Linda Seemeyer
Secretary

State of Wisconsin
Department of Health Services

1 WEST WILSON STREET
MADISON, WI 53703

OPEN MEETING NOTICE

Wisconsin Council on Long Term Care

Tuesday, March 13, 2018

9:30 AM to 3:30 PM
Clarion Suites -- 2110 Rimrock Rd
Madison, WI 53703

AGENDA

9:30 AM **Meeting Call to Order**
Heather Bruemmer, *Long Term Care Advisory Council Chair*
-Introductions
-Review of agenda and approval of minutes

9:35 AM **Department Updates**
Curtis Cunningham, *DHS – Assistant Administrator of Long Term Care Benefits and Programs*
Carrie Molke, *DHS – Bureau of Aging and Disability Resources*

9:50 AM **Assisted Living Oversight Updates**
Otis Woods, *Administrator, DHS – Division of Quality Assurance*

10:35 AM *Break*

10:45 AM **Introductions with Heather Smith, Medicaid Director**

11:00 AM **NCI 2016 Survey Results on Staff Stability: Direct Support Professionals in LTC**
Mary Lou Bourne, *NASDDDS - Director of NCI and Quality Assurance*

12:00 PM **Comments from the Public**
Heather Bruemmer, *Long Term Care Advisory Council Chair*

12:15 PM *Lunch (catered)*

12:45 PM Transportation Discussion Summary - Final
Carrie Molke, *DHS – Bureau of Aging and Disability Resources*

12:50 PM 17-19 Budget Initiative - Direct Care Workforce Funding Updates
Grant Cummings, *DHS - Bureau of Long Term Care Financing*
Dave Varana, *Director, DHS - Bureau of Long Term Care Financing*

1:05 PM Wisconsin Caregiver Career Program Updates
Kevin Coughlin, *Long Term Care Benefits and Programs*
Pat Benesh, *DHS - Division of Quality Assurance*

1:15 PM LTC Workforce demands and innovations within waiver services
JoAnna Richard, *Associate Director, DHS - Bureau of Adult Long Term Care Services*
Betsy Genz, *Associate Director, DHS - Bureau of Adult Long Term Care Services*

2:15 PM *Break*

2:30 PM Council Discussion - MA-LTC Workforce recruitment and retention strategies.
Discuss Provider Strategies for retaining sufficient MA workforce to ensure adequate HCBS supports.
JoAnna Richard, *Associate Director, DHS - Bureau of Adult Long Term Care Services*
Betsy Genz, *Associate Director, DHS - Bureau of Adult Long Term Care Services*

3:15 PM Council Business
Heather Bruemmer, *Long Term Care Advisory Council Chair*

3:30 PM Adjourn
Heather Bruemmer, *Long Term Care Advisory Council Chair*

The purpose of this meeting is to conduct the governmental business outlined in the above agenda. The Wisconsin Long Term Care Advisory Council was first created through the 1999 Wisconsin Act 9 with the responsibility to report annually to the legislature and to the Governor on the status of Family Care and assist in developing broad policy issues related to long-term care services. Wisconsin Act 9 sunset the Council as a legislative council as of July 21, 2001, but the council was reappointed a few months later as an advisory group to the Department on emerging issues in long-term care. The Council has continued to provide guidance to the secretary and make recommendations regarding long-term care policies, programs, and services. More information about the council is available at wcltc.wisconsin.gov.

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OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Wisconsin Advisory Council on Long Term Care			Attending: Beth Anderson, Roberto Escamilla II, Mary Frederickson, Tim Garrity, Amie Goldman, Dan Idzikowski, Denise Pommer, Maureen Ryan, Beth Swedeen, Sam Wilson, and Christine Witt
Date: 1/9/2018	Time Started: 9:32 a.m.	Time Ended: 3:00 p.m.	
Location: Clarion Suites at the Alliant Energy Center, Madison			Presiding Officer: Heather Bruemmer, Chair

Minutes

Members absent: Cindy Bentley, Carol Eschner, Robert Kellerman, Lauri Malnory, Jessica Nell, Audrey Nelson, and John Sauer.

Others present: Heather Bruemmer, Kevin Coughlin, Hannah Cruckson, Curtis Cunningham, Betsy Genz, Carol Hutchison, Lindsey Kreitzman, Amber Mullett, JoAnna Richard, Dave Varana, Patricia Virnig, Angela Witt, and Otis Woods.

The minutes from the November 2017 meeting were unanimously approved with correction on a motion from Amie Goldman, seconded by Maureen Ryan. Draft summaries of the council charges were included in the packets for the current meeting.

Department Updates
Curtis Cunningham, Assistant Administrator, Division of Medicaid Services, Long Term Care Benefits and Programs, gave the following Department of Health Services updates.

- **DMS director named** – Heather Smith has been named the new Medicaid Director and Administrator of the Division of Medicaid Services (DMS). Heather is a Wisconsin native and UW-LaCrosse graduate who comes to DMS from her current position as Deputy Chief of Staff for Budget, Legislative, and Intergovernmental Affairs in the Office of the Governor. She extensive experience in policy and government.
- **2018 priorities** – These are being determined. As they roll out, they will be presented to the council.
- **DMS reorganization** – Work continues on bringing together the long-term care and the acute and primary care areas of DMS.
- **Dane County transition** – 1,400 members (out of 2,200) have selected a program or a provider: 48% are IRIS and 52% are Family Care/Partnership. Enrollments begin February 1.
- **CLTS expansion** – Plans on how to eliminate the children's waitlists have been received from all the counties. DMS is working with counties on coordinated plans.
- **Tribal option** – Working on satisfying both federal and state rules. It's very complex.
- **2018 contracts** – MCO and ICA contracts and rates have been finalized for 2018.

The following clarifications and updates were provided at the request of council members.

- **Proportion of IRIS members to Family Care members statewide** – Usually it's 20% IRIS, but Dane County is different. Other counties had

a different structure and feel.

- **Contract changes** – There were no additional changes to the ones provided at the September 2017 meeting. Rate changes are certified by an actuary. Historical experience is taken into consideration. It's an annual process.
- **Electronic visit verification (EVV)** – The deadline for implementation is January 2019. There are still a lot of questions. For example, what is considered a direct-care service? Snow shoveler? Supportive home care? CMS plans to issue more guidance. We need to know the criteria to hit in order to avoid a reduction in Federal Medical Assistance Percentage (FMAP).
- **IRIS Advisory Committee** – A meeting has been scheduled for the end of this month. Meetings will be scheduled into 2018. Conversations continue around how to use this group effectively.
- **Tribal waiver** – Initially, we looked at MCO administrative roles that could be given to a tribal federally qualified health center (FQHC). We had thought there could be a closer relationship to DHS and a majority of care management from the FQHC. With more investigation into what's allowable under the federal rules, we have run into some barriers.
- **HCBS rule** – Letters were sent to facilities at the end of November, informing people of heightened scrutiny and setting benchmarks. We expect to have conversations around meeting those benchmarks. It may be on the agenda for this month's advocates meeting. Approximately 80 out of 4,300 facilities fell into the category for "heightened scrutiny." About 1,600 letters were mailed to providers that were determined to be compliant with the HCBS residential requirements.

Amber Mullett gave the following Bureau of Aging and Disability Resources (BADR) updates:

- **Strategic planning** – BADR is using the "long path philosophy," i.e., looking 30 or 40 years out and using visionary thinking in their planning. They are talking with related councils to identify long-term goals.
- **Coordination of councils** – BADR is using quality improvement and Lean projects to figure out how to coordinate councils on shared topics of concern, such as transportation.
- **Supervisors hired** – Ann Sievert, Office of Blind and Visually Impaired; Lisa Sobczyk, The Office of Physical Disabilities and Independent Living; and Jeffrey Becker, Office of Aging, have been hired. The supervisor for the Office of Deaf and Hard of Hearing has been reposted.
- **WisTech plan** – The Wisconsin Assistive Technology (WisTech) Program will be putting out the state plan for its 60-day review period in the next two to three weeks.

Transportation Discussion Draft Summary

Amber Mullett, BADR, led a discussion on the council recommendations for improving transportation. (See page 17 in council packet; Hannah will email pages 17 to 19 to council members for their edits.) The following issues were brought up for discussion.

- **Rural vs. urban areas** – In transportation, there's a big difference between rural and urban areas. Clarification is needed.
- **MCO and ICA contracts** – MCOs and ICAs must provide transportation if the care plan requires it. If transportation is bundled, residential service providers may be asked to provide transportation, but that's not their business. It needs to be unbundled so people can travel wherever and whenever they want to. It's a matter of allowing members to exercise their freedom. Whether the service is bundled or unbundled (and there is no contractual requirement either way), it should always to be provided. The concern was then expressed that there are not sufficient resources to fulfill the transportation needs for all the members who might want them. It's a bigger systemic issue. Members were asked to send in their

recommendations on this issue.

- **NEMT** – The new Non-Emergency Medical Transportation (NEMT) requirements and RFP have been released. DHS has submitted comments on both.

The various councils will continue the conversation outside of this council. Members have their support. Members are asked to submit any suggestions from other councils they may be on to Heather Bruemmer, and she will forward to Amber.

Nursing Home Quality and Oversight Updates

Otis L. Woods, Administrator, DQA, and Patricia Virnig, RN, Director, Bureau of Nursing Home Resident Care, updated the council on the changes taking place in nursing home regulations and quality. (See pages 21 through 27 of the packet.)

- **Phase I (the Mega Rule)** – Implemented November 2016, the Mega Rule made fairly minor changes to nursing home (NH) regulations. CMS presented regulations for all three phases, but NHs were not held responsible for Phase II or III regulations. Interpretive guidelines were not presented along with the regulations.
- **Phase II** – Implemented November 2017, this phase includes Phase I requirements. It changes the tag numbers (citation numbers). NHs could be cited, but are not given penalties. Instead, they receive a directed plan of care or inservice, giving them a chance to get used to new regulations. A new computer-generated survey process was started in the 22 states that were paper-based (including Wisconsin). Interpretive guidelines are provided automatically through the surveyor's computer, which provides more consistency. Survey is more resident-focused.
- **Phase III** – Will be implemented November 2019. This phase includes Phases 1 and II requirements. Having the deadline so far out gives NHs more time to implement the most complex or costly systems: personnel hiring and training (infection control), quality programs, etc.)
- **Emergency Preparedness** – Also in November 2017, NHs (Medicare provider types) were directed to have an emergency preparedness plan in place and coordinate it with those of other facilities in their community to avoid resource shortages in a disaster.
- **Workforce shortage** – The WisCaregiver Career Program has a goal to hire and train 3,000 CNAs statewide. The workforce shortage is impacting all health care sectors, including nursing homes. DQA is hopeful that many current nurse aide training programs and technical colleges participate in this initiative to spend $2.3 million dollars over the next two years.
- **NH closures** – 16 NHs have closed since 2016, which takes beds out of the system. Meanwhile, the acuity level in assisted living facilities (ALFs) is going up. Question: If NH level-of-care people cannot get rooms at NHs, are ALFs qualified to take care of high acuity people? DHS does not want to take over NHs. NHs are an important part of the healthcare mix. What changes can we make to ensure that there is sufficient access to NHs?
- **Facility-initiated discharges** – CMS is looking at increases in involuntary discharges of residents. There is a lot of discussion around what is an appropriate reason to discharge. The long-term care ombudsman program at the Board On Aging is a critical partner to ensuring that residents are not inappropriately discharged from their home.
- **CMS Nursing Home Compare** – This website gives consumers a way to compare nursing homes. It's a five-star system. Health inspection is being frozen for 18 months so the ratings will not change, but we will continue to cite, and the citations will show on Nursing Home Compare.

Council members made the following observations and raised the following issues in their discussion.

Comment: Please clarify the regulatory changes for NHs and what surveyors' work should be.

Otis: The new survey process is a survey and certification process. There are two ways to get updates: 1) you can sign up for the DQA listserv, and 2) providers can get administrative memos, which give states guidance on oversight of the process. CMS looks at the state oversight process in 19 critical areas (about 50 overall).

Comment: Are there any changes to the survey or enforcement processes that have occurred in the last six months? How is it impacting what the surveyors do?

Otis: The federal government has decided that the regulations that went into effect in November 2017 will not draw civil penalties or directed plans; instead facilities will/may be given direction to correct. There is a delay in enforcement. We're using different tools (computerized survey) to complete the work. We have changed how we walk through the process, but the regulations have not changed. CMS is pulling back on serious enforcement.

Comment: I get railroad retirement benefits. We should say not just Medicare but also programs under Medicare. 2) I've been looking at some surveys. Over what period of time do they cover? 3) How much is the change in NH use due to Family Care? 4) When was the CMS quality rating introduced?

Pat: For surveys it's basically every year. Deficiencies need to be posted in the facility. When an NH is closed, we have a Closure Team to make sure the resident goes where the resident needs and that their rights are maintained. NH Compare is updated every quarter.

Comment: DHS is contracting the residential LTC facilities.

Otis: As of January 1, 2018, we'll be looking at Home and Community Based Services regulation for assisted living facilities, in addition to our oversight on the NH side.

Comment: Is HCBS the tool you're using to review?

Curtis: The tool was used by surveyors. Those will be rolled into annual license review. DMS is still the policy side, but DQA is the operational side. We're creating the checklist and how to evaluate.

Otis: It's pretty much the same as the NH side for the HCBS facilities. Set follow-up for HCBS facilities.

2017 LTC Scorecard

Angela Witt, Integrated Data & Analytics Section Chief, Bureau of Long Term Care Financing, walked the council through a presentation on the LTC Scorecard Report, which provides information on the strengths and weaknesses in Wisconsin's Long Term Services and Supports (LTSS) System. (See pages 28 through 39 of the packet.)

- The LTC Scorecard surveys elderly, physically disabled, and developmentally disabled adults.
- Five dimensions (areas of measurement): 1) Access, 2) Choice of setting and provider, 3) Quality of life, 4) Support for family caregivers, 5) Effective transitions, and then the sixth area (Reform Initiatives) directs the focus.
- Our data is compared to national metrics, where possible. Our data is extractable from existing databases, is relevant, consistent, and tells us something about the topic.
- Each indicator features three consecutive years, so 2013-2015 data was made available in 2017. We'll always be two years behind. It can take longer for 50 states to get the data together.
- Two metrics have been added: 1) Nonworkshop employment breakouts and 2) Preference for less restrictive living situation.

Council members made the following observations and raised the following issues in their discussion.

Comment: I love the new scorecard, that it's three years and good data. Something for future consideration: the fact that our data shows some people are underutilizing services. Eventually we won't have a waitlist, but that doesn't mean we won't have an issue.

Dave: A big part of what the LTC Scorecard is talking about is health disparities.

Comment: Is the reference to LTSS Medicaid funding [in 1.2] as opposed to institutional funding?

Angela: It's as opposed to fee-for-service funding. This is statewide. "Choice of Settings and Providers" is the people version of the money measure.

Dave: Talk a bit about how you counted the folks who are in SDS.

Angela: People in SDS are self-directing one or more services.

Curtis: We have received a lot of feedback from the council on employment so we put it in.

Comment: Could people who are retiring be having an effect on the numbers?

Angela: They could be moving into retirement earlier.

Comment: Wonder if digging into age groups would provide a clearer picture. We need to know more about the data set.

Angela: We have seen the overall percentage of working people going down. (See detailed employment data set.)

Comment: Given that the governor is supportive of employment, it begs to dig into the data more. How does the department think about employment and

disparities?

Curtis: This scorecard is that system-level look. We have an employment initiative to increase community-integrated employment. This report says we can do better. Now how do we break it out and figure out how to go about it?

Comment: Is there a way to tie it back? The three-year lag is not helpful. Can we get it sooner?

Curtis: Sounds like an issue the council is interested in.

Angela: National Core Indicators–Aging and Disabilities (NCI-AD) will provide some information on that, too.

Comment: Is there a definition of "working"?

Angela: Anyone who appears to be working from the functional screen or their PPS data sets. It should be paid work. There are no criteria around how much they're paid.

Comment: Is there a definition of "burdensome end-of-life transfers"?

Angela: It's taken from the national scorecard. Usually refers to multiple hospitalizations in the last few months of life, usually dementia patients.

There were no comments from the public.

Managed Care Rule (MCR) LTC Quality Strategy

Lindsey Kreitzman, Quality & Performance Measurement Analyst, Bureau of Adult Long Term Care Services, guided the council through the LTC quality strategy. See pages 40 through 48 in packet.

- A cohesive managed care strategy is being developed that covers both acute programs (BadgerCare Plus and Supplemental Security Income [SSI]) and LTC programs (Family Care and Family Care Partnership). The following information addresses the LTC programs portions of the strategy.
- The Managed Care Quality Strategy is a three-year goal and meets the federal requirement.
- Public comment period is projected to begin in February 2018.
- The DMS Managed Care Rule (MCR) quality strategy domains correspond to the LTC goals:
  Access to care and choice – LTC Goal #1: Empower people with access to an array of services and supports.
  Cost-effectiveness – LTC Goal #2: Promote efficient and cost-effective services and supports through innovation, standards, data-driven quality and evidence-based practices.
  Person-centered care and member experience – LTC Goals #3 and #4: Focus on the whole person, including their physical, psycho-social, and spiritual needs to live and work freely in their home and community, #4, Engage people to have meaningful choices about where and with whom

they live, their services, and who provides them.

Health outcomes and reducing disparities – LTC Goal #5: Ensure continuous improvement of high quality programs to achieve people's identified goals and outcomes.

Council members made the following observations and raised the following issues in their discussion.

Comment: Clarify 4b (page 45).

Lindsey: We want to make sure that our subcontractors are doing what they are supposed to be doing. Our oversight teams look at that.

Comment: Did we get anything about having adequate access to providers as needed?

Curtis: It's something that we can address in the future.

Jo: DHS has to confirm that we have an adequate network of providers.

Comment: Clarify 1a: IMD (page 42). Once they're psychiatrically stable, isn't it that they can't be in IMD?

Curtis: There are a few parts. One is how to prevent them from going to IMD, then how do you minimize the number of days, and then how do you provide a place to go to afterward.

Overview of LTC Quality Strategy

Curtis Cunningham, Assistant Administrator, Long Term Care Programs and Benefits, gave an overview of the DMS Long Term Care Quality Strategy. See pages 49 through 66.)

- Quality strategy has several components. This is a conceptual plan of where we want to go in a framework that allows us to move forward. We are serving the whole person, not a program or a specific benefit area. Each component offers ways to measure quality:
- **Statewide measures** – We would work with the Bureau of Aging and Disability Resources (BADR) on aging metrics.
- **Medicaid LTC programs** – The LTC Scorecard is a reflection of how we are doing.
- **Medicaid programs** – With the NCI data coming out, we'll be able to see quality at the program level.
- **Medicaid contractors** (MCOs and ICAs) – This is where consumer reporting would come in.

- **Medicaid providers** – We would look at the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL) surveys for this information.
- Curtis reviewed the DHS mission, vision, and values; the DMS mission, vision, and values; and the DMS Long Term Care mission, vision, and values. The DMS LTC values correspond to the LTC Scorecard goals. We are using these goals as the framework to look at the different metrics to find out if we are achieving the goals with the programs.

Prepared by: Carol Hutchison on 1/16/2018.

These minutes are in draft form. They will be presented for approval by the governmental body on: 3/13/2018

Bureau of Assisted Living

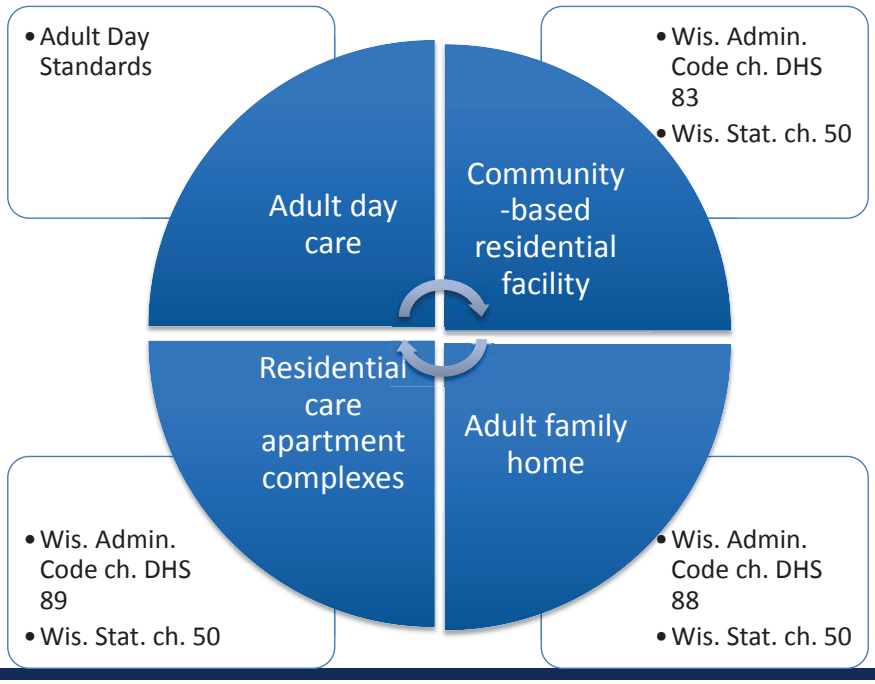
STATE OF ASSISTED LIVING

Summary

Calendar Year 2017

Otis Woods
Administrator
Division of Quality Assurance
March 13, 2018

Wisconsin Assisted Living Facilities



Regulatory Trends

Regulatory Trends

- **Number of Assisted Living Facilities**
  - 4,166 (2016)
  - 4,052 (2017)
  - Adult Family Home
    - 2061 (2016)
    - 1995 (2017)
  - Community Based Residential Facility
    - 1620 (2016)
    - 1597 (2017)
- **Licensing/Certification**
  - Common assisted living application
    - Adult Family Home
    - Larger Community Based Residential Facility
  - Change of Ownership

Regulatory Trends

- **Assisted Living Facility Closings**
  - Never serving residents
  - Voluntarily
  - Financial issues
- **Client Groups Served**
  - AFH
    - Advanced Age (965)
    - Irreversible Dementia/Alzheimer's Disease (734)
    - Intellectual Disability (1894)
    - Mental Illness (1303)
  - CBRF
    - Advanced Aged (1091)
    - Irreversible Dementia/Alzheimer's Disease (1006)
    - Intellectually Disability (589)
    - Mental Illness (531)
- **Affiliated vs Single Operator**
  - More Assisted Living Facilities are affiliated

Regulatory Trends

- **Citing Trends**
  - AFH
    - Entity sanction/4 year background check
    - Home environment
    - Smoke Detectors-Testing and Maintenance
    - Training-15 hours within 6 months
    - Training-8 hours annually
    - Licensee responsibilities
    - Prescription medications
  - RCAC
    - Tenant Rights (including Medication, Safe Environment, Freedom of abuse, Confidentiality of records)
    - Staff Training
    - Nursing Services

Regulatory Trends

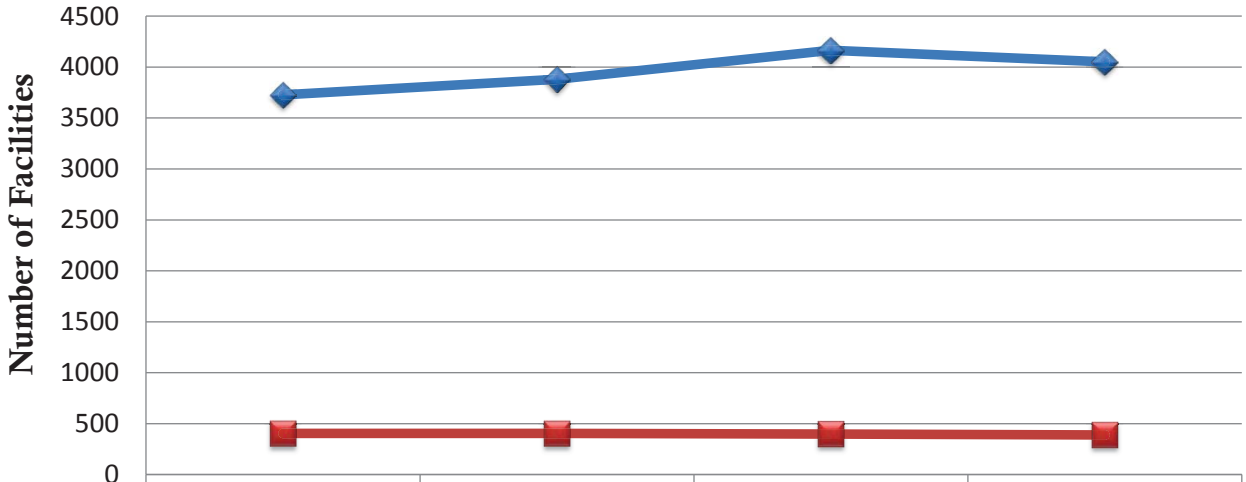
- **Citing Trends**
  - CBRF
    - Rights to receive medication
    - Service plans updated annually or when changes
    - Health monitoring
    - Prompt and Adequate Treatment
    - Qualified Staff in charge, on duty and awake
    - Adequate staff to meet resident needs
    - Not permit a condition of substantial risk

Regulatory Trends

- **Complaints**
  - Complaint subject areas
    - Program Services
    - Physical Environment
    - Resident Rights
    - Staff Training and Proficiency
  - More complaints for affiliated provider vs single operator provider
  - Highest source of complaint is anonymous and relative/guardian/POA-HC

Assisted Living vs. LTC Facilities

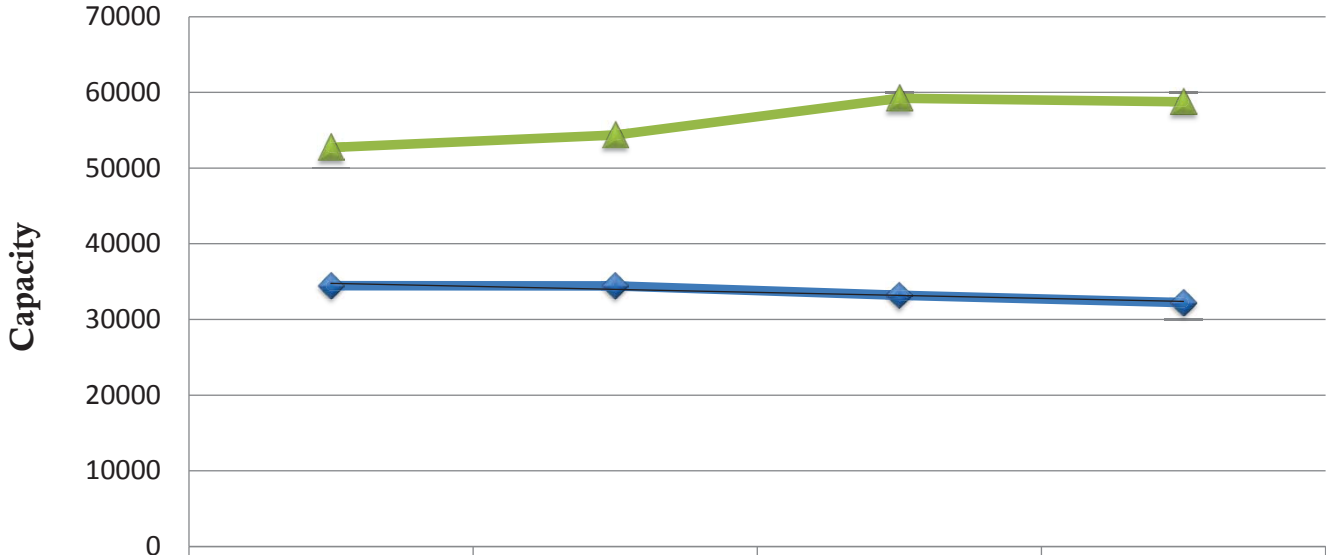
Trend in Number of Facilities



	2014	2015	2016	2017
AL	3727	3881	4166	4052
LTC	405	403	397	388

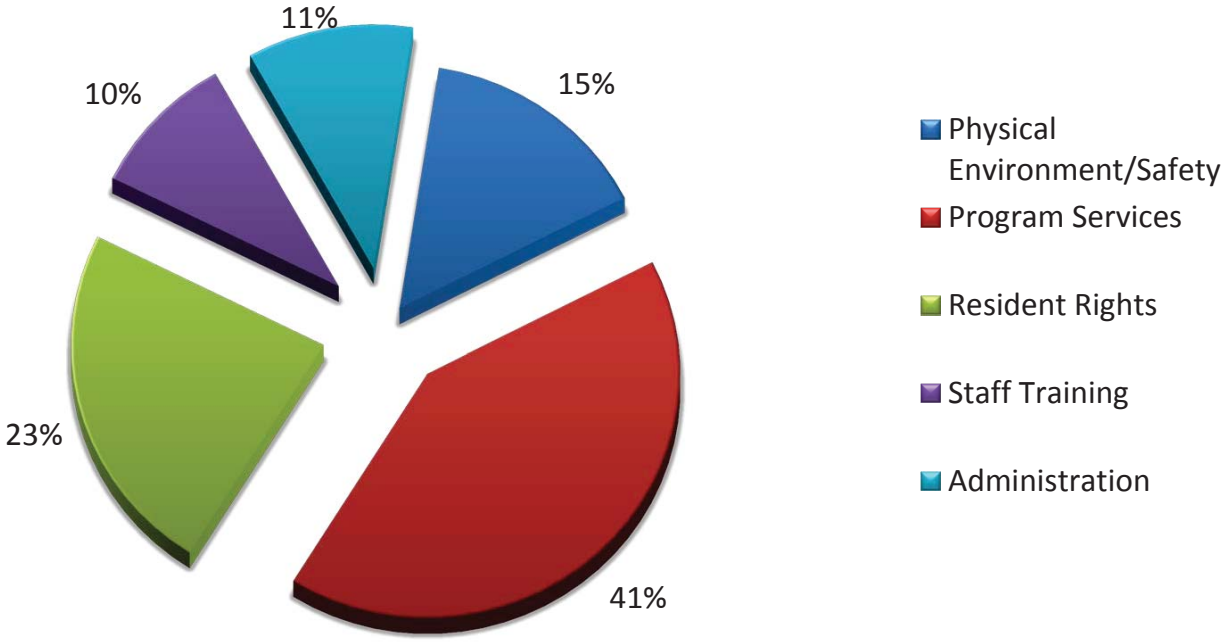
Assisted Living vs. LTC Capacity

Trend in Capacity for Residents

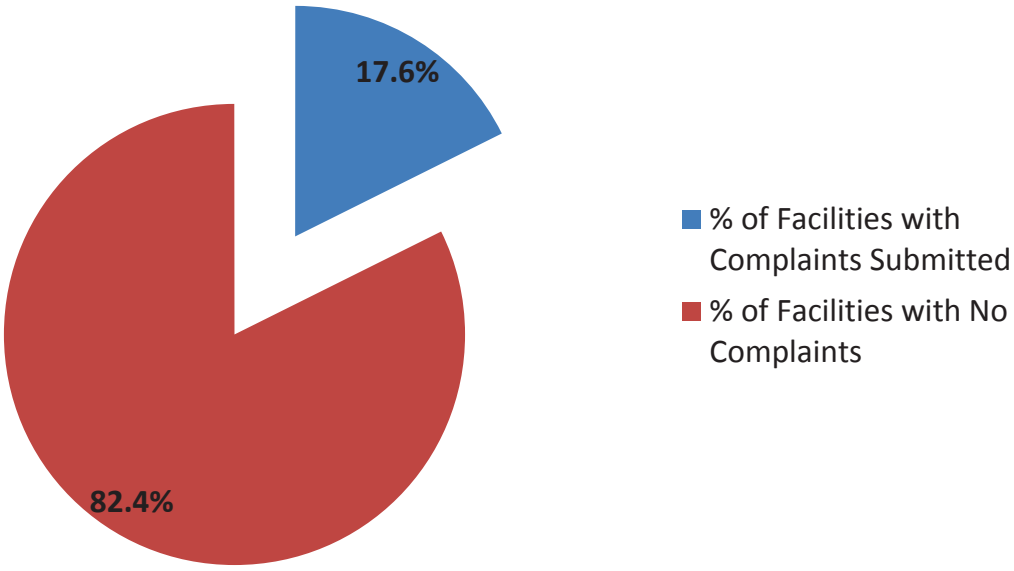


	2014	2015	2016	2017
LTC	34463	34433	33205	32236
AL	52719	54383	59224	58748

Findings of Complaint Investigation by Type of Violation CY 2017

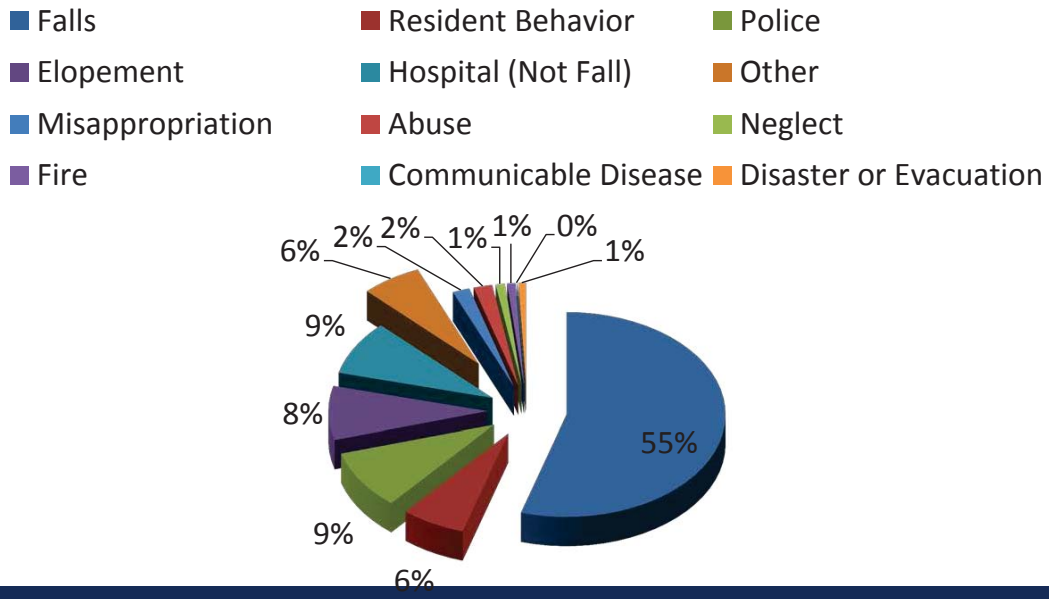


Percentage of Facilities with Complaints Submitted

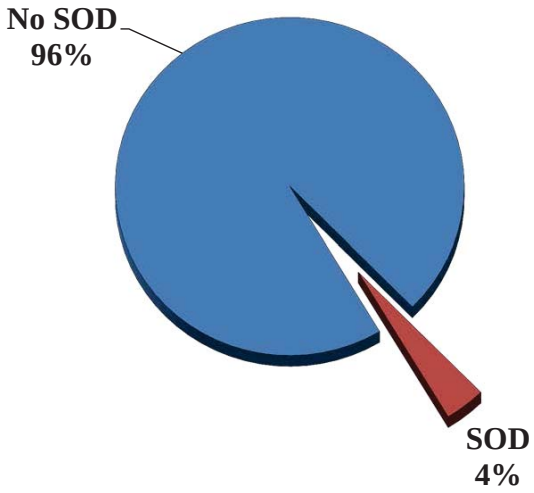


Number of Self-Reports by Subject Area

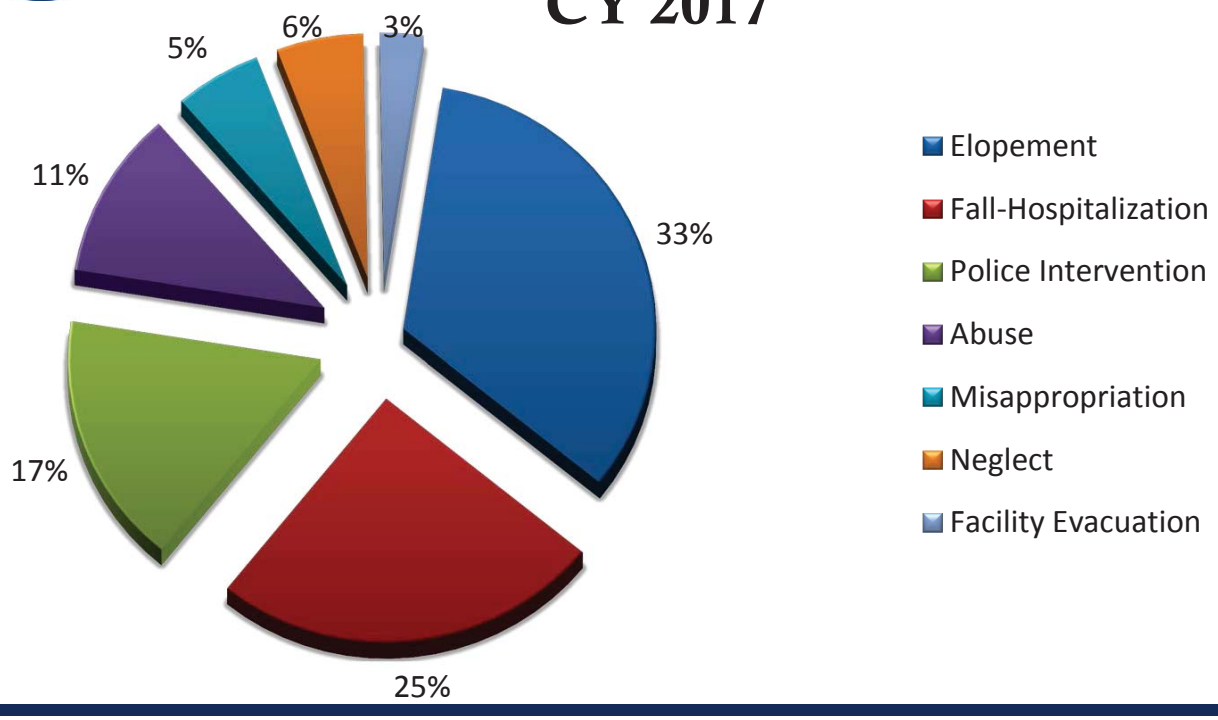
CY 2017



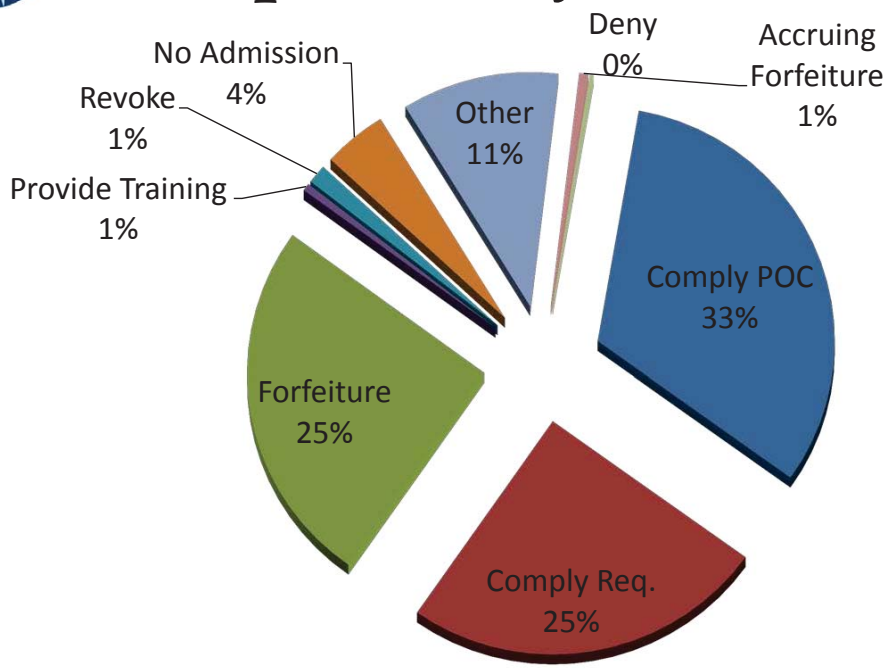
Self Reports Investigated – CY 2017 (857)



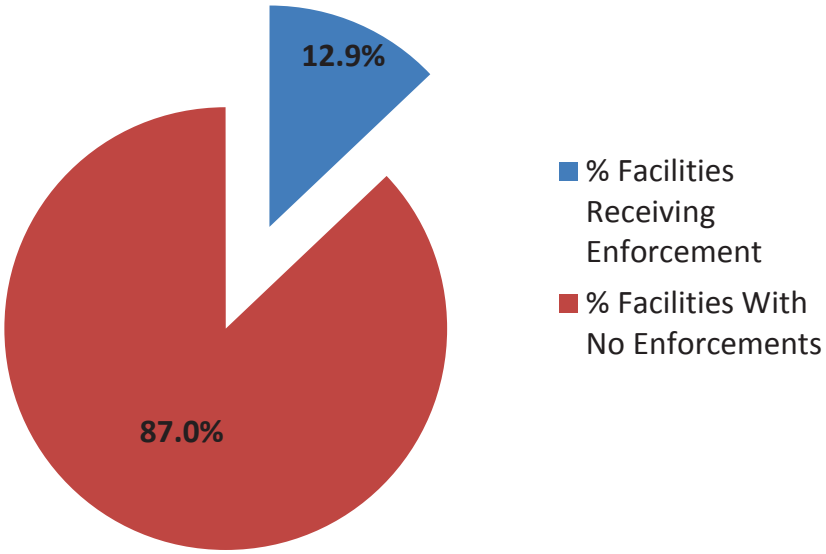
Findings of Self Report Investigation by Type of Violation CY 2017



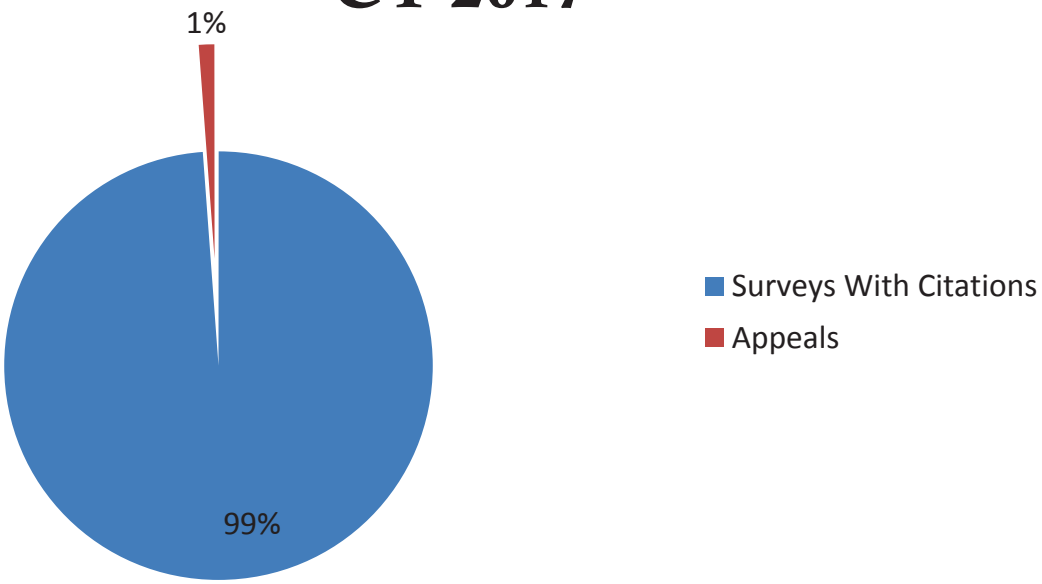
Type of Enforcement Sanctions per survey CY2017



Percentage of Facilities Receiving Enforcements CY 2017



Assisted Living Surveys with Citations and Percentage of Appeals CY 2017



Bureau of Assisted Living Initiatives

BAL Initiatives

- Completion of LEAN Application Project
  - Phase II E-Licensing/E-payment system
- Transition in Care coordination guide
- Home & Community Based Services (HCBS) validation reviews
- BAL self report publication
- RESOLVE Forums

BAL Initiatives

- Increase provider participation in the usage of BAL e-renewal system
- Study the use of technology in assisted living facilities
- Examine updates to annual/ biennial reports
- Promote internal quality improvement strategies within assisted living facilities
- Wisconsin Coalition for Collaborative Excellence in Assisted Living
- Conduct regional forums

Thank You

The Division of Quality Assurance (DQA) is responsible for assuring the safety, welfare and health of persons using health and community care provider services in Wisconsin.

DQA - Working to Protect - Promote - Provide Quality in Wisconsin's Health Care Facilities

Alfred C. Johnson, Director
Bureau of Assisted Living
Phone: 608-266-8598
Email: alfred.johnson@wi.gov

National Association of State Directors of Developmental Disabilities Services

2016 Staff Stability Survey Report
For Wisconsin's Long Term Care Council
March 2018

NASDDDS

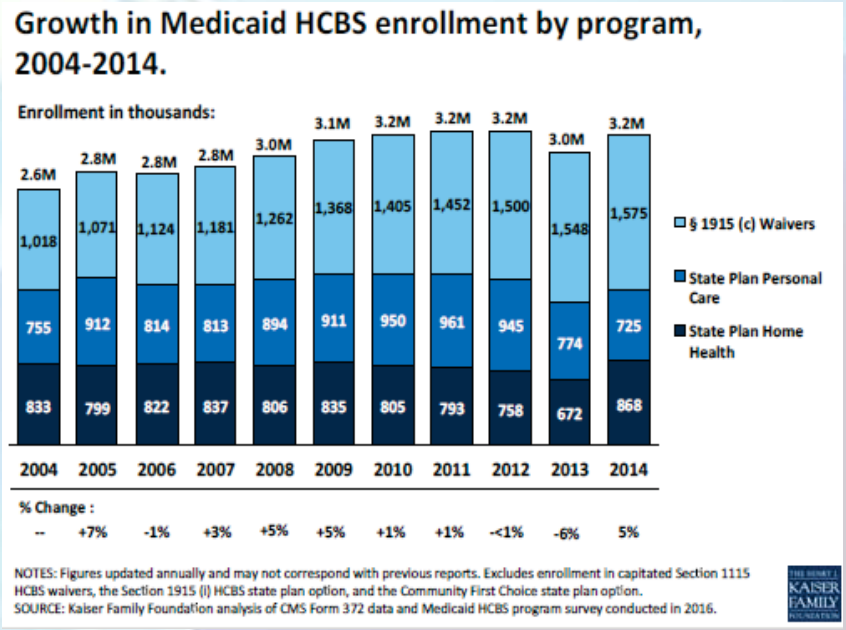
NATIONAL CORE INDICATORS™

Why does it matter?

We are only seeing the proverbial tip of the iceberg

- Enrollment in HCBS increasing
- By 2024, 1.1 million **more** workers needed from among this skill set/ demographic (BLS)

Kaiser Family Foundation 2018 Report on Medicaid HCBS



Impact on Workforce and Agencies

Wages below Federal Poverty Levels =

DSPs eeligible for public benefits (e.g., food stamps, Medicaid)

Reduced training contributes to DSP skill stagnation

High vacancy /turnover rates impact service delivery – staffing ratios, access, stress, mandatory OT

High turnover rates: extra incurred costs to providers – errors, work comp injuries, recruiting and training

- Estimated cost of turnover per employee

Approximately $4200

**ANCOR and

*Iowa Prepare to Care

Resist the temptation to only look at wages when examining workforce challenges

Wages are very important, but the context matters too

Consider tenure, turnover and vacancy rates.

Consider age, location and manager when sorting/analyzing data

Full experience of work is important—Why do people leave jobs?

The size of the agency appears to have an influence

Look at both wages, benefits and additional benefits such as offering some type of retirement benefit-

Potential factors which Impact Workforce Recruitment and Retention

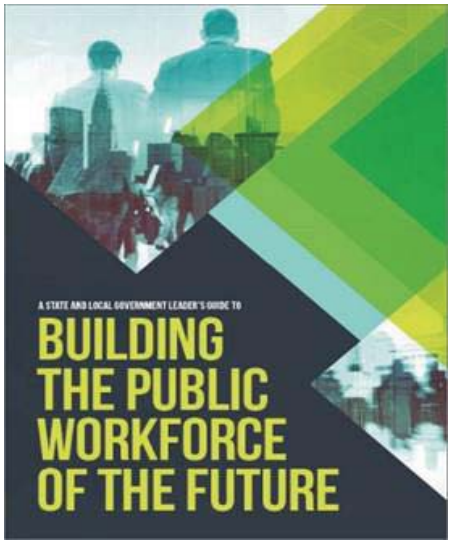
- **PCPID Report 2017:**
  - Low Wages
  - Meager benefits
  - Physically challenging work (physical injury rates)
  - High accountability for actions (responsibility without authority)
  - Isolation of location/work (lack of oversight and camaraderie/belonging)
  - Lack of career ladder/learning
  - Insufficient training/preparation

- **Additional Factors Frequently identified:**
  - Culture of organization/culture of the work site (peer pressure)
  - Lack of technology/generation differences
  - Supervisor support (lack of/skills of supervisors)
  - Schedule

Recruitment:

"The Top 5 Keys to Recruitment“ a reported in Governing Magazine are:

- Competitive salary
- Competitive benefits
- Work-life balance
- Work satisfaction
- Job stability



https://afd34ee8b0806295b5a7-9fbee7de8d51db511b5de86d75069107.ssl.cf1.rackcdn.com/GOV18_HANDBOOK_Colonial_Life_V.pdf

Factors Tied to Retention

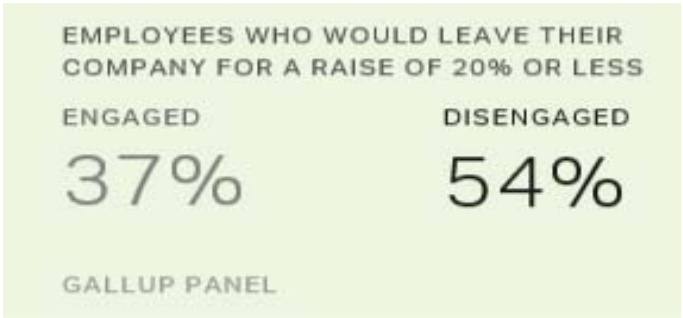
1. Do I know what is expected of me at work?
2. Do I have the materials and equipment I need to do my work right?
3. Do I have the opportunity to do what I do best every day?
4. Does my supervisor, or someone at work, seem to care about me as a person?
5. At work, do my opinions seem to count?

Buckingham M and Coffman C, First Break All The Rules: What the Worlds Great Managers do Differently 1999, Simon and Shuster and Gallup Organization. P 33

Worker Retention:

Money Matters:

- Engagement: Feeling involved in, enthusiastic about and committed to work
- Wellbeing: helping employees with: purpose, social, financial, community and physical



When employees report well-being, they are 54% less likely to look for a job with a different organization in the next 12 months

Table 3: Medisked Survey Results on DSP Reasons for Leaving Employment.

Reason for Leaving	Percentage
Inadequate pay	88.54%
Lack of supervisory support/appreciation	42.04%
Insufficient training/guidance	28.66%
Difficulties/stress of work performed	66.88%
Lack of advancement opportunities	49.68%

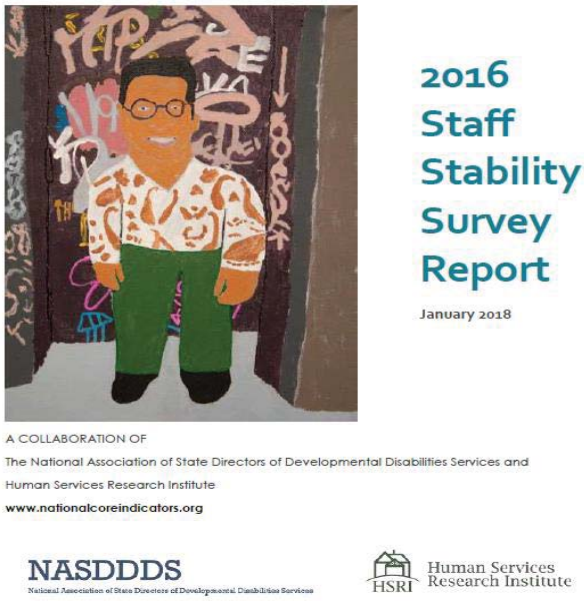
Source: Medisked survey. Multiple choice allowed therefore results add up to more than 100 percent.

http://www.gallup.com/businessjournal/188399/retaining-employees-money-matter.aspx
https://cqrcengage.com/ancor/file/ZuL1zlyZ3mE/Workforce%20White%20Paper%20-%20Final%20-%20hyperlinked%20version.pdf

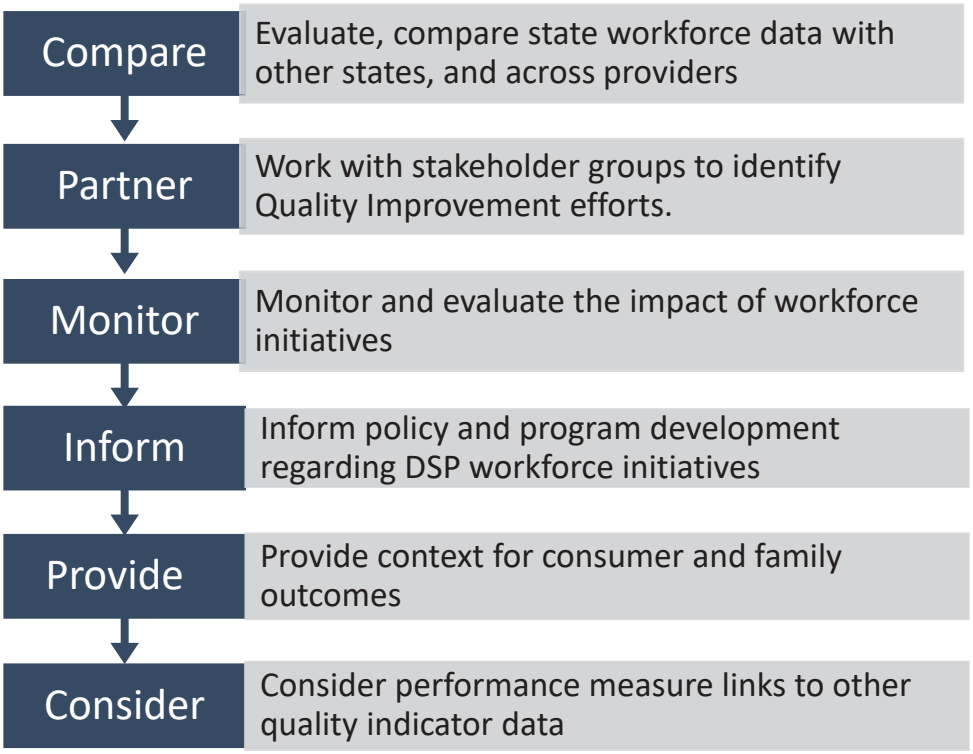
What does the 2016 NCI Staff Stability Survey Tell Us?

National Core Indicators Staff Stability Survey

- 21 States
- 3rd Year
- PA participated in 2016
- Select results provided here-
- Tested with providers and experts in the field
- Validity through multiple steps



How Can States Use the NCI Staff Stability Data?



A note on response rates

Response rates varied

- States provided email lists of providers--
- Some states did not include ALL providers in the list they sent—margin of error was not calculated
- Some states had more robust follow-up protocols to encourage participation
  - Examples
- Some states made mandatory

Email survey: may not be random

- Difference in the population who chose to participate and those who didn't—we don't know.

Important to keep in mind when looking at results

- Comparing with other states
- Assessing your state's DSP workforce

- All data refer to: Jan 1, 2016-Dec 31, 2016
- State operated facilities (employees of the state/ state wages)were not included
- "AVERAGE" data are average of state averages (not averages of all responding agencies)
- Important to note that in the report, data are shown aggregated by state (not by individual provider)
- See Appendix in report for more info on state sampling procedures

NOTES Unique to this Report

Size of agency

Table 4: Size of Provider Agencies (Based on Number of DSPs)

	1-20 DSPs	21-40 DSPs	41-60 DSPs	61+ DSPs	Mean # of DSPs employed by agencies per state	Std. Deviation		
AL	44.4%	13.3%	15.6%	26.7%	56.84	79.359		
AZ	35.2%	19.4%	7.4%	38.0%	120.18	259.921		
CT	37.9%	10.3%	3.4%	48.3%	144.47	293.560		
DC	40.7%	17.3%	7.4%	34.6%	67.73	80.260		
GA	56.0%	20.7%	5.4%	17.9%	36.23	62.371		
HI	35.3%	5.9%	11.8%	47.1%	74.82	94.858	55.00	17

	1-20 DSPs	21-40 DSPs	41-60 DSPs	61+ DSPs	Mean # of DSPs employed by agencies per state	Std. Deviation	Median # of DSPs	N
DC	40.7%	17.3%	7.4%	34.6%	67.73	80.260	30.00	81

81 DC agencies responded to this question

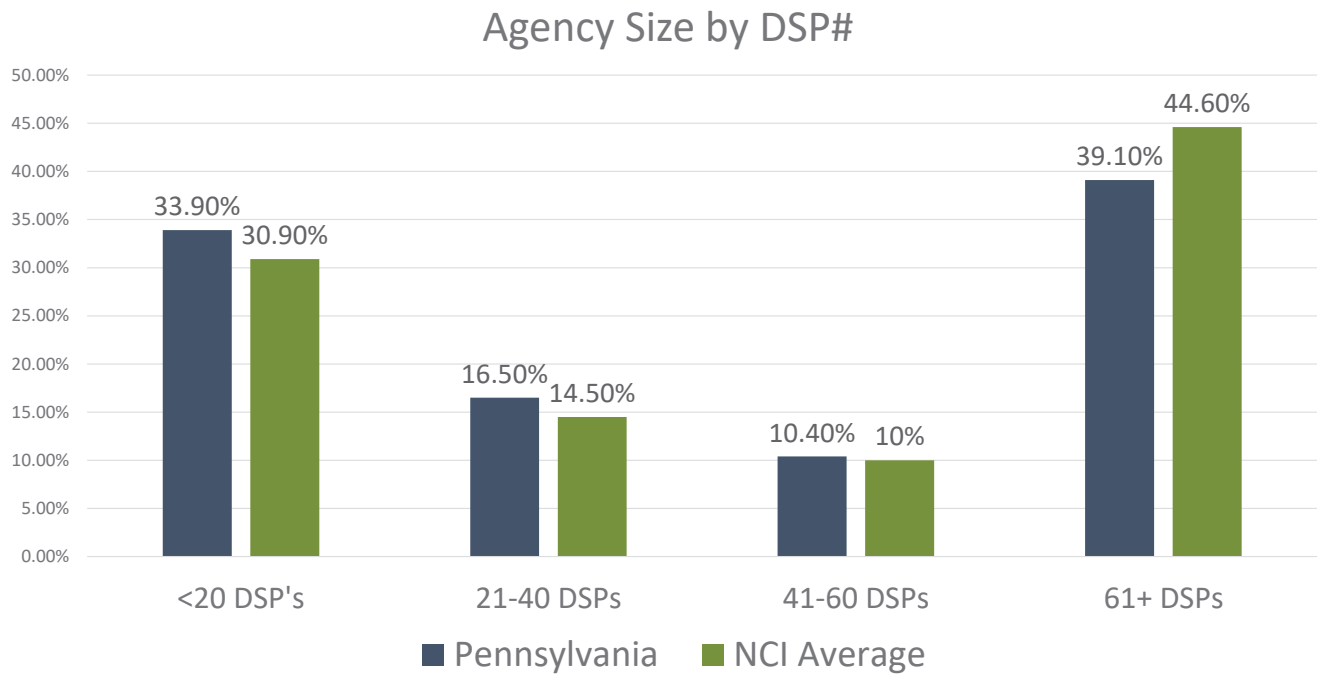
Of 81, 40.7% employed 1-20 DSPs

...17.3% employed 21-40 DSPs...

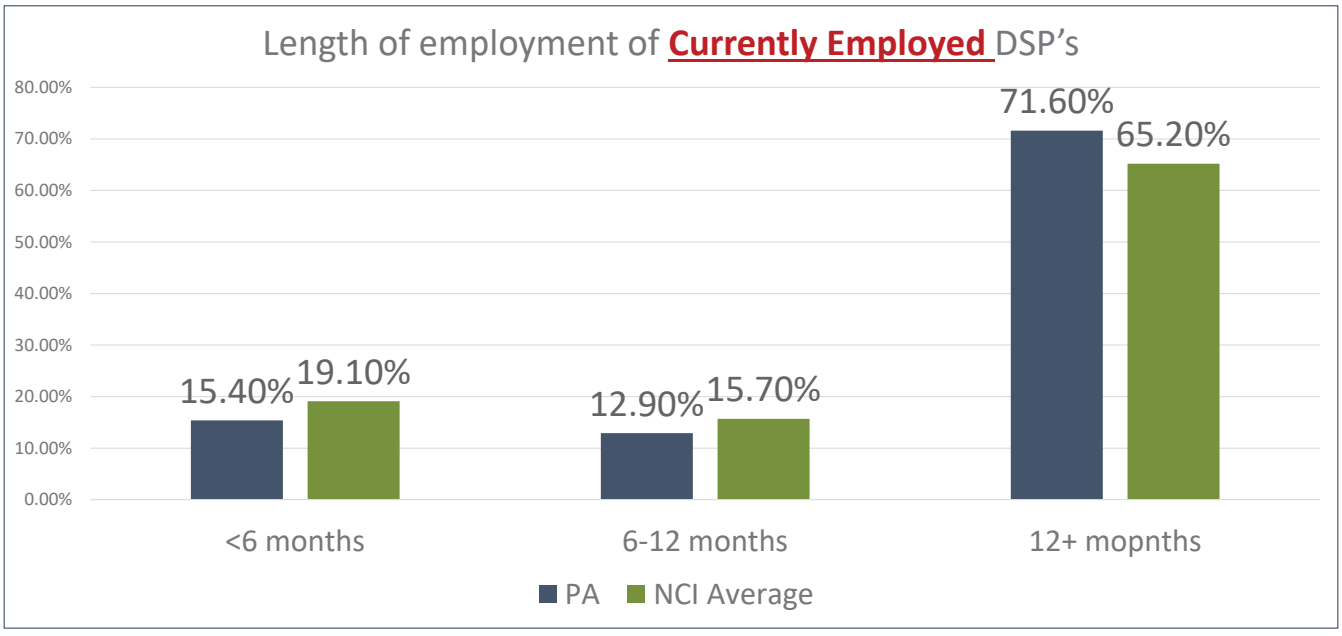
The mean (avg) number of DSPs employed by the 81 responding agencies in DC is 67.73

.....while the median is 30.00

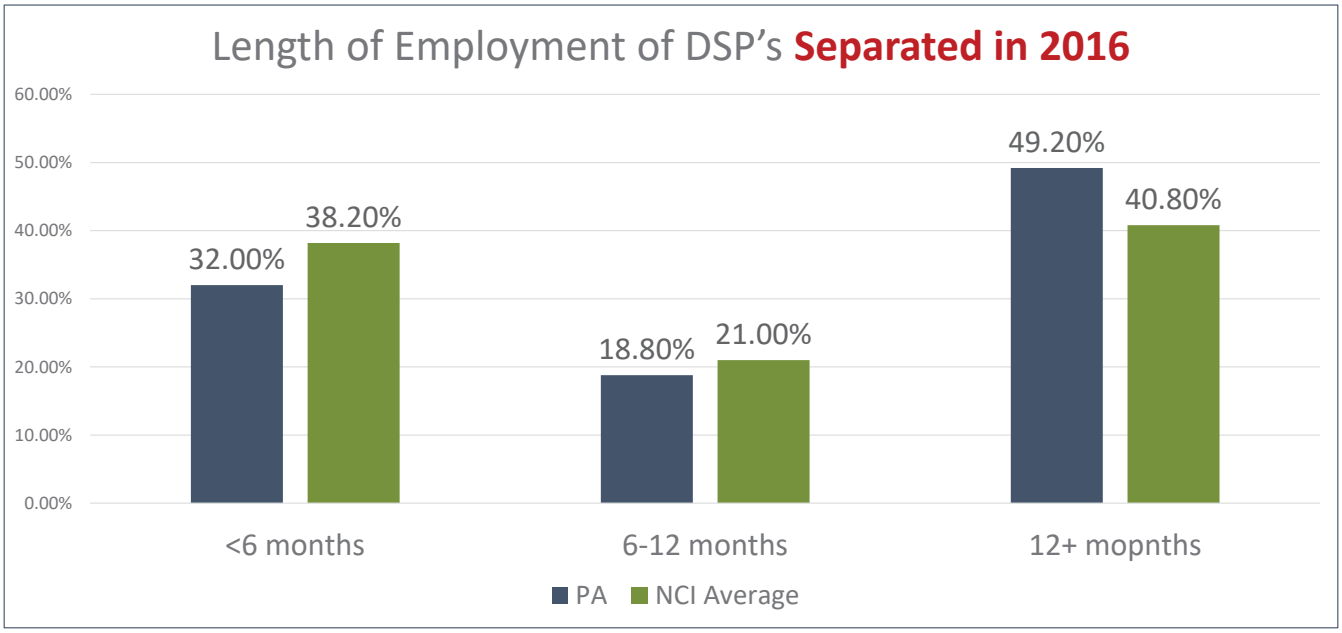
Size of Agency N=115



Tenure



Tenure – Separated DSP's



Turnover Rate

number of DSPs separated in last 12 months / number of DSPs on payroll as of 12/31/16

	# DSPs on payroll as of 12/31/16	N	# DSPs Separated in last 12 months	N	Statewide Turnover Rate	*2016 Annual Average Unemployment rate*
PA	**15260**	**115**	**5842**	**112**	**38.3%**	***5.4%***

- Responding PA agencies→15,260 DSPs on payroll.
- Responding PA agencies →5,842 DSPs separated from agency in past 12 months.

- **Turnover rate → 38.3% (5,842 divided by 15,260) as of 12/31/16**

Does not include PRN, on-call, temporary or relief staff

NCI Average Turnover Rate: 45.5%

Vacancy Rates

Pennsylvania Full and Part Time

- Full Time Vacancy rate is 11.2%
- Part Time Vacancy rate is 15.9%

NCI Average Full and Part Time

- Full Time Vacancy Rate is 9.8%
- Part Time Vacancy Rate is 15.4%

Wages

ALL DSP's Average Overall Wage

	State Minimum Wage	Average Hourly wage	Std. Deviation	Median Hourly wage	Minimum Hourly wage	Maximum Hourly wage	N
PA	$7.25	$12.67	2.850	$12.00	$8.25	$25.00	87
NCI	$7.25 (fed)	$11.76		$11.41	$9.14	19.26	2361
Average STARTING Hourly Wage							
PA		$11.65	2.826	$11.00	$8.25	$25.00	92
NCI		$10.79		$10.51	$8.52	$17.30	2449

Benefits: Paid Time Off

TIME OFF: Pooled

	To All DSPs	FT DSPs Only	PT DSPs Only	Do Not Offer	Don't Know	N
PA	38.1%	39.3%	1.2%	14.3%	7.1%	84
NCI Avg	35.2%	33.3%	0.4%	25.2%	5.9%	2271

Time Off: Separated (VACATION)

	To All DSPs	FT DSPs Only	PT DSPs Only	Do Not Offer	Don't Know	N
PA	10.0%	35.0%	0.0%	30.0%	25.0%	20
NCI Avg	10.6%	39.2%	0.2%	41.1%	8.9%	871

Benefits: Health Care

	To All DSPs	FT DSPs Only	PT DSPs Only	Do Not Offer	Don't Know	N
PA	9.2%	81.6%	1.1%	5.7%	2.3%	87
NCI Avg	14.5%	66.0%	0.5%	17.1%	1.9%	2310
Dental						
PA	17.2%	66.7%	0.0%	13.8%	2.3%	87
NCI Avg	17.5%	60.5%	0.1%	20.3%	1.6%	2301
Vision						
PA	18.4%	67.8%	0.0%	11.5%	2.3%	87
NCI Avg	16.2%	51.4%	0.1%	29.8%	2.5%	2311

Retirement/Professional Development

	Post-secondary education support*	Employer-paid job-related training	Employer-sponsored retirement plan	Employer-sponsored disability insurance	Flexible spending account	Health incentive programs	Life insurance	N
PA	27.9%	55.9%	**61.3%**	**41.4%**	22.5%	17.1%	3.6%	111
NCI Avg	29.0%	**60.8%**	53.9%	35.8%	**32.6%**	**21.8%**	3.2%	2982

National Data Has It's Limits:

- Provides a big picture, like the exit sign on a highway
- Intended for states who want to know how they are performing
- Comparison gives context, but not enough detail for improvement

For Improvement, LOCAL DATA MATTERS!!!

But, what can we DO?

The picture is bleak

What Can Be Done?

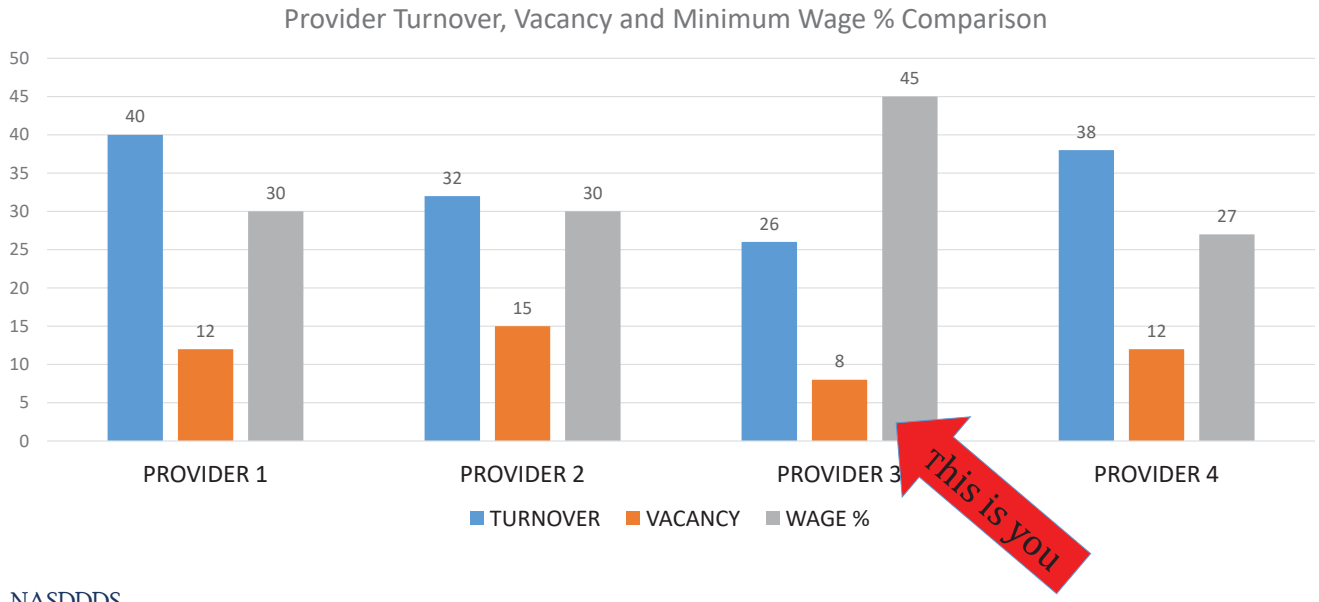
At the state level:

- Collect data among all agencies through a trusted source
- Provide reports to each agency – where they stand comparatively
- Emphasize recognition by establishing statewide award process

At the provider association (or individual provider) Level:

- Set standards for their members to use
- Design employee engagement survey/employee feedback methods for their members to use
- Survey recently separated employees for candid information
- Use formal quality tools for analysis and improvement (scatter diagrams, pareto charts, cause and effect diagrams)

Generate Reports of Performance for Providers Anonymously



What are other states doing?

- Using NCI Staff Stability Data to fulfill legislative mandates on data provision.
- Using data in legislature to support requests for additional resources
- Tracking whether rate increases are being allocated to wages (cost reports)
- Working with provider associations to carry out root cause analysis and establish clear accountability for provider performance measures in this area.

Helpful References

- Castle, N., Engberg, J., Men, A. (2007) *Nursing home staff turnover: Impact on nursing home compare quality measures* The Gerontologist (47) 5 650-661

- Antwi Y., Bowblis, J. (2016) *The Impact of nurse turnover on quality of care and mortality in nursing homes: Evidence from the Great Recession* Upjohn Institute Working Paper

- Lerner, N., Trinkoff, A., Storr, C., Johantgen, M., Han, K., Gartrell, K. *Nursing home quality deficiencies increase in facilities with high nursing staff turnover* [PowerPoint Slides]

Questions?

Email:

Mary Lou Bourne
mlbourne@nasdddds.org

2017 Wisconsin Long Term Care Advisory Council

Meeting Date: November 14, 2017
Meeting Topic: Community Development

INTRODUCTION

At the Long Term Care Advisory Council (LTCAC) on November 14, 2017, Carrie Molke with the Department of Health Services, Bureau of Aging and Disability Resources shared the Secretary's council charge for Community Development:

> Develop strategies to keep people safe and healthy in the community to prevent and delay the need for long-term care services by:
> - Looking at strategies to prevent individuals from going into residential setting before necessary.
> - Ensuring that individuals in residential settings are in the right setting for their acuity.
> - Providing advice and guidance on prevention strategies that should be developed to delay the need for long-term care services.

The consensus of the Council was that DHS should prioritize improving coordination and access to transportation as a way to impact the overall charge.

COUNCIL RECOMMENDATIONS

1. **Institute methods to improve transportation coordination, including:**

    a. **Establish a Transportation Coordinating Committee**
        i. Include key governmental agencies such as DOT, OCI, DVA and DWD and critical stakeholders, including transportation consumers and providers.
        ii. Deliverables:
            1. Develop an inventory of transportation options and funding programs in the state;
            2. Develop a state plan that identifies roles and responsibilities of state and local agencies and coordinates transportation funding and services across the state;
            3. Identify and recommend solutions for other barriers experienced by older adults and people with disabilities.

    b. **Dedicate Staff Resources Within DHS**
        i. Establish a point of contact within DHS; an employee dedicated to transportation, who has responsibilities across Divisions and programs.

    c. **Evaluate and remove barriers within current DHS programs** that fund transportation, including medical and non-medical transportation. View transportation more holistically and coordinate policies across payers. For example:
        i. Clarify when and whether consumers can share trips in various programs;

ii. Explore ways to cover medical and non-medical transportation that happen, or could happen, on the same trip.
iii. Conduct a third party evaluation to understand the degree to which the current, statewide approach to non-emergency medical transportation (NEMT) is effective and meeting customer's expectations.
iv. Consider piloting a regional NEMT approach and evaluate the effectiveness and ability to meet customer's expectations- compared to the current statewide approach.

d. Incorporate into MCO/IRIS contracts a responsibility to build options and coordinate transportation for members with existing services.
i. Include transportation as part of existing outcomes, like employment, and include in Care Plan Development.

2. Explore options for the expansion of programs that work, including:

a. **Mobility Managers.**[1] Expand mobility managers statewide. They provide local coordination and transportation navigation services to consumers. There are currently approximately 40 in the state.

b. **Volunteer Driver Programs.**[2]
i. Address barriers to volunteering:
1. Explore options for increasing the Federal Charitable Driving reimbursement rate (currently at $0.14 per mile);
2. Pursue insurance solutions (volunteers are sometimes given inaccurate information about their coverage while volunteering and sometimes required to carry a commercial insurance policy); and
3. Educate policy makers about the "Good Samaritan" law to fix the barrier created by the law not applying to situations involving the operation of a motor vehicle.
ii. Consider a coordinated, statewide volunteer driver recruitment initiative.

c. Consider Older Adults and People with Disabilities in Long-range Transportation Planning
i. Address older drivers and people with disabilities in the state highway safety plan and roadway design.
ii. Promote and expand pedestrian safe streets.
iii. Explore ways to improve walking and biking amenities, benches, and public transit to facilitate continued mobility.

d. **Expand Employment Transportation Options.** Recognize that transportation is a critical need for people to become employed and maintain employment. Ideas include:
    i. Expand ride-share opportunities;
    ii. Provide tax-incentives for providers or health systems that provide transportation.

3. Explore Innovative Solutions for the Future

a. **Autonomous vehicles.** Promote the inclusion of an aging or disability representative on the "Autonomous and Connected Vehicle Taskforce" that has been established by the Governor or encourage the committee to consider the impact on older adults and people with disabilities' when developing recommendations.

b. **Technology.** Explore technological solutions for coordinating rides with other consumers, finding rides or drivers, and for improved safety so people can drive longer.

[1]Mobility Managers are funded through a variety of sources, but the primary sources are 5310 (federal) funding and 85.21 (state) funding. Both funding sources are distributed by WisDOT.

[2]The $.14/mile is the Federal Charitable Driving Reimbursement rate - similar to the business, moving and medical mileage rates that are set by the IRS. The difference with the charitable driving rate is that it is set in statute. Unlike the other rates that can vary due to vehicle operating costs, the charitable rate can only be changed through federal legislation.

WISCONSIN DEPARTMENT of HEALTH SERVICES

WisCaregiver Careers Wisconsin Council on Long Term Care

Pat Benesh, Policy Advisor
Kevin Coughlin, Policy Advisor
Dana Philipp, Project Manager

March 13, 2018

WisCaregiver Careers
WisCaregiver.com

Agenda

- Updates for WisCaregiver Careers
- Media campaign
- Employee engagement
- Future webinars
- Website demo
- Questions

Participants

- 14 technical colleges with approved nurse aide training programs (NATPs)
- 19 nursing homes with approved NATPs
- 292 nursing home participants who agreed to pay a $500 retention bonus

Student Sign-Up

March 1st was the first day students can start signing up: www.wiscaregiver.com.

Media Campaign

- Starts April 9
- Will highlight the program and rewarding aspects of working as a nurse aide caring for Wisconsin's elders and people with disabilities:
  - TV and radio ads
  - Social media advertising

PIGORSCH • MEDIA DESIGN

Employee Engagement – 3/1/18

Denise Boudreau-Scott, MHA, LNHA

drive
Outcomes Through Culture

- 161 attendees. Most stayed on for the entire webinar.
- 94% of the respondents indicated very good (68%) or good (26%) overall.

Workforce Solutions

Monthly webinars (1:30–2:30)

- April 5: **Recruitment, Retention and Best Practices**, Cagney Martin, North Central Health Care and Jill Gengler, Colfax Health & Rehabilitation Center
- May 3: TBD
- June 7: **Peer Mentorship Programs**, Anna Ortigara, RN, MS, FAAN
- Other dates: TBD

https://connect.wisconsin.gov/wiscaregiver_career/

Website Demo

WisCaregiver Careers
WisCaregiver.com

www.wiscaregiver.com

Resources

- **Mailbox:** dhscaregivercareer@dhs.wisconsin.gov
- **Website:** www.dhs.wisconsin.gov/caregiver-career/index.htm
- **Student Sign-up:** www.wiscaregiver./com

Resources (continued)

- **Student recruitment:** wiscaregiver.com
- **Listserv:** https://public.govdelivery.com/accounts/WIDHS/subscriber/new?topic_id=WIDHS_430

Questions

Workforce Demands and Innovations in HCBS Waivers

Council Ideas and Suggestions

Innovations and Next Steps

- **Submitted items**
  (including federal workforce recommendations)
  - ✓ Current HCBS Benefit
  - ✓ Current State Plan Benefit
  - ✓ Market
  - ✓ Regulatory (DQA, Wisconsin statutes, federal law, etc.)
- **Examples of HCBS benefits from ICAs and MCOs**
- **Gap analysis**

HCBS Waiver Benefit

Remote Monitoring Systems/Electronics

TMG

- Front door electronic monitoring
- Med drawer electronic monitoring
- Night Owl
- Echo/Alexa used for reading

Care Wisconsin

- GPS monitoring
- Door monitors

Connections

- Smartphone reminders, including when to take medications and how to report emergencies
- Alexa—has alarms on all doors and alerts when doors are open

3

HCBS Waiver Benefit

Remote Monitoring Systems/Electronics

Lakeland Care

- Recognized the value
- Believed infrastructure was a barrier
- Issued RFP—selected Innovative Services—partnering with SimplyHome technology

4

HCBS Waiver Benefit

Remote Monitoring Systems/Electronics

- Dynavox telephone system gives nonverbal individual a way to call the service provider if needed for assistance
- iPad that controls television
- iPad that controls heating/air controls
- Tablet to control door switches and video monitoring for front door access
- Tablet to control light switches
- Lifeline with fall detection

Barriers

- Guardians uncomfortable with increased independence
- Unreliable internet/broadband, especially in rural areas

5

HCBS Waiver Benefit

Remote Monitoring Systems/Electronics

Inclusa

- Multiple contracts with remote monitoring companies
- Electronic medication dispensing devices
- Currently use:
  - Sensors
  - Computer-assisted devices (tablets and smartphones)
  - Transportation technology
  - Medical alerts systems
  - Home motions
- Home modifications allow for:
  - Fall prevention technology
  - Floor mat alarms

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HCBS Waiver Benefit

Smart Phone or Other Devices

TMG

- Front door electronic monitoring
- Med drawer electronic monitoring
- Night Owl
- Find Friends
  - Enables tracking of son's independent running and skiing activities

Inclusa

- Job coaching queues

HCBS Waiver Benefit

Home Helper Ideas

Bubble Packing

- Used universally for members in the community

Meal Delivery Options

- Several vendors provide drop-shipped meals in addition to traditional county-based meal delivery options

Grocery Shopping

- Allowable service
- Could also pay for transportation or attendant care for the member to do their own grocery shopping

HCBS Waiver Benefit

Other Ideas

- **Smart Homes** (Alexa/Echo) being used
- **Mandated social network access** (allowable if meets a needed goal of the members/participants)
- **Congregate Meals**
  - Allowable
- **Transportation of providers to members**
  - Allowable

State Plan Issues

Health Care Improvement Ideas

- Telehealth

Private Sector Market

Other Improvement Ideas

- Internet/broadband coverage for rural areas
- Worker cooperatives
- Independent providers being developed
- Direct support workforce registries
- Competency-based training programs
- Personal robots and assistants
- Self-driving cars
- Family-led support groups
- Paying workers a living wage
- Bus passes for employees (federal tax allows pretax benefit)
- Childcare for caregivers

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Regulatory

Identified Problems

- Transfer aids and coding issues, e.g., Hoyer lifts
  - Could be a Medicare coordination of benefits. HCBS covers these devices.
- Portable ramps–need to regulate for safety
- Number of bid requirements (IRIS)
  - Standard language in most federally funded programs
- Independent assessors for home modifications
  - Inclusa uses RN DME who receive training from UW-Stout
  - Also use PT/OT and ATPs to perform evaluations and make recommendations
- Telehealth for health care professions – insurance company policies, Department of Safety and Professional Services (DSPS)
- Short periods of needs and back-and-forth (can be negotiated in advance—part of RAD)
- Nursing scope of services delegation—DSPS
- Social network for members
- Criminal background check policies

12

Next Steps

Best Practices and Communications Teams

- Focus communications on examples for external audiences
    - Work with ICAs and MCOs to produce communications plan and member information
- Review “Identified Problems” and work on eliminating that list through referrals and interagency collaboration

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