPAA) and employer confidentiality guidelines
2.7	Explain the direct-care worker's responsibility to identify, prevent, and report abuse, exploitation and neglect
2.8	Describe the rights of consumers as addressed in the Americans with Disabilities Act (ADA)

3	Communication, Problem Solving and Relationship Skills
3.1	Explain the term "communication" including the difference between verbal and non-verbal communication
3.2	Demonstrate effective communication, including listening, paraphrasing, and asking open-ended questions

3.3	Demonstrate ability to resolve conflict
3.4	Demonstrate respect and cultural sensitivity in communicating with others
3.5	Demonstrate the use of effective problem-solving skills
3.6	Demonstrate respectful and professional interaction with the consumer, significant other(s), and family members
3.7	Demonstrate basic language, reading, and written communication skills

4	Individualized Personal Care Skills According to Consumer Preference and Service Plan
4.1	Assist with tub bath and shower
4.2	Provide bed baths
4.3	Shampoo hair in bed
4.4	Assist with oral hygiene
4.5	Assist with fingernail and toenail care
4.6	Shave consumer
4.7	Turn and/or position consumer in bed and wheelchair
4.8	Transfer consumer from bed to wheelchair
4.9	Provide consumer with back rubs, foot rubs, leg rubs, arm/hand rubs
4.10	Assist with routine skin care
4.11	Assist with eating and drinking
4.12	Assist with dressing, including using elastic support stockings
4.13	Assist with walking
4.14	Make an occupied and unoccupied bed
4.15	Assist with basic toileting needs, including assistance with disposable briefs, using a bathroom or commode.
4.16	Demonstrate proper use of bedpan, urinal, and commode
4.17	Provide perineal care (cleaning of genital and anal areas)
4.18	Clean and ensure appropriate function and care of appliances such as glasses, hearing aids, orthotics, prostheses, and assist with application/removal
4.19	Observe, record, and report as appropriate

5	Individualized Health Care Support According to Consumer Preference and Service Plan
5.1	Assist consumers with self-administered medications

6	In-Home and Nutritional Support According to Consumer Preference and Service Plan
6.1	Assist with meal planning, food preparation and serving, food shopping, storage and handling
6.2	Assist with the preparation of simple modified diets
6.3	Assist consumers with care of the home and/or personal belongings
6.4	Support a safe, clean and comfortable living environment

7	Infection Control
7.1	Demonstrate proper hand washing procedures
7.2	Demonstrate application of principles of infection control in all activities
7.3	Demonstrate the use of standard precautions as indicated
7.4	Prepare soiled linen for laundry

8	Safety and Emergencies
8.1	Use proper body mechanics at all times and demonstrate safe transfer techniques
8.2	Explain procedures in case of emergencies

9	Apply Knowledge to the Needs of Specific Consumers
9.1	Describe basic anatomy and physiology of body systems
9.2	Recognize and report abnormal signs and symptoms of common diseases and conditions of body systems
9.3	Describe the normal aging process and its effects
9.4a	Identify the specific needs of a person with Alzheimer's disease and related dementia.
9.5a	Identify the needs of people with various physical disabilities
9.6	Identify the specific needs of and demonstrate the ability to care for a sensory deprived consumer
9.7	Describe how age, illness and disability affect sexuality
9.8a	Identify the special needs of a consumer with mental illness
9.9a	Identify the special needs of a consumer with intellectual and developmental disabilities

10	Self Care
10.1	Recognize signs of burnout in self and others, and identify stress reduction techniques
10.2	Demonstrate use of time-management and organizational skills
10.3	Identify resources to maintain personal health and well-being
10.4	Identify options and strategies to respond to abusive behavior directed toward direct-care workers by consumers

Schmieding Model

The Schmieding Center for Senior Health and Education in Northwest Arkansas is one of eight regional centers on aging in the state, each of which has two components: a senior health clinic, and an education program. The education programs provide service to the public, health professionals, and paraprofessionals.²⁰ The Schmieding Center, founded in 1999 with major funding from Lawrence Schmieding, is the only one of the eight centers that provides in-home caregiver training at this time, although there are plans to replicate the program in the future at each of the other sites, effectively implementing statewide training for individuals providing paid care in the home.

The Schmieding Model of in-home caregiver training adheres to the competency-based approach advocated by PHI. The Schmieding Model meets all core competencies included in PHI's approach with the exception of a cultural module. Dr. Vaughan-Wrobel explained that the Schmieding Center is located in a part of the country where there is relatively little cultural diversity. The vast majority of residents in Northwest Arkansas are white, and there are relatively few Hispanics and blacks. The Schmieding Center plans to add a cultural module to its training program in the near future.

Guidelines for program development considered by the Schmieding Center when they instituted their program included the following:

- Arkansas Department of Health and Human Services Office of Long-Term Care
- Arkansas Medicaid Participation Requirement off Personal Care Aide Training
- Rules and Regulations for Home Health Agencies in Arkansas
- Condition of Participation: Home Health Agencies from the Federal Registry
- Barbara Broyles Alzheimer's and Dementia Training Program for Nursing Assistants.

Although the Schmieding Center trains people primarily to work in home settings, they added an Alzheimer's/dementia training module after Arkansas adopted a requirement in 2006 that certified nurse aides (who usually work in nursing homes and other institutions) receive 15 hours of dementia and Alzheimer's training.

○ ***Curriculum versus guidelines and competencies.*** When the Schmieding Center began to develop its program, according to Dr. Vaughan-Wrobel, there were guidelines and competencies to consult, but “we couldn't find anything that told us how to teach” the content. Dr. Vaughan-Wrobel and her team of nurses created a curriculum that “has everything that one would need to do turnkey

²⁰ Dennis, Gusmano, Knapp et al. (2005).

teaching” of content. The curriculum includes teacher’s guides, schedules, a student workbook, testing, and all the procedures of how to teach the content.

○ **Specialized versus universal training.** The Schmieding curriculum and training are very specific to older adults, and very specific to in-home care. Dr. Vaughan-Wrobel said that the Schmieding Center believes that universal training, such as a program that includes pediatrics and disabilities content, distracts from caring for the older adult. As an example, she asserted that someone caring for an older adult with dementia in a home setting needs to be trained on specific skills and exposed to specific information.

This position of the Schmieding Center is supported by professionals in geriatric medicine and nursing who recognize differences in the needs of elder care recipients compared to those of other age groups. Differences include age-related physical, mental, and social characteristics. The Schmieding Center argues that content incorporated into the training of caregivers working with older people must include specialized information, skills, attitudes, and approaches.²¹

Specialized training is also needed when care is provided in the home, as opposed to institutional care. More independence exists in home-based care than in institution-based care—in-home caregivers must be able to make decisions, know when to contact the family, “know when they need to do some things that in a nursing home they just run down the hall and get the nurse,” according to Dr. Vaughan-Wrobel. The lack of supervisory support, absence of organizational policies or procedures, and variability of environmental features all argue for specialized training for in-home settings.²²

○ **Private pay versus public pay.** The Schmieding Center’s training program for in-home caregivers was specifically created to address a perceived gap in availability of such training in Northwest Arkansas, especially for families who pay out of pocket for care. Training for certified nurse aides is much more common than in-home training in the Schmieding Center’s service area. As mentioned, CNAs do not usually provide in-home care but rather work in nursing homes. The Schmieding Center decided to focus training people who were primarily going to be paid privately by families for the care of an older adult in a home setting.

○ **The career ladder.** A career ladder (or “education ladder,” as Dr. Vaughan-Wrobel prefers to call it), is built into the Schmieding program. The program comprises training for three successive skill levels:

- Elder Pal: 25 hours of training
- Personal Care Assistant (PCA): Elder Pal training plus 25 additional hours
- Home Care Assistant: PCA training plus 50 additional hours

²¹ Caregiving Project for Older Americans (2007, March).

²² Caregiving Project for Older Americans (2007, March).

An additional 15 hours of training is provided under the Schmieding Center's Dementia Care module, for a total of 115 hours of training.

The Schmieding Center awards certification for all levels of training, notwithstanding the absence of guidelines by the State of Arkansas. Students who complete all levels of training, including the Dementia Care module, are prepared to sit for the State's CNA examination.

Students are required to demonstrate competencies and pass written exams after each level of training: Elder Pal, Personal Care Assistant, and Home Care Assistant. Students who do not pass one level are not certified and are not permitted to enter training for the next level.

As mentioned, the home care assistants trained at the Schmieding Center are prepared to work in home settings. Dr. Vaughan-Wrobel said that "home care agencies are blooming by the day" in Northwest Arkansas, and their training of home care aides is aimed at area demand for private-pay caregivers. In contrast, home *health* aides, who typically work for home health agencies that are reimbursed by Medicare and Medicaid, are not the Schmieding Center's focus.

The environmental scan presented in this report found that best practices programs such as that of the Schmieding Center might not always be practical. Dr. Vaughan-Wrobel acknowledged that the \$7,500 they charge for the Schmieding curriculum, including DVDs, manuals, notebooks and all other material, may not be practical for everyone wishing to establish a caregiver training program. She and other members of the Task Force stressed the importance of establishing standards for training and of recognizing best practice programs that could be altered to meet specific community needs.

Tuition/fees for training and support from foundation, philanthropy and grants are the two largest sources of revenue for the Schmieding Center's training program. Approximately 100 individuals enroll each year; most complete all levels of training. Including all levels, a total of about 250 certificates are awarded very year by the Schmieding Center.

The needs of family caregivers are comprehensively addressed by the Schmieding Center. Activities include: training sessions for family caregivers, teaching direct-care workers about interaction with families, providing information and support to families, sponsoring a hotline in the event of problems, and providing a Caregiver Directory of persons who have graduated from the Schmieding program and who want to work under private contract.

The Schmieding Center provides strong job/career counseling as well as continuing education opportunities for their graduates and others. A recent innovation of the program is implementation of curriculum by telecommunications, in collaboration with a community college in Arkansas.

Further information about the Schmieding Center, including its caregiver curriculum and training program, are available on their website at <http://www.schmiedingcenter.org/index.php>.

Special Topics: Perspectives from Southern California

In this section, special topics related to caregiver training are discussed: training of family caregivers, dementia training, and elder mistreatment. As discussed elsewhere in this report, these are among the topics that should be of special concern to caregivers and those providing training. The topics are discussed in the context of experiences of three Southern-California-based experts, based upon their presentations at the May 2008 conference: Dr. Donna Benton (family caregiving), Dr. Cordula Dick-Muehlke (dementia), and Dr. Laura Mosqueda (elder mistreatment).

Do Family Caregivers Need Training?

The future demand for long term care workers will significantly increase over the next fifty years, based on a jump to almost 20 million people age 65 and older by 2050. At the same time, projections show a decline in the supply of direct care workers. The baby boom generation does not have savings or pensions to secure their old age and will have to depend on their families to provide caregiving.

Many older people go entirely without the help they need. Unfortunately, even among those who find help, appropriate care is not always provided—even by intimate family members. In one study, nearly 40 percent of physically disabled people age 65 or older being cared for by a spouse reported emotional distress from receiving the assistance, 50 percent reported being helped with activities “unnecessarily,” and 28 percent reported not receiving help they needed.²³ This study was limited to care of people with physical limitations; since caring for people with Alzheimer’s disease and other cognitive impairments is usually more challenging,²⁴ the investigators of the study note that the incidence of inadvertently inappropriate care by family caregivers probably is higher than reported in the study.²⁵

Only about 20 percent of family caregivers receive formal caregiver training.²⁶ Do family caregivers need training? Addressing this question in her presentation at the May 2008 conference, Dr. Donna Benton said that the answer was “a no-brainer,” yes.

This section draws upon Dr. Benton’s presentation of her work with California’s Caregiver Resource Centers—she is director of the center located in Los Angeles. The Caregiver Resource Centers is a statewide program that serves as a point of entry to services available to caregiving families in every county of California. Working with families for over 23 years, the Resource Centers have accumulated a wealth of information regarding the needs of family caregivers.

²³ Newsom and Schulz (1998).

²⁴ Wright (2006).

²⁵ Newsom and Schulz (1998).

²⁶ NAC and AARP (2004).

○ ***The changing nature of family caregiving.*** Over the years the nature of caregiving has undergone many changes. Although historically American families have always provided for their aged family members to one degree or another, caregivers today are required to provide a new kind of care:

- Patients are discharged from hospital quickly, and sent home to recuperate. Where once nurses provided care, now family members must assume responsibility.
- Surgical patients undergo outpatient surgeries and go home the same day; again family members are required to learn how to change dressings and deal with common situations that arise for patients post operatively.
- Before the advent of medical breakthroughs aged family members either recovered from an illness or died. They now live longer and need chronic care.
- Families are smaller and spread out; a family caregiver can no longer rely on an extended family to spread responsibility and offer respite.
- Many caregivers are women who have employment outside the home as well as the responsibility of caring for a family member at home.
- Generational expectations of the baby boomers who now have caregiving responsibilities differ from the World War II and Korean War generation. They have a different sense of responsibility, as well as different levels of education, mobility, and job access.

Family caregivers are caught between personal feelings of achievement and society's approval at helping a family member, and the demands caregiving places on their time, sleep, and independence. Research findings consistently point to health problems that caregivers sustain over time. Family caregivers have the highest rate of depression—about 40 to 70 percent have clinically significant symptoms. They also have mental health issues, demonstrate high anxiety levels and often express feelings of anger, guilt and worry. Caregivers tend to have lower levels of self esteem and feel less in control of their lives. In one study, elderly spousal caregivers who reported caregiver-related stress were 63% more likely to die within 4 years than non-caregivers.²⁷ Family caregivers have increased risk for alcohol and substance abuse, use more psychotropic medications, and are at increased risk of heart disease, lower levels of self care.

Paradoxically, family caregivers often have trouble letting go and trusting outsiders who come into their home to provide some of the care, fearing that an outsider will do harm since a stranger cannot possibly show the same loving care and concern for their family members as they.

Studies have shown that education and training programs in behavioral skills can help reduce some of the burden. Clinical issues of depression can be addressed, and programs tailored to meet specific needs can help caregivers deal with the guilt and anxiety that accompany their responsibilities. Training families in the practical aspects of caregiving can raise their level of competency

²⁷ Schulz and Beach (1999).

and their comfort level as they acquire skills and gain a better understanding of the nature of caregiving for an older person.

Although there are many benefits to caregiving and many people find meaning and purpose, it's a very difficult job. Family issues too must be dealt with, such as financial and work-related issues, childcare and retirement security.

○ **Discharge planning.** The primary reason why a significant number of older people who are discharged from hospitals get readmitted is because family members are not trained to be caregivers and are not equipped emotionally to handle the responsibilities that accompany this task. The discharge team often assumes that when an older person leaves the hospital a son or daughter will take charge, without taking into account job commitments, care of young children, to say nothing of training. The family may not know where to turn for resources, or even how to address the simple but necessary needs of their aged family member.

There are ethical questions implicit in the one question the family is asked on the discharge of a loved one: "Are you willing and able?"

- What does it mean to be willing and able?
- What are the social and psychological ramifications of someone saying : "I can't do this"? What kind of supports can we provide for people that allow them to say "No"?
- Are we outpacing the expectations for people to be caregivers in the future?

The vast majority of older people who require caregiving rely exclusively on informal help—family members but also friends and volunteers.²⁸ The economic value of family caregiving amounts to hundreds of billions of dollars annually, and is about twice the combined cost of home healthcare and nursing home care that is currently provided.²⁹ Dr. Benton noted in her presentation that research has shown that people with moderate dementia can avoid being institutionalized and can remain in the home for up to a year when family members are trained, an obvious benefit to people with dementia both in financial terms and in terms of their quality of life.

To ensure that older people and others needing care receive appropriate care, and that the needs of caregivers themselves are not neglected, it is essential that family caregivers have access to relevant education, training and support.

²⁸ Caregiving Project for Older Americans (2006).

²⁹ Arno (2002).

In-Home Care: Unprepared for the Dementia Epidemic

Alzheimer's and other dementia-related diseases affect approximately four percent of people between ages 65 and 74 in the United States. From ages 75-84, numbers increase to about 17 percent of the population. Studies report anywhere from a third to one half of people 85 plus are affected by dementia, and at age 100 up to 70 percent of people are affected. In the coming decades, the number of persons 85 and older will increase significantly, rising from about 5.6 million today to over 19 million by 2050.³⁰ By 2050 in the United States alone there will be nearly a million new cases of Alzheimer's disease every year.

Currently, about two thirds of home care recipients are 75 or older, which makes them especially vulnerable to Alzheimer's disease. Seventy percent of people already suffering with the disease are not institutionalized, partly a reflection of the strong desire of people to live at home for as long as possible as they age. In her presentation at the conference, Dr. Dick-Muehlke asserted that society is largely unprepared for the challenges posed by caring for the increasing numbers of older people with dementia living at home.

○ ***Hidden costs of living at home.*** Making the decision to care for a family member with dementia presents moral and ethical dilemmas that are generally not explained to families as they struggle to come to a decision regarding the care of an aging relative. For example, families seldom realize that if they choose to become caregivers they will in all likelihood need to negotiate their work life with caregiving responsibilities, and may end up having to leave the paid workforce entirely. Nor are they trained to handle the tremendous stress and isolation they will experience as a caregiver for someone with dementia, or warned about the significant physical and mental health consequences. Family caregivers are vulnerable to depression and immune disorders, and caregiver stress leads to higher risk for mortality. The financial consequences, stress, social isolation, negative physical and mental health consequences, and increased risk for mortality are what Dr. Dick-Muehlke referred to as "the hidden costs" of family caregiving in her presentation.

○ ***Education and training can make a difference.*** For the same reasons that paid home caregivers require training to equip them with the knowledge and skills to care for older persons affected with dementia, so too family caregivers require training. The benefits of caregiver training are abundantly clear. In one study, after a 15-week set of classes, family caregivers reported being significantly less "disturbed or upset" by behavioral symptoms, particularly disruptive ones, and reported less behavior and memory problems.³¹ Similarly, caregivers completing a 12-week course as part of another study reported significantly less anxiety and agitation in loved ones.³² A further example of the

³⁰ U.S. Census (2008).

³¹ Hébert et al., (2003).

³² Haupt et al., (2000).

benefits of training is the research by Oswald, et al. (1999), who found that caregivers who participated in a 7-week set of workshops reacted significantly less negatively to disruptive behaviors and experienced significantly less burden.

Few studies have been conducted on the efficacy of dementia training specifically targeting home care workers. A very recent study³³ was conducted by a team of researchers lead by Robin Fenley, Director of the Alzheimer's and Caregivers Resource Center, Department for the Aging (DFTA) in New York City, a program that was discussed earlier in this report. The findings reported by Fenley and her team are based upon the first 2 years of an ongoing project at DFTA to train entry-level personal care aides. As discussed earlier, classes are taught in English, Spanish, and Mandarin. A significant increase in knowledge of Alzheimer's disease for all groups was observed at the conclusion of the training. Significant improvement in retention of this knowledge after 3 months was also found.

In the DFTA study, workers received 10 hours of training in dementia, involving multi-modal classroom instruction as well as a field placement, over two to three days. Dr. Dick-Muehlke emphasized that the hands-on component is especially critical for dementia care training. An 11-item questionnaire about knowledge of Alzheimer's disease was used as the pre- and post-test. Questions addressed a variety of skills, such as communication and behavior management, with a score of 11 representing a high level of knowledge.

Sixty-two percent of students enrolled had no prior dementia training. Students rated the training as helpful and noted that it increased their competence in the job. They reported feeling more self-confident, more empowered in their ability to care for the person with dementia, and nearly 80 percent stated that they wanted more training to be able to do even better.

When students were asked how they would respond to a patient who was challenging to bathe prior to the training, only 11 percent responded correctly. At post-test, 100 percent were able to answer correctly. Despite the limited educational background of students, ten hours of training enabled them to make better choices during interactions with someone with dementia.

Dr. Dick-Muehlke pointed out that mentoring is the key to success in a dementia care training program for caregivers. She noted that such a program should include information about dementia, its effects and common coexisting conditions, as well as how to provide personal assistance, managing challenging behaviors and effective communication.

³³ Fenley et al. (2008).

○ **Challenges of home care.** Most care recipients with dementia have moderate to severe dementia. For example, in one study of 5,788 community dwelling individuals with dementia, 74 percent were dependent in 1-4 activities of daily living; 67 percent asked repeated questions; 59 percent wandered; and over half were delusional. Individuals who care for such people face real challenges.

Working largely without supervision and in isolation, a home care worker who is hired to assist a family that is trying to care for a loved one suffering from dementia is frequently confronted with a host of unknowns. The care recipient is a total stranger, as are the family members. Are there family conflicts and discord that will likely erupt during these stressful times? Is the physical environment safe or are there hazardous conditions? What is the family caregiver's emotional state, knowledge base and stress level? Dr. Dick-Muehlke stressed the importance of a family caregiver developing a partnership with the home care worker, effectively collaborating in developing solutions to problems they face together, and educating the worker about who the care recipient is as a person.

The challenges involved in caring for persons affected with Alzheimer's disease and other dementias represent a compelling reason for the development of training programs that acknowledge the difficulties of caring for this population, provide the educational and mentoring tools that increase a sense of competency and control, and decrease desperation and isolation. In the end, care recipients with dementia stand to be the beneficiaries of training programs for those who care for them.

Elder Mistreatment: Vulnerability among Care Recipients

The vulnerability of an older person to being mistreated arises chiefly from conditions that lead to physical and mental frailty, disability, and incapacity. It also is related to socioeconomic factors such as income, ethnic background and social isolation.

The characteristics of the caregiver are often more important than that of the care recipient in determining if a person is at risk for abuse. Some characteristics of care recipients that make them more likely to be victims of abuse are dependency, dementia, physical aggressiveness, and verbal abusiveness. An older adult who is physically combative and verbally abusive is at risk for being abused in return, although how the caregiver perceives and internalizes the words and actions of such an individual is critical to the outcome. People with inadequately treated mental illness and/or who are substance abusers are more likely to abuse a care recipient.

Paid home caregivers are unsupervised, often underpaid and frequently assume responsibilities that are beyond their level of training. They are expected to deal with difficult behaviors, to show kindness and restraint toward people who may be verbally or physically abusive and are often working with people who are

culturally and socially alien to themselves. However, family members commit the majority of reported cases of elder mistreatment and abuse.

During her presentation at the conference, Dr. Laura Mosqueda summarized findings of a study that examined who may be at high risk for committing elder abuse and who is likely to be a victim. Recruiting through the Alzheimer's Association, the Institute for Brain Aging and Dementia, and physicians' primary care offices, Dr. Mosqueda and her research team interviewed 140 dyads of people with dementia and their caregivers in the home. The study showed a high prevalence of multiple types of caregiver abuse:

- Psychological abuse—42 percent
- Physical abuse—9 percent
- Neglect—17 percent
- Any type of abuse—47 percent

Likelihood of abuse was greater among caregivers with the following characteristics:

- Low education level
- Living with a patient greater than two years
- Feeling extremely burdened and stressed
- High symptoms of anxiety and depression
- Isolation

There are multiple vulnerabilities that make an older person susceptible to abuse:

- Emotional vulnerability or fear of losing independence. An older person is more susceptible than younger adults to threats. For example, "If you don't sign over this house I'm putting you in a nursing home" plays on the greatest fear of older persons.
- Physical vulnerability. It is much more difficult for an old person to physically defend themselves or to run away from a dangerous situation. A physically abused older person frequently sustains more severe injuries, and recovery is slower and more difficult than it is for younger adults.
- Relationships. Changes in interpersonal dynamics within families play a major role in the development of abusive relationships. When children become caregivers or when a husband or wife develops dementia and needs care, the nature of the relationship that has evolved over many years undergoes profound changes, as care recipient relinquishes authority to the caregiver.

Financial as well as emotional dependency occurs when a care recipient lives with a child or relative who owns the home where care is being provided. Parents find themselves in the position of being cared for by children who used to depend on them, creating role reversals that are played out by adult children treating a parent like an infant. This sometimes leads to condescending remarks or "talking down" to an elder. There is no evidence, though, to prove that family caregivers who were beaten by their parent as children are at greater risk for abusive behavior.

- Level of care needed. When older persons require major assistance with activities of daily living they become vulnerable to victimization

Every state has its own laws related to elder abuse, with its own definition of the age at which a person is considered “elderly”, and the types of abuse that must be reported. Forty seven states require mandatory reporting of cases of elder abuse, but it may be difficult to determine if a case warrants further action. Physical markers such as pressure sores, bruises or fractures may be signs of abuse or may have occurred despite good care to a vulnerable elder. Distinguishing between an innocent and an abusive cause for an injury in an older adult is often a significant challenge.

Mistreatment by caregivers can take many forms: financial, physical, and sexual abuse, neglect and abandonment. There a variety of ways that medications are used to abuse an elder. Pain medicine may be withheld to coerce an older person into signing a legal document that is against his/her best interests. Medications that cause drowsiness may be used in excess to keep the person from getting out of bed. Narcotics intended for a dying hospice patient may be used by the caregiver instead.

Primary care physicians should routinely inquire about abusive situations when they are seeing an elder in their practice. Screening and assessment could then lead to appropriate and early intervention and even prevention if a high-risk situation is identified. Examples of interventions include providing family caregivers with the tools to use if they are feeling overly-stressed and realize they may strike out at their loved one, working out a plan with the caregiver to deal with the stresses, and assisting with day care arrangements. It is important for all health care providers to know, understand and comply with their state’s laws regarding elder abuse.

Recognition of the dangers and signs of elder abuse, and knowledge about tools for intervention once signs are observed, are crucial for social workers, nurses, physicians and others. Equally important, care recipients, their families, and paid caregivers all should have access to information and training about avoiding elder mistreatment.

Conclusion and Next Steps

Main findings of the national review of caregiver curricula and training programs presented in this report may be summarized as follows:

- **Influence of regulations.** Federal and state regulations influence the content, hours, and delivery of caregiver training, but in themselves do not guarantee effective practices. The *presence* of required hours/content of training does not necessarily lead to quality training, and the *absence* of such requirements does not necessarily lead to inadequate training. There are many examples of quality programs that go above and beyond federal or state requirements, or that provide quality training even in the absence of requirements. Other programs that follow the letter of the law may not adequately prepare trainees for all of the challenges that arise in caregiving occupations.
- **Variation.** There is great variation in content, hours, delivery methods, populations served, types of caregivers trained, quality of instructors and other aspects of caregiver training in the U.S. This is largely the result of the absence of national standards, and the fact that states vary on whether or not to mandate training, and if so, then for what kinds of caregiving occupations. The variation is also the result of differences in leadership: what often matters most is the people on the ground doing the training and implementing the programs—their leadership and innovative thinking.
- **Best practices are important.** Best practices are important, and national standards are needed to ensure quality care. The absence of uniformity of standards for in-home care workers and of a national consensus about the information, understanding, and training required of caregivers are among the other impediments to ensuring an adequate supply of quality care in the United States. The development of uniform, acceptable national standards of care and caregiver curricula would enhance the value and reward of caregiver occupations and help alleviate the worker shortage. High national standards of performance and curricula could help change society's negative perception of caregiving occupations and would have a positive impact on the value society places upon caregivers.³⁴
- **Modest programs are important, too.** Best practices are not always practical. Not every locality can implement best practice programs that combine all the key elements of hours of training, content; skilled instructors, on-the-job support, specialized modules and so on. While falling short of an idealized best practices model, given practical limitations, many localities nevertheless have implemented programs that serve their communities very well.

³⁴ Stone and Wiener (2001).

Next Steps

Our work and that of other researchers has demonstrated that improved availability of quality education, training and career development of in-home caregivers is urgently needed. This is one of the primary goals of our national Caregiving Project.

The environmental scan we have conducted has both underscored the urgency and provided us with the additional information necessary to move forward on several fronts to promote caregiver education and training:

- (1) Implement customized training programs
- (2) Create a library of training modules
- (3) Inform and engage discharge planners and health professionals
- (4) Understand and learn from state regulatory differences

Each of these is described briefly below:

- **Implement customized training programs.** Training programs are needed in many underserved areas, but resources may be limited—information about practical solutions is greatly needed. The UniHealth-sponsored environmental scan has acquainted us with a number of programs where obstacles to implementation of recognized best practices have been overcome, or where practical realities have resulted in more modest but greatly needed programs.

Working with a sample of educational centers and other agencies either currently providing training or considering doing so, our Caregiving Project could document why and how relatively ambitious programs offer what they offer, and why more modest programs do not offer the same.

We also would provide the information needed to help educational centers implement programs. While it may not always be practical—for example, given financial resources, local labor market conditions, and local demand for caregiving services—to implement best practices, it may often be the case that all that is needed for a modest program to be “upgraded” is access to information about what more ambitious programs have accomplished, and how their programs were implemented.

Another outcome of this initiative would be to document the accomplishments of more modest programs. Even though a relatively modest program may not be widely recognized as among the best practices, it may represent the best *possible* practice, given local circumstances. Such a program would have much to offer in terms of what models are replicable across localities.

- **Create a library of training modules.** There are thousands of training programs throughout the country, many of which could benefit from access to information about best practice models, and about how these models can be tailored to meet local needs and resources. This is not to mention the many areas of the country that are without caregiver training programs entirely. A

nationally available library of training modules for caregivers and caregiver training institutions would provide an extremely valuable service.

- ***Inform and engage discharge planners and health professionals.*** In many areas, there is a serious lack of coordination between overburdened hospital discharge planners, caregiving agencies, and other community service providers, resulting in unnecessary and costly re-hospitalization. At the same time, home care workers are largely unsupervised and in isolation, and in dire need of access to information about the hospitals and health care programs, social services, recreational opportunities and other resources available in their communities.

Information—or lack of it—is the heart of the matter. The International Longevity Center’s team of researchers has developed tools to improve coordination among hospitals, health care practitioners, in-home care workers and other service providers by providing them with information about:

1. Where are the most vulnerable populations in the community, and are their needs being met? Related to this is the need for the discharge team to assess family members’ ability to provide care, whether the family has unmet needs, whether they know where to turn for resources, or whether they know how to address the simple but necessary needs of their aged family member. Using effective tools to conduct these assessments, in combination with a geographic indicator developed at the International Longevity Center would enable community-based health professionals to identify neighborhoods where resources are most needed, allowing for early detection and proactive community health practices that would significantly reduce the number of hospitalizations.
2. Where are the community resources? The ILC has developed a practical asset map for use by paid in-home caregivers and others to understand the locations and utility of various resources in the community, including hospitals, adult daycare centers, medical specialists, local area organizations with disease/disability specialties (e.g. diabetes, heart conditions, etc.), poison control centers, grocery/pharmacy delivery services, health and community resource hotlines, and other local resources potentially useful in caring for an older adult..

- ***Understand and learn from state regulatory differences.*** To date, no systematic documentation has been published on how individual state regulations differ with regard to caregiver training requirements of direct-care workers, especially for non-medical home care and personal care aides, who typically work in the private pay sector. Knowledge of differences in state regulations, and of how differences may affect quality of caregiver training, would be invaluable to advocates and policymakers alike when making decisions about how resources should be directed in the training of in-home care workers.

○ ***Moving forward.*** As the Caregiving Project for Older Americans moves forward, pursuing these four activities will be of paramount importance. The importance of these activities—implementation of customized training programs, creation of a library of training modules, informing and engaging hospital discharge planners and health professionals, and documenting state regulatory differences and their effects—is well-supported by the findings of the environmental scan presented in this report.

Appendix 1. Professional advisors, expert panel, and project staff for the Caregiving Project for Older Americans.

Advisory Committee

Frank Broyles, former NCAA football player, coach, broadcaster, and athletic director for the University of Arkansas Razorbacks, was inducted into the College Football Hall of Fame in 1983.

Rosalynn Carter, former First Lady and founder of The Carter Center has worked for more than three decades to improve the quality of life for people around the world.

Walter Cronkite has covered virtually every major news event during his more than 65 years in journalism - the last 54 affiliated with CBS News.

Hugh Downs has enjoyed a distinguished 64-year career in radio and television as a reporter, newscaster, interviewer, narrator and host.

Dr. John R. Finnegan, Jr. is Dean of the School of Public Health at the University of Minnesota.

Val J. Halamandaris is the President of the National Association for Home Care, representing the interests of the ill, dying and disabled and those who care for them at home.

Carol Raphael is President and Chief Executive Officer of Visiting Nurse Service of New York, the country's largest voluntary home health care organization.

Humphrey Taylor has served as chairman of The Harris Poll, a service of Harris Interactive, since 1994.

Expert Panel

Dr. Marie A. Bernard, Chairman, Donald W. Reynolds Department of Geriatric Medicine, University of Oklahoma

Dr. Claudia Beverly, Director, University of Arkansas for Medical Sciences, Center on Aging

Dr. Jeremy Boal, Medical Director, Long Island Jewish Medical Center

Dr. John Crews, Lead Scientist, Disability and Health Team, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention

Steven L. Dawson, President, PHI

Dr. Linda Emanuel, Director, Buehler Center on Aging, Northwestern University's Feinberg School of Medicine

Lynn Friss Feinberg, Deputy Director, National Center on Caregiving, Family Caregiver Alliance

Claudia Fine, Chief Professional Officer, SeniorBridge Family Companies

Mary Jo Gibson, Senior Policy Advisor, AARP Public Policy Institute

Rick Greene, Aging Program Specialist, U.S. Department of Health and Human Services, Administration on Aging, DHHS National Family Caregiver Support Program

Gail Gibson Hunt, President and CEO, National Alliance for Caregiving; Senior Advisor to The Caregiving Project for Older Americans

Dr. Robert Kane, Professor and Minnesota Chair in Long-Term Care and Aging, Health Policy & Management, University of Minnesota School of Public Health
Carole Levine, Director, United Hospital Fund, Families and Health Care Project
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Dr. Jeanette Takamura, Dean, Columbia University School of Social Work
Dr. Sandra Timmermann, Director, MetLife Mature Market Institute

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Michelle Wright, Director of Grants and Administrative Services

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Donald W. Reynolds Institute on Aging and Arkansas Aging Initiative

Special Guest of the May 8, 2008 Conference—Presenter

Laura Mosqueda, M.D., FAAFP, AGSF

Director of Geriatrics, Professor of Family Medicine

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Appendix 3. Profile of Professional, In-Home Caregivers

This appendix provides socio-demographic information about paid, in-home caregivers of older adults. For perspective, other types of caregivers such as nursing home aides or hospital aides are also discussed. Descriptions of the variety of in-home care workers—nursing assistants, home care aides, personal care workers, and others—and of their work environments are provided, as well as data on wages, job growth, and other occupational features.

About 90 percent of both nursing home aides and home care aides are women.³⁵ Among hospital aides, who provide some caregiver services but who work in hospital settings, about 80 percent are female.

About 70 percent of paid caregivers (both in-home and in those working in other settings) are white, which is considerably lower than the national rate (82 percent). The proportion of whom are black (25 percent) is nearly twice that of the national population (13 percent).^{36,37} Although the proportion who are not U.S. citizens is about the same as is true for the whole population (7 percent in 2000)³⁸ among nursing home aides and hospital aides, it is much higher (16.2 percent) among home care aides.³⁹ These statistics exclude undocumented workers, who are likely to work off the books, a phenomenon that is likely more prevalent among home care workers than among those working in nursing homes and other institutional settings.

Educational attainment is considerably lower among paid care workers than among the general U.S. population. One-fourth of the U.S. population has completed at least four years of college,⁴⁰ compared to only 4.2 percent of nursing home aides and 6.5 percent of home care aides.⁴¹ The percent of nursing home aides (22.6) and home care aides (31.5) who have not graduated from high school is considerably higher than the national average of about 16 percent.⁴²

³⁵ Yamada (2002).

³⁶ U.S. Census Bureau (2001).

³⁷ U.S. Census Bureau (2001), Tables 44 and 45.

³⁸ U.S. Census Bureau (2001), Tables 44 and 45.

³⁹ Yamada (2002).

⁴⁰ U.S. Census Bureau (2001).

⁴¹ Yamada (2002).

⁴² U.S. Census Bureau (2001).

Table 3.1. Alternative Titles of Workers**NURSING AIDE**

Type of Facility	Job Title Often Used
Skilled Nursing Facilities	Nurse Aide, Nursing Assistant
Assisted Living Facilities	Health Aide, Medication Aide
Residential Home Care	Health Aide, Medication Aide
Personal Residences	Home Health Aide, Residential Medication Aide
Intermediate Care	Health Aide
Hospitals	Health Aide, Patient Care Attendant
Rehabilitation Facilities	Physical Therapy Aide, Occupational Therapy Aide
Hospice Facilities	Nursing Aide
Psychiatric Hospitals	Psychiatric Aide

PERSONAL CARE AIDE

Type of Facility	Job Title Often Used
Personal Residences	Personal Care Attendant, Developmental Disability Aide, Residential Habilitation Specialist, Home Care Attendant, Housekeeper, Respite Worker, Homemaker, Companion, Dietary Aide
Residential Home Care	Service Aide
Intermediate Care	Developmental Disability Aide, Residential Habilitation Specialist, Behavioral Assistant
Hospice Facilities	Hospice Worker, Respite Worker
Hospitals	Orderly

Source: U.S. Department of Health & Human Services, Health Resources & Services Administration (2004).

Many professional caregivers are employed part-time, and some take other jobs to supplement their caregiving work.⁴³ Only 55 percent of nursing home aides and 46 percent of home care aides work full-time all year round.⁴⁴ Another 16 percent of nursing home aides and 12 percent of home care aides work full-time for part of the year and the remainder work only part-time, either year round or part of the year.⁴⁵

Within the caregiving industry, job titles are used interchangeably, and there is great variation across states. Table 3.1 illustrates the absence of standardization in the industry. Job titles sometimes depend on the setting of care, for example, whether the position is in a skilled nursing facility, group residence, or personal home.

The issue of nomenclature for caregiving job titles in the U.S. is even more convoluted than suggested by Table 3.1, since it reflects only one list of titles from one source (the U.S. Dept. of Health and Human Services). There is no universally accepted job title for a particular position, and one cannot definitively know from the job title applied to a care worker whether the person works in a home or an institutional setting. For example, the Bureau of Labor Statistics' O*NET database, which lists the characteristics of all jobs in the United States, lists "certified nursing assistant" as a job title for both home health aides and for nursing aides.

Job descriptions of four categories of workers are provided in Table 3.2: nursing aides, home health aides, psychiatric aides, and personal and home health aides.

⁴³ Stone (2004).

⁴⁴ Yamada (2002).

⁴⁵ Yamada (2002). This is a simplification—some direct care workers are classified by the source as "non-workers," meaning that they are either unemployed or currently unavailable for work.

Table 3.2. Job Description of Direct Care Workers

<p><i>Nursing aides</i>, also known as nursing assistants, certified nursing assistants, geriatric aides, unlicensed assistive personnel, orderlies, or hospital attendants, perform routine tasks under the supervision of nursing and medical staff. They answer patients' call lights, deliver messages, serve meals, make beds, and help patients to eat, dress, and bathe. Aides may also provide skin care to patients, take their temperature, pulse rate, respiration rate, and blood pressure, and help them get into and out of bed and walk. They also may escort patients to operating and examining rooms, keep patients' rooms neat, set up equipment, store and move supplies, and assist with some procedures. Aides observe patients' physical, mental, and emotional conditions and report any change to the nursing or medical staff. Nursing aides employed in nursing care facilities often are the principal caregivers, having far more contact with residents than do other staff members. Because some residents may stay in a nursing care facility for months or even years, aides develop ongoing relationships with them and interact with them in a positive, caring way.</p>
<p><i>Home health aides</i> help aged, convalescent, or disabled persons live in their own homes instead of in a health care facility. Under the direction of nursing or medical staff, they provide health-related services, such as administering oral medications. Like nursing aides, home health aides may check patients' pulse rate, temperature, and respiration rate, help with simple prescribed exercises, keep patients' rooms neat, and help to move patients from bed. They may help patients bathe, dress, and groom. Occasionally, they change non-sterile dressings, give massages and alcohol rubs, or assist with braces and artificial limbs. Experienced home health aides also may assist with medical equipment such as ventilators, which help patients breathe.</p>
<p><i>Psychiatric aides</i> are also known as mental health assistants or psychiatric nursing assistants, who care for mentally impaired or emotionally disturbed individuals. They work under a team that may include psychiatrists, psychologists, psychiatric nurses, social workers, and therapists. In addition to helping patients to dress, bathe, groom themselves, and eat, psychiatric aides socialize with patients and lead them in educational and recreational activities. Psychiatric aides may play games such as cards with the patients, watch television with them, or participate in group activities, such as sports or field trips. They observe patients and report any physical or behavioral signs that might be necessary for the professional staff to know. They accompany patients to and from examinations and treatment. Because they have such close contact with patients, psychiatric aides can have a great deal of influence on their patients' outlook and treatment.</p>
<p><i>Personal care and home care aides</i> generally provide unskilled, nonmedical caregiving to the aged, physically and/or mentally disabled and ill who live in their own homes or in residential care facilities instead of in health facilities. Most personal and home care aides work with aged or physically or mentally disabled clients who need more extensive personal and home care than family or friends can provide. Some aides work with families in which a parent is incapacitated and small children need care. Others help discharged hospital patients with relatively short-term needs.</p>

Source: Bureau of Labor Statistics, U.S. Department of Labor (2006). Most text verbatim from source.

The critical shortage of paid caregivers in the United States is partly the result of a variety of factors: low wages, few fringe benefits, unpleasant working conditions, low job satisfaction, the emotional and physical burdens of the job, and the lack of a real possibility for career development.⁴⁶

Although work surroundings vary among both home-based and institutionally-based direct care workers, in general, unpleasant working conditions and work tasks contribute to the high turnover rates among paid caregivers. Caregivers spend much of their time standing or walking. Hazards from minor infections and major diseases are often part of the job, as are the physical burdens of lifting and moving clients, and unpleasant duties such as emptying bedpans and changing linens. Clients may be irritable, abusive, depressed, angry, or otherwise difficult, although many are cooperative and pleasant. Home-based caregivers may work in residences that are unclean or untidy.⁴⁷

Few fringe benefits and low wages are barriers to the recruitment and retention of paid caregivers.⁴⁸ The lack of health insurance coverage for many paid caregivers is a primary example. Caregiver wages are among the lowest among U.S. occupations—the median hourly wage in 2004 was just over \$10 among nursing aides, under \$9 among home health aides, and about \$8 among personal care and home care aides.⁴⁹ (The national median in 2004 was about \$14 per hour).⁵⁰

About 1.5 million nursing aides are employed in the United States; there are about 625,000 home health aides and about 700,000 personal care and home care aides.⁵¹ The difficulty in obtaining reliable counts of self-employed caregivers, many of whom work off the books, means that the number of paid direct care workers in the United States is probably higher than these official numbers.⁵²

The fastest growing occupation in the United States is home health aides,⁵³ with the number needed expected to increase 56 percent over the next decade. An additional 41 percent of personal and home care aides will be needed over the next decade, making it the tenth fastest growing occupation.⁵⁴ Not only is demand leading to more job openings for these and other direct care workers, but also replacement needs due to the high turnover rates among paid caregivers are creating even more job openings.

⁴⁶ Stone and Wiener (2001); Stone (2004); Harris-Kojetin et al. (2004); and U.S. Department of Health and Human Services et al. (2003).

⁴⁷ U.S. Department of Labor, Bureau of Labor Statistics (2006).

⁴⁸ Stone (2004).

⁴⁹ O*NET Online, <http://online.onetcenter.org>, and Hecker (2005).

⁵⁰ U.S. Department of Labor, Bureau of Labor Statistics (2005).

⁵¹ O*NET Online, <http://online.onetcenter.org>, and Hecker (2005).

⁵² U.S. Department of Health and Human Services et al. (2003).

⁵³ Hecker (2005).

⁵⁴ Hecker (2005).

Appendix 4. Number of Medicare-Certified Home Health Agencies by State (as of Dec. 2007)

States	Medicare-Certified
Alabama	210
Alaska	16
Arizona	110
Arkansas	207
California*	736
Southern CA*	533
Imperial County*	22
Kern County*	65
Los Angeles County*	454
Orange County*	268
Riverside County*	198
San Bernardino County*	253
San Diego County*	59
San Luis Obispo County*	12
Santa Barbara County*	13
Ventura County*	209
Colorado	151
Connecticut	96
District of Columbia	40
Delaware	32
Florida	1,005
Georgia	151
Hawaii	14
Idaho	72
Illinois	529
Indiana	241
Iowa	253
Kansas	162
Kentucky	156
Louisiana	241
Maine	39
Maryland	102
Massachusetts	163
Michigan	427
Minnesota	236
Mississippi	95
Missouri	243
Montana	46
Nebraska	96
Nevada	80

New Hampshire	53
New Jersey	82
New Mexico	129
New York	307
North Carolina	217
North Dakota	43
Ohio	691
Oklahoma	253
Oregon	83
Pennsylvania	349
Rhode Island	33
South Carolina	87
South Dakota	79
Tennessee	203
Texas	2,249
Utah	84
Vermont	18
Virginia	244
Washington	73
West Virginia	108
Wisconsin	173
Wyoming	40
Total U.S.	11,547

Source: U.S. DHHS/Medicare, www.medicare.gov/hhcompare/.

*The number of agencies that serve a county are shown. Since some agencies serve multiple counties, summing across counties will result in double-counting.

Appendix 5. Number of Agencies Listed in CarePathways.com Directory

State	Non-medical home care agencies (private pay only)	Medicare Certified home health agencies
Alabama	13	143
Alaska	7	15
Arizona	47	84
Arkansas	11	172
California	185	618
Colorado	38	133
Connecticut	44	83
District of Columbia	5	23
Delaware	12	17
Florida	146	774
Georgia	58	98
Hawaii	2	14
Idaho	10	49
Illinois	71	478
Indiana	37	184
Iowa	15	175
Kansas	21	131
Kentucky	23	101
Louisiana	16	220
Maine	8	29
Maryland	41	48
Massachusetts	67	126
Michigan	85	369
Minnesota	657	206
Mississippi	6	55
Missouri	25	164
Montana	10	36
Nebraska	8	68
Nevada	23	66
New Hampshire	13	36
New Jersey	76	49
New Mexico	10	65
New York	51	185
North Carolina	84	166
North Dakota	8	23
Ohio	140	457
Oklahoma	36	211
Oregon	11	57
Pennsylvania	120	290

Rhode Island	9	22
South Carolina	32	66
South Dakota	10	39
Tennessee	30	137
Texas	176	1,775
Utah	13	66
Vermont	2	12
Virginia	64	185
Washington	39	59
West Virginia	8	60
Wisconsin	43	126
Wyoming	3	27
Total U.S.	2,669	8,792

Source: Carepathways.com Directory, <http://carepathways.com/Facility Search-HC.cfm>, accessed 4/29/08.

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References used both specifically for our search for caregiving curricula and training programs and generally for other information provided in this report are listed in this appendix.

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Appendix 7. Online Search for Programs

This appendix lists the websites of major organizations included in our online search for caregiver curricula and training programs. Publications, links to other resources, and other information obtained from these websites were reviewed. Among the types of organizations included in this search are nonprofits with interests in family caregivers or paid caregivers, foundations, corporations and government agencies.

AARP Family, Home and Legal Program

<http://www.aarp.org/families>

Administration on Aging

<http://www.aoa.gov>

American Academy of Home Care Physicians

<http://www.aahcp.org>

American Association for Homecare

<http://www.aahomecare.org>

American Association of Homes and Services for the Aging

<http://www.aahsa.org>

American Geriatrics Society

<http://www.americangeriatrics.org>

American Health Care Association

<http://www.ahca.org>

The Archstone Foundation

<http://www.archstone.org>

The Atlantic Philanthropies

<http://www.atlanticphilanthropies.org>

California Community Colleges Health Occupations

<http://www.healthoccupations.org>

Carepathways.com

<http://www.carepathways.com>

Centers for Disease Control and Prevention

<http://www.atpm.org>

Center for Medicare and Medicaid Services

<http://www.cms.hhs.gov>

Consumer Consortium on Assisted Living

<http://www.ccal.org>

Department of Labor, Employment and Training Administration

<http://www.dol.gov>

Donald W. Reynolds Foundation

<http://www.dwreynolds.org>

Family Caregiver Alliance, National Center on Caregiving

<http://www.caregiver.org>

Henry J. Kaiser Family Foundation

<http://www.kff.org>

John A. Hartford Foundation

<http://www.jhartfound.org>

Johnson & Johnson Consumer Products Company

<http://www.strengthforcaring.com>

Medicare.gov

<http://www.medicare.gov>

MetLife Foundation

<http://www.metlife.com>

Mount Sinai Visiting Doctors

<http://www.mountsinai.org>

National Alliance for Caregiving (NAC)

<http://www.caregiving.org>

National Association of Area Agencies on Aging (n4a)

www.n4a.org

National Association for Home Care and Hospice (NAHC)

<http://www.n4a.org>

National Association of Local Long-term Care Ombudsman Program

<http://www.nalltco.org>

National Association of Professional Geriatric Care Managers

<http://www.caremanager.org>

National Family Caregivers Association

<http://www.thefamilycaregiver.org>

New York Business Group on Health, a subsidiary of the National Business Coalition on Health

<http://www.nybgh.org>

Office of Assistant Secretary for Planning & Evaluation

<http://aspe.hhs.gov>

Pfizer Inc.

<http://www.positiveprofiles.com>

PHI (formerly called Paraprofessional Healthcare Institute)

<http://www.paraprofessional.org>

Pioneer Network

<http://www.pioneernetwork.net>

Robert Wood Johnson Foundation

<http://www.rwjf.org>

Rosalynn Carter Institute for Caregiving

<http://rci.gsw.edu>

Service Employees International Union

<http://www.seiu.org>

United Hospital Fund

<http://www.uhfny.org>

Visiting Nurse Associations of America

<http://www.vnaa.org>

Visiting Nurse Service of New York

<http://www.vnsny.org>

Appendix 8. Call for Caregiver Curricula and Training Programs

Following is the Call for Caregiver Curricula and Training Programs that was widely disseminated for the environmental scan described in this report.

Boldface text represents areas where hyperlinks were inserted for respondents to obtain further information. An example survey, completed by the IHSS Consortium of San Francisco, is also included below.

Call for Caregiver Curricula and Training Programs

Are you training in-home caregivers, or are you aware of an organization that is? With the generous support of the UniHealth Foundation, the ILC-USA and **The Caregiving Project for Older Americans** are in the process of conducting a comprehensive review of caregiver curricula and training programs throughout the United States.

The findings from our survey will be used to highlight the importance of educating and training paid in-home caregivers, as well as improving understanding of best practices and opportunities for standardization.

The final report will include recommendations of a caregiver training task force comprised of distinguished experts from around the country, and will be widely circulated among journalists, policymakers, educational institutions, health care practitioners, and other interest groups.

If your organization trains paid caregivers to provide **in-home care of older adults**, please take a moment to **download and complete our very brief survey** (it should only take about 5 minutes) to ensure that your voice is heard. Programs that train people to work in institutional settings, or to care for younger disabled persons, are also eligible for the review as long as training for **in-home care of older persons** is provided.

Thank you in advance for taking the time to **complete our survey**, and for helping us to make sure that your voice is heard!

Read More About the Survey.

Example Response: IHSS Consortium, San Francisco

Please provide the following information about the caregiver curricula or training program.

1. Is the organization not-for-profit?

Yes

No

2. What type of organization is this?

- School
- College/University (4-year institution)
- Community college or other 2-year institution
- Cooperative extension
- Occupational and skills center
- Adult education center
- Other school (please specify)
- Home care agency
- Home health agency
- Hospital
- Area Agency on Aging
- Governmental agency
- Work Force Development
- Veteran's Administration
- Other governmental agency (please specify)
- Developer of training/educational resources
- Other (please specify)

3. Which of the following statements best describes the extent to which the curricula and/or training program focuses on the care of older people?

- The program is **exclusively** focused on the care of older people.
- While the **main focus** of the program is on the care of older people, the program **also** addresses the care of other populations.
- The main focus of the program is on the care of **populations other than older people**, although the care of older people is also addressed.
- The care of older people is **not addressed** by the program.

4. Does the organization hire the caregivers it trains to provide care?

- Yes
- No

5. Is the training program approved by a federal or state agency?

- Yes
- No

If YES—Please list the agencies:

6. Please select any of the following items that contribute to total revenue.

- A. Tuition or fees for training
- B. Sales of training materials
- C. Support from foundations, philanthropy, grants
- D. Medicaid
- E. Medicare
- F. Area Agency on Aging
- G. Workforce development agency
- H. Private insurance
- I. Out-of-pocket pay for services
- J. Parent institution provides support
- K. Other major sources of revenue (please specify): In Home Supportive Services Program – San Francisco, CA – which is funded through Federal, State and County \$. (Federal and State Medicaid).

7. Of the items indicated in **Question 6**, which represent the **two largest** sources of revenue? (Please indicate by letter A, B, C, etc.) D, K

8. What types of caregivers are trained by the program?

- Home health aide (skilled/medical)
- Personal care aide or home care aide (non-skilled/non-medical)
- Certified nursing aide (skilled/medical)
- Other (please specify)

9. Do you offer multiple levels of training, each building upon the previous level achieved?

- Yes
- No

If YES—Please list the levels:

10. How many people are trained per year by the program? 200-250

11. How many hours of training is offered by the program (for each level, if applicable)? 64 hours

12. Does the training program for paraprofessionals also address the needs of family members (or volunteers) who provide care?

- Yes
 No

If YES—Please select any of the following that apply:

- Train direct care paraprofessionals about interaction with families
 Provide training sessions to family caregivers
 Provide information or support to clients/families
 Provide a hotline for paid caregivers or families in the event of a problem/concern
 Other (please specify): Case Managers work with family members and clients on service needs and issues to remain at home.

13. How many years has the program been in existence? Home care training since 1994 - 2005 (minimum 24 hours). Current training program - 2 years.

14. Have any aspects of the program been professionally evaluated?

- Yes
 No

If YES—Please provide references (these may be appended): The Allied and Auxiliary Health Care Workforce Project, funded by the California Endowment identified and supported the development of innovative programs and would attract students and retain current workers in the allied health professions. The IHSS Consortium's project: Developing a Quality Workforce for the Urban Delivery of In-Home Supportive Services was chosen to be one of these programs. Our project – The Care Mentoring Program (now called the Peer Mentor Program – see question #16) – was evaluated as part of this Project. Reference: Allied Health Workforce – Innovations for the 21st Century, Center for the Health Professions, University of California, San Francisco, 2004.

15. Please select any of the following career development features that apply to the program.

- Job placement services
 Job or career counseling
 Continuing education, retraining or refresher courses
 Training for jobs up the “career ladder”
 Other (please specify) Vocational ESL, Customer Service training

16. If you wish, **briefly** describe any innovative or other features of the program. Since 2001, our training program has utilized peer mentors to do on-the-job training and home care provider skills evaluations. Besides our Vocational ESL and consumer services training, we provide greater in-dept training on specific topics – i.e. elder abuse, hoarders and clutterers, behavioral and substance abuse issues, etc. We also offer support groups to discuss handling of difficult client situations.

17. To whom may we send the final report of findings?

- Contact person and title
- Name of organization
- Address
- Telephone
- Email

THANK YOU!

We welcome additional materials about your program. (Please indicate any materials you want returned.) Additional materials may be either sent by **email**, **faxed** or **mailed** to Dr. Kenneth A. Knapp (contact information above).

About The Caregiving for Older Americans Project

The Caregiving Project for Older Americans is an action-oriented collaboration that aims to improve the nation's caregiving workforce through training, the establishment of standards, and the creation of a career ladder. Bolstering support for family caregivers is another goal of the project. A joint venture of the International Longevity Center-USA and the Schmieding Center for Senior Health & Education, the effort combines the talents of a policy research center with a clinical outpatient and health education program. To learn more about the project visit <http://www.ilcusa.org/prj/caregiving.htm>.

Appendix 9. Distribution List of Call for Curricula and Training Programs—Selected Listing

AARP Public Policy Institute
Administration on Aging
Alzheimer's Association
American Assoc of Homes and Services for the Aging
American Association for Caregiver Education
American Association for Homecare
American Association of Community Colleges
American Association of Retired Persons
American Geriatrics Society
American Health Care Association
American Nurses Association
American Red Cross Family Caregiving
American Society on Aging
Centers for Disease Control and Prevention
Center for Medicare and Medicaid Services
Department of Labor
Direct Care Alliance, The
Family Caregiver Alliance
Institute for the Future of Aging Services
Joint Commission, The
National Alliance for Caregiving
National Alliance for Direct Support Professionals
National Association for Direct-Care Workers of Color
National Association for Home Care and Hospice (including 50 State Associations of NAHC)
National Association for Practical Nurse Education and Service
National Association of Geriatric Nursing Assistants
National Association of Health Care Assistants
National Commission on Nursing Workforce for Long-Term Care
National Family Caregivers Association
National Federation of Licensed Practical Nurses
National Hospice and Palliative Care Organization
National Institute on Aging
National League for Nursing
National Network of Career Nursing Assistants
Office of Assistant Secretary for Planning and Evaluation
Paraprofessional Healthcare Institute, including its National Clearinghouse on the Direct Care Workforce
Research and Training Center on Community Living, University of Minnesota
Service Employees International Union
United Hospital Fund
Visiting Nurse Associations of America
Visiting Nurse Service of New York
Workforce Alliance, The

Note: This is not a complete list. In addition to the organizations listed, a wide variety of local and state worker associations, geriatric education centers, community colleges, caregiver training programs, area agencies on aging, caregiving experts and other stakeholders were contacted. Approximately 650 individuals and organizations were sent the call for curricula and training programs.

Appendix 10. Detailed summary of responses to call for programs survey

Key to Summary of Responses. Questions across top row (heading) of the summary refer to the survey questions (see example survey in Appendix 8). Answers provided in the columns are indicated with the numbers or letters provided below.

3. Which of the following statements best describes the extent to which the curricula and/or training program focuses on the care of older people?

1= The program is exclusively focused on the care of older people.

2= While the main focus of the program is on the care of older people, the program also addresses the care of other populations.

3= The main focus of the program is on the care of populations other than older people, although the care of older people is also addressed.

4= The care of older people is not addressed by the program.

4. Does the organization hire the caregivers it trains to provide care?

Y= Yes

N =No

5. Is the training program approved by a federal or state agency?

Y= Yes

N= No

6. Please select any of the following items that contribute to total revenue.

A= Tuition or fees for training

B= Sales of training materials

C= Support from foundations, philanthropy, grants

D= Medicaid

E= Medicare

F= Area Agency on Aging

G= Workforce development agency

H= Private insurance

I= Out-of-pocket pay for services

J= Parent institution provides support

K= Other

7. Of the items indicated in Question 6, which represent the two largest sources of revenue? (Please indicate by letter A, B, C, etc.) These are indicated by asterisks in the summary table.

8. What types of caregivers are trained by the program?

1= Home health aide (skilled/medical)

2= Personal care aide or home care aide (non-skilled/non-medical)

3= Certified nursing aide (skilled/medical)

4= Other

9. Do you offer multiple levels of training, each building upon the previous level achieved?

Y= Yes

N= No

10. How many people are trained per year by the program?

11. How many hours of training are offered by the program (for each level, if applicable)?

HHA= Home Health Aide

PCA= Personal Care Aide

HCA= Home Care Aide

CNA= Certified Nursing Assistant

12. Does the training program for paraprofessionals also address the needs of family members (or volunteers) who provide care?

Y= Yes

N= No

If YES—Please select any of the following that apply:

1= Train direct care paraprofessionals about interaction with families

2= Provide training sessions to family caregivers

3= Provide information or support to clients/families

4= Provide a hotline for paid caregivers or families in the event of a problem/concern

5= Other

13. How many years has the program been in existence?

15. Please select any of the following career development features that apply to the program.

1= Job placement services

2= Job or career counseling

3= Continuing education, retraining or refresher courses

4= Training for jobs up the “career ladder”

5= Other

Note: Y* means that agency [Q.5] (or level [Q.9]) was reported; A* or C*, etc shows the largest source of revenue (Replies received by 08/26/2008)

Nos	Organization	State	3. Focus on care of elderly	4. Hiring of trained caregivers	5. Fed or State agency approved TP	6 - 7. Revenue sources	8. Types of caregivers trained	9. Multiple levels of training	10. Nos of people trained/year	11. Nos of hours offered by TP	12. Family members or volunteers	13. Nos of years TP is existing	15. Career development features
(1) Community College or other 2-year institution a) Not-for-PROFIT													
1	American River College, Sacramento	CA	1	N	Y*	A*	1, 3	Y*	60	CNA: 63+135 HHA: 27+27	N	18+	4
2	Feather River Community College, Quincy	CA	1	N	Y*	A*, K*	1, 2, 3	Y*	CNA: 25 LVN: 30 (in 2 yrs)	CNA: 124 HHA: 40 LVN: 1,531 IHC: 21	Y (2)	CNA: 20+ LVN: 15 HHA & CA: pending	4
3	Macomb Community College, Center for Continuing Education, Warren	MI	1	N	N	A*, G	2	N	35-50	42	Y (1, 2)	3	3, 4
4	Middlesex County College, Professional & Community Programs, Edison	NJ	1	N	N	A*	4*	N	10 (enrolled this yr)	78	Y (1, 2, 3)	Spring 2008 - 1st semester	2, 3, 4
5	Portland Community College	OR	1	N	Y	A*, C, G, K*	1, 2, 3	Y*	150-300	Work based: 36 units/level (2 levels) Offers 10-15, 2-3 hr classes/term. 1-yr certificate: 46 term credits AAS Degree: 90 credits	Y (5*)	1	2, 3, 4, 5*
6	Lackawanna College, Scranton	PA	1	N	Y*	A*, G*	1, 2	Y*	40	EC: 45 NA: 200	Y (1, 2, 3)	2008 - 1st year	1, 2
7	Workforce Service, Piedmont Virginia Community College, Charlottesville	VA	1	N	Y*	A*, C*, F, G, J, K	1, 2	Y*	50 (It's 1st yr)	CA: 18 PHA: 42	Y (1, 2, 3, 4, 5*)	2008 - 1st year	1, 2
8	Southwestern Community College, Creston	IA	2	N	Y*	A*, G*, J	3	Y*	no data	CNA: 75+10 CMA: 40+20 RA: 60	Y (3)	19	3, 4
9	Greenville Technical College, BMC 184	SC	2	N	Y*	A*, C	1	Y*	50 RCC - new	60	N	1	2
10	Brookdale Community College, Lincroft	NJ	2	N	N	A*, G	1	N	100	75	N	15	1, 2
11	Neosho County Community College, Chanute	KS	2	N	Y*	A*, C, G*	1, 2, 3	Y*	no data	CNA: 90 PHA: 13 HHA: 24	Y (1, 2, 3)	20+	3, 4
12	Clark College, Vancouver	WA	2	N	Y*	A*	1	N	1,240	Fundam-s: 28 Safety TP: 4 Cont-ous: 10	Y (2)	11	3
13	Spokane Falls Community College, Gerontology Dpt, Spokane	WA	2	Y	Y	A*, K*	1, 2, 4*	Y*	30	1 course: 55 (3 courses)	Y (1)	25	1, 2, 3, 4
14	Tulsa Community College	OK	1	N	Y	A*, G, J*	3	Y*	~75	Level 1: 32 Level 2: 32 Level 3: 128	Y (1)	5	1, 4
15*	Kenosha Co. LTC Workforce DHS, Kenosha	WI	2	N	Y	D*, E*	2	Y	120 60 (1/2 yr)	40 +	Y (1, 2, 3)	New	2, 3, 4
* - It could be also classified as (7) HCA, (8) HHA, and (11) GWTD													
16	The University of New Mexico - Valencia Campus, Los Lunas	NM	3	N	Y	A*, B, C, G*, I	1, 2, 3, 4*	Y*	60	CMA: -- PCA: 80	Y (1)	CNA: 11 PCA+CMA: New	2, 4

Note: Y* means that agency [Q.5] (or level [Q.9]) was reported; A* or C*, etc shows the largest source of revenue (Replies received by 08/26/2008)

Nos	Organization	State	3. Focus on care of elderly	4. Hiring of trained caregivers	5. Fed or State agency approved TP	6 - 7. Revenue sources	8. Types of caregivers trained	9. Multiple levels of training	10. Nos of people trained/year	11. Nos of hours offered by TP	12. Family members or volunteers	13. Nos of years TP is existing	15. Career development features
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(1) Community College or other 2-year institution

b) For-PROFIT

1	Quinebaug Valley Community College, Danielson	CT	1	N	Y*	A*, G*	3	N	100-115	110	N	15+	2
2	Ann Arundel Community College, Arnold	MD	1	N	Y*	A*	1,2	N	Starts in summer 2008	130	Y (1,2,3)	Starts in summer 2008	3
3	Technical College of the Lowcountry, Beaufort	SC	1	N	Y*	A, J, I	3	N	125+	100	Y (1)	19	1,4
4	Morgan Community College, Fort Morgan	CO	2	N	Y*	A	3	Y*	20	NA: 100	Y (1)	NA: 30	3,4

(2) Other Schools

a) Not-for-PROFIT

1	University of California, Cooperative Extension, Sacramento	CA	1	N	Y*	...	4*	N	200	16	N	5	3
2	TTUHSC Garrison Institute on Aging, Lubbock	TX	1	N	Y*	A*, C*, J	3	N	100	80	N	4	3
3*	Institute on Community Integration (UCEDD), University of MN, Minneapolis	MN	3	N	Y*	B	1, 2, 3, 4*	N	68,000 (per day)	CDS - 240	Y (1, 2)	8 (4 - on market)	3, 4, 5*

3* - It could be classified also as (14) DTER and (15) Other

4	Bethleem AVTS, Bethleem	PA	2	N	Y*	A*, C*, F*, G	1, 2	Y*	12	64	Y (1)	< 1year	1, 2, 3, 4
5	Golden Care Academy, San Diego	CA	2	N	Y	B, C*, I, K*	1, 3	N	CNA: 120 CHHA: 40-50 CEV: 160	CNA: 255 CHHA: 40 CEV: 6-24	Y (1)	12	3,4
6	Direct CareGiver Association	AZ	2	Y	Y	A*, C*, K	3, 4	N	132	200	N	6	1

(3) Home Care Agency

a) Not-for-PROFIT

1	Child & Family, Middletown	RI	1	Y	Y*	D*, F*, I	4*	N	0 (in 2007)	25	Y (1, 3)	40	3
2	In Home Supportive Services Consortium, San Francisco	CA	2	Y	N	D*, K*	2	N	200-250	64	Y (1,2,3,4)	HCT: 13 Current: 2	5*
3	Home Care Partners, Washington	DC	2	Y	Y*	A, C, J, K*	2	N	50-100	HCA: 75	Y (1,2,3)	Agency: 50 TP: 20+	1, 3, 4
4	Virginia Association for Home Care & Hospice, Richmond	VA	2	N	N	A*, B, I*	1, 2, 3	N	500+	60+	Y (1,2,3)	25	3
5	Senior Action Service	IL	1	N	N	C*, I*	2	N	~150	8 hrs in first yr, subsequent yrs: 12 hrs	N	New	?
6	Companions for Seniors, Chicago	IL	2	Y	N	?	1, 2, 3	?	15-20	3 hrs + mandatory continuing ed. classes	?	3,5	?

(3) Home Care Agency

b) For-PROFIT

1	Orange Grove Home Care	CA	2	Y	N	I*	2	N	5 to 10	4 hours per person min	Y (3, 4)	2.5	no data
2	Seniors Choice at Home, Plymouth	MN	1	Y	N	I*	2,4*	N	20	4+	Y (2)	13	no data
3	ARMISTEAD INC [See e-mail]		2	Y	N	H, I	2	N	40	40	Y (1,2)	4	3

Note: Y* means that agency [Q.5] (or level [Q.9]) was reported; A* or C*, etc shows the largest source of revenue (Replies received by 08/26/2008)

Nos	Organization	State	3. Focus on care of elderly	4. Hiring of trained caregivers	5. Fed or State agency approved TP	6 - 7. Revenue sources	8. Types of caregivers trained	9. Multiple levels of training	10. Nos of people trained/year	11. Nos of hours offered by TP	12. Family members or volunteers	13. Nos of years TP is existing	15. Career development features
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(4) Home Health Agency

b) Not-for-PROFIT

1	Jewish Home	NY	2	Y	Y	D*, E*	1, 3	Y*	?	individual basis, no set hours	Y (1, 2, 3, 4)	?	1, 2, 3, 4
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(4) Home Health Agency

b) For-PROFIT

1	HelpSource Home Health Services	PA	2	Y	Y*	D, E, F, H,	1, 2	N	varies	75	Y (1, 3)	4	1, 3
2	ElderWise, Inc. Middlebury	VT	1	N	Y	A, K*	4*	N	New TP	70-75	Y (1,2)	TP: 11 NE: < 1	1, 2, 3

(5) Area Agency on Aging

a) Not-for-PROFIT

1	Middle Alabama Area Agency on Aging, Calera	AL	1	N	Y	D, F	4	Y	15	8	Y (2,3)	25	no data
2	Care Love Link, North Little Rock	AR	1	Y	Y*	C*, D*, F, H, I	2	N	250	40	Y (2,3, 4)	4	1, 2, 3, 4
3*	Area Agency on Aging of WC Arkansas, Hot Springs	AR	2	Y	N	D*, F, H, I*, J	2	N	20 - 30	40	N	15	3

* - Organization classified itself as (7) HCA

4	DeSoto Council on the Aging, Inc Mansfield	LA	2, 3	Y	Y*	C, D*, F, K	2	Y*	30	20	Y (3)	10+	3
5	Cape Fear Area Agency on Aging, Wilmington	NC	1	N	N	A, F*	1, 2, 3	N	100	4 - 4.5	Y (1)	7	3
6	Community Action Team, St. Helens	OR	1	Y	Y	F*	2	N	10 - 15	3 - 6	Y (2,3)	10	no data
7	Upper Arkansas Area Agency on Aging, Region XIII, Salida	CO	2	N	N	A*, F*	4*	N	50	2 - 4	Y (1, 2, 3, 5)	30	3
8	NYC Department for the Agig, New York	NY	2	N	Y*	F*, K*	2	N	250	WEP: 245 Other: 105	Y (1, 3, 4, 5*)	19	1, 3, 5*
9	Development District Area Agency on Aging & Disability, Cookville	TN	3	N	Y*	C*, F*	2	N	20	30	Y (1, 2, 3, 4)	20	1, 2

(6) Governmental Agencies:

a) Not-for-PROFIT

1	Mountain Caregiver Resource Center, Chico	CA	2	N	Y*	J	2	N	40 - 50	12	Y (1, 2, 3, 4)	13	1, 2
2	Department of Health and Human Resources, Augusta	ME	2	N	Y*	B, D*, G, I	1, 2, 3, 4*	Y*	CRMA: 4,875 DSP: 1,000 PSS: 720 BHP: 150 RFA: 150	CRMA: 24-40 DSP: 45 PSS: 50 BHP: 57 RFA: 72 MHSS: 35 CNA: 150 CNA-M: 120	Y (1, 2, 3, 4)	Private: about 27 through the State: since 2003 for PSS & CRMA	3, 4

(6) Governmental Agencies:

b) For-PROFIT

1	Office of Aging and Adult Services, City of Alexandria	VA	1	Y	N	no data	2, 4*	N	50-100	10	Y (1, 2, 3)	1	3
2	NC DAAS, Raleigh	NC	2	N	no data	A, F, K	4*	no data	100+	18	Y (2)	6	no data

Note: Y* means that agency [Q.5] (or level [Q.9]) was reported; A* or C*, etc shows the largest source of revenue (Replies received by 08/26/2008)

Nos	Organization	State	3. Focus on care of elderly	4. Hiring of trained caregivers	5. Fed or State agency approved TP	6 - 7. Revenue sources	8. Types of caregivers trained	9. Multiple levels of training	10. Nos of people trained/year	11. Nos of hours offered by TP	12. Family members or volunteers	13. Nos of years TP is existing	15. Career development features
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(7) Developer of Training/Educational resources

a) Not-for-PROFIT

1	Workers of Color, Inc South Bend	IN	2	N	N	A*, B, F, G*	1, 2, 3, 4	N	250	no data	Y (1, 2, 3)	5	1, 2, 3, 4
2	PHI . Bronx New York	NY	2	N	Y*	C*, J*	1, 2, 3	Y*	no data	PCW: 77 HHA: 140	N	no data	5*
3	Partners in Care	NY	2	Y	Y*	B, D*, E*, G, H, I	1	Y	about 2500/yr	beginner: 16 days, 114 hrs. intermediate: 6 days, 40 hrs. certified aides:	N	25	1, 3

(7) Developer of Training/Educational resources

b) For-PROFIT

1	HealthCare Interactive, Inc Minneapolis	MN	1	N	N	B*	1, 2, 3, 4	Y*	Log-in: 7,008 Trained: 1,160	6 + 7	N	2	no data
2	Home Care Companion, Medford	OR	2	N	N	B*	2, 4*	N	Tens of thousands	HC TP: 21 PCA TP: 40	Y (1, 2, 3)	HC TP: 8 PCA TP: 4	3, 4, 5*
3	College of Direct Support, Knoxville	TN	3	N	Y*	B*, D*	1, 2, 3, 4	Y*	no data	CNA: 70 DSP: 90 Super: 22 GNICEV: 22	Y (1, 2, 5*)	11 (Marketing - 4)	3, 4

(8) Other institutions

a) Not-for-PROFIT

1	Schmidling Center for Senior Health Education, Springdale	AR	1	N	Y*	A*, B, C*, I	4*	Y*	100-300	PCA: 25 HCA: 50 EP: 25 DA-DM: 15	Y (1, 2, 3, 4, 5*)	9	2, 3
2	California Association for Health Services at Home	CA	2	N	Y*	A*, B*	1, 2	Y*	New program	75 total, broken into 3 levels	Y (5*)	new program	3, 4
3	Center for Advocacy for the Rights and Interests of the Elderly, Philadelphia	PA	1	N	Y*	A, B, C*, F*, K*	1, 2, 3	N	300	no data	no data	30	4, 5
4	United Way of the Greater Lehigh Valley	PA	2	N	N	C*	1, 2	N	40	48	Y (1)	2	no data
5	Indiana Association for Home & Hospice Care, Inc Indianapolis	IN	2	N	N	A, B, C	1, 2, 4*	Y*	New program	no data	Y (1, 3)	Starts in July 2008	1, 4
6	Massachusetts Council for Home Care Aide Services, Inc Boston	MA	2	N	Y*	B*, K*	1, 2	Y*	Supportive training (not direct)	PCH: 60 HHA: 75 HM: 40 SH CA: 90	Y (1)	41	3, 4
7	The SKILL Center, New York	NY	2	N	Y*	C*, G*, K	1, 2	N	500	160+28	Y (1)	CHCA: 20 SKILL: 1.5	1, 2
8	LEAP, Cleveland	OH	2	N	Y*	A*, C*, G	1, 2, 3, 4*	Y*	Varies	HHA: 100 STNA: 100	Y (1, 3, 5)	18	1, 2
9	OHL, Brewer	ME	3	Y	Y*	A*, D*	1, 2	Y*	200	50	Y (1, 2, 3)	5	4
10	Oregon Home Care Commission, Salem	OR	5	N	Y*	K*	4	N	2,000+ (Since Jan.2006)	no data	no data	2	no data
11	Legacy Health System, Portland	OR	2	N	N	A*, K*	2	N	70	17	N	20+	3

(8) Other institutions

b) For-PROFIT

1	Bridge Builders, Ltd Seakim	WA	2	N	Y	C	2	Y	80	32	N	< 1	no data
2	Advocate, Irvine	CA	2	N	Y/N	C*, F*	1, 2, 3, 4*	N	4,000	2 - 4	Y (1, 2, 3)	7	no data
3	Eldercare Training Associates	MA	2	N	N	A*, B, I	1, 2, 3, 4	Y*	75-100	3-6 hours for single course	Y (1, 2, 3, 5)	1	3, 4

Appendix 11. Summary of the Types of Organizations that Responded to the Call for Curricula and Training Programs

Organization Type	Number of Responses
Community College	20
Other School*	6
Home Care Agency	9
Home Health Agency	3
Area Agency on Aging	9
Governmental Agency	4
Developer of training or educational resources	6
Other Institution	14
Total	71

*Other schools include 4-year colleges or universities, cooperative extensions, occupational & skill centers, adult education centers, etc.

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