PERFORMANCE AUDIT

Office of the Washington State Auditor
Pat McCarthy

I-1163: Evaluating the Relevance of Required Training for Long-Term Care Workers

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Executive Summary

Background (page 6)

Long-term care workers support people who need extended care due to age or disability. Washington requires certain groups of long-term care workers to meet minimum training requirements, and the Department of Social and Health Services (DSHS) is responsible for overseeing their training. Some long-term care workers, known as "individual providers," must take 75 hours of training in order to provide paid care to Medicaid-eligible clients in the clients' own homes. While Washington's training is highly regarded overall, some stakeholders question the relevance of this training for individual providers to certain client needs. As a result, this audit examined how Washington could make the required 75-hour training for individual providers more relevant to clients with complex or special care needs.

Providers and clients were generally satisfied with the required training, though DSHS could further enhance its relevance going forward (page 11)

The audit found through surveys that providers and clients were generally satisfied with the state's required training. Most providers were satisfied with the training and said the training helped them feel confident about meeting the needs of their clients. Most clients felt that their provider met their needs.

Despite general satisfaction with the training, some providers and clients thought it could be improved. A small percentage of providers and clients were dissatisfied with the training, and a larger percentage felt there was room for improvement. Training that lacks relevance to certain client needs can mean that clients, their families and their providers must take on the responsibility of training. While there are inherent challenges in making standardized training more relevant to the needs of all members of a diverse client and provider population, this audit nonetheless considered opportunities to further enhance the training's relevance.

The training could better cover certain population-specific topics such as mental health, managing challenging behaviors, developmental disabilities and caring for children. Greater flexibility in population-specific training could make it more relevant to diverse client needs.

Some providers would also like training in first aid and CPR, as is required for other long-term care workers in other settings. In Washington, other long-term care workers with the same scope of practice as individual providers receive training in first aid and CPR. Some long-term care training models in other states also require or include first aid and CPR.

DSHS could establish a more robust process for ensuring alignment between training content and client needs (page 19)

State law requires DSHS to implement a system of quality improvement for long-term care services, with a focus on customer satisfaction and outcomes. DSHS does not currently have a robust process for regularly assessing alignment between training content and client needs, nor does it appear to thoroughly review the training for relevance to client needs when it approves training curricula. Establishing such a process is consistent with the stated goal of DSHS' quality improvement system, and would ensure the training is more relevant to the full range of its providers and clients going forward.

State Auditor's Conclusions (page 21)

Washington voters have twice approved initiatives to strengthen the training requirements for long-term care providers, and the state's current 75-hour training requirements are some of the best in the country. This sentiment was validated by our surveys of individual providers and clients, with both groups indicating they are happy with the training and how it helped providers better meet the needs of their clients.

The training program for individual providers is clearly strong, but that doesn't mean it can't be improved. Specifically, some providers have expressed a desire to receive training in first aid and CPR, as is required for other long-term care providers in other settings. More broadly, the training could benefit from more population-specific options to recognize that a one-size-fits-all approach may not work. To keep the training relevant over time, we recommend DSHS develop an ongoing process to assess alignment between training content and the needs of clients, and adjust the training requirements accordingly.

Recommendations (page 22)

We recommended the Department of Social and Health Services better align the first aid and CPR training requirements for individual providers with those of other providers in Washington by offering training in first aid and/or CPR. We also recommended the agency improve the relevance of the training going forward for the full range of clients and individual providers by establishing a more robust process for ensuring alignment between training content and client needs.

Next steps

Our performance audits of state programs and services are reviewed by the Joint Legislative Audit and Review Committee (JLARC) and/or by other legislative committees whose members wish to consider findings and recommendations on specific topics. Representatives of the Office of the State Auditor will review this audit with JLARC's Initiative 900 Subcommittee in Olympia. The public will have the opportunity to comment at this hearing. Please check the JLARC website for the exact date, time and location (www.leg.wa.gov/JLARC). The Office conducts periodic follow-up evaluations to assess the status of recommendations and may conduct follow-up audits at its discretion. See **Appendix A**, which addresses the I-900 areas covered in the audit. **Appendix B** contains information about our methodology. See the **Bibliography** for a list of our primary resources.

Background

Long-term care workers support people who need extended care due to age or disability

Long-term care helps people who need support caring for themselves due to age or disabling conditions. This type of care is important because it can help people preserve their independence, avoid institutional care and sustain the best possible level of functioning. Long-term care workers help people perform activities of daily living such as dressing, bathing, preparing meals and other household chores.

People need long-term care for a variety of reasons ranging from cognitive performance concerns to physical challenges. This means one person's needs can differ significantly from those of another, such as a child with a developmental disability compared to an older adult with a chronic illness. Even two people with the same condition can need different levels of support for the same task. For example, two people with dementia both need help preparing meals, but one only needs help with cooking while the other depends entirely on the caregiver to assemble, cook and serve food.

Long-term care workers themselves are just as diverse, especially in terms of the settings they work in and their career intentions. Caregivers can work in residential facilities, such as assisted living facilities and adult family homes. They can also provide care in people's homes, either by working for a home care agency or by working for the person receiving care and getting paid through a contract with the state. Many caregivers provide care only for family members or friends, while others provide care for people they did not know. Some workers care for only one person while others serve several people during a typical work week. Some make caregiving a career; others leave when circumstances change.

Washington requires certain groups of long-term care workers to meet minimum training requirements

Training helps prepare long-term care workers to care for people with a variety of needs. Without quality training, workers may be poorly prepared to provide care, which could result in people receiving inferior care or having needs go unmet. PHI, a nonprofit organization that conducts research and advocacy related to the long-term care workforce, testified to the importance of training before Congress in 2021. PHI's

representative said that "without proper training [of the workforce]... older adults and people with disabilities cannot receive quality care."

Voters in Washington have twice approved initiatives to increase the training requirements for long-term care workers. Initiatives 1029 and 1163, approved in 2008 and 2011 respectively, increased the training, certification and background check requirements for some home care workers. These initiatives require long-term care workers to pass an examination after they complete training, in order to be certified by the Department of Health as "home care aides." The goal of these training requirements is to equip long-term care workers with the knowledge and skills to meet the needs of people who are elderly and people who have disabilities.

The Department of Social and Health Services (DSHS) is responsible for overseeing in-home care services and training

Initiative 1163 tasks DSHS with designing, developing and implementing a long-term care training program that is "flexible, relevant, and qualifies towards the requirements for a nursing assistant certificate." State law grants DSHS regulatory authority, which means the agency writes rules in the Washington Administrative Code (WAC) related to long-term care training. This includes rules for required training content and the curriculum approval process. DSHS contracts with training entities to develop and deliver the training to long-term care workers, but DSHS holds the authority to review and approve training curricula. DSHS' rules also outline the responsibilities training entities' hold, such as coordinating and teaching classes and assuring that the curriculum used is DSHS-approved.

Some long-term care workers known as "individual providers" must take 75 hours of training to provide paid care

As of 2021, DSHS estimated that about 55,000 Medicaid-paid long-term care workers were working in Washington; about three-quarters of them (40,000) were individual providers. These providers contract with the state to provide paid care to Medicaid-eligible clients in the clients' own homes. Many individual providers care for specific clients: at least 75 percent are related to the person they care for, and roughly 85 percent work with a single client.

DSHS estimates that about half of all currently authorized individual providers, or about 20,000 providers, were required to complete 75 hours of training in order to provide paid care as a home care aide. Certain circumstances exempt other providers from the full 75-hour training requirements:

- Parents or children of the client
- Only providing a limited number of hours of respite care
- Working limited hours
- Holding another relevant certification
- Past employment history that qualifies for exemption

Terms in this report

"Providers" refers to individual providers. "Clients" refers to people that receive in-home care from an individual provider.

DSHS contracts with the Training Partnership to develop and deliver this 75-hour training to providers, as mandated under state statute. The Training Partnership is a non-profit organization formed by the Service Employees International Union (SEIU) 775 and participating employers including the state of Washington. Currently, all individual providers required to complete the 75-hour training take the same standardized training through the Training Partnership.

State statute and DSHS' rules set out the requirements for the content of the 75-hour training for all home care workers, including individual providers (listed in **Exhibit 1** on page 9). They specify that two hours are spent on orientation and three on safety training. The remaining 70 hours of basic training include both core competencies and population-specific training, but neither statute nor rules spell out the amount of time to be spent on these topics. That is left up to the Training Partnership, subject to DSHS approval. DSHS reports that stakeholders, including clients and their advocates, participated in the development of the rules that specify the training content.

Washington's training is highly regarded, although some stakeholders question its relevance for certain clients

Washington's long-term care training prepares workers to provide quality care to their clients. Some sources suggest that it is among the best in the nation. *Health Affairs*, a journal focused on health policy and research, cites Washington as "an exemplar" in training home care workers. A report by the Health Workforce Research Center on Long-Term Care at the University of California San Francisco recognized Washington as a leading state in personal care training standards. Similarly, a report by the Aspen Institute, a research and advocacy nonprofit organization, stated that "Washington state has the nation's highest training and certification requirements for the home care workforce."

However, some stakeholders are concerned that the content of Washington's 75-hour basic training for individual providers is not as relevant for certain clients. In their view, the training focuses too heavily on caring for the elderly, and lacks sufficient instruction on skills specific to caring for younger people and those with developmental disabilities or certain conditions such as autism. In such circumstances, stakeholders reported that some clients and their families may have to teach providers skills not taught in the formal training. Stakeholders are also concerned that the state does not require providers to be trained in first aid and CPR, which are important because providers are often home alone with their clients.

Exhibit 1 – Required training content for long-term care workers providing care in clients' homes

Category	Required content
Orientation WAC 388-71-0841	The long-term care worker's role and the applicable terms of employment
Safety WAC 388-71-0850	Essential safety precautions, emergency procedures and infection control. Note: WAC does not require long-term care workers providing care in clients' homes to receive training in first aid or CPR.
Core competencies WAC 388-71-0906 "The behavior and skills that a long-term care worker should exhibit when working with clients" (WAC 388-71-0911)	Communication skills
	Long-term care worker self-care
	Problem solving
	Client rights and maintaining dignity
	Abuse, abandonment, neglect, financial exploitation and mandatory reporting
	Client directed care
	Cultural sensitivity
	Body mechanics
	Fall prevention
	Skin and body care
	Long-term care worker roles and boundaries
	Supported activities of daily living. Topic includes *helping a client with activities such as walking; dressing; transferring from bed to wheelchair; eating; toileting, bathing and hygiene* (WAC 388-71-0911 (11)).
	Food preparation and handling
	Medication assistance
	Infection control, blood-borne pathogens and HIV/AIDS
	Grief and loss
Population-specific competencies	While "*there are no DSHS mandatory competencies or learning objectives for population specific training*," this training is intended to include "*competencies and learning objectives that best meet the care needs of the population(s) served*" (WAC 388-71-0921). This training may include but is not limited to one or more of the following topics: *dementia, mental health, developmental disabilities, young adults with physical disabilities, and aging and older adults* (WAC 388-71-0916).

Source: Auditor compiled from relevant WACs.

This audit examined how Washington could make the required 75-hour training for individual providers more relevant

Initiative 1163 requires the Office of the Washington State Auditor to conduct a performance audit of Washington's in-home long-term care worker program every two years. The Office has published five previous performance audits, listed in **Appendix C.**

This audit, the sixth in the series, answers the following question:

- How can Washington improve the relevance of required home care worker training to better prepare long-term care workers to meet the needs of people who have complex or special care needs?

We focused on assessing the relevance of the current 75-hour training for individual providers, and used five primary sources of evidence to do so:

- Conducted an online survey of providers that recently took the training
- Conducted telephone surveys with clients who receive care from providers that recently took the training
- Analyzed the prevalence of diagnoses and needs of clients who receive care from providers
- Researched training models in other states and leading organizations
- Compared the results of these analyses to the training requirements and curriculum to identify opportunities to improve the relevance of the training

Audit Results

Providers and clients were generally satisfied with the required training, though DSHS could further enhance its relevance going forward

Results in brief

The audit found through surveys providers and clients were generally satisfied with the state's required training. Most providers were satisfied with the training and said the training helped them feel confident about meeting the needs of their clients. Most clients felt that their provider met their needs.

Despite general satisfaction with the training, some providers and clients thought it could be improved. A small percentage of providers and clients were dissatisfied with the training, and a larger percentage felt there was room for improvement. Training that lacks relevance to certain client needs can mean that clients, their families and their providers must take on the responsibility of training.

The training could better cover certain population-specific topics such as mental health, managing challenging behaviors, developmental disabilities and caring for children. Greater flexibility in population-specific training could make it more relevant to diverse client needs.

Some providers would also like training in first aid and CPR, as is required for other long-term care workers in other settings. In Washington, other long-term care workers with the same scope of practice as individual providers receive training in first aid and CPR. Some long-term care training models in other states also require or include first aid and CPR.

The audit found providers and clients were generally satisfied with the state's required training

We conducted two separate surveys of providers and clients (the latter is discussed on page 12). The online survey of providers was intended to learn how well they believed the training prepared them to meet the needs of their clients. We invited all providers who had completed the 75-hour basic training between June 2020 and June 2021, and had delivered paid care to their clients after taking the training, to participate. Survey questions asked if the training helped providers feel confident about meeting the needs of their clients; which aspects of required

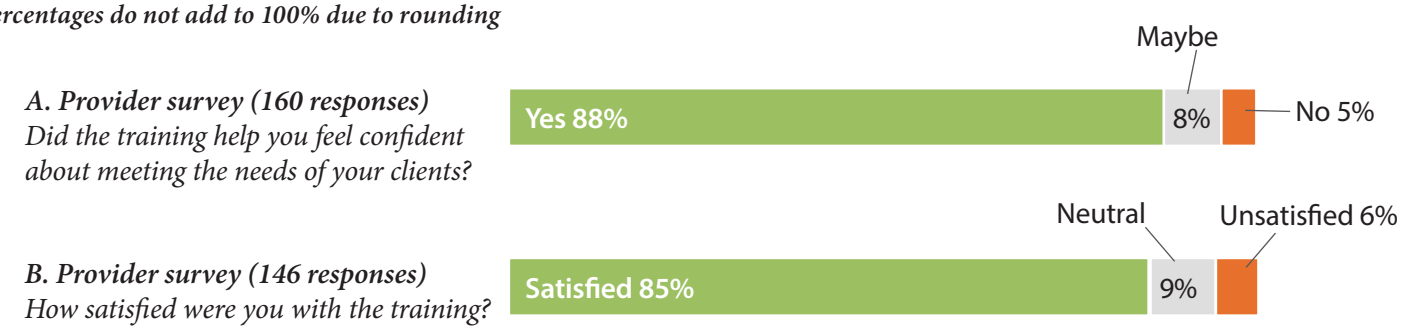
training that they found most and least useful or relevant; and key topics and skills they believe the training could have better taught to help prepare them to meet clients' needs. We sent the survey to 647 providers and received 175 responses.

Most providers were satisfied with the training and said the training helped them feel confident about meeting the needs of their clients

Survey results showed that providers were generally satisfied with the training. Nearly 90 percent of providers said the training helped them feel confident about meeting the needs of their clients (**Exhibit 2A**). Multiple providers mentioned that the training had taught them new skills that improved their ability to care for clients.

Exhibit 2A, 2B – Providers were generally satisfied with the training

Percentages do not add to 100% due to rounding



Source: Auditor created from survey data.

> *"Before I took the training, I was well aware of what I had to do to take care of my clients. But after the training, it made me feel more comfortable doing everything... It helped me gain more knowledge of certain skills."*

> *"I did not know many of the skills that I learned in my training and that has helped me put them into practice to satisfy my client's needs."*

We also asked providers how satisfied they were with the training overall (**Exhibit 2B**). Most providers (85 percent) said they were satisfied. Several offered positive feedback about the training content and instructors.

> *"Training was broad in scope with focus on details for most important info. Instructors were excellent in addressing needs of culture, language, care-giving settings and previous levels of experience of students."*

Most clients felt that their provider met their needs

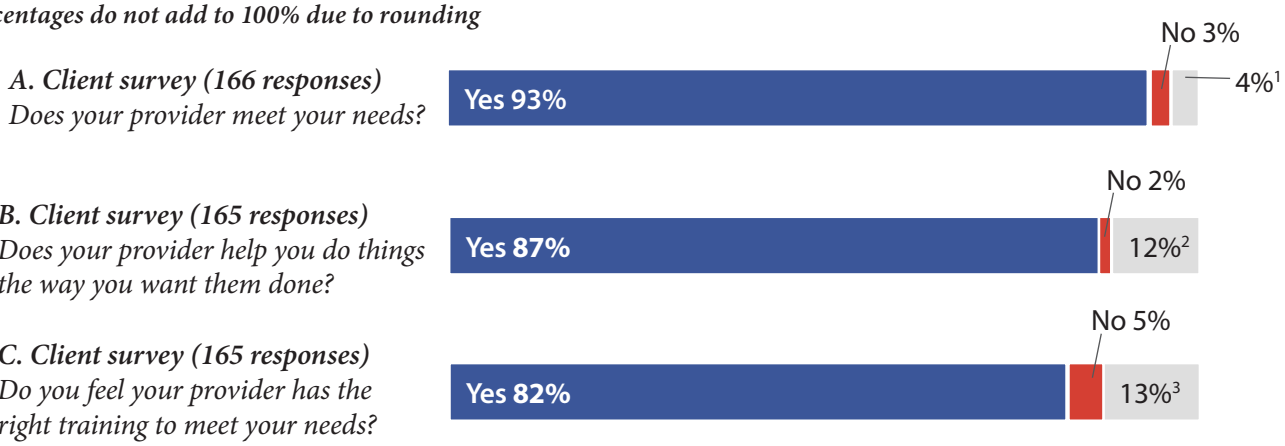
We also conducted a telephone survey of clients who were served by recently trained providers. This survey was designed to gather clients' perspectives on how well the training prepared their provider to meet their needs. We interviewed clients directly whenever possible; however, a proxy respondent who was familiar with the client's care could serve as a respondent if the client was unable or

unavailable to respond. We sampled 372 clients, some of whom were randomly selected and others who had certain characteristics of interest, for example to ensure a reasonable sample size for clients with dementia or autism. Of this initial sample, we completed interviews with 166 clients or their proxy.

This survey showed that most clients (93 percent) said their provider met their needs (**Exhibit 3A**). Clients said their providers were doing a good job helping them with a range of personal care needs, such as dressing, bathing and meal preparation. They often offered very positive feedback about their provider, with many describing them as conscientious, respectful, professional or good listeners. Nearly 90 percent said that their provider helps them do things the way they wanted them done (**Exhibit 3B**), which suggests that many providers incorporate client preferences into their caregiving activities.

Exhibit 3A, 3B, 3C – Clients were generally satisfied with their provider's care and training

Percentages do not add to 100% due to rounding



1. Entire percentage is 4% "maybe/sometimes."
2. This percentage combines: 10% "maybe/sometimes" with 2% "don't know" and unclear responses.
3. This percentage combines: 9% "maybe/sometimes" with 4% "don't know" and unclear responses.

Source: Auditor created from survey data.

We also asked clients whether they felt their provider had the right training to meet their needs; more than 80 percent answered "Yes" (**Exhibit 3C**). Some clients said that they noticed their provider's knowledge and skills improved after the training, resulting in improved care. In addition, some clients and their families said the provider taught them certain topics or skills, such as proper technique for transfers, which they had learned in the training.

Despite general satisfaction with the training, some providers and clients thought it could be improved

The following several pages present the perspectives of those providers and clients who thought the training could be improved, while recognizing there are inherent challenges in making standardized training more relevant to the needs of all

members of a diverse client and provider population. With a limited number of hours for training, it is not feasible to cover every kind of client and individualized care need providers might encounter in the course of their careers. Furthermore, DSHS' rules already specify many topics that must be covered within a set number of hours, making it challenging to include new or better cover existing topics without taking time away from required content providers must learn to pass their certification exam. Continuing education or advanced training may be a helpful, or even perhaps necessary, avenue for providers to gain client-specific training. Nonetheless, the audit considered opportunities to further enhance the 75-hour training's relevance for the full range of providers and clients going forward.

A small percentage of providers and clients were dissatisfied with the training, and a larger percentage felt there was room for improvement

While most providers and clients were satisfied with the training, there were small percentages who were not. About 5 percent of providers said the training did not help them feel confident about meeting the needs of their clients. Similarly, 5 percent of clients did not feel their provider received the right training to meet their needs. While these are small percentages, they do suggest opportunities exist for DSHS to improve the training's relevance to these particular clients' needs.

> *"The entire course had next-to-nothing to do with me… The training itself was too focused on one type of clients… although I know the elderly are [primary] clients."*

Furthermore, some providers and clients who were satisfied with the training nonetheless felt there was room for improvement. While 5 percent of providers and clients were dissatisfied with the training, larger percentages of those surveyed – almost half of providers and more than a third of clients – suggested topics or skills they believed the training should include or better cover. Twenty-seven percent of providers also said they learned topics that had not been useful or relevant to their job (**Exhibit 4**).

Exhibit 4 – Some providers learned things in the training that were not relevant

Percentages do not add to 100% due to rounding

Provider survey (146 responses)
Are there things you learned in the training that have not been useful or relevant at all to your job?

1. This percentage combines: 10% "maybe" with 5% "don't know."

Source: Auditor created from survey data.

Training that lacks relevance to certain client needs can mean that clients, their families and their providers must take on the responsibility of training

One potential effect of training that is not relevant to client needs is that providers and clients must close gaps in knowledge themselves. One-third of providers said they needed to learn a topic or skill because it was not included or covered well in the training (**Exhibit 5A**). Some of these providers learned these things on their own, while others relied upon their clients to teach them. Similarly, 43 percent of clients and their families reported teaching their providers how to do some things for the client (**Exhibit 5B**). It is reasonable to expect some degree of on-the-job training to teach any provider about a client's particular need or care preferences, especially because providers can begin caregiving before completing their training. However, some clients and their families explicitly said that they had to teach their provider specific topics or skills, such as how to manage a client's behavioral issues, because they felt there was a gap in the training.

Exhibit 5A, 5B – Some providers and clients had to assume responsibility for training themselves

A. Provider survey (149 responses)
Was there anything you had to learn on your own, or which your clients taught you, because it was not included – or not covered well – in the training?

B. Client survey (165 responses)
Did you have to teach your provider how to do some things for you?

1. This percentage combines: 8% "maybe" with 5% "don't know."
2. This percentage combines: 4% "maybe/sometimes" with 1% "don't know" and unclear responses.

Source: Auditor created from survey data.

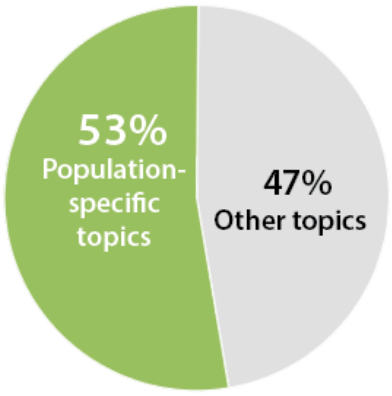
The training could better cover certain population-specific topics

All providers currently take the same standardized population-specific training regardless of their clients' needs. DSHS' rules broadly note that population-specific training is a required component of basic training that should include topics based on the needs of the clients to be served. The Training Partnership curriculum provides eight hours of population-specific training in physical disabilities, developmental and intellectual disabilities, dementia, behavioral health and aging. Providers currently have no flexibility in this training – for example, they cannot select topics from a menu of population-specific courses that best align with the needs of their clients.

Of the providers and clients who offered suggestions about improving the training, more than half felt that the training could better cover population-specific topics to be more relevant to certain client needs (**Exhibit 6**).

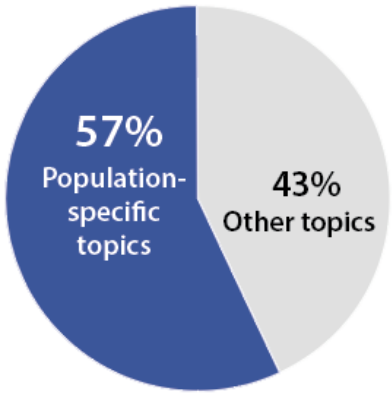
Exhibit 6 – Some providers and clients felt the training could better cover population-specific topics

Provider survey: List topics or skills you wish had been included or better covered to make you more confident about meeting your clients' needs



78 responses of 175 providers surveyed

Client survey: What kinds of things do you think your provider should be trained to do to better meet your needs?



60 responses of 166 clients surveyed

Source: Auditor created from survey data.

Providers and clients described a variety of population-specific topics they felt the training should include or better cover. However, specific topics emerged across results from both our surveys, our analysis of prevalent client diagnoses and needs, and our research of other training models. These topics include mental health, managing challenging behaviors, developmental disabilities and caring for children, as listed in **Exhibit 7**. See **Appendix D** for more detailed results.

Exhibit 7 – Population-specific training topics that emerged in audit results

	Mental health	Managing challenging behaviors	Developmental disabilities	Caring for children
Providers who want the training to include or better cover this topic (out of 78)	17%	10%	Less than 10%*	Less than 10%*
Clients who want their provider to be better trained in this topic (out of 60)	10%	12%	22%	32%
Percent of client population with this need	46%	12%	29%	Less than 10%*
Number of **other training models** that include this topic (out of 8 reviewed)	4	1*	4	3
Included in Washington's training?	**Yes** (80 minutes)	**Yes** (Less than 10 minutes)	**Yes** (90 minutes)	**No**

* Note: This table includes all results for each topic. Results that were not as strong are marked by an asterisk.

Source: Auditor created using results from provider and client surveys, prevalence analysis of client diagnoses and needs, research into other training models, and review of Washington's training requirements and curriculum.

Greater flexibility in population-specific training could make it more relevant to diverse client needs

Because of the diversity in client needs, providers – and thus their clients – could benefit from having greater flexibility in population-specific training. For example, developmental disabilities like autism are more common conditions among younger clients. Caring for them may require providers to be skilled in managing challenging behaviors. However, these conditions are not prevalent amongst clients who are older.

DSHS' rules allow some flexibility on the content included in the population-specific component of the training, which could be used to make the training more relevant to diverse client needs. DSHS does not specify a minimum number of hours to be spent on population-specific content nor does it require any particular topics to be covered in the training. Instead, DSHS' rules list possible topics but specify that the Training Partnership has the discretion to determine population-specific content based on the needs of the client population. In addition, the rules allow providers to take specialty training in a particular topic such as developmental disabilities to meet the population-specific component of basic training. However, DSHS officials have stated that this does not happen in practice, because the training's current design lacks the flexibility to allow providers to pick and choose individual courses.

Some providers would also like training in first aid and CPR, as is required for other long-term care workers in other settings

State regulations do not require providers be trained in first aid and CPR, but some providers felt such training would prepare them to help their clients until emergency services arrived. Of those providers who mentioned topics they wished had been included in the training to make them feel more confident about caring for their clients in an emergency, 40 percent mentioned first aid and/or CPR. One provider said, "[the training] could be… better if [it] include[d] how to assist our client in case of emergency while waiting for the ambulance… like first aid or CPR." The Training Partnership confirmed that its list of top 15 continuing education topics requested by providers included first aid and/or CPR. Only 17 percent of surveyed providers reported that they were currently certified in both first aid and CPR, and less than half (46 percent) felt confident performing CPR.

DSHS does not consider first aid and CPR within the scope of an individual provider's job, and thus does not require either skill. DSHS officials explained that home care aides are not medical professionals, and that they do not consider first

Provider survey results

Our survey asked a sample of providers to list topics or skills they wish had been included or better covered in the training to make them more confident about caring for their clients in an emergency.

40% (21 of 53) of them said first aid and/or CPR

aid and CPR to be within the scope of practice of long-term care workers as defined in the Department of Health's administrative rules. DSHS and Training Partnership officials have also mentioned numerous challenges and risks associated with training providers in first aid and CPR, including costs and increased liability. For these reasons, DSHS does not include first aid and CPR in the list of training topics required by their rules, and thus they do not appear in the Training Partnership's 75-hour training curriculum. Furthermore, providers are unable to count training in first aid and CPR toward their continuing education requirements.

Other similar long-term care workers in Washington and in other states receive training in first aid and CPR

Despite the agency's concerns, it would appear reasonable for DSHS to provide first aid and CPR training to providers because long-term care workers in other care settings in Washington and other states receive this training.

In Washington, other long-term care workers with the same scope of practice as individual providers are already trained in first aid and CPR. DSHS' rules require both first aid and CPR certification for long-term care workers in residential settings like adult family homes and assisted living facilities. Even though DSHS' rules do not include a corresponding requirement for in-home long-term care workers, one Washington home care agency said it nevertheless requires its workers to be trained in first aid and CPR.

Some long-term care training models elsewhere also require or include first aid and CPR. Of the eight other state or organizational training models we reviewed, four required or included first aid / CPR certification or related topics such as "first aid and choking." They are: Alaska, Arizona, Minnesota, and PHI's Homecare Aide Workforce Initiative. Two other models, Oregon and the San Francisco In-Home Support Services Public Authority, pay long-term care workers for first aid/CPR certification, although neither requires such training.

DSHS could establish a more robust process for ensuring alignment between training content and client needs

By establishing a robust process for ensuring alignment between training content and client needs, DSHS could improve the training's relevance to the full range of providers and clients going forward. State law requires DSHS to implement a system of quality improvement for long-term care services, with a focus on customer satisfaction and outcomes. The results of our audit show there are some providers and clients who felt the training could be improved, so establishing a process to evaluate and adapt the training based on client needs could help make the training more relevant, in alignment with the stated goals of DSHS' quality improvement system. Needs within the client population the state serves may also change over time, so periodically assessing whether the training content aligns with them can help ensure the training remains relevant in the future.

DSHS could better assess alignment between training content and client needs, and use the results to revise the training

DSHS could improve its process for assessing the alignment between training content and client needs, and use the results of this assessment to improve the relevance of the training it requires. The sidebar offers one example of such analysis. DSHS officials described the current process, saying they conduct meetings with stakeholders about the training and are in frequent communication with the Training Partnership about the training curriculum. However, DSHS could not show auditors evidence that it systematically assesses the alignment between client needs and the training.

An example of relevant analysis

An example of relevant analysis might be for DSHS to analyze its annual client care-needs assessments and other client data in aggregate, to understand the overall population's diagnoses and needs. The agency could then compare the results to the training requirements and curriculum. This is similar to our prevalence analysis of DSHS client data described in appendices B and D.

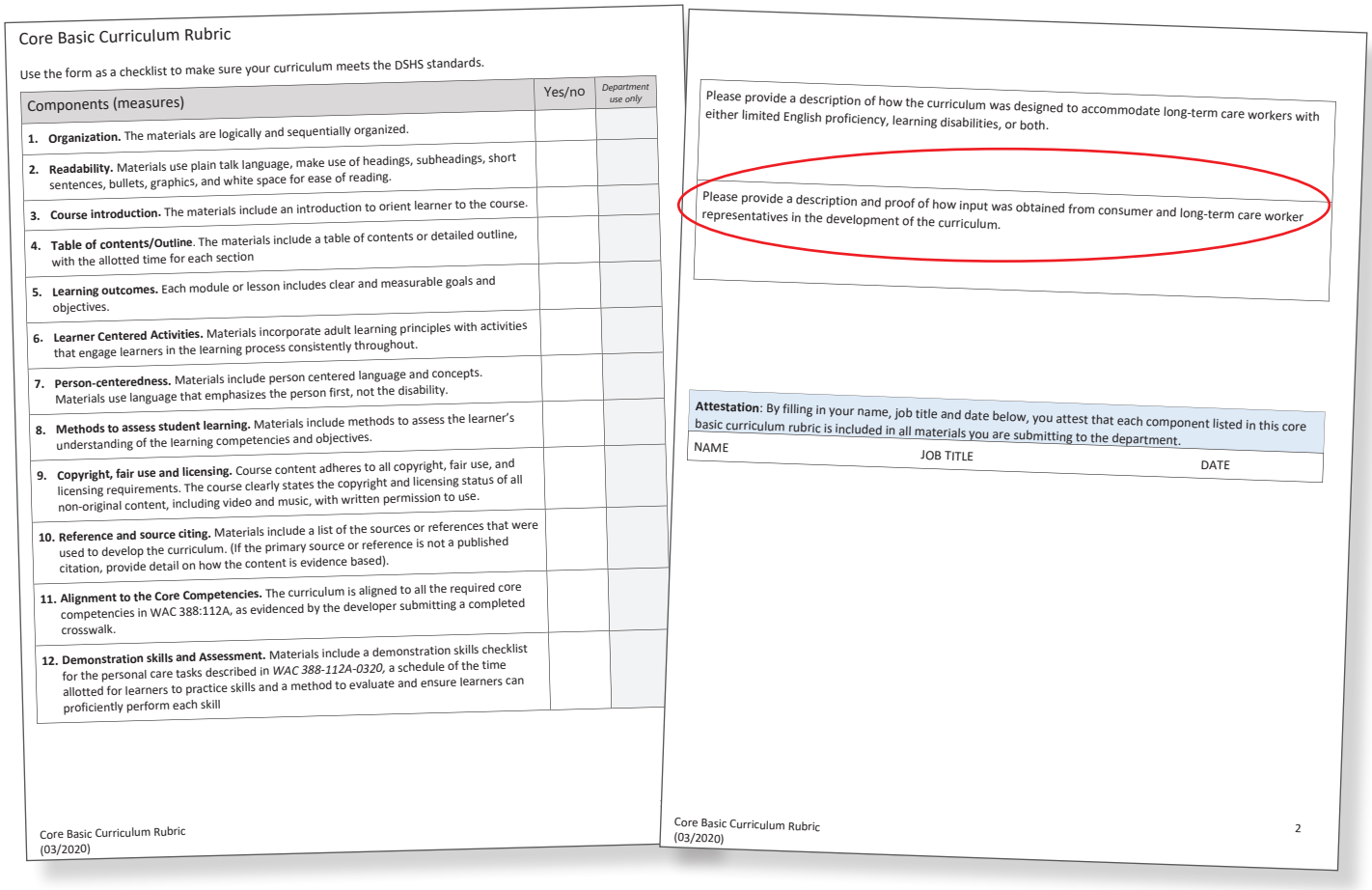
DSHS could improve its review of the training's relevance

Initiative 1163 tasks DSHS with designing, developing and implementing a long-term care training program that is "flexible" and "relevant." DSHS holds the authority to review and approve training curricula for long-term care workers, but could improve its review of the training's relevance to client needs. The agency currently uses two checklists to review the content of the training, but neither explicitly evaluates the relevance of the training to client needs. The first confirms that the training includes the content DSHS' rules require, but does not consider whether or not

those topics are aligned with client needs. The other evaluates whether the training meets other DSHS standards for 12 components such as readability and person-centeredness; this checklist is illustrated in **Exhibit 8**.

Exhibit 8 – Checklist used by DSHS in its curriculum review and approval process

Area circled in red shows space for demonstrating how the training entity obtained consumer and worker input



Core Basic Curriculum Rubric

Use the form as a checklist to make sure your curriculum meets the DSHS standards.

Components (measures)	Yes/no	*Department use only*
1. **Organization.** The materials are logically and sequentially organized.		
2. **Readability.** Materials use plain talk language, make use of headings, subheadings, short sentences, bullets, graphics, and white space for ease of reading.		
3. **Course introduction.** The materials include an introduction to orient learner to the course.		
4. **Table of contents/Outline**. The materials include a table of contents or detailed outline, with the allotted time for each section		
5. **Learning outcomes.** Each module or lesson includes clear and measurable goals and objectives.		
6. **Learner Centered Activities.** Materials incorporate adult learning principles with activities that engage learners in the learning process consistently throughout.		
7. **Person-centeredness.** Materials include person centered language and concepts. Materials use language that emphasizes the person first, not the disability.		
8. **Methods to assess student learning.** Materials include methods to assess the learner's understanding of the learning competencies and objectives.		
9. **Copyright, fair use and licensing.** Course content adheres to all copyright, fair use, and licensing requirements. The course clearly states the copyright and licensing status of all non-original content, including video and music, with written permission to use.		
10. **Reference and source citing.** Materials include a list of the sources or references that were used to develop the curriculum. (If the primary source or reference is not a published citation, provide detail on how the content is evidence based).		
11. **Alignment to the Core Competencies.** The curriculum is aligned to all the required core competencies in WAC 388:112A, as evidenced by the developer submitting a completed crosswalk.		
12. **Demonstration skills and Assessment.** Materials include a demonstration skills checklist for the personal care tasks described in *WAC 388-112A-0320*, a schedule of the time allotted for learners to practice skills and a method to evaluate and ensure learners can proficiently perform each skill		

Core Basic Curriculum Rubric
(03/2020)

Please provide a description of how the curriculum was designed to accommodate long-term care workers with either limited English proficiency, learning disabilities, or both.

Please provide a description and proof of how input was obtained from consumer and long-term care worker representatives in the development of the curriculum.

Attestation: By filling in your name, job title and date below, you attest that each component listed in this core basic curriculum rubric is included in all materials you are submitting to the department.

NAME JOB TITLE DATE

Core Basic Curriculum Rubric
(03/2020) 2

Note: This checklist refers to WAC 388-112A, which is relevant to long-term care workers in residential settings such as adult family homes. WAC 388-71 is the correct WAC for individual providers.

Source: DSHS "Core Basic Curriculum Rubric" checklist.

However, none of these components explicitly address the relevance of the training to client needs. One question is somewhat related to client needs: it asks how the training entity obtained client and provider input during curriculum development (highlighted by the red circle). But DSHS officials did not provide an example of a completed checklist during the audit, so we were unable to assess the quality of the agency's review of this or other questions.

Because DSHS does not currently have a robust process for regularly assessing alignment between training content and client needs, nor does it appear to thoroughly review training content for relevance when it approves training curricula, the agency may be missing opportunities to ensure the training is more relevant to the full range of its clients going forward.

State Auditor's Conclusions

Washington voters have twice approved initiatives to strengthen the training requirements for long-term care providers, and the state's current 75-hour training requirements are some of the best in the country. This sentiment was validated by our surveys of individual providers and clients, with both groups indicating they are happy with the training and how it helped providers better meet the needs of their clients.

The training program for individual providers is clearly strong, but that doesn't mean it can't be improved. Specifically, some providers have expressed a desire to receive training in first aid and CPR, as is required for other long-term care providers in other settings. More broadly, the training could benefit from more population-specific options to recognize that a one-size-fits-all approach may not work. To keep the training relevant over time, we recommend DSHS develop an ongoing process to assess alignment between training content and the needs of clients, and adjust the training requirements accordingly.

Recommendations

For the Department of Social and Health Services

To better align the first aid/CPR training requirements for individual providers with that of residential providers in Washington, as described on pages 17-18, we recommend the agency:

1. Offer training in first aid and/or CPR to individual providers in collaboration with stakeholders such as the Training Partnership

To improve the relevance of the training going forward for the full range of clients and individual providers, as described on pages 19-20, we recommend the agency:

2. Establish a more robust process for ensuring alignment between training content and client needs. Such a process should include:
    a. A mechanism to assess how well the training aligns with client needs
    b. Using the results of the analysis to evaluate relevance during DSHS' formal review and approval of training curricula
    c. Implement revisions to the training as needed. For example:
        - Work with the Training Partnership to modify the training curriculum
        - Revise relevant WACs in Chapter 388-71 to better align training requirements with client needs
        - Work with the Training Partnership to grant providers flexibility in selecting population-specific training

Agency Response

STATE OF WASHINGTON

February 15, 2022

Honorable Pat McCarthy
Washington State Auditor
P.O. Box 40021
Olympia, WA 98504-0021

Dear Auditor McCarthy:

Thank you for the opportunity to review and respond to the State Auditor's Office performance audit, *I-1163: Evaluating Relevance of Required Training for Long-term Care Workers*. The Department of Social and Health Services and Office of Financial Management worked together on this response.

We appreciate that the report recognizes that most providers and clients were satisfied with the state's required training. The report found that 85% of the providers are satisfied with the training and that the training helped them feel confident about meeting the needs of their clients. It also is reassuring to note that 93% of the clients felt that their provider met their needs as well.

We are limited in our ability to modify the 70-hour basic training content due to statutory requirements. However, we will continue to work closely with the Training Partnership to address the training needs of the long-term care workforce and to offer continuing education courses targeted to client and worker needs based on research conducted by DSHS.

Sincerely,

Jilma Meneses
Secretary
Department of Social and Health Services

David Schumacher
Director
Office of Financial Management

cc: Jamila Thomas, Chief of Staff, Office of the Governor
Kelly Wicker, Deputy Chief of Staff, Office of the Governor
Keith Phillips, Director of Policy, Office of the Governor
Patricia Lashway, Deputy Director, Office of Financial Management
Christine Bezanson, Director, Results Washington, Office of the Governor
Tammy Firkins, Performance Audit Liaison, Results Washington, Office of the Governor
Scott Frank, Director of Performance Audit, Office of the Washington State Auditor

Official Cabinet Agency Response to Performance Audit on I-1163: Evaluating Relevance of Required Training for Long-Term Care Workers – February 14, 2022

The Department of Social and Health Services and the Office of Financial Management provide this management response to the State Auditor's Office performance audit report received on January 14, 2022.

SAO Performance Audit Objectives:

This performance audit was designed to address the question:

- How can Washington improve the relevance of required home care worker training to better prepare long-term care workers to meet the needs of people who have complex or special care needs?

Recommendations to DSHS:

SAO Recommendation 1: To better align the first aid/CPR training requirements for individual providers with that of residential providers in Washington, as described on page 18, we recommend the agency:

1. Offer training in first aid and/or CPR to individual providers in collaboration with stakeholders such as the Training Partnership.

STATE RESPONSE:

DSHS' Aging and Long-Term Support Administration does not have the authority to extend the basic training beyond 70 hours, per RCW 74.39A.074 and voter approval of I-1163. State law stipulates the required core competencies and learning objectives for basic training, as well as population-specific competencies. The Training Partnership provides continuing education (CE), and certified individual providers are required to complete 12 hours of CE each year.

The Training Partnership was approved to provide continuing education for CPR, First Aid or CPR, and First Aid to individual providers since September 2014, but these courses are currently not offered as a CE option.

Action Steps and Time Frame:

- Clarify on the training website that CPR and First Aid are required for certain long-term care workers, but are not required for other long-term care workers, including individual providers. *By March 15, 2022*
- Discuss the feasibility of the Training Partnership offering First Aid and CPR courses as continuing education. *By April 30, 2022*
- While discussions take place with training partners, the training website will be updated to include the locations of Red Cross offices, American Heart Association offices, and online courses for individual providers who have a desire to take the CPR, First Aid, or CPR and First Aid trainings. *By June 15, 2022*

SAO Recommendation 2: To improve the relevance of the training going forward for the full range of clients and individual providers, as described on pages 19-20, we recommend the agency:

2. Establish a more robust process for ensuring alignment between training content and client needs. Such a process should include:

   A. A mechanism to assess how well training aligns with client needs

B. Using the results of the analysis to evaluate relevance during DSHS' formal review and approval of training curricula

C. Implement revisions to the training as needed. For example:

- Work with the Training Partnership to modify the training curriculum
- Revise relevant WACs in Chapter 388-71 to better align training requirements with client needs
- Work with the Training Partnership to grant providers flexibility in selecting population-specific training

STATE RESPONSE: While we cannot change the statutory requirements for the 70 hours of basic training for individual provider home care aides, we are currently working with the Training Partnership on the revised curriculum for Basic Training 70 v4, as well as the Advanced Home Care Aide Specialist v3 training that includes a holistic track and a behavioral health track for addressing client needs. These trainings were revised based on research conducted by the DSHS Research and Data Analysis Division. New training content includes person-centered care, trauma-informed care, mental health and challenging behaviors.

Continuing education is available to caregivers who can select topics based upon population-specific needs of clients they serve. These topics include verbal de-escalation, anxiety disorders, mental and emotional health, traumatic brain injury, autism, and others.

The Training Partnership conducts research to determine training needs through:

- Provider surveys
- Course evaluations from individual providers
- Continuous communication loops to solicit feedback
- Focus groups
- Customer experience roundtables with employers and DSHS field staff
- Reports from research done by the Service Employees International Union
- Regular meetings and collaboration with DSHS

DSHS data is obtained through annual quality assurance client surveys and annual research conducted by the DSHS Research and Data Analysis Division, and DSHS shares the information with the Training Partnership.

The Training Partnership plans to roll out the revised Basic Training 70 this summer and pilot the revised Advanced Home Care Aide Specialist Training by June 2024. This revision is structured around three pillars: core, holistic and behavioral health. Client surveys are planned to assess if the course:

- Strengthened client/caregiver relationships
- Improved client engagement (fostering choice, independence, autonomy, and control)
- Increased client satisfaction with the care and support they receive
- Improved client physical, mental, and emotional well-being

Action Steps and Time Frame:

- Continue collaboration with the Training Partnership to assess training and client outcomes by analyzing data gathered annually to evaluate the relevance of training curricula; however, we are limited by the need to meet statutory requirements. *Complete and ongoing*
- Discuss with the Training Partnership leadership flexibility in selecting population-specific training. *By February 28, 2022*

State Auditor's Response

As part of the audit process, our Office provides a final draft of the report to the audited agency and offers management the opportunity to respond. The response from the Department of Social and Health Services (DSHS) is included in this report. DSHS officials made a comment that requires clarification, and they provided new information that they did not present during earlier stages of this audit. We summarize these issues below and offer our responses.

DSHS Clarification No. 1

In response to Recommendation No. 1, DSHS officials state the agency does not have the authority to extend the basic training beyond 70 hours, per RCW 74.39A.074 and voter approval of I-1163.

Auditor's Response

We appreciate and acknowledge that DSHS plans to take several steps, including clarifying training requirements on its website, discussing the feasibility of offering first aid and CPR courses with the Training Partnership, and updating its website with information for where individual providers can seek first aid and CPR training.

However, we think it's possible that DSHS can meet the recommendation within the existing law. For example, DSHS currently requires long-term care workers in adult family homes and assisted living facilities to train in first aid and CPR. This requirement occurs outside the 70-hour basic training for long-term care workers. Offering training in first aid and/or CPR to individual providers, whether it is within the 70-hour basic training or outside of it, would better align individual provider requirements with those of residential providers in Washington.

DSHS Clarification No. 2

In response to Recommendation No. 2, DSHS officials state they obtain data on client satisfaction and training content through annual surveys and other research, and that the agency shares this information with the Training Partnership to revise training curriculum.

Auditor's Response

The actions that DSHS described in its response meet the intent of our recommendation. However, the agency did not provide this information until the very end of the audit, which was too late in the process for us to conduct additional verification procedures.

Appendix A: Initiative 900 and Auditing Standards

Initiative 900 requirements

Initiative 900, approved by Washington voters in 2005 and enacted into state law in 2006, authorized the State Auditor's Office to conduct independent, comprehensive performance audits of state and local governments.

Specifically, the law directs the Auditor's Office to "review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts." Performance audits are to be conducted according to U.S. Government Accountability Office government auditing standards.

In addition, the law identifies nine elements that are to be considered within the scope of each performance audit. The State Auditor's Office evaluates the relevance of all nine elements to each audit. The table below indicates which elements are addressed in the audit. Specific issues are discussed in the Results and Recommendations sections of this report.

I-900 element	Addressed in the audit
1. Identify cost savings	**No.** This audit was not intended to assess saving costs for the training.
2. Identify services that can be reduced or eliminated	**No.** While the audit identified areas where individual providers felt their training was not useful, it did not make specific recommendations about topics to curtail or eliminate from the training.
3. Identify programs or services that can be transferred to the private sector	**No.** Training for providers is already contracted out to the Training Partnership, a non-profit organization formed by the Service Employees International Union (SEIU).
4. Analyze gaps or overlaps in programs or services and provide recommendations to correct them	**No.** This audit did not analyze gaps or overlaps in programs or services. However, it did identify specific topics or skills that could be enhanced or better covered within the state's training program for providers.
5. Assess feasibility of pooling information technology systems within the department	**No.** This audit did not address pooling information technology systems.

I-900 element	Addressed in the audit
6. Analyze departmental roles and functions, and provide recommendations to change or eliminate them	**Yes.** This audit assessed the role of DSHS in reviewing the relevance of training curricula for providers and made recommendations to enhance current practices.
7. Provide recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions	**No.** This audit does not directly make recommendations for statutory or regulatory changes. However, DSHS may find it needs to make some revisions as it pursues the audit's recommendations.
8. Analyze departmental performance data, performance measures and self-assessment systems	**Yes.** This audit examined how DSHS assesses and reviews the relevance of training for providers.
9. Identify relevant best practices	**No.** This audit audit did not identify best practices. However, it did use client and provider surveys, a client needs analysis, and research into other training models to identify opportunities to improve the relevance of training.

Compliance with generally accepted government auditing standards

We conducted this performance audit under the authority of state law (RCW 43.09.470), approved as Initiative 900 by Washington voters in 2005, and in accordance with generally accepted government auditing standards as published in *Government Auditing Standards* (July 2018 revision) issued by the U.S. Government Accountability Office. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The mission of the Office of the Washington State Auditor

To provide citizens with independent and transparent examinations of how state and local governments use public funds, and develop strategies that make government more efficient and effective. The results of our work are widely distributed through a variety of reports, which are available on our website and through our free, electronic subscription service. We take our role as partners in accountability seriously. We provide training and technical assistance to governments and have an extensive quality assurance program. For more information about the State Auditor's Office, visit www.sao.wa.gov.

Appendix B: Scope, Objectives and Methodology

Scope

This performance audit examined the relevance of the 75-hour training for individual providers to clients with complex or special care needs. The audit focused on the relevance of the requirements and content of the training that was in place from June 2020 to June 2021, which was reviewed and approved by DSHS. The audit touched on, but did not examine in depth, aspects of the state's training model, such as offering providers flexibility to select which modules they take in the training.

These areas were outside the scope of this audit:

- The shorter trainings taken by providers who are exempt from the 75-hour training
- The relevance of the trainings for other types of long-term care workers, including those who work for home care agencies or residential facilities
- The quality of training
- The home care aide examination and certification process through the Washington State Department of Health

Objectives

The purpose of this performance audit was to answer the following question:

- How can Washington improve the relevance of required home care worker training to better prepare long-term care workers to meet the needs of people who have complex or special care needs?

Methodology

We obtained the evidence used to support the findings, conclusions and recommendations in this audit report during our fieldwork period (March to October 2021), with some additional follow-up work afterward. To address this audit's objective, we used a combination of audit methodologies.

- Conducted an online survey of providers to learn how well they believed the training prepared them to meet the needs of their clients
- Conducted a telephone survey of clients to learn how well they believed the training prepared their provider to meet their needs
- Analyzed DSHS data to identify the most prevalent client diagnoses and needs, to assess their alignment with the training requirements and curriculum
- Researched training models in other states and organizations to identify potential improvements to Washington's training model
- Compared the results of these analyses to the content DSHS requires in its rules and the training curriculum offered by the Training Partnership

The work we performed to address the audit objective is described on the following pages.

Note: This audit was placed on hold in June 2020 due to difficulties in obtaining data and interviews as DSHS prioritized the state's response to the COVID-19 pandemic. We resumed audit work in March 2021.

Surveys

Online survey of providers

On June 30, 2021, DSHS gave auditors a requested list of recently trained providers of in-home long-term care services. The operational definition for a 'recently trained provider' as defined for this audit was someone who had billed DSHS for:

- 70 hours of basic training in addition to the 5 hours of orientation and safety training, with the last billing coming in after June 1, 2020
- Providing care at least once following the final billing for training

We chose this approach to ensure the provider had provided care after having completed the training. The data set included providers who completed their training between June 1, 2020, and the date DSHS pulled the data.

We sent all recently trained providers an electronic survey. The voluntary survey asked providers if the training helped them feel confident about meeting the needs of their client(s), aspects of required training that they found most and least useful or relevant, and key topics and skills they believed the training should teach to better prepare them to meet the needs of clients. We designed the survey to be accessible to the state's diverse worker population, including those with different language preferences and literacy levels. We contracted with a translation company to offer the survey in the most common languages spoken by providers other than English.

We sent surveys to 647 providers and received a total of 181 partial and complete responses, for a response rate of about 28 percent. Six respondents indicated they had not taken the 75-hour training, so we eliminated their responses from our analysis, leaving a total of 175 provider responses.

Telephone survey of clients

We also asked DSHS to supply a list of clients currently receiving in-home care from those recently trained providers, with information about their individual characteristics and support needs. The initial list included 869 clients.

We designed a survey to gather client perspectives on how well training prepared their provider to meet their needs. We conducted the surveys by telephone. The audit team incorporated best practices into the design for the client survey protocol that are recommended by the Human Services Research Institute in their National Core Indicators surveys for people who are aging and have developmental disabilities.

We selected a random sample of 150 clients, equally distributed between the two DSHS administrations that serve them: the Aging and Long-Term Support Administration and the Developmental Disabilities Administration. This group was supplemented by selected additional clients to ensure a reasonable sample size for clients who had particular characteristics of interest, including: clients with behavior issues, complex disabilities, youth and young adults with physical disabilities, autism, dementia, mental health disorders, ongoing pain, and specialized diets. The final sample, including alternates, totaled 372 clients.

We interviewed clients directly whenever possible; however, a proxy respondent who was familiar with the client's care could serve as a respondent if the client was unable or unavailable to respond. For example, we spoke to parents of child clients who received care from a provider who recently completed the 75-hour training. Proxy respondents could not be the paid provider for the client. Auditors used a telephone interpretation service when needed to complete the survey with clients and proxies whose preferred language was not English.

We completed interviews with 172 clients or their proxy, for a response rate of 46 percent. We excluded six responses from our analysis due to concerns about their validity, leaving a total of 166 client responses.

Data cleaning, coding and analysis

We used SurveyMonkey® for the provider survey and Microsoft Forms for the client survey. Once the surveys had closed, auditors cleaned the data. For qualitative data, we coded responses to open-ended survey questions about topics and skills to categorize similar responses and then reviewed these codes for prevalent themes, taking into consideration factors such as the number of respondents to that question. Finally, we analyzed both quantitative and qualitative responses to form conclusions.

Limitations and extrapolating results

Results from our surveys should not be interpreted as representative of the entire population of providers and their clients. The intent of the audit was not to obtain statistically representative results, but rather to identify potential areas where training could be more relevant to client needs. Furthermore, while auditors took steps to mitigate bias in survey results, there are still risks that the opinions of clients and providers differ from those of the overall population. It is also possible that respondents did not understand questions and were not able to provide valid responses, or did not feel comfortable doing so. Statistics in this report were not adjusted for differences between our sample and the overall population of clients and providers, nor were they tested for statistical significance.

Analyzed prevalent client diagnoses and needs

We also requested data for all clients currently authorized by DSHS to receive in-home long-term care services through an individual provider, regardless of whether the provider was required to take the 75-hour training or was exempt. We used this data to analyze the care needs of the entire population of clients receiving in-home care from any individual provider.

Data for each client included information on diagnoses, needs and other characteristics as determined through the client's most recent Comprehensive Assessment and Reporting System (CARES) evaluation. A CARES evaluation assesses each client's needs; DSHS uses it for case management documentation and to determine service allocation and support plans. We analyzed CARES data to determine the prevalence of certain client diagnoses, client characteristics and support needs across the population of DSHS clients.

DSHS officials caution that client medical diagnoses information from CARES may contain some inaccuracies. During the audit period, CARES still used the International Classification of Diseases Ninth Revision (ICD-9) even though the medical community generally used ICD-10. In addition, case managers must sometimes manually enter diagnoses, and DSHS officials caution that because case managers are not trained in medical coding there may be inconsistencies in how this information was recorded.

Data reliability testing

We performed data reliability testing on all data received by DSHS for the surveys and prevalence analysis, to determine whether the data were sufficiently reliable to support the audit findings, conclusions and recommendations. We concluded that the data appeared to be sufficiently reliable. DSHS officials also said the agency has a strong quality control process when it assembles and provides data. Requests for reports and data are fully documented before staff develop and test the query, and then an independent team of data analysts conducts a code review. Auditors also consulted with a team of subject matter experts at DSHS to make sure they were interpreting fields and values in the data set appropriately.

Researched training models in other states and organizations

We reviewed the training requirements for long-term care workers in six states – Alaska, Arizona, Arkansas, Idaho, Minnesota and Oregon – and two highly regarded organizations: PHI's Homecare Aide Workforce Initiative and the San Francisco In-Home Support Services Public Authority. Five of the six states were identified as leaders in a report by the UCSF Health Workforce Research Center on Long-Term Care. We also included Oregon in the analysis because it recently implemented new, statewide training requirements for home care workers; Oregon's training is conducted by Service Employees International Union (SEIU), similar to Washington's model. We identified the two leading organizations based on a report by the International Longevity Center-USA. While we also reviewed the training requirements for the Schmieding Center for Senior Health and Education at the University of Arkansas, also praised by the International Longevity Center-USA, we excluded it from our analysis of training requirements to avoid over-representing Arkansas' requirements in our results.

We conducted online research to determine training requirements for long-term care workers and interviewed officials from each state to obtain details about their training models. We then compared these training models to Washington's model and core curriculum under Washington Administrative Code (WAC) Chapter 388-71.

Reviewed Washington's training for individual providers

We drew conclusions about training content from survey responses that were particularly strong or emerged multiple times, from items that recurred in our research into other training models, and from our analysis of client diagnoses and needs. For each conclusion, we reviewed DSHS' rules as set in Washington Administrative Code (WAC) to determine if the topic or skill must be included in training. We also reviewed the current curriculum (Version 3) offered through the Training Partnership to determine if the topic or skill was included and, if so, how much time was dedicated to it.

Because the Training Partnership curriculum is considered proprietary (defined in RCW 74.39A.200), we had limited access to the curriculum (see "Reporting confidential or sensitive information" section below). We focused our review on two main training guides and then confirmed our conclusions with the Training Partnership.

Work on internal controls

Internal controls at DSHS were significant to our audit objective, which sought to identify opportunities to improve the relevance of required training for individual providers. We assessed whether DSHS' internal controls were effectively designed to ensure the relevance of the training. We did this by gathering information and interviewing DSHS officials to learn more about their process for assessing and reviewing the training for its relevance to client needs.

Reporting confidential or sensitive information

This report does not include any specific details about the content of the 75-hour training curricula for basic training contracted by DSHS and developed by the Training Partnership. The reason for this exclusion is that this content is considered proprietary information.

According to RCW 74.39A.200, "Any proprietary curricula and material developed by a private entity for the purposes of training staff in facilities licensed under chapter 18.20 or 70.128 RCW or individual providers and home care agency providers under this chapter and approved for training by the department are not part of the public domain." Excluding this material did not impair the conclusions or recommendations made in this report.

Appendix C: Earlier I-1163 Audits

Earlier performance audits in the I-1163 series, conducted by our Office, are available on our website.

Report title	Report number	Publication date
Assessing Extended Family Exemptions for Individual Providers	1023358	February 21, 2019
Barriers to Home Care Aide Certification	1018059	November 28, 2016
I-1163: Long-term Care Worker Certification Requirements 2016	1017262	August 4, 2016
Initiative 1163: Long Term Care Worker Certification Requirements [2014]	1012952	December 18, 2014
Initiative 1163: Long-Term Care Worker Certification Requirements [2013]	1008965	January 8, 2013

Appendix D: Detailed Audit Results on Population-Specific Training and Prevalent Client Diagnoses

Detailed results on population-specific training topics that emerged in audit fieldwork

This section describes in greater detail the audit's examination of four population-specific topics: mental and behavioral health; managing challenging behaviors; developmental disabilities; and caring for children (see pages 15-16 in the report). Evidence from surveys and other audit fieldwork suggested the training should include or better cover these topics. See Appendix B for details about our methodology.

Mental and behavioral health

While Washington's population-specific training does include mental and behavioral health, some providers and clients felt that the training should better cover this topic. Mental health is listed as a possible, but not required, population-specific topic in DSHS' rules (listed in the Background section of this report), and the Training Partnership's curriculum does include a 90-minute module on behavioral health and mental illness. However, some clients and their families felt their provider needed better training in mental health. Similarly, some providers also said they wished the training better covered mental health generally, as well as specific mental health conditions such as depression. Mental health conditions, particularly anxiety and depression, are also prevalent in the overall client population. See **Figure 1** below.

Figure 1 – Detailed audit results on mental and behavioral health

Of those clients or proxies and providers who offered suggestions about improving the training…	Percentage of client population with this need	Of the eight other training models researched...
Clients: 10% (6 of 60 responses) mentioned mental health *Providers:* 17% (13 of 78 responses) mentioned mental health	46% of clients currently receiving in-home care from a provider have one or more mental health diagnoses*, primarily anxiety and depression	Four included topics related to mental health in their curricula: • Alaska • Arizona • PHI's Homecare Aide Workforce Initiative • San Francisco In-Home Support Services Public Authority

* Note: Percentage includes mental health diagnoses except developmental disabilities or substance use issues.

Managing challenging behaviors

Some providers and clients felt that the training should better cover managing challenging behaviors, which at present is only briefly covered in Washington's training. This could be considered a cross-cutting topic throughout the training, in that many core competencies such as communication, problem-solving, and person-centered care are important to effectively manage challenging client behaviors. However, this is not an explicitly required topic in DSHS' rules, and the Training Partnership's curriculum dedicates fewer than 10 minutes specifically to managing challenging behaviors as part of a module on communication. Some clients and their families felt their provider needed better training in managing challenging behaviors, and some providers said they wished the training better covered it as well. For example, providers mentioned that the training could be improved by covering topics such as "deescalating a client from a situation," "how to handle clients who are not cooperative," and "dealing with difficult or combative behavior." See **Figure 2** below.

Figure 2 – Detailed audit results on managing challenging behaviors

Of those clients or proxies and providers who offered suggestions about improving the training…	Percentage of client population with this need	Of the eight other training models researched...
Clients: 12% (7 of 60 responses) mentioned challenging or unique behaviors *Providers:* 10% (8 of 78 responses) mentioned challenging or unique behaviors In addition, 53% (23 of 43) of *clients* who had behavioral concerns and their families said they had to teach their providers how to do some things for them, compared to 43% for all respondents.	12% of clients currently receiving in-home care from a provider have behavioral concerns	One included topics related to managing challenging or unique behaviors in its curricula: • Minnesota

Developmental disabilities

While Washington's population-specific training does include developmental disabilities, some clients and their families felt that the training should better cover this topic. Developmental disabilities is listed as a possible, but not required, population-specific topic in DSHS' rules; the Training Partnership's curriculum does include an 80-minute module on developmental and intellectual disabilities. However, some clients and their families felt, often strongly, that their provider needed better training to provide appropriate care. In some cases, clients' family members expressed frustration because they felt the training focused on caring for older people, when the needs of people with developmental disabilities are so different. Similarly, although some degree of on the job training is necessary for most new providers, clients with developmental disabilities and their families had to teach their providers things specific to their unique care needs and condition more often than other clients did. See **Figure 3** below.

Figure 3 – Detailed audit results on developmental disabilities

Of those clients or proxies and providers who offered suggestions about improving the training…	Percentage of client population with this need	Of the eight other training models researched...
Clients: 22% (13 of 60 responses) mentioned developmental disabilities or delays *Providers:* Less than 10% of providers mentioned developmental disabilities. In addition, 51% (35 of 69) of *clients* served by DSHS' administration for people with developmental disabilities said they had to teach their providers how to do some things, compared to only 38% (36 of 96) for those served by DSHS' administration for seniors and adults with other disabilities.	29% of all clients receiving in-home care from a provider are served by DSHS' administration for people with developmental disabilities	Four included topics related to developmental disabilities in their curricula: • Alaska • Arizona • PHI's Homecare Aide Workforce Initiative • San Francisco In-Home Support Services Public Authority

Caring for children

Some clients and their families felt that non-parent providers should receive better training on caring for children within the 75-hour training. While many personal care tasks apply to both children and adults, DSHS' rules do not require population-specific training on children or list it as a possible topic; the Training Partnership curriculum lacks any content specifically about caring for clients who are children. By contrast, three training models we researched do include topics specific to children. Some parents felt that their child's provider needed better training in caring for children, and a few expressed frustration that the standardized training was geared toward serving clients who were elderly and irrelevant to their situation. However, less than 10% of the population of clients receiving in-home care from providers in Washington are children. See **Figure 4** below.

Figure 4 – Detailed audit results on caring for children

Of those clients or proxies and providers who offered suggestions about improving the training…	Percentage of client population with this need	Of the eight other training models researched...
Clients: 32% (19 of 60 responses) mentioned children. Many of these respondents mentioned needs or conditions specific to children. *Providers:* Less than 10% of providers mentioned children.	Less than 10% of all clients currently receiving in-home care from a provider are minors	Three included topics related to mental health in their curricula: • Alaska • Minnesota • PHI's Homecare Aide Workforce Initiative

Results on client diagnoses from the prevalence analysis

Our analysis of DSHS client data examined the prevalence of certain client diagnoses across the total population of clients currently receiving in-home care from an individual provider.

Results are disaggregated by DSHS' two administrations serving long-term care clients in their homes:

- **The Aging and Long-Term Support Administration (ALTSA)** serves seniors and other adults with disabilities who need long-term support. ALTSA serves 71 percent of all clients currently receiving in-home care from an individual provider.
- **The Developmental Disabilities Administration (DDA)** serves children and adults with developmental disabilities, such as intellectual disabilities, cerebral palsy, epilepsy, autism or other similar conditions. DDA serves 29 percent of all clients currently receiving in-home care from an individual provider.

Figures 5 (below) and **6** (on the following page) list prevalent client medical diagnoses for each of DSHS' two administrations. We included diagnoses for which greater than 15 percent of clients within each DSHS administration had that diagnosis. Please see Appendix B for information about this methodology, including the limitations of client medical diagnosis data.

Figure 5 – Prevalent medical diagnoses for clients served by DSHS' Aging and Long-Term Support Administration (ALTSA)

Diagnoses	Percentage of ALTSA client population
Essential hypertension disease	65%
Affective psychoses	44%
Osteoarthrosis and allied disorders	41%
Diabetes	38%
Diseases of esophagus	38%
Neurotic disorders	28%
Disorders of the eye and adnexa	25%
Rheumatism, excluding the back	22%
Osteopathies, chondropathies, and acquired musculoskeletal deformities	19%
Asthma	18%
Cerebrovascular disease	18%
Hereditary and idiopathic peripheral neuropathy	18%

Figure 6 – Prevalent medical diagnoses for clients served by DSHS' Developmental Disabilities Administration (DDA)

Diagnoses	Percentage of DDA client population
Intellectual disabilities	59%
Psychoses with origin specific to childhood	35%
Specific delays in development	24%
Neurotic disorders	19%
Disorders of the eye and adnexa	17%
Chromosomal anomalies	16%
Infantile cerebral palsy	16%

Bibliography

Choitz, Vickie, Matt Helmer, and Maureen Conway. "Improving Jobs to Improve Care. The SEIU Healthcare NW Training Partnership." Workforce Strategies Initiative at the Aspen Institute. Washington, DC, March, 2015. http://www.aspenwsi.org/wordpress/wp-content/uploads/SEIU-CaseStudy.pdf

Espinoza, Robert. "Investing in direct care workforce interventions to improve the quality of services and supports for older adults and people with disabilities." PHI Congressional Testimony, July 20, 2021. https://edlabor.house.gov/imo/media/doc/EspinozaRobertTestimony072021.pdf

International Longevity Center (ILC)-USA. "Caregiver Training in America and Southern California: Results of a National Review." 2008. https://www.issuelab.org/resources/11791/11791.pdf

Marquand, Abby, Susan A. Chapman. "Leader States in Personal Care Aide Training Standards." University of California San Francisco Health Workforce Research Center on Long-Term Care. October 31, 2014. https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/Issue_Brief-Leader_States_in_Personal_Care_Aide_Training_Standards.pdf

Spetz, Joanne, Robyn I. Stone, Susan A. Chapman and Natasha Bryant. "Home And Community-Based Workforce For Patients With Serious Illness Requires Support To Meet Growing Needs." Health Affairs, 38(6), 902-909. June 2019. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00021

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