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Hiring and Screening Practices of Agencies Supplying Paid Caregivers to Older Adults

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Abstract

Objectives—To assess what screening practices agencies use in hiring caregivers and how caregiver competency is measured prior to assigning older adult responsibilities.

Design—One-to-one phone interviews where interviewers posed as prospective clients seeking a caregiver for an older adult relative.

Setting—Cross-sectional cohort of agencies supplying paid caregivers to older adults in Illinois, California, Florida, Colorado, Arizona, Wisconsin, and Indiana.

Participants—462 home care agencies were contacted, of which 84 were no longer in service, 165 offered only nursing care, and 33 were excluded. 180 agencies completed interviews.

Measurements—Agencies were surveyed about their hiring methods, screening measures, training practices, skill competencies assessments, and supervision. Open ended responses were qualitatively analyzed by two coders.

Results—To recruit caregivers, agencies primarily used print and internet (e.g. Craigslist.com) advertising (n=69, 39.2%) and word-of-mouth referrals (n=49, 27.8%). In hiring, agencies required prior “life experiences” (n=121, 68.8%) of which less (n=33, 27.2%) were specific to care giving. Screening measures included federal criminal background checks (n=96, 55.8%) and drug testing (n= 56, 31.8%). Agencies stated that the paid caregiver could perform medication reminding (n=169, 96.0%). Skill competency was assessed by caregiver self-report (n=103, 58.5%), testing (n=62, 35.2%), and client feedback (n=62, 35.2%). General caregiver training length ranged from 0–7 days. Supervision ranged from none to weekly and included home visits, phone calls, and caregivers visiting the central office.

Conclusion—Using an agency to hire paid caregivers may give older adults and their families a false sense of security regarding the background and skill set of the caregiver.

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Keywords

caregivers; older patients; home care agencies

INTRODUCTION

Older adults often need assistance in order to remain in their own homes, as their cognitive and physical challenges increase.^{1–7} When family or friends are unable to assist, a paid caregiver is frequently hired to help the older adult in the home.^{8–10} Paid caregivers (e.g. personal care attendants, private duty attendants, home care aides, direct care workers, or sitters) are defined as non-familial individuals who receive payment to directly assist a person in daily self-care activities within their home.¹¹ Home health aide positions are the fastest growing occupation in the United States; the number of available jobs is expected to increase by 56% over the next decade.¹² To date, the typical job candidate has primarily been middle-aged, foreign-born, female, and new to the United States within the past 3 years.^{13–15} On average, non-familial paid caregivers receive low wages (\$7.25/hr), and those that live with clients earn (\$5.44/hr).¹⁵ Only 24% of paid caregivers have health insurance and many rely on public aid or government programs.¹⁵

Previous research suggests that those serving in these caregiving positions currently may not be adequately prepared for all that the position requires of them when caring for an older adult.^{15–18} This can include supporting proper use and adherence to often complex medication regimens, setting and accompanying older adults on medical appointments, and nutrition assistance.¹⁵ Lindquist and colleagues recently found that over a third of paid caregivers have inadequate health literacy, and that rates of limited English proficiency (LEP) in this group are also high.¹⁵ This is of great concern, as paid caregivers assume responsibility for the majority of older adults' health needs.¹⁹ When a sample of paid caregivers' abilities to perform medication regimen-related tasks were assessed, 65% made dosing errors that could lead to suboptimal treatment or serious adverse events.¹⁵

In the Lindquist et al. study, two-thirds of paid caregivers had been hired through a home care agency, yet medication task performance did not differ by whether the caregiver had been hired independently or through such an agency.¹⁵ This suggests that there are missed opportunities to adequately train these individuals prior to placement. It is unclear what practices are currently in place to screen candidates, impart necessary competencies for the position, and thereby prevent any harm or unintentional neglect towards older adults. We sought to determine how home agencies hire potential caregivers and ensure that they are capable of providing quality care to their older adult clients.

METHODS

Identification and Selection of Home Care Agencies

We selected five states with large populations of older adults (Illinois, California, Arizona, Florida, and Wisconsin). Through the use of the national census, we identified cities in the selected states with the largest population of older adults and the communities in a 60 mile radius of each city. To identify agencies in each area that provided paid caregiver services for older adults, we used web based search engines (Google, Bing, Yahoo), with the following keywords: private duty attendants, caregiver, caregiver services, companions, homemakers, direct care worker, personal care attendant, and non-nursing home health worker. We obtained these key words through discussions with geriatricians, geriatric-based social workers, lay hirers of caregivers, agency industry representatives, and representatives from the Chicago based Area Agency on Aging. We also searched area telephone pages and

contacted social workers and representatives at senior buildings, nursing homes, and area hospitals for agency referrals. Every possible caregiver agency was included in the sampling and the sampling was exhaustive for the specific geographic area. We excluded agencies that (1) consisted of 2 people or less, as these were unlikely to perform screening of each other and have limited supervision needs, (2) contracted only with government agencies, (3) were volunteer-based, (4) did not have an English-speaking representative, and (5) did not serve older adults. Each agency was called up to three times (with messages left that included a call back number).

Data Collection

Data were collected via a telephone interview intended to simulate calls made by lay people in acquiring paid caregiver services. A script was created with researchers posing as offspring of an older adult who needed paid caregiver assistance in their home. We sought to generate the actual responses that caregiver agencies provide to potential clients. We contacted each agency and asked to speak with a representative about hiring a caregiver. We then administered the questionnaire to the identified representative in a conversational manner. During the interview, researchers did not identify participation in the study or academic affiliation. We felt that doing so would limit the participation and affect the responses received. The Northwestern University Institutional Review Board approved the study and its protocol prior to its initiation.

The questionnaire was developed with the assistance of a social worker, nurse, geriatricians, older adults, and several family members of older adults who all had previous experiences with agencies and paid caregivers. We inquired how agencies recruited their employees and what their hiring requirements were. Specifically, we asked about whether and how they perform a criminal background check at federal and state levels, psychological evaluation, drug screening (and frequency), tests of English fluency, health literacy assessments, and any other screening modalities not mentioned (open ended). We felt that these specific hiring requirements were important to effective care of older adults (e.g. a violent person who uses cocaine may be unfit to care for the older adult).

We then listed specific responsibilities and inquired whether each could be done by the caregiver. These responsibilities were created from prior research with caregivers of their actual duties and included: 1) medication reminding and handling, 2) physician appointment scheduling and following physician directions, 3) lifting/transfers, 4) personal care skills, 5) food preparation, 6) laundry, 7) house cleaning, 8) garbage removal, 9) telephone use and 10) managing the older adult's money. After establishing the expected duties, we inquired how the agency assessed caregiver competency in the tasks (open-ended).¹⁵ We also inquired about the training given to the caregiver prior to and after being hired and supervision practices (frequency and type). Finally, the cost of care to the older adult, as well as how much the caregiver would receive in compensation, was assessed.

Data Analysis

Data were analyzed using SPSS version 17.0 statistical software (SPSS Inc, Chicago, Illinois) for frequencies. For analysis of qualitative data, responses from open-ended questions were distributed to 2 independent coders (K.A.C., E.F.). The two coders used the inductive approach of latent content and constant comparative analysis on the detailed interview notes to organize the content into operational categories.²⁰ Multiple coders are often used in the development of such categorical systems to control for the subjective bias each coder brings to the analytic process.^{21–23} The two coders initially met, discussed a general plan, and determined that each would independently review the notes from interviews to familiarize themselves with the data, initially identifying individual focal and

then overarching categories that emerged from agency responses. In the second meeting, the coders then convened to compare and compile findings, creating a preliminary list of categories. The coders then returned independently to the interviews and revisited if any categories were absent. They met five times to discuss the identified categories, alternating group meetings with independent review of the field notes, until consensus was obtained and both coders believed that saturation of categories had been reached. The coders then returned to the data independently to assess the exhaustiveness and adequacy of the created system. Any discrepancies were resolved through discussion. There were no cases in which the coders were unable to reach consensus.

Verification of Responses from Agencies

Where able, verification of responses was performed by obtaining print and web information from the agency representatives. We requested print information to be sent to a private non-University address for verification of information received during the interview. We also went on each agency's website, of which 150 (83.3%) had active websites, to confirm responses that could be verified (e.g. services offered, fees, certifications, licensing, etc). We then compared verbal responses with their written documentation. We were not able to verify verbal responses where no written material existed.

During the interviews, we obtained several unexpected answers regarding background checks, drug testing, and caregiver performance. We further performed web engine searches, contacted area social workers, certified nursing assistants, and nurses, as well as hired a law student to examine state/federal legislation to verify the veracity of some of the assessments and regulations mentioned by the agencies.

RESULTS

In all, 462 home care agencies were contacted, with the final study sample consisting of 180 agencies (Figure 1). Four agencies were located in Indiana that served Illinois and one national agency was based in Colorado. Predominantly, the agencies (167, 92.8%) were employee-based, meaning that the agencies employed and paid the caregivers. The remainder were referral-based agencies (13, 7.2%), which introduce caregivers to older adults and then the older adult is responsible for paying the caregiver directly. All agencies offered hourly care (180, 100%) and 169 (93.8%) provided live-in or 24 hour care. Several agencies offered services such as skilled nursing (49, 27.2%), geriatric care managers (34, 18.9%), and physical therapy (22, 12.2%). (Table 1)

Caregiver agencies primarily recruited employees using advertisements (69, 39.2%), of which 25 (14.2%) were by internet (e.g. Craigslist.org) and 20 (11.4%) were by print. Other recruitment modalities included referral from other caregivers (49, 27.8%), approaching Certified Nursing Aide schools (7, 3.8%), potential employees came directly to them (7, 3.8%), and hiring through nursing homes or hospitals (5, 2.7%).

Screening and Hiring Practices

In interviewing prospective caregiver employees, 112 (63.6%) agencies asked for references. 121 (67.2%) of agencies stated that their employees must have experience prior to hiring. When asked to clarify "experience", less than a third (33, 18.3%) stated that potential hires must have prior experience as a caregiver. Other qualitative responses were: "Everyone we hire has experience", "they must have life experiences", and "they have some medical experience from another country." Only a small proportion of agencies (29, 16.5%) administered a test of basic knowledge which candidates had to pass prior to hiring.

Agencies also performed screening and background checks (Table 2). Most commonly, agencies performed criminal background checks in the state of the employment (159, 91.9%). No agencies performed state criminal background checks outside their state of business. English language skills were assessed by 122 (69.3%) of the agencies, with the majority (112, 62.2%) stating that it was done through the interview. No agencies performed health literacy assessments. 22 (12.5%) agencies stated that they performed no screening prior to hiring.

Drug testing prior to hiring was performed by 56 (31.8%) of the agencies interviewed. One agency responded that “most of our caregivers are Filipinos, who tend not to use drugs, smoke, or drink. We ask them about this in the interview process.” Another agency stated that they “cannot test before hiring but (we) can test if you like after the caregiver is hired.” Several agencies stated that they checked their State Abuse Registry (n=4), National Sexual Offender Registry (n=3), Ten Most Wanted Lists (n=1), and Terrorist Watch List (n=1). Agencies also reported performing a National Caregiver Background Check (n=1), National Scantron Test for Inappropriate Behaviors (n=1), Assessment of Certification of Christian Morality (n=1), and Quality Seal of Assurance Online Program Completion (n=1); we were unable to confirm the existence of any of these.

Responsibilities

Almost all of the agencies (96.0%, 169) stated that the paid caregiver could perform medication reminders (which is legal in all states where agencies were interviewed).²⁴ All but five agencies stated they could schedule physician appointments, 98.8% (174) could accompany them to the physician office, and 96.0% (169) could follow physician instructions. All agencies stated that their paid caregiver employees could assist with daily housekeeping activities, meal preparation, and the personal care needs of the older adult. When asked whether they could assist with handling money (e.g., paying of bills), 65.9% affirmed but made several caveats. Open responses included: “You don’t really want a stranger handling her money, do you?” “We do not recommend allowing caregivers access to credit cards.” “We don’t recommend trusting the caregiver.” When asked whether their employees could perform CPR and first aid, 34.4% (62) agencies promised that their employees could do this responsibility. However, one agency stated that “some caregivers have CPR training but they are not permitted by law to perform it.”

Training

The most common method for assessing skills competencies of candidates was self-report (103, 58.5%). A third (62, 35.2%) stated that they performed a test of caregiver skills (e.g. infection control, lifting, dementia care, etc.). Another method of assessment was “client feedback” (62, 35.2%), which was explained as the older adult or family member would call the agency and alert them that a caregiver needed training in performing a task. Shadowing or on-site training occurred at 27 (15.3%) of the agencies. Other modalities included asking previous references about skills (19, 10.8%) and giving the employee a manual (2, 1.1%). The amount of timing spent training was variable, ranging from none to one week. Several agencies contracted out their training component to area programs. In researching these programs, classes were taught by nurses, hospice volunteers, medical equipment salesmen, firefighters, and non-medical school teachers. Other agencies named a training program after their business, such as “Company X Caregiver University” with certification of completion given to their employees. Paid Caregivers were then referred to as graduates of “Caregiver University” during the telephone interview. On further prompting and review, these universities were not accredited by any educational association or commission.²⁵

Supervision

Referral-based agencies did not provide supervision (13, 7.2%). Of the employee-based agencies (n=167), the majority supervised their caregivers (152, 91.0%). Other employee-based agencies offered supervision only initially (n=3), only at the request of the family (n=6), and for extra charge (n=1). The frequency and type of supervision was variable (Table 3).

Fees, Benefits, and Wages

The average fee among agencies was \$20.27 per hour (range \$12-\$28, n=140) and \$239.20 per day (range \$99-\$552, n=145). While we prompted agencies for what they paid their caregiver employees, most would not divulge. Of those who answered, average compensation was \$11.47 per hour (n=76, range \$6-\$14) and \$121.43 per day (n=14, \$115–135).

DISCUSSION

The results of our study show that the screening and training practices, in use by caregiver agencies, are highly variable and often of poor quality. Using an agency to hire paid caregivers may give older adults and their families a false sense of security regarding the background and skill set of the caregivers.

Criminal background checks were only performed in the state of employment. This is highly problematic, as caregivers could be convicted of abusing an older adult in one state and easily move to another where they could feasibly be re-hired in the same position. While each state has a listing of caregivers who were found guilty of abuse, these databases are not interlinked between states. In addition, drug testing was only conducted by a third of agencies. Considering that paid caregivers have close proximity to medications that could be diverted or used illicitly, drug testing would seem to be an essential screening measure. Equally troubling, we uncovered many potentially false responses from agencies when describing their screening process. A consumer may be more willing to hire an agency which used the “National Scantron Test for Inappropriate Behaviors” or “Assessment of Christian Morality”. In reality, these tests could not be substantiated and may not actually exist. It would be difficult for an average consumer to determine whether an agency is making potentially false statements.

While agencies frequently stated that their employees could assist with medication reminding and following physician orders, neither health literacy or specific task performance were frequently – if ever - assessed. Instead, agencies commonly used self-report and client feedback as a means of determining a candidate’s skills, which seem inadequate. A person seeking employment may incorrectly self-report their capabilities in order to obtain a job. Using client feedback for tailoring of training is also a substandard screen since most clients are (1) older adults with cognitive impairment and (2) families of older adults who are not present. About a third of the agencies interviewed performed testing prior to placing a caregiver. Since we were unable to review these tests, we do not know the relevance or extensiveness of the assessments with regard to medication reminding or understanding physician instructions.

Supervision was limited at many agencies. Home visits are necessary to understand how both the caregiver and the older adult are managing. A reasonable expectation would be to have a supervisor visit the home at least once or twice a month. Agencies that rely on phone calls are unlikely to gain a full picture of the older adults’ care. Our interviewers had to frequently prompt agency representatives during interviews to obtain the specific details of supervision. For instance, agencies stated that supervision occurred twice a month. Further

explanation revealed that the caregiver picked up their paycheck at the central office and were then asked about their work.

A striking finding of this study was that a number of agencies had active websites but phone numbers that were no longer in service. In personal correspondence with members of the industry, owners will create a business plan for exit from the field in 3–5 years after starting or upon reaching a level of profitability. Exiting from the field is a fairly common occurrence and we found many who may have stopped service but did not eliminate their websites. This turnover is troubling as: (1) it makes finding a paid caregiver difficult and (2) many older adults require caregivers for more than 3–5 years and it is unclear what happens to their employees or the effects that this pose for their clients. Our sample consisted of 87.8% of agencies that were in operation 6 years or longer which may limit the generalizability.

A limitation of this study is that the agency representative interviewed may not have been the most knowledgeable about their agency practices. In follow-up to our phone conversation, most agencies were prepared to send an individual to present contracts and set-up services. It is possible that these representatives would have been more informative; however, at that point, the agencies are expecting to be hired. Although this may be a limitation, this representative is the first point of contact for patients and caregivers which may make or break whether the agency is hired. If false or incomplete information is being disseminated, even if it is at the first point of contact, it is still important. Another limitation is that we did not survey agencies in all 50 states and there may be variation between states and geographic regions.

Our study findings suggest that more stringent regulation and sets of standards are urgently needed at the state and federal level. However, policy responses should be considered very carefully, as regulatory measures that are costly could translate into increased fees passed onto older adult consumers. Using these agencies is already a costly endeavor for most older adults. Older adults and their families may resort to hiring cheap, unskilled caregivers “off the street”, potentially resulting in greater patient safety and quality concerns if reforms are not thoughtfully devised.

To help provide some concrete implications for clinicians, older adults, and family members, we have included 10 key questions from our survey that clinicians should recommend families ask agencies (Figure 2). In applying the results of this study to clinical practice, it is important to identify agencies that perform federal/state background checks, drug testing, have a clear protocol for training, and routinely supervised employees in the home of the older adult. For clinicians who work with patients who have accompanying paid caregivers, it may be helpful to involve family members besides the caregivers to ensure instructions are followed in the home.

As our population ages, more seniors will need to rely on paid caregivers to remain independent in their homes, and this may hinge on the skills of a paid caregiver. The 2008 Institute of Medicine report, *Retooling for an Aging America: Building the Health Care Workforce*, predicts that the current health care workforce, including paid caregivers, is too small and critically unprepared to meet the health needs of older adults.²⁶ Agencies that supply paid caregivers play a vital role in ensuring high quality home care and well-supervised caregivers. While greater oversight of this industry’s practices are needed, in the short-term, consumers need to know how to define quality in the context of home health agencies, and what explicitly to look for as far as screening measures, hiring practices, training, and supervision.. Consumers also should be vigilant and attuned to false information and illicit marketing tactics. Once educated, consumers can use these skills to

hire dedicated caregivers from quality agencies. An informed consumer may be the best tool to improve the paid caregiver industry by creating market pressure through the selection of caregivers from high-quality agencies.

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References

1. MaloneBeach EE, Langeland KL. Boomers' prospective needs for senior centers and related services: A survey of persons 50–59. *J Gerontol Soc Work*. 2011; 54:116–130. [PubMed: 21170782]
2. Ritchie CS, Roth DL, Allman RM. Living with an aging parent: "It was a beautiful invitation". *JAMA*. 2011; 306:746–753. [PubMed: 21846856]
3. Weeks LE, LeBlanc K. Housing concerns of vulnerable older Canadians. *Can J Aging*. 2010; 29:333–347. [PubMed: 20712917]
4. Mauser E, Miller N. A Profile of Home Health Users in 1992—Issues in Reforming Home Health Care. *Health Care Finance Review*. 1994 Fall;:1–13.
5. McCann M, Donnelly M, O'Reilly D. Living arrangements, relationship to people in the household and admission to care homes for older people. *Age Ageing*. 2011; 40:358–363. [PubMed: 21427114]
6. Sands LP, Xu H, Craig BA, et al. Predicting change in functional status over quarterly intervals for older adults enrolled in the PACE community-based long-term care program. *Aging Clin Exp Res*. 2008; 20:419–427. [PubMed: 19039283]
7. Hellstrom Y, Hallberg IR. Determinants and characteristics of help provision for elderly people living at home and in relation to quality of life. *Scand J Caring Sci*. 2004; 18:387–395. [PubMed: 15598246]
8. Sudore RL, Covinsky KE. Respecting elders by respecting their paid caregivers. *J Gen Intern Med*. 2011; 26:464–465. [PubMed: 21424164]
9. McMackin S. What Is Private Duty Home Care? An Industry Overview Home Health Care Manage Pract. 2006; 18:92–97.
10. Hanyok LA, Finucane T, Carrese J, et al. Potential caregivers for homebound elderly: More numerous than supposed? *J Fam Pract*. 2009; 58:E1–6. [PubMed: 19607768]
11. Lindquist LA, Tam K, Friesema E. Paid caregiver motivation, work conditions, and negative outcomes among seniors clients. *Arch Gerontol Geriatr*. 2012 Feb 21. [Epub ahead of print].
12. Caregiving in America. [Accessed October 24, 2011.] A Report Prepared Under the Auspices of the Caregiving Project for Older Americans. www.schmiedingcenter.org/pdf/caregiving_in_america.pdf
13. Rosa E, Lussignoli G, Sabbatini F, et al. The immigrant paid caregivers' role in the care of patients with severe dementia. *Int J Geriatr Psychiatry*. 2008; 23:331–333. [PubMed: 17708585]
14. Montgomery R, Holley L, Deichert M, et al. A profile of home health workers from the 2000 Census: How it can change what we know. *Gerontologist*. 2005; 45:593–600. [PubMed: 16199393]
15. Lindquist LA, Jain N, Tam K, et al. Inadequate health literacy among paid caregivers of seniors. *J Gen Intern Med*. 2011; 26:474–479. [PubMed: 21161420]
16. Kietzman KG, Benjamin AE, Matthias RE. Of family, friends, and strangers: Caregiving satisfaction across three types of paid caregivers. *Home Health Care Serv Q*. 2008; 27:100–120. [PubMed: 18928207]

17. Skovdahl K, Kihlgren A, Kihlgren M. Different attitudes when handling aggressive behaviour in dementia--narratives from two caregiver groups. *Aging Mental Health*. 2003; 7:277–286. [PubMed: 12888439]
18. Hellstrom Y, Hallberg IR. Perspectives of elderly people receiving home help on health, care and quality of life. *Health Soc Care Community*. 2001; 9:61–71. [PubMed: 11560722]
19. National Association for Home Care and Hospice. Basic Statistics about Home Care. Washington, D.C: 2004. Available at <http://www.nahc.org>
20. Neuendorf, KA. *The Content Analysis Guidebook*. Sage; Thousand Oaks, CA: 2002.
21. Lincoln, YS.; Guba, EG. *Naturalistic Inquiry*. Sage; Beverley Hills, CA: 1985.
22. Cameron KA, Rintamaki LS, Kamanda-Kosse M, et al. Using theoretical constructs to identify key issues for targeted message design: African American seniors' perceptions about influenza and influenza vaccination. *Health Commun*. 2009; 24:316–326. [PubMed: 19499425]
23. Brashers DE, Neidig JL, Haas SM, et al. Communication in the management of uncertainty: The case of persons living with HIV or AIDS. *Commun Monogr*. 2000; 67:63–84.
24. California Department of Social Services. [Accessed October 24, 2011.] Social Services Standards Manual. <http://www.dss.cahwnet.gov/ord/PG310.htm>
25. The Database of Accredited Postsecondary Institutions and Programs. Office of Postsecondary Education, U.S. Department of Education; <http://ope.ed.gov/accreditation/Search.aspx>
26. Institute of Medicine. *Retooling for an aging America: Building the health care workforce*. Washington, DC: National Academy; 2008.

Figure 1.
Paid Caregiver Agency Selection

- 1. How do you hire caregivers - What are your hiring requirements?**
- 2. What types of screening are performed on caregivers prior to you hiring them?**
 - Criminal Background check – Federal/State**
 - Drug Screening**
 - Other**
- 3. Are they certified in CPR or have any medical training?**
- 4. Are the caregivers insured and bonded through your agency?**
- 5. What competencies are expected of the caregiver you send to the home? (e.g. lifting/transfers, homemaking skills, personal care skills (bathing, dressing, toileting), training in behavioral management and cognitive support)**
- 6. How do you assess what the caregiver is capable of doing?**
- 7. What is your policy on providing a substitute caregiver in the event a regular caregiver cannot provide the contracted services?**
- 8. If there is dissatisfaction with a particular caregiver, can he/she be replaced “without cause”?**
- 9. Does the agency provide a supervisor to evaluate the quality of home care on a regular basis? How frequently?**
- 10. Does supervision occur over the phone, via progress reports, or in person at the home of the older adult?**

Figure 2.

10 Questions to ask agencies prior to hiring a paid caregiver

Table 1

Characteristics of Paid Caregiver Agencies - n (%) (n=180)

Locations	
California–San Diego	40 (22.2)
Illinois–Chicago	35 (19.4)
Illinois–Suburban/Rural	45(25.0)
Wisconsin –Milwaukee	24 (13.3)
Florida–Sarasota	20 (11.1)
Arizona – Scottsdale	11 (6.1)
Indiana	4 (2.2)
Colorado	1 (0.6)
Services Offered	
Hourly Caregiver Care	180 (100)
Live-In Caregiver Care	169 (93.8)
Skilled Nursing	49 (27.2)
Geriatric Care Managers	34 (18.9)
Physical Therapy	22 (12.2)
Hospice	15 (8.3)
Well Being Checks	14 (7.8)
Alert Systems	8 (4.4)
Adult Day Services	5 (2.8)
Website	150 (83.3)
Certifications	
Better Business Bureau	38 (21.1)
Home Care Pulse	2 (1.1)
Alzheimer Association	11 (6.1)
Licensed by State Department	32 (17.8)
National Organization Membership *	49 (27.8)
Year Opened/Years in Operation (n=107)	
0–5 years	13 (12.1)
6–9 years	26 (24.3)
10–19 years	39 (36.4)
20 years and longer	29 (27.1)

* National Private Duty Association (NPDA) or Private Duty Home Care Association (PDHCA)

Table 2

Hiring Requirements of Paid Caregiver Agencies - n (%) (n=180)

Required Experience	121 (67.2)
Specified Duration of Experience	55 (30.5)
Type - General (e.g. Life Experience)	55 (30.5)
Type - Prior Caregiver Experience	33 (18.3)
Certified Nursing Assistant Training - Required	12 (6.7)
Certified Nursing Assistant Training - Preferred	34 (18.9)
Pass a Written Test	29 (16.1)
Agency Created	17 (9.4)
Health Related	6 (3.3)
Criminal Background Check - State (n=173)	159 (91.9)
Criminal Background Check - Federal (n=172)	96 (55.8)
Checked References	112 (62.2)
English Language	122 (67.8)
Driving Record Check	50 (28.4)
Drug Screening – Prior to Hiring	56 (31.1)
Drug Screening–Randomly / For cause	15 (8.3)
Citizenship/Visa Verified	12 (6.7)
Copy of Driver's License	12 (6.7)

Table 3

Supervision Types and Frequencies - n (%)

Check in at Home of Older Adult	117 (66.5%)
Twice Yearly	4 (2.3%)
Quarterly	22 (12.5%)
Every Other Month (6–8 a year)	33 (18.9%)
Monthly	40 (22.7%)
Every Other Week	6 (3.4%)
Weekly	8 (4.5%)
Check In Via Telephone Call	62 (35.2%)
Quarterly	1 (0.6%)
Every Other Month (6–8 a year)	20 (11.4%)
Monthly	15 (8.5%)
Every Other Week	3 (1.7%)
Weekly	14 (8.0%)
Daily	5 (2.8%)
Check in at Agency Office	13 (7.4%)
Check in through Daily “Clock-in”	58 (33.0%)
Check in through Daily Written Log	68 (38.6%)