

**Evaluation of Personal Attendant  
Training Programs**

**Texas Department of Human Services**

*Submitted by*  
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# **Senate Bill 95: Evaluation of Personal Attendant Training Programs**

## **Introduction**

Section 5 of Senate Bill 95 of the 76th Legislature requires the Texas Department of Human Services (TDHS), with assistance from the Texas Workforce Commission (TWC), the Texas Rehabilitation Commission, the Texas Commission for the Blind, the Texas Commission for the Deaf and Hard of Hearing, the Texas Higher Education Coordinating Board (THECB), and providers and consumers of personal attendant services to review training programs for personal care attendants and develop recommendations for improvement in those programs. The legislation requires TDHS to take into account the probable cost of increased training and wages to the Medicaid program.

Senate Bill 95 is based on a recommendation from the report issued during the interim of the 75th Legislature by the Texas Senate Committee on Home Health and Assisted Living, chaired by State Senator Mike Moncrief, with a membership including Senators Gonzalo Barrientos, Mario Gallegos, Jr., Jane Nelson and Drew Nixon. The report recommended that the above-named agencies review personal attendant training programs, and emphasized the committee's concern with low wages, lack of benefits and training and high turnover. It mentioned the potential for reducing turnover by developing a career ladder. However, the report was careful to note that "(t)his is not a recommendation mandating minimum levels of training, rather, it is recommendation to better utilize existing agency resources for training."

The purpose of this report is to address the charge from Section 5 of Senate Bill 95. TDHS finds that issues relating to personal attendants in this state cannot be viewed in isolation. For that reason, this report discusses, in addition to the specific issues mentioned in Section 5, the goals of the Texas long-term care system as articulated in state strategic plans and the economic and demographic context in which it seeks to provide service. This necessarily entails a discussion of the broader labor market of which personal attendants are a part, and which also includes other types of personnel offering direct care services in other settings, including facilities. It is also critical to keep in mind that a labor shortage in this area has an all too real human cost, in the form of difficult working conditions for direct care staff and an erosion of quality of care for clients.

## **Texas' Long-Term Care Goals**

It is important to begin with a clear understanding of the goals and objectives of the Texas Long Term Care system, as stated in the principal governing documents, beginning with the Long-Term Care vision adopted by the Texas Legislature as part of the Texas Government Code, Section 531.043(b). The Code affirms that "(t)he guiding principles and goals of the plan focusing on the individual and the individual's family must:

- (1) recognize that it is the policy of this state that children should grow up in families and that persons with disabilities and elderly persons should live in the setting of their choice; and

- (2) ensure that persons needing assistance and their families will have:
  - (A) the maximum possible control over their services;
  - (B) a choice of a broad, comprehensive array of services designed to meet individual needs; and
  - (C) the easiest possible access to appropriate care and support, regardless of the area of the state in which they live.”

The Texas Long-Term Care Plan, developed by the Texas Health and Human Services Commission, in conjunction with appropriate agencies, as directed to Senate Concurrent Resolution 14 of the 75<sup>th</sup> Legislature, recognizes this fact in detail. Objective 2 emphasizing increasing access to services through a variety of strategies. Objective 3 states that “(a)gencies envision a service delivery system in which Texans who need long-term care services easily access the array of individualized long-term care services they need to achieve the greatest possible independence, autonomy, and quality of life, and are unaware of the particular program or funding source paying for the services.” Objective 4 mentions “individualized, culturally competent services that maximize independence and autonomy of the individual.” Objective 5 is dedicated to “(m)aximizing resources through developing funding strategies that support consumer choice.”

TDHS is working with other state agencies and Long-Term Care stakeholders to develop a plan for the future of Long-Term Care services at this agency. The plan promotes ongoing incorporation of consumer and provider concerns and serves as a focal point for inter-agency coordination of Long-Term Care services in order to support the most appropriate system of such services for Texas. Additionally, the Health and Human Services Commission is leading an inter-agency planning effort for Promoting Independence, in which TDHS staff have been very active. Together, these initiatives will emphasize the importance of meeting the needs of Texas’ population of individuals with disabilities by emphasizing consumer access, choice and independence.

In accordance with those plans, TDHS emphasizes the following recommendations as necessary steps toward any resolution of the crisis in direct care staffing:

- 1) Increase the number of individuals willing to enter and stay in the direct care labor pool.
- 2) Identify areas in which additional training programs would be beneficial to clients and develop a core curriculum that emphasizes stronger linkages between client needs and training components;
- 3) Enhance client independence and autonomy wherever appropriate; and
- 4) Look for cost-effective methods of funding additional training.

A more thorough discussion of each of these strategies is included in the body of the report under the section regarding Recommendations, beginning on page 18.

TDHS intends to develop and carry out these strategies in consultation with advocate organizations, providers, and the other state agencies involved in the regulation and training of direct care staff.

## **Direct Care in Texas**

### **Definitions of the Terms “Personal Attendant” and “Direct Care Staff”**

Because of the variety of settings in which direct care is provided, the key terms are not always clearly defined, and some terms have different meanings in different contexts. It is therefore critical to define those key terms at the outset.

Senate Bill 95 calls for an evaluation of training programs offered to “personal attendants.” Generally, that term refers to paid staff working in the client’s home, to provide assistance with one or more activities of daily living. The personal attendant may work directly for client, or for a home and community support services agency (HCSSA), a term which includes both those firms generally described as “home health agencies,” and the home and community support Medicaid waiver providers (HSC/Ws) that contract with the Texas Department of Mental Health and Mental Retardation (TDMHMR). Finally, it also includes several other groups of unlicensed health care workers, including rehabilitation technicians, and mental health workers who assist in the on-site direct care and management of clients with medical or behavioral issues under the supervision of a treatment team, and specialized personal attendants, such as those who receive specialized training to work with deaf clients from the Southwest Collegiate Institute for the Deaf.

However, many of the advocates, providers and state agencies involved in the regulation of the long-term care system believe that training issues for personal attendants cannot be viewed in isolation. Many of the individuals who provide personal attendant services come from the same labor pool as employees of long-term care facilities, such as nursing facilities, assisted living facilities, and intermediate care facilities for the mentally retarded (ICF/MRs). Any serious consideration of the economic context for direct care, which is essential to an understanding of the constraints faced by the current system, and any discussion of a career ladder, as recommended by the Senate Committee on Home Health and Assisted Living, requires the consideration of other types of direct care staff beyond personal attendants. Such direct care staff can include nurse aides (who, despite obtaining a registration based only on employment in nursing facilities, work across the spectrum of direct care settings) and medication aides.

In this report, “personal attendant” refers to an unlicensed individual who does not have a professional license and provides direct care services in a home setting as an unlicensed employee of either the client or a HCSSA. “Long-term care facility employee” refers to an individual who provides direct care services in a personal care (or assisted living) facility, an ICF/MR or an adult day care facility. The term “nurse aide” refers to individuals who have satisfied the requirements of nurse aide training and obtained nurse aide registration, regardless of where they work. Finally, “direct care staff” is intended to refer to all of these categories of workers who provide direct care services to clients, regardless of setting, and therefore includes all three categories. For the purposes of this report, “direct care staff” will include nurse aides, but not licensed vocational or registered nurses.

## The Growth and Diversity of Need for Direct Care

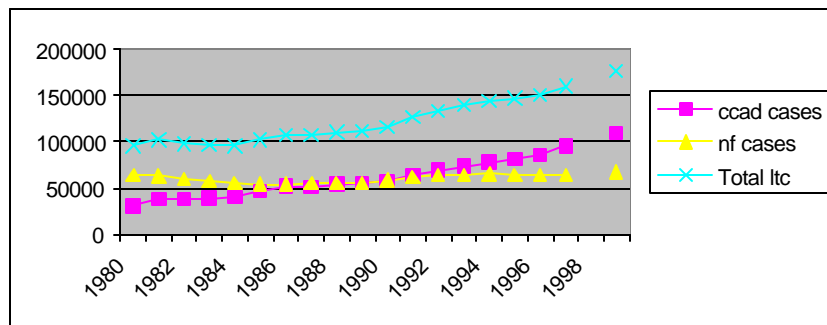
The recruitment, retention and training of direct care staff is of ever-increasing importance. The future growth of the senior population who will need personal attendant and long-term care services is well-documented. Less well known is the rapid growth in the number of individuals with disabilities. Both of these populations vary widely along a number of parameters, all of which affect the kind of services they will need, including: the number of activities of daily living with which they need assistance; cognitive deficits, if any; behavior problems, if any; age; and family and community support. An effective long-term care system cannot assume that the needs of all individuals with disabilities are the same and should be flexible enough to accommodate the diversity of the populations that it is designed to serve.

In addition, the demands of the modern economy have eroded the informal support once offered by family and community networks. In more and more families, all adult members are expected to work outside the home. In an increasingly mobile society, the family members who once would have provided support no longer live nearby and communities themselves are more transitory and do not provide a social safety network the way they once did.

TDHS data indicates that the number of people receiving personal assistance under its programs has tripled since 1980 to the present figure of 109,153 individuals. Simultaneously, TWC figures show the total number of persons employed in the field of personal assistance (including the categories of personal and home care aides, home health aides, and nursing aides) to be 165,100.

The chart below represents the increase in the number of people receiving Texas Department of Human Services (DHS) Community Care for the Aged and Disabled (CCAD) services from 1980 to 2000. In this time period the total number of people receiving personal assistance in the community has increased from 31,119 to 109,153. The number of nursing facility (NF) beds has remained fairly constant, bringing the total number of people receiving long term care or (LTC) personal assistance to 176,748.

### Number of persons receiving Personal Assistance in Texas (source: DHS Annual Reports: 1980-1999)



## **Evolution of Direct Care from Institutional to Community Settings**

The growth in the populations needing services has been accompanied by a dramatic shift in the guiding philosophy for meeting the needs of individuals with disabilities, away from institutional solutions and toward community ones, and, consequently, by growing emphases on consumer control and self-determination. The governing documents of the Texas Long-Term Care system, which are discussed above, all stress the key concepts of this approach, using terms like “choice,” “access,” “independence,” “control,” and “autonomy.”

The result of this shift in guiding philosophy is to increase the demand for personal attendants even more, especially with regard to people with significant disabilities who depend on reliable personal assistance with activities of daily living, health care, or even the support necessary to continue working. In practical terms, the growth in the number of people receiving support at home (and thereby avoiding institutionalization) magnifies the difficulty of finding qualified, motivated personnel to perform personal assistance tasks.

The emphasis on consumer choice has great implications for training the attendants who provide direct care services to certain populations of clients. Many clients are capable of and desire to train their own attendants in support tasks. Some personal attendant programs are organized to allow the clients to manage and train their attendants. The Consumer Managed Personal Assistance Services program administered by TDHS is one example. In addition, the Vendor Fiscal Intermediary (VFI), which is expanding in application to additional programs in Texas, will allow for further responsibility for training to be assumed by clients.

As the state moves in the direction of greater client autonomy and independence, it is important to recognize that client service must remain flexible. Not all clients can achieve autonomy. This is most clearly seen among those nursing facility residents, although there are also TDMHMR clients, participants in adult day care, and other settings whose cognitive impairments or behavioral problems prevent real autonomy. Even for some home health care clients, such as those in the Deaf/Blind Waiver program, autonomy is not a realistic goal. Other clients may not desire to train the attendant who provides services to them. The ideal would be to design a system that emphasizes client service, recognizes the variety of needs that clients have, and is flexible enough to meet those needs.

## **Recruitment and Retention**

The same economic and societal pressures that have increased demand for personal attendants have reduced the supply of them. There are no reliable statistics to measure the shortage of personal attendants in the home health care system, but organizations representing both the industry and clients report difficulties in hiring and retaining them. This corresponds with TWC figures showing the total number of persons employed in the field of personal assistance (including the categories of personal and home care aides, home health aides, and nursing aides) is 165,100. TWC estimates the annual number of openings

in these fields to be 6,416. This is reflected in high competition among agencies and individuals to attract personal attendants in a tight labor market.

Traditionally, one of the steps on a career ladder that is accessible to direct care staff is to obtain work in a nursing facility, obtain the federally-required training and pass the examinations prior to being listed on the Nurse Aide Registry. This training is offered at community colleges, proprietary schools, high schools, and in the nursing facilities themselves. The minimum statewide curriculum is 75 hours. The 75-hour training at nursing facilities is funded by Medicaid. Nurse aide training programs at proprietary schools and community colleges are under the dual authority of TDHS and TWC or TDHS and THECB, respectively.

Many nurse aides, after obtaining the certificate, return to home health agencies or take employment in hospitals. Home health agencies report that they are paying less in part due to the reduction in Medicare payments contained in the Balanced Budget Act of 1997, and are having difficulty in employing nurse aides.

TDHS' Credentialing Department, which operates the Nurse Aide Registry, maintains a statistic representing the number of nurse aides who have earned a nurse aide certificate who maintain active status by notifying the Department of having worked at least one eight-hour shift in a nursing-related job within the past two years. By that measure, the number of nurse aides actively involved in nursing-related employment, declined by 12.5 percent between the end of FY 1998 and December 2001. Similar problems have been reported with nurses.

Another measure of the quality of the labor pool can be seen in the number of criminal history reports provided to long-term care providers. TDHS' Credentialing Department processes requests from long-term care providers for criminal history checks regarding applicants. Chapter 250 of the Texas Health and Safety Code lists those Texas Penal Code convictions which act as a bar to employment in long-term care and home health care settings. However, all reports of convictions are provided to the facilities. (If an individual has a conviction that bars employment, then the provider is prohibited from employing that person; if the conviction is not listed as a bar to employment, the employer makes the decision as to whether the individual is hired or not). In FY 1995, the percent of criminal history requests that resulted in reports mailed to facilities was 3.4 percent. By FY 2000, that percentage had risen to 9.1 percent. For the first four months of FY 2000, the percentage was 10.4 percent. Even if, as some have argued, an undetermined number of these requests are made on behalf of individuals who make repeat applications in different facilities, the steady increase in the number of reports returned over a period of only six years is cause for alarm.

Recruitment is not the only difficult issue; turnover appears to be increasing. The best available measure of turnover among direct care staff is data collected by the TDHS from nursing facilities for Medicaid cost reports. TDHS develops a ratio by taking the number of staff employed during the cost-reporting period and dividing it by the normal staffing at the end of the cost-reporting period. The ratio may be somewhat inflated due to the use of part-time and temporary staff in facilities. It is also important to remember that, unlike the rate-related sections of the cost reports, TDHS does not audit this data.

In FY 1995 and FY 1996, TDHS treated the medication aide and nurse aide categories separately. In FY 1997 and FY 1998, these categories were combined. In any given year, medication aides represent approximately nine percent of the total; nurse aides represent ninety-one percent. For that reason, the combined number for FY 1995 and FY 1996 would be closer to the nurse aide rate than to the medication aide rate.

These are the statistics for those years:

FY 1995 medication aide turnover:	72 percent
FY 1995 other direct care turnover:	161 percent
FY 1996 medication aide turnover:	113 percent
FY 1996 other direct care turnover:	202 percent
FY 1997 combined turnover:	177 percent
FY 1998 combined turnover:	180 percent

The methodology used to develop these ratios almost certainly overstates actual turnover because it takes temporary and part-time staff into account. In addition, there was a change in the calculation of the ratio between FY 1996 and FY 1997, which makes it difficult to draw conclusions based on a straight comparison over time. Still, it is clear from even this imperfect data that the turnover rate for nurse aides and medication aides in nursing facilities is high, and it is probable that the turnover rate rose significantly between FY 1995 and FY 1998.

### **The Reasons Behind the Decline in the Number of Direct Care Workers**

No discussion of the shortage of direct care workers or programs to train them can begin without first addressing the reasons behind the declining numbers. One of the paramount factors is certainly pay, especially in those parts of the state where there are alternatives to working in direct care. According to the TWC, the average wage for a personal attendant is \$5.94 compared to a \$6.66 average wage for food preparation workers. TWC also reports that it is often difficult for nurse aide and similar training programs to meet the initial minimum performance standards established by the United States Department of Labor. Specifically, graduates must earn an average wage that is at least twenty percent more than the federal minimum wage. At the current federal minimum wage, that threshold is \$6.18 per hour. Meeting the minimum requirements for remaining an approved training provider for clients who receive funding from the Work Investment Act (WIA) is challenging for the same reason. Although some local workforce development boards have some flexibility in identifying the minimum self-sufficiency wage for their respective areas, the relatively low wages paid to direct care workers often do not meet the self-sufficiency wage requirement. Were it not for the subsistence wage requirement, employment in the area of nurse aide, home health aide and personal care aide would meet the threshold for a targeted, or high demand, occupation in every workforce area.

Low pay is a very difficult hurdle to overcome, but it is also important to recognize other critical factors that reduce the number of people who are willing to work in these settings.

- *Lack of benefits and support systems:* Low-wage, entry-level positions are dependent on individuals who are entering the work force for the first time. Many of those individuals already have families and are in need of medical benefits, transportation, child care, and flexible hours. These benefits are not available in most situations in the industry.
- *Economic Alternatives:* A strong economy allows competitors to offer higher wages and greater benefits. It also increases demand for skilled direct care workers by attracting family members who would otherwise care for people with disabilities at home.
- *Lack of opportunity for advancement:* Texas has an existing career ladder, consisting of the nurse aide certification and medication aide permit, but it is disjointed and ineffective. There is evidence that, at least in some instances, it has worked in reverse, as trained nurse aides go to work as personal attendants in home health care agencies. That activity has apparently diminished with the decline in the number of home health agencies and the pay they can afford to offer. Corporations in the burgeoning fast food sector, which provide the greatest competition for unskilled entry-level workers, often advertise tuition payment as part of their benefits packages, making advancement a core part of their recruitment package.
- *Lack of a coordinated system of outreach/orientation/back-up:* Currently, providers contracting to provide personal assistance services perform outreach and orientation in a “crisis mode.” There is little coordination between these providers, consumers, Personal Attendant Services (PAS) funding agencies or employment agencies.

The Work School program developed by The University of Texas Medical Branch (UTMB) at Galveston is a notable exception to the dearth of career ladders for nurse assistants. UTMB implemented the Work School program in 1988 as a retention and recruitment strategy for health care workers. At that time, unlicensed staff such as nurse assistants, housekeepers, hospital technical assistants, and other entry-level staff received training for associate degrees in nursing at the local community college, with the training paid for by UTMB. The hospital also provided paid release time for participants to attend training. In return, participants signed a payback agreement, agreeing to work at the hospital for a specified time after completing their licensed vocational nurse training programs, or repaying training costs after completion. Providing basic skills training when necessary and coordinating academic and family support services have both been important factors in the success of the program for unlicensed health care workers. The program has expanded to include baccalaureate, masters, and doctoral level nursing degrees. Approximately 87% of Work School graduates have completed, or are in the process of completing their contracts by working at UTMB. As a result of this program, and its investment in employees, the staff turnover rate has decreased significantly. UTMB received funding from the Robert Wood Johnson Foundation (RWJF) to transfer their Work/School program model to other hospitals in the Gulf Coast area as part of a national demonstration project. Although RWJF funding ended in 1999, each of the participating hospitals has continued the program. Future opportunities for expanding the career ladder for paraprofessional staff at UTMB may include helping nursing assistants become emergency medical technicians.

Much of the discussion surrounding the difficulty of finding direct care workers focuses on the difficult and disagreeable aspects of this kind of employment. It is critical to remember that significant numbers of direct care workers report a high degree of job satisfaction over a long period of time. There are workers who enjoy working with and caring for disabled or senior populations. One critical piece of the solution to this problem is to identify the kind of worker who receives satisfaction from this kind of work so that a campaign can be targeted to them.

None of these issues can be addressed in isolation. At the rate of pay, it is very difficult to attract workers into the field, especially if they have already experienced success in any other economic sector. A concentrated and sustained effort is necessary to attract new workers into the field and reduce turnover is necessary to ensure that Texas' efforts to provide services to its growing population of seniors and persons with disabilities.

### **The Human Cost of a Shortage of Direct Care Workers**

Thanks to enormous progress in medical treatment and technology, we are living much longer and, given access to appropriate care, more fruitful lives than any other generation. However, it is also true the kind of family and community networks that provided care in the past are increasingly rare.

A shortage in qualified, trained and committed direct care workers has clear and deleterious effects on the long-term, home health and even acute care services provided by home health care workers. For some disabled individuals, it means a lack of access to the home health care services they need to live healthy and productive lives. Ninety to ninety-five percent of the services provided by home health agencies are provided by personal attendants. In most cases, if personal attendants cannot be found, the client must do without the services necessary to live an active life. If Texas cannot meet the demand for home care, the likely result is an increase in demand for nursing home and hospital admissions.

The effects of a shortage of direct care staff on facilities do not affect access as much as the quality of care. Facilities will not close because of short-term fluctuations in staff. It is more likely that the facility will either be understaffed or require overtime from its direct care staff. Understaffing results in less time being given to each resident, regardless of the care required. Overtime, especially in significant amounts, reduces an aide's ability to provide quality of care even if the number of staff is sufficient. The result, in both cases, is a reduction in the quality of care that is possible and a worsening of working conditions for the direct care staff.

This report enumerates the many obstacles to attracting and caring and committed work force into direct care, such as low pay, lack of benefits and support, and lack of opportunity for advancement. The fewer advantages that this system offers workers, the more likely that the best ones will go elsewhere, resulting in a lower quality of care to the disabled and senior populations who need services.

## **Direct Care Staff Training in Texas**

### **State Agency Oversight**

#### *The Role of TWC*

TWC provides regulatory and coordinating oversight for the state of several aspects of the training system. First, TWC regulates about 350 proprietary schools with training programs and continuing education seminars that are not regulated by other state agencies. In 1998-99, over 83,000 students attended vocational training programs at licensed schools, including 3,014 nurse aide, medication aide, physical therapy aide, home health aide (or personal attendant), and mental health worker students. In order to license a proprietary school, TWC requires a broad array of information, including instructional staff qualifications, occupational demand, and course outlines or syllabi. TWC also inspects equipment and facilities. On-site visits are conducted before proprietary schools' licenses are renewed.

#### *The Role of THECB*

THECB coordinates the higher education system in the state, including health-related institutions, universities, community and technical colleges and degree-granting proprietary schools. Most of the courses offered in the area of direct care are for the purpose of continuing education and do not provide credit for a degree. TWC and THECB have dual regulatory authority for degree-granting proprietary schools.

### **Occupational Requirements for Specific Programs**

#### *Nurse Aide Training*

Federal regulation requires that direct care staff employed by a nursing facility be trained within 120 days of hire. The training is based on the Texas "Curriculum for Nurse Aides in Long Term Care Facilities," which was originally developed in 1988 and was revised in 1997. The second edition was developed by Texas Department of Human Services staff in conjunction with nurse aide training providers and representatives of the Texas Health Care Association and the NACES Plus Foundation.

The minimum curriculum, which providers of nurse aide training in Texas must use, is to be taught in a 75 clock hour (or more) course consisting of 51 classroom hours and 24 clinical hours. The curriculum outlines training and minimum training time in the following major areas: Orientation to Long Term Care (16 hours); Personal Care Skills (toileting, grooming, and other activities of daily living, 12 hours); Basic Nursing Skills (13 hours); Restorative Services (4 hours); and Mental Health & Social Service Needs (6 hours). TDHS requires that students complete at least the first 16 hours of nurse aide training before working with clients during clinical practice. Some nurse aide training programs at proprietary schools and community colleges are longer than 75 hours, including Patient Care Attendant/Technician programs at community colleges for over 700 hours. The majority of nurse aide training programs at public and private institutions have a duration between 75 and 150 hours.

Nurse Aides must show competency by successfully passing both a skills and written examination. Individuals may request to be given the test orally in English or Spanish, but must record their own answers on the form provided. The skills exam requires that the individual correctly demonstrate 4 out of 5 manual skills. The National Nurse Aide Assessment Program (NNAAP) examination consists of 70 multiple choice questions.

Upon successful completion of a nurse aide training program and passing the statewide skills and written examinations, a nurse aide is listed in the Texas Nurse Aide Registry and may work in any nursing facility.

#### *Medication Aide Training: Long-Term Care*

The Medication Aide Program is governed by Chapter 242 of the Texas Health and Safety Code, which addresses the administration of medications to facility residents. Medication Aides must complete an approved 140 hour training program, including 100 hours of classroom instruction and training, 20 hours of return skills demonstration laboratory, 10 hours of clinical experience including clinical observation and skills (demonstration under the direct supervision of a licensed nurse in a facility), and 10 hours in a return skills demonstration laboratory.

The curriculum covered includes the following major areas:

- 1) Introduction, orientation and basic concepts;
- 2) Administration of medications; and
- 3) Drugs affecting the body system.

The examination consists of 100 written questions and must be passed with a grade of 70 or above. Currently, there are 72 approved Medication Aide Training Programs, several of which have more than one campus. Training programs can be offered at community colleges, proprietary schools and agencies. The Credentialing Department reviews training programs and approves them if they meet the curricular standards. Curricula at proprietary schools and community colleges are also reviewed, respectively, by TWC and THECB.

#### *Medication Aide Training: Home Health Care*

In Chapter 142 of the Texas Health and Safety Code, the Legislature authorized the Texas Department of Health (TDH) to operate a medication aide program specifically oriented toward home health aides. The curriculum and the examinations were modeled on the long-term care medication aide program. However, this program never really developed as a separate program. To the degree that home health care programs needed medication aides, they hired permit holders from the long-term care program and offered them whatever additional training was deemed necessary. As a result, the educational market for the home health medication aide program never developed. By 1999, when the Legislature transferred the responsibility for the licensing and regulation of the home health care program from TDH to TDHS, there were only four certified providers of this kind of training, and only three active permit-holders.

TDHS is proposing that the home health care medication aide program be made a specialty of the long-term care medication aide program. Under this proposal, the requirement for a higher level of supervision for home health care because of the community setting would be maintained, as would a training curriculum with a greater emphasis on home health issues.

### *Home Health Aide Training Requirements*

HCSSAs in Texas with the category of Personal Assistance Services are not required to use home health aides. In this service category, the unlicensed personnel must demonstrate competency in the task(s) assigned. For those HCSSAs providing the category of service of licensed home health (LHH), the unlicensed personnel may qualify in one of six ways. The HCSSAs providing licensed and certified home health care (LCHH) or Medicare, the unlicensed personnel providing care must successfully complete the training and competency or competency evaluation required by Code of Federal Regulations (CFR) 484.36.

The definition of a home health aide under the Medicare program is defined CFR 484.1. That regulation provides that home health care aides must successfully complete state-established

or other training program, or pass a competency examination or meet the requirements of another training program.

In Texas, TWC's Proprietary School program has established the minimum curriculum requirements for home health aide training programs at licensed proprietary schools, based on the Texas Department of Health's earlier rules for home health agencies providing training. The aide training program must address each of the following subject areas through classroom training and supervised clinical experience totaling at least 75 hours, of which at least 16 must be devoted to supervised practical training.

The curriculum includes the following elements: communications skills; observation, reporting and documentation of patient status and the care or services furnished; reading and recording temperature, pulse, and respiration; basic elements of body functioning and changes in a client's condition that must be reported to an aide's supervisor; maintenance of a clean, safe and healthy work environment; recording emergencies and knowledge of emergency procedures; the physical, emotional and developmental needs of the client; the need for respect for the patient, including his or her privacy and his or her property; appropriate and safe techniques in personal hygiene and grooming; safe transfer techniques and ambulation; normal range of motion and positioning; adequate nutrition and fluid intake; and other tasks as judged necessary by the agency.

TWC has also established minimum curriculum requirements for licensed proprietary schools offering short courses to train individuals who are already nurse aides to become home health aides. Because of the reduced supervision, home environment variations, and isolated situation encountered by many home health aides, TWC requires that these courses must be at least 20 hours and include the following topics: qualities and characteristics of a home health aide; the home environment; ethics; infection control; housekeeping skills; safety issues; dietary considerations and meal planning; personal care; observation, reporting, and recording; and personal safety.

Satisfactory completion of this training is one of six ways in which an aide may qualify in Texas to work in a LHH agency. The other five are:

- 1) to have a minimum of one year of full-time experience in direct client care in an institutional setting (hospital or nursing facility);
- 2) to have one year of full time experience within the past five years in direct client care in an agency setting;
- 3) to have satisfactorily completed a competency evaluation program which complies with the requirements of this section;
- 4) to submit to the agency documentation from the director of programs or the dean of a school of nursing that states that the individual is a nursing student who has demonstrated competency in providing basic nursing skills in accordance with the school's curriculum; or
- 5) to be on the TDHS Nurse Aide Registry with no finding against the aide relating to abuse, neglect or misappropriation of client property.

*Specialized Training for Specific Populations in Home Health Programs:  
The Deaf/Blind (DM-MD) Waiver*

Certain special populations may require training. For example, the Deaf/Blind (DM-MD) Waiver Program has developed a curriculum, which is provided to all organizations providing services under this waiver, both for-profit and non-profit. The curriculum is built around the special needs of individuals in this population. It includes the following topics: communication; orientation and mobility; active participation to help clients achieve a level of self-sufficiency; and understanding and reacting appropriately to difficult behavior.

The Deaf/Blind curriculum may point the way for further development of the training system for direct care staff. It is relatively short and focussed on the needs of a particular group of clients. This curriculum, and the development of an educational market of providers and trainers, shows that a smaller, less costly, more flexible model can work in the home health care arena. There are other populations, such as those served by the Commission for the Blind and the Texas Commission for the Deaf and Hard of Hearing, that would benefit from additional training, especially in the area of communication.

*Specialized Training for Mental Health Facility Workers*

Direct care workers also work in mental health facilities, which have their own training Programs, depending on whether the attendant works at a state hospital, state school or in a group home situation. At the state hospital in Austin, direct care workers receive three full days of training and orientation before observing or working with clients in a hospital unit. Initial topics covered that are not specific to the agency or mental illness include infection control (1 ½ hours), emergency safety (1 ½ hours), ethics (1 ½ hours), and patient rights/abuse and neglect (2 hours). After new hires have observed experienced staff in the hospital unit for a day, they receive additional training, including HIV/AIDS, diversity (2 hours),

lifting/transfers/wheelchair safety/first aide/medication observation (4 hours), CPR (4 hours), and vital signs (1 ½ hours). After a period of observation on the unit lasting two days, new hires receive additional training on nursing roles and clinical delegation (1 hour) and observing and reporting (2 ½ hours).

Additional specialized training for TDMHMR direct care workers in any setting is required prior to working with the following clients: children (CPR for children, 2 hours), deaf clients (2 hours), mentally ill clients (2 hours), blind and visually impaired clients (8 hours), and clients with seizures (2 hours).

### *National Curriculum Initiative*

The Home Care Aide Association of America has proposed three levels of home care aide training. These levels include 1) basic housekeeping and homemaking services, 2) non-medically directed personal care and client instruction on basic tasks to increase clients' independence, and 3) complex personal care and appropriate client instruction consistent with personal care skill training. As with federal minimum requirements for nurse aide training, a minimum of 16 hours of training must be completed before working with clients. It is always difficult to mandate training without a funding stream. The curriculum may, however, serve as a useful resource for content development in shorter training modules.

### *Summary*

The most well-developed direct care training system for direct care is the nurse aide training program, which is required by federal regulation and supported by Medicaid funding. It has proven so successful that other segments of the health care industry, such as hospitals and home health agencies (at times of higher Medicare reimbursement rates) have sought out individuals with that training. The state has contributed, through the TWC and THECB, to regulate course offerings.

In the rapidly-expanding arena of home health, regardless of whether the direct care staff is employed directly by the client or services are provided through a home health agencies, the long-term care model may not be feasible. Certainly, that is the conclusion to be drawn from the lack of demand for a home health medication aide program. That does not mean that medication aides do not work for home health agencies. It means that there was no need for a separate additional medication aide permitting program, particularly since the home health medication aide program was almost exactly the same as the long term care medication aide curriculum.

Any additional training program for direct care staff working in home settings must meet the needs of both clients and staff, in the widest sense of the term. It must take into account the diversity of the client population, including the fact that many clients have the desire and the need for greater autonomy, independence and control over their situation. It is also evident that it will be difficult to develop a large-scale training program on the model of long-term care without a federal requirement to provide training and the Medicaid program to subsidize it. For those reasons, it is apparent that the most logical next step is to explore shorter, more flexible training programs. The basis would be a common core curriculum for working with clients in the home, to which specialized training components could be added as appropriate

to meet the special needs of groups of clients. The training would be shorter and less expensive than the nurse aide training.

This approach does not exclude certifications for specialized competencies or skill sets if there is a market for each one that is developed. In addition, it allows for greater input by clients into the development of a core training program and optional components. Finally, there is a need to develop training for the clients themselves, where appropriate, to allow for greater independence in the management and training of the direct care staff providing services to them. Such a training package could only be developed in coordination with organizations representing clients, providers, training institutions, and medical professionals.

### **Texas' Direct Care Staff Career Ladder**

A properly-functioning career ladder should provide workers with a sense of opportunity. If they stay in their current field, workers need to know that they can, by performing well and acquiring new skills, achieve greater responsibility, pay and independence in their work. On paper, the Texas system looks as though it has developed an informal career ladder, beginning with personal attendants. Intermediary steps are available through training to become a nurse aide and a medication aide. The next rung is the licensed vocational nurse, and the final option is the registered nurse.

There are no statistics on how many individuals use this career ladder. Licensed vocational nurse students sometimes work as nurse aides while completing their studies. There is substantial anecdotal evidence that many individuals have in fact migrated in reverse along the training continuum. Specifically, nurse aides, having already received their training in nursing facilities, often accept higher-paid employment in hospitals and home health care, both of which are settings that offer limited training. In essence, the better-paying industries offered greater pay and took advantage of the training funded by Medicaid in association with nursing facility care. Home health care agency associations report that fewer nurse aides work in that setting since the reduction in Medicare payments under the Balanced Budget Act of 1997. Whatever the current status of the home health care agency employment of nurse aides, the fact that, at least for a time, this career ladder seems to have operated in reverse is a clear indication that it does not function well.

Therefore, despite appearances, it looks as though in general there is no functioning career ladder, at least in the traditional sense, where pay, responsibility and training increase as an individual ascends through the steps. As noted earlier, however, a program model has been implemented and replicated in which unlicensed staff have been supported by employers to achieve nursing degrees.

Recently, a grant proposal was submitted to TWC to support nurse aide skills training for individuals employed as launderers, housekeepers, cooks, food preparation workers, dishwashers, and the other lowest-skilled service jobs at nursing homes. Supportive and referral services will also be provided so that when students complete their training, they will receive a promotion and raise. Additional training in more advanced patient care skills will be offered, which will result in a salary increase of \$1.00 per hour. The funding source was a U.S. Department of Labor Achieving Performance Excellence (APEX) Grant

to TWC. The proposal was developed by the Tarrant County Workforce Development Board in collaboration with Integrated Health Services, Inc., the nursing home employer, and SER National, a non-profit organization focusing on improving opportunities for Spanish-speaking individuals. The training curriculum will include nurse aide skills, English as a Second Language in the context of the nursing home setting, and soft skills training. Soft skills will include actively helping clients, as opposed to waiting to be asked to help, social perceptiveness, active listening, and workplace behavior. Soft skills training may also include confidence/self-esteem building, valuing cultural diversity, and career planning. The nature of the partnership -- an employer, a workforce development board, and a training provider -- to train incumbent workers may offer another option and potential resource for personal attendant training and building meaningful career ladders.

## **Client and Provider Attitudes**

During the development of this report, TDHS sustained ongoing discussions with home health care providers and client advocacy organizations. During those discussions, several concerns were raised that merit note. Some of the advocacy organizations were concerned that clients prefer to provide training and that additional training requirements would restrict access. Providers were concerned that additional requirements would raise their costs without any increase in reimbursement.

To further explore these attitudes, TDHS worked with advocacy organizations, providers and other state agencies to develop two short surveys addressing the key questions, such as how much training is currently provided, how much should be provided, and what topics should be covered. The first was sent out to HCSSAs through the newsletter of the Texas Association for Home Care. The second was provided to advocacy organizations across the long-term care spectrum.

These surveys were intended to elicit input, and do not in any way provide a scientific sampling of either the provider or advocate communities. The response rate was very low, but some of the comments bear repeating. Advocacy organizations representing clients in facilities or with cognitive deficiencies favored longer and more detailed training than those which represent people receiving direct care in the community. The latter group supported training of ten hours or less. One respondent noted, in answering the question about length of training, that “Time should not be the issue,” but instead should be linked to client needs, “with clients training providers whenever desired by the client.” That position was echoed by some providers in their responses to the HCSSA survey.

All providers provide some sort of training or orientation. The cost of additional mandated training was of concern to many respondents. One provider wrote the following: “If additional training was required, it would place unnecessary costs on the agency.” Another stated “I’d never find attendants – and surely couldn’t afford them.”

Length of training varied between one hour to a week; some agencies, including the one that gives an hour of initial training, conduct ongoing training for each client. One agency noted that the level of training depends on the workers’ experience and another wrote that “(w)e need to look at client qualifications – many clients have needs too intense for routine attendant care.” Estimates of annual training costs per direct

care staff ranged from \$100 to \$3,000 per attendant; estimates of total costs for training per year ranged from \$5,500 to \$22,000. From the responses, it appears that some of the variation can be accounted for because some agencies included costs, such as work lost because staff was in training or in-service day costs, that others did not. Still, the survey is best viewed as a tool for soliciting broad information and is no way scientific. Firm conclusions cannot be drawn on the information provided in response to it.

Agencies responding to the survey offered some recommendations. The only recommendation volunteered by a majority of the respondents was an increase in pay. Others recommended increases in benefits, more training, paid training, and access to transportation.

On the basis of the discussions and surveys, it is clear that there is consensus about what kind of training program should be developed for personal attendants. The issues that generated the most discussion were not the content of such training, but the cost of it, the length of time devoted to it, and whether the client should provide it or not. It is important to note that these issues are inter-related. In general, shorter times means that the training is less comprehensive, but also less costly.

## **Recommendations**

### *Increase the Number of Direct Care Staff*

TDHS is in the process of developing a pilot project in HHSC Region 7 to increase the availability of personal attendants through the identification, development and coordination of key factors aimed at increasing the number of qualified personnel to provide PAS for people with disabilities.

In addition, TDHS will develop a survey of current direct care staff to determine what factors increase job satisfaction and develop information so that TDHS can better identify what factors will increase both recruitment of individuals interested in this field.

It is clear that, at least under current economic conditions, the number of individuals entering this field will not meet demand in most, if not all, parts of the state. To make up the difference, the long-term care field will have to look for individuals in programs that have not been fully explored, including high schools and colleges.

While much of this report argues for the development of smaller, more flexible training, on the basis of greater responsiveness to client needs, it is very important that the state continue to explore avenues for providing and promoting career opportunities to direct care staff. One innovative proposal that deserves notice, and, hopefully, funding is the proposal by the Texas Senate Interim Committee on Human Services, which has recommended that the state establish a program to provide a stipend for direct care staff wishing to become licensed vocational nurses, provided they stay in the long-term care field for a specified period after graduation. The possibility of developing and implementing a common core of competencies and knowledge -- for direct care workers across agencies, organizations, and employers with additional optional modules -- would add consistency and create a shared training system. Such a system would support the

portability of training credentials and benefit direct care staff, their employers, and, most importantly, the clients they serve.

*Develop additional training, with emphasis on strengthening linkages between client needs and training*

Working with other state agencies, providers and advocacy organizations, TDHS should develop a common minimum core curriculum for direct care workers before they work with clients. Specialized skill sets and, possibly, certification could build on the core skills and knowledge. It may be best to design the specialized training as workshops or in-service training. TDHS, as part of the pilot project, will be exploring the development of a curriculum for PAS workers in order to enhance skills and professionalism. Instead of further developing a formal career ladder, TDHS believes that the clients and the direct care staff is best served by a more flexible system that provides them with the opportunity to enhance competencies or particular skill sets. It may prove useful in future for programs to develop certifications associated with those competencies.

*Enhance client independence and autonomy wherever appropriate*

The Client Managed Attendant Care and VFI programs have already been mentioned. As part of its pilot program in Region 7, TDHS is looking at the possibility of developing training materials for increasing consumer skill in recruiting and training personal attendants.

*Seek cost-effective sources of funding and promote partnerships for training*

Expanding the training available to personal attendants depends in part on the funding streams to pay for it. There are at least two strategies for defraying the cost of these programs. It may be possible to use Medicaid to fund training for eligible programs, such as Community-Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), Primary Home Care, and the Deaf/Blind Multiple Disabilities (DM-MD) programs. Since Senate Bill 95 directs TDHS to discuss the specific impact of the recommendations on the Medicaid program, more analysis is provided in a separate section below.

Job training programs should also be examined as a potential source of funding. TWC oversees a variety of programs to help adults and youth transition from economic dependency to self-sufficiency. Each of these programs is administered at the local level by 28 local workforce development boards around the state. The largest of these is the WIA, which replaced the Job Training Partnership Act (JTPA). WIA provides United States Department of Labor funds for board clients to attend training programs for 61,098 clients statewide. Approved training providers include community colleges, proprietary schools, and non-profit organizations. As noted earlier, for a training course to maintain approval to enroll WIA-funded clients, the average starting wage for program graduates must meet the minimum subsistence wage identified by the board. Many of the nurse aide and personal attendant programs do not qualify because of wages that fall below the subsistence wage for the local area.

Choices is the federal funded employment and training program that serves applicants and former recipients of Temporary Assistance for Needy Families (TANF) cash assistance. Applications for TANF assistance are made at TDHS, and local boards administer services, including job skills training, work-based training, and assistance with child care, work-related expenses, and transportation expenses. In FY 1999-2000, Choices provided funding, in whole or in part, for 59,595 clients.

The Food Stamp Employment and Training (FSE&T) Program is funded by the United States Department of Agriculture to assist Food Stamp recipients to obtain employment. Services may include vocational training and workfare. FSE&T provided funding for 15,298 clients statewide.

Finally, the Welfare-to-Work (WTW) Block Grant, authorized under the Balanced Budget Act of 1997, targets the hardest-to-serve of TANF recipients. The United States Department of Labor funds supplement state welfare efforts to provide employment activities, vocational training, and any necessary supportive services for a person to achieve and maintain economic self-sufficiency.

The number of workforce-board clients statewide whose training was all or partially funded by TWC-administered programs is shown below:

Program	Number of Clients	Number of TANF Clients	Number of Clients in Direct Care Training Programs	Number of TANF Clients in Direct Care Training Programs
WIA	61,098	5,038	398	80
Choices	59,595	59,595	1,951	1,951
FSE&T	15,298	2	82	0
WTW	10,008	4,431	477	466
Unduplicated Totals	132,760	37,128	2,638	1,138

In addition, it will take funds to pay the training providers. WIA funds are linked to the level of pay earned by graduates. TANF funds represent another possibility. TANF funds can be used for non-financial services like training, but their expenditure is limited to adults with a dependent child in the household or who are the non-custodial parent of a child receiving TANF cash assistance. It is not necessary that the residents be TANF recipients but they must meet an eligibility standard to be established by the state for this purpose.

Thus, there are options that merit further exploration: agencies collaborating with workforce boards and employers to support personal attendant training. It would be necessary to screen individuals to determine those interested in, and best suited for, the helping paraprofessions. Support services, such as child care, transportation, and other family assistance services are necessary to assist individuals to make the transition to the working world. Training curricula for low-skilled individuals would need to be participatory, involving active, hands-on learning. Public and public/private partnerships could bring a wider array of resources in support of personal attendant training.

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However, none of these steps will address the key problems faced by the system: the low level of pay, lack of benefits and lack of support systems faced by direct care staff. These factors not only affect availability of staff to fill the existing need, but also limit access to educational opportunity for workers. The 76<sup>th</sup> Legislature took a very important step by adopting Texas Department of Human Services (DHS) Riders 37 and 38. Appropriations rider 37 directed DHS to provide incentives to increase wages and benefits for attendants in community care programs and appropriations rider 38 direct DHS to provide incentives to increase direct care staffing and direct care wages and benefits in nursing facilities. Rules were established implementing these riders effective May 1, 2000, for nursing facilities and September 1, 2000, for community care programs. It is critical that the state continue to look for innovative ways of increasing opportunities for those who provide the greatest proportion of care in Texas' nursing facility and home health care systems.

## **Impact of the recommendations on Medicaid rates**

Senate Bill 95 requires that this report take into account the effect of the recommendations of this report regarding pay and training on Medicaid rates. It is difficult at this time to foresee with precision what effect these programs would have on Medicaid rates for nursing facilities and community care. There are three areas in which the proposals in this report may have an effect on Medicaid rates: provider recruitment and retention costs; training costs; and pay. To the degree that these proposals increase the supply of direct care workers, reducing the recruitment and retention costs for providers, they may have an eventual, small positive effect on expenditures. If Medicaid will share in the cost of training personal attendants in Medicaid programs, the state's share of the cost to implement such training programs will be reduced. It is unclear that any of the recommendations in this report will necessarily lead to increases in pay for direct care workers. If they lead to pay increases in Medicaid community care programs, there will be an increased cost. However, as with training programs, since Medicaid will share in the increased cost for attendant pay, the state's share in any attendant pay increases will be limited to the state's required matching funds.

## **Conclusion**

As the population of senior and disabled Texans continues to grow, one of the most critical issues is the shortage of workers to provide the services they need. Many factors contribute to that shortage, including low pay and benefits, competition from better-paying industries, and lack of access to transportation and child care. As demand will continue to rise for personal attendant services, failure to

address the shortage of people willing and able to do the work will be measured in the quality of life of senior and disabled Texans.

This combination of circumstances presents a serious challenge to the state's ability to provide services. To meet that challenge a comprehensive response that is not limited to training issues. Without efforts to increase the supply of workers, best training curriculum will have no effect. Moreover, to be effective, strategies designed to address this challenge must be coordinated with all affected partners, including client advocacy and provider organizations and other state agencies. TDHS has already begun this process with a pilot project designed to identify innovative strategies toward increasing the supply of direct care workers. This agency will also move forward with the other steps outlined in this plan, working with all willing partners to address the critical shortage in both training and labor force.