Washington State
Long-Term Care Worker Training Workgroup

Established by ESSHB 2284

Literature on Impacts of LTC Worker Training: Findings

September 26, 2007

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Introduction

- In 2007, ESSHB 2284 was enacted to address the training of and collective bargaining over the training of care providers. This report provides support to the task force on long-term care training workgroup charged with making recommendations regarding *training requirements for long-term care workers with respect to the quality of care provided to vulnerable people across all home and community-based settings.* The workgroup is charged with evaluating:
  - Current Training Requirements
  - Care Deficiencies
  - Training Needs
  - **Literature on Impacts of LTC Worker Training**
  - LTC Apprenticeship and Certification Programs
- This report will review Literature on Impacts of LTC Worker Training.

Source: ESSHB 2284

Introduction – Objectives

- *This report focuses on evaluation of the impacts of worker training upon the quality of LTC services provided, including recruitment and retention.*

- *The objectives of this report are to:*
  - *Present existing "best practices training programs" data in a meaningful way that demonstrates impacts of worker training in settings covered in the bill, and*
  - *Provide evidence-based outcomes and lessons learned, and answer the questions:*
    - *What evidence-based data can be tied to desired outcomes identified in the bill?*
    - *How can the programs with successful outcomes be replicated or applied in the WA LTC settings?*
    - *What are the potential or perceived impacts to workers and consumers?*

Introduction – Methodology

- ***Information sources:***
  - *Robert Wood-Johnson Foundation, Pursuing Perfection – Bellingham, WA, http://www.peacehealth.org/PursuingPerfection.*
  - *Health Care, High Growth Industry Profile, June 2005.*
  - *Best Practices Selection Criteria, National Clearinghouse on the Direct Care Workforce, 2004.*
  - *Sharing a Vision to Transform Long-Term Care, The Honorable Josefina G. Carbonell, US Department of Health and Human Services Assistant Secretary on Aging, AARP, Special Issue 2006.*
  - *Better Jobs Better Care Quarterly Newsletter Insights: No 10, Summer 2007.*
  - *Training TANF Recipients & Low-Income Populations for LTC Paraprofessional Jobs, Mathematica Policy Research, Inc. March 2005.*
  - *Better Jobs Better Care Program, Institute for the Future of Aging Services, AAHSA.*
  - *Home Care Quality: Emerging State Strategies to Deliver Person-centered Services, Public Policy Institute, Issue Paper #2006-07. Feb. 2007.*
  - *Pulling Together: Administrative and Budget Consolidation of State LTC Services, Wendy Fox-Grage, AARP, PPI #3006-05 February 2006.*
  - *The Role of Training in Improving the Recruitment and Retention of Direct-Care Workers in LTC. Workforce Strategies No. 3. PHI and Institute for the Future of Aging Services (IFAS). 1/2005.*
  - Caregiving in America, Lawrence Schmiedling, The Caregiving Project for older Americans, ILC-SCSHE Taskforce 2006.
  - *Current and past WA LTC Task Force reports, presentations, agency reports, and recommendations.*

Interviews/Speakers/Supplemental Materials:

- *Michael Johnson, RN MSW,* Program Manager, DOH FSL - In-home Services, Rural Health and Child Birthcenters interviews.
- *Mary K Walker, PhD, RN, FAAN, Dean, Seattle University College of Nursing, interview.*
- *Panel speakers, presenters, and WA LTC organization position statements.*

Newspapers: New York Times

Background

A brief history of Training Changes Impacting WA LTC Workers:

2000

2000 Steering Committee for Community LTC Training and Education expanded training requirements to include an additional 6 hours for skills training and demonstration and required learning outcome development for all curricula. Learning Outcomes designed to: assure consistency of skills taught with focus on quality consumer care, while retaining the flexibility for alternate curriculums.

2006

LTC Task Force noted transitions in care for clients between acute and long term care systems required consistency of care and coordination using evidence-based practices to promote improved health outcomes and to reduce medical system interactions. The Intensive Chronic Care Management (ICCM) project was designed to achieve optimal health and to utilize resources more efficiently and effectively. Final report due 12/2008.
Federal government increased support of a more person-centered approach to quality management for home- and community-based service programs and imposed more stringent program requirement to ensure quality standards are met.

2007

2007 ESSHB 2284 increased Continuing Education from 10 to 12 hours beginning in 2010 and all providers shall be offered one hour per week peer mentorship or on-the-job training for first 120 days.

Sources: LTC Training & Education Steering Committee presentations, ADSA Chronic Care Summary 6/07, PPI Home Care Quality: Emerging State Strategies to Deliver Person-Centered Services. 2/2006.

Findings – Premise

Premise:

- Emphasis of WA LTC delivery system is based on a Person-Centered Consumer model where support services are designed to:
  - Help individuals develop and maintain self-sufficiency;
  - Remain valued and contributing members of their community;
  - Maximize quality of life; and
  - Be responsive to individual needs and preferences.*
- Life-long learning philosophy is based on individual empowerment and personal responsibility to pursue skills and knowledge needed to foster career security, and include two design elements:**
  - Voluntary participation of workers.
  - Employee involvement in the design and implementation of training.

Sources: *ADSA Strategic Plan 2006-2011 and **PHI A Blue Print for the Future 2/2007.

Findings – Definitions

- **Best Practices Criteria defined as:**
  - The National LTC Workforce Initiative Criteria for Selection of Best Practices is abbreviated below:
    - Each practice includes at least one of the following categories or strategies. (Note: this is not intended as a comprehensive list).
      - Recruitment & selection. Successful outreach and screening techniques and client in-home visits prior to recruitment.
      - Education & training. Soft or life skills training, as well as specialized training beyond state requirements.
      - Workplace strategies to create quality jobs and quality care.
      - Care giving strategies to create quality jobs and quality care.
      - Leadership, management and supervisory training and practices.
      - Wage enhancements, benefits and worker supports.
    - Practice has been operational for at least 6 months.
    - Written documentation about procedures, implementation, and contact information is available.
    - Quantitative or qualitative evidence of the results and outcomes.
    - Practices in all LTC settings and include home- and community-based settings.

Source: National Clearinghouse on the Direct Care Workforce: Best Practice Selection Criteria. 2004.

Findings – Federal Trends

- Federal government moving toward improved person-centered Quality Assurance systems for home- and community-based service programs, and has imposed more stringent program requirements to ensure quality standards are met. These actions include:
  - Establishing Quality framework for QA redesign.
  - Requiring concrete evidence of monitoring activities and resolving problems.
  - New waiver programs that require more detailed information on Quality Management Systems.
  - Providing substantial grant support for Quality Redesign initiatives.
- Challenge: Quality Assurance systems that place consumer needs and goals for quality of life first.

Source: PPI Issue Paper #2006-07, Home Care Quality: Emerging State Strategies to Deliver Person-Centered Services. February 2006

Findings – Model Trends

- **Choices for Independence (Choices)—** advances the President's New Freedom Initiative and compliments the administration's policy for modernizing Medicare and Medicaid and the Older Americans Act (OAA).

  Choices embodies the values of consumer choice, control, and independence, and the principles of community-living, local flexibility, and accountability. The three-pronged strategy:

— Empowers individuals to make informed decisions about their care and support options,
— Enhances the targeting of OAA resources to high-risk individuals, and
— Creates more opportunities to build prevention into community living.

Source: Sharing a Vision to Transform Long-Term Care, The Honorable Josefina Carbonell, US Dept of Health and Human Services Assistant Secretary for Aging. AARP Global Report on Aging, Special Issue 2006.

Findings – Model Trends

- **Movement to New Models of Care:**

  According to Institute for the Future of Aging Service (IFAS), traditional nursing homes may not exist in the future. Home and community-based services will dominate long-term care service delivery.

  - Tomorrow's LTC (Baby Boomer) consumers will make decisions about:
    - services they want,
    - who they want to deliver them, and
    - how and when they are delivered.

- **A 2002 survey conducted for AARP found:**
  - 85 percent of people aged 50+ wanted self-managed services vs. agency managed services,
  - Majority of consumer-directed service participants were more satisfied than under traditional agency-directed models,
  - Consumer-directed service participants reported a higher quality of life, and
  - Consumer-directed service participants had fewer unmet needs and said they got more care for their money (Kassner, 2006).

Source: Institute for the Future of Aging Services, The Long-Term Care Workforce: Can the Crisis be Fixed?, January 2007.

Findings – Model Trends

- **Consumer-directed models will require a reorientation of the direct care workforce.** The workforce must adapt to consumers who have the right to hire and fire them and to make care decisions.

  — Emerging issues include:
    - exploitation around scheduling,
    - wages and benefits.
    - requirements for quality oversight, and
    - training and worker protections.

- "**California**, **Washington** and **Oregon** have begun to address such concerns by establishing public authority models, which act as the employer of record for workers hired directly by consumers."

Source: Institute for the Future of Aging Services, The Long-Term Care Workforce: Can the Crisis be Fixed? January 2007.

Findings – IT Trends

- **Introduction of New Technology:**
  "The future impact of new technology on the supply and demand for personnel is promising but uncertain. The introduction of labor-saving technology may reduce paperwork burdens and rates of injury and improve worker efficiency, allowing fewer personnel to do more with less."*

- **Advance in technology such as informatics**, standardized data, integrated electronic health record to increase effectiveness of LTC staff and managing chronic illness will continue to become increasingly complex and require complementary care practices. As the field becomes more sophisticated and growth in costs continue to rise, there is evidence for a drift toward a two-tiered system of care based on financial resources.**

- **WA SSB 5064 Health Information Infrastructure:** Final Report and Roadmap for State Action, uniquely positions WA to demonstrate benefits of a cohesive health information system. A central feature of this model is the active role of consumers in determining access to their secure health records.***
  - Emphasize evidence-based health care.
  - Promote prevention, healthy lifestyles, and healthy choices.
  - Better manage chronic care.
  - Create more transparency in the health care system.
  - Make better use of information technology.

Sources: *Institute for the Future of Aging Services, The Long-Term Care Workforce: Can the Crisis be Fixed?, January 2007.
** Improvement & Innovation in LTC: A Research Agenda www.pragmaticinnovations.unc.edu December 2005.
***HIIAB HCA Health Information Infrastructure: Final Report and Roadmap for State Action, December 2006.

Findings – LTC Wage Trends

- **Supreme Court Decision – Long Island Care at Home, Osborne vs. Evelyn Coke:**

  Evelyn Coke challenged Labor Department regulations that say home care attendants are not covered by federal minimum-wage and overtime laws.* Fair Labor Standards Act (FLSA) exempted , "domestic workers," and "companionship services" to individuals who are unable to care for themselves. 29 CFR § 552.109 (a).

- **Supporters and Opponents**: SEIU and AARP backed Ms. Coke's effort citing that increased pay would reduce turnover and prevent a shortage. Federal government, NY state Association of Counties and Mayor Michael R Bloomberg's administration opposed Ms. Coke; citing costs as main issue.

- **Decision 4/2007**: Supreme Court decided DOL interpretation of the congressional law is valid; namely, direct care workers working in peoples' homes are exempted from minimum wage and overtime protections, even if employed by an agency to perform such work. Fact sheet cited that most states pay minimum wage and states are free to set wages that go beyond minimum wage and can provide more protection than the Federal law provides.

- **Proposed advocacy strategies included:**
  - National legislative change (New White House administration.)
  - State legislation (in states not offering higher protections.)
  - Working with Department of Labor.(Engaging DOL to change view on home care and direct care as a whole.)

Source: *NY Times, Justices to Hear Case on Wages of Home Aides, by Steven Greenhouse, 3/25/07, and follow up Fact Sheet on decision.

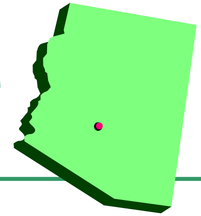
Findings – LTC System Trends

- **Consolidated State Long-Term Care Agencies**
  - ***Rationale:*** to overcome barriers to consumer access and ensure viable choices.
  - Five states were among top six states in terms of allocation of Medicaid LTC spending for home and community-based services (HCBS) compared to institutional care in FY 2004.

    Those states included:
    - Minnesota
    - New Mexico
    - Oregon**
    - Vermont
    - Washington**
  - To streamline the LTC services process several strategies were employed:
    - *Global Budgeting* to overcome an "institutional bias" and achieve a more balanced LTC system. This allows the financing to follow clients through the system as their needs and preferences change, reduces competition among agencies and improves accountability.
    - *Single point of entry* to determine functional and financial eligibility and coordinated delivery of service and provides one place at the state level to resolve LTC issues, reduces duplicative administrative costs, and leverages limited resources.
    - *Fast track eligibility* procedures to accommodate consumer needs.
    - *Integrated quality assurance systems* focused on client "outcomes" and "person-centered" care, allowing for comprehensive integrated view of preferences, satisfaction, and outcomes for the consumer and provides a cost effective and efficient QA system the results in economies of scale and scope.
  - Minnesota summed it up as: "It's about people, not programs."

Source: *Pulling Together: Administrative and Budget Consolidation of State LTC Services by Wendy Fox-Grage, AARP #2006-05 , Feb. 2006.
** WA and OR consolidated roughly 20 years ago.

Findings – Models that Work - TANF



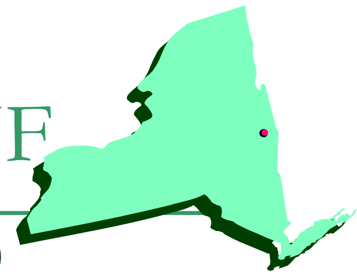
ARIZONA: Learn, Earn, Advance, and Prosper (LEAP)

Housed at TMC Healthcare (a nonprofit hospital system in Tucson, Arizona), provides on-the-job training, life skills, job placement, and advanced training opportunities for TANF recipients and low-income youth interested in health care careers; CNA training is only available after graduation and six months of employment at TMC. Note: LEAP focuses on training and employment in more acute care settings than LTC setting.

Best Practice	Description	
Program Structure (Inception: 1998)	TMC is a nonprofit organization. Workforce Development operates LEAP	Funding Sources: TMC, Dept of Labor, and AZ Dept of Economic Security
Program Rationale	Meet 1996 federal welfare legislation	Reduce high staff turnover costs.
Recruitment & Retention	Targeted approach: Screen TANF recipients using a strict criteria of 1) interest in healthcare, 2) min. literacy skill levels, 3) motivation to complete the program, 4) transportation and childcare in place 5) Drug screening and background checks.	
Quality Training	Includes: 2 days orientation, 3 days job shadowing various jobs, 4 days/wk over 10 wks in OTJ. 1 day/wk Life skills class & goal setting, attitude and self-esteem, communications, problem solving, and anger management, GED classes mandatory as applicable.	
Incentives	Transportation: $5/day, vehicle insurance/registration assistance, Clothing & meal vouchers, childcare assistance, medical/dental coverage, counseling services, tools or equipment and a $2,000 allowance for post-employment education. Monthly support groups. CNA training tuition/books available if eligible to enter program.	
Outcomes & Strengths	210 enrolled, 144 graduated. 65% of grads remained 1+ yrs. Approx 4/5 of 144 graduates participated in the CNA training offered by TMC to date. Strengths: multiple funding sources. Willingness to invest in workers.	

Source: Training TANF Recipients and Low-income Populations for LTC Paraprofessional Jobs. 3/2005 Mathematica Policy Research, Inc.

Findings – Models that Work - TANF



NEW YORK: Cooperative Home Care Associates (CHCA)

CHCA is both a training provider and employer in Bronx and upper Manhattan NYC, who provides home care services to elderly and persons with disabilities. They recruit, train and hire low-income women for home health aide positions.

Best Practice	Description	
Program Structure (Inception: 1980s)	For private for profit home care agency founded on quality care = quality jobs. Employee-owned cooperative. Employs 750 workers. Trains 200-300 workers/year.	Funding Sources: Private and foundations, WIA, DOH grants, TANF, Perkins Act, and SEIU funding as training provider. SEIU reimburses $2,000/TANF training expenses
Program Rationale	Designed to create jobs via a cooperative.	New regs for Medicare reimbursements
Recruitment & Retention	Word of Mouth (WOM) approach: 70% of recruits come as a referral from someone already in training or working at CHCA. Although 40% are TANF recipients; no direct recruitment is done through TANF offices. Clean drug screening, criminal background check are required prior to training/employment. No literacy test, or GED is required.	
Quality Training	Includes: 154 hours of classroom, 8 training cycles (4 in English/4 in Spanish). DOH state curriculum, plus customized modules. 3 support groups 1/last day of class, 2 wks after start of work, 3rd mo. of work. Upon successful completion 3 mo probationary employment (OTJ) assigned peer mentors to ease transition. After probation, 8 hrs of in-home supervision by a Registered Nurse, they receive a certificate and are hired as regular status employees.	
Incentives	Transportation: metro card, benefits package worth $2.13/hr, life insurance, vacation, 401(K), auto wage increases to reward continued employment. Personal/professional growth opportunities.	
Outcomes & Strengths	247 enrolled, 188 graduated. 145 were TANF, 55% of grads remained 2+ yrs. Among those who leave 20% still in healthcare elsewhere. Strengths: innovation in terms of structure, wage/benefits, and personal/professional growth opportunities.	

Source: Training TANF Recipients and Low-income Populations for LTC Paraprofessional Jobs. 3/2005 Mathematica Policy Research, Inc.

Findings – Models that Work - TANF

- **Lessons Learned:**
  - Common implementation challenges for targeting TANF recipients:
    - Matching right person requires stringent selection criteria to achieve success.
    - Two in five TANF recipients had a low potential for employment in LTC jobs.
    - Selection requires extensive application/interview processes to find good fit, where "goodness of fit" is judged by an applicant's personality, ethics, and prior care-giving experience and work motivation, resulting in "best and the brightest."
    - Screening also includes identifying barriers to success such as transportation, childcare, health issues, and self-esteem or confidence issues to justify ROI.
  - Work-first philosophy can impede program efforts:
    - Cross-purposed. Focus on employment vs. career path and or investing in training.
    - Not sufficient time to pursue training (5 – 8 weeks of training required) while completing Work Experience Program (WEP) obligations.
    - Requires TANF waiver to certify program as a community work experience activity.
  - Successful programs more likely when training provider & employer same entity.
    - Provides a seamless transition between training and employment.
    - LEAP sought government support to bring youth into the program.
    - Community-based organizations (CBO) provided payroll and other services for youth in internships and training programs allowing LEAP to focus on providing services.

Source: Training TANF Recipients and Low-income Populations for LTC Paraprofessional Jobs. 3/2005 Mathematica Policy Research, Inc.

Findings – Models that Work - TANF

- **Lessons Learned:**
  - Job shadowing or work experience component
    - Exposes workers to the realities of the LTC work environment early on.
    - Successful programs all included peer mentoring/job shadowing as part of training.
    - Consumers also benefit by observing potential employees in their care setting.
  - Multiple funding sources critical to sustainability:
    - Relying on TANF funding only poses financial risk.
    - Linkages to supportive services that TANF and other social agencies provide such as transportation stipends, childcare subsidies, uniforms, etc. saves on program resources.
  - Retention must be a central component of program efforts.
    - Peer mentoring and support counseling help participants to become self-sufficient after the training is complete.
    - CHCA's retention strategy includes an emphasis on advancement opportunities, pay increases, and full-time employment (30 hours).
  - Dedicated and committed staff ensure program stability and performance.
    - CHCA and LEAP were products of health care experts with extensive experience in LTC communities.

Source: Training TANF Recipients and Low-income Populations for LTC Paraprofessional Jobs. 3/2005 Mathematica Policy Research, Inc.

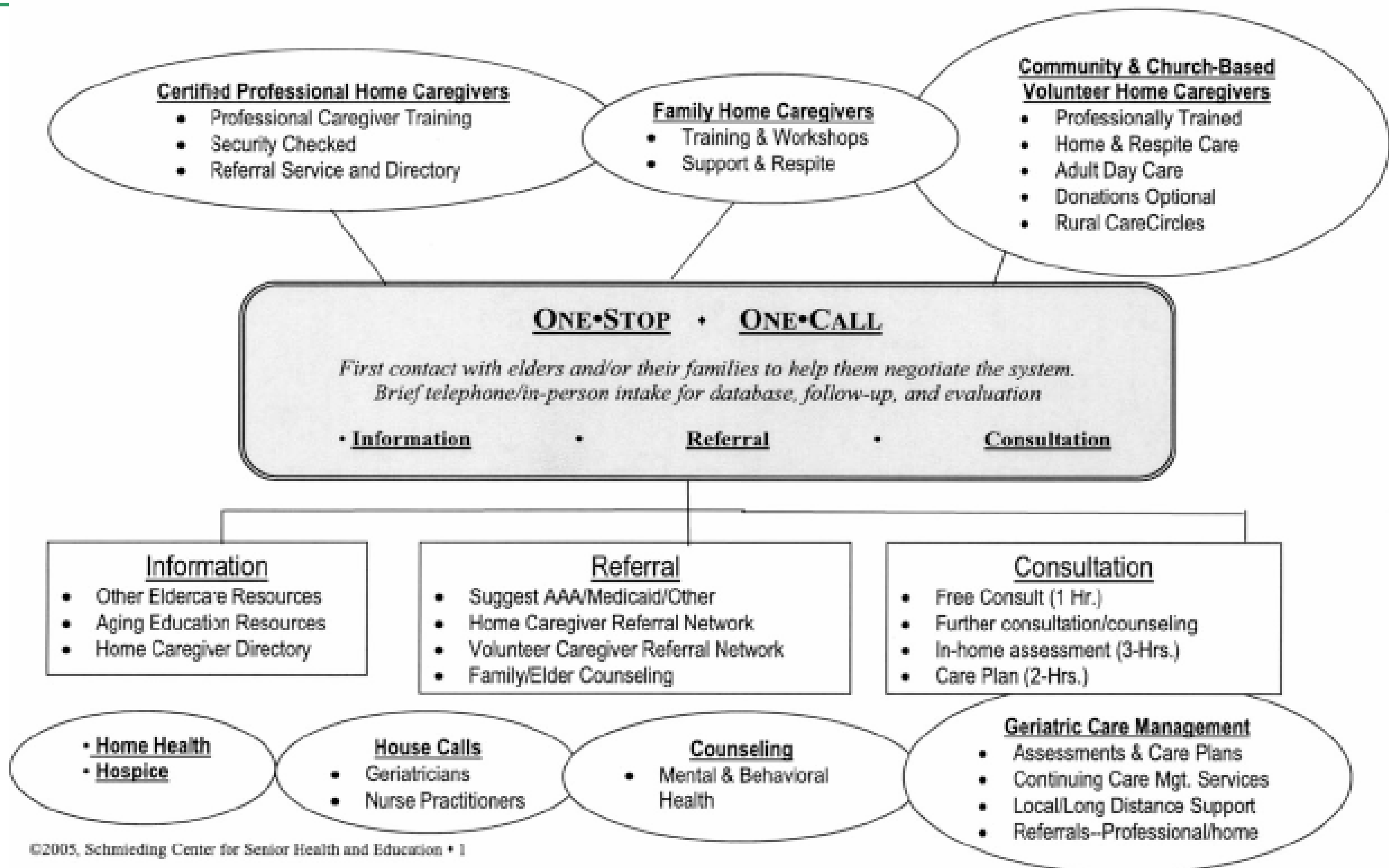
Findings – Models that Work - BJBC

- **Better Jobs Better Care** demonstration pilots across the nation build quality and stable direct care workforce:
  - Win-win for **Michigan**. Operation ABLE surveyed job seekers 55+ and LTC consumers to explore feasibility of engaging older workers in LTC. More than half of LTC consumers have positive perceptions of older workers. Both older workers seeking employment and LTC employers facing shortages make a good match.
  - **California** former family caregivers add to pool of home care workers.
    - University of Ca, LA, conducted a study of one-time paid caregivers to families and friends in CA's In-Home Supportive Services (IHSS). Majority were willing to provide care again; 67% were willing to care for strangers.
    - Surveyed 2,200 in-home supporters (IHSS) from 8 CA counties to address turnover. Influencing factors to remain in caregiving included: Higher wages, greater flexibility , and health care benefits.

- Jobs to Careers program in **Oregon** created career paths for direct care workers in assisted living by implementing a curriculum based on the occupational profile. Plan to extend to home care aides. Direct care workers are attending care conferences and doing self-scheduling, report they have a greater voice in career advancement and work place.

Source: Insights: Better jobs Better Care Quarterly Newsletter No 10 Summer 2007.

Findings – Models that Work – AR: ElderStay@Home

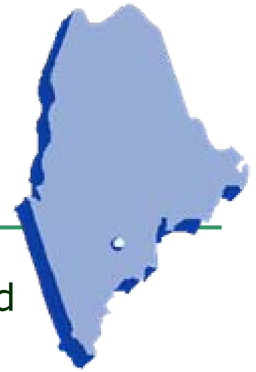


Findings – Models that Work – ElderStay@Home

- **The ElderStay@home Certified Home Caregiver Training** program was developed by Schmieding Center for Senior Health and Education (SCSHE) located in **Arkansas.** The center is a partnership of the University of Arkansas for Medical Sciences Institute on Aging, the Area Health Education Center-NW, and NW Health System. Team initiatives include:
  - National curricula for paid and informal caregivers, including the Arkansas model by SCHSE.
  - National accreditation to train caregivers, provide a national, certification/licensing process, and continuing education requirements to maintain certification for providers in the residential and institutional settings.
  - Career Ladder initiative to include a component to recruit men into the caregiving profession.
  - National Association for Professional Home Caregivers to promote and develop members.
- SCSHE intends to go forward using formal research knowledge and field experience to refine programs.

Source: Caregiving in America, Lawrence Schmiedling, The Caregiving Project for older Americans, ILC-SCSHE Taskforce 2006

Findings – Models that Work



- **MAINE**: OHI Comprehensive retention program for direct support professionals. The program include regular feedback and merit-based raises for its mental health division.

Best Practice	Description	
Program Structure (Inception 1996)	For nonprofit private agency with 325 employees located in Maine. Provides services to people with developmental disabilities, or mental health needs.	Funding Sources: Medicaid and revenue from for fee external training programs.
Program Rationale	Designed to provide employee recognition and merit-based wage increases.	
Recruitment & Retention	Retention focused on maintaining a high level of employee morale, providing responsive care to consumers, assessing and improving practices to ensure employees have input into the lives of people they support.	
Quality Training	Includes: orientation and training. New hires attend a paid 2 wk intensive training and orientation before beginning work. Topics grounded in Direct Support Professionals Code of Ethics. Topics: sexuality awareness, dealing with difficult behavior, communications, mentor shadowing, (paired with experienced and exemplary aide for first 2 wks on the job). Training methods: adult learning techniques. Each employee develops a professional plan settings goals for 6 mo – 2 years.	
Incentives	Evaluation and Merit-based wage increases. Employees required to maintain a portfolio of certificates, achievements, etc. And meets monthly w/supervisor for a "fireside chat" to discuss work-related problems. Employees participate in 360-degree feedback groups annually. Employee Recognition: employee of the month, team of quarter, employee of year nominations. Benefits: medical, dental, retirement, insurance, connections to food stamps, childcare & transportation.	
Outcomes & Strengths	OHI has a low turnover rate and receives a constant stream of applicants through word of mouth. Exist interview show main reason for leaving is moving or going to school full-time.	

Source: National Clearinghouse on the Direct Care Workforce, OHI: Comprehensive retention program, www.ohimaine.org

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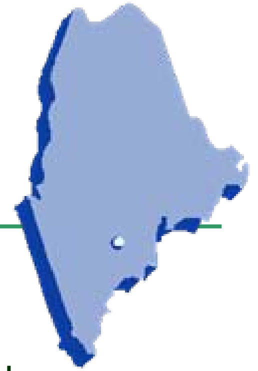
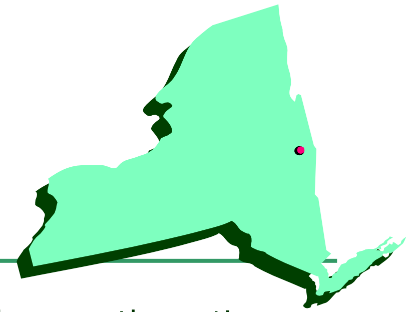
Findings – Models that Work



- **MAINE: Cross-Training and Cross-Certification:**
  - Educational Technicians certified to work in school settings for children with learning disorders, could not continue to provide support in a home or other non-school setting. Maine recently initiated a new cross-certification program for Educational Technicians as Behavioral Specialists to provide care in and out of school settings. This has led to greater opportunities for children and their families to find in-home or community-based care.*
  - Note: The Fredrickson Home, Kent, WA, has used this philosophy of recruiting from already credentialed candidates successfully as part of their recruitment efforts. They target already trained and certified professionals who are working in schools with children with developmental disabilities and cross-train them for the residential setting. In this model, screening by observation and vocational choice, has resulted in a very low turnover. **

Source: * www.mainerealchoices.org/workgroup_materials/DCWorkforceChallenges.htm December 28, 2000.
** The Fredrickson Home, Craig Fredrickson interview 8/2007.

Findings – Models that Work



- **NEW YORK: Self-help Neighbors** – Village Concept: a movement in New York and across the nation to make neighborhoods a comfortable place to grow old, for baby boomers anticipating the future. Residents are organizing and registering as nonprofit corporations with member fees to provide transportation, home repair, companionship, security, personal care and other ADLs.

- Urban planners and senior housing experts predict this could make "aging in place" safe and affordable for elderly people.

- Naturally Occurring Retirement Community (NORC) is a 20 yr old model with financed social services, including nurses and case managers in apartment buildings with a concentration of residents needing services. Last year it added a few suburban neighborhoods, so-called horizontal NORCs. In rural areas transportation vouchers too costly, so they recruit volunteer drivers from 118 home owners' associations and 17 churches (potential liability issues were noted).

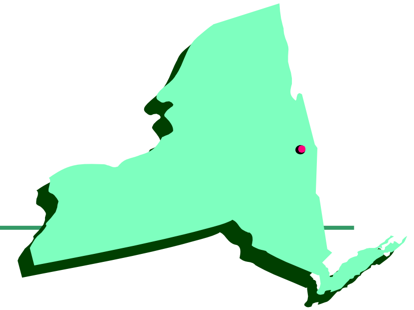
- Members of all these groups share an independent streak and the willingness to plan for the future. They tend to be real estate rich, but cash poor, resulting in considerations of reverse mortgages. Majority felt that asking for help was a negative and would be less likely to be humiliated if the help was provided in their own home.

- Concerns are whether these models may become care for the privileged.

- Not a panacea for those with complicated medical needs

** Source: "A Grass-Roots Effort to Grow Old at Home – New York Times Jane Gross, August 14, 2007.*

Findings – Models that Work



- The **Green House™** is a model of skilled LTC designed to transform nursing facilities into homes providing meaning and growth for residents. Instead of a large facility, green homes are designed to accommodate 6 – 10 residents; each with a private bedroom and bath opening to a communal living and dining area.
- Funded by RWJF with an initial solicited grant of $1 million. The subsequent two grants were awarded "unsolicited" to provide alternatives for the aging Boomers.
- RWJF's support for the replication initiative awarded an additional 5-year $9.5 million grant in November 2005.

Source: "Green Houses" Provide a Small Group Setting Alternative to Nursing Homes – a Positive Effect on Residents' Quality Care. RWJF January 25, 2007.

Findings – Models that Work

- **California**: Self-Help Neighbors – Village Concept: a movement in California for low-income families, such as in Richmond District of San Francisco has diverse populations who rely on bartered services keep fees down. They also share regional resources, and utilize online expertise to accommodate some care needs. Sustainability has been successful over a 30+ year period.

- On Lok – San Francisco:

  On Lok is a not-for-profit organization founded in the early 1970s by a group of citizens concerned about the plight of frail elders and the lack of long term options in the community. On Lok serves seniors in the community through:

  - **On Lok SeniorHealth-** a comprehensive health plan that provides long-term care for eligible seniors living in San Francisco and Fremont, CA. The program offers full medical care and support services with the goal of helping seniors live at home and in the community for as long as possible.
  - **30th Street Senior Services-** the largest multi-purpose senior center in San Francisco offering a broad range of programs including a senior center, nutrition and congregate meals, home delivered meals and bilingual case management.
  - **On Lok Intergenerational Program-** a program that brings together On Lok Senior Health members and children from neighboring childcare centers and elementary schools.
  - **Housing-** three buildings with various types of residential units for older adults.

*Source: *"A Grass-Roots Effort to Grow Old at home," The New York Times, August 14, 2007. **On Lok Web: http://www.onlok.org*

Findings – Models that Work

- **NORTH CAROLINA**: A Paradigm Shift of the institutional model to the resident-centered approach occurred when Pennybyrn at Maryfield, NC transformed its staff and facility into a "household model."

- The organizational cultural change happened nearly three years ago:
  - To provide a more livable and flexible environment to serve the baby boomers' preferences for care.
  - To empower residents to make decisions about their care; they also had to empower CNAs to care for residents differently. They created "empowered" teams who met weekly to share supervisory responsibility such as scheduling, monitoring of performance, etc. Overcoming 50 years of hierarchical structure presented some challenges.

- Successful Outcomes:
  - After 16 months of adopting the "empowerment" and cultural change activities, CNAs and nursing staff performance measures were higher; and family members and residents reported care had improved.
  - Robyn Stone, Dr. PH, executive director of the AAHAS, conducted an evaluation for the Fund of the Wellspring module of nursing home care and noted, "One of the powerful things about the evaluation was the importance of peer mentoring at the organizational level to not only implement but to sustain (culture change) activities."

*Source: *"Transforming Long-Term Care: Giving Residents a Place to Call "Home," Christine Haran, April 2006.*

Findings – Models that Work

- **Choosing Independence: A summary of the Cash & Counseling (C&C) Model of Self-Directed Personal Assistance Services.**
  - Medicaid consumers offered more choices about home care
    - manage a flexible budget to best meet their personal care needs , and
    - live independently with improved quality of care outcomes.
  - As of January 2007, federally approved "waivers" no longer required.
  - To date, 12 states use C & C; Washington is one.

- **Six most significant findings of the C& C evaluation research conducted by Mathematica Policy Research (MPR) over 5 year period in Arkansas, Florida, and New Jersey, include:**
  - C & C significantly reduced unmet needs of Personal Assistance Services.
  - Participants experienced positive health outcomes.
    - Demonstrated reduced risk of urinary tract infections, falls and adverse events.
  - Improved quality of life for participants and their caregivers.
    - Across all 3 states evaluated C & C participants were up to 90% more satisfied with how they led their lives.
  - Medicaid PCA costs higher under C & C due to enrollees receiving more of the care authorized to receive.
  - Medicaid costs under C & C were partially offset by savings in institutional and other LTC costs.
  - C & C need not cost more than traditional programs if designed/monitored carefully.
    - Recovering allowance amounts not used recommended be returned to the state.
    - Median monthly allowances: (AR = $313) (FL = $829 Adults/ $831 Children) (NJ = $1,097).

Source: Choosing Independence: A Summary of the Cash & Counseling Model of Self-Directed Personal Assistance Services, RWJF 2007.

Findings – WA Model Initiatives LTC

- **State-Level Application of Chronic Illness Breakthrough Series: Results from Two Collaboratives on Diabetes:***

  In 1995 the Institute of Medicine (IOM) pioneered the Breakthrough Series Collaborative to create systems that are more evidence-based, patient centered, efficient, and effective. Two state-level collaboratives were conducted 1999 – 2000; both took place in Washington State to address Chronic Care Model.

  Their conclusions about the benefits of holding collaboratives more locally were:

  - Increased technical support
  - Increased participation
  - Wider implementation of prevention-focused
  - Person-centered care.

*Source: * Joint Commission Journal on Quality and Safety, February 2004, Vol. 30 No 2, **http://www.wwpp.org*

Findings – WA Model Initiatives LTC

- **Governor Gregoire in her 01/20/06 memo regarding Chronic Care Improvement, cited that 5% of Medicaid recipients are responsible for roughly 50% of the programs' costs.***

  – Chronic Care Management provides evidence-based assessment and interventions, coordination of health care and other supportive services, education and training that assists program participants in improving self-management skills to improve health outcomes, reduces medical costs, improve functional and self-care abilities, and slows progression of disease of disability.

  – The LTC Task Force Advisory Committee Draft Recommendations noted the transitions in care for clients between acute and long term care systems are of particular concerns and clients are vulnerable to negative outcomes during these transitions.

*Source: *ADSA Chronic Care Summary 6/2/2007.*

Findings – WA Model Initiatives LTC

- **Current focus of DSHS ADSA and Health and Recovery Services Administration (HRSA) is to develop effective models of chronic care.**

  The Intensive Chronic Case Management Project (ICCM) is design to provide integration of acute and LTC services through coordination of care. The ICCM model builds on ADSA's existing LTC casework and in-home service delivery infrastructure through AAAs.*

- ICCM project piloted at five Area Agencies on Aging:
  - Olympia Area Agency on Aging
  - NW Regional Council
  - Pierce County Aging and LTC
  - SE WA Aging and LTC
  - Aging and LTC of E WA
- How ICCM project works:
  - Provides enhancement of case management interventions
  - Combines medical/LTC services into a care plan focused on client's needs in an integrated manner.
  - Based on Chasm Report aims; effective, safe, timely, efficient and client centered
  - Implements preventive care measures to delay decline and promote abilities.
  - Improves cost effectiveness and utilization to achieve individual's outcomes.
  - Client identified individual health goals.

*Source: *ADSA Chronic Care Summary 6/2/2007 and ICCM Project Study Model presentation LTC Task Force, 6/14/2007.*

Findings – WA Model Initiatives LTC

- **The ICCM pilot project is design to:**
    - — Lower Medicaid expenditures by providing integration of acute and LTC services through coordination of care. The ICCM model builds on ADSA's existing LTC casework and in-home service delivery infrastructure through AAAs.
    - — Provide a 3 way relationship: client, practitioner and DSHS.
    - — Maintain health status, minimize acute episodes, limit disability and reduce costs.

- **Project Evaluation:**

— First four quarters demonstrated a return on investment of 3:1.

— 10 clients enrolled in Medicare.

— Number of health system interactions reduced 18%

— Other reductions in utilization:

- ER 9%
- Home Health visits 60%
- Hospital days 15%
- Prescriptions 19%
- Physician office visits 22%

*Source: *ADSA Chronic Care Summary 6/2/2007 and ICCM Project Study Model presentation LTC Task Force, 6/14/2007.*

Findings – WA Model Initiatives LTC

- **The ICCM themes include:**
  - Care organized around the consumer
  - Progressive nature of chronic care
  - Disabling aspects (Total reduction in $$)
  - Self determination and management
  - Engaging family/informal supports

- **Future Evaluation:**

— Pursuant to SSSB 5930, the study will be guided by a group that includes representatives from HRSA and DOH and a preliminary report will be completed by June 2008. A final report will be completed by December 2008.

*Source: *ADSA Chronic Care Summary 6/2/2007 and ICCM Project Study Model presentation LTC Task Force, 6/14/2007.*

Summary

- **Impacts of worker training upon the quality of LTC services provided include the following factors:**

— **National Trends –** Paradigm shift from nursing facilities to home care. National trends show a move away from a highly structured care system to a highly independent and diverse care system. Washington's LTC training is aligned with current national trends for a more person-centered model that provides flexibility for consumers and workers to determine scheduling, type, and amount of care.

— As demands for LTC care increases so does the need to contain costs. An example of this is evidenced by the 4/2007 Supreme Court decision - Long Island Care at Home, Osborne vs. Evelyn Coke involving exemption of overtime and benefits for home care workers, citing costs. Another example is cite in ESSHB 2284 (6) (c) State laws and regulations that should be revised and/or eliminated in order to reduce or contain LTC costs to individuals and the state.

— Recruitment and retention are listed as a top priority for the LTC industry.

— Federal focus on quality assurance measures and worker protection. Washington has begun to address such concerns by establishing public authority models, which act as the employer of record for workers hired directly by consumers and by implementing improved Quality Assessment tools.

Summary

- **Impacts of worker training upon the quality of LTC services provided include the following factors:**
  - **Models that work** reviewed, used diverse and emerging strategies to address common LTC problems with varying degrees of success. Each shared a commonality of key elements:
    - Consumer directed care based on person-centered goals and quality of life first
    - Flexibility for consumers and workers
    - Stringent selection process to identify right people for the right job
    - Strong orientation with OTJ, peer mentoring, job shadowing in setting
    - High degree of consumer and worker satisfaction with venue for input
    - Multiple funding sources to address sustainability
    - Strong evaluation metrics to provide feedback and oversight of performance

Summary

- **Considerations for a WA LTC training model:**
  - TANF partnerships may provide access to an untapped labor to address recruitment/retention issues:
    - Targeted approach to recruiting from the TANF recipient pool of workers has been successful in non-profit and for profit structures in others states and can be applied in the WA LTC settings, including nursing homes.
    - Benefits for workers and consumers using this model are realized by identifying and retaining the right people to ensure job satisfaction and advancement opportunities, while providing employers/consumers with an opportunity to observe workers prior to hiring or placement.
    - Opportunities for multiple funding and leveraging resources exists with this model.
  - Both programs reviewed include a CNA certification and training component.

Summary

- **Potential impacts expressed in public and panel presentations regarding changes to the current LTC worker training program summarized below:**
  - One training model does not and should not fit all settings.
    - Although the trend is toward a more self-directed in-home model of care, it may not meet the needs for those unable to direct their care needs or for those with acute medical care needs, or for people with disabilities.
  - Additional training may increase costs and/or burden for providers and consumers.
    - Some Agency providers expressed in panel presentations increased costs may cause business closures and increase shortages in LTC labor pools, citing "Do No Harm" as a guiding principle.
    - Questions posed several times of who will pay for additional training and who will license Certified workers?
  - Additional training and certification requirements perceived as unnecessary and based on assumptions the LTC system is broken and that majority of workers want full time hours and/or career advancement opportunities.
    - A majority of IPs are family members/friends, some of whom expressed additional training would cause financial and/or replacement burdens for perceived unnecessary training.
    - Some indicated scheduling flexibility was a key for remaining in LTC.
    - Supported Living training requirements currently include 102 – 140 hours and are more relevant to clients needs than proposed training.
  - Changes to current training system focused on worker vs. consumer needs.
    - Many expressed the need for training to remain flexible and focused on person's functional capacity needs vs. workers needs. Current measurement is based on number of tasks performed vs. quality of relationships.

Summary

- **Potential impacts or unintended consequences:**
  - As mentioned in Deliverable #5 Training Needs Report, the step for identifying cost benefit analysis to determine Return on Investment for proposed training is outside the scope of this report and therefore any impacts on costs are unknown.
  - Impacts of Certification and Apprenticeship programs are not included here and will be reviewed in Deliverable #7.
- **Washington is ahead in many areas of emerging strategies used in LTC training programs and is in a unique position to explore opportunities for additional improvement.**

  The ICCM pilot project is underway to address chronic care and disability prevention interventions that will reduce LTC costs and improve individual health – ESSHB 2284 (7).

  Areas for potential improvements cited in several consumer and provider surveys, public and panel presentations include:

  - Increased statewide access to support, peer mentoring, and expertise
  - Increased supervision and oversight within the home care setting
  - Improved or targeted recruitment and selection process
  - Increased retention incentives for workers