

**Governor's Commission  
on Health Care and Community Support Workforce**

**MEETING MINUTES**

**August 23, 2016**

**Philbrook Building**

**Concord, NH**

**Members Present:** Susan Huard, Chair, Kathy Bizarro-Thunberg , Lisa DiMartino, Jon Eriquezzo, Yvonne Goldsberry, Brenda Howard, Judith Joy, Joelle Martin, Dennis Powers, Susan Reeves, Deb Scheetz

**Guests:** Gina Balkus, Home Care Assn, Alisa Druzba, DHHS; Heather Donnell, CSNI; Cathy Gray, Cedarcrest Center; Daniel Hebert, Consumer; Danielle Keiss, DPHS; Susan Paschell, The Dupont Group;

**Staff:** Leslie Melby, DHHS

Commission members approved the minutes of the July 26, 2016 meeting.

**PRESENTATION: Challenges in Home Health Staffing**

**Gina Balkus, Home Care Association of New Hampshire (HCANH)**

Home care agencies provide a wide range of services including skilled nursing and rehabilitative care, complex care, hospice care, long term services and supports to those who require assistance to live independently, as well as private duty care for people who need non-medical assistance.

HCANH's 38 member agencies are primarily medical-based agencies accounting for 4,400 employees, over 1 million care visits and 46,500 clients served. Employees include RNs, LPNs, physical, occupational, and speech therapists, social workers, licensed nursing assistants, personal care service providers (PCSPs), and homemakers.

Over 80% of home care services are paid for by Medicare and Medicaid. Fees are set by federal and state government, which in many cases do not cover the cost of care. This shortfall impacts salaries and wages. Types of care and criteria for care varies by payer, i.e. Medicare pays for intermittent skilled care but the patient must be "homebound," while Medicaid covers intermittent skilled care without the homebound requirement. Other sources of payment include the VA, commercial health insurance, self-pay and long term care insurance. Medicare is highly regulated, thereby increasing the cost of care. Hourly wage ranges for all types of positions were provided based on a February 2016 survey. For Medicare, LNAs must have 80+ hours of training.

**Staffing Challenges:** Home care providers must have the confidence and competence to work independently and be willing to travel long distances to clients' homes. Home care is highly regulated and any lack of compliance compromises reimbursement. Unpredictable census fluctuations require the use of per diem staff.

**Vacancy Rates:** A survey from one week in July 2016 revealed vacancy rates as well as a significant number of per diem positions needed to meet the demand for services including the ability to make initial visits within 48 hours of discharge.

Question: Do HHAs track the number of people who lose services if the agency cannot meet the need.

A: They do not.

**Turnover Rates:** Over the past year, the turnover rate for HCANH agencies' employees was 13%. Recruitment is expensive and competitive with settings that provide greater clinical support. LNAs and PCSPs who earn lower wages go elsewhere for a small hourly wage increase. Retention strategies include better training, a longer orientation period, and effective preceptor programs.

Question: Does HCANH quantify recruitment and training costs?

A: No but would be willing to use a suggested tool.

*Reimbursement:* The aging population requires more home-based services and adult day services, and the need cannot be met without adequate staffing. Keeping up with competitive wages is increasing the cost of care, so Medicare and Medicaid reimbursement should reflect additional labor costs.

*Education:* Academic institutions should better prepare students for home and community based settings; currently there is a disproportionate emphasis on acute care. Preceptors are burdened with training while performing their jobs.

*Licensure:* Criminal background checks take too long. Providers are experiencing significant delays (4-6 months) in obtaining licensure for those already licensed in other states.

*Regulatory:* Many challenges are derived from federal Medicare and Medicaid requirements.

*Medicaid MCOs:* Prior authorization (PA) is required for home care services, not previously required for Medicaid fee-for-service; However MCOs now allow the first five visits without PA.

## **PRESENTATION: Consumer Perspective**

### **Dan Hebert**

Mr. Hebert asked to appear before the Commission to share his experiences with consumer-directed community based care in other states. He suggested doing more with existing funding rather than appropriating additional funds.

Mr. Hebert is a participant in the Medicaid for Employed Adults with Disabilities (MEAD) Program which entitles him to 50 hours per week of personal care services. (See handout.) Direct service providers are hired at \$2.56/15-minute unit. Personal care attendants are not earning a livable wage. He described what he refers to as consumer warehousing, whereby people are unnecessarily residing in nursing homes so that beds are filled. He has concerns about the profit motive of private companies.

Mr. Hebert proposed a model that puts the consumer who has a chronic and lifelong disability before the provider by permitting the consumer to choose and hire the HR company and manage other aspects of staffing at no additional cost to the state. He explained how the MEAD program (not managed care) in Kansas was less costly while providing the same level of services.

Questions:

Jon: very helpful. What state did you receive more seamless services?

Dan: Kansas.

### **Work Session**

Dr. Huard announced that the Commission will convene regional meetings throughout the state in October in order to bring draft recommendations to the general public. The Commission's October 25<sup>th</sup> meeting will be devoted to a review of public comments.

The group opined about the emerging recommendation topics:

1. Data collection
2. DSPs

3. Education
4. Recruitment and retention of workforce
5. (Licensing (part of each of the 4 major areas))
6. Training and professional development
7. Reimbursement and wages

Data collection and DSPs cut across all the other categories. Definition of DSPs includes homemakers, personal care service providers.

Discussion ensued regarding the notion of reducing the demand for services. Current policies restrict may prevent an increase in the size of the workforce.

Might view this as a framing section of the Commission's recommendations to include with overarching concerns regarding barriers and other major challenges and policies, including end of life care, supply and demand

The two subgroups of the Commission discussed possible recommendations:

### **Health Care Worker Subgroup**

Licensing:

1. Empower licensing boards to collect workforce data (Licensing)
2. Review RSA narrative to determine where to vest responsibility for analysis (Licensing - short-term recommendation)
3. Enable resources to analyze gathered data (see #1) to make projections and identify gaps
4. Achieve imagined benefits of the professional board merger in terms of effectiveness and efficiency. Ask new leader to meet a definite date.

Education:

1. Launch a campaign aimed at high school students (involve AHEC)
2. Create a study group to establish an internship/preceptor program for health care professions (long-term recommendation)

### **Direct Service Provider (DSP) Subgroup**

1. Advancement: Need opportunities for advancement for people to stay in DSP role for the life of their careers. Need lateral promotions so DSPs remain in these roles.
2. Education: Recommend a certificate program as an opportunity to professionalize the role of DSPs. Such programs should not be onerous or create a barrier.
3. Livable wage: DSPs need a livable wage. Too many DSPs are earning poverty level wages that present huge economic disruption to their lives.
4. Work environment requirements to retain DSPs
  - Empower DSP to make decisions
  - Good supervisors
  - Safety
  - Opportunity for creativity
  - Bonuses/regular wage increases

There is a disparity in payment for children's services versus adult services in the State. The state recently capped payment for DSPs for DD/brain injury at \$15/hr. Yet, the NH Department of Education provides rate increases. The survival of the DSP workforce depends on livable wages and regular rate increases.

We should tap into a larger provider population by offering competency testing for immigrants in lieu of demonstration of educational (high school) requirements that might not have been available in foreign countries.

It was mentioned that the workforce shortage is often masked by the efforts of family caregivers. Consider the cost of allowing that to continue.

Future presentations

1. Licensure: Peter Danles, Office of Professional Licensure and Certification
2. Health professionals opportunity programs: Trini Tellez, MD, Division of Public Health Services - Increasing minority participation in the health workforce
3. Area Health Education Center
4. Long term care

**PUBLIC COMMENT:**

Gina Balkus, HCANH: Suggestion to collaborate with the SB 439 Study Commission on the Nursing Shortage

A parent provided her experience in caring for her 6-year old son who is cared for at home with two feeding tubes and IV therapy. Due to lack of staffing, he went for ten months without a nurse in the home and was air lifted to Boston due to complications arising from having no nurse in the home. She emphasized the importance of understanding what is really happening to people. Do not view consumers as percentages on paper.

Cathy Gray, Mondadnock Regional Healthcare Workforce group. Due to the push for baccalaureate trained nurses, LPN programs are closing down. Only two LPN programs remain in the state. However, LPNs jobs are a stepping stone for a nursing career. Long term care is experiencing the shortage particularly hard because RNs are being lured to other areas.

Meeting adjourned.