RI EOHHS Healthcare Workforce Transformation Committee
HWT Home and Community-Based Care 11/17/2016 (3:00 – 4:30 pm)
DLT Conference Room (73-1)

Facilitator: Rick Brooks
Presenter: Michelle Szylin, Chief of Family Health Systems, EOHHS
Prepared by: Cheryl Wojciechowski
Participants: Jean-Marie Klinn (Capitol Home Care Network), Daniel West (Jobs for the Future), Jen Jaswell (CareLink), Irene Qi (Hope Nursing Home Care), Tammy Russo (RIPIN), Vinnie Ward (Home Care Services of RI), Kathleen Kelly (RIALA), Tonya Glantz (RIC), Doreen B (Health Care Connections), S Williams (Health Care Connections), Sandy Curtis (EOHHS), Desi Santurri (Phenix & Coventry home Care), Kathleen Heren (LTC Ombudsman), Amy Chirichetti (Optum/United), Karen Statser (EOHHS), Jessica Walsh (NHPRI), Robert Haigh (Health Care Services), Nicholas Oliver (RI Partnership for Home Care), Mary Barry (Capitol Homecare), Bethany Skinner (Healthcare Services), Carmen Boucher (RIDOH), Michelle Szylin (EOHHS), Holly Garvey (EOHHS), Lynn Blanchette (RIC School of Nursing), Michelle Kornberg (Nursing Placement), Alison Croke (NHPRI), Hilary Jansson (CCRI).

Agenda Item	Key Discussion Points
Welcome & Introductions	Rick Brooks welcomed participants and provided background on today's subcommittee meeting. The full HWT Committee met on October 7th to begin to plan strategies to transform Rhode Island's healthcare workforce development system. Elizabeth Roberts, Secretary, EOHHS, Nicole Alexander-Scott, MD, MPH, Director, DOH, Rebecca Boss, Acting Director, BHDDH, and Marti Rosenberg, Director, RI SIM Project each spoke to provide a sense of direction and the overarching goals derived from Reinvent MA and SIM. Seven HWT goals were extracted from that meeting: 1. Primary Care 2. Behavioral Health: Practice & Integration 3. Social Determinants of Health/Cultural Competency & Diversity 4. Data Quality, Reporting & HIT 5. Community and Home-Based Care 6. Chronic Disease 7. Dental Care This Home and Community-Based Care subcommittee meeting is the fifth of the seven. The remaining two subcommittees will meet to discuss the other goals through December 1st and the full group will come together again on December 6th to develop concrete workforce development strategies with the likelihood of having the greatest impact and of being accomplished. Rick added that Jobs For the Future (JFF) will be conducting about two dozen one-on-one interviews with key informants after all subcommittees have met. The meetings will conclude by the end of February. JFF will be assist in distilling

	information from these interviews, the subcommittee meetings, and additional research to craft strategies that will have the most impact.
Issue Overview (Michelle Szylin, *Chief of Family Health Systems, EOHHS*)	Michelle worked at the Department of Elderly Affairs for 17 years before coming to EOHHS and provided a look back at what home care was like 20 some years ago and where we are today. Over 20 years ago there were no home care workforce issues. There were fewer cases and the cases were less complicated, there was a wage increase, and then acuity rates were developed. Since then changes have occurred including the Personal Choice Program (individuals can hire, fire, and train their own home care workers) in 2006, and the Shared Living Program (24 hour care mostly by loved ones) in 2010. Currently there is a very limited workforce and we cannot fill cases. The reasons for this include difficulty recruiting and retaining aides, low wages and limited health benefits, geographic areas, and more complicated cases. Reasons why it is difficult to retention aides include: ▪ Patients have needs that require greater skill and judgement for which aides are not trained. ▪ Patients are more medically complex and often have mental health and/or social issues. ▪ Home care aides are not provided with over-time and mileage. ▪ Home care aides are facing environmental issues like unsafe neighborhoods, communicable diseases, hording, no over-time and mileage. ▪ Home care aides are isolated as opposed to those that work in a facility. Michelle pointed out that she understands it has been a rough road for the past several months for home care agencies and that the home care industry is critical to rebalance. Michelle suggested that there are actions that can be taken to improve the situation: ▪ Change the curriculum. ▪ Change RIDOH licensing. ▪ Change the current culture to one that respects the value of CNAs. ▪ Develop a career ladder. ▪ Enhance training for CNAs such as soft skills, behavioral health issues, conflict resolution, cultural competency, etc. ▪ Develop certificate programs in specialty areas. ▪ Empower aides by welcoming their participation in care plan and team meetings. ▪ Develop non-financial incentives. ▪ Develop different levels on career path.

	Michelle took questions/comments from participants: One participant voiced her appreciation that EOHHS recognizes agencies' issues but pointed out that this doesn't just affect CNAs. It also affects nurses, therapists, and social workers. Agencies struggle to identify and then compensate and create career ladders and specialty training. They are limited by current funding levels. Another participants pointed out that he lost four CNAs in the last two weeks, all due to low wages. He added that CNAs will expect more money as they move through a career ladder and that the money just isn't there. He also pointed out that all of the potential strategies listed on the worksheet are useful but come down to money and that the state does not pay a proper wage. Lastly, he noted that home care nurses do not usually choose home care as a career, rather they are just picking up a shift here and there. Rick responded that the work of this committee is one more way to focus attention on the problem and that it is something that EOHHS has invited. The more attention and support for an issue the more likely to get results. We cannot write a check or change the state budget but we can include these issues in a report/plan. He encourage the agencies to not give up. It was pointed out that RIDOH says there are about 15,000 licensed CNAs but the group would like to know how many of these are actually working in Rhode Island. Rick assured the group that JFF is in the preliminary stages of collecting this data to gain a better understanding of how RI pay compares nationally, where people are employed, etc. Rick also pointed out that after acknowledging more money is needed we need to discuss what training and certification should look like, how collaborate with schools. A participant shared the model of a pyramid with "safe and effective care" at the top. She stressed that everything we do needs to fall under this, that if a patient is not at top of pyramid, nothing will work. Many strategies on the worksheet focus on paraprofessionals but nurses, therapist, social workers also need to be addresses. Care New England has a new year-long nurse residency program paid for by a with a HRSA grant. Agencies need to be licensed to provide their own CNA certification program. Colleges want to be part of the conversation to find out how they can modify their curriculum to better prepare their graduates and to create pathways from CNA to nursing or other healthcare professions. Vocational and technical program graduates are often looking to use their CNA training as a path to other healthcare careers such as nursing. By contrast, "welfare-to-work" program participants often do not purposefully choose to become a CNA, they are not necessarily interested in a healthcare career. They also cannot work more than 10 hours per week for

	fear of losing their benefits (housing, food stamps, etc.). Therefore we need to support those who are purposefully choosing CNA certification as a pathway to other healthcare careers with incentives, etc. It is fine to have improve education and create specialties, but workers need the basic skills to be able to "care" for patients.
Large Group Discussion of Workforce Strategies	The group discussed proposed workforce strategies in a large group rather than breaking into small groups. The discussion included: **1. Develop specialized training and certification for home care CNAs, and/or for specific needs such as pediatrics, hospice, mental health, substance abuse.** ▪ Currently there is only one CNA license with one curriculum and test which is geared to the facility setting. Rick asked the group is they think we need multiple curricula or a base line and then specialties? Answers from participants included: ▪ Make it longer and more clinical. ▪ We first need to define home health aides and certified nursing assistants. ▪ Change the name from certified nursing assistants to home care attendants though we would not want them to get additional duties that nurses should do. ▪ Open up who can run trainings and what topics should be covered. ▪ All should have basics and then institution that hires them can do specialized training. ▪ A community college in Massachusetts provides accreditation for nurses' aides then added specialties. We would need a common level of education. ▪ Core curriculum for CNA then various specialty options. ▪ Some institutes of higher education offer certificate programs instead of a degree program such as the early care in education certificate from RIC. ▪ Stackable credentials makes an individual more employable. ▪ Core competencies are needed for health care workers across the board. ▪ Many CNA candidates pass the competency/skill portion of the test but if English is not their primary language they have difficulty taking the written test. Several participants agreed that the written test should be offered in several languages while others disagreed. There are other states that do allow to test in languages other than English. The RIDOH position on this is unclear. **2. Utilize other occupations to enhance homecare workforce (e.g., EMTs, CHWs, LPNs, Medication Techs, Peers, etc.)** ▪ Some states are starting to look at other occupations to support home and community-based care. RIDOH is looking at mobile integrated health using EMTs in some ways when patients don't need transportation to the

	ER. Central Falls is using 1st responders in this way to divert from ER so this could be considered a viable resource. Med Techs are well known in LTC but not it is not clear if they have role in home care. ▪ Rick asked participants if they think peer support workers could be used as a resource to help CNAs know how to deal with patients with mental health and/or social issues. It was pointed out that RIPIN uses these folks successfully. For example, the Communities of Care Program (Medicaid emergency room diversion program) uses peer navigators to provide resources to families (economic, housing, etc.) A program in Philadelphia uses older folks as peer support workers. The money for these types of programs comes from different sources including federal and state. Medicaid is seeking a waiver to pay for peer recovery coaches. The Providence Center currently has peer recovery coaches. ▪ Rick asked participants about certified case managers. One participant responded that Rhode Island had initiated a program that required one certified care manager on staff but "the program went nowhere". So maybe we could build on this if the investment has already been made. ▪ 35 years ago there were only eight agencies that each provided a whole range of services. Now different agencies provide the services so there ends up being many services provided in a single home that are not well coordinated. We need some central place that manages this. **3. Encourage and support cultural and linguistic diversity (e.g., ESL classes, bi-lingual training and testing)** ▪ English-only written tests as a barrier was voiced again and added that the ability to take the test orally would be helpful. ▪ Rick asked about the idea of diversifying the non-CNA workforce. It was pointed out that CCRI has a diverse student body and that students from diverse cultures tend to stay in state after graduation and go back to their communities to work. ▪ The issue of home care agencies competing with acute care facilities for staff. The question was posed, "What can colleges do to promote careers in home care?" CCRI is increasing its community involvement with faculty out in the community setting with students. ▪ One participant stressed that the current workforce needs training on how to work with diverse populations and on diverse teams.

- Participants agreed that they are limited in who they can hire due to regulations that require one year experience prior to working in home care. One solution might be one-year residencies. A barrier to residencies is that they have paid very little in the past.

- One participant referenced that RIDOH conducted a study that was required by the legislature (Health care Inventory). The data highlighted on gaps. Recruiting a workforce that could fill those gaps could be useful. However, populations not served would need to be carefully defined. An example is that data showed that the LGBTQ population wasn't accessing healthcare at the same rate as other populations. It was later determined that this was due to self-selection not physicians refusing to provide care.

4. Develop pre-employment training programs to prepare students and unemployed adults to work in home care

- Rick clarified that these pre-employment training programs could be in high schools, community-based organizations, proprietary training provider, etc. and could include outreach, screening, assess, training, coaching, support in training and when graduate. Rick asked "What do we need of pipelines to get needed?", "Do we have enough of these programs?", and "Is there support to get into the workforce after graduating from career and technical high school programs?" One agency has hired these graduates but many leave to go on to college after the summer.

- CCRI takes in approximately 310 students per year. For the last 10-15 years, about 250 per year graduate. About 200 students per semester are turned away so they are losing people we need to increase capacity. It was also pointed out that we need to be responsible not to flood the market to ensure graduate can find jobs.

- A participant asked if anyone follows graduates to see where they are employed. Rick pointed out that we are working on this now, to match program graduates and those working in RI so we can identify where graduates are working (ex: nursing facility or home care). CCRI can do this by tracking state boards. Home care agencies would need this data for graduates who have been working for one year so they can identify the number of graduates eligible to work in home care.

- Other participants asked, "What happens to those who are qualified but can't get in to nursing school?" and "Could we hire them as CNAs and then they could later get into a nursing program?" RIC steers those who are qualified but unable to get into the nursing program to other healthcare workforce options like imaging, etc. It was also pointed out that for all nursing programs if a student takes two nursing courses the can sit for the CNA test.

	▪ A question was asked about home care agency offered CNA certification programs. Participants responded that some are licensed to provide their own certification program and that RIDOH data shows that there are 45-48 CAN certification programs but only 20-30 are active annually. ▪ Rick asked how often data about training programs (how many students, DOH surveys, etc.) is made available to home care agencies. Nursing programs have to submit annual reports to the state but not to providers. Rick asked if this type of information would be useful. One participant that only CNA data would be useful. A suggestion to create a data base of CNAs that are available was made. RIDOH has data on how many individuals took the exam and how many passed but not if and where they are working. A participant added that national BCI may have this information at least for the agencies that request BCI information on employment candidates. NE Tech may be resource as they are market savvy. A participant also pointed out that St Elizabeth Home does a good job helping their employees climb the career ladder. ▪ The group was asked if we can challenge the requirement of one year experience to be eligible to work in home care but one participant stated that Medicare certified agencies are mandated to adhere to the one year minimum clinical experience. ▪ One participant from a home care agency noted that last year workers comp cost him $38K and this year it increased to $63K to illustrate the financial difficulties of running such a business and hiring and retaining quality staff. ▪ A final comment from a participant was that obtaining a BCI can be an issue to get CNAs in the door because it costs the individual $35 plus the cost of parking and they need their fingerprints rescanned each time apply for a job even if less than a year between requests. Though CCRI use a third party for BCI checks, a participant stated that a new law bars a third party like is used at colleges. Time ran out before the group could discuss the remaining strategies from the worksheet. **5. Develop strategies to improve recruitment and retention of home care CNAs, including compensation and career ladders.** **6. Clarify RN delegation regulations to expand scope of practice of home care CNAs.** **7. Increase utilization of telehealth resources.** 8. **Provide training and support for family caregivers.**
Next Steps	Rick Brooks thanked participants for their time and input and reminded the group that there will be two other subcommittees through December 1st and that the next large HWT Committee meeting will be on December 6th.