U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

EXAMINING COMPETENCIES FOR THE LONG-TERM CARE WORKFORCE:

A STATUS REPORT AND NEXT STEPS

June 2009

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EXAMINING COMPETENCIES FOR THE LONG-TERM CARE WORKFORCE: A Status Report and Next Steps

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June 15, 2009

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I. INTRODUCTION AND PURPOSE

According to the U.S. Department of Health and Human Services (HHS), the aging population is likely to impact the necessary size and composition of the health care workforce (Center for Health Workforce Studies, 2006). There are now 35 million people over the age of 65 in the United States. They use 48 percent of hospital days and 83 percent of nursing home days. About 1.6 million older adults live in nursing homes. Almost half are over age 85. According to the National Association of Homecare, 69 percent of home care users are 65 and older and 16 percent are 85 and older (Kovner et al., 2007). Ensuring that there are enough qualified health professionals to meet the demands of this population will be a key issue in the coming years.

In April 2008, the Institute of Medicine (IOM) released "Retooling for an Aging America: Building the Health Care Workforce" (IOM, 2008). According to the report, there are too few geriatric specialists and most physicians lack the broad based knowledge of aging necessary to effectively treat many of the unique needs of older adults. It recommends that:

- health care workers be required to demonstrate competence in basic geriatric care to receive and maintain their licenses and certifications;
- all health professional schools and health care training programs expand coursework and training in the treatment of older adults; and
- more work be done to determine the appropriate content of training necessary to teach needed competencies based on staff responsibilities and the settings in which they work.

Competencies generally refer to demonstration of knowledge, skills, or abilities required to successfully perform critical job functions or tasks. While the IOM report addressed competency issues across all care settings, this paper focuses specifically on the competencies required for work in long-term care. Long-term care covers a range of medical and/or support services that are designed to help people who have disabilities or chronic care needs. Services may be needed for a short period of time, or extend over months or years. Long-term care may be provided in a number of settings including within a person's home, in a residential care or assisted living facility, or in a nursing home.

Geriatric competencies may overlap with long-term care competencies, but there is a distinction between the two. A geriatric curriculum may include instruction rooted in knowledge of aging processes, but not include specific long-term care issues. On the other hand, long-term care proficiency may be based upon medical management for a patient of any age who is admitted to a nursing home, not just an older patient. Staffing, delegation of tasks, and patient needs will vary from acute and ambulatory settings Patients with chronic conditions who require person-centered approaches to long-term services and supports are likely to receive better attention to health needs when they

are attended by formal providers and informal caregivers who are trained to recognize complicated conditions and make differential diagnoses that may not be immediately recognized in an acute care setting.

This paper provides a snapshot of workforce competencies that have been identified for professionals who work in long-term care settings. This is provided through examination of basic roles and responsibilities of professionals and options presently available for specialization, through an analysis of the long-term care workforce literature, and through identification of initiatives launched by professional associations and providers to determine progress in defining the competencies needed by this vital workforce. Additionally, the paper examines whether there might be differences in the competencies required to care for the geriatric population in long-term care settings compared to acute and ambulatory care settings. Although individuals of all ages have disabilities that require long-term care services, this paper focuses primarily on providers who serve long-term care needs of the older population, and excludes competencies required in caring for younger individuals with physical or intellectual disabilities. A majority of available literature is confined to the nursing home workforce, but where the literature is available the paper discusses other long-term care settings as well.

II. METHODS AND ORGANIZATION OF THE PAPER

To prepare the concept paper/literature review, the authors:

- Examined the gerontological and long-term care workforce literature between 2000 and 2008 (searching Medline, CINAHL, and Google Scholar).

- Reviewed web sites of key professional associations, long-term care providers, worker/advocacy organizations and academic institutions, which influence the education, training and licensing/certification of the professional long-term care workforce.

- Informally interviewed stakeholders from the major professional organizations and university-based centers involved in developing/diffusing geriatric competencies in the curricula of nursing, medical and social work schools.

The remainder of the paper includes:

- A brief summary of the roles played by various professionals employed in long-term care.

- A literature review of the educational infrastructure of the professional workforce and the current thinking on core-competencies for long-term care professionals.

- A description of some of the new strategies proposed for improving the core-competencies of long-term care professionals.

III. ROLES AND RESPONSIBILITIES OF THE LONG-TERM CARE WORKFORCE

The following section provides background information on the workforce that cares for individuals in various long-term care settings. Rules and requirements regarding staffing (i.e., ratios, licensure requirements, continuing education) are sometimes federal requirements and sometimes state requirements depending on the care setting. Similarly, long-term care settings themselves are regulated differently depending on the type of setting. Hence, the following description of roles and responsibilities of the workforce are intended as an overview only.

A. Facility and Home Health Administrators

Facility and home health administrators are responsible for all aspects of their respective organizations including the supervision and management of staff and compliance with federal and state regulations. Nursing home administrators are licensed by individual states, and licensing requirements vary significantly across states. Some states require a high school diploma and passing an exam, whereas other states require a bachelor's or higher level degree with coursework in long-term care/health care, gerontology and personnel management. The extent to which administrators in assisted living facilities, home health agencies and other home and community-based services agencies are credentialed is left to states.

B. Physicians

Physicians in long-term care are usually formally involved as nursing home and home health agency medical directors, and as such, they are the individuals required to sign off on nursing home and home health care plans. Nursing homes reimbursed by Medicare or Medicaid are required to have a physician medical director who is responsible for overseeing the medical care of residents and for participating in the development of residents' care plans. Assisted living facilities and home health agencies are not required to have a medical director, although many do.

Physicians can be certified as geriatricians to practice specifically with older adults. Geriatricians typically originate in family practice or internal medicine and subsequently specialize. According to the 2008 IOM report, there are approximately 7,000 practicing geriatricians; this accounts for less than one percent of all physicians. Projections show that 36,000 will be needed to provide services to the aging baby boom population by 2030 (IOM, 2008).

C. Nurses

The nursing profession has several levels of licensure related to the educational degree attained. Nurses can be licensed as Registered Nurses (RNs), Nurse Practitioners (NPs), or Licensed Practical Nurses/Licensed Vocational Nurses (LPN/LVNs).

Registered Nurses (RNs) are responsible for assuring the quality of clinical care in long-term care settings, assessing health conditions, developing treatment plans, and supervising LPN/LVNs and paraprofessional staff. RNs are trained at an associate's degree level or higher.[1] Most nursing home RNs hold administrative and supervisory positions. By law, the Director of Nursing in a skilled nursing facility must be an RN. Home health RNs assess a patient's home environment, care for and instruct patients and their families in self-care and supervise home health aides (HHAs). Of the estimated 2.9 million RNs employed in the United States, about 260,000 are employed in long-term care settings, usually in nursing homes and home health agencies (Bureau of Health Professions, 2006). Substantial research evidence supports the critical role of nurses--particularly in nursing home settings--in improving the quality of care (Harrington et al., 2000; Rantz, 2003; Reinhard and Reinhard, 2006; Bostick et al., 2006).

Nurse Practitioners (NPs) are also employed in some nursing homes to augment medical care provided to residents by physicians. These nurses are RNs with advanced education and training who operate in an expanded nursing role, conducting physical exams, making urgent care visits, prescribing medications and providing preventative care to residents. A minimum of a master's degree in nursing is required for certification as a NP. As of 2007, there were over 125,000 NPs practicing in the United States, and 6,000 new NPs graduate each year. Thirteen percent of NPs work in long-term care (American Academy of Nurse Practitioners, 2009). Studies have shown that NPs can improve the quality of care, improve communication, and can be cost effective for a nursing home resident's care (Intrator, 2005). A survey of physicians who are members of the American Medical Directors Association (AMDA) found that large majorities of respondents perceived NPs to be very effective in maintaining physician, resident and family satisfaction in nursing homes (Rosenfeld et al., 2004).

Licensed Practical/Licensed Vocational Nurses (LPNs/LVNs) provide direct patient care including taking vital signs and administering medications. LPNs obtain licensure following 12-18 months of post-secondary education. Their scope of practice varies from state to state, but is always more limited than that of RNs; however, they play an integral role in long-term care settings. According to surveys conducted by the National Council of State Boards of Nursing, more than 60 percent of LPNs practice in

[1] In 2004, 1,227,000 RNs graduated with an associate's degree, whereas 903,000 RNs graduated with a bachelor's degree or higher (Bureau of Health Professions, 2006). Nurses who have obtained an RN licensure through any of the available avenues have been found to provide similar care with respect to patient safety (Ridley, 2006). However, research has show that the quality of care that is given by an RN is improved among more experienced nurses without regard to whether their training was through an associate or bachelor's level program (Blegen, 2001).

nursing homes and other long-term care settings, and the majority of respondents also specifically reported caring for older persons in these settings. Almost 50 percent of respondents also reported holding administrative responsibilities in nursing homes, and 72 percent reported similar responsibilities in other long-term care environments (National Council of State Boards of Nursing, 2007).

D. Mental Health Professionals

Mental health professionals in long-term care settings include professionals trained in psychology, psychiatry, and social work. Numerous studies show there is a severe shortage of practitioners in the mental health workforce who can provide services to older adults regardless of setting (Presidents New Freedom Commission on Mental Health, 2003; Halpain, 1999; Bartels, 2002).

The current estimated need for psychologists who specialize in geriatric care (geropsychologists) is 5,000-7,500 practitioners, yet there are only 700 currently practicing (IOM, 2008). A study of mental health services in nursing homes found that psychiatric services--if they are available at all--are most commonly provided by psychiatric consultants who also have their own practice, come only when called to see a specific patient, and provide no follow-up unless called back (Bartels, 2002). Yet, a majority of older adults in residential care are reported to have a significant mental disorder and are in need of mental health services. A review of medical records by the Office of the Inspector General in a sample of skilled nursing facilities showed that 95 percent of Medicare beneficiaries who received a psychosocial assessment had at least one psychosocial service need and 39 percent did not have a care plan (OIG, 2003).

The burden of providing mental health services in nursing homes falls most heavily on social workers. Yet a survey by Bern-Klug et al. (2009) of nursing home social service directors found that 20 percent lacked a four-year college degree. Another 25 percent had a bachelor's degree in a non-social work field. The authors of the survey speculate that social workers who have been educated appropriately and supervised in the field would be more effective in providing for the psychosocial needs of residents, although there is no evidence in the literature to indicate a relationship between educational training and patient care.

Social workers carryout a broad and sometimes diffuse set of functions in nursing homes, assisted living, and home care settings. Twenty-nine percent of master of social work programs offer an aging certificate, specialization, or concentration (IOM, 2008). The National Association of Social Workers (NASW) has defined "areas of focus" for social workers in nursing homes as follows:

- the social and emotional impact of physical or mental illness or disability;
- the preservation and enhancement of physical and social functioning;
- the promotion of the conditions essential to ensure maximum benefits from long-term health care services;

- the prevention of physical and mental illness and increased disability;
- the promotion and maintenance of physical and mental health and an optimal quality of life (NASW, 2003).

Federal regulations require nursing homes over 120 beds to have a qualified social worker (i.e., an individual with a bachelor's degree in social work or in a human services field with one year of supervised social work experience in a health care setting). Estimates of the number of professional social workers in long-term care settings range from 36,071 to 44,156 (Center for Health Workforce Studies and NASW Center for Workforce Studies, 2006). According to a recent survey over half of the social services respondents reported they were the single staff member providing social services (Bern-Klug, 2009). Since social workers in nursing home settings usually practice alone, they may find it more difficult to have access to colleagues or supervisors, or participate in organized in-service training to upgrade their skills (Parker-Oliver, 2003).

Social workers may also provide medical social services to frail and disabled elders under Medicare's home health benefit, including counseling, assessment, care planning and case management, if provided in conjunction with treating social and/or emotional problems that impact a patient's medical condition.

E. Pharmacists

Consultant Pharmacist and Senior Care Pharmacists are pharmacists who fill a special niche in pharmacy practice. They take responsibility for patient medication-related needs in nursing homes and other long-term care settings. Their responsibilities also include ensuring that medications are appropriate, effective and safe and are used correctly, and identify and resolve medication-related problems. Consulting pharmacists counsel patients in long-term care facilities, provide information and recommendations to prescribers, review patient drug regimens and oversee medication distribution services (American Society of Consultant Pharmacists [ASCP], 2008).

Pharmacists have the option of completing a geriatric residency called a Certification in Geriatric Pharmacy after earning a doctor of pharmacy degree. Of approximately 200,000 practicing pharmacists, 720 have a geriatrics certification (Kovner et al., 2007). Senior Care and Consultant Pharmacists typically have experience and/or interest in geriatric practice, but are not required to acquire a certification in geriatric practice.

F. Therapists

Physical Therapists (PTs), Occupational Therapists (OTs), Speech Language Pathologists (SLPs) and Audiologists help restore function and independence that result from disease, injury, or the aging process. They provide their services in virtually all long-term care settings. Geriatrics is required in the curricula for all therapy

professionals (Center for Health Workforce Studies, 2005). In long-term care settings such as nursing homes, therapies are usually provided as a part of rehabilitation or post-acute care of eligible patients rather than for long-term care generally.

Physical Therapists (PTs) most commonly graduate from accredited programs with a doctor of physical therapy degree, although 20 percent of accredited programs still graduate PTs at a master's level (Bureau of Labor Statistics, 2008-09). PTs practice in various long-term care settings and help patients to improve mobility, relieve pain, and try to prevent permanent disability resulting from injuries. PTs who graduate from an accredited program must pass a licensure examination to practice and can subsequently practice in any setting. Some states require continuing education to maintain licensure but this varies state to state. Fifteen percent of practicing PTs work in home health or long-term care facilities (Center for Health Workforce Studies, 2006).

PTs have a specialized residency in geriatrics, but only a small number of PTs complete this program and become credentialed. As of 2006, 488 PTs were Board Certified Geriatric Clinical Specialists, and projections showed 50 new specialists graduating annually (Center for Health Workforce Studies, 2006).

Occupational Therapists (OTs) typically enter the workforce as entry-level clinicians with a master's degree, although in 2007, five schools around the country offered doctoral degrees (Bureau of Labor Statistics, 2008-09). OTs are required to fulfill supervised field work and must pass a licensure examination. In some states, continuing education is required for license renewal. OTs help people regain, develop, and build skills that are necessary to function in daily living. Specific to the older population, OTs can help their patients to remain in their homes and care for themselves. Eleven percent of OTs work in nursing homes or home health care settings (Center for Health Workforce Studies, 2006). They help people overcome disabilities associated with aging, and help patients perform self-care, work, and leisure activities (Center for Health Workforce Studies, 2006). Board certification in Gerontology is available to OTs to advance their level of clinical expertise but is not required to practice.

Speech Language Pathologists (SLPs) jobs generally require a masters-level degree, in addition to passing a licensure exam and fulfilling supervised field work hours. Most, but not all, states require continuing education hours for license renewal. In 2007, all but three states regulated licensure or credentialing of SLPs (Bureau of Labor Statistics, 2008-09). SLPs treat older adults for conditions from diseases ranging from traumatic onset such as a stroke, to degenerative onset such as dementia. They provide many services depending upon the need of the individual, but their qualifications include the ability to evaluate, diagnose, and treat speech, language, cognitive-communication and swallowing disorders. Although most SLPs work in educational settings, about 6 percent of SLPs work in either nursing homes or home health care, where most of their patients are older adults (Center for Health Workforce Studies, 2006). No certifications exist for geriatric populations.

Audiologists can also train with a combined SLP/audiology degree. Audiologists practice with a master's degree, but a doctor in audiology degree (AuD) is becoming more common. In 2007, eight states required a doctoral degree in order to practice, and another 50 programs were newly accredited in the AuD degree (Bureau of Labor Statistics, 2008-09). All states require licensure for an audiologist to practice, and some require continuing education for license renewal. Audiologists work with older adults who have balance, hearing, and other inner-ear related disorders. The profession does not currently have a geriatric competency.

G. Direct Care Workers

Direct care worker (DCW) is an umbrella term for professionals who provide the bulk of hands-on care to residents in long-term care settings. DCWs often assist with activities of daily living such as bathing, eating and dressing, may provide basic health monitoring (such as taking temperature or blood pressure) and typically provide care under the supervision of nursing or medical staff. Training requirements vary depending on the care setting and the position. Below are some common examples of DCWs who work in long-term care settings.

Certified Nursing Assistants (CNAs) usually work in Medicare certified nursing homes and are (federally) required to have 75 hours of training and pass an examination in order to be certified. States may have additional training requirements. Because a large proportion of CNAs work in nursing homes, they are generally trained for work in long-term care settings. The training is typically delivered through a combination of classroom and hands-on clinical training.

Home Health Aides (HHAs) working for Medicare certified home health agencies are required to have 75 hours of training and pass an examination similar to CNAs. States may have additional requirements. HHAs are specifically trained to work in a home care setting. The training is typically delivered through a combination of classroom and hands-on clinical training (Bureau of Labor Statistics, 2008-09).

Personal and Home Care Aides may provide housekeeping, routine personal care services, and record clients' conditions and progress. They usually receive a short period of on-the-job training. Personal and home care aides typically work in an individual's home or residential care setting (such as an assisted living facility) (Bureau of Labor Statistics, 2008-09).

IV. EDUCATIONAL INFRASTRUCTURE CHALLENGES TO ASSURING LONG-TERM CARE AND GERIATRIC COMPETENCY

Once they have completed their classroom training, health care professionals are typically required to participate in subsequent clinical experiences, rotations, internships, residencies, or other specialized programs. Training opportunities for competencies in caring for older patients, particularly in long-term care, vary by profession. In general, literature suggests that the educational infrastructure to prepare professionals to care for a growing population of older adults, with chronic illnesses, complex medical conditions and/or functional and cognitive limitations may be inadequate. Multiple studies of the readiness of the health care workforce to care for an aging population in various settings, including long-term care, have concluded that the current system is in need of reforms such as more experience in geriatric care and more educators with expertise in geriatric care. (Knickman and Snell, 2002; Alliance for Aging Research, 2005; Center for Health Workforce Studies, 2005; National Commission on Nursing Workforce for Long-Term Care, 2005; National Commission on Quality Long-Term Care, 2007; Kovner, Mezey and Harrington, 2007).

A. Physicians

Training for physicians in geriatrics and long-term care is inconsistent across schools of medicine, and the majority appear to provide limited education or experience in care of the older patient. Less than 10 percent of medical schools require a geriatrics course. Although 86 medical schools offer an elective in geriatrics, only 3 percent of medical students take it. Finally, almost no programs require a rotation in a geriatric or long-term care setting. In contrast to this, every medical school requires students to complete a clinical rotation in a pediatrics setting (Kovner, 2007). There are several challenges to recruiting and retaining physicians to specialize in geriatrics. First, there has been a recent decline in medical students pursuing family practice and internal medicine, so there are less potential candidates who can further specialize into geriatric care. A second obstacle to recruitment of geriatricians into the workforce is a lower average salary for geriatricians compared to other areas of medicine (Institute for the Study of Health, 2009). Finally, trends indicate geriatricians are not pursuing recertification through continuing education and re-examination when their certifications expire. The reasons include retirement, the burden of the process, and lack of perceived benefit (IOM, 2008).

Despite these statistics, 70 percent of graduating medical students in 2007 reported being exposed to expert geriatric care by the attending faculty of his or her medical program; this was an increase from 61 percent in 2003 (Bragg and Warshaw, 2008). Self-perceived preparation to care for older adults in long-term health care settings is also improving (from 55 percent in 2003 to 62 percent in 2007). However, it

continues to lag behind acute and ambulatory care by 14 and 19 percentage points respectively (Bragg and Warshaw, 2008). It remains unclear whether a new physician's self-assessment reflects actual expertise.

B. Nurses

The educational infrastructure for nurses has similar challenges as those facing physicians. Only one-third of nursing students in baccalaureate nursing programs have a required course in geriatrics (Kovner, 2007). Fifty-eight percent of nursing programs have no full-time faculty certified in geriatric nursing. Students in baccalaureate-level nursing programs are rarely exposed to the complexities of the geriatric care needed by long-term care clients. A typical experience is an introductory clinical experience in a long-term care setting to learn about the provision of personal care and basic assessment skills (Williams, 2006). A comparison of average wages for nurses working in nursing homes verses acute care hospitals demonstrates the financial incentive to work in acute care. In 2004 the average annual wage for RNs working full-time in a hospital was $59,963; this was the highest of any employment setting. In contrast, the average income for RNs working in nursing homes was $53,796 (Bureau of Health Professions, 2006).

C. Social Workers, Physical Therapists, Pharmacists

In spite of efforts to improve care for older adults, providers such as social workers, PTs, and pharmacists also have challenges in providing adequate training in caring for older patients. As of 2002, about 3.6 percent of masters-level social work students specialized in aging, and only about 5 percent of social workers at the baccalaureate-level identified aging as their primary area of practice (Center for Health Workforce Studies, 2006). It is estimated that 80 percent of bachelor of social work students graduate without any specific course in aging (HHS, 2006). PTs have identified geriatric content as important for general curricula. However, relatively few graduating students have specialized in geriatrics because the typical physical therapy student has a low intention of working in geriatrics (Center for Health Workforce Studies, 2006). A survey of physical therapy curriculum content found that although 92 percent of schools incorporated aging content into various other courses, only 10 percent of programs offered a formal course in geriatrics. Finally, in a survey of pharmacy schools, the majority of the respondents relied on part-time faculty members to teach geriatrics, and less than half of the respondents offered a stand-alone geriatrics course (Odegard, 2007).

In summary, health professions schools and programs may not be sufficiently equipped with faculty, coursework and/or clinical experiences to prepare the future health workforce for the impending demand of the aging population.

V. ARE THE COMPETENCIES NEEDED FOR LONG-TERM CARE PROFESSIONALS DIFFERENT FROM THOSE REQUIRED IN ACUTE AND AMBULATORY CARE SETTINGS?

While intuitively we assume that geriatric training would be important in a long-term care setting, it is reasonable to ask whether there are skills and knowledge specific to long-term care that are not being addressed within current geriatric curricula. The research literature provides little insight into the similarity between the basic geriatric competencies needed by health and social work professionals and those needed to effectively perform in long-term care settings.

The Hartford Institute for Geriatric Nursing at New York University completed a project in 2006, funded by the Commonwealth Fund, to compare geriatric competencies expected of students trained in nursing, medicine, social work, pharmacy, and nursing home administration, and to learn how nursing homes were used to meet these competencies. The project team compared competencies across these professions in the domains of assessment, diagnosis, plan of care and implementation, evaluation, professional role, teaching and coaching, cultural competence, and managing and negotiating health care systems.

The project found a high degree of overlap between the geriatric competencies expected of students from each discipline. Some examples of similarities across professions include physical assessment, functional assessment, age-related changes, and diagnosis of acute health problems. Despite the high degree of similarity, some differences between disciplines were found. Social work geriatric competencies differed most from the other disciplines, although social work included competency in areas that were not found in the other disciplines (Mezey et al., 2008). The competency comparisons may be a useful starting point for examining the relevance of geriatric competencies to those needed by professionals who practice in long-term care settings.

An earlier study (Utley-Smith, 2004) sheds some light on whether different settings required different competencies. The investigator compared the perceptions of hospital administrators, nursing home administrators and home health administrators in three states regarding the importance of selected competencies of recent baccalaureate-level nursing graduates. Competencies were categorized as health promotion, supervision, interpersonal communication, direct care, and computer use and case management. The administrators from the three work settings gave similar mean importance ratings to interpersonal communication competence and direct care competence. Home health agency respondents gave the highest rating to health promotion competence. Nursing home administrators differed strongly from home health and hospital administrators in the importance they attached to supervision competence--a finding that reinforces the

need to address deficiencies in the preparation of nurses to supervise other staff and or delegate or monitor the work of others.

Many unique aspects of long-term care make these settings different from acute or ambulatory health care settings. Here are several examples:

- the reliance on unlicensed staff and the need to delegate nursing tasks;
- the need to integrate informal care and formal services in home health and home care environments;
- the one-on-one nature of the relationship between health professions and a client in home health;
- nurses in some long-term care settings may have a significantly increased management role compared to other care settings;
- the use of negotiated or managed risk in assisted living and residential care; and
- a regulatory environment with its emphasis on survey and certification, the required use of the minimum data set.

These aspects of the long-term care environment make it somewhat different than traditional health care settings. For example, a long-term care client is typically a long-stayer--an individual who has a good chance of dying in a nursing home; an individual who may be far more interested in preserving his or her dignity and living life with as much autonomy and functional capacity as possible compared to those in traditional health care settings. For these older adults, the quality of the relationship between resident or client and staff, and the ability of the staff to deliver proper care, may be the most important factor determining care quality.

VI. SNAPSHOT OF THE LITERATURE ON LONG-TERM CARE COMPETENCIES

A first step in enhancing the preparation, credentialing and on-going training of long-term care professionals is to define the competencies needed by licensed staff to effectively care for older adults in long-term care settings. A review of the long-term care workforce literature indicates that definitions are at an early stage. Professional and provider associations have so far taken the lead in defining competencies, generally with the goal of improving the quality of nursing home care. Initiatives tend to focus on bringing more standardization and specification to the roles and functions of licensed nursing home staff rather than identifying the tasks, skills and abilities that are necessary to perform identified roles.

Once the skills and knowledge for competency have been identified, the question of how to administer such a competency training remains. Two emerging options for enhancing or improving training for professionals who care for older adults in long-term care are: (1) modifications to the educational curricula and clinical training; or (2) creation of continuing education programs to supplement a professional's qualifications. Below are examples of current initiatives that have recently been completed or are currently underway to define and infuse geriatric training in medical, nursing and social work schools/programs, and into the workplace for established health care professionals. Although some are pertinent to geriatrics in general, and therefore not all specific to long-term care, they are initiatives that demonstrate a point from which long-term care could be considered in the future.

John A. Hartford and Donald Reynolds Foundations have made significant investments to develop, support and disseminate geriatric and gerontological competencies for health care professionals--including medical and nursing students, practicing physicians and nurses and social workers. In addition, there is some public infrastructure to support education and training in geriatrics and gerontology for health professionals (e.g., the Veterans Administrations Geriatric Research, Education and Clinical Centers; the Geriatric Education Centers funded by the Bureau of Health Professions; and the Hartford Centers of Geriatric Nursing Excellence [NCGNE]).

A. Interdisciplinary

The **University of California Academic Geriatric Resource Program** partnered with the **American Geriatrics Society** to develop a curricular framework that includes core-competencies necessary for caring for diverse elderly populations. The curriculum addresses the attitudes, knowledge and skills needed by health care professionals to promote good provider-patient relationships (Xakellis, 2004). However, one limitation is that it does not address the ethnic, racial and cultural differences among caregivers that

influence how they relate to patients or deliver care, a particularly important issue among nursing home staff (Sanders, 2008).

The **American Association of Homes and Services for the Aging** has established a Workforce and Talent Cabinet made up of health educators, providers, and other workforce experts to develop a blue print for improving the long-term care workforce. The first action to be taken by the cabinet is to develop recommendations to strengthen the geriatric competencies of DCWs and professional staff across all long-term care settings (Institute for the Future of Aging Services, 2009).

The **Health Resources and Services Administration (HRSA)** in HHS started a grants program in 1998 to encourage junior faculty such as instructors, clinical instructors, or assistant professors to pursue academic careers in geriatrics, with the goal of reducing faculty shortages for health care professionals. Junior faculty in accredited schools of medicine who are board certified in internal medicine, family practice, or psychiatry are eligible to apply. A component of the career development plan specifically requires the intent to train others in clinical geriatrics, and training of interdisciplinary teams in particular (HRSA, 2007).

The **Partnership for Health in Aging (PHA)**, sponsored by the **American Geriatrics Society**, is coordinating a PHA Geriatrics Competencies Work Group in an effort to develop entry-level geriatric competencies. These competencies would be applicable across disciplines and taught in an interdisciplinary approach. The competencies will be common among many disciplines including medicine, nursing, occupational therapy, physical therapy, pharmacy, psychology and social work. The project is scheduled for completion by the end of 2009.[2]

B. Long-Term Care Administrators

The **American College of Health Care Administrators (ACHCA)** published "Principles of Excellence for Leaders in Long-Term Care Administration," a broad guide to help administrators assess their own leadership roles. The document is intended to set a framework for educational preparation, licensure, on-going educational curriculum, job descriptions and self-assessment. However, it is not an endorsement of the competencies that long-term care administrators need to effectively operate. **ACHCA** also published a position paper in 2007 on effective leadership in long-term care. The paper concludes that ACHCA should endorse a leadership model for preparing nursing home administrators that focuses on "gaining knowledge, utilizing processes and practicing effective behaviors during content-focused and application stages of learning."

The **National Association of Boards of Examiners** recently updated a job analyses describing the "knowledge, tasks and skills" of an entry-level nursing home

[2] Information is not available on their web site but more can be obtained by contacting the American Geriatrics Society (personal communication with PHA representative, April 22, 2009).

administrator and residential care/assisted living administrator. The job analysis discusses “domains” of knowledge such as how to provide resident-centered care and quality of life, and specifically recognizes the need for an administrator to understand physiological and psychosocial age-related processes.

In 2007, the **Long-Term Care Professional Leadership Council** (a collaboration between ACHCA, AMDA, ASCP and the National Association of Directors of Nursing Administration) developed a core document describing essential functions of and knowledge needed by nursing home administrators, directors of nursing, consultant pharmacists and medical directors. This is a start toward creating a nationally accepted scope of practice for these positions. For example, the document states that a nursing home administrator must have knowledge and expertise in management of frail geriatric and other long-term care patient/residents. However, it does not specify what the administrator needs to be able to do to care for a geriatric population.

C. Physicians

The **American Geriatrics Society’s Board of Directors** approved a strategic plan to help ensure that the nation’s growing population of older adults gets high quality care. The plan outlines several key projects, including: (1) defining core-competencies for health professionals caring for older adults; (2) establishing requirements to ensure competence in the care of older adults in a greater number of health professions training programs; (3) creating comprehensive leadership education programs for geriatrics health care professionals (Spivack, 2005).

In July 2007, a national conference convened by the **American Association of Medical Colleges (AAMC)** and the **Hartford Foundation** reached consensus on a minimum set of geriatric competencies that all medical students should acquire. This collaboration between multiple medical schools and the AAMC resulted in the development of geriatric specific competency-based performance standards needed by medical students to adequately care for older adults. A draft was developed by geriatricians to identify measurable performance tasks associated with accepted standards of evidence-based geriatric care, patient safety and “do no harm” within the physicians expected scope of practice. Leaders in medical education identified 26 key competencies in geriatrics in eight general categories: medication management; cognitive and behavior disorders; self-care capacity; falls, balance and gait disorders; health care planning and promotion; atypical presentation of disease; and palliative care and hospice care for the elderly (AAMC, 2009).

In 2006, **AMDA** published a position statement on the roles and responsibilities of the nursing home medical director. It describes the responsibilities of the medical director in the areas of physician leadership, patient care-clinical leadership and quality of care and education. However, it does not specify what competencies are needed to oversee the care of older adults in nursing homes. The **Pioneer Network** and **AMDA** are working on an initiative called Advancing Culture Change Together (ACCT) with

sponsorship from the **Commonwealth Fund**. A component of the ACCT Project is helping physicians incorporate principles of resident-centered care into nursing homes by leading the development of explicit core-competencies for resident-centered care. These competencies are under review and have not been publicly released yet, but will be available on AMDA's web site in the future.

D. Nurses

Of all the long-term care professionals, our review finds the most geriatric/long-term care competency activity is related to nursing. The gold standard for defining geriatric and gerontological competencies for baccalaureate schools of nursing is the American Association of Colleges of Nursing (AACN) "Older Adults: Recommended Baccalaureate Competencies and Curricular Guidelines for Geriatric Nursing Care" developed by the **Hartford Foundation Institute for Geriatric Nursing** in collaboration with **AACN**. The document was released in 2000 to help nurse educators incorporate specific geriatric nursing content into baccalaureate nursing curriculum. It is not explicitly targeted on nursing in long-term care settings. Competencies are based on: (1) a review of the literature at that time, including the work of the Association for Gerontology in Higher Education, the National League of Nursing and the Bureau of Health Profession; and (2) the proceedings of a conference of geriatric nurse educators. The AACN competencies cover the areas of functional, physical, cognitive, psychological, social and spiritual changes common in old age (AACN, 2009).

A survey of baccalaureate schools of nursing looked at trends in nursing education since the advent of the AACN competencies. Of the 36 percent of schools responding to the survey, half reported integrating geriatrics and gerontology into the nursing curriculum and half reported stand-alone courses (Gilje, 2007). A study of barriers to incorporating geriatric competencies into baccalaureate nursing curricula found the key to success is the development of qualified and committed faculty. This study purports that faculty members should foster positive attitudes toward aging, expand their geriatric nursing knowledge base and integrate geriatric content into the curricula (Latimer and Thornlow, 2006).

The **University of Minnesota School of Nursing** requires all nursing students to take a required course which introduces them to the roles, necessary skills, and contributions of nurses in a range of long-term care settings including nursing homes and community-based care. The course integrates curriculum modules with on-site assignment to a nursing home. As part of the course, students must complete a clinical practicum in a long-term care facility and are assigned to specific residents. After completing the course, students are asked to fill out a survey indicating whether course participation makes it more likely they will select a career in long-term care. According to the architect of the course, participation does not affect student responses (Buckwalter, 2008). Although nursing homes are commonly used as clinical sites to expose student nurses to geriatrics, the authors were not able to identify any other

schools of nursing which require their students to learn about the unique nature of nursing in long-term care settings.

The **Oregon Health Sciences University (OHSU) School of Nursing** and the **Hartford Center of Geriatric Excellence** created the Older Adult Focus Project (published in 2006), a set of learning activities to assist nursing students in developing competencies in the care of older adults. The curriculum is built into the online studies program of the OHSU School of Nursing. Competencies are identified in nine areas: communication, assessment, adapting care plan, maximizing function, optimal aging, complex systems, organizational systems and advocacy (Felver, 2007).

AACN and the **Hartford Foundation** sponsored an initiative to educate all advanced practice nurses with basic education and grounding in gerontological nursing care (Thornlow, 2006). They developed national, consensus-based competencies for new graduates of master and post-master programs preparing NPs and clinical nurse specialists (CNSs) in specialties that provide care to older adults but are not specialists in gerontology. An expert panel comprised of NP and CNS educators and practitioners developed a draft set of these competencies that address both NPs and CNSs providing care to older adults. Their work was reviewed by an independent validation panel involving 21 nursing-related organizations.

The competencies were inserted into the Domains of Nurse Practitioner Practice--the conceptual framework for nurse practice and the foundation for specialty competencies. These domains include: assessment of health status, diagnosis of health status, plan of care and implementation of treatment, the NP-patient relationship, the teaching coaching function, the professional role, managing and negotiating health care delivery systems, monitoring and ensuring the quality of health care practice, and cultural and spiritual competence.

The **Atlantic Philanthropies** funded the “Nurse Competence in Aging” initiative, collaboration between the American Nurses Association, the American Nurses Credentialing Center and the New York University Steinhardt School of Nursing. The purpose of the initiative is to maximize the sustainability of geriatric competence-enhancing activities within national specialty nursing associations and to assure that association members deliver improved care to older adults (Mezey, 2007).

Although many studies have concluded that nursing home RNs are poorly prepared in gerontological nursing content (Tellis-Nayak, 2005; Reinhard and Reinhard, 2006; Sanders, 2008), a review of the nurse education literature found few efforts to define the competencies nurses need to work in long-term care settings (Harvath et al. 2008). One early attempt to instill geriatric competencies into the nursing curriculum, which explicitly encompassed long-term care, was developed in 2002 by the **Texas Tech School of Nursing.** Nursing school staff conducted an extensive study of the nursing curriculum and concluded there was minimal or no geriatric content in courses taken by undergraduates. Working from the hypothesis that nursing students must be trained to provide a continuum of care as older adults progress from independent to

assistive to dependent living status, the nursing curriculum was redesigned. **AANC** and the **John A. Hartford Foundation Institute for Geriatric Nursing** competency guidelines (see above) were the framework for the course, which was supplemented by a 30-hour practicum in long-term care required of all nursing students. The practicum introduced students to some of the complexity and uniqueness of long-term care nursing--developing plans of care for assigned nursing home patients and responding to changes in orders and treatment plans. Case studies of pain, pressure ulcers, diabetes complications, respiratory distress palliative care and Alzheimer's disease were also part of the course (Scott-Tilly et al., 2005).

In addition to the AACN guidelines, a number of other initiatives are aimed at increasing the supply of geriatric nurses and improving their competency. The **Hartford Institute for Geriatric Nursing at the New York University College of Nursing** developed a tool (published in 2006) for evaluating the competency of nurses caring for older adults in hospitals. The instrument "Geriatric Competencies for RNs in Hospitals" includes competencies in eight categories: communication; physiological and psychological changes in older adult; pain, particularly among dementia patients; skin integrity; functional status; urinary incontinence; nutrition and hydration; elder abuse and discharge planning (Mezey, 2006).

There is some evidence that long-term care provider organizations are becoming more active in helping to define needed competencies for long-term care positions. The **American Association of Long-Term Care Nursing (AALTCN)** established a small practice committee made up of its members, and has developed standards and core-competencies that all nursing personnel, such as a director of nursing, LPN, RN, unit manager, and staff development director should possess. The goal is to help employers understand the competencies they need to seek in job applicants; help prospective nursing employees understand the realities of the positions they are entering; and demonstrate the complexities and unique characteristics of various long-term care nursing roles (AALTCN, 2009).

The **American Health Care Association (AHCA),** as part of its ***Radiating Excellence*** initiative, developed the "Nurse Leader in Long-Term Care Program," which defines leadership and management competencies needed by senior nurses in nursing homes. The competencies were validated using a mailed survey to a stratified random sample of 600 long-term care facilities. The extent to which these competencies are being used by AHCA members has not been evaluated. **AHCA** was also funded by the Commonwealth Fund to develop competencies around person-centered care for nursing home administrators (personal communication with author, 2008).

There are also many initiatives aimed at improving staff competencies for caring for older adults with dementia, which include nurses. For example, the State of Florida requires all nursing home staff to receive dementia training and has developed a guide to competency-based curriculum on dementia care. Washington State has also developed consensus documents identifying core-competencies for dementia training for LPNs in long-term care. However, there is no information that shows whether and

how these competency initiatives are used in practice or whether they impact nurse behavior.

Selected schools of nursing are also now beginning to tackle gaps in the preparation of and on-going training of nursing home nurses as a result of funding from the **Hartford Foundation** and the **Atlantic Philanthropies**. These foundations have funded the **Nursing Home Collaborative**, a promising partnership between the **HCGNE** at the Universities of Arkansas, Iowa, Pennsylvania, California at San Francisco and the Oregon Health and Science University and nursing home providers, regulatory, advocacy and payer groups. Established in 2007, the goal is to increase the quality of care and quality of life in nursing homes by increasing the expertise, authority and accountability of RNs. A key aspect of this work is to promote the acquisition of geriatric nursing competencies in RNs now practicing in nursing homes (Bourbonniere and Strumpf, 2008). The core of the project is the development of a nurse practice model, which empowers RNs with the authority and accountability for their practice (Beck, 2008).

The primary role of nursing home RNs is the supervision and leadership of LPNs/LVNs and DCWs. Several studies have focused on the poor academic preparation of nursing home RNs to take on these responsibilities (Reinhard and Reinhard, 2006; Sanders et al., 2008; Harvath, 2008). A number of nurse leadership training programs have emerged to address this gap such as the **Leadership, Empower, Achieve and Produce Program (LEAP)**, **University of Pennsylvania School of Nursing,** and **Pacific Northwest Nursing Leadership Institute**. With the exception of LEAP, these programs are local in scope, lack an evidence base and usually develop from a relatively narrow consensus process that excludes many key stakeholders (Harahan, 2008). There are also a growing number of programs to improve the competencies of LVNs and LPNs to supervise direct care staff including **Institute for the Future of Aging Services' Project Leadership Enrichment and Development**, **Good Samaritan**, and **Florida Association of Homes and Services for the Aging**. They too tend to be provider initiated and/or local in nature (Harahan, 2008).

A recent review of the literature on long-term care nurse leadership programs identified the following elements as essential: interpersonal skills such as communication, motivation and conflict resolution; clinical skills; organizational skills such as planning and change theory; and management skills such as regulatory compliance, financial and budgetary planning, supervision and mentoring (Harvath, 2008). The literature review did not find any training programs that included all these dimensions. The authors of the review recommend that leadership training be part of all nursing school curricula and that it persist throughout a nurses' career. They also conclude that leadership training programs should differentiate the competencies needed by nurses who occupy different positions and who are employed in different settings.

Studies of end-of-life care in nursing homes indicate that most nurses are not prepared to deliver care to older adults who are dying, even though increasingly numbers of Americans die in nursing homes (Ersek and Ferrell, 2005). A significant initiative to improve the preparation of nurses to deliver such care in all settings was launched by the **Robert Wood Johnson Foundation (RWJF**) in 2002. The RWJF funded the development of a comprehensive end-of-life curriculum (ELNEC) for nurses, items from which were integrated into AACN--recommended competencies and curricular guidelines for end-of-life nursing care. The guidelines covered cultural issues, communication skills, grief and bereavement, and pain and pain management (AACN, 2009).

The **Hospice and Palliative Nurses Association (HPNA)** has also been involved in the development of a variety of curriculum guidelines and standards of practice for end-of-life care including the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, the HPNA Scope and Standards of Hospice and Palliative Nursing Practice, the Professional Competencies for Generalist Hospice and Palliative Nurses and the Competencies for Advanced Practice Hospice and Palliative Care for licensed nurses. These initiatives tend to address what a palliative care program should look like rather than what an individual nurse or social worker or physician needs to be able to do. They are not specifically targeted to nursing in long-term care settings or to working with a geriatric population (HPNA, 2006). A second edition was released in June 2009 in which the project provides examples of how to operationalize optimal end-of-life care (National Consensus Project, 2009).

The **American Assisted Living Nurses Association (AALN)** has promulgated a Scope and Standards of Assisted Living Nursing Practice to: (1) describe the ethical obligations and duties of the assisted living nurse; (2) guide the practice and conduct of the assisted living nurse; and (3) articulate the assisted living nurses' understanding of the professions commitment to health care, nursing and society. Written in 2007, the scope and standards for assisted living practice reflect a relatively new nursing practice specialty that did not exist 15 years ago. The AALN also offers an Assisted Living Nurse Specialty Certification, which requires passing an online exam. The exam is based on the identification of competencies necessary to provide high quality care to older adults in assisted living. It has been modestly adapted from the AACN Recommended Baccalaureate Competencies and Curricular Guidelines for Geriatric Nursing Care (AALN, 2006).

E. Social Workers and Mental Health Professionals

The **Council on Social Work Education** and the **John A. Hartford Foundation** have been creating a model for academic programs to embed gerontology education into curricula**.** From 1998-2004 they developed the Strengthening Aging and Gerontology Education for Social Work (SAGE-SW) a guide for curriculum development for undergraduates and masters degree social work programs based on competencies for gerontological social work. Sixty-five gerontological social work competencies in the

domains of values and ethics, assessment, intervention and aging services, programs and policies were identified through a literature search and input from national experts (Rosen, 2000). In 2001, they sponsored the Geriatric Enrichment in Social Work Education Program which funded 67 bachelor and master of social work programs to incorporate and infuse gerontology into their programs (Council on Social Work Education, 2009; Rosen, 2002).

The **Geriatric Social Work Education Consortium** is working on development of competencies for social workers working with older adults. They are identifying field-based skills necessary for entry-level social workers. They have used the SAGE-SW domains to delineate key competencies needed during field experience. These competencies have been shown to be effective in evaluating students (Damron-Rodriguez, 2006).

The Hartford Partnership Program for Aging Education, housed at the **New York Academy of Medicine's Social Work Leadership Institute** and funded by the **John A. Hartford Foundation**, is a program aimed to establish aging curricula in social work programs across the country. It is intended for second-year students pursuing a master's in Social Work who are interested in aging and provides competency-based education (Social Work Leadership Institute, 2009). A list of pilot competencies is available on the Social Work Leadership Institute's web site (Social Work Leadership Institute, 2009).

The **California Social Work Education Center (CalSWEC)**, with the assistance of multiple grants from the **Hartford** and the **Archstone Foundation**, specified aging social work competencies with the goal of preparing social workers to provide effective interventions to California elders within the aging network encompassing health, mental health and social services. The CalSWEC Aging competencies are the result of a consensus-building approach that included a literature review and the collaboration of multiple schools of social work in California and feedback from over 100 subject matter experts. The competencies were also distributed to over 200 community stakeholders for their inputs and comments including Country Welfare Directors, Deans and Directors of Schools of Social Work (CalSWEC Aging Initiative, 2006). Competencies were developed around the following domains:

Foundation competencies:

- age, diversity and disadvantage;
- core foundation practice with older adults;
- aging, human behavior and the social environment; and
- aging social welfare policy and administration.

Advanced competencies:

- culturally competent social work practice in aging;
- advanced practice with older adults;

- perspectives on aging, human behavior and the social environment; and
- advanced aging social welfare policy and administration.

The **Institute for the Advancement of Social Work Research** in collaboration with the **University of Maryland, School of Social Work** and the **Institute for Geriatric Social Work at Boston University** convened a working conference in 2005 to examine the provision of social work services in nursing homes (Institute for Geriatric Social Work, 2005). A major goal was to clarify and specify the role, function and interventions that should be expected of licensed nursing home social workers and to examine measurement approaches to increase accountability. The conference summary identified six broad functional areas that form the core of social work practice in nursing homes settings:

- conduct psychosocial assessments through information gathering;
- provide psychosocial interventions that enhance coping skills for residents and their families;
- assist with long-term care transitions though case management;
- participate in care planning;
- collaborate with the nursing home team; and
- attend to individualized decision making.

Attendees recommended that the "actual tasks, strategies and procedures" used in implementing these six functions be specified to "map accountability for a consistent set of services across facilities." Although attempts have been made to define competencies for each of the functions (Robert Green, University of Texas School of Social Work), they do not appear to have been incorporated into a national recognized competency model for long-term care social workers.

NASW also publishes standards for social workers in long-term care facilities (NASW, 2003). According to these standards, social workers in long-term care settings should focus on several key areas:

- social and emotional impact of physical or mental illness or disability;
- preservation and enhancement of physical and social functioning;
- promotion of the conditions essential to ensure maximum benefits from long-term health care services;
- prevention of physical and mental illness and increased disability; and
- promotion and maintenance of physical and mental health.

While the standards clarify the functions of these workers, they do not define needed competencies. Standards of practice have also been developed for professional geriatric case managers, many of whom are social workers. The literature review did not uncover any comparable standards that define standards of practice for medical social workers or other social workers caring for older adults in home care settings.

F. Pharmacists

ASCP publishes the **Geriatric Pharmacy Curriculum Guide,** a tool for pharmacists and student pharmacists who are seeking guidance to direct their professional development in senior care pharmacy regardless of practice setting. The curriculum guide can be used by pharmacy educators to evaluate their curricula and in planning further development of educational programs to enhance their students' knowledge and skills in senior care pharmacy. It includes the identification of a broad range of competencies that may be needed in a particular practice or setting. The guide can then be used as a checklist to document the attainment of needed competencies (http://www.ascp.com/education/curriculumguide).

G. Direct Care Workers

In 2003, the **U.S. Department of Labor** developed and launched the Long-Term Care Registered Apprenticeship Program (LTC/RAP). Approximately 40 long-term care employers currently offer LTC/RAP employment and training to about 2,000 apprentices in 20 states. A number of additional employers, agencies, and associations have expressed interest in the LTC/RAP model. Apprenticeship programs include:

- Certified Nursing Assistant -- For nursing assistants working in nursing homes; apprentices gain skills and advance in several specialty areas: restorative, dementia, geriatric, mentor, hospice and palliative care, disabilities, and medication aide.

- Health Support Specialist -- The apprenticeship is directed toward universal workers who work in residential long-term care facilities; allows a specialist to start in housekeeping or dietary and move to a multi-skilled nursing assistant position.

- Home Health Aide -- For aides who work with consumers in their own homes; apprentices gain skills and advance in several specialty areas: hospice and palliative care, geriatrics, disabilities, mental illness, dementia, and peer mentor.

LTC/RAP apprentices undertake a minimum of 2,000 hours of on-the-job training with 144 hours of related instruction. This is substantially more than the federal training requirements for long-term care workers mandated by the Centers for Medicare and Medicaid Services.

Paraprofessional Healthcare Institute (PHI) has developed a 77-hour training of core-competencies for personal care aides in a range of long-term care settings. The training was designed for adult-learners, and can be used as a stand-alone training or to prepare individuals who intend to go on to become CNAs or HHAs (PHI, 2008).

The WIN A STEP UP (**W**orkforce **I**mprovement for **N**ursing **A**ssistants: **S**upporting **T**raining, **E**ducation, and **P**ayment for **U**pgrading **P**erformance) is a program based at the **Institute on Aging at the University of North Carolina (UNC) at Chapel Hill**, aimed at reducing turnover of nursing assistants through improved training and compensation. The 36-hour training program provides enhanced training for CNAs working in nursing homes. CNAs who complete the program receive increased compensation from their participating employer (UNC Institute on Aging, 2009).

VII. POTENTIAL STRATEGIES TO ENHANCE GERIATRIC COMPETENCIES IN LONG-TERM CARE

The literature review did not find many proposals for physicians, pharmacists or mental health professionals, however, it did uncover a variety of proposals to improve the geriatric competencies of long-term care nurses, primarily nursing home nurses. In a recent article in *The Gerontologist,* Mathy and colleagues (2008) make a number of recommendations, including revisiting an old concept--the teaching nursing home.

Teaching nursing homes emerged in the 1980s, funded by RWJF, to improve the geriatric competence of health care professionals by forging links between nursing homes and academic medicine and nursing. A summit of health educators was convened to examine the potential role of teaching nursing homes in geriatric education. Participants agreed that teaching nursing homes were an important vehicle for undergraduate and graduate students to receive interdisciplinary training in geriatrics and for faculty development. Of particular importance, teaching nursing homes were viewed as a way to alter the often negative perceptions of nursing homes in the academic community by offering up an exemplary training environment that promotes interdisciplinary education and practice and person-centered care.

The authors also made a number of other recommendations to strengthen geriatric competence among long-term care nurses, including: (1) making the renewal of nursing licenses contingent on expertise in geriatrics; and (2) tying the survey process for home health and nursing facilities to evidence that staff has received geriatric training.

Writing about the nursing home in long-term care education, White (2008) observes that nursing homes have served as traditional sites to teach geriatric medicine to medical students and primary care residents. She suggests that these clinical placements in these settings also need to emphasize specific opportunities to learn about long-term care, including how to maximize functioning of frail elders, quality improvement, interdisciplinary team participation, and transitioning patients between health and long-term care settings.

Maas and colleagues (2008) suggest that university-based schools of nursing should develop nurse training programs leading to certification as a geriatric nursing long-term care specialist. Certification would be aimed at baccalaureate-level RNs and would cover both content in gerontological nursing and management and leadership. The authors also propose a new model “Geriatric Nursing Long-Term Care Specialist Program” aimed at RNs with less than a baccalaureate-level of training--the dominant nursing presence in long-term care settings. This program would prepare RNs with an associate degree or nursing diploma to manage the care of older adults in nursing

homes and to lead and manage staffs who provide direct care. The “Geriatric Nursing Long-Term Care Specialist Program” would be trained in the processes of normal aging; illnesses and disabilities associated with aging; health, functioning and safety assessment of older adults; prevalent nursing diagnoses of older adults; evidenced-based gerontological nursing interventions and mentoring and team building strategies.

VIII. CONCLUSIONS

The IOM report “Retooling for an Aging America” (2008) identified critical gaps in the way the health care workforce in the United States is educated and trained to care for older adults. More specialized education in all areas, including long-term care, is needed to ensure the highest quality care possible. Virtually all medical professions currently provide opportunities to specialize in geriatric care, but several factors emerged that exemplify why implementing more rigorous competencies is such a challenge:

- Licensure requirements for most health care professionals are variable and therefore do not include mandatory competencies;
- Professional competencies that pertain to older populations in long-term care settings are difficult to define; and
- The alternatives for additional or supplemental training come in the form of modifying curricula, and/or adding continuing education; both are viable avenues but would require consensus within individual fields to determine the most optimal path.

There is considerable momentum to define the geriatric competencies needed by health care professionals to care for older adults, although there could be more specific attention placed on long-term care settings. We have outlined a sample of many related initiatives that are underway. By and large, they are framed by the knowledge and experience of experts familiar with patient needs in acute and ambulatory care settings. These efforts are generally national in scope and include a process that promotes collaboration and information sharing across the various professions and stakeholders. As life expectancy increases and the baby boom generation ages, these initiatives provide a foundation and a framework to improve quality of care for our aging population.

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