ESSHB 2284
Long Term Care Worker Training Workgroup
Meeting Notes

Date:	August 29, 2007
Location:	John L. O'Brien Building Meeting Room B Olympia, Washington

Workgroup Attendees

Attendees:	Representative Dawn Morrell – Co-Chair, Rick Hall – Co-Chair – Executive Director HCQA, Cynthia Smith – Consultant - Trienen Associates & North Sound Consulting, Ingrid McDonald – Paraprofessional Healthcare Institute, Patty Weaver – Eagle Healthcare, Inc., Randy Hartman – Addus Healthcare, Peter Nazzal – Catholic Community Services, Craig Frederickson – The Frederickson Home, Charissa Raynor – SEIU Healthcare 775NW, Elizabeth Smith - L&I Apprenticeship, Hilke Faber – Resident Councils of Washington, Donna Patrick – DD Council, Kathy Leitch – Aging & Disability Services Administration, Jonathan Seib – Governor's Executive Policy Office within OFM, Eleni Papadakis – Workforce Training & Education Coordination Board, Louise Ryan – Washington Long Term Care Ombudsman, Staff: Marta Acedo – Aging & Disability Services Administration, Jane Beyer – Senior Council Democratic Caucus, Annie Johnson – Assistant to Representative Dawn Morrell, Denise Gubbe Administrative Assistant for , Long Term Care Workgroup, Virginia Brooks – Treinen Associates, John Wissler – Treinen Associates.
Invitees Not in Attendance:	
Public Attendees:	Aaron Mountain, Janet Rhode - , Leslie Emerick, Laurita Paulsen, David Maltman, Michael Johnson, Nancy Dapper, Jay Crosby, Barbara Hanneman, Doris Barret, Pat Ward, Alice Curtis, Julie Peterson, Eric Mandt, Joyce Stockwell, Vickie McNealley, Sylvia Feurstenberg, Mary Margaret Cornish, Dan Murphy, Martha Johnson, Nancine Hawkins, Gary Weeks, Kendra Pixler, Judith Personcet, Rhonda Jacobson, Ron Ralph, Michael Ralph, Madeline Thompson, Sandy Kerrigan, Amy Paulsen, Julie Ferguson
Agenda Topic:	

Minutes

1. Welcome a. Housekeeping b. Minute Approval c. Revision Review 2. Agenda Review	a. Cynthia reminded everyone to talk into microphones for accurate minutes. b. It approval of minutes deferred to September 12 meeting. c. Cynthia briefed the group on the Ground Rules and Preamble. One new ground rule has been added; that we will add the stakeholders input and information into the meetings. Donna Patrick brought up the issue of "Do no harm" to increase the workforce as opposed to things that would decrease the workforce.

	Cynthia confirmed that had been put into the Preamble. Ground Rules - Ground Rules were approved. Preamble – Added two new terms. #5 and #8. Incorporated "do no harm" into #8. Donna doesn't feel that it should be put there. Cynthia asked Donna to provide alternative. #5 – Got to diversity and understanding relationships around cultures and health and not creating a negative impact on disparity. #8 – Preparing workers for multiple settings and include safety and economic security. Preamble is a working draft – Will update as necessary. 2. Cynthia reviewed Agenda
3. Current Training Requirements Deliverable #2	"The workgroup accepted deliverable #2 as presented with minor modifications to add clarity.
4. Current Training Requirements – Marta Acedo, Chief, ADSA	Marta gave presentation on current Training Requirements. Please refer to web site for presentation. The Workgroup thanked Marta for the presentation. Marta will follow-up with providing additional information requested on slide #20 as to "Who Pays" Hours requested on slide 20 are listed on slides 23-25.
5. Public Comments On Presented Topics	Michael Johnson – DOH – If intent is to apply to all workers--some sort of centralized approach like the North Carolina model may address this Kathy Leitch - Medicaid – in AFH and BH, they apply to both public and private. More expansive than what you're saying. Michael Johnson – Not a real simple situation is my point. Aaron Mountain – Own two AFHs and two BHs. Our needs are different. Aaron Mountain – I need to qualify, and since I have been educated, I don't have the same issues….Eg. The Hoyer lift –training is more effective if you are trained by doing it in the setting than by a book. Dawn Morrell – Need to train the client. The client generally knows what they need more than anyone. Craig Frederickson – Look at what's basic and then see what we need as individual agencies to remain flexible to accommodate our client's needs.

Ron Ralph – Concur with Craig. DDD is unique in our training needs…important to allow provider to best help the client in their setting. OTJ training is the best. RFOC portable to their setting.

Sylvia Fuerstenburg – SLStart provides tailored life plans matching right person to right PC plan, including the person's preferences. Agree that OTJ is best training.

Most workers feel that they get adequate training and have ample training. The problem for most workers is not the training. It's the lack of money.

Janet Rhode – Need clarification of number of Adult Family Home workers.

Randy Hartman – Agreed – with the need to clarify numbers.

Cynthia Smith – We'll look into it.

Aaron Mountain – Could we source data?

Julie Ferguson – Reiterate – Private duty companies –concerned about impacts of costs for additional training.

Dawn Morrell – Question to Julie - Do you provide training prior to placing caregiver in the home?

Julie Ferguson –We train to the client's needs and under supervision.

Randy Hartman– Suggested we look at NC –levels of care approach.
Aaron Mountain Can't pigeon hole by level…state doesn't want to get into that. Concern additional costs passed onto private consumer & will become care for the privileged.

Dawn Morrell – Does every agency do it this way?

Julie Ferguson – Depends on the agency licensure. Washington state is one of the few states that require licensures of agencies.

Dawn Morrell – Have to wear my hat that protects consumers here. If you write a check – consumer protection piece.

Patty Weaver – Nurses have requirements. There is still individual care requirements individualized for each specific person. We need to differentiate the skill set of the caregiver and the one they're providing care for, because they are two separate things.

Michael Johnson - We have good home care rules that protect the public.

	There is no minimum training requirement.
6. Care Deficiencies – Deliverable #3	Will be covered at the next meeting—the presentation is on theweb site.
7. Deficiencies from a Regulatory and Oversight Perspective – Joyce Stockwell, ADSA, RSC	Joyce Stockwell reviewed top reportable citations in boarding homes and adult family homes and nursing homes. There is no data that shows that problems are due to lack of training. Janet Rhode explained that RCS licenses nursing homes, boarding homes and adult family homes. We also certify IP's and some adult family homes. The provider is held accountable.. We use information based on what happens. Not the cause of why it did/didn't happen. Cynthia Smith – Noted difficulty in finding empirical data that links anything from what we currently track to training issues. One option is to determine if training has been suggested in the Plan of Correction to a Statement of Deficiency. We are looking into this option and will and share our findings on September 26. Louise Ryan – With the ombudsman program –We're looking at what is the resident telling us is the problem vs. failed deficiency.. We have a complaint tracking system that might relate to problems with caregiver training. Louise distributed a handout with this information to the Workgroup. Cynthia Smith – This information will be made available on the web site under today's meeting. Louise Ryan – common complaint is staff talking to resident with no respect. Hilke Faber – We also have to look at staffing, numbers of staff. Keep in mind that the best training does not necessarily yield the best outcome when you don't have some other ingredients in place to enhance that training. We need to make sure we look at the surrounding issues. Randy – Some people are not suited for this industry…. We can't blame this on training. . Marta Acedo – That is part of the reason why we have the 120 days to go through the training. To assess suitability.

8. Provider Panel – Training Needs	Sam Miller – Director of Clinical Services and owner of Care Force – Representing Home Care Association of Washington and Washington Private Duty Association. Our caregivers include anyone from a home maker to CNA's. The continuum of care from basic to complex medical care. Most of the caregivers in Washington State are CNA's with federal standards. There are no requirements in training for home care aids in Washington State. Private duty is paid for out of pockets of private citizens. We require Fundamentals of Care giving and nurse delegation. Fundamentals of Care training has been an excellent entry point we build on it and add CPR. Increased training requirements will reduce the number of home care workers and add to the shortage, creating a barrier. Many will go out of business and will end up increasing the cost to the client. Opportunity to increase career is there for those that want to pursue it…Don't create an artificial ladder why they may not be needed. Mary Margaret Cornish – Executive Director for Community Living – People with disabilities are living longer, increasing demand for care. We are not a medical model. Our required training comes up to 140 hours. Our main training need is how to deal with challenging behaviors. We need access to experts that will come to us and help us with autism or mental health in our settings. Brian Dahl – Background in Advocacy and the Disability Rights Movement, also provides independent provider services. The amount of training that I have received has been inadequate at best. Training on respecting people is needed. JoAnne O'Neill – ARC of King County - Parent Provider Council – Parent of two adult children with developmental disabilities. 67% live with their families. Fundamentals of Care giving are not appropriate for parents. Our concerns are the costs and the impacts will force the in-home option back into institutional care option. This is of great concern to us. Submitted a Position Statement paper for workgroup's review. Contact Sue Elliott at the ARC of Washington For more information. Vickie McNealley – Director of Assisted Living for Washington Health Care Association – WHCA represents Boarding Homes for profit. Cost concerns–70% of BH private pay. Competency – Comparison of hours is difficult-- it's the competencies that are necessary. Outcome based - Our training is outcome based with student demonstration of competencies. FOC is a great start; we add Post mortem care not in the basic training. Our model is based on OTJ model with Peer mentoring. Access - 328/450 to own training. We have rural access via computers. . In conclusion – we feel that this is not relevant. One size training doesn't fit all. We need core competencies and we'll build on that. Please keep in

mind we want basic!

Julie Peterson – Washington Association of Housing and Services for the Aging – BH acuity level based. Training should be based on client's needs and be the responsibility of the provider. Premise is that the system is broken. Why would we require HC workers to become CNAs or NACs if they don't need to?

- Care giving needs at different settings are not equal. – Specifically, there are statutes that say who, what, when, where.
- Many boarding homes often solely employ NAC's. Data should be able to support that.
- Is it presumed that more hours of training = more cases?

Aaron Mountain – President, WA Residential Care Council. Washington has more than 2500 adult family homes. One size fits all doesn't work for the AFH residential setting and results in unnecessary training, skills and costs. Our training can include 320 hours of experience, 48 hours of business administration and how to prepare a PC plan, GED minimum, and 10 hours CE annually. It's about client care. WA developed a wonderful community based setting over the last 20 years to allow consumer choice. We've developed this so we don't have to put our loved ones in institutions. With this choice of adult family homes and residential care, comes individualized educations and training.

WSRCC and the adult family homes has passed a Bill relative to a voluntary certified AFH and Hospice Manager. Classes are available at the school of nursing at the University of Washington. It is a geriatrics specialist. It is education specifically for the types of populations we've been talking about. Also available is the Resident manager Program at Edmonds Community College, it's successful and available at UW and statewide online.

I believe that it's not the state's responsibility to do individual/specialty care training…they do baseline minimum qualifications.

Randy Hartman – I agree we need to be specialized to the need. Does a degree show you how to do your job? It's once you're in a job that you get your training. What could be a good base line?

Charissa Raynor – Vickie's point – we all agree that home care worker is caring for someone with individual needs.

Patty Weaver – Question: Are there items that go above and beyond that?

Vickie McNealley – If we have a specific resident that needs more training I would specify it.

9. Public Comments on Presented Materials	Mary Margaret – Where is the accountability to the supervision on the individual IP program? More information on the CARE tool. Jane Beyer - AAA's have case managers who have clients assigned to them to make sure the provider is adhering to the clients care. Marta Acedo – Will get information on IP's, how they are audited and tracked. Dee Dee Garmin – Parent of a child with developmental disabilities. Her daughter has three providers – one is a college student – one is single mom and one who is a CNA and didn't like working in the profession, but likes working with her daughter one on one. This is a people business – Serving people and what they want and need. Showed her manual – her daughter is non verbal. Dee Dee explained that no one trained her to make the manual, but it takes a team of people to care for her daughter. You couldn't learn this in a training class. Each individual has specific needs. Dee Dee recommends that the Workgroup really looks at the ramifications that the union's current proposal will have on the people who are dependent on the care system to assist them in keeping choices and independence about their care.
10. Next Steps and Closing	Action items: Cynthia: • Update number of hours and who pays on slide number 20. • Follow up on the pie chart around the 14%. • Population of consumers to be laid out better. Have some information to put around the slide to determine the actual numbers. To lay out the whole population. There's a variety of places people put numbers and we may end up just putting a range. • Survey limitation issues that we want to get documented. Marta & Kathy: • Issue of CARE assessment tool –"provide project brief and fact sheet for workgroup." • Find community trainers who are nurses. • IP - MPC Accountability measures – How are they tracked and audited to ensure they are doing their job? Ingrid and Charissa: • Lay out more around the articulation details and what that might mean in other states.

	Donna • Write a draft on another principle.
11. Pros and Deltas	Deltas – • Need to start on time, not over schedule. • Craig – detail what were talking on – make restrictions on what is addressed. • Donna – Need to be more realistic with time.
12. Amendments	Sam Miller requested the following amendments be made to her verbiage. 1. Training needs in home care agencies licensed by the department of health are met through supervision and are individualized to specific clients. In home care agencies, there is the feedback loop of caregiver and consumer to the supervisor with the ability of the supervisor to train to the home care needs. Supervision and agency screening in home care is the key to good care. This provides for on the job training specific to the client needs. 2. The term basic was not in my verbiage, I pointed out that many caregivers are companion only and are not addressing medical needs. The majority of private duty agencies do non-medical care and many do no personal care. 3. I also addressed the Medicare home health agencies are beholden to federal standards for both entry training as well as ongoing training, This level of entry is 75 hours with part of that in clinical settings. 4. I also described the difficulty in doing on site mentoring programs in private pay home care and clients would not be willing to have two caregivers in their home and would definitely not be willing to pay for a second caregiver in their home. Home care does not lend itself to side by side training in a setting where both caregivers are being paid to do so. Most clients do not like the intrusion of training in their own homes.