Commission on Long-Term Care
Public Hearing on "Addressing LTSS Service Delivery and Workforce Issues"
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Introduction

Chair Chernof, Vice-Chair Warshawsky, and Members of the Commission, good afternoon. My name is Charissa Raynor and I am Executive Director of the SEIU Healthcare NW Training Partnership. The Training Partnership is a non-profit school in Washington state training more than 40,000 home care workers annually. We are the largest educational institution in the nation dedicated to home care worker training.

I've been asked to share with you insights from on-the-ground implementation of the nation's most ambitious training and workforce development initiative for home care workers. Thank you for this opportunity.

Washington's Story: Training should keep pace with HCBS expansion

Washington state has led the nation in providing home and community based service (HCBS) options. They are in front of a nationwide trend to re-balance. In Washington state, people receiving home care services would in many other states be in an institution or at home with unmet need.

Others have testified before this Commission and in other venues on the need for more HCBS options to meet the impending and unprecedented demand for services and the overwhelming preference of those receiving services to do so at home. And, much has been said about policy measures to finance and organize HCBS options to meet this need. These are truly exciting developments. As we move more and more towards HCBS and away from institutional care nationally, you will likely find what we found in Washington state - HCBS options are only as good as the workforce we have to operationalize them. And, right now across the nation we are dangerously short on both number of workers and the skills needed to meet this looming demand.

Home care workers are the fastest growing occupation in the nation, not in healthcare, but across all occupations.[i] By 2018, demand for home care workers will increase by more than 90%.[ii] In numbers this means, for example, in Washington state, assuming a 35% annual turnover rate, nearly 440,000 total home care workers would need to be trained between 2010 and 2030 to meet the estimated demand.[iii] How do we train so many workers with such limited training infrastructure in the states today? What

should the training look like? Will training not only support goals of quality of care, but also reduce turnover and vacancy rates thereby improving access?

To answer these questions, we need to have at the forefront that our goal cannot be limited to keeping people out of institutions. In Washington state, our goal is making sure that people who want to stay in their own home and receive services can and that the services they receive are high quality. That goal is 100% reliant on a qualified, committed home care worker on the other side of the front door. Having HCBS options is the start, not the end, of how we ensure that older adults and people with disabilities have a qualified, committed home care worker when they need one.

Any examination of HCBS options on the national front can benefit from lessons learned in Washington state. Washington has led the nation in providing HCBS options. They are in the forefront of a nationwide trend to re-balance services towards home and community-based care. Again, in Washington, people receiving home care services would in many other states be in an institution or at home with unmet need.

As Washington re-balanced, the care needs of home care consumers shifted from chore and companion care to much more complex care needs. Today, home care aides in Washington are supporting individuals with serious mental illness, end stage dementia, developmental and intellectual disabilities, spinal cord injuries, traumatic brain injury, and complex chronic disease. And, they do it without a nurse supervisor or peer down the hall. And, they do it not in an institution, but in someone's home.

With this expansion of HCBS in Washington state came a growing recognition that home care workers were being asked to provide nursing home level care with a fraction of the training their peers in nursing homes were required to have. And recognition that this "skills gap" created by re-balancing was leading to a serious and expensive problem -- high vacancy and turnover rates as well as quality of care and consumer satisfaction concerns.[iv]

In response, Washington state has created the nation's highest training requirement for home care workers: 75 hours of entry level training, a Department of Health credentialing exam, and 12 hours of annual continuing education.

Since there is no federal training requirement for home care workers (as exists for nursing home workers), most home care workers across the country have little or no training. In fact, the Institute of Medicine, in its 2008 report "Caring for An Aging America," notes that the education and training for home care workers is insufficient to provide quality care and recommends the establishment of minimum training requirements for home care workers.[v] Without a minimum federal standard, one can imagine that as HCBS options continue to trend upwards across the country, more and more states will face the skills gap experienced in Washington state – hamstringing the great potential that HCBS expansion offers with high turnover and vacancy rates that threaten access and quality. For these reasons, it is critical that you consider policy recommendations to strengthen HCBS options in tandem with policy changes needed to strengthen the home care workforce.

Training Partnership Model: Implementing Highest Training Standards in the Nation

Fast forwarding you now into that HCBS future that so many have underscored we need, I want to share with you what implementation of the nation's highest training and certification standard for home care workers looks like today.

The Training Partnership is a nonprofit school created and sponsored by a labor-management partnership including the State of Washington, SEIU, and 20 home care agencies. We deliver training to more than 40,000 home care aides in Washington state annually. To put this in context, we are second only to the University of Washington in terms of educational institution enrollment in the state. To succeed, we have had to overcome the challenges of training delivery for a disaggregated workforce spread over urban/rural divide with linguistic diversity and varying literacy and tech literacy. We've learned to overcome these challenges and other states can too.[vi]

In terms of delivery infrastructure, we have more than 100 sites across the state offering training in even the most rural communities. We deliver training in 13 languages -- Arabic, Cambodian, Cantonese, Korean, Laotian, Russian, Samoan, Somali, Spanish, Tagalog, Ukrainian, Vietnamese, and English. We use adult learner centered pedagogy which means all training engages the experiences that the learner brings to the table and curbs traditional theory to make learning 100% applied – it is all about how the learner will use what she learns on-the-job. We develop training from the position that consumers, workers, and industry know what they need. We have a rigorous process to understand their needs and then cross walk with subject matter experts and the published evidence to produce relevant, engaging, evidence based adult learning. We have a rigorous quality assurance program to maintain consistent quality across the state.

In terms of training content itself, again, we take our cue from consumers, workers, and industry. We emphasize five key areas: First, is mastering core skills to support ADLs and IADLs safely and effectively. Without this mastery, workers are at risk for injury, client injury, and being completing overwhelmed by lack of preparedness resulting in the occupation's notorious churn. Second, is individualizing those core skills to the unique needs of the consumer. Central to this is understanding person-first principles and cultural competency and how to solicit and honor consumer direction and diversity. Third, is care context including applied understandingof mental illness, dementia, chronic disease, developmental disabilities, spinal cord injuries, and traumatic brain injury. Fourth, is professionalism, which includes communication, problem solving, maintaining professional boundaries, recognizing self-care needs and how to support those needs. Fifth, is connecting to the care team, which includes establishing a baseline of what is typical for the individual consumer and using observe and report skills to identify significant change from this baseline and report to the care team, if that is appropriate.

We know that quality in long-term care (like healthcare) is not enough, that we have to be mindful of costs. Healthcare worker training is part of the triple aim of better health, better care, and better costs. That is why our training model has been developed to prioritize affordability by emphasizing scalability, self-serve solutions, and rigorous utilization management.

I've described to you the basic model of training in Washington state. This foundation has allowed us to take the next step and build a career pathway for home care workers, which provides even more value

to the industry, to consumers, and to workers. We have now scaled a U.S. Department of Labor Registered Apprenticeship for Advanced Home Care Aide. This career path optimizes home care workers' role in reducing total cost of care and supporting consumer health goals, not just long-term care goals. With a focus on discharge transitions, health coaching including motivational interviewing skill, early warning system observe and report, and more integrated connection with the consumer's care team, this role is aimed at helping to reduce avoidable ER, re-admits, and nursing home placement.

More needs to be done in Washington, we need to figure out how, for example: (1) We can create a more seamless path for immigrant workers into this type of work. This is a growing segment of the workforce, now estimated at 25%.[vii] Immigrant workers should be set up not only for success as home care aides, but also have a supported path into other healthcare occupations, which not only benefits the worker, but our entire healthcare system. By increasing diversity in the healthcare workforce, we can reduce health disparities across populations; (2) We need to do a better job of evaluating the difference we are making in turnover, vacancy, quality of care, quality of life, and worker/employer/and consumer satisfaction; and (3) We need to continue exploring how we can better use technology to extend initial training to the job site through mobile phone enabled job aids.

Conclusion

In conclusion, I want to urge the Commission to consider embedding the following recommendations into their report to Congress:

First, we need a federal minimum training standard for home care workers just as we have for Certified Nursing Assistants in nursing homes. It is not enough to create policy change that strengthens HCBS options. We need to concurrently create policy change that strengthens the home care workforce so they are positioned to successfully deliver the HCBS options. It won't work without them. Observers may ask whether we can afford a training standard for home care workers. My view is that the cost of higher training standards for home care workers will be more than offset by decreasing turnover and vacancy rates. And the value will grow as quality and satisfaction grows in a market that is about to be flooded with baby boomer demand. Training isn't the only answer to the challenges facing home care, but it is essential to meeting peoples' long-term care needs at home and offering a real alternative to expensive institutional care.

Second, in order to determine what initiatives are and are not working we need: (1) the U.S. Department of Labor to develop a data management system for collecting and reporting on HCBS workforce trends like turnover and vacancy rates, (2) we need the U.S. Department of Health and Human Services to develop a data management system for collecting and reporting on quality of care and quality of life measurement for HCBS delivery, and (3) we need more funding to evaluate specific best practice models that exist.

Thank you for the opportunity to share with you today.

[i] "Occupational Outlook Handbook, Home Health Aides and Personal and Home Care Aides." 2010-11 Edition. Bureau of Labor Statistics, U.S. Department of Labor. www.bls.gov/oco/ocos326.htm

[ii] "Occupational Projections for Direct-Care Workers, 2008-2018, FACTS 1." February 2010. PHI. www.directcareclearinghouse.org/download/PHI%20FactSheet1Update_singles%20(2).pdf

[iii] "Home Care Aides in Washington State: Current Supply and Future Demand." January 2011. Center for Health Workforce Studies, University of Washington. www.depts.washington.edu/uwrhrc/uploads/Home_Care_Aides_Brief.pdf

[iv] "The SEIU 775 Long-Term Care Training, Support & Career Development Network: A Blue Print for the Future." February 2007. Paraprofessional Healthcare Institute and 1199 SEIU Training and Education Fund. http://www.phinational.org/sites/phinational.org/files/clearinghouse/Blueprint%20SEIU%20775.pdf

[v] "Retooling for an Aging America: Building the Health Care Workforce." Committee on the Future Health Care Workforce for Older Americans, Institute of Medicine. 2008. www.nap.edu/catalog/12089.html

[vi] One pager supplement about the SEIU Healthcare NW Training Partnership. www.myseiubenefits.org

[vii] "Caring For America: A Comprehensive Analysis of the Nation's Fastest-Growing Jobs: Home Health and Personal Care Aides." December 2011. Dorie Seavey, PhD with Abby Marquand, MPH. PHI. www.phinational.org/sites/phinational.org/files/clearinghouse/caringinamerica-20111212.pdf