

Credentialing of Direct Caregivers for People with Disabilities and Elderly New Mexicans



Final Report of House Memorial 37 Legislative Task Force

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Background: House Memorial 37 Task Force

Frances Vescoso, a resident of Las Cruces, has been called a mother who truly feels she will need to live another 67 years so she can take care of her son, one who was brain damaged at birth and who functions today at the level of a four or five year-old. Frances is worried that no else will be able to competently care for her son when she is gone. For this reason, Frances called state Representative Jeff Steinborn in early 2009 and asked that he sponsor a memorial to address her concern.

As a result, the House Memorial 37 Task Force (“Task Force”) was created during the 2009 Regular Session of the New Mexico legislature. The memorial requests a study to plan and implement a training and education program leading to credentialing of individuals who work as direct caregivers for individuals with disabilities and with elderly New Mexicans.

The topic is especially timely for New Mexico for several reasons, including predicted workforce shortages in health care and other fields, significant increases in the elderly population in the state, and an increased focus on consumer choice and home and community-based care.

Average wages for caregivers in the state of New Mexico are much lower for people in these occupations than for other occupations. In New Mexico, a home health aid worker earns approximately \$8.00 per hour, \$7.53 per hour less than that of an average New Mexico worker.¹ And, while average hourly wages for direct caregivers increased ten percent from \$6.62 (1999), these are wages at 150 percent of the Federal Poverty Level!

Occupational growth in the field of direct care is rapidly increasing. Personal and home health aides are the second fastest-growing occupation, both nationally and in New Mexico. The U.S. Department of Labor reports 21,520 New Mexicans were working as nursing assistants, home health aides or personal care/home care aides in 2006.² Projected annual job openings for these occupations predict 6,190 additional job openings--an increase of 58 percent between 2006 and 2016!


High job turnover in the field of direct care occurs as a result of worker shortages, low wages, few to no benefits, little training and little recognition for the work performed. Persons who are elderly and disabled suffer the effects of direct care worker shortages and high turnover. The quality of care is compromised since employers are unable to meet the need for high-quality services to elders and people with disabilities.

Charge of the Task Force

House Memorial 37 resulted in passage of a memorial to plan and develop a training and education program leading to credentialing of direct caregivers, paraprofessional workers who provide care to New Mexico’s aging and disabled populations. The plan was to include training and education credentialing for the variety of occupations in the field of direct care. Caregivers are defined as

¹ May 2007 State Occupational Employment and Wage Estimates: New Mexico. U.S. Bureau of Labor Statistics, May, 2007. <http://www.bls.gov/oes/current/oes_nm.

² Current and future workforce projections seriously understate the need. State agency data from the Developmental Disabilities Planning Council and University of New Mexico indicate our state’s workers often hold a second job often as a direct caregiver. Second occupations are not counted in occupational data.



those who work as personal care assistants, home care aides, home health aides and certified nursing assistants (CNAs).

Legislation directed the New Mexico Developmental Disabilities Planning Council to convene a task force of experts to study, plan and implement a training and education program leading to credentialing of direct caregivers in the state. The Task Force was to include a variety of state agencies associated with care for persons who are elderly and/or disabled as well as those from the education community, licensing agencies, family and professional direct caregivers, service providers and advocates and self-advocates. Appendix I lists the members of the Task Force.

A special thanks to Frances Vescoso and Representative Jeff Steinborn for their persistence and for making this early collaborative effort in New Mexico possible.

The Direct Care Workforce at a Glance

Researchers do not have a clear understanding of the connection between the amount of or quality of training and its impact on worker recruitment and retention. Some believe that inadequate training leads to higher turnover, and a growing body of research supports that hypothesis. Nationally, turnover was estimated at more than 71 percent among nursing home CNAs in 2002,³ while a study of home health aides found that 40 to 60 percent leave after one year or less on the job and 80 to 90 percent during the first two years.⁴


We know of several outstanding examples of excellence in quality care in New Mexico. Ours is one of only five states with a statewide curriculum for direct support professionals who work with individuals with developmental disabilities. The training, provided and paid for by the Department of Health, includes classroom training on topics like introduction to persons with developmental disabilities, emergency procedures, blood-borne pathogens consumer rights, CPR and first aid. In addition, forty hours of care-specific training within the first year of employment is required for caregivers. A practicum is required, as is annual recertification.

Tresco, Inc., located in southwest New Mexico, partnered with Dona Ana Community College to create an eight-week certificate program in Disabilities Support Services. The Developmental Disabilities Supports Division (DDSD) of the Department of Health assists the partnership by allowing use of training modules and processes used within the Developmental Disabilities (DD) Medicaid Waiver program. This certificate program grants students four hours of college credit that is transferable when the student gains employment at a DD Waiver-provider agency. DDSD is working with New Mexico State University–Alamogordo to replicate the program.

Statewide training also exists for direct caregivers serving consumers assisted by the Aging and Long-Term Services, Human Services, Children, Youth and Families departments too, and depends largely on the clients served, his/her individual needs and state and Federal requirements (see “Credentialing of Direct Caregivers for Elderly and Disabled New Mexicans: Education and Training Requirements, May 2009” in Appendix II).

³ American Health Care Association (AHCA), *Results of the 2002 AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes* (Washington, DC: AHCA, February 12, 2003).

⁴ New York Association of Homes and Services for the Aging, “The Staffing Crisis in New York’s Continuing Care System,” Unpublished (March 2000).



There are also a few national training and credentialing programs for direct caregivers. The College of Direct Support (CDS), developed by the University of Minnesota's Institute on Community Integration at the Research and Training Center on Community Living, incorporates web-based instruction for direct caregivers. On average, four new courses or tools are added to the College of Direct Support on-line curriculum annually.

PHI is a national organization that provides technical assistance to family and professional caregivers. PHI developed a 77-hour, adult learner-centered, competency-based curriculum for direct caregivers designed to meet three major goals: to help participants develop the core competencies needed to provide person-directed personal care in a range of long-term care settings; introduce potential workers to all the different settings; and lay the foundation for further training as nurse assistants and/or home health aides. PHI's curriculum can be used as a stand-alone curriculum to train workers who provide personal care services. It can also be used as a first level of training to prepare workers for jobs in nursing facilities and home health care agencies.

While we hear more often about New Mexico's and these few national success stories, it takes only one tragedy resulting from an inexperienced worker to again bring our attention to the need for education and a minimum set of core competencies a caregiver should be able to demonstrate before being allowed to work with our most vulnerable citizens.

Key Organizing Principles


Caregivers are at different ages and stages of development. Some are just beginning their work in the field of direct care, actively seeking career pathways, and ways to advance within the field and connect to a profession. Others may be nearing the end of their careers. They may be seeking annual recertification to continue working, or they may now be in need of their own health insurance or retirement benefits.

We believe that duplication of effort, funding and training requirements most probably exists within New Mexico agencies serving persons who are elderly and those with disabilities. Additional research is needed on how those funds are distributed and accounted for as a way of achieving greater efficiencies.

We also agree that any system for education and credentialing of New Mexico's direct care workers should:

1. Balance considerations that afford the greatest possible liberty to caregivers who are self-directed, who can and do get what they need to promote their advancement, career growth and provide quality care versus those who require education, training or credentialing to be able to work effectively with our state's most vulnerable citizens;
2. Continue to involve service providers and direct caregivers in developing a plan for a better-trained, more highly-skilled direct care workforce; and
3. Accomplish better outcomes for consumers and for direct care workers with fewer administrative burdens.


Our recommendations focus on *functional* occupational classification rather than the setting in which a direct caregiver works (group, residential, one-on-one, etc.). Though our recommendations



are focused on occupational classifications, we understand the complexity of this undertaking, and have attempted to consider the workforce in New Mexico, the multitude of settings in which direct caregivers work and the diverse needs of the populations they serve.

Recommendations


1. *Define a core curriculum common to all direct care workers, building discipline-specific or sub-specialty training from that foundation.* Direct caregivers undertake agency-specific have training depending on the setting and needs of the populations they serve. We recommend a foundational, or core, curriculum for all direct care workers regardless of work setting or needs of consumers served. A basic level credential would teach the skills common to all fields of direct care (elderly, physically, developmentally, psychologically, cognitive disabled). We recommend that advanced, discipline-specific curricula be developed once a crosswalk has been conducted (See Further Study Needed) and after a learner has mastered a foundation credential.
2. *Direct care workers must be able to demonstrate skills acquired.* Any direct caregiver, regardless of setting, must be able to demonstrate competence in skills acquired. And, for those individuals directing their own care, they too should be held accountable for demonstrating an appropriate level of training and competency of their caregiver.
3. *Meet adult learners at their levels, reaching them through a variety of methods.* There are many ways adults learn, just as there are a variety of learning resources, geographic settings and life circumstances of workers themselves. A focus on development of core competencies (rather than educational attainment) will result in mastery of the requirements needed for direct care workers as well as a learner's identification of career pathways and transferable skills needed to transition among a variety of occupations within the field. A full menu of delivery mechanisms should be developed that includes classroom training, web-based/on-line learning and self-paced or independent study. Language adaptations may be required depending on the needs of the individual learners.
4. *Educational credit should be granted to adult learners for experiential knowledge.* When developing the core foundation curriculum and subsequent discipline-specific training, provide a way to grant educational credit for life experience and for training provided by state agencies and service providers.
5. *Consolidate resources for educating and training direct caregivers.* The range of state and Federal agency and service provider resources, tools and websites should be consolidated and made available to all direct caregivers. This clearinghouse would hold resources including education and training standards, workforce development tools and information on job/career advancement.
6. *Remove barriers to granting wage increases for direct caregivers' additional training.* Existing obstacles to wage increases should be removed for those who obtain additional job training. For example, the Mi Via Waiver budget should be amended to grant wage increases (or benefits) for attendant care training.

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7. *Continue to involve consumers and direct care workers in development of a credentialing system.* We strongly encourage continued involvement of consumers and direct caregivers so they may provide feedback to these recommendations and subsequent development of training, tools and resources.
 8. *Use Federal and state regulations to reinforce quality of care, asking that service providers, contractors and advocates re-draft certain rules. Consider additional documentation requirements as needed and by exception, employing these for clients who have ill-defined or more intensive clinical or behavioral needs.* Government rulemaking generates attention to detail but not necessarily better quality of care. Further, there is a distinction between quality operating standards and regulations that reflect no more than a possibility of eliminating risk for vulnerable populations.
 9. *Promote a “duty to report” as an essential safety mechanism to protect consumers from abuse, neglect and exploitation, describing a policy and procedure for if and when a “self-directed” consumer loses his rights in self-directed care.* The responsibility of the individual, family, community, service provider and government to provide oversight needs better definition and clarity. While we strive to promote individual liberty, there is a need to define the criteria for “involuntary termination” of a self-directed waiver when one’s own or another’s safety is threatened.
 10. *Improve and promote a positive image of direct care as a profession.* There is a high degree of interest among direct caregivers, agencies and providers alike for gaining recognition, increasing the sense of professionalism and developing public awareness of the work of direct caregivers.
 11. *Develop and encourage adoption of a professional Code of Ethics that is daily demonstrated by direct caregivers across New Mexico.* We believe that a Code of Ethics will help to promote a sense of professionalism and excellence.
 12. *Promote self-management and stress reduction skills to direct caregivers so they may deal with difficult work-related and personal care situations.*

Anticipated Barriers to Implementation

Geography, setting and opportunity may limit our ability to meet direct caregivers’ needs. In recommending that a full menu of delivery mechanisms be developed that includes classroom training, web-based/on-line learning and self-paced or independent study, we realize a number of potential barriers exist.

Many people who are drawn to the field of direct-care are low-income women between the ages of 25 and 55. Many of these women have not graduated from high school; some are immigrants with limited English-language skills. On average, trainees have functional reading and math skills that range between the fourth- and eighth-grade levels. In addition to the educational challenges, many trainees have had little formal work experience and face daunting life challenges of raising children and caring for extended family members on limited incomes.



Because many of these women are intimidated by the idea of being in school—and perhaps even of holding a regular job—our first concern for an effective training is to create a supportive and safe learning environment in which trainees can develop the necessary competencies in an atmosphere that builds and reinforces self-confidence and self-esteem. Positive learning environments also encourage personal and professional networking, important for new entrants to the workforce as well as seasoned workers.

Many direct caregivers do not have ready access to job and career counseling because they live in remote areas; they may not have access to the Internet; low wages may only pay the bills but not an education; they may already be juggling two jobs just to support a family. There is little time left for travel to school or for study.

The practical effect of unfunded mandates. Standards should not be lowered and civil penalties should be imposed on service providers (employers) who fail to properly train or supervise workers. Nevertheless, employers legitimately worry that if credentialing is adopted without adequate processes and structure, both quantity and sophistication of training will increase while employers' reimbursements for training (if available) will remain flat. Exacerbating employers' worries is the fact that an increasing number of entry-level employees are not ready to work or learn.

Rules governing education and training are defined by the Federal Centers for Medicare and Medicaid Services (CMS) and enforced by state government. As state government more uniformly enforces Federal rules, employers have been more vigorously monitored. When the Federal rules were developed, no one anticipated that turnover of front line employees might be as high as 200 percent each year in some areas!

There are a variety of best practice examples in other states for education and credentialing.⁵ All but nine of the 50 states and the District of Columbia require some training for personal assistants who work in licensed assisted living facilities, but the range of skills required varies widely. In some states, workers must be trained as Certified Nursing Assistants (CNAs) or demonstrate competency in a detailed list of skills. In others, they are required only to attend a few hours of annual in-service education or to obtain "appropriate orientation and training."⁶

The most promising approaches to improving education for direct caregivers appear to involve a combination of improvements in content and teaching methods. Additional study, as indicated in the next section, will help determine the content and methods that best prepare direct caregivers for the complex emotional work of direct care, and in turn, help shape training required. Without smarter use of New Mexico's educational resources, credentialing will be counterproductive.

⁵ See Practices in Education and Training for Direct Care Workers: Prepared for the Legislative House Memorial 37 Task Force. Education and Workforce Consultants, LLC (July 8, 2009).

⁶ Lyn Bentley, Shelley Sabo, and Amy E. Waye, *Assisted Living State Regulatory Review 2003*. Washington, DC: National Center for Assisted Living (May 2003).



Further Study Needed

The following are areas requiring additional study.

1. *Seek and obtain a planning grant for ongoing work of the Task Force.* In order to build a model of training and credentialing, we recommend a planning grant that funds additional work to study the barriers to implementation and develop a statewide core curriculum of education and credentialing for direct care workers. Specifically, the Task Force needs additional time to pursue the following:
2. *Conduct a crosswalk of skills and competencies among the Certified Nursing Assistants (CNAs), Home Health Aides and Personal Assistants.* We need to know the training requirements of the Federal Center for Medicare and Medicaid Services (CMS) for the service provided, regardless of relationship to the individual who is receiving services. And, while HM37 directs us to include “*personal care assistant, home care aide, home health aide and certified nursing assistant*,” additional time is required to develop a core curriculum common to these occupational titles.
3. *Locate, document and correct program funding inefficiencies.* Evaluating system efficiencies is the key to effectively funding a program of education and credentialing. Though the study provided to the Task Force, “*Credentialing of Direct Caregivers for Elderly and Disabled New Mexicans Education and Training Requirements*,” in Appendix II identified training requirements for the variety of direct care workers by agency and program, there is a need to research what agencies are currently providing funding for and what caregivers receive for that funding. We believe that duplication most likely exists within agencies providing education, training and credentialing for those serving persons who are elderly and those with disabilities. As a way of gaining greater efficiencies, additional research is needed on how those funds are distributed, spent and accounted for.
4. *Information provided to the Task Force indicates a lack of standardization of Articulation Agreements or processes among New Mexico’s community college system so that training, life experience and education gained through a state agency or service provider might count toward degree credit.* A process should be developed so that Higher Education Department grants college credit for life experience and education gained through a state agency or service provider.
5. *Study the U.S. Department of Labor Apprenticeship Model.* We appreciate the apprenticeship model’s emphasis on education, practical training and the requirement that skills must be demonstrated by the apprentice before the credential is granted. We need to understand better how it might be implemented in New Mexico and which employer(s) could be named to test the model.



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Appendix II

Credentialing of Direct Caregivers for Elderly and Disabled New Mexicans Education and Training Requirements May 2009

Occupation	Number of Hours ⁷	Competencies Required	Required Documentation of Skills	Minimum Instructor Credentials	In-Service Training Required	Performance Review
Certified Nursing Assistant	75 hours	Ambulation and transferring patient Communication skills Emergency response, CPR and first aide Gathering samples Vital Signs Range of motion exercises Positioning Nutrition and Hydration Bedpan use and output measurement Oral Care, Dressing, Personal hygiene & grooming, Bathing Observing patients	New Mexico Nurse Aide Competency Examination Registered on the NM Nurse Aide Registry	Must be approved by State of New Mexico	12 hours/yr	None Specified
Home Health Aide	75 hours	Communication skills Recordkeeping Reading/recording of vital signs Infection control Body functioning	Agency must document minimal information (name, purpose of class, instructor name, number of hours,	Must be performed by, or under supervision of, registered nurse who	12 hours/yr	Performance review, including written evaluation and skills demonstration must be completed

⁷ For Homemaker/Personal Care Attendant, 10 hours training must be completed prior to placement in patient home; 2 of the 10 may include agency orientation training; 8 of the 10 must be patient-specific.

For Home Health Aide and Medically Fragile, at least 16 hours devoted to supervised practical training, meaning training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a RN or LPN.

		Clean and safe environment Emergency response, incl. CPR and first aide Physical, emotional and developmental needs of populations served Personal hygiene and grooming Patient transfer techniques Normal range of motion and positioning Nutrition and hydration Patient/client rights	method to determine competency)	must have minimum of 2 years nursing experience and 1 year in the provision of home health services		every year
Medically Fragile	75 hours	Communication skills Documentation of patient status Recording vital signs Infection control procedures Body functioning and changes that must be reported Maintenance of clean and safe environment Emergency recognition Physical, emotional and developmental needs of population served Personal hygiene and grooming Safe transfer techniques Normal range of motion Nutrition and fluid intake	Agency must determine competency through written examination	Must be performed by RN with at least 1 year of exp in home health care Supervision must be performed by RN and occur at least once every 60 days	12 hours/yr	
Developmental Disabilities Service and Case Mgmt⁸	Safety Training within first 30 days	Operating a fire extinguisher Proper lifting procedures General vehicle safety Assisting passengers with cognitive and/or physical impairments	Trainers must document minimal information (name, purpose of class, instructor name, number of hours,	Certified trainer who has completed DDSD trainer certifications	10 hours/yr, a maximum of 4 of them that can be applied outside of a formal	None specified

⁸ DD Policy pertains to DD Waiver (including Case Management, Community Living Services, Adult Habilitation, Supported Employment, Personal Support, Respite Services, Tier III Crisis), Residential and Day Services for Adults and ICF/MR residential and day services.

	40 hrs care-specific training in first yr of assignment	<p>Operating wheelchair lifts Wheelchair tie-down Emergency and evacuation procedures</p> <p>Individual Service Plan/Core Curriculum⁹ Incident reporting OSHA and other safety training above Hazardous chemicals Behavioral Intervention Medication Management</p>	Pass/Fail, date and level of certification) 100% pass rate required		classroom setting	
Family infant Toddler Program Developmental Specialist	75 hrs	<p><u>Developmental Specialist I Basic:</u> HS diploma or GED, at least 18 years old, FIT application</p> <p><u>Developmental Specialist I Advanced:</u> Assoc degree or 1-yr Vocational Certificate from CYFD & 3 yrs experience w young children</p> <p><u>Developmental Specialist II:</u> Bachelor's degree, FIT application</p> <p><u>Developmental Specialist III:</u> Masters or Ph.D., FIT application</p> <p>For all above , requirements include: Academic coursework Mentorship Self-Study Formal reflective supervision</p>	For all levels, competencies must be documented in certificates of completion with supervisor's initials	None specified	For all levels, IDP to be developed each yr within 3-yr recertification period	For all levels, Corrective Action Plan developed is requirements not met

⁹ DD provides the following levels of certification: Introductory, Orientation, Level I (Level II and Level III planned). Core Curriculum is extensive for each of these levels and is shown as Attachment A.

Homemaker OR Personal Care Attendant	40 hours	Communication skills Patient/consumer rights Recording of information for recordkeeping Nutrition and meal preparation Housekeeping skills Care of the disabled Emergency response, incl CPR and first aid Basic infection control Home safety	Agency must document minimal information (name, purpose of class, instructor name, number of hours)	None specified	10 hours/yr	None specified
Personal Care Option (PCO)	12 hours	Overview of PCO program Living with a disability in the community CPR and First Aid training Written competency test with a minimum passing score of 75%	Agency must document competency	None Specified	12 hours /yr	None Specified

Source Notes: New Mexico Department of Health, Public Health Division and Developmental Disabilities Supports Division
State Regulations, Chapter 7.28 Homemaker / Personal Care Attendant; State Regulations Chapter 8.315 Consumer-Directed Personal Care Option.
Code of Federal Regulations 42 CFR 440.70 and 484.
New Mexico Regulations Governing Home Health Agencies, 7NMAC 28.2.
New Mexico Association for Home and Hospice Care <http://www.nmahc.org>.
New Mexico Board of Nursing <http://www.bon.state.nm.us/>
IDEA Part C and 7NMAC 30.8 Requirements for Family Infant Toddler Early Intervention Services .

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