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Industry roundtable: Home Care

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How do you find qualified workers? Is it sustainable to be in constant hiring mode? How do you prepare students for careers in home health care? What is the future of the industry? Law firm Hodgson Russ and the Albany Business Review hosted a discussion to answer these questions and more. Melissa Mangini, editor of the Albany Business Review, moderated the discussion.

How do you find qualified workers?

Kathy Febraio, president and CEO, New York State Association of Health Care Providers Inc.: Generationally, it's a challenge that the workforce population is shrinking while the need for home care is growing. This industry is feeling it a little more so than others for that very reason.

Mildred FerRiter, executive director, Community Health Center: We have resorted to cold calling. We are on the internet constantly. Our big crunch is nursing staff. That is the largest turnover that we have, and it really upsets how we can perform our business. We use LinkedIn, Liquid Compass, Facebook, Twitter. We use every social media source that's out there to attract a nurse. Everybody's been stealing everybody else's staff, and it creates more problems than it does anything else by doing that.

What's the reaction when you're cold calling? Is it generally favorable?

Ferriter: It depends. If you're putting a deal on the table, they'll listen.

Al Cardillo, president and CEO, Home Care Association of New York State: Agencies try every means available to them to attract workers. One of the issues is not just initial recruitment but also retention. That's one of the major problems that affect agencies, whether it's with nursing staff, home health or labor therapy. It's a very challenging field to work in. I will say that people who work in the field, love the field.

One of the issues is there really isn't — particularly from a state perspective and perhaps even a federal perspective — a lot out there that says, look at this field, this is a field that is growing, this is a field that we value, so that it draws into the pipeline process. We've actually written some legislation that would compel that kind of effort on the part of the state.

How do you get students interested in this field and get those qualified workers ready for the employer?



DONNA ABBOTT-VLAHOS

Standing, left, Tiziana Rota, Al Cardillo, Mildred Ferriter. Seated, left, Kathy Febraio, Emina Poricanin.

Tiziana Rota, project director, SUNY Schenectady County Community College: We try every possible means. When we received the Health Profession Opportunity Grants (HPOG) in 2011, we were in the middle of a recession. We had waiting lists. People wanted to come to work and be trained because there were jobs. Health care is recession-proof. People get sick whether the economy is good or bad. People age, and aging in place is the way the most people tend to go.

Now, it's a totally different ballgame. You see people with needs and more barriers that we need to address even before they get to the educational component. We try everything. We partner with the Times Union and Polygon Advertising in every laundromat in Albany. People that are at the entry level don't own washers and driers, so laundromats are the way to go. We're wrapping buses and bus shelters just to get the word out that this is a free training.

Febraio: We have a program where we recognize home health aides and provide our member agencies a means to do that. We recognize individuals with stories of what the aide has done for a particular patient. It recognizes the person and elevates the perception of the field. We have a scholarship program for nurses interested in either entering home care or developing a business concept.

How do you manage being constantly in hiring mode? Do you have staff dedicated to recruitment?

FerRiter: It's the responsibility of the whole organization to make sure that we're engaging everyone in this process. And we do that.

Emina Poricanin, attorney, Hodgson Russ, LLP: I regularly work with over 100 health care providers. The job these people perform is very difficult. It is rewarding once you're on the job, but it is difficult. Sometimes the individual is lifting and transferring dead weight. It's a lot of responsibility to be in charge of a disabled or elderly individual. There are some dangers in being in someone's home. Visitors could be coming in; there could be animals that are living with the patient who bite caretakers. There are all sorts of work-related challenges that kept people from staying on the job.

New York's minimum wage has been going up rather quickly in the last few years. This used to be a very decent paying job upstate, but now there's very little difference between the state's minimum wage and these positions. People are having the option of choosing a job at McDonalds, where they're not taking on all of those dangers and responsibilities and actually getting paid slightly more or equal to what they would be paid working this type of a job. That's one of the problems.

Downstate, this tends to be a good career opportunity for refugees and immigrants. It's a huge workforce population for this industry. And so with all of these challenges now at the federal level regarding immigration laws and some of the issues there, there's definitely been a noticeable shortage of people who are willing to come in and apply for these jobs. If they're concerned about their status, they're not willing to apply for these jobs to begin with.

Rota: The Department of Education and the Department of Health do not offer authorized training in other than English. In Albany, for example, you have a large Korean population. We've not been able to attract anybody in Schenectady from the Guyanese population, and some are willing to come and be trained. Wouldn't you be better served by someone who understands your culture?

Do you see any prospects of that changing in the future?

Rota: The associations could probably have more impact.

Cardillo: That's an area that we've been doing a lot of work in. We actually have legislative sponsors. There's a bill that would utilize home care, physicians and collaboration to respond to these culturally sensitive conditions.

How do you reconcile staff training, regulation and other costs with government payment for these services?

Febraio: The state is one of the largest payers in this industry, and that affects the taxpayer, too. The state wants to regulate the health care industry and make sure that everyone is providing the best care possible. It comes down to cost and the two don't always jive. They don't always talk to one another during these policy discussions. They want the best care possible but they want it at the least cost possible. There's a breaking point and we're all going to learn where that is if something doesn't change.

Rota: I recently had a conversation with one of the staff members of the U.S. House of Representatives from the Ways and Means Committee. They are looking at potential solutions for solving some systemic issues but also alleviating some of these problems. On one hand, there are over-regulations and a lack of flexibility. On the other hand, there's the expectation that you have to make due with a minimum-wage level.

What help would you need from the federal level to alleviate some of the issues you are experiencing?

Cardillo: The federal system that was created to fund home care was created in the 60s, and in the 70s in New York state. It's a very different world today in terms of who goes into the hospital, how sick they are when they come out, who goes into nursing homes, and who we want being cared for in the community. There are over 1.5 million patients in home care, and many of these patients cannot miss a day of care. Part of what needs to be done is the regulatory structure. The funding structure that wraps around home care needs to be modernized to the way that services are provided today.

We are increasingly in a health care system where words like "integration," "coordination," and "team care," are really highlighted. But the regulatory and payment processes don't facilitate that. For example, to be covered by Medicare, you have to be home bound. So if somebody's being referred from a hospital and now back to their primary care position and they want to organize services for that individual, if they can't meet the homebound requirement but are at high risk of a potential re-hospitalization or further morbidity, you can't get the Medicare coverage for that patient. That was fine in 1965, but it's not fine in 2020.

Another big issue is regulation and financing. There's a law in New York state that provides for commercial coverage of home care services. It was written in 1972 and has not changed substantially in 50 years. In 1972, you walked out of a hospital and got on your motorcycle and came home. You weren't walking out of a hospital with tubes and surgical wounds that would scare somebody. From a perspective of how the system should work, the insurance coverage provision should roll with the mainstream of the way that we provide services today.

Febraio: The conversation needs to change because home care is saving the health care industry money. And still, the conversation is surrounding, what about the hospitals? How are we going to deal with hospitals? We're moving away from that model of care but our conversations aren't. Recently, the Medicare Payment Advisory Commission (MedPAC) recommended cutting Medicare rates for home care

by 5 percent. How does that work if the ultimate goal is to move away from hospital care and provide it in the home?

FeRRiter: Over the last 10 years, MedPAC has cut probably close to 20 percent. Home care agencies are struggling very hard to take patients. I'll speak for my agency alone. We used to have a daily census of 500. Now, our daily census is 225 in CHCA, or certified home care agency. What has affected that is the fact that we cannot attract RNs. So, we are not taking all these cases and they're not going to our competitors because they do not have the staff, either. So the big question is, what is happening to that patient?

RoTa: And conversely, I cannot attract students because at the end of the line \$11.75 is not a living wage. For people that are dedicated and committed, the requirements are getting higher and higher and higher. So what do we recommend to individuals? The ones that cannot find jobs are the ones that are coming in. And then you have people that don't have a high school diploma, or have perhaps some small level of learning. The question I always ask myself from the nurses that work with me is: Would you want your grandmother to be taken care of by this person?

What could New York do better to help this industry?

FerRiter: One of the big things we struggle with is the misalignment of state and federal regulations and the unfunded mandates that are put on us. For all the programs that we have to monitor, it adds both inefficiencies and costs to the system. We're not asking that we never be looked at. We're just asking for some sensible and logical regulatory requirements on both sides of the fence that would help us streamline our processes so that we do become more efficient and cost effective.

We're not paid what we should be paid. Fully loaded on our end, visits cost us \$180. The managed care and the commercial organizations pay us \$120. They don't pay us for travel times, yet the Department of Labor laws require us to pay travel time and mileage. And we have to have individuals that are at a high level of competencies because of the regulatory requirements that we're under.

Poricanin: Between the state and federal requirements, I have yet to meet a provider that's doing everything correctly. And it's not because they're trying to avoid their obligations. It's because the obligations keep changing from year to year. These folks should be focusing on recruitment, on efficiencies on compliance, and not necessarily, on what's going to change from one season to the next. There needs to be oversight, but there is too much oversight to the point that most organizations have two or three people working at single point in time on some sort of an audit.

Rota: There have been efforts from a variety of groups to push for community health workers, and for home care visits that work on prevention rather than addressing the issue after it presents itself.

We don't deal with health care. We deal with sick care. If we were to deal with health care, you would have more preventative medicine. On average, the United States spends \$9,600 per capita on health care. Leaving aside all the political ramifications, Cuba spends \$813 per person and they have the same level of wellness as people in the United States. Why these enormous gaps? Their training is free. Medical school is free. It just goes to a different approach and a different set of values.

Can you talk about the governor's new designation, the advanced home health aide, which expands the availability of services for seniors and people with disabilities?

Rota: Two years ago, the governor signed into law the “advanced home health aide,” or HHA. And very quietly in December, both the Department of Education and the Department of Health issued the regulations regarding advanced home health aides. The advanced HHA may work in home care services, long-term care, hospices and enhanced assisted living. They cannot work in nursing facilities and long-term care nursing facilities.

The curriculum itself is pretty rigorous. It’s 125 hours minimum of training with 45 hours of on-site clinical work with some very specific mandates. The cost of running this education is going to be quite high because for 20 students, I would need seven nurses.

The one significant change is that you currently have various home care providers doing medical training and medication training in-house. They’re very different from each other and very spotty. Some providers may have five hours of training, while others may have 20 hours of training. This creates a standard that is across the board.

Cardillo: At the time it was being developed, we made a very strong case that it’s not going to fly unless there’s some financial support for it. And that it should not be so overregulated as to suffocate it.

In 1992, New York took what was really a national step in the Nurse Practice Act that involved working with the nurses and the disabilities community to create an exemption such that an individual similar to a family member could be trained and instructed by a nurse to perform a task that otherwise was precluded by the act. We now call it the Consumer Directed Program, but at the time it was called Patient Managed Home Care. Generally, the consumer trains that person to perform those tasks and the limits are of a practical nature.

Poricanin: I know only a select few that have taken this on to train their aides to be advanced home health aides. They’re not going to be rolling it out among their entire workforce because they cannot pay them to do the training. And secondly, once the aide does receive the training, they’re not going to be getting a higher rate of pay for the advanced home health aide work. So the worker’s wondering, why go through all of this when I’m not going to be paid?

The providers who have thought of this as an opportunity are adopting the advanced home health aide as an opportunity to reduce the hospitalization or readmission rates because there are incentives for providers when they deal with managed care organizations if they have a low rate of their patients going into hospitals.

What is the future of the industry? Are you optimistic?

Cardillo: What we need as an industry is affirmative validation for the practices and the models of care that we have. It will really help the whole process to be able to say that in this case, if you put this person in home care, here’s the result that you get.

I was looking at a study comparing the outcome and the cost of home care versus nursing homes on a clinical pathway from hospital to home. What they generally found is in the home, it was less costly and outcomes were better. That’s an important recognition. It’s not to pick on the nursing homes; it’s just to quote that study. This recognition is going to grow as people accept the fact that home care can do all of these positive things that right now may not be so much on the radar.

Febraio: The changing population and the changing needs of the population are going to have to force the conversation to change. And that will happen when we begin to change some policies and regulations — when there is the final recognition that this is an investment and not a cost center. This is, unfortunately, where we are right now. We still have that mindset of how health care was provided years ago, and we haven't changed laws in decades to accommodate that. But the shift in demographics is going to force that or the system is not going to be able to sustain it. We're at a crossroads, but I think there's great opportunity if we can change that conversation.

FeRriter: I do see opportunity as long as we can align some regulatory requirements and what we need to do in order for us evolve into something else. That's because the model of care that we are doing today is not going to be the model care that we doing tomorrow. And we are already seeing the shift: social deterrence, population health models, behavioral health, wellness versus illness, technology, value based payment models, Medicare shifting from the service.

Poricanin: Neither federal nor state government can refute that home care is a more efficient and cost-saving way of delivering care to people. And so there will continue to be home care. The population is aging and staying in their homes longer. Time and time again we hear that people do not want to go into nursing homes. They would prefer to live out their life in their home, no matter how acute of an issue they have. And so people are going to continue receiving care in their home. This industry employees hundreds and thousands of people.

How do we respond to statistics that anticipate 1.2 million nursing vacancies between 2017 and 2022?

Rota: Where do we find the people? Where do we find the creative structure? Does home care and the future of home care look at the reduction of long-term care nursing facilities or is it just a tendency to want to stay home but the reality is that more people are going to go to the nursing homes because there is not enough home care? But nursing homes are suffering very similar issues, in that there are not enough certified nurses.

In a most immediate sense, the regulatory and the financial rewards have to be modified. The fact that I still cannot come to grips with on a personal level is where do we spend all this money? If it costs so much, where is the cost coming from? We are paying the people that are doing the hard work — the eye and the ear of the physician and the nurse — minimum wage.

They come out of a three-hour session with a patient and they are drained. They have 25 minutes to get to the next job and no one to talk to. It's a very solitary job that affects the behavioral health and mental health of the individual.

What role does technology play in home health care?

Cardillo: In 2007, the state adopted a telehealth law that has really been a landmark nationally. Through it, individuals with very unstable conditions like congestive heart failure, COPD, diabetes and even mental health conditions are monitored. It allows every day monitoring of those patient vitals and intervention in a secondary, preventive way. If somebody has congestive heart failure and they've just gained three pounds in the last day, gained another pound the next day, you know there's something going on with the retention of fluid. The nurse can then intervene with a doctor and avoid a hospitalization, perhaps by adjusting the Lasix or whatever that individual would need.

FeRriter: I would also like to have home care recognized as a provider that could be financed through some of the programs that the physicians in hospitals are able to have. We would like to be added to that list as well. We have an ambulatory medical record (AMR) system. We use telemonitoring. We are also looking into a new program with actual smartwatches and tablets. It's a three-way system where the nurse could actually get the doctor and the patient on the phone at the same time. That's pretty exciting. But we're small nonprofit agency with limited finances, and in these last two years we have run negative bottom lines. And so, investing in a technology is difficult. But we are looking at technology as a way to invest to help the staff take off some burdens.

Can you talk about the difficulties in serving the rural population as well as the transportation challenges that a lot of workers face?

Ferriter: Home health aides are not making as much money as the professionals. Their cars have a tendency of breaking down or not being maintained. We have a program that helps them, but you can only do that for so long because that is not a funded program, either. We do our best in making sure that they have a safe car to drive from patient to patient. We also try to cluster as much as possible so they're not traveling all over the world.

We do need technology to help offset that disparity that the people are feeling because they cannot access the home care services that are not between the hours of eight and five.

Have you had to turn down cases because you don't have enough personnel to get to them?

Rota: The vacancy rate continues and retention is an issue. Some employers have tried to address that to the employee resource network, where you buy a share of time from a coach. The time does not deal with work issues or HR issues, but rather personal issues that their workers, especially at the entry level, are dealing with. For example, they're still trying to get food stamps because they still qualify for food stamps and they still qualify for public assistance. It's an unfunded mandate, though it is cheaper to pay the \$4,000 for half a share of a coach than to replace the person. It costs \$2,000 to replace a certified nursing assistant, or CNA. I presume it's pretty much the same for a HHA.

Cardillo: There's a very compelling argument for this field to be looked at in a priority way. We need to engage the professional schools to include in their curriculum a focus on the multiple levels of care. I think that would go a long way.

Febraio: This is a very rewarding career. It gives the health care worker the opportunity to build a relationship with the patient. In a lot of other health care settings these days, you're in and you're out in minutes and you don't have that opportunity. This is an opportunity to create that caring relationship and that reward you feel when you're changing someone's life.

We've talked about the emotional toll that it takes on workers. How do you manage that as a business owner or as an association?

FeRriter: We do a lot of different things for our staff. We let them control their own schedule. Yes, we have to know what they're doing and where they're going, but if they want to work three days a week, 12 hours each day, we can accommodate that. At least once a quarter, we have massage therapists come in and do massages for the staff. We also have roundtable discussions on some of the triggers that they see out in the field that we in the office can help solve for them.

Some of what we manage has to do with animals. We had a nurse get a brand-new car and when she went to a home, a goat decided to go on top of her car. Destroyed the paint, of course. We got the car repainted for her, free of cost. It was like a brand-new car again. Going forward, we told them the goats must be put away in order for the nurse to come.

It's this kind of stuff. But until you sit down in a group, you don't realize some of the issues or problems or challengers they're facing out there. And we can't help until we talk about them. We do a lot of different things to support them on every level. We have big parties. I'm a big party person. I love having staff parties so they can engage with one another and develop that team network.

Do you see any opportunities for the business community, outside of health care, to support efforts in your industry?

Febraio: We have an opportunity to help employers educate their employees. What is home care? How do you access home care? How do you pay for home care? Most of us don't deal with it until we have to. Only then, it's in a critical timeframe and you're at loss as to what to do.

Cardillo: If the business community were behind this as a career, I think that could have a very big influence.