

**Defining Core Competencies for the
Professional Long-Term Care Workforce:
A Status Report and Next Steps**

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by

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I. Introduction and Purpose

The long-term care workforce crisis is well documented. Large numbers of vacancies in professional and direct care positions create significant obstacles for providers and workers committed to delivering high-quality care. Adding fuel to an already raging fire is the difficulty of attracting new talent to long-term care and retaining employees once they are hired. These difficulties are exacerbated by demography, high turnover, long-term care's negative public face, wages that are typically lower than what can be earned in the acute care sector, a pervasive failure to create work environments where people want to work and an education and training system that too often fails to prepare individuals for the work they must perform.

Efforts to analyze and respond to the long-term care workforce crisis typically have emphasized staff shortages—particularly shortages of direct care workers. However, as observed by Kane, “although some minimum number of staff are necessary just to get core tasks done, the quality of those workers, their skills, motivation, their kindness and concern is bound to play a substantial role” (Kane 2004).

In April 2008, the Institute of Medicine (IOM) released a new report, *Retooling for an Aging America: Building the Health Care Workforce* (IOM 2008). The central theme of the IOM report is that although almost all health care providers treat older patients to some extent during their career, they largely lack the essential skills required to effectively care for the growing older population and its unique needs. The report found there are too few geriatric specialists, and generalists do not have enough training and experience to properly treat older patients. It recommends that:

- Health care workers be required to demonstrate competencies 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.
- 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.

While to some extent the IOM report encompasses long-term care, most of its orientation and emphasis is on the professional health care workforce employed in hospital and ambulatory care settings and on direct care workers.

The goal of this paper is to analyze the gerontological workforce literature, as well as initiatives launched by professional associations and providers, to determine progress in defining the competencies needed by the licensed long-term care workforce. The authors' assumption is that unless the community of employers, educators and payers, in collaboration with the workforce, is able to define the competencies needed by long-term care professional staff to achieve high-quality long-term care services, these positions in long-term care will never gain the recognition they deserve as worthy careers or be accorded a professional status. As a result, long-term care will

continue to take a back seat to the health care sector in recruiting and retaining needed talent, and the quality of long-term care will continue to suffer.

The paper addresses three questions:

1. To what extent have professional schools and others defined the core competencies needed by physicians, nurses, social workers and other licensed staff to care for frail older adults in various health care settings?
2. What is being done to define the core competencies needed by health care professionals who care for older adults in long-term care settings?
3. What next steps could be taken to strengthen the competencies of licensed long-term care staff?

The primary focus is on the core competencies needed by medical directors, agency and facility administrators, nurses, social workers, other mental health professionals and consulting pharmacists who are employed by nursing homes. Where the literature is informative, some attention also is devoted to the competencies needed by professionals employed in assisted living facilities and home health agencies.

This paper does not address the core competencies needed by direct care staff—the individuals who are the heart and soul of long-term care service delivery. Although extremely important, this issue has and continues to receive substantial attention in the literature, within the long-term care provider community, within the workforce itself and by those who advocate on its behalf, e.g. PHI, the SEIU, etc. In addition, identifying competencies for direct care workers must take into account the long-standing role of the federal government, which establishes basic requirements for direct care worker certification.

II. Definitions and Method

For our purposes, the term “competency” refers to a person’s capacity to apply or use a set of related knowledge, skills and abilities to successfully perform critical job functions or tasks. Put another way, competency generally is used to define the set of behaviors and actions that people must be able to do to hold a particular job (in contrast to a description of the functions and tasks that are associated with the job). Competency models (collections of related competencies) are the foundation of important human resource functions such as recruitment and hiring, training and staff development and performance management.

To prepare the concept paper/literature review, the authors carried out the following activities:

- Examined the gerontological and long-term care workforce literature between 2000 and 2008 (searching MEDLINE, CINAHL—the Cumulative Index to Nursing and Allied Health Literature and Google Scholar).
- Reviewed selected 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 selected 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.

III. Organization of the Paper

The remainder of this paper is organized around the following topics:

A. Geriatric Core Competencies for Health Care Professionals

1. How well are health care professionals prepared to care for older adults?
2. Initiatives to define geriatric core competencies for the professional health care workforce.

B. Core Competencies for Health Care Professionals in Long-Term Care Settings

1. The roles of licensed long-term care professionals.
2. The need for long-term care specific core competencies.
3. The “state of the art” in defining core competencies for long-term care professionals.

C. Potential Strategies to Enhance Long-Term Care Specific Geriatric Competencies

D. Conclusions and Proposed Action Agenda

IV. Findings

A. Geriatric Core Competencies for Health Care Professionals

1. How Well Are Health Care Professionals Prepared to Care for Older Adults?

According to the U.S. Department of Health and Human Services, the aging population and increase in the size of the elderly population are likely the most important demographic trends that will impact the future health care workforce (Bureau of Health Professions 2003). There are now 35 million people over the age of 65 in the U.S. They use 23 percent of ambulatory care visits, 48 percent of hospital days and 83 percent of nursing home days. About 1.6 million older adults live in nursing homes, almost half of whom are over the age of 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).

The educational infrastructure that is supposed to prepare professionals to care for a growing population of older adults—many of whom experience chronic illnesses, complex medical conditions and/or functional and cognitive limitations—is not doing the job. Multiple studies of the readiness of the health care workforce to care for an aging population have concluded that the current system borders on catastrophic (Knickman and Snell 2002, Alliance for Aging Research 2005, Center for 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). The literature presents a stark portrait of the geriatric workforce and the infrastructure that prepares it. For example:

Physicians

- One pediatrician is available for every 1,000 children in the U.S., while only one geriatrician is available for every 2,000 older people.
- Every medical school requires students to complete a clinical rotation in pediatric settings, while almost no programs require a rotation in geriatric settings.
- 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.
- The vast majority of physicians (77 percent) do not even treat nursing home patients (Levy et al. 2005).
- A study of nursing home medical directors found that 86 percent reported spending eight hours or less per week in a facility, and 62 percent reported visiting the facility one time per week or less (U.S. Department of Health and Human Services 2003).

Nurses

- Almost 70 percent of RN and LPN graduates are not baccalaureate prepared.
- Only one-third of nursing students in baccalaureate nursing programs have a required course in geriatrics.
- 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, Nowar and Scobee 2006).
- 58 percent of nursing programs have no full-time faculty certified in geriatric nursing. Less than 1 percent of practicing RNs are certified in geriatrics.
- Only 4 percent of nursing programs could be considered exemplary in their emphasis on geriatric nursing, e.g. they have a stand-alone geriatrics course, two or more clinical placements in geriatric settings and one full-time faculty certified in geriatrics (Kovner et al. 2007).
- Although one of the primary functions of RNs in long-term care is the management and supervision of LPNs, nurse aides and other health care professionals, most have not received training in management and leadership skills (Harvath et al. 2008).
- The National State Boards of Nursing reported for 2003 that only 6.4 percent of recent nursing graduates are practicing in long-term care, compared to almost 40 percent who are practicing in critical care (Scott-Tilly et al. 2004).

Social Workers and Mental Health Professionals

- 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 (ASPE 2006).
- The supply of social workers who practice in aging related fields is decreasing (NASW 2006).
- There is scant evidence that mental health students have even minimal exposure to gerontological content in their foundation course work or field practicums (Rosen et al. 2002).

Consulting Pharmacists

- Of approximately 200,000 pharmacists, only 720 have geriatrics certification.

2. Initiatives to Define Geriatric Core Competencies for the Professional Health Care Workforce

Weaknesses in the readiness of health care professionals to care for an aging population have received increasing attention by philanthropic organizations, government and academic centers. The John A. Hartford and Donald Reynolds Foundations and the Hartford Centers of Geriatric Nursing Excellence 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 Administration’s Geriatric Research, Education and Clinical Centers and the Geriatric Education Centers funded by the Bureau of Health Professions. While some of these centers and programs periodically support projects in long-term care, it is not the driving force behind their agenda. The infrastructure that has emerged to support geriatric education for health professionals at the baccalaureate and graduate levels lacks the capacity to identify, promote and advocate for the education and training needs of long-term care professionals.

It is also worth noting that investments in geriatrics for health care professionals are beginning to make a difference. For example, the American Geriatrics Society longitudinal study of the geriatric workforce found:

- 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 (up from 61 percent in 2003).
- 76 percent reported being well prepared to care for older adult patients in acute care settings (up from 69 percent in 2003).
- 81 percent reported being well prepared to care for older adults patients in ambulatory settings (up from 78 percent).

While self-perceived preparation to care for older adults in long-term health care settings also is improving (from 55 percent in 2003 to 62 percent in 2007), it continues to lag behind acute and ambulatory care (Bragg 2008).

Summarized below are a few of many examples of initiatives that have been developed or are underway to define and infuse geriatric competencies in schools of medicine, nursing and social work. Many are relatively new.

Comprehensive

The American Geriatrics Society’s Board of Directors recently approved a strategic plan to help ensure that the nation’s growing population of older adults receives 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 and (3) creating comprehensive leadership education programs for geriatrics health care professionals.

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 et al. 2004). However, 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, Stone et al. 2008).

Physicians

Collaboration between the medical schools at **Mount Sinai, Florida State, the University of Wisconsin and the American Association of Medical Colleges (AAMC) and the Hartford Foundation** resulted in the development of geriatric-specific, competency-based performance standards needed by medical students to adequately care for older adults. Geriatricians developed a draft 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.

The competencies then were assessed for content validity by key stakeholders, including geriatricians, family physicians, internists, neurology program directors, survey program directors and others. They were refined in a 2007 consensus conference on competencies in geriatric education attended by representatives of almost half of the nation’s medical schools. Competencies were identified in the following content domains: medication management; cognitive and behavioral disorders; self-care capacity; falls, balance and gait disorders; atypical presentation of disease; health care planning and promotion; and palliative care. The competency set is available through the Portal of Online Geriatrics Education (www.pogo.org) (American Geriatrics Society 2008).

Nurses

The gold standard for defining geriatric and gerontological competencies for baccalaureate schools of nursing is the American Association of Colleges of Nursing’s “Older Adults: Recommended Baccalaureate Competencies and Curricular Guidelines for Geriatric Nursing Care” developed by the **Hartford Foundation Institute for Geriatric Nursing** in collaboration with the **American Association of Colleges of Nursing (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 to 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 Professions 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.

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. Unless faculty members foster positive attitudes toward aging, expand their geriatric nursing knowledge base and are able to integrate geriatric content into the curricula, progress cannot be made (Latimer and Thronlow 2003).

In addition to the AACN's 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 nine 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.

The Oregon Health Sciences University (OHSU) School of Nursing and the Hartford Center of Geriatric Excellence (HCGE) 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 eight areas: communication, assessment, adapting care plans, maximizing function, optimal aging, complex systems, organizational systems and advocacy.

The **AACN and the Hartford Foundation** sponsored an initiative to develop national, consensus-based competencies for new graduates of masters and post-masters programs preparing nurse practitioners (NPs) and clinical nurse specialists (CNSs) in specialties that provide care to older adults but are not specialists in gerontology. The goal is to educate all advanced practice nurses with grounding in gerontological nursing care.

An expert panel comprised of NP and CNS educators and practitioners developed a draft set of competencies that address both NPs and CNSs who are providing care to older adults. Their work was reviewed by an independent validation panel involving 31 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 nurse practitioner-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, a 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.

Social Workers

The Council on Social Work Education SAGE-SW Project developed a guide for curriculum development for undergraduates and masters-degree social work students 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.

The list of competencies was fielded in 2000 through a large national survey of practitioners and academics with aging and non-aging interests. Respondents were asked to rank the level of specialization (all social workers, advanced practitioners, aging specialists) needed across three domains: (1) knowledge about older people and their families, (2) professionals skill and (3) professional practice. Each competency was then ranked according to its mean level of specialization. The council prepared a report based on the survey, as well as a literature review that includes a list of geriatric knowledge, skills and values for infusion in undergraduate and masters of social work required courses and skills-based scales for students and supervisors. The goal is to guide programmatic curriculum development and integration into foundation social work courses.

The California Social Work Education Center (CalSWEC), with the assistance of multiple grants from the **Hartford** and **Archstone Foundations**, 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 also were distributed to over 200 community stakeholders for their inputs and comments, including county welfare directors, deans and directors of schools of social work. 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
- 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
- Advanced aging social welfare policy and administration

Pharmacists

The American Society of Consultant Pharmacists 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. Pharmacy educators can use the curriculum guide to evaluate their curricula and plan 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 then can be used as a checklist to document the attainment of needed competencies.

B. Core Competencies for Health Care Professionals in Long-Term Care Settings

Health care professionals in long-term care face a very different environment than professionals in acute care and ambulatory settings. While all health care professionals benefit from the work being done to develop and implement geriatric core competencies, health professionals in long-term care settings may need to develop special competencies to be effective in that setting.

This section describes the:

- Roles of long-term care professionals.
- Need for long-term care specific core competencies.
- State of the art in defining competencies for long-term care professionals.
- Potential strategies to enhance long-term care specific geriatric competencies.

1. The Roles of Licensed Long-Term Care Professionals

Physicians

Physicians are formally involved in long-term care as nursing home and home health agency medical directors and as the individuals who are 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 participating in the design of residents' care plans. Assisted living facilities and home health agencies are not required to have a medical director, although many do. Research on the extent of involvement of other physicians in caring for patients in long-term care facilities is largely lacking, although anecdotal evidence suggests few maintain their relationship with patients once they are institutionalized. There is a small cadre of geriatricians who are heavily involved in integrating primary, acute and long-term care services on behalf of older adults living in their own homes and apartments (Sanders and Harahan 2008).

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. The federal government requires states to license nursing

home administrators, although there are no national standards. Licensing requirements across states are highly varied—some states only require a high school diploma and passing an exam. The extent to which administrators in assisted living facilities, home health agencies and other home and community-based service agencies are credentialed is left to states. There is no national database that identifies the number of active, licensed administrators working in long-term care settings or where they work.

Registered Nurses

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 licensed practical nurses (LPNs) and licensed vocational nurses (LVNs) and direct care worker staff. 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 patients' home environments, care for and instruct patients and their families in self-care and supervise home health aides. Of the estimated 2.9 million RNs employed in the U.S., about 260,000 are employed in long-term care settings, usually in nursing homes and home health agencies. Substantial research evidence supports the critical role of nurses—particularly in nursing home settings—in improving the quality of care (Harrington et al. 2000, Reinhard and Stone 2001, Rantz 2003, Reinhard and Reinhard 2006, Bostick et al. 2006).

Nurse practitioners (NPs) also are employed in some nursing homes to augment medical care provided to residents by physicians. These nurses are RNs with advanced training who operate in an expanded nursing role; conducting physical exams, making urgent care visits, prescribing medications and providing preventative care to residents. Of the estimated 78,500 nurse practitioners licensed in the U.S. (most of whom work in hospitals), only about 2,000 serve nursing homes. An unknown number of NPs also are employed by home health agencies. Studies have shown that NPs can have a positive impact on nursing home residents' care (Garrand et al. 1990, Ronsenfeld et al. 2006). A survey of physicians who are members of the American Medical Directors Association found that large majorities of respondents perceived NPs to be very effective in maintaining physician, resident and family satisfaction in nursing homes.

LPNs and LVNs provide direct patient care, including taking vital signs and administering medications. An estimated 271,000 LPNs/LVNs work in long-term care settings, most often in nursing homes and other extended care facilities. LPNs/LVNs' scope of practice is more limited than that of RNs; however, they play an extremely important role in nursing homes. According to surveys conducted by the National Council of State Boards of Nursing, more than 60 percent act as charge nurses or team leaders with responsibility for supervising and directing the care provided by direct care workers. Anecdotal evidence suggests that because of the difficulty recruiting RNs in many states; it is not unusual for an LPN/LVN to be the only nursing presence in a nursing home, other than the director of nursing.

Social Workers

Social workers carry out a broad and sometimes diffuse set of functions in nursing homes, assisted living and home care settings. The National Association of Social Workers has defined “areas of focus” for social workers in nursing homes (National Association of Social Workers 2003) 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.

Federal regulations require nursing homes with over 120 beds to have a qualified social worker, e.g. 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 (U.S. Department of Health and Human Services 2006).

Social workers 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 it is provided in conjunction with treating social and/or emotional problems that impact a patient’s medical condition. They are not allowed to bill Medicare directly for these services.

Mental Health Professionals

Mental health professionals in long-term care settings include social workers as well as professionals trained in psychiatry, psychology and nursing. Numerous studies (President’s New Freedom Commission on Mental Health 2003, Halpain et al. 1999, Bartels, Moak and Dums 2002) show there is a severe shortage of practitioners in the mental health workforce who can provide mental health services to older adults regardless of setting.

A study of mental health services in nursing homes found that psychiatric services, if they are available at all, are typically provided most commonly 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, Moak and Dum 2002). 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 (OIG 2003) 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. However, 39 percent did not have a care plan.

Consultant Pharmacists and Senior Care Pharmacists

Consultant pharmacists and senior care pharmacists 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, as well as identifying and resolving 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 (ASCP 2008).

2. The Need for Long-Term Care Specific Core Competencies

In light of the numerous efforts to define geriatric core competencies for health professionals and infuse them in the curricula of professional schools, it is reasonable to ask whether this is sufficient for long-term care professionals—are there competencies that may be specific to long-term care that are not being addressed? Intuitively, the answer is probably yes.

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

- A regulatory environment with an emphasis on survey and certification and the required use of the minimum data set (MDS) and/or OASIS.
- The need to develop an interdisciplinary care plan.
- The reliance on unlicensed staff and the need to delegate nursing tasks.
- A very labor-intensive sector with few professionals managing large numbers of direct care staff.
- 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 nurse and client in home health.
- The negotiated risks aspects of assisted living.
- The limited experience with information technology such as the use of computers, e-mail and the Internet in facility-based settings.

All these aspects of the long-term care environment make it somewhat different than traditional health care settings. However, the most important differences likely lie at the heart of long-term care. A long-term care client is typically a long-stayer, someone who has a good chance of dying in a nursing home or assisted living facility. This individual may be far more interested in preserving his or her dignity and living out life with as much autonomy and functional capacity as possible, as opposed to receiving life-saving treatments to prolong life. To these older adults, the quality of the relationship between resident or client and staff may be the most important variable defining quality of care. In addition, the caregiver is working in someone's home.

The research literature provides little insight into the similarity between the 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 (Burger 2006), to compare geriatric competencies expected of students trained in nursing, medicine, social work, pharmacy and nursing home administration to learn how nursing homes were used to meet these competencies. The project team developed a grid to compare 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 congruence between the geriatric competencies expected of students from each discipline, although there were substantial differences in terminology used to describe similar competencies. A sample of approximately 24 geriatric program directors (three to five from each discipline) also confirmed their use of nursing homes to help students acquire skills related to communication, collaboration, cultural sensitivity and professional role. Results of the study are waiting publication. The competency grid may be a useful departure 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 require 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, 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.

3. The “State of the Art” in Defining Core Competencies for Long-Term Care Professionals

A first step in upgrading the preparation, credentialing and ongoing training of long-term care professionals is to define the competencies needed by licensed staff to effectively perform their jobs in long-term care settings. A review of the long-term care workforce literature indicates that such work is at a very early stage. Professional and provider associations so far have taken the lead, 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.

Research on the content of continuing education for long-term care professionals is weak. Most studies address the relative effectiveness of various formats for delivering training to practicing professionals (Bourbonniere and Strumpf 2007). This knowledge gap is

particularly critical for the vast majority of nursing home and assisted living facility RNs who only have an associate degree or nursing diploma. They are, therefore, particularly dependent on in-service opportunities to improve their clinical competency in geriatrics, supervision and leadership.

Administrators, Medical Directors, Directors of Nursing and Consulting Pharmacists

In 2007, the **Long-Term Care Professional Leadership Council** (a collaboration between the American College of Health Care Administrators, the American Medical Directors Association, the American Society of Consultant Pharmacists 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 patients/residents. However, it does not specify what the administrator needs to be able to do to care for a geriatric population.

In 2006, the **American Medical Directors Association (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** is working collaboratively with **AMDA** to help physicians incorporate principles of resident-centered care into nursing homes by leading the development of explicit core competencies for resident-centered care. The identification of these competencies is not yet publicly available.

The **National Association of Boards of Examiners (NAB)** recently updated a job analysis describing the “knowledge, tasks and skills” of an entry-level nursing home administrator and residential care/assisted living administrator. While the job analysis could be the basis for defining competencies, it does not, in and of itself, specify what the occupant of an administrator position needs to be able to do.

The American College of Health Care Administrators (ACHCA) published *Principles of Excellence for Leaders in Long-Term Care Administration*, a very broad guide to help administrators assess their own leadership roles. The document is intended to set a framework for educational preparation, licensure, ongoing 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 American Association of Homes and Services for the Aging (AAHSA) has established a Talent Cabinet to develop a blueprint for improving the long-term care workforce. The cabinet is developing recommendations for strengthening the geriatric and long-term care competencies needed by professional staff across all long-term care settings. Cabinet members include aging service providers, policymakers, thought leaders, educators, researchers, workforce development experts, representatives from state government and consumers.

Nursing Home Nurses

Although many studies have concluded that nursing home RNs are poorly prepared in gerontological nursing content (Tellis-Nayak 2005, Reinhard and Reinhard 2006, Sanders, Bowers and Stone 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 for 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. **The American Association of Colleges of Nursing (AACN)** competency guidelines were the framework for the course, 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 also were part of the course (Scott-Tilly et al. 2004).

The University of Minnesota School of Nursing requires all nursing students to take a course that 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 in 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 complete 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 that require their students to learn about the unique nature of nursing in long-term care settings.

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) has established a small practice committee, made up of members, to develop standards and core competencies that all nursing personnel, such as the DON, LPN, unit manager, certified nursing assistant and staff developer 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. The work is at an early stage (personal communication with executive director in 2008). The extent of external stakeholder involvement in the initiative is not clear.

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** also received funding from 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 nursing staff's competencies for caring for older adults with dementia. For example, Florida requires all nursing home staff to receive dementia training and has developed a guide to competency-based curriculum on dementia care. Washington also has developed consensus documents identifying core competencies for dementia training for licensed practical nurses in long-term care. 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 ongoing 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**, an extremely promising partnership between the **Hartford Centers of Geriatric Nursing Excellence (HCGNE)** at the Universities of Arkansas, Iowa, Pennsylvania and California at San Francisco, the Oregon Health and Science University, nursing home providers and regulatory, advocacy and payer groups. Established in 2007, the goal of the collaborative 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 promoting 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 collaborative is at an early stage. It will use the American Association of Colleges of Nursing (AANC) guidelines to define the core geriatric competencies needed by nursing home RNs, augmented by the development of a module on leadership skills (Burger 2008).

The primary role of nursing home RNs is the supervision and leadership of LPNs/LVNs and direct care workers. Several studies have focused on the poor academic preparation

nursing home RNs receive to take on these responsibilities (Reinhard and Reinhard 2006, Sanders and Stone 2008, Harvath 2008). While a number of nurse leadership training programs have emerged to address this gap—such as **LEAP, the 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 of the key stakeholders (Harahan 2008). There are also a growing number of programs to improve the competencies of LPNs and LVNs to supervise direct care staff. For example, the Institute for the Future of Aging Services (IFAS) collaborated with the University of Wisconsin School of Nursing to develop and pilot test a leadership and supervisory training program for LVNs in four California nursing homes (Project LEAD). **Good Samaritan, and the Florida Association of Homes and Services for the Aging** also developed competency based curriculum to improve the performance of LPN/LVNs. These and similar efforts 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 (Harvath 2008) 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. The literature review did not find any training programs that included all these dimensions.

The authors recommend that leadership training be part of the curriculum of all baccalaureate-level nursing school curricula and that it be available throughout a nurse's career to reach the majority of nurses who do not matriculate from baccalaureate-level programs. 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.

Nurses and Palliative Care

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 increasing numbers of Americans die in nursing homes (Ersek and Ferrell 2005). In 2002, the Robert Wood Johnson Foundation (RWJF) launched a significant initiative to improve the preparation of nurses to deliver such care in all settings.

RWJF funded the **End-of-Life Nursing Education Consortium (ELNEC)** project, a comprehensive end-of-life curriculum for nurses. Items from ELNEC were integrated into the American Association of Colleges of Nursing-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. In 2007, the California HealthCare Foundation provided funding for the development of a geriatric curriculum to address the unique needs of geriatric nurses who work in nursing homes and the hospices that service these facilities.

The Hospice and Palliative Nurses Association (HPNA) also has been involved in the development of a variety of curricular guidelines and standards of practice for end-of-life care (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, 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 (National Consensus Project 2007).

Assisted Living Nurses

Attention to the competencies needed by the professional nursing staff in assisted living facilities is scant in spite of the growing number of older residents who are aged 85 or older, who need assistance with chronic illness and activities of daily living (ADLs) and who may require interventions to prevent acute illness and further functional loss (Zimmerman, Sloane et al. 2005). Education and training requirements are left to the discretion of the states and are generally low (Golant and Hyde 2008). Most states do not require RNs to receive education in age-related changes, psychosocial needs and death and dying. Most have little or no training in the care of persons with dementia or other mental or emotional problems (Mass and Buckwalter 2006). A national survey of assisted living facilities conducted in 2000 found that 80 percent of staff did not know what is entailed in normal aging (Hawes et al. 2000).

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 nurse's understanding of the profession's 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. According to the AALN Web site, 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.

Social Workers and Mental Health Professionals

Many studies have documented severe shortages of social workers and qualified mental health practitioners—e.g. professionals trained in psychiatry, psychology, social work and nursing—to provide mental health services to older adults in all settings (Halpain et al. 1999, New Freedom Commission 2003, Colenda et al. 2005). The burden of providing

mental health services in nursing homes falls most heavily on social workers. While responsible for the social and psychological well-being of residents, a survey of nursing home social workers found that one in three lacked a college degree. Since social workers in nursing home settings also usually practice alone, they may find it more difficult to take advantage of colleagues, supervisors or organized in-service training to upgrade their skills (Parker-Oliver 2003).

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 through case management.
- Participate in care planning.
- Collaborate with the nursing home team.
- 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.” Roberta Green, from the University of Texas School of Social Work, defined the roles, functions and related competencies of nursing home social workers for the 2005 conference referenced above. However, her work does not appear to have been incorporated into a nationally recognized competency model for long-term care social workers.

The National Association of 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, including the:

- 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.
- 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 also have 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.

4. Potential Strategies to Enhance Long-Term Care Specific Geriatric Competencies

The literature review uncovered a variety of proposals to improve the geriatric competencies of long-term care nurses, primarily nursing home nurses. Mathy et al., in a recent article in *The Gerontologist* (Mathy, Mezey, Mitty and Burger 2008), makes a number of recommendations, including revisiting an old concept—the teaching nursing home.

Teaching nursing homes emerged in the 1980s, funded by the Robert Wood Johnson Foundation, to improve the geriatric competence of health care professionals by forging links between nursing homes and academic medicine and nursing. The authors convened a summit of health educators to examine the potential role of teaching nursing homes in geriatric education. Participants agreed that they could be 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 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 demonstrated evidence that staff has received geriatric training.

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

Mass, Spectht, Buckwalter et al., writing in the *Journal of Research in Gerontological Nursing* (Mass 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 called the Geriatric Nursing Long-Term Care Specialist Program, which would be 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 staff who provide direct care. The Geriatric Nursing Long-Term Care Specialist 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.

There also may be a variety of strategies developed in the acute and ambulatory care sectors, which may be adaptable to long-term care. The Hartford Foundation has supported a number of new models of care worth further exploration. These include:

- Care Transitions that coordinates care for patients who are moving among health care settings, e.g. hospital to rehab to home (www.caretransitions.org).
- Guided Care that uses a specially trained nurse based in primary care practice to coordinate all aspects of care (www.guidedcare.org).
- Care Management Plus that combines a trained care manager in primary care with a high-tech electronic health record (www.caremanagementplus.org).

V. Conclusions and Proposed Action Agenda

This review shows there is some significant momentum in the fields of medicine, nursing and social work to define the gerontological and geriatric competencies that health care professionals (physicians, nurses, pharmacists) and social workers need to care for older adults. 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 embedded in processes, which promote collaboration and information sharing across the various professions and stakeholders. They are supported by generous funding from the Hartford and Reynolds Foundations and The Atlantic Philanthropies. It is too early to tell whether they will pay off with respect to increasing the number of physicians, nurses and social workers who are geriatricians or who are certified in or knowledgeable about geriatrics and gerontology—but as noted above, they do seem to be making some difference.

However, this review concludes that these efforts to improve the competency of the health care workforce to care for older adults have only encompassed long-term care at the margin. In addition, the competencies needed for professionals who work in long-term care settings are much less developed, if they exist at all.

Until very recently, long-term care's workforce debate has centered on the need to increase supply—a critical but insufficient goal. We recognize that important efforts have been made to define competencies for direct care workers in long-term care settings. There is also an emerging emphasis on leadership training for long-term care nurses (Harahan 2008). However, these initiatives tend to be local in nature, often developed by individual providers, without the benefit of an evidence base or the experience and wisdom of other stakeholders. Generally operating with little funding, they typically lack the capacity to create widespread consensus and buy-in among stakeholders or to impact the curricula of education and training institutions.

We believe it is time to take stock of the role competency-based education and training for long-term care professionals can play in improving the provision of high-quality long-term care. We propose that a practical and relatively low-cost first step would be to launch a national study group, modeled after the recent IOM study of the health care workforce. The study group, selected from health educators; the professional associations that represent physicians, nurses and social workers; long-term care providers; representatives of the professional and direct care workforce; federal and state health and long-term care policy officials; and advocates for families and clients, would be charged with:

- Commissioning a study to examine the geriatric competencies developed for the health care workforce and to what extent and how they need to be adapted and modified for licensed professionals employed in long-term care settings.
- Identifying a set of core competencies that should be present in all professionals working in long-term care settings.

- Vetting the competency set with study group members and identifying any additional competencies that seem unique to different long-term care settings.
- Disseminating the results to external stakeholders for feedback.
- Recommending a process for building consensus among the principal stakeholders on specific competencies that need to be incorporated into professional schools at the masters, baccalaureate and associate degree levels and into the continuing education offerings mandated by states and providers.
- Recommending a process for diffusing these competencies into the curricula of schools of nursing, medicine and social work and continuing education vendors.
- Identifying/ disseminating new models of practice that support the diffusion of competencies in geriatrics and gerontology to professionals who practice in nursing homes, assisted living and home care settings.

Gaining consensus on the competencies that long-term care professionals need at the associate degree and diploma level and at the baccalaureate and graduate degree level will take time and some money. Infusing these competencies into the curricula of professional schools, as well as the other educational institutions and vendors who prepare and train licensed long-term care staff, is a long-term challenge.

We believe the time, effort and money is worth it. The end result will be the professionalization of long-term care careers that are more attractive to and respected by prospective students and a higher quality long-term care system.

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