

Committee on Direct Care Workforce Issues
WI Council on Long Term Care Reform

Meeting of July 27, 2004 – Approved Minutes

Members present: Lynn Breedlove, Beth Hadley, LaVerne Jaros, Jo Ellen Kilkenny, Chris Nordberg, Jessica Schmidt, Karen Secor, and Chuck Wilhelm

Others present: Robert Kraig (for Debbie Timko), Susan Duvall (for Amy Ambrose), Lorraine Barniskis, Carrie Molke, Lyle Updike, Marcie Brost, Judy Zitske, Ellen Felix, Ruthanne Landsness, George Potaracke and Sue Larsen

Meeting call to order. Outline for data collection.

Chair Lynn Breedlove called the meeting to order at 9:40 a.m. The committee suggested a number of edits for the framework for organizing information used to develop and support recommendations. See separate redraft titled “What Do We Know about the Direct Care Workforce?”

Draft statement of values and principles

Members suggested a number of edits to the draft statement of LTC direct care workforce values and principles. See separate redraft of this document.

Elements of facility and agency review relating to the direct care workforce

Sue Larsen, Director of the Office of Caregiver Quality in the Bureau of Quality Assurance (BQA), provided several handouts and briefed the committee on a number of BQA quality review elements that relate to workforce issues. (See handouts “General Facility Survey Guidelines,” Nurse Aide Employment Eligibility Verification,” and Caregiver Program Compliance Check.” These describe the licensing requirements and review processes related to nurse aides in nursing homes, facilities for the developmentally disabled, home health agencies, hospice programs, and assisted living facilities, as well as the nurse aide registry and caregiver background checks.

Sue noted that facility survey guidelines are federal requirements that focus on baseline, minimum competencies. There is no recognition in this system of experience or extra skills. In response to a question, Sue advised that this committee should focus on the minimum requirements for initial nurse aide training and in-service training. Wisconsin’s current requirement for 75 hours of initial training is the federal minimum and is among the lowest state requirements in the nation. There is a federal and Wisconsin requirement for 12 hours annually of in-service training, but compliance is not tracked in Wisconsin’s registry. It was noted that additional initial training tends to increase proficiency levels, not necessarily adding subject content. In three surveys, direct care workers responded that their training was inadequate.

The number of nurse aide training programs has declined recently from 230 to 127 programs. A large percentage of facility-based programs are no longer active, and about

half of all new CNAs now are trained at technical colleges. About 175,000 CNAs are listed in the nurse aide registry; of these, about 57,000 have active status. Active status requires only that a CNA perform paid nursing or nursing-related services for 8 consecutive hours during the previous 24 months. Further, not all those with active status are working in the long term care field.

The requirement that LTC facilities have “sufficient staff available” is not federally defined. State statutes do require a minimum number of CNA hours per resident day in nursing homes. To determine whether a facility is adequately staffed, surveyors usually look at resident outcomes. Uniform staffing ratios are difficult to establish, since the number of available staff should vary by the needs of the residents.

Sue agreed to bring back to the committee information on other states’ training and other certification requirements for nurse aides. George Potaracke reminded the committee that the number of nursing homes is shrinking, while assisted living is growing rapidly. He urged the committee to cover all LTC settings.

How current public reimbursement policies encourage quality, especially workforce quality

Carrie Molke, Bureau of Long Term Support (DDES), provided information on CBRF quality policies under the Community Options Program (COP) and the CIP II Waiver Program. A policy established by DHFS in 2002 required that county agencies administering COP and CIP II incorporate quality standards in their contracts with CBRFs. A workgroup of state and county staff developed model quality performance standards and measures and a checklist for the evaluation of quality in CBRFs. (See September 2002 memo to counties from Donna McDowell.) Counties began contracting for CBRF quality in 2003.

No statistical information on the results of these efforts is available yet. Anecdotal information about the approaches that various counties have taken was submitted with their annual COP Plan Updates and is being compiled. When non-compliance with established standards is found, some counties are withholding funds, some are canceling or not renewing contracts and some are imposing fiscal sanctions.

Carrie noted that objective and consistent criteria and evaluation processes are needed within and across counties if these standards are to be meaningfully enforced. Kenosha County is working on a model using a more objective measurement tool for all populations and all assisted living settings. Efforts currently underway through the CMS-funded Quality Close to Home project are designed to make quality processes in Family Care and all the waiver programs similar.

Lyle Updike, Bureau of Fee-for-Service Health Care Benefits (DHCF), provided information about the Medicaid fee-for-service nursing home reimbursement formula. No specific parameters in that formula directly relate to workforce issues, but several factors do relate indirectly:

- The direct care allowance portion of the formula is based on a facility's historic costs (creating a disincentive to hiring more staff or increased pay or benefits for existing staff).
- An adjustment to rates compensates facilities that serve a higher proportion of Medicaid residents.
- Another adjustment increases rates up to 20% if a facility is small.

Lyle noted that about 75% of facilities are spending more than Medicaid pays, making up the difference from Medicare, private pay and smaller amounts of LTC insurance and managed care payments. He also noted that the staff to resident ratio is largely a function of occupancy levels and that occupancy rates are increasing rapidly as facilities de-license beds in response to the bed tax.

Lyle cited a Journal of Gerontology article reporting on research that found a relationship between staffing levels and quality (as defined by quality survey outcomes). However, the same research found a stronger relationship between this measure of quality and other factors such as facility size, ownership type, and other facility characteristics. This implies that higher staffing levels and reimbursement will not necessarily result in better outcomes as measured by BQA quality reviews. He suggested, however, that more and better trained and paid staff may result in higher quality of life for residents. The committee's review of research in this area should identify what measure of quality is used when relationships are found between quality and staffing. He advised that financial incentives could be used to spur improvements, but should not be expected to produce results dollar for dollar. If financial incentives are tied to retention rates, those rates will have to be independently verified by the state, not just self-reported by facilities. It was noted that reimbursement rates to facilities for initial nurse aide training and testing have not been increased since the early 1990's and there is no reimbursement for ongoing training.

Jessica Schmidt, Provider Network Manager for Portage County's Family Care program, noted that Family Care is in the infancy of developing performance-based contracting with service providers. Specific standards, including those related to staffing, are being developed and baseline data collection is underway. She provided a sample contract excerpt showing standards included in contracts with supportive home care agencies. (See "Appendix II, Supportive Home Care, Community Care of Portage County, Purchase of Service Agreement.") It is unclear at this early stage how findings will develop into real performance contracting, a process that is likely to take 3 to 5 years. Community Care of Portage County (the Family Care CMO) uses a 4-tiered reimbursement methodology for the CBRFs with which it contracts. This will be sent to committee members and discussed at the next meeting.

Marcie Brost, Bureau of Long Term Support (DDES), described quality assurance and improvement efforts for programs serving people with developmental disabilities. The Birth to Three program conducts program reviews that include interviews with workers. State staff from the Community Integration Program (CIP IA and CIP IB) conduct annual reviews of a sample of consumers, including interviews of their support staff. Program

staff conduct both scheduled and random reviews of local programs, including follow-up with workers. Technical assistance and training are provided as requested or needed. The CIP manual includes training requirements for staff; most providers provide more extensive training than required. Some, but not all, counties have standards for contracting with providers. State staff also work directly with providers on workforce improvement, including providing them with tools for self-evaluation.

Judy Zitske, Bureau of Long Term Support, described the quality assurance and improvement processes for the COP and CIP II Waivers, which serve older people and people with physical disabilities. DHFS contracts with The Management Group (TMG) for these reviews. Standards have been established for every waiver service. TMG conducts county monitoring visits every two years for most counties, more often for large counties and for those that have experienced problems in the past. These direct reviews include interviews with a sample of consumers. When problems are found, the usual response is the provision of technical assistance from TMG and/or state staff.

Judy also provided a summary of the Community Links Workforce Projects from 1999-2004. (See handout of same title.) She also summarized some of the ways that county COP agencies administer in-home services, concentrating on the extent to which they can encourage quality under various methods. (See handout titled "Organizing In-Home Direct Care Workers.")

Committee business

The minutes of the June 28, 2004 meeting were approved unanimously. Future meeting dates were confirmed (attached).

Information on what other states are doing to tie reimbursement policies to quality

Lorraine Barniskis highlighted major points of her handout titled "State Initiatives to Tie Outcomes to Reimbursement." The first section of this handout provides information about Iowa's efforts to reward high quality in nursing homes, along with very brief information about several states' efforts. The second segment provides fairly extensive information about Minnesota's nursing home reimbursement initiative.

Members suggested that information be obtained about the workforce efforts underway in California, which have included a Public Authority system to assist home care workers, a more workable wage pass-through mechanism for nursing homes, and higher CNA training requirements.

Development of recommendations related to quality assurance and reimbursement policies. This item was deferred until the next meeting.

Meeting adjourned at 3:00 p.m.