Invited Editorial

Preparing Social Workers With Person-Centered and Participant-Directed Services for the Changing Aging and Disability Network

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A competency-based approach in social work curriculum, guided by the 2008 Educational and Policy Statement (EPAS), is now expected of all BSW and MSW programs. Additionally, to ensure the preparation of social workers with geriatric competencies, the Council on Social Work Education (CSWE) National Center for Gerontological Social Work Education (Gero-Ed Center) and the New York Academy of Medicine Social Work Leadership Institute developed and implemented the Geriatric Social Work Competencies Rating Scale of 50 competencies and related these to the EPAS required competencies (CSWE, 2010). Within this context of increased emphasis on competency-based education, the authors, who represent a partnership of the CSWE Gero-Ed Center and the National Resource Center for Participant-Directed Services (NRCPS), contend that social workers also need to acquire competencies to implement person-centered (PC) and participant-directed (PD) care within long-term services and supports (LTSS).
The need for social workers to acquire PC and PD competencies is shaped by four social and political trends. These include (a) the demographic transition of the US population and increased demand for community-based LTSS to support older adults in their preferred home settings; (b) the forecasted growth of disability in the coming decades, intensifying the demand for Aging and Disability Network services; (c) the increasing diversity of the aging population, necessitating a flexible culturally competent approach to services; and (d) changes in public policy, including the integration of aging and disability services under the Administration for Community Living (ACL), the development of Aging and Disability Resource Centers in each state to serve both older adults and persons with disabilities, the passage of the Patient Protection and Affordable Care Act of 2010 (ACA), and expanded consumer demand, particularly among Boomers, for greater choice and control, including participant-direction.

With the rapid growth of the oldest-old, the risk of needing LTSS increases with age with an estimated 70% of persons age 65 and older needing LTSS during their lifetimes (O'Shaughnessy, 2013). Among these individuals, 40% will require LTSS for 2 years or more after age 65 (Kemper, Weaver, Short, Shea, & Kang, 2008). Approximately 40 million people in the United States have a disability (defined by the Institute of Medicine Committee on Disability in America as impairments, activity limitations, or participation restrictions; Field & Jette, 2007). Although data on disability trends vary, there is general agreement that the numbers of people with a disability needing LTSS will grow (Miller, 2011). With the increasing diversity of the older population by race/ethnicity, gender identity, and ability, community-based approaches such as PC and PD are imperative to empower older service recipients and take account of their distinctive circumstances and preferences. Additionally, the ACA sets the context for the future growth of PC/PD services in healthcare and LTSS. For example, the ACA creates the Community First Choice option and extends the Money Follows the Person demonstration—both using a PC approach and PD service model. Moreover, section 2402(a) of the ACA calls on the Department of Health and Human Services Secretary to establish a common framework of principles and process elements supporting PC/PD across its programs.

Most relevant to the implementation of PC and PD competencies is that the ACL and the Centers for Medicare and Medicaid Services have invested in expanding the Aging and Disability Resource Center (ADRC) model. This is designed to ensure that for people of all ages and disabilities, there is no wrong door for accessing one-on-one information and counseling and establishing eligibility for available LTSS options. They aim to promote choice through PC/PD to support older adults and people with disabilities to live with autonomy in their communities. Currently all 50 states are operating or are in the process of implementing ADRCs. Additionally, ACL has funded eight states (Connecticut, Maryland, Massachusetts, New Hampshire, Oregon, Vermont, Washington, and Wisconsin) to receive the Enhanced
ADRC Options Counseling Program grant. These states are intended to be high-performing national models for providing LTSS options counseling and to use their Enhanced ADRC Options Counseling programs as a strategy to rebalance their LTSS and promote more PC, PD, and efficient systems and supports for individuals living in the community. Additionally, the ACL is developing national training standards for the implementation of PC/PD competencies with ADRC staff; particularly options counselors who help individuals make informed choices about LTSS. Last, the Older Americans Act directs the Assistant Secretary for Aging to:

promote the development and implementation of comprehensive, coordinated systems at Federal, State, and local levels that enable older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers... including the provision of such care through self-directed models. (Administration on Aging, 2006)

In summary, increasing demand for choice and control from a more diverse population who is aging and living longer with disabilities, combined with a focus on PC and PD care, will challenge the LTSS industry.

Within this national emphasis on assisting individuals to maintain their dignity and independence in their homes and communities, it is imperative that social workers acquire PC/PD competencies to work effectively with older adults and people with disabilities. This is critical because over 60% of Area Agencies on Aging (AAAs) employ licensed social workers or individuals who identify as such, who comprise the majority of staff. A recent study funded by the Retirement Research Foundation and conducted by the CSWE Gero-Ed Center, the NRCPDS, and the National Association of Area Agencies on Aging, surveyed directors and select social work staff members in the 629 AAAs regarding their extent of competency development and training needs. AAA staff members in SW-oriented positions (the majority holding a BSW) indicates they most need additional training in PC/PD, and least need least training in geriatric competencies (they received such gerontological preparation within their field of study—typically through field placements). These findings regarding geriatric social work competencies may reflect that a critical mass of educators and SW programs now has the capability to provide gerontological training to their students (Hooyman & Diwan, 2009; Hooyman & St Peter, 2006; Reinhardy & Zoff, 2006; Robbins, 2013). However, most social workers are not prepared with the necessary PC/PD competencies when they enter the home and community-based LTSS network. This preparation gap is problematic for the delivery of quality services for older adults and people with disabilities.

The PC approach, first implemented with adults with disabilities, is guided by principles of community inclusion, dignity, and respect. The individual is at the center of the planning process and the PC plan reflects what
is most important to the person and their capacities, strengths, and supports that they require. The plan focuses on the person’s life, not just services, and utilizes informal supports whenever possible. This type of approach is the foundation for PD services, which help people of all ages, across all types of disabilities, maintain their independence and determine, for themselves, what mix of personal assistance supports and services work best for them. PD is built on the premise that the individual receiving services is in the best position to identify their needs and goals and then direct and manage their own services. PC/PD represents a major paradigm shift from traditionally-provided services, in which the decision-making and managing authority is vested in professionals.

With PC/PD services, a substantial portion of such decision-making and authority is transferred to the participant, sometimes with assistance from family or a representative. This approach has proven effective in improving quality-of-care and life satisfaction for both older adults and younger people with disabilities. Additionally, it has improved service access while controlling costs (Reed et al., 2009; Simon-Rusinowitz, Loughlin, Ruben, Garcia, & Mahoney, 2010). Moreover, the PC approach was endorsed by the Institute of Medicine (IOM) as a way to improve healthcare quality (IOM, 2001). The efficacy of PD as a service delivery model was proven through the rigorous comparative effectiveness evaluation of the Cash and Counseling (C&C) Demonstration (Brown et al., 2007). Self-directing C&C participants reported fewer unmet personal care needs and improvements in a number of health outcomes, scored higher on measures of control and empowerment, and were more likely to be satisfied with the quality of their care and their caregivers than their peers enrolled in the traditional agency-based service delivery system.

Since 2002, the number of PD programs has increased from 139 to 286, and the number of self-directing individuals from 400,000 to 810,000. Of the 286 programs, 75% serve older adults. All states have at least one LTSS program that gives participants the authority to be an employer and hire, fire, and manage their own personal care workers, and 45 states give participants additional authority to manage their service budgets. ACL has provided financial support to develop PD service options to 28 states and to the Veterans Health Administration’s Veteran-Directed Home and Community-Based Services (VD-HCBS) program. VD-HCBS is currently in 30 states and will be operational in all 50 states by 2014 (Sciegaj & Seklow, 2011).

A review of the relevant literature on the Aging and Disability Network workforce competencies identified a range of ways of defining competencies (e.g., specific requirements, knowledge, technical skills, and abilities) as well as useful distinctions of competency level ranges (Sciegaj & McGuirk, 2010). The review also revealed that much has been accomplished in defining LTSS workforce competencies for current ADRC/AAA staff—most notably the Department of Labor’s Employment and Training Administration Long-Term...
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Care, Supports, and Services Competency Model. The NRCPDS has revised and expanded upon this workforce competency model for ACL’s efforts in developing national PC/PD competencies and workforce standards, which can be adapted for the preparation of social work students (Administration for Community Living, 2012).

Although gains have been made in training the existing Aging and Disability Network workforce in PC/PD competencies, no corresponding efforts to prepare the SW workforce of tomorrow with such competencies have been identified. A 2010 survey of SW deans and directors conducted by the NRCPDS found that nearly 80% of social work programs do not include course content on PC/PD (NRCPDS, 2010). Within a growing body of literature on the PC approach and PD service model, the authors did not identify any curricular initiatives to embed these competencies within SW programs. This is surprising because such competencies are congruent with the strengths-based and empowerment approaches that guide the curriculum of most programs.

Given changes in funding and models of service delivery and the central role of social workers in the A/D network, it is imperative that social workers acquire PC/PD knowledge, values, and skills to effectively implement such practices. This will ensure that social workers enter the workforce prepared for positions in an A/D network that promote PC/PD competency-based approaches and services, thereby reducing the need for resource-constrained ADRCs and other A/D Network agencies to train them in this area (Mahoney, 2011).

We propose the use of an infusion curricular change approach to implement PC/PD competencies within social work curriculum. With an infusion approach, such competencies, content, and teaching resources are embedded in every aspect of a course (goals and objectives, readings, lectures, class discussions and exercises, assignments, media resources, and student outcomes evaluation criteria). When infused competencies and teaching resources are linked to course structure and requirements, they are more likely to be sustained and institutionalized and to reach a broad student population (Hooyman, 2006; Robbins, 2013). To address potential faculty resistance to adding new competency-based content to their courses, an infusion approach builds intersections with other content that faculty teach (e.g., health, mental health, disabilities, and substance use). This helps to ensure that infused material is not just added on with one or two readings, mentioned once in a course description, or taught in a last class session, and thus promotes the content’s impact and sustainability.

Such an infusion approach has demonstrated considerable progress in preparing SW graduates with geriatric competencies, largely due to the Geriatric Enrichment in Social Work Education Project and Gero-Ed Center curricular change initiatives funded by the John A. Hartford Foundation from 2001. Extensive evaluations of Gero-Ed Center-funded programs have documented the successful and sustainable infusion of geriatric
competencies and content in required generalist courses and significant increases in the numbers of students interested in working with older adults (CSWE, 2010; Damron-Rodriguez, Goodman, Ranney, Won Min, & Takahashi, 2013; Kropf, 2002; Robbins, 2013).

We recognize that faculty members are frequently asked to include new competency-based content in their courses, congruent with EPAS, even though they may feel that there is no room for one more thing. However, PC/PD knowledge, values, and skills are at the center of significant changes in the way health services and LTSS are to be administered and delivered in the future. For those committed to a well prepared aging and disability network workforce and quality care, we are compelled to add one more thing. Why? Let us conclude with words from a current participant in the new Veterans-Directed Home and Community-Based Services Program. Mr. Z., speaking at a conference at a Veterans Medical Center in New Jersey, told how he used his budget to move out of a nursing facility. Referring to the new program, he concluded by saying, “It’s a godsend. Believe me when I tell you.” Being the boss and having the flexibility to individualize one’s supports and services can make a difference.

REFERENCES


