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PHI's Comments on Senate Finance Committee Report

Transforming the Health Care Delivery System:
Proposals to Improve Patient Care and Reduce Health Care Costs

May 14, 2009

PHI applauds the Senate Finance Committee efforts to transform our health care delivery system in order to improve the quality of patient care and reduce health care costs. In your deliberations, PHI encourages the committee to take special note of the nation's direct-care workforce-- a vast and underleveraged workforce ideally positioned to assist with chronic care management, health promotion, disease prevention and control of health care costs.

- Nationwide, 3 million direct-care workers provide assistance and support to many of the 10 million elders and people with disabilities who need help with basic activities of daily living.
- Over the next decade, these positions combined will add one million more jobs, more than any other occupation in the entire economy.
- At 4 million workers, there will be more direct-care workers than nurses, more than law enforcement and public safety officers, and more even than the number of teachers needed to educate our youth in grades K through 12.

But as significant as these jobs are based on overall size and growth, they are even more important due to the critical role they play in our health care system:

- Direct-care workers provide 70 to 80 percent of the hands-on long-term services and supports received by Americans with disabilities or living with chronic conditions.
- Because they spend the most time with consumers, these frontline caregivers are often in the best position to notice changes in the consumer's condition, which left unattended might develop into serious medical problems.

PHI submits the following comments on specific sections of the Delivery Report for your consideration:

Management Innovation Center

In support of the concept of the CMIC, PHI recommends that the coordination models considered by CMIC include those that more effectively utilize the front-line paid caregiving workforce deployed every day in hundreds of thousands of homes and tens of thousands of facilities around the country every day. These workers are a substantial human capital asset to leverage in improving care quality and lowering costs, and they are ideally positioned to play foundational role in retooled system promoting new models of care.

We suggest the following specific changes to the paragraph stating minimum criteria for models to be tested in the Proposed Option section (p. 12):

1. Change third criteria to: "(3) maintains a close relationship between care coordinators, primary care physicians, and *direct-care providers*;"
2. Change fourth criteria to: "(4) relies on a team-based, *integrated* approach to interventions such as comprehensive care assessments, care planning (including end-of-life care planning, such as advanced directives), *continuing care across settings*, and self-management coaching."

Section III/Health IT: Improving Quality Measurement

PHI supports the efforts underway at HHS to focus on quality improvement measures and the need for good data to make policy recommendations. In particular, we believe that the input of multiple stakeholders is crucial in order to bring different experiences to the table. We strongly urge you to include "representatives of the direct care workforce" in the list of representatives in your proposed language.

"Stakeholders must include, but are not limited to representatives of: hospitals, physicians, post-acute providers, quality alliances, nurses, *direct-care workers*, and other health providers, health plans, consumer representatives, life sciences industry, employers and public purchasers, labor organizations, and relevant government agency representatives."

More importantly, we urge you to add measures of health care workforce capacity and stability to the minimum list of measures to be made publically available, since the adequacy of the workforce is critical to both quality of care and consumer satisfaction.

Section III/Transparency: Nursing Home Transparency

PHI supports all the proposed options listed in this section aimed at improving the transparency of information about skilled nursing facilities and nursing homes, increasing the enforcement of rules and standards, and enhancing staff training. In addition, PHI recommends improvements to the following sections as noted:

Ensuring staffing accountability

Add two additional data elements: The measures listed will provide policymakers with important information on the capacity and stability of the facility-based long-term care workforce. PHI recommends adding two additional data elements: vacancy rates and average wage. Vacancy rates -- added to information on number of staff, tenure, turnover, use of contract staff and staffing per resident -- would provide a clearer picture of providers' staffing patterns and the extent to which recruitment and retention efforts are adequate to meet workforce demand. The average wage data would provide important information on the adequacy of prevailing wages to make long-term care jobs competitive with other occupations.

Implement Comparable Data Requirements for Home and Community-Based Services: While PHI recognizes that the context of this section is nursing facilities, it is important to note that these data elements [with the additions of vacancy rates and average wage] are equally important to ensuring quality in home- and community-based services. Given the goal of expanding the availability of HCBS, implementing a comparable effort to collect and track staffing data for those services, will allow policymakers to assess progress toward that goal.

Civil Monetary Penalties

Regarding the allowable uses of accrued Civil Monetary Penalties, PHI recommends that the Committee add activities that benefit direct-care nursing staff as well as those that benefit residents. New CMS interpretative guidelines for nursing care facilities were issued in late 2008 that commit skilled nursing facilities to embarking on a significant culture change process that is likely to have important ramifications for staffing ratios as well as training for Certified Nurse Assistants and their supervisors. Allowing Penalties to be expended in support of the implementation of these new culture change guidelines would be expedient.

Dementia and abuse prevention training

PHI believes that dementia management and abuse prevention training would constitute important enhancements to current training for Nurse Aides. Given the tremendous growth in home- and community-based services and the increasing complexity of the cases seen in those settings, PHI recommends that such training also be incorporated into federal Home Health Aide training requirements.

Study and report on training required for CNAs and supervisory staff

PHI strongly supports upgrading the federal training standards for Certified Nurse Aides. These standards are now over 20 years old and a review of the competencies necessary to provide quality person-centered care is long overdue. Currently, 26 states and the District of Columbia have implemented training standards that exceed the federal requirements, and a number of other states are in the process of reviewing the adequacy of their training standards. The Institute of Medicine in its 2008 report, *Retooling for an Aging America: Building the Health Care Workforce*, recommended increasing the federal requirement for nurse aide training hours

to at least 120. The IOM report also recommended increasing the Home Health Aide training requirements to at least 120 hours, as well as establishing training standards for Personal Care Aides.

As referenced above, given the growth of HCBS, PHI recommends that the study and report be expanded to include the training needs of Home Health Aides and Personal Care Aides. PHI further recommends that the review focus on the competencies necessary to provide person-centered long-term services and supports, and then on the training hours needed to adequately convey the competencies.

Section III/Workforce

In light of the fact that some of the coverage proposals under consideration would be likely to have a significant impact on the demand for long-term services and supports provided in home- and community-based settings, we recommend that the workforce section of this document be broadened to include an explicit focus on encouraging and guiding states to develop sufficient workforce capacity to meet the increasing demand for non-institutionally-based care. The proposed TANF Grants are a step in this direction but not sufficient for the scale of the task at hand.

We, therefore, recommend inserting the TANF Grants concept under a new broader section called "Investing in the home- and community-based workforce for LTSS" that would also address the need for three additional components which have already been developed in existing federal legislative proposals:

- State workforce plans (S. 434)
- Improved Training for Frontline Health Care Workers in HCBS settings (S. 245)
- Workforce Data Collection and Monitoring for the Direct-Care Workforce (S. 647, S. 434, S. 245)

New workforce sections for your consideration

- **State Workforce Plans**

In order to expand the availability of home and community-based services and to meet the growing demand for long-term services and supports for our aging population, we need a workforce development policy that can bear the weight of these policy and demographic changes. PHI urges you to adopt the following language in section 201 of S. 434,introduced by Senators Kerry and Grassley, that would provide grants to states to develop specific workforce plans to ensure a sufficient of supply of workers to provide HCBS services:

> "(IX) create workforce development plans on a regional or statewide basis (or both), to ensure a sufficient supply of qualified home and community-based services workers, including reviews and analyses of actual and potential worker shortages, training and retention programs for home and community-based services workers (which may include, as determined appropriate by the State, allowing participation in such training to count as

an allowable work activity under the State temporary assistance for needy families program funded under part A of title IV), and plans to assist consumers with finding and retaining qualified workers."

PHI further recommends that such grants be accompanied by technical assistance to states through the National Direct Service Workforce Resource Center, a technical assistance consortium funded by CMS to support state workforce recruitment and retention initiatives.

Finally, PHI urges the inclusion of grants to states as set forth in the amendment by Senator Wyden and Kohl to H.R. 1, the American Recovery and Reinvestment Act of 2009, to evaluate recruitment and retention strategies (including wage enhancements) for Personal Care Aides, Nurse Aides and Home Health Aides. Such grants would support the development of innovative strategies needed to build an adequate and stable workforce to meet our nation's needs for long-term services and supports.

- **Improved Training for Frontline Health Care Workers in HCBS settings**

Consistent with PHI's proposal above for a study and report on training for Certified Nurse Aides (see section on Nursing Home Transparency), PHI supports a review of training standards for all direct-care workers – Certified Nurse Aides, Home Health Aides, and Personal Care Attendants. PHI supports the language of S.245 introduced by Senator Kohl to establish a stakeholder expert panel to advise the secretary on competencies for PCAs and additional competencies for CNAs and HHAs. PHI also recommends the inclusion of provision of that bill that establish state demonstration grants to pilot curricula based on the suggested PCA competencies.

- **Workforce Data Collection and Monitoring for the Direct-Care Workforce**

Around the country, states are grappling with how to meet the escalating demand for long-term services and supports while at the same time re-orienting their service delivery systems toward home- and community-based settings and away from institutional ones. Meeting these goals has enormous workforce implications. However, **policy makers are hampered by a lack of ongoing, reliable information about their direct-care workforces**. State claims and payment systems and cost-reporting requirements generally do not allow for estimating the number of direct-care workers employed in public programs, the level of their compensation, and important stability indicators such as turnover and vacancies.

While ultimately it is states that need to improve their data collection and workforce monitoring, the federal government can play a critical role in encouraging and facilitating these activities. PHI recommends the following federal actions:

a. Direct the HHS Secretary, acting through the CMS Administrator, to make workforce an explicit part of CMS's review processes by including greater oversight and guidance to states about the adequacy and quality of their direct-care workforce in Home and Community-Based Services waiver applications/ renewals and Medicaid State Plan Amendments.

b. Through the CMS National Direct Service Workforce Resource Center, provide funding for technical assistance to states for creating workforce data collection and monitoring systems, including creating systems for collecting and publicly reporting a minimum data set of information on their direct-care workforce across long-term care settings.

c. Direct the HHS Secretary, acting through the CMS Administrator, to revise certain data reporting forms and systems to ensure uniform and consistent state reporting on state plan amendments and all HCBS waivers. Targeted reporting forms should include CMS Forms 372, 64, and 64.9, and reporting results need to be publicly available in a state-identifiable manner. New data to be reported shall include those specified in S. 434, Section 501 ("Improved Data Collection") and also data relating to the number of workers, their compensation, and the stability of the workforce (e.g., turnover and retention). To align data collection and monitoring across institutional and HCBS settings, these workforce variables should mirror those specified in S. 647, Sections 103 and 104.

Additional recommendations for already proposed workforce options:

1. TANF Health Professions Competitive Grants

PHI supports establishing national competitive grants under TANF. Given the tremendous anticipated demand for direct-care workers, PHI recommends expanding the program to include other low-income individuals in addition to TANF recipients in order to generate a pool of potential workers sufficient to meet this demand. State TANF agencies should be encouraged to modify their work requirements, if needed, to allow TANF recipients to participate. Further, PHI recommends the grants be available high growth occupations not just high-growth and high wage. Direct care jobs are amongst the fastest growing occupations in the nation and are gateway positions to other jobs in the health care sector and should not be excluded from these grants. Finally, we recommend that joint labor-management partnerships be added to the list of eligible grantees.

2. Proposal on Development of a National Workforce Strategy

PHI supports the development of a national workforce strategy. To ensure that it addresses the largest and fastest growing healthcare occupations, such planning must include a workforce development strategy for building an adequate and stable direct-care workforce. Therefore, we suggest inclusion of the need for analysis of the current and projected needs for the long-term care workforce (demand and supply assessment) as well as assessment of the future training and education needs of that workforce along with turnover and retention for professional and paraprofessionals.