Jobs to Careers

Transforming the Front Lines of Health Care

Practice Brief

Part of a series of reports and practice briefs on advancing and rewarding the skill and career development of incumbent workers providing care and services on the front lines of our health and health care systems

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Jobs to Careers in Community-Based Care

Case Study of an Oregon Project To Improve the Quality of Elder Caregiving

By Randall Wilson and Charles Goldberg

Robert Wood Johnson Foundation

THE HITACHI FOUNDATION

JOBS FOR THE FUTURE

Jobs to Careers

Transforming the Front Lines of Health Care

Jobs to Careers explores new ways to help frontline health care workers get the skills they need to provide quality care and build sustainable careers. It helps health care providers improve the quality of patient care and health services by building the skills and careers of their frontline employees.

Through *Jobs to Careers*, health care employers build strong partnerships with education institutions and other organizations to change the way frontline employees are trained, rewarded, and advanced. Career paths are developed and made readily available to frontline employees. Employer and education partners make systematic changes that better recognize the needs of working adults and that improve access to and success in skill-building programs.

A hallmark of *Jobs to Careers* is work-based learning: frontline employees master occupational and academic skills in the course of completing their job tasks and fulfilling their day-to-day responsibilities. While working full time, frontline employees enter college and earn academic credit for workplace training. Other learning approaches in *Jobs to Careers* include technology-enabled, experience-based, and traditional worksite and off-site learning.

To realize the unique *Jobs to Careers* approach to learning, employers and educators implement systems changes, such as:

- *At the workplace:* Developing new job positions and responsibilities; deeply involving supervisors in employee training and career development; and offering paid release time, pre-paid tuition assistance, job coaching, and mentoring.
- *At the educational institution:* Providing college credit for work-based learning, prior learning, and entry-level health care credentials; offering accelerated and part-time degree and certificate programs; contextualizing college preparatory math and English courses to health care concepts and job tasks; and appointing professional staff from health care employers to be adjunct college faculty.

Jobs to Careers moves everyone toward a healthier future. Frontline employees receive rewards for building skills and expanding knowledge necessary for their current jobs and qualifying them to advance to new positions. Employers build and retain talented and committed employees, while bolstering a workplace culture that supports professional development, mentorship, and collaboration across the entire health care team. And health care consumers receive high-quality care and services, delivered by a high-quality workforce.

Jobs to Careers is a $15.8 million initiative of the Robert Wood Johnson Foundation and the Hitachi Foundation, with additional support from the U.S. Department of Labor. Jobs for the Future manages the initiative. Seventeen partnerships representing hospitals, community health centers, long-term care, and behavioral health received multiyear *Jobs to Careers* grants.

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Executive Summary

This case study explores a project in Oregon to improve the work of elder caregivers in community-based settings. Launched in 2006, *Jobs to Careers in Community-Based Care* is a collaboration among Portland Community College, five Portland-area assisted living facilities, and two health care industry associations. It is one of seventeen projects in *Jobs to Careers*, a national initiative that is creating ways to support the career development of frontline health care workers by blending education and work.

The Portland project is a timely response to the convergence of several pressing factors: an aging population, growing demand for community-based alternatives to nursing homes, the more complicated care needs of today's elders, and an increasingly prescriptive regulatory setting. The project is creating standardized training—grounded in a comprehensive, competency-based curriculum—in an environment that has had few, if any, formal models or practices for training. Community-based care also traditionally has lacked opportunities for direct care workers to increase their skills and advance to higher-paid positions or career paths.

Addressing these gaps, *Jobs to Careers* offers a model of potential benefit to care providers and their employees, as well as consumers and their families. Employers stand to benefit from better worker retention, less turnover, and higher-quality care that attracts new customers. Workers benefit by gaining confidence in performing their jobs, certification for potential wage and career advancement, and better awareness of career and educational options, along with financial assistance to pursue them. Residents and families benefit by having caregivers with the skills and knowledge to provide quality services in a safe and supportive, homelike environment.

PROJECT OVERVIEW

To enhance job skills and career development options for unlicensed, non-certified direct care workers in assisted living facilities, the partners in *Jobs to Careers in Community-Based Care* undertake four main activities:

- Designing and providing work-based training for direct care workers;
- Training supervisors and other workplace staff to deliver the training and reinforce learning on the job;
- Supporting career development through counseling and tuition assistance for workers who wish to pursue further education; and
- Creating certificate programs at the community college as a bridge for direct care workers seeking to advance in community-based care or other health care careers.

Jobs to Careers in Community-Based Care builds on several Portland-area collaborations that had identified the competencies needed for direct care workers in assisted living—a critical step toward creating career ladders for workers to advance. Based on extensive discussions with employers and direct care workers, consortium members analyzed the tasks performed and the competencies required in entry-level, unlicensed direct care positions. They codified the first- and second-rung occupations as "Resident Assistant I" and "Resident Assistant II." A curriculum developed for training resident assistants in the competencies now forms the nucleus for *Jobs to Careers in Community-Based Care*.

IMPLEMENTING CHANGE IN COMMUNITY-BASED CARE

Portland's project is ambitious. By integrating training into the workplace, it aims to improve the skills of every direct care worker (as well as support staff, such as housekeepers, in some cases) in five facilities. In addition, it seeks to support the career development of caregivers by: training supervisors as coaches and changing employer practices, such as tuition assistance policies; developing career pathways through community college certificate programs; and providing college credit for work-based learning. Ultimately, it seeks to establish Resident Assistant I and II as industry-recognized credentials.

Integrating Training into the Workplace: To support the workplace component of the curriculum, each assisted living facility designated a point person responsible for a variety of assignments: scheduling trainings and other activities; providing release time to workers and supervisors for training; recognizing workers who obtain certification as Resident Assistant I or II; and changing organizational policies and procedures to support career development.

Bringing College to the Workplace: To establish educational pathways for community-based care, project members from Portland Community College's Gerontology Program convinced the college to award credit to those completing the Resident Assistant curriculum through workplace training. The partners also worked with PCC to develop short-term credentials in specialized topics of aging.

Preparing for Career and Educational Development: Providing opportunities for community-based care workers to earn short-term credentials introduces adults to college coursework and achievement. Supervisors learn about career coaching methods and receive resource materials they can share with direct care workers. Caregivers receive workbooks with tools for researching career choices, guidance for "informational interviews," and other supports. Supervisors then assist workers with developing their own individual career development plans.

LESSONS LEARNED

The team of workplace and college-based staff for *Jobs to Careers in Community-Based Care* has made substantial progress toward formalizing and deepening the training of community-based caregivers. Moreover, the five work sites have adapted material to fit specific needs of their resident and employee populations.

In addition, Portland Community College has conducted workshops on career management for supervisors and caregivers in the participating assisted living facilities. These have encouraged further education by offering tuition assistance up front, rather than reimbursing workers after they complete a course. All participants in *Jobs to Careers*, whether or not they enroll formally in college courses, will soon receive credit toward certificates and degrees in gerontology, based on an agreement with the college to accept competency-based requirements fulfilled at the workplace.

Perhaps most significant has been the engagement of employers, who award employees completing the curriculum with certificates signed by the state's major long-term care employer associations. In addition, managers, supervisors, and trainers report promising signs of progress toward a higher standard of care for residents, greater confidence and morale for workers, and a model for training that is uniquely adapted for those providing care in community-based settings.

The progress of the project points to several important lessons:

- The systematic training of direct care workers can potentially contribute to higher-quality care and greater resident satisfaction.
- Training for community-based care requires curricula tailored to the particular caregiving environment.
- Training at the workplace, embedded in the real demands of the job, can help foster a culture of learning throughout the organization.
- Comprehensive instruction at the workplace can contribute to increased job satisfaction for direct care workers.
- Implementing a comprehensive curriculum is challenging but doable.
- Bridging the direct care workplace with higher education can generate greater interest and engagement in career development.

Portland's project matters because quality, person-centered care matters. With an aging population—one more demanding of home or community-based care in lieu of traditional nursing home care—a well-trained workforce is essential. Building that workforce requires consistent, competency-based standards for the delivery of training.

At the same time, standardized training must be flexible enough to match the needs of residents in the homelike environment of assisted living. If those providing care are to be motivated and retained, they need quality jobs that offer progression to higher-skilled jobs and college-level certificates and degrees.

Jobs to Careers in Community-Based Care: Case Study of an Oregon Project to Improve the Quality of Elder Caregiving

Introduction

More and more aging Americans are choosing to live at home longer or in residential facilities rather than moving to nursing homes. At the same time, the nation has made considerable progress on developing a model of residential care that allows older people needing assistance to retain greater freedom, dignity, and comfort than that allowed in traditional long-term care facilities. However, there has been decidedly less progress in making the work of residential caregivers rewarding in terms of wages, job satisfaction, education, or skill development (Kemper et al. 2008; Stott et al. 2007; Maas & Buckwater 2006).

This case study explores a project in Oregon to improve the work of caregiving in community-based settings for elders. *Jobs to Careers in Community-Based Care* is based in five Portland-area assisted living and residential care facilities for elders, in cooperation with Portland Community College. It is one of seventeen projects in *Jobs to Careers*, a national initiative that is creating novel ways to provide work-based learning for frontline health care providers, to improve the quality of care they give, and to support their career development. The Oregon project was conducted over three years, ending in September 2009.

The Oregon *Jobs to Careers* project has taken shape within an increasingly prescriptive regulatory setting. It is a timely response to the convergence of several pressing factors: the aging of the population, the growing demand for community-based alternatives to nursing homes, the more complicated care needs of today's residents, and the more exacting requirements of state regulators.

The project is also significant for creating standardized training—grounded in a comprehensive, competency-based curriculum—in an environment that has had few, if any, formal models or practices for training. Community-based care also traditionally has lacked opportunities for direct care workers to increase their skills and advance to higher-paid positions or career paths. By addressing these gaps, *Jobs to Careers* offers a model of potential benefit to care providers and their employees, as well as to consumers and their families.

Employers stand to benefit as worker retention increases, turnover costs are reduced, and care improves—all of which can attract new customers. Workers benefit by gaining confidence in their job performance, opportunities to earn certification that may increase wage and career advancement, and awareness of career and educational options, as well as financial assistance to pursue them. Residents and families benefit by having caregivers with the skills and knowledge to provide resident-centered care in a safe and supportive, homelike environment.

To place the Portland project in context, this study retraces the origins of community-based care, and assisted living in particular, through policy developments in Oregon. This state's experience has presaged broader national trends toward community-based care and away from reliance on medically based institutional care. And Oregon's evolving regulation of the assisted living

workforce—in the formality, scope, and content of training for job candidates—also points to national issues for direct care workers. The experience of *Jobs to Careers in Community-Based Care* has built on this foundation to develop standardized training and common credentials for an occupation that previously lacked them.

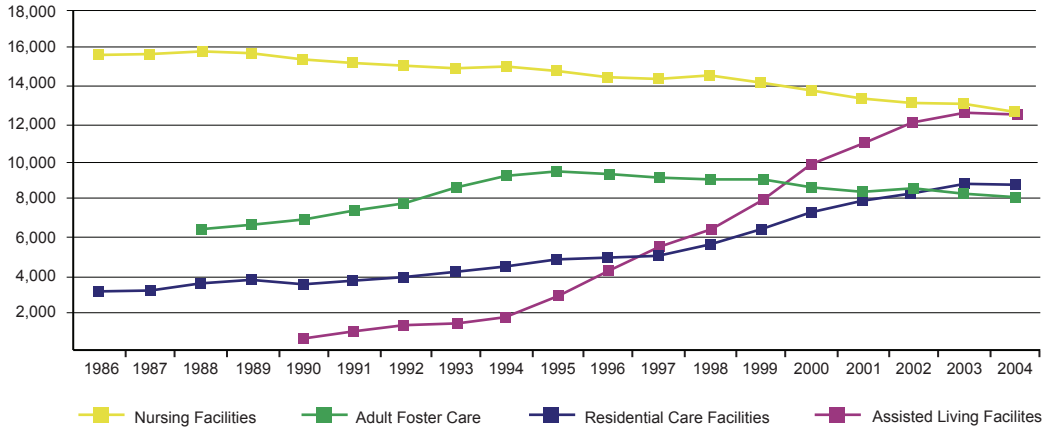
Assisted Living:
The Concept and Its Development

Every year, more Americans reach a point in their lives where they no longer can live independently. While they do not need around-the-clock nursing care, they do need help with certain daily activities, such as bathing, dressing, or taking medications. To meet those needs, they turn either to personal assistants in their own homes or to a variety of community-based, group-residential options. Assisted living, one of the most popular of these community options, provides needed services while preserving individual privacy, independence, dignity, and choice.

The assisted living model emerged in Oregon during the 1980s as part of a statewide policy to reform the long-term care system for the elderly and disabled. In 1981, state legislation called for the consolidation of services to the elderly under a single administrative agency and mandated that those services be provided in the least restrictive and least institutional setting possible (Gulyas 2002; National Health Policy Forum 2000; Sparer 1999; Kutza 1998). At the same time, Oregon received the first-ever 1915(c) waiver from the federal government, allowing it to use Medicaid nursing care funds to pay for home-based and community-based services for the elderly and disabled.

With these administrative reforms in place, the state encouraged the development of a variety of community-based residential models for elders and other adults, including those with physical or developmental disabilities. In each case, residents receive a range of services, ranging from help with housekeeping, transportation, and money management to assistance with personal care needs, depending on individual need. Unlike nursing homes, the service model

Figure 1:
Long-Term Care Beds in Oregon by Licensed Setting, 1986-2004



emphasizes personal independence over hospital-like medical care, as found in traditional nursing homes:

- Adult foster care, providing home-like settings for five or fewer unrelated adults.
- Residential care facilities, with 24-hour assistance for six or more residents.
- Assisted living facilities, which are residential care facilities that offer individual apartments with private baths, kitchens, and lockable front doors.

In 1989, the state issued its first regulations for licensing assisted living facilities.[1] To encourage both nonprofit and for-profit organizations to develop facilities, Oregon used federal and state funds to offer low-interest loans to underwrite construction. The state also set the Medicaid rates for low-income residents in assisted living facilities at a level comparable to private-pay rates.

In this climate of reform, community-based care options for the elderly grew rapidly. The number of beds in assisted living facilities rose from less than 700 in 1990 to almost 12,700 by 2004, with the supply more than tripling between 1995 and 2000 alone *(see Figure 1 on page 2)*. The rise in assisted living facilities and residential care facilities was accompanied by a decline in nursing home beds—from 15,500 in 1986 to 12,600 in 2004 (Hernandez 2007).

As of 2004, 63 percent of Oregon's Medicaid long-term care clients were receiving care in community-based facilities while 37 percent were in nursing facilities—a reversal of the situation in 1990, when 31 percent were in community-based care and 69 percent were in nursing homes (Hernandez 2007). In 2005, Oregon ranked first in the country in the percentage of Medicaid long-term care expenditures (50 percent) going to home- and community-based services (Houser et al. 2006).[2]

Over the past 20 years, many states have followed Oregon's lead in developing and licensing assisted living options for the elderly. Definitions of "assisted living" vary across the states, but certain core elements are common (National Center for Assisted Living 2008):

- Assisted living facilities are congregate residential settings that provide or coordinate personal and health-related services, with 24-hour supervision and assistance (scheduled and unscheduled) with at least one staff member awake at all times.
- They are designed to minimize the need to move by accommodating residents' changing needs and preferences.
- They are designed to maximize residents' dignity, autonomy, privacy, socialization, independence, choice, and safety.
- They are designed to encourage family and community involvement.
- They provide assistance in maintaining and enhancing the physical, emotional, intellectual, social, and spiritual well-being of residents, based on individual preferences.

In 1998, the 50 states and Washington, DC, reported a total of 28,131 assisted living facilities, with 612,063 beds or residential units (Mollica 1998). By 2007, the total number of facilities had increased 36 percent, to 38,373, and the number of beds or residential units had increased 59 percent, to 974,584 (Mollica et al. 2007).

THE REGULATORY SETTING

The regulations certifying nursing assistants to work in Medicaid-funded care facilities are more prescriptive than those governing assisted living caregivers. While the minimum training in skilled nursing facilities is just 75 hours followed by 12 hours of annual in-service trainings, this certification represents a nationally recognized credential and a "floor" for basic skills and knowledge.

Assisted living is different. There is no particular credential requirement, such as "certified nursing assistant," to work in assisted living, although some facilities do employ CNAs. Training requirements vary from state to state *(see Appendix II)*.

> *Jobs to Careers in Community-Based Care* is designed to enhance job skills and career development options for unlicensed, non-certified direct care workers in assisted living facilities in Oregon.

In Oregon, regulations established in 1989 required that caregivers receive orientation in specific topics, such as principles of assisted living and activities of daily living, but they did not stipulate the number of hours devoted to orientation. The state also did not require a minimum level of training on the job, through in-service instruction.

In the two decades that have followed, resident acuity has risen, but residents have more complicated care needs. In addition, researchers and advocates for the community-based care workforce have recognized the need to formalize training and certification (Menne et al. 2007; Maas & Blackwater 2006). Doing so would both help employers provide a more consistent level of care, and offer caregivers a path to higher skills and transferable credentials. New regulations in Oregon, responding to increased care needs of residents, now require direct care staff to demonstrate knowledge and proficiency in a wider variety of areas. These rules, effective in 2008, also require a minimum of 12 hours of in-service training on topics relevant to community-based care.

Project Overview

Jobs to Careers in Community-Based Care is designed to enhance job skills and career development options for unlicensed, non-certified direct care workers in assisted living facilities in Oregon. Launched in 2006, JCCBC began as a collaboration among Portland Community College, two Portland-area assisted living facilities, and two health care industry associations. Three more assisted living facilities joined the project in January 2008. The project is managed by the college's Customized and Workplace Training Department, which collaborates with the Department of Gerontology. The project's five employer partners implement the training for their direct care workers and assist in governing the project. Statewide employer associations also participate in governance and in outreach to providers.

- *Lead Partner, Fiscal Agent:* Portland Community College. Develops training materials; provides career exploration workshops for caregivers; develops new certificates of completion; develops opportunities for workers to receive academic credit for participating in training.
- *Employers:* Cedar Sinai Park, Rose Schnitzer Manor; Providence Benedictine Community Care, Orchard House; Concepts in Community Living, Taft Home,[3] Marquis Companies, Vintage Suites; Farmington Center, Salem.[4] Implements training for direct care staff; releases supervisors and other management staff for training; participates in steering committee and implementation team; changes policies and procedures to facilitate career enhancement for direct care workers.
- *Employer Associations:* Oregon Alliance of Senior and Health Services; Oregon Health Care Association. Recruits additional employer partners; helps gain recognition for caregiver credentials; participates in steering committee.

Portland's project is ambitious, with many moving parts. It aims to raise the skill levels of *every* direct care worker (and in some cases support staff, such as housekeepers) in five facilities by integrating training into the workplace. In addition, it seeks to support the career development of caregivers by: training supervisors as coaches and by

changing employer practices, such as tuition assistance; developing career pathways through community college certificate programs; and providing college credit for work-based learning. Ultimately, it seeks to establish Resident Assistant I and II as industry-recognized credentials throughout the state.

At the center of *Jobs to Careers in Community-Based Care* is the Resident Assistant curriculum. It outlines what is essential to know in order to provide good care to elders in assisted living homes. Its development signals to industry, the workforce, and consumers that these are jobs that matter. This is unprecedented in a field whose only frontline caregiver job requirements are to be 18 years of age with no criminal background. Developing the curriculum and defining the competencies required of caregivers, however, has considerable precedent.

Building on Precedent

Jobs to Careers in Community-Based Care rests on a foundation of prior initiatives and collaborations in the Portland region, chiefly, the Assisted Living Facility Training Consortium (2003-04) and Oregon Better Jobs, Better Care (2003-06). These projects, which involved several employers participating in *Jobs to Careers*, built relationships and set precedents for upgrading both the quality of jobs and the quality of care provided in assisted living facilities. These efforts were in turn preceded by a range of projects, dating from the 1980s, which engaged providers, public agencies, employer groups, and educators in promoting models of care improvement in the sector.

> “These efforts . . . engaged providers, public agencies, employer groups, and educators in promoting models of care improvement in the sector.”

The Assisted Living Facility Training Consortium identified the competencies needed for direct care workers in assisted living, a critical step in creating ladders for workers to advance in careers. Funded by the U.S. Department of Labor, the consortium included Portland Community College and several assisted living employers, including Cedar Sinai Park. Based on extensive discussions with employers in the region, members analyzed the tasks performed and the competencies or skills required for entry-level, unlicensed direct care positions, codifying the first- and second-rung occupations as Resident Assistant I and Resident Assistant II. A curriculum was then developed for training resident assistants in the competencies. The curriculum forms the nucleus for *Jobs to Careers in Community-Based Care*.

Better Jobs, Better Care—like *Jobs to Careers*, a national initiative of the Robert Wood Johnson Foundation—further cemented the partnership assembled for the current effort. Partners worked to improve both worker and resident satisfaction through changes in caregiving practice and policy. Among the local employers in Oregon's Better Jobs, Better Care project were Cedar Sinai Park and Providence Benedictine Community Care, both of which focused on career growth for licensed caregivers in skilled nursing facilities. Statewide employer associations and public agencies also participated. Better Jobs, Better Care extended the skills analysis begun under the Assisted Living Facility Training Consortium, creating an occupational profile of the Resident Assistant I position.[5]

The tasks that formed the backbone of the Resident Assistant curriculum are wide-ranging.[6] They reflect both the breadth of activities encompassed in caregiving

and the intention of community-based care providers to offer a social model of care, focused on the needs and preferences of individual residents, rather than a medical model, traditionally associated with nursing facilities and geared to the needs and routines of the institution. Tasks and competencies still clearly include health and safety concerns, ranging from infection control and skin care of residents to incident reporting and fall prevention. And, similar to certified nursing assistants, resident assistants are expected to help residents with everyday activities such as bathing, toileting, dressing, and exercise. But the Resident Assistant task list also delineates a wide variety of skills associated with ensuring the emotional well-being of residents, such as "emotional care," verbal communication, problem solving, and written communication. Examples include:

- *Emotional Care:* Cue residents by encouraging and reminding them to participate in activities; encourage socialization among residents by introducing them to others who share common interests; gain insight into residents' needs and preferences by using listening skills, open-ended questions, and paraphrasing with residents and coworkers.
- *Verbal Communication and Problem Solving:* Promote teamwork in providing services to residents by sharing helpful hints on residents' needs to coworkers; assess the health, emotional state, or needs of the residents by reading body language; talk with coworkers about tasks and to residents about needed activities, discuss problems, create solutions, and get help when needed; listen to residents and coworkers to gain insight into resident needs and preferences.
- *Written Communication:* Read the resident care plan to become familiar with needs, personal information, and medical issues; read and make entries in a notebook, journal, or message board to track residents' statuses, daily needs, or changes in services from previous shifts; update other caregivers on residents' statuses by writing events down in a communication log, 24-hour report, alert chart, and/or shift-change report.

The curriculum was revised over the course of the *Jobs to Careers* project to conform to new statewide regulations for assisted living care and to incorporate concerns specific to the providers in the JCCBC partnership. The occupational profile also was expanded to cover the responsibilities of Resident Assistant II, such as administering medications and being shift leaders. The revised curriculum encompasses 27 training modules (*see Appendix III*).

IMPLEMENTING CHANGE IN COMMUNITY-BASED CARE

As the initial standard bearers for *Jobs to Careers*, the project designers selected Cedar Sinai Park and Providence Benedictine Community Center and their respective assisted living centers. Each had committed executives and managers in place with experience in the Assisted Living Facility Training Consortium or Better Jobs, Better Care, as well as other efforts promoting improvements in caregiving. These organizations would test the model of a comprehensive work-based curriculum for direct care workers in varied organizational and caregiving settings and for serving varied employee and patient populations. While both are nonprofit organizations, Rose Schnitzer Manor is a much larger and more formal organization, with clearly delineated supervisory and reporting structures. Orchard House is smaller, with little formal supervision; its "Service Partners" combine caregiving, food service, activities, and other responsibilities into one position.[7]

INTEGRATING TRAINING INTO THE WORKPLACE

To realize the project vision in these facilities, *Jobs to Careers in Community-Based Care* appointed a manager, Suanne Jackson, based at Portland Community College, and established governing committees that

steer the project and monitor developments at each of the employer sites and PCC. To support the work-site component of the curriculum, Jackson asked each partner to designate point people responsible for a variety of assignments: scheduling training and other activities; providing release time for training; recognizing workers who obtain certification as Resident Assistant I or II; and changing organizational policies and procedures to support career development, among other activities. Less formally, she received commitments from all partners to function as "learning organizations" and to treat JCCBC as integral to their missions.

Jackson also believed it was important for managers in each facility to understand that the curriculum was more than clinical—that interpersonal skills were vital to the organization's mission of providing "resident-centered" care. Moreover, each employer was asked to designate staff to be trained as instructors for the resident assistant curriculum and who would establish regular meetings for the training team and a schedule for carrying out the 27 modules. Each site had discretion to teach the modules in the order managers saw fit, given training needs and priorities in the facility.

Despite using a standard curriculum, the work sites have not implemented the training in a "cookie cutter" fashion. Rather, they have adapted material to fit the specific needs of their resident and worker populations. Taft Home, for example, expanded the mental health curriculum from a focus on dementia to provide more instruction on mental illnesses, such as schizophrenia. In several facilities, including Rose Schnitzer Manor and Farmington Square, instructors have devoted extra time and used supplementary materials to address the needs of workers with limited English-language skills.

The Resident Assistant curriculum is extensive and complex; nothing this comprehensive has been used before to train assisted living staff in Oregon, and possibly nationwide. The material grew as it was updated to conform to new state regulations governing community-based care. Implementing training on this unprecedented scale has been operationally challenging. The sheer novelty of mounting the course in the workplace demanded a lengthy "learning curve" for managers, supervisor/trainers, and trainees alike (*see box, "Educational Challenges"*).

In many instances, the order and pacing of training sessions have been adjusted in response to daily demands of caregiving, as well as changes in staffing or resident levels. Employers limited the delivery of career development workshops at their facilities to one hour due to time pressures. In general, however, employers have kept their commitment to dedicating work time to the initiative. The prominent display of charts in work areas highlighting progress on workers trained and modules completed has helped keep the program on track and participants motivated, according to Suanne Jackson.

Educational Challenges

Immigrants, particularly those who are English language learners, comprise a major part of the direct care workforce in Oregon. Just over half of workers surveyed by JCCBC's evaluators did not speak English as their first language. The Farmington Square facility has a significant Spanish-speaking workforce. Rose Schnitzer Manor in Portland is the most diverse of the five: 25 languages are represented among caregiving and ancillary staff, with speakers of Bosnian and Spanish most numerous. Limited English ability and a lack of resources for formal English for Speakers of Other Languages courses have made participation in training difficult for these learners. Low literacy and education levels also create hurdles to successful training and to further education; one in five caregivers did not finish high school.

Trainers in these facilities have responded in several ways to such constraints. One is to provide extra assistance to English language learners: devoting extra time to lessons; providing translation; slowing down delivery; and providing one-on-one attention, informal peer-to-peer assistance, and translation and instruction. Other solutions have included translation of curricula into Spanish, as Farmington Square has done, and informal peer efforts to assist with language instruction, using vocabulary books, as workers in Rose Schnitzer Manor have done.

BRINGING COLLEGE TO THE WORKPLACE

To establish educational pathways for community-based care, project members from the Gerontology Program at Portland Community College asked the college to award credit for those completing the Resident Assistant curriculum via training at the workplace. The partners also worked with PCC to develop short-term credentials in specialized topics of aging, including Activities Assistant and Advanced Behavioral and Cognitive care.[8] The latter "certificates of completion" prepare graduates for jobs in elder-serving settings, such as assisted living, and also to pursue further academic studies. Both certificates articulate with Associate's and Bachelor's degrees in gerontology (*see box, "Institutional Challenges"*).[9]

PREPARING FOR CAREER AND EDUCATIONAL DEVELOPMENT

The certificates of completion introduce community-based care workers to college coursework. Jan Abushakrah, director of the Gerontology Program, also brought the resources of the college into the assisted living workplaces, with sessions on career management for both supervisors and caregivers. PCC career professionals conduct workshops geared to each group, and provide them with customized guidebooks. Supervisors learn about career coaching methods and receive resource materials they can share with direct care workers, including information on how to navigate college admissions and support services.

Caregivers, in turn, receive workbooks with tools for researching career choices, guidance for "informational interviews," and other supports. Supervisors then assist workers with developing their own individual career development plans. The overall objective is for both supervisors and workers to give more systematic thought to career development (*see box, "Steps to Careers in Caregiving"*).

Institutional Challenges

Achieving the goal of academic credit for the Resident Assistant curriculum met with considerable resistance and delay from academic committees within Portland Community College that determine policies for establishing new courses and granting credit for prior learning. This resistance stemmed partly from academic authorities' concerns about a potential dilution of scholarly standards when credit is granted for nontraditional methods of learning that are experiential or work-based rather than classroom-based. Faculty members also raised concern about increased workloads involved in determining standards and assessing whether students had met them. In addition, bridging the credit and noncredit divisions within community colleges has been challenging for many workforce initiatives, including other projects supported by *Jobs to Careers*.

After a series of administrative processes and delays stretching over several years, college authorities agreed to grant two credits for Resident Assistant I and one additional credit for those attaining Resident Assistant II status. This required considerable persistence and creativity on the part of Gerontology Program director Jan Abushakrah and her colleagues. In addition, the agreement remains a "work-around," applying to this curriculum only, rather than serving as a permanent change in policy for the college.

Steps to Careers in Caregiving

Oregon's initiatives at the workplace and the college campus offer direct care workers multiple routes to advancing their careers. Completing the Resident Assistant I curriculum while working results in a certificate endorsed by the state's long-term care employer associations; with additional modules, participants can attain the Resident Assistant II certificate, which generally results in a modest wage increase.[10]

Direct care workers who take advantage of tuition assistance from their employer also can aid their careers by enrolling in the newly established certifications for activities assistant, advanced behavioral and cognitive care, and palliative and end-of-life care. These short-term, modular (or "stackable") credentials apply toward more advanced certificates and degrees in gerontology, and also prepare students for higher-skilled roles in elder care.[11] For example, holders of the Activities Assistant certificate can progress, with additional study and credentials and gain higher-level employment in care facilities or start a business independently:

Activities Assistant → Activities Director (Associate's degree) →
Activities Consultant (Bachelor's degree)

Accomplishments

The team of workplace and college-based staff for *Jobs to Careers in Community-Based Care* has made substantial progress toward the project's goal of formalizing and deepening the training of community-based caregivers, improving their skills while developing careers. Their most visible accomplishment has been training the majority of workers with the Resident Assistant curriculum, including both newly hired and incumbent workers. This has occurred during work time and at all five project worksites. As of the project's conclusion in September 2009, 86 individuals had completed the training and received certificates, or 75 percent of all enrolled. An additional 30 workers were in the process of completing training.

This training has yielded significant results for direct care workers, their employers, and the residents they care for. Both caregivers' understanding of what their jobs require and the specific needs of their residents increased over the course of the training program. This was documented both by informal interviews for the present report and by systematic surveys and focus groups conducted by local and national evaluators. Local evaluators found that workers saw their "self-efficacy"—their confidence in their ability to give care to residents—increase by statistically significant levels (White & Cadiz forthcoming). Greater self-confidence on the job, in turn, was correlated with increased job satisfaction and a greater sense of support from management. More confident workers, according to evaluators, were also found to have significantly higher career aspirations (e.g., interest in continuing one's education; thinking about career goals).

Other seeds for career progress have been sown. Portland Community College has conducted workshops on career management for supervisors and caregivers in all facilities. This has been well received by managers and caregivers. At each work site, supervisors have begun to engage direct care workers in conversations about careers. At Orchard House, for example, director Deana Wentworth helped every direct care worker establish an individual education plan. The Marquis management is considering this as well.

The participating assisted living facilities have encouraged further education by providing funds for tuition up front, rather than reimbursing workers after they complete a course. All of the facilities report an increased utilization of tuition assistance by direct care staff. Use of tuition assistance has increased by 25 percent for employees at Vintage Suites, while six workers in one department alone at Rose Schnitzer Manor enrolled in college courses. While college remains out of reach for many due to cost, family obligations, or other obstacles like transportation, at least three workers from each of the participating homes are attending or planning to attend college, or 17 percent of direct care workers from the participating sites.

All participants in *Jobs to Careers*, whether or not they enroll formally in college courses, will soon receive credit toward certificates and degrees in gerontology. At Portland Community College, academic officials have approved granting credit for all who obtain the Resident Assistant certificates.

Perhaps the most significant change in community-based care work has been the engagement of employers. Each of the organizations participating will award employees completing the curriculum with certificates signed by the state's two major employer associations in long-term care: the Oregon Health Care Association and the Oregon Alliance for Senior and Health Services. The project's two for-profit chains—Marquis and Farmington Square—are considering adopting the curriculum

at other facilities in their systems. In addition, employers throughout Oregon have responded positively to presentations on JCCBC in recent months, with at least 18 additional organizations agreeing to adopt the curriculum and a total of 61 staff members signing up as trainers to deliver it.

Lessons Learned

Managers, supervisors, and trainers interviewed for this study described promising signs of progress toward a higher standard of care for residents, greater confidence and morale for workers, and a training model uniquely adapted for community-based settings. So far, several important lessons have been learned. These are illustrated below in the voices of project leaders, instructors, and frontline workers:

The systematic training of direct care workers can contribute to a higher quality of care and greater resident satisfaction (Kemper et al. 2008; Stott et al. 2007; Maas & Buckwater 2006).[12]

When asked to compare current training with that provided before, staff from the participating facilities made such comments as:

> "It's like night and day."
>
> "Before, [the direct care workers] were just thrown into the job."
>
> "We didn't have anything this concrete before in such an organized fashion."
>
> "Now there is an improvement in the caregivers' knowledge base; it has made it a better workplace."[13]

According to managers and supervisors, direct care workers at the participating facilities now learn important content material in a systematic and consistent fashion, as opposed to the ad hoc and inconsistent manner in which knowledge and skills were transmitted in the past.

Frontline workers interviewed by the local evaluation team reinforced this, with both new and experienced caregivers observing that the training "put them all 'on the same page' so that everyone provided care in the same way and met the same standards of care" (White & Cadiz forthcoming). As a result, they can respond to resident needs with higher levels of knowledge, skills, confidence, and professionalism. In addition, the caregivers are engaging residents in more conversations, learning more about their needs and preferences. A caregiver echoes this assessment:

> For me, it's a really good thing that we have those module trainings. I've been in this field and I never seen this kind of training before. So it's really expanding your knowledge of doing the caregiving job as we're doing right here. . . . We learned more things than we ever thought could be related to our career.

A few examples suggest that, in practice, caregivers now possess keener observation skills, as well as greater understanding of residents' health and emotional needs. As a result, direct care workers play a stronger role in planning and carrying out service plans for residents, creating the potential for more personalized and sensitive care.

As one caregiver explained to local evaluators, recounting her newly improved observational skills:

> When the resident is different than the day before, I report what happened . . . . When the residents don't eat very well, I report it. When they're not sleeping, not eating, roaming around and around asking

> “We use the input we get from the caregivers to develop better service plans for the residents.”

to go home, I report that (White & Cadiz forthcoming).

Managers and supervisors reinforced this view:

> Understanding why and how insulin works has improved caregivers' ability to handle people with complicated diabetic problems, especially when blood sugars go low. We have a lady now who just recently had to change her diet because of swallowing issues. Her blood sugar dropped low and the caregivers pointed out what was happening and why. That wouldn't have happened before.
>
> *—Deana Wentworth, director, Orchard House*

> When someone needs a two-person transfer, it's easier to make that happen now since it was part of the training and is in the manual. People know about it and what is expected.
>
> *—Suesan Thompson, nurse and assisted living nursing consultant, Marquis Vintage Suites*

> Having caregivers go through the service planning module and teaching their peers gave us much more insight on how to make revisions to the service plan, to make it more user-friendly. It gives [us] a better sense of what can be done to make the service plan a more useful tool, not just something to be checked off. The service plans are being used more now because people are more comfortable with them and feel they can have more input.
>
> *—Suesan Thompson*

> When we have trainings with the staff, we usually use examples of residents who are currently living here. We now use the input we get from the caregivers to develop better service plans for the residents.
>
> *—Pina Ibabao, Health Services Department coordinator, Rose Schnitzer Manor*

Orchard House, which conducted resident satisfaction surveys in March and October 2008, found evidence that JCCBC contributed to higher levels of resident satisfaction as well:

> “Staff treat me with dignity and respect”: 55 percent increase in positive responses.
>
> “Service partners [direct care workers] respond in a timely manner when I push my call button”: 55 percent increase in positive responses.
>
> “I would recommend Orchard House to friends and family”: 64 percent increase in positive responses.

Managers at Orchard House attribute these improvements to the fact that the facility's direct care staff completed most of the JCCBC training modules in the period between the two surveys. Rose Schnitzer Manor also experienced significant increases in resident satisfaction survey responses to questions related to competency of staff, sufficiency of personal assistance, and sufficiency of meeting health care needs. The increase in resident satisfaction there was also thought to be due to the JCCBC training modules and number of staff trainings completed at the time of the survey. A participant summed up the importance of her training to resident satisfaction:

> [The modules have helped] in how to approach residents. Because that can make a big difference. If you approach them wrong, if the resident is having a bad day and then you approach them in the wrong way, it just gets things really complicated for the resident, for yourself, too.

Training for community-based care requires curricula tailored to the distinct environment for caregiving.

Training for direct care workers in assisted living and other community-based facilities must take place in ways that can meet the health care needs of residents while respecting their privacy and autonomy within their own homes. At Rose Schnitzer Manor, for example, the training provided an opportunity to focus on infection control in an assisted living situation:

> Hand washing is huge when it comes to providing services in community living situations. It's a simple task but difficult to

> “Staff walk with family members and physicians in a very professional manner now and they know what they’re talking about. That’s new.”

understand when to wash your hands and what to use, because of the sanctity of the residents’ apartments. . . . Before, they used gloves as a substitute for washing their hands. The training was an opportunity to turn that around. We discussed when to wash our hands and when to wear gloves. And this same training was reinforced in different ways in three or four different modules: chain of infection, hand washing, disinfecting and cleaning, those kinds of things. It was a breakthrough in how they do their jobs everyday.

—Linda Bifano, health services director and a trainer at Rose Schnitzer Manor

Similarly, caregivers participating in the training attested to newly won knowledge about residents’ needs for privacy and respect (White & Cadiz forthcoming):

> I knock first to see if I’m allowed in their room, because it is their room. And then I ask them how they’re doing. Then I go through what I need to go through with them, and at the end I say, “Is there anything else I can do for you?” in case there’s something we forgot, and then leave.

Training at the workplace, embedded in the real demands of the job, can help foster a culture of learning throughout the organization.

Staff members remarked that JCCBC has fostered a culture of learning at their facilities. Direct care workers, supervisors, and other staff are engaged in an ongoing process of learning from one another to improve the quality of residents’ care. This was fostered by having a variety of staff members within the homes assume teaching roles, including experienced caregivers, and, in some cases, having trainers complete each of the modules themselves:

> The thing about workplace learning is that it has to be a two-way partnership. It needs to be a priority on both sides in order for it to work.
>
> *—Suesan Thompson*

> I’m learning from [the direct care workers] as well. I’m supposed to be the teacher, but I’m learning from them.
>
> *—Pina Ibabao*

> We’re creating a culture here. I said to the direct care staff when we started this program, “When you come to work now, you’re also coming to learn.” So we’re learning how to take care of [the residents]; we’re learning from each other and we’re learning from the people we’re taking care of. I think what we’ve learned is how to break down barriers related to how we acquire knowledge. I don’t think we would have been able to do this on our own because traditionally we assign knowledge to people in positions of authority. Now we can all teach each other and continue the learning process.
>
> *—Linda Bifano*

Comprehensive instruction at the workplace can contribute to increased job satisfaction for direct care workers.

Nearly all respondents spoke of the greater self-esteem and self-confidence direct care staff appear to have as they do their daily jobs:

> I’m seeing greater self-confidence. Staff talk with family members and physicians in a very professional manner now and they know what they’re talking about. That’s new. I’m observing that for the first time.
>
> *—Deana Wentworth*

> When training new staff, there just hasn’t been anything for assisted living or home care as far as formalized training [in the past]. This is a huge, huge thing for this type of work, for them to have a certificate and feel like they’re not less than a [certified nursing assistant], that they can use this at any other facility; and they will have completed the competencies and have a certificate. It will be looked upon as something positive.
>
> *—Pina Ibabao*

> I hear stories from the supervisors and people who come to practice committee meetings, mainly the trainers, supervisors

and administrative staff. I hear them say that morale is better.

—*Suanne Jackson, project coordinator*

In addition, the facilities report improved relationships between the direct care workers and other professional staff, including nurses and administrators. They now speak together more freely and appear to show greater respect and concern for one another.

Research on the caregiving workforce has found that policies that signal recognition and respect for workers foster greater satisfaction and influence workers' decisions to stay in their positions (Bishop et al. 2008). While it is too early to gauge the precise impact of this initiative on worker retention, Oregon recently recognized Rose Schnitzer Manor's workforce policies through the state Innovative Practices Program. The center was one of three applicants statewide to be recognized for care and service practices that foster workforce recruitment and retention (Jewish Review 2009). Both Marquis Vintage Suites and Farmington Square have informally reported signs of reduced turnover.

Implementing a comprehensive curriculum is challenging but achievable.

The facilities participating in *Jobs to Careers in Community-Based Care* had a steep learning curve in implementing the curriculum for their direct care workers. This reflects the extensive nature of the trainings: 27 modules, requiring 30 hours or more of instruction per employee. It also speaks to the novelty of providing training on this scale in the assisted living environment, where no previous credentials were required and where very little training, beyond in-service material, is offered on the job. Even with trainers receiving 24 hours of preparation for their role, it took time for instructors and their managers to fully comprehend the material and determine the best ways to communicate it to caregivers. This was particularly challenging in facilities where the majority of caregivers had limited English proficiency (*see box, "Educational Challenges," on page 7*).

The greatest challenge to implementation, and one common to workplace training in all sectors of health care, was balancing the competing priorities of delivering health care to frail or impaired individuals with providing training to frontline staff. A virtue of the training model in this case—personalized instruction, one on one or in small groups—creates challenges when schedule conflicts arise. The loss of staff in some facilities, both frontline and managerial, also made this balance difficult. Administrators echoed these findings to both local and national and evaluators, describing "timing and scheduling" to be among the chief obstacles. Those employers outside the project who were reluctant to implement the training model cited time and cost as primary reasons not to do so (White & Cadiz forthcoming).

Employers and their staff found the trainings easier to implement over time. They adopted systems and "real time" strategies to fit learning into their workday routines. As these managers explain:

> It was a struggle to get the thing set up, but I think that we've finally found ways to do the scheduling, to pull people off the floor without additional hours, to fit it into our schedules and not freak out if we have to postpone it.
>
> If it's looking like we're going to have 15 or 20 minutes of down time, we say, "Hey, [worker's name], come over here for a minute; I want to talk to you about this."

In some facilities, modules were delivered at required monthly staff meetings. In other cases, managers made adjustments to workers' schedules, or workers arrived early or stayed for 30 minutes or more after their shifts. These and other strategies were shared at monthly practice team meetings representing the five employers.

Bridging the direct care workplace with higher education can generate greater interest and engagement in career development.

Direct care workers have responded positively and strongly to the opportunity of going to college and building a career in caregiving or related fields, such as social work. Some are entering college while others are making plans to do so.

> At first it was intimidating; it was expected that an educational institution would not be responsive. The direct care workers especially felt that way. They thought higher education was way beyond their reach. But now they see we're responding to them.
>
> —*Jan Abushakrah, Gerontology program director, Portland Community College*

> In our department alone, we now have six people registered at community college who a year ago were not.
>
> —*Linda Bifano*

> Caregivers from each site have signed up for community college classes. That is another indication we are making some progress, because of the self-confidence we are giving people through the training.
>
> —*Suanne Jackson*

The new tuition assistance strategy the facilities use is likely another important reason for the increased enrollment in community college classes. The direct payment of tuition costs in advance has relieved workers of the necessity of finding the funds to pay for their own tuition pending reimbursement.

> "With an aging population, and one more demanding of home or community-based care . . . it is essential to build a well-trained workforce."

Next Steps for *Jobs to Careers in Community-Based Care*

Training and other formal activities for JCCBC are winding down, but the energy for pursuing change in the community-based care workplace remains strong. As of September 2009, workers in the five facilities were completing the course of instruction, while newly hired employees were beginning the training modules. Administrators of the homes have said that they plan to continue resident assistant training with their own resources.

There remains considerable work to be done, both to consolidate and maintain progress on building the skills and career growth of caregivers in the five homes, and to disseminate the model more widely throughout the state. The employers will use the curriculum—revised to reflect new state regulations for community-based care—to help meet in-service training requirements for staff. All workers completing the course will receive certification of their status, signed by the employer and by the state provider associations. But ensuring that these titles are truly portable to other employers—and that they make similar investments in their direct care workforce—will require further organization with the state's employer associations and policymakers. To this end, Suanne Jackson and her colleagues have begun meeting with state funders and regulators of community-based care. Their goal is to gain recognition for the training model and curriculum as a statewide standard, especially when state agencies inspect assisted living centers.[14]

Project leaders have taken initiative to engage wider circles of employers in Oregon. They have presented the curriculum to groups of employers in Portland, Eugene, and Medford, Oregon, with planning for additional outreach and sessions to train instructors at interested workplaces. During the last six months of the project, four

additional sessions were held to train 61 employees from 18 worksites as instructors for the curriculum. At this writing, an additional 16 employers have been contacted about "train the trainer" classes.

According to Jackson, the goal is to expand the curriculum to between 25 and 50 percent of assisted living facilities in the state. She and her colleagues are also planning a parallel effort to bring standardized instruction and career development to home care workers, if funding can be secured to support it.

For caregivers to realize significantly improved wages and living standards, they will need access to higher education and to career steps beyond Resident Assistant I and II. Portland Community College has supported this advancement by enacting the new short-term certificates for activities and advanced behavioral and cognitive care. The next steps include finalizing the End of Life certificate and developing new ones being planned, such as a certificate supporting elder fitness work. A longer-term issue is the need for more systematic ways—at Portland Community College and statewide—to grant credit for work-based and other forms of experiential learning. From the workplace, caregivers will need continued support for planning their careers, navigating college options, and using tuition aid offered by employers.

Teaching and Learning Organizations

Portland's project matters because high-quality, person-centered care matters. With an aging population, and one more demanding of home or community-based care in lieu of traditional nursing home care, it is essential to build a well-trained workforce. Doing so demands consistent, competency-based standards for delivering training. At the same time, standardized training needs to be flexible enough to match the needs of residents in the homelike environment of assisted living. In addition, if those giving care are to be motivated and retained, they need quality jobs that offer progression to higher-skilled jobs and college-level certificates and degrees.

The JCCBC project is also notable because the vast majority of other training initiatives for direct care workers involve certified nursing assistants employed by nursing facilities. With far fewer examples of comprehensive training for assisted living workers, the JCCBC experience offers a foundation for further interventions and research. The project offers a promising model as other states follow Oregon in moving to community-based care, and a larger proportion of the caregiving workforce is employed in such settings.

Grounding training in the workplace with participation from many levels of staff builds more than just the skills of individuals. The Portland experience suggests that it can foster development of "teaching and learning organizations," in the words of Rose Schnitzer Manor's Linda Bifano (Jewish Review 2009). And such change cannot end at the doors of the care facility. Providing more workers, residents, and employers with the benefits of this model requires policy action from state and federal governments to codify new training standards and positions, and to support them financially. It means concerted action from employers to provide collective recognition and portability of these standards, and vigorous advocacy for change in public policy. Only then can the promise of quality jobs in community-based care be fully realized.

Appendix I:
The Labor Force in Community-Based Care

Who are the people who work in assisted living and other community-based facilities? Answering this question is difficult, since the occupational titles and industry classifications used by state employment departments and the U.S. Bureau of Labor Statistics do not capture the specific occupations and workplaces under consideration here. However, it is possible to arrive at some general estimates based on the data that are available.

With regard to the characteristics of the direct care workforce, the available data are for home health aides and paraprofessional direct care workers in hospitals and nursing homes. It seems reasonable to infer that these general characteristics are probably applicable to the workforce in community-based care facilities as well.

According to a demographic analysis of workers in these categories nationwide, 89 percent of direct care workers are women, 49 percent are minorities, and 20 percent are foreign-born. About one-quarter (24 percent) are single mothers, compared with 14 percent of all female workers; and about one-third (38 percent) are married, compared with 54 percent of all female workers. Their average age is 41, and 62 percent have no education beyond high school (Smith & Baughman 2007).

The task is equally challenging when it comes to estimating the numbers of direct care workers in assisted living and other community-based facilities. Two specific occupational titles—"personal and home care aides" and "nursing aides, orderlies, and attendants"—are the ones most likely to capture the direct care workforce at those facilities (*see Table 2 for the numbers of these workers, along with their average wages*).[15]

The Bureau of Labor Statistics projects that the number of jobs for nursing aides, orderlies, and attendants will grow by 28 percent between 2006 and 2016, and that the corresponding increase for personal and home care aides will be 51 percent, the second-highest projected growth rate for all U.S. occupations. In Oregon, the state's Employment Department projects 24 percent growth in jobs for nursing aides, orderlies, and attendants and 26 percent growth for personal and home care aides.

Note that these statistics relate to a larger universe of work settings beyond assisted living and community-based facilities. According to the Bureau of Labor Statistics, most personal and home care aides serve people in their own homes, and nursing aides, orderlies, and attendants are more likely to be employed by hospitals and

Table 2:
Number and Hourly Wages of Direct Care Workers in Selected Occupations, 2006[16]

	Oregon	Nationwide
Number of personal and home care aides	3,890	578,290
Median hourly wage	$10.12	$8.54
Number of nursing aides, orderlies, and attendants	11,910	1,376,660
Median hourly wage	$11.07	$10.67

SOURCE: Data compiled from Bureau of Labor Statistics databases by the National Clearinghouse on the Direct Care Workforce: www.directcareclearinghouse.org/s_state_det.jsp?action=null&res_id=52&x=11&y=8

nursing homes than by community residential facilities.

Even with these qualifications, it should be clear that the occupations in question tend to be low-paid, making them especially susceptible to turnover. The Oregon Employment Department estimates a 64 percent turnover rate for all direct care staff in 2007. A 2001 study on assisted living found turnover rates of 40 percent for personal and home care aides and 39 percent for nursing aides. It also cites data from the U.S. Department of Health and Human Services that direct care workers in long-term care average about 30 hours per week, thus reducing their annual earnings to $17,000 or less (AARP Public Policy Institute 2008).

Appendix II:
The Regulatory Setting for Working in Community-based Care

In the 19 years since Oregon issued the nation's first licensing regulations for assisted living facilities, 42 states plus the District of Columbia have followed suit. However, there is wide variation in how states use the term "assisted living." Only 13 states have followed Oregon's lead in requiring that licensed assisted living facilities provide private apartments for their residents, and only 10 states are similar to Oregon in distinguishing between assisted living and residential care facilities in terms of whether they offer private apartments (Mollica et al. 2007).

Of particular interest to *Jobs to Careers* are the regulations relating to direct care staff in assisted living facilities. Training requirements for direct care workers in community-based facilities are subject only to state regulations. In contrast, certified nursing assistants in nursing homes are required under federal law to complete 75 hours of initial training and to pass an examination on what they have learned.

Here, again, the states vary widely. Most states require that initial training be completed in specific topics; others specify a number of training hours; and 10 specify both the topics and the number of hours. Most states also have requirements for annual in-service training, but a significant minority—18 states—do not require such training *(see Table 3)*.

In Oregon, the 1989 regulations stipulated that direct care staff must receive pre-service orientation in certain topics. But they did not say how many hours should be devoted to the orientation, nor did they provide for in-service training. The required topics included the principles of assisted living, changes associated with the aging process, residents' rights, how to perform ADL (activities of daily living) care, how to implement resident service plans, fire safety and emergency procedures, responding to behavior issues, precautions for infection control, food preparation, service and storage (if applicable), and observation and reporting skills.[17]

Since the 1989 regulations were issued, many residents in community-based facilities have presented higher levels of acuity and increased need for medical care. Responding to these concerns, Oregon added requirements to its regulations for residential care facilities in 2004, and revised

Table 3:
State Requirements for Initial and In-Service Training for Direct Care Workers[18]

	Number of States Requiring Initial Training	Number of States Requiring Annual In-service Training
Specified topics only	28*	10
Specified number of hours only	7	18*
Specified topics and hours	9	5
Complete training course	4	N/A
Other or not specified	3	18

* Includes Oregon

the regulations for assisted living facilities in November 2007. These newest regulations, which took effect at the beginning of 2008, include more stringent training requirements for direct care workers. Newly hired direct care staff must now demonstrate their knowledge and proficiency in a number of topical areas within 30 days of being hired. New topics include identifying and reporting on changes in residents' physical, emotional, and mental functioning; conditions that require assessment, treatment, observation, and reporting; understanding resident actions and behavior as a form of communication; understanding and providing support for residents with dementia or related conditions; and, where applicable, the administration of medications and treatments. All new staff members "must be directly supervised by a qualified person until they have successfully demonstrated satisfactory performance in any task assigned and the provision of individualized resident services."[19] In addition, all direct caregivers must receive at least 12 hours of in-service training each year "on topics related to the provision of care for persons in a community-based care setting."

Appendix III:
Assisted Living Facility Training Curriculum Session Map

- Introduction
- Instructor's Guide
- Page of Acknowledgements
  - Roles and Responsibilities (Module 1)
  - Self Care (Module 2)
- Infection Control in Assisted Living Communities
  - Proper Hand-Washing Technique (Module 3)
  - Chain of Infection (Module 4)
  - Disinfection and Cleaning (Module 5)
  - Service Plan (Module 6)
  - Personal Care (Module 7)
  - Observation and Reporting (Module 8)
  - Documentation (Module 9)
- Safety for Residents and Direct Care Workers in Assisted Living Communities
  - Fall Prevention (Module 10)
  - Alternative to Restraints (Module 11)
  - Body Mechanics (Module 12)
  - Emergency Situations (Module 13)
- The Physical Effects of Aging
  - Circulatory Function (Module 14)
  - Digestive Function (Module 15)
  - Common Diets (Module 16)
  - Hydration (Module 17)
  - Diabetes: What Is It? (Module 18)
  - Immune Function (Module 19)
  - Musculoskeletal Function (Module 20)
  - Nervous Function (Module 21)
  - Respiratory Function (Module 22)
  - Skin (Module 23)
  - Urinary Function (Module 24)
  - Catheter (Module 25)
  - Behavioral Conditions (Module 26)
- Medications and the Elderly
  - Medication Administration and the Elderly (Module 27)

Endnotes

[1] Also important in this context was Oregon's Nurse Practice Act, which allowed for the delegation of nursing care tasks to unlicensed caregivers under the direction and periodic inspection of a registered nurse or physician.

[2] Oregon's Division of Seniors and People with Disabilities reports that 11,599 people were living in 205 assisted living facilities as of November 2008. By contrast, the 232 residential care facilities in the state had a total of 8,601 residents, and the 142 nursing homes had 12,453 residents.

[3] Taft Home joined the project in 2008.

[4] Marquis Vintage Suites joined the project in January 2008. The Farmington Center was part of the project between January and fall 2008 and was replaced by the Farmington Center's Tualitin facility.

[5] WorkKeys is a skills assessment tool used in industry and workforce development. It is used to profile the skills and proficiencies necessary for particular jobs (within an organization) and occupations (across organizations and, in some cases, across industries).

[6] To obtain a copy of the Assisted Living Facility Training Curriculum referenced in this report, contact Diane White at Portland State University, dwhi@pdx.edu.

[7] The three project sites added in the second year of implementation (Marquis, Taft Home, and Farmington) were also chosen to provide varied contexts for demonstrating the project. Marquis and Farmington are large, for-profit chains with facilities in suburban settings; nonprofit Taft Home, a residential care facility, serves mentally ill elders in downtown Portland.

[8] Activities professionals assist long-term care residents with recreational pursuits to enhance their quality of life physically, socially, and mentally. The Advanced Behavioral and Cognitive Care certificate prepares students to assist individuals with dementia and other cognitive disorders. The Activities Assistant certificate, and succeeding credentials for activities directors and activities consultants, prepare students for a credential examination administered by the National Certification Council of Activities Professionals.

[9] The college is reviewing a third certificate, in palliative (end-of-life) care.

[10] With the project nearing its conclusion, none of the five employers have formally granted wage increases, bonuses, or promotions for those attaining the resident assistant title, citing economic constraints. Participants have been rewarded with non-economic incentives, such as graduation ceremonies, new titles, and badges or other physical signs of their accomplishment. The organizations reportedly are seeking ways to make some form of raise or bonus feasible, such as using the demonstration of new skills as part of employee performance evaluations.

[11] Certificates of completion for activities professionals and advanced behavioral and cognitive care (ABCC) are designed to meet industry requirements. Educational requirements in "Activities" matches the educational requirements of the National Certification Council of Activities Professionals, while the ABCC certificate is aligned with curricula of the National Certification Board for Alzheimer Care and prepares graduates for the national certification exam.

[12] Diana White of Portland State University is leading a more systematic study of the role played by training in contributing to quality of care in the project facilities. Results will be available in summer 2010.

[13] Quotes without attribution come from focus groups conducted by the project evaluators. Names are withheld to preserve confidentiality.

[14] As in other states, Oregon's care facilities are inspected regularly by state "surveyors" who check for compliance with regulations and award a score based on the number of deficiencies found in the survey. According to Suanne Jackson, inadequate training of caregivers consistently ranks among the top three deficiencies found in survey visits.

[15] A recent publication of the National Academy of Sciences states that the workers serving residents of community-based facilities "are typically personal and home care aides rather than home health or nurse aides." *See: Institute of Medicine* (2008).

[16] The data were compiled from Bureau of Labor Statisics databases by the National Clearinghouse on the Direct Care Workforce: www.directcareclearinghouse.org/s_state_det.jsp?action=null&res_id=52&x=11&y=8.

[17] *See: Oregon Administrative Rules, Chapter 411, Division 056.*

[18] Data compiled from Mollica et al. 2007, modified to include the most recent changes to the Oregon regulations.

[19] *See: Oregon Administrative Rules, Chapter 411, and Division 054.*

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