

The SEIU 775 Long-Term Care Training, Support & Career Development Network

A Blue Print for the Future

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Submitted by:

**Paraprofessional Healthcare Institute
1199 SEIU Training and Education Fund**

ABOUT THE AUTHORS

INGRID MCDONALD, PARAPROFESSIONAL HEALTHCARE INSTITUTE (PHI)

Ingrid McDonald is a Seattle-based consultant to the Paraprofessional Healthcare Institute (PHI). She served previously as Senior Policy Analyst for SEIU International, and before that Coordinator of the Long Term Care Campaign, a project of AARP, the Alzheimer's Association and the Paralyzed Veterans of America. Ms. McDonald holds a Master's degree in public policy from Georgetown University and has published numerous articles on long-term care and related issues.

The Paraprofessional Healthcare Institute (PHI) works to improve the lives of people who need home or residential care—and of the workers who provide that care. Its practical workplace and policy expertise helps consumers, workers, and employers improve care by improving the quality of direct-care jobs. PHI's goal is to ensure caring, stable relationships between consumers and workers so both may live with dignity, respect, and independence.

PHI is affiliated with a network of direct-care worker staffing agencies, training programs, and a Medicaid-managed care plan for people with complex disabilities. In addition, PHI runs the National Clearinghouse on the Direct Care Workforce, www.directcareclearinghouse.org, an on-line resource center informing the movement to improve long-term care by improving job quality for direct-care workers.

For this paper, Ms. McDonald drew on the expertise of many of PHI's distinguished staff, including Steven Dawson, President, and Peggy Powell, Director of Workforce Strategies.



349 East 149th Street, 10th Floor • Bronx, New York 10451
Telephone: 718-402-7766 • Fax: 718-585-6852 • info@paraprofessional.org

GLENN SCOTT DAVIS, 1199 SEIU TRAINING & EMPLOYMENT FUNDS

Glen Davis is the Director of the Nursing Home Department and Regional Programs at the 1199 Service Employees International Union Training and Employment Funds (1199 TUF), a “family” of several joint labor-management educational and training organizations based in New York City. The funds serve workers and employers in the acute care, long-term care, and community health centers sectors.

In his role as director of nursing home programs, Mr. Davis is responsible for the design, development, implementation and evaluation of training and education programs for nursing home workers. As director of regional programs, he is responsible for the development of programs outside of New York City in Long Island New Jersey, throughout Upstate New York and in Massachusetts. For this paper, Mr. Davis worked collaboratively with Amy Trommer, a consultant to the funds for ten years with expertise in strategic planning, program and budget development, curriculum design.

The 1199 SEIU Training & Employment Funds operate programs and services throughout New York State, New Jersey, and Massachusetts and include:

- 1199 SEIU League Training and Upgrading Fund
- 1199 SEIU Homecare Industry Bill Michelson Education Fund
- 1199 SEIU Greater New York Education Fund
- 1199 SEIU League Job Security Fund
- 1199 SEIU Labor-Management Project
- 1199 SEIU League Labor-Management Initiatives, Inc. Employment Center
- 1199 SEIU Registered Nurse Training and Job Security Fund

Together, this family of funds offers a full range of educational, tuition assistance, training, career development, job placement, and labor-management quality improvement programs. These organizations are funded through employer contributions negotiated in collective bargaining agreements between employers and 1199 SEIU Health Care Workers East, and supplemented by state, federal and foundation grants. Also, each fund was founded as a nonprofit organization and is governed by a joint labor-management Board of Trustees.

The 1199 SEIU Training and Employment Funds support the potential of health care workers to grow and make a full contribution to building an efficient and caring health care industry. They also aim to develop the ability of union and management to problem-solve difficult issues and create innovative solutions. Through their work they intend to support a world-class health care workforce and service delivery system.

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PREFACE / ACKNOWLEDGEMENTS

SEIU 775, Washington's long-term care workers' union, is committed to improving the quality of care and the quality of caregiving jobs. They seek to develop a training, support, and career development platform for their members to achieve these goals. To assist in this effort, SEIU 775 has contracted with the Paraprofessional Healthcare Institute (PHI) and the SEIU 1199 New York Training and Upgrade Fund (1199 TUF), organizations with considerable expertise in the area of long-term care workforce development.

This "Blue Print," authored by PHI and 1199 TUF for SEIU 775, offers a detailed plan for how to build an adult-learner centered training, support, and career development organization for Washington State. It draws on trends occurring in other states and successful models pioneered by PHI and 1199 TUF, including the highly successful training and mentoring program developed by PHI for Cooperative Home Care Associates (a Bronx-based worker-owned home health agency) and services provided to long-term care workers through the 1199 TUF.

The proposal is based on an analysis of the current training model and infrastructure in Washington juxtaposed to the immediate and future demand for a qualified long-term care workforce. Background for this report was gathered through conversations with SEIU members who work in both home and nursing home settings, interviews with long-term care stakeholders in Washington state conducted in June 2006 (for list of individuals see Appendix A) and a stakeholders conference convened by SEIU 775 in September 2006.

This Blue Print is offered as a contribution to continued cross-stakeholder discussion about how to professionalize home care and strengthen the long-term care workforce in all settings through a workforce development approach to caregiver training. It should be considered in the context of other parallel efforts, including reimbursement reform, pay and benefit increases, culture change, and efforts to maximize independent living and consumer choice, which together will prepare Washington to meet the long-term care needs of the future.

EXECUTIVE SUMMARY

Washington has re-designed its long-term care system to maximize consumer choice and flexibility, but its approach to caregiver training has not kept pace with this change. With minimal training, today’s home care workers are caring for clients who in the past would have received care in nursing home settings. To ensure quality care in all settings and build the workforce necessary to meet future demand, Washington needs a more sophisticated approach to workforce development within the long-term care sector.

SEIU 775 envisions creating a more comprehensive, cohesive, and consistent training platform for their members through the establishment of a multi-employer trust. This new entity, “The SEIU Long-Term Care Training, Support & Career Development Network,” will provide quality training, on-the-job support, and career development services for workers across the spectrum of long-term care. This paper establishes the need for this Network and provides a “blue print” to guide its development and design.

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PART 1: WASHINGTON’S CAREGIVERS: WHO THEY ARE AND HOW THEY ARE TRAINED

Paid caregivers provide the daily hands on assistance that many seniors and people with disabilities need to maintain their quality of life. In Washington, approximately 12,000 nursing home residents and more than 35,000 clients who receive home- and community-based services rely on the long-term care workforce every day.

Washington’s long-term care workers provide care in a variety of settings and are known by a variety of job titles. This workforce includes:

- 9,400 Certified Nursing Assistants (CNAs) in addition to other frontline workers who work in nursing home facilities.
- 23,500 individual provider (IP) home care workers who are hired and supervised directly by the client or clients they serve or their family members.
- 12,500 home care workers employed by agencies
- 7,000 direct-care workers employed by adult family homes (AFHs)

Training requirements for the long-term care sector are inconsistent between settings. Caregivers who provide home- and community-based services complete 34 hours of training including an

orientation, safety training, and entry-level course called “Revised Fundamentals of Care,” within 120 days of employment. In contrast, training programs for Certified Nursing Assistants (CNAs) in nursing homes must be a minimum of 85 hours, and typically include between 120 to 150 hours of classroom and clinical training in order to prepare graduates for a state examination.

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The infrastructure for delivering caregiver training is distinct both by sector and by region. In the home- and community-based sector, most caregiver training is overseen by 13 regional Area Agencies on Aging who subcontract with a wide variety of local and regional training vendors. Training for caregivers in adult family homes and boarding homes is regulated separately and typically conducted in-house. Finally, training for parents who are paid providers to their own adult children with developmental disabilities is contracted to the ARC, a private, nonprofit organization. In the nursing home sector, the state approves CNA training programs which are offered through the community college system and in some cases through employer-based training programs.

PART 2: LIMITATIONS OF WASHINGTON’S CURRENT APPROACH TO CAREGIVER TRAINING

According to state officials, 80 to 90 percent of the clients currently served by home- and community-based workers have acuity levels that would also qualify them for nursing home care. But while caregiving needs in different settings are equivalent, training opportunities are not. Home- and community-based workers receive less than half as much training as their counterparts who work in nursing homes, and are ill-prepared by a training model with the following limitations:

The training curriculum:

- Covers too much material in too little time and is not grounded in the realities of caregiving work;
- Does not give caregivers the tools they need to meet their clients individualized needs; and
- Does not prepare workers to care for a client base with increasingly complex and challenging conditions.

And the training delivery system:

- Is inconsistent across the state’s geographic regions, causing access problems in rural areas and for workers who do not speak English.
- Is inefficient and does not take advantage of economies of scale.
- Does not have the centralized tracking and verification systems necessary to ensure transparency and accountability across the system.

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Most importantly, caregiver training is not connected to a broader workforce development plan for the long-term care sector. As the population in Washington ages, the demand for caregivers will increase dramatically. The current approach to caregiver training is failing to support the development of the long-term care workforce in three key areas: **retention**, **recruitment**, and **expansion** of the labor pool.

PART 3: BLUE PRINT FOR A WORKFORCE DEVELOPMENT APPROACH TO CAREGIVER TRAINING

The SEIU 775 Long-Term Care Training, Support and Career Development Network will offer an adult-learner centered, workforce development approach to caregiver training. To lay the groundwork for this model, SEIU 775 is calling on the state to increase entry-level training requirements for home- and community-based workers from 34 hours to 85 hours and to establish a Certified Home Care Aide (CHCA) designation. The Network will offer SEIU 775 members entry-level training courses to fulfill this higher training standard, in addition to a broad range of advanced training and career development services, launched in three phases:

PHASE I: ENTRY LEVEL TRAINING AND APPRENTICESHIP

Beginning in the first year of operation, the Network will offer three entry-level courses designed to prepare SEIU 775 members to become Certified Home Care Aides. These will include the following:

The curricula will be flexible in nature, so that participants master all of the core competencies necessary to deliver quality care and also have opportunities to focus in on particular topics and issues most relevant to their client’s individualized needs.

Course	Hours	Must Be Completed Within
Orientation	2	2 weeks or 50 hours of work
Safety Course	3	2 weeks or 50 hours of work
Long-Term Care Core Competencies	80	6 months or 600 hours of work
TOTAL	85	
Certification Exam	***	Participants who pass state approved test will become Certified Home Care Aides

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By year two, the Network will launch a peer mentor program that will complement the required entry-level classroom training. Workers will be offered the support of a mentor or “buddy” who will coach them and provide on the job support in their first three to six months of employment. By the end of Phase I, the Network will offer a voluntary apprenticeship program for CHCAs that will build on the entry-level training and peer mentor programs with a broad menu of advanced and specialty courses designed to refine care giving skills in specific specialty areas. Through this program, workers who complete a total of 150 hours of classroom training (including 85 hours of entry-level training in addition to at least 65 hours of advanced and specialty training), who work with a peer mentor, and who accumulate 2,000 hours of work experience will receive a certificate for having completed a state-approved apprenticeship program as well as a pay increase as outlined in SEIU 775 collective bargaining agreements.

Over time, as the Network begins to also provide training to SEIU members who work in nursing home settings, a similar apprenticeship program will be designed for CNAs. In addition, the Network will seek articulation agreements to enable CHCAs who want to also become CNAs to apply their training towards the requirements necessary for CNA certification.

PHASE II: ADULT EDUCATION AND CAREGIVER SUPPORT

In Phase II, the Network will begin offering additional voluntary services, including adult education classes to assist workers in building skills for career advancement, as well as workshops to support them in handling stress in their personal and professional lives.

Adult education classes will be offered either directly by the Network or in partnership with community colleges. They will include classes in areas such as:

- General Education Diploma (GED)
- English as a Second Language (ESL)
- Basic Computer Instruction
- Pre- Licensed Practical Nurse (LPN)
- Pre-College Preparation
- Citizenship

A “Caring for the Caregiver” workshop series will be designed to offer isolated workers a sense of community and belonging while also helping them to achieve personal and professional goals. Workshops will be held on a flexible, drop-in basis in all areas of the state.

PHASE III: CAREER PATHWAYS

Beginning in Phase III, the Network will offer career counseling and tuition assistance support to workers interested in pursuing new career paths in health and long-term care. The purpose of the individual and group counseling services will be to ensure that participants make good decisions about what career paths to pursue, based on their personal interests and strengths. This will be combined with a tuition assistance benefit program that will assist workers in removing obstacles to continuing education and career ladders.

PART 4: A FRAMEWORK FOR BUILDING THE NETWORK

LEGAL STRUCTURE

The Network will be organized as a joint labor-management educational program, a model commonly known as a “Taft-Hartley Multi-Employer Fund.” It will be a nonprofit educational and training organization that will receive specific IRS tax-exempt status. The purpose of the Network would be to provide educational benefits (i.e., tuition assistance, scholarships), education and training programs, and related services to all eligible participants (members of the applicable collective bargaining units).

GOVERNANCE

A Board of Trustees comprised of an equal number of union and management representatives will govern the Network. The trustees of the Network will determine the level of benefits and number of programs to be offered as well as the eligibility requirements for participants. Federal law, under the Employment Retirement Income Security Act (ERISA), sets forth the responsibilities, duties, and obligations of Taft-Hartley trustees.

FUNDING

The funding for the Network’s core programs—including the entry level training courses, advanced and specialty training, the peer mentor program, and continuing education—will be funded by employer contributions, as determined by the collective bargaining agreements between SEIU and participating employers. In addition, the Network will leverage other public and private foundation funds to cover the cost of the adult education, career development, and support services to be launched in Phases II and III.

STAFFING AND INFRASTRUCTURE

The organizational architecture necessary to implement the Network will include the following senior staff positions:

- Executive Director (overall management, strategic planning, and fundraising)
- Finance Director (infrastructure development and financial systems)
- Education Director (program development, implementation, and management)
- Member Services Director (member communications and area coordination)
- IT Director (database systems and website management)

In addition, the Network will develop its own faculty of instructors, and enter into contracts with existing high-quality training providers. Infrastructure for delivering training services will include: the Network’s headquarters office located in the Seattle/Tacoma area; an Eastern Region office located

in Spokane; and mobile classrooms. Classes will also be offered in space rented from partnering organizations and in community college settings.

This Blue Print offers a sample budget for the Network. It estimates total expenses of more than \$5 million in Phase I, \$12 million in Phase II, and \$16 million in Phase III, with variability depending on actual participation. While efficiencies will be gained by offering a cohesive statewide program, training costs will be significantly greater than current expenditures. Higher costs will reflect a far greater scope and duration of training in order to ensure quality care for Washington State's ever-growing long-term care consumer population.

PART 5: CONCLUSION AND RECOMMENDED ACTION STEPS

When established, the Network will provide caregivers the training and support they need to ensure quality long-term care services and greater mobility to pursue career paths within and beyond long-term care.

Key action steps necessary to implement this vision include:

- Engage in a consensus building process.
- Conduct a training needs assessment.
- Achieve necessary state policy changes.
- Establish the Network.
- Draft a Business Plan.
- Create a curriculum development process.
- Build a statewide infrastructure of high-quality training providers.

Washington is at a critical juncture in the development of its long-term care system. The Network, as described in this blue print, is an opportunity for key stakeholder groups to work together to ensure quality jobs, quality care, and an adequate supply of caregivers for the next generation of care consumers.

INTRODUCTION

In the past decade, Washington has dramatically transformed its long-term care delivery system. Today, people who are frail and elderly, chronically ill, or living with a severe disability have more choices and greater flexibility than ever before to decide where they want to live and to choose who will care for them or assist them in living independently. Growth in the nursing home sector, a budget concern for many state policy makers, is under control.¹ Opinion leaders hold up Washington as a national model for the “rebalancing” of long-term care.

As a result of this shift, the nature of home care work has changed dramatically. Home care workers are now caring for individuals who in the past would have received care in a nursing home or other type of institution. Clients have a broader range of disabilities, diseases, and complex conditions than ever before. Jobs that used to be limited to “chore services” are now more multifaceted and demanding.

At the same time, the demand for long-term care services is rising. The U.S. Census estimates an increase in Washington’s elder population of over 136 percent over the next three decades. This dramatic increase suggests that the state faces an impending “care gap” between the supply of young workers—expected to rise by only 30 percent during the same period—and the growing number of older people and persons with disabilities in need of long-term care. As the baby boomers age, it is far from clear who will be there to care for them.

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SEIU 775 seeks to create a more comprehensive, cohesive, and consistent training platform for their members.

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To ensure that consumers today and tomorrow receive high-quality services across a variety of settings, Washington needs a more sophisticated approach to workforce development in the long-term care sector. To this end, SEIU 775 seeks to create a more comprehensive, cohesive, and consistent training platform for their members, who include the individual provider (IP) home care workforce, a significant percentage of the state’s home care agency workers, and a growing number of Certified Nursing Assistants (CNAs) employed by nursing homes.

Specifically, SEIU proposes the creation of a multi-employer trust, known in labor law as a “Taft-Hartley Fund,” an independent organization governed by a board of trustees designated by both labor and management. Funded by contributions from participating employers, this new entity, “The SEIU Long-Term Care Training, Support & Career Development Network,” (hereafter referred to as “the Network”) will provide quality training, on-the-job support, and career development services for workers across the spectrum of long-term care.

This paper establishes the need for this Network and provides a “blue print” to guide its development and design. It is organized into five parts:

¹ The number of nursing home beds has fallen from 25,152 in 2001 to 22, 401 today.

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- **PART 1** lays the groundwork by describing who the long-term care workforce is, whom they serve, and the design of the current training model.
 - **PART 2** discusses the limitations of Washington’s current approach to caregiver training.
 - **PART 3** describes the products and services that the Network will offer, including entry level training, peer mentoring and a voluntary apprenticeship program in Phase I; adult education classes and a “caring for the caregiver” workshop series beginning in Phase Two; and career counseling and tuition assistance programs added in Phase Three.
 - **PART 4** addresses the pragmatic questions of how the Network will be structured, funded, and governed, and offers a recommended organizational structure and staffing configuration in addition to a sample budget.
 - **PART 5** summarizes the need for the Network and offers a series of immediate action steps necessary to move forward.

Washington can no longer count on a seemingly infinite supply of workers to accept low-wage care-giving jobs in which the work they do is undervalued and underappreciated. Expecting home care workers to “go it alone” with little support or direction is undermining the quality of consumer care. SEIU 775’s vision is to professionalize home care and create a more valued and valuable workforce across the spectrum of long-term care. The following pages describe in more depth an approach for realizing this vision.

PART 1: WASHINGTON’S CAREGIVERS: WHO THEY ARE AND HOW THEY ARE TRAINED

A. PORTRAIT OF WASHINGTON’S LONG-TERM CARE WORKFORCE

People who are frail and elderly, chronically ill, or living with a severe disability often need more than occasional help from family or friends for their day-to-day care. Paid caregivers provide the daily hands on assistance that many seniors and people with disabilities need to maintain their quality of life. We rely on them to respond to our mother’s call bell in the nursing home, cook food for a friend who has had a stroke, or help an adult with a developmental disability to answer the phone or shave.

In Washington, approximately 12,000 residents in nursing homes and more than 35,000 clients who receive home- and community-based long-term care services depend on the long-term care workforce every day.² Of the latter, approximately 60 percent are elderly (over that age of 65) and 40 percent are people with disabilities.³ While some of these clients pay privately for their care, most receive assistance through publicly funded programs, including Medicaid and Medicaid waiver programs⁴ such as COPES (Community Options Program Entry System).⁵

Long-term care workers provide care in a variety of settings and are known by a variety of job titles (see Box 1: The Washington Long-Term Care Workforce at a Glance for a brief overview). In all settings, they provide the same basic set of services and supports. They help clients to bathe, eat, dress, move about, and perform other necessary daily tasks. For many clients, aides or assistants are their key to independence. Consumers direct them to carry out the physical tasks that they cannot manage on their own, enabling them to live in their own home and manage their own affairs.

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For many clients, home care aides are their key to independence.

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To one extent or another, caregivers also serve as advisors, advocates, and companions for people who are often alone and isolated. Because they spend more time with clients than any other health care or social service provider they get to know their clients intimately. They help people with disabilities advocate for the supports they need to live independently. And if there is a significant change in an elderly or developmentally disabled client’s medical or mental condition that may require attention, they take responsibility for notifying family members, case managers, or supervisors, as necessary.

In home care settings, caregivers work either as individual providers (IPs) or they are employed by home care agencies. IP home care workers are hired and supervised directly by the client they serve.

² Data provided by DSHS; also see www.ofm.gov for annual figures comparing nursing home and home and community services case loads.
³ These figures were provided by DSHS in response to an information request in October 2006.
⁴ “Medicaid Waiver programs” are programs established by states with federal approval that allow for a defined set of Medicaid benefits for specific populations.
⁵ Medicare also pays for some home health services; however, these services are generally short-term. These services are provided by home health aides. This report covers only workers who are providing long-term care services and, thus, does not apply to this category of workers.

This consumer-directed model is designed to maximize clients' autonomy. Clients can choose to hire a friend or family member or employ an IP whom they locate through word of mouth, through advertisements, or through a statewide referral registry.⁶

A significant number of the approximately 23,500 IPs in Washington are family members of the clients whom they serve.⁷ A daughter, for example, may choose to quit her job in order to take care of her mother who needs full-time care. Becoming an IP enables these individuals to support themselves while they care for their loved ones. Across the country, the practice of hiring family members is relatively common in consumer-directed state Medicaid programs. A recent national study of 40 states operating 62 consumer-directed programs found that 79 percent of the programs allow family members to be paid caregivers.⁸

BOX 1 The Washington Long-Term Workforce at a Glance

Worker Title	Approximate Size of Workforce	Setting	Training Requirement
IP Home Care Worker (Individual Providers)	23,500	In-Home	34 hours + 10 hours continuing education
Agency Home Care Worker	12,500	In-Home	30 hours + 10 hours continuing education
Direct-Care Workers	7,000 plus*	Adult Family Homes and other home & community based settings	30 hours + 10 hours continuing education
Certification Nursing Assistant (and trainees)	9,400 ⁹	Nursing Homes	85 hours + 12 hours continuing education

* In addition to approximately 7,000 caregivers who work in Adult Family Homes, thousands more are employed by other community-based long-term care providers such as boarding homes, supported living and assisted living facilities, and adult day health providers and for other programs serving people with developmental disabilities.

IPs, both family members and non-family members alike, are popular with adults with disabilities and elders who are capable of directing their own care. Of consumers who use state-funded home care services in Washington, 65 percent choose to hire an IP, whereas 35 percent hire a worker through an agency, although this ratio is changing in the direction of the agency workforce.

Agency home care workers provide the same services as IPs but instead of being hired directly by the client they serve, they care for clients assigned to them through their agency. Currently there are

⁶ Approximately 4,000 IP home care workers are listed in a referral registry, a database managed by the Washington Home Care Quality Authority that is made available to clients looking for someone to hire.

⁷ There is no demographic data available for the entire population of IPs and no way to know precisely what portion of IPs are relatives of the clients they serve. In a September 2003 survey conducted by Washington State University on behalf of the Home Care Quality Authority, 67 percent of 1,114 respondents described themselves as family members to the client they serve. According to the researchers, however, there was no way to ensure that this was a representative sample and care should be taken when ascribing these survey results to the population as a whole.

⁸ National Association of State Units on Aging. States' Experiences Implementing Consumer-Directed Home and Community Services: Results of the 2004 Survey of State Administrators, Opinions Survey, and Telephone Survey available at www.nasua.org/pdf/20026_text.pdf.

⁹ There are 36,500 CNAs on the registry. This includes CNAs working in all venues, not just nursing homes. There were 17,114,686 CNA hours reported at nursing homes in 2004. This would require approximately 9,400 CNAs at 35 hours per week.

90 home care agencies in Washington State who employ approximately 12,500 home care workers.¹⁰ They include a mix of nonprofit organizations and for-profit businesses, with five large agencies providing more than 45 percent of all home care agency services in the state.¹¹

Caregivers also work in community-based settings, including more than 2,000 adult family homes (AFHs)—residential homes licensed to provide long-term care services for up to six adults—and more than 500 “boarding homes,” which provide assisted living and other levels of care and serve an average of 50 residents at a time. Aides in these settings provide the same type of personal care services as home care workers and may also coordinate group activities or outings for residents.

In nursing homes, Certified Nursing Assistants (CNAs) provide 80 to 90 percent of the hands on care for residents. While the majority of home care workers work part time, with their hours and schedule determined by the needs of their clients, CNAs more frequently work full-time on a regular morning, afternoon, or overnight shift. They are responsible for the same type of personal care services as home care workers with the added challenge of balancing the competing needs of multiple residents. Unlike home care workers who work in the isolation of their clients homes, CNAs have peers and work under the supervision of nursing and medical personnel.

In all settings, the profile of the typical caregiver is a middle-aged woman with a high school education who is living on a limited budget. Often she is juggling more than one part-time job in addition to child care or other family caregiving responsibilities. And frequently, especially if she is over 50 years old, she is coping with a chronic health problem such as a back injury, diabetes, or heart disease without adequate health care coverage (see Box 2, Characteristics of the Long-Term Care Workforce).

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With the interests of workers across all settings in long-term care in mind, SEIU is well positioned to lead in creating a workforce development approach to caregiver training.

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SEIU 775 represents a large and growing portion of the long-term care workforce, including the more than 23,000 IP workers contracted with the state to provide home care services. SEIU 775 also represents more than 5,000 agency home care workers, including workers employed by four of the five largest agencies, and nearly 2,000 workers employed by eighteen nursing homes across the state. With the interests of workers across all settings in long-term care in mind, SEIU is well positioned to lead in creating a workforce development approach to caregiver training.

¹⁰ According to CMS there are 68 Medicare-certified home health agencies.

¹¹ These include Catholic Community Services, Addus Healthcare Inc., Chesterfield Services Inc., Armstrong Uniserve Inc. and the Korean Women’s Association.

BOX 2 Characteristics of the Long-term Care Workforce

Gender, Age and Ethnicity

Nine out of ten direct-care workers in the U.S. are women, their average age is approximately 40, and nearly half are people of color.ⁱ In Washington, the average age of the IP home care workforce is 47, and their ranks include a significant population of new immigrants from countries such as Mexico, Southeast Asia, East Africa, and Eastern Europe.

Income

In 2003, direct-care workers in the U.S. earned an average of \$9.20 per hour, and nearly one-fifth earned annual incomes below the poverty level,ⁱⁱ which is \$15,670 for a family of three. Direct-care workers are often so poor that they or their children qualify for public assistance programs. For example, 30 to 35 percent of all nursing home and home health aides who are single parents receive food stamps.ⁱⁱⁱ In Washington, home care workers represented by SEIU 775 earn an average of \$9.65 per hour, and 40 percent receive some form of public assistance, according to a recent SEIU survey.

Education

Nationwide, two-fifths of those in home care (41 percent) and nearly half of those in nursing homes complete their education with a high-school diploma or GED. In Washington, the state writes their informational materials for home care workers at an eighth-grade level.

Marital Status and Children

One-quarter of direct-care workers in home care and nearly a third of those in nursing homes are unmarried and living with children, compared to 11 percent of the total US workforce.

Health Status

People within these demographic groups suffer disproportionately high rates of chronic medical conditions. For example, a recent survey found that 37 percent of African-American women over the age of 45 report poor health and 29 percent have diabetes.^{iv}

Benefits

Nationally, one in every four nursing home workers^v and more than two out of five home care workers^{vi} lacks health insurance coverage. In Washington, SEIU 775 members who work at least 86 hours per month and meet other eligibility requirements can receive full health coverage. While more than 6,000 SEIU members are enrolled in this plan, more than half of all IPs do not qualify or do not enroll.

ⁱ William J. Scanlon, GAO Testimony: Nursing Workforce: Recruitment and retention of nursing assistants is a growing concern (General Accounting Office, May 2001).

ⁱⁱ Health Resources and Services Administration (HRSA), Nursing aides, home health aides and related health care occupations: National and local workforce shortages and associated data needs (Washington DC: HRSA, February 2004).

ⁱⁱⁱ William J. Scanlon, GAO Testimony: Nursing Workforce: Recruitment and retention of nursing assistants is a growing concern (General Accounting Office, May 2001).

^{iv} Women and Health Care: A National Profile. Kaiser Family Foundation, July 2005

^v William J. Scanlon, GAO Testimony: Nursing Workforce: Recruitment and retention of nursing assistants is a growing concern (General Accounting Office, May 2001).

^{vi} D. Lipson and C. Regan, "Health Insurance Coverage for Direct-care Workers: Riding Out the Storm," Better Care Better Jobs Issue Brief, Vol. 1, No. 3 (March 2004).

B. CURRENT TRAINING REQUIREMENTS

Washington State’s training requirements for the long-term care workforce are not consistent between settings. Even though their work is very similar, most home- and community-based workers are required to complete only 28 to 34 hours of training, less than half as much as the minimum of 85 hours of training required for CNAs who work in nursing homes and far less than the average of between 120 and 150 hours of instruction that CNAs typically receive.

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Even though their work is very similar, home- and community-based workers have access to less than half as much training as facility-based CNAs must complete.

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The Washington Department of Social and Health Services establishes caregiver training standards for all publicly funded long-term care programs and state licensed facilities. Within DSHS, caregiver training is overseen by the Aging and Disability Services Administration (ADSA) and the Division of Developmental Disabilities Administration (DDD).

TRAINING REQUIREMENTS FOR HOME- AND COMMUNITY-BASED WORKERS

Under Washington post-employment training model, home- and community-based workers begin working immediately, with no training at all. Within two weeks of employment, they complete a 2-hour orientation either in a classroom setting or by reading a manual and watching a video.¹² This orientation is followed by a 4-hour safety training and 28-hour entry-level course called the “Revised Fundamentals of Caregiving” (RFOC), which must be completed within 120 days of employment (see Box 3: Washington’s Caregiver Training Requirements for Workers in Home- And Community-Based Settings).¹³ Workers are paid at the same rate as they receive for providing care giving services for all time spent in training.

Upon completion of these courses, caregivers must take a state-approved test. Those who pass this test are eligible to work as home care workers or in adult family homes, boarding homes, or other home- and community-based settings. To maintain their eligibility for work in these settings, they must complete 10 hours of continuing education each year beginning in their second year of employment.

In addition to these requirements, caregivers and managers in adult family homes and boarding homes must also complete specialty training if they serve clients in any one of three special needs categories: developmental disabilities, mental health or dementia. These trainings, which in some cases may be integrated into the RFOC curriculum, are 18 to 20 hours each.

¹² The state pays for only two hours of orientation. There is standard curriculum for IP home care workers only; home care agencies, adult family homes, and boarding homes may use this or their own proprietary orientation.

¹³ As illustrated in Box 3, certain providers are exempt from all or some of these requirements.

BOX 3 Caregiver Training Requirements for Home and Community-Based Settings

Course	Hours	To Be Completed Within
Orientation (video & self study)	2	14 days
Safety Course (required for IPs only)	4	120 days
RFOC (Revised Fundamentals of Caregiving)	28	120 days
TOTAL	34	
Continuing Education	10	Every year beginning year 2

These requirements apply to IP home care workers, agency home care workers, and aides in adult family homes, boarding care homes and other specified home- and community-based settings. Exceptions are made for parent providers of adult children with developmental disabilities, for respite providers funded by the Division of Developmental Disabilities, and for those with health care degrees in related fields. These requirements do not apply to home health aides who provide Medicare certified home health services

TRAINING REQUIREMENTS FOR CERTIFIED NURSING ASSISTANTS (CNAS)

The training requirements for CNAs in nursing homes are far more extensive. They must complete a state-approved training program, pass a certification exam, and become licensed within 120 days from the day they start work in a nursing facility. The CNA training curriculum must be competency based and must be no less than 85 hours, with at least 32 hours of classroom training and 50 hours of clinical training.¹⁴ Within these parameters, each training program director determines the amount of time required in the curriculum, with typical training programs running between 120 and 150 hours. To maintain their certification, CNAs must complete at least 12 hours of continuing education each year.

Authority for governing CNA training and licensure of Health (DOH) and the Nursing Care Quality Assurance Commission within the DOH assure that nursing assistants meet minimum requirements to work in any setting as a nursing assistant and also issue all CNA licenses.

FEDERAL VS. STATE TRAINING STANDARDS

Training requirements for caregivers doing the same or similar work but in institutional versus home care settings are very different today in part because they were developed in separate historical contexts and by different levels of government. On the nursing home side, Washington's training requirement is based on OBRA '87, otherwise known as the "Nursing Home Reform Act," a bill passed by Congress in 1987 in the wake of national outrage over the poor quality of nursing home care.

Among other quality standards, OBRA '87 established a 75-hour mandatory training requirement, curriculum guidelines, and a certification process for nursing assistants. Today, states establish their own regulations based on OBRA, with many, including Washington, requiring more than the 75-hour minimum. Washington's current 85-hour minimum requirement is greater than the federal minimum but less than many states that require at least 100 hours of training.

¹⁴ See Washington Administrative Code 246-842-190 for a full description of core curriculum in approved training programs.

BOX 4 Examples of Home Care Worker Training Requirements from Other States

State	Basic Training Requirements for Non-Certified Home Care Workers
Colorado	20-hour training or successful completion of a skills validation test required for personal care provider (PCP)/homemaker.
Georgia	40-hour training required for personal care assistants
Iowa	60-hour training required for home care aides
North Carolina	Level I Home Management 21 hours recommended Level II Personal Care Aide, 59 hours recommended Level III Personal Care Aide, must be Nursing assistant, 75 hours required
Illinois	15 hours for homemakers
Wisconsin	40-hour requirement

On the home care side, there are few federal training standards for frontline caregivers, in part because home care has traditionally been viewed as a state, not federal, responsibility. The only federal requirements that do exist apply to home health aides who provide Medicare-certified home health services,¹⁵ typically physician-ordered short-term care for Medicare beneficiaries just leaving the hospital. These standards, however, do not apply to the vast majority of home care services, which are funded either by Medicaid or state programs.

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In the absence of federal standards, many states are now establishing state training requirements for home care workers

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In the absence of federal standards, many states are now establishing state training requirements for home care workers (see Box 4: Examples of Home Care Worker Training Requirements for Non-Certified Home Care Workers). Washington began moving in this direction in the mid 1990s, after establishing the COPES program and other Medicaid waivers. Prior to this time, state programs, known as “chore services,” did not require any training for home care workers.¹⁶ However, as greater numbers of consumers, as well as more consumers with higher levels of need, became eligible for home care, consumer advocates urged the legislature to establish mandatory training requirements and a standardized training curriculum.

The Evolution of Home- and Community-Based Services Training Requirements in Washington State
In the 1990s, the Department of Social and Health Services (DSHS), Aging and Disability Services

¹⁵ Home Health Aides employed by Medicare-certified agencies must complete at least 75 hours of training and more in some states.
¹⁶ The state-funded Chore Services program is now discontinued, with less than 100 clients still utilizing these services.

Administration (ADSA) developed a standardized curriculum called the “Fundamentals of Caregiving” for workers providing home- and community-based services. This curriculum was formalized in 1995 when the state established a 22-hour training requirement for adult family home providers, in-home caregivers, and boarding homes with Medicaid contracts.¹⁷

At this juncture, the legislature made an exception for parent providers of adult children with developmental disabilities, who are only required to complete six hours of training. In addition, they allowed for the option of a shorter course, “Modified Fundamentals of Care,” for individuals who already have a related health care degree.¹⁸

In 2002, the state increased the training requirement to 28 hours and added the orientation to be completed within the first two weeks of work. To meet the new requirement ADSA issued “Revised Fundamentals of Caregiving.”¹⁹ Two years later, SEIU’s collective bargaining established an additional 4-hour safety course for IP home care workers.²⁰

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The current infrastructure for delivering caregiver training is highly fragmented, with variation by sector and by region.

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C. WASHINGTON’S CURRENT TRAINING DELIVERY SYSTEMS

The current infrastructure for delivering caregiver training is highly fragmented, with variation by sector and by region. For the nursing home sector, ADSA approves CNA training programs, which are offered primarily through the community college system and, in some cases, through employer-based training programs. These programs vary in their duration, quality and availability throughout the state.

The training delivery system for workers who provide home- and community-based services also varies considerably by sector and by region. ADSA grants the authority for overseeing most in-home caregiver training to the state’s 13 Area Agencies on Aging (AAAs), which are responsible for coordinating long-term care services at the local level. Only 3 of the 13 Area Agencies on Aging (AAAs) responsible for overseeing caregiver training act as the training providers themselves. The remaining 10 AAAs sub-contract with a variety of vendors to provide training services. These include home care agencies, community-based organizations, private contractors, and community colleges. The largest single provider is Professional Registry of Nursing, Inc. (PRN), a for-profit company that contracts with 5 out of the 13 AAAs. Of those organizations that receive training contracts from the

¹⁷ Training requirements were later expanded to include all boarding homes.

¹⁸ According to Washington Administrative Code, “Modified basic training may be taken, instead of the full basic training, by a person who can document they have successfully completed training as a registered or licensed practical nurse, certified nursing assistant, physical therapist, occupational therapist, or Medicare-certified home health aide. In addition, modified basic training may be taken by a natural, step, or adoptive parent who is the individual provider for his or her adult child who is not receiving services through DSHS’ division of developmental disabilities.”

¹⁹ The Revised Fundamentals of Caregiving first edition was published in January 2003; second edition, July 2005; current edition, May 2006.

²⁰ This requirement was established for risk management purposes in conjunction with the establishment of L&I (workers compensation) coverage for IPs.

AAAs, some sub-contract again to other agencies or individual instructors to deliver training programs.

Each of the training vendors is responsible for recruiting and training instructors, scheduling trainings, tracking attendance, and reporting that the caregiver's training has been completed to the AAAs and home care agency employers. Each training vendor offers a different menu of courses, which may or may not include the safety training, the "Revised Fundamentals of Care" curriculum, and a variety of continuing education courses.

Training for caregivers in adult family home and boarding home settings and other caregivers serving clients with developmental disabilities is governed separately by the Division of Developmental Disabilities (DDD). Training for caregivers in adult family home and boarding home settings is typically conducted in-house by qualified managers. The abbreviated training required for parents who are paid by the state to provide care for their own children with developmental disabilities is delivered by the ARC (formerly known as the Association for Retarded Citizens), a private, nonprofit organization.



PART 2: LIMITATIONS OF WASHINGTON’S CURRENT APPROACH TO CAREGIVER TRAINING

Washington has led the country in the move toward rebalancing, but the approach to caregiver training has not kept pace with this change. While training for home- and community-based workers has improved, it still does not reflect the reality that the needs of clients receiving care at home is now parallel to those receiving care in institutions. According to the state officials, 80 to 90 percent of the clients currently served by home- and community-based workers have acuity levels that would also qualify them for nursing home care.²¹ Thus, under the current system, the caregiving needs in different settings are equivalent, but the training provided to caregivers who work in those settings is not.

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Of the clients currently served by home- and community-based workers, 80 to 90 percent have acuity levels that would also qualify them for nursing home care.

— Washington Department of Social and Health Services

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As illustrated in the last section, home- and community-based workers receive less than half as much training as their counterparts who work in nursing homes. While consumers are benefiting from greater opportunities to stay in their homes, they are receiving services from workers who have far less training and on-the-job support than those who work in institutions.

Washington has begun to address this discrepancy through the development of the RFOC curriculum and a common training standard for workers across the spectrum of home- and community-based services. However, much work remains. This section discusses the limitations of the entry-level training curriculum and the training delivery system. In short, the training curriculum:

- Covers too much material in too little time and is not sufficiently grounded in the realities of caregiving work.
- Does not give caregivers the tools they need to meet their clients individualized needs.
- Does not prepare workers to care for a client base with increasingly complex and challenging conditions.

In addition, the training delivery system:

- Is inconsistent across the state’s geographic regions, with access problems in rural areas and for workers who do not speak English.

²¹ According to ADISA, the DSHS Caseload Forecast Council and other department sources.

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- Is inefficient and does not take advantage of economies of scale.
 - Does not have the centralized tracking and verification systems necessary to ensure transparency and accountability across the system.

In addition to these limitations, the training for home- and community-based workers is not connected to a broader workforce development plan for the long-term care sector. If left unaddressed, these issues will evolve into major challenges for the state in the near future, as the scope of who receives care in their own homes continues to expand, while at the same time the overall demand for long-term care services rises dramatically.

The Paraprofessional Healthcare Institute and the SEIU 1199 New York Training and Upgrade Fund reviewed the current Washington home care training programs, and then interviewed more than 20 stakeholders and caregivers across the state. Based on this combined review, the authors arrived at the following assessments:

A. CRITIQUE OF THE RFOC AND CONTINUING EDUCATION TRAINING CURRICULA

The training curriculum (RFOC) covers too much material in too little time and is not grounded in the realities of caregiving work.

After completing the 2-hour orientation and 4-hour safety training, home care workers are required to complete the 28-hour Revised Fundamentals of Care (RFOC) course within 120 days of employment. The curriculum for this course includes modules on the following subjects:

- The Client and Client Rights
- The Caregiver
- Infection Control
- Mobility
- Basic Communication
- Skin and Body Care
- Nutrition and Food Handling
- The Process of Elimination
- Medications and Other Treatments
- Self-Care and the Caregiver
- Common Diseases and Conditions

In the opinion of seasoned educators in this field, this curriculum addresses the right set of necessary and appropriate subjects, but it incorporates more material than trainers can meaningfully cover in just four days. Instead of giving learners sufficient opportunity to absorb, practice, and demonstrate that they have mastered the skills, the curriculum breezes through a huge menu of topics. Facilitators are instructed to focus on “highlighted” content (as most essential) and to refer learners to a resource guide to sort through additional information.

According to TJ Janssen, who has worked as both an IP and agency worker for several years, “I learned little more than how to properly wash my hands and put gloves on during the [RFOC] course. While other important topics were covered, they were reviewed in a very cursory fashion.”

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The RFOC curriculum devotes less than two hours to communication, even though relational skills are at the heart of quality caregiving. Instructors lecture students about the importance of being good listeners, but do not give learners opportunities to observe or practice active listening skills. IP and agency workers interviewed for this paper said that they found the RFOC course “boring, not relevant, and unhelpful,”²² and expressed frustration that the current training design fails to integrate actual workers into the training model. While regulations state that instructors must have at least one year of caregiving experience,²³ SEIU 775 members who have gone through the training state that few instructors appear to know what it is really like to work in a home care setting. Many find that the training is not mindful of the home care worker experience or grounded in the realities of the job.

BOX 5 PHI’s Training Model

In the model home care training program developed by PHI, trainees cover similar material to that outlined in the RFOC curriculum in four weeks rather than four days. This model has been used successfully for more than 20 years by Cooperative Home Care Associates, a South Bronx-based home care agency affiliated with PHI. CHCA employs 950 African-American and Latina women—90 percent of whom had previously been dependent on public assistance or unemployed.

The PHI approach manages the amount of content presented in any one learning session, and gives learners sufficient time to learn by doing, through role-plays, case studies, and other problem-based exercises. Trainings are team-taught by an RN and former or practicing home health aides who are employed as associate instructors. In addition to providing clinical competency in “hard” skills, the PHI approach seeks to strengthen “soft” skills by preparing trainees to communicate effectively, solve problems, and think critically.

As the author of a case study on Cooperative Home Care Associates’ training observed, “For many low-income women, completing the training program is an empowering experience that broadens their opportunities and expectations.”²⁴ Turnover rates at Cooperative Home Care Associates hover around 20 percent, compared to an industry average of 40 to 60 percent.

Cooperative Home Care Associate’s model training program is distinct from the training model in Washington in that it is a pre-employment training program that participants complete on a voluntary (unpaid) basis. In addition, it prepares participants to serve both Medicaid and Medicare clients. Nonetheless, it illustrates the value of investing in quality training and provides many useful lessons for Washington to draw from.

²² Personal conversations with SEIU IP home care workers.

²³ According to the Washington Administrative Code 388-71-05890, instructors must have one year of professional or caregiving experience within the last five years in an adult family home, boarding home, supported living or home care setting; or an associate degree in a related health field and six months of caregiving experience.

²⁴ Anne Inserra et al. Cooperative Home Care Associates: A Case Study of a Sectoral Employment Approach (Aspen Institute, February 2002).

Current training does not give caregivers the tools they need to meet their clients individualized needs.

The training needs of home care workers vary greatly according to their own life experience and the needs of the clients they serve. While one caregiver may need to become an expert on specific developmental disabilities, another may need to focus on improving listening skills to better follow the directions of an adult with physical disabilities. Yet another may need to understand Alzheimer's disease and its progression.

The most common concern voiced by caregivers is that current training does not prepare them to meet their clients individualized needs. For example, Libby Richards, an IP caring for a developmentally disabled client remarks, "most of my training and knowledge on caring for clients with developmental disabilities comes from my volunteer work with the Special Olympics. I've found that the state home care training focuses on issues facing aging clients and very little time is spent on the needs of clients with developmental disabilities. I think that caregivers need training that will address the specific needs of their clients. This is a common feeling among other caregivers I know."

In some cases, consumers, or their family members, have the ability to educate those who assist them about their particular condition and instruct them regarding their specific individual care needs. However, many clients do not have this ability, either because they have cognitive issues or simply because they do not have the skills or inclination to do so. Thus, beyond the basic skills briskly covered in the RFOC, many home care workers are on their own to figure out how to meet the particular needs of their client. While more specialized courses are available through continuing education, workers do not have access to these courses until their second year of employment—and from then on they are limited to 10 hours of coursework per year.

Continuing education course offerings vary throughout the state. For example, in the five regions served by the largest training provider, the Professional Registry of Nursing, workers can choose from numerous courses such as "HIV / AIDS," "The Dynamics of Disabilities" and "Dementia and Depression." In most areas, however, the course selection is far more limited. According to ADSA, course offerings for continuing education are based on local surveys of need and every year the offerings change. However, caregivers interviewed for this paper expressed frustration that there were not more courses to choose from and that the same courses were offered in their regions year after year.

Current training does not prepare workers to care for a clients with complex and challenging conditions.

The limitations of the current training design are particularly problematic for workers assigned to clients with complex care needs. According to data provided by ADSA, more than one-third of all IP and agency workers care for clients who are classified as belonging to groups "D" and "E" and thus qualify for a higher number of hours of personal care than clients classified in lower groups (see Box 6: Classification Groups for Home Care Clients). Examples of these types of clients include seniors with dementia, in addition to chronic health conditions such as heart disease or diabetes; adults with multiple mental and physical disabilities; and children with severe autism or similar developmental disabilities.

BOX 6 Classification Groups for Home Care Clients

Classification Groups	% of Total Care Provided by Home Care Workers
A (qualify for lowest number of hours of care)	10%
B	46%
C	10%
D	29%
E (qualify for highest number of hours of care)	5%

Data Source: ADSA, April 2006

According to the Comprehensive Assessment Reporting Evaluation (CARE), the system used to assign individuals to these groups, these clients have clinically complex conditions, significant cognitive impairments, and also in many cases, have mood and behavior issues. They are individuals who in the past would have received care in nursing homes or other institutions. Today they have the opportunity to stay at home, but as we have documented above, the people who care for them don't have the same level of training and on-the-job support as those who work in institutions.

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A common complaint from both IP and agency workers is the experience of being assigned a “total care client” who requires the use of a Hoyer lift and/or other assistive technologies—even though the worker has never been trained to use those devices.

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Workers interviewed for this paper say that they feel unprepared to assist clients with increasingly complex conditions, since those conditions are not addressed with any depth in the training curriculum. Specifically, a common complaint from both IP and agency workers is the experience of being assigned a “total care client” who requires the use of a Hoyer lift and/or other assistive technologies—even though the worker has never been trained to use those devices. While workers in an institutional setting would have the ability to seek out a colleague or supervisor for instruction, home care workers are often completely alone with their client, and that client may or may not have the capacity to explain how to operate fast-changing assistive technologies.

B. CRITIQUES OF THE TRAINING DELIVERY SYSTEM

The quality of training system is inconsistent across the state's geographic regions and plagued by access problems in rural areas and for workers who do not speak English as their first language.

The quality and availability of training varies by region. Workers report difficulty accessing entry-level training and continuing education in rural areas. In addition, workers who do not speak English as their first language have difficulty finding instruction in their own language or translation services. Both of these issues are compounded by the division of authority for training between the 13 regional AAAs.

Achieving the economies of scale necessary to make a regional training program cost effective is challenging in rural communities. Out of the 13 AAA regions, six provided the entry-level "Revised Fundamentals of Care" to less than 300 home care workers in FY '05. During that time period, the Northwest Regional Council subcontracted with Bellingham Technical College to provide RFOC to just 214 workers. SEIU 775 members in rural areas report that trainings in their counties are frequently scheduled but later cancelled because not enough people signed up. Others noted that some course may be offered very infrequently or not at all.

Rural Okanogan County in northeast Washington provides a good example of these issues. The AAA in this region, Aging and Adult Care of Central Washington, contracts with the Professional Registry of Nursing (PRN) to provide training. According to a home care agency that employs SEIU 775 members, the RFOC course is offered only once per quarter in the Okanogan area, making it very difficult to ensure that their employees complete this training within 120 days of employment.

The availability of continuing education in this region is also very limited. Workers in Twisp, a small town located along the path of Interstate 20, say they are told to go to the library and check out a book, and that is the extent of their continuing education. A report from PRN on training offered in FY '04 – '05 shows that only four continuing education courses were offered in Okanogan County during that time period.

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Workers in the small town of Twisp are told to go to the library and check out a book, that is the extent of their continuing education.

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Divisions between AAA regions exacerbate these access issues. In Tonasket, located on the eastern side of Okanogan County, workers are not allowed to travel to the nearby town of Republic to take RFOC and continuing education courses because Republic is in Ferry County, which is under the auspices of a different AAA. Instead, they must travel several hours by car to Wenatchee where RFOC courses contracted by their AAA are offered.

In rural areas, access to training is even more difficult for workers who do not speak English as their first language. While urban areas, such as King County, offer the RFOC and continuing education classes in a wide range of languages,²⁵ other AAA regions offer a very limited range of instruction in languages other than English. According to ADSA, training curricula are translated into 5 languages and certified interpreters are available for 14 languages when requested in advance. Nonetheless, SEIU members in some areas report difficulty accessing training in languages other than English.

For example, in southeast Washington, where the largest population of Latino immigrants in the state work as farm workers and also frequently as paid caregivers, interpreters are available if workers request them in advance, but there is only limited training available directly in Spanish. According to one home care agency employer, the AAA agency in this region, Southeast Washington Aging and Long-Term Care (SE WA ALTC), only offers the RFOC course to non-English speakers once every six months. Of the 65 continuing education classes offered by SE WA ALTC between January 2005 and April 2006, 11, or 17 percent, were offered in Spanish or Russian or otherwise made available through translation to individuals speaking other languages.²⁶

Making training accessible to a workforce that speaks perhaps more than 50 languages is a challenge under any circumstances.²⁷ Today access is limited because:

- Workers may not understand how to schedule an interpreter,
- There may not be an interpreter available in the language the worker speaks, or
- Written materials are not always translated into the learner’s language.

In addition, because training vendors are not taking advantages of simultaneous translation and other available translation technologies, the quality of training is often diminished for all participants when translation slows the pace of training and creates distractions.

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Funding passes through AAAs, which in turn subcontract with other training vendors without adding significant value.

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The disjointed nature of the training delivery system is inefficient and does not take advantage of economies of scale.

In the current system, each regional AAA or training vendor (and in some cases multiple vendors per region and/or subcontractors) must develop its own systems for recruiting and training instructors, scheduling trainees, verifying that training was completed, and, in the case of vendors, report-

²⁵ For example, King County, through their contract with Professional Registry of Nursing, offered continuing education courses in Russian, Vietnamese, Korean, Spanish, Cambodian, Tagalog, Somali, Bosnian, Cantonese, Laotian, and Mandarin, according to a report by PRN on training offered between January 2005 – February 2006.
²⁶ According to a report to DSHS by the Southeast Washington Aging and Long-Term Care, which was made available to SEIU 775.
²⁷ There is no current demographic data indicating the primary language spoken by the long-term care workforce. However, in a survey of IP home care workers conducted by SEIU in 2003, respondents reported speaking 57 different languages.

ing back to the AAA. AAA contacts interviewed for this paper report that PRN is efficient at each of these functions, while other vendors appear less so. (Because they serve five regional AAAs, PRN has had the opportunity to develop expertise in this area and duplicate what works well in one region in other regions.)

The multiple levels of contracting and subcontracting appear to be an unnecessary waste of limited resources and may in some cases also compromise quality. Funding passes through AAAs, which in turn subcontract with other training vendors without adding significant value. This structure makes little sense from an administrative perspective, and also reduces the potential for information sharing between training providers in different parts of the state. In addition, although the AAAs must adhere to specific requirements regarding qualifications and experience for subcontractors, SEIU 775 members report that instructors who are subcontractors often provide less than high quality instruction and many have little relevant background or experience to draw from.

Finally, the “silo-ing” of training functions between home- and community-based services and institutional settings further weakens the delivery system. For example, community colleges in rural areas are teaching the same personal care skills to nursing assistants that other training providers are teaching to home care workers. Thus, two separate entities in the same region are teaching the same content to small groups, rather than taking advantage of the economies of scale that would come with offering a single course that could lead to multiple credentials.

Tracking and verification systems are not centralized, resulting in a lack of transparency and accountability across the delivery system.

The state does not have a single statewide database to track caregiver training. The current system for both delivering and tracking training mirrors the decentralized service model wherein contracts for most home care providers begin and end with local case managers and contracts for individuals with developmental disabilities are managed separately through the Division of Developmental Disabilities.

Thus, there is no “one stop shopping” data system to report system-wide information about how many caregivers have completed training requirements and whether they have completed their training according to the timelines required by law. Training for caregivers who work in adult family homes and boarding homes is tracked by facility rather than by individual and verified through the facility licensure process. Training for parent providers and others who serve clients with developmental disabilities is tracked by the Division of Developmental Disabilities. Finally, training for the IP and agency home care workforce is tracked and verified on an individual basis by the regional AAAs, with each AAA utilizing a different data system.

At the request of SEIU 775, the state surveyed the AAAs to gather the information about training coordinated by each of the Area Agencies on Aging in FY '05 –'06. This data, compiled in Appendix B, Home- and Community-Based Training Data by Region, FY 2006, indicates that during this time frame, 18 training vendors provided training services and 4,791 IP home care workers completed the Revised Fundamentals of Care course. This data gathering process illustrated the challenges of a decentralized system in that it took several weeks to collect the data and, when the information did

arrive, it was inconsistent and in different formats, with some AAAs reporting calendar year data and others fiscal year, some including agency home care workers along with IPs, and some reporting on different types of training than others..

A separate statewide data system used for reimbursement is not linked to these regional systems for tracking training. This system reports an average of 727 new IPs per month and a total of 8,725 new IPs between March '05 and March '06.²⁸ The number of workers that the AAAs reported training in a year's time (4,791) should at least approximate the average number of new IPs contracted in the same time period (8,724). While differences in the way the AAAs report that data likely explain some of this discrepancy, it unclear why the AAAs reported training approximately 4,000 fewer IPs than are typically hired in a given year.

According to ADSA, this data does not demonstrate a gap in training. They point out that the data provide by the AAAs does not capture several groups, including IP workers who are contracted but who have not yet completed training or parent providers and respite workers who are exempt from training requirements. These workers would be reflected in the statewide database that tracks IP contracts. According to one official, "these numbers will never add up because of work flow and billing issues."²⁹

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The absence of a statewide data base for tracking caregiver training makes it impossible for the state to monitor exactly how many workers are being trained at any given time.

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As this example illustrates, the absence of a statewide data base for tracking caregiver training makes it impossible for the state to monitor exactly how many workers are being trained at any given time. This system results in a lack of transparency and dispersed accountability for verifying that all training requirements are fulfilled. It has the potential to compromise the safety and security of clients who assume that state- funded workers have completed all applicable training requirements.

When the training requirements were first imposed by the legislature they did not come with funding for a statewide tracking system. As statewide standards become more rigorous, the necessity of investing in a more integrated statewide database for tracking and verifying caregiver training will become even more apparent.

C. TRAINING, WORKFORCE DEVELOPMENT, AND THE FUTURE CHALLENGES FOR LONG-TERM CARE

Caregiver training is not connected to a broader workforce development plan for the long-term care sector. As the population in Washington ages, the demand for caregivers will increase dramatically.

²⁸ See Box 8: IP Workforce Volatility, pg. 24.

²⁹ Written comment on blue print draft provided by ADSA to SEIU 775, December 2006.

In the year 2000, 11.2 percent of Washington’s population was over the age of 65 and 1.4 percent was over the age of 85. The U.S. Census estimates that by the year 2030, Washington’s elder population will increase by 136.2 percent. By that time 18.1 percent of the population will be over 65 and 2.4 percent will be over 85.

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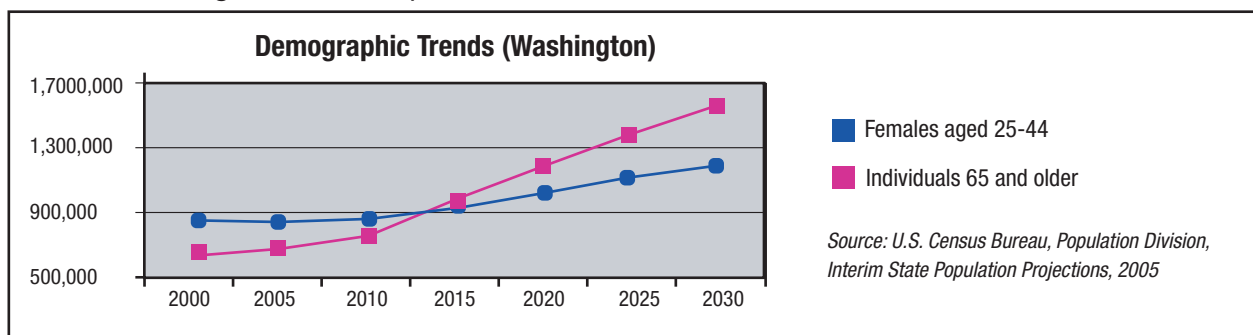
The U.S. Census estimates an increase in Washington’s elder population of over 136 percent over the next three decades.

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This dramatic growth in the elder population will create huge demands on the state’s long-term care system. But the U.S. census predicts that Washington’s population of women between the ages of 25 and 44, the people who most typically fill caregiving jobs, will grow by only 30 percent during this same period. Without fundamental changes to improve the quality of caregiving jobs and attract new workers into the profession, this situation could lead to a serious “care gap” between those needing care and those available to care for them (see Box 7: Washington’s Care Gap).

The current approach to caregiver training is not preparing Washington to meet this rising demand. Instead, it is failing on three key fronts necessary for successful workforce development: retention, recruitment, and expansion of the labor pool.

BOX 7 Washington’s Care Gap



RETENTION

The current training approach is not building a stable workforce of home care workers who view caregiving as a long-term career. With limited entry-level training and little or no on-the-job support, many workers are unprepared to face the realities of caregiving work. Inadequate training combines with other factors, including low wages, few benefits, and stressful work environments, and leads to high turnover rates in both nursing home and home care settings.

An estimated 9,000 IP home care workers entered and exited the system between April 2005 and

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The current training approach is not building a stable workforce of home care workers who view caregiving as a long-term career.

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April 2006, suggesting a turnover rate of approximately 37 percent (see Box 8: IP Workforce Volatility). However, turnover in the IP home care context is hard to define because unlike a traditional workplace there are not a set number of slots or positions to be filled. Instead, the workforce fluctuates as clients enter and exit the system and sign and end contracts with their IP providers. According to ADSA, the turnover rate for consumers is 34 percent.

BOX 8 IP Workforce Volatility

Yes	Month	New IP Home Care Workers	Total IP Home Care Workers
2005	April	662	23,456
2005	May	899	23,521
2005	June	723	23,539
2005	July	776	23,794
2005	August	886	23,684
2005	September	786	23,538
2005	October	697	23,567
2005	November	729	23,519
2005	December	603	23,480
2005	January	627	23,641
2005	February	635	23,686
2005	March	702	23,726
	Total	8,725	
	Average	727	23,596

Approximate number exiting (8,725) / total IP workforce (23,596) = 37 percent turnover

Data Source: DSHS, ADSA

Note: There is no accurate data on the number of IPs exiting the system. This is hard to track because some IPs continue to serve the same client but go to work for an agency, and others do not work temporarily when their client is hospitalized and then continue working when their client returns home.

How many different workers an individual client sees come and go within a given year likely varies considerably between family and non-family member providers. While parents of developmentally disabled adult children and some other family member IPs might care for the same loved one for many years out of a sense of love or family obligation, non-family members are more likely to end a contract with a client who they find particularly difficult to work for or who has conditions which they do not have adequate training to understand or handle. Thus, the turnover rate for non-family member IPs is probably closer to 40 to 60 percent, the norm for agency home care workers. This volatility creates challenges for some home care clients who must repeatedly recruit new workers and familiarize them with their particular needs and routines.

Retention is also a problem in Washington’s nursing homes, where turnover rates are commonly greater than 70 percent.³⁰ Nursing home employers report that they typically see a core group of CNAs who stay for many years while others leave within their first three months of employment. This “revolving door” workforce endangers the quality and continuity of care for residents.

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Fulfilling current training requirements fails to offer home- and community-based workers a credential that they can build on or take with them to other long-term care or health settings.

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RECRUITMENT

Recruiting is a huge challenge for nursing home and home care employers (agencies and individual consumers) alike. This challenge is exacerbated by the structure of current training requirements, which essentially renders caregiving a “dead-end job.”

Fulfilling current training requirements fails to offer home- and community-based workers a credential that they can build on or take with them to other long-term care or health settings. For example, home care workers who want to become CNAs have to complete the full 85 hours of CNA training, with no credit for the 34-hour RFOC training they have already completed or their previous caregiving experience.³¹

The fragmentation of training requirements also stifles workers’ ability to combine part-time jobs in different settings in order to achieve full-time work. The instability of hours and part-time nature of the work deter people who might otherwise be interested from pursuing caregiving work and hurts the efforts of incumbent workers to combine part-time jobs in order to earn a decent and stable living.

³⁰ According to a survey by the American Healthcare Association (AHCA) in 2002, the statewide turnover rate for CNAs was 71.1 percent.
³¹ CNAs who want to move to home- or community-based settings are allowed to take a shorter, modified version of the Revised Fundamentals of Care course.

To supplement their income, some workers in Washington are combining their part-time home care clients with shift work or temporary work in nursing homes, but to do so they must fulfill two separate training tracks. Without greater flexibility and portability of credentials, recruiting will become increasingly difficult for home care consumers and other employers.

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The more than 10,000 paid family caregivers in Washington state are an example of a workforce with huge potential that is untapped by the current approach to caregiver training.

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EXPANSION OF THE LABOR POOL

In addition to hindering those interested in moving within and across long-term care settings, the current system is not making caregiving jobs attractive to the new workforce pools that will be necessary to meet the caregiving demands of the future. Existing programs such as skills panels, centers of excellence, and job ladders are a step in the right direction but focus almost exclusively on filling RN and related health care jobs rather than developing the frontline workforce in long-term care.

The more than 10,000 paid family caregivers in Washington state are an example of a workforce with huge potential that is untapped by the current approach to caregiver training. Today, only a small portion of these workers take on additional non-family clients either concurrently or after they have completed their responsibilities to their loved ones. While this will always be true for some individuals who are providing care out of a sense of familial obligation, with the right encouragement and incentives, some portion of this workforce could continue successfully as caregivers.

In a study of home care workers in California’s In-Home Supportive Services (IHSS) program, A. E. Benjamin concludes that former family member caregivers could add significantly to the pool of caregivers. Benjamin found that “of about 44,000 family caregivers in IHSS who stop (family) caregiving in one year, about 4,400 will continue working elsewhere as caregivers.” And in addition, “Among leavers (defined as those no longer working in home or health care), 58.6 percent would definitely or probably care again for a friend or family member, about 23,000 altogether, and 43.4 percent would definitely or probably care again for a stranger, about 17,000 in all.”³²

This study illustrates the potential in Washington for family caregivers to significantly expand the labor pool and help to fill the “care gap” of the future by expanding their client base beyond their own family. By offering this workforce better training, support and career pathways, Washington could capture a skilled and experienced segment of the workforce who have already self-selected as caregivers and who frequently have the high level of compassion, patience, warmth, and maturity necessary to provide high quality care.

³² A. E. Benjamin, PhD. “Labor Force Expansion Through Retention of Related Caregivers,” March 2006, Better Jobs Better Care Research Study. Available at <http://www.bjbc.org/content/docs/UCLAExSummaryFinal31406.doc>



PART 3: BLUE PRINT FOR A WORKFORCE DEVELOPMENT APPROACH TO CAREGIVER TRAINING

A. OVERVIEW OF THE NETWORK

What is now known by many as a “dead-end job” can be transformed into a sustainable career of choice—if these jobs offer quality training, support, and the opportunity for advancement. The SEIU 775 Long-term Care Training, Support and Career Development Network will approach this task of creating sustainable careers for caregivers with an adult-learner, workforce development approach to caregiver training. Through training, education and support services, the Network will:

- Improve the quality of care,
- Attract new workers into the system, and
- Lay the groundwork for developing an adequate supply of caregivers for the next generation of long-term care consumers.

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The Network will make training relevant through a flexible core curriculum design and a broad selection of specialized courses to assist workers in meeting each client’s individualized needs.

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This Network will be a partnership between SEIU 775 and participating employers, including the state (in its role as the employer for the purposes of collective bargaining for the 23,000-plus IP home care workforce), home care agencies, and nursing homes. This labor-management partnership, known under labor law as a “Taft Hartley Trust,” will be modeled after labor-management training partnerships in other states and will be parallel in its legal and governance structure to SEIU 775’s Health Insurance Trust.

The products and services offered by the Network will include:

- Entry-level training courses to prepare workers for certification
- A peer mentor program for continued on-the-job training and support
- An apprenticeship program with advanced and specialty training opportunities
- Continuing education
- Adult basic education offerings
- A “Caring for the Caregiver” workshop series
- Professional development counseling and partnerships
- Tuition assistance for advanced degrees in related fields

These services will be developed and implemented in phases over time, as outlined in the remaining sections of this report.

In addition to providing an extensive array of training programs, the Network will: 1) Make training more relevant by maximizing worker and consumer participation at all levels; 2) Build on the knowledge that adults bring with them into the learning setting; and 3) Assist workers in meeting each client’s individualized needs through specialized training opportunities.

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What is now known by many as a “dead-end job” can be transformed into a sustainable career of choice—if these jobs offer quality training, support, and the opportunity for advancement.

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As described below, SEIU proposes that the Network be built in three phases: Phase I – Entry Level Training and Apprenticeship; Phase II – Adult Education and Caring for the Caregiver, and Phase III – Career Counseling and Tuition Assistance, (see Box 9: The SEIU 775 Long-term Care Training, Support and Career Development Network, Product and Services Development).

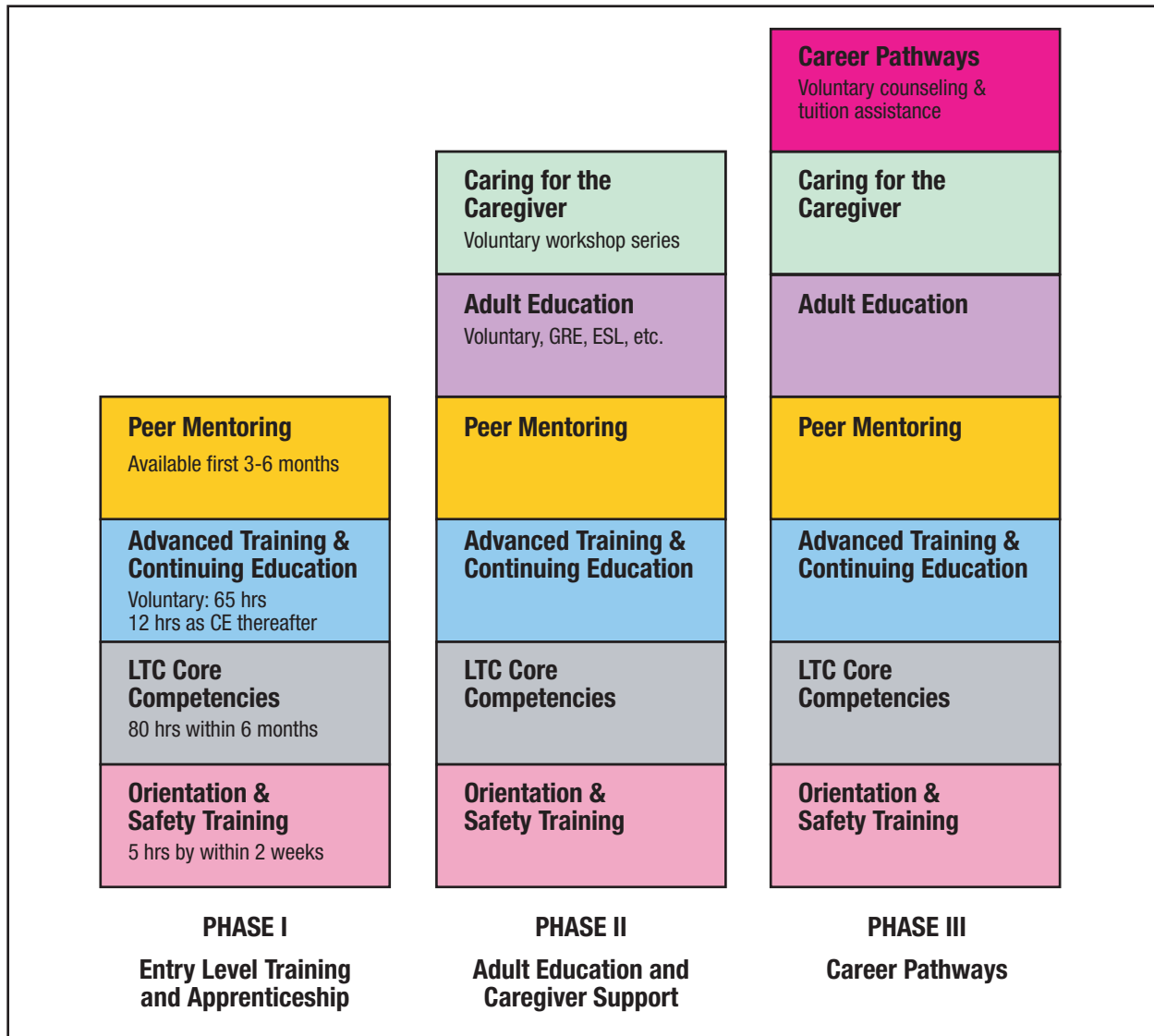
SEIU envisions that the Network will become the primary, though not sole, provider of training for its members, with an instructor base that includes both in-house faculty and partnerships with existing high-quality contractors and community colleges. Eliminating multiple layers of subcontractors and streamlining the delivery system across settings and geographies will increase accountability and improve efficiency.

The Network will offer a higher standard of training than currently exists for workers providing home- and community-based services in Washington State. As SEIU 775 plans for the development of the Network, they are also advocating for state-level policy changes to the training requirements for the home- and community-based workforce:

- Increase the current 34-hour training requirement to a minimum of 85 hours, to be completed with within the time frames outlined in this blue print.
- Raise the continuing education requirement from 10 to 12 hours per year
- Create of a new “Certified Home Care Aide” testing process and designation

These new requirements would cover all union and non-union workers alike. Non-union providers who employ workers covered by this new standard would have the option of enrolling their workers in classroom training provided by the Network, at a fair price to be determined by the Network, or providing training that meets the new standards on their own or through alternative training vendors.

BOX 9 The SEIU 775 Long-term Care Training, Support and Career Development Network: Overview of Training and Career Development Services



B. PROGRAM PHASES

PHASE I: ENTRY-LEVEL TRAINING AND APPRENTICESHIP

A. Entry Level Training Leading to Certification

In its first year in operation, the Network will offer entry-level training designed to fulfill a new 85-hour training requirement for home- and community-based workers and prepare SEIU 775 members to pass a state-approved test to become a Certified Home Care Aide (CHCA). The entry-level training program will be available and required for all participants in the Network who are newly

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Entry level training will be interspersed with experience in the field in order to create a dynamic learning process that is closely linked to the realities of the work.

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hired home- and community-based workers. Because existing workers would be “grandfathered in” to any new training standard established by the state, they will not be required to complete additional entry level training or become certified.

Entry level training will be interspersed with experience in the field in order to create a dynamic learning process that is closely linked to the realities of the work. It will begin with an orientation and brief safety training, designed to acclimate caregivers quickly and provide the vital information necessary to begin serving clients. Within a few months, workers will return to the classroom for the Long-Term Care Core Competencies training sessions, which will focus on building the personal care and relational skills necessary for quality caregiving.

The entry-level training will be offered in four steps:

Step 1. Orientation
 Class time: 2 hours
 Complete within: 2 weeks
 (or 50 hours of work)

Step 2. Safety Training
 Class time: 3 hours
 Complete within: 2 weeks
 (or 50 hours of work)

Step 3. Long-Term Care Core Competencies
 Total class time: 80 hours
 Complete within: 6 months
 (or 600 hours of work)

Step 4. Testing and Certification
 Participants take state approved test to become a Certified Home Care Aide

These courses will be offered directly by the Network, and through contracts with community-based organizations and other training vendors. The Network will also explore partnerships with community colleges to develop coursework that would be credit-bearing for members interested in applying their training towards the attainment of an Associate or Bachelor’s degree. The following sections describe each of the three entry-level training steps and the peer mentor program in more detail.

STEP 1. ORIENTATION

Entry-level training will begin with an orientation that participants will complete within 50 hours of work (or within approximately 2 weeks). The orientation will be facilitated by Network instructors and seasoned caregivers, with an opportunity for representatives from SEIU 775 to discuss the role of the union and the collective bargaining agreement. The orientation will accomplish the following:

- Affirm the new employee’s decision to become a caregiver through personal testimony from a seasoned worker that illustrates the rewards of caregiving work and the importance of advocating for client and worker’s rights.

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- Introduce the role of the caregiver, person-centered care, and consumer-directed models.
 - Ensure that all caregivers understand the standards of apprenticeship in addition to other support and career development services available through the Network.
 - Provide an overview of SEIU 775 and the union contract.
 - Provide clear information about the terms of their employment and administrative procedures, and who to contact for more information or in the case of an emergency.

To achieve this last objective, workers will break into small groups according to what type of setting they will be working in. For IP home care workers, this portion of the orientation will review the administrative procedures covered in the ADSA Employment Reference Guide, in addition to emergency procedures and safety precautions particular to in-home settings. Parallel but more generic information will be provided for those on track to work in agencies or other settings. These groups will also participate in on-site orientations conducted by each individual employer.

STEP 2. SAFETY TRAINING

The second step of the classroom training will be a required 3-hour safety training which participants will also need to complete within the first two weeks of employment to ensure both client and worker safety. It will be similar in content to the safety training currently required for IP home care workers and will include the following content:

- Emergency procedures and making an emergency plan
- Back safety and proper lifting techniques
- Safe use of medical equipment
- Infection control
- Violence in the workplace / home environment

This training will complement training that workers receive directly from their employers about their specific emergency procedures and policies (and in the case of IPs, in the IP portion of the orientation).

STEP 3. LONG-TERM CARE CORE COMPETENCIES

Workers will have up to six months or 600 hours of work to complete the “Long-Term Care Core Competencies” training sessions, which will include a total of 80 hours of instruction. This course, which will be broken up into three- to four-hour modules offered over the course of several weeks, will cover all of the core competencies necessary for quality giving and also allow time for participants to explore in more depth particular skills or issues that will be most relevant to their individual clients needs.

The core competencies training will:

- Be developed with worker and consumer participation.
- Employ an adult-learner centered approach.
- Be flexible in its design to enable participants to focus more deeply on issues or skills most relevant to their care giving situation.
- Be rigorous and challenging, but also respectful and supportive of trainees who may have already been caring for family members for years.
- Be culturally competent and delivered in languages in addition to English.

- Provide learners with core competencies that they can build on with advanced / specialized training and on-the-job support.
- Ask learners to evaluate what they are learning and identify further on-the-job support or training desired on specific topics/issues.

Curriculum for the Long-Term Care Core Competencies will be developed through a participatory process among key stakeholders, consumers, and workers. This curriculum will include topics such as client’s rights and the role of the caregiver, personal care tasks, body systems, common diseases, problem solving, communication skills, nutrition / food handling and self-care. The curriculum will be relevant to care needs across the spectrum of home- and community-based settings. Content will be organized along a continuum, from simple to complex, with skills that will be most relevant offered first and then built upon based on real experience in a process known as “scaffolding knowledge.” (See Appendix D, Suggestions for the Long-Term Care Core Competencies Training, for an outline of potential topics for this training.)

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Curriculum for the Long-Term Care Core Competencies will be developed through a participatory process among key stakeholders, consumers, and workers.

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The Long-Term Care Core Competencies Course will include a strong focus on the relational skills necessary for quality caregiving, drawing on PHI’s field-tested “4-Ps Approach to Problem Solving,” which teaches workers to:

- Pull back: gain emotional control in stressful work environments
- Paraphrase: listen actively and ask open questions
- Present options: identify the critical fact or problem, brainstorm solutions, and present possible solutions
- Pass it on: communicate with others about a problem, using objective language.

(For a more complete description of this curriculum, see Appendix E, Introduction to the 4Ps Approach to Problem-Solving.)

The curriculum will be designed to reach people with different learning styles, something the RFOC curriculum attempts to do, yet appears to achieve only in a perfunctory way. The Network’s approach will integrate multiple teaching techniques to accommodate people who learn by seeing, hearing, or doing. For example, a lesson on body mechanics might include a brief lecture, a demonstration by a trained worker and his/her client, and an activity in which trainees lift heavy objects off the floor. In addition to incorporating varying training techniques, this approach will allow instructors to recycle information and encourage participants to work together in order to help one another learn.³³

³³ For more on multiple learning styles, see Training Quality Home Care Workers, A PHI Technical Series Publication (Paraprofessional Healthcare Institute, 2003), page 10.

BOX 10 Adult-Lerner Centered Education

*Tell me and I'll forget
Show me and I may remember
Involve me and I'll understand.
- Native American Saying*

Participant-centered education facilitates learning by building upon the knowledge and skills that adults bring with them to the learning setting. Although adults often resist learning due to past experiences and educational settings, everyone learns and incorporates new knowledge throughout their lives. The learner-centered classroom is built on the following assumptions about how adults learn. Learners:

- Achieve the best results when they feel safe, supported and respected.
- Will understand and retain material more effectively if they are actively engaged in the discovery process.
- Have different strengths and weaknesses and different styles of learning.
- Learn best when what is being taught is relevant to their needs.
- Need to be held to high standards; this is best accomplished through clear, appropriate, and regular feedback that reinforces and celebrates success.

Adapted from "Training Quality Home Care Workers, A PHI Technical Series Publication."

To ensure that the training is grounded in the realities of caregiving, instructors will use a problem-posing model in which learners are asked to apply knowledge to real-life situations that they might encounter as workers. In addition, the Network will employ current and former caregivers as instructors and invite consumers to teach certain modules, including those addressing topics such as client's rights and the philosophy of consumer direction.

Upon completion of the core competencies training sessions, caregivers will have built on and more fully integrated the skills that they have already begun practicing in the field. They will have broad knowledge of all the core competencies necessary for quality caregiving across long-term care settings and quality relationships with trainers, mentors,³⁴ and fellow caregivers upon whom they may call for continued peer support.

STEP 4. TESTING AND CERTIFICATION

After completing a total of 85 hours of entry level training through these three steps – the Orientation, Safety Training and Long-term Care Core Competencies Course, participants will be eligible for certification. The Network will administer a state-approved test through which participants will demonstrate the core competencies necessary for quality caregiving. Participants who complete the training and pass the state exam will become certified as a CHCA, a new designation created by the state.

³⁴ A specific peer mentor program will be described later in this section.

B. Peer Mentoring

As a complement to the required entry-level training, by its second year in operation, the Network will launch a peer mentor program that will provide on-the-job training and support to workers in their first three to six months of employment.³⁵ Mentors will be offered or made available to all home- and community based workers participating in the Network, including IP home care workers who are most isolated and in need of peer support and also home care agency and other community-based long term care workers. Home care agencies and other participating employers will coordinate with the Network to tailor it this program to their specific settings.

DEMONSTRATED NEED

Research shows that much of the constant churning of direct-care staff happens during the first few months of employment.³⁶ In addition, long-term care employers often lose seasoned staff because their jobs offer few opportunities for growth and advancement. Peer mentoring helps to solve both of these problems, reducing turnover among new employees and providing opportunities for advancement for committed workers.³⁷

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For home care workers, the first few months of work can be an incredibly challenging and isolating experience.

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For home care workers, the first few months of work can be an incredibly challenging and isolating experience. Most begin working before receiving any formal training or preparation for the realities of caregiving work. While some clients are capable of communicating their needs and directing the IP, others are not. Thus, beyond basic information provided in the care plan and limited instructions from their client's case manager, many new IPs and their clients are simply on their own to define the IP's role and understand how best to meet the clients needs.

In a recent poll of IP home care workers, more than 70 percent said that they would have welcomed the support of an experienced home care worker in their first six months on the job.³⁸ Dana Simons is an IP home care worker who quit her job as an airport screener to care for her mother when she suffered anoxia leading to brain damage. According to Dana, "I was never coached on what to expect from someone with brain damage, so when I first started caring for my mother on a full-time basis, I was frequently hurt by her behavior changes and sometimes violent actions. I really needed someone to call for advice on how best to manage her outbursts or just to talk with for support."

³⁵ While in the future the Network may work with participating employers to expand this program to facility-based settings, peer mentoring will be implemented with home care workers first because they have less on-the-job support and fewer opportunities for mentoring than other types of workers.

³⁶ For example see Karl Pillemer, *Solving the Frontline Crisis in Long-Term Care. A Practical Guide to Finding and Keeping Quality Nursing Assistants* (Frontline Publishing, 1996). Pillemer found that 40 to 50 percent of all nursing assistants leave during orientation and training.

³⁷ For more information about peer mentor programs and descriptions of how they have been implemented across long-term care settings see "Introducing Peer Mentoring in Long-Term Care Settings," *Workforce Strategies* No. 2 (2003), a PHI publication available on the National Clearinghouse website, www.directcareclearinghouse.org

³⁸ In this poll, conducted by the Feldman group on behalf of SEIU 775, 46 percent of respondents said it would be "very helpful" and 26 percent said it would be "helpful" to have "support from an experienced home care worker who had been trained to help guide new workers through questions and problem-solving."

MENTOR-MENTEE RATIO

Peer mentoring will address this need by offering workers like Dana a mentor or “buddy” who can answer questions and offer support when the learning curve is the steepest. Peer mentoring is currently being piloted for the IP workforce in a limited way by the Home Care Quality Authority (HCQA). However, in this model, teams of two mentors are expected to serve up to 375 IPs, a ratio which allows for little or no real interaction between mentors and mentees.³⁹

To ensure a meaningful program, where mentors have the time necessary to build trusting relationships, the Network will assign each mentor no more than 10 mentees at any given time. Mentors will act as role models and coaches, helping IPs to resolve personal and professional problems as they arise. They will use both in-person meetings (job shadowing) and telephone check-ins, with the level of contact with each mentee varying according to their needs.

OPPORTUNITY FOR ADVANCEMENT

Peer mentoring will also provide an opportunity for home care workers to advance in their jobs without having to move into institutional care or away from direct caregiving. Mentors will be expected to combine caregiving work with their own clients with up to 40 hours of mentoring per month. In recognition of their leadership role, mentors will earn \$1 per hour above their already established rate for all peer mentoring hours worked.

SELECTION, TRAINING, AND MENTOR MATCHING

The Network will use a competitive application process to select mentors who demonstrate excellent clinical and interpersonal skills in addition to the desire and patience to teach these skills to others. Once selected, they will complete an extensive training before being assigned to new workers. They will be eligible to receive continuing education credit for this training or apply it towards attainment of an apprenticeship completion certificate.

All new workers will meet their mentor in person at the orientation or hear from them by phone shortly thereafter if they complete the orientation remotely. To the extent possible, the Network will match mentees with mentors who have appropriate skills and who share similar experiences. For example, if a mentee is caring for a person who is a quadriplegic, effort will be made to match her with a mentor with experience in caring for people with disabilities; or if a mentee is caring for a relative, effort will be made to match her with a mentor who is also a family caregiver. More specific matches will be possible in the more populated regions of the state where the pool of available mentors will be relatively greater.

Another mentoring approach that the Network will consider is employing mentors with expertise in caring for individuals with specific diseases and conditions. These “specialty mentors” could be employed to support home care workers in any part of the state through phone and/or e-mail consultations. These individuals could combine “specialty mentoring” with their own caregiving work and/or work as instructors for the Network, delivering courses in their specialty area or other topics.

³⁹ Under contract with the HCQA, the Referral and Workforce Resource Centers (RWRCs) manage peer mentor programs in four regions serving nine counties (Ferry, Lewis, Mason, Pend Oreille, Snohomish, Spokane, Stevens, Thurston, Whitman). This program is scheduled from May 2005 through December 2006, with each RWRC sponsoring two mentors throughout this period. The HCQA established a target of service to 375 mentees for each RWRC. For more information see “A Preliminary Analysis of the Peer Mentor Program in Nine Washington Counties,” The Home Care Quality Authority (March 2006).

MANAGEMENT

To be successful, peer mentoring will be managed at the regional level with clear accountability systems in place to ensure that mentors understand their role and carry out their duties. Oversight for the mentors will be integrated with the entry-level training delivery system, ensuring a continuous flow of information between classroom trainers and mentors who are providing on-the-job support. With proximity and close communication, mentors will be able to inform classroom instructors as to subject areas that need more focus and, thus, keep classroom training grounded in the realities of the job.

In addition, the Network will train mentors to encourage their mentees to complete their classroom training requirements as early in their tenure as possible. They will also be able to advise mentees as to what advanced courses or specialty clusters might be most relevant to their caregiving situation. This level of integration will maximize the impact of both training opportunities.

C. Apprenticeship Program

By the end of Phase I, the Network will begin offering a voluntary apprenticeship program that will build on the entry-level training and peer mentor programs with a broad menu of advanced and specialty courses designed to refine care giving skills in specific specialty areas chosen by the participant. The Network will seek approval for this program in the form of an apprenticeship agreement from the Washington State Apprenticeship and Training Council and create an apprenticeship committee to oversee the program.

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The advanced and specialty training courses for the apprenticeship program will be designed to enable caregivers to tailor their skills and knowledge to meet the individualized needs of each client they serve.

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The standards for this apprenticeship will include a total of 150 hours of classroom training (including 85 hours of entry-level training in addition to at least 65 hours of advanced and specialty training) complemented by on-the-job training and support through the peer mentor program. Upon completing this training and 2,000 hours of work experience, participants will receive an apprenticeship completion certificate from the Washington State Apprenticeship and Training Council,⁴⁰ as a pay increase as outlined in SEIU 775 collective bargaining agreements.

The advanced and specialty training courses for the apprenticeship program will be designed to enable caregivers to tailor their skills and knowledge to meet the individualized needs of each client they serve. The apprenticeship standard will recommend that workers complete all 65 hours of this

⁴⁰ This certificate will be recognized by the US Department of Labor.

advanced and specialty training within their first year of employment and require that they have completed it within 2,000 hours of work.

The course offerings will be developed with input from workers, consumers, and employers. They will include advanced courses that build on the knowledge and skills base developed in the core competency training and specialty courses that focus in on a specific skill, disease, or population. For example, courses will be offered on topics such as advanced communication skills, fetal alcohol syndrome, and quadriplegia. Training on nurse delegation responsibilities—required by Washington State for home care workers who will be completing nurse-delegated duties such as administering medication—will also be offered as an advanced course.

The Network will propose the creation of both a general apprenticeship and specialty apprenticeships that will prepare workers to address specific types of client needs or specific skill sets (see Box 11: Examples of Specialty Apprenticeships). Caregivers who complete specialty apprenticeships will receive recognition for this through their apprenticeship completion certificate, which can be presented to employers and clients. In addition, the Network will propose that the statewide referral registry used for matching clients with IP home care workers identify any apprenticeship certificates achieved by listed IPs.

BOX 11 Examples of Possible Specialty Apprenticeships

Specialty	Courses in...
Aging Issues	<ul style="list-style-type: none"> • The Aging Process • Abuse and Victimization of Older Adults • Dementia Care • Death and Dying
Mental Illness	<ul style="list-style-type: none"> • Depression and Anxiety • Personality Disorders • Understanding and Managing Challenging Behaviors • Dementia Care
Consumer Direction	<ul style="list-style-type: none"> • People-First Language • Active Listening • Assistive Technologies • Quadriplegic Care
Developmental Disabilities	<ul style="list-style-type: none"> • Overview of Developmental Disabilities • Inclusion and Community Integration • Autism and related issues • Down Syndrome and related issues

D. Continuing Education

To maintain their certifications, both CHCAs will be required to complete at least 12 hours of continuing education credit per year beginning in the second year of employment. The Network will make the broad menu of advanced and specialty courses available for continuing education credit. Participants will receive credit only for courses that they had not already completed as part of an apprenticeship program.

To ensure equal access to training across regions, the same menu of advanced and specialty courses will be offered in every region of the state, with rotating schedules. Class times will be varied to accommodate different work schedules and shifts and modules will vary in length, with some shorter courses and other day- or weekend-long sessions that combine several courses within a cluster.

E. Cross-Sector Applications

In the initial years of operation, most of the workers who complete the training programs outlined in this section (entry level training, advanced and specialty training curricula, mentor program, and apprenticeship) will be home care workers. This may change, however, as the program expands and community-based employers and nursing home employers agree to participate through collective bargaining agreements with SEIU 775. To address the training needs of nursing home workers and encourage portability across long term care settings, cross-sector applications could be developed (see Box 12: Cross Sector Applications).

These potential cross-sector applications of the Network training program reflect the growing recognition that the core competencies for direct-care workers are strikingly consistent across settings and target populations. For example, in a recent analysis, PHI found that 86 out of 93 core competencies are necessary in both nursing home and in-home settings (see Box 13: Core Competencies for Direct-Care Work).

BOX 13 Core Competencies for Direct-Care Work

To more clearly understand the similarities between skill sets necessary for direct-care workers in different long-term care settings, PHI conducted an analysis that maps 69 specific core competencies grouped into the following categories:

Role of the Direct-Care Worker	Consumer Rights and Confidentiality
Communication and Problem Solving Skills	Personal Care Skills
Health Related Tasks	In-Home and Nutritional Support
Infection Control	Safety and Emergencies
Apply Knowledge to the Needs of Specific Consumers	Self-Care

Based on expert opinion, the analysis indicates for each competency whether or not it is necessary for workers in five distinct long-term care settings. While some competencies are setting specific (e.g., the need for CNAs to assist with admissions, discharges and transfers or the need for home care workers to assist consumers with meal planning, food shopping, and meal preparation), PHI's analysis finds that the vast majority of core competencies, such as assisting with bathing, hand washing, and demonstrating the ability to resolve conflicts, are necessary and relevant across all five settings. Found to be necessary were 86 out of 94 competencies across both nursing home and in-home settings (see Appendix C, Definition of Core Skill Competencies for Entry-Level Direct-Care Workers, for the full analysis).

BOX 12 Cross Sector Applications

<p>CNA Entry-Level Training</p>	<p>Nursing home employers could use the Network to train newly hired nursing assistants rather than hiring already certified assistants or using their own in-house training programs. In these circumstances, the Network would work with participating employers to develop a training track that would be consistent with all state and federal standards for CNA training (see Appendix F, Core Curriculum Requirements for CNA Training). For example, the Network could develop a specifically tailored 85-hour Long -Term Care Core Competencies Course that would include 50 hours of supervised on-site facility based clinical training. This training would be designed so that participants could achieve certification within 120 days of beginning work in a facility as directed by state and federal law.</p>
<p>CNA Apprenticeship</p>	<p>Already certified CNAs working in nursing homes that bargain to join the Network could work with mentors in their facilities and take advanced and specialty courses through the Network in order to achieve a specialized apprenticeship completion certificate. In this case, the 85 hours of training that they have already completed to become certified could be applied to the requirement for 150 hours of classroom training.</p>
<p>CHCA to CNA Mobility</p>	<p>In partnership with nursing home employers, the Network could also offer SEIU home care workers the opportunity to build on the training that they have already completed in order to become CNAs. This would require articulation agreements such that the classroom training already completed by CHCAs would be accepted as fulfilling the 35-hour classroom training requirement for CNAs. Members could then become eligible to take the CNA exam after completing 50 hours of clinical training, which could be offered at one of the participating employer’s facilities. This arrangement would make it easier for home care workers to move into work in a facility-based setting or increase their hours by continuing to work for home care clients and increasing their hours by also working shifts in a nursing home.</p>
<p>CNA to CHCA Mobility</p>	<p>Articulation could also be agreed to in the opposite direction for CNAs who want to work in home- or community-based settings. In this case, the Network could make a brief, home care setting specific training course available to member CNAs who wanted to prepare for the CHCA exam. The state could allow CNAs the option of a taking a challenge test without completing extra home care specific training or completing extra training prior to taking the test. Those who do not pass the challenge test would be required to complete the extra home-care specific training.</p>
<p>CHCA, CNA Dual Certification Training Track</p>	<p>Within the framework of the articulation agreements outlined above, a dual CHCA-CNA apprenticeship program could be designed for newly hired workers. These caregivers would work with peer mentors in both home care and nursing home settings. They would complete the required 85 hours of CHCA training and following that complete at least 50 hours of their 65-hour advanced and specialty apprenticeship training as clinical training in a facility-based setting. After achieving 2,000 hours of work experience, they would qualify to take both certification exams and receive a certificate of apprenticeship.</p>

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Because the basic building blocks are the same, workers should not be forced to repeat training that covers the same core competencies necessary for quality caregiving across settings.

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Because the basic building blocks are the same, workers should not be forced to repeat training that covers the same core competencies necessary for quality caregiving across settings. Thus, to the extent possible, the Network will work to ensure that workers can more easily move between or combine work in different settings. This will enable caregivers to build on a common body of knowledge with specific tools for each particular setting or client base. And for home- and community-based workers, the new CHCA designation will provide a credential that is valued across settings and, potentially in the future, also in other states.

Many states are moving in the direction of establishing certifications that are applicable across a variety of settings. For example, Pennsylvania is exploring this approach; New Hampshire has established a Licensed Nursing Assistant credential for workers in home care, assisted living facilities, and nursing homes; and the District of Columbia recently passed legislation to establish a cross-sector certification for direct-care workers.

Policymakers are attracted to cross-sector training and apprenticeship as strategies that address workforce shortages by improving the portability of worker credentials and opening up career pathways. Three long-term care occupations, home health aide, direct support professional and Certified Nursing Assistant, have been approved recently by the U.S. Department of Labor as “apprenticeable” occupations.

F. Capacity

In the year leading up to Phase I, the Network will develop the capacity necessary to deliver the training and apprenticeship programs described in this section in all regions across the state. As described later in this report, this will be accomplished through a combination of in-house faculty and contracts with existing high-quality training providers and training venues.

For the following reasons, the Network will be in a stronger position than existing training providers to ensure equal access to quality training across the state:

- Offering the advanced / specialty training courses for credit either towards apprenticeship or as continuing education will increase demand for these courses and create greater economies of scale at the local level.
- The Network will offer the same menu of continuing education / advanced training in every part of the state (rather than each region re-inventing the wheel and developing their own course selections).

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- The Network will have greater capacity to pool resources and use the same resources (instructors, mobile classrooms, e-learning technologies) to serve members in different regions.

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These services will be specifically designed to meet the diverse personal and educational needs of the long-term care workforce and provide workers with the skills necessary to advance their careers.

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PHASE II: ADULT EDUCATION AND CAREGIVER SUPPORT

In Phase II, the Network will offer a range voluntary services that will support long-term care workers in achieving their personal and professional goals. These services will include a menu of adult education courses and a “Caring for the Caregiver” workshop series. These services will be specifically designed to meet the diverse personal and educational needs of the long-term care workforce and provide workers with the skills necessary to advance their careers.

A. Adult Education

The Adult Education menu of classes will include classes in areas such as:

- Pre-GED and Skills Enhancement
- GED
- English as a Second Language (ESL)
- Contextualized English as a Second Language
- Basic Computer Instruction
- College Preparation
- Preparation for Training to become a Licensed Practical Nurse (LPN)
- Citizenship

The Network will offer this training at the Tacoma/Federal Way and Spokane satellite offices and other locations (such as community colleges/mobile classrooms) to be determined according to geographic distribution of the long-term care workforce. The Network will develop a faculty of quality instructors with expertise in adult education and health care and partner with local community colleges for the delivery of instruction. All training providers will employ an interactive approach to learning—combining didactic instruction and experiential learning.

PRE-GED AND SKILLS ENHANCEMENT

These classes will provide basic education and foundation skills for workers who may have been away from school for a long period of time and need to improve their writing, reading, and math skills before enrolling in GED preparation. Materials used will reflect language and experiences oc-

curing in the workplace and topic areas covered on the GED. Individuals testing at a seventh-grade reading level will require two semesters of instruction before being ready to take the GED examination. (Each semester is approximately 14 weeks long, Fall and Spring, with 2 sessions per week for 3 hours per session for a total of 84 hours each semester.)

GED

The Network will provide classroom instruction for students wishing to earn a high school diploma. Competency areas covered will include: reading, writing, math, science, and social studies. The Network will also offer a flexible GED program to accommodate workers with limited time to attend classes. These students will be able to participate in a self-study program, but will be placed in “virtual study groups” with other participants and receive ongoing support/guidance from Network counseling staff. Test-taking, time management, and study skills will be offered to students in both programs. The length of the instruction will vary according to reading and writing capability.

ENGLISH AS A SECOND LANGUAGE (ESL)

These classes will assist adult, non-native English speakers with the skills necessary to improve their English comprehension, speaking, reading, and writing skills. Instruction will be offered in both introductory and intermediate levels. (Please note that an advanced level of instruction can be offered if there is a documented need.)

ESL Level 1: This introductory class will be offered to workers with little or no English skills. Students will concentrate on basic listening, speaking, reading, and writing activities in order to acquire basic skills.

ESL Level 2: This class will be geared to students who have mastered a basic understanding of English. An integrated approach to instruction that uses both life situations and experiences in the workplace to further develop oral and written skills will be emphasized. Students will improve their understanding of the structure of the English language and ability to read and write.

ESL Level 3: At this level, students with an intermediate command of the English language will study the structure of English through various reading and writing assignments. They will improve their speaking and listening skills through class discussions and oral presentations. Teaching materials will reflect the language used in a home care setting.

CONTEXTUALIZED ESL

The Network will offer “Workplace ESL” to introduce the type of terminology used in a long-term care settings. Materials for the Orientation, and Safety, Core Competencies, and Advanced / Specialty trainings will be integrated into these classes.

BASIC COMPUTER INSTRUCTION

The following modules will be offered for the student interested in achieving basic computer literacy: Keyboarding/Basic Typing, Using a Mouse, Microsoft Word, and Navigating the Internet. Each module will range from 15 to 30 hours of instruction. These courses are essential to prepare participants for continued learning at college, at home via distance learning, and at the workplace.

COLLEGE PREPARATION /BRIDGE TO COLLEGE

Workers interested in pursuing either a two-year or four-year college degree will be able to take

courses designed to enhance their skills and prepare them to succeed in a college environment. Classes will be offered in topics such as time management, study skills, listening skills, problem-solving skills, and oral and written communication skills.

A course will also be offered in academic English where students will learn how to write a research paper and collect data using the Internet. Additional coursework concentrating on academic listening and speaking will be offered to prospective students. This course will enable advanced learners to develop public speaking skills, construct persuasive oral arguments, and develop a portfolio of completed assignments. These will be semester courses, consisting of 14-week sessions offered in the fall and spring. Most students are expected to spend two semesters in the “Bridge to College” program.

PREPARATION FOR TRAINING TO BECOME A LICENSED PRACTICAL NURSE

This training will provide students with the skills and knowledge required to take licensed practical nurse (LPN) entrance exams. Classes emphasize skills such as: critical thinking, test-taking, understanding details, basic science, basic calculations, reading tables and graphs, pre-pharmacology, and more. Students interested in enrolling in this training will be required to have a high school diploma or GED. The Pre-LPN program will be 9 to 12 months in length and require a commitment of 6 to 9 hours per week.

CITIZENSHIP

The Network will provide classes and legal assistance to students who are eligible and interested in obtaining U.S. citizenship. Modules concentrating on U.S. history, government, civics, requirements for citizenship, and oath of allegiance to the United States will be available.

Citizenship classes may be offered in two different formats, designed for English speakers and non-English speakers. The length of the class will vary depending on the level of English comprehension. For students emigrating from English-speaking countries, the course will range from a total of 3 to 9 hours (one to three, 3-hour sessions). For students in need of English language skills, the following modules will be offered: conversational English, basic reading and writing (using contextualized materials), and test-taking skills. Limited English proficient students may require two semesters of instruction (approximately 168 hours). Students will be given practice questions and dictations, which are part of the interviews for citizenship.

B. Caring for the Caregiver Workshops

Across the spectrum of long-term care, workers experience high levels of stress and burnout that can threaten their well-being, undermine their ability to provide quality care, and contribute to their decision to leave caregiving work. In Phase II, the Network will launch a series of “Caring for the Caregiver” workshops to provide peer support and guidance for caregivers and prepare them to handle challenges in their personal and professional lives.

POOR SUPERVISION AND LACK OF SUPPORT

Caregivers are attracted to the work because they are interested in helping others. Yet once on the job, many find that they are undervalued and overwhelmed. Many caregivers report that they do

not feel respected, listened to, or supported.⁴¹ Studies suggest that the poor relationships with supervisors, clients, and family members lead to burnout and the decision to look for work elsewhere.⁴² In a recent California focus group, CNAs reported that “charge nurses did not know them, failed to call them by name in some cases and often did not respect them or acknowledge their work.”⁴³

Home care workers feel stress because they are isolated in their work lives, with no one to turn to if they feel overwhelmed by their clients’ needs or frustrated by their clients’ behaviors. This is particularly true in consumer-directed home care, where the integration of consumer and employer roles creates a level of complexity that some self-directing clients are not prepared to deal with effectively. For example, consumers may be reticent to raise issues until they reach a boiling point, because they are so in need of the help provided by their assistants; other clients can be highly controlling, overly scrutinizing, and demanding.

STRESS AT HOME

For many caregivers, stress in the workplace is compounded by stress at home. As low-wage workers, many have few resources to fall back on when the complexities of life—a broken down car, a sick child, or an over-due bill—conflict with their caregiving responsibilities. And as a population of primarily middle-aged women, many are struggling with health issues themselves, such as diabetes, heart disease, and back injuries.

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The Network will design workshops to bring isolated workers a sense of community and belonging while also helping them to reach personal and professional goals.

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WORKSHOP STRUCTURE AND TOPICS

Therefore, the “Caring for the Caregiver” workshop series will provide opportunities to discuss topics such as:

- Caregivers’ health and well-being
- Building support networks
- Setting limits / professional boundaries
- Racism and sexism on the job
- Understanding and respecting cultural differences
- Balancing the multiple roles of the family caregiver
- Being a self-advocate
- Family-work balance

⁴¹ Ingrid McDonald, “Respectful Relationships: The Heart of Better Jobs Better Care,” Better Jobs Better Care Issue Brief (Institute for the Future of Aging Services, forthcoming).

⁴² For example see At a Glance, Report of the Certified Nurse Assistant Recruitment and Retention Project. (Iowa Caregivers Association, September 1999).

⁴³ “Addressing Shortages in the Direct Care Workforce: The Recruitment and Retention Practices of California’s Not-for-Profit Nursing Homes, Continuing Care Retirement Communities and Assisted Living Facilities” (Institute for the Future of Aging Services, June 2003), pg. 22.

The Network will design workshops to bring isolated workers a sense of community and belonging while also helping them to reach personal and professional goals. The workshops will be voluntary and those who attend will not receive continuing education credit. The workshops will be facilitated by professional counselors and seasoned caregivers, including IP peer mentors and others who complete a facilitator training developed by the Network. Facilitators will focus on providing participants with a safe place where they can raise issues and engage in open discussion outside of their everyday work environment.

Workshops will be available on a flexible, drop-in basis at regular intervals in all regions of the state. These workshops will be short, between one and two hours each. When appropriate, facilitators will invite participants to stay in touch with each other and continue meeting if they wish as an ongoing support group.

BOX 14 Racism on the Job

Caregivers across the spectrum report that they are experiencing racism on the job, a demoralizing experience that damages relationships and disrupts their ability to provide quality care. For example, in interviews with 648 direct care workers who work in nursing homes, assisted living facilities, and home care agencies in Ohio, the Margaret Blenker Research Institute, Benjamin Rose, found that:

- 70 percent of direct-care workers (DCWs) had heard residents/clients make racial or ethnic remarks.
- Of DCWs surveyed, about a third had never heard racial or ethnic remarks directed at DCWs but nearly a third had heard these remarks directed at DCWs either daily or several times a week.
- DCWs in nursing homes heard significantly more remarks directed at them than DCWs in assisted living facilities and home care agencies.
- 15 percent of DCWs had heard family members make racial or ethnic remarks.
- 21 percent of DCWs had heard other staff members make racial or ethnic remarks.

Source: Ejaz, Farida K. and Linda S. Noelker. "Better Education = Better Jobs: The Impact of Job Preparation, Ongoing Education and Training on Job Satisfaction and Commitment Among Front-Line Workers and Their Supervisors. BJBC Research and Evaluation Program Final Narrative Report (The Margaret Blenker Research Institute, Benjamin Rose, April 2006).

PHASE III: CAREER PATHWAYS

In Phase III, the Network will offer career counseling and tuition assistance support to workers interested in pursuing new career paths in health and long-term care.

A. Career Counseling Services

During Year 2, the Network will create the position of Intake/Program Specialist, whose job responsibilities will include the provision of individual and group counseling to workers interested in pursuing new career paths in health and long-term care. The program specialist will offer advice about different occupational areas, such as nursing, mental health, social work, and case management. In addition, the program specialist will provide information about educational requirements necessary to pursue different career paths, including requirements for admission to degree programs, locations for pursuing particular degrees, and coursework required for graduation.

The purpose of the counseling services will be to ensure that participants make good decisions about what career paths to pursue based on their interests and strengths. Effective counseling services will:

- Support high levels of retention in education programs.
- Guide members to careers in health and long-term care occupations.
- Ensure that tuition assistance funds are not wasted.

Career counseling will help participants select the educational program most appropriate for their needs and goals.

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The purpose of the counseling services will be to ensure that participants make good decisions about what career paths to pursue based on their interests and strengths.

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B. Tuition Assistance

Tuition assistance is an essential element of building a system of continuing education and career ladders. Many current and future long-term care workers have the life experience, knowledge, and skills to succeed as students in certificate and college-level programs; however, low-wage workers simply do not have the financial ability (even at the community college level) to pay all of the costs of tuition and related educational expenses such as books and fees. Many are forced into loan arrangements, which place an increased financial burden on their families.

In traditional tuition reimbursement programs, individual employees must pay upfront for the costs of tuition and then wait for reimbursement. To overcome this obstacle, the Network will negotiate agreements with various technical schools and colleges and universities to create a voucher system. Under this system the Network will pay the schools directly for tuition and related costs. This will expand opportunity and access.

The governing body of the Network will determine tuition eligibility requirements and the level of tuition assistance benefits.

PART 4: A FRAMEWORK FOR BUILDING THE NETWORK

This section proposes a joint labor-management legal structure for the Network and describes how the Network, as a Taft-Hartley Fund, will be governed and funded. This section then provides a picture of the organizational architecture of the Network and a sample budget of its first three years.

A. TAFT-HARTLEY LEGAL STRUCTURE

The Network will be organized as a joint labor-management educational program, which is generally referred to as a Taft-Hartley Fund. This name is derived from the Taft-Hartley Act, which was passed by the U.S. Congress in 1947 and became known as the Labor-Management Relations Act. The Network, as a joint labor-management educational program (“Joint Program”), will be established as a nonprofit educational and training organization under IRS.⁴⁴ The purpose of the Network will be to provide educational benefits (i.e., tuition assistance, scholarships), education and training programs, and related services to eligible participants (members of the applicable collective bargaining units).

The joint program model was originally developed in a variety of building trades in the form of apprenticeship training programs. During the 1980s, the nature of American industry and work were undergoing fundamental change. The need for increasing the training and education of incumbent and dislocated workers was addressed by a number of unions and employers who created joint labor-management educational programs through their collective bargaining agreements or other cooperative arrangements.

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In Washington, Governor Gregoire has made access to apprenticeship programs a central component of both education and workforce development initiatives.

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During the past three decades, joint labor-management programs have become significant providers of both education and training in a variety of industries, among them auto; aerospace; building service and maintenance; construction; health care; hospitality; maritime; municipal, state, and federal public service; transportation; steel; telecommunications; and other industries. These programs now serve an eligible workforce of nearly two million union-represented workers. Currently, a number of new joint labor-management education initiatives are emerging, particularly in the health care field in both public and private sectors.

In Washington, Governor Gregoire has made access to apprenticeship programs a central component of both education and workforce development initiatives. The Washington State Apprenticeship

⁴⁴ Taft-Hartley Funds are registered with the IRS as 501C(9); it is also common practice to establish a separate 501C(3) organization for the purpose of grant fundraising.

and Training Council (WSATC) oversees 246 sponsored apprenticeship programs and of those, 180 are jointly sponsored labor-management Taft-Hartley Funds. These jointly sponsored programs are either "group-joint" or "individual-group" programs representing either multiple or individual employers respectively. Programs range from traditional trade union apprenticeships in carpentry and plumbing to nontraditional trade union careers in culinary arts. These programs are popular because they bring business and labor together and supply a skilled and motivated workforce where qualified workers may be scarce, such as in construction and health care.

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Hundreds of thousands of workers have participated in joint labor-management programs, engaging in a range of educational and training activities that have resulted in valuable outcomes for workers, their employers, and the public.

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Nationally, hundreds of thousands of workers have participated in these programs, engaging in a range of educational and training activities that have resulted in valuable outcomes for workers, their employers, and the public. As educational institutions in their own right, joint labor-management educational programs and other institutions of workers' learning share with other more traditional educational entities the characteristic of supporting the creation and transmission of knowledge and skills.

The result has been the emergence of a "joint" training and education philosophy that recognizes the value of cooperatively addressing the developmental needs of employers, unions, and individual workers. This philosophy has spawned the dramatic growth of labor-management partnerships that jointly fund, plan, implement, and oversee workplace training and education initiatives. Specifically, new partnerships are constantly being formed, while existing initiatives continue to evolve, reflecting changes in the business, technological and budgetary environments.

The Conference Board of Canada conducted an in-depth research project on joint labor-management training funds and concluded that the following design elements make such programs successful:

Proactive Communication between Labor and Management

- Continuous process of balanced consultation between labor and management
- Program marketing and promotion

Needs Analysis, Program Evaluation, and Redesign

- Conducting learning needs analysis
- Evaluating program effectiveness

Extended Time Horizons

- Career and education planning services that help people create and follow their own

- career path
- Continuing educational opportunities
- Tuition assistance

Personal Responsibility and Choice

- Full participation of workers
- Employee involvement in the design and implementation of training

Sound Learning and Educational Strategies

- Multiple learning strategies
- Specific criteria for selecting and evaluating training providers

Dual Training Focus: Meeting Worker and Workplace Needs

- Dual training focus, on both the individual and the workplace or organization

The Network, as described in this blue print, reflects these design elements in its operations, management, and governance. (For more a more detailed summary of the Conference Board of Canada study see Appendix G.)

B. GOVERNANCE

Like other joint programs, a board of trustees will govern the Network and will be composed of an equal number of union and management representatives (representing contributing employers). The trustees in their governance will be guided by a Declaration of Trust (Trust Agreement). The Declaration of Trust sets forth who may sit on the board of trustees and under what terms. Federal law, under the Employment Retirement Income Security Act (ERISA), sets forth the responsibilities, duties, and obligations of trustees. The board of trustees will have the authority to waive training requirements for members with special circumstances, such as for members who already have health care degrees in related fields.⁴⁵

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A board of trustees will govern the Network and will be composed of an equal number of union and management representatives (representing contributing employers).

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C. FUNDING

The funding for the Network’s various programs will be provided by employer contributions and set aside in a trust fund intended for the benefit of eligible participants. The amount of employer contributions will be determined by collective bargaining agreements and set by the trustees to support the operations of the Network. The trustees of the Network determine the level of benefits and number of programs to be offered and the eligibility requirements for participants.

⁴⁵ Any new training requirements established by the state should also include flexibility for workers with degrees in related health care fields.

Modeling other joint programs, the Network will seek to supplement its income from employer contributions with municipal, county, state, federal, and private foundation grants. Such grants will enable the organization to expand and enhance its programs and services. Joint programs in both the public and private health care sectors have experienced particular success in leveraging public dollars through state and federal grants, reflecting the strong public interest in the quality health care and the quality of health care jobs.

D. ORGANIZATIONAL ARCHITECTURE

Appendix H, Organizational Architecture, illustrates a recommended organizational structure and staffing configuration to launch and sustain the Network. The chart depicts the key positions and partnerships that will be needed to carry out the administrative activities and programmatic initiatives of the Network and dramatically improve the quality and scope of training for Washington's long-term care workforce.

The board of trustees will provide leadership and guide the overall development of the Network. They will hire an executive director who will be responsible for the overall management of the Network, strategic planning, and fundraising. The executive director will lead a senior management team consisting of the following positions:

- **Education Director**
Key Responsibilities: program development, implementation, and management
- **Member Services Director**
Key Responsibilities: marketing, communications, and management
- **Information Technology Director**
Key Responsibilities: database systems, website management, call center
- **Finance Director**
Key Responsibilities: infrastructure development and financial systems

Under the direction of the senior management team, program managers will oversee the day-to-day delivery of each of the key products and services offered by the Network, including the classroom training and peer mentoring components of the apprenticeship program and the voluntary career development and support services launched in Phases II and III. These programs will be delivered through a combination of in-house faculty who will team teach with SEIU 775 members employed as associate instructors; contracts with other individual instructors and training vendors; and partnerships with community colleges.

Area coordinators will assist members to choose their coursework and enroll in training courses and will monitor their movement through the apprenticeship program. They will participate in the in-person orientation sessions and be responsible for matching new workers with their mentors. Their work will be one component of a sophisticated member communications process that will ensure that workers understand the requirements they must fulfill and fully utilize the services and programs available to them through the Network.

E. BUDGET

To illustrate the global costs associated with establishing the Network and providing high-quality training and career development services, this blue print offers a sample budget in Appendix I. It portrays the annual income, expenses and fund balance for the Network, for services provided during Phase I, Phase II and Phase III respectively.

While in practice, full implementation of each of these program phases may take longer than one year, for simplicity this budget illustrates three sample years. This budget is based on informed estimates of many variables including the total number of new SEIU 775 members in the future and the percent of all members who will elect to participate in voluntary services. These variables may be quite different in actual implementation. Thus, this budget is offered as a sample only rather than a precise prediction.

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While efficiencies will be gained by offering a cohesive statewide program, training costs will be significantly greater because the Network will offer training with a far greater scope and duration than what is presently available to ensure quality care.

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As illustrated in Appendix I, the products and services described in this blue print will cost approximately \$9,197,000 in Phase I, \$14,855,000 in Phase II, and \$15,556,000 in Phase III, with variability depending on actual participation. While efficiencies will be gained by offering a cohesive statewide program, training costs will be significantly greater than current training expenditures because the Network will offer training with a far greater scope and duration than what is presently available to ensure quality care.

INCOME

The primary source of income to the Network will be in the form of employer contributions. Participation in the Network and the contribution rate per member will be determined by collective bargaining agreements between SEIU 775 and respective employers.

The sample budget assumes an employer contribution rate of \$.35 per hour worked by each member of the bargaining unit. Based on this rate, the budget estimates that by Phase III, the state will contribute approximately \$11,280,000 each year on behalf of the individual provider home care worker bargaining unit. In addition, the sample budget estimates that home care agency employers with collective bargaining agreements with SEIU 775 will contribute approximately \$4,665,000 by that time. While in the future, SEIU 775 may also reach agreements with nursing home employers to participate in the Network, this sample budget does not assume any income stream from nursing home employers during the first three years of operation.

Collectively bargained contributions will fund the core program offerings, including entry-level

training, the peer mentor program, and advanced and specialty training coursework leading for apprenticeship, continuing education and administration of the Network. As the Network develops it will seek additional private and public funding streams to support elective programs such as career development services and caregiver support workshops. Some programs areas are more likely than others to be strong candidates for external funding. For example, adult education, citizenship, pre-LPN, and bridge-to-college programs may be eligible for funding through the Washington State Department of Education, federal funds, and foundation sources. The sample budget assumes \$500,000 in grants beginning in Phase III, an income stream that would be expected to grow over time.

While not reflected in the sample budget, funding for a start-up phase of a minimum of six months will be essential. During this time, the Network would hire staff, develop programs, contract with vendors and prepare to begin offering the services that begin in Phase I. A funded start-up phase will allow the Network to accumulate resources and construct its administrative and programmatic infrastructure. Therefore, the collective bargaining creating the Network must include a provision for an upfront infusion of cash. This is needed to ensure adequate cash flow and resources to launch the programs in a reasonable time frame.

ADMINISTRATIVE EXPENSES

The sample budget estimates administrative expenses of \$1,460,000 by Phase III. These expenses include the senior management team; support, accounting and information technology staff; computer and related equipment expenses; rent and related expenses to equip the headquarters office; and other administrative expenses such as professional, legal and accounting services, travel expenses for senior staff. The sample budget estimates a base salary of \$90,000 for the executive director and \$72,500 each in addition to fringe benefits for the other members of the senior management team.

PROGRAMMATIC EXPENSES

The sample budget estimates total program expenses of \$14,096,000 by Phase III. Program expenses include management and instructional costs for each program, travel for program staff, infrastructure costs including mobile classrooms and classroom rental, evaluation and impact studies, and meetings and conferences.

The budget assumes a flat salary structure for program staff which includes \$60,000 for program managers, \$50,000 for in-house faculty, \$42,500 for area coordinators, \$50 per hour for hourly instructors and career counselors, and \$20 per hour for associate instructors. The budget does not account for the variation in actual instructional costs that would occur when the Network contracts out for training services with other parties. Instructional costs for each program include instructor salaries, curriculum development, materials, program evaluation, staff development, translation and interpreter services.

ORIENTATION & SAFETY TRAINING

The sample budget assumes that the total projected number of new entrants in to the IP workforce and all new direct-care employees of participating home care agencies will participate in the orientation and safety training offered by the Network, with total participation at approximately 17,180 workers per year by Phase III. Assuming that 859 two-hour orientation sessions will be necessary to accommodate these workers, the budget estimates the total cost of orientation to be \$154,000 by Phase III. Assuming 859 safety training sessions, the budget estimates the total cost of safety training to be \$321,000 by Phase III.

LONG-TERM CARE CORE COMPETENCIES COURSE

The sample budget assumes that the total projected number of new entrants into the IP workforce and all new direct-care employees of participating home care agencies—a total of 17,180 workers by Phase III—will complete the 80-hour Long Term Care Core Competencies course within their first six months employment. To meet this demand, the budget assumes a total offering of 859 courses at a total cost of \$3,587,000 by Phase III.

ADVANCED AND SPECIALTY TRAINING FOR APPRENTICESHIP

The budget predicts that participation in the voluntary apprenticeship program will grow over time, with approximately 10 percent participation in Phase I, 15 percent in Phase II and 20 percent in Phase III. Based on these participation rates, the budget assumes that by Phase III, 3,440 participants will take a total of 172 classes offered through the advanced and specialty course menu for a total cost of \$557,000.

MENTOR PROGRAM

The sample budget estimates the cost of the mentor program based on several assumptions, including:

- Mentors provide mentees an average of 12 hours of on-the-job training and support over the course of 3 to 6 months.
- The total number of mentees, including IP and home care agency workers will be 7,581 in Phase I, and 16,321 by Phase III
- A mentor: mentee ratio of 1:10.
- A total of 1,632 mentors by Phase III
- A mentor salary rate of \$9.50 an hour plus the added \$1.00 an hour for providing mentor services and 40 percent fringe for a total of \$14.70 an hour in Phase I.
- Additional costs for mileage, internet, and phone services.

Based on these assumptions and the additional cost of mentor program managers, the three-year cost of the mentor program is \$3,900,000 by Phase III.

ADULT EDUCATION

The Network will conduct a needs analysis to determine interest in the proposed course offerings. After reviewing the results of that study, a select number of adult education courses (GED, Bridge to College, etc.) will be piloted during Phase II. These courses will be taught by a team of qualified instructors hired directly by the Network, as well as in partnership with local community colleges and/or organizations that have demonstrated expertise. The cost of these programs will vary according to the length of the instruction and how the instruction is being delivered (internal vs. external vendors). In Phase II the anticipated cost will be \$179,000 and in Phase III after the expansion of services, it is projected that the costs will be \$715,000.

“CARING FOR THE CAREGIVER” WORKSHOP SERIES

The Network will hire and train their own group of qualified facilitators to deliver the Caring for the Caregiver workshops. This will begin as a pilot in Phase II, with a goal of 40 workshops and 500 participants. The estimated cost of launching this program in Phase II is \$15,000. By Phase III, the program will expand to reach 1000 participants, at a total cost of \$25,000.

CAREER COUNSELING

This service, beginning in Phase III, will include both individual and group counseling sessions. It will be launched as a pilot in targeted areas of the state. Assuming approximately 5 percent participation in the first year, the sample budget accounts for 500 individual counseling sessions and 70 group sessions (serving 700 participants). The budget assumes a total cost of \$57,000 to launch this program in Phase III.

TUITION ASSISTANCE

The budget estimates a tuition assistance program starting in Phase III. The cost of \$364,000 is estimated to support 260 individuals at an average of \$1,400 each.

CONTINUING EDUCATION

The sample budget assumes that the Network will become the sole provider of continuing education for its members by Phase III, with 80 percent participation beginning in Phase I, 90 percent participation beginning in Phase II and 100 percent participation by Phase III. The costs associated with the services are calculated at 12 hours of instruction per member per year, to a total cost of \$587,000 by Phase III.

CONFERENCES

The budget allocates funding for three statewide learning conferences to promote the program and assemble participants and stakeholders to build support and momentum for program sustainability. In addition, this will cover costs of staff expense to attend professional conferences. These costs are \$100,000 for each phase.

EVALUATION AND IMPACT STUDY

A multi-year evaluation study, beginning in Phase I, will cost \$75,000.

PART 5: CONCLUSION — ACTION STEPS

A. SUMMARY

Washington is at a critical juncture in the development of its long-term care system. Policymakers have succeeded in re-designing the system in order to control growth in the nursing home sector and to allow consumers greater opportunities to remain at home or in their own communities. But without further reform and an intentional strategy for how to develop an adequate supply of workers to meet rising demand, the state will soon face unprecedented challenges.

Without reform, home- and community-based workers will continue to receive less than half as much training as nursing home workers, even though they are caring for a very similar client base. With limited training and essentially no on-the-job support, they will continue to feel unprepared to care for clients living with a broad range of increasingly complex and challenging conditions. And finally, workers in home- and community-based care will continue to have a separate, yet partly redundant, set of training requirements—making it unnecessarily difficult to combine caregiving work in different care settings or to pursue new career paths.

This blue print outlines SEIU 775’s vision of addressing these issues through the establishment of a new labor-management organization called the “The SEIU 775 Long-Term Care Training, Support and Career Development Network.” It calls for the establishment of a cross-sector certification process and outlines a series of products and services that the Network will offer over time, including an apprenticeship program beginning in Phase I; followed by adult education services and a “Caring for the Caregiver” workshop series in Phase II; and finally, the addition of professional development services and tuition assistance in Phase III.

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The Network will raise caregivers’ expectations of who they are and what they are capable of; improve the quality of care; and better position Washington to meet the long-term care needs of the future.

.....

When established, the Network will raise caregivers’ expectations of who they are and what they are capable of. With better training and support, they will have the tools they need to ensure quality care. And with more portable credentials, workers will have the mobility to pursue career paths within and beyond long-term care. This workforce development approach to caregiver training will improve Washington’s ability to recruit and retain the workforce necessary to meet the long-term care needs of the future.

B. ACTION STEPS

To establish the Network and prepare to launch the products and services scheduled to begin in Phase I, PHI and 1199 TUF recommend that SEIU 775 and its partners:

- **Engage in a consensus building process.**

Further refine the concepts sketched out in this Blue Print through continued discussions with a broad range of stakeholder groups, including workers, consumers, employers, current training providers, and state officials.

- **Conduct a training needs assessment.**

Discern the training needs of SEIU 775 members through an assessment that includes an analysis of the caregiving needs of the clients served; a comparison of current training curricula with curricula used by other states and providers who serve a similar client base; and surveys and focus groups with workers and consumers.

- **Achieve necessary state policy changes.**

Encourage the state to establish a Certified Home Care Aide designation with enhanced training requirements and a testing process equivalent to those required of a Certified Nursing Assistant.

- **Establish the Network.**

Found the Network through the establishment of a Taft-Hartley labor management fund, with trustees designated by SEIU 775 and participating employers. In addition, support the new board of trustees so that they can quickly begin the work of approving a budget, establishing employer contribution levels, and hiring an executive director.

- **Draft a business plan.**

Based on this blue print, develop a business plan that includes detailed descriptions of each product and service offered by the Network, in addition to administrative support structures, infrastructure needs, information systems, an organizational chart, job descriptions, and specific goals and objectives for each phase.

- **Create a curriculum development process.**

Engage the expertise of frontline workers, consumers, long-term care practitioners, and adult education specialists in order to develop high-quality, adult learner-centered training products that meet all relevant state and federal training and certification guidelines.

- **Build a statewide infrastructure of high-quality training providers.**

Implement an instructor recruitment program to build the Network's in-house faculty (including the recruitment of instructors who are themselves seasoned caregivers) and to implement a statewide train-the-trainer program. On a parallel track, evaluate and then contract with existing high-quality providers in selected areas of the state.

PHI and 1199 TUF hope that the vision outlined in this blue print will assist stakeholders in Washington in developing an adult learner-centered, workforce development approach to caregiver training. It is our belief that SEIU 775, as representatives of a large percentage of the state's long-term care workforce, is well positioned to lead in this area. The union has already played a dramatic role in raising wage and benefit standards and in professionalizing home care work in order to make it a more attractive long-term career choice. The Network will provide a new platform from which the union, participating employers and consumers can work in partnership to improve the quality of care and develop an adequate supply of caregivers for the next generation of long-term care consumers.





APPENDIX A: STAKEHOLDERS INTERVIEWED FOR THIS REPORT

1. Speaker Frank Chopp, Washington State House of Representatives
2. Rich Feldman and Joan Weiss, Worker Center, King County Labor Council
3. Katrinka Gentile, Advocate for People with Disabilities
4. Randy Hartman, Addus Healthcare, Inc.
5. Chris Hedrick, Intrepid Learning Solutions
6. Tony Lee, Fremont Public Association
7. Kathy Leitch, Dan Murphy, Marta Acedo and Liz Prince, Department of Social and Health Services, Aging and Disability Administration.
8. Dennis Mahar, Thurston County Area Agency on Aging
9. Andy Martini, Evergreen Nursing Home
10. Rich Nafziger, Washington State House of Representatives
11. Peter Nazzal, Catholic Community Services
12. Sally Nixon, Pierce County Area Agency on Aging
13. Donna Patrick, Washington State Developmental Disabilities Council
14. Pam Piering, City of Seattle Human Services Department, Aging and Disability Services
15. Charlie Reed, Home Care Quality Authority
16. Mark Rupp, Office of Governor Gregoire
17. Roy Walker, Olympic Area Agency on Aging

APPENDIX B: HOME- AND COMMUNITY-BASED TRAINING DATA BY REGION, FY 2006

Regional AAA	Training Vendor	Vendor Type	# Workers Trained Safety	# Workers Trained RFOC	# Workers Trained CE
Olympic Area Agency on Aging	Olympic Community Action Program	HC Agency*	156	265	775
Northwest Regional Council	Bellingham Technical College	Community College	100	214	162
Snohomish County Long-Term Care and Aging Division	1. Catholic Community Services	HC Agency	32	49	1
	2. Sunrise Home Care Services	HC Agency*	75	189	646
	3. Everett Community College	Community College	0	0	209
Aging and Disability Services (King County)	Professional Registry of Nursing, Inc.	For-Profit	596	738	1748
Pierce County Aging and Long-term Care	Professional Registry of Nursing, Inc.	For-Profit	340	435	1113
Lewis/Mason/Thurston AAA	Professional Registry of Nursing, Inc.	For-Profit	18	25	66
Southwest Washington Area Agency on Aging	Professional Registry of Nursing, Inc.	For-Profit	34	100	547
	2. Clark College	Community College	101	304	116
	3. Elder Options	n/a	8	19	104
	4. Lower Columbia College	Community College	56	108	508
	5. Columbia Gorge Community College	Community College	15	14	64
Aging & Adult Care of Central Washington	Professional Registry of Nursing, Inc	For-Profit	58	193	403
Washington	Nursing, Inc	HC Agency*	15	14	775
Southeast WA Aging and Long-term Care	Southeast WA Aging and Long-term Care	AAA	182	322	1334
Yakama Nation AAA	Yakama Nation AAA	AAA	60	516	248
Aging & Long-Term Care of Eastern WA	Aging & Long-Term Care of Eastern WA	AAA	773	1115	5630
Colville Confederated** Tribe, AAA	n/a	n/a	n/a	n/a	n/a
TOTALS			2,717	4,791	14,276

*Other AAAs are serving this area for training purposes.

**This is a consortium of home care agencies.

Source: This chart is based on information provided to SEIU by DSHS.

Note: Number of workers includes IP and agency workers only and not DD Parent Providers, except in the following counties in which only IPs are included: King, Pierce, Southwest Washington AAA.

APPENDIX C: CORE SKILL COMPETENCIES FOR ENTRY-LEVEL DIRECT-CARE WORKERS

Analysis by the Paraprofessional Healthcare Institute

DEFINITION OF WORK SETTINGS

A: In-Home Services (Aide/Personal and Home Care Aide/Attendant, including those subject to federal requirements).

B: Nursing Facility Services (Nursing Assistant subject to federal requirements)

C: Adult Day Services (Personal Care Aide)

D: MR/DD Agency (Direct Support Professional)

E: Assisted Living (Personal Care Aide)

1	ROLE OF THE DIRECT-CARE WORKER	A	B	C	D	E
1.1	Explain the role of the direct-care worker in relation to the consumer receiving services	X	X	X	X	X
1.2	Explain the importance of the relationship between the consumer and the direct-care worker for quality of care	X	X	X	X	X
1.3	Explain the role of the direct-care worker in supporting community inclusion and engagement	X			X	X
1.4	Define the role of the direct-care worker in relation to other members of the service team in various long-term care settings	X	X	X	X	X
1.5	Define the differences between the role of workers in various long-term care settings	X	X	X	X	X
1.6	Demonstrate professionalism and responsibility, including in timeliness and appearance	X	X	X	X	X
1.7	Observe employer policy regarding emergency absence from work	X	X	X	X	X
1.8	Explain the purpose of the service or care plan	X	X	X	X	X
1.9	Recognize the direct-care worker's legal responsibility to identify, present and report abuse, exploitation and neglect.	X	X	X	X	X

2	CONSUMER RIGHTS, ETHICS AND CONFIDENTIALITY	A	B	C	D	E
2.1	Listen to and observe the preferences of the consumer	X	X	X	X	X
2.2	Respect the right of the consumer for privacy, respect and dignity	X	X	X	X	X
2.3	Demonstrate ways of promoting the consumer's independence	X	X	X	X	X
2.4	Explain the philosophies of consumer-direction, independent living, and community inclusion	X			X	
2.5	Facilitate the consumer's desire to express his or her personal faith and observe religious practice as requested	X	X	X	X	X
2.6	Respect the confidentiality of consumer information and adhere to Health Insurance Portability and Accountability Act of 1996 (HIPAA) and employer confidentiality guidelines	X	X	X	X	X
2.7	Identify types, examples and indicators of abuse, including physical abuse, psychological abuse, exploitation, neglect and improper use of physical and chemical restraints	X	X	X	X	X
2.8	Identify methods to prevent abuse, exploitation, neglect and the improper use of physical or chemical restraints while providing care.	X	X	X	X	X
2.9	Define procedures under state law for reporting abuse, exploitation, neglect and improper use of physical and chemical restraints to appropriate supervisory, law enforcement or government authorities	X	X	X	X	X
2.10	Explain the role of the direct-care worker in relation to the consumer receiving services	X	X	X	X	X
2.11	Describe the rights of consumers as addressed in the Americans with Disabilities Act (ADA)	X	X	X	X	X

3	COMMUNICATION, PROBLEM-SOLVING AND RELATIONSHIP SKILLS	A	B	C	D	E
3.1	Explain the term “communication” including the difference between verbal and non-verbal communication	X	X	X	X	X
3.2	Demonstrate effective communication, including listening, paraphrasing, and asking open-ended questions	X	X	X	X	X
3.3	Demonstrate ability to resolve conflict	X			X	X
3.4	Demonstrate respect and cultural sensitivity in communicating with others	X	X	X	X	X
3.5	Demonstrate the use of effective problem-solving skills	X	X	X	X	X
3.6	Promptly notify supervisor related to consumer needs, concerns and/or problems encountered	X	X	X	X	X
3.7	Serve as an advocate for the consumer as directed by the consumer	X	X	X	X	X
3.8	Demonstrate respectful and professional interaction with the consumer, significant other(s), and family members	X	X	X	X	X
3.9	Demonstrate basic language, reading and written communication skills	X	X	X	X	X

4	PERSONAL CARE SKILLS ACCORDING TO CONSUMER PREFERENCE AND SERVICE PLAN	A	B	C	D	E
4.1	Assist with bathing	X	X	X	X	X
4.2	Provide bed baths	X	X		X	X
4.3	Shampoo hair in bed	X	X	X	X	X
4.4	Assist with oral hygiene	X	X	X	X	X
4.5	Assist with fingernail and toenail care	X	X	X	X	X
4.6	Shave consumer	X	X		X	X
4.7	Turn consumer in bed	X	X		X	X
4.8	Provide consumer with back rubs	X	X	X	X	X
4.9	Assist with eating	X	X	X	X	X
4.10	Assist with dressing	X	X	X	X	X
4.11	Assist with the use of elastic support stockings	X	X	X	X	X
4.12	Make an occupied bed and unoccupied bed	X	X	X	X	X
4.13	Assist with toileting needs including demonstrating proper use of bedpan, urinals and/or commode	X	X	X	X	X
4.14	Provide pericare	X	X		X	X
4.15	Assist with use of condom catheters and daily catheter care	X	X	X	X	X
4.16	Demonstrate proper lifting technique and use of lift equipment	X	X	X	X	X
4.17	Clean and ensure appropriate function and care of appliances such as glasses, hearing aids and prostheses, and assist with application	X	X	X	X	X

5	HEALTH-RELATED TASKS ACCORDING TO CONSUMER PREFERENCE AND SERVICE PLAN	A	B	C	D	E
5.1	Accurately measure and record temperature, pulse, respiration and blood pressure, height and weight	X	X	X	X	X
5.2	Collect routine urine, stool and sputum specimens according to proper procedures	X	X		X	X
5.3	Prepare and assist consumers with complex modified diets	X	X	X	X	X
5.4	Assist consumers with prescribed exercise programs, including walking, standing, transfer and passive range of motion exercises	X	X	X	X	X
5.5	Assist consumers who have lung disease with postural drainage	X	X	X		
5.6	Assist with the use of prescribed medical equipment, supplies and devices	X	X		X	X
5.7	Assist with special skin care to prevent decubitus ulcers; observe, record and report skin conditions	X	X		X	X
5.8	Provide comfort measures to assist in relieving pain	X	X	X	X	X
5.9	Apply non-sterile dressing	X	X	X	X	X
5.10	Apply non-sterile compress and soak	X	X	X	X	X
5.11	Apply cold and/or heat applications	X	X	X	X	X
5.12	Assist consumers with ileostomy, colostomy, gastrostomy and tracheotomy care	X	X	X		
5.13	Observe, record and report as appropriate	X	X	X	X	X

6	IN-HOME AND NUTRITIONAL SUPPORT ACCORDING TO CONSUMER PREFERENCE AND SERVICE PLAN	A	B	C	D	E
6.1	Assist with meal planning, food preparation and serving, food shopping, storage and handling	X			X	X
6.2	Assist with the preparation of simple modified diets	X		X	X	X
6.3	Assist consumer with fluid intake; measure and record	X	X	X	X	X
6.4	Assist and encourage consumer to consume nutritional supplements/snacks	X	X	X	X	X
6.5	Assist consumers with family spending and budgeting	X			X	X
6.6	Assist consumers with care of the home and personal belongings	X			X	X
6.7	Provide a safe, clean and comfortable living environment	X	X		X	X
6.8	Report unsafe conditions including pests and nonfunctioning equipment.	X	X		X	X
6.9	Prepare soiled linen for laundry		X			
6.10	Assist with preparing the unit for admission, transfer or following discharge		X			
6.11	Arrange furniture and equipment for the consumer's convenience and safety	X	X	X	X	X

7	INFECTION CONTROL	A	B	C	D	E
7.1	Demonstrate proper hand washing procedures	X	X	X	X	X
7.2	Demonstrate application of the principles of infection control in all activities	X	X	X	X	X
7.3	Demonstrate the use of standard precautions as indicated	X	X	X	X	X
7.4	Demonstrate correct isolation and safety technique in care of consumers with infectious illness	X	X	X	X	X

8	SAFETY AND EMERGENCIES	A	B	C	D	E
8.1	Use proper body mechanics at all times and incorporate safe transfer and lifting techniques	X	X	X	X	X
8.2	Explain procedures in case of emergencies	X	X	X	X	X
8.3	Check equipment before use and notify supervisor of any problems identified	X	X	X	X	X
8.4	Demonstrate how to perform CPR and the Heimlich Maneuver	X	X	X	X	X
8.5	Demonstrate techniques of crisis prevention and intervention				X	

9	APPLY KNOWLEDGE TO THE NEEDS OF SPECIFIC CONSUMERS	A	B	C	D	E
9.1	Describe basic anatomy and physiology of body systems	X	X	X	X	X
9.2	Recognize and report abnormal signs and symptoms of common diseases and conditions of body systems	X	X	X	X	X
9.3	Describe the normal aging process and its effects	X	X	X	X	X
9.4	Identify the specific needs of a person with Alzheimer's and related dementia and demonstrate basic principles of intervention strategies such as validation therapy	X	X	X	X	X
9.5	Identify the specific needs of and demonstrate the ability to care for a person with mental illness	X	X	X	X	X
9.6	Identify the specific needs of and demonstrate the ability to care for consumers with intellectual and developmental disabilities	X	X	X	X	X
9.7	Identify the needs of and demonstrate the ability to care for people with specific physical disabilities	X	X	X	X	X
9.8	Identify the specific care needs of and demonstrate the ability to care for a person who is dying	X	X		X	X
9.9	Identify the specific needs of and demonstrate the ability for care for a sensory deprived consumer	X	X	X	X	X
9.10	Describe how age, illness and disability affect sexuality	X	X	X	X	X

10	SELF CARE	A	B	C	D	E
10.1	Recognize signs of burnout in self and others, and identify stress reduction techniques	X	X	X	X	X
10.2	Demonstrate use of time-management and organizational skills	X	X	X	X	X
10.3	Identify resources to maintain personal health and well-being	X	X	X	X	X
10.4	Identify options and strategies to respond to abusive behavior directed toward direct-care workers by consumers	X	X	X	X	X

APPENDIX D: SUGGESTIONS FOR THE LONG-TERM CARE CORE COMPETENCIES TRAINING

I. INTRODUCTION TO CAREGIVING

- The Home Care Client (e.g., care plans, types of services, self-directing clients)
- Client Rights (e.g., confidentiality, choice, mandatory reporting, abuse)
- Caregiver Role and Responsibilities within the Care Team (e.g., observe, record, report)
- Infection Control and Standard Precautions (e.g., hand washing, gloves)
- Communication and Relationship Building

II. INTRODUCTION TO BASIC PERSONAL CARE TASKS

- Body Mechanics
- Assisting with Mobility and Simple Exercises (e.g., passive range of motion)
- Assisting with Basic Care (e.g., simple bathing, grooming, dressing, eating)

III. UNDERSTANDING HOW THE BODY WORKS (BODY SYSTEMS) AND COMMON DISEASES

- Working with People with Disabilities (e.g., developmental disabilities such as autism, cerebral palsy, mental retardation, dementia, mood disorders, mental illness and physical disabilities)
- Common Diseases (Osteoporosis, Diabetes 1, Hepatitis and HIV / AIDS, etc.)
- The Aging Process

IV. INTRODUCTION TO PROBLEM SOLVING (4P APPROACH)

- Listening, Paraphrasing, and Asking Open-Ended Questions.
- Effective Problem-Solving Skills
- Serving as an Advocate for the Consumer as Directed by the Consumer.

V. ASSISTING WITH/ADMINISTERING MEDICATIONS

- Understanding Role and Reading/Understanding Labels

VI. BASIC NUTRITION AND FOOD HANDLING

- Meal Planning, Food Preparation and Serving.
- Food Shopping, Storage, and Handling
- Simple Modified Diets
- Monitoring Fluid and Food Intake

VII. SELF CARE

- Recognizing Signs of Burnout
- Time Management and Organizational Skills
- Responding to Abusive Behaviors
- Identifying Resources to Maintain Personal Health and Well-Being

APPENDIX E: INTRODUCTION TO THE 4P APPROACH TO PROBLEM-SOLVING

INSTRUCTION TIME: 5 HOURS

LEARNING OUTCOMES

Trainees will be able to:

- Improve quality care
- Explain the importance of active listening
- Explain the importance of communication in the workplace
- Demonstrate improved communication and problem solving
- Work effectively with all types of people
- Think through a problem before reacting
- Use tools that increase self-confidence and support positive attitude
- Use a common language for problem-solving steps
- Use a common framework and language for providing feedback
- Demonstrate awareness of the behaviors and the nonverbal messages they communicate
- Differentiate between professional and nonprofessional behavior
- Demonstrate the ability to respond to a problem situation using the 4 Ps: Pulling Back, Paraphrasing, Presenting Options, and Passing It On.

KEY CONTENT

I. ASPECTS OF WORKING AS A CAREGIVER

II. PULL BACK: THE ABILITY TO GAIN EMOTIONAL CONTROL IN STRESSFUL WORK SETTINGS

Pull Back Goals

- To stay calm and maintain emotional control
- To focus attention in order to assess the situation

Pull Back Skills

- To pause before responding by taking a deep breathe
- To talk to yourself in a way that provides support for gaining emotional control (using positive self-talk strategy)
- To focus attention on the problem at hand, to be able to assess the situation.

III. PARAPHRASE: THE ABILITY TO LISTEN ACTIVELY, AND ASK OPEN QUESTIONS

Paraphrase Goals

- To understand the importance of listening fully.
- To be clear about what is being communicated.
- To ask questions, when necessary, to gain a complete understanding of facts and feelings.

Paraphrase Skills

- To listen in a focused way using non-verbal skills.

-
- To rephrase what the person has said to insure that you clearly understand the facts.
 - To acknowledge that you have heard and accept the other person's perspective and feelings.

IV. PRESENT OPTIONS: THE ABILITY TO IDENTIFY THE CRITICAL FACT OR PROBLEM, BRAINSTORM SOLUTIONS, AND PRESENT OPTIONS TO A CLIENT OR FAMILY MEMBER OR SUPERVISOR.

Presenting Options Goals

- To think through all possible solutions/responses to a situation, as well as the consequences of those solutions/responses.
- To present to the nurses, family members, co-worker, supervisor, or others, the best solutions/responses.

Present Options Skills

- To identify the most critical fact being presented.
- To think of more than one-way to respond.
- To think about the consequences of each possible solution/response.
- To choose and present two or three options for resolution of the situation.

V. PASS IT ON: THE ABILITY TO DOCUMENT WORK, OR COMMUNICATE WITH OTHERS ABOUT A PROBLEM, USING OBJECTIVE LANGUAGE.

Pass It On Goals

- To provide clear information to the appropriate people involved in the situation.
- To give required information verbally or in written documentation.

Pass It On Skills

- To identify who else needs to know about the situation.
- To communicate the situation clearly and appropriately.
- To report in writing or by phone, as required.

Source: The Paraprofessional Healthcare Institute

APPENDIX F: CORE CURRICULUM REQUIREMENTS FOR CNA TRAINING

(AS SPECIFIED BY WASHINGTON ADMINISTRATIVE CODE 246-842-190)

CORE CURRICULUM IN APPROVED TRAINING PROGRAMS.

(1) Curriculum will be competency based; that is composed of learning objectives and activities that will lead to the attainment of knowledge and skills required for the graduate to demonstrate mastery of the core competencies nursing assistants-certified must hold, as per WAC 246-842-100.

(2) The program director will determine the amount of time required in the curriculum to achieve the objectives as above. The time designated will be expected to vary with characteristics of the learners and teaching/learning variables. In no case will the hours be less than eighty-five hours total, comprised of thirty-five hours of classroom training and fifty hours of clinical training.

(a) Of the thirty-five hours of classroom training, no less than seven hours must be in AIDS education and training, in the subject areas of: Epidemiology, pathophysiology, infection control guidelines, testing and counseling, legal and ethical issues, medical records, clinical manifestations and diagnosis, treatment and disease management, and psychosocial and special group issues.

(b) Training to orient the student to the health care facility and facility policies and procedures are not to be included in the minimum hours above.

(3) Each unit of the core curriculum will have:

(a) Behavioral objectives, that is statements of specific observable actions and behaviors that the learner is to perform or exhibit.

(b) An outline of information the learner will need to know in order to meet the objectives.

(c) Learning activities (that is, lecture, discussion, readings, film, clinical practice, etc.,) that are designed to enable the student to achieve the stated objectives.

(4) Clinical teaching in a given competency area will be closely correlated with classroom teaching, to facilitate the integration of knowledge with manual skills. An identified instructor(s) will supervise clinical teaching/learning at all times. At no time will the ratio of students to instructor exceed ten students to one instructor in the clinical setting.

(5) The curriculum will include evaluation processes to assure mastery of competencies. Written and oral tests and clinical practical demonstrations are common methods. Students will not be asked to, nor allowed to, perform any clinical skill on patients or clients until first demonstrating the skill satisfactorily to an instructor in the practice setting.

APPENDIX G: CONFERENCE BOARD OF CANADA RESEARCH: KEY DESIGN ELEMENTS OF SUCCESSFUL JOINT LABOR-MANAGEMENT TRAINING PROGRAMS

To complement this systemwide profile, research by the Conference Board of Canada gathered in-depth feedback from successful joint labor-management training programs in the following sectors: IT /telecommunications, health care, and hospitality. The Conference Board research provides an opportunity to gain more detailed insight into the design elements that support an effective joint training partnership.

The Conference Board research concluded that the “design elements” of joint programs explain why such programs are successful. **Their report recommended that stakeholders wishing to launch their own joint training programs consider building these design elements into their programs, which we have integrated into the design of the Network.** These key design elements are set forth below:

PROACTIVE COMMUNICATION BETWEEN LABOR AND MANAGEMENT

The Conference Board research indicates that open and proactive communication lies at the heart of two key design features that support the foundation of joint program success:

1. **Continuous process of balanced consultation between labor and management**, based upon concurrence gained through collective bargaining, is seen as one of the most critical ingredients in the success of all joint partnerships. Having core funding dedicated in the collective bargaining agreement is a critical step for joint program sustainability. While the joint planning process is solidly in place, the importance of communication remains critical as misconceptions are not uncommon. For example, the research reveals that first line supervisors are not always aware of management’s critical role in the joint partnership. This can result in missed opportunities to apply new skills on the job and further promote the value of joint training among the eligible population.
2. **Program marketing and promotion**, in a very similar vein, are identified as essential design ingredients that directly support this balanced collaborative process. That is, the effectiveness of marketing and promotional initiatives “largely determine worker participation and stakeholder buy-in.” This is essential to the sustained viability of the joint programs.

NEEDS ANALYSIS, PROGRAM EVALUATION, AND REDESIGN

To ensure the effective targeting and allocation of limited program resources, the research suggests that a measurement-based approach be adopted in two key steps in the planning process:

3. **Conducting learning needs analysis** must be approached in a rigorous manner to ensure that the “content and objectives of the training actually address real individual and workplace developmental needs.” This entails thoroughly assessing both individuals’ current skills, as well as the competencies required for a specific job.
4. **Evaluating program effectiveness**, when employed, is seen as a critical design feature and

step in the planning process. Specifically, a comprehensive evaluation strategy serves two key purposes. First, by generating periodic program feedback, it provides the basis for steadily improving the quality and effectiveness of training services. Secondly, a rigorous evaluation is seen as the most effective way to generate program support by clearly demonstrating the value and benefits of training.

EXTENDED TIME HORIZONS

One of the founding principles of many joint programs is the commitment to lifelong learning in pursuit of career security. In promoting this mission, the research clearly confirms the importance of an extended time horizon in the planning and delivery of effective joint training services. Specifically, the importance of two program design features are emphasized:

5. **Career and education planning services** that help individuals “create and follow their own career path.” The study emphasizes the importance of providing continued access to funding that supports the tools and counseling that participants need to pursue longer-term career goals and personal success.
6. **Continuing educational opportunities** that allow individuals to sustain their pursuit of personal or career goals.
7. **Tuition Assistance.** This entails continued access to funds. This support helps to maintain the workers’ interest and momentum.

PERSONAL RESPONSIBILITY AND CHOICE

The emphasis on life-long learning, which underlies most joint training partnerships, is based on the philosophy of individual empowerment and personal responsibility. In this spirit, employees create their own opportunities to pursue the skills and knowledge needed to foster their long-term career security. The Conference Board research suggests that two design elements are important in promoting this philosophy:

8. **Voluntary participation of workers**, long a hallmark of joint training partnerships, is felt to be important in that it allows workers to “control their own education plans and career futures.” Furthermore, it is felt to offer a more “receptive” learning environment, particularly for those returning to education after a long absence.
9. **Employee involvement in the design and implementation of training** is also seen as an important opportunity for workers to shape their own educational future. While not yet the norm among joint programs, the research nonetheless indicates that workers can provide valuable inputs into the planning process. Specifically, their participation allows curriculum design decisions to incorporate more effectively “insights on the reality of their job tasks and work environment.” Currently, the emphasis is on union representation and the employer providing input into the design elements, with employer, union, and worker providing leadership in marketing and promotion.

SOUND LEARNING AND EDUCATIONAL STRATEGIES

While numerous design factors shape the joint training environment, program success is ultimately rooted in educational and instructional quality. As such, the research emphasizes the importance of two factors that directly shape the effectiveness of the educational offerings.

10. **Multiple learning strategies** need to be incorporated into the service delivery menu in an effort to accommodate the diverse learning styles and preferences of adults. A related challenge is to make participants more aware of the potential value and benefits of alternative learning strategies.
11. **Specific criteria for selecting and evaluating training providers** is also seen as a critical step in ensuring the desired educational outcomes. Specific training needs and expectations must be explicitly communicated to prospective providers. At the same time, interested vendors must demonstrate their capacity to customize offerings to directly reflect the specific characteristics and/or requirements of the work environment and workers learning needs.

DUAL TRAINING FOCUS: MEETING WORKER AND WORKPLACE NEEDS

12. **Dual Training Focus:** A simultaneous dual training focus on the individual worker-student and on the workplace or organization helps to ensure that the training plans and delivery are genuinely relevant to the learning needs of both workers and the employer.

ASSESSING THE IMPACT, VALUE AND BENEFITS OF EDUCATION AND TRAINING

A final aim of this research initiative was to demonstrate the effectiveness of the joint training strategy by measuring preliminary outcomes and impacts in the IT/telecommunications, health care, and hospitality sectors. Specifically, nine training initiatives offered by three joint programs were examined in detail. Based on a series of in-depth interviews with program participants and a range of union and company stakeholders, the research identified several key outcomes. Some are highlighted below.

We believe that the Network, as described in this blue print, can expect to accomplish similar results, provided that the above design elements are incorporated into the organization's operations, management, and governance.

Participating workers reported skill gains that "greatly helped them at work" including strengthened:

- Job specific communications
- Self-confidence
- Adaptability
- General literacy
- Understanding of the value of life-long learning

First line supervisors of training participants observed related improvements in job performance in such areas as:

- Customer relations
- Higher work quality
- Increased productivity
- Decision-making abilities

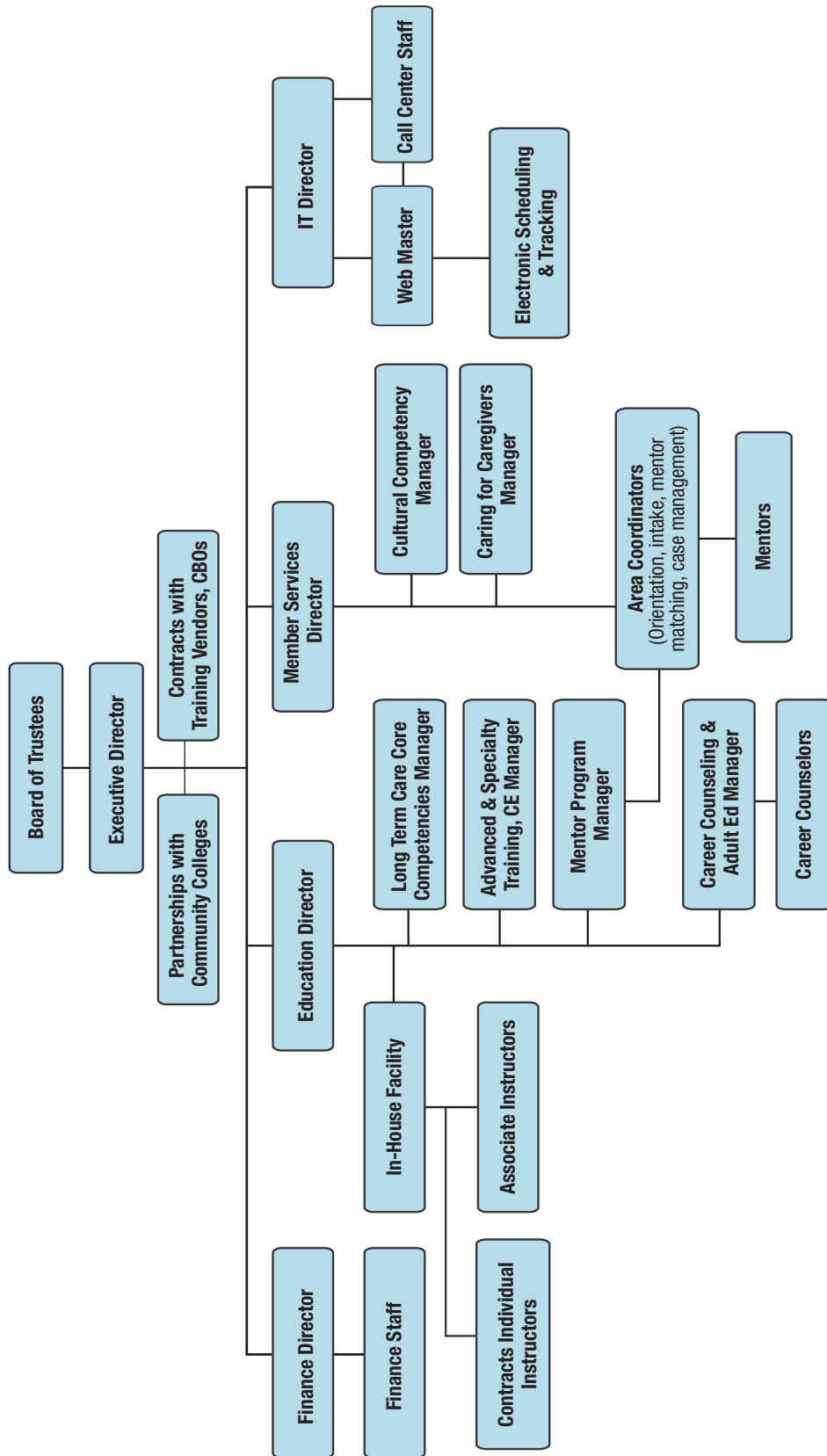
Union representatives reported an improved labor-management climate resulting from the joint training partnership. Additionally, they report:

- Improved attitudes toward the union
- Increased application of skills in union activities
- Better communication with other members

Despite the widely acknowledged impacts, stakeholders also agree that joint training programs “could have even a greater impact in the future” by both attracting more participants, and continuing to refine their program design. Stakeholders feel strongly that joint partnerships have the potential to generate:

- Increased ability to deal with change
- Improved ability to use new technology
- Increased workplace morale
- Improved attitudes toward labor management relations
- Greater desire to participate in training

APPENDIX H: ORGANIZATIONAL ARCHITECTURE - A FRAMEWORK



APPENDIX I: THE NETWORK - SAMPLE BUDGET*

(All figures rounded to the nearest \$1,000)

INCOME	PHASE 1	PHASE 2	PHASE 3
IP Employer Contributions (.35 cents per hour worked)	\$11,020,000	\$11,149,000	\$11,280,000
Other Employer Contributions (.35 cents per hour worked)	\$4,068,000	\$4,356,000	\$4,665,000
Grants	\$0	\$0	\$500,000
Total Income	\$15,088,000	\$15,505,000	\$16,445,000
EXPENSES			
Administrative Expenses			
Senior Management Teams (5)	\$532,000	\$548,000	\$564,000
Support, Accounting & IT Staff	\$416,000	\$426,000	\$438,000
Computer & Related Equipment	\$26,000	\$16,000	\$16,000
Rent & Related Expenses	\$50,000	\$50,000	\$50,000
Member Comm. & Service	\$266,000	\$277,000	\$288,000
Other Administration Costs	\$92,000	\$97,000	\$104,000
Subtotal Administrative	\$1,382,000	\$1,414,000	\$1,460,000
PROGRAM EXPENSES			
Program Managers (7)	\$420,000	\$433,000	\$446,000
In-House Faculty (6-24)	\$362,000	\$1,853,000	\$1,751,000
Area Coordinators (16)	\$784,000	\$808,000	\$832,000
Mobile Classrooms & Staff Travel	\$250,000	\$75,000	\$75,000
Language Interpretation	\$500,000	\$500,000	\$500,000
Classroom Rental	\$100,000	\$100,000	\$100,000
Orientation	\$196,000	\$160,000	\$154,000
Safety Training	\$340,000	\$315,000	\$321,000
LTC Core Competencies	\$1,794,000	\$4,186,000	\$3,587,000
Advanced & Specialty Training	\$378,000	\$452,000	\$557,000
Mentor Program	\$2,566,000	\$3,667,000	\$3,900,000
Adult Education	\$0	\$179,000	\$715,000
Caring for Caregiver	\$0	\$15,000	\$25,000
Career Counseling	\$0	\$0	\$57,000
Tuition Assistance	\$0	\$0	\$364,000
Continuing Education	\$0	\$573,000	\$587,000
Evaluation and Impact Study	\$25,000	\$25,000	\$25,000
Meeting & Conferences	\$100,000	\$100,000	\$100,000
Subtotal Program	\$7,815,000	\$13,441,000	\$14,096,000
Total Income	\$15,088,000	\$15,505,000	\$16,445,000
Total Expenses	\$9,197,000	\$14,855,000	\$15,556,000
Total Income Over Expenses	\$5,891,000	\$650,000	\$889,000
FUND BALANCE	\$5,891,000	\$6,541,000	\$7,430,000

*For simplicity, this sample budget portrays one sample year within each Phase and does not portray the funded start-up phase leading to Phase I.