Healthcare Task Force Report

2023

Tennessee Healthcare Task Force

RECOMMENDATIONS
Compensation:
Raise wages to current market.
High school equivalency level positions – $18-20/hour
Bachelor's level positions – $25.50-28.00/hour
Private sector providers' wages will be improved commensurate with state employee annual raises.
Future wage improvement recommendations will take inflation under consideration.
Best Practices and Workforce:
Family Scholar House HealthCorps: Expand the Family Scholar House healthcare workforce program in Tennessee.
Matching Registries: Create a registry platform connecting healthcare workers with those in need of healthcare services.
Targeted Recruitment: Develop strategies on recruiting and retaining adults to meet the demand for direct care workers.
International Workforce: Expand visa work program opportunities.
Certification Programs: Scale existing models of affordable healthcare certification programs.
Marketing Campaign: Develop a statewide marketing campaign to attract frontline healthcare workers.
Explore Family-Working-Family Caregiving Model: Redefine the current rules under which individuals can provide care to family members in home services to empower these individuals while also taking care to prevent fraud.
Medication Aide Program: Review current practices and guidelines for opportunities to increase the number of medication aides in the state and enhance their ability to impact the overall delivery of healthcare in facility settings.
Clinical Resources for Children/Young Adults: Develop policies and strategies to attract resources to this area of need.
TennCare Program: Increase provider awareness of existing programs to support and grow the healthcare workforce.
Regulatory Updates: Leverage the regulatory process to assist in the mitigation of healthcare direct care provider workforce challenges through the implementation of additional regulatory action and amend previously enacted regulatory actions.
Tennessee's Workforce System: Support the state's workforce system plans regarding healthcare access, specifically high school pathways, bridge programs, and certified pre-apprenticeship and apprenticeship programs.
Continued Investment: Recognition of recent investments as examples of impact actions.
Creation of advisory council: Consider creating an advisory council to continue the Healthcare Task Force's work and assist with implementation of recommendations.

Executive Summary

Public Chapter 1138 of 2022 created a healthcare task force to review the reimbursement of health professionals employed by agencies performing healthcare services in the state and look for workforce development strategies to lessen the healthcare worker shortage. Several state departments rely heavily on private, primarily non-profit, agencies to perform functions and services on behalf of the state. The task force focused on the lowest compensated employees of the state and private contractor providers who were non-degree/high school equivalency and bachelor's degree front line employees. Studies show direct care workers will grow by one million jobs nationally, as the population continues to age and require more services. The task force was composed of a state legislator, private providers, and state agency stakeholders. Over the past year, they heard from a variety of industry experts on the workforce difficulties facing direct care workers. *Note, representatives of State Agencies contributed their expertise to this report, however, they abstained from formal approval or disapproval of the recommendations.* The task force was divided into two subcommittees: compensation and best practices. These subcommittees developed the recommendations described below.

According to the legislation, the task force was charged with providing strategic action plans addressing the following:

- Address the challenges of quality, affordability, and accessibility of healthcare professionals in this state;
- More effectively use public resources to address those challenges;
- Study the rates paid to healthcare workers employed in state government compared to healthcare workers in the private sector who perform the same function;
- Address the challenges facing health professionals, generally; and
- Address current workforce shortage challenges and future projections for such shortages.

Compensation

The sub-committee gathered primary source information from nearly 20 sources during its review of compensation and wages.

Recommendations:

I. Strategic Plan
   a) Begin with raising current salaries of private agencies to a base that is at market;
      i. High school equivalency positions - $18-20/hour (benchmark 2023)

ii. Bachelor’s level positions- $25.50-28.00/hour (benchmark 2023)

b) Once wages are at market, adjust wages incrementally to be commensurate with state employee raises and conduct reviews every three years to ensure wages have not fallen behind and are adjusted for inflation.

i. Adjust reimbursement annually commensurate with state employee raises;

ii. Conduct a retrospective review every three years (based on annual inflation rate metric set by federal government i.e. CPI) to assure wages have not fallen behind unexpectedly.

II. Research on the disparity in salary structure for the healthcare workforce

Best Practices

The best practices subcommittee focused on potential workforce, regulatory, and budgetary initiatives to help decrease the healthcare worker shortage. The task force realizes that wage increases will not solve the industry’s workforce struggles alone but will need to think innovatively on how to increase and broaden the worker pipeline to serve this population.

Recommendations:

- Family Scholar House HealthCorps: Expand the Family Scholar House healthcare workforce program in Tennessee.
- Matching Registries: Create a registry platform connecting healthcare workers with those in need of healthcare services.
- Targeted Recruitment: Develop strategies on recruiting and retaining adults to meet the demand for direct care workers.
- International Workforce: Expand visa work program opportunities.
- Certification Programs: Scale existing models of affordable healthcare certification programs.
- Marketing Campaign: Develop a statewide marketing campaign to attract frontline healthcare workers.
- Explore Family-Working-Family Caregiving Model: Redefine the current rules under which individuals can provide care to family members in home services to empower these individuals while also taking care to prevent fraud.
- Medication Aide Program: Review current practices and guidelines for opportunities to increase the number of medication aides in the state and enhance their ability to impact the overall delivery of healthcare in facility settings.

- Clinical Resources for Children/Young Adults: Develop policies and strategies to attract resources to this area of need.
- TennCare Program: Increase provider awareness of existing programs to support and grow the healthcare workforce.
- Regulatory Updates: Leverage the regulatory process to assist in the mitigation of healthcare direct care provider workforce challenges through the implementation of additional regulatory action and amend previously enacted regulatory actions.
- Tennessee's Workforce System: Support the state's workforce system plans regarding healthcare access, specifically high school pathways, bridge programs, and certified pre-apprenticeship and apprenticeship programs.
- Continued Investment: Recognition of recent investments as examples of impact actions.
- Creation of advisory council: Consider creating an advisory council to continue the Healthcare Task Force's work and assist with implementation of recommendations.

Introduction

Public Chapter 1138 passed by the General Assembly in 2022 created this Healthcare Task Force to study provider reimbursement rates and possible solutions to the healthcare worker shortage. This serves as the final report of recommendations from the task force as required by the public chapter. The Task Force is composed of a member of the Senate, department commissioners of pertinent agencies, and private providers and stakeholders. *Note, representatives of State Agencies contributed their expertise to this report, however, they abstained from formal approval or disapproval of the recommendations.*

The task force was composed of the following members:

- Chair – Commissioner of the Department of Labor and Workforce Development
  - Designee, Deputy Commissioner Dewayne Scott
- 1st Vice Chair – Brian Barnes, President and CEO, Blakeford Senior Life
  - Appointed by the Speaker of the Senate
- 2nd Vice Chair – Jennifer Enderson, President, Emory Valley Center
  - Appointed by the Speaker of the Senate
- Commissioner of the Department of Mental Health and Substance Abuse Services
- Director of the bureau of TennCare
  - Designee, Chief of Staff, Jessica Hill
- Commissioner of the Department of Children's Services
  - Designee, Deputy Commissioner Dr. Deborah Lowen
- Commissioner of the Department of Health
  - Designee, Director of Patient Care Advocacy, Sally Pitt
- Commissioner of the Department of Intellectual and Development Disabilities
  - Designee, Chief of Staff, Lauren Legate
- Executive Director of the Tennessee Commission on Aging and Disability
  - Designee, Director of Operations, Shelley Hale
- Member of the Senate: Senator Becky Massey
- Chelsea Williams, Corporate Compliance Officer, At Home Healthcare
  - Appointed by the Speaker of the House
- Jerry Vagnier, Strategic Consultant, McNabb Center
  - Appointed by the Speaker of the Senate

In 2022, Senator Becky Massey brought this legislation after her own experience serving individuals with intellectual and development disabilities as executive director of the Sertoma Center. In her many years leading the organization, there was only one day where

they were fully staffed, and they rarely received provider rate increases to raise wages for workers. Following the legislative intent, the task force's work centered on entry level direct care workers (DCW), nondegree required positions, and similar jobs within healthcare.

When reviewing the report, it is important to understand that different healthcare sectors refer to these positions by different titles/classifications. This creates limitations and ambiguity in some data analysis. Possible positions within the scope of the task force are direct service providers, direct care workers, home health aides, LPNs, CNAs, nursing assistants, medication aides, direct support professionals, and personal care aides.

According to the legislation, the task force was charged with providing strategic action plans addressing the following:

- Address the challenges of quality, affordability, and accessibility of healthcare professionals in this state;
- More effectively use public resources to address those challenges;
- Study the rates paid to healthcare workers employed in state government compared to healthcare workers in the private sector who perform the same function;
- Address the challenges facing health professionals, generally; and
- Address current workforce shortage challenges and future projections for such shortages.

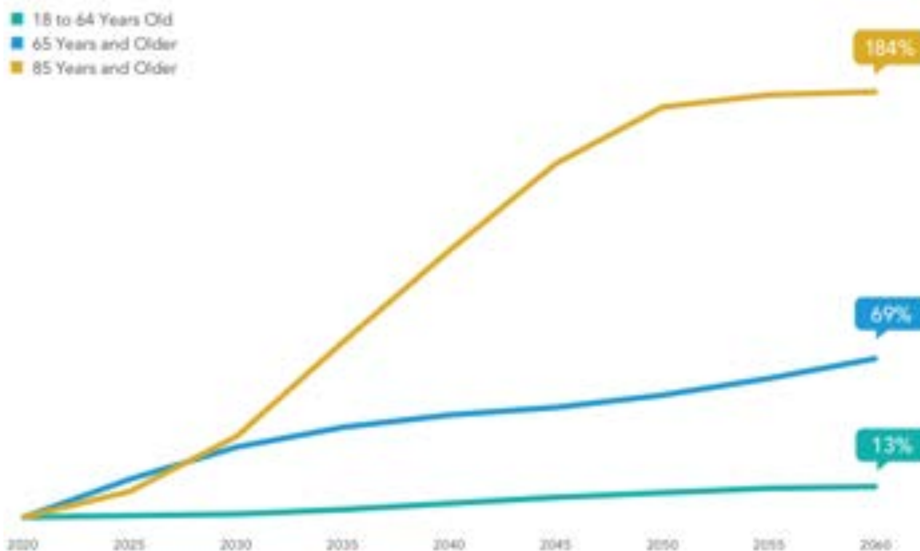
Until recent rate increases, it has been over a decade since the direct service provider community had seen any increases. While the pandemic did provide additional resources through more federal dollars to fund wage rate increases, it also exposed the importance of these jobs in the healthcare industry as workers moved to lower stress and higher paid employment. With the pandemic and extra federal money behind us, the state must look at other solutions to decrease the worker shortage.

According to the Tennessee Hospital Association, between 2021 and 2035, Tennessee's population is projected to grow almost 10%. The population over the age of 75 will increase more than 50% while the working age population is decreasing. These demographic shifts will create an even greater strain on the healthcare industry and require a stronger pipeline of workers to meet the need.

The Paraprofessional Healthcare Institute (PHI), which represents home care workers, residential care aides, and nursing assistants, using Bureau of Labor Statistics (BLS) data reports the direct care workforce is expected to add over 1 million new jobs nationally in the next ten years. This is more than any other single occupation in the country. "When also accounting for jobs that must be filled when existing workers transfer to other

occupations or exit the labor force, there will be an estimated 9.3 million total job openings in direct care from 2021 to 2031" (2023). At the same time, DCWs have a turnover rate of around 50%. This is a very difficult statistic for an industry with significant projected growth and need in the coming years. The DCW occupation is traditionally known as a low-wage, labor-intensive job. This occupation is predominately filled by minorities and women. While there are no federal or state requirements for training, DCW are expected to be proficient in a variety of skills, including proper body mechanics to support mobility, protection from infectious diseases, and preparing nutritious meals for a variety of diets. Since many believe current wages do not reflect the complexity or skill that is required to adequately provide hands-on care, fewer people are entering into the occupation.

The Healthcare Task Force hopes intentional investments and innovative workforce strategies will put the industry on a more sustainable path and lessen the workforce shortage they are experiencing.



For the past year, the task force met bimonthly to hear presentations from stakeholders and discuss possible recommendations. The Chair appointed two subcommittees: Compensation, chaired by Jennifer Enderson; Best Practices, chaired by Brian Barnes. The subcommittees also met bimonthly and served as the primary driver of the task force's

work in developing the recommendations to follow. Using the task force's enacting legislation, the subcommittees were assigned stated objectives to research and bring forward recommendations. The Compensation Subcommittee looked at current wages for direct care workers, goals for future wage increases, and potential processes to allow for continual rate reviewal. The Best Practices Subcommittee looked at possible workforce and regulatory actions to improve the healthcare workforce.

Compensation

The task force focused on the lowest compensated employees of the state and private contractor providers that were non-degree/high school equivalency and bachelor's degree front line employees. The logic employed was that higher degree professionals working in the health care space typically have credentials or licenses that are recognized and reasonably compensated in the market. Direct care staff (front line employees) typically have extensive job specific training and significant responsibility for safety, monitoring, and coordination of care. These employees are not generally certified or licensed professionals. If wages for this segment of the workforce are addressed, market forces will likely improve other health care positions with greater educational requirements.

Primary source information was gathered from nearly 20 sources during its review of compensation and wages. All sources were recent publications with the majority in the last two years. National, state, and regional data was compiled with an emphasis on hourly wage comparison. Hourly wage was selected as the benchmark to eliminate any potential data skewing caused by the number of hours considered full time (32-40 hours a week). While benefits are a considerable tool in recruiting and retaining employees, the task force elected to define a minimum benefit package recommended which includes health insurance and paid leave. The variation of benefits throughout the health care space is wide, which does not lend itself to parity hence the recommendation to offer at a minimum a base benefit package. The minimum base benefit package should include health insurance and paid time off (PTO).

Primary Source Resources related to Compensation for Health Care

The primary source documents outlined below are found in the Appendix.

Resource	**Date of publication**
TNCO Survey	2023
A Snapshot of Occupational Dynamics associated with TAMHO	2023
Tennessee Alcohol, Drug, and other Addiction Services Survey	2023
Tennessee Association of Mental Health Organizations Survey	2023
Tennessee Dept. of Children's Services wage data	2023
Tennessee Dept. of Mental Health and Substance Abuse Services wage data	2023
CHOICES Rates TN	2023
TN VA Rates	2023
PCA/DSP wage comparison TN and surrounding states	2023

State of Tennessee annual increase non-exec wage data	2022
Addressing Wage of the DS Workforce w/Medicaid Policy	2022
Nursing Home Salary and Benefits Report	2022
Economic Policy Institute	2022
Health Management Associates (HMA) report	2022
Virginia Association of Community Services Board	2022
NCI-IDD 2021 State of the Workforce Survey Report	2021
QuILTSS Workforce Initiative Survey (Year Four Report)	2021
All Hands on Deck Behavioral Workforce Shortage	2019

Research Conclusions:

Private Agency Wage Data:
Home care data from several well-respected sources reveal the actual wages for home visitation professionals (i.e., personal care, attendant care, and respite) for seniors, intellectual and developmental disabilities (IDD), and home health.

1. Tennessee Direct Service Provider wage average is **$12.60** an hour as reported by QuILTSS workforce survey.
2. Bureau of Labor Statistics wage estimate for Home Health and Personal Care Aides with a high school diploma or equivalency credential - **$14.07**
3. NCI-IDD state of the workforce survey reports for Home Health/Personal Care Aides with a high school diploma or equivalency credential - **$14.50**

The Economic Policy Institute recommends a Tennessee wage target of $20.51 for home care worker (non-degree/High school equivalency).

There are three primary trade associations representing IDD, substance use, and mental health in our state. Summarized below is their survey data for hourly compensation:

1. The Tennessee Community Organization membership survey for 2023 report an average hourly wage for
    - High school diploma or equivalency credential – range **$14.25**
        - Annual salary of $29,640
2. The Tennessee Association of Alcohol, Drug, and other Addiction Services membership survey for 2023 report an average hourly wage for
    - High school diploma or equivalency credential – range **$13.37-14.85** (Annual average hourly rate is $15.00)
        - Annual salary of $29,348
    - Bachelor’s level – range **$16.65-17.13** (Annual average hourly rate is $16.89)
        - Annual salary of $35,131

3. The Tennessee Association of Mental Health Organizations membership survey for 2023 report an average hourly wage for
    - High school diploma or equivalency credential – **$11.40-16.59** (Annual average hourly rate is $15.00)
        - Annual salary of $31,200
    - Bachelor's level – **$14.00-23.72** (Annual average hourly rate is $18.75)
        - Annual salary of $39,000

There is a stark contrast between wages paid to state employees and private agency employees contracted with the state to do service on behalf of the state. These are specifically wages for similar positions with like educational requirements. The discrepancy in wages between state employees and private agencies providing health care services on behalf of the state is two-fold. 1) The state of Tennessee has routinely provided employee raises over the last ten years; the state has not provided commensurate reimbursement improvements to private agencies contracts over that same time period. 2) In recent years, the state has aggressively improved wages in the human service areas of state employees, particularly the Tennessee Department of Children's Services. The wage improvements for state employees were warranted, but it merely created a larger gap than normal circumstances would have trended.

State of Tennessee 10-year History of Annual Increases
Non-executive positions

	% annual increase	
2021/2022	2	
2020/2021	0	
2019/2020	2	
2018/2019	2.5	
2018/2017	3	
2017/2016	3	
2016/2015	2	
2015/2014	0	
2014/2013	1.5	
2013/2012	2.5	
	18.5	Total increase over the last 10 years

The USA inflation rate over the same period was 24.7%

State of Tennessee Wage Data:
The Tennessee Department of Mental Health and Substance Abuse Services wage data for 2023 report an average hourly wage of

- High school diploma or equivalency credential – Psychiatric Technician – **$17.66**
- High school diploma or equivalency credential – Lead Psychiatric Technician – **$21.82**

The Tennessee Department of Intellectual and Developmental Disorders wage date for 2023 report an average hourly wage of

- High school diploma or equivalency credential – Direct Support Professional – **$18.67**

The Tennessee Department of Children's Services wage data for 2023 report an average hourly wage of

- High school or equivalency credential – **$19.95-24.35**
    - Annual starting salary of 38,904-$47,496
- Bachelor's Case Manager 1 (entry level) – **$27.90**
    - Annual Starting salary of $54, 396
- Bachelor's Case Manager 2-4 (with 1 to 3 years experience) **– $29.85-35.07**
    - Annual average salary range w/experience of $58,200-68,400

Comparative retail/restaurant/warehouse in Tennessee (hourly wages December 2022)

- McDonald's – **$12.33**
- Chick-fil-A – **$12.50-14.71**
- Walmart **– $14-19.00**
- Starbucks – **$17.00**
- Amazon – **$16.10-25.00**
- Buc-ee's Cashier **– $16.24**
- Fed Ex Package Handler **– $22.00**
- Buc-ee's Car Wash Attendant – **$31.00**

*While the retail/restaurant/warehouse jobs require the same educational requirements, the level of responsibility is significantly less than employees in the healthcare space.

Compensation Recommendations:

I. Strategic Plan
    a. Begin with raising current wages to a base that is at market;
    b. Once wages are at market wages, adjust wage incrementally with the following methods:

   i. Adjust annually commensurate with state employee raises;
   ii. Review every three years based on the annual inflation rate metric (CPI) set by federal government to assure wages have not unexpectedly fallen behind.

II. Research on the disparity in salary structure for the healthcare workforce.

After considerable review of wage data, it is apparent that wages for direct care professionals in home care, intellectual and developmental disabilities, and behavioral health are significantly below market. The primary fund sources for the private sector doing work for the state are TennCare and the state (Department of Intellectual and Developmental Disabilities and Department of Mental Health and Substance Abuse Services). Flat reimbursement over decades and inflation during this period compounded the issue.

Base Salary Recommendation:

High school equivalency positions – $18-20/hour (benchmark 2023)

- Trained professionals for personal care, behavior management, and associated medical care coordination.
- Responsible for personal support for community independence, short-term acute care.
- Assuring medication compliance, safety, skill development for treatment and rehabilitation goals.
- An estimated 13,896 positions in this category statewide

Bachelor's level positions – $25.50-28.00/hour (benchmark 2023)

- College educated healthcare professional (unlicensed) to help development, children, mentally ill, substance use population.
- Responsible for monitoring health, medication training, employment support, and intervening using Evidence Based Practices.
- An estimated 1934 positions in this category statewide

Incremental wage improvement methodology

- Private providers' wages will be improved commensurate with state employee annual raise percentage.
    - The annual state wage improvement over the last ten years has averaged 1.85%.
- To sustain the workforce going forward, wage improvement recommendations will take into consideration inflation.

A review of wages against inflation and parity with state salary improvements for similar positions should be conducted at a minimum every 3 years by the private providers and be presented to the General Assembly and Governor for consideration**.**

TennCare, Department of Intellectual and Developmental Disabilities (DIDD), and Tennessee Commission on Aging and Disability (TCAD) are committed to a collaborative process for determining aligned rates across programs for direct support professionals.

While this report focused on the lowest paid direct care workers, any reimbursement improvements by the state or TennCare should recognize the need to raise wages and benefits for administrative and support staff in these agencies i.e., human resources, finance, etc.

Best Practices Recommendations

Plan for increasing the availability of high quality, affordable, and accessible healthcare professionals in the state:

1. **Family Scholar House HealthCorps: Expand the Family Scholar House healthcare workforce program to Tennessee.**

Support the approval of Family Scholar House to expand its healthcare workforce program to Tennessee. In partnership with AmeriCorps, Family Scholar House HealthCorps will develop partnerships with nonprofit healthcare facilities across the state to serve as host sites for Tennessee HealthCorps members (approximately 200 members in Tennessee).

Members will receive paid, quality work-based learning opportunities, mentoring, wrap-around support services, and will complete their service ready to enter the workforce or continue their education. Upon completion of their term of service, they will receive the Segal AmeriCorps Education Award to repay qualified student loans and to pay current educational expenses at eligible institutions of higher education and training programs.

The Healthcare Task Force submitted a letter of support signed by every member of the task force to Family Scholar House to be included in their grant application.

2. **Matching Registries: Create a registry platform connecting healthcare workers with those in need of healthcare services.**

Matching registries provide a platform for workers to find people in need of their services and people in need of services to find workers. As an example, in the state of Oregon, the Oregon Home Care Commission operates a statewide registry and referral system matching people in need of direct care to those who provide direct care. A person who wants to hire a direct care worker (the employer) submits a profile that allows them to identify their preferences (e.g., for a non-smoker or a worker of a specific gender), any special conditions required (e.g., the ability to work for someone with a pet), preferred training, the types of personal care needed, and the type of schedule required. The worker provides information on the geographical areas where they can work, their credentials, limits on what conditions they will accept, the types of personal care and household tasks they are willing to provide and the types they have experience providing, the type of schedule they will consider (e.g., full time, part time, working as a live-in), and their preferred schedule. The registry also collects data on training, history of investigations for abuse and criminal background checks.

According to the Paraprofessional Healthcare Institute (PHI), there are 15 matching registries in 10 states. These registries vary in several ways, including whether they are operated by the state or a nonprofit agency. (Raise Act State Policy Roadmap, John A. Hartford Foundation, Section 3, 2022, (The Direct Care Workforce - NASHP)

3. **Targeted Recruitment: Develop strategies on recruiting and retaining adults to meet the demand for direct care workers.**

In Tennessee, the highest population group working in this occupation are those ages 25 to 54. While creating pathways and career ladders for young adults are vital in building this workforce, the Task Force recognized that most workers currently in the field are middle to older age adults. As such, the Task Force recommends an increased focus on recruiting and retaining adults to meet the demand for direct care workers. One opportunity to do this is through the Department of Labor and Workforce Development's administration of the Workforce Innovation and Opportunity Act (WIOA) program. WIOA provides states with an important vehicle for coordinating employment and educational programs with a state's workforce development needs. Under WIOA, states are required to align policy and resources across six core programs, including vocational rehabilitation, adult education, and literacy, and those helping job seekers, youth, dislocated workers, and individuals with barriers to employment.

4. **International Workforce: Expand visa work program opportunities.**

Expand opportunities for temporary workers through a further review of various work visa options that would allow qualified foreign health care professionals (e.g., registered nurses) to temporarily fill critical degreed and non-degreed positions (e.g., registered nurses and nursing aides) in licensed nursing home and assisted care living facilities to recruit health care professionals in health care shortage areas of the state. While this issue is the federal government's jurisdiction, the task force views this as a possible solution still requiring recognition.

5. **Certification Programs: Scale existing models of affordable healthcare certification programs.**

Scale existing models of affordable healthcare certification programs (e.g., certified nursing assistants) that can be completed in 5-6 weeks and offered in person, online, and hybrid learning options.

For example, the University of Tennessee-Chattanooga, Center for Professional Education's Development implemented a five-week Certified Nursing Assistant Program partnership

with local employers, such as Life Care and Parkridge Hospital, to provide sponsorship and employment opportunities to community members. Specifically, these employers cover the cost of tuition, pay students while in training, and guarantee full-time employment as a CNA after completion of the training program. The program's current CNA state licensure exam pass rate is 12% higher than the state average (89% v. 77%), with over 22 cohorts and nearly 250 students graduating since the program launched in spring 2021.

6. **Marketing Campaign: Develop a statewide marketing campaign to attract frontline healthcare workers.**

The task force recommends developing a statewide marketing campaign to attract frontline healthcare workers. Through a variety of campaigns (digital, print, billboard, etc.), departments that depend on direct care workers can pool resources to target and recruit statewide a multitude of prospective employees, spanning all the way from high school graduates to retirees looking for a supplemental career. These campaigns will showcase direct care as a profession rooted in service and compassion. The campaign can link to one resource that can illustrate the different populations that need direct care workers.

7. **Explore Family-Working-Family Caregiving Model: Redefine the current rules under which individuals can provide care to family members in home services to empower these individuals while also taking care to prevent fraud.**

In many situations, it can be beneficial for front-line workers to care for their family members when the family member is already approved to receive in-home care services. Service recipients may feel more comfortable receiving care from family members and the care provider may otherwise feel like they must seek outside employment for self-support instead of doing the job they prefer (caregiving). It is a unique opportunity to provide service recipients with care providers that are both highly qualified and trained through the provider agency and are familiar and comfortable to the service recipient. This also allows provider agencies to attract employees who may otherwise have felt they had no choice but to remain home with their loved one instead of seeking outside employment. These employees are also likely to pick up additional shifts when their loved ones do not need care during the day. The Task Force recognizes that while there are extensive benefits through this arrangement, there are also increased opportunities for fraudulent activity either intentionally through the use of the familiarity of the relationship, or unintentionally, through forgetting the difference between the roles of "employee" and "family member".

The Task Force recommends supporting a family-working-family caregiving model, with the provision that there will be a greater partnership between TennCare, Managed Care

Organizations (MCOs) (or other payer sources), and provider agencies to provide education, support, and stringent oversight by the provider agencies to the individuals providing care to family members and support from the MCOs when doing so. The Task Force recognizes provider concerns of increased fraudulent activity and recommends the following considerations, with the understanding that service recipient or care provider fraudulent activity may result in program disenrollment and/or care provider termination. Specific considerations include:

- Service recipients wishing to utilize the family-working-family care giving model must utilize a licensed provider agency through which to receive services. This model may not be offered through the consumer direction model or any similar model that bypasses the oversight of a licensed agency.
- The family-working-family care giving model cannot be utilized to provide family members with overtime hours. Care providers who service family members should be restricted to a maximum 40-hour work week. Any exception to this would be approved by the provider agency in advance of the overtime being worked.
- Unannounced quality assurance visits should be implemented by both the payer source and provider agencies to ensure compliance with all agency guidelines. Clients should also be educated that this a requirement of the family-working-family caregiving model and is not optional. Care Coordinators or other liaisons should similarly be educated to ensure continuity of messaging, support for provider agencies performing the visits, and reassurance to the service recipients who may have questions about this practice.
- Increased and repeated training should be implemented at the provider agency level to ensure care providers fully understand the distinction of being a family member vs. being an employee and the scope of practice differences.
- MCOs and other payer sources should implement enhanced and repeated training for Care Coordinators and other staff members that serve as liaisons between service recipients and provider agencies to ensure complete understanding of the family-working-family model regulations and understanding of how to educate service recipients accordingly.
- The option of installing cameras or other monitoring devices at service recipient home entrance/exit points should be further explored to reduce worker time and attendance fraud.

Identifying resources across state government to be streamlined, coordinated, and more effectively utilized to address healthcare workforce challenges:

1. **Medication Aide Program: Review current practices and guidelines for opportunities to increase the number of medication aides in the state and**

enhance their ability to impact the overall delivery of healthcare in facility setting.

A medication aide is a direct care staff position. The duties of a medication aide include managing daily medications and ensuring they are given to patients (prescription or non-prescription), recording medication dosages and times they should be administered, observing patients, and documenting any changes (and responding to any calls or signals identifying patient needs).

An effective medication aide program can provide relief to a nursing staff by assuming basic medication administration, thereby allowing the nursing staff to focus on providing nursing care to patients. Given the current nurse staffing challenges across the state, this could have a significant positive impact on overall healthcare.

In addition, the medication aide position represents an additional career option for healthcare workers. Medication Aides are required to have 365 days of full-time employment as a CNA or Occupational Therapy Assistant in a nursing home, assisted living, or Program of All-Inclusive Care (PACE). The medication aide position, which generally commands a higher wage than CNA, could attract more workers to the healthcare field and help retain existing workers by offering them the opportunity to advance in their career.

There are potential regulatory and statutory changes needed to expand the impact of the medication aide program in the state including:

A. Allow more medication aide course instructors to serve as medication aide test observers. This change would allow more tests to be administered and create more opportunities to become a medication aide.
B. Develop a training and certification plan that would allow the expansion of certain medication aide medication administration functions. Specifically: a) allow medication aides to administer metered dose inhalers without a spacer; b) remove requirement for an “assessment” prior to administration of PRN medications; and c) allow nebulizer treatments.

It is recommended that these opportunities be evaluated by collaborating with Tennessee’s nursing home associations and for-profit and non-profit nursing homes and that these findings be shared with our state’s nursing regulatory body during policy and advocacy discussions specific to scope of work, statues, and regulations.

2. **Clinical Resources for Children/Young Adults: Develop policies and strategies to attract resources to this area of need.**

Specific needs for pediatric patients differ than those for adults. Although this report focuses on direct service providers who are unlicensed, the greatest needs for service provision to the children of Tennessee involves licensed personnel, especially in the area of children's mental and behavioral health. As such, this report would be incomplete without discussing this issue.

Since the COVID pandemic of 2020, there has been a significant increase in the number of children and youth suffering with mental or behavioral health needs. Unfortunately, the lack of appropriate and adequate service provision in the community, combined with a lack of facilities that will admit these youth for acute mental health crises, has led to children and youth ending up in Emergency Departments. ED's are not designed for, nor equipped to, manage these youth, and the lack of beds for acute psychiatric stays means the children "board" in ED's, using valuable resources while not receiving the care they desperately need. The state of Tennessee relies on private facilities to be willing to admit these youth in acute mental health crises.

There is a great need for mental health clinicians trained and able to see children and youth. These clinicians range from care technicians in acute psychiatric hospitals and residential care facilities to social workers and masters' level counselors in community mental health clinics. Additionally, there are not enough psychologists (PhD or PsyD) or psychiatrists specializing in children and youth in our state. The training needed, the lack of adequate reimbursement, and the time required to provide appropriate care for these youth are key issues that need to be addressed to begin to remedy this crisis.

3. **TennCare Programs: Increase provider awareness of existing programs to support and grow the healthcare workforce.**

TennCare has worked with stakeholders across the state to implement additional resources for providers during this time of national workforce challenges. These efforts are supporting provider organizations with recruitment and retention efforts, supporting the direct care workforce through high-quality competency-based training and additional career development opportunities, and providing financial incentives for implementing evidence-based workforce development practices, as well as financial incentives for specific workforce and quality of life outcomes.

For example, TennCare partnered with the National Alliance for Direct Support Professionals (NADSP) to offer Direct Support Professionals (DSPs) and Frontline Supervisors (FLSs) the ability to earn national certifications that demonstrate the knowledge, skills, and values that direct care professionals in Tennessee utilize every day. Participating DSPs, FLSs, and HCBS providers are eligible for incentivized payments upon

meeting specific quality metrics related to the completion of certifications. TennCare partnered with the Tennessee Board of Regents to offer the TN DSP Training program which is a nationally accredited competency-based training for HCBS DSPs at TN Colleges of Applied Technology (TCATS) and Community Colleges. Additionally, this training is offered as an Apprenticeship program for individuals who currently work in healthcare and are looking to re-skill into a different occupation or for individuals who would like to start a career in healthcare and have no prior experience in the field. Participating DSPs can earn 18 college credits and apply this coursework toward the NADSP certification. TennCare has also implemented a program called Leaders in Inclusive Services (LINCS) for high school and college students who are interested in impacting the lives of others while preparing for a future in healthcare, human services, social services, and more.

The Task Force recommends increasing provider awareness of these existing programs to support and grow the workforce.

Reviewing budgetary and regulatory actions taken to mitigate workforce challenges and assess their impact:

1. **Regulatory Updates: Leverage the regulatory process to assist in the mitigation of healthcare direct care provider workforce challenges, through both the implementation of additional regulatory action and amendment of previously enacted action.**

While navigating the extensive administrative landscape can be challenging for healthcare providers, it is worth noting that key administrative changes cannot only assist in allowing these providers to better use scarce financial and personnel resources, but they can also assist in mitigating the on-going shortage of healthcare workers, specifically those that are considered frontline workers.

1.1 Substantially amend the current Reportable Event Management (REM) process for CHOICES and DIDD providers.
Implemented at the end of 2021, the Reportable Event Management Alignment and Restructuring project was undertaken with the goal of aligning incident reporting procedures across programs that provide care to the elderly and those with disabilities, specifically within the Department of Intellectual and Developmental Disabilities (DIDD) programs and the TennCare CHOICES and ECF CHOICES programs, because there is often an overlap of providers in these programs. This alignment was intended to create a more efficient, effective, and streamlined process for providers, managed care organizations (MCOs), DIDD, and TennCare, while ensuring compliance with federal regulations. However,

the Task Force recognizes concerns that the implementation has not entirely fulfilled these stated goals and even introduced unintended consequences.

For provider agencies, extensive investigations previously not required by agencies are now being performed within the provider agencies, even when the reported incident does not occur while the agency employee is not in the home, and even when the incident does not even involve the agency or its employee. In practice, this means that chosen agency individuals must undergo lengthy training that takes them away from normal job duties, must engage in investigations that involve evidence collection, extensive interviews, and other procedures that are not within the scope of practice for a non-medical home care agency. For example, non-medical home care employees are expected to interview pharmacists if there is an allegation of missing medication. If an incident occurs that involves the police, the investigator is expected to interview the responding officer, who is typically hesitant to release information and often refuses on the grounds of investigation interference. Home care agencies must also gather evidence, including photographic evidence, physical evidence (brooms, blood-stained clothing, etc.) that was involved in the incident, drawings and diagrams of the scene, medical records for ER admissions and any other evidence deemed pertinent by DIDD staff. This is despite the fact that no evidence storage facilities exist and no legal protected afforded to the employee gathering the evidence. Provider agencies report frustration with this and the increased liability that places on them.

Agencies report that the submission process is also cumbersome, as many investigations require multiple interactions with DIDD staff, as reports are rarely deemed sufficient at initial submission. While the specific facts of every incident will vary, and along with it, the investigative processes required, agencies report that it is not uncommon for staff to devote weeks to a single investigation. Since these staff were not hired by the agency to complete investigations, they were already engaged in other job duties essential to the function of the agency. This required diversion of agency resources has resulted in an incredible hardship for agencies who were already facing severe staffing-related challenges. Provider agencies must then either hire additional staff (and absorb the cost) or place additional burdens on existing staff for these lengthy investigations. This does not take into account the multitude of reports that must be submitted each month regarding events that are reportable, but do not rise to the level of extensive investigation. The Task Force recognizes, though, that this may be an unintended outcome of the REM mandate. Upon further discussion with both TennCare and DIDD, it was clarified that this was not the intent of the mandate, and the parties are working diligently to determine whether there needs to be modification to the current requirements or clarifications around existing requirements and expectations to reduce provider administrative burden while also continuing to ensure the health, safety, and welfare of all members.

While these extensive burdens that are placed on provider agencies certainly negatively impact the ability of these agencies to undertake efforts to recruit and hire new employees, this new REM project has also negatively impacted employees directly. Front-line workers, those who earn the least and are shortest staffed, are most negatively impacted. This program has evolved into one that is punitive against these individuals, encouraging reporting and punitive action for every infraction, regardless of how small. Provider agencies see, firsthand, the negative impact this has had on employee retention, employee job satisfaction (front line workers constantly “living under a microscope” while earning lower wages than peers in much lower skilled industries), and the negative impact of having multiple incident reports in their employment files when looking to advance their career when considering future employment. For many of them, the risk is simply not worth the career fulfillment that may come from caring for clients. The Task Force believes that there must be an appropriate middle ground.

The Task Force recommends a significant restructuring of the REM mandate and its effects on provider agencies, considering the federal mandates, the intended objective of REM alignment, and the practical implications these regulations have on providers, understanding that a “one size fits all” implementation structure is not always appropriate. The Task Force recognizes the wide range of provider agencies and services that are included under the REM “umbrella” and recommends that the REM mandate be revised to take this into account and only require what is necessary to achieve pre-determined goals from providers, taking into account the burden that the requirements will place on providers and considering whether achieving the goal is worth the additional burden. The Task Force recognizes that this is a significant recommendation but has been encouraged by the initial discussions from all state partners, including TennCare and DIDD. The Task Force recommends continued communication between all stake holders, including providers from all services impacted, increased education to reflect the updated expectations from providers, continued dedication to partnership from all stakeholders, and a removal of unnecessary or burdensome requirements based on the level of services rendered by providers. The Task Force would request that the stakeholders also consider the option of another entity absorbing some or all of these reporting or investigative requirements if the burden to providers cannot be reduced, but the information gathered still deemed necessary.

1.2 Transition to an open Electronic Visit Verification (EVV) model.

In 2016, the 21st Century CURES Act was signed into federal law, which included the requirement that all states adopt an electronic visit verification (EVV) system to combat time and attendance fraud. TennCare adopted the MCO Choice Model, which allowed their contracted Managed Care Organizations (MCOs) the choice of which external EVV software

they would adopt. The MCOs were allowed to choose individually, resulting in providers being required to use multiple systems depending on which MCO had enrolled their client. These EVV software systems are then required to be used by provider agencies for care givers to electronically register their time in and out of client homes. The software is also used for inputting client schedules, monitoring missed visits, and increased accountability between provider agency and MCO, as both parties have access to the system. This EVV system is currently required for all CHOICES providers, DIDDs providers providing certain services, and is currently being implemented for home health agencies. The Task Force supports the initiative to combat time and attendance fraud.

However, the Task Force recognizes provider agency administrative concerns surrounding this implementation, namely that these EVV systems are "closed," meaning that they do not allow integration with other software systems, namely those timekeeping and payroll software systems implemented by individual providers. This results in duplicative time keeping practices by the front-line workers (they must clock in/out of shifts multiple times in multiple software systems), unintentional errors, and unnecessary confusion for these workers. The MCOs do not all utilize the same software system; therefore, all of the software systems require individual logins, and workers must maintain all of these system apps (and individual agency apps) on their phones, remember all of their log-in information, and remember which MCO serves each of their clients so they can log into the correct apps.

In recognition of these challenges and their impact on providers, TennCare has recently announced the transition to an Open EVV Model, which will allow provider agency software systems to send data to the MCO EVV systems, eliminating multiple apps, multiple log-ins, additional training, and caregiver confusion. This process is expected to begin in 2024 and the Task Force recognizes the magnitude of this implementation for TennCare and applauds TennCare's dedication to reducing provider administrative burden where possible. The Task Force supports this shift to an Open EVV Model and recommends the continued collaboration between state agencies and provider agencies to best support the service recipients.

1.3 Reduce the duplicative audit and monitoring burden facing care providers.
Across all sectors of the healthcare industry, the number of audits seem to be increasing, even when there have been specific movements to reduce the numbers. In the CHOICES program, specifically, each provider undergoes an annual licensure monitoring done through the Tennessee Department of Mental Health and Substance Abuse Services, plus three additional audits conducted by each managed care organization that are almost entirely duplicative. Any additional payer sources outside of the CHOICES program would also add additional audits. There has been discussion of having a combined managed care

organization audit with a single standardized audit tool, wherein the three managed care organization auditors rotate their provider agency visits on a three-year cycle. Implementing this measure would reduce CHOICES provider agency audit loads in half, from 4 audits annually to only 2 audits annually.

Mental health providers use different tools and resources which can lead to numerous auditing and monitoring procedures, even when accredited. Agency accreditation by an independent national or international body should allow for a decreased number of audits by managed care organizations and other payor sources. Instead, accreditation only increases the audit burden. Meeting the standards required for accreditation should be recognized by the payors, in lieu of their additional audits. Also, like CHOICES providers, mental health providers also see multiple audits when contracted with multiple managed care organizations. Administrative burdens could be significantly eased by adopting a single standardized audit tool for all managed care organizations and undergoing a single audit annually, representing all managed care organizations. Because the audits would be standardized and the managed care organizations could rotate who completed the provider's audit, this would in no way impair or inhibit the review process that the Task Force recognizes is necessary for ensuring high quality care.

While accreditation can bring services to a higher standard and sense of accomplishment, it also comes with additional administrative burdens for DIDD providers. There is current consideration for these providers to undergo fewer state audits (specifically considering the annual Quality Assurance Survey) when a national accreditation would measure these standards as well as many others. The Task Force recommends reducing or removing duplicative audits to reduce provider agency administrative burden, personnel time, and financial resources used in preparation in order to better direct these resources to the primary purpose of these agencies: providing high quality care to individuals and hiring high quality staff to do so. The Task Force recognizes the collaboration that would be required among state agencies and then with the managed care organizations to achieve this outcome but has been continually encouraged by the dedication to collaboration and providers that has been demonstrated by nearly every agency. In the same vein, the Task Force also recommends reviewing accreditation standards for applicable providers and identifying those audits currently required at the state level that can be removed or modified upon receipt of national accreditation.

2. **Tennessee's Workforce System: Support the state's workforce system plans regarding healthcare access, specifically high school pathways, bridge programs, and certified pre-apprenticeship and apprenticeship opportunities.**

It is well known that the employment landscape in the United States is as wide and varied as anyone's imagination. Therefore, it is crucial to expose and promote vital career pathways, such as healthcare, during those timeframes where career opportunities are being explored. For a majority of Americans, this happens when they are engaged in schooling, whether at the high school or collegiate levels. The Task Force supports the efforts of all school systems in Tennessee in their efforts to expose career pathways. In this support, the Task Force recognizes the unique role that community and technical colleges play in engaging Tennessee's high school and college students because of the local community-based focus and location of these schools. These schools often partner with local high schools and offer the initial training and bridge programs to the skillsets needed for the frontline workers in highest demand. These schools also often expose students to additional pathways to increased education at 4-year colleges and universities, should these individuals wish to continue their education within their chosen field.

In Tennessee, the Tennessee Board of Regents is the governing body for community and technical colleges state-wide. These schools have already created healthcare training programs in high schools across the state and offer additional training in their collegiate level programs at a majority of community and technical colleges across the state. In the Fall of 2022, nearly 11,000 students were enrolled in allied health programs and in the 2021-2022 school year, over 5,000 credentials were awarded in this same field. These community and technical colleges know how to reach students in high school, begin their education there, and assist them in transitioning or beginning new credentials in the collegiate environment after high school.

The Tennessee Board of Regents has crafted a proposal to be able to continue to meet this need and reach additional Tennesseans through their innovative and already existing program models. This expansion would allow additional high school and college students to receive allied health credentials and the opportunity to expand their training to achieve higher level licensure such as an LPN or RN licensure, if desired. Reaching individuals while they are still in high school and providing such programs as bridge programs and apprenticeships after high school encourages early career individuals to consider healthcare fields as early as possible, potentially increasing the pool of employees for years to come.

The Task Force recognizes the importance of education and the unique role that community and technical colleges play in the lives of Tennesseans. The Task Force recommends that the Tennessee Board of Regent's Proposal to Expand TBR's Support of Healthcare Access be considered and explored for financial and practical applicability and viability in the State of Tennessee as a potential method of expanding the frontline healthcare worker workforce.

3. **Continued Investment: Recognition of recent investments as examples of impact actions.**

TennCare with the partnership and approval from the Governor's Office and the Tennessee General Assembly has made significant recent investments in long term services and supports (LTSS) and behavioral health.

Examples of these investments include $129 million in direct support professionals (DSP) wage increases (state fiscal years 22-24), $130 million to serve an additional 2,300 individuals with intellectual and developmental disabilities (SFY 23), and $85 million investment in behavioral health including investments for community mental health centers, mobile crisis, supported housing, members with mental health needs and intellectual or developmental disabilities and provider recruitment and retention (SFY 23-24).

Creation of advisory council: Consider creating an advisory council to continue the Healthcare Task Force's work and assist with implementation of recommendations.
The task force recognizes the healthcare worker shortage will not be solved overnight and requires ongoing work and innovation. As the aging population in Tennessee continues to grow, the services of direct care workers will only grow in importance. The task force recommends the creation of an advisory council to continue gathering workforce and wage data, studying potential workforce strategies, and assisting in the implementation of this report's recommendations.

Conclusion

The healthcare worker shortage, particularly in the direct care worker sector, will continue to be evident with the state's increasing population and changing demographics. Raising wages and finding new workforce strategies must remain at the forefront of discussions. The task force believes the recommendations described within this report are important first steps for the vitality of providers' frontline staff. Continued partnerships of the Administration, General Assembly, and private providers will be crucial for the implementation of these recommendations. The task force hopes this report proves helpful in assisting Tennesseans receive the care they need and gainful employment.

Appendix/Sources

Atwood, R. Executive Director, Tennessee Community Organizations (TNCO) membership survey on wages, 2023.

Arik, M. and Devi, R. A Snapshot of Occupational Dynamics associated with TAMHO, MTSU Jones College of Business, Business and Economic Research Center, 2023.

Baker, J. (2023, April 3). The 2023 Direct Support Professional (DSP) Survey Report. Relias.

Block, L., Maxey, H., Medlock, C., Johnson, K., Nielson, B. Addressing Wages of the Direct Care Workforce through Medicaid Policies. Washington, DC: National Governors Association, Oct 2022.

Bureau of Labor Statistics, U.S. Department of Labor, *Consumer Price Index (CPI) Databases,* 2023.

Health Management Associates (HMA) Review of States' Approaches to Establishing Wage Assumptions for Direct Support Professionals When Setting I/DD Provider Rates, 2022.

Kidd, A. Deputy Commissioner of Fiscal and Administrative Services, PCA/Direct Service Provider wage data, Tennessee Department of Intellectual and Developmental Disabilities, 2023.

Martinez Hickey, Sebastian; Sawo, Marokey; Julia Wolfe, "The state of the residential long-term care industry," 2022.

Massey, B. Tennessee historical record of increases for non-executive wage data, Tennessee Department of Finance and Administration, 2023.

Mizell, K. Senior Associate Counsel TDCS, Tennessee Department of Children's Services wage data, 2023.

Murat Arik, PhD., "All Hands on Deck Behavioral Workforce Shortage Tennessee," MTSU Jones College of Business, Business and Economic Research Center, 2019.

National Core Indicators Intellectual and Developmental Disabilities. (2022). National Core Indicators Intellectual and Developmental Disabilities 2021 State of the Workforce Survey Report.

Paraprofessional Healthcare Institute (PHI). (2023). (rep.). Direct Care Workers in the United State Key Facts 2023.

Salter, M. L. Executive Director, Tennessee Association of Drugs Alcohol, and Other Addiction Services (TADAAS) membership survey on wages 2023

Smith-Knight, Executive Director, A. Tennessee Association of Mental Health Organizations membership survey, 2023.

Tenn. Code Ann. § 63-1-703

Tennessee Hospital Association. (2022). Tennessee Health Workforce Projections: 2021-2035.

Pettingell, S., Kleist, B., Sanders, M., Zhang, A., & Oteman, Q. (2022). QuILTSS Workforce Initiative Survey 2021 Year Four Report. University of Minnesota, Institute on Community Integration, Research and Training Center on Community Living.

Veterans Administration, Tennessee Veterans Administration rate data for home care services, 2023.

Virginia Association of Community Services Boards Compensation Data, 2022.

Yancey, M. Deputy Commissioner of TDMHSAS, Tennessee Department of Mental Health and Substance Use Services wage data, 2023.

Williams, C., CHOICES rate and historical data since 2010, StaffCo/At Home Healthcare, 2023.