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**Training Programs for  
Certified Nursing Assistants**

**by**

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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

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## FOREWORD

Certified nursing assistants (CNAs) provide most of the care received by nursing home residents. Although their work is often perceived as “unskilled,” CNAs perform complex and important functions. Despite their title, their main role is not to assist nurses, but to assist residents. They help residents with daily activities, measure their vital signs, watch for and report changes in their conditions, and provide companionship and emotional support.

Good quality care for residents and a stable CNA workforce depend on providing CNAs with the training they need to be well prepared for their jobs. In 1987, the federal government enacted standards for CNA training, requiring CNAs to receive a minimum of 75 hours of training within four months of working with residents. Although the needs of nursing home residents have become more complex since 1987, federal standards for CNA training have not changed. This raises concerns that CNAs may be unprepared to provide good quality care to today’s nursing home residents. In addition, inadequate training contributes to staff dissatisfaction and high turnover, which also adversely affect quality of care.

This report adds to the literature on CNA education and training by examining how many hours of initial training and clinical training are needed. The study also examines pre-training screening, remedial education, training in English as a Second Language, and shadowing; CNA testing; and reimbursement of CNAs for their training and testing expenses. Based on the findings, the report makes recommendations for ensuring that CNAs receive adequate training to provide good care to residents, improving student retention, and ensuring that CNAs are properly reimbursed for their training and testing expenses. AARP chose Susan Eaton as principal researcher for this study because of her nationally known expertise on direct care workers and her distinguished career as a researcher and advocate working to improve the quality of jobs for these workers. Between December 2002 and December 2003, Dr. Eaton and her research assistant Esther Hernández-Medina conducted the site visits and interviews, began synthesizing information from the interviews, and developed a general outline and strategy for analyzing and writing the report. We were very saddened to hear of Dr. Eaton’s untimely death on December 30, 2003. After Dr. Eaton’s death, Ms. Hernández-Medina completed the initial draft report. Donna Hurd and Alan White of Abt Associates reviewed and edited the initial draft and prepared the final report.

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## EXECUTIVE SUMMARY

### Background

Certified nursing assistants (CNAs) make up 60 to 70 percent of the total nursing staff in nursing homes and provide 80 to 90 percent of the direct care for nursing home residents. The care that CNAs provide centers around helping residents with activities of daily living such as eating, dressing, bathing, and toileting. It also includes observing and reporting changes in residents' physical and psychosocial status.

The Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987, mandates that CNAs have a minimum of 75 hours of training. Federal regulations require that a training program must include 16 hours of "supervised practical training." Supervised practical training is defined as "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 registered nurse or a licensed practical nurse" (42 CFR §483.152(a)(3)). This component of training is also referred to as "clinical" or "hands-on" training. CNA students must complete the training and pass a state certification exam and skills test within four months of beginning work at a nursing facility. The exams vary from state to state, but must include the elements required in federal law. Federal regulations delegate the oversight of nurse aide training programs to the states. CNAs must also complete 12 hours of in-service or continuing education each year.

Approximately 60 percent of training programs are sponsored by nursing homes (Department of Health and Human Services (HHS), 2002a). In these cases, a nursing home may provide training for its own staff, or facilities may join together to train each other's workers (HHS, 2001). The remaining training programs can be found in high schools, community colleges, private schools, and other locations. Thirty-two states hire private contractors to administer their nurse aide exams, while in 17 states the exams are administered directly by the government. In most states, the class instructor is prohibited from participating in the exams.

About half of the states go beyond the minimum federal training requirements for CNAs. This reflects the concern that the 75-hour federal minimum may not be sufficient to prepare CNAs to provide adequate care, given that the complexity of caring for nursing home residents has increased since the passage of the 1987 Nursing Home Reform Act.

### Purpose

Well-trained CNAs are crucial if residents of nursing homes are to receive quality care. Previous studies have consistently found that the 75-hour minimum requirement for initial CNA training is insufficient to prepare CNAs to provide good quality care to residents. Studies have also found that inadequate training contributes to high turnover of CNAs and that more and better training may reduce turnover. This report adds to the literature on CNA education and training by exploring how many additional hours of initial training and clinical training are needed to equip CNAs to provide good quality care to residents. The study also examines pre-training screening, remedial education, training in English as a Second Language, and shadowing; CNA testing; and reimbursement of CNAs for their training and testing expenses. The paper does not address continuing education requirements for CNAs. Based on the findings, the report makes

recommendations for ensuring that CNAs receive the training they need to provide good care to residents, improving retention of CNA students, and ensuring that CNAs are properly reimbursed CNAs for their training and testing expenses.

## **Methodology**

In this report, we examine state nurse aide training programs in 10 states. The states were selected based on their differences in the number of training hours required; size, population, and geographical location; relative importance of rural and urban areas; relative importance of union and non-union areas; and number and proportion of older residents compared to the state population. Five of the states require more than 75 training hours (California, Florida, Maine, Maryland, and New York). The other five states (Massachusetts, Michigan, Pennsylvania, Texas, and Wisconsin) require only the 75-hour federal minimum. The training programs are located in various settings, including nursing homes and technical and community colleges. The study methodology is qualitative. Information for the study has been gathered by interviews with 55 key informants, including CNAs and CNA students, state officials, experts in CNA training and testing, and state long-term care ombudsmen.

## **Findings**

Federal regulations require that CNA training programs be approved by the state's federally-mandated Nurse Aide Training and Competency Evaluation Program. State regulators have reported difficulties in complying with the federal requirement that programs be reviewed every two years and often have been unable to conduct the site visits that are required as part of the review process. Because of insufficient survey staff, reviews generally have been delayed or focused on checking basic items only, such as the instructor's credentials and the topics addressed in the curriculum.

The actual hours of training that CNAs receive often exceeds the federal and state minimum requirements. In several states, respondents said that between a quarter of the training programs and "most" training programs exceed the state minimum requirement and, in some cases, are considerably longer than what is required. In these states, longer programs are offered largely because program directors do not believe that the required topics can be adequately covered without the additional time. In other states, respondents said that most programs provide the minimum or close to the minimum number of hours.

Informants demonstrated a clear consensus that 75 hours is insufficient for adequately training CNAs. Although a few of the interviewees suggested higher thresholds, the majority suggested an increase to between 100 and 120 hours. Informants were hesitant to give specific figures, but they generally believed that clinical training should account for a higher proportion of total training time than it does currently. Several informants emphasized that 50 to 60 hours of clinical training was the minimum needed for CNAs to safely work with residents, and some informants said that more even more clinical time was needed.

Federal regulations regarding reimbursement for nurse aide training are straightforward—aides who are employed by (or have been offered employment from) a Medicare- or Medicaid-certified nursing facility are not to be charged for their training, and those who are employed by (or receive an offer of employment from) such a facility within 12 months of completing their training program are to be reimbursed for their training costs (42 USCS § 1395i-3, [(f)(2)(A)(iv))). However, our interviews revealed that many CNAs pay for the training programs themselves.

Trainers, testers, and state regulators emphasized the importance of screening applicants before enrollment in CNA courses. Interviewees also emphasized that “English as a Second Language” courses significantly improve the chances for Spanish-speaking and other immigrant students to successfully complete CNA training and testing.

### **Summary and Recommendations**

The results of this study suggest a number of recommendations for improving CNA training programs. These recommendations are targeted to federal and state policymakers and training program officials.

- For federal policymakers, the study points to a need to increase the 75-hour minimum requirement to at least 100 to 120 hours, to ensure that CNAs have the training they need to provide good quality care to residents. In addition, improving training may reduce CNA turnover, thereby improving the quality of care and reducing the costs associated with high turnover rates.
- For federal and state policymakers, the study indicates a need to increase clinical training to at least 50 to 60 hours.
- For federal and state officials, the study points to the need for additional resources for training program reviews. Additional resources may allow state practices to become more closely aligned with federal requirements.
- The study identifies a need to increase CNAs’ awareness of federal law regarding reimbursement of CNAs for their training and testing expenses and to penalize facilities that do not reimburse these costs as the law requires. Improved reimbursement of CNAs may help improve recruitment into the profession.
- Upgrading training programs to screen applicants before enrollment can improve the proportion of students who successfully complete the programs and become CNAs. This might also increase CNA retention. Thus, better screening would lead to better care for residents and increase the value of the investments made by nursing facilities, students, and the government in CNA training programs. One part of better screening may be addressing widespread needs in terms of remedial and English as a Second Language courses. At the same time, training programs should consider whether strict English requirements might disqualify too many good workers.



## 1.0 Background

Certified Nursing Assistants (CNAs) make up 60 to 70 percent of the total nursing staff in nursing homes and provide 80 to 90 percent of the direct resident care (Institute of Medicine, 2004, p. 84). According to the Bureau of Labor Statistics, almost 600,000 CNAs are employed in nursing homes, typically working under the supervision of registered nurses (RNs) and licensed practical nurses (LPNs) (Institute of Medicine, 2004, p. 84).<sup>1</sup>

Federal requirements for CNA training were established with the passage of the 1987 Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987. The 1987 Nursing Home Reform Act created the Nurse Aide Training and Competency Evaluation Program. Under the law, each state is responsible for ensuring that the nurse aide training programs offered in their state meet minimum federal requirements (HHS, 2002a). Individuals must receive a minimum of 75 hours of training and pass a state examination within 120 days of employment to become certified to work in a nursing home as a CNA. Federal regulations require that 16 of the required 75 hours consist of “supervised practical training,” which is defined as “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 registered nurse or a licensed practical nurse” (42 CFR § 483.152(a)(3)). This component of training is sometimes referred to as “clinical training” or “hands-on training.” Federal law also established a basic curriculum and other requirements for program administration and testing. In addition, CNAs must receive 12 hours of in-service or continuing education each year.<sup>2</sup>

More than 50 percent of the states have gone beyond the minimum federal training requirements for CNAs. According to the Department of Health and Human Services (HHS) Office of the Inspector General’s (OIG) 2002 studies on nurse aide training, 26 states required more than 75 hours of training, and 29 states required more than 16 hours of clinical training (HHS, 2002a and 2002b).<sup>3</sup> States varied in how they allocated additional hours. For example, California required 160 hours of training with 100 of those hours devoted to clinical training and 24 hours of in-service education a year, while Florida required 120 hours of training with 40 hours of practical training and 18 hours of in-service training a year. States also differed on a number of other training program characteristics, with some requiring an expanded curriculum, specific instructor qualifications,<sup>4</sup> student/instructor ratios, and program approval and oversight processes.

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<sup>1</sup> An exception to this organizational structure can be found in the Green House model, which aims to transform the culture of nursing homes. In Green House nursing homes, CNAs do not report to nurses, but instead work in self-managed teams that report to the administrator. Nurses are members of a clinical support team that visits the Green House as needed to provide skilled treatment but the clinical support team is not housed in the Green House (Green House Project, 2002).

<sup>2</sup> In-service training, intended to ensure the continuing competency of CNAs, can cover topics such as infection control, care of the cognitively impaired, resident rights, skin care, communication techniques, safety and disaster training, and resident confidentiality.

<sup>3</sup> Note that two states did not respond to the OIG survey and four states did not specify minimum clinical training hours.

<sup>4</sup> Note that federal regulations require that instructors must be RNs with a minimum of two years of nursing experience, of which at least one year must be in a long-term care setting.

## **1.1 Nurse Aide Work**

The largest component of CNA work is assisting residents with activities of daily living. CNAs help residents eat, dress and undress, bathe, transfer, ambulate, and maintain range of motion. They also assist them with toileting and care for their mouths, skin, and nails. Ideally, a CNA's knowledge of intimate details, such as knowing each resident's level of cognitive functioning or how best to approach a resident for a bath, enables the individualization of care that enhances both quality of life and quality of care.

In addition to basic skills, CNAs are taught how to measure basic body functions (e.g., vital signs such as temperature, pulse, respiration, blood pressure, and urine output). They are also taught to look for changes in residents' physical and emotional status, including activity level, cognitive status, appetite, elimination, skin integrity, and mobility, and to report any such changes to licensed nurses.

Although the majority of direct care workers find their jobs intrinsically rewarding (Mickus, Luz, and Hogan, 2004), CNAs are frequently paid low salaries and receive limited or no benefits. They often face demanding workloads, unsafe working conditions, inadequate training, a lack of respect from supervisors, a lack of control over their jobs, and few opportunities for advancement.

Median hourly wages in 2004 were \$10.20 for nursing aides, orderlies, and attendants in nursing facilities,<sup>5</sup> compared to \$13.98 for all occupations (Department of Labor (DOL), 2003). From 1997 to 1999, 45 percent of nursing home aides had pensions provided by their employers (HHS, 2004). Forty-three percent received employee health insurance, and another 18 percent were insured through Medicaid or other public programs. The remaining 40 percent of nursing home aides were uninsured. In 2003, 10.1 injuries or illnesses per 100 full-time workers occurred in nursing and residential care facilities, compared to 6.8 per 100 workers in the construction industry and 5 per 100 workers in all private workplaces (DOL, 2004).

All of these factors lead to high turnover, although estimates of rates vary widely because various studies use different methodologies for calculating worker turnover. In a 2003 survey of 44 states, annual turnover rates for direct care workers in nursing homes ranged from 39 percent to 98 percent in the 6 states that collected such data ((PHI and NCDHHS, March 2004). Some other studies have found even higher turnover rates. For example, in a 2002 Wisconsin study, annual turnover among direct care workers in nursing homes ranged from 99 percent to 127 percent (Whitaker, undated), and in a 2002 North Carolina study, it was 95 percent (PHI and NCDHHS, March 2004).

## **1.2 Federal and State CNA Training Requirements**

Before the 1987 Nursing Home Reform Act, CNA training and certification were not covered by federal law. The 1986 Institute of Medicine (IOM) study that was influential in the passage of

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<sup>5</sup> This category consists mainly of CNAs in long-term care settings, although it also includes nursing aides, orderlies, and attendants working in acute care and psychiatric hospitals (National Clearinghouse on the Direct Care Workforce, 2004).

the act found that nursing home care was seriously deficient and that CNAs were responsible for delivering the majority of care (IOM, 1986). The IOM found that only 17 states mandated training programs for CNAs and that the requirements varied widely. Some states mandated as few as 20 hours, while others required 150 hours (50 hours of classroom and 100 hours of clinical training). There was no consistency in format or course content.

The IOM study recommended federal standards for nurse aide training. It further recommended that nursing homes that participate in Medicare or Medicaid employ only nursing assistants who had completed a state-approved training program in a state-accredited institution such as a community college.

The Nursing Home Reform Act contains federal guidelines for nurse aide training. States are responsible for certifying and periodically recertifying all training programs (HHS, 2002b). Approximately 60 percent of training programs are sponsored by nursing homes (HHS, 2002a). The rest can be found in high schools, community colleges, private schools, and other locations. Thirty-two states hire private contractors to administer their nurse aide exams, and 17 states use state-administered exams (HHS, 2002b). In most states, class instructors are prohibited from participating in the state examinations.

A nursing home may employ a nurse aide for up to four months before he or she completes the training program and passes the certification exam. Nurse aides must complete a minimum of 75 hours of training, with 16 of the hours spent in supervised practical instruction. Training must be performed by, or under the general supervision of, a registered nurse who has a minimum of two years of nursing experience, of which at least one year has been spent in a long-term care setting. Federal regulations also establish basic curriculum requirements for nursing assistant training programs (42 CFR § 483.152). The following topics are required (HHS, 2002b):

- *Basic nursing services*, including taking and recording vital signs, measuring and recording height and weight, caring for the resident's environment, recognizing abnormal changes in body functioning and reporting such changes to a registered nurse, and caring for residents when death is imminent.
- *Personal care services*, including assisting the resident with bathing, grooming (including mouth care), dressing, toileting, eating and hydration, skin care, transfers, positioning, and turning.
- *Basic restorative services*, including training the resident in self care to the fullest extent possible; using assistive devices in transferring, ambulation, eating, and dressing; maintaining the resident's range of motion; proper turning and positioning in the bed and chair; bowel and bladder training; and care and use of prosthetic and orthotic devices.
- *Mental health and social services*, including modifying one's own behavior in response to the resident's behavior, awareness of developmental tasks associated with the aging process, allowing the resident to make personal choices and reinforcing positive behavior or behavior changes consistent with the resident's dignity, and using the resident's family as a source of emotional support.

- *Care of the cognitively impaired resident*, including techniques for addressing the needs and behaviors of the individual with Alzheimer’s disease and other dementias, communicating with and understanding the behavior of a cognitively impaired resident, appropriate responses to behavioral symptoms, and methods of reducing the effects of cognitive impairments.
- *Resident’s rights*, including providing privacy and maintaining confidentiality; promoting the resident’s right to make personal choices to accommodate his or her needs; giving assistance in resolving grievances and disputes; providing needed assistance in participating in resident and family groups and other activities; maintaining care and security of the resident’s personal possessions; promoting the resident’s right to be free from abuse, mistreatment, and neglect; reporting instances of such treatment to appropriate facility staff; and avoiding the need for restraints in accordance with current professional standards.
- *Other topics*, including communication and interpersonal skills, infection control, safety and emergency procedures, and promoting the resident’s independence.

### ***Reimbursement for Training and Testing***

In a 2002 OIG study of nurse aide training, the states reported training fees for non-facility-based training ranging from \$190 to \$9,372 (HHS, 2002b). Exam fees ranged from \$10 to \$200 (HHS, 2002a). According to federal regulations, a student who is employed by a Medicare- or Medicaid-certified nursing facility or who has received an offer of employment from one when he or she begins taking classes may not be charged for any portion of the program, including any fees for textbooks, other required course materials, or testing (42 CFR § 483.152(c)(1)). In such cases, the nursing facility that employs or will employ the newly certified nursing assistant must pay for the training. The state will then reimburse the facility (through the Medicaid program) for at least part of its costs.

Despite these mandates, some nursing assistants who pay for their certification training and testing are not reimbursed, even when they go to work for a Medicare- or Medicaid-certified nursing facility within a year.

### **1.3 Federal and State CNA Testing Requirements**

In establishing the Nurse Aide Training and Competency Evaluation Program (NATCEP), the 1987 Nursing Home Reform Act defined standards for evaluating newly trained CNAs who work in nursing homes. This competency evaluation must consist of a written or oral examination and a skills demonstration. The skills demonstration is a demonstration of randomly selected items drawn from a pool of the tasks generally performed by nurse aides (42 CFR § 483.154(b)(2)). This pool of skills includes all of the personal care skills in the nurse aide training curriculum: bathing; grooming (including mouth care); dressing; toileting; assisting with eating and hydration; proper feeding techniques; skin care; and transfers, positioning, and turning. In the states selected for this report the student is permitted to choose either a written or an oral competency exam, which allows students with poor or no literacy skills to pass (HHS, 2001). Some states, including Texas and Florida, permit students to take the oral test in Spanish.

Although federal law has no requirements that CNAs be able to read and write in English, some CNA training programs require that potential students pass a reading and writing exam before enrollment.

Each state is responsible for complying with the federal law. Although some states have developed their own certification exams (typically created by the Department of Education), most study states use tests developed by organizations such as the American Red Cross, PROMISSOR, Assessment Services International (ASI), and D&S Diversified Technologies.<sup>6</sup> According to a study prepared for the Centers for Medicare and Medicaid Services (CMS), about two-thirds of the states use at least part of the ASI test. Some states pair the competency part of ASI's test with a skills test of their own (HHS, 2001). Thirty-two states use private contractors to administer nurse aide exams (HHS, 2002b).

### ***Challenging the Test***

Federal law gives states the option of allowing prospective nurse aides to take the CNA exam without completing an approved training program. This practice is called "challenging the test." In a 2004 survey of 44 states, 24 states allowed challenging, and 20 states prohibited challenging (Iowa Caregivers Association, 2004).

Some of the states that permit challenging allow it only under certain circumstances, such as when an aide is certified in another state, only when certification has lapsed, or only if the person has taken training that is equivalent to the state-approved training. In Florida, the only requirement for a person to challenge the test is that he or she has at least a General Equivalency Degree (Iowa Caregivers Association, 2004). People who challenge the test may include those certified as CNAs in other states who move to Florida, individuals who have taken a CNA training program that is not approved by the state, those enrolled in an approved training program who have not finished the program at the time of the exam, and people with work experience or education who believe that they can pass the test without formal CNA training (Brian Peacock Consulting, Inc., 2000). Up to 40 percent of individuals who take the CNA exam in Florida are challengers who have not completed a state-approved training program.

### ***Testing Requirements and Immigrant Workers***

The percentage of foreign-born nurse aides in U.S. long-term care settings has increased substantially in recent years, from 6 percent in 1980 to 16 percent in 2003 (Redfoot and Houser, 2005). Poor English skills may make it difficult for many of these workers to pass the CNA test, although some states allow the test to be taken in Spanish. This raises complicated issues related to CNA testing requirements.

On one hand, in order to provide good quality care, it is important that the staff has the ability to communicate with the residents and with their families, physicians, and outside service providers. On the other hand, many immigrant nurses spend some time working as lower-paid

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<sup>6</sup>PROMISSOR, ASI, and D&S Diversified Technologies are companies that provide examination and testing services.

nurse aides while they are preparing to take or retake the nurse licensing exam (Redfoot and Houser, 2005). Those who fail the exam the first time frequently do so because of poor English skills. With their experience as nurses, these workers have excellent clinical skills but may be disqualified from working as CNAs because of strict language requirements.

In addition, immigrant workers may have advantages in meeting the needs of diverse nursing home residents (Redfoot and Houser, 2005). A 2004 survey found that although foreign-educated nurses in the United States were somewhat more likely to have problems understanding English-speaking clients or staff than were newly licensed nurses educated in America, they were far less likely to have such problems when communicating with non-English-speaking clients or staff (Smith and Crawford, 2004).

#### **1.4 Research on CNA Training**

Since the passage of the 1987 Nursing Home Reform Act, several studies have attempted to measure the adequacy of federal nurse aide training requirements and the effect of increasing nurse aide training (HHS, 2001, p. 6-10). Those studies have concluded that federal requirements for training are inadequate to prepare CNAs to care for residents and that increased nurse aide training would be beneficial. In addition, the research suggests that inadequate training contributes to high staff turnover and that more and better training may reduce turnover rates.

A 1995 study found that nurse aide skills had improved following the passage of the 1987 Nursing Home Reform Act. For the study, 352 long-term care professionals ranked 15 key skill areas during 2 time periods—shortly before the passage of the federal training requirements and 5 years later (Gross, 1995). The experts believed that there had been improvements in all of the skill areas after training requirements were enacted, with all but two skill areas (work ethics and reduction in resident abuse) showing substantial improvement.

More recent research, however, has concluded that federal nurse aide training standards are inadequate to prepare CNAs to meet the needs of today's nursing home residents. For example, a 2001 Institute of Medicine (IOM) report, *Improving the Quality of Long-Term Care*, found that federal standards for caregivers are generally weak in all long-term care settings, especially in light of the changing characteristics of residents receiving care. The IOM recommended that

federal and state governments, in consultation with consumers develop training, education, and competency standards and training programs for staff based on better knowledge of the time, skills, education, and competency levels needed to provide acceptable consumer-centered long-term care [p. 211].

Also in 2001, CMS delivered a report to Congress on the *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, which included a chapter describing nurse aide training and testing and the related issues of supervision, ongoing education, career advancement, and support services. The report noted that, while the acuity level of nursing home residents had increased in the time since training regulations were first established, nurse aide training requirements had not changed. Many of the key informants interviewed for the CMS report suggested that CNAs need

considerably more than 75 hours of training to learn the technical, cognitive, emotional, and interpersonal skills required to manage the various demands of the job. Some participants also recommended increased clinical training, including more time in nursing homes working with residents.

In its 2002 study, the OIG surveyed NATCEP directors in 48 states and the District of Columbia and interviewed nursing home administrators, nurse supervisors, and nurse aides in 5 states (HHS, 2002b). Forty of the 49 state NATCEP directors who responded to the survey said that they did not believe that 75 hours of training was sufficient to prepare CNAs for their first day on the job. Among states with the minimum 75-hour programs, two-thirds of respondents said they believed that the number of hours required in their state was too low. About 50 percent of the CNAs interviewed reported not being satisfied with their clinical training, citing insufficient time on the floor, a lack of “hands-on” training, and unrealistic scenarios (HHS, 2002b). Several CNAs discussed the importance of experiencing real-life scenarios during clinical training so that they could handle these situations on the job. The OIG report concluded that nurse aide training has not kept pace with the nursing home industry because it does not meet the needs of current nursing home residents, does not adequately address interpersonal skills (e.g., communication skills, time management, teamwork, relationships with residents, and coping with death and dying), and has not kept pace with nursing home practices and new technologies. A second major conclusion was that teaching methods are often ineffective, with clinical exposure too short and unrealistic.

For a study funded by the Better Jobs Better Care program, researchers are surveying both direct care workers and their supervisors in nursing homes and other settings (Better Jobs Better Care, 2005). Preliminary data from 211 nursing assistants in nursing homes document the need for more training. Only 54 percent of nursing assistants said that their initial training made them well prepared for their jobs. Respondents expressed a need for longer and more comprehensive training and more “hands on” instruction.

Other research has examined nursing assistant and resident outcomes as a result of training programs that focus on specific subject areas, most often the care of residents with dementia. These studies have consistently found that increased training results in improved staff knowledge and better quality of care. For example, in a 1999 report (pp.546-58), McCallion, et al. found that a group of nursing assistants who attended a series of personalized training, practice, and feedback sessions on dementia care improved their ability to manage “verbally aggressive behaviors such as yelling, physically non-aggressive behaviors such as wandering, and aggressive behaviors such as hitting.” The residents with dementia cared for by these nursing assistants exhibited significantly fewer depressive symptoms at both three and six months after the training, even as they became more disoriented due to the progression of the disease.

Also in 1999, Beck, et al. summarized the findings of 15 publications reporting on 9 separate studies of dementia training programs for nursing assistants (pp. 197-212). Only one of the nine reports found no improvements in staff knowledge, resident behaviors, or both after nursing assistants underwent specialized training in dementia care. Of the other eight studies, four reported a decrease in combative or otherwise problematic behaviors by residents. One example is the research of Barrick, et al. on *Bathing Without a Battle* (2002), which describes how CNA

knowledge about dementia (and support from management) can lead to a dramatic increase in the quality of life for residents and improve the quality of work for CNAs.

A 2005 study by the Paraprofessional Healthcare Institute and the Institute for the Future of Aging Services summarized the research on the impact of training programs on direct care worker recruitment and retention (PHI and IFAS, 2005). This research found that inadequate training contributes to the high turnover of CNAs and that more and better training may reduce turnover.

## **2.0 Purpose**

Well-trained CNAs are crucial if nursing home residents are to receive good quality care. Previous studies have consistently found that the 75-hour minimum requirement for initial CNA training is insufficient to prepare CNAs to provide good quality care to residents. Studies have also found that inadequate training contributes to high turnover of CNAs and that more and better training may reduce turnover. This report adds to the literature on CNA education and training by exploring how many additional hours of initial training and clinical training are needed to equip CNAs to provide good quality care to residents. The study also examines pre-training screening, remedial education, training in English as a Second Language, and shadowing; CNA testing; and reimbursement of CNAs for their training and testing expenses. The paper does not address continuing education requirements for CNAs. Our study is structured around the following questions:

- What are the nurse aide training requirements in the selected states? To what extent do training programs provide more training than the minimum required?
- If the 75 minimum hours of training required by federal law is not sufficient to prepare CNAs to meet resident needs? If not, how many additional hours are needed and what topics should be covered?
- Are the 16 hours of clinical training sufficient to prepare CNAs? If not, how many additional hours are needed and what should be their focus?
- What types of screening do potential CNAs undergo before enrollment in training programs? What, if any, improvements are needed in screening?
- How are the states administering competency and skills testing? What, if any, improvements are needed in CNA testing?
- What is the process for reimbursing CNAs and facilities for the cost of nurse aide training? Are federal requirements for CNA reimbursement being met? If not, what changes are needed to ensure that CNAs receive all reimbursement to which they are entitled?



Based on the findings, the report makes recommendations for ensuring that CNAs receive the training they need to provide good care to residents, improving retention of CNA students, and ensuring that CNAs are properly reimbursed for their training and testing expenses.

### **3.0 Methodology**

This qualitative study is based on interviews with 55 key informants in 10 states.

#### **3.1 State Selection**

The 10 states included in our research were selected because of their differences in several areas:

- Minimum number of required hours for CNA training;
- Size, population, and geographical location;
- Relative importance of rural and urban areas;
- Relative importance of union and non-union areas; and
- Number and proportion of older residents compared to the state population.

Five of the selected states go beyond the mandatory 75 hours—California, Florida, Maine, Maryland, and New York. Maryland and New York require 100 hours, Florida requires 120 hours, Maine requires 150 hours, and California requires 160 hours. The other five states—Massachusetts, Michigan, Pennsylvania, Texas, and Wisconsin—do not require more than the 75 hours mandated by the Nursing Home Reform Act.

We visited five of the states—California, Florida, Massachusetts, Maine, and Wisconsin. California, Florida, and Maine require more than 75 hours of training and Massachusetts and Wisconsin require only the federal minimum.

These five states were selected because their CNA training programs and testing requirements were considered to be the most distinctive. In these states, we conducted in-person interviews with key stakeholders in the nurse aide training process. Information about the other five states—Maryland, Michigan, New York, Pennsylvania, and Texas—was collected through telephone interviews with public officials, the background materials they provided, informants from other states, and Internet searches.

#### **3.2 Interviews and Site Visits**

Interview guides were developed for (1) CNAs and nurse aide students, (2) regulators and trainers, and (3) testers and test supervisors. These interview guides are contained in Appendix A. The interviews were designed to elicit information about:

- CNA training and testing experiences, the conditions they face in their work, and how well training prepares them for employment;

- Training regulations, enforcement and oversight, and recommendations for improving the system in each state;
- The ways in which certification tests are administered and the differences in testing requirements among the selected states;
- Reimbursement for training and knowledge about the pertinent regulations; and
- The adequacy of training programs, including clinical training.

### ***Selection of Interviewees***

A total of 55 interviews were conducted—19 with CNAs and CNA students, 16 with state officials, and 17 with experts in CNA training, testing, and registries. We also spoke with three state long-term care ombudsmen to obtain background information on the nurse aide training programs in their states.

Training programs and facilities were selected based on the personal contacts of the researchers, the advice of the provider associations in each of the study states, or some combination of the above. As a result, the programs that are described in this report may be more representative of nurse aide programs with best practices than representative of all CNA training programs.

### ***In-Person Interviews***

Access to CNAs and CNA students was provided by nursing facility managers and training program officials. CNAs, nursing home administrators, and trainers were interviewed on site. A public official in charge of nurse aide training in each of the study states was contacted for either a telephone or in-person interview.<sup>7</sup> Interviews were conducted by one or two researchers and recorded on paper. The majority of interviews occurred between May and August 2003.<sup>8</sup>

### ***Interviewees and Study Topics***

*CNAs and CNA Students.* Our objective was to understand how prepared CNAs and CNA students felt for taking the state tests after completing (or nearly completing) their training programs and their opinion on what a good training program might include. We asked them for details (e.g., number of hours, topics covered in the training, testing, and reimbursement) and whether they believed that their training programs helped them prepare for their current positions. The interviewers also sought background information such as previous job experience, education, and length of time as a nurse aide.

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<sup>7</sup> Unfortunately, the researchers were not able to interview the New York state regulator in charge of nurse aide training.

<sup>8</sup> The principal researcher, Dr. Susan Eaton, began synthesizing information from the interviews in September 2003 but was forced to stop because of health problems later that year. She and her research assistant, Esther Hernández-Medina, agreed on a general outline and a strategy for the analysis and writing of the report in early December 2003. After Dr. Eaton's untimely death on December 30, 2003, the report was completed by Ms. Hernández-Medina and Donna Hurd and Alan White of Abt.

*Public Officials.* The public officials from state agencies in charge of regulating CNA training were interviewed about many issues:

- The legislative and political history of the regulations on CNA training and testing in the state;
- The process of updating and reviewing CNA training programs and curricula;
- Relevant stakeholders interested in these subjects;
- Number and types of providers for both training and testing;
- Average passing rates;
- Number of active and inactive CNAs in the registry; and
- Their opinions on the ideal number of minimum hours for adequate CNA training.

Public officials also were asked about related topics such as the relevance of English as a Second Language (ESL) classes. Most of the background materials obtained for this study, particularly samples of CNA training program review forms, were provided by this group of interviewees.

*Experts in CNA Training and Testing.* This group consisted primarily of nurses currently in charge of CNA training programs in various settings, including nursing homes and technical and community colleges. Also interviewed were nursing home administrators in charge of facility-based training programs. The experts were questioned about the effectiveness of mentoring and in-service training programs. Interviewees in these categories were asked similar questions to the ones asked of public officials but more emphasis was placed on their opinions about the content and structure of the CNA training programs, the structure and skills evaluated in tests for potential CNAs, and the relationship between CNA training and testing in the selected states.

## **4.0 Results**

### **4.1 Adequacy of the 75-Hour Requirement**

#### ***How Much Training Is Actually Provided?***

The respondents revealed that the state minimum training requirements did not reflect the typical offerings of training programs. Because the federal and state minimums were widely perceived to be inadequate, training programs frequently provided more hours of training than were mandated by law. This occurred not only in states with only the federally required 75 hours of training, but also in states with additional requirements.

#### ***States Without Additional Requirements Beyond the Federal Minimum***

In the five study states with only the 75-hour federal minimum, respondents said that many programs exceeded the state minimum requirements. The estimated proportion of programs with more than 75 hours ranged from “no more than 10 percent” of programs in Michigan to “many”

programs in Massachusetts and “most” programs in Wisconsin and Pennsylvania (see Table 1). Training program coordinators indicated that this reflected a widely held conviction that it was not possible to adequately prepare CNAs for their jobs in 75 hours.

- Interviews with trainers from Massachusetts revealed that many training programs have more than the 75-hour state minimum, although no specific figures were available. One interviewee explained that often more hours were necessary to meet the needs of providers and to address changes introduced in the competency evaluation testing.
- A Pennsylvania official estimated that most of the state’s programs tend to be between 90 and 100 hours.
- According to Wisconsin informants, the average length of CNA training programs in the state is around 120 hours, but some programs are much longer. The director of a training program at a technical college in the state said, “I can hardly imagine to teach them for less than 180 hours....I’m [even] scared with some of the ones who get 180.”
- State informants in Texas said that at least 25 percent of their programs go beyond the minimum of 75 required hours, with programs averaging an estimated 120 hours.

**Table 1:****Training Hours in Selected States Without Additional Requirements Beyond the Federal Minimum, 2003**

<b>State</b>	<b>Minimum total hours required by the state</b>	<b>Minimum clinical hours required by the state</b>	<b>Estimated percentage of training programs in the state with 75+ hours</b>	<b>Estimated length of training programs in the state</b>
MA	75	16	Respondents said that “many programs” are longer than 75 hours.	An estimated 45 percent of programs have more than 100 hours and some programs are 150 hours or more.
MI	75	25	“No more than 10 percent” are above 75 hours, according to the state regulator in charge of nurse aide training.	A small number of programs are longer than 75 hours; the maximum is 125 hours.
PA	75	37.5	According to an official from the Pennsylvania Department of Education “most programs” are above the 75-hour minimum.	Most programs in the state are 90-100 hours.
TX	75	24	“At least 25 percent” of programs are above the 75-hour minimum.	Non-facility-based programs are usually much longer than 75 hours—120 hours on average.
WI	75	16	“Most programs” in the state are longer than 75 hours.	The estimated average number of hours is around 120 and the median is 102. Some programs are 180 hours.

Source: Interviews by the authors, which occurred primarily between May and August 2003.

***States With Additional Requirements Beyond the Federal Minimum***

Interview participants in some of these states reported that many training programs exceed the state minimum requirements. Participants from other states said that their programs were close to the minimum or they were unable to estimate the actual length of training provided (see Table 2).

- In Maryland, informants estimated that 45 percent of programs require more than the 100-hour state minimum.
- New York officials noted that the average number of hours is closer to 120 than the 100 hours required. Most non-profit facilities and colleges offer longer programs (except for the American Red Cross), with a typical range of 100 to 180 hours.
- In California, which has the highest number of minimum required hours (160 hours), most programs are close to the minimum.
- No estimate of the actual length of training programs was available for Florida or Maine.

**Table 2:  
Training Hours in Selected States With Additional Requirements  
Beyond the Federal Minimum, 2003**

<b>State</b>	<b>Minimum total hours required by the state</b>	<b>Minimum clinical hours required by the state</b>	<b>Estimated length of training programs in the state</b>
CA	160	100	Close to minimum.
FL	120	40	No estimate available.
ME	150	50	No estimate available.
MD	100	40	According to state officials, 45 percent of programs are longer than the state requirements.
NY	100	30	Approximately 120 hours.

Source: Interviews by the authors, which occurred primarily between May and August 2003.

### ***How Many Training Hours Should Be Required?***

Interviewees agreed that it is necessary to increase the federal minimum number of hours required for nurse aide training, but most were hesitant to commit to a particular number or did not have any basis for the number they specified. The answers were somewhat different depending on whether the respondent's state currently requires more than 75 hours.

### ***States Without Additional Requirements Beyond the Federal Minimum***

In general, regulators and training program officials from states following the federal minimum agreed on the need to increase it. Several respondents suggested a range of between 90 and 120 hours, although they often said that the hours needed could vary depending on the instructor and

the trainee. Respondents had a difficult time specifying how the additional training hours should be used.

A state regulator in Michigan told us:

Seventy-five hours is the bare minimum. I'm not a nurse so I'm hesitant to say how many it should be. It probably should be closer to 90, to 100. [The] clinical part depends on who is teaching it. Right now we're requiring 25 hours [of clinical] out of 75. That's probably enough now. If we increased it [the number of training hours] to 90, I would like to see it [the number of clinical hours] increased.

An official in Texas talked about increasing the number of hours of training required, particularly the hours spent on behavior management and the understanding of cognitive impairment:

I know that it is the general opinion of most people in the industry that 75 [hours] doesn't quite get us there. It is very difficult to say what a good number of hours would be. I'm thinking probably 100 to 120. Because most of our programs are still in the facilities I don't know if that is consistent with other states....A lot more time could be spent on behavior management, understanding of cognitive impairment. I would like to see being able to enhance training in those areas. I really can't say in terms of the clinical component.

A state regulator in Pennsylvania agreed with the need for more than 75 hours of nurse training:

My opinion, minimum I'd say 120 if you really want a good nurse aide. Pennsylvania has a minimum of 37 hours for the clinical part. That's why people can't make it in 75 hours. I think 40 to 50 is probably sufficient [for the clinical part]. They need two to three weeks of orientation after the class. By the fourth day they should be introduced to the residents to do minor things but not [put in] a full day until the end of the program.

A CNA trainer in Wisconsin argued that at least 90 hours were necessary to adequately train CNAs:

I can't imagine less than 90 [hours] because I know how I can teach in 90 hours. I can't believe that you can teach anyone in 75 hours and put them safely out there. And I find that after 180 hours I still have students who are...nervous or haven't been sufficiently exposed.

A CNA trainer and tester in Massachusetts emphasized that "100 hours is important if you want to pass [the test] the first time." Another trainer from the state talked about her experience with a program of 60 hours for work in the classroom and 60 hours for the clinical component. She insisted that although both components are carefully integrated, the students "are not prepared....They need all that classroom practice on each other before they go out."

Respondents emphasized that, to a large extent, the amount of nurse aide training time that is required can vary tremendously based on who is doing the training and who is being trained. As one state regulator told us, “A lot depends on who is doing the training. They’re not necessarily giving the students the real experience of the nursing facility either.”

An experienced nurse aide trainer also emphasized this point, stating:

Not everybody needs 160 hours; some need 300 hours. I think it is going to be [related to] so many things tied to screening, community-based or facility [-based programs], orientation, mentoring....If you studied at a community-based program [with] only 75 hours, and [if] your nurse trainer is not good, you are in trouble....Everybody could benefit from more but this is a comprehensive system that needs to change if we want quality results.

Respondents offered few specific details about how the additional CNA training time should be used, other than discussing the need for more clinical training.

The CNAs that we spoke with were generally satisfied with the length of their training programs. This may be because the training programs and facilities in which the CNAs were interviewed generally exceeded the federal 75-hour requirement. These programs may be more representative of nurse aide programs with best practices than representative of all CNA training programs in the study states.

### ***States With Requirements Beyond the Federal Minimum***

Most regulators and trainers from states that required more than the 75-hour federal minimum also indicated that they did not believe that 75 hours was sufficient to adequately train CNAs, although they had varied opinions on how many hours they believed should be required. One state regulator from Maine, a state that requires 150 hours of nurse aide training, told us that 200 hours should be required:

I would tell people I go to 175, but with the acuity of the residents that we are getting in nursing homes (10 years ago they were in hospitals), I believe strongly that it should be 200. I’ll be dead before that happens but....I really think 100 [hours] of class and 100 [hours] of clinical. We are setting up these people for failure by giving them 150 hours.

An official from Maine described how the additional time is used in that state:

We have 80 hours of class, 20 hours of labs, and 50 hours of clinical. And we probably do more anatomy and physiology and disease process. We work with patients with unique needs: mental health and mental disability. Our students work with pediatrics, acute care, and home safety. Our CNAs can apply creams and lotions. They provide personal care to patients with respiratory systems, they do enemas, colostomy care, specimens, they deal with pulse oxymetry, oxygen. They do vital signs, CPR, glucose monitoring, preoperative and postoperative, charting, etc.



Two state regulators from California, which requires 160 hours of training, argued for increasing CNA training time. One told us, “What is the gold standard? I wanted to see it [at] 220.... Eyeballs went up...”

The other regulator argued that increasing training time beyond 75 hours could help increase CNA retention:

There is no way you can cover everything that needs to be covered in that amount of time (75 hours)...We also felt retention would be improved. The longer you invest in someone and the better prepared they are for what they are getting into, the more likely they are to stay....Most people [students] don't have any idea of [what the job is like] until the clinical. The first time they have to clean up someone's mess, they are out of there.

#### **4.2 Adequacy of the 16 Clinical-Hours Requirement**

Many stakeholders agreed that increasing clinical time is important for helping students to develop their skills, giving them a realistic impression of the job, increasing nurse aide confidence, and increasing job retention. The clinical training requirements in the selected states ranged from 16 (the federal minimum) to 100 hours (California). Two of the study states that did not exceed the federal 75-hour minimum required a higher than minimum number of clinical hours (37.5 hours in Pennsylvania and 24 hours in Texas).

There was a clear consensus for increasing the number (and quality) of clinical training hours. Increased clinical training was supported by instructors and nearly all of the CNAs and students in training, who emphatically shared their preference and the need for hands-on training. One public official involved in CNA training for more than 20 years stated that at least “50 percent of the program should be clinical.”

Most of the CNAs and CNA students interviewed highlighted the importance of getting early exposure to the reality of the job. Hands-on training can make the difference between being well prepared to continue their learning process after the training program is over or not. Several of the CNA interviewees talked about how valuable their clinical training was to them. For example, one CNA told us:

I really loved my program. It was really a hands-on program. And then you got to interact with the family members. And then you know when you made someone feel good, you know. When you have a resident, and a family member is delighted to see them, to interact with them, that brings you joy, too.

The CNA interviewees consistently stressed that the most useful learning methodology was “actually doing it.” Practicing their skills also had other advantages. A group of interviewees referred to the fact that working in pairs during their training helped them a lot. One of them shared that even when she was working on her own, “just to hear the voices” of her peers around her made her feel more confident.

A state regulator emphasized that increased hands-on training is perceived as a problem by the long-term care facility managers who, because of difficulties in recruiting and retaining staff, want nurse aide trainees to start working as soon as possible. “The problem with doing more clinical is that the facilities want the students to be up to speed then.”

However, cutting training can have negative consequences for nurse aide retention. A trainer in another state highlighted how ill-prepared some CNAs were due to the lack of hands-on training:

We have heard from these focus groups—the CNAs had no experience—she was shocked that she had to deal with a male naked body....She walked out of the facility....It is a problem—the educational system, these programs are extremely expensive, one of the most expensive in a community college setting. They try to cut those costs by having a contractual relationship with the facility. Charge nurses will not really do oversight of students. That’s the piece they try to cut corners on, to save money.

Trainers from two successful programs in two different states emphasized having “post-conferences” after each clinical session to build upon the knowledge and the increased confidence gained in the session. According to a trainer from a technical college: “...as far as skills go, once they give someone a bed bath, the process of touching someone, if they make it through that they will make it through all of it.”

### **4.3 Adequacy of Student-Teacher Ratios in Clinical Training**

Federal requirements do not specify the environment or conditions under which the clinical training is to take place, but only that 16 hours of training on certain topics is to be accomplished before the student has contact with residents (42 CFR § 483.152a(6)(b)(1)(i-v)).<sup>9</sup> The law states only that it may occur “in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse.”

Clinical training may take place in a laboratory setting with students practicing on each other or at a nursing facility where students work with residents. Federal regulations are not specific about ratios of instructors to students. Some states, however, have instituted requirements on instructor to student ratios. For example, Florida recently developed regulations that a maximum of 15 students may be supervised in the clinical area by one instructor, and Pennsylvania requires that no more than 10 students be assigned to one instructor in a clinical setting. For clinical training to be effective, interviewees said, the ratio of students to instructor must be reasonable. A state regulator recommended a much lower ratio, one instructor to five students, so that students would not have to spend time waiting for the instructor:

They give out [a] calendar to the students. On the calendar, they have their clinical rotation, every afternoon, or at the end for three or four days, or whatever. During their

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<sup>9</sup> At least a total of 16 hours of nurse aide training is to be provided in the following areas prior to any direct contact with residents: communication and interpersonal skills; infection control; safety/emergency procedures, including the Heimlich maneuver; promoting residents’ independence; and respecting residents’ rights.

clinical time, they are supposed to be with the instructor. [They] pair the students up with one resident. State regulations are [an instructor-to-student ratio of] 1:10, and that's a lot, so the students wait. There's no quality—more like 1:5 would make sense to me.

#### **4.4 Pre-Training Screening, Remedial Classes, and Shadowing**

Prerequisites for CNAs vary from state to state and from training program to training program within a state. As of 2005, 44 states require nursing home staffs to pass criminal background checks before employment (Tanner, 2005). Some states require that students be CPR-certified and others do not (HHS, 2001, Chapter 7). Training programs also vary in their requirements regarding educational attainment and reading and writing skills. Researchers conducting the 2001 CMS nursing home staffing study visited four training sites (HHS, 2001). One of the sites required a high school diploma or General Equivalency Degree to enroll in the course and two required that a prospective student must pass a reading and writing exam. The fourth program had no such educational requirements or pre-tests, but instead encouraged nursing facilities sponsoring students for training to conduct their own pre-testing.

Most of the training providers and several of the nursing home administrators interviewed for this study emphasized the importance of screening and, if necessary, remedial classes before allowing students to enroll in the training program. One program director gives “a little quiz” to prospective students to assess reading, writing, and basic math skills. As she reviews the results with the prospective students, she determines whether any apparent difficulties can be addressed in the program or whether the individual needs remedial classes. The program also requires that applicants attend an orientation session where the director:

Tells them everything they need to know—health requirements, quizzes, term paper, criminal background checks, and how difficult the job is. That is a result of making sure that people know what they are getting into. Now they know. They hear it.

The program has a 90 percent completion rate, which is almost certainly due in part to this policy. Other facilities develop their screening processes through interviews with the director of the long-term care facility or with the person in charge of human resources.

Several regulators and CNAs highlighted the need to expose students who are not in facility-based training programs to the nursing home environment as soon as possible. In the words of a state regulator:

As far as orientation to what the job is about, the schools might want to take all of their students and take them through the building. [Give them] some visual representation... Some people have no idea what it's like.

Screening tools can be as simple as short tests established by the facilities. For example, a regulator in charge of CNA training advises facilities to “make up” these tools to avoid frauds:

The [institution in charge of testing] has devised a regular screening tool, a reading test, because of ESL [English as a Second Language] issues. Then it gets out on the street

and everybody knows the issues. I encourage the facilities to make up a test, a little bit of math and reading portion, and matching words—as a pre-screening tool.

The Florida Health Care Association uses a more complex process that includes “shadowing,” the procedure through which CNA candidates spend one or more days accompanying an experienced CNA or an instructor. During the shadowing period, the instructor also takes notes on the candidate’s interest and her or his attitude towards residents:

We have a multi-tiered screening process. First step: criminal history screening (one of the strictest ones in the country), the social skills of the person, normal interview thing. Then if [the nursing facility] like[s] the candidate they do a shadowing process with the candidate. The pre-screening process takes usually one to two weeks. It depends on the facility. We recommend a shift for the shadowing—just a preliminary shadowing, to see what it means to be a CNA. You can start with 40 people interested and then end up with 10. But those are the folks you want.

We have mentors. The prospective student will shadow with the mentor (typically a more experienced CNA). The mentor will make an evaluation at that time looking at the student’s interest in residents, if they want to go outside and take a break, what’s their attitude. Then they start the class....And then we have the curriculum, a book that they follow. At the end of the program, there are one to two weeks before they take the test and we do more mentoring.

Although we do not know the degree to which Florida’s multi-tiered process is responsible, the state reports relatively high program completion and pass rates. According to recent data from the state, 71 percent of CNA students completed the program and 88 percent of these students passed the CNA competency exam and were eligible to be added to the state’s nurse aide registry (Brian Peacock Consulting, Inc., 2000).

#### **4.5 Training in English as a Second Language**

Federal law has no requirements that CNA trainees be able to read and write in English. As mentioned earlier, some CNA training programs require that potential students pass a reading and writing exam before enrollment. To do their jobs effectively, CNAs need to be able to read and write at a minimum level, and achieving fluency in English is important for following directions and delivering quality care. Many CNAs do not have a good command of the English language, however. English as a Second Language has become a critical issue in multicultural states such as Florida, California, and New York, particularly when it comes to the high numbers of Spanish-speaking women who are now part of the pool of potential and current CNAs. That is also the case for states with still small but increasing numbers of immigrants such as Massachusetts, Maine, and Pennsylvania. Taking the CNA test may be especially challenging for immigrants whose first language is neither English nor Spanish. For example, a trainer in Massachusetts talked about Ukrainian immigrants preparing to take the CNA test:

These were people who were housekeepers and took ESL classes and started taking CNA classes when they felt more comfortable with their English. They are very loyal and committed folks. They appreciate the opportunity. I had translators at some point,

because unfortunately the state exam is [in] English and Spanish. We even tried to let the translator get in the exam but they wouldn't let us. They had to take the test a couple of times.

A regulator from another state expanded on the same point:

Yes, probably Spanish is the biggest. But we have anything from individuals from India, Korea, Pakistan. Some parts of the state have quite big immigrant communities. We have been encouraging the trainers not to admit them until they get ESL courses. It does not work very well. The nursing homes see them as ...warm bod[ies] and want them now.

Experienced trainers from both coasts of the United States agreed that a narrow vision of CNA training could be even harmful if problems related to language and communication are not taken into account. A trainer from California explained:

[It's] not the question of hours—it's the question of the curriculum, what is needed to have a base knowledge to take care of the patient. They are the direct caregiver, 75 percent of our nursing component. Everyone wanted them to know everything...that's the problem....What would be a good curriculum? Any curriculum has to address their reading level and language deficits.

The Massachusetts regulator mentioned above emphasized that “[CNAs] theoretically are supposed to be fluent before they start these classes. [They] have to be able to speak, comprehend, read, and write English.” She also considered that the:

best way with a CNA [training program] is to incorporate an ESL that is particularly oriented to the program. It has to be an adjunct to the program—...[there needs to be] a basic knowledge base about the program....[The] test is in English.

She found that “[with] people who did the shorter program in ESL it did not work.”

#### **4.6 CNA Certification Exams**

All but one of the study states contracted CNA testing to a private for-profit firm such as Assessment Services International (ASI) or PROMISSOR. The selected states varied considerably in terms of the structure of their CNA exams, exam pass rates, and the number of times that students were permitted to take the exams.

The written examination of the ASI test consists of 10 pre-test questions that are not scored and 60 test questions that are scored. To pass, a candidate must get approximately 80 percent of the scored questions right. To pass the skills test, the student must get all of the critical element steps correct, along with about 80 percent of the remaining steps within each set of five skills demonstrated.

In our study states, the great majority of students who take the certification exam pass it.<sup>10</sup> The pass rate varied from about 55 percent in Maryland to more than 90 percent in Maine. In Texas, for instance, where the test is given in three different forms, 94 percent of those tested in 2001 to 2002 passed the written English version, 70 percent passed the oral English version, and 83 percent passed the oral Spanish version. Sources in Massachusetts told us that between 68 and 75 percent of students pass the exam the first time they take it, and 90 percent eventually pass.

A higher proportion of students typically fail the skills component of the exam than the written component. In Michigan, for example, the passing rate is around 95 percent for the written exam but only around 75 percent for the skills exam. New York was an exception to this general trend: the pass rate for the written part of the exam was around 85 percent in 2001, compared to around 90 percent for the skills component.

In Maryland, the high failure rate for the skills part of the exam is a source of concern among many of the stakeholders with whom we spoke. Several recommendations were made to address this problem: create a video series for instructors, develop resources to augment what is taught, increase the quality of language tapes for non-English-speaking students, provide an annual “train the trainer” course specific to nurse aide training, and speed up the application process (from graduation to testing day to receipt of certification).

### ***Challenging the Test***

Interviewees disagreed over whether candidates should be allowed to take the tests if they have not attended accredited training programs. Some expressed concern that the challenger program provides a disincentive to go through CNA training programs. Some also worried that those who pass the exams through the challenger provision may be poorly prepared to provide care, compared to those who complete approved training programs. However, nursing homes value the challenge option as an essential tool for being able to staff at the minimum levels required by the state. At this point, insufficient accurate data exist to compare the skills of challengers versus those in regular training programs. A 2000 report for the Florida Department of Elder Affairs recommended that the CNA exam be amended to collect information on the circumstances of people who challenge the exam, including their education and experience as nursing assistants and whether they had ever been certified in another state (Brian Peacock Consulting, Inc., 2000).

### ***Exam Testing Fees***

Initial costs for the combination knowledge and clinical skills exam in the study states ranged from \$76 in Texas to \$164.50 plus an initial registry fee of \$12 (for a total of \$176.50) in Michigan. Re-testing fees for the knowledge exam ranged from \$35 to \$58, and clinical retesting ranged from \$31 to \$119. The majority of CNAs and CNA students interviewed stated that they paid for their own testing. Table 3 summarizes testing fees for the study states.

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<sup>10</sup> Note that it is not always clear how the states report their pass rates. Some states report those who pass the first time, some report eventual pass rates, and some report pass rates for the written and clinical components separately.

**Table 3: CNA Testing Fees in Selected States, 2003**

	<b>Knowledge (written) and clinical skills combination</b>	<b>Knowledge (written) only</b>	<b>Clinical skills only</b>	<b>Other fees</b>
California	\$15 application fee plus fingerprinting fee			
Florida	\$82 (English) \$92 (Spanish) Oral versions are \$5 additional	\$35 (English) \$45 (Spanish)	\$47	
Maine	Not available			
Maryland	\$86 \$105 (oral exam)	\$36 \$55 (oral exam)	\$50	\$20 endorsement/reciprocity fee
Massachusetts	\$87 \$97 (oral exam)			
Michigan	\$164.50 + \$12 initial registry fee (\$176.50 total)	\$45.50	\$119	\$20 renewal fee
New York	\$115 \$135 (oral exam)	\$47 \$57 (oral exam)	\$68	\$40 for reciprocity and NY State RNs and LPNs; \$40 recertification (paid for by employer)
Pennsylvania	\$93 \$103 (oral exam)	\$37 \$47 (oral exam)	\$56	
Texas	\$76 \$89 (oral exam in English or	\$45 \$58 (oral exam in English or	\$31 (skills retest and written exam)	

**Table 3: CNA Testing Fees in Selected States, 2003**

	Spanish)	Spanish)	\$31 (skills retest and oral exam in English or Spanish)  Candidates must pass the skills test before taking the written (or oral) test	
Wisconsin	\$100 (written and oral exam)	\$41 (written and oral exam)	\$59	

Source: Interviews by the authors, which occurred primarily between May and August 2003.

#### **4.7 Reimbursement for CNA Training and Testing**

Several CNAs with whom we spoke were not aware of the federal provisions that cover training and testing expense reimbursement and expressed skepticism about this. Almost none of the CNAs and CNA students interviewed knew of their rights in terms of reimbursement for training and testing expenses. Although this group cannot be assumed to be representative of all CNAs and CNA students in those states, their lack of awareness may indicate a problem in the dissemination of relevant information. One CNA explained:

It's \$85 for the state exam and \$45 for the fingerprinting. In the beginning they didn't tell us [what the cost was]....Most of them [the students] have social workers, have to write to their social worker to get some money, the ones on welfare. They should tell you at the beginning how much it costs. Most of them dropped [out of the course]....No one bought the uniforms.

A trainer explained: "The cost of the state-approved program was \$600 plus books, plus equipment. It's very difficult for people to afford. Yes, you can get reimbursement but often you don't get those people." Another interviewee made a similar point:

The other state-approved programs don't have a screening process. If you pay for the state fee and the program [fee] you can take it [the training program]. The problem is that they [the CNA students] need to make an income. Once again, [there is a] lack of respect for the people who are working.

In contrast, some facilities pay students to enroll in their training programs:



We pay them to go to the program. When they pass the test we increase their pay, \$6 to \$8 when they are certified and to \$9.50 in the 90 days afterwards.

The selected states vary in terms of how information on reimbursement is presented to the students. In candidate handbooks reviewed for this study, the location and format of the information varied, with some states creating a separate section to highlight reimbursement; others included it within sections on fees. States were also varied in how definitive the entitlement to reimbursement was explained. The Wisconsin handbook said, “you may be entitled to reimbursement of some of these expenses...” and New York wrote that, “you will be reimbursed...for part of the training and/or testing fee you paid.” Texas and Pennsylvania stated that, “CNAs...are prohibited from paying their examination fees.”

The state handbooks generally pointed out that CNAs are entitled to reimbursement by employers, but not all states made it clear to CNAs and CNA students that, if they are employed within 12 months of training, then they are entitled to reimbursement, that CNAs should keep receipts from training and testing costs, or that CNAs should be reimbursed for re-testing fees. Appendix B includes the text from candidate handbooks from 8 of the 10 study states.

Massachusetts has a scholarship program that sponsors free training for individuals who would like to become CNAs or home health aides. In 2003, approximately 2,000 scholarships were awarded with total state funding of \$600,000. In early February 2004, the Massachusetts Extended Care Federation surveyed the training providers to determine the level of demand for scholarship training. The trainers reported a steady to very strong demand for direct care scholarships. Since funding was made available on November 1, 2003, 1,164 persons had applied for a scholarship (more than 3 times the number of scholarships the program could actually allocate), and 722 had been placed on waiting lists. Unfortunately, with the current fiscal limitations on the scholarship program, most of these individuals (who are unable to afford training on their own) will be on the waiting list indefinitely and may eventually choose a different career path.

#### **4.8 State Oversight of CNA Training Programs**

Federal regulations delegate the oversight of nurse aide training program curricula to the states. The states are supposed to review the curricula of approved programs to determine whether they satisfy the required standards, and the states can revoke or suspend approval of training programs or impose a plan of correction if these standards are not met. State governments are to recertify training programs and conduct on-site visits every two years to ensure adherence to federal and state requirements.

Regulators in a number of our selected states have had difficulties in complying with this requirement. As a general rule, reviews are delayed, are insufficient, or focus only on checking basic items (e.g., space available, instructor credentials, topics addressed in the curriculum). We found that the three largest states included in this study have never conducted on-site reviews of CNA training programs or have had to discontinue such procedures in the last five years.

A Massachusetts official commented on the state oversight process by saying:

[I work] doing on-site every other year, visit the facility; talk to the trainer, to the administrator, the director; go over curriculum. They have to have a space, classroom, bed, books. [The] rest of it is paper compliance....The nurses have to have two years of long-term care [LTC] [experience] plus a year of teaching or training, or anyone who works in LTC for two years has some experience training. Have to be an RN, the primary instructor....[I also] interview current CNAs. Check off their skills. Make sure they know how to brush someone's dentures. How [can I] tell a good program from a bad program? Based on curriculum, instructor, pass rates...

A Maine official described the review process this way:

We have a lot of assurances that we request. The first part is just me making sure that the assurances have been met—location, number of hours, funding, number of students served, that they use the curriculum approved by the Board of Nursing, the instructors' credentials, who selects the candidates, whether they have criminal background checks. Have the instructors gone to training, student ratios: 1 to 10. Current contract agreement, admission/retention policy, text, audiovisuals, student files, written documentation of student evaluations. Does the instructor maintain professional membership. Who administers the state test, financial records.

State regulators in Texas said that they do not have sufficient staff to conduct site reviews of CNA training programs. The intermediate solution for them has been to ask the Department of Aging to include questions regarding nursing aide training in their annual visits to the facilities. According to one interviewee:

We ask them to include a record review and do an interview with the program director and instructor as part of the survey. And they send the results to us and we also send additional sets of questions for renewal.

State surveyors also are asked to review classrooms, equipment, training records, instructors' credentials, and other similar issues such as whether enough space is available for the classes.

Officials in Maine concurred with interviewees from other states that they have found it increasingly difficult to review training programs every two years due to a lack of personnel.

No data are available on the number of CNA training programs that are decertified as a result of state oversight.

## **5.0 Conclusions and Recommendations**

Our interviews with key stakeholders have allowed us to draw a number of conclusions.

## **5.1 Recommendations for the Federal Government and the States**

### ***Increase Training Hours for CNAs to At Least 100 Hours***

Since the passage of the 1987 Nursing Home Reform Act, the average acuity level of nursing home residents has increased and the types of care CNAs provide have become more complex because of the increased care needs of residents. The 2002 Office of the Inspector General (HHS) report identified several clinical skill areas that have become crucial in the last 15 years: cognitive and behavior disorders, catheter care, colostomy care, feeding, hydration, and infusion therapies. During this time, the federal training requirements for CNAs have not changed. There was a clear consensus among those interviewed that 75 hours was not enough time to teach CNAs the skills that they need to safely care for residents.

Although some of the state officials and trainers that we interviewed for this study suggested higher thresholds (between 150 and 300 hours), the majority suggested an increase to between 100 and 120 hours. In the states that had only a 75-hour minimum, many programs were longer, as training program coordinators did not believe that all of the required material could be adequately covered in 75 hours.

### ***Increase Clinical Skills Training***

Most interviewees also shared the belief that the amount of clinical instruction should account for up to half of the total training time. Several informants emphasized that 50 to 60 hours of skills or “hands-on” training would be the very minimum for which it would be safe to have CNAs working with long-term care residents. Some informants believed that even more clinical training is needed. California requires 100 hours of clinical training. One state regulator recommended a student-teacher ratio of one to five to improve the quality of the clinical training.

Increased clinical training time may be important for several reasons:

- It helps students to better develop their skills;
- It may increase retention of CNAs by giving them early and realistic exposure to the reality of working with nursing home residents;
- Clinical training can facilitate the kind of solidarity and exchange among CNAs (and nurses) that contributes to improving the overall quality of care in the facility; and
- Clinical training helps less experienced CNAs and CNA students deal successfully with the challenges associated with their profession.

### ***Establish More Specific Guidelines for CNA Training Programs***

More specific state guidelines for CNA training programs are needed. Some states mandate the use of a single state-approved curriculum and others require a core set of curricula. Some have no specific requirements other than that the program meets federal standards. Some of the regulators that we interviewed argued that it is better to have a unified state-wide CNA

curriculum to create more uniformity in the skills taught to CNAs during training. If a uniform curriculum is not feasible, then at a minimum, a set of clear guidelines that reflects what CNAs graduating from each program are expected to be able to do would be very helpful.

### ***Enforce Federal Regulations Regarding Reimbursement for Training and Testing Expenses***

Many CNAs are not reimbursed for their training and testing costs, even though federal regulations indicate that they must be. The Centers for Medicare and Medicaid Services should attempt to increase awareness of the existing policy of requiring facilities to reimburse CNAs for training and testing expenses incurred and rigorously enforce this law. This would benefit CNAs tremendously and could help to improve recruitment. In addition, scholarship programs like the one in Massachusetts could be made available to cover the costs of training. Perhaps the costs of such scholarship programs should be partially reimbursed by the federal government for CNAs that are hired by nursing homes.

### ***Increase Resources Assigned to Review CNA Training Programs***

All the state regulators in charge of CNA training interviewed for this study talked about the difficulties they face in trying to comply with the federal requirement that training programs be reviewed every two years. As a general rule, reviews have to be delayed, are insufficient, focus on checking only basic items, or some combination of the above. State officials told us that they do not have the time and the resources to evaluate content and teaching methods as needed, let alone be able to support trainers in other ways such as offering teaching strategies and opportunities for exchange with other trainers. Several of the selected states have never conducted on-site reviews of CNA training programs or have discontinued these reviews in the last five years. This lack of state oversight may have implications for the quality of training programs and is inconsistent with federal guidelines.

In addition, both the federal and state governments could improve the effectiveness of CNA training by increasing funds and support for supervisory training for nursing home administrators and managers in each state.

## **5.2 Recommendations for Training Programs**

### ***Improve Screening for CNA Students***

CNA trainers and long-term care facilities with their own training programs may be able to increase the proportion of CNA students who complete the programs and eventually become CNAs by improving their pre-training screening procedures. Improved screening might also increase CNA retention. Thus, better screening would lead to better care for residents, and increase the value of the investments made by nursing facilities, students, and the government in CNA training programs. Screening strategies shared by our interviewees include formal and informal pre-tests such as short math exams, writing samples, and interviews with potential students. Some programs convene orientation meetings with question and answer sessions before the training program begins to help potential students know “what the job is really about.” Other programs, such as Florida’s “pre-test” course, put a lot of emphasis on “shadowing.”

### ***Address the Need For Remedial and English as a Second Language Courses***

According to our interviewees, remedial and ESL courses need to take place before the CNA training program begins, and they should be designed in connection with the program. Trainers and testers interviewed for this study highlighted the urgency for remedial courses in math and basic reading and writing skills. Trainers, testers, and state regulators emphasized even more the role of ESL classes in significantly improving the chances for completing CNA training and testing procedures for Spanish-speaking and other immigrant populations. It is important that ESL programs be made more accessible to CNAs. At the same time, training programs should consider whether strict English requirements might disqualify too many good workers.

### ***Conduct Exit Interviews with CNA Students***

Some of the CNA trainers interviewed highlighted the usefulness of implementing regular exit interviews with graduating students to identify new avenues for improvement. Follow-up procedures, such as maintaining a database with names, addresses, and current employment of former students also helped trainers evaluate the success of their programs. Moreover, one of our interviewees held periodic seminars and celebrations for her former students with funding provided by the nursing homes in the area.

In conclusion, this study revealed wide variation in the quality of training that CNAs receive. Better training programs, including the programs that participated in this study, go beyond federal and state minimum training requirements to ensure that CNAs are adequately prepared to safely care for residents. However, many programs provide only the minimum required levels of classroom and clinical instruction. Such minimal training puts nursing home residents at risk and can lead to low employee morale and high turnover rates. An increase in the required minimum to at least 100 to 120 hours of training, including 50 to 60 hours of clinical training, is needed to ensure that all CNAs receive the education and training they need to care for residents competently and with confidence. More and better training may also reduce CNA turnover, thereby improving quality of care and reducing turnover costs. Federal regulations regarding reimbursement of CNAs for their training and testing expenses need to be better enforced. Finally, wider implementation of successful screening, shadowing, and remedial education programs could help to increase the proportion of students who successfully complete the training programs and become CNAs, which will increase the value of investments made by nursing facilities, students, and the government in CNA programs.

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## APPENDIX A: INTERVIEW GUIDE

### Interview Guide 1: Certified Nursing Assistants (CNAs)

OBJECTIVE: Learn where CNAs/CNA students are coming from and what conditions they face in their work. Do they feel that their training programs prepared them well?

#### *Background information:*

- Ask them to introduce themselves: name, age, family (e.g., kids, single-mothers),
- How did you get into working as a CNA? Include specific mechanism and reason.
- Previous types of jobs? Why did you leave those jobs?
- For how long you have been CNAs?
- If immigrant: home country and language? Problems with ESL? How did you learn English?

#### *Info on their training and testing experiences:*

- How was your training program as a CNA? Do you feel it helped you to get prepared for your current job?
  - Number of hours?
  - Types of problems (similar to those you're facing here)?
  - Topics you wished the program would have covered?
- How was your experience with the test? Was the test related to what you saw in your training? If you failed it, what part did you fail/you felt less prepared for?
- How many times did you take it? How many people do you think pass the test?
- Did you have to pay for the test? If not, who paid for it? Do you know that there is an option for you to get reimbursed through the facility?

#### *Info on their job experiences:*

- What are the things you like the most about your job? What are the things you don't like about your job?
- What kind of follow up or additional training you would want to have after you start your job as a CNA? (continuing education, group support, etc.).
- Do you have another job in addition to this one? Would you consider getting another job instead of this one?
- In your opinion, how is the interaction between:
  - Younger CNAs and the more experienced ones?
  - CNAs and administrators?
  - CNAs and residents?



## **Interview Guide 2: Regulators and Trainers**

**OBJECTIVE:** Learn the legislative and political history of the CNA training hours. Were they more (or less) before OBRA of 1987? If more than federal requirements, how and when did that come about?

### ***Background on requirements and regulations:***

- What has been the legislative history of minimum hours requirements in the state? If the state requires more than 75 hours, which groups were in favor of and against raising the minimum requirement?
- How is curriculum updating and review accomplished in your state? Who is responsible? What percentage of those responsible has this responsibility as their full-time job?
- How are the curricula defined [check number of them]? What are the key topics not covered by the OBRA regulation? Has your state added topics to the test or curriculum?
- Is the review done on site or a desk review only? Why is that the case?
- How is the regulation enforced in your state? Is supervision contracted out or done directly by the agency? How frequently? If it is done by the agency, how many people are working directly on that?

### ***Background on training and “active” CNAs:***

- Do the training programs in the state include various levels? (Example: tri-level training [CNA, home health aide, and acute care.])
- Different types of providers in the state: names of major trainers, percent of training provided for-profit versus not-for-profit?
- Language: included in pre-CNA training and/or translation in CNA training?
- How many aides are on the state’s registry? How many are active [confirm OIG data]? How does the state define “active” requirements?
- How is training funded? Any scholarships?
- Are trainers decertified? Any quality control? By whom and how?

### ***Sub-sectors and specific roles within the system:***

- What is the relationship between *home health* training and CNA training? Is there a home health requirement?
- Is the state using *single task workers*? If so where and how? [Get language, guidelines, etc. after research on their website].
- We have found that in some cases, the quality of the services provided by CNAs is affected by the high turnover among the *administrators* at the facilities. Is that a problem in your state? What is the role of administrators?

### ***Opinions and recommendations to improve the system:***

- Based on your experience, what should be the minimum number of hours for NA training? And what should be the minimum for clinical hours?
- What is your view on the relationship between training and testing? How up-to-date are the tests with respect to what is included in the training programs and what takes place in reality?
- Which components do the training program test-takers tend to experience more/less difficulty with? Why? Have you seen any difference between programs in this regard?

- What do you think about the number of hours devoted to clinical training in programs in the state? Opinion in terms of timing (earlier or not), more or less, etc.?
- What do you think could be the best way to follow up on the training? Continuing education? Mentoring? Others?

### **Interview Guide 3: Testers and Test Supervisors**

**OBJECTIVE:** Learn how the tests for CNAs are administered and the differences in terms of testing requirements among the states.

#### ***Background about testing in the state:***

- How many testing sites are in the state?
- Is there a centralized or key provider, as there is in Massachusetts (Red Cross) or in community colleges?
- How many people work on supervising at the testing sites?
- How often are curricula actually reviewed and do people go out on site?
- How many versions of the test? Languages or translation services?
- How many opportunities to take it? Is the same number for both parts of the test?
- How many people take it? Who pays for their tests (facilities, scholarships, themselves)?

#### ***Structure of the test:***

- Number of questions
- Written (“knowledge”) vs. skills components (which skills are being measured?)
- Can we have a sample test (the one they show to students)?
- Can testing be done on-line for the written part?
- How are clinical skills measured (random 3, random 5)? On patients or on each other?

#### ***Pass/fail rate:***

- How many people pass the first time they take the test? (initial pass rate)
- How many people eventually pass the test? (eventual pass rate)
- Which parts of the test lead to higher fail rates (if any)?

#### ***Security:***

- Have tests ever been compromised?
- Do people need IDs and how many?
- Additional requirements and procedures?
- Do you give the scores right away? When?

#### ***Reimbursement:***

- Who typically pays for the test?
- Do student test-takers know that they can be reimbursed (when working for a nursing home)?
- Are there scholarships to pay for the cost of the program?
- What is the procedure?

#### ***Relationship between training, testing, and work:***

- What is your view on the relationship between training and testing? How updated are the tests with respect to what is included in the training programs and what takes place in reality?
- Which components of the training program tend to be the most difficult for test-takers? Why? Have you seen any difference between programs in this regard?
- What do you think about the number of hours devoted to clinical training in programs in the state? Opinion in terms of timing (earlier or not), more or less, etc.?

- What do you think could be the best way to follow up on the training? Continuing education? Mentoring? Others?

**APPENDIX B: STATE POLICIES ON REIMBURSEMENT OF TRAINING AND TESTING FEES**

State	Text on Reimbursement of Training and Testing Fees
California	<p>The <i>Exam Costs Reimbursement</i> section states: “Upon request from the applicants, long-term care (LTC) facilities must reimburse exam costs within one year of passing the exam and after at least four months of continuous employment if the applicant paid for the cost of their exam. The CNA must show the employer the original receipt of the payment for the exam to be reimbursed. (Reimbursement is only required for the cost of the original exam. An individual who takes the exam to reactivate his/her certificate is solely responsible for exam costs, which is not reimbursable.)” California Department of Health Services, Licensing and Certification. February 25, 2004. <i>Nurse Assistants, Home Health Aides, Hemodialysis Technicians Certification Facts</i>.</p>
Florida	<p>The <i>Examination Registration</i> section states: “You are responsible for test fee payment unless a facility or other entity pays on your behalf. If you become employed by a nursing home within 12 months of completing certification, under Federal law and Florida facility handbook guidelines, the facility is required to reimburse nursing assistants’ fees for training and testing. Contact the District Medicaid Office in your area if you have any questions regarding reimbursement.” The Chauncey Group International and Exporior, Florida. June 2004. <i>Certified Nursing Assistant Information Bulletin</i>.</p>
Maryland	<p>The <i>Fees</i> section states: “Under Federal and Maryland laws, nursing homes are required to pay NNAAP fees for their GNA employees, including individuals required to re-test.” PROMISSOR and the National Nurse Aide Assessment Program National Council. July 2004. <i>State of Maryland Geriatric Nursing Assistant Candidate Handbook</i>.</p>
Michigan	<p>The <i>Who pays for testing and training?</i> section states: “A nurse aide who is employed by, or who has received an offer of employment from, a Federally certified nursing care facility on the date on which the aide begins a nurse aide training and/or competency evaluation program cannot be charged for any portion of the program. (This includes any fees for textbooks or other required course materials.) If you are not employed, or do not have an offer to be employed as a nurse aide, however, you become employed by or receive an offer of employment from a Federally certified nursing care facility not later than 12 months after completing a nurse aide</p>

State	Text on Reimbursement of Training and Testing Fees
	<p>training and competency evaluation program, the State must provide for the reimbursement of cost incurred in completing the program. This reimbursement will be prorated during the period in which you are employed as a nurse aide. You will apply for this reimbursement through your nursing facility employer, who will require proof that you paid for your training and testing.” The Chauncey Group International. <i>Michigan Nurse Aide Competency Evaluation Program Bulletin of Information for Candidates</i>.</p>
New York	<p>The <i>Testing and Certification Fees</i> section states: “Nursing homes shall not charge a fee to any individual for the cost of training, including textbooks and materials, or for the cost of the Competency Examination. If you are employed by a nursing home, you will not have to pay the testing fees. If you are not employed by a nursing home, you may be required to pay the testing fee and should consult the training program for directions about testing fees. If you obtain nursing home nurse aide employment or an offer of nursing home nurse aide employment within 12 months of the completion of your training program or within 12 months of the date of testing, you will be reimbursed by New York State for part of the training and/or testing fee you paid. You should give copies of the receipts for these fees to the nursing home upon employment or offer of employment. The nursing home will process the state voucher for reimbursement on your behalf. Payment is made by the state to the nursing home that will reimburse you. The state will determine the amount you will be reimbursed.” The Chauncey Group International and Experior. August 1, 2003. <i>New York State Department of Health Nursing Home Nurse Aide Certification Handbook</i>.</p>
Pennsylvania	<p>The <i>Reimbursement for Training and Testing</i> section states: “Long-term care nursing facilities are responsible for the full payment of training and testing costs if you are employed or offered employment as a nurse aide at the time you enter a nurse aide training and competency evaluation program. <b>Federal law prohibits these charges from being imposed on you.</b> If you are not employed with a long-term care facility at the time you are accepted into a nurse aide training and competency evaluation program, but become employed or receive an offer of employment within twelve (12) months of completing the program, you will be reimbursed by the long-term care facility that employs you. Reimbursement will be made on a prorated basis. You will be reimbursed for half the costs of training and testing after you have worked at the long-term care facility for 130 hours and for the remaining half of the training and testing costs after you have worked an additional 130 hours. You must provide written documentation to the long-term care facility to support your request for</p>

State	Text on Reimbursement of Training and Testing Fees
	<p>payment.” PROMISSOR and the National Nurse Aide Assessment Program National Council. September 2003. <i>Commonwealth of Pennsylvania Nurse Aide Candidate Handbook</i>.</p>
Texas	<p>The <i>Exam Fees</i> section states: “Under Federal and Texas state laws, nurse aide candidates employed as CNAs in nursing homes that participate in Medicaid/Medicare programs are prohibited from paying their examination fees. Employers must pay the initial examination fee and any re-test for those nurse aide candidates in their employ as CNAs or candidates who have a written commitment or signed acceptance of employment on file in a Medicaid certified nursing home. Nurse aide candidates not employed as CNAs are permitted to pay their own examination fee.” PROMISSOR and the National Nurse Aide Assessment Program National Council. February 2003. <i>State of Texas Nurse Aide Candidate Handbook</i>.</p>
Wisconsin	<p>The <i>Program Reimbursement</i> section states: “If you pay for your own training and testing prior to employment, you may be entitled to reimbursement of some of these expenses from a Federally certified nursing home. To qualify however, you must be employed by a nursing home within twelve (12) months after you successfully complete a nurse aide training program and the NNAAP Examination.” PROMISSOR and the National Nurse Aide Assessment Program National Council. September 2004. <i>State of Wisconsin Nurse Aide Candidate Handbook</i>.</p>

CNA training programs are offered by a variety of institutions, including the American Red Cross, local health care providers, community colleges, vocational and technical schools, and online training programs. CNA programs last from four to 16 weeks, depending on the institution. After CNA training, graduates can apply for their first jobs. It's important to remember that certified nurse assistants can only practice under the supervision of licensed nurses, meaning it is illegal to offer their services as independent providers. CNA roles are expanding much more rapidly than the national average for job growth, providing graduates with a variety of options when pursuing their first positions. Unlike nursing, certified nursing assistant programs are not accredited. Instead, state boards of nursing and public health departments approve professional training programs. After meeting state requirements, CNAs are placed on the state's certified nursing aide registry, a list of individuals who have met the minimal testing and training requirements to work under the supervision of a nurse. It is important to attend a state-approved program for two important reasons: 1) to qualify for state certification examinations and 2) to qualify for state licensure.