

LDs 400, 1059, 1078, and 1364

Direct Care Workers' Task Force

Monday, November 16, 2009

1:00 to 4:00

221 State Street – Lean lab

Minutes

Purpose of Meeting: to review materials prepared by Elise Scala from Muskie

I. Reviewed the implementation plan for HCBS-VSM:

1. This Direct Care Workers group would like to work on the actions identified in the Implementation plan that involve Direct Care Workers; e.g.
 - A. The “Change” noted on Line 51 “Create & maximize flexibility in the planning and delivery of services” – “action” line 58: “Encourage direct care workers to work together as a team for the consumer, providing coverage for each other as needed” in order to make “fill-in’s” easier to arrange

II. Elise Scala's materials

- 1: Rate-Setting Methods in Maine's Long-Term Care Programs** was constructed to compare the rate setting methods for programs that employ direct service workers. (draft with updates as of 4/23/09)
- 2.a: Summary Chart of Maine Programs that Employ Direct Care/Support Workers** - drafted to highlight the employment of the direct care and support titles across Maine's DHHS programs.
- 2.b: Profile of Employment of Direct Service Workers, Maine DHHS Programs** was compiled as a reference document to the reimbursement table to provide background information on the direct service jobs and selected information to aid the discussion of rates and workforce planning. (drafted in early 2009 and updated in Fall 2009)
- 2.c: Summary Chart of Direct Care/Support Worker Job Titles and Job Functions** drafted to compare job functions across the multiple job titles.
- 3.a: Maine Direct Care Worker Employment Count and Median Hourly Wage, 2001-2008** provides a comparison of wages by category, over time.
- 3.b.#2: Maine Direct Care Workforce Top Employers and Projections** drafted to see a snap shot of where direct care/support workers are employed and their wages. .
- 3.c: Maine Fact Sheet**, a recently released state profile of Maine's direct care workforce, compiled by PHI National.

Please note::

1. these materials are subject to rapid change
2. the reimbursement structure forms the basis for training, retention, and recruitment of workers

III. dated 11/16/09 “Explanation of Handouts”

1. Provides an overview of all the documents presented

2. Includes "Summary Points"
3. Reimbursement rate setting system could be used to address certain needs: cost of providing services, what process will the state use to define what should rightfully be included in the reimbursement structure, etc.
4. Jay Hardy – Question: Shouldn't we promote uniformity in the way in which services are reimbursed in the system? In order to gain equality. Means for rate-setting, funding, paying - including wages, administrative rates, etc.
 - A. Diana- LD 1364 endorses establishing uniformity
 - B. Every reimbursement rate should be examined to find what's included in that rate. For instance, for MR , the rate includes cost of training, supervision, as well as salary.
 - C. Other Qs: Is the funding set in the rate sufficient to retain workers?
 - D. Q: Is the funding sufficient to attract the number of workers needed in that classification to meet the need?

IV. Don Harden: Is the Direct Care Workers group intended to deal with reimbursement rates?

1. Elise's work provides a broad basis for making further progress.
2. invite people to meet with us who are rate-setters and finance in DHHS
3. Jay – intent was to look at wage-rates, but also – these businesses are driven by worker wage-rate and associated costs. (salary, transportation, training). Since wages are the biggest driver, it's good to start by looking at the wage rate array, plus the system by which wages are set.
4. in order to support the workforce and deal with recruitment & retention, we need to develop a framework that provides equity in amount of funding, as well as how these rates are managed over time,
 - A. need to consider "what are we comparing?" - regardless of the intricacies of the rate-setting process. – jobs, consumers, work-setting for Direct Care Workers - are all different from each other

Molly – do we need to review the legislation?; e.g. making a name consistent will take an act of the legislature

Jay – we are at a point-in-time that we need to ask radical questions; it's a good time to rationalize the system. Where do we want to be in the future? Creating a standard definition of these workers. A meaningful wage-rate. Have state establish this. Then build up the system from there.

Elise – a framework of how to look at the Direct Care Workers is helpful. Start with the program, as the basis for the structure that we have now. And define workers in the context of the programs. Can now look at similarities – home and community-based services and consumer-direction has changed the role of these workers.

Summary Chart 2a and 2c

- Includes 20,000 to 30,000 people
- For chart 2.c. – perhaps needs to add a column entitled “Health Maintenance functions” as an important job function

Document 2.b – “Profile of Employment of Direct Care Workers in Maine Department of Health and Human Services Programs:”

- this chart shows the 26 Service Programs which employ 24 different titles of Direct Care Workers , as defined in the rules & regs.

Future: We should use the same title, with 3 different levels, reflecting different levels of training and skills – create a training ladder; e.g.

- Direct Service Worker 1
- Direct Service Worker 2
- Direct Service Worker 3

People with Level 1 training, could then move into a Level 2 and on to Level 3 – wouldn't have to start all over again with training, if a worker wanted to change positions.. All Direct Care Workers should have the same solid foundation in medical competencies, then, as desired, the Worker should be able to move on to add more training; for instance in Mental Health needs, Mental Retardation needs, etc.

All Direct Care Workers should have a set of core skills, then could pursue special expertise. Also need to recognize experience, as well as classroom activity

Molly – Home Care for Maine's titles for CNAs and Home Health Aides come from federal law, and under The Omnibus Budget Reconciliation Act (OBRA) [also known as the Nursing Home Reform Act of 1987]. So probably won't be able to change the CNA title, since it's nationally set, with a baseline of training and a registry in each state, since 1987.

Many of the new titles have been created since 1987, because the marketplace wanted to get outside the definitional confines of the CNA, in order to deliver the care that was needed –

The plethora of names creates confusion. Contributes to “silos”, since titles were created for a specific program. Clarity would be created by developing some common titles, and defining the competencies involved (although probably won't include CNAs)

Jay: we have created a system of silos, which is a disservice to the workforce as well as to providers when the labor market has difficulty attracting and retaining workers – which results in not being able to provide services needed and wanted by consumers

The aging demographics in Maine will require a change in worker requirements and development.

Elise- training requirements need to also describe quality (and competencies), not only just describing the tasks required. What's required to provide these things well? E.g. What does it mean to provide consumer choice?

Ted – Direct Care Alliance has developed a hand-book for Direct Care Workers , which describes tasks, competencies, communication skills needed

Another issue is the merging of the departments, which served to place types of 3 workers, each with 3 different wage rates, in the same department, doing much the same work.

IDEA: Perhaps develop a rational system of nomenclature, and develop a cross-walk of the new titles against the current titles. Let's define these roles and rationale. Reasons to do so:

- Dysfunction of system costs taxpayers and consumers money
- limits employment
- Costs consumers when providers are unable to find workers
- When the economy recovers, the availability of people to do Direct Care work will shrink

Molly: previously, DOE had conducted a course for prisoners on CNA work, seemingly unaware that people with a criminal background are disqualified from doing CNA work. Now has changed to require background check before training is commenced.

Elise – could lay-out what exists in next meeting, which could be a start toward developing the new model. But, some descriptions of the training are more up-to-date than for others. Competencies? Attitudes, skills, abilities. Also need to consider adding standards for quality

Diana - Can we learn from elsewhere in the country?

Jay Hardy – should take time to identify the current state, then pull forward the helpful things into the future state. Need to strip the system down. Look at outcomes, rather than tasks.

Molly – perhaps start by looking at the competencies needed, rather than looking at what's here now.

To do's

- Ask Elise Scala to prepare a draft of a new classification model, for review and discussion at the next meeting.
- Arrange for discussion with DHHS staff on rate-setting.

Next Meetings:

- November 30, 1:00 to 4:00
- December 14, 1:00 to 4:00

Reserve the final ½ hour of each meeting for discussion with Direct Care Workers themselves.