



## Dementia 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 and Assisted Living Facilities. 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.

Broadly speaking, requirements for the training of dementia specialty caregivers varies widely from state to state and in other jurisdictions. Some require no additional training in order to care for patients with dementia, while some require far more training than Washington's current requirements. We found many areas where current thinking and research points to ways in which the dementia specialty training can be made better, and we heard from many stakeholders what they would like to see in future versions of the training. This research effort also included visits to Adult Family Homes and interviews with caregivers and providers.

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 Dementia 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/ALISA/stakeholders/documents/specialtytraining/DSHS Outreach Report.pdf](https://www.dshs.wa.gov/sites/default/files/ALISA/stakeholders/documents/specialtytraining/DSHS%20Outreach%20Report.pdf)

### Key Stakeholder Comments Related to Content of Dementia Specialty Training

**One of the most important topics covered by the training is communication, and those skills and techniques cannot be emphasized enough.**

Because communication skills are so central to the interactions between caregivers and residents, stakeholders emphasized the need for the specialty training to provide caregivers with the knowledge and tools they need. This includes verbal and non-verbal communication skills, as well as skills related to approaching residents and communicating across language barriers. Caregivers need additional training in how to build understanding of where the patient is coming from.

- › “Knowing special communication skills and techniques, enabling the caregiver to communicate with the resident and to help the resident communicate with others is key.”
- › “[On the job], I learned a lot about non-verbal communication and how it impacts the dementia clients.”
- › “I find caregivers often struggling in interpreting what [residents] are attempting to communicate, even if it is non-verbal. A lot of times, it is more body language.”

**Many of the biggest challenges at facilities are related to an inability to mitigate behaviors. There is a training gap to prevent and deal with challenging behaviors.**

Stakeholders believe that a greater emphasis should be put on techniques for preventing and diverting disruptive behaviors, rather than on diagnoses and responses to behaviors. This includes caregivers having sensitivity to the resident's environment, and to the use of touch in communication. Caregivers need to understand how much of an influence their actions can have on preventing behaviors, and because so many caregivers are entry-level, they need the basic understanding of how to deal with the behaviors that do arise.

- › “I think the concept that [resident] behavior is a form of communication is invaluable to all the specialty trainings.”
- › “Whenever I experience a difficult situation with a sufferer of dementia I remember what is actually happening in this person's physical body that can create this behavior and I am able to remain compassionate. I believe it lessens the frustration that can occur, as then my frustration is with the disease not the person suffering from it.”
- › “[Important skills include] behavior management and how to deal with people in crisis, [as well as] how to determine causes of unwanted behavior and how to deescalate a situation.”

## 2 | Summary of Stakeholder Input

- › “Spend more time instructing caregivers how to be proactive – approaching the residents better and setting up situations where problematic behaviors don’t emerge, rather than so much of the curriculum being focused on responses once the behaviors have occurred.”
- › “The behavior module has some good ideas, but they are so far off from the real world - they are so technical that they don’t do the basic problem solving that we used to do in the old days.”

### **Specialty training should build empathy and recognition of the individuality of residents.**

Stakeholders identified that Adult Family Homes and Assisted Living Facilities are people’s homes, and should focus on maximizing independence and help people live out the end of their lives. Allowing residents to have their own voices is invaluable to this process, and caregivers need to develop empathy for clients and understand them as individuals. Understanding each resident’s background may be one of the most important inputs to how they are cared for, and this is not adequately covered in the current dementia caregiver training curriculum. Stakeholders also agreed that a quality facility includes the family as part of the team, and will learn the history of the resident from their family. Understanding a resident’s history and baseline are essential to the caregiver’s ability to note changes when they occur.

- › “[There should be more] discussion about empathy - training should ‘teach’ or at least ‘wake them up’ to understanding the other person.”
- › “These people are individuals and need to be treated as such.”
- › “Encourage a team approach in the delivery of care. Create a Person Centered Care Philosophy for your facility.”
- › “It’s important that they know to get the resident’s history from the families.”

### **The specialty training should build a basic understanding of physiological changes and disease progression, without dwelling on rote memorization of details such as diagnoses and medications.**

A particularly consistent theme among stakeholders was that the training spends too much time focusing students on memorizing technical facts, when it should spend more time on helping them build understanding and skills. Many stakeholders believe that caregivers can get by with a basic understanding of physiological changes and disease progression, and that an understanding of these will lead to greater empathy for the clients.

- › “Add two more hours to teach the basic causes of various types of dementia along with some basic anatomy and physiology. This would allow the students to better understand why they are seeing the various symptoms and behaviors in the people they are caring for.”
- › “Learning the disease process, the progression and also all the symptoms that come with it has helped me immensely to appreciate [the residents] more and be able to provide respectful and compassionate care for dementia clients.”
- › “The photos, and [gaining] understanding of the brain changes was very important.”

## **Key Stakeholder Comments Related to Instruction for Dementia Specialty Training**

### **Dementia specialty training is not as thorough as it once was, and is now inadequate.**

Dementia specialty training was once a much longer and more involved affair, and those stakeholders who remember that training believe that the entire system has been weakened because of the shortened training and lower requirements.

- › “When I got trained, it was a week, and [even then] I didn’t have a full understanding until I was out there meeting residents.”
- › “Training has gone downhill since what I took many years ago.”

### **The dementia specialty training materials need to be updated, including the video.**

Although updating the training materials is the expressed purpose of this Stakeholder Outreach Tour, stakeholders nevertheless were explicit about the need for a refresh of these materials. They believe that there is new information and knowledge about dementia that is important to include, that the materials are not as engaging as they should be, and that they could also be improved in terms of their ability to convey information.

## 2 | Summary of Stakeholder Input

- › “Update your manuals. Update your videos. Refresher courses are needed.”
- › “Your videos and dementia care specialty training manuals are a little outdated.”
- › “One of the biggest things is to recognize that book was written a long time ago, and we have new information.”

### **Care for residents with Dementia is a complex subject and cannot be adequately taught in one day of training.**

Stakeholders said that the training is not long enough for a caregiver to be well-prepared or a “specialist”. More time is needed to discuss each topic, ask questions, and go back and forth to ensure learning, and optimal learning often occurs from a combination of classroom and hands-on training environments. Many stakeholders questioned whether it might be possible to assess the actual interactions with clients in care homes, in addition to the formal training. It should be noted, however, that other stakeholders were resistant to the idea of lengthening training because of the added cost burden it would impose.

- › “There are a lot of topics that are covered, almost too much information in one day. Suggest the class be over a couple of days to prepare for the test.”
- › “Eight hours is not sufficient to teach someone who has no experience with dementia.”
- › “There is too much information to learn in only eight hours of training. More time is needed to discuss each topic, ask questions and go back and forth to ensure learning.
- › “We have extended the trainings to nine hours (including the test) based on feedback from our trainers - they told us that it was too much information [for eight hours].”
- › “Feels like caregivers are short-changed in the information that they need, which ultimately shortchanges the population under care.”
- › “I think that (the shortening of the training) has done harm for Adult Family Homes.”

### **Training is often difficult to access, and there is interest in other delivery methods including online training.**

For those who are not trained within the organization they work for, accessing training is often difficult and expensive. This includes challenges with the need for “covering” a caregiver while they are away at training, and the relative lack of trainings during evening and weekend hours. For more rural homes, traveling to training is a barrier. Many caregivers suggested that DSHS look into alternative options for the delivery of training.

- › “The content is fine, but we need improved access [to the training].”
- › “Online training would be helpful for rural areas.”
- › “Offer online class, then go meet with real person for assessment; would allow for self-pacing and more time to digest information. (Could have a blend of both online and in-person.)”
- › “I would like to see interactive ONLINE training.”

### **Training is not delivered in a consistent manner.**

The skills of trainers vary greatly, from highly-experienced community trainers, to providers training their own staff. In some cases, there may even be fraudulent confirmations that training has taken place. Many stakeholders indicated a need to find ways to ensure that training happens in fact, and that there is greater consistency in the delivery of the materials.

- › “The ability of the provider to delegate knowledge is not working.”
- › “Taking this training a couple times by two very educated trainers was tremendous.”
- › “Some instructors just play the video and don't interact much. Consider monitoring/observing how training is delivered to ensure that trainers are competent.”
- › “...The manager says they cannot afford to send folks to training so he/she became a facility instructor, and now just hands the book to the staff member, tells them to read it, and then gives them the test. The staff tell me they are supposed to take it in class, and the manager just tells them to tell the surveyors they did if they ask.”

**Learning should not end once a caregiver takes the training. Options for refreshers, resources, and reference materials should be examined.**

Many stakeholders recalled that they didn't truly begin to understand the material from their training until they were in the home providing care. Recognizing that much of the learning of skills happens on the job, questions were raised about how that ongoing learning could be supported with additional materials, ongoing access to resources, and portable "quick guide" sheets.

- › "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."
- › "Training needs to be more 'real world' and longer. 4-6 hours is not enough. At least 2-3 times a year that they go back and get a refresher."
- › "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."

**Key Stakeholder Comments Related to Dementia Specialty Training Requirements and Testing**

**The test is overly academic and creates anxiety without effectively validating understanding.**

Stakeholders frequently indicated that the specialty training test is overly academic and creates anxiety without effectively validating understanding. One idea that surfaced in response to the testing discussion was to consider interspersing the testing between modules, instead of all at the end.

- › "[The entire training is] too much like memorizing material in high school to pass a test."
- › "[The exam] feels stressful, awkward and fake."
- › "[The manager test is] a terrible, awful test. It feels like a very academic exercise, and that it has not tested whether I as a manager am going to be able to lead the way in managing patients with dementia."
- › "At the class, they [caregivers] get nothing – they are stressed for how to take the test."

**There are challenges related to varied levels of English proficiency.**

Because many caregivers do not speak English as a first language, there are lingual challenges related to the training and the test. Many stakeholders felt that it is essential for caregivers to have enough English proficiency to take the training and pass the test, while others argued that building an understanding of the care principles is more important, regardless of the language it is learned in or tested in. Some suggested translating training documents into 5 most common languages and offering training in those languages to help caregivers that do not speak English as their first language.

- › "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."
- › "Another training item to consider is how well [owners and managers] can relate to their [staff members who] do not speak English."
- › "Right now I have a specialty training going on, and two ladies are going to fail the test, and it's because they don't speak English."

**There is interest in looking at different "levels" of training, beyond what exists now.**

Aside from specialty training improvements that stakeholders suggested for all caregivers, there was also interest expressed in making higher levels of specialization available. Many suggested that referring to the current level of training as "specialization" is misleading, but that if higher levels were added, it could become an appropriate label.

- › "[We should have] multiple levels of training. I think it would help."
- › "[There should be] caregiver, manager and instructor levels for the test. I would like instructors to have teaching experience, but also more intensive training."

## 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.

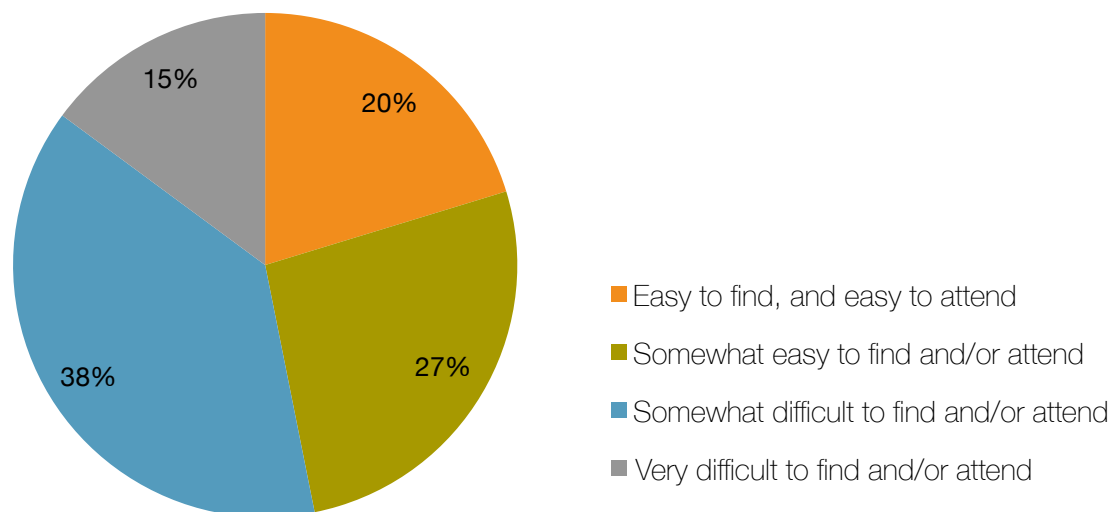
- › "I have heard that we should break out the manager training... a lot of what is in the training for the caregivers..."
- › "What skills should managers have? Should there be different training? It seems to me that maybe something around leadership and quality - how to evaluate and how to be a good 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."
- › "[DSSH 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.

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. 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 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 dementia specialty training, and what requirements they had for trainers. A brief summary of those findings follows:

## Alaska

Alaska has no dementia training requirements.

## Arizona

Arizona requires those working in direct care have an overview of Alzheimer's and other dementias.

## Arkansas

All staff must be trained within five months of hiring, with no less than eight hours of training per month during those five months. The following subjects must be covered in the training: facility policies; etiology, philosophy and treatment of dementia; stages of Alzheimer's disease; behavior management; use of physical restraints, wandering, and egress control; medication management; communication skills; prevention of staff burnout; activity programming; ADLs; individual-centered care; assessments; and creation of individual support plans. At least two hours of ongoing in-service training is required every quarter.

## District of Columbia

Assisted Living Residences: After the first year of employment, and at least annually thereafter, a staff member shall complete a minimum of 12 hours of training on cognitive impairments approved by a nationally recognized and creditable organization with expertise in Alzheimer's disease and related disorders.

## Georgia

In addition to the requirements for all staff, staff in facilities that serve residents with cognitive deficits must develop and train staff on policies and procedures to deal with residents who may elope from the facility. Staff of a specialized memory care unit or home must also have training on the facility's philosophy of care for residents with dementia, common behavior problems, behavior management techniques, the nature of Alzheimer's disease and other dementias, communication skills, therapeutic interventions and activities, the role of the family, environmental modifications that create a more therapeutic environment, development of service plans, new developments in diagnosis and therapy, skills for recognizing physical or cognitive changes that warrant medical attention, and skills for maintaining resident safety.

## Idaho

If the facility admits or retains residents with a diagnosis of dementia, staff must be trained in the following topics: overview of dementia; symptoms and behaviors of people with memory impairment; communication with people with memory impairment; resident's adjustment to the new living environment; behavior management; ADLs; and stress reduction for facility personnel and resident. If a resident is admitted with a diagnosis of dementia or if a resident acquires this diagnosis, and if staff have not been trained in this area, staff must be trained within 30 calendar days. In the interim, the facility must meet the resident's needs.

## Illinois

All staff members must receive 4 hours of dementia-specific orientation prior to assuming responsibilities without direct supervision. Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Annually, direct care staff must complete 12 hours of in-service education regarding dementia disorders.

## Kentucky

The assisted living community must maintain a description of dementia-specific staff training that is provided, including at a minimum the content of the training, the number of offered and required hours of training, the schedule for training, and the staff who are required to complete the training.

## Maine

Pre-service training is required for staff who work in Alzheimer's or dementia units.

#### Minnesota

Supervisors and direct care staff must be trained in dementia care. Areas of required training include: An explanation of Alzheimer's disease and related disorders; Assistance with ADLs; Problem solving with challenging behaviors; and Communication skills. The licensee must provide to consumers a written or electronic description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.

#### New Jersey

Staff are required to have attended a mandatory training program.

#### New York

Any care facility with approved dementia units is required to provide staff training in characteristics and needs of persons with dementia, including behavioral symptoms, and mental and emotional changes. The training should include methods for meeting the residents' needs on an individual basis.

#### Virginia

The administrator and direct care staff must complete four hours of training in cognitive impairments due to dementia within two months of employment. The administrator and direct care staff must also complete at least six more hours of training in caring for residents with cognitive impairment due to dementia within the first year of employment. Topics that must be included in the training are specified. There are annual training requirements for direct care staff and for the administrator.

Many states have chosen to use third-party training materials and/or online training. While some states, such as Indiana, have worked closely with the Alzheimer's Association to develop a written curriculum, many others use online training systems such as the training provided by Health Care Interactive (<http://www.hcinteractive.com>). Oregon has developed its own online training modules for dementia care that are available free of charge to any state resident, whether they are paid caregivers or caring for family members with dementia. This program also includes several in-person events each year around the state, including free seminars with Teepa Snow. However, Oregon's training materials do not appear to have a direct correlation to the Oregon state content requirements for caregiver training. It is worth noting that, although there are content requirements, there is not a formal process for verification of caregiver training in Oregon.

We discovered that Scotland, based on a 2010 *National Dementia Strategy*, has developed a robust training system for that nation's dementia caregivers. This program includes four levels of training:

- › Dementia Informed Practice Level
- › Dementia Skilled Practice Level
- › Dementia Enhanced Practice Level
- › Dementia Expertise Practice Level

These training levels each have written and video materials available, as well as trainer workshop guides. For the purposes of comparison, we have used the "Informed Practice Level" content when comparing to Washington's caregiver training, as it is the introductory level of training.

We were able to analyze four state-designed dementia care trainings, as well as one international dementia caregiver training, to compare them with Washington's in terms of content. These included documents from Arkansas, Arizona, Minnesota, New Jersey, and Scotland. The table below summarizes which modules are included in each of these trainings. In the interest of comparison, reasonable efforts were made to collate similar topics with the same title. The five highlighted rows represent topics that have been included by three or more states in their training. Among those appearing with high frequency, three align with where Washington's curriculum places emphasis: *Introduction to Dementia*, *Dealing With Dementia-Related Behaviors*, and *Communication*. It is interesting to note that several states have a module on activities that is distinct from the *Activities of Daily Living* (ADL) module.

## Count of Module Titles in State and International Dementia Trainings

| Modules   | AR | AZ | MN | NJ | WA | Scot | Total |
|---|----|----|----|----|----|------|-------|
| Activities  | 1  | 1  |    | 1  |    |      | 3     |
| Activities of Daily Living                            |    | 1  |    | 1  | 1  |      | 3     |
| Caregiver Experience                                  |    |    |    | 1  |    |      | 1     |
| Caregiver Support                                     |    |    | 1  |    |    |      | 1     |
| Cognitive Assessment and the Value of Early Detection |    |    | 1  |    |    |      | 1     |
| Communication   | 1  | 1  |    | 1  | 1  | 1    | 5     |
| Creative Approaches to Challenging Behaviors          |    |    |    |    | 1  |      | 1     |
| Dealing with Dementia Related Behaviors               | 1  | 1  |    | 1  |    | 1    | 4     |
| Defining Dementia                                     |    | 1  |    |    |    |      | 1     |
| Dementia as an Organizing Principle of Care           |    |    | 1  |    |    |      | 1     |
| Demographics  |    |    | 1  |    |    |      | 1     |
| Disease Description                                   |    |    | 1  |    |    |      | 1     |
| Disease Diagnosis                                     |    |    | 1  |    |    |      | 1     |
| Effective Interactions                                |    |    | 1  |    |    |      | 1     |
| Hallucinations and Delusions                          |    |    |    |    | 1  |      | 1     |
| Introduction to Dementia                              | 1  |    |    | 1  | 1  | 1    | 4     |
| Legal and Financial Planning for Families             |    | 1  |    |    |    |      | 1     |
| Maintenance of Respect, Dignity and Quality of Life   | 1  |    |    |    |    |      | 1     |
| Medications and Dementia                              |    |    |    |    | 1  |      | 1     |
| Nutrition   | 1  |    |    |    |    |      | 1     |
| Philosophy of Dementia Care                           |    | 1  |    |    |    |      | 1     |
| Quality Interventions                                 |    |    | 1  |    |    |      | 1     |
| Risk Enablement, Rights, and Safety                   |    |    |    |    |    | 1    |       |
| Screening   |    |    | 1  |    |    |      | 1     |
| Setting the Tone                                      |    |    |    |    | 1  |      | 1     |
| Sexuality and Dementia                                |    |    |    |    | 1  |      | 1     |
| Societal Impact                                       |    |    | 1  |    |    |      | 1     |
| Staff Stress and Burnout                              | 1  |    |    |    |    |      | 1     |
| Valued Lives and Relationships                        |    |    |    |    |    | 1    | 1     |

The table below details the percentage of the total training material devoted to each topic, as a way to measure how each state prioritizes particular topics. It is perhaps not surprising that the two of the three outliers, representing 25% or more of their respective curricula, are related to behaviors. We heard from many stakeholders that approaches to challenging behaviors could not be over-emphasized in the training:

- › “Whenever I experience a difficult situation with a sufferer of dementia I remember what is actually happening in this person's physical body that can create this behavior and I am able to remain compassionate. I believe it lessens the frustration that can occur, as then my frustration is with the disease not the person suffering from it.”
- › “[Important skills include] behavior management and how to deal with people in crisis, [as well as] how to determine causes of unwanted behavior and how to deescalate a situation.”
- › “Spend more time instructing caregivers how to be proactive – approaching the residents better and setting up situations where problematic behaviors don’t emerge, rather than so much of the curriculum being focused on responses once the behaviors have occurred.”

### 3 | State and International Trends

#### Topics, As Percentage of Overall Training Content in State and International Dementia Trainings

| State    | Topic   | Percent |
|----------|---|---------|
| AZ       | Defining Dementia                                     | 11%     |
| AZ       | Philosophy of Dementia Care                           | 16%     |
| AZ       | Communication   | 10%     |
| AZ       | Dealing with Dementia Related Behaviors               | 15%     |
| AZ       | Activities of Daily Living                            | 24%     |
| AZ       | Activities  | 10%     |
| AZ       | Legal and Financial Planning for Families             | 14%     |
| AR       | Introduction to Dementia                              | 11%     |
| AR       | Maintenance of Respect, Dignity and Quality of Life   | 11%     |
| AR       | Communication   | 17%     |
| AR       | Dealing with Dementia Related Behaviors               | 33%     |
| AR       | Activities  | 6%      |
| AR       | Nutrition   | 11%     |
| AR       | Staff Stress and Burnout                              | 11%     |
| MN       | Disease Description                                   | 10%     |
| MN       | Demographics  | 5%      |
| MN       | Societal Impact                                       | 7%      |
| MN       | Effective Interactions                                | 5%      |
| MN       | Cognitive Assessment and the Value of Early Detection | 9%      |
| MN       | Screening   | 5%      |
| MN       | Disease Diagnosis                                     | 17%     |
| MN       | Quality Interventions                                 | 22%     |
| MN       | Dementia as an Organizing Principle of Care           | 8%      |
| MN       | Caregiver Support                                     | 10%     |
| NJ       | Introduction to Dementia                              | 17%     |
| NJ       | Communication   | 13%     |
| NJ       | Activities of Daily Living                            | 21%     |
| NJ       | Dealing with Dementia Related Behaviors               | 17%     |
| NJ       | Caregiver Experience                                  | 15%     |
| NJ       | Activities  | 17%     |
| WA       | Introduction to Dementia                              | 23%     |
| WA       | Communication   | 8%      |
| WA       | Creative Approaches to Challenging Behaviors          | 25%     |
| WA       | Activities of Daily Living                            | 12%     |
| WA       | Hallucinations and Delusions                          | 6%      |
| WA       | Sexuality and Dementia                                | 10%     |
| WA       | Medications and Dementia                              | 8%      |
| WA       | Setting the Tone                                      | 8%      |
| Scotland | Introduction and Background                           | 13%     |
| Scotland | About Dementia  | 28%     |
| Scotland | Communication, Feelings and Behaviours                | 23%     |
| Scotland | Valued Lives and Relationships                        | 13%     |
| Scotland | Risk Enablement, Rights and Safety                    | 18%     |
| Scotland | Summary   | 5%      |

Based on our comparative assessment, Washington's current training requirements and curriculum are not optimized, and significant extensions, inclusions, and revisions are necessary in order to have the greatest positive influence on care outcomes possible. The following chapters detail our recommendations for updates to the design of the dementia caregiver training program, improvements in instructional quality, and updates and improvements to the content of the curriculum, as well as the changes these updates imply for the Washington Administrative Code.



## 4 | Recommendations: Content

The recommendations in this section call for doubling the length of time that caregivers will spend learning about the dementia specialty. In part, this is to bring the three existing specialty trainings closer together in terms of time requirements, but it is also a reaction to what we heard from stakeholders—namely, that the current dementia specialty training does not sufficiently prepare new caregivers on topics specifically related to care of those with dementia.

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, memory loss, and decision-making. Behaviors that are common with dementia were also highly correlated with frequent moves, including delusions, hallucinations, and wandering.



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.

We have also included recommendations for Washington to begin to include new ways of thinking about care delivery, and to continue its role as a leader in the field.

### 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:

- › Expand the basic dementia training to 12 hours – approximately half online, half in-person
- › Create online learning modules that will total approximately 5.5 hours of instruction:
  - Module 1: Understanding Dementia (approximately 3 hours)
    - Introduction To Dementia
    - Hallucinations & Delusions—Dementia-Related (part I)
    - Setting the Tone
    - Working with Families
  - Module 2: Living with Dementia (approximately 2.5 hours)
    - Sexuality
    - Medications
    - Activities of Daily Living
- › Redesign the instructor-led training materials to total approximately 6.5 hours of instruction, including:
  - Module 3: Fostering Communication & Understanding
    - Trauma-Informed Care
  - Module 4: Creative Approaches to Challenging Behaviors

- Hallucinations & Delusions—Dementia-Related (part II)
  - › Split the *Hallucinations and Delusions* portion of the training between technical descriptions in the online module and hands-on learning in the instructor-led modules.
  - › Combine the current *Communicating With People Who Have Dementia* and *Setting the Tone* sections into a single *Fostering Communication and Understanding* module, to be included in the instructor-led portion of the training.
  - › Include Trauma-Informed Care (TIC) as a topic in the *Fostering Communication & Understanding* module.
  - › Redesign the *Resource Section* as a stand-alone module with detailed descriptions of each type of dementia, other reference material, and contact information that becomes a tool for caregiver use.
  - › Update the look and feel of the training materials to reflect the importance of the topics.

### Expand the dementia training to 12 hours – approximately half online, half in-person.

We heard from many caregivers that the current four-hour training is not sufficient to prepare a caregiver to begin working with residents who have dementia:

- › “When I got trained, it was a week, and [even then] I didn't have a full understanding until I was out there meeting residents.”
- › “Training has gone downhill since what I took many years ago.”
- › “Six hours on any topic is very minimal. Not sure how much more is needed, but not enough to be considered a 'specialist'. Might suggest 2x.”
- › “Training needs to be more 'real world' and longer. 4-6 hours is not enough.”

Considering the quantity of material that is implied by the required learning objectives, and the length of the current manual, it is clear that caregivers would benefit greatly from a training curriculum that goes into more depth, while also being less rushed.

Access to training was also expressed as a concern by many stakeholders, particularly those in less-populated portions of the state. Our recommendation that only portions of the training be in-person allows that the instructor-led training will still be delivered within one day, while the online portions would allow for more flexible scheduling of training. While this may not improve access overall, per se, this arrangement will not exacerbate the issue.

### Create online learning modules that will total approximately 5.5 hours of instruction.

There is a significant amount of technical and background material in the dementia specialty training that we believe will be best delivered via multimedia online training. This will allow learners to self-pace on complicated materials, and will also to allow for translation of technical materials into caregivers' native languages (see translation recommendation on page 34).

- › “Add two more hours to teach the basic causes of various types of dementia along with some basic anatomy and physiology. This would allow the students to better understand why they are seeing the various symptoms and behaviors in the people they are caring for.”
- › “Learning the disease process, the progression and also all the symptoms that come with it has helped me immensely to appreciate [the residents] more and be able to provide respectful and compassionate care for dementia clients.”
- › “The photos, and [gaining] understanding of the brain changes was very important.”

We also believe that adding an online portion to the training addresses, in part, the access challenge that was cited by stakeholders. In fact, many stakeholders specifically called for online training:

- › “Online training would be helpful for rural areas.”

#### 4 | Recommendations: Content

- › “Offer online class, then go meet with real person for assessment; would allow for self-pacing and more time to digest information. (Could have a blend of both online and in-person.)”
- › “I would like to see interactive ONLINE training.”

We recommend the following topics be included within the two online modules:

- › Module 1: Understanding Dementia (approximately 3 hours)
  - Introduction To Dementia
  - Hallucinations & Delusions—Dementia-Related (part I)
  - Setting the Tone
  - Working with Families
- › Module 2: Living with Dementia (approximately 2.5 hours)
  - Sexuality
  - Medications
  - Activities of Daily Living

Of special note is the inclusion of two modules in the caregiver training that are currently only part of the manager training: *Setting the Tone* and *Medications*. We believe, and heard from stakeholders, that these two topics are very important for all caregivers to understand:

- › “Touch more on family denial of dementia and how to deal with the families of those with dementia, as for the most part families are lost and do not understand basic dementia physiology. Famous words of the family: ‘Don’t you remember?’”
- › “...while also taking care of the family members, how to support them.”
- › “Family members have different expectations - Training covers how to work with family members, but only for managers. (Some trainers share with caregivers also.)”
- › “Dementia is a disease process similar to other disease processes. The resident and the family need support. Keeping families informed as to why different behaviors are happening and what they can do to help their loved one.”
- › “The importance of communicating with family members... the first two homes my wife was in... I had to pull information out of them.”
- › “Might be good to have classes about how the medication works.”
- › “The use of medication is sometimes necessary for their quality of life when they are in the later stages of dementia. It is important to give them quality of life, keep them safe and those around them.”

In part because of the extended length of the training, these topics should be integrated into the training that all caregivers receive.

#### Redesign the instructor-led training materials to total approximately 6.5 hours of instruction.

While the online portions of the training will allow for more technical information to be conveyed at a custom pace, and in select languages, we believe the balance of the training should be instructor-led, should include practice activities and role-playing, and should be conducted in English in order to best simulate conditions in the care facility. Accordingly, these two modules deal with the interactive elements of caregiving:

#### 4 | Recommendations: Content

- › Module 3: Fostering Communication & Understanding (approximately 3 hours)
  - Trauma-Informed Care
- › Module 4: Creative Approaches to Challenging Behaviors (approximately 3.5 hours)
  - Hallucinations & Delusions—Dementia-Related (part II)

It is worth noting that the *Creative Approaches to Challenging Behaviors* module we propose is nearly as long as the entirety of the current training. We believe that providing caregivers with a solid foundation in managing behaviors 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. This data sample included instances of clients who moved one to five times. Because the sample size for the four- and five-move clients was too small to be statistically significant, we discarded that portion of the data for our analysis. 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%          |

| Current Behaviors                 | One Move | Two Moves | Three Moves |
|-----------------------------------|----------|-----------|-------------|
| 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%         |

Split the *Hallucinations and Delusions* portion of the training between technical descriptions in the online module and hands-on learning in the instructor-led modules.

Because there is both technical medical information and behavior management strategies associated with hallucinations and delusions, we recommend that this portion of the curriculum be split into two parts: a technical overview of the causes, symptoms, and behaviors associated with dementia-related hallucinations and delusions would be included in the online training modules, while instruction about working with residents suffering from dementia-related hallucinations or delusions would be covered in the instructor-led portion of the training, where hands-on approaches could be demonstrated and applied in a role-playing exercise.

Combine the current *Communicating With People Who Have Dementia* and *Setting the Tone* sections into a single *Fostering Communication and Understanding* module, to be included in the instructor-led portion of the training.

These two portions of the current curriculum have a lot in common, and the ideas expressed in the *Setting the Tone* module, in that they help to foster understanding, help set the stage for effective communications both with residents and their families. We believe that, rather than being a separate module, these topics should be supportive and additive to the communication topics. Additionally, because we are recommending that self-care be discussed in relationship to Trauma-Informed Care (see below), that portion of *Setting the Tone* will likewise find an appropriate home in this new module.

Include Trauma-Informed Care (TIC) as a topic in the *Fostering Communication & Understanding* module.

Trauma-Informed care presents an alternative to traditional care techniques by focusing on increasing function rather than curing conditions. 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.

#### 4 | Recommendations: Content

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 dementia specialty training materials will be a demonstration of Washington's leadership in preparing caregivers.

According to Jennings (2007), an appropriate curriculum should cover:

1. The Prevalence and Impact of Trauma
2. Dynamics of Traumatization
  - a. How some caregiving actions can potentially mimic traumatic experiences
  - b. Avoidance of retraumatization
3. Impact of 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. Trauma-informed understanding of difficult behaviors
5. Maintenance of professional boundaries
6. Vicarious traumatization / 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. [A home or facility providing] 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."

#### **Redesign the *Resource Section* as a stand-alone module with detailed descriptions of each type of dementia, other reference material, and contact information 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" for resources specific to the specialty (in this case dementia), 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. 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 the cards for their residents is also desirable. For instance, having a space to add phone numbers for specific social workers may be helpful. Such a card 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.

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 dementia. 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. Hake 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 Hake, 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

The Dementia specialty training is offered by a wide variety of trainers across the state, and is often taught by providers, supervisors, and corporate trainers within care facilities. Because the WAC defines detailed instructor qualifications for community instructors, yet only defines minimal requirements for providers, supervisors, and corporate trainers who may deliver the training within the facilities, it is likely that the training is delivered at different levels, and is possible that in some cases the training may not be delivered at all. Many stakeholders expressed concern about this variation in training quality:

“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 [their] own experience, [and] real-life scenarios.”



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

- › 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.

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

Instructors who have experience working with people with dementia bring their experience into the classroom to enrich the learning experience. In light of this, we recommend that DSHS develop a consistent set of instructor requirements, applying the same standard to both community trainers and in-facility trainers.

“Overall knowledge of the particular condition. Many people who work in the system do not have a fundamental understating of the illness.”

“There needs to be a higher-level requirement for training. The minimum is not working.”

The current requirements are detailed in WAC 388-112-0390:

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

(a) The instructor must be experienced in dementia caregiving practices and capable of demonstrating competency in the entire course content;

(b) Education:

(i) Bachelor's degree, registered nurse, or mental health specialist, with at least one year of education in seminars, conferences, continuing education or college classes, in dementia

or subjects directly related to dementia, such as, but not limited to, psychology. (One year of education equals twenty-four semester hours, thirty-six quarter hours, or at least one hundred ninety-two hours of seminars, conferences, or continuing education.)

(ii) If required in WAC 388-112-0160, successful completion of the dementia specialty training, prior to beginning to train others.

(c) Work experience - Two years full-time equivalent direct work experience with people who have dementia; and

(d) Teaching experience:

(i) Two hundred hours experience teaching dementia or closely related subjects; and

(ii) Successful completion of an adult education class.

(A) For instructors teaching alternate curriculums, a class in adult education that meets the requirements of WAC 388-112-0400.

(iii) For instructors teaching DSHS-developed dementia specialty training, successful completion of the DSHS instructor qualification/demonstration process;

(iv) And has been approved and contracted by the department as a community instructor.

(e) Instructors who will administer tests must have experience or training in assessment and competency testing.

(2) Instructors for long-term care worker dementia specialty training:

(a) Long-term care worker dementia 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 manager dementia specialty training. A qualified instructor under this subsection may teach specialty to long-term care workers employed at other home(s) licensed by the same licensee.

(b) Long-term care worker dementia specialty taught by a person who does not meet the requirements in subsection (2)(a) must meet the same requirements as the instructors for manager dementia specialty in subsection (1).

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 actively enforce the adult education qualifications that are currently in place, and ensure that these are enforced for both community instructors and in-facility instructors. 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). We have also recommended the development of a two-hour online adult education course that would fulfill this requirement (see page 36). We recommend that anybody wishing to offer this training should meet these requirements, whether they are providers, supervisors, corporate trainers, or community trainers.

- › “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)

## 5 | Recommendations: Instructional Quality

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.

We recommend that DSHS create a course evaluation form and process that is similar to, if not the same as, the Service Alternatives evaluation form in use with the Developmental Disabilities Specialty Training.

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 will 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.

“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.”

“Some instructors just play the video and don’t interact much. Consider monitoring/observing how training is delivered to ensure that trainers are competent.”



## 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/location access, and in terms of cognitive access. This includes a doubling of the length of the training.

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:

- › Expand training to 12 hours, and split it into 2 parts:
  - 5.5-hour competency-based online training
  - 6.5-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
- › Bear the cost of basic dementia caregiver training directly through ALTSA, rather than indirectly through the daily rate.
- › 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 dementia, 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



### **Expand training to 12 hours, and split it into 2 parts: a 5.5-hour competency-based online training, and a 6.5-hour in-person skills training**

As stated in the Content section, we recommend that the training for the Dementia specialty be expanded to approximately 12 hours of instruction, approximately half online and half in-person. This would make the length of the training consistent with our recommendations for the other specialties.

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. This connectivity should be accommodated within the Learning Management System (LMS), if possible. We recognize, however, that the creation of such a system will have a fiscal impact to DSHS.

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 Dementia 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:

**Module 1: Understanding Dementia (approximately 3 hours)**

- Introduction To Dementia
- Hallucinations & Delusions (partial)
- Setting the Tone
- Working with Families

**Module 2: Living with Dementia (approximately 2.5 hours)**

- Sexuality
- Medications
- Activities of Daily Living

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.

**Bear the cost of basic dementia caregiver training directly through ALTSA, rather than indirectly through the daily rate.**

Currently, providers have the option of training caregivers themselves, or paying to have their caregivers trained by a community trainer. This cost is offset by DSHS through an addition to the daily rate, though our outreach highlighted that few providers understand this arrangement.

One would expect that the contribution to the daily rate would encourage providers to secure high-quality community trainings for their caregivers. However, the system has created a “perverse incentive” where the most financially advantageous thing for a provider to do is to pocket the additional daily rate, and train the caregiver themselves at no additional out-of-pocket cost.

Because the money comes to the provider through the daily rate, it feels as if it is part of their compensation. The behavioral economics hypothesis of the “endowment effect”, which has demonstrated that people value more highly that which they already possess, explains why this happens: once the money is in their hands, they feel as if they own it, and therefore paying for training feels like an additional expense.

By contrast, Developmental Disabilities specialty training is paid for directly by DDA, and although there are also provisions that allow for providers to train their own staff, that option is rarely exercised.

We recommend that ALTSA re-design the compensation system for dementia specialty training to directly cover training costs, in the interest of encouraging the best available training for all caregivers.

**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 has the potential to 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/learning management system should provide an automatic update to a DSHS database when learners complete the online portion of the training, and should also allow the learner to download a certificate of completion that could be presented to a trainer in order to demonstrate completion of the

pre-requisite for the in-person 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 dementia, 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. Currently, the manager training for the Dementia specialty is an add-on to the existing six-hour course, with a separate assessment.

"[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 a standalone 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 for homes caring for residents with special needs. The balance of the training could be customized to dementia-specific materials.

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 dementia specialty
2. Laws and regulations, specific to dementia specialty
3. Use and misuse of medication, specific to dementia 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 managers and 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.**

Currently, providers and managers may train their own staff in the dementia specialty. 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.



## 6 | Recommendations: Program Design

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 36.

### **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 specialty(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 “professional” designation**

The current training, while designated as “specialty” training, does not truly create specialists in the care of individuals with dementia. 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 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.

A model that we would recommend, developed by DSHS’s curriculum specialist, includes the following:

For individuals whose primary job responsibilities include providing long-term support for aging populations with dementia, 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 Dementia Caregiver, Level 1
- › Level 2: Certified Dementia Caregiver, Level 2

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- › Level 3: Certified Dementia Caregiver, Level 3

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

| Dementia Caregiver Trainings   | Requirements |     |         |         |         |
|--|--------------|-----|---------|---------|---------|
|  |              | Hrs | Level 1 | Level 2 | Level 3 |
| Basic Dementia Technical Training (Level 1)                            | O            | 5.5 | x       | x       | x       |
| Basic Dementia Skills Training (Level 1)                               | IL           | 6.5 | x       | x       | x       |
| Dementia Caregiver Level 2 Training                                    | O; IL        | 12  |         | x       | x       |
| Dementia Caregiver Level 3 Training                                    | O; IL        | 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           | ?   | n/a     | n/a     | n/a     |
| *Trainers are subject to additional requirements, per WAC 388-112-0390 |              |     |         |         |         |

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

### Basic Dementia Caregiver (Level 1)

Complete a combination of 12 hours of training in each population category (5.5 hours technical training online as prerequisite to 6.5 hours skills training, instructor led). Once you have completed both workshops for a total of 12 hours, you will receive your Basic Dementia Caregiver Level 1 Certification:

#### Basic Dementia Technical Training

- › Module 1: Understanding Dementia
  - Intro. To Dementia
  - Hallucinations & Delusions (partial)
  - Setting the Tone
  - Working with Families
- › Module 2: Living with Dementia
  - Sexuality
  - Medications
  - Activities of Daily Living

#### Basic Dementia Skills Training

- › Module 3: Fostering Communication & Understanding
- › Module 4: Creative Approaches to Challenging Behaviors
  - Hallucinations & Delusions (partial)

### Dementia 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 Dementia 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

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

- › AIDS-Related Dementia
- › Alzheimer's
- › Creutzfeldt-Jakob Disease
- › Down's Syndrome
- › Huntington's Disease
- › Korsakoff's Syndrome
- › Lewy Body Dementia
- › Parkinson's Related Dementia
- › Pick's Disease
- › Traumatic Brain Injury
- › Vascular Dementia

### **Dementia 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 Dementia Caregiver Level 3.

Minimum requirements for certification: (i) Bachelor's degree with at least three years of full-time work experience in the dementia 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 population of individuals with dementia

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

- › AIDS-Related Dementia
- › Alzheimer's
- › Creutzfeldt-Jakob Disease
- › Down's Syndrome
- › Huntington's Disease
- › Korsakoff's Syndrome
- › Lewy Body Dementia
- › Parkinson's Related Dementia
- › Pick's Disease
- › Traumatic Brain Injury
- › Vascular Dementia

### **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. DSHS should consider charging a modest fee for the provision of this training outside the caregiver community, as an offset to other system expenses, particularly those related to the development of caregiver curriculum.



## 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.

Expand the dementia training to 12 hours – approximately 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.



Create online learning modules that will total approximately 5.5 hours of instruction:

- › Module 1: Understanding Dementia (approximately 3 hours)
  - Introduction To Dementia
  - Hallucinations & Delusions—Dementia-Related (part I)
  - Setting the Tone
  - Working with Families
- › Module 2: Living with Dementia (approximately 2.5 hours)
  - Sexuality
  - Medications
  - Activities of Daily Living

WAC 388-112-0130 and 388-112-0132

Because the topics/modules are recommended to change, the learning objectives in this section of the WAC would need to be updated.

Redesign the instructor-led training materials to total approximately 6.5 hours of instruction, including:

- › Module 3: Fostering Communication & Understanding
  - Trauma-Informed Care

## 7 | Recommendations: Washington Administrative Code

- › Module 4: Creative Approaches to Challenging Behaviors
  - Hallucinations & Delusions—Dementia-Related (part II)

WAC 388-112-0130 and 388-112-0132

Because the topics/modules are recommended to change, the learning objectives in this section of the WAC would need to be updated.

Split the *Hallucinations and Delusions* portion of the training between technical descriptions in the online module and hands-on learning in the instructor-led modules.

WAC 388-112-0132

Because this portion of the training would be redesigned, a change to this portion of the WAC may be required in terms of updating learning objectives specific to hallucinations and delusions

Combine the current *Communicating With People Who Have Dementia* and *Setting the Tone* sections into a single *Fostering Communication and Understanding* module, to be included in the instructor-led portion of the training.

WAC 388-112-0132

Because this portion of the training would be redesigned, a change to this portion of the WAC may be required in terms of updating learning objectives specific to communications and working with families.

Include Trauma-Informed Care (TIC) as a topic in the *Fostering Communication & Understanding* module.

WAC 388-112-0132

The addition of TIC into the curriculum would require the addition of appropriate learning objectives in this portion of the WAC.

Redesign the *Resource Section* as a stand-alone module with detailed descriptions of each type of dementia, other reference material, and contact information that becomes a tool for caregiver use.

WAC 388-112-0125

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.

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

WAC 388-112-0390

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 388-112-0390

## 7 | Recommendations: Washington Administrative Code

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.

WAC 388-112-0365

This portion of the WAC describes the rights of DSHS to terminate the approval of specialty training entities. Should this recommendation be carried forward, it may not require edits to the WAC, *oper se*, but DSHS may want to consider adding poor evaluations as cause for termination under this portion of the WAC.

Expand training to 12 hours, and split it into 2 parts:

- › 5.5-hour competency-based online training
- › 6.5-hour in-person skills training

This recommendation, in and of itself, does not appear to require a change in the WAC.

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. There is a requirement in WAC 388-76-10135 that the caregiver be able to speak and understand English, which we would not recommend changing—while caregivers need to be able to speak and understand basic English for their roles, we believe the complex information in the curriculum will be better communicated in native language(s). WAC 388-112-0305 states that DSHS must provide accessibility guidelines for students with limited English proficiency. While our recommendations would not require a change to this portion of the WAC, it may necessitate a change to DSHS's guidelines.

Bear the cost of basic dementia caregiver training directly through ALTSA, rather than indirectly through the daily rate.

This recommendation does not appear to require a change 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 dementia, and require both online and in-person assessment of managers.

WAC 388-112-0160

## 7 | Recommendations: Washington Administrative Code

Because this recommendation adds a general 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 any of the three caregiver specialties.

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

WAC 388-112-0390

Because this would add an additional qualification for trainers, this portion of the WAC would 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.



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