Senate Bill 19-238: Improve Wages and Accountability for Home Care Workers

Recommendations regarding home care worker training requirements and notification of compensation and wage changes

December 2019

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Executive Summary

Background Information

In May 2019, Governor Jared Polis signed into law Senate Bill (SB) 19-238, requiring, among other things, stakeholder-driven recommendations concerning training and notification requirements for homemaker and personal care workers. The Department of Health Care Policy and Financing (HCPF), in partnership with the Department of Public Health and Environment (CDPHE), launched an initiative to establish a Training Advisory Committee (TAC), gather key stakeholder input, and develop specific and actionable recommendations related to minimum training, worker notification of pay increases, and training enforcement. A complete overview of the requirements of SB 19-238 and the Training Advisory Committee can be found here.

During October-December 2019, the TAC met 5 times and reviewed summary findings from a listening tour that gathered stakeholder feedback from participants across Colorado. A summary of the listening tour can be found in this report, here.

Recommendations

The TAC respectfully submits 10 recommendations in three categories for consideration:

Training Content and Delivery:

1. The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should develop standardized core training requirements for home care workers that are portable and based on principles of learning and development and person-centeredness. Such training should include, at minimum, the topics outlined in this recommendation report (see Appendix 1), which also clarifies which topics would require competency testing and skills demonstration/evaluation.

2. The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should develop standardized advanced training requirements for home care workers regarding specialized topics, as outlined in this recommendation report (see Appendix 1), which also clarifies which topics would require competency testing and skills demonstration/evaluation.

3. In addition to standardized, portable training, the Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should update requirements and Rules related to minimum content for agency-specific training, skills demonstration/evaluation, and competency testing. Such minimum content for agency-specific training shall not serve to limit agencies from providing additional in-house training. Agencies shall have the flexibility to obtain their training from any qualified internal or external provider.

4. The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should explore opportunities to create standards for trainer qualifications that enable flexibility and contribute to improved quality.

5. The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should review minimum training requirements on an interval not to exceed 24 months to make adjustments based upon stakeholder feedback, required enforcement actions and other relevant findings. HCPF should ensure that training content falls within the scope of service delivery allowed for Personal Care and Homemaking Services, as deemed allowable under Colorado Medicaid.

Worker Notification of Wage Increases and Compensation Changes

6. The Colorado Department of Health Care Policy and Financing (HCPF), in collaboration with the Training Advisory Committee, will publish notification language to be used by agencies through at least two notification methods (e.g. text messages, emails, phone calls, letters, posters, notice with pay statements, etc.). All such notices should be made available upon request in a caregiver's preferred language to the extent practicable by the Department.

7. As part of its onsite surveys, the Colorado Department of Public Health and Environment (CDPHE) should verify compliance with the compensation notifications required through SB 19-238 and ensure the agency has met the notification, verification and language recommendations as required by statute.

Training Enforcement

8. By July 1, 2020, the Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) (as needed) should begin to collaborate to align existing and develop prospective Rules requiring agencies to provide state-required minimum training to employees, documenting such training in each employee's record, and to be responsible for providing oversight for meeting minimum training requirements.

9. Consistent with current licensing inspection procedures, the Colorado Department of Public Health and Environment (CDPHE) should examine evidence of compliance with minimum training requirements, as determined by the Department of Health Care Policy and Financing (HCPF).

10. The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should collaborate to develop a resource for home care workers on the available reporting processes and worker's rights information and protections under State labor laws.

The rationale for each of these recommendations is in the body of this report.

Implementation Considerations

The direct care industry is experiencing rapid growth in the demand for services. Over the next 7 years, the US Department of Labor estimates a 45% increase in the personal care workforce alone. A well-trained workforce promotes high quality care for clients, job satisfaction, and employee retention. At the same time, direct care agencies and employers face challenges in providing effective and affordable training and monitoring employee development. As such, the Departments should take into account the following considerations as they review and implement any of the above recommendations:

- stakeholder feedback, including clients and workers;
- requirements versus better practices;
- cost implications; and
- timeline for implementation.

Project Overview

In May 2019, Governor Jared Polis signed into law Senate Bill (SB) 19-238, requiring, among other things, stakeholder-driven recommendations concerning training and notification requirements for homemaker and personal care workers. The Department of Health Care Policy and Financing (HCPF), in partnership with the Department of Public Health and Environment (CDPHE), launched an initiative to establish a Training Advisory Committee (TAC), gather key stakeholder input, and develop specific and actionable recommendations.

To understand the current and proposed training and notification requirements, 6 in-person and 2 virtual listening sessions were held in locations across the state, including Colorado Springs, Fort Collins, Montrose, and Frisco. Additionally, the Training Advisory Committee held 5 meetings to review, investigate, and discuss various topics facing homemaker and personal care workers, agencies that employ them, and clients receiving care from them. Results from the listening sessions and meetings have been synthesized and are presented as recommendations in this report.

There are several important characteristics of training that became consistently evident while gathering input during listening sessions and Training Advisory Committee meetings, including:

- the method of delivery and qualifications of the training provider matter in terms of efficacy and uptake;
- the challenges associated with ensuring the consistent application of requirements from worker to worker and agency to agency; and
- the importance of clear communication about requirements and resources to support both workers and agencies.

This report contains:

1) Background information on the legislative requirements of SB 19-238, including roles and responsibilities;

2) A summary of the stakeholder engagement processes and participation; and

3) Recommendations for initial and ongoing training requirements, enforcement procedures, and wage increase and compensation change notification processes.

Additional information is included for consideration in the appendices, including a detailed training summary, key themes distilled from listening sessions, comments submitted by the public and contact details.

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Background Information and Critical Roles

Senate Bill 19-238

Among other requirements, SB 19-238 mandates the development of stakeholder-driven recommendations concerning training and notification practices for employees providing homemaker services, personal care services, and in-home support services. The bill outlines the composition of the stakeholder group and provides a clear timeline for required activities.

Training Advisory Committee

The Departments of Health Care Policy and Financing (HCPF) and Public Health and Environment (CDPHE) established a Training Advisory Committee to perform the stakeholder engagement work outlined in the bill. The Training Advisory Committee was charged with:

- reviewing the current state of initial and ongoing training for home care agency employees;
- reviewing the current enforcement practices for initial and ongoing training for home care agency employees;
- advising the Departments concerning the manner in which non-administrative employees will be notified of the compensation increases and minimum wage established in the bill;
- developing recommendations for future initiatives to be reviewed by the Departments; and
- producing a report of its findings and recommendations by January 1, 2020.

Members of the Training Advisory Committee included:

Melissa Benjamin	David Bolin	Christina Brown
Lorin Chevalier	Pat Cook	Stephanie Felix
Liz Gerdeman	Jennifer Gilchriest	Cynthia Hardiman
Jeanette Hensley	Kelley Horton	Alexa Lanpher
James Moore	Sarah Serrar	Stacy Warden

Members of the Training Advisory Committee represented:

1. Consumer advocacy organizations
2. Personal care workers
3. Worker organizations
4. Home care agencies
5. Disability advocacy organizations
6. Senior advocacy organizations
7. Children's advocacy organizations
8. Members / representatives of members who receive personal care, homemaker, or in-home support services
9. Representatives of state departments

Department Involvement

HCPF administers rules for Medicaid providers pertaining to personal care and homemaker training requirements. For purposes of SB 19-238, HCPF was responsible for executive oversight and coordination of the Training Advisory Committee, policy and recommendation analysis, stakeholder engagement, and public reporting.

CDPHE promulgates licensure rules pertaining to personal care worker training and, per SB 19-238, collaborated with HCPF to verify the training requirements for home care service agency staff.

Additionally, the Colorado Departments of Regulatory Agencies (DORA) and Labor and Employment (CDLE) provided expertise concerning professional licensure, education, and workforce development and training.

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Stakeholder Engagement Process and Participation

As key means of soliciting feedback and holding discussion from key stakeholders and the interested public, the TAC meetings and listening tours sessions were open to the public with time held for public comment. Additionally, stakeholders and the public were invited to share comments with HCPF via email.

Training Advisory Committee Meetings

During the meetings held between October and December 2019, at least 14 individuals attended in person or on the phone, in addition to the members of the TAC. The TAC covered topics necessary to meet the requirements of SB 19-238, including training content and delivery, worker notification of wage increases and compensation changes, and training enforcement. Ancillary feedback from participants, both public and members of the TAC, is included in this report.

Listening Sessions

In October and November 2019, a total of 71 individuals participated in regional and virtual listening sessions. The Department hosted 8 listening sessions, five of them in Colorado Springs (2), Ft. Collins (2), Montrose (1), Frisco (1), as well as 2 virtual focus groups.

Participation in the listening sessions included home care workers, representatives from home care agencies, community-based resources, family members of care receivers, senior advocates, trainers, and other interested parties. A summary of insights is included in Appendix 2 of this document, derived from discussion notes and reflecting a tally of brainstormed topics.

Recommendations

After careful consideration of stakeholder and member input, the TAC crafted 10 recommendations in three categories including training content and delivery, worker notification of wage increases and compensation changes, and training enforcement. The 10 recommendations and the rationale for each are shown below:

Training Content and Delivery

Recommendation 1: The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should develop standardized core training requirements for home care workers that are portable and based on principles of learning and development and person-centeredness. Such training should include, at minimum, the topics outlined in this recommendation report (see Appendix 1), which also clarifies which topics would require competency testing and skills demonstration/evaluation.

Recommendation 2: The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should develop standardized advanced training requirements for home care workers regarding specialized topics, as outlined in this recommendation report (see Appendix 1), which also clarifies which topics would require competency testing and skills demonstration/evaluation.

Rationale for Recommendations 1 and 2: The importance and impact of well-trained homemaker and personal care workers cannot be understated in terms of quality of care and workforce development. Standardized training paired with competency tests and skills demonstrations/evaluations where appropriate ensures a minimum level of skills and knowledge, regardless of where an individual is employed. Attributing the satisfactory completion of standard minimum training requirements to individuals allows portability of skills and knowledge while allowing agencies to allocate

training resources to client- and agency-specific standards. As such, a potential minimum training curriculum has been drafted. The curriculum includes multiple modules containing relevant topics with recommended timing and recurrence intervals for initial and ongoing requirements. Where defined, recommendations regarding delivery models, trainer certifications, evidence of competency and skill are included. The modules include topics covering:

- Privacy, Ethics, and Compliance
- Scope of Service
- Person-centered Supports
- Agency Orientation
- Basic Health and Safety
- Homemaker-Specific Topics
- Personal Care Worker-Specific Topics
- Specialized Topics

Recommendation 3: In addition to standardized, portable training, the Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should update requirements and Rules related to minimum content for agency-specific training, skills demonstration/evaluation, and competency testing. Such minimum content for agency-specific training shall not serve to limit agencies from providing additional in-house training. Agencies shall have the flexibility to obtain their training from any qualified internal or external provider.

Rationale: Agency-specific training includes topics designated by individual agencies *in addition to* the standard minimum training requirements described in recommendations 1 and 2. Formalizing minimum training requirements via rulemaking procedures codifies the standards for individuals and agencies and provides the backstop for regulatory services while preserving flexibility for agencies to provide additional training, from internal or external qualified providers.

Recommendation 4: The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and

Environment (CDPHE) should explore opportunities to create standards for trainer qualifications that enable flexibility and contribute to improved quality.

Rationale: Feedback from the listening sessions pointed to the impact of well-qualified (and poorly-qualified) trainers on homemaker and personal care workers, their clients, and their agencies. Exploring standards for qualified training providers supports effective, reliable, and consistent training services.

Recommendation 5: The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should review minimum training requirements on an interval not to exceed 24 months to make adjustments based upon stakeholder feedback, required enforcement actions and other relevant findings. HCPF should ensure that training content falls within the scope of service delivery allowed for Personal Care and Homemaking Services, as deemed allowable under Colorado Medicaid.

Rationale: Given that the direct care industry and workforce are anticipated to face significant growth and changes in the coming years, it is important to review minimum requirements to ensure they are meeting the needs of clients, workers, and agencies and reflect current trends and continuous quality improvement efforts.

Worker Notification of Wage Increases and Compensation Changes

Recommendation 6: The Colorado Department of Health Care Policy and Financing (HCPF), in collaboration with the Training Advisory Committee, will publish notification language to be used by agencies with at least two notification methods (e.g. text messages, emails, phone calls, letters, posters, notice with pay statements, etc.). All such notices should be made available upon request in a caregiver's preferred language to the extent practicable by the Department.

Rationale: To meet the notification requirements of SB 19-238, HCPF and the Training Advisory Committee must develop a method of sharing wage increase and compensation change information with workers. Information dissemination should be targeted at reaching workers by the most effective and accessible means possible.

Recommendation 7: As part of its onsite surveys, the Colorado Department of Public Health and Environment (CDPHE) should verify compliance with the compensation notifications required through SB 19-238 and ensure the agency has met the notification, verification and language recommendations as required by statute.

Rationale: Confirming that agencies are compliant with notification requirements rests on agencies producing evidence demonstrating their means of communication and information sharing.

Training Enforcement

Recommendation 8: By July 1, 2020, the Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) (as needed) should begin to collaborate to align existing and develop prospective Rules requiring agencies to provide state-required minimum training to employees, documenting such training in each employee's record, and to be responsible for providing oversight for meeting minimum training requirements.

Rationale: Ensuring minimum standards for training, including training provided by agencies, promotes consistency and quality in skill and knowledge development for homemaker and personal care workers. Regulations that involve multiple state authorities should be regularly reviewed and revised to improve alignment and clarity. See rationale for recommendation 1 for more detail.

Recommendation 9: Consistent with current licensing inspection procedures, the Colorado Department of Public Health and Environment (CDPHE) should

examine evidence of compliance with minimum training requirements, as determined by the Department of Health Care Policy and Financing (HCPF).

Rationale: Current licensing and re-licensing inspection procedures by CDPHE provide opportunities to include additional survey elements, including compliance with minimum training requirements as such minimums are developed by HCPF. The existing regulatory framework should be adequate to address new training regulations.

Recommendation 10: The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) should collaborate to develop a resource for home care workers on the available reporting processes and worker's rights information and protections under State labor laws.

Rationale: Feedback provided during the listening sessions clearly indicated that homemaker and personal care workers do not consistently know the process for reporting concerns or grievances to state authorities, nor are they always aware of their individual worker rights. Developing a clear and simple resource for direct care workers to access easily would support their needs while offering an opportunity for state authorities to deepen their understanding of the issues and concerns facing this workforce.

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Appendix 1: Recommended Training Requirements

A potential minimum training curriculum has been drafted. The curriculum includes multiple modules containing relevant topics with recommended timing and recurrence intervals for initial and ongoing requirements.
Recommendations regarding delivery models, trainer certifications, evidence of competency and skill are defined in the draft curriculum as follows:

- Role: Homemaker, Personal Care Worker or Both
- Timing: Before Contact with Client, Within 45 Days, Other (Specialized/Advanced)
- Recurrence: interval at which the training must be repeated/refreshed; R1=at least annually, R2=every 2 years, etc.
- Competency test: testing for knowledge
- Skills demonstration: demonstrating gained skills, practicing, role-playing
- Portable: proof of completion of training follows the worker
- Acceptable training modes: in-person/live, video or online, or a hybrid model (in-person + video/online, based on specific content)

Guiding Principles, as defined by the TAC (comments from TAC members included in footnotes)

- When training is put to practice, approach should be customized to each individual client and balance health and safety with client choice
- Consider the alignment between, or merging of, CDPHE and HCPF rules
- Balance robust, meaningful training to meet individual needs, but not require too many trainings as this may be a deterrent for entry into the field[1]

This footnote and all subsequent footnotes are commentary from TAC members

[1] "Balance robust..." Current personal care providers and potential providers are aware of the vast amount of information and training that goes into providing proficient care to the Senior community, they actually welcome it, are asking for it, and complain that they are not properly prepared. I believe that they would appreciate, extended session knowing that the outcome would be beneficial to them and most importantly the clients /consumers who rely on providers to be trained and informed to handle various services, cultural lifestyles and emergency situations. To imply that extended sessions would be a possible deterrent is false.

- Recognize the need for consistency in quality and offerings across home care agencies[2]
- Offer ongoing training and on-demand training for home care workers to access as needed
- Make training available in multiple formats and languages that account for different learnings styles, learning disabilities, education levels, cultures, etc.[3]
- Establish a reliable way to determine training comprehension (e.g., observation, demonstration, testing, etc.)

Items for Resolution by Those Designing/Approving Curricula, as defined by the TAC

- Structure of training (e.g., courses comprised of modules, topics that build on prior learning, etc.)
- Specific ADLs for homemaker vs. PCW to ensure that agencies, PCWs, and homemakers clearly understand the differences in scope of practice within their assigned roles, including tasks appropriate for PCWs

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[2] The statement "Home Care Agencies recognize the need for consistency in quality offerings" is very vague and should provide specific intentions regarding this statement. Agencies should be held responsible for the misinformation and jargon used to confuse the consumer as well as the Personal Care Providers. To use Core training requirements for non-skilled services for that are actually skilled services based on assessments that do not cover the dynamics of these services are insulting. It is also the responsibility of the agencies to establish a reliable way to determine training comprehension, observation techniques and demonstration testing in a face to face environment and care setting that gives the common service environment.

[3] This is likely to be difficult for smaller agencies with reduced resources and will likely require multiple format and multiple language trainings to be outsourced.

[4] If BOTH Competency Test and Skills Demonstration are required, then Training Mode should be Hybrid. Otherwise, Training Mode can be either In-Person or Video/Online.

[5] General concept: In-person training allows greater customization on the part of each agency, while video/online training from a 3rd party provider can achieve greater consistency across agencies.

[6] There is no requirement for PCW/Homemakers to be certified and may present a barrier to entry to the field.

[7] To remain compliant with CDPHE Home Care Licensure Rules, Class B agency caregivers including personal care and homemaking services workers must not perform any form of medication administration EXCEPT in the case of licensed IHSS agencies authorized to perform Health Maintenance Activities where "Attendants" but not personal care and homemaking services employees may administer medication. No Class B agencies may perform QMAP services, which under the QMAP rules are limited to certain defined facility types under RN oversight.

(including providing ADL assistance) and tasks appropriate for homemakers (does not include providing ADL assistance).
- File v. clip (nail maintenance): HCPF rules v. CDPHE rules
- Different scope of practice for I/DD v non-I/DD waivers
- PCW performing homemaker tasks within care plan
- Concept: certification - prehire, portable; standardization on delivery, core curriculum
- Gathering input from receivers of care
- Need to address IADLs

Draft Curriculum: Modules and Topics

The draft curriculum has been organized into modules that include specific topics. Details on the following modules are included in the pages that follow:

- Privacy, Ethics, and Mistreatment, Abuse, Neglect, and Exploitation (MANE) Compliance
- Scope of Service
- Person-centered Supports
- Agency Orientation
- Basic Health and Safety
- Homemaker-Specific Training
- Personal Care Worker-Specific Training
- Specialized Topics

Module: Privacy, Ethics, and MANE Compliance **Role(s):** Personal Care Workers + Homemaker							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Fraud prevention	BCC	R1	Y	N	Y	N	In person or Video/online
Social media protocols (e.g. photos, etc.)	BCC	R1	Y	N	Y	N	In person or Video/online
Ethics	BCC	R1	Y	N	Y	N	In person or Video/online
HIPAA and confidentiality	BCC	R1	Y	N	Y	N	In person or Video/online
Abuse and neglect (e.g. types, prevention, mandatory reporting, elder, pediatric, etc.)	BCC	R1	Y	N	Y	N	In person or Video/online
Incident reports and emergencies (including CAPS)	BCC	R1	Y	N	Y	N	In person or Video/online
Sexual harassment	BCC	R1	Y	N	Y	N	In person or Video/online
Boundaries (e.g. personal, professional, family v. client, etc.)	BCC	R1	Y	N	Y	N	In person or Video/online

Module: Understanding My Scope of Service **Role(s):** Personal Care Workers + Homemaker							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Knowing when a task is "skilled" (e.g. what to do if asked by a client or agency, acute skilled v. chronic skilled, etc.)	BCC	R1	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online
Scope of practice (i.e. what can I/can't I do, changes in conditions, risk management and understanding consequences, when to stop and ask for help)	BCC	R1	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online
Resources available in the community	BCC	R1	Y	N	Y	N	In person or Video/online
Reporting (e.g. lack of training, agency out of compliance with rules/regs, whistleblower, escalation, etc.)	BCC	R1	Y	N	Y	N	In person or Video/online

Module: Providing Person-centered Supports (1 of 2) **Role(s):** Personal Care Workers + Homemaker							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Respecting clients and their homes (e.g. generational differences)	BCC	R2/3	Y	N	Y	N	In person or Video/online
Personal approach (e.g. understanding individual likes/dislikes)	BCC	R2/3	Y	N	Y	N	In person or Video/online
Communication (effective, overcoming language barriers, asking tough questions, listening skills, building rapport, compassion & empathy skills)	BCC	R2/3	Y	Y	Y	N	Hybrid
Family communication (including family dynamics)	BCC	R2/3	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online
Bullying	BCC	R2/3	Y	N	Y	N	In person or Video/online
Cultural competency (e.g. understanding and respect, history, demographics, religious/spiritual differences, etc.)	BCC	R2/3	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online

Module: Providing Person-centered Supports (2 of 2)							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Person-centered thinking	BCC	R2/3	Y	N	Y	N	In person or Video/online
Impact of bias (ageism, "my way or I leave", etc.)	BCC	R2/3	Y	N	Y	N	In person or Video/online
Intro to behavior management (e.g. dealing with difficult clients, de-escalation, etc.)	BCC	R1	Y	Y	Y	Supplemental client-specific training	Hybrid
Behavioral training (CPI) (combative behaviors/yelling, personal hygiene refusal, mental health, emotional regulations, understanding trauma-induced behaviors, etc.)	BCC	R2/3	Y	Y	Y	Supplemental dient-specific training as needed	Hybrid
Preserving dignity	BCC	R2/3	Y	N	Y	N	In person or Video/online
Preserving independence	BCC	R2/3	Y	N	Y	N	In person or Video/online
Sexual harassment	BCC	R1	Y	N	Y	N	In person or Video/online
Boundaries (e.g. personal, professional, family v. client, etc.)	BCC	R1	Y	N	Y	N	In person or Video/online

Module: Agency Orientation **Role(s):** Personal Care Workers + Homemaker							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)***	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Basic documentation	BCC	N/A	Y	N	N	N	In person
Understanding best practices for the profession	BCC	N/A	Y	N	N	N	In person
Electronic visit verification (EVV)	BCC	N/A	Y	N	N	N	In person
Scheduling/routine (e.g. tasks, time management)	BCC	N/A	Y	N	N	N	In person
Seeking assistance from the agency (i.e. how do I get help?)	BCC	N/A	Y	N	N	N	In person
Agency policies and procedures	BCC	N/A	Y	N	N	N	In person

*Note: Agencies could meet the competency test requirement by obtaining from each employee a signed attestation that the employee has taken this training and understands each topic

Module: Basic Health and Safety (1 of 2) **Role(s):** Personal Care Workers + Homemaker							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Medication reminders (Managing controlled drug requests)	BCC	R1	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online
First aid and CPR (including Lift Assistance)[1]	BCC	R1; mirror certification intervals	Y	Y	Y	N	Hybrid
Basic food safety and food handling (e.g. cooking, expiration, norovirus, E-coli, etc.)	BCC	R1	Y	N	Y	N	In person or Video/online
Safe transfers (e.g. required equipment training, injury avoidance, etc.)	BCC	R1	Y	Y	Y	Supplemental client-specific training as needed	Hybrid
Early dementia care (including undiagnosed memory issues)	BCC	R1	Y	N	Y	Supplemental dient-specific training as needed	In person or Video/online

[1] The TAC recommends that required First Aid and CPR training for PCWs be phased in over the next 24 months but not necessarily immediately due to the cost of this formal training program. Recommended but not required for Homemakers.

Module: Basic Health and Safety (2 of 2)							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Basic observation and reporting (noticing change in care needs, required RN/specialist intervention, health decline/changes: skin, wounds, etc.)	BCC	R1	Y	N	Y	N	In person or Video/online
Universal precautions and infection control (e.g. blood-borne pathogens, standard precautions, bed sore prevention, etc.)	BCC	R1	Y	Y	Y	N	Hybrid
Safe techniques for personal and companion care	BCC	R1	Y	Y	Y	N	Hybrid
Home safety (e.g. fire prevention, gas leaks, emergency procedures, environment, trip hazards, etc.)	BCC	R1	Y	N	Y	N	In person or Video/online
Elder abuse for the community	BCC	R1	Y	N	Y	N	In person or Video/online
Recognizing and reporting alcoholism and other social determinants	BCC	R1	Y	N	Y	N	In person or Video/online
Fall prevention (ensuring the home is free from hazards; potentially build from community assessment tool from CDC)	BCC	R1	Y	Y	Y	Supplemental client-specific training as needed	Hybrid

Module: Homemaker Core Training (limited discussion) **Role:** Homemaker							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Homemaking/housekeeping (e.g. cleaning, laundry, making beds, etc.)[1]	BCC	N/A	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online

Module: Personal Care Worker Core Training (limited discussion) **Role:** Personal Care Worker							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Activities of daily living (ADLs) (e.g. bathing, dental hygiene, dressing assistance, toileting, mobility, transfers, feeding, supervision, etc.)	BCC	R1	Y	Y	Y	Supplemental client-specific training as needed	Hybrid
Adaptive equipment (e.g. how to use lifts for transfers, walkers, wheelchairs, etc.)	BCC	R1	Y	Y	Y	Supplemental client-specific training	Hybrid

[1] Personal Care Workers may benefit from this as well; may consider moving this topic to Person-centered Supports module

Module: Specialized or Advanced Training (1 of 2) **Role(s):** TBD							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Diet Specific to Health Condition (e.g., diabetes, gout, hepatitis, etc.)	Optional/As Needed	N/A	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online
Advanced behavioral health management	Optional/As Needed	N/A	Y	Y	Y	Supplemental client-specific training as needed	Hybrid
Medication Administration (only for PCWs working for licensed IHSS agencies authorized to perform Health Maintenance Activities)[1]	Optional/As Needed	N/A	Y	Y	Y	Supplemental client-specific training as needed	Hybrid
Diabetic client observation skills	Optional/As Needed	N/A	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online

[1] Only "Attendants" and not PCWs or Homemakers can perform Medication Administration under IHSS. Likewise, PCWs and Homemakers may not perform Medication Administration under any other Medicaid HCBS Waivers or benefits. For this reason, the topic "Medication Administration" was removed.

Module: Specialized or Advanced Training (2 of 2)							
Topic	**Timing** (BCC = Before client contact OR w/in 45 days)	**Recurrence Interval**	**Competency Test (Y/N)**	**Skills Demonstration (Y/N)**	**Portable (Y/N)**	**Client Specific Training (Y/N)**	**Acceptable Training Modes**
Dementia - beyond the basics	Optional/As Needed	N/A	Y	Y	Y	Supplemental client-specific training as needed	Hybrid
Condition-specific care and personalized plan of care (e.g. Parkinson's, dementia, Alzheimer's, ALS, mental health, visual impairment, terminal illness, special needs, traumatic brain injury, etc.)	Optional/As Needed	N/A	Y	Y	Y	Supplemental client-specific training as needed	Hybrid
Maintenance of fingernails/toenails (e.g., non-diabetic v. diabetic, filing v. clipping, etc.)	Optional/As Needed	N/A	Y	Y	Y	Supplemental client-specific training as needed	Hybrid
Death, dying, and terminal illness (e.g., pre-bereavement, trauma recovery, etc.)	Optional/As Needed	N/A	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online
Coordination of Care with Hospice/palliative care	Optional/As Needed	N/A	Y	N	Y	Supplemental client-specific training as needed	In person or Video/online

Appendix 2: Stakeholder and Public Comment

SB 19-238 Listening Session Summary

Training Topics

Discussion at the listening sessions centered around specific training topics and the timing and frequency with which they ought to occur. Participants provided insight into current methods of acquisition, demonstration, and confirmation of knowledge and practical skills. A complete list of training topics discussed during listening sessions is included in the pages below. Key highlights of the discussions included:

- *Basic or core topics*: Participants at each listening session identified several common topics they consider to be basic or fundamental training. The top mentions included:
  - ADLs (bathing, dressing, toileting, mobility, transfers, eating, supervision)
  - Communication and rapport-building
  - Nutrition (food safety, preparation, diet, etc.)
  - Homemaking (cleaning, laundry, making beds, etc.)
  - Home safety (fire prevention, gas leaks, environment, etc.)
  - First aid and CPR

- *Specialized:* Participants also identified specialized training topics as those to be delivered to augment and deepen knowledge and skills once personal care and homemaker workers have gained hands-on experience. The top mentions included:
  - Condition-specific care (dementia, Parkinson's, MS, mental health, terminal illness, diabetes)
  - Behavioral training (combative or difficult behavior)
  - Death, dying, and terminal care (including pre-bereavement and trauma recovery)
  - Adaptive equipment
  - Emotional support (client and home care worker)

Method of Delivery

Among participants, there was consensus that attending in-person training with opportunities to practice and demonstrate skills (and receive immediate feedback and coaching) for those topics that require hands-on demonstration is a highly-effective method of training.

- Quality, consistency, and accessibility of in-person training should be carefully considered when determining minimum training requirements.
    - Participants noted that video- and/or online-based training without in-person or onsite demonstration may be inadequate for certain training topics and more difficult to verify hands-on skills (e.g., how to safely perform a transfer, how to use a lift device, and how to provide personal hygiene care). Yet, participants noted that video- and/or online-based training often are satisfactory for knowledge-based topics that do not require skills demonstration and for which worker comprehension can be evidenced through a written competency test (e.g., knowledge of agency policies and procedures, emergency preparedness, and basic observation and reporting).
    - These delivery methods support personal care and homemaker workers in remote areas, who may not have access or resources for in-person training courses.
- Several participants suggested that a combination of video- and/or online-based training together with in-person or in-field demonstration of knowledge and skills could be a successful method of ensuring access to and effectiveness of training.
    - Caregiver respite and back-up support services are important to consider if in-person training becomes a requirement.
- Participants noted that the qualifications of individuals or programs providing the training is important. Experience matters and several participants suggested that some agency owners or administrators may

not necessarily have adequate credentials or experience to provide training, simply on the basis of owning or administering an agency.

Enforcement

Though TAC members discussed enforcement topics during scheduled meetings, participants in the listening sessions were not asked specific questions pertaining to the enforcement of training requirements. However, several comments relative to enforcement emerged, including:

- the importance of defining the responsibility and accountability of agencies and individual workers;
- the process for reporting and filing complaints along with the rights of protected reporting (e.g. whistleblower protections, which pathway for different types of complaints) related to inadequate training and worker support; and
- the process for and frequency of on-site survey and assessment of training.

Training Topics (sorted by frequency of mention during public listening sessions)

Basic or Core Training
☐ ADLs (bathing, dressing, toileting, mobility, transfers, eating, supervision, etc.) *
☐ Communications (effective - overcoming language barriers, asking tough questions, listening skills, building rapport, empathy, etc.)
☐ Nutrition - including feeding, preparing food safely, diet
☐ First aid and CPR
☐ Home making / housekeeping (cleaning, laundry, making beds, etc.)
☐ Abuse and neglect prevention including elder abuse and reporting abuse, MANE*
☐ Home safety (i.e. fire prevention, gas leaks, environment (i.e. trip hazards like rugs or icy sidewalks), emergency procedures including what constitutes and emergency) *
☐ Infection control, blood borne pathogens and standard precautions, bed sore prevention, etc.*
☐ Behavioral management skills or dealing with difficult clients (i.e. de-escalation training) *
☐ Safe transfers (including required equipment training and injury avoidance)
☐ Basic dementia* (including undiagnosed memory issues)
☐ Scope of practice (what can, or can't I do as a PCW)
☐ Boundaries (personal, professional, family vs. client)
☐ HIPAA and confidentiality
☐ Personal approach – understanding individual likes/dislikes
☐ Cultural competency – understanding and respecting a person's culture
☐ Incident reports and emergencies*
☐ Protocols - reporting (i.e. lack of training, agency out of compliance with Rules/Regs)
☐ Safety training (i.e. safe techniques for personal and companion care)
☐ Medication reminders
☐ Scheduling/routine (tasks and time management)
☐ Self-determination*
☐ Documentation
☐ Ethics
☐ Observation (such as noticing change in care needs) and reporting (i.e. when RN intervention is required)
☐ Respecting elders, their homes
☐ Universal precautions
☐ Agency orientation
☐ Knowing when a task is considered "skilled" and what to do if asked to perform (by client or agency)
☐ Preserving dignity
☐ Preserving independence
☐ Sexual harassment
☐ Basics of Medicaid
☐ Gerontology basics (what happens to the body as it ages)

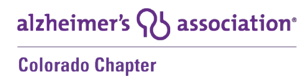
* Denotes topics for ongoing/recurrent training

Training Topics (sorted by frequency of mention), continued

Specialized or Advanced Training
☐ Specific conditions (i.e. Parkinson's, dementia, Alzheimer's, ALS, mental health, visual impairment, terminal illness, disabilities, special needs, PTSD, IDD, etc.) - specialized training for each individual client and personalized plan of care
☐ Behavioral training (CPI) - how to handle combative behaviors (i.e. person refuses to engage in personal hygiene, yells, etc.) and mental health (emotional regulation)
☐ Death, dying, terminal illness (including pre-bereavement & trauma recovery)
☐ Dementia (beyond the basics)
☐ Adaptive equipment (i.e. how to use lifts for transfers, walkers, wheelchairs)
☐ Emotional support (client and worker)
☐ Diabetic client observation skills (i.e. skin care, diet)
☐ Diet specific to health condition (i.e. diabetes, gout, hepatitis)
☐ Care giver burnout
☐ Emergency/disasters (i.e. floods, fires, severe weather, etc.)
☐ Hospice / palliative care
☐ Medication (including QMAP)
☐ G-tube feeding
☐ Family communication (including family dynamics)
☐ Resources available in the community
☐ Brushing teeth/dental hygiene
☐ Clipping toenails/fingernails
☐ Health decline/changes (i.e. skin, wounds, etc.)
☐ Preserving dignity and independence
☐ Remote service delivery (e.g., tele-health)

Additional Public Comment

Written public comments submitted to HCPF are included below:



Dementia Training Recommendations: Direct Care Workers

Issue Background

A crucial factor in delivering quality long-term care to people with Alzheimer's and other dementias in any care setting is the availability of staff equipped to manage the unique challenges of dementia and the needs of those who are living with it. **This is important to people living with dementia because they are more than twice as likely to require home health care as individuals without dementia.**[i]

As the disease progresses, individuals are unable to complete activities of daily living without assistance. Over time, people with dementia will lose the ability to use words and may communicate their needs through behavior, which presents added challenges for direct care workers. Additionally, more than 95 percent of individuals with dementia have at least one other chronic condition.[ii] Caring for someone with multiple chronic conditions – especially when that includes dementia – significantly complicates the individual's care needs.

How do we know this is a problem? Our organization operates a 24/7 Helpline (800-272-3900) to answer questions about dementia and connect people to needed services. Approximately 6,000 Coloradans called the Helpline in Fiscal Year 2019. During those contacts, many families express concerns regarding the lack of dementia-specific training of the staff who are attending to their loved one(s). Although Colorado has some training requirements in place for them, there is still much room for improvement.

Dementia-specific training **provides staff with the tools they need to care for the individual adequately** and enables them to **de-escalate behavioral situations** before they turn into crises. Adequate dementia training can also help **minimize the stress and frustration** experienced by the person with dementia, improving their quality of life.

To improve the lives of both Alzheimer's and dementia patients and caregivers, **Colorado should require competency-based dementia training of all direct service, administrative, supervisory, and other staff who come in contact with dementia patients.**

Why Dementia Training Matters

In 2019, an estimated 73,000 individuals are living in Colorado with Alzheimer's, a progressive disease for which there is currently no prevention, treatment, or cure. That number is expected to increase by 26 percent by the year 2025[iii]. **Thus, the availability of adequately trained direct care workers is critical to the growing population of Coloradans who will be impacted by dementia.**

Direct care workers constitute one of the largest and fastest-growing workforces in the country. These workers provide an estimated 70 to 80 percent of the paid hands-on, long-term care and personal

assistance to the elderly, disabled, and those suffering from chronic conditions, such as Alzheimer's and other dementias.[iv] However, turnover rates are high among direct-care workers, and recruitment and retention are persistent challenges. Inadequate education, challenging work environments, and few career advancement opportunities have also contributed to higher turnover rates among nursing staff across care environments. Studies show staff trained specifically in dementia care are able to provide better quality of life for residents and have increase confidence[v], performance[vi], and job satisfaction[vii].

Elements of Adequate Dementia Training

Despite the growing need for adequately trained direct care workers, they often do not have sufficient dementia-specific knowledge to effectively support those with dementia. Under federal law, certified nursing assistants and home health aides receive at least 75 hours of required training. But, dementia care is only one of 40 required topics that must be covered in this time frame.[viii] Furthermore, training that is provided often does not cover the skills and competencies that will equip workers to appropriately care for those with a significant cognitive impairment. Although Colorado has some standards in place for dementia training, many of these policies are vague, cover only a subset of workers, lack competency standards, and have inadequate enforcement mechanisms.

The Alzheimer's Association recommends the following elements (content, delivery method and process) for adequate dementia care training of Colorado's direct care workforce.

Content

Topics, Curriculum, and Timeline

Any employee whose work involves contact with people living with Alzheimer's or another form of dementia should receive training **before any interactions occur**. The Alzheimer's Association supports regulations that enable direct care workers to (1) provide person-centered dementia care based on thorough knowledge of the care recipient and their needs; (2) advance optimal functioning and high quality of life; and (3) incorporate problem-solving approaches into care practices. **At a minimum, the curriculum used for initial training of direct care workers should cover the following topic areas:**

- Basic understanding of the disease, including its progression in regards to memory loss, psychiatric and behavioral symptoms;
- Strategies for providing person-centered care;
- Communication issues;
- Techniques for understanding and approaching behavioral symptoms, including alternatives to physical and chemical restraints;
- Strategies for addressing social needs and providing meaningful activities; and
- Information on how to address specific aspects of care and safety (e.g., pain, food and fluid, wandering, etc.)

Hours

There is no consensus regarding a specific number of training hours that staff should receive in dementia care. Rather than requiring a minimum number of hours, the emphasis should focus on encouraging professional caregiving staff to develop their competency in dementia care. Participating in training sessions does not, in and of itself, translate to competency.

However, dementia care training that covers the content listed above already exists. Two examples are the CARES® Dementia Basics™ Online Training Program (run by HealthCare Interactive®) and the Alzheimer's Association Central New York Chapter's training on Quality Dementia Care. Both cover the topics listed above and assert that it can be **adequately covered in approximately four hours**.

Continuing Education

To reinforce and enhance the foundational knowledge that individuals will receive with initial dementia training, **Colorado should also implement continuing education requirements**. For individuals who have undergone initial dementia training, Colorado should:

- Ensure that facilities, agencies or programs provide ongoing onsite support, supervision, and mentoring for those trained to provide treatment and care for individuals with dementia; and
- Determine when and how often continuing education on dementia will be required. Such continuing education shall include new information on best practices in the treatment and care of individuals living with dementia.

Delivery Method

Online or In-Person

A number of individual chapters of the Alzheimer's Association have offered, or still offer, dementia-specific training for direct care workers. The Colorado Chapter discontinued its training in 2017. While our training was conducted entirely in-person, other training programs are provided entirely online.

Process

Requirements for Trainers

Minimum standards for trainers who offer in-person dementia care education should include:

- Two years of work experience related to Alzheimer's disease and other dementias, health care, gerontology or a related field; and
- Completion of at least the minimum core training requirements as provided in the enacted statute or regulation, including the successful passage of any skills competency or knowledge test required by the state.

Portability of Certification

After completing required dementia care training, direct care workers should receive a certificate as evidence of their training achievement and newly obtained knowledge. To reduce turnover and retention, certificates obtained by workers should be transferrable between employers. Once a worker has a certificate of completion (as long as that individual does not have a lapse in direct care employment for 24 consecutive months or more) they should be exempt from taking duplicative training courses just because they start a new job with a different employer.

Enforcement

Without adequate oversight and enforcement, the adoption of dementia-specific training standards would be rendered ineffectual. State governments and regulatory agencies are well-positioned to direct the type of dementia care training workers receive and shape how broadly the long-term care industry embraces it. Strong state oversight ultimately leads to consistent, quality care for people with Alzheimer's and other dementias. The state agency should:

- Identify which training programs meet the criteria for required dementia training;
- Determine the process for deeming the training programs adequate; and
- Be responsible for ensuring direct care workers caring for people with dementia have successfully completed the training.

References

[i] Alzheimer's Association Fact Sheet: Dementia Training for Direct Care Workers. June 2019. Link.
[ii] Alzheimer's Association Fact Sheet: Dementia Training for Direct Care Workers. June 2019. Link
[iii] Alzheimer's Association. 2019 Alzheimer's Disease Facts and Figures. Alzheimers Dement 2019;15(3):3
[iv] PHI National: Quality Care Through Quality Jobs. February 2011. Fact Sheet.
[v] Hobday, J. V., Savik, K., Smith, S., & Gaugler, J. E. (2010). Feasibility of Internet training for care staff of residents with dementia: The CARES program. Journal of Gerontological Nursing, 36, 13–21. doi:10.3928/00989134-20100302-01
[vi] Burgio, L. D., Stevens, A., Burgio, K. L., Roth, D. L., Paul, P., & Gerstle, J. (2002). Teaching and maintaining behavior management skills in the nursing home. The Gerontologist, 42, 487– 496. doi:10.1093/geront/42.4.487
[vii] Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. The Gerontologist, 45, 686–693. doi:10.1093/ geront/45.5.686
[viii] Alzheimer's Association Fact Sheet: Dementia Training for Direct Care Workers. June 2019. Link.

Hello,
Regarding today's Training Advisory Committee Meeting. I was invited by Committee member Kelley Horton who is aware of my skill set to attend today's meeting. My concern regarding the committee itself, is the absence of anyone from law enforcement as many of the training core topics that will require future ongoing training have a direct impact on M.A.N.E and whether or not if abuse is even recognized and how to prevent and properly report it to law enforcement.

The Committee which implemented Mandatory Reporting Laws in 2014 for elders and in 2016 for those with an IDD, I later learned only had one representative from law enforcement who was less than helpful which is why the law as written now has created the conundrum that it has now for law enforcement and personal care workers. To the point where I have created a business consulting caregivers and law enforcement on how to navigate within the scope of the laws and be efficient in doing so.

Training is key when it comes to abuse, preventing, documenting and reporting to the correct agencies. This is vitally important as every time I ask a caregiver if they know what Mandatory Reporting is, they either get the answer wrong or can not articulate accurately what it is. Please don't take this as a condescending tone as I don't mean it to come across this way, but my point is, every time I bring up these issues everyone in the industry of caregiving and oversight over the caregiving profession has an aha moment, but then status quo continues. We have a real opportunity to change that perception. If you would like to discuss further I'm available most of the time. My contact and website info is below which can also lead you to my social media presence and I'd be more than happy to continue to assist your committee in the future.

Damon Vaz
Founder/CEO
LEMRS,LLC
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Thank you for hosting the LISTENING SESSION at the Harmony Library in Fort Collins. I learned a lot. I particularly found it helpful to hear some of the challenges that non-medical home care agencies and caregivers face.

Here are a couple of thoughts at this time:
One question that I asked of non-medical care home agencies was, if they were able to hire a CNA rather than a caregiver, would they then need to do as much training as currently required by regulations? Their response was a bit confusing, but ultimately the answer was no. Because a CNA is already trained and certified by the state, the training

needs would be less for that agency, rather for them more of an orientation.
So why don't more non-medical agencies hire CNAs?
The big challenge that arises for the CNA working strictly as a PCW, CNAs can only renew their license if they have been working as a CNA in a skilled licensed facility or agency. Maybe that requirement could be adjusted?

I have a couple of suggestions:

1. Allow the renewal of a CNA license to include non-medical employment history. Or
2. If that is not possible, allow a supplemental training course for the CNA as a secondary way to renew their license, without having to seek employment with a medical agency, but instead can continue as a PCW and not jeopardize their CNA license.

Another point I would like to make is that some of the students that take a CNA course end up NOT passing the STATE exam. MOST WOULD MAKE GREAT CAREGIVERS! Failure often occurs on the basis of educational challenges (like language barriers, or struggle taking a multiple-choice exam or have severe anxiety when passing off skills to a state tester, etc). Many of these students have caregiving hearts.
Our program offers a PCW course completion document for some interested students in this opportunity. Along with a bit more training from us on scope of practice information, we feel comfortable offering this option for the student that failed to show to an employer hiring for a PCW position. Their may be other ways to not loose these potential PCW workers like notifying the student that failed along with their NA test results.
Let's keep those that showed an interest in the field of caring for others, in this field!

Thank you for the consideration of these comments.

Kathy Anderson, RN, BSN
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only thing that I have experience in working in Colorado nursing home is I have never ever seen any bed pressure that go down to your bone they need to start changing positions every 2 hours so they take pressure off the bottom part I'm from Texas I

never seen that but when I came to work in a nursing homes in Colorado I see the bone of the butt

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I used to work for a HHC company.
I started with no previous experience. I took a 3 hour welcome class with the company, after the class I was asked to cover shifts until I was scheduled the following week.
I worked shifts at a memory care facility that weekend...I did what I could (glad I had a ton of food service experience) but felt like I had no clue... staff there had to show me everything, which seemed to stress them out more. I picked things up quickly, asked tons of questions and I became one of the few people the facility asked for by name.
I since have passed my CNA certification and am working privately with 4 clients. I worked hard to go to school and keep hours at my job but I've seen WAY to many "warm bodies" take over for me or that I relieved.... people who do nothing but sit on a chair and read or play on their phone.
I'm glad I was given the opportunity to start at a HHC company but I couldn't continue working there. I was run all over town for 13$/hr. I'm working on a work comp claim because I was in an accident heading to clients but the company is denying I was on the clock.

Hello,

I am unable to attend a Training Advisory Committee for Senate Bill 19-238 to support in the "establish[ment] a process for reviewing and enforcing initial and ongoing training requirements" for home care agency employees. However, as a person who previously worked in the In-Home Care field as a companion/caregiver for 10-15 years, I would like to offer feedback or suggestions regarding the practical application and content of staff training.

Repeated challenges I observed in the field, whether working in-home privately, with an agency, or in assisted living facilities, were regarding: 1) handling behavioral issues and communication with clients, 2) staff communication and camaraderie, and 3) staff self-care and health.

I believe that ample staff training for responding to behavioral issues and communication with clients needs to be a required and prioritized portion of any support person's understanding of their work with clients. Many positions I held did not include this in their staff training. Trainings in topics such as non-violent communication techniques, non-verbal communication, and person-centered and/or trauma-centered approaches would increase the compassion and positive interaction between clients and staff (as well as increase understanding between staff members.)

Some of the most difficult scenarios I encountered were not challenges with clients, however, staff to staff transitions and communication. I believe that this type of training (mentioned above) can foster greater knowledge and compassion, retainment and camaraderie in staff, and a happier, more productive workforce when applied. One example of a successful team training I was a part of did, was that during their monthly meetings staff had dinner together and conversational "getting-to-know you" topics along with formal training. This team developed positive communication and camaraderie, in which in turn affected the results of the work with the client.

In regards to staff self-care and health, again, some of the most challenging aspects I or others have faced in the In-Home health field are: compassion-fatigue, burn-out, or the observation of other staff members unhealthy behavior and habits. Staff are typically not trained to remember that they are role models in our society that care for our vulnerable populations. When they engage in unhealthy behaviors (such as coming to work sick or smelling of alcohol), it is both unhealthy for them and for others to witness. All of these experiences mentioned can be disheartening and create perpetual hopelessness or helplessness for staff. Training surrounding the topic of self-care and health (beyond staff simply being presented with the idea) with formal activities such as journalling, creating a self-care plan to be accountable to, etc. would be highly valuable to include in required training and support in maintaining or retaining exceptional staff.

Thank you for this opportunity to make suggestions for this bill. As someone who worked in the field for many years, I am grateful to have a voice regarding these issues.

Warmest regards,

Susan Brown, MA, LPCC, CBIS / Brain Injury Advisor / Susan@BIAColorado.org

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BIAColorado.org

I've been a caregiver on and off for 5 years in the clients that we work with they need care and we as caregivers also need good pay to keep up with Denver's cost of living which is insane, as caregivers are caring that's why were there.

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thank you for the invite to participate in your survey but i only worked for a private pay individual. if i may say tho i do feel that private health care should be monitored more. i know they have the right to pick who cares for them but i feel even family should have to take some trainings to provide the proper care. sad to see a family member with NO training of first aid. cpr or even basic adl care is in charge of an individuals total health care ...
thanks again

I will report that when I moved to Denver, I had expected my national formulary medication to continue along with my 33hrs/week homecare. When I arrived over a year ago, I was told to speak only of my physical injuries and we could always increase the hours once I found a worker I was comfortable enough with to share my home.

At that time nobody told me that you do not possess a centralized training center and that there is no workers union for the homecare worker. I was not told a full day of work or one 8hr shift a week was a choice id be making to consciously "be difficult". In fact I have not successfully found any non smokers who drive their own vehicles also willing to pay for parking in the metro area. When my first location underwent renovations, I was lucky enough to relocate. Even relocating didn't solve the problem of the full day shift challenging your current set up.

How this doesn't work is clear to me. You have an agency and then within that agency is fraud. Fraud? You mean call the fraud line fraud? Nope. I mean systemic oversight because of job duplication is negated. Let's unpack that statement together. If the agency cannot find someone to match your shift you will be ignored. Someone from the office might come, a male, a smoker, someone being audited by the IRS whose mom wants to keep her job as finds people for this company, who cares what they need or their hours available.

TAC Member Comment (Pat Cook)

Portable education is a must for Colorado workers, employers and consumers who use the services. In the marketplace, this worker may work in home care (non-medical), assisted living or adult day care at any given week. Workers with more training and skills work in Class A home services, nursing homes, hospitals and other medical settings. They have not only the core training but advanced. What is seen in the market is that folks have had training, but may not be competent in the demand of this level of services nor understand the obligations in serving the market place. Caring for more needs of people with disabilities has increased. The workers who have life experience may be a good fit, but the community demands are more professional and need more consistency. It is not the industry of 1985 any longer. Our IHSS workers are committed to their families and survive below poverty due to this commitment.

We have vetted trainings for parts of what this workforce needs. That includes basic training in CPR, First Aid, Food Handling, At Risk Adult Abuse Training, basic infection, control measures, etc. The workers who want to work with more complicated care may have additional training for equipment, specific tasks and disease processes. The core topics are already in training modules and evidence based.

In the 1960's into the 1970's, it was identified there were not enough nurses, so the LPN program at Emily Griffin and Community College of Denver was birthed. The RN program for those trained as LPN was then activated by Community College and grew across the state. Nurses were then able to complete a 2+2 program and obtain a bachelors and for those who wished a masters. In the mid 80's, Metro College developed a Nurse Practitioner program to help the growing need of primary care. We as a state have continued to grow in this model. I was lucky to be part of all this and was in the right place at the right time in the very first programs.

To prepare for the needs of a diverse population which many cultures and language, it is time to retool. Having a portable education will help keep people working with the folks and meeting the basic care needs. Workers will have more pride and should be able to grow into any professional lane that interests them or stay in the industries and provide the demand of our communities. Workers will feel less insulted and costs of training will help so that employers can concentrate on advance trainings to meet the needs of the population served. Workers must be able to communicate in verbal and written formats.
I advocate that we take this need, demand and opportunity to retool, rethink and reprogram this segment of vocational training. It can start at the high school level, alternative education programs and community colleges.