

# ESSHB 2284

## Long Term Care Worker Training Workgroup

### Meeting Notes

<b>Date:</b>	November 8, 2007
<b>Location:</b>	John L. O'Brien Building, Hearing Room A

### Workgroup Attendees

<b>Attendees:</b>	<p>Representative Dawn Morrell – Co-Chair, 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, Patty Weaver – Eagle Healthcare, Inc., Donna Patrick – DD Council, Kathy Leitch – Aging &amp; Disability Services Administration, Jonathan Seib – Governors Executive Policy Office within OFM, Louise Ryan – Washington Long-Term Care Ombudsman, Peter Nazzal – Catholic Community Services of Western Washington; Alice Curtis/Jody Robbins – L&amp;I (for Elizabeth Smith)</p> <p>Staff: Marta Acedo – Aging &amp; Disability Services Administration, Jane Beyer – Senior Council Democratic Caucus, Denise Gubbe Administrative Assistant for Long Term Care Workgroup, Virginia Brooks – Treinen Associates</p>
<b>Invitees Not in Attendance:</b>	Eleni Papadakis – Workforce Training & Education Coordination Board
<b>Public Attendees:</b>	<p>Barbara Hanneman – ADSA, Grace Kiboneka – ADSA, Jay Crosby – PRN, Susan “Sam” Miller – Careforce, Sylvia Fuerstenburg – SLStart CRSA, Melissa Johnson – ADDUS, Julie Ferguson – WAPDA, Pat Ward – SBCTC, Linda Gil – ADSA, Marcia Ives – With a Little Help, Nancy Mohrman – Foss Home &amp; Village/WAHSAs, Joanne O'Neill – The Arc of King County/Parent Coalition, Leslie Emerick – WSH PCO HCAW, Deb Murphy – WAHSA, Bonnie Blackley – WAHSA, Patricia Hunter – Alzheimer's Association, Margaux Gillespie – Alzheimer's Association, Sandy Kerrigan – ADSA, Amy Ai – SCOA, Cecil Cromwell – Merrill Gardens, Mary Cornish – CRSA/DDD, Gary Weeks – WHCA, Anita Koyier-Mwamba – DRW, Nancy Dapper – Alzheimer's Association</p>
<b>Agenda Topic:</b>	Final Recommendations

### Minutes

<p><b>1. Welcome</b></p> <p>Housekeeping</p> <ul style="list-style-type: none"> <li>• Review of Workgroup Purpose</li> <li>• Minutes Approval 10/30/07</li> <li>• Agenda Review</li> <li>• Recap recommendations to</li> </ul>	<p>Cynthia Smith briefed the group on presented documents which can all be found on the LTC Workgroup website.  <a href="http://www.governor.wa.gov/lctcf/workgroup.htm">www.governor.wa.gov/lctcf/workgroup.htm</a></p> <p>Cynthia Smith asked for approval on minutes dated 10/30/2007. Alice Curtis made a correction. She was present in the last meeting as delegate for Liz Smith. Denise Gubbe will make changes and post.</p> <p>Minutes were approved.</p>
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date	<p>Peter asked if this document was final [referencing the Basic Training Competencies document] and that positioning should be added to the CORE. Cynthia explained the process for submitting comments and oppositions to the recommendations as a comment to the final report</p>
<p><b>2. Workgroup Deliberations on Recommendations: Hours (continued)</b></p>	<p><b>HOURS</b></p> <p>Cynthia Smith: reviewed the hours discussed at the previous meeting and noted that the discussion ended with a range of 28 to 120 hours.</p> <p>Donna Patrick asked what was the time frame for completing training?</p> <p>Cynthia Smith: Currently it is 120 days.</p> <p>Donna Patrick asked Ingrid if there was research regarding best timing for training.</p> <p>Ingrid McDonald: Unable to quote research right now, but usually the earlier the better. Noted that it's highly unusual for training to be post-employment.</p> <p>Rick Hall: Reminded group of the Medicaid match formula which is valid for training that takes place within 120 hours of hire and what is reasonable to accommodate. If we add hours, do we consider extending or changing the timing?</p> <p>Rep Dawn Morrell asked Marta if anything new has been added to RFOC that would support more hours similar to the apprenticeship requirements over a longer period of time</p> <p>Marta Acedo answered, not really. She noted that some training topics from the RFOC were left out of the recommended Basic Training Competencies, as noted by Peter on page #7 of the worksheet (Positioning). However, she suggested that they could be added as the work goes forward.</p> <p>Donna Patrick believes that the number of hours chosen should be logically connected to the timing of delivery of training, and referenced continuing education after that time.</p> <p>Rick Hall: Clarified that Core plus Population/Setting Specific, together represent Basic Training. Posed questions to group: Should we increase time frame to accommodate more hours? Or, could we break off CORE from Population Specific to be delivered to workers at a different time? Addressed Kathy specifically: Would you contemplate a longer timing to complete training?</p> <p>Kathy Leitch explained that we have an issue in the preamble as far as consumer choice. We have complaints now that it's very difficult to get these workers to take the training. It's not so much the availability of it, it's getting</p>

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them to take it within 120 days. Fear is if you increase the number of hours they need to take in 120 days that could cause a bigger problem. According to law these people should be terminated if the training is not completed within the 120 day time frame. So essentially, it could cause a workforce problem. Charissa Raynor: believes we should make sure we have a bench mark time frame set to make sure IPs aren't going out with less training than they do now.

Louise Ryan: Concerned the training time frame is already too long.

Cynthia Smith explained that in learning methodologies some ways around this particular issue were job shadowing and mentoring to allow flexibility in training.

Louise Ryan stated that she is not opposed to on the job training, but asked who would be an appropriate mentor or coach and how do we verify relevance of this flexible training.

Marta Acedo: We could use the tiered training format proposed by ADSA vs. extending 120 days. Real issue is that there's a lot of content and a perception that there is insufficient time to complete.

Ingrid McDonald suggested to pull out safety, role of care giver, and responding to emergencies included in orientation and require them within the first 14 days.

Craig Frederickson: We need to be very careful of violating the federal laws that are tied to the Medicaid funding. Would also like to make a correction to previous comment – There is, in house training orientation that is required by the provider of an adult family home before they work in the home.

Marta Acedo: Original statute allowed us to define hours, days, and timing. ADSA has spent a lot of time with stakeholders figuring out hours in all settings to come up with a consensus on the 120 days to complete.

Peter Nazzal/Nancine: also clarified that for Agencies with Medicaid Contracts, workers are not sent out without a minimum of 4 – 12 hours direct training – depending on the setting.

Charissa Raynor agreed with Ingrid. . The more training we can have up front the better. A lot of the turnover is in relation to not having sufficient training up front.

Craig Frederickson asked what settings she is referring to?

Ingrid McDonald explained that it's commonly known in all settings.

Peter Nazzal would like to see the evidence or data. Never seen anything that

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directly ties training to retention. Cautioned against drawing a conclusion that more training equals retention.

Cynthia Smith asked if there was consensus so that we do at least have 28 hours in 120 days.

Marta Acedo: Currently there are 34 minimum not 28.as noted in the current proposed range (additional 6 hours of safety and orientation training). Also, there are agreements with the Department of Health and the Board of Health for the food worker permit issued for Adult Family Home and the nursing commission and the seven hours of HIV Aids Training; wants to make sure this isn't lost in the content.

Kathy Leitch: There were a lot of discussions by providers during Legislative Session about how to incorporate into Fundamentals other types of requirements. That you have a food handlers permit if you work in an Adult Family Home for example. In a number of settings, workers will be expected to work with people that will require infection control procedures and HIV/AIDS training. There was a lot of work done to make sure that people didn't go to three separate trainings. That can all be undone if that's the policy decision. Just be deliberate in your intent.

Patty Weaver would like to draw attention to preamble - #8 include for as many settings as possible. Let us not limit ourselves without remembering those elements. Comment was made that we don't want to overwhelm people with too much information. Think it would seem appropriate to pull the CORE apart from the setting and population specific and consider that for the 120 days.

Ingrid McDonald suggested a second proposal that is there consensus that some subset of the CORE including orientation and safety could be completed within 14 days. Currently IP's don't have to do their safety training for 120 days and that doesn't make any sense.

Louise Ryan agrees that 14 days is good to get some basic safety training.

Kathy Leitch asked for clarification if they are now expanding safety training to the definition of all LTC workers?

Rick Hall explained that the reason the IP's were done differently is because they weren't always entitled to workers' compensation insurance. That separate safety training for IPs is a part of risk management.

Cynthia Smith: asked group if there was a consensus around moving safety, role of caregiver into 14 days or any other modules earlier in the process?

Marta Acedo agreed there are opportunities to consider moving something up in the process.

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Ingrid McDonald suggested a minimum of 6 hours be completed within 14 days.

Peter Nazzal agreed that the training needs to be moved up. He is also concerned about the availability of the training. He suggested allowing agencies; including Adult Family Homes and Boarding Homes do that training themselves.

Craig Frederickson agreed it could be incorporated into the agencies own orientation.

Marta Acedo confirmed regulations already exist to complete orientation, work setting safety, etc.

Hilke Faber supported the modular approach and pulling out what is essential to learn first. We need to consider the consumer.

Cynthia Smith asked if there was a consensus on pulling out the safety, role of caregiver, prevention modules to be done in the first 14 days all across the LTC spectrum.

Rep Dawn Morrell clarified that they would be able to do it in the setting that they are in.

Peter Nazzal explained that the reason why he made that comment is because there is certain training that can and should be done quickly and the best way to do that would be locally. Need to state that it can be done.

Hilke Faber disagreed with Peter in that our purview here is to look at the hours, content and the certification. How it gets done is for someone else to decide.

Craig Frederickson agreed with Peter because there does need to be a note that it is setting and population specific.

Cynthia Smith again asked if there was a consensus around critical modules being pulled out and done within 14 days.

Marta Acedo explained that for IP's and HCA workers. There is a system that has been developed over the last 10 or 12 years and much of that training is done "in house".

Peter Nazzal added that it is limited for Agency Home Care. We couldn't just say that we want to go to that training.

Rick Hall: Not sure we reached consensus.

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Ingrid McDonald believes the conversation is getting confusing because we're mixing what we are going to recommend with what we already have.

Cynthia Smith explained that we have two areas of consensus. One would be that we don't have less than the current training, which is 34 hours and two that we have a top of 120 hours in the range.

Charissa Raynor commented that the recommendation is to give a number for basic hours. Last meeting 3 numbers were asserted, 28, 85, to 120. Now the discussion is delving deeper into the discussion of the basic training.

Craig Frederickson questioned, what the very bare minimum is now is not the 34 hours. The parent providers are only expected to currently take 6 hours of training.

Rick Hall reminded group, we agreed we wanted relevant and flexible and across all settings. However you get the training, whatever the methodologies that we have a core across all settings and that core and population specific is basic. We have not said that we're going to put everyone in RFOC, the methodologies get us there. We made learning methodologies wide open, so that by whatever means one gets the training or competencies, they can meet the BASIC training requirements, which is CORE + Population Specific. Our discussion began with a range, where we had 28 as minimum and 120 hours as top of range. Eleni came up with the 120 hours so only one person expanded it to 120 hours.

Louise Ryan thinks we need more practice time in the basic activities of basic living. Starting with 14 on care plans to 21, and then picking up at 26 again on mobility. More classroom time and then on the job time. That's an area that we need to work more on.

Rick Hall: Good point but we're at the hour's recommendation now.

Louise Ryan believes that the ADL's alone could be 28-30 hours.

Rep. Dawn Morrell asked that the Workgroup be aware this money will come out of someone's pocket.

Charissa Raynor asked, if the range is 28 - 120 do we want to keep 28 as a floor?

Louise Ryan suggested 85 hours combination of on the job and classroom training.

Jonathan Seib believes the issue is primarily the depth of training. What we want and what exists is very similar. Each additional hour of training will be a benefit. Assuming there is sensitivity with additional hours. This document is intended to inform the decision makers. So we need to note the benefits of

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the hours and why they are worthwhile.

Ingrid McDonald presented a proposal is assuming flexible methodologies on the flip chart as follows:

	What	By When	Hours
BASIC	Orientation & Safety	14 Days	5
	CORE	120 Days	50
	Population & Setting Specific	120 Days	30
SUBTOTAL			85
OPTIONAL	Advanced	1 Year	65
TOTAL			150

Rep. Dawn Morrell commented that we ended up coming to basically, the same thing as the RFOC. She has to take this to the legislature how can she go there and recommend the same training but more hours?

Hilke Faber/Charissa agreed that comments from stakeholders indicated that more hours were needed to accommodate current training.:

Louise Ryan: It's going to cost consumers even more. Cost to the state is tooling up to the future. Gearing for the big wave of people who will need in home care.

Jonathan Seib explained that people don't disagree but the money needs to come from somewhere, so what will we cut?

Craig Frederickson: Need to make clear that when making specific recommendations. We need to clearly demonstrate a substantial need for substantial change. If we can clearly demonstrate that there will be obstacles that will create problems then that's an issue.

Ingrid McDonald would like to underscore one point. She doesn't think it's at all accurate to teach the list of competencies within 28 hours. The list looks good but there is no way you can teach that in 28 hours. Too much all crammed in.

Patty Weaver asked for clarification that 28 hours includes HIV Aids training?

Marta Acedo explained that they get credit for each competency of training.

Donna Patrick would like to state for the record that she is going to agree for a number of hours that is appropriate for **Non Parent IP's**. Not for the DD

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	<p>parent providers or DD respite workers.</p> <p>Charissa Raynor stated that we must not lose site of the larger investment value of the training that is meaningful. There is a threshold at which you would begin to lose your gains and investments. But no one here believes we have reached that threshold at 28 hours. In addition, she doesn't know that it's this group's decision or purview to balance the decisions between quality of care and access of care and the budget.. Believes that process will play out during session. There are ways that we can target training so that dollars are used for people that need the training. Called for a vote.</p> <p>Rick Hall: I'm not comfortable with a call for a vote when we agreed up front to work on a consensus basis.</p> <p>Donna Patrick suggested we have a minimum hours and additional hours tagged for certification.</p> <p>Kathy Leitch asked to make a comment in regards to Charissa mentioning the value to the worker. Kathy does not get the investment. Not just in parents but in a lot of relatives either. That is not what she see's as a professionalization of the workforce. Unless those people want to voluntarily do that. You seem to indicate that there might be an exemption there.</p> <p>Hilke Faber reiterated that all of this can in no way be done in 28 or 34 hours. Rep. Dawn Morrell would like to broach the idea of everyone having the basic hours but then the certification can come later.</p>
<p><b>3. Public Comment</b></p>	<p>Sam Miller: Noted Jay's presentation, which said RFOC is very adequate. Heard many people say today that the RFOC was a very solid course and meets a lot of needs. Heard many caregivers say that where they really learn is when they are learning to give care to the individual client. Asked group to recognize that in WA current LTC model you can't put a number hour on that as it is a competency structured to each individual client. Please don't forget that.</p> <p>Nancy Dapper: Acknowledged group's efforts to resolve issues and complexity of LTC. Concerned that the group won't come to some kind of conclusion around hours and fail the public. Urges the group to come to a decision because their (persons receiving care) families are dependent on it.</p> <p>Joanne O'Neill: Currently parent providers have 6 hours training plus the 4 hour safety training so a total of 10 hours. So the bottom number of hours is 10. Is curious how do we do pre-employment training for parents? Training is going to go so far over what is necessary for respite. This issue will be presented at the King County DD Legislative Forum. Concerned about preparing workers to work in as many possible settings as possible. Can not get away from the cost issue. Seems like an incredible waste of money for parents to have to take training. Very easy to sit around the table and have academic discussions, but her concern is what will happen to the families?</p> <p>Leslie Emerick: We have real concerns about the cost and reducing access</p>

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for caregivers. Was encouraged by the variables in the training methodologies, such as allowing the internal training to be done because that is very much what we already do. We do train people specifically to the homes. The current system is working well, the RFOC is working very well. The system is not broken and that we should invest money appropriately and we should get the biggest bang for the buck.

Julie Ferguson: Is not an IP expert but she is a private duty home care. Expert. At this time there is no requirement for us so any hour is going to be an hour more than we are required to take. Each agency already has their own training that they do on site.

Caesar Cromwell: When the original FOC came out it was in module settings that you could pull out. Would like us to consider that again. Would like us to take into consideration that there are many single moms and how hard is it going to be for them to get to training. Full time goes down to 30 hours so you need to realize that many of these people are working two jobs. They are already doing 61 hours and they do their own med tech training on top of that. If you add more on to that then the cost will be passed on to consumers. Like to see group consider ADSA's proposal. His industry requires 100+ hours currently.

Amy Ai: Her point is, in this occupation, the experience can range from a college professor to a high school graduate. So the workers will vary. When immigrants come over, those who have held very high positions in their country, because of language barrier they have to take this kind of job until they can learn more about the system, values etc. Wonder if there is a way to target an exemption for some people.

Mary Margaret Cornish: If we had all the money then she doesn't believe there would be an argument over hours, as an Executive Director of an agency that serves people with developmental disabilities, in their home and all the liability and safety issues, she finds herself feeling defensive when it comes to the number of hours but in her heart and in her head she knows what many of you are saying needs to be done out there. But it gets back to being realistic that, (and is only speaking for the DD population) the employees in King County and in Bellevue they have not for seven months been able to get one employee in the door. We're working on overtime and are very concerned about our exposure and our liability. How can you add all these requirements to people who can't even make a living wage and think there's not going to be a price to pay? Last wage increase netted 15 cents/hr due to the healthcare benefit costs. So when you increase training requirements, workers will expect more wages. I support more training, but at what cost/impact to the workforce?

Nancy Mohrman: Doesn't believe 85 hours is a basic hours of training. Agrees with Craig that that is a substantial change to what we have now. Doesn't believe there has not been any substantial based data that supports making that kind of change. As a boarding home administrator who sends out employees for the past six plus years to RFOC training, she never had an

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	<p>employee come back and tell her the training was not sufficient and has only heard feedback about how good the training was.</p> <p>Sally Croomer: Has taken the RFOC. Has been waiting for topics to come up that are not in there and none have. Brought an RCW on requirements. Orientation that covers safety - going back in own mind and found it to be sufficient. Have not heard any data on inadequacies. Has anyone gathered any hard data? Because that would be important. When she sees the 10,000 people waiting that are not receiving services, can't justify additional training without hard data. If anything is deficient, it is around supervision and oversight as indicated in the reports, but it's not a training issues. Concerned that the additional training will cut the level of service and cause harm.</p>
<p><b>4. Workgroup Deliberations on Recommendations: Training Hours (continued)</b></p>	<p>Cynthia Smith: Suggested the Challenge Tests need to be discussed more. Acknowledged that many providers do their own training. That training would be able to count towards these hours. Would like to keep those two points in mind as we move forward. We left off hours with somewhere around 28. We talked about 85 and 120. There has been a plea to come to a conclusion on hours.</p> <p>Patty Weaver suggested we narrow the range to 40 – 90 hours.</p> <p>Ingrid McDonald: When you say 28 as the bottom range. Is that for population and setting specific as well? Is the 28 hours for core only?</p> <p>Kathy Leitch: The issue is the topics and competencies currently in the RFOC shows that there are topics covered in both core and population setting specific.</p> <p>Patty Weaver thinks that's what were struggling with, is the whole number thing. Want to focus on needs of clients in whatever setting. The net is wide and we can't change that. In the spirit of compromise, I would propose narrowing the range of hours. Can we narrow the range from 45 to 90?</p> <p>Ingrid McDonald is not opposed but, do we believe there are three elements for basic?</p> <p>Rep Dawn Morrell explained that they are all intertwined so would be very hard to pull them out.</p> <p>Craig Frederickson has a concern that if we do include the population and setting specific in the CORE, it will make the base number of hours very difficult to assign. Suggested that we draw the line at CORE and then beyond that, the number can vary from setting to setting.</p> <p>Cynthia Smith confirmed the components were integrated.</p>

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Jonathan Seib is fine with 45 to 90 as a range. With each additional hour there is value and with each additional hour there is cost. Suggested we put forth in the recommendation that we accept learning methodologies as counting towards requirements and that each additional hour has a demonstrated value and relevance.

Louise Ryan would like to underline that the hours do not have to be classroom. They can be on the job training. She is concerned with how do we get the skills and make it relevant.

Jonathan Seib stated that we have the consensus on methodologies. Now we are talking about the hours.

Craig Frederickson asked, what is the process for recognizing and making it legitimate? The in-house training that occurs. It needs to be clearly defined.

Jonathan Seib indicated that the acceptance would include quality metrics.

Hilke Faber stated that this is competency-based, you can train in many different ways, and it's the outcomes that are going to be measured. Pop – setting specific. Everyone is doing a lot more training anyways so this is not asking too much. If we are looking at people who are less supervised than the people in the nursing homes, then 28 hours is not enough time. 85 hours is not unreasonable.

Charissa Raynor: We owe it to ourselves to see if we have consensus around a number. If that can't be decided then see if we can get a range. We are serious about a challenge test. We are serious about flexibility, relevance, and various methodologies but also in the quality of care. Would like by show of hands that 85 is appropriate.

Craig Frederickson commented that we are throwing numbers around. Asked Representative Morrell, is that the number that the state would be paying for? (Asked Representative Morrell, If provider doesn't fit criteria of training, it forces the caregiver to seek training elsewhere. If we agreed to 85 hours, would the State pay?)

Rep. Dawn Morrell referred the question to Kathy Leitch.

Kathy Leitch answered that we include payment for required training in the rate and we pay workers to attend training and we pay for replacement training. But we don't have anything to do with private pay agencies or their workers.

Marta Acedo added that the State also pays the tuition rate, development of curriculum, printing of curriculum, storing of curriculum, etc...

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Rick Hall: Charissa has asked that we go around the table and see what the workgroup thought of 85 hours as a requirement.

Cynthia Smith: We have a range of 45 to 90 on the table and 85 hours. Let's start with Jonathon.

Jonathan Seib has discomfort with the number on both sides. Feels that to land on a number as the correct number doesn't increase the value, but it decreases the value. It will be seen as picking an arbitrary number that isn't much better or worse than any other number. Will have hard time picking a particular number. I can support the range, but would have to abstain on vote.

Peter Nazzal: No number. I support the range.

Nancine Hawkins: No number. Yes, the range.

Charissa Raynor: Support 85 hours as a baseline to have meaningful training.

Craig Frederickson: No Number and no range.

Donna Patrick: Not able to decide on a range, but would like more hours for non-parent IP's. For non-parents the range is ok I guess.

Kathy Leitch: Did give proposal that showed some increase in classroom training and what we discussed was within this range.

Ingrid McDonald: Someone will pick a number and my guess is they will pick the lower number of the range. What if they pick 45? What people want is more specific needs on the people that they support. Doesn't believe we should recommend a range. Supports 85 hours.

Hilke Faber: 85 is what CNA's are required to do in Nursing Homes. These settings are much more complex. Eleni talked about 120 hours in the state of Massachusetts. Disturbs me because the quality of life for these people is dependent upon these people we are sending out to be trained. Strongly support the 85.

Jody Robbins: 85 hours.

Louise Ryan: supports the 85 hours. Need more practice time with relevance to the person, setting and their needs. Already have that so it's more just re-packaging.

Patty Weaver: Competency and Skills check off and challenge test to opt out. Have to agree with Jonathan, what is the magic number? Need to have more curriculum writers, recognize fiscal restraints. Supportive of the range and of the 85 hours..

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	<p>Representative Morrell: abstained from commenting.</p> <p>Rick Hall – Looks like the committee is split on the issue. Since we have no consensus and we are split in the recommendation on hours, this will be reflected in the final report.</p>
<p><b>5. Workgroup Deliberations on Recommendations: Certification Criteria</b></p>	<p>Cynthia Smith: distributed the certification criteria discussion guide</p> <p>Jane Beyer briefed the workgroup on the document. Even though document says certification on it, that word will not go through my lips. I'm going to propose a different way to think about this. We have a test, a challenge test. At that point we pay people to go into homes and provide care. For purposes of discussion – Jane suggested the word certification be changed to “credential”- LTC Worker – Level one – formalizing what current policy is. At some point if there is a consensus reached to the minimum number of hours. We would have a level one. Want to structure in such a way that a person could move up because of the structure that 2284 put into place.. Could then have LTC Level 2 . LTC Level 3, providing an opportunity to advance through the ranks.</p> <p>Cynthia Smith clarified when we discuss criteria, we're talking about background checks, age, drug screening, whether or not high school graduate, etc...</p> <p>Rep. Dawn Morrell asked how that would fit in an apprenticeship model.</p> <p>Jody Robbins: There are additional occupations under apprenticeship standards. Defining Level I and providing Continuing Education to achieve greater versatility or standing in position and counting towards 144 hours requirement for apprenticeship or advanced levels..</p> <p>Ingrid McDonald explained that someone would not achieve apprenticeship until they had a certain number of hours over our basic.</p> <p>Marta Acedo clarified, so we're not defining care needs as level one we're defining worker as level one. This doesn't interfere with the ability for someone who wants to stay at level I, is that correct?</p> <p>Several workgroup members responded: Yes</p> <p>Rep. Dawn Morrell would like use something besides Level one, suggested perhaps Step 1..</p> <p>Ingrid McDonald iterated that population and setting specific is very different, hard to make a competency? Suggested having a test that tests the CORE.</p> <p>Jonathan Seib explained that she divided step one into two parts in order to work in long term care you would have to have CORE and population and</p>

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setting specific. That would be step one.

Ingrid McDonald feels it's too much information to develop one test.

Louise Ryan agreed that to prove you are competent you do need to take a test that includes specialty training. She would like to ensure that still carries on as it does now

Cynthia Smith referred to number three on the discussion guide, accountability, and explained that the idea was around testing and holding one countable for the competency.

Louise Ryan disagrees to an attest.

Cynthia Smith asked Louise for clarification.

Louise Ryan: Challenge tests work. Wouldn't want to unravel something that works.

Marta Acedo agreed that there are times ADSA uses an attestation. One example would be safety training. They attest that they read the manual, but that has been eliminated. Some are going to require new ways of doing things.

Ingrid McDonald suggested that a more appropriate time for the test would be after the core. Have access to the type of training. That needs to be considered in the mix of this.

Discussion ensued regarding the value credentialing would add in terms of worker commitment, pride, opportunity, while still providing the flexibility of remaining non-credentialed for parent providers, or non-career bound providers.

	Training	What Level	Compliance
<b>BASIC</b>	Orientation/Safety/CORE	Step A	
	Population Specific	Step B	1 Test and/or competency demonstration for A/B
	= LTC Worker		
	Advanced (Optional) Training	Step C	Test
	Resulting in a Credential*		
	<ul style="list-style-type: none"> <li>Dawn added that credential also include a minimum number of hours</li> </ul>		

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worked.

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The above was written on the white board.

Jonathan Seib explained step A would be CORE and step B setting specific And credentialing would occur with the additional hours in Step C and hours worked,

Craig Frederickson wanted to clarify that they were not required to take a test. Wanted to clarify that we're not doing more than we are already doing.

Jody Robbins would be interested to know what you had in mind for step three

Rep. Dawn Morrell would do credentialing in step three where you would have to have at least 300 hours.

Ingrid McDonald: Where are you are credentialed after A and B or Step C?

Jonathan Seib had thought after 1<sup>st</sup> level it would acknowledge your capacity to be a LTC worker. After step a and b you are a level one.

Ingrid McDonald agreed and added that perhaps moving on would come with a pay increase.

Rep. Dawn Morrell: Our goal is to make a career and give them pride in what they are doing. Not only did they do the training but they tested out and put in the hours. An apprenticeship shows that you have committed in a large amount of hours. This would show a standard that this person went above and beyond. It gives the person pride.

Jody Robbins noted that apprenticeship is a time honored tradition. There is flexibility to transfer hours.

Rep Dawn Morrell talked about how hours could go towards training.

Hilke Faber likes Rep. Morrell's idea but thinks Step C Apprenticeship needs to come before credentialing.

Ingrid McDonald clarified, so I'm hearing you say adding hours work. Want to encourage people to take training as early as they can. Don't want to discourage people from hurrying to get their hours in.

Patty Weaver clarified, if they went through the training and took the test they still wouldn't have credentialing until they put in the hours?

Rep. Dawn Morrell answered, yes.

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Cynthia Smith asked for other prerequisites.

Rick Hall brought up background checks and if there should be a list of disqualifying crimes. We don't want to eliminate everyone who had a dui ten years ago.

Louise Ryan brought up the fact that if they moved here from another state and that we need to do more for people who come from out of state and make sure we check their backgrounds..

Rick Hall explained that if the worker has been in the state for less than 3 years they are already required to have one.

Cynthia Smith: PRE-REQUISITES

Consensus was agreed that LTC workers be 18 years of age, include a background check, and not on DSHS violations/revocation list. At least 8<sup>th</sup> Grade competency was mentioned.

Rick Hall is concerned that it could create a barrier to consumer choice to say that they need to be of 8<sup>th</sup> grade competency. There are complicating factors here also such as language.

Patty Weaver agreed and mentioned that the fact that they passed the test shows their competency.

Ingrid McDonald: The notion is that there are different ways to demonstrate competency.

Rep. Dawn Morrell asked, do we have to set this up?

Marta Acedo: I've done this for a number of years so do I need to take the test?

Jonathan Seib: They don't have to pay for exam but if they fail the test then they have to take the in class training and pay for RFOC themselves.

Marta Acedo: Flexibility has to be considered for example, how often do we provide challenge testing. Currently, if one fails. They have to pay for the RFOC themselves and are required to take it in a classroom. Will that still be the case?

Charissa Raynor: National testing is organized at specific times and within a given framework.

Cynthia Smith: Do we want to credential Population Specific?

Discussion regarding current designations for Dementia, Mental Health, Disabilities, etc. No consensus. Discussion about portability/credit for cross-

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trained or academic achievement recognition, experience, etc.

Jonathan Seib: We don't want to go backwards or weaken existing competency evaluations.

Craig Frederickson supports options for accepting teaching DD credentials as cross training for IPs and building IPs portfolios to become more specialized.

Charissa Raynor: Are we charged with prerequisites and accepting reciprocity?

Marta Acedo: We currently have a process and policy in place through the Modified ROC for professional from related field or with similar credentials.

Ingrid: Could we look into waving training and sitting an exam and accommodate reciprocity in that way?

Marta Acedo: We would need to combine testing and skills demonstration.

Kathy Leitch reminded the group that first the list of providers is not a public list. Second, this would be a new function for ADSA and we do not currently track all providers. We only have and maintain a database on our area of responsibility and not the total workforce.

Jody Robbins: Having a minimum level of hours is easy to get from an employer in the form of an affidavit.

Marta Acedo: Let's say the BH want to initiate a fall prevention program. If it includes say 20 hours of training it can also be counted as hours worked as well.

Charissa Raynor asked if we knew who tests the CNA's?

Marta Acedo answered that it's a national test. You have to take the test in a certain amount of time. It's half day written and half day skills.

Ingrid McDonald asked about testing out of specific modules.

Louise Ryan feels that would get very cumbersome and that it needs to be all or nothing.

Donna Patrick believes if it was all or nothing it would go against their flexibility and relevancy principles.

Rep. Dawn Morrell thought that for IP's this could work and they could test out of certain modules.

Jonathan Seib: Every hour is sensitive so to the extent that we can accommodate testing out of modules, I don't know how complicated that would be. I agree that it could get too cumbersome but if doable would be worthy of considering.

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The above is to be for consideration within the report.

Cynthia Smith asked if the workgroup would like credentialing around a specific setting to apply towards a career ladder.

Rep. Dawn Morrell asked if we didn't already do that in boarding homes.

Cynthia Smith agreed and that since there is already an element of that do we want to incorporate that.

Jonathan Seib explained that the credentialing recognizes that you have received, if step b is setting and population specific, the credentialing recognizes that it doesn't preclude you from being trained to work in ever setting. But it gives you the option of being trained to work in a particular setting, and once you've done that then you would be credentialed to work in that setting.

Rick Hall went on to say that you could literally have a credential in DD or credential in HCS.

Charissa Raynor thinks that's a good idea because you have a core and then you can have a dash developmental disabilities or a dash mental health, dash dementia, or all of the above as you continue through your ten year you may need to add those other pieces.

Rep. Dawn Morrell stated that hope in long term care would be that we actually be developing some our own experts. So if an adult family home called and said we have a problem with a disruptive patient. The facility or patient shouldn't have to be moved but rather the whole facility trained on how to deal with a disruptive person and how that works. You could actually develop some specialists through this type of training.

Patty Weaver suggested that maybe even more than credentialing, we have the broad credentialing but then further credentialing infers another test. We could have that specialty that recognizes either the time or would we administer a test to determine if they are proficient in that area. Or would it just be recognition for the time spent?

Rep. Dawn Morrell thinks it would be time spent and classes taken. Part of plan is to push higher education to accept these portfolios. To not be so rigid in what you have to take.

Louise Ryan asked for clarification, when we talk about credentialing for LTC worker - developmental disabilities, where that means that they have completed A and B. That would have a competency test along with it. Or what we would call a credentialing test.

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Rep. Dawn Morrell explained that the second part, B, is going into the homes. That's a setting specific. So she can't imagine that there would be a test.

Louise Ryan explained that there is a test now for developmental disabilities and she doesn't want that to get lost.

Rep. Dawn Morrell said that would be C.

Louise Ryan argued no, that is required now and she doesn't want to lose that because that happens before what you're saying C could be. C is obviously beyond A and B. We have our credentialing testing for A and B now and we don't want to lose that.

Marta Acedo explained that those are currently license requirements in adult family homes. Mental Health, Developmental Disability and Dementia Training. We have two levels, a caregiver level and a manager level.

Louise Ryan asked for further clarification. So right now those are called competency testing, correct?

Marta Acedo answered yes.

Louise Ryan said then that her question is, would that be considered credentialing or would the credentialing test be something above and beyond?

Hilke Faber believes that would be above and beyond.

Ingrid McDonald stated that Louise is raising some very key implication issues. It's very clear how you would create a test for A. For B it would be more challenging. Right now there are three established specialties that there are competency tests for. So one option would be to just broaden that pool. You might design eight or nine or twelve specialties and design competency tests for those. Or an alternative would be attestation so that you could still test for the three existing but you would have other methods. But we need more clarity. Think more detail about the policy design of how you evaluate B.

Charissa Raynor suggested that it may be possible to design the credentialing exam that will build into population and setting-specific but core is the same all the way across.

Ingrid McDonald: You'd probably need more than three.

Cynthia Smith: But we'd be testing after the....And we did talk about having competency demonstrations as opposed to testing.

Patty Weaver doesn't think that we can explore fully all of the needs. We've heard the community talk about autism. You have diabetics, you have those different areas and if someone has specialty in caring for that person, then

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that should be recognized and then the consumer can say, this person has done this for three years, that's who I want. We want to be careful not to limit choices here.

Rep. Dawn Morrell states that she is confused. She thought that when we were talking about step B we were talking about specifics such as I'm going to go work in an adult family home. I'm going to go be an IP.

Jonathan Seib explained it's setting or population specific.

Rep. Dawn Morrell asked, then so if I decide I don't want to choose a population, because I'm going to work in an adult family home and it's going to be a generic....?

Jonathan Seib explained that's what Ingrid was just saying that there would have to be some thought to go into the discrete setting or population. Maybe it's enough to note that step B would be setting and population specific. And that there would need to be designed a process, likely a test, to measure that the competencies in thus settings would be met. But emphasize that we don't want to go backwards on what we already have.

Ingrid McDonald asked, what about the IP who says, I don't want to specialize in anything particular. I want to serve a whole different range of clients. I'll do the hours of required training but I want to take a mix and match of advanced or specialized courses. So how do you design a competency outline for that person?

Jonathan Seib answered, wouldn't they take all of them? It would be the notion of Charissa's. Which is they would have a lot of dashes behind their name. And then it would be noted that they had the competencies to work in those settings. The notion would be that we provide them with both flexibility and opportunity.

Hilke Faber mentioned that setting specific is not our focus. It has to be population based and in nursing we have, for example an adult nurse practitioner or we have a pediatric nurse practitioner. So the adult encompasses a whole bunch and then we have the geriatric nurse practitioner which encompasses some basic core stuff. You know, just as a beginning. Then if they want to specialize and they start with this basic core in these different areas and if they want to they go further.

Rep. Dawn Morrell says then that makes her ask the question, do we want to have step B connected to step A then. That we should maybe have setting specific in step A and then specialty training in step B.

Craig Frederickson replied, No, that would be taking some steps backwards if they were to do that. Also Dawn, what you were talking about, in terms of building a portfolio. Looking at it, included in the basic is some setting and/or population specific training that fits into that. And then eventually, again for

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the caregivers that are choosing more of a career path down the road, that's when they get to step C and beyond.

Cynthia Smith: So, we had sort of contemplated that to talk about but we just sort of naturally flowed into that. Speaking of those is learning endorsements or specialty portfolio elements that then articulate to specific career ladders. That's in keeping with what we're talking about.

Charissa Raynor asked, is it your understanding that this group is also charged with discussing various reciprocity or articulation pathways as a prerequisite into this?

Jonathan Seib answered that he thinks they have if only for the minimal prerequisites to sit for the exam, and we'd provide that opportunity.

Cynthia Smith answered Charissa also, stating that HB2284 doesn't prohibit that but it doesn't mandate that we talk about that either.

Marta Acedo stated that, currently we have health professions who are coming to work in home and community based services take the RFOC. They do have a test that has to do with mandatory reporting others mentioned but no long exam as far as their skills.

Ingrid McDonald pointed out that there are two issues. One is testing and two is portability.

Charissa Raynor clarified that she was going the other direction, talking about portability from existing occupations to this. There is existing policy around this.

Kathy Leitch: Which, if people agree then it would be a good thing to say we want to look to something that doesn't have those people going through the whole.....basically to support existing policy.

Rick Hall: I think there is consensus on that.

Random workgroup members said "yes".

Ingrid McDonald asked about portability the other direction.

Kathy Leitch answered that she thinks it's a decent idea but is harder to achieve than people think. Over all it's the flexibility. If you work your way up against the requirements currently for the NAC program, for example, you make it difficult to actually capture people's hours. National testing has certain requirements attached to it.

Ingrid McDonald agrees with Kathy but there is a test in option which the states can establish. So we could recommend to the legislature, look into this

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option that people who have completed this level of training can automatically test in to become a CNA. There is an option for states to waive the training. Some states allow you to walk in, take a test and qualify immediately. Washington doesn't currently have that.

Marta Acedo suggests requiring a skills test be part of that.

Ingrid McDonald asked if there was agreement around recommending that the state look into creating a test in option for people who have created this training to become CNA's.

Cynthia Smith asked if there was consensus on this and the workgroup agreed that yes, they did have consensus.

Cynthia Smith reiterated that we have consensus on the following:

- A test at core level results in step A.
- Test at step b results at pop and setting specific.

Hilke Faber: I don't think so. I thought it was A and B.

Craig Frederickson: It wasn't a test after both Step A and Step B. It was just that you already had the test inherent with, you know, the training that exists with that.

Hilke Faber explained that the testing is after Step A and B.

Cynthia Smith: So then, you would become a long term care worker one after Step B. Is that correct? Workgroup replied, "yes".

- LTC Worker one after step B
- In order to take the credentialing exam you need to take a background test and you need to be greater than 18 years old.

Hilke Faber added and x number of hours of one the job training.

- X number of hours of on the job training.

Jane Beyer explained that people who took step A and B passed, but are not credentialed until they put in the hours.

Cynthia Smith further explained that the test administration would be both written and a competency demonstration.

Rick Hall mentioned that he was a little confused. He didn't know that he had heard before. He would like the workgroup to think back to all discussions and meeting that they have had. Core being step A, population specific being step

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B equals basic training level one. Those are the hour's level one, that's where credentialing occurs.

Rep. Dawn Morrell said that you have to have a certain number of hours before you can get credentialed.

Rick Hall explained that we had talked about methodologies, and lots of ways to do it in certain settings, but it had to be structured. Within that discussion there is the range but I didn't have in my mind an additional set of anything else that was a credential.

Craig Frederickson explained that this is different from training hours... it is on the job hours. But also he did not think that included in that there was a credential test. I knew there was already testing, just not a credential test.

Ingrid McDonald asked Rick what his confusion was.

Rick Hall explained that he's assuming that you do what you need to do in step A, it's required. You do what you need to do in step B, it's required. Somehow you determine the person's competency when they do that by testing or some type of demonstration, and if you pass that and you meet the pre-requisites, that you get a credential for doing that.

Rep. Dawn Morrell explained that her thoughts were not only that but to get that credential and to let the public know that you're a credentialed LTC Worker Number One. That you have worked a certain number of hours on the job, so that's part of your testing in it's own way that you actually stuck to it for 6 months or whatever it be. Then at that time the person hiring can know that they have worked in the field.

Craig Frederickson asked for clarification. You are a basic caregiver but you're not credentialed until you've worked the certain number of hours. Any credentialing beyond that is by choice for people who are choosing a career path that starts with Step C and beyond.

Charissa Raynor said that her understanding more closely follows Rick's logic. A and B are basic, you complete it. More than likely you will be working so the hours should not be an issue. Then you take an exam and you pass then you meet the credentialing requirement and you receive a credential.

Patty Weaver added that there should be some recognition for doing so many hours and passing the test. Who's going to track it?

Rep. Dawn Morrell explained you would be a LTC Worker. Step A and step B able to pass exam and proved myself by working 200 hours.

Patty Weaver said that she's hears Dawn saying you have to have hours before you get credentialed.

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Rep. Dawn Morrell agreed that yes she is. That's What apprenticeships do.

Rick Hall: We're not talking about Apprenticeships. That's Step C.

Rep. Dawn Morrell: Want the public to know that you can perform and that's by a certain number of hours. Believes it will keep them in the door.

Charissa Raynor added that one of the issues is that many of the people who work in this area, do not work full time. So we have to keep that in mind. You may work for six months and not meet a specified number of hours.

Rep. Dawn Morrell specified that she's not saying it's within a year or any set amount of time for that matter. Just saying that you have to actually work x number of hours before you get a credential.

Craig Frederickson added that it's not preventing a person from being a caregiver. Only from having that credential.

Ingrid McDonald is concerned that it's adding another layer of complexity without adding value. It would be administratively complex to track. If you want to do that, the simplest way to do that would use the same bench mark, 120 days. You complete your training within 120 days and that's when you come eligible. Because you're already tracking that, right?

Kathy Leitch would like to correct something. When you say we're tracking that. This is not a publicly posted list of people. As you move to a concept of certification, I think your moving to something that's a database, and there's ways you want people to get on and there will be ways you want people to get off. This is a new function of government. It's not new in terms of other kinds of certification lists but it isn't something we track now. Plus you're expanding it to all different kinds of workers some of which are private pay, not publicly paid and that brings in a whole new element. From a public perspective it's a great idea but not something that were doing.

Rep. Dawn Morrell: The burden of proof would be on the worker. You have pay stubs, you have everything else.

Jody Robbins: With regard to the hours, he has heard that working with the clients is the most valuable time anyone gets in their training and if that's a consensus item, having a minimal number of hours to get that credential is easy. You just have an employer sign an affidavit, saying that you've worked this many hours in the industry.

Rick Hall: We have bigger issues than the public side of it. SSPS has issues with it. Just to let you know.

Cynthia Smith asked if there was consensus to this point with the exception of

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	<p>hours on the job training?</p> <p>Charissa Raynor explained that we're not talking about on the job training. We're talking about hours worked, which were going to happen anyways.</p> <p>Rep. Dawn Morrell clarified that her idea was when we're working on those on the job hours, they could help us with the training. Because when your working on the module of say bathing, you are there actually doing it. We have mentors there with our IP's who could actually check that off. So it would actually take time away from having to be in the classroom because you're learning it on the job.</p> <p>Marta Acedo: For instance, in boarding homes. Say there's a boarding home that wants to initiate a falls prevention initiative in there boarding home. And so they may, during these hours, work. They initiate a fall prevention and put in a bunch of hours of training. They bring people in, they do this and maybe it adds up to 20 hours of training. So, that's still hours worked but it's still training. But it could be counted as both.</p> <p>Cynthia Smith asked if we had consensus around the hours worked as part of the credential. The number of hours hasn't been determined but we're just saying that there should be some number of hours worked to get the credential. As part of the pre-requisite.</p> <p>Consensus was made around hours worked as part of the credential.</p> <p>Cynthia Smith clarified that step C would then come into place for apprenticeship. And at that point we're talking about a test, as well as on the job training.</p> <p>The workgroup clarified that it wasn't on the job training. It was hours worked. There was talk about what would happen beyond step C.</p> <p>Craig Frederickson stated that anything beyond step C is beyond our scope.</p> <p>The workgroup agreed.</p>
<p><b>6. Public Comment</b></p>	<p>Sylvia Fuerstenberg: Frustrated by discussions because she feels SL provides training beyond the requirements and the training needs to remain flexible and in the control of where the care is being provided.</p> <p>Sam Miller: DOH currently handles the credentialing and licensing...Would the newly proposed credential be under DOH or ADSA?</p> <p>Kathy Leitch: There are two parts to DOH process: Licensing and Credentialing. Owners have a designation requirement for their license and caregivers have to have the credential and specialty designation if</p>

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	<p>appropriate. Discussion ensued regarding mandated pay increases.</p> <p>Rick Hall stated no one can mandate pay increases on training requirements, supply and demand will force the issue.</p> <p>Sam Miller: So will private workers be required to comply?</p> <p>Jonathan Seib: The Scope of practice laws and mechanisms to ensure compliance are already in place in many industries.</p> <p>Julie Ferguson: Who will monitor compliance in the private sector?</p> <p>Jonathan Seib: How this will be implemented, who will be responsible will be the discussions of legislators. This is not new to regulate health care or medical arenas.</p> <p>Marta Acedo: Process for instructors to apply to do own training will remain ADSA's responsibility.</p> <p>Craig Frederickson: Can we clarify credential is optional?</p> <p>Jonathan Seib: You are correct, someone could do Step A and B and meet requirement, but opt not to build hours towards or apply for credential status.</p> <p>Amy Ai: Caregivers want flexibility; she supports flexibility and cultural training to fulfill gaps in training to meet cultural expectations.</p> <p>Joanne O'Neill: Concerned about including respite workers in this training requirement. Feels it will restrict access to respite providers.</p>
<p><b>7. Next steps</b></p>	<p>Minutes will be posted and sent out to workgroup members. Draft Report will be completed by Nov. 20 Report will be drafted in power point. Will be between 6-10 pages and will be en-bound.... Restrain yourself from word-smithing. Will need comments back by Tuesday November 27. Final report due by November 30 – to be delivered Dec. 1. The draft document will not be posted on the internet. Workgroup members will receive the draft final report.</p>
<p><b>8. Amendments</b></p>	<p>Hilke Faber would like to explain what she meant on the bottom of page 20: She believes that we need to focus on the population needs as people can live in a variety of settings. It is the care needs not the setting that defines training needs. Adjusting to the setting in which the care needs are provided, would require an orientation by the employer. So, there is training, but more oriented to adjusting the care setting.</p>