# MEMORANDUM

**To:** Medical Care Advisory Committee (MCAC)

**From:** Ted Goins, MCAC Member

**Re:** Direct Care Workforce Crisis

**Date:** June 6, 2019

The work plan developed by the members of the Direct Care Workforce Crisis Summit continues. As a reminder, the members of the summit group are:

| | |
|---|---|
| Adam Sholar | North Carolina Health Care Facilities Association |
| Amanda Borer | North Carolina Eldercare Workforce Alliance |
| Bob Konrad | University of North Carolina |
| Charmaine Cooper | AARP |
| Dave Richard | Department of Health and Human Services |
| Donna Snyder | North Carolina Health Care Facilities Association |
| Karen McLeod | Benchmarks of North Carolina |
| Kezia Scales | PHI |
| Lori Byrd | North Carolina Community Colleges |
| Mary Bethel | North Carolina Coalition on Aging |
| Polly Welsh | North Carolina Health Care Facilities Association |
| Sandi Lane | Appalachian State University |
| Sandra Terrell | Department of Health and Human Services |
| Tara Fields | Benchmarks of North Carolina |
| Ted Goins | Lutheran Services Carolinas |
| Tom Akins | LeadingAge North Carolina |
| William Lamb | Friends of Residents in Long Term Care |

The minutes of the last meeting and the presentations from that meeting are attached.

Before summarizing the progress, members of the MCAC should know the problem is worsening. In preparation for a nursing home civil money penalty (CMP) grant application, the North Carolina Health Care Facilities Association (NCHCFA) surveyed its members in the spring to determine how many vacant nurse aide positions existed in its member nursing facilities, for which there are funds budgeted and that the nursing facilities would fill if qualified applicants presented themselves. 124 nursing facilities responded to the survey, and the average number of budgeted-for vacancies was 8.9 nurse aides per facility. Extrapolated statewide across the roughly 425 nursing facilities in NC, this is a total of 3,800 vacant and budgeted-for nurse aide positions that would be filled by nursing facilities if qualified applicants existed. This is roughly the same number of nurse aides that would need to be added to increase the statewide staffing average by an additional star on the star rating system. For comparison, NCHCFA also surveyed its members in late 2018 and, at that time, based on the responses received, (~sample of 10% of the state) there were, on average, 7.5 vacant nurse aide positions at nursing facilities that were budgeted for and would be filled if qualified candidates were available. If extrapolated statewide, this would be ~3,200 vacant, budgeted-for nurse aide positions.

A few other data points are also relevant and worth mentioning. First, the total number of active nurse aides is down 8% from 2016 through 2018. Second, the number of students who tested to become a nurse aide is down 30% from 2014 to 2018. Third, the number of nurse aide training programs has grown slightly in the last few years, but roughly 40% of the nursing facilities in the state have been unable to continue a clinical training site for a training program because of a survey citation, which may or may not be related to their ability to train nurse aides. There are other points but these are the most worth noting here.

To try to address this problem, NC's nursing homes have been trying a number of different approaches. Many nursing facilities have been developing closer relationships with their local HOSA program in their high school, or with their local community college. NCHCFA has also been working closely with NC HOSA at the state level to bring HOSA representatives to NCHCFA events to meet with nursing facilities and start to forge those relationships.

The American Health Care Association (NCHCFA's national affiliate) and LeadingAge have also developed comprehensive workforce resource websites for their members. With the shrinking pipeline and pool of workers, nursing facilities are trying many innovative approaches about culture, workforce development, and new recruitment and retention tools that are being developed by these state and national trade associations and their members. One item of note here, NCHCFA is holding yesterday and today (June 5 and 6) a Quality and Workforce Summit, bringing together nursing facilities from across the state to learn and share innovative approaches to improve workforce culture, retention, and explore the links to patient and resident outcomes.

NCHCFA and LeadingAge North Carolina are working together to develop a CMP grant application to create a CaregiversNC program similar to one operating in the state of Wisconsin. Through the CaregiversNC program, these groups are attempting to recruit 4,000 new nurse aides and incentivize them to remain in the long term care field, thus improving the quality and continuity of care for nursing home residents. This forthcoming grant proposal would fund training and testing for 4,000 new nurse aides through community colleges as well as private and facility-based training sites. Those nurse aides who complete the training and testing through the CaregiversNC programs, and who then work in a nursing facility for 6 months would be paid by that nursing facility a $500 retention bonus. To achieve the ambitious goal of certifying 4,000 new nurse aides over three years, CaregiversNC will be promoting the nurse aide profession to potential program participants through a multi-media communications campaign.

NC's nursing facilities are also sharing this message with elected and appointed officials in Raleigh and Washington DC. Most recently in Washington, nursing facilities educated members of NC's delegation about the workforce challenges and secured several commitments to write letters in support of the NCHCFA/LeadingAgeNC grant application for nurse aide training and marketing funding.

NCHCFA discussed its member's workforce challenges with state lawmakers at its Legislative Conference in April. Several of the points made during these meetings are particularly relevant for this group. First, Medicaid funding. North Carolina's average daily nursing facility reimbursement is the lowest in the Southeast. Nursing facilities are very appreciative of some of the recent investments the Medicaid program and the legislature have made in the program, but more is needed. A proposal to modernize a portion of the rate structure has been made to the Medicaid agency, and we are hopeful progress will continue on this. With staffing costs being the biggest portion of the costs of a nursing facility, and with

a vast majority of nursing facility revenue being Medicaid and Medicare—which are not really subject to rising prices to support increased labor costs—additional funding in the program is necessary and supported by members of the Direct Care Worker group. The second item discussed with state lawmakers was the difficulty in some areas with recruitment challenges exacerbated by the State's decision to set a minimum wage for its own employees at $15/hr. Private nursing facilities in markets with state-operated facilities have even more difficulty recruiting nurse aides when the competing state institution can offer employees a higher wage than Medicaid revenue will support. Achieving parity in this area is critically important for the nursing facilities in those areas.

The support of the Medical Care Advisory Committee of these efforts would be of great help to NC's nursing facilities, particularly as it relates to encouraging the Medicaid program to continue to invest in the nursing facility reimbursement program to begin moving it out of the lowest position in the Southeast. Other sectors are invited to be involved in the summit group, and have similar needs relating to the direct care workforce crisis.

Lastly, below are links to a number of articles highlighting the direct care workforce crisis.

- Nursing home care: A growing crisis for an aging America. Click here for link.
- New Research: 7.8 Million Direct Care Jobs Will Need to Be Filled by 2026. Click here for link.
- To read the article "Immigrants Make Up 1 in 4 U.S. Health Care Workers," from *HealthDay*, click here.
- To ready the article from the *Hendersonville Times-News*, "Hendersonville Chick-fil-A raises full-time wage to $14 an hour Hendersonville Times-News," click here.
- *Gallup News* article, "The U.S. Healthcare Cost Crisis." Click here to read the Executive Summary.
- *NY Times* Article - Good overview of the plight of rural nursing communities. Click here for the article.
- *PHI* e-newsletter - Good read about the depths of the Direct Care Workforce Crisis. Click here for this article.

Thank you for your time and attention to this crisis and to this serious threat to the quality of care and quality of life of our most vulnerable North Carolina citizens.

# ATTACHMENT #1

***Second Direct Care Workforce Crisis Summit held on 1-4-19 at the NCHCFA Office in Raleigh, NC***

Present were: Adam Sholar, Dave Richard, Sam Clark, Polly Welsh, Sandi Lane, Bill Lamb, and Ted Goins. Mary Bethel, Tara Fields, and Amanda Borer participated by phone. Tom Akins, Lisa Eads, and Sandy Terrell were not able to attend.

Ted Goins noted that Renee Batts was appointed by President Peter Hans of the NC Community College System as his representative to the group. She has since retired. Lisa Eads is interim representative, and will transition to the new person when appointed. Ms. Eads could not be at the meeting today, but expressed the commitment of the System to this important effort.

Ted Goins discussed the work of the Sustainable Reimbursement Subcommittee, including the need for data collection, discussion of the many different facets of the issues, and the desire of multiple provider groups to be involved in these efforts that affect all of us. Adam Sholar shared an overview of sustainable workforce issues specifically as they relate to the long term care profession, and statistics on the general workforce and the aging population. Next steps include gathering data from other provider groups, request for information on how the State of NC decided on a $15 minimum wage for state workers, root cause analysis of the issue, etc.

Sandy Terrell could not attend but shared a brief on unlicensed personnel rules and regulations. This was another Sustainable Reimbursement issue to consider opportunities to remove barriers or improve systems.

Tom Akins could not attend but shared the report of the Workforce Development Subcommittee. Two main issues that arose: quantifying the need for more NAs and pursuing a CMP grant similar to the Wisconsin model. Different urban and rural issues need to be addressed. Sandi Lane asked if an apprenticeship program could be developed, similar to SC and Georgia. Polly Welsh said there is one under development with the NC Community College System for LPNs. Could be applied to RNs. Adam suggested that a Wisconsin model might work with an institution in the mountains, central, and eastern part of the state (to recognize those regional differences).

Polly Welsh presented the report of the Regulations Subcommittee. Many of the nursing students and other students have to attain their CNA, but will never work as a CNA. But they take up the slots for people who might like to get trained as CNAs. Also, it is difficult to get a CNA training program approved in a nursing home. Hiring nurses and CNAs from Puerto Rico has faced many difficulties in getting through the bureaucracy. Immigration could help, but the proposed "public charge" rules will hurt. State licensure rules are being updated, but don't have much impact. The federal rules are the primary driver and they will not change. The federal government requires staff reporting, but many NFs don't have enough RNs, or have a replacement if an RN calls out for a shift.

The participants had a general discussion of related issues.

- Mary Bethel mentioned that the regional hospitals have workforce enhancement grants that are coming due for renewal. There may be an opportunity to partner.
- A number of long term care organizations are recruiting in Puerto Rico, which is part of the United States. They are sharing their experiences and pitfalls with other providers.
- Immigrants could be part of the solution. Is a guest worker program possible?

- The NC Nurse Aide Registry is a regulatory barrier. CNAs from other states could not even come assist NC during the hurricane.

Ted Goins reached out to The Duke Endowment to gauge any interest in helping fund an effort similar to the 2004 Task Force on the Nursing Shortage. We need a lead organization and a funding source, if we were going to move in that direction.

The issue also needs additional public exposure. Polly Welsh spent some time with Tommy Goldsmith with NC Health News about CMPs. And he has just contacted Mary Bethel.

Where do we go from here? What can we address fairly quickly?:

- NA Registry change to encourage reciprocity, etc.
- Collaborate with local workforce centers and NC Works.
- A CMS grant on the Wisconsin model. Adam and Tom will plan
- Investigate a Keeper's Committee concept.
- Improve Medicaid Reimbursement.
- MCAC's Behavioral Health Committee, could an LTC person get on that committee to help bridge the gap across health and human services.
- HHS Oversight Committee. Would be helpful to present together to that group.

LSC will coordinate a meeting in person and by phone for early March.

Respectfully submitted,

Ted Goins, Scribe

# ATTACHMENT #2


Advancing Skilled Nursing Care Since 1955

NCHCFA

NORTH CAROLINA
HEALTH CARE FACILITIES ASSOCIATION

# January 4, 2019 Workforce Summit

## Sustainable Reimbursement Subcommittee

North Carolina Health Care Facilities Association
5109 Bur Oak Circle | Raleigh, NC 27612 | (919) 782-3827 | Fax (919) 787-8418
https://www.NCHCFA.org

# Skilled Nursing Facilities at a Glance

429 nursing facilities

- Ownership
  - 76.2% multi-facility (2 or more under same ownership)
  - 23.8% independent
  - 3.7% hospital based
- Status
  - 80.2% for-profit
  - 17.0% non-profit
  - 2.8% governmental
- Certification
  - 4.7% Medicare
  - 0.5% Medicaid
  - 94.9% Medicare & Medicaid

Source: CASPER data, June 30, 2018

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# Skilled Nursing Facilities in NC

- 83.4 average residents
- Resident Days
  - 14.6% Medicare
  - 64.4% Medicaid
  - 21.0% Other
- Activities of Daily Living Score
  - US – 4.26
  - NC – 4.46 (8th highest in US)

Source: CASPER data, June 30, 2018

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# LTC Economic Impact

- Long Term Care (LTC) facilities* support an estimated $12.68 Billion of the state's economic activity
- 143,590 Jobs
- $4.75 Billion Total Labor Income
- $12.68 Billion Total Economic Activity
- $1.72 Billion Total Tax Revenue

*Long Term Care (LTC) facilities include nursing homes, assisted living, and other residential care facilities. These facilities do not include government-owned or hospital-based facilities.

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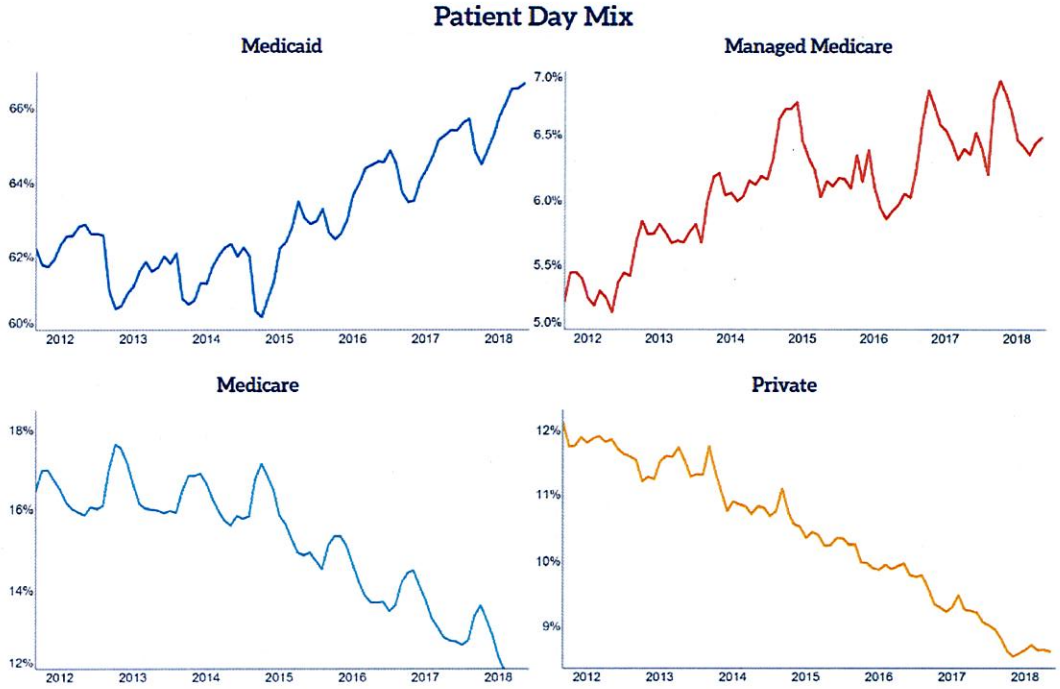
# Trends in Skilled Nursing - National


Skilled Nursing occupancy rates are down approximately 600 basis points since 2012

Source: National Investment Center for Seniors Housing & Care (NIC), Skilled Nursing Data Report, Jan 2012 – Sept. 2018 [hereinafter NIC 2018Q3 Report]

# Trends in Skilled Nursing - National




Percentage of days of care paid for by Medicaid and Medicare Advantage increasing, while percentage of days paid for by Medicare Part A and Private sources are decreasing

Source: NIC 2018Q3 Report

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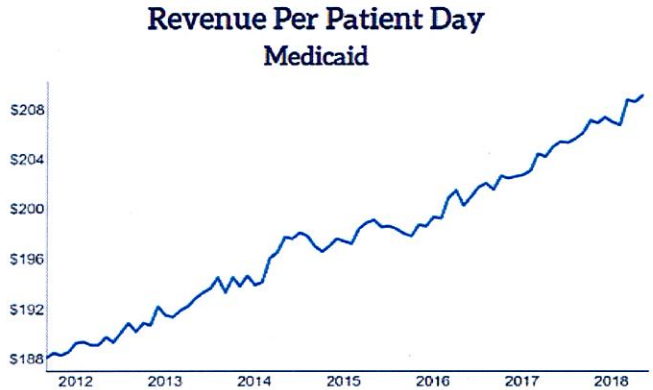
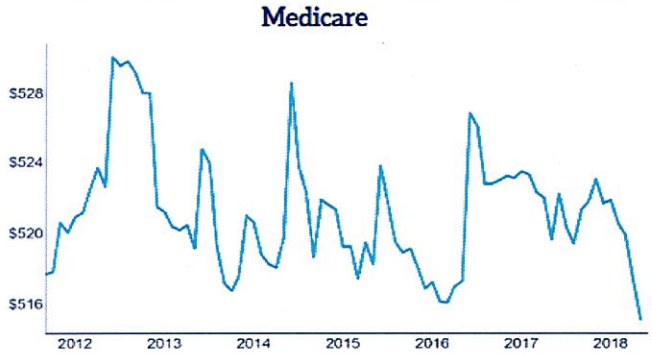
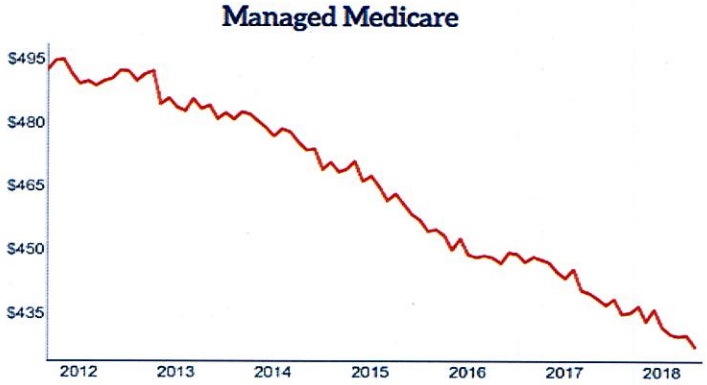
# Trends in Skilled Nursing - National





Medicaid and private pay rates are steadily increasing nationally; Medicare Advantage rates are decreasing; Medicare Part A rates largely flat.

**NOTE: Medicaid rates shown are national figures, not NC.**

Source: NIC 2018Q3 Report

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# Trends in Skilled Nursing - National

**TABLE 8-12**

**Over the past nine years, non-Medicare margins have been negative, but total margins remained positive in freestanding SNFs**

| Type of margin | 2008 | 2010 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|
| Total margin | 2.2% | 3.6% | 1.8% | 1.9% | 1.9% | 1.6% | 0.7% |
| Non-Medicare margin | –2.4 | –1.5 | –2.0 | –1.9 | –1.5 | –2.1 | –2.3 |

Note: SNF (skilled nursing facility). "Total margin" includes the revenues and costs associated with all payers and all lines of business. "Non-Medicare margin" includes the revenues and costs associated with Medicaid and private payers for all lines of business.
Source: MedPAC analysis of Medicare freestanding SNF cost reports for 2008 to 2016.

Source: MedPAC. Report to the Congress: Medicare Payment Policy, March 2018. Available at: http://www.medpac.gov/-documents-/reports

# Trends in Skilled Nursing - NC

## North Carolina

### Average Occupancy (median)

- June 2018 80.6% (84.7%)
- June 2017 81.7% (85.0%)
- July 2016 82.4% (86.1%)
- July 2015 82.8% (86.7%)
- June 2014 83.4% (86.7%)
- June 2010 85.6% (89.5%)
- June 2005 88.7% (91.9%)

| North Carolina | | | |
|---|---|---|---|
| Cost Report Data | | | |
| | 2014 | 2015 | 2016 |
| Medicare A days | 1,977,448 | 1,957,454 | 1,847,636 |
| Percentage of Change | | -1.0% | -5.6% |
| HMO Days | 3,162,477 | 3,191,922 | 3,221,810 |
| Percentage of Change | | 0.9% | 0.9% |
| Medicaid Days | 7,804,235 | 7,735,896 | 7,818,934 |
| Percentage of Change | | -0.9% | 1.1% |

If the average is lower than the median, it means that most values in the data set are higher than average.

Source: CASPER data

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# Average Daily Medicaid Reimbursement Rates

**Rate Current as of December 2018 (assessment current as of 2/2018):**

- Florida* – $248.65 ($17.27) = $231.28
- Tennessee* - $210.83 ($13.00) = $197.83
- Alabama* - $200.72 ($5.92) = $194.80
- Mississippi* - $207.64 ($14.08) = $193.56
- Virginia - $189.00
- South Carolina - $183.91
- Kentucky* - $188.31 ($12.85) = $175.46
- Georgia* - $189.80 ($17.10) = $172.70
- North Carolina* - $184.18 ($13.68) = $170.50

*State has a provider assessment that would reduce the net daily rate; amount in parenthesis is assessment.

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# Daily Costs

- For the 2015 period, NC had a shortfall of $14.68 per day (Medicaid costs higher than Medicaid revenue).

Source: NCHCFA Analysis of Medicaid Cost Reports

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# Workforce Statistics - NC

**LTCTT - Staff Turnover Report**

| Metric | NC 2017 | US 2017 | NC 2016 | US 2016 | NC 2015 | US 2015 |
|---|---|---|---|---|---|---|
| Skilled Nursing Centers - All Staff Turnover | 73.40% | 65.30% | 68.70% | 57.70% | 56.90% | 51.80% |
| Skilled Nursing Centers - Direct Care Staff Turnover | 72.60% | 61.80% | 79.30% | 59.50% | 60.40% | 54.40% |
| Skilled Nursing Centers - Staff RNs Turnover | 68.20% | 61.90% | 88.50% | 62.50% | 77.80% | 61.20% |
| Skilled Nursing Centers - LPNs/LVNs Turnover | 57.30% | 48.50% | 61.70% | 47.10% | 52.50% | 41.70% |
| Skilled Nursing Centers - Certified Nursing Assistants Turnover | 78.90% | 66.90% | 84.70% | 63.40% | 59.90% | 57.40% |

**LTCTT - Staff Retention Report**

| Metric | NC 2017 | US 2017 | NC 2016 | US 2016 | NC 2015 | US 2015 |
|---|---|---|---|---|---|---|
| Skilled Nursing Centers - All Staff Retention | 75.90% | 69.80% | 55.80% | 68.50% | 75.50% | 70.00% |
| Skilled Nursing Centers - Direct Care Staff Retention | 73.40% | 66.90% | 52.70% | 66.30% | 71.60% | 67.50% |
| Skilled Nursing Centers - Staff RNs Retention | 67.50% | 63.80% | 48.90% | 66.50% | 62.00% | 65.80% |
| Skilled Nursing Centers - LPNs/LVNs Retention | 79.10% | 69.30% | 57.40% | 68.50% | 72.20% | 70.60% |
| Skilled Nursing Centers - Certified Nursing Assistants Retention | 72.70% | 66.60% | 51.50% | 65.50% | 73.30% | 66.80% |

Source: LTC TrendTracker

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# Workforce Statistics

**BLS - May 2017 National Occupational Employment and Wage Estimates**

**United States v. NC**

| Occupation code | Occupation title (click on the occupation title to view its profile) | Employment | Employment RSE relative standard error | Employment per 1,000 jobs | Median hourly wage | Mean hourly wage | Annual mean wage | Mean wage RSE relative standard error |
|---|---|---|---|---|---|---|---|---|
| US | Nursing Assistants | 1,453,670 | 0.5% | 10.198 | $13.23 | $13.72 | $28,540 | 0.2% |
| NC | Nursing Assistants | 62,820 | 1.9% | 14.614 | $11.67 | $11.87 | $24,680 | 0.6% |

Of the nearly 1.5 Million NAs, 40% worked in SNFs; 26% in Hospitals; 11% in CCRCs or ALFs; 5% in Home Care; and 4% in government. See: Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Nursing Assistants and Orderlies, on the Internet at https://www.bls.gov/ooh/healthcare/nursing-assistants.htm (visited December 17, 2018).

Source: Bureau of Labor Statistics Report

# Workforce Trends

- More employers of CNAs are increasing their minimum wages well above the average CNA wage of $11.87 per hour:
  - State of North Carolina pays its employees at least $15 per hour: https://www.journalnow.com/business/raising-n-c-minimum-wage-likely-limited-to-state-government/article_8b9c482e-94c2-52f6-9de9-a8f3038e9fa1.html
  - UNC Health Care will raise to $15 per hour: https://www.wral.com/unc-health-care-to-raise-minimum-wage-to-15-for-9-000-employees/18057396/
  - Duke Health to $15 per hour: https://today.duke.edu/2017/08/duke-move-15-minimum-wage-2019

# Workforce Projections

- In the LTSS industry, direct care workers (Nursing Assistants, Home Health Aides, Personal Care Aides and Psychiatric Assistants/Aides) comprise 71% of the workforce.
  - Continued increases in national-level demand for this industry are anticipated for these four occupations between 2015 and 2030.
- In 2015, there was a demand for approximately 2.3 million direct care workers. Based on the projected demand, by 2030 an estimated 3.4 million direct care workers will be needed to work in LTSS settings.
- Many people with LTSS needs reside in the community, and the workforce demand reflects this fact. Half (50%) of the direct care workforce demand is in home-and community-based settings, 25% of the workforce demand is in residential care facilities, and the remaining 25% is in nursing homes.
- Under an alternative scenario which takes into account possible improvements in population health, short-term demand for direct care workers in LTSS will likely decline. However, because of the increased longevity associated with these improvements in population health, changes, long-term demand for direct care workers in LTSS would increase by 7% (255,000 Full Time Equivalents).

Source: National Center for Health Workforce Analysis; Long-Term Services and Supports: Direct Care Worker Demand Projections, 2015-2030, March 2018

# Workforce Projections

**Exhibit 1: Projected FTE Demand for Direct Care Workers by Occupation, 2015-2030**

| Occupation | 2015 | 2020 | 2025 | 2030 | % Change |
|---|---|---|---|---|---|
| Direct Care Occupations | 2,318,900 | 2,604,100 | 2,974,100 | 3,430,900 | 48% |
| Nursing Assistants | 756,200 | 843,900 | 959,900 | 1,122,000 | 48% |
| Home Health Aides | 522,600 | 592,300 | 683,300 | 791,200 | 51% |
| Personal Care Aides | 1,028,300 | 1,154,700 | 1,315,600 | 1,499,400 | 46% |
| Psychiatric Aides | 11,800 | 13,200 | 15,300 | 18,300 | 55% |

**Exhibit 1: LTSS Demand for Registered Nurses by State, 2015-2030**

| | 2015 | 2020 | 2025 | 2030 | Percent Change |
|---|---|---|---|---|---|
| NC | 13,530 | 15,930 | 18,560 | 21,310 | 58% |

**Exhibit 2: LTSS Demand for Licensed Practical Nurses by State, 2015-2030**

| | 2015 | 2020 | 2025 | 2030 | Percent Change |
|---|---|---|---|---|---|
| NC | 11,060 | 13,040 | 15,230 | 17,560 | 59% |

Source: National Center for Health Workforce Analysis; Long-Term Services and Supports: Direct Care Worker Demand Projections, 2015-2030, March 2018

# Population Growth Projections

- Carolina Demography at the Carolina Population Center at UNC-Chapel Hill's analysis of US Census Bureau files shows, from 2010-2030:
  - NC's population grows from 9,535,483 to 11,558,205 (+21.2%)
  - NC's 65-84 age population grows from 1,086,618 to 2,041,739 (+87.9%)
  - NC's 85+ age population grows from 147,461 to 263,219 (+78.5%)
  - Over 50% of NC's population growth from 2010-2030 would be in the age 65 and older category
  - During this time period, the percentage of NC's population aged 65 and older will increase from 13% to 20%; and the median age in NC will increase from 37.4 to 40.4

# ATTACHMENT #3

Briefing on
NC Unlicensed personnel rules and regulations

This is to serve as a high level summary to provide an overview of current rules and regulations in NC Statutes, Administrative rules, NC Board Of Nursing, and the Division of Health Service Regulations for unlicensed personnel use in North Carolina.

**§ 131E-255 Nurse Aide Registry**
Pursuant to U.S.C § 1395i-3(e) and 42 U.S.C. § 1396r(e), the Department shall establish and maintain a registry containing the names of all nurse aides working in nursing facilities in North Carolina. Nursing facilities defined as a combination home as defined in G.S 131E-101(1) and a nursing home as defined in G.S 131 E-101(6).
1) NC Medication Aide Registry
2) NC Nurse Aide I Registry (must meet State and Federal requirements to work as a nurse aide in a nursing home)
3) NC Geriatric Registry

**§ 131E-256 Health Care Personnel Registry**
The Department shall establish and maintain an health care personnel registry containing names of all health care personnel working in health care facilities in NC who have been subject to findings of neglect, abuse, misappropriation of property of a resident or health care facility diversion of drugs, or fraud.

Prior to employment, the health care facility shall access the registry to note each incident of access in the appropriate business files.

**Role of unlicensed personnel: 21 NCAC 36.0401**
The NC BON authorized by G.S 90-171.23 (b)(1)(2)(3) is the determining authority to identify nursing care activities which may be delegated to unlicensed personnel.
All tasks to any level of nursing aide must be delegated by the Registered Nurse and supervised by the RN.

**Medication Aide**
Qualifications:

- High school diploma or GED
- Successful completion of a 24 hour Medication aide training program approved by the NCBON
- Successful completion of a state approved competency evaluation program and
- Listing on NC DHSR Medication aide registry.

Medication aide registry G.S 131 E-114.2(b) NC G.S. 131 E -270 and 10A NCAC 130.0202 Operates under the state nursing home rules and statutes. To work as a medication aide in a nursing home , a person must be listed on this registry and on the Nurse Aide I Registry. No reciprocity, endorsement, or transfer from other states allowed. Renewal every 2 years and can be obtained by qualified work experience.

December 11, 2018 V.1.0
Sandy Terrell
Division of Health Benefits
Information obtained by review of current NCAC rules, NC General Statutes and federal regulations.

Briefing on
NC Unlicensed personnel rules and regulations

Note: Listing on the NC Medicaid aide registry does not qualify a person to administer drugs in an adult care home. NC DHSR requires the completion of a test administered by DHSR, Adult Care Licensure Section.

**Nurse Aide I**
Qualifications:

- Successful completion of a Nurse Aide I training and competency evaluation
- Completion of the facility's orientation program specific to the employing facility
- Employing agency or facility assures the State that the individual is enrolled in a State approved nursing aide I training and competency evaluation program and must complete within 4 months of employment

Duties:
Personal care (ADL), general ambulation/transfer, nutrition, elimination, safety, and special procedures (Vital signs, skin preps, applying/removing EKG leads)

**Nurse Aide II**
Qualifications:

- Completion of a State approved nursing Aide II training course and competency evaluation program.
- Successful completion of the facility's orientation
- Individual is listed on the Nurse Aide I Registry with no substantiated findings of abuse, neglect, or misappropriations of property

Duties
Nurse Aide II shall perform more complex nursing skill with emphasis on sterile techniques, in elimination, oxygenations, and nutrition.

**Geriatric Aide**
Qualifications

- Must be listed as a Nurse Aide I on the NC State Registry
- Successful completion of a state -approved Geriatric Aide Training Program taught by community colleges
- Training program submits name to the Geriatric Aide Registry

**Home Health Aide**
Qualifications:

- Can either be Nurse Aide I or II (see above qualifications)

Duties:
Provide hands-on services provided by a Nurse Aide I or II (NA I or NA II) under the supervision of the RN and be provided in accordance with the federal conditions of participation (CoP) 42 CFR 484.80.
Home Health Aide services can be provided without other skilled services being ordered but require skilled nursing supervision.

# ATTACHMENT #4

Workforce Development Subcommittee Report
January 4, 2019

The group met on Monday, November 19 at the LeadingAge NC office.

Participants included Renee Batts, Amanda Borer, Sam Clark, and Bob Konrad

We segmented the work in front of us into three areas:

- Finding
- Training
- Retaining

Given the sheer scope of the work in front of us, it is the subcommittee's recommendation that we focus at this point on FINDING.

We do think that our work will overlap with the other two subgroups (i.e. Training with some of the work of the regulatory subgroup, Retaining with some of the work of the reimbursement subgroup).

At this point, we see our work concentrated in two buckets:

#1: Quantifying the need for CNAs. Included in this bucket is engaging a third party to help produce quantifiable numbers related to supply needs (now and in the future), current retention rates, and geographic factors influencing both supply and retention in different parts of the state (i.e. rural vs. urban). Our thought at this point is for us to pursue grants from foundations, associations, and others to fund this study.

#2: Pursue a CMP application relative to the Wisconsin model. While the data gathered in #1 can certainly be used in a CMP application, we already have the Wisconsin application and their website.

The subcommittee would also like to recruit 3-5 additional members for our work.