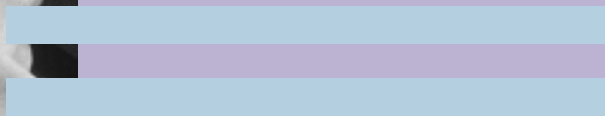
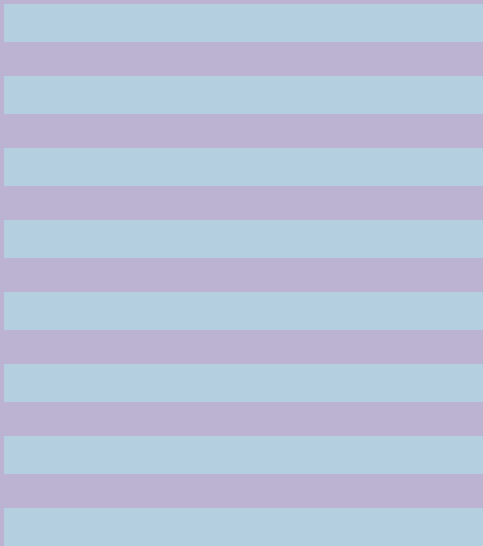


Training Quality Home Care Workers

A PHI Technical Series
Publication



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

PHI's workplace practice and caregiving innovations have been developed in cooperation with several closely affiliated direct-care staffing agencies and training programs, including the highly successful **Cooperative Home Care Associates** of the South Bronx and **Independence Care System**, a nonprofit managed long-term care program for people living with physical disabilities. Through its consulting practice, PHI assists health care providers across the long-term care spectrum to adapt these practices to their specific environments.

A recognized leader in long-term care workforce policy, PHI runs the **National Clearinghouse on the Direct Care Workforce**, a national information center on the staffing crisis in long-term care. In addition, PHI staffs the national **Direct Care Alliance**, an advocacy voice representing consumers, workers, and concerned providers who, together, are creating both quality jobs and quality care within the long-term care sector. Finally, PHI has state-based policy and practice experts working with providers, consumers, and worker/labor organizations in New York, Pennsylvania, Massachusetts, Michigan, Maine, and New Hampshire.

PHI's expertise in both industry *practice* and *public policy* has made the organization a valued partner to state and federal agencies and industry stakeholders. In affiliation with the Institute for the Future of Aging Services, PHI draws on this dual expertise in its role as designated national technical assistant for the **Better Jobs: Better Care Demonstration Project**, funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies. Through this project, PHI's state-based work expands to Vermont, Iowa, North Carolina, and Oregon.

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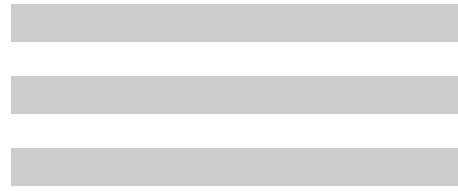
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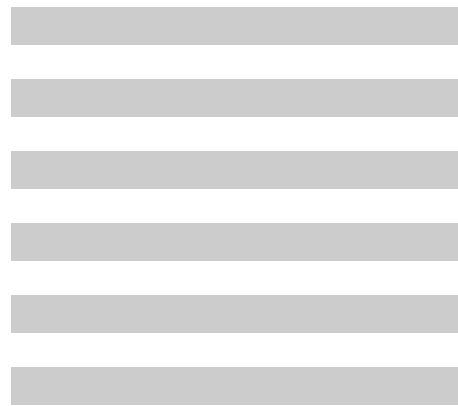
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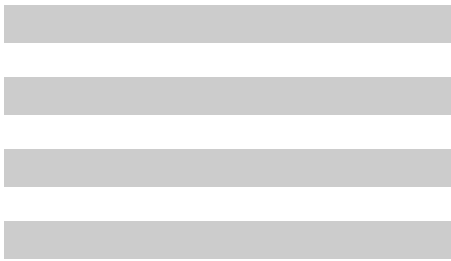


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Preface

This publication is intended to assist agencies that provide home care services in developing quality training programs for their employees. Whether your agency provides Medicare-certified home health services or other personal assistance in the home, the approach to training described here can form a solid foundation on which to build a competent and stable workforce. If this overview of PHI's approach is helpful to you, please consider purchasing our *Guide to Implementing Learner-Centered Home Care Training*, which provides more detail on initiating and implementing our training model. (For information on ordering, see inside back cover.)

This publication is not a curriculum; requirements for training home care workers vary enormously from state to state, and we have not tried to incorporate the specific elements of these requirements into our discussion. For example, though home health aides who are employed by Medicare-certified agencies must attend 75 hours of training and/or pass a competency exam, no national requirements exist for workers who are employed directly by consumers or by a range of agencies that provide various types of home support services. In each state, different requirements apply to different categories of workers, agencies, and services. If you plan to initiate a training program, contact the appropriate state office to review the relevant rules and regulations.

Although specifically focused on the training of home care workers, much in this publication is equally relevant to the training of direct-care workers who are employed by long-term care facilities. As part of its technical series (see p. 26 for titles and ordering information), PHI is preparing a separate publication that focuses exclusively on training for certified nursing assistants.

Introduction

Home care services are critical to the quality of life of elders and people living with disabilities. These consumers of long-term care services cherish independence, which is often made possible by a paid caregiver who provides support and assistance with a wide range of tasks, from personal care to shopping and bill paying (see “Types of Home Care Workers,” below). Not surprisingly, consumers frequently identify their relationship with their caregiver as the most important factor in the quality of care they receive.

Unfortunately for consumers, high rates of turnover among home care workers interfere with establishing consistent, ongoing relationships with caregivers. Often home care workers stay with an agency only a couple of months, leaving the consumer to cope with adjusting to a new caregiver just as she or he has become comfortable with the first.

To provide their clients with the quality care they demand and deserve, all home care providers need to address this constant churning of direct-care staff. Turnover rates of over 50 percent undermine the ability of any agency to provide quality services. In addition, for the provider agency, this kind of turnover creates added expenses in recruitment, orientation, and training, which eat into the bottom line.¹

1 Estimates for the cost of replacing workers range from \$1500 to \$5000 per employee. For a discussion of turnover costs, see *The Personal Assistance Services and Direct Support Workforce: A Literature Review*, available through the National Clearinghouse on the Direct Care Workforce: www.PHInational.org/clearinghouse

Types of Home Care Workers ²

Home health aides are employed by Medicare-certified home health agencies or licensed agencies that contract with Medicare-certified agencies. Home health aides are required by federal law to undergo 75 hours of training and/or pass a competency exam, and they work under the supervision of a registered nurse. They assist consumers, usually elders, with personal care as well as some clinical care. In addition, they may perform light housekeeping tasks such as helping to prepare food or changing linens.

Other home care workers, employed directly by consumers or agencies providing various non-Medicare-related home support services, go by a range of titles, including: *personal assistance workers*, *personal care attendants*, *home care aides*, *home attendants*, and *homemakers*. The home support services provided by these workers may be paid for by Medicaid programs, Departments of Aging, other state funding sources, or privately paid for by consumers. Home care workers who are not providing Medicare-certified services help with personal care such as toileting, bathing, eating, and transferring as well as everyday activities such as housekeeping, meal preparation, shopping, and bill paying. There are no national training standards for these home care workers, though some states have established their own requirements.

2 Throughout this publication, the term “home care worker” refers to any frontline caregiver providing support services in a consumer’s home; thus, the term is inclusive of home health aides providing Medicare-certified services and all other home care workers.

Direct caregivers may not need extensive formal education, but they do require a special set of skills.

The Paraprofessional Healthcare Institute (PHI) has found that one way to improve retention is by providing a high-quality employer-based educational program. Each of the agencies that has adopted PHI's training model has implemented an enhanced home care training program that is rigorous and challenging, but also respectful and supportive of trainees who have often been failed by traditional educational institutions. Participants work hard because they know that if they can meet the challenges of the program—usually three to five weeks of full-time training—they are guaranteed a job with the same agency that trained them—one that respects them and the work they will do as caregivers.

This publication provides an overview of key elements of this enhanced training program. This is not a curriculum, but rather a discussion of PHI's overall approach to educating and supporting new home care workers. For specific curricula needs, check with relevant state offices on training requirements for home health aides and other categories of home care workers in your state.

Overview

The goal of PHI's approach to entry-level training is to *create a learning environment that enables participants to become confident home care workers, capable of delivering the highest quality client-centered care*. By high-quality client-centered care, we mean support and assistance that attends to the personal care and basic health needs of the consumer while enhancing his or her independence, dignity, safety, and comfort.

To provide high-quality support and assistance, direct caregivers may not need extensive formal education, but they do require a special set of skills. For example, a home care worker must be prepared to respond to health care crises, talk with depressed clients, and calm irate relatives, all without the immediate availability of a supervisor. Thus, caregiving requires not only compassion but also

- Critical-thinking and problem-solving skills,
- The ability to establish quality relationships with clients and family members,
- Health-related knowledge, and
- Personal care/clinical skills.

With this in mind, we identified three primary objectives for graduates of quality training programs:

- To enhance their interpersonal, critical-thinking, and personal care skills as well as their health-related knowledge;
- To ensure they are "job ready"; and
- To ensure they feel confident in their ability to provide quality support and assistance.

Though all the agencies that have adopted PHI's training model share these overall goals, no two agencies use an identical curriculum—each tailors its educational program to meet the needs of its employees, satisfy the demands of the local market, and comply with state regulations. What these programs have in common is the following core set of practices:

- **A learner-centered approach to training** that develops critical-thinking skills in the context of teaching health care content and clinical/personal care skills;
- **An enhanced three- to five-week curriculum** that emphasizes developing interpersonal problem-solving and communication skills in an environment that carefully balances support and accountability in order to prepare trainees for employment;
- **Three to six months of intensive on-the-job training** and support that follows classroom training;
- **Peer support** that emphasizes learning from more experienced employees who understand the complexities of direct-care work and the obstacles that new trainees often face as they take on new responsibilities; and
- **An employment counselor** who helps trainees and new employees overcome barriers to full-time employment—for example, by helping new employees access transitional public benefits.

In addition to this core set of practices, several of the agencies that use PHI's training model share two other critical practices that contribute to the success of their educational programs. First is a *rigorous selection process* and second is *guaranteed job placement*.

PHI has worked with several agencies to develop not only quality training but also effective recruitment programs. Rather than accepting anyone who walks through their doors, these agencies seek out individuals for their training and employment programs who demonstrate a high level of compassion, patience, warmth, and maturity. These individuals may have supported a family member or friend through a long illness or have had other experiences that demonstrate their capacity to care for others. During a three-part selection process, each agency assesses the ability of candidates to solve problems in their own lives, express themselves clearly, take initiative, and establish caring relationships. We have found that candidates who show some innate skill in these areas are much more likely to become quality caregivers.³

Another factor that has been critical to success in building a stable, well-trained workforce is that each agency guarantees a job to all trainees who graduate. This not only makes the program attractive to motivated individuals in search of employment, but also allows each employer to establish, during training, a culture that is at once supportive and demanding. Trainees understand that the high expectations that are a hallmark of their training programs carry over into employment, but they also know that their employers will do their best to provide the supports workers need to perform at their highest level.

³ See *Recruiting Quality Health Care Paraprofessionals* (PHI, August 2000), available through the National Clearinghouse on the Direct Care Workforce: www.PHInational.org/clearinghouse

Although we developed the PHI educational model as an employer-based training program for home care workers, freestanding training programs have successfully adapted our model by establishing strong relationships with one or more employers.⁴ In this context, the training agency (as opposed to the employer) often offers supportive services during the first year of employment. Regardless of how these supportive services are provided, we have found that ongoing support during the first three to six months of employment is essential to long-term retention.

Employers can no longer count on a seemingly infinite supply of poor women to accept low-wage caregiving jobs, in which the work they do is undervalued and underappreciated. Constant turnover is undermining quality of care, at the same time that consumers are demanding more and better services. We offer a successful, field-tested approach to creating a more valued and valuable workforce, capable of caring for an increasingly older, sicker, and more vulnerable population. In the following pages we describe that approach to educating new home care workers in more depth.

Adult Learner-Centered Education

*Tell me and I'll forget
Show me and I may remember,
Involve me, and I'll understand.*

— Native American Saying

Adult learner-centered education is the teaching philosophy that underlies the success of PHI's training model. This teaching practice begins with the fundamental assumption that *all* people are capable of learning, regardless of age. Although adults often resist learning due to past experiences in educational settings, everyone learns and incorporates new knowledge throughout their lives. Learner-centered education facilitates that learning by building on the knowledge and skills that adults bring with them into the learning setting. We have found that the varied experiences of trainees tremendously enrich the learning environment.

The learner-centered classroom is built around some fundamental assumptions about how adults learn. These can be summarized as follows:

- Learners achieve the best results when they feel safe, supported, and respected.
- Learners will understand and retain material more effectively if they are actively engaged in the discovery process.
- Learners have different strengths and weaknesses and different styles of learning.
- Learners learn best when what's being taught is relevant to their needs.
- Learners need to be held to high standards; this is best accomplished through clear, appropriate, and regular feedback that reinforces success.

⁴ The Good Faith Fund Careers in Health Care program in Pine Bluff, Arkansas, is an example of such a program. This program trains nursing assistants and places them with local employers.

A Safe and Supportive Learning Environment

Creating a safe and supportive learning environment for a diverse group of learners is not easy. First and foremost, instructors must establish an atmosphere of respect, in which all participants feel valued for what they bring to the classroom. Second, it is essential to establish a structured environment with clearly articulated expectations—a learner-centered classroom may appear loosely structured, but in fact, *a safe space is created by establishing unambiguous standards for behavior and participation and holding everyone accountable.*

Training programs modeled on PHI's approach use a number of techniques to increase the comfort level of participants. First, all training sessions begin with an orientation. The focus of the orientation is team building and establishing clear expectations. (See Appendix 1 for an example of how HomeCare Associates of Philadelphia structures their orientation.)

Instructors reinforce these expectations during the first week of training, reviewing mutually established ground rules for participation and making a connection between appropriate classroom behavior and appropriate standards of behavior in a client's home. They also use learning games and other activities to ensure that participants get to know each other early in the training.

Instructors must establish an atmosphere of respect.

Techniques for Creating a Safe Classroom

The Koosh. The *koosh* is a small rubber ball that instructors use to manage participation. In every classroom some people like to talk and others are quiet and shy. The person holding the koosh shares her experience or thoughts—while others listen and learn. Sometimes training participants pass the koosh among themselves; at other times, the instructor might pass the koosh, using it as a tool to draw out those who are too shy or intimidated to speak up on their own.

Icebreakers. Icebreakers—learning games that help people relax and laugh—are a great way to start each day of training. There is nothing like movement and laughter to break through tensions and fears and to create a sense of community. In the few minutes that it takes to do an icebreaker, participants let go of the stress of their everyday lives and re-focus on what they are there for—learning to be a home care worker. Icebreakers ensure that everyone in the classroom is better prepared to learn. Instructors often find icebreakers useful in introducing new topics.

Examples of icebreakers can be found in many reference books; for example, *The Complete Games Trainers Play*, Volumes 1 & 2, by Edward E. Scannell et al. (McGraw-Hill Trade, 1995 & 1998) and *201 Icebreakers*, by Edie West (McGraw-Hill Companies Inc., 1997).

During the training, much of the learning process takes place in learning teams—small groups of trainees who work together analyzing problems posed by the instructor, developing role-plays, or practicing personal care skills. These learning teams are often facilitated by peer instructor—senior home care workers who understand the challenges of learning and of taking on a new career (see “Who Supports Trainees and New Employees?” p. 15).

Active Learning

In a traditional classroom, the teacher has knowledge, which she imparts to her students. In this passive learning model, students are empty vessels waiting to be filled. Learner-centered education uses a problem-posing model, in which learners are asked to apply knowledge to real-life situations they might encounter as workers. The table below contrasts these two models of teaching and learning.

The problem-posing model can be applied to teaching health content, personal care skills, or interpersonal problem-solving and communication skills. The goal is to engage learners in reflecting on new information, analyzing it, and applying it to the situation at hand. In problem-posing classrooms, learners are more likely to develop the critical-thinking skills they need to respond to unpredictable situations they confront at work and at

Information Model	Problem-Posing Model
Teacher imparts information and skills usually by lecturing and use of drills.	Teacher presents an audio/visual or written stimulus and facilitates discussion of a given concept, topic, or problem.
Stimulus (i.e., teaching materials, etc.) has complete information as possible, leaving little or nothing for the learner herself to contribute.	Stimulus has only partial information. Learner contributes from her own life experience and gathers additional data to better understand the topic or problem.
Learner assimilates information like a sponge, from the teacher’s mind and from texts.	Learner analyzes the concepts or problem, evaluates its importance, considers causes and effects, considers alternative solutions, decides on action, if any, and discovers skills helpful in problem solving.
Emphasis is on mastery of subject matter and on learning by rote.	Emphasis is on use of learner’s own mind for inquiry and problem solving.
Exams are used to assess mastery of material.	Exams are only one form of assessment; presentations and other activities combine review and assessment.

home. Moreover, active learning considerably improves the ability of learners to retain new knowledge as they integrate new concepts into their understanding of the world around them.

Instructors who adopt PHI's approach to training use several techniques to engage participants in the learning process. At the core of each teaching program is the *case study*. Trainers prepare a case study by creating a care plan and duty/time sheet for a fictional client. After reviewing the case with training participants, the instructor complicates the situation by posing questions: for example, "As the home care worker in this case, what would you do if the client refused to eat the food you prepared?" A problem such as this encourages trainees to think about how to talk with the client about the food he or she enjoys, about whether or not the client is feeling physically well, about depression or other factors that may contribute to loss of appetite. It also stimulates discussion about how to encourage clients to eat—for example, by talking with the client about foods he or she once enjoyed preparing or eating, or by learning to prepare culturally appropriate foods. Case studies become increasingly complex over the course of a training cycle, challenging trainees to address complex disease-related questions, caregiving practices, and work-related policies.

We find that integrating questions regarding workplace policies into case studies and other classroom activities is critical to enhancing job readiness. For example, all case studies include paperwork identical to what the trainees will encounter on the job. Trainers also pose workplace policy-related questions; for example, an instructor might introduce a case study and ask, "Your client refuses to take her medication at the time stated in his care plan; what do you do?" Or, "You wake to find your child is sick; you can arrange care, but it will take an extra hour of your time, making you late to your client visit. What will you do?" In discussing situations such as these, trainees come to understand that policies such as "no call/no show" or "observe, record, report," are not just "rules," but meaningful guidelines that ensure client safety and comfort.

Many teaching techniques promote active learning. In addition to the case study, we encourage the use of learning team activities/discussions, role-plays, and interactive lectures in which the instructor draws on the knowledge that trainees bring with them into the classroom. Role-plays are a great way to get into a case study, giving participants a chance to try out different responses to a situation and then analyze which response might have been most successful. Role-plays can also be used to reinforce new skills—for example, by asking trainees to integrate several personal care skills while role-playing a morning with a client.

On Using a Textbook

Many home care trainees have weak English-language literacy skills; thus, we discourage the use of a textbook as the primary classroom learning resource. When a program requires the use of a particular text, we suggest that trainers take time to teach trainees how to use a textbook and create easy-to-use study guides that are accessible to learners who may have difficulty reading.

Multiple Learning Styles

Learners have different strengths and weaknesses and different styles of learning: Some people learn best by seeing, others by hearing, and still others by doing. A learner-centered classroom integrates teaching techniques across this continuum in order to ensure that all participants have a chance to learn in a way that works for them. For example, a lesson on body mechanics might include an interactive lecture, a demonstration, and an activity in which trainees lift heavy objects off the floor.

In addition to varying their teaching techniques, instructors can recycle information in different forms, encourage participants to work together to help one another learn, and use end-of-lesson review activities to reinforce new learning at the end of the day. These review activities can be creative and fun experiences that help participants integrate new knowledge with past learning. (See Appendix 2 for an illustration of how Cooperative Home Care Associates uses learner-centered activities to teach a lesson on body systems.)

Relevance of Material

As adult learners, trainees are motivated to learn what is relevant to their goal: to become successful home care workers and employees. If the content and process of learning does not seem relevant to that mission, adult learners tune out—their lives are too complicated, their responsibilities too overwhelming, to spend time trying to learn something that doesn't appear relevant to their immediate needs.

Good instructors look for ways to connect what they are teaching to their participants' past experiences and to their future employment as caregivers. They are aware of the level of complexity of the material—and gear their lessons to the needs of the direct-care workforce, not professional health care workers. A home care worker does not need a sophisticated understanding of the digestive system to know how to identify and respond to symptoms related to digestive problems. What is more important is that the material being taught can be shown to be applicable to a real situation in the workplace. (See Appendix 3 for an example of linking a lesson on nutrition to a “real” home care situation.)

Assessment and Feedback

Learners in any classroom need regular feedback on their performance. Instructors using PHI's model for training and support provide feedback in the three critical knowledge/skill areas: personal care skills, health-related content, and interpersonal/work-readiness skills. In traditional educational systems, the primary feedback tool is the exam.

Review and Assessment Activities

- Self-corrected quizzes
- Learning games such as Concentration or Jeopardy
- Small group presentations
- Return demonstrations
- Role-plays
- Exams
- Individual trainee mid- and end-of-cycle evaluations with instructor

We have found that using exams as the singular mode of assessment is neither accurate, nor useful, for the majority of trainees.

PHI recommends a layered assessment system that ties assessment to the reinforcement of learning. Rather than only giving exams, instructors following our approach assess what trainees have learned through daily review activities. Sometimes these take the form of self-correcting quizzes, but more often instructors ask trainees to demonstrate their learning in a more active fashion. For example, small groups might make presentations, or the class might play a learning game such as Concentration to review key facts about a new body system. When instructors give tests, they always review the answers with the class to ensure that those who didn't understand the first time—or forgot—have another chance to learn the material. Personal care skills are assessed through return demonstrations and role-plays in which participants demonstrate their understanding of how to prioritize a client's needs and integrate multiple skills learned in the classroom setting.

An important part of learning to be a home care worker is developing “relational” skills. These skills include bringing a cooperative and caring attitude to the job, treating colleagues and clients respectfully, resolving interpersonal problems with classmates or instructors through appropriate communication, and following workplace policies. Through regular feedback, instructors can reinforce these skills throughout the training program. We encourage instructors to call trainees on behavior that is inappropriate to the classroom setting—and would be equally inappropriate in a client's home.

In addition, our assessment process includes formal mid- and end-of-cycle evaluations of knowledge and skill development. Participants receive feedback on their knowledge of specific content areas and their attitude and behavior. *Trainees know from their initial orientation that they will be evaluated on issues such as attendance, lateness, listening to classmates and instructors, dressing appropriately, and general demeanor.* These more formal evaluations provide a time to sit down with each trainee to review strengths and weaknesses, any critical gaps in learning, and significant achievements. Reinforcing positive growth, we find, is one of the most effective ways of motivating learners.

The adult learning principles discussed above form the framework for PHI's educational model. In this section, we have reviewed these principles and introduced some strategies for implementing learner-centered teaching in the classroom. In the next section, we discuss PHI's enhanced curriculum and the critical importance of the relational skills component.

Home Health Aide Competency Evaluation

Requirements for determining the competency of home health aides vary by state. In states where written exams are required, PHI recommends that trainers teach test-taking skills. Instructors can give quizzes and tests throughout the training session to familiarize trainees with question formats and to develop test-taking skills. By reviewing each test with the class, instructors not only improve comprehension of the material but also insure that participants are prepared for the kinds of questions that will appear on the final exam.

Enhanced Classroom Training

We have found that even the federally required 75 hours of training for Medicare-certified home health aides is inadequate to ensure that home care workers are prepared to provide the high-quality support and assistance that people living with disabilities and elders deserve. We want home care trainees not only to know how to perform clinical/personal care skills, but to feel confident in their ability to handle unpredictable emotional and physical problems that may arise with clients in their care.

To meet these needs, we have enhanced the standard home health aide curriculum to include a focus on critical-thinking and relational skills and have expanded the time frame for classroom training, from the federally required two weeks, to between three and five weeks.⁵

The learner-centered approach to training discussed above develops critical-thinking skills in the context of teaching basic health-related content and personal care skills. In this section, we focus on a specialized relational skills curriculum that PHI developed to improve the interpersonal problem-solving and communication skills of trainees.

Relational Skills Curriculum: Teaching Communication and Problem Solving

Agencies that adopt PHI's approach to training integrate into their curricula several lessons that focus on team-building, interpersonal problem-solving and communication skills, and understanding work culture and expectations. We have found that these skills are critical to successful employment as a home care worker.

Like other human service jobs, home care is about relationship building—and good communication skills are key. Moreover, we want trainees to become responsible employees—to arrive on time, dress appropriately, call in when emergencies arise, and so on. We don't assume that trainees, who may never have held a full-time job, will necessarily know the "rules" of a workplace setting. We do assume that, with adequate support and understanding, trainees can become committed caregivers and valuable employees.

Below we describe the core components of our relational skills curriculum:⁶

Team Building: Using focused activities beginning early in training, instructors build group bonds that support a positive socialization process and a safe place for learning. These activities include:

- Games that help participants get to know one another
- Focused discussions that have as their goal mutually establishing ground rules for the training
- A specific lesson on cooperation

⁵ Training programs using the PHI approach vary in length due to budget restrictions, market factors, and trainee population.

⁶ For more information about the availability of PHI's Relational Skills Curriculum, contact the National Clearinghouse on the Direct Care Workforce: clearinghouse@PHInational.org

Throughout the training, instructors emphasize cooperative learning, as opposed to individual competition. Trainees often work in small groups, helping one another to solve problems, learn a concept, or teach material to other class members.

Interpersonal Problem Solving and Communication Skills (“The Four Ps”):

The Four Ps break down problem solving into a series of sequential steps that trainees can practice and learn:

- **Pull Back:** Gain emotional control in a stressful situation.
- **Paraphrase:** Listen actively and ask open questions.
- **Present Options:** Identify critical facts, brainstorm solutions, consider consequences, and present options to a client or supervisor.
- **Pass It On:** Document in writing or communicate with others (e.g., a supervisor, coordinator, or nurse) about the problem, using objective language.

To teach the Four Ps, instructors use experiential activities and role-plays that focus on each step in a building-block manner. By creating realistic workplace scenarios, trainees become increasingly adept at resolving conflicts that arise with clients, family members, supervisors, and other members of their health care teams. (See Appendix 4 for an illustration of an “Active Listening” exercise that helps build more effective communication skills.)

Work-Culture Training. The workplace has a distinct culture that is often unfamiliar to home care trainees. “Professionalism” is not an intuitive concept; it is a learned set of behaviors. Using lectures, video presentations, role-plays and other activities, instructors teach trainees work-appropriate body language, dress, and verbal tone. Importantly, trainers provide ongoing opportunities to practice what may be an entirely new set of behaviors and interpersonal relationships.

To succeed in the workplace, trainees must be able to work with people in authority. To teach about this aspect of work, the curriculum is designed to explore dynamics of race, class, and gender in the workplace and how these differences intersect with structures of authority and power. Rather than glossing over some of the unfairness and injustice that is likely to affect the work lives of home care workers, instructors explore feelings about authority and appropriate responses to disrespectful attitudes and behaviors. The goal is to identify responses that allow the worker to maintain dignity while still keeping her job. We find that agencies are much more successful in keeping their employees when they acknowledge the realities of power in the workplace and acknowledge that home care workers are often undervalued and poorly treated—even by those with whom they work closely every day.

By combining this relational skills curriculum with a learner-centered approach to teaching, our training model ensures that trainees develop a set of critical-thinking and

*“Professionalism”
is not an intuitive
concept; it is a
learned set of
behaviors.*

PHI's training model calls for extensive on-the-job support during the first three months of employment.

interpersonal skills that serve them well both in the workplace and in their personal lives. Graduates are able to build positive relationships with supervisors, peers, and clients. In addition, they are able to meet the many challenges of home care work by successfully analyzing the problems they confront, communicating their concerns, and negotiating workable solutions.

On-the-Job Training and Support

The transition from training to actually caring for clients is often difficult for new home care workers. Some new employees are overwhelmed and frightened; others have trouble handling the changes in lifestyle necessitated by employment. No one learns everything about how to support a frail or physically challenged person in a classroom. New employees need tremendous support during this period—and they need to continue the learning that began during classroom training.

Recognizing the need to provide new caregivers with continued support while reinforcing learning, PHI's training model calls for extensive on-the-job support during the first three months of employment. During this time, new home care workers receive regular supervisory visits in the field, opportunities to practice clinical and problem-solving skills, and a chance to simply share experiences with peers and receive emotional support. At many PHI-affiliated agencies, this three-month period is a formal probationary period and is followed by a formal review and an offer of permanent employment. Even after this formal review process is complete, some agencies that have adopted PHI's training approach continue to provide the same level of employee support for an additional three months.

Supervision in the Field

Home care workers often feel isolated and alone during their first weeks of employment; thus, maintaining close contact with new employees is essential. Agencies use different strategies to achieve this goal. For example, some agencies immediately pair new employees with peer mentors who check in regularly to provide support and answer questions. In other agencies, service delivery coordinators call new employees frequently to assist with problem solving and to provide immediate feedback. (For role definitions of mentors, coordinators, and others who support new employees, see "Who Supports Trainees and New Employees" on the following page.)

In addition, during the first two weeks, agencies serving Medicare clients have a nurse supervisor (an RN or an LPN working under the supervision of an RN) visit each new home care worker while at a case assignment.⁷ This first visit is usually informal—

⁷ In cases where nurse supervision is not appropriate, a social worker may be able to play this supervisory role.

the nurse supervisor is there to provide support rather than to perform a formal competency review. During subsequent supervisory visits, which occur monthly during this period of intensive support, the nurse supervisor talks with the new employee, answers questions, and observes communication and problem-solving skills as well as clinical/personal care skills. The nurse supervisor may also talk privately with clients to determine if they are satisfied with the assistance they are receiving. Nurse supervisors record their observations on a standard form, which is incorporated into the employee's three-month review.

If a worker appears to need additional clinical training, the clinical supervisor can arrange a time when she (or a member of the training team) and the employee can meet at the training site to go over the particular skill. If several employees are having similar problems, we recommend the training program director incorporate a review session into a scheduled in-service training. Another option used by some agencies is to have a new home care worker who is having difficulty shadow a senior employee or peer mentor in the field.

The nurse supervisor talks with the new employee, answers questions, and observes.

Who Supports Trainees and New Employees?

Training Staff: Educational staff who train new home care workers.

Peer Instructors: Senior home care workers who assist with the training program, particularly during personal care/clinical skill instruction. Peer instructors model success in the workplace for new trainees; their presence is a positive motivator for those who may be struggling with the demands of a rigorous training program.

Employment Counselor: An employee who helps trainees and new employees overcome barriers to employment, such as lack of affordable child care or unreliable transportation. The employment counselor often helps trainees access transitional public benefits and to balance the demands of work and family.

Peer Mentors: Home care workers who are trained to provide support to new employees. Mentors check in with new employees during the first few weeks of employment, answer questions, provide emotional support, and help to build new employees' on-the-job problem-solving skills.

Service Delivery Coordinators: Agency employees who schedule cases and supervise home care workers. The coordinator checks in with a new caregiver frequently during her first month on the job.

Nurse Supervisor: An RN, or an LPN working under the direction of an RN, who visits home care workers at the homes of their clients. The nurse supervisor ensures that the home care worker understands and follows care plan instructions, answers questions, and observes the client/caregiver relationship to ensure there are no problems. Nurse supervisors are required for Medicare-certified services.

Peer Mentoring

Mentors can answer questions, give advice, help resolve problems, and provide emotional support.

To support new employees as fully as possible, we recommend that each new employee be assigned a peer mentor. Mentors can answer questions for new hires, give advice, help resolve problems, and provide emotional support when a worker faces the early challenges of caring for people who have complex physical and emotional needs. As role models and coaches, mentors make a significant difference, helping new employees further develop their caregiving and problem-solving skills. We find that a new employee who may fear going to a direct supervisor with a problem, is often willing to seek help from an experienced peer who supports, yet is outside of, the line of authority.

Effective peer mentors need training and support themselves. PHI's mentor training focuses primarily on developing leadership and coaching skills, particularly an ability to listen carefully, communicate clearly, and help mentees confront any challenges or obstacles that hinder work performance.⁸ Some agencies that have developed mentor programs with PHI have created full-time peer mentor positions, in which mentors coach not only new employees, but any worker who is struggling with personal or professional problems.

In-Service/Peer Support Sessions

Federal regulations require that home health aides receive twelve hours of in-service training annually. We recommend that agencies schedule as much as six hours of this training during the first three months of employment. Structuring these early in-services as "in-service/problem-solving sessions" provides an effective means of helping new employees gain confidence and improve their skills during their first few months in the field.

These in-service sessions have several purposes:

- To give new employees an opportunity to share problems and get support from peers;
- To further develop critical-thinking, interpersonal, and work-readiness skills; and
- To reinforce agency policies and procedures.

Staff allow plenty of time during these initial in-services for new home care workers to share their feelings, especially their frustrations and concerns. Some agencies even organize "rap sessions," separate from the in-services, to promote this kind of dialogue. Peer mentors often lead these rap sessions, along with agency employment counselors, typically without a supervisor present in order to allow greater freedom to describe problems and express concerns.

⁸ See "Introducing Peer Mentoring in Long-Term Care Settings," *Workforce Strategies No. 2* (PHI, May 2003).

During the first part of the in-service, new workers share their experiences and their emotional responses to caring for clients. A trainer, peer mentor, or counselor leads a discussion among the home care workers that focuses on issues such as unexpected challenges on the job, successful or delightful visits, communication problems with clients or family members, and difficulties balancing work and home life.

After participants share their experiences, operations staff usually join the group to discuss specific case-related issues and to review workplace policies: e.g., professional behavior, lateness, completing time sheets, taking relief cases, and so on. If particular problems have been raised during the first half of the in-service that relate to these policies and procedures, the facilitator engages the group in role-plays and problem-solving activities that help participants think through the issues they have raised. *The goal of these sessions is not to reprimand, but to help develop interpersonal skills that are appropriate to a workplace setting and to reinforce policies and procedures.* However, if the facilitator hears someone describe a client visit in which the caregiver behaved inappropriately, she will ask a supervisor or counselor to follow up with that individual.

By sharing their experiences and working together to figure out ways to handle problems in the future, new home care workers not only become better problem-solvers, but they continue to build a sense of community within their agency. This contributes positively to long-term retention. If an agency has an on-site employment counselor and/or peer mentors, it is useful to have them attend these sessions to observe and take notes. Issues often arise that the counselor or mentor can assist with by providing coaching and support and referrals to supportive services.

Staff allow plenty of time during these initial in-services for new home care workers to share their feelings.

Supportive Services

Supportive services for trainees and new employees are critical to the PHI approach to training and employment. Most often, these services are provided by an on-site employment counselor (see “Employment Counselor Job Responsibilities,” p. 18).⁹ We have found that the cost of this position is often offset by the gains made in retaining new employees.

Many new home care workers face enormous challenges. Some are transitioning from public assistance, others face language and cultural barriers, others are just struggling to keep their children warm, dry, and well fed on low wages. Some are committed to their jobs but find that transportation and child care are insurmountable obstacles. Without support, low-wage workers often can’t keep up with the responsibilities of employment and, as a result, they leave their jobs—or are fired for being “irresponsible.”

⁹ Agencies that can’t afford to employ a counselor might be able to obtain these services by partnering with a human service agency.

Without support, low-wage workers often can't keep up with the responsibilities of employment.

In their effort to support trainees and new employees, on-site counselors often take on a range of duties. Most importantly, they meet with trainees to evaluate work readiness and assist them with accessing any public benefits for which they may be eligible: for example, food stamps, Medicaid, or child-care benefits. These supports can make an enormous difference to a new employee's ability to succeed in the workplace.

The counselor also provides crisis intervention services and general emotional and logistical support for those who are struggling to make it through the training program or their initial months of employment. For example, if a trainee or new employee receives an eviction notice, the counselor is available to help them find the resources needed to pay back rent or find a new place to live. Counselors may also provide domestic abuse counseling and referrals: Abusive relationships cause physical and emotional harm and often undermine the ability of the individual to maintain employment.

In some cases, counselors take on a formal training role in the classroom, providing sessions on goal setting, transitional benefits, or money management. In addition, they might provide special workshops on benefits such as the Earned Income Tax Credit, a public program that provides supplemental income to low-wage workers.¹⁰ Finally, at some agencies, counselors participate in ongoing worker review meetings, in which they share with other staff their assessment of each new home care worker's progress and any barriers that may interfere with long-term retention.

10 To learn more about the Earned Income Tax Credit and how it can benefit your employees, contact the Center for Budget and Policy Priorities: www.cbpp.org

For more information about a range of supports available for low-income workers, see *Finding and Keeping Direct Care Staff*, a joint publication of PHI and the Catholic Health Association, available through the National Clearinghouse on the Direct Care Workforce: www.PHInational.org/clearinghouse

Employment Counselor Job Responsibilities

- Identifying specific employment barriers experienced by direct-care workers;
- Introducing workers to the benefits and services for which they may qualify;
- Providing a connection to the appropriate organization or person that can accept and facilitate an application for assistance;
- Troubleshooting, if necessary, with specific programs to ensure that eligible home care workers actually receive benefits;
- Supporting employees through the inevitable crises that could disrupt their ability to maintain their jobs; and
- Providing skill-building workshops in areas such as goal setting, transitional benefits, and money management (optional).

Program Assessment

Just as trainees need regular feedback to assess their progress in achieving learning objectives, instructors need feedback to evaluate the effectiveness of their educational programs. Although each process is different, they are related. An effective learning partnership between trainees and instructors is only possible when everyone—including trainers and supervisors—is open to feedback and willing to learn.

We recommend a three-component evaluation process that instructors use to assess and adapt their curricula and teaching strategies to fit the needs of their training populations. This formal evaluation process is *in addition to weekly staff meetings*, in which the training team meets to discuss the progress of trainees, to evaluate individual lessons, and to plan for future lessons. The formal evaluation process includes: daily trainee feedback, trainee end-of-cycle program evaluation, and training staff end-of-cycle review. Each is summarized below.

Daily Trainee Feedback

Through discussion or anonymous feedback forms, trainees provide observations and comments concerning each day's lesson. This gives trainees a chance to let the instructor(s) know whether the training is working for them: Did they find the material too complicated? Was a particular teaching method effective for them? Did they find the material interesting? Trainees are asked to rate the usefulness and clarity of presentations, specific teaching strategies, and the ability of individual instructors to hold their interest.

This process is useful to trainees as well as instructors. Trainees are given a chance to reflect on the day's lesson, what they've learned, and how well they have understood the material. Instructors use this feedback, along with their own observations, to evaluate their teaching strategies and make adjustments as needed. Reviewing these evaluations is a standard part of weekly training team meetings.

Trainee End-of-Cycle Evaluation

To solicit feedback on the overall effectiveness of the educational program, we recommend small group discussions modeled on focus groups. We find that if someone responsible for overall program delivery, rather than the lead instructor, facilitates this discussion, they are able to solicit more honest feedback. (The lead instructor usually lets the trainees know that they are encouraged to critique the program and share their thoughts with the facilitator, but then leaves the room.)

The facilitator first asks trainees to fill out an anonymous feedback form. Then she leads a discussion about the trainees' responses. Useful discussion topics include:

- Do trainees feel that they have been well prepared to go out and work as caregivers in people's homes?
- Are there particular areas of the training that worked well for them?

- Are there areas that they found less helpful or less interesting?
- Did the sequencing of the material help or hinder their learning? Would they have preferred to organize the time differently?
- What were the strengths and weaknesses of individual instructors?

These questions help training staff adapt the curriculum and their teaching strategies to the needs of their program participants.

Educational programs that provide the supports new employees need can significantly increase retention.

Staff End-of-Cycle Review

The third component of the evaluation process is a team meeting at the end of the training cycle to review and evaluate outcomes and overall team performance. The goal of this meeting is to identify positive and negative outcomes and to determine what changes need to be made in the structure, format, and content of the educational program to improve results. As part of this evaluation, team members review the end-of-cycle trainee evaluation and brainstorm ideas for the next training cycle.

Conclusion

Developing high-quality educational programs for home care workers is essential to improving the quality of care for consumers. Moreover, educational programs that provide the supports new employees need to meet the challenges of employment can significantly increase retention.

Recognizing the importance of quality education in ensuring a stable, loyal, and competent workforce, PHI has focused on developing an effective approach to entry-level training. This approach integrates the development of critical thinking, communication, and interpersonal problem-solving skills into the standard home care curriculum and offers significant on-the-job supports to new employees.

In this guide, we have described the five core practices that define PHI's training model:

- **Adult learner-centered education**, which emphasizes creating a challenging but supportive learning environment with high performance standards;
- **An enhanced curriculum** that focuses on developing relational skills—i.e., communication and problem-solving—in the context of developing clinical competency;
- Three to six months of **intensive on-the-job training and support** following classroom training;
- **Peer support** institutionalized through peer instructors and mentors; and
- **Supportive services** provided by an on-site employment counselor.

These elements work together to instill confidence, enhance knowledge, and support workers as they transition to employment.

Though the PHI training model emphasizes providing a supportive environment for trainees, an equally important principle is accountability. For many of the participants, completing a training program modeled on our approach is a significant challenge. Each person is expected to work hard, to cooperate in learning and teaching, to show respect for classmates and instructors, and to demonstrate his/her ability to be a responsible employee. Those who are unable to meet these expectations are asked to leave the training long before graduation.

Because direct care is about building relationships, communication and problem-solving skills are fundamental to providing high-quality services. The best bathing technique in the world is of no use if a home care worker doesn't have the skill to put a client at ease and ensure safety and comfort. A home care worker who performs clinical skills well, but doesn't provide warmth and companionship, may see her client fail nonetheless. This isn't to say that clinical skills are not important—they are essential. Yet these skills must be combined with the ability to coax a depressed client into eating a meal, to adapt a care plan to a client's wishes without compromising health or safety, to know when to contact medical or emergency personnel, to offer a shoulder on which to cry or the moment of laughter that brings hope.

Just as we expect home care workers to treat their clients with respect and compassion, we can create compassionate and respectful training programs and workplaces that show we value home care workers and the work that they do. A challenging educational program that offers a safe and supportive learning environment is a first step toward this goal. Providing supportive services for trainees and new employees who face multiple barriers to employment is another way to show that your agency values their skills and is willing to go the extra distance to help them succeed.

Agencies that adopt the PHI training model offer employees a chance to join a community that offers the support they need to grow professionally and personally. In return, they take their work seriously. This investment in education and professional development pays off with a more stable and competent workforce capable of providing the high-quality services demanded by consumers in a rapidly changing marketplace.

Just as we expect home care workers to treat their clients with respect and compassion, we can create compassionate and respectful training programs and workplaces.

Appendices

Appendix 1: Orientation

HomeCare Associates of Philadelphia (HCA) begins each training cycle with an orientation or trainee-assessment day, one day prior to the first day of training. During this half-day orientation, participants learn the policies and procedures for the home health training program, including policies related to attendance, tardiness, dress, and turning off pagers and cell phones during class.

After everyone is familiar with these policies, participants collectively develop “ground rules” or promises to one another concerning how they will interact over the next four weeks. Some examples of these ground rules include: “being patient with one another,” “acknowledging that everyone learns at their own pace,” and “respecting differences in style or culture.” Usually the training group will establish a minimum of five ground rules, but some groups will identify as many as a dozen.

Following the ground rules discussion, which begins the team-building process, participants take required math and reading tests. The group is then divided according to funding source programs—for example, Temporary Assistance for Needy Families (TANF) recipients and Philadelphia Workforce Development Corporation grantees—to complete additional paperwork and learn about any specific requirements related to their grants. During these meetings, the employment counselor explores any potential employment barriers that still need to be addressed.

This half-day orientation session provides HCA trainees a chance to experience what the training program will be like and to learn a little about classmates, expectations for participation, and the supportive services that are there to help them succeed. By using the ground rules discussion to build community, HCA ensures that new trainees feel that the learning environment is a safe place to take risks and meet the challenges ahead of them.

Appendix 2: Teaching Body Systems Using Learner-Centered Activities

Rather than using a traditional lecture format to teach the eight body systems and the diseases that affect them, instructors at Cooperative Home Care Associates in the South Bronx incorporate several learner-centered activities. These activities allow learners to discover information on their own, grapple with new concepts in small groups, and teach each other, thereby helping them to remember the information down the road.

Instructors begin their two-hour session using a simple introductory game to introduce the concept of a system and how systems work. Trainee volunteers are asked to move 15 objects arranged in a specific pattern from one side of the room to another with the exact same arrangement. The class is instructed to observe the volunteers to discern how they organize themselves, and what system they use to accomplish this task. The instructor then leads the group in a discussion about the definition, importance, and roles of systems, and specifically what a body system is.

The instructor then creates four to eight small study groups, depending on the class size. Working with a course textbook as their basic resource, each group receives a set of pictures representing the components for one body system and is asked to label each part. Then, each group is provided with a set of index cards describing the function of each system and its various components. An individual group member selects an index card and reads the function. The group decides to which organ the function is attached and records their answers on a newsprint graphic drawing of their body system. Finally, a matching worksheet that associates several major diseases with each body system is distributed to the groups. Trainees decide the appropriate answers to related questions within their small group and add these to the newsprint. Throughout this small group activity, classroom instructors provide assistance and support to ensure accuracy. Finally, each small group presents what they have learned about their body system to the full class. The lead instructor facilitates a discussion to clarify facts or provide new information.

Appendix 3: Nutrition/Diet Activity

The following 45-minute exercise teaches home care workers about nutrition and preparing appropriate meals for clients with special dietary needs. This activity usually follows a lesson reviewing basic nutritional information.

The night before class, the instructor sets out play food around the training room, simulating a grocery store (i.e., vegetable counter, dairy, bakery, meats, etc.). After reviewing information on special diets and discussing some of the factors, other than disease, that affect meal planning, the class is broken into small groups. Each group draws an index card identifying their client's special diet and food preferences and then goes shopping, choosing the items for the meal they will prepare.

Once each group has decided on its meal plan, they report out to the group, identifying their client's diet, why they chose the particular foods, and how they plan to prepare the foods. The descriptions of how the food will be cooked are specific, including seasonings, quantity, and presentation. The instructor then asks the class to provide feedback: Is this a meal they would like to eat? Would they have made any different choices? Were there other ingredients that would have worked for this diet? If the client had been of a different ethnicity, would they have made a different meal?

This is an exercise that makes learning about diet and nutrition relevant to the needs of home care workers. Rather than abstractly discussing diabetes or hypertension and how these diseases affect diet, trainees use their knowledge to solve a problem they will confront on a daily basis once they begin assisting clients: "Knowing what I do about this client's condition, ethnicity, food likes and dislikes, how can I prepare a meal that fits his/her needs?" Having discussed a variety of different complex diets in the classroom, trainees are able to apply this information when they begin their case assignments.

Appendix 4: Active Listening

To initiate a discussion of communication, instructors use the following active listening scenario. This activity highlights how easy it is to be misunderstood, even when we think we are communicating clearly. During the follow-up discussion, instructors focus on how paraphrasing and asking questions help to prevent misunderstandings.

The activity involves the following:

- Trainees pair up and sit back to back.
- One trainee has a figure drawing, while the other trainee has a blank piece of paper and a pencil.
- The trainee with the drawing tries to give instructions to her partner on how to draw the same figure.
- The partner who is trying to draw the figure may ask questions for clarification, but cannot see the original drawing.
- After ten minutes, the partners compare the drawings to see how well they communicated.

Discussion questions:

- Did your drawings come close to the original? If not, why not? (*Poor communication!*)
- For those that did come close, what did you do to communicate? (*Paraphrase, ask questions.*)
- Who found this exercise frustrating? Why? (*It is easy to be misunderstood; it is hard to communicate clearly. We think we understand what was said, but we don't.*)
- What is the goal of communication? (*To be understood.*)
- How can you communicate to another person what you heard them say? (*Paraphrase.*)

This exercise is part of a module that includes role-plays and other activities that give trainees a chance to practice paraphrasing information provided by a client, nurse, case coordinator, or family member.

Additional Publications from the Paraprofessional Healthcare Institute

Effective Practice Descriptions

Finding and Keeping Direct Care Staff, by the Catholic Health Association and the Paraprofessional Healthcare Institute. Catholic Health Association, 2003. (52 pgs.)
This guide provides employers with immediate, concrete suggestions on how to find and keep direct-care staff.

Creating a Culture of Retention: A Coaching Approach to Paraprofessional Supervision. 2001. (22 pgs.)

An introduction to coaching supervision: how coaching differs from traditional supervisory practice, the skills needed to become an effective coach, and the organizational structures that make coaching effective.

Recruiting Quality Health Care Paraprofessionals. August 2000. (26 pgs.)

A description of a successful recruiting strategy that relies on targeting specific populations, building recruitment partnerships with community-based organizations, and using a rigorous selection process.

Case Studies

We Are the Roots, by Ruth Glasser and Jeremy Brecher. University of California Center for Cooperatives, 2002. (130 pgs.) \$10 plus shipping and handling.

We Are the Roots tells the compelling story of Cooperative Home Care Associates (CHCA), a highly successful worker-owned agency in the South Bronx. Through the voices of managers and workers, we learn of CHCA's culture of cooperation, caring, and learning, which has sustained a vibrant community through tremendous growth and change over 17 years.

The Cooperative Home Care Associates: A Case Study of a Sectoral Employment Development Approach, by Anne Inserra, Maureen Conway, and John Rodat. The Aspen Institute, February 2002. (86 pgs.)

The Aspen Institute uses Cooperative Home Care Associates and its affiliation with PHI to demonstrate the success of industry-based workforce development strategies.

Quality Care Partners: A Case Study, by Karen Kahn. August 2000. (24 pgs.)

This case study traces the early development of a home care cooperative, initiated as a sectoral development project, in Manchester, New Hampshire. The study draws attention to key "lessons learned" in the areas of financing, leadership, market analysis, and customer development.

Policy Papers

Long-Term Care Financing and the Long-Term Care Crisis: Causes and Solutions, by Steven L. Dawson and the Paraprofessional Healthcare Institute. Citizens for Long Term Care, 2003. (36 pgs.)

This paper examines the “care gap” in long-term care and the negative impact of staff shortages on the three primary stakeholders: consumers, providers, and workers. It recommends a national strategy—integrating both federal and state policy into a comprehensive system of long-term support and services—to address the direct-care crisis.

Pennsylvania’s Care Gap: Finding Solutions to the Direct-Care Workforce Crisis, by Mark Davis and Steven L. Dawson, 2003. (60 pgs.)

The authors examine the reasons that Pennsylvania is facing a direct-care workforce crisis, including a rapidly aging population, policies and practices that have undermined the quality of direct-care jobs, and an increased reliance on home- and community-based care. The paper includes an array of policy and practice recommendations.

Michigan’s Care Gap: Our Emerging Direct-Care Workforce Crisis, by Hollis Turnham and Steven L. Dawson, 2003. (60 pgs.)

This paper provides a detailed analysis of the direct-care workforce crisis in Michigan. In addition to describing the key stakeholders, the demographic changes that underlie the crisis, and the negative impact of poor quality jobs on each stakeholder group, the authors review current initiatives within the state to stabilize the workforce and make recommendations for future actions.

Collaborating to Improve In-Home Supportive Services: Stakeholder Perspectives on Implementing California’s Public Authorities, by Janet Heinritz-Canterbury. 2002. (46 pgs.)

This paper analyzes the four-stakeholder coalition that successfully passed legislation and implemented the county public authority structure to improve the quality of jobs and services offered by California’s In-Home Supportive Services.

Cheating Dignity: The Direct Care Wage Crisis in America, by the Paraprofessional Healthcare Institute. AFSCME, August 2001. (38 pgs.)

This report provides a detailed analysis of how our nation fails to pay our direct-care staff “self-sufficient” wages and benefits, by comparing wages across several service sector occupations.

“Direct Care Health Workers: You Get What You Pay For,” by Steven L. Dawson and Rick Surpin. *Generations*. Vol. XXV, No. 1, Spring 2001. (6 pgs.)

This paper examines labor supply and demand and suggests that improving the price of labor, through changes in policy and practice, is the only way to attract workers to long-term care.

Direct Care Health Workers: The Unnecessary Crisis in Long-Term Care, by Steven L. Dawson and Rick Surpin. The Aspen Institute, January 2001. (33 pgs.)

Dawson and Surpin examine the structure of long-term care, its financing, and the current labor crisis, arguing for sector-wide restructuring supported by labor, welfare, and health care policies that work together to support high-quality care for consumers, decent jobs for workers, and a more rational environment for providers.

“The Home Health Aide: Scarce Resource in a Competitive Marketplace,” by Steven L. Dawson and Rick Surpin. *Care Management Journals*, Vol. 2, No. 4, Winter 2000. (6 pgs.) Noting that labor has become a scarce resource, this paper suggests that employers must create higher quality jobs for home care workers to compete successfully for workers in today’s economy.

“Toward a Stable and Experienced Caregiving Workforce,” by Mary Ann Wilner. *Generations*, Vol. XXIV, No. 3, Fall 2000.

Wilner reviews some of the mechanisms available for establishing a stable workforce for consumer-directed care.

Health Care Workforce Issues in Massachusetts, by Barbara Frank and Steven L. Dawson.

Presented at the Massachusetts Health Policy Forum, June 22, 2000. (32 pgs.)

Arguing that the price of labor must rise to attract direct-care workers, Frank and Dawson make a number of key recommendations for changes in state policy and provider practice.

“Who Will Care for Mother Tomorrow?” by Andy Van Kleunen and Mary Ann Wilner. *Journal of Aging & Social Policy*, Vol. 11, No. 2/3, 2000. (11 pgs.)

This essay confronts the caregiving crisis by offering a closer look at paraprofessional caregivers and the nature of their jobs, summarizing some of the public policies that currently shape the quality of those jobs, and proposing some possible steps that policymakers could take to start rebuilding our nation’s direct-care workforce.

Paraprofessionals on the Front Lines: Improving Their Jobs—Improving the Quality of Long-Term Care, by Mary Ann Wilner and Ann Wyatt. A conference background paper prepared for the AARP Long-Term Care Initiative. AARP, 1998. (75 pgs.)

This paper explores the role of the paraprofessional in long-term care and highlights the relationship between the paid caregiver and the consumer.

Jobs and the Urban Poor: Privately Initiated Sectoral Strategies, by Peggy L. Clark and Steven L. Dawson, et al. The Aspen Institute, November 1995. (41 pgs.)

Analyzing four sectoral initiatives, this report proposes a definition for “sectoral employment development,” explores thematic issues, and makes recommendations for pursuing sectoral development as an approach to improving employment prospects in urban areas.

Workforce Strategies Series

Workforce Strategies No. 1. "State Wage Pass-Through Legislation: An Analysis," by the Paraprofessional Healthcare Institute and the Institute for the Future of Aging Services. Department of Health and Human Services, April 2003. (8 pgs.)

In this issue brief, the authors describe the structure of wage pass-through programs in several states; summarize what is known about the impact of these programs on recruitment and retention of direct-care workers, and identify key design elements that states should consider if they choose to implement a wage pass-through.

Workforce Strategies No. 2. "Introducing Peer Mentoring in Long-Term Care Settings." May 2003. (8 pgs.)

This publication identifies the benefits of mentoring programs, defines the peer mentor's role, discusses critical mentoring skills, and outlines the key design elements that long-term care organizations need to consider when developing their own peer mentor programs.

Workforce Strategies No. 3. "The Role of Training: Building a Stable and Qualified Direct-Care Workforce," by the Paraprofessional Healthcare Institute and the Institute for the Future of Aging Services. Department of Health and Human Services, Fall 2003. (8 pgs.)

This issue brief describes federal and state pre-employment and on-the-job training requirements; summarizes available research and consumer, worker, and provider perspectives on workforce training issues and needs; assesses the impact of job preparation and training on worker recruitment, retention, and quality; and identifies key policy and practice issues and options for addressing them.

Workforce Tools Series

Workforce Tools No. 1 "The Right People for the Job: Recruiting Direct-Care Workers for Home- and Community-Based Care," by the Paraprofessional Healthcare Institute and MEDSTAT. Centers for Medicare and Medicaid Services, Fall 2002. (8 pgs.)

This publication provides agencies and individual consumers with straightforward information on how to recruit, assess, and select personal assistance workers and home health aides.

Workforce Tools No. 2. "The Right Start," by the Paraprofessional Healthcare Institute and MEDSTAT. Centers for Medicare and Medicaid Services, Fall 2003. (8 pgs.)

This publication outlines standard training practices for home- and community-based workers, identifies training gaps, and provides examples of outstanding programs in order to help agencies, individual consumers, and workers find and develop appropriate educational resources.

Video

HeartWork: A video celebrating the lives and work of direct-care workers. 2001. (43 min.) \$149, plus shipping and handling, for video and discussion guide.

HeartWork chronicles the development of an original theater piece created and performed by women who work as home health aides and certified nursing assistants (CNAs). Through music, dance, storytelling, and interviews, the video provides a real, honest, moving and often humorous account of what it means to be a direct caregiver.

To order any of the publications described above, send your request to: National Clearinghouse on the Direct Care Workforce, 349 East 149th Street, 10th Floor, Bronx, New York 10451. Email: clearinghouse@PHInational.org. For bulk orders, please call the National Clearinghouse at: 718-402-4138 or toll-free: 866-402-4138. Many of these publications are available on the Internet at: www.PHInational.org/clearinghouse or www.PHInational.org

Consulting Services Available from PHI

Paraprofessional Healthcare Institute consultants work with home care and nursing home providers across the country to improve recruitment, training, and supervision of direct-care workers. We offer a full range of consulting services, including:

- **Introductory presentations**
- **Educational programs for all levels of staff**
- **Program design**
- **Ongoing support and coaching for leadership teams**

Our consultants begin all projects with an assessment of our client's particular workforce challenges; we then design our assistance to meet the client's immediate needs and objectives. Depending on your goals and resources, we can provide targeted workshops or trainings or we can work with your organization over an extended period of time, providing ongoing assistance as you transform your culture of turnover to a culture of retention.

Our consulting team is ready help you:

Find and Keep Direct-Care Workers

- Design effective recruitment strategies
- Implement peer mentor programs
- Train frontline supervisors to use a "coaching" style of supervision
- Link new workers to supportive services

Improve Quality of Care

- Create more effective entry-level and advanced training programs
- Improve problem-solving and communication skills of frontline staff
- Identify and adopt client-centered caregiving practices
- Build a leadership team that engages the entire workplace community in innovation and change

To find out more about how PHI can help you find and keep direct-care workers, call 718-402-7446, or email consulting@paraprofessional.org

Recruitment and Training Guides

Not yet ready for a consultant? PHI offers in-depth handbooks and curricula to assist providers with establishing effective recruitment and training programs:

Guide to Recruiting Quality Health Care Paraprofessionals. This how-to manual focuses on recruiting and selecting qualified candidates for direct-care positions. (\$75)

Guide to Implementing Learner-Centered Home Care Training. This is a step-by-step guide to implementing a learner-centered training program that integrates communication, problem solving and job readiness into the curriculum. (\$100)

Relational Skills Curriculum: Teaching Communication and Problem-Solving Skills to Home Care Workers. This curriculum, which incorporates PHI's unique "4P" approach to problem-solving, includes four units: Team Building; Respecting Differences; Problem Solving; and Working with Authority. The lessons can be integrated into pre-employment training or used for in-service training. (\$199)

Coaching Supervision Skills for Frontline Supervisors. This two-day curriculum introduces supervisors to four key skills—Active Listening, Self-Management, Self-Awareness, and Presenting the Problem—necessary to helping direct-care workers solve problems and improve work performance. (\$149)

To purchase these guides, contact the National Clearinghouse on the Direct Care Workforce, clearinghouse@PHInational.org or call (toll-free), 866-402-4138.

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