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Developmental Disabilities Specialty Training

Recommendations for Improvement
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1 | Introduction

The State of Washington Department of Social and Health Services, within one of its functions, licenses and monitors the state's Assisted Living Facilities and Adult Family Homes. Within that network of care, three care specialties exist which require caregivers to receive specialty training: dementia, mental health, and developmental disabilities. These three specialties have established training curricula and requirements that are detailed in the Washington Administrative Code (WAC), Chapter 388-112—Residential Long-Term Care Services.

Beginning in January of 2014, DSHS retained the services of Coraggio Group to assist them in implementing sections of SSB 5630 that enact recommendations of the Adult Family Home Quality Assurance Panel and relate to improvement of and expansion of specialty training for Adult Family Homes, Assisted Living Facilities, and other care environments. As a first step, DSHS and Coraggio Group undertook a statewide Stakeholder Outreach tour to:

- Solicit feedback on the current specialty trainings and requirements,
- Identify opportunities to improve the trainings,
- Identify needs for additional specialty trainings, and
- Identify opportunities for the revision of relevant portions of the WAC.

Planning for the Stakeholder Outreach effort began with identification of target stakeholder groups, assessment of geographic distribution of homes, and development of discussion guides to ensure that the conversations generated consistent categories of feedback. Forty meetings were held, including individual interviews, focus groups, public meetings, telephone interviews, and telephone focus groups. An online survey was also employed to gather feedback. The Stakeholder Outreach effort concluded in mid-June, 2014 and ultimately included nearly 400 individuals sharing their perspectives about the specialty trainings.

A research effort followed this gathering of stakeholder input, where the content, instructional quality, and program design of the specialty training was reviewed against current research in care and adult education, as well as trends among other states and international care programs. This research effort also included visits to Adult Family Home facilities and interviews with caregivers and providers.

The broadest observation that can be made about the research is that Washington seems to be ahead of most, if not all, of its peers in terms of the quality and depth of the training that is required for caregivers of individuals with Developmental Disabilities. However, this may say more about the general state of long-term caregiving in the United States than it does about Washington, and it is clear that there are improvements that can be made. We found many areas where current thinking and research points to ways in which the Developmental Disabilities training can be made better, and we heard from many stakeholders what they would like to see in future versions of the training.

Based on this combination of stakeholder input and research, we have formulated the recommendations contained in this report. Many of these recommendations are "common sense" and will be relatively easy to adopt. Others will pose a challenge for DSHS to implement, and will likely require a phasing plan in order to prioritize the most important changes.

2 | Summary of Stakeholder Input

The pages that follow compile many of the key themes heard during stakeholder outreach that took place between January and June 2014. While this is by no means a comprehensive list of issues identified, it does represent those themes that were most commonly discussed, and those that are most salient to the revision of the specialty training.

NOTE: For a full report of all collected comments related to the Developmental Disabilities Specialty Training, please see the appendix to the DSHS Specialty Training Stakeholder Outreach Report. This report is available for download on the DSHS website at:

https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/specialtytraining/DSHS Outreach Report.pdf

Key Stakeholder Comments Related to Content of Developmental Disabilities Specialty Training

Helping residents to live full lives, and preserving those residents' rights, is at the core of what's important in this training.

Stakeholders discussed that the caregiver mindset is very important and training should discuss the difference in supporting people who will spend the majority of their lives in a care facility. Caregivers should be trained to understand that they are there to be an assistant to the life of the disabled person, not their overseer or boss.

- "I would like to see 'Individual Rights' up front and covered in depth during the training. Not just an afterthought in the training. For example, taking away a cell phone can really raise some ugly issues and violates individual rights."
- "One thing that could be added is conflict resolution/negotiation—that could work into what is going on. Having a daily walk through negotiating and making sure that people's rights are being protected while you are also protecting the rights of five other people."
- "Sexuality seems like it's a taboo subject, but to have a full life, you [have to] deal with that."
- "Does the place where they will be living offer the opportunity to live a full life… whatever that might be?"
- "It is important to have all of the trainings reinforce the idea that a person living with a DD is an adult who has the right to live a full life defined by the individual's dreams and aspirations."

Staff should be better trained to be in the habit of discovering what is causing behaviors, rather than just dealing with behaviors.

At almost every location around the state, stakeholders stressed that more training on practical skills to deal with and resolve challenging client behaviors is needed. This should also help caregivers develop the habit of discovering what is causing behaviors, rather than just trying to minimize disruptive behaviors.

- "Understating why they are doing what they do, and the steps you can take to understand and empower them overcome the behavior or challenge. More real life scenarios and examples are great to help learn these techniques."
- "Challenging behaviors are typically caused by physical pain."
- "How to address challenging behaviors. How to support the person in looking at that behavior - positive behavior support. Every behavior has a function - not necessarily a 'bad' behavior."

- "Understanding behavior, so they can understand why somebody is acting a certain way and what you can do to prevent that."

The training could place more emphasis on the development of negotiated care plans, as well as how to include families and residents themselves in designing the plan.

Stakeholders shared many observations about caregivers having incomplete understanding of what is involved in the development of a care plan, and in how to use a care plan once it is developed. This includes a lack of knowledge about how to include the client and their family in the development of the plan.

- "Is the family appreciated for their knowledge and part of the care plan?"
- "There has to be a connection between the family and their loved one. Training should include how to include the family in the care plan."
- "The negotiated care plan should be part of the training."
- "I see that paperwork and negotiated care plans are done but incomplete. I think there is some training that could go around that."

The developmental disabilities specialty training should place more emphasis on recognizing and adapting care for cultural differences.

Stakeholders felt that one of the greatest gaps in the current specialty curriculum for developmental disabilities is around cultural differences. The caregiver culture-of-origin may have an influence on how developmental disabilities are viewed, and the variety of cultures from which residents and caregivers originate indicates a need for stronger training in this area.

- "I wouldn't say that (culture) is in the curriculum - I use a couple of scenarios that we have come across that kind of help make the point. We will hit on that, but because of our experiences, not because it's in the curriculum."
- "I don't recall any cultural sensitivity… there is a part about privacy and personal space, and respect. A lot of that, but nothing on cultural differences."
- "There is a cultural thing in the DD world where cultural differences are not emphasized enough, so it doesn't come up in the DD curriculum."
- "Scenarios, videos, or practice around culture would be helpful for training."

Communication—especially non-verbal communication—could be given more time in the training.

Stakeholders discussed that modules on communication and behavior should perhaps be the most-emphasized parts of the training, and should specifically find opportunities in the training materials to stress the importance of non-verbal communication. Adding more real-life scenarios and examples are great ways to help caregivers learn better ways to communicate with their clients.

- "Caregiver communication can be an issue - both ESL and communicating with those who communicate minimally."
- "[Caregivers should be] learning about other ways of communication—communication boards, etc."
- "Communication frustrations can lead to a lot of other challenging behaviors."
- "Communication is more than just the words you say. Many people with DD might have difficulty processing any spoken language and might use other things than words to express themselves. Any caregiver needs to be multi-lingual in those situations and figure out how to support clients in this. Regardless of what your spoken language is, if someone is hitting their head, can you interpret it and respond to the communication appropriately (ex: I have a head ache…)?"
- "Effective communication—in the manual—I would do that one differently. It is really more about strategies that you would learn in a management class, where I would think something about non-verbal communication might be more useful."

Key Stakeholder Comments Related to Instruction for Developmental Disabilities Specialty Training

The curriculum for developmental disabilities specialty training is generally very strong, and is taught by excellent instructors.

Among the three existing specialty trainings, there is clearly the most support for the current DD curriculum. Stakeholders indicated that it is thorough, relevant, and well taught.

- "The training was pretty good… my instructor was very good. She had to retrain how everybody thought. She taught a lot about disability rights and the struggle for that that a lot of us didn't know about. And she integrated "rights" and "choices" into the curriculum. These individuals do not need protection - they need somebody to help them promote those rights. You aren't there to keep them cared for and protected, you are there to help them exercise their choices."
- "We've had positive feedback to the curriculum and the instructors - so yahoo!"
- "I thought the 18 hours of instruction, over three days, worked very well and the methodology of instruction was very good."

Developmental disabilities training is limited, tough to schedule, and courses fill up very quickly.

Many stakeholders raised the issue that—although the training itself is free—a three-day training that is often not local to the facility represents a significant cost to providers and caregivers. There is a desire for this training to be made more frequent and accessible, especially to rural areas.

- "The classes aren't accessible enough - it's better in frequency and range of locations, but previously we had to send folks to Seattle, and when we are up in the Everett area, that is a big deal. Considering the pay rate that these folks are on, and that they can't work until they have done that… more frequency and more locations."
- "We need to broaden the accessibility of the training so rural people don't have to pay through the nose."
- "I have a comment as a community instructor who doesn't teach DD - the calls I get from remote locations who can't get their people trained in their areas, and they need to send them to another location and put them up in a hotel. There is no training within three counties."

There is interest in alternative methods of training and alternative ways to deliver the training.

In conjunction with the desire to have DD training deployed more frequently and in more locations, stakeholders asked for other ways to access the training, including online training. They also brought up opportunities around skills training being a more experiential addition to the training, potentially even completed later in the care environment.

- "Make the DD training more accessible to all potential caregivers. On-line training is very helpful and [could] help us get caregivers onboard in a reasonable amount of time."
- "I don't do a lot of role playing, because I don't think it's as respectful to the population we serve. We do a lot of group work and learning about each other and who has experiences with relatives or past clients - trying to pull their experiences out."
- "Look at whether alternate forms of delivery are workable. There is research now that supports it. I'm a strong proponent of online training and I want that pursued as part of this. There was short space where we did it before it got taken back offline. And now they are handing them the book or taking their citations."
- "Can we require people to do things outside the training [within the requirements of the WAC]? If we could do it, I would [make it a] condition of passing and [require caregivers] to demonstrate it by doing something experiential. An oral or written presentation on how it was applied to make a person's life improve."
- "If you could have something where there was an AFH consult group - where they could video in to a webinar. Where they could talk out problems regularly."
- "[It would be] great to have regional mentorship team or 'hotline' accessible via app or phone, [which] would need to be very specific to specialties. (Difficult to fund and will need to have incentives built in.)"

Key Stakeholder Comments Related to Developmental Disabilities Specialty Training Requirements and Testing

Opinions vary about the current length of the training.

Opinions were split on whether the current 18-hour training requirement was too long to appropriately cover the necessary material, or whether it is just long enough. Very few advocated for even more time. Beyond content delivery, cost to providers and caregivers is an important factor to consider.

- "It is repetitious, [and] full of "filler" material to stretch it to 3 days, even with the multiple breaks and off-line discussions. There is really only about 8 hours of solid material."
- "The eighteen hours could be cut back to two days potentially. That is the feedback that comes back in the evaluations."
- "I had some women who didn't want to do the training. It was clear that they cared about their residents, but they had to take days off without pay to come… and that amount of money was huge to them. Three days without pay in one month."
- "The burden of cost in terms of three days out of our location, paying for housing and travel, and paying the wages… it is tough. There are no options near here for the training."
- "18 hours is about the right amount of time, with a full class, to cover all of the material and exercises to help students think it through and learn."
- "When it was expanded to the three days, I think… we were doing two days and there was typically so much discussion about behavior that we understood we needed to talk more about rights."

Language barriers are consistently one of the biggest challenges of the specialty training.

Given the demographics of the caregiver labor pool, it is likely that debate will continue as to whether the training and exam should be provided in other languages. While some pointed out that providers and caregivers are currently required to have basic English fluency, others pointed out that failing to meet the language needs of those taking training might mean that potentially great caregivers are not able to pass the exam.

- "[It is] important to have a certain amount of English (e.g. WAC - ability to communicate in an emergency, call 911 and share information), so it may not be advisable to provide training in another language."
- "Same issue as offering drivers licenses in multiple languages and other services that provide good for the community. Shift and be more language-neutral. The language in the regulation is 'the language of the person.' Maybe we should provide language courses in the facilities?"
- "English as a second language is a problem with the training. The number one problem I receive complaints on is that we do not provide a translator for the DD specialty training."

Stakeholders questioned the ability of the test to measure the desired outcomes of the training.

Many stakeholders had questions as to whether the test was able to measure readiness for caregivers, and whether it is aligned with the intended learning outcomes of the training. Alternative examination techniques and translation into other languages were both mentioned as potential remedies.

- "I do not know if the test is a good measure of knowledge. Based on what I remember [from] taking this class, I do not think so."
- "Passing the test does not really provide good feedback on what you have learned and how to apply it."
- "I don't know how well it measures readiness – [I'm] not in the homes to observe. The only way we know is through incident reports. [It would be] ideal to have some follow up, but [that would be] difficult to structure."
- "I think the content is right, but how do you know you are testing the right thing, or that they will do a good job if they pass? How do you test what's in peoples' hearts? I understand that there has to be some way to test it, but someone else put the test together."
- "I think the exam should be more rigorous."

Key Stakeholder Comments Related to Content of All Current Specialty Trainings

Trainings should be updated to be more person-centered and trauma-informed.

Many stakeholders felt that the current trainings do not adequately represent new ways of thinking about caregiving for clients with dementia, mental illness, or developmental disabilities.

- "There is a growing enlightenment of how to care for people. The current model is a medical model. The future model should take into account the whole person. Long-term care is a person's home and should focus on maximizing independence and help people live out their life. Training should be more trauma-informed and be more experiential vs. medical."
- "The shift across our industry is [towards] person-centered care. So this training is a good place to jump into that a little bit. The more you know your resident as an individual, the better you will be able to provide care to them."
- "The person-centered approach should be the focus of the training model, not the medical model."

Caregivers consistently struggle with communication, and the training modules for communication should be among the most emphasized.

Across the state, stakeholders asserted that the communication portions of the trainings cannot be stressed heavily enough—this is central to the caregiver's ability to be successful. When stakeholders were asked to rank the modules in terms of importance, communication consistently came out on top.

- "There is not enough emphasis on training about communication differences of people with Intellectual and Developmental Disabilities (IDD). Respectful non-minimizing language is currently not the norm, nor is people-first language. The term "mentally retarded" is still in use by program staff."
- "[Trainings should emphasize] communication with older adults with limited communication skills."
- "I think the communication strategies that are presented in the specialty classes are essential in providing care to our residents in the community settings."
- "[Caregivers should be] learning various communication techniques to work with dementia and mental health clients."

Training modules related to challenging behaviors should likewise be among the most emphasized.

Similarly to communication, stakeholders felt that a solid foundation in dealing with challenging behaviors—and in understanding the communicative aspects of certain behaviors—is essential to preparing a caregiver to work with clients.

- "[A critical skill is] understanding behaviors for both dementia and mental health, and becoming creative in addressing needs."
- "[Caregivers should learn to understand] what behaviors and moods are not baseline and not to assume that moods and behaviors that are ongoing are not considered 'normal for that person'."
- "I would like to see more training on how to deal with DD behaviors, what to expect when living with them, how to understand them better, how to set realistic goals and how to handle behavior problems such as hygiene, temper tantrums, fighting or not getting along with other residents, etc."
- "Understanding of the disease processes, learning how to interpret behaviors to find [the] root cause, not just putting them on meds."
- "[Caregivers] really want practical applications to the challenging behaviors."
- "Caregivers are not prepared to deal with these behaviors. Some caregivers, with experience, are better at working with people and these behaviors."

The current specialty trainings shy away from the subject of sexuality, yet this represents a very real set of issues for caregivers.

Stakeholders felt that sexuality is given short shrift in the trainings. Improving those parts of the training that address client sexuality, and building new sections, is especially important in light of the growing understanding of the responsibility to protect the rights of residents.

- "Some of the issues with dementia and sexual health have helped me to train staff how to appropriately address sexual expression and a safe environment for sexual expression."
- "[The] video is awful regarding sexuality – because it comes from a 'shame on you' perspective."
- "[Caregivers need] real-life management of sexual issues. The course poses situations with many perspectives, but never says, 'this is what you do.' Caregivers want and need concrete answers."
- "[The trainings should include] more on sexuality, including residents' rights and how to handle behaviors."

Key Stakeholder Comments Related to Instruction for All Current Specialty Trainings

Many stakeholders questioned whether manager training shouldn't be given a greater differentiation from the standard caregiver training.

The current training practice is that managers receive the same training as the caregivers, but receive a short additional segment of training, and are also given a separate exam. Stakeholders wished for more clarity around the differentiation, and possibly a complete separation.

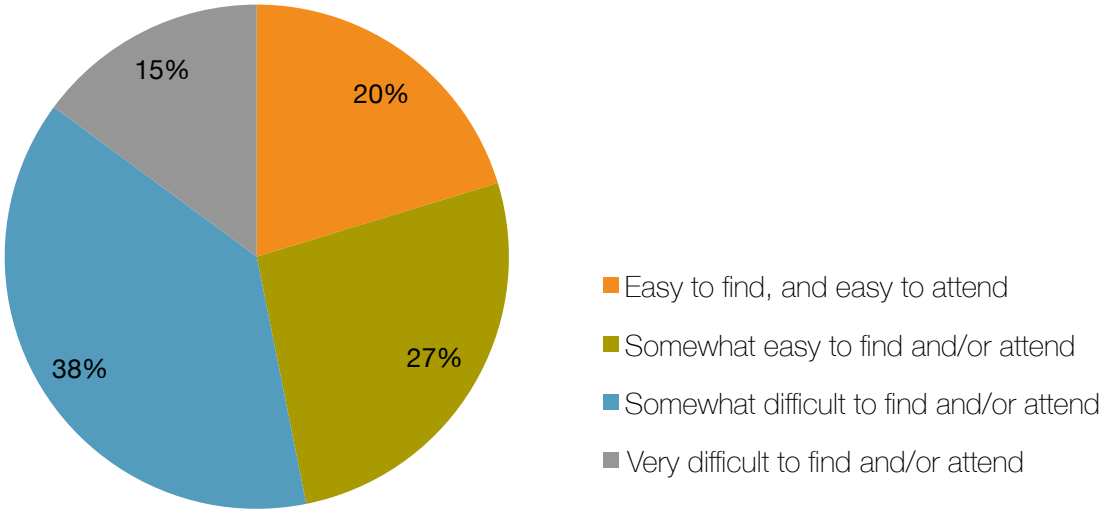
- "I have heard that we should break out the manager training… a lot of what is in the training for the caregivers…"
- "What skills should managers have? Should there be different training? It seems to me that maybe something around leadership and quality - how to evaluate and how to be a good manager. How to follow through. Seems like those would be good manager training. A lot of time people get hired, but they don't get the training that goes with the title."
- "It is also difficult to train managers in the same class as others. I think they should be offered as different classes. Everyone else had to stay an extra hour and a half while the managers were going through the extra training and skills testing."
- "[DSHS needs to] clarify [the] intended difference between manager and caregiver skills and training."

There is a desire for the specialty trainings to be more accessible in terms of frequency, location, and audience.

Stakeholders are eager to have greater access to trainings. The need is especially acute in rural areas, where traveling to trainings adds additional cost burdens for caregivers and providers. A desire for family members to have access to these trainings was also noted.

- "Improved access. Content is fine."
- "The classes aren't accessible enough."
- "Classes need to be more frequent and more local – staff cannot work in an AFH unsupervised until they have completed this class and sometimes staff need to wait anywhere between 4-8 weeks to get [into] a class."
- "DD training not in the private sector is a problem and not accessible."
- "Some of my AFH providers say there used to be online training that was accessible."
- "I think specialty training should be opened up to family members."

The following chart represents how survey respondents answered a question about how easy to find and/or attend specialty training is:



Key Stakeholder Comments Related to Requirements and Testing of All Current Specialty Trainings

DSHS should look at ensuring consistent delivery of trainings and examinations across the state.

While recognizing that the specialty trainings will likely never be perfectly consistent, stakeholders believe that there is room for improvement, and that new delivery methods or requirements may ensure a greater consistency in the delivery of training.

- "[It would be] helpful if training were more consistent - so that home owners or administrators can rely on what people have learned, regardless of where they were trained."
- "The level of training is not consistent across the state of Washington."
- "Training is not consistent. Trainers are human [and they have] different approaches, expertise, [and] and knowledge. Sometimes managers teaching the classes don't really grasp the material themselves, [and] may just be reading/following [the] structure or showing video, vs. adding own experience, real-life scenarios."
- "Consider a better 'train-the-trainer' model that ensures more consistent delivery and skills."

DSHS should carefully consider how to address language differences, and their effects on training and care.

It is likely that there will continue to be a significant number of caregivers for whom English is not their first language. There are trade-offs to be identified and discussed between current requirements for a basic level of English to be spoken and the desire to create opportunities for highly skilled and empathetic caregivers to succeed—regardless of their English proficiency. As specialty trainings and WAC requirements are reviewed or updated, this is a topic that a great many caregivers identified as a critical one to address, although there was a plurality of opinions as to how these trade-offs should be handled.

- "Currently, training is one-size-fits-all. If we are moving into the 21 century, we could look at translating training documents into the 5 main core languages and offer training done in English and translated into the 5 core languages."
- "Maybe even provide a test on communication as a prerequisite before taking the class. If students do not pass, then they must take a class until they pass the examination on communication. It is not about their deficiency in the English language but they must be able to communicate clearly to a population who are already vulnerable due to their cognitive impairments."

- "Many of the medical terms will be difficult for those who are less fluent in English, while the concepts will not. Find ways to adapt training so that there are alternative paths to understanding, or different ways for the provider to communicate the concepts to the caregivers if they are giving the training."
- "Language in the test makes it unnecessarily difficult for people who are not native English speakers. Uses words like 'may' 'inheritance' 'heredity' 'strengths' ' meaningful' that are not clear and/or familiar. Test-takers don't want to speak up."
- "We need to have greater access to teaching English as a second language to help empower our staffs."
- "If I have dementia and English is a second language for the caregiver, it is hard to have good communication."
- "Caregivers who are not clear in English have more difficulty communicating with residents, receiving training, and comprehending the test. [They were] able to demonstrate that they understood in person, but couldn't pass the test."
- "[It] could be helpful to translate the materials. The Home Care Aid exam is translated into 12 languages [but these specialty trainings are] only in English. [This] may eliminate people who could be very effective."

Stakeholders felt that the system would benefit if the Ombuds and DSHS staff were required to take the specialty trainings, so that they have the same understanding as caregivers.

Many stakeholders observed that their interactions with DSHS staff members and Ombuds are sometimes challenged because these individuals don't always have a full understanding of how caregivers are trained and what best practices for care may be.

- "Training for Ombudsman – [they] may come in to interview/assess dementia residents, but the ombudsman doesn't have appropriate skills for working with a person with dementia, and causes new problems."
- "I think bringing the ombudsmen into the training would be very helpful and valuable."
- "We would like it if the licensors had to take the training. They would better understand what we are doing and why. Case managers too—so they understand how much time it takes to deliver this care."
- "Ombudsman should be trained also—they need to know how to interact with the residents."
- "The licensors should also be trained or informed of the training requirements."

3 | State and International Trends

In order to assess how Washington's curriculum compares to the curriculum required or provided by other jurisdictions, we structured a research effort that looked at a cohort of other states, as well as a handful of English-speaking countries. Private sector training materials proved difficult to gain access to without signing up for the training programs themselves, and although we did find some international training documents, we were not able to locate any that were specific to developmental disabilities.

Among non-state documents, the one training document that was available under a creative commons license was a Paraprofessional Healthcare Institute training document, *Providing Personal Care Services to Elders and People with Disabilities: A Model Curriculum for Direct-Care Workers* (PHI). This training is for caregivers across long-term settings, and therefore the developmental disabilities portion is grouped with mental health and abuse/neglect in a combined 3.5-hour module, as part of the overall 77-hour training.

To determine a cohort that would provide a good baseline to compare Washington against, we began with research promoted by AARP, the Commonwealth Fund, and the Scan Foundation: the *2014 Long Term Scorecard*. (Reinhard, Kassner, Houser, Ujvari, Mollica, and Hendrickson, 2014) Thinking about impact in terms of care outcomes, we began with the data category of "Quality of Care and Quality of Life", from which we identified the top five states:

1. Minnesota
2. Alaska
3. North Dakota
4. Iowa
5. South Dakota

Through online investigation and telephone conversations with state agency representatives, we learned that there was little correlation between states that were top performers in this category and rigorous training requirements for caregivers. In most of these states, there is no requirement whatsoever for specialized training related to care for persons with disabilities. It appears as though other factors are driving the successful outcomes in these states, possibly including rural settings with deeper community connections, higher caregiver retention based on limited availability of jobs, and a regional culture of care (note that four of these five states are adjacent to one another).

In order to form a cohort for our research that was more similar to Washington, we turned to *Personal Care Aide (PCA) Training Requirements: Summary of State Findings* (Marquand, 2013), which summarizes training requirements in all fifty states. From that document, we identified a cohort for comparison that included 11 states that require 40 hours or more of training for caregivers (Washington requires 75), and five which have specific skills and curriculum provided by the state. Overlap in these two lists left us with a 13-state cohort for which we conducted additional research to learn their general requirements for caregiver training, their requirements for specialty training, and what requirements they had for trainers. A brief summary of those findings follows:

Alaska

For Alaska, we found no evidence of required training for specific specialized needs, nor did we find specific training requirements for trainers. A form is required to be approved as a PCA trainer, however.

Arizona

Arizona has specialized curricula for aging, DD, and Alzheimer's; they also have experience and competency requirements for trainers. They use a tiered system, starting with basic core competencies then moving up to the specialized training.

Arkansas

We found no evidence of any training for specialized needs, nor could we access the requirements to be a trainer of PCAs in Arkansas

District of Columbia

The District of Columbia does not require specific training for DD, but they do require all PCAs are certified CNAs.

Georgia

No evidence of special training requirements for DD, while there is agency provided training, there seem to be no clear qualifications beyond being approved as a care provider.

Idaho

Training is offered online in Idaho. There are no clear requirements or curricula to work with clients with DD, although some rudimentary materials are available from the state. The employer trains and assesses the PCA. Idaho does have a fairly strong "train the trainer" curriculum.

Illinois

Illinois requires a total of 120 hours training, and a section on DD is included in the state provided curricula. There are no additional requirements for DD. However, Illinois also has an on-the-job training assessment.

Kentucky

The state provides training through webinars and appointments; there does not appear to be any kind of specialized training.

Maine

The state of Maine provides the training for general PCAs. Maine also has specialized programs for intellectual disabilities and autism, and it seems these are independent of the state-provided training, being offered through a private company, College of Direct Support.

Minnesota

In Minnesota, the state is the trainer, using webinars and in-person workshops. There doesn't appear to be DD-specific training.

New Jersey

New Jersey provides general PCA training. PCAs working in DD need to take courses through the College of Direct Support, similar to Maine. There are other routes to complete this training and it is possible to become a certified trainer.

New York

New York has a state-developed curriculum, administered by an RN.

Virginia

In Virginia, the state provides most training, although agencies can do it themselves. Virginia does require additional training for DD on top of the 40-hour PCA training.

We were able to analyze four state-designed Developmental Disabilities care trainings, as well as a number of other state-designed caregiver trainings, to compare them with Washington's in terms of content. These included documents from Arizona, Illinois, Oregon, and Virginia. The table on the following page summarizes which modules

are included in each of these trainings. In the interest of comparison, reasonable efforts were made to identify similar topics with the same title. The four highlighted rows represent topics that have been included by three or more states in their training, aside from the introduction section, which is included in all five. Generally, this aligns well with the modules where Washington has placed emphasis: communication, behaviors, and support planning. The one glaring exception is the "abuse and neglect" section included in the Arizona, Illinois, and Oregon trainings, but not in Washington's. These two topics are mentioned in Values of Service Delivery and Crisis Prevention and Intervention sections of the Washington specialty training, and are also covered in basic caregiver training in Washington. However, given national statistics indicating that persons with developmental disabilities are at a significantly higher risk of abuse, and in particular sexual abuse, it is worth considering whether a greater emphasis should be placed on the topics of abuse and neglect—specifically related to Developmental Disabilities—in future curricula.

Count of Module Titles in State Developmental Disabilities Trainings

Module Title	AZ	IL	OR	VA	WA	Grand Total
Abuse & Neglect	1	1	1			3
Basic Health & Safety		1				1
Behavior Problems	1		1		1	3
Communication		1		1	1	3
Crisis Prevention and Intervention					1	1
Daily Living	1					1
Documentation			1			1
Environmental & Individual Safety		1				1
Facility Standards			1			1
Health & Safety				1		1
Helping with Daily Activities		1				1
Hiring Caregivers			1			1
Human Growth & Development		1				1
Human Rights		1				1
Incident Reporting	1					1
Introduction	1	1	1	1	1	5
Legal Issues & Rights					1	1
Medications			1			1
Organizational Structure				1		1
Positive Behavior Support				1		1
Role of the Division of DD	1					1
Safety & Accident Prevention			1			1
Service Plan Development & Implementation		1				1
Support Planning	1		1		1	3
Values				1	1	2
Vital Signs & Symptoms		1				1
Wellness		1				1
Working with People with DD	1					1

The table on the following page details the percentage of the total training material devoted to each topic, as a way to measure how each state prioritizes particular topics. The three outliers (highlighted), in comparison to Washington, are the Daily Living section, which represents 33% of Arizona's training; Values, which represents 29% of Virginia's DD training; and Medications, which represents over half of Oregon's DD training.

It is our opinion that none of these three instances represents a direction that the Washington state training should embrace, and that in fact Washington's distribution of topics is generally comparable and reasonable when compared to these other states' training documents. However, we have made some specific recommendations related to the redistribution of focus on training modules in the "Recommendations: Content" section of this report.

State	Topic	Percentage
AZ	Abuse & Neglect	12%
AZ	Daily Living	33%
AZ	Incident Reporting	7%
AZ	Introduction	10%
AZ	Behavior Problems	7%
AZ	Role of the Division of DD	7%
AZ	Support Planning	6%
AZ	Working with People with DD	18%
IL	Abuse & Neglect	15%
IL	Basic Health & Safety	9%
IL	Communication	12%
IL	Environmental & Individual Safety	12%
IL	Helping with Daily Activities	12%
IL	Human Growth & Development	5%
IL	Human Rights	7%
IL	Introduction	16%
IL	Service Plan Development & Implementation	13%
IL	Vital Signs & Symptoms	16%
IL	Wellness	12%
VA	Communication	18%
VA	Health & Safety	11%
VA	Introduction	11%
VA	Organizational Structure	11%
VA	Positive Behavior Support	21%
VA	Values	29%
OR	Introduction	2%
OR	Hiring Caregivers	4%
OR	Facility Standards	20%
OR	Medications	55%
OR	Documentation	9%
OR	Support Planning	3%
OR	Behavior Problems	13%
OR	Abuse & Neglect	9%
OR	Safety & Accident Prevention	3%
WA	Introduction	20%
WA	Values	18%
WA	Communication	12%
WA	Support Planning	8%
WA	Behavior Problems	20%
WA	Crisis Prevention and Intervention	11%
WA	Legal Issues & Rights	12%

Generally speaking, it appears as if Washington's Developmental Disabilities specialty training is near the top of state caregiver trainings in terms of rigor and requirements, and it can also be said that Washington's Developmental Disabilities specialty training is stronger than the other two required specialty trainings in Washington: dementia and mental health. It should be noted, however, that training is only one input among many to create good long-term care outcomes, and that neither of these observations should indicate that improvement of the curriculum is not necessary and desirable.

4 | Recommendations: Content

Broadly speaking, the recommendations made in this section are simply updates to and adjustments of what is widely considered to be an excellent curriculum for training caregivers in the Developmental Disability specialty.

Updating the curriculum is not merely "catching up", however—it is also an opportunity for Washington to begin to include new ways of thinking about care delivery, and to continue its role as a leader in the field.

In our analysis of DSHS data, we found a correlation between certain client needs and frequency of moves from one facility to another. Many of these client needs are topics that can be addressed in the training content, such as: medication management, decision-making, and self-feeding.

We believe that if Washington takes special care in redesigning the curriculum to bolster understanding around these and other key client needs, it will positively affect not only the number of moves that clients endure, but also may have positive impacts on caregiver engagement and retention.

Key Recommendations

The following ten recommendations are, among all changes considered, those that were most requested by stakeholders, most indicated through our research, or most urgently in need of updating:

- Collapse 18 hour training to 12 hours – half online, half in-person
- Increase focus on the *Understanding Behavior* section
- Reduce focus on the Overview of Developmental Disabilities and Values of Service Delivery sections
- Include Trauma-Informed Care as a topic in the *Crisis Prevention and Intervention* section
- Add the topic of sexuality to the Values of Service Delivery and Overview of Legal Issues and Individuals' Rights modules of the training
- Update the *Overview of Legal Issues and Individuals' Rights* section to include current information related to Home and Community Based Services and impending changes with the Community First Choice option, both resulting from the Affordable Care Act
- Bolster instruction around the inclusion of families
- Augment topic of self-care currently found in basic training
- Redesign the *Resource Section* as a stand-alone module that becomes a tool for caregiver use
- Update the look and feel of the training materials to reflect the importance of the topics

Collapse 18 hour training to 12 hours – half online, half in-person

The most significant change recommended for the Developmental Disabilities Specialty Training is to shorten the training from the current length of 18 hours over three days to an approximate 12-hour length, split between one six-hour day of in-person training and several online modules. It is our belief that shortening the training and moving half of the content online will provide greater access to the training, will make the training more cost-effective for small care businesses, will make technical portions of the training available in selected additional languages, and will guarantee a greater consistency in the delivery and content of the training.

Throughout the stakeholder outreach, providers and caregivers stressed that the DD training was not accessible enough. Fifty-three percent of the respondents to the online survey said that specialty training was somewhat or very difficult to find and/or attend, and anecdotally this frustration is felt to an even greater degree for the Developmental Disabilities training. This issue is also tied to cost: while the DD training itself is free to the caregiver, the owner of the facility still may pay that employee for three days to attend the training, and may have additional travel expenses. When the provider does not pay wages to the caregiver for those three days, it is three days of lost wages for the caregiver. This is exacerbated when caregivers need to travel from rural to urban areas to receive the training. As one AFH provider put it, "We need to broaden the accessibility of the training so rural people don't have to pay through the nose."

There was also significant interest in having some or all of the training accessible online, as exemplified by this quote: "Make the DD training more accessible to all potential caregivers. Online training is very helpful and [could] help us get caregivers onboard in a reasonable amount of time." Education at all levels is moving online to some degree, and while online training is not a panacea, it does allow for the efficient and equitable sharing of standard information.

> "Look at whether alternate forms of delivery are workable. There is research now that supports it. I'm a strong proponent of online training and I want that pursued as part of this. There was short space where we did it before it got taken back offline. And now they are handing them the book or taking their citations."

The modules recommended for the online portion of the training are the more technical and informational portions, while the in-person modules are those portions that will require more role-playing and interaction between class members. This split retains the most critical portions of in-person training, while allowing the more technical portions to be learnt at the student's pace, and in some cases in the student's native tongue. If possible, the online training modules should be interactive and allow for learners to experience the training as "cohorts" who can share ideas with one another.

As it stands, the delivery of the DD Specialty Training is more consistent than for the two other specialty trainings, but presenting the informational portions of the training online will guarantee that each caregiver receives the exact same information.

NOTE: for details about the efficacy of online training, and the efficacy of trainings translated for ESL understanding, please see the Program Design recommendation section of this document, on page 33.

Training Module Recommendation:

Online Modules, available in English and up to 5 other languages

- Overview – approx. 1 hour
- Values – approx. 1 hour
- Legal Issues & Rights – approx. 2 hours
- Intro to Interactive Planning – approx. 1.5 hours
- Self Care – approx. ½ hour

Total: approx. 6 hours

In-Person Modules, available in English only

- Understanding Behavior – 3 hours
- Effective Communication – 1.5 hours
- Crisis Prevention & Intervention—1.5 hours

Total: 6 hours

Increase focus on the Understanding Behavior section

Among stakeholders, there was broad consensus that Understanding Behavior is one of the most important portions of the training. Because the total training time is recommended to decrease, this recommendation should be understood not as a call to lengthen the training portion on behavior, but rather to ensure that—as a share of the total training time—behavior's *portion* goes up. In the current training manual, Understanding Behavior represents 20% of the page length, while it represents 25% of the total training time in the proposed module distribution. As one stakeholder put it, "I would like to see more training on how to deal with DD behaviors, what to expect when living with them, how to understand them better, how to set realistic goals and how to handle behavior problems such as hygiene, temper tantrums, fighting or not getting along with other residents, etc."

We believe that providing caregivers with a solid foundation in managing behaviors, especially behaviors specifically related to Developmental Disabilities, may help decrease caregiver turnover and may also help decrease the frequency with which clients are moved from one facility to another. DSHS client data supports this assertion: we analyzed a sample of 3,705 client moves, and the assessments most proximate to each move. Within the 38 identified "current behaviors", we found that 24 of these behaviors were correlated with a higher incidence of client movement. That is, a client who moved three times within the sample window was more likely to have one of these 24 behaviors than a client who had moved once or twice. In the table below, these behaviors correlated with move frequency are highlighted:

Current Behaviors	One Move	Two Moves	Three Moves
Accuses other of stealing	6%	7%	4%
Assaultive	5%	5%	8%
Breaks-throws items	5%	7%	3%
Combative during personal care	7%	7%	9%
Crying-tearfulness	22%	25%	25%
Delusions	14%	14%	19%
Disrobes in public	2%	2%	5%
Easily irritable/agitated	48%	52%	52%
Eats non-edible substances	1%	1%	2%
Fire setting behavior	0%	0%	0%
Hallucinations	14%	14%	18%
Hiding items	5%	5%	4%
Hoarding/collecting	7%	8%	7%
Inappropriate toileting/menses activity	8%	10%	14%
Inappropriate verbal noises	4%	4%	1%
Injures self	4%	3%	5%
Intimidating/threatening	6%	7%	8%
Law breaking activities	1%	0%	1%
Left home and gotten lost	1%	1%	1%

Manic symptoms	2%	1%	2%
Mood swings	17%	22%	22%
Obsessive re health/body functions	9%	12%	4%
Repetitive complaints/questions	26%	26%	33%
Repetitive movement/pacing	14%	16%	19%
Resistive to care	31%	32%	43%
Rummages/takes belongings	4%	3%	9%
Seeks vulnerable sexual partner	0%	0%	2%
Sexual acting out	3%	2%	4%
Spitting	1%	2%	3%
Unrealistic fears or suspicions	15%	16%	18%
Unsafe cooking	0%	0%	0%
Unsafe smoking	1%	1%	2%
Up at night/requires intervention	16%	15%	18%
Uses foul language	12%	13%	12%
Verbally abusive	10%	11%	13%
Wanders/exit seeking	6%	6%	7%
Wanders/not exit seeking	4%	3%	4%
Yelling/screaming	17%	22%	13%

Learning objectives currently include the following:

- Identify the guiding principles of the Positive Behavioral Supports process
- Define the "ABCs" and describe how to use that process to discover the function of behavior
- Explain why it is critical to understand the function of behavior before developing support plans
- Define reinforcement and identify ways to utilize it as a tool to increase an individual's ability to be successful
- Identify the problems with using punishment to manage behavior
- Identify behavior management techniques that are not allowed under DSHS policies and applicable laws
- Identify factors that can positively and negatively influence the behavior of individuals with developmental disabilities

Because the overall time dedicated to this module is likely to decrease, we do not recommend any additional learning objectives. However, we do recommend that the "ABC" model be reconsidered, as stakeholders told us that many, especially English Language Learners, struggle with the words, even with "ABC" as a mnemonic device. While the basic idea is valid, there seems to be an opportunity to re-design this portion of the training.

Reduce focus on the *Overview of Developmental Disabilities* and *Values of Service Delivery* sections

In past iterations of the Developmental Disabilities Specialty Training, a great emphasis has been placed on the history of the treatment of persons with developmental disabilities, and on contemporary values related to how these individuals should be treated. This has been very important in shaping the thinking of new caregivers, and has reflected changing societal norms related to these topics. However, we heard from a great number of people that it is time to begin to reduce the overall proportion of these parts of the training, and that the overall training should be shortened:

> "One full day is focused on the history of DD and the training does not reflect what is needed for caregivers."

> "The current training has a lot of history."
>
> "It is repetitious, [and] full of "filler" material to stretch it to 3 days, even with the multiple breaks and off-line discussions. There is really only about 8 hours of solid material."
>
> "The eighteen hours could be cut back to two days potentially. That is the feedback that comes back in the evaluations."

In the current manual, these two modules combined represent 37% of the manual's pages. In the recommended module distribution, these two sections would take up approximately two hours of the online portion of the training, or 17% of the overall content. This is still a very significant portion of the training.

Although we recommend that these two portions of the training be reduced in overall length, we are not recommending that any specific learning objectives be eliminated. Rather, we advocate for a careful edit of the material that condenses the total time spent while still addressing each of the existing learning objectives. Because this portion of the training is recommended for online training, some efficiencies of delivery may be gained through the change in delivery media.

Include Trauma-Informed Care as a topic in the Crisis Prevention & Intervention section

Research shows that the risk of being physically assaulted for an adult with developmental disabilities is 4-10 times higher than for other adults (Sobsey, 1994), this must be taken into account when determining best practices for caring for those diagnosed with DD. Trauma-Informed Care (TIC) presents an alternative to traditional care techniques by focusing on increasing function rather than curing mental illness. The principles of TIC are: safety, trustworthiness, choice, collaboration, and empowerment. Through these principles, facilities can improve not only quality of care, but also quality of life for its clients (Keesler, 2014). While it will be impossible to fully instruct caregivers in TIC during the specialty training, an introduction to the topic will go a long way toward building awareness and understanding of factors that may influence the interactions of the caregivers and residents. This instruction may include information about the Adverse Childhood Experiences Study (ACES), to provide caregivers with some understanding of how childhood trauma can affect health outcomes in adults.

It is worth noting that Trauma-Informed Care is not highly prevalent in training materials of other states, and is a relatively recent addition to the field. In this sense, the inclusion of TIC in Washington's DD specialty training materials will be a demonstration of Washington's leadership in preparing caregivers.

We recommend the following learning objectives for this addition, based in part on the 2008 update report of the National Center for Trauma-Informed Care (NCTIC) (Jennings, 2007):

1. Understand the prevalence and impact of trauma
2. Understand the dynamics of traumatization
    a. How some caregiving actions can potentially mimic traumatic experiences
    b. Avoidance of retraumatization
3. Understand the impact that culture, race, ethnicity, gender, age etc. can have on perceptions of trauma and healing mechanisms: "Cultural issues affect not only those who seek help but also those who provide services. Each group of providers embodies a culture of shared beliefs, norms, values, and patterns of communication. They may perceive mental health, social support, diagnosis, assessment, and intervention for disorders in ways that are both different from one another and different from the culture of the person seeking help."
   (President's New Freedom Commission on Mental Health Final Report, 2003)
4. Develop a trauma-informed understanding of difficult behaviors
5. Understand how to maintain professional boundaries
6. Develop an understanding of vicarious traumatization and self-care

As one stakeholder put it, "There is a growing enlightenment of how to care for people. The current model is a medical model. The future model should take into account the whole person. Long-term care is a person's

home and should focus on maximizing independence and help people live out their life. Training should be more trauma-informed and be more experiential vs. medical."

Add the topic of sexuality to the Values of Service Delivery and Overview of Legal Issues and Individuals' Rights modules of the training

> "Sexuality is an integral part of the personality of everyone: man, woman, and child. It is a basic need and an aspect of human life."
>
> —World Health Organization

The current training manual mentions sexuality only once, near the beginning of the Values section. We heard from a number of stakeholders that this topic has been shied away from, and is approached from a shame perspective when it is broached at all. Recently, there has been an ideological shift in the way those with developmental disabilities are thought of in regards to sexuality. Historically, those with DD were thought to be asexual, or rather that they should be asexual. Now the sexuality of those with DD has become a more acceptable idea, however services have yet to make the same progress with about 12% of caregivers ever receiving any training in the topic (Healy, 2009). A lack of clear policies in institutions contributes to the ambiguity of what is permissible, causing the caregiver to have to resort to personal judgment (Saxe, 2014).

We recommend frank discussion of this topic within two sections of the training: *Values of Service Delivery* and *Overview of Legal Issues*.

Learning Objectives for a sexuality section within the *Values of Service Delivery* module may include:

- Caregivers feel more comfortable speaking about sexual issues with residents.
- Caregivers are able to identify when a resident may be having health issues related to sexuality.
- Caregivers can teach how to properly discuss their bodies and identify issues.
- Caregivers can identify potential cases of sexual abuse.

Specific topics that may be covered include:

1. The privacy rights of residents & informed consent
    a. The laws regarding consent are fairly complicated and must take into account the knowledge, intelligence, and voluntariness of each situation. (Eddy, 2011)
2. Sexual Education – techniques for conversation
3. Promotion of self-care
4. Disability Issues regarding sexuality
    a. Health issues related to sexual activities (Eddy, 2011)
    b. In order to fully support those with DD, specific disability issues must be incorporated (Gilmore, 2010)
5. Lesbian, Gay, Bisexual, Transgender (LGBT) awareness in the care setting
6. Addressing family concerns
    a. Research has shown family members are more likely opposed to those with DD partaking in sexual activities. (Healy, 2009)

Within the *Overview of Legal Issues* module, the following topics may be included:

1. Consent
    a. Knowledge by the person of the nature of the activity and its consequences including physical, moral, ethical, psychological, and emotional consequences;
    b. Intelligence of the person in realizing the benefits and risks of the activity, and a demonstrated ability to rationally process the knowledge or information by applying to personal standards of living; and
    c. Voluntariness in that the decision is free of any unreasonable coercion to choose to engage in, or refrain from, sexual activity. (Eddy, 2011)
2. DD Rights related to sexuality
    a. Right to make decisions about their lives
    b. Right to pursue meaningful lives
    c. Right to have interdependent relationships
    d. Right to achieve full integration and inclusion in society (Developmental Disabilities Assistance and Bill of Rights Act of 2000)

Update the *Overview of Legal Issues* and *Individuals' Rights* section to include current information related to Home and Community Based Services and impending changes with the Community First Choice option, both resulting from the Affordable Care Act

The Affordable Care Act (ACA) brings changes to the landscape of residential care, and it will be important for the updated specialty training to inform caregivers about requirements of ACA that will need to be met in the care setting.

Specifically, the Community First Choice Option (CFCO), when it applies to residents with developmental disabilities, will require that the following services are available:

- Assistance with ADLs, IADLs, and health related tasks through hands-on assistance, supervision or cueing.
- The acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.
- Back-up systems or mechanisms to ensure continuity of services and supports.
- Voluntary training on how to select, manage, and dismiss attendants. (Federal Register, 2011)

Additionally, the CFC option defines an integration requirement, as well as requirements for self-direction of the clients. Compliance with these new requirements will have an impact on how caregivers perform their duties and how they document their work.

Bolster instruction around the inclusion of families

Currently, the Developmental Disability specialty training materials discuss the importance of families to residents, but are not specific in detailing strategies for including families in decision-making and in the creation of Negotiated Care Plans. We heard from a number of stakeholders that Negotiated Care Plans are often done incompletely, and that families are not adequately included in these decision-making process:

> "There has to be a connection between the family and their loved one. Training should include how to include the family in the care plan."

Further, we heard that communication with families and balancing resident rights with family expectations are among areas that create unexpected challenges for caregivers. In most cases, the families will have knowledge and understanding of the resident that will be helpful to the caregiver, but the mechanisms for transferring that information are not working. A deeper discussion of interactions with families, and the inclusion of specific strategies

to engage families are recommended. Because of the important support role of families, this portion of the curriculum should also provide recommendations for supporting residents when families are not involved.

Although there appears to be limited research about the inclusion of families in person-centered planning, there is growing recognition of the importance of such inclusion, particularly in other English-speaking countries. Inclusion Ireland, that country's national association for people with an intellectual disability, has stated the importance of family inclusion in its *Making Inclusion a Reality: Inclusion Ireland Strategic Plan 2007-2012:*

> Families are integral… and must receive the necessary supports to ensure healthy and positive relationships with their family member with an intellectual disability. (Inclusion Ireland, 2007)

The Department of Health in the Australian state of Victoria has published a document, *Help Sheet No. 30*, that stresses the importance of involving residents' families, citing benefits for the families, the residents, and the caregiving staff. This document also lists many specific strategies that caregivers may employ to increase family involvement, such as:

> Involve [family] carers in developing and reviewing care plans. [Family] carers can provide information about resident meal preferences and recreation interests, particularly where residents have cognitive deficits and memory problems. Encourage the [family] carer to sign the care plan to indicate they accept it. (Victoria Department of Health)

Kyeong-Hwa Kim and Ann Turnbull, in their 2004 article in Research & Practice for Persons with Severe Disabilities, entitled *Transition to Adulthood for Students with Severe Intellectual Disabilities: Shifting Toward Person-Family Interdependent Planning,* suggest that:

> The term *person-family interdependent planning* [should] be used to describe an approach designed for young adults with disabilities and their families to enhance improved overall individual and family quality of life as the desired outcomes. (Kim & Turnbull, 2004)

Their proposed approach does not replace person-centered planning, but rather recognizes the importance of family inclusion in such planning, and the potential for benefits to both the individual with intellectual disabilities and their family members.

As mentioned above, there is scant research that directly measures the impact of family involvement, though anecdotal evidence abounds. A meta-analysis of available research stated that:

> It has been argued that increased family involvement is important to residents and is directly linked to improved quality of life. However, few studies have determined whether family involvement influences resident psychosocial or functional outcomes. (Gaugler, 2005)

Despite the lack of quantified evidence, we believe that a greater inclusion of families in decision-making, and in the lives of residents, will yield benefits for all parties involved, and deserves a greater emphasis in the training materials.

Augment topic of self-care currently found in basic training

Caregiver self-care is included in the basic training that all caregivers receive as part of their initial 75 hours of training. For caregivers who will be working in settings that require specialty training, the complexity of the work is in many cases greatly increased, and therefore the associated risks for caregivers are increased. We recommend that this additional discussion of self-care include specific anecdotes about settings that include clients with developmental disabilities, how caregivers discovered the need for self-care, and how they managed to make time and space for self-care both in and away from the care setting. We believe that specific examples of successful self-care will be more powerful in helping caregivers to imagine themselves using these strategies.

In our research, we were able to identify only one other state that included self-care as a topic within specialty training—Minnesota has a short online module that focuses mainly on identifying and managing stress for caregivers. We believe that this is, in fact, an opportunity for Washington to show leadership in advocating for these measures that, by improving stress management for caregivers, directly contributes to better care outcomes.

Redesign the Resource Section as a stand-alone module that becomes a tool for caregiver use

Two consistent themes we heard from stakeholders—the desire to reduce the technical detail in the training materials, and the need for caregivers to have easy access to resources, contacts, and information—combine to form this recommendation. We recommend that DSHS design a stand-alone resource guide that will be distributed with the training materials, and will provide the caregiver a "cheat sheet" (Resource Card or App) for resources specific to the specialty (in this case Developmental Disabilities), and if possible specific to geographies. This may take many forms, but it should be simple, portable, and durable:

> "Could we develop a "student guide" that would be more useful to caregivers working in the field? Something they could have after the training that would give them quick access to the most critical information."

> "To have a resource available to call 24/7 when situations arise. This is after basic training of course. I think a 24/7 resource is important. A pocket guide would also be good."

> "We need to provide resources so caregivers know who to go to in the event of these crises."

The current Resources module is largely comprised of internet links, and it would be possible to list all of these links on one centralized webpage that could be referenced on the Resource Card or via a Resource App. In addition to the current resources listed, a redesigned Resource Card may include contact information for local or regional advocacy, informational, or service organizations. Providing a way for caregivers to customize their references for their residents is also desirable. For instance, having a space to add phone numbers for specific social workers may be helpful. Such a resource would allow the caregiver to have a single "go-to" source if they needed to reach out for information or assistance.

Update the look and feel of the training materials to reflect the importance of the topics

Current training materials are presented in a font that mimics handwriting, and are illustrated with nature-themed clip art graphics. This presents a somewhat dated look to the materials, and also may communicate a whimsical stance that does not convey to caregivers the importance of the topics they are learning. We recommend that updates to training materials receive a graphic treatment that is crisp and professional, and that the materials be illustrated with informational graphics and include photographs of caregivers interacting with clients. Such photographs would allow caregivers to envision themselves in the role of caregiver to clients with disabilities. Among the principles of andragogy (adult education) stated by Malcolm Knowles, the use of photographs would support both "need to know" – the need to understand the reason for learning something, and "readiness" – the principle that adult learners better attend to subjects that they perceive as having direct relevance to their work.

Further, Dual Coding Theory (DCT), first proposed by Allan Paivio in 1971, supports the inclusion of photographs and diagrams within the learning materials. DCT holds that human beings process information through parallel intellectual paths—one for language-based information and the other for non-verbal stimuli, such as visual imagery. When the two modalities are engaged simultaneously, retention and recall of the subject matter is heightened, and this effect has been demonstrated by many studies that have tested this theory over the past four decades. In a Change Magazine article, entitled *Applying the Science of Learning to the University and Beyond*, Diane F. Halperin and Milton D. Hakel state:

> A given piece of information can be organized and "stored" in memory in either or both of these representational systems. According to dual-coding theory, information that is represented in both formats is more likely to be recalled than information that is stored in either format alone. Learning and recall are thus enhanced when learners integrate information from both verbal and visiospatial representations. (Halperin and Hakel, 2003)

Use of photographs should be judicious and respectful, and should also reflect the diversity of both caregivers and those they care for.

5 | Recommendations: Instructional Quality

There is widespread support for the current level of instructional quality, both from the perspective of trainer qualifications and training efficacy. Where concerns were expressed, they generally had to do with opportunities to ensure greater consistency of training for all caregivers:

> "Training is not consistent. Trainers are human [and they have] different approaches, expertise, [and] knowledge. Sometimes managers teaching the classes don't really grasp the material themselves, [and] may just be reading/following [the] structure or showing video, vs. adding own experience, real-life scenarios."

Our recommendations related to instructional quality for the Developmental Disabilities specialty training are to update the trainer requirements, and to apply more rigor to the preparation, validation, and ongoing evaluation of those offering training:

- Maintain, to the degree possible, the use of the current cadre of experienced community trainers
- Enforce validation of subject matter expert (SME) qualifications for instructors
- Verify and enforce adult education qualifications for instructors
- Update the course evaluation/feedback mechanism, aligned to the principles of adult education, and institute an ongoing evaluation process for trainers

Maintain, to the degree possible, the use of the current cadre of experienced community trainers

Having a small cadre of highly trained instructors facilitates an environment of sharing ideas and best practices. This environment of collaboration contributes to knowledge sharing that can be seen in the training classroom through both curriculum and hands-on exercises.

We recommend that DSHS continue using a small group cadre of highly qualified trainers that are contracted from Service Alternatives. All the contracted trainers are developmental disabilities experts, have taken an adult education course, and have at least 200 hours of teaching.

In accordance with the application for contracted trainers, the minimum qualifications, as stated in WAC 388-112-0395, include teaching adults (e.g. the WAC requires 200hrs of teaching), work experience (e.g. The WAC requires two years full-time direct work experience with people who have developmental disabilities if you have a bachelor's degree, or a high school diploma and four years full time experience in the field of developmental disabilities with two of those in direct service with people who have developmental disabilities.), and education (The WAC requires a bachelor's degree, or high school diploma with four years full time work experience in the field of developmental disabilities.)

Many stakeholders voiced support for the current group of trainers, indicating that the current training is generally very strong, and is taught by excellent instructors:

> "The training was pretty good… my instructor was very good. She had to retrain how everybody thought. She taught a lot about disability rights and the struggle for that that a lot of us didn't know about. And she

> integrated 'rights' and 'choices' into the curriculum. These individuals do not need protection – they need somebody to help them promote those rights. You aren't there to keep them cared for and protected, you are there to help them exercise their choices."
>
> "We've had positive feedback to the curriculum and the instructors - so yahoo!"
>
> "I thought the 18 hours of instruction, over three days, worked very well and the methodology of instruction was very good."

Washington's requirements for trainers also compare very favorably to other states, generally surpassing their requirements. For instance, Vermont, which has a good reputation for its DD care, merely requires that trainers be registered nurses in order to teach its DD specialty training.

Enforce validation of subject matter expert (SME) qualifications for instructors

> "Taking this training a couple times by two very educated trainers was tremendous."

Instructors who have experience working with people with developmental disabilities can bring their experience into the classroom to enrich the learning experience. In light of this, we recommend that DSHS maintain the subject-matter expertise (SME) verification process that is currently in place, whereby the developmental disabilities specialty training instructor application for contracted trainers provides the mechanism for verifying that Service Alternative trainers meet the SME requirements of WAC 388-112-0395:

(1) The minimum qualifications for instructors for developmental disabilities specialty, in addition to the general qualifications defined in WAC 388-112-0380 (1) and (2), include:

> (a) The instructor must be experienced in developmental disabilities caregiving practices and capable of demonstrating competency in the entire course content, including the administration of competency testing;
>
> (b) Education and work experience:
>
> > (i) Bachelor's degree with at least two years of full-time work experience in the field of disabilities; or
> >
> > (ii) High school diploma or equivalent, with four years full time work experience in the field of developmental disabilities, including two years full time direct work experience with people who have a developmental disability; and
> >
> > (iii) Successful completion of the eighteen-hour developmental disabilities specialty training under WAC 388-112-0120. *(Note: this would be the 12-hour training if the recommendations of this report were implemented.)*
>
> (c) Teaching experience:
>
> > (i) Two hundred hours of teaching experience; and
> >
> > (ii) Successful completion of an adult education class as follows:
> >
> > > (A) For instructors teaching alternative curriculums, a class in adult education that meets the requirements of WAC 388-112-0400;
> > >
> > > (B) For instructors teaching developmental disabilities specialty training, successful completion of the DSHS instructor qualification/demonstration process.
>
> (e) Has been approved and contracted by the department as a community instructor.
>
> (f) Instructors who will administer tests must have experience in assessment and competency testing.

(2) Instructors for developmental disabilities specialty training:

> (a) Developmental disabilities specialty may be taught by an assisted living facility administrator (or designee), adult family home provider (or designee), or corporate trainer, who has successfully completed the mental health or manager dementia specialty course, the eighteen hour developmental disabilities specialty training, and has successfully completed the instructor qualification/demonstration process. A

> qualified instructor under this subsection may teach developmental disabilities specialty to long-term care workers employed at other home(s) licensed by the same licensee.
>
> (b) Developmental disabilities specialty taught by a person who does not meet the requirements in subsection (2)(a) must meet the same requirements as the instructors for developmental disabilities specialty in subsection (1).

To the extent that there is a reasonable system in place at DDA or ALTSA to ensure that these requirements are met, this should be maintained. Otherwise, it is recommended that active review and enforcement of these requirements be implemented.

Verify and enforce adult education qualifications for instructors

Instructors who understand how adults learn are more able to meet learners where they are, based on their learning styles, and ensure all students achieve the learning outcomes and objectives for training. Currently, adult education is woven through the curriculum, the trainer preparation, and reflected in the DSHS Training Guide.

We recommend that DSHS maintain the adult education qualification process that is currently in place. In accordance with the WAC 388-112-0390, the minimum requirements for instructors include the successful completion of an adult education class. In accordance with WAC 388-112-0400, an adult education class must include adult education theory and practice, facilitation techniques, learning activities for adults, competency testing, and working with adults with special training needs (e.g. ESL).

Applicants are reviewed by DSHS to ensure that they meet these requirements, and vendors presumably ensure that each applicant meets the requirements of the contract before an application is submitted to DSHS for contracting consideration.

> "During the training - lets talk about if this work is for you, who you are comfortable supporting, how do you spend your working time, how do you handle people who challenge you? (From a trainer perspective) Some people welcome this; others decide it is not what they want to do after all. Some people come and do not understand the concepts and not getting the message [to determine if the job is appropriate for them and their capabilities]. Sometimes they cannot visualize what the job entails."
>
> "Communication style of the trainer has to be flexible, so that all cultures can learn the information"
>
> "Consider a better 'train-the-trainer' model that ensures more consistent delivery and skills."

Adult learner-centered training is also characterized by its focus on the competencies that trainees need to perform well on the job. It takes into consideration their concrete, immediate needs and builds on the knowledge, attitudes, and skills that trainees have gained through their life experiences. The varied experiences of participants enrich the learning environment and bolster participants' confidence in learning new material. (PHI, 2008)

Update the course evaluation/feedback mechanism, aligned to the principles of adult education, and institute an ongoing evaluation process for trainers.

Continuous improvement is an important part of any training program. By actively seeking and receiving feedback instructors take an active role in the intentional learning process ensuring that course content, materials, and activities are continually refreshed and up to date.

As per the Service Alternatives contract, there exists an evaluation form that is collected after each training session. These evaluations are provided to DSHS once a year, or upon request. The tool itself is simple to read, understand, and use. We recommend a relatively simple change to this existing course evaluation mechanism: update 2 or 3 questions that focus on adult education best practices to help instructors identify growth opportunities and quality of training experience for those going through the training.

> "It would be great if an outside party would come in assess our trainers and provide feedback to make it better and more consistent. We want caregivers to walk out of training being wowed."

Specific questions that may be added to the evaluation include:

- Did the instructor actively involve you in the learning process?
- Did the instructor draw out the learners' own experiences and knowledge that is relevant to the topic?
- Did the instructor explicitly tell the learners how and when they would be able to use/apply what they are learning?
- Did the instruction include a variety of visual, auditory, read/write, and motion-based activities?

In addition to the ongoing collection of these assessments, we recommend that DSHS institute a regular process for ongoing in-person observations of trainers, perhaps on an annual basis, to monitor quality of instruction.

6 | Recommendations: Program Design

A guiding principle of our analysis has been to keep an eye on how changes are likely to affect outcomes in terms of care delivery. Affecting care outcomes means that information must be delivered to caregivers easily and in ways that will best support their learning. Of the changes recommended in this section, those that indicate the most radical change are in support of greater accessibility, both in terms of physical/locational access, and in terms of cognitive access.

The following recommendations suggest changes we believe would increase access, support greater understanding of training materials, and add greater rigor and accountability to the existing system:

- Reduce 18 hours of training to 12 hours, and split it into 2 parts:
  - 6-hour competency-based online training
  - 6-hour in-person skills training
- Update language options for trainings:
  - Online training available in English, plus the five most commonly-spoken languages in care settings
  - In-person training in English only
- Training validation: online training validated automatically by the training system; in-person training validated by the trainer
- Develop a two-hour online manager training for managers and supervisors in care settings where residents have developmental disabilities, and require both online and in-person assessment of managers.
- Develop a two-hour online adult education training, and require completion of this course for any managers or providers who wish to train their staff in any of the three caregiver specialties.
- Require active demonstration of training competency for managers or supervisors who wish to train their employees.
- Require caregivers to have specialty training for every specialty in the home or facility, if they are providing care to those clients.
- Rename the training, and develop additional levels of training in order to achieve “specialty” designation
- Open online and/or in-person training to families and others

Reduce 18 hours of training to 12 hours, and split it into 2 parts: a 6-hour competency-based online training, and a 6-hour in-person skills training

As stated in the Content section, we recommend that the training for DD specialty be reduced to approximately 12 hours of instruction, half online and half in-person.

The online training should be competency-based, whereby learners can learn at their own pace, can “test out” of portions they already have knowledge of, and move forward to new competency sections upon completion of a previous section. Learners should not be expected to “sit through” training if the material is already known to them, as this likely does nothing to improve care outcomes and has the potential to cause learners to disengage from the material. To the degree possible, learners should be provided with an opportunity to connect with other learners online. This may take the form of online forums, video chats, or other options.

The in-person portions of the training would continue to be taught by approved community instructors, and would focus on interactive learning experiences around behaviors and communication. This is where learners would get the chance to try out care approaches in a safe space with other learners.

A 2010 US Department of Education meta-analysis looked at how online learning compared to in-person learning, and found that studies generally indicated an advantage for online training:

> Learning outcomes for students who engaged in online learning exceeded those of students receiving face-to- face instruction, with an average effect size of +0.20 favoring online conditions. (Means, Toyama, Murphy, Bakia, and Jones, 2010)

The analysis, focused primarily on adult learners learning job-related information, found that different methods of online instruction did not lead to significant changes in learning quality, with one exception—when online learning was combined with in-person learning, learning was enhanced. The study's authors were careful to point out that this may have more to do with other factors such as additional learning time, and may not be related, per se, to the combination of online and in-person learning. Nevertheless, this provides validation that the split we are recommending between in-person and online training will not be likely to diminish learning outcomes.

An additional factor that may prove to be useful in the design of future specialty training curriculum is the use of learner reflection:

> …manipulations that trigger learner activity or learner reflection and self-monitoring of understanding are effective when students pursue online learning as individuals. (Means, Toyama, Murphy, Bakia, and Jones, 2010)

To the extent that any future online curriculum is developed for the Developmental Disability Specialty Training, this finding suggests that the incorporation of "break points" within the training—especially the online portions—that engage the learner in reflection and self-assessment of learning may enhance reception and retention of information.

Update language options for trainings: create an online training available in English, plus the five most commonly-spoken languages in care settings; redesign the remainder of the training as an in-person training in English only

As indicated in the Content section of this report, we recommend that the proposed online portion of the specialty training be made available not only in English, but also in up to five of the most commonly-spoken languages in care settings. These languages should be identified based on an analysis of the native languages of caregivers throughout the system, and not based on the languages spoken by clients or the state's population at large. Because of the unique demographics of caregivers, there are languages spoken by groups of caregivers that may not be among the most common languages in Washington.

The portions of the training we recommend translating are those that require comprehension and retention of technical information, which we believe will be more effectively learned in the caregiver's native language, regardless of whether that language is used in the care setting. These modules are coincident with those modules that we are recommending for the online portion of the training, so that the in-person portions of the training—particularly those parts that require role-playing of care scenarios—would still be conducted in English.

Those modules, which would be translated, include:

- Overview – approx. 1 hour (7-pg equiv.)
- Values – approx. 1 hour (7-pg equiv.)
- Legal Issues & Rights – approx. 2 hours (13-pg equiv.)
- Intro to Interactive Planning – approx. 1.5 hours (9-pg equiv.)
- Self Care – approx. ½ hour (4-pg. equiv.)

We recognize that the creation of translated online training that may include some video and interactive elements will be a significant challenge for DSHS, but we also believe that the potential for improvement of care outcomes is great, and warrants this change.

Training validation: online training should be validated automatically by the training system; the trainer should validate in-person training

If our recommendation to split the training into online and in-person segments is adopted, it will cause some additional clerical burden for DSHS in keeping track of when caregivers have successfully completed training sections. Splitting the training in two effectively doubles the number of validations that must take place.

Therefore, if possible, the online training system should provide an automatic update to a DSHS database when learners complete the online portion of the training. In-person training would continue to be validated by the trainer, with details submitted to DSHS.

Develop a two-hour online manager training for managers and supervisors in care settings where residents have developmental disabilities, and require both online and in-person assessment of managers.

Caregiver turnover is most often associated with poor supervision practices (Larson, Lakin, and Bruininks, 1998). When a caregiver leaves, a replacement will start the training cycle over again, and the new caregiver will need to learn all the intricacies of the specific care environment. For these reasons, among others, it is desirable to retain caregivers to provide continuity and quality of care to residents. This means having sufficiently trained supervisors who can create engaging work environments. However, there is currently no manager training for Developmental Disabilities specialty, while there are manager trainings for the other specialties.

> "[There should be] caregiver, manager and instructor levels for the test. I would like instructors to have teaching experience, but also more intensive training."

We propose an online manager training be developed that would supplement the caregiver training for those who will be supervising other caregivers. This training would be the equivalent of approximately two hours of in-person training. Much of the content could be standardized for all specialties, and could cover topics related to the additional challenges in homes with specialty designations. The balance of the training could be customized to Developmental Disabilities.

Many other states having specific caregiver supervisor trainings require far greater than a two-hour training, but we believe that a few basics can be communicated in this short training module. Some topics may include:

1. Resident assessment, admission, retention, specific to DD specialty
2. Laws and regulations, specific to DD specialty
3. Use and misuse of medication, specific to DD specialty
4. Employee engagement, general
5. Washington state requirements, general

Currently, providers and their designated supervisors are required to meet many requirements, but demonstrated managerial knowledge and skills are not among them. We propose a much more rigorous process that would require managers to be assessed not only within the online training module, but also through an in-person competency evaluation conducted by DSHS. We recognize that this recommendation adds considerable complexity for both DSHS and for providers. However, the potential for enhanced leadership skills to positively impact employee engagement and retention could offer significant improvement for care outcomes and for the bottom line of facilities, as recruitment and training are more expensive than retention. Additionally, no amount of training can replace the skills and knowledge gained providing direct care. With that in mind, the shortest path to improved care outcomes is to retain good caregivers, rather than better training for new ones.

Develop a two-hour online adult education training, and require completion of this course for any managers or providers who wish to train their staff in any of the three caregiver specialties.

While the great majority of DD specialty training is currently provided by highly-qualified community instructors, there is also an option available for providers and managers to offer the training themselves, to their own employees. Within the other specialties, this option is likely more commonly used, as the DD training is currently the only specialty training paid for by DSHS. In other words, the financial incentive for providers and managers to offer the DD training to their employees is diminished. However, in the spirit of maintaining accessibility for the training, we recommend that this option remain, with the condition that the provider or manager has received both the manager training (specified above) and an additional two-hour equivalent "train the trainer" course that would provide instruction in adult learning principles and best practices for instruction of the material. This training module could be developed in such a way that it would be universal for all current and future specialties, including Developmental Disabilities, Dementia, and Mental Health.

Specific topics of this training may include:

1. Actively involving learners in the learning process.
2. Drawing out learners' experience and knowledge relevant to the topic.
3. Providing clear course goals and objectives.
4. Describing explicitly how and when the learners will be able to use/apply what they are learning
5. Using tones, gestures, eye contact and language to communicate respect for the learner
6. Addressing VARK preferences in each class: visual, auditory, read/write and kinesthetic

Many of these themes would be actively reviewed for each trainer in the additional training evaluation questions we recommend on page 32.

Require active demonstration of training competency for managers or supervisors who wish to train their employees.

Given the importance of the information to be conveyed, we recommend the highest rigor in the screening of managers who wish to train their staff, requiring documentation of all requirements, and no longer allowing for self-attestation on any items. Active demonstration of training competency should also be required upon completion of the two-hour adult education training, as described on page 38.

Require caregivers to have specialty training for every specialty in the home or facility, if they are providing care to those clients.

Currently, the WAC (388-112-0115) allows that a caregiver working in a care setting where multiple specialties are present (e.g. a home where one or more clients have both developmental disabilities and dementia) may choose one specialty to train in, and is not required to train in the other specialt(ies). Presumably, this is to avoid placing an onerous burden on providers and caregivers, but we believe it is a loophole that is not in the best interest of clients, and does not contribute to best possible care outcomes.

We recommend that, moving forward, new caregivers are required to receive specialty training for all specialties present in their care environment, when and if those specialties become present. The state may wish to mitigate this change by allowing secondary or tertiary specialty trainings to occur over a longer timeframe, in order to distribute the burden over time.

Rename the training, and develop additional levels of training in order to achieve "specialty" designation

The current training, while designated as "specialty" training, does not truly create specialists in the care of individuals with developmental disabilities. This was expressed many times by stakeholders, and applied to all three current specialty trainings:

> "Calling it specialty training is misleading—it doesn't make people specialists… it's a misnomer when we say a home is now a specialized provider [when their caregivers have taken this training]."

At the same time, we heard from many stakeholders that they would be very open to the notion of tiered training that would allow caregivers and facilities to gain increasingly specialized training and designation over time. This may take the form of additional training modules that are additive to the revised introductory training, and taken as part of continuing education. A caregiver would gain higher designations only after completing these additional tiers of training, and completing a certain number of hours of direct caregiving. Based on these conversations and our research, we recommend the following model for tiered training:

For individuals whose primary job responsibilities include providing long-term support for populations with Developmental Disabilities, a three (3) tier education approach is offered within Washington State. To be awarded a certificate for each level, all workshops and additional requirements must be completed:

- Level 1: Basic DD Caregiver, Level 1
- Level 2: Certified DD Caregiver, Level 2
- Level 3: Certified DD Caregiver, Level 3

The table below illustrates the levels of training and their prerequisites:

	Requirements				
Developmental Disabilities Caregiver Trainings		**Hrs**	**Level 1**	**Level 2**	**Level 3**
Basic DD Technical Training (Level 1)	O	5.5	x	x	x
Basic DD Skills Training (Level 1)	IL	6.5	x	x	x
Developmental Disabilities Caregiver Level 2	O	12		x	x
Developmental Disabilities Caregiver Level 3	O	12			x
Manager and Trainer Classes					
Care Manager Training	O	2	n/a	n/a	n/a
Adult Education Training*	O	2	*	*	*
Active Demonstration of Trainer Competency	IL	TBD	n/a	n/a	n/a
*Trainers are subject to additional requirements, per WAC 388-112-0395					

O = Online Learning, IL = Instructor Led, D = Documentation

Basic Developmental Disabilities Caregiver (Level 1)

Complete a combination of 12 hours of training in each population category (5.5 hours technical training online, 6.5 hours skills training, instructor led). Once you have completed workshops for a total of 12 hours, you will receive your Basic DD Caregiver certification:

Basic DD Technical Training

- Overview
- Values
- Legal Issues & Rights
- Intro to Interactive Planning
- Self-Care

Basic DD Skills Training

- Understanding Behavior
- Effective Communication
- Crisis Prevention & Intervention

Developmental Disabilities Caregiver Level 2

Once you have completed Level 1 training, complete an additional 12 hours of training for a total of 24 hours. Receive a certificate for DD Caregiver Level 2.

Minimum requirements for certification: (i) Bachelor's degree with at least two years of full-time work experience in the applicable field; or (ii) High school diploma or equivalent, with four years full time work experience in the applicable field, including two years full time direct work experience with the applicable population of individuals; (iii) Additional requirements outlined in the WAC for community instructors.

Choose a combination of modules to equal the 12 hours of relevant training for your population/interest:

- Autism
- Bipolar
- Cerebral Palsy
- CJD
- Down Syndrome
- Epilepsy
- Parkinson's Disease
- Substance Abuse

Developmental Disabilities Caregiver Level 3

Once you have completed Level 2 training, complete an additional 12 hours of training for a total of 36 hours. Receive a certificate for DD Caregiver Level 3.

Minimum requirements for certification: (i) Bachelor's degree with at least three years of full-time work experience in the applicable field; or (ii) High school diploma or equivalent, with five years full time work experience in the applicable field, including three years full time direct work experience with the applicable population of individuals

Choose a combination of modules to equal 12 hours of relevant training for your population/interest:

- Autism
- Bipolar
- Cerebral Palsy
- CJD
- Down Syndrome
- Epilepsy
- Parkinson's Disease
- Substance Abuse

Care Manager Certification

Advance your professional development and get your Care Manager Certification. Complete an additional 2 hours of training specific to the manager's role to receive a Care Manager Certification:

- Resident assessment, admission, retention
- Laws and regulations
- Use and misuse of medication
- Employee engagement (general)
- Washington state requirements

Specialty Trainer Certification

Complete two hours of adult education training and document all trainer requirements as described in WAC 388-112-0390 to earn designation as a Specialty Trainer. Learning objectives for the adult education training include:

- Actively involving learners in the learning process
- Drawing out learners' experience and knowledge relevant to the topic
- Providing clear course goals and objectives
- Describing explicitly how and when the learners will be able to use/apply what they are learning
- Using tones, gestures, eye contact and language to communicate respect for the learner.
- Addressing VARK preferences in each class: visual, auditory, read/write and kinesthetic

Open online and/or in-person training to families and others

We heard from many stakeholders that these trainings would be valuable to a broader community than caregivers who are employed by Adult Family Homes or Assisted Living Facilities. Families who care for loved ones directly, families who want to understand the care provided for their loved ones, DSHS employees who oversee care programs, and Ombuds volunteers were all cited as possible audiences for these trainings. While the current training is provided to caregivers free of charge, it may be possible to offset some of these costs by offering the training for a fee to other audiences.

7 | Recommendations: Washington Administrative Code

The recommendations in this report, if adopted by DSHS, will also require changes to related passages in the Washington Administrative Code. Because of this likelihood, the outreach part of this process also served the purpose of allowing public input around potential WAC updates.

It is our belief that the changes recommended in this report can be undertaken without changes to the Revised Code of Washington, and that any changes would apply solely to passages of the Washington Administrative Code. In other words, these changes can be made by rule, and will not require a change in statute.

We have listed below the WAC sections that we believe are affected by each of our recommendations, though a thorough review of potential WAC changes and potential RCW intersections by DSHS staff and/or legal counsel is recommended.

Collapse 18 hour training to 12 hours – half online, half in-person

The length of training is not specified in the WAC, and therefore this recommendation is not likely to require changes.

Increase focus on the *Understanding Behavior* section

WAC 388-112-0120

Because it does not add or remove a section, this recommendation does not appear to require a change to this portion of the WAC.

WAC 388-112-0122

To the extent that competencies or learning objectives are changed based on this recommendation, a change to this portion of the WAC may be necessary.

Reduce focus on the Overview of Developmental Disabilities and Values of Service Delivery sections

WAC 388-112-0120

Because it does not add or remove a section, this recommendation does not appear to require a change to this portion of the WAC.

WAC 388-112-0122

To the extent that competencies or learning objectives are changed based on this recommendation, a change to this portion of the WAC may be necessary.

Include Trauma-Informed Care as a topic in the *Crisis Prevention and Intervention* section

WAC 388-112-0120

Because it does not add or remove a section, this recommendation does not appear to require a change to this portion of the WAC.

WAC 388-112-0122

To the extent that competencies or learning objectives are changed based on this recommendation, a change to this portion of the WAC may be necessary.

Add the topic of sexuality to the Values of Service Delivery and Overview of Legal Issues and Individuals' Rights modules of the training

WAC 388-112-0120

Because it does not add or remove a section, this recommendation does not appear to require a change to this portion of the WAC.

WAC 388-112-0122

To the extent that competencies or learning objectives are changed based on this recommendation, a change to this portion of the WAC may be necessary.

Update the *Overview of Legal Issues and Individuals' Rights* section to include current information related to Home and Community Based Services and impending changes with the Community First Choice option, both resulting from the Affordable Care Act

WAC 388-112-0120

Because it does not add or remove a section, this recommendation does not appear to require a change to this portion of the WAC.

WAC 388-112-0122

To the extent that competencies or learning objectives are changed based on this recommendation, a change to this portion of the WAC may be necessary.

Bolster instruction around the inclusion of families

WAC 388-112-0120

Because it does not add or remove a section, this recommendation does not appear to require a change to this portion of the WAC.

WAC 388-112-0122

To the extent that competencies or learning objectives are changed based on this recommendation, a change to this portion of the WAC may be necessary.

Augment topic of self-care currently found in basic training

WAC 388-112-0120

Because it does not add or remove a section, this recommendation does not appear to require a change to this portion of the WAC.

WAC 388-112-0122

To the extent that competencies or learning objectives are changed based on this recommendation, a change to this portion of the WAC may be necessary.

Redesign the *Resource Section* as a stand-alone module that becomes a tool for caregiver use

WAC 388-112-0120

Because this may create a stand-alone module, which DSHS may want referenced in the WAC, attention should be paid to this section of the WAC if this recommendation is implemented.

Update the look and feel of the training materials to reflect the importance of the topics

This recommendation does not appear to require a change to the WAC.

Maintain, to the degree possible, the use of the current cadre of experienced community trainers

WAC 388-112-0395

This recommendation reinforces existing requirements, and is not likely to require a change to this portion of the WAC.

Enforce validation of subject matter expert (SME) qualifications for instructors

WAC 388-112-0395

This recommendation may require revision of this portion of the WAC, because we are recommending that assisted living facility administrators, adult family home providers, and their designees be required to demonstrate and document the same level of qualification as community trainers.

Verify and enforce adult education qualifications for instructors

WAC 388-112-0395

This recommendation may require revision of this portion of the WAC, because we are recommending that assisted living facility administrators, adult family home providers, and their designees be required to demonstrate and document the same level of qualification as community trainers.

Update the course evaluation/feedback mechanism, aligned to the principles of adult education, and institute an ongoing evaluation process for trainers.

This recommendation does not appear to require a change to the WAC.

Reduce 18 hours of training to 12 hours, and split it into 2 parts:

- 6-hour competency-based online training
- 6-hour in-person skills training

The length of training is not specified in the WAC, and therefore this recommendation is not likely to require changes.

Update language options for trainings:

- Online training available in English, plus the five most commonly-spoken languages in care settings
- In-person training in English only

Training delivery language does not appear to be specified in the WAC, and therefore this recommendation may not require any changes to the WAC.

Training validation: online training validated automatically by the training system; in-person training validated by the trainer

WAC 388-112-0155

Because online portions of the training will be auto-validated by the system, which was not foreseen by this portion of the WAC, an update is likely to be necessary if this recommendation is adopted.

Develop a two-hour online manager training for managers and supervisors in care settings where residents have developmental disabilities, and require evaluation of managers

WAC 388-112-0160

Currently, adult family home applicants, providers, entity representatives and resident managers must either take manager training or the 18-hour developmental disabilities training. Because this recommendation adds a specific manager training for all specialties, changes are likely necessary for this portion of the WAC.

Develop a two-hour online adult education training, and require completion of this course for any managers or providers who wish to train their staff in the specialty

WAC 388-112-0400

Because we are recommending the development of a new adult education online curriculum, the details of this section of the WAC are likely to require updates.

Require caregivers to have specialty training for every specialty in the home or facility, if they are providing care to those clients

WAC 388-112-0115

This recommendation is likely to require a change to this portion of the WAC because it will require more training than is currently required.

Rename the training, and develop additional levels of training in order to achieve "specialty" designation

WAC 388-112-0110

Because this recommendation will likely change the very definition of "specialty" training, this portion of the WAC will likely require updates.

Open online and/or in-person training to families and others

It does not appear that opening the training to others will require changes to the WAC.

8 | Resources & Bibliography

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