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Co-Learning With Home Care Aides and Their Clients: Collaboratively Increasing Individual and Organizational Capacities

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Abstract

Changes in health care provide unprecedented opportunities for collaboration across research, education, and practice for the common goal of enhancing the well-being of older adults and their caregivers. This article describes how a pilot project, “Promoting Seniors’ Health with Home Care Aides,” has synergistic education, research and practice effects that enhance individual and organizational capacities. This pilot is an innovative partnership with home care aides to deliver a safe physical activity program appropriate for frail seniors in a real-life public home care program. The intervention and research occur in older adults’ homes and thus provide rare opportunities for

the research team and partners to learn from each other about dynamics of home care in older adults' life contexts. Co-learning is essential for continuous quality improvement in education, research and practice. We propose to establish "Teaching Home Care" to ensure ongoing co-learning in gerontology and geriatrics.

Keywords

physical activity; teaching home care; team; continuous quality improvement; collaboration; community-based long-term care; home care

INTRODUCTION

Current changes in the U.S. health care system, triggered by the Patient Protection and Affordable Care Act, present unprecedented opportunities and challenges for gerontology and geriatrics education. Health care practice increasingly highlights the importance of health promotion and care coordination, especially for persons with multiple chronic conditions. Managed care is rapidly evolving to integrate medical, behavioral, and long-term services and supports (LTSS). Increased emphasis on patient-centered care and research promotes collaboration across disciplines and health care sectors for the common goal of promoting the health and well-being in older adults. However, education in gerontology and geriatrics continues to be done in silos: students, trainees, and faculty have few opportunities to work with people outside their own disciplines and specialized practice settings. Curriculum changes take time and can rarely keep abreast of rapidly changing health systems. Informal and incidental learning, the essence of adult education (Marsick & Watkins, 2001), receives less attention than formal, classroom-based learning. Educational institutions cannot produce the next generations of researchers and practitioners by relying on academic curricula alone.

Research in gerontology and geriatrics, on the other hand, can address these educational gaps during the process of studying cutting-edge practice issues. In particular, the process of setting up a research project in a practice setting provides a wealth of educational opportunities for researchers and educators to learn from practitioners, trainees, and students, and vice versa. Co-learning, or a two-directional learning process, occurs during the research process, rather than from the results of research. The heart of this education is experiential, informal learning, which is largely a byproduct of research but can be probed intentionally (Marsick & Watkins, 2001).

Informal educational components embedded in the research process, however, are seldom shared by researchers who focus on publishing research results. This article intends to fill this gap. Rather than sharing research data to be reported at a later stage, this article describes how an ongoing pilot project funded by the National Institute on Aging, entitled "Promoting Seniors' Health with Home Care Aides," has synergistic education, research and practice effects that enhance individual and organizational capacities at multiple levels. The overall goal of the project is to pilot test an evidence-based safe physical activity program for frail seniors, delivered by home care aides (HCAs) in clients' homes in a real-life state and Medicaid-funded home care program using a single group pre- and post-test research

design. The results will be used to design a larger randomized controlled trial to demonstrate program effects on home care clients' function and well-being. The intervention and research activities center around older adults' homes and thus provide rare opportunities for gerontologists and geriatricians to obtain intimate knowledge of older adults' life contexts that largely determine their lifestyle and well-being. This article focuses on educational components of the initial project preparation and pretest stage, which has turned out to be critical for the research implementation stage. The learning curve in the preparation stage was certainly steep. This article demonstrates how the project preparation stage has facilitated individuals and organizations to co-learn, or learn from each other, with the common goal of enhancing the well-being of older home care clients, and concludes with a proposal for developing "teaching home care programs."

BACKGROUND

Against the backdrop of the rapidly aging U.S. population, an increasing number of older adults receive help from paid caregivers. The need for paid caregivers will continue to grow in home care, one of the fastest growing industries in the United States (Institute of Medicine, 2008; Kaye, Harrington, & LaPlante, 2010; Richards & Terkanian, 2013). Especially for low-income older adults who are eligible for publicly funded-LTSS programs, federal and state governments are turning from costly traditional nursing home services to greater use of in-home and community-based services (Muramatsu, Hoyem, Yin, & Campbell, 2008; Muramatsu et al., 2007; Muramatsu, Yin, & Hedeker, 2010). Some of the potentially most effective but so far underutilized sources for this care are home care aides (HCAs), also known as homemakers, personal attendants, or personal care assistants. This large work force (more than 1 million in 2009) are typically middle-aged women, often members of ethnic minorities with limited economic resources (Montgomery, Holley, Deichert, & Kosloski, 2005; Seavey & Marquand, 2011). These non-medical home care workers regularly provide routine housekeeping and personal care for an extended period of time. However, they seldom play active roles to stimulate older adults' physical reserve capacity to maintain independence.

Regular physical activity benefits older adults physically and mentally. Research indicates that it is never too late to start physical activity and that it benefits seniors with disabilities (Gill et al., 2002; Jette et al., 1999). Yet, community-dwelling older adults who have difficulties with walking and basic daily activities commonly lack any physical activity. 1.7 million older Americans live in the community with "nursing home-level care needs," operationally defined as needing help with 2+ activities of daily living (ADL, e.g., bathing, dressing, walking across the room). Seniors with 2+ ADL limitations in the community outnumber the 1.1 million older nursing home residents with similar needs (Kaye, et al., 2010).

Few existing physical activity programs are appropriate for nursing home-eligible seniors. Medical professionals (e.g., physical therapists, nurses) are qualified to lead physical activity for this population. Nevertheless, physical activity using medical professionals, however efficacious (Gill, et al., 2002), will be too expensive for wide dissemination, especially for Medicaid home care programs that are jointly funded by the financially stricken federal and

state governments. Most existing non-medical home care programs have no medical staff. Thus safety is a major concern among program managers. Healthy Moves for Aging Well (HM) is a low-cost physical activity program developed by Partners in Care Foundation (www.picf.org), specifically designed to safely enhance the activity level of nursing home-eligible older Medicaid clients. HM builds on evidence-based physical activity (Rikli & Jones, 2013a) and behavioral change research (Prochaska & DiClemente, 1983) and has been endorsed by the Administration on Aging and the National Council on Aging's Evidence-based Prevention Initiative (National Council on Aging, 2011). HM, adapted from the Senior Fitness Test (Rikli & Jones, 2013b) (six exercise tests linked to ADLs), involves two components: (1) a brief motivational enhancement and (2) three chair-bound movements, targeted to home care clients with 2-4 ADL limitations. HM has evolved based on inputs from case managers who care about safety and liability issues. The original HM was delivered by case managers and monitored by trained lay coaches. Observational studies of 338 clients showed that HM produced positive outcomes, namely increased performance in the face-to-face coaching group, reduced falls and pain (Yan, Wilber, & Simmons, 2011; Yan, Wilber, Wieckowski, & Simmons, 2009).

Our project, "Promoting Seniors' Health with Home Care Aides," translated the original case manager-led program into a program delivered by HCAs for their home care clients. Following up on a feasibility study of HM with HCAs conducted in a non-metropolitan area (Park & Chodzko-Zajko, 2014), our goal is to establish the feasibility of the program, test data collection and measurements, and document program costs, in a real-life state- and Medicaid-funded home care setting in a large metropolitan area.

METHODS AND RESULTS

Research Context

This project takes place in Chicago as part of the Illinois Department on Aging Community Care Program. This state program is partly financed by the Medicaid waiver program, a rapidly growing program that is the main mechanism through which U.S. states finance home and community-based services for low-income seniors. Older adults assessed to be eligible for the program (aged 60, with assets \$17,500 and difficulties with daily activities) receive in-home personal care services (e.g., cleaning, preparing meals, shopping, dressing and bathing) from HCAs. Eligible seniors may receive services from agency workers or their relatives, if the latter qualify and become home care agency employees. All HCAs are required to attend 24 hours of initial pre-service training before employment, and thereafter a minimum of 12 hours per calendar year of interactive in-service training approved by the provider agency. In our pilot project, HCAs receive a one-time 4-hour training to learn HM that counts toward the state-mandated in-service training hours. The project involves a variety of key partners including a home care agency, one of the largest of more than 100 home care agencies that offer Illinois' Community Care Program, through which HCA and client study participants are recruited; SEIU (Service Employees International Union) Healthcare Illinois & Indiana, the labor union that represents HCAs; the Illinois Department on Aging, which administers the Community Care Program; and Case Coordination Units, community-based social-service organizations that contract with the state to provide case

management services. The partner home care agency identifies home care aide-client pairs who are likely to meet the study inclusion criteria (Community Care Program in-home service program participants with abilities to speak English, sit in a chair independently for 15+ minutes, follow simple directions, and answer survey questions, excluding those who have a legal guardian appointed, receive hospice care or have a terminal diagnosis; and HCAs who are aged 21+ , able to speak English, willing and able to implement the HM routine with their client for the full 4 months, and intend to be a HCA for the next 8 months). The university research team screens all the potential participants for the eligibility criteria and obtains informed consent.

Co-Learning: Project Members and Partners Learning from Each Other

The core of co-learning occurs in HCA-client dyads. HCAs learn how to enhance clients' motivation for increasing physical activity, and how to teach and encourage their clients to do three movements as part of their regular home care visits. In this process, older clients become aware of the importance of physical activity for reaching their daily activity goal and learn to do the movements regularly. In addition to this core co-learning process, various individuals and organizations, whether in education, research or practice, learn from each other, as shown in the co-learning conceptual framework (Figure 1). Surrounding the HCA-client dyads are those who directly interact with them: older adults' family and caregivers, the home care agency's supervisors, and the university's research team members (e.g., research interviewers who make home visits to assess older clients in their homes, the core research staff and the principal investigator who make phone calls and in-home visits to assess whether and how HCA-client dyads have implemented HM).

The university-based research team learns whether and how the program works from HCA-client dyads and those who work directly with the dyads. The research team involves the core faculty that represent multiple disciplines (gerontology, geriatrics, health services research, kinesiology, sociology, psychology, education, biostatistics, economics, public health, and occupational health); the project director, research assistants, and student interns and volunteers, all of whom are current doctoral, master's, or undergraduate students in various disciplines; and geriatrics fellows in the College of Medicine. The research team is advised by a local Advisory Board that represents key partner organizations mentioned above (the home care agency, the labor union, Illinois Department on Aging, and social services agencies that contract with the state to provide case coordination services), as well as a representative of older home care clients receiving the Community Care Program's in-home services; and the national Expert Panel, which includes researchers and practitioners who contributed to the development and evaluation of HM.

The following sections describe co-learning opportunities that occurred in the project's preparation stage, focusing on its milestones and key activities: project setup (obtaining Institutional Review Board approval with community partners, establishing communication infrastructure), kick-off meeting, developing and pretesting research instruments and data capturing systems, interviewer training, and participant recruitment.

Project Setup

Obtaining Institutional Review Board Approval with Community Partners—

Approval from the University of Illinois at Chicago's Institutional Review Board (IRB) was the first milestone. While most academic researchers, trainees and students are familiar with initial and continuing IRB requirements, two specific requirements deserve particular attention in projects involving community partners.

First, partner organizations may need to file Federalwide Assurance (US Department of Health and Human Services [HHS], 2011) if they are “engaged in human subjects research” (i.e., obtain data through intervention or interaction with a living human being, obtain identifiable private information from a living human being, or receive a direct federal award to conduct human subjects research) (HHS, 2008). FWA is an agreement whereby these organizations commit themselves to certain standards for conducting research involving human subjects. FWA must be approved by the Office for Human Research Protections. As an employer of HCAs and home care providers, our partner home care agency interacts with potential participants and thus is “engaged in human subjects research”. Thus for our project it was necessary that the home care agency obtain an FWA number online, complete the paperwork to have the university's IRB serve as the agency's IRB (as the agency does not have its own IRB), and have the agency's manager complete the university-approved initial human subjects research training and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) training.

Second, we were required by the IRB to train the home care agency staff on the essence of human subjects research requirements. To accommodate this training in the busy home care agency staff's schedule, the research team conducted a face-to-face 1-hour session for the staff at one branch office (N=15). The staff at another branch office (N=9) participated via a conference call. To make the training appropriate for our partners, we used materials extracted from CERTification, a training program tailored to the unique roles of community research partners (Anderson, 2011). For example, the training program addresses ethical issues in plain language and discusses issues relevant to the particular project. This training was repeated throughout the project as new staff at the home care agency joined the research project.

To many community-based practice organizations, human subject research requirements are new and unknown. The IRB processes described here involved various levels of the home care agency (from the vice president, directors, managers and direct supervisors to the office staff), providing the partner organization with opportunities to learn about important aspects of human subjects research. The research team, in turn, learned to digest complex federal and campus requirements into explanations that make sense to the community partner, convey required information to multiple levels of the agency, and take into consideration the time required for the university and the community organization to execute agreements. Without the agency-wide commitment and support, it would have been extremely difficult to obtain IRB approval, a major initial milestone for the project setup.

Establishing Communication Infrastructure—Open, transparent communication is key to productive collaboration. This is especially true for our project since it involves frail

older adults and their HCAs, whose health and life circumstances change over time. Research activities need to be coordinated with the home care agency's operations, which in turn may change with state and agency policies. For example, the research team learned to adapt HCA recruitment and training to the home care agency's in-service training schedules, adapt client recruitment protocols to the rapidly evolving rollout of the state's Medicare and Medicaid Alignment Initiative, and adapt research activities to new methods of recording HCAs' work time. We maintain regular communication with community partners (weekly or monthly with our key partner home care agency, depending on the intensity of activities, and as needed with other partners). We use e-mails for routine communication such as project progress reports, conference calls for discussing ongoing participant recruitment and enrollment issues, and face-to-face meetings for in-depth, open discussion, such as initial discussion of participant recruitment plans and significant modifications of plans. We aim to have each research team member and partner continue to feel that participating in a meeting or conference call is worthwhile. The principal investigator and her core research staff make every effort to visit each collaborating organization to meet individuals who are new to the project. Initial face-to-face meetings are worth the time and effort to establish mutual trust and rapport: collaborators learn about their specific roles in relation to the project goals first-hand from the principal investigator and her core staff, and the research team in turn learns each new collaborator's perspective and level of commitment.

Regular research meetings with university-based co-investigators, significant contributors, the geriatric medicine team (the section chief, an attending physician, and fellows), and the research staff and students are held every other week. These meetings focus on substantive issues that are critical at any given project stage for achieving the project's scientific goals (e.g., how a particular data capturing method for keeping track of program participation may affect later data analysis). Each member of the multidisciplinary research team brings his or her own perspective to discussions to produce synergistic effects. Equally important are weekly staff meetings to plan and evaluate tasks, reassess priorities and assignments, and discuss substantive operational issues. Frequent communication among the principal investigator and the staff is critical, especially for a pilot project like ours, because evaluation of each project component feeds into corrective actions and future plans. Intellectually stimulating discussion and effective communication energize collaboration and co-learning.

Kick-off Meeting

The initial project setup was followed by a successful kick-off meeting with 25 attendees, including directors and leaders of the Illinois Department on Aging, the home care agency, the labor union, and social-service agencies. The meeting started with welcoming and supportive remarks from the Directors and leaders of all the key participating organizations, filling the room with energy and excitement. Video conference software allowed participation of geographically remote collaborators. The program booklet with all attendees' pictures and biographic summaries, produced by a student intern, facilitated communication both during and after the kickoff meeting. Face-to-face conversation with refreshments had ice-breaking, enthusiasm-producing effects that are difficult to achieve by e-mails and phone calls (meeting face-to-face facilitates subsequent e-mail or telephone

communication). Having all the research partners, Advisory Board members, and research team members in one room set the stage for productive collaboration towards the goal of empowering HCAs and enhancing the well-being of older home care clients.

Research Instruments and Data Capturing Systems: Developing, Pretesting, and Refining

Our project involves multiple research instruments, including participant eligibility screening instruments, pre- and post-intervention assessment tools (for face-to-face interviews and fitness tests with clients, and self-administered questionnaires for HCAs), and fidelity check instruments (Gearing et al., 2011). The process of developing, pretesting, and refining those instruments and intervention materials presented learning opportunities for all the parties involved. For example, the research team engaged geriatric medicine faculty and fellows in discussion on our strategies to enhance physical activity in frail older adults. The geriatrics team, in turn, provided clinical advice and tips for effectively communicating with frail seniors and their families.

To capture research data efficiently and safely in this home-based intervention research project, we use REDCap electronic data capture tools hosted at the University of Illinois at Chicago (Harris et al., 2009). REDCap is a secure, web-based application designed to support data capture for research studies, providing an intuitive interface for questionnaire development and validated data entry. With a tablet linked to a mobile “hotspot” device, research interviewers directly enter their observations and older adults’ responses into data capture forms while reading the questions aloud from those forms at the respondent’s home. Data are saved instantly on the university’s secure server (but not on the tablet itself, which protects the data even if the tablet is lost). The research staff in the office can monitor interview progress and entered data in real time, and the office staff or interviewers can schedule multiple interviews and phone calls using REDCap’s scheduling function from anywhere, as long as they have an internet-connected device (e.g., a smartphone, a computer). Access to sensitive information, such as participants’ names and contact information, can be limited only to the principal investigator and key staff. This user-friendly and flexible technology has been particularly helpful for managing the complex project and for accommodating special needs and schedules of HCA-client dyads. Furthermore, REDCap has facilitated timely communication and co-learning among the researchers and the research staff.

Research instruments and data capturing systems were pretested for further refinement. For pretesting research instruments and physical activity intervention with older adults with multiple functional limitations, the university’s geriatrics medicine team helped recruit five of their geriatric patients who met the study eligibility criteria. Pretest participants were primarily African-American (80%) females (80%) ranging in age from 80 years to 101 years (mean 88.2). The research team met with the geriatrics medicine team multiple times to discuss the research project and participant recruitment protocols. Under the guidance of the chief of the geriatrics section, geriatrics fellows gained hands-on experience with recruiting frail seniors for the research project.

The principal investigator and her research team, in turn, learned a great deal, not only from the geriatric medicine team, but also from geriatric patients in the process of testing the

sequence of participant recruitment, phone and in-home screening, pre-intervention assessment, and delivering the intervention. Five geriatrics patients learned HM from a student intern who played the role of a HCA. The research team, trainees and students, and research interviewers learned from interacting with those geriatrics patients and prepared themselves to conduct the main pilot study. The research team members did not know what to expect before their first pretest home visit with frail older persons. In the process of their first pretest home visit, however, they reported experiencing their initial anxiety gradually being replaced by confidence, feeling “I can handle this.” We learned quickly from observing and listening to pretest participants whether research instruments and intervention materials that we developed would work.

For pretests with HCAs, the labor union that represents HCAs helped recruit 7 HCAs that do not work for the home care agency involved in our main pilot project that follows. Those HCAs were middle or old-age women (average age 55.8 years), primarily African-American (86%), who had worked in homecare for 6.4 years (SD 6.4 years, ranging from 9 months to 18 years). The research team pretested the whole sequence of the HCA training in a focus group format, starting with the informed consent to participate in the session, pre-intervention survey administration, and an abbreviated version of HCA training. In the discussion following each component, HCAs provided overwhelmingly positive feedback, indicating that the script for enhancing motivation to engage in physical activity was natural, clear, and not “preachy.” HCAs provided valuable suggestions, such as using a magnet to place HM materials on the refrigerator, stickers to place on the physical activity calendar log forms, and setting a goal to do HM during clients’ favorite television shows. HCAs also shared their thoughts about their clients’ potential reactions to our program; for example, about how clients who have familial relationships with HCAs might be more resistant in motivation enhancement dialogues than non-family home care clients. HCAs learned motivational enhancement and physical activity components of HM. HCA pretest participants seemed to appreciate the opportunities to express themselves in the session, as indicated by hugs that they gave to the research team at the end of the session. The pretest of the HCA training session was a two-way learning experience for the research team and HCAs.

Interviewer Training

Research interviewers play critical roles in this project: visiting home care clients’ homes to assess eligibility and obtain informed consent, and scheduling and conducting pre- and post-intervention assessment home visits. The research team targeted interviewer recruitment to people with kinesiology training and interview experience with older adults, and selected two recent graduates of kinesiology programs who could make home visits and establish rapport with frail older adults in predominantly African American inner-city neighborhoods. The interviewers received 20 hours of training on essential skills and knowledge (e.g., human subjects research requirements, interview protocols, safety for interviewees and interviewers). Additionally, they received on-the-job training with pretest geriatric patients and an Advisory Board member who represents older home care clients. Again the learning has been a two-way street. For example, the research team learned how to refine a protocol to measure older adults’ ankle flexibility from an interviewer who had experience in the

particular measurement in his practice as a physical therapy rehabilitation aide. The research team is continuously learning from interviewers about strengths and weaknesses of the research instruments as well as clients' health conditions, home environments and family situations that could impact clients' HM activities.

Participant Recruitment

Recruiting participants from a real-life home care setting is critical for testing a sustainable home care-based program. To identify clients who are potentially eligible for the program (i.e., can sit independently for 15 minutes, can follow simple instructions and respond to health-related questions, have no terminal illness, have no legal guardian appointed), the home care agency relies on HCAs or their supervisors who have direct knowledge of clients' health and functional status. All the identified clients are referred to the research team, who conduct screening interviews and obtain informed consent. However, the real-life home care setting poses logistical challenges. For example, as part of governmental rules for home care practice that are intended to protect home care clients, our state requires that home care clients provide a written consent to release contact information to the research team, an entity outside the home care program. This turned out to be a major challenge because the research team cannot directly explain to frail homebound older clients what the program is about without knowing their contact information. Clients, on the other hand, may not feel comfortable signing such a legal document without receiving an explanation of the program from the research team. And most clients need help with reading, signing, and sending the form. To break through this catch-22 situation, the agency-wide support and commitment of our partner home care agency were critical. Our team worked closely with the agency to try out multiple ways to obtain written consent to release contact information. Most helpful in this process for the home care agency and their clients were HCAs, who regularly assist their clients with their daily activities and know about their clients' conditions better than anyone else in the home care agency. At the time of this writing (November 2014), the project enrolled approximately three quarters of the target sample of HCA-client dyads. Clients (N=57) enrolled so far are mostly female (79%) African Americans (95%) with multiple daily activity limitations, aged 77 years old on average (range: 62-101). HCAs (N=37), mostly female (89%) African Americans (95%), have taken care of those clients for 1.7 years on average (ranging from 1 month to 9 years). Our future goals are to investigate the feasibility and acceptability of the intervention program for home care clients, HCAs, and partner organizations, and to examine if this HCA-led physical activity program helps maintain and improve home care clients' function. Our journey will continue, but one thing is certain: the co-learning process described above was essential for recruiting home care clients and engaging them in a HCA-led physical activity program.

DISCUSSION

In testing a physical activity program led by HCAs for their older home care clients, our ongoing pilot research project has produced co-learning opportunities. Co-learning occurred in HCA-client dyads and among individuals and organizations surrounding the dyads, enhancing individual and organizational capacities. For example, the project has provided researchers and trainees with rare opportunities to observe frail older adults' physical

activity in their homes, which could lead to new ideas for future home-based interventions for frail seniors. A relatively small-scale pilot project like ours provides opportunities for students and trainees in gerontology and geriatrics to experience multiple components of the project, including developing research instruments and intervention materials, pretesting and piloting them, and observing the process and outcomes of the intervention. Such opportunities are infrequent in a large-scale research project that tends to have clearly defined research protocols and specific roles for each research team member. Our project has also provided several graduate students with research assistantship, field practicum, and independent study opportunities for acquiring hands-on experience with research conducted in a real-life practice setting.

Students and trainees in gerontology-related fields, such as public health, kinesiology, social work, and nursing, have few opportunities to interact with people outside their chosen field. Trainees in geriatrics medicine lack opportunities to work with non-medical researchers, practitioners, and front-line workers, especially HCAs. Our project has provided unique opportunities to learn about current and potential roles of HCAs, who have been underutilized in the U.S. health care system.

We have learned many lessons in our project. Conducting a pilot research program with frail older adults in a real-life home care setting requires time, effort and commitment, as well as co-learning. Some of this learning was anticipated, and some was a response to emergent challenges that were unanticipated. Projects that focus on co-learning must be prepared to be flexible and open to modifications and iteration based upon lessons learned. Co-learning continues to be fostered by ensuring that all partners' ideas, feedback, and contributions are considered, utilized, and heard. We take special care to foster a learning environment where partners feel empowered to offer substantive contributions to the team as a whole, while upholding and maintaining the integrity of each individual institution.

CONCLUSIONS

The idea of HCAs taking an active health-promoting role for their older clients is new. In a HCA-led pilot program in a rapidly changing home care setting, no single person or entity is an expert of the whole system. We need to learn from each other to make the project a success. Co-learning occurs within and across multiple levels: state, organizational, professional, and individual levels. All of the collaborating organizations are learning from each other through actions and the exchange of knowledge and ideas. The university is learning from community and governmental organizations, and vice versa. People at leadership levels learn from front-line workers and staff, and vice versa. Research investigators learn from their staff and students, and vice versa. Older frail home care clients learn from HCAs who are paid family caregivers or agency workers, and vice versa.

Co-learning has been the core of individual and organizational development and continuous quality improvement (Argyris & Schön, 1978; Berwick, 1989; Freire, 1970; Ishikawa, 1985; Revans, 1982; Wuchty, Jones, & Uzzi, 2007). Continuous quality improvement in home care and, more generally health care and service industries, is only possible if all the parties continue to learn from each other. Those who are closest to the action, like HCAs, know

“what is going on” best. If individuals or organizations are to continue to produce better outcomes in education, research, and practice, it is essential that front-line people feel empowered and that leaders learn from front-line people.

An externally funded research project is short-lived. How can we sustain co-learning to promote linkages among education, research and practice in gerontology and geriatrics? We propose “Teaching Home Care.” Modeling after the Robert Wood Johnson Foundation's Teaching Nursing Home Demonstration Program, Harrington proposed a national Teaching Home Care demonstration program (Harrington, 1991). Her proposal centered on collaboration between home care programs and schools of nursing. Our vision of “Teaching Home Care” is more inclusive, involving not only professionals and academics in nursing and other medical fields, but also individuals and organizations in non-medical fields (including HCAs, family caregivers, and older adults themselves). Although limited in scope and time, our pilot project provides elements of “Teaching Home Care.” With more formal organizational structures and stable resources, “Teaching Home Care” programs could provide ongoing learning opportunities for educators, researchers, and students, and allow home care providers to address ongoing and emerging challenges and continuously improve the quality of care for older adults and their caregivers in their most important life environment, the home.

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Figure 1.
Conceptual Framework of Co-Learning in "Promoting Seniors' Health with Home Care Aides"