

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

Date:	October 30, 2007
Location:	John L. O'Brien Building, Hearing Room B

Workgroup Attendees

Attendees:	<p>Rick Hall – Co-Chair – Executive Director HCQA, Cynthia Smith – Consultant - Treinen Associates, Hilke Faber – Resident Councils of Washington, Craig Frederickson – The Frederickson Home, Charissa Raynor – SEIU Healthcare 775NW, Nancine Hawkins – Addus Healthcare, Donna Patrick – DD Council, Kathy Leitch – Aging & Disability Services Administration, Jonathan Seib – Governors Executive Policy Office within OFM, Eleni Papadakis – Workforce Training & Education Coordination Board</p> <p>Staff: Marta Acedo – Aging & Disability Services Administration, Jane Beyer – Senior Council Democratic Caucus, Denise Gubbe Administrative Assistant for Long Term Care Workgroup, Virginia Brooks – Treinen Associates</p>
Invitees Not in Attendance:	<p>Representative Dawn Morrell – Co-Chair, Elizabeth Smith – L&I Apprenticeship, Patty Weaver – Eagle Healthcare, Inc., Louise Ryan – Washington Long-Term Care Ombudsman</p>
Public Attendees:	<p>Barbara Hanneman – ADSA, Jay Crosby – PRN, Susan “Sam” Miller – Careforce, Sylvia Fuerstenburg – SLStart CRSA, Melissa Johnson – ADDUS, Eric Erickson – WA Home Care Coalition, Julie Ferguson – WAPDA, Pat Ward – SBCTC, Benita Hyder – OPEIU L8, Jack Arntzen – WSRCC, Linda Gil – DSHS/DDD, Nancy Mohrman – Foss Home & Village WAHSA, Joanne O'Neill – ARC of King County, Leslie Emerick – HCAW, Nancy Dapper – Alzheimer's Association, Patricia Hunter – Alzheimer's Association, Janet Rhode – WSRCC, Yolanda Sanchez-Lovato – ADSA, Ninfa Quiroz – Sea Mar, Ferguson Adesoye – Amicable Health Care, Cecil Cromwell – Merrill Gardens, Kathy Medford – SE WA ALTC</p>
Agenda Topic:	Finalize Recommendations

Minutes

<p>1. Welcome</p> <p>Housekeeping</p> <ul style="list-style-type: none"> • Review of Workgroup Purpose • Minutes Approval 9/26/07 and 10/10/07 • Stakeholder Input • Action Items Follow up <p>Agenda Review</p>	<p>Rick opened the meeting, gave apologies from Representative Morrell for her absence and commenced introductions.</p> <p>Cynthia Smith reviewed the statute: Section 8D Line 26 – To reiterate the scope and charge of the workgroup. Purpose is to provide broad recommendations at a high level vs. detailed implementations and not an exhaustive list in terms of curriculum content, etc.</p> <p>Minutes were presented and approved for October 18, 2007.</p> <p>Cynthia Smith reviewed the workgroup's packet of materials including Basic Training Components and the updated version of the Decision Making Matrix. All materials can be found on the LTC Workgroup web site at www.governor.wa.gov/lctcf/workgroup.htm</p>
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ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

<p>2. Workgroup Deliberations on Recommendations: Core Curriculum (continued)</p>	<p>Cynthia Smith began the deliberations with review of the Initial Selection – Basic Training Components worksheet compiled from last meeting; starting with Parking Lot items.</p> <p>Ingrid McDonald is concerned how we can come up with CORE before deciding what the structure will be for specialty training.</p> <p>Cynthia Smith Assured the group that basic decisions can be made regarding competencies and appropriate settings through group discussions and notations included where needed to indicate that the individual competency can be made “subject to”, “in consideration of” or “dependent upon” a condition qualifier.</p> <p>Jane Beyer referred back to the statute – 2284, which addresses basic training, and reminded the group that advanced training is not mandatory.</p> <p>Rick Hall recapped that the discussion maintained in the previous meeting was whether or not the competencies should be setting or population specific or if it should be a CORE component, or parking lot.</p> <p>Parking lot items: #31-34 Cynthia Smith led a discussion on numbers 31 – 34 listed on the Basic Training Components worksheet.</p> <p>Craig Frederickson suggested an overview of them be included in the CORE training and a more in-depth course be included in the setting and population specific training .</p> <p>Rick Hall queried the Workgroup members and confirmed consensus on including #31-34 in CORE.</p> <p>Charissa Raynor made a suggestion that “Specialty” on the flip chart be changed to Population and Setting Specific, to avoid confusion. The Group agreed with suggestion and noted that Core + Population and Setting Specific = Basic Training Recommendations.</p> <p>Parking lot item: #35 Craig suggested #35 be excluded from CORE and moved to Population Specific. This was done with consensus of the Group.</p> <p>Parking lot item: #36-37 #36 – Medications and other treatments was one of the biggest problems with infractions in AFH's.</p> <p>Kathy Leitch: In recalling the compliance to Boarding Homes, she thought they represented a management and supervision issue, but not necessarily a training issue.</p>
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ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

Craig Frederickson reminded the group that there was no clear connection between infractions and training deficiencies.

Marta Acedo discussed content in the RFOC around medications and nurse delegation was a basic overview.

Charissa Raynor asked how does nurse delegation play into 37 – do they do more training to become a nurse that gets delegated?

Marta Acedo: Yes, but it is client specific.

Ingrid McDonald asked if anyone thought they should not be in the CORE.

Consensus was made that Numbers 36. Medication & Other Treatments and 37. Medication Assistance should be in the CORE.

Parking lot item: #38

#38 Emergency Awareness - Divided it out and talked about emergency awareness, not actually performing, but rather an awareness.

It was discussed that emergency awareness should be basic. People should know what to look for in emergencies and who and how to report.

Consensus was made that Number 38. Emergency Awareness will be in the CORE.

Parking lot item: #39 Self Care – Loss/Grief

It was discussed that empathy should be included in the section on loss and grief of the client and caregiver.

Craig Frederickson suggested that that Empathy should also be in the title.

Consensus was made that Self Care & Empathy – Loss/Grief will be in CORE.

Parking lot item #40 Identification of Consumer Needs

It was discussed that there is a distinction between identifying consumer needs and diagnosing consumer conditions and care. In the course of care, there is a role of the caregiver to report changes. There is a need for training on recording and reporting change.

It was decided that Identification of Consumer Needs should be called, Documenting and Reporting Changes.

Charissa Raynor suggested that we need to have it explicitly noted so that

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

it doesn't get missed or lost.

Craig Frederickson was concerned that different populations have different reporting requirements.

Documenting and Reporting Changes, there was consensus that it should be in CORE. There will be a caveat for "how they document" which would be population specific.

Parking lot item #41 -Common Diseases:

Ingrid McDonald requested that Common Diseases be referred to as Common Conditions.

Charissa Raynor mentioned that she hesitates to include it in CORE. As it may imply a medical model.

Kathy Leitch brought up the fact that people do not like to be referred to by what is wrong with them but more by their abilities.

Rick Hall reminded the workgroup not to focus on details of the curricula. All of that will be decided by the legislature.

Cynthia Smith asked the group to take a moment to see if there were any items left unresolved.

Ingrid McDonald believed there were two. The first, Death and Dying. The second is Sexuality.

Marta Acedo said that it is covered a little in the loss and grief in the RFOC in Modules 11 and 2. Thinks that overview is good, but can't go into details because every situation is different.

Craig Frederickson believes it is already in basic and if you go any further then it goes into setting specific.

Donna Patrick brought up the fact that Death and Dying should not be in self-care because it is about the client...our focus is the caregiver's training. Charissa Raynor agreed our focus is on the worker.

Craig Frederickson felt as if that sounded more like a medical model and doesn't believe it should be in basic. Explaining that it's not a priority for a 26 year old person who is developmentally disabled to learn about death and dying and the aging process. Cautious about identifying needs and assessments...that's not what the caregiver is paid to do.

Consensus was made that Death and dying will be taken out of CORE, but

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

	<p>will be included in an overview within loss and grief.</p> <p>Sexuality</p> <p>Marta Acedo brought to attention that sexuality needs to be handled in a different way. Values create many issues within a lot of training. However, if we develop it, it needs to be handled with sensitivity.</p> <p>Peter noted that the importance is in respecting the dignity of clients.</p> <p>Consensus was made that it should be acknowledged in CORE and detailed in population and setting specific.</p> <p>Charissa Raynor asked what was in the RFOC now in regards to sexuality.</p> <p>Marta Acedo answered the RFOC doesn't have anything on sexuality but does have a section on professional boundaries – e.g. identifying when you're getting too close.</p> <p>Sexuality was further discussed and the consensus was made that sexuality will be put in the permanent parking lot.</p> <p>Donna Patrick suggested the workgroup consider Isolation, loneliness and emotional needs. Such as finding community resources or helping people to connect with groups.</p> <p>Consensus was made that Resources are made available for both the caregiver and the client at time of CARE assessment. The suggestion of resources and dealing with isolation will be put in permanent parking lot as no consensus was made on this.</p>
<p>3. Workgroup Deliberations on Recommendations: Curriculum, Methodologies & Hours</p>	<p>Sample Learning Methodologies were distributed and explained by Cynthia Smith.</p> <p>Ingrid McDonald requested more time for CORE curricula discussion. Believes it will be helpful for the group if they see a comparison. Requested Marta's group do a comparative analysis of the worksheet and the RFOC current training.</p> <p>Marta Acedo volunteered to review, to ensure nothing was missed. Will provide by next meeting.</p> <p>Back to Methodologies.</p> <p>Cynthia Smith requested that the workgroup look and suggest which methodologies could be put forth in the content. Cynthia reviewed the list of Learning Methodologies and noted that the adult learning specific list came from Ingrid's presentation.</p>

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

Donna Patrick suggested that “Attestation” be added to the methodologies, but reconsidered and asked that it be saved to the Certification Criteria discussion.

Peter Nazzal requested supervisors be added to mentoring. This is what the assigned supervisor does currently in AFH.

Marta Acedo talked about the RFOC having a specific section they could hire a professional to come and train on that specific topic.

Eleni Papadakis believes it’s important that every training have a mix of book and experiential learning. She queried as to whether there is a requirement that determines ratio of experiential learning to classroom in the current RFOC? For example MA had 40% ratio for experiential learning.

Marta Acedo: Yes, through the instructor/facilitator guide. We’ve outlined appropriate time allocations for how to utilize various learning methodologies.

Jonathan Seib: It’s useful to note that quality matters regardless of methodology. We need to measure quality of competency and link training to outcomes in such a way to determine if the competency was acquired.

Hilke Faber noted that we haven’t talked about evaluation. Perhaps after each section there could be one?

Ingrid McDonald believes we should simply state that an adult training methodology should be used and then define it. Asked whether #5,#6,#8 are population specific or continuing education?

Charissa Raynor agrees with Eleni that we emphasize the need for both classroom and experiential. But that 5 – Client Health Professional Training, 6 – On-the-job Training, and 8 – Skills Development Classes are difficult to keep in CORE. How do we structure so it ties back to competencies?

Donna Patrick suggests leaving 5,6, and 8 in for options. They do not have to use them, they are only options. Would like to maintain flexibility by keeping that in CORE.

Craig Frederickson reminded the workgroup that these are just possible tools and we do not have to use all the tools.

Charissa Raynor thought we could perhaps have a broader recommendation statement through a balance of methodologies.

Cynthia Smith agreed there needs to be flexibility and different resources to

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

choose from.

Jonathan Seib: The bill talks about appropriate number of training hours and we should bear in mind whether any of the methodologies listed result in improved quality of care in the hours of training determined.

Rick Hall suggested that if we have an openness toward methodologies we can better determine to hours to accomplish the training content and achieve consensus.

Ingrid McDonald doesn't believe mentoring should be in methodologies.

Marta Acedo: Mentoring already exists in BH and AFH.

Rick Hall, Charissa Raynor and Kathy Leitch see mentoring as a way to fulfill the commitment in the training program.

Ingrid McDonald asks that mentoring be left on the table for discussion.

Eleni Papadakis brought up job shadowing.

Eleni Papadakis referred to #8 doesn't like Skills Development Classes title Requested new title.

Craig Frederickson agreed that the title needed to be changed.

Jonathan Seib would like clarification as to what criteria will be accepted as prerequisite to certification & testing? We're saying, have you done these things to prepare you for the exam. In the end you need to pass the exam. If there is a certification process will they pass? What of these will prepare them to pass the exam?

Marta Acedo added that it's more than that, it's the process toward certification. There's a continuum of courses and clinical required prior to testing. #8 is too labor intensive and who will accept and pay for the evaluation of it?

Charissa Raynor: The challenge test can address or provide an alternative to the labor intensive validation of #8.

The group added job shadowing to the list of training methodologies. (Challenge testing and attestation were determined to be evaluation instruments and not learning methodologies and will be discussed at that time.)

Rick Hall queried the group and declared consensus on learning methodologies.

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

HOURS:

Make recommendation to the appropriate number of basic training hours.

Craig Frederickson wants to keep ADSA's position paper in mind.

Cynthia Smith reminded that the ADSA position paper is focused on implementation and makes assumptions for training hours to be used. If the Workgroup wants to adopt those assumptions, it is certainly able to do so. However, this is an opportunity to be thoughtful about the hours actually needed and necessary to carry out training..

Hilke Faber doesn't believe 28 hours is enough.

Kathy Leitch explained that the problem is there is no magic number. Has a really hard time knowing why she would recommend more hours than she would be for nursing assistant which is 35 hours.

Ingrid McDonald noted that it's reasonable to compare and consider the same as the federal requirement of 75 hours in nursing homes and CNAs. Washington is currently at 85 for CNAs. Concerned about using 35 as a bench mark.

Eleni Papadakis see's flipping it to 50 class and 35 experiential.

Craig Frederickson cautioned assuming that the majority of workers are career bound. That is not the case. If additional hours are mandated, it will restrict the ability to attract workers. He believes that we need to keep CORE as the minimum and additional training as optional.

Cynthia Smith and Rick Hall reminded that we can use the different methodologies such as on the job training to get there. Rick suggested that workers can meet requirements without additional training hours through OTJ, peer mentoring, job shadowing, etc.

Hilke Faber would like to focus on the hours and how we get the content across. We need supervision.

Marta Acedo reminded the group that family member caregivers are supervised by family.

Peter Nazzal noted that the largest group is family IP's the second are agency workers, and the third group are people who are not related.

Ingrid McDonald asked how the state came up with 28 hours?

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

Marta Acedo answered that the legislature and budget dictated the hours that were available for training.

Jonathan Seib wants to assure that he's comfortable standing behind a particular number. He does think there would be value in additional hours but not convinced we have maxed out on what would be beneficial. It would be valuable to note the trade offs. Additional hours need to be weighed against access to costs. In the end there are real restrictions on what is realistic.

Hilke Faber suggested 85 hours and going with Eleni's suggestion of switching the 35 and 50.

Donna Patrick voiced concern that we will not be able to get people if the hours are so high, this will impact the interim workers as well.

Eleni – suggests there are some really quality and competent people who can challenge out of the additional training. Turnover and recruitment issues were discussed.

Kathy Leitch believes the turn over issue isn't the training but the wages.

Cynthia Smith asked then should the focus be more on-the-job training? Should we increase to %60? Which methodologies should we use?

Charissa Raynor asked how do you structure on the job training to show competency?

Eleni Papadakis explained that experiential methods are generally more expensive. We want to give people flexibility.

Kathy Leitch brought up the idea of parents being paid providers and doesn't want that population to be discouraged.

Craig Frederickson: I don't hire employees -- I am looking for quality people to provide respite care, typically less than 10 hours a week.

Ingrid McDonald explained the debate is fundamentally, do you believe training is a workforce development strategy, or a barrier to entry?

Rick Hall doesn't believe it's black and white as Ingrid stated. Consumers had an issue that if we set the bar too high it could create a barrier to get the care that they needed.

Hilke Faber doesn't believe we will lose current workforce because they are grandfathered in.

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

Charissa Raynor stated for the record that SEIU 775 passed resolution for higher number of hours for more meaningful training.

Ingrid McDonald asked that the workgroup be mindful that the original 28 hours was a budget decision not necessarily what would be best. We need to be aware of budget constraints, but really look at what would be best. The critique was not about content issues, but practice time.

Nancine Hawkins questioned how the issue of cost figures into our decision.

Kathy Leitch: Every hour is a million dollars. Firmly believes that throwing all the relatives into this is not a good use of our resources or funds.

Cynthia Smith recapped – The group currently has agreed to a range of 28-120 hours

Rick distributed a letter to the Workgroup that was sent to Representative Steve Conway from the Board of Directors of the Home Care Quality Authority in February 2007. HCQA had concerns about the 85 hours. Fiscally we want to be responsible and look to the future to the long term care.

Hilke Faber argued that our responsibility is to come up with the best quality services necessary.

Jonathan Seib said, not necessarily. The bill says the appropriate number of hours. We can acknowledge that if cost is not an issue then this would be the recommendation.

Hilke Faber: We have a budget; we need to decide what's important and what's not.

Eleni Papadakis asked that we don't just look at the long term care upfront training costs but also consider the benefits of training long term.

Jonathan Seib explained that the budget is only for the next 2 years. Jonathan queried, How do we make the transition from focus on today to focus on long term workforce development? It's not black and white. We do have to worry what folks will do to find respite care in the near future.

Craig Frederickson: I am looking long term and I don't want to change dramatically. Workforce development philosophically doesn't fit in with my need for respite care.

Donna Patrick explained that the nature of the current grandfathered in workers doesn't help when this person leaves and you need someone else immediately.

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

	<p>Marta Acedo referred back to the idea of a challenge test. There are a number of people who do not speak English. ADSA has tracked 18 different languages. When we talk about a challenge test it is going to need to be able to be accessed in their language. Equal access will be critical.</p> <p>Cynthia Smith set the record that the range for hours is undecided and currently stands at between 28 and 120 hours as determined by the group. Discussion will pick up where we left off on Nov 8.</p>
<p>4. Public Comments on Presented Material</p>	<p>Janet Rhode: Her experience has been great retention of staff. One reason is resident to staff ratio is 1-3. Her turnover rate is probably 1-2% a year. Worries about English as a second language. Don't want it to be too simple for them to pass a competency test. If we ignore the budget it's going to waste the number of hours everyone has put into this. Warns that 85 hours is unrealistic.</p> <p>Leslie Emerick: Concerns about barriers from this amount of training. Support what Peter mentioned. Agencies provide great support and specialized training to their home health aides and have low complaint rate.</p> <p>Julie Ferguson for private duty home health and home care agencies: Both groups of Caregivers who are certified and have gone through the training and testing and doesn't make a difference in quality of care. Some similarities. They all come in anxious. They are all afraid of the test. These are people that love with their hands and their hearts. To put an obstacle in their way will cause them to not work. They want to work for an employer...don't turn them away.</p> <p>Sam Miller – Private duty home care: When the economy goes to pieces we have people that come back, some people just need a break from the intensity. In five years she believes we will have the same type of workforce as we do now. Mentoring is different than peer mentoring. Like Peter said it's more a role of supervision. Be careful that were not talking about peer mentoring please distinguish the two. Competency happens in the midst of several situations. Respect happens in an employment situation not in the classroom. This is a group that has great anxiety over testing. Define how that testing happens. Even the most capable caregivers will be very nervous.</p> <p>Joanne O'Neill – ARC of King County and Parent Providers – Parent Providers give medications to their sons or daughters. Other two issues around supervision. The DD assessment triggers supervision issues and also seems to be a good time to identify resources specific to the needs of the person. Treatment around the dying issue that has also changed. We are now facing situations where the children are dying first. As far as mentoring to the parent providers. Not sure how that would work out? Very concerned about increased training and testing and how that will work out. Concerned that being so prescriptive to training that you would eliminate the flexibility of consumer choice.</p>

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

	<p>Rick Hall wanted Joanne to know that they did include it.</p> <p>Nancy Mohrman: Echo comments on the anxiety that testing creates. When you're talking about the brief overview. See the core training as being relevant. In the boarding home world they believe the training they provide goes beyond RFOC and works very well. That model works very well and is affective for each provider. There is a great deal of flexibility. A very high acuity level. Can not include all that in a core training. Some you will just have to trust that the providers will provide that to their workers. Be careful not to confuse training issues with performing issues. Some people are just in the wrong field. Give the training but leave it up the supervisors to decide when it no longer is a training issue.</p> <p>Ferguson Adesoye has been doing this for the last 10 years. Training very hard to get people to get the training they need now. Each client is unique and no amount of training can help that. 85 hours training is too much. The training doesn't do anything, it's performance that is crucial and the person has to love the job. Because it's a very difficult job. If I go for more training, I expect more money. Additional training will be a big obstacle for many. Suggests we spend money on higher wages not more training to solve turnover and recruitment problems.</p> <p>Nancy Dapper recommended to the Workgroup that they come to some agreements about the basic skills. Talking about building a workforce for the future, then consider that more elderly will be living alone. If I have dementia I'm not going to be able to train a replacement. How can you think 85 hours is not enough? On the subject of the budget. The budget is about political priorities and she believes it's time for legislature to fund the demand.</p> <p>Ninfa Quiroz - SeaMar Health Clinic: Training is important because of the ethnic diversity, for example: learning how to cook for someone from another country. Somebody that comes from Africa or Asia is very challenged to sometimes know how to make a sandwich for the Caucasian client.</p> <p>Kathy Medford – SEWALTC: Indeed need better cooks. Suggest that after reading the ADSA proposal, mentoring that could happen in the first 120 days. The one thing I do want to say is that the training needs to be grounded in reality and hands on. Paying for substitute. The ADSA proposal looked do-able.</p>
<p>5. Next Steps & Closing</p> <ul style="list-style-type: none"> • Confirm Assignments, Due Dates and Action Items • Next Meeting • Next Steps • Plus/Delta 	<p>Donna Patrick brought to attention that the IP's who provide personal care for children only have 4 hours of safety training. Is this a gap?</p> <p>Cynthia Smith agreed and explained that although we didn't go over it in depth, there are rather large gaps for may of the LTC settings across the matrix. It was put together as a background for the Workgroup to use to note where the impacts will occur when considering recommendations.</p>

ESSHB 2284

Long Term Care Worker Training Workgroup

Meeting Notes

Next meeting will be in hearing room A. It will be our final meeting and the Final Report will begin to be drafted.

Craig Frederickson would like to make sure we look at the different populations as we make recommendations.

Cynthia Smith reminded everyone this is their opportunity to speak up if they have a different opinion regarding any of the issues or recommendations discussed.

Next Steps: 10:15 am to 12 noon is allotted to discussion of recommended training hours and the remainder of the day will be dedicated to determining curriculum criteria.
