

**Darla Helt**

**[www.peacenw.org](http://www.peacenw.org)**

Hello, my name is Darla Helt, from Clark Co. WA and I am a parent of two adult sons who experience intellectual /developmental disabilities (I/DD). Both my sons are clients of DDA, and we are so grateful they have received services of individual providers (IP's) for over 20 years. I am also the Executive Director of a non-profit, which runs programs that have served our I/DD community and families in WA state for the past 30 + years.

Historically, the basic training for IP's was 32 hours and was accessible through the local community colleges, ongoing yearly training was flexible to meet the client's needs. The client being employer of record, and the IP provider being the employee could jointly identify what training would best suit the needs of the client. This training could then be located wherever it was available, colleges, conference's, national, state or local trainers, local agencies, or the wide variety offered by DDA just to name a few. This model saved the state funding as providers were able to access training needed specifically for the client they were serving and much of it was available at minimal or no cost to the state. The flexibility of that model provided a way to address everyone's needs, the current training is focused on addressing the needs of the elderly and does not begin to address the needs for the DD community. Individuals, parents, and guardians are then forced to private pay for additional training so that the provider has the needed skill sets to care for their clients, this along with shadowing is common practice in the DD community. As taxpayers we are paying for training that is not appropriate for many in the DD system, while forcing those individuals to private pay for the training that is needed.

I believe we can find a better way.

Veterans with PTSD, seniors, individuals with Alzheimer's or those who experience I/DD, each have very different needs. The current training through the training partnership, is not meeting the needs for the I/DD community. We need a more flexible training system that is tiered, shorter basic training that includes, first aid, CPR, food handling, & nutrition. A second level that is specialty training, specific to the population/individuals being served, and a third tier that is person centered which would include shadowing of trained individuals for new providers. Trainings need to be available online, so that they can be accessed 24/7. By building flexibility into the second and third tiers, we can access the multitude of trainings being offered online nationally by topic experts. This will also eliminate barriers to building the provider base, by increasing access to the providers who are wanting to work part time but are unable to leave other responsibilities for the current two week basic training. Thank you for taking time to read my testimony, I am sorry I could not be there with you today. If you have any additional questions, please do not hesitate to reach out to me. Gratefully, Darla Helt

**Peter Nazzal**

**Catholic Community Services of Western Washington (In-Home Care License)**

We are very supportive of personal care training. We have been a key of caregiver training since the 1990s. We are proud of the fact that the training we created in the early 1990s became the basis for the first training DSHS required - Fundamentals of Caregiving. Over the past three decades caregiver training has expanded as home care services have expanded to meet the needs of vulnerable people. We have been involved with the revision of training over the past several decades. We are a community trainer who trains thousands of caregivers every year.

The issue of CPR has come up from time to time. We do not support the inclusion of CRP training for the following reasons:

1) Current System Works

When a person we serve is experiencing an emergency, staff are instructed to call 911 and follow the 911 operator's instructions. Our staff who are CPR trained are instructed to explain to the 911 operator that they are CPR trained. The operator may or may not instruct them to perform CPR, depending on the situation. Do Not Resuscitate orders are also part of the process.

This system works. We are not aware of any bad outcomes related to calling 911 rather than implementing CRP first. You may want to study the possibility of negative outcomes if this was reversed and staff were to provide CPR before 911 was called or instead of calling 911. Valuable time would be lost; perhaps enough time to result in a bad outcome.

Our main reason for opposition to inclusion of CPR training is the current system works. Staff who desire CPR training can get it through CE. Many have it via their CNA license.

2) Liability - Good Samaritan Law

Employers and employees are not covered by the Good Samaritan law as it relates to providing CPR as part of their job. This would open up liability for both employers and possibly employees.

3) Scope - license

We are of the understanding this may be out of the scope of practice for our staff and is not allowed/covered under our Home Care License. The in-home care license is divided into three categories - Home Care, Home Health, and Hospice. CPR is required for Home Health - WAC 246-335-530 (9). CPR is required for Hospice - WAC 246-335-630 (8). It is not required for Home Care.

4) DNR Orders

Many people we serve have DNR orders.

5) Funding & Changing WAC

The current training meets statutory requirements and it would not be possible to remove any to create time for CPR training. If CPR is added, additional training will be needed and the cost is unknown.

Licensure and training WAC may also need to be changed if CPR is required for training.

**David Lord**

Dear JLARC Committee,

This testimony is submitted in response to the JLARC audit of the caregiver training, for which public testimony was taken at 1 PM on 3/23/22.

I am not currently affiliated with any organization, and I submit this testimony on my own.

Before retiring a year ago, I was employed for many years by Disability Rights Washington (DRW). While working for DRW, I provided staff support for a group of individuals with disabilities who used in-home personal assistance services. This included several individuals who used the maximum number of hours of caregiver assistance, and all of whom supervised their caregivers. The group - which went by the name "PAS-Port for Change" - included some who qualified for services by the Developmental Disabilities Administration, but most were qualified for services through Aging and Long-Term Services Administration. The members of PAS-Port were active for many years as a group that met regularly and followed the changes in caregiver training requirements closely. Over the years the group frequently provided comments and testimony at legislative hearings.

My experience with these advocates taught me that it is very difficult for people with disabilities who rely on independent providers to recruit people willing to become caregivers, and even more difficult to shepherd them through the rigid training and administrative requirements for providers. PAS-Port members all supported training requirements, but as implemented by the Training Partnership most or all of the group saw the current training as a major barrier - not an asset - as they sought to find enough caregivers to meet their needs in community living.

The testimony you heard from the panel was consistent with what I heard from the people I supported in the PAS-Port group. In particular the recommendations made by Shawn Latham were entirely consistent with what I heard from people who participated in PAS-Port - indeed, Mr. Latham was one of the active members of PAS-Port.

Members of the PAS-Port group emphasized that caregiving training should be individualized to meet the needs of the client. This is particularly important for people whose caregiving is "self-directed". The current caregiving training makes no provision that the specific needs of the individual will be addressed as part of meeting the hours of training requirement. As the panel pointed out yesterday, many people have mobility limitations, and they have a physical or occupational therapist who they trust who can instruct caregivers in safe transfers and other personal needs. The time it takes to provide this training should be credited in meeting the hours requirement for new caregivers.

I agree with the suggestions from the panel you heard testify in response to the audit. It makes sense to maintain a "core curriculum" of basic skills and information, but that curriculum should be reviewed and modified with input from people who actually use the services, and family members who typically are providing caregiving help. The training should also include instructional faculty who use caregiving services.

Thank you for this opportunity to comment.

David Lord

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