



## Specialty Training Recommendations

Overview of Recommendations; Recommendations for Additional Specialty Training  
June 29, 2015

Coraggio Group  
2240 N. Interstate Ave. Suite #300  
Portland, OR 97227  
503.493.1452  
coraggiogroup.com

## Table of Contents

1   EXECUTIVE SUMMARY .....	3
2   RECOMMENDED ADDITIONAL SPECIALTY TRAININGS .....	5
3   DECISION PACKAGE RECOMMENDATIONS .....	9

## 1 | Executive Summary

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, telephone focus groups, and visits to Adult Family Homes. 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.

Subsequent to the Stakeholder Outreach phase, research was conducted to identify opportunities to update the content in the three curricula, to identify best practices in adult instruction, and to identify current trends in how training programs for long-term caregivers are structured in other states and other countries.

From the combination of stakeholder input and research, a set of recommendations was developed for updating each of the three existing curricula. The table on the following page provides a high-level overview of the recommended changes for the three existing specialty trainings.

## Current State

## Recommendation

DD training is 18 hours, Dementia training is 6 hours, and Mental Health training is 4 hours.	Align all specialty trainings at approximately 12 hours.
Training modules on behavior and communication are important parts of the training.	Increase the proportion of each training that is on the topics of behavior and communication.
Overview portions of training are uneven.	Decrease the overview portion of the DD training, and increase the overview portions of both Dementia and Mental Health.
Trauma Informed Care (TIC) is not included in the training curricula.	Include TIC as a topic in all three curricula, including content related to Adverse Childhood Experiences (ACEs).
Resident sexuality is rarely discussed in the current curricula.	Include content about sexuality and resident rights, particularly in the DD and Dementia trainings.
The current curricula were written before the Affordable Care Act, and don't reflect the current state of healthcare requirements.	Update DD training to reflect changes stemming from the Affordable Care Act (Home and Community-Based Services; Community First Choice Option).
Content around the inclusion of families is minimal.	Bolster instruction around the inclusion of families.
The topic of self-care is discussed in the basic training, but not in the specialty trainings.	Augment the topic of self-care by repeating it in the specialty trainings, and possibly include population-specific content.
Resource section is general, and in the back of the training manual.	Redesign the Resource section as a stand-alone module that becomes a tool for caregiver use.
Training manuals have a dated look.	Update the look and feel of the training materials to reflect the importance of the topics.
Subject Matter Expertise for trainers is spelled out in the WAC, but is not actively enforced for all trainers.	Enforce the validation of Subject Matter Expertise (SME) qualifications for all trainers.
Adult Education requirements for trainers is spelled out in the WAC, but is not actively enforced for all trainers.	Verify and enforce adult education requirements.
The course evaluation/feedback mechanism is uneven between the specialties, and does not provide for the ongoing evaluation of all trainers.	Update the course evaluation/feedback mechanism, aligned to the principles of adult education, and institute an ongoing evaluation process for trainers.
All trainings are provided in-person.	Split the trainings into two parts: an approximately 6-hour online technical portion and an approximately 6-hour in-person skills training.
All trainings are provided in English only.	Provide online trainings in English, plus the five most commonly spoken languages in care settings. Provide in-person training portions in English only.
Trainers validate that the training took place.	Use the online Learning Management System (LMS) to verify online trainings, and continue to have trainers verify in-person training.
The DD training is paid for directly by the state, while the Dementia and Mental Health trainings are paid indirectly through the daily rate.	Bear the cost of Dementia and Mental Health trainings directly through ALTSA, rather than indirectly through the daily rate.
The manager trainings for Dementia and Mental Health are focused on additional population-specific content, rather than information about managing care staff. There is no manager training for Developmental Disabilities.	Develop a two-hour online manager training for managers and supervisors, and require both online and in-person assessment of managers.
Trainers are required to have taken adult education training, but DSHS does not offer a course.	Develop a two-hour online adult education training, and require completion of this course for community instructors, or any managers or providers who wish to train their staff in any of the three caregiver specialties.
Providers and managers are allowed to train their own staff without demonstrating competency and they are not required to meet any instructor qualifications.	Require active demonstration of training competency for managers or supervisors who wish to train their employees and require them to meet the same qualifications as community instructors.
Caregivers who have residents with more than one specialty designation may choose which specialty training to take.	Require caregivers to have specialty training for every specialty in the home or facility, if they are providing care to those clients.
"Specialty" training implies that a specialist is the outcome, when the trainings are essentially basic care instruction.	Rename the trainings, and develop additional levels of training in order to achieve "specialist" designation (for caregivers, not for facilities).
Training is open to prospective caregivers only.	Open online and/or in-person training to families and others.

## 2 | Recommended Additional Specialty Trainings

As part of the specialty training review process, DSHS requested an analysis of possible additional specialty trainings, and recommendations as to which ones should be prioritized. In our stakeholder outreach report, we ranked six potential new specialty trainings into three tiers, based on the frequency with which they were requested:

- › Tier One
  - Traumatic Brain Injury
- › Tier Two
  - Substance Abuse
  - Bariatric Care
- › Tier Three
  - Post-Traumatic Stress Disorder
  - Diabetes
  - Medically Fragile Individuals

Further description of these six areas, along with our observations about the stakeholder comments, can be found in the Stakeholder Outreach Report, which is available for download on the DSHS website at:

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

In considering which of these six specialty areas should be prioritized by DSHS for the development of additional training, we took into account not only the stakeholder requests, but also the complexity of care and the frequency of comorbidity with other conditions. Additionally, we believe that some conditions can be covered as part of continuing education in other specialty areas—accordingly, we have recommended that both substance abuse and PTSD become part of the continuing education options for the Mental Health specialty.

Our resulting recommendation is that the three highest-priority areas for the development of further specialty training are:

- › Traumatic Brain Injury
- › Diabetes Care
- › Bariatric Care

### Traumatic Brain Injury (TBI)

Recent years have seen a growing awareness of TBI and its after-effects, particularly in high-profile cases such as the struggles of retired NFL players who were subjected to large numbers of head injuries throughout their careers. While rates of Emergency Department TBI admissions have climbed, survivability of TBI has also increased. This increased survivability is particularly noteworthy in our veteran population, wherein many soldiers have sustained head injuries from blasts that would simply not have been survivable a decade or two ago.





## 2 | Recommended Additional Specialty Trainings

The increase in the incidence of TBI, combined with the increase in survivability, means that many more individuals are left with permanent disabilities as a result of their injuries, and will require long-term care. We heard anecdotally from many stakeholders about this increasing population in both Adult Family Homes and Assisted Living Facilities. Of all the possible additional specialties, TBI was the most frequently requested:

- › “TBI has its own set of challenges. Where my daughter resides, most of them have a very hard time communicating, but it has nothing to do with their intelligence, and that is tremendously frustrating. It brings up their social needs. It contributes to depression, anxiety—those kinds of things. And it's highly individualized. I would hope that DSHS has some sort of criteria set for people with TBI. While each case is different, I think you can bring attention to some of the needs. Folks with TBI have pretty high expectations. Their energy levels and their abilities are such a roller coaster that it's very hard for them to maintain what they expect of themselves. It's a separate issue from their mobility, and their ability to speak and communicate. They still have that whole set of where they would like to be in their expectations and where they would like to be in the world.”
- › “Then if you add TBI, we have no resources in our area, and folks feel like they can treat them like a dementia patient, and that's a huge miss.
- › “When you delve into more specialties, it means more time for the provider that they have to pay for, but as an Ombudsman... if you have an individual in your home who has a TBI, you should have the training for that, and you should have to pay for it. That's kind of black and white, but that's my take on it.
- › “[We need training on] TBI - we just don't have the resources down here. We don't have any training that helps providers prepare.”

## Diabetes Care

The Centers for Disease Control estimates that 9.3% of the U.S. population has diabetes, making this one of the most prevalent health risks in our society today. Further, diabetes is often comorbid with other medical conditions that are common in long-term care settings. According to a University of Kansas study, the rate of diabetes among individuals with Developmental Disabilities may be as high as 18.5%.

Diabetes adds significantly to the complexity of caregiving in long-term care settings, with ramifications related to insulin management, nutrition, exercise, and skin care, among other care issues. In a sense, having a specialty training for diabetes may not simply be about disease management, but may also be about disease prevention in high-risk populations.

Many stakeholders felt that training for diabetes would be a good addition to the current specialty trainings:

- › “From a nurse perspective, I think that when providers take a patient with diabetes, they should have so many hours of diabetes training.”
- › “...overall general health and wellness... Proper nutrition, hydration... diabetes, there is so much that could proactively be done.”
- › “Help clients prevent chronic disease. For example, diabetes.”
- › “[Another specialty training could be] diabetes, and some of the chronic illnesses... COPD, kidney disease, MS... those seem to be big ones.”
- › “Nutrition - how that relates to other subjects... could be included in diabetes training, for instance.”

## Bariatric Care

Many stakeholders also cited the need for specialty training to address Bariatric Care which, like diabetes, is also often comorbid with other conditions. In the case of long-term care, this refers to the specialized treatment and care of obese and morbidly obese clients with coexisting medical diagnosis. (Obesity is defined as a BMI of 30 or greater and morbid obesity is defined as a BMI of 39 or greater.)

## 2 | Recommended Additional Specialty Trainings

Bariatric care brings additional complexity to long-term caregiving. These additional challenges, which may indicate needed training topics, include: mobility, positioning, skin integrity, nutrition, behavioral support, trauma-informed care, promotion of dignity, and environmental modifications for timely evacuations and client accessibility.

- › “Another big growth is with bariatric clients. We have very few places where we can get the clients placed because the homes aren't built to handle them. They are also needing to add staff in order to meet the care needs.”





## 3 | Decision Package Recommendations

Because many of these recommendations, if adopted, will have a fiscal impact, DSHS will need to prepare a Decision Package for the Legislature. The topics identified below are intended to start the consideration of what should be included in the Decision Package, and are organized by the major questions that need to be answered as part of a Decision Package:

### Recommendation Summary Text

Because this text is recommended to be 100 words or less, this narrative should focus on the purpose of creating better care outcomes in long-term care settings for individuals with dementia, mental illness, or developmental disabilities.

### Fiscal Detail

Not every recommendation has a direct or indirect fiscal impact. Those that may have fiscal impacts, if implemented, include:

- › The creation of a stand-alone Resource Guide, if the Resource Guide is developed in a digital or other complex format
- › The verification and enforcement of instructor qualifications, the active review of competency demonstrations for trainers, and the active review of instructor feedback will all likely have an impact in terms of FTEs.
- › The development of online training content
- › The translation of online training materials into additional languages, and the production of online training materials for each language
- › The development or purchase of an online Learning Management System (LMS)
- › Bearing the cost of Dementia and Mental Health directly through ALTSA, rather than through the daily rate (However, an argument could be made that this is a cost transfer, rather than a new cost.)
- › Opening online training to families and others may be an opportunity to bring revenue into the training system and offset some other costs.



### Package Description

The table on page 4 provides an overview of proposed changes, which could provide a basis for the development of this narrative. Additionally, the text should note that these recommendations are based on a process coming out of SB 5630, and are responding to identified challenges that led to the creation of that Bill. This Decision Package, in other words, is a direct response to a request from the Legislature.

### What Specific Performance Outcomes Does the Agency Expect?

Ultimately, this is about improving care outcomes. This means that measurable changes may be a reduction in negative outcomes. This may be measured through fewer complaints, fewer resident moves, fewer violations or citations issued from DSHS, or other measures that indicate fewer negative outcomes. Desired results that will be increased will be related to the knowledge of care staff, better-managed care

### 3 | Decision Package Recommendations

homes, better care interactions with residents, and possibly better retention of care staff. These impacts will primarily be felt by the citizens who are residents, and by their families.

#### Performance Measure Detail

The Aging and Long-Term Support Administration (AL TSA) has goals related to timely response to all abuse and neglect allegations, as well as timely case close-outs related to abuse and neglect allegations. To the degree that improved trainings are able to reduce the incidence of negative outcomes, the caseload should be reduced, which should allow AL TSA to improve scores on both counts.

The Developmental Disabilities Administration (DDA) has a goal related to the timely identification of individual health and welfare needs for clients, which may be positively affected by improved training.

#### Is this decision package essential to implement a strategy identified in the agency's strategic plan?

Included in the AL TSA Strategic Plan, under "DSHS Goal 4: Quality of Life" is the following: "Each individual in need will be supported to attain the highest possible quality of life." This Goal is supported by Strategic Objective 4.1, which states, "Ensure seniors and individuals with a disability who are in need of long-term services and supports are supported in their community."

Also noted in the AL TSA Strategic Plan is a commitment to "Continue to ensure access to, and the availability of, a well-trained and qualified provider workforce statewide," which would be directly supported by this decision package.

#### Does this decision package provide essential support to one of the Governor's priorities?

This package supports the Governor's priorities related to Health Care & Human Services, particularly in the area of Mental Health.

#### Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Performance of Government (POG) process?

This package is unlikely to contribute directly or substantially to any POG measures.

#### What other important connections or impacts are related to this proposal?

These recommendations have been shared with an extensive body of stakeholders, including the organizations that represent the owners and operators of Assisted Living Facilities and Adult Family Homes. Stakeholders external to state government are likely to be most concerned about the recommendations that may increase costs for them, including more rigorous training requirements for caregivers, managers, and trainers.

#### What alternatives were explored by the agency and why was this alternative chosen?

Because the process has only come to the recommendation phase, it will be up to the agency to determine whether alternatives to the recommendations should be explored.

#### What are the consequences of not funding this package?

Not funding the package would result in the continuation of the status quo in terms of caregiver training, a failure to make the improvements requested by the Legislature, and a probable relative reduction in quality compared to other states, as Washington's training becomes more and more outdated.

#### What is the relationship, if any, to the state capital budget?

This package is unlikely to have any capital budget impact.

#### What changes would be required to existing statutes, rules, or contracts to implement the change?

Most, if not all, changes recommended in this package would be made in rules (Washington Administrative Code). The details of these probable changes are listed in each of the three recommendation reports (Dementia, Mental Health, and Developmental Disabilities).

### Expenditure and revenue calculations and assumptions

Because the process has only come to the recommendation phase, it will be up to the agency to determine expenditure and revenue calculations and assumptions.

### Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

Curriculum development will be a one-time cost. The purchase or development of a Learning Management System would be likely to have a one-time cost and recurring annual costs. Most other costs would be FTE-related, and would recur annually.