OPEN MEETING MINUTES

Name of Governmental Body: Governor's Task Force on Caregiving			Attending: Ted Behncke, Sen. Kathy Bernier, Stephanie Birmingham, Carol Bogda, Jane Bushnell, Todd Costello, Bill Crowley, Elsa Diaz Bautista, Jason Endres, Adien Igoni, Laverne Jaros, Rep. Deb Kolste, Jane Mahoney, Helen Marks Dicks, Irma Perez, Michael Pochowski, Lisa Pugh, Anne Rabin, Susan Rosa, John Sauer, Sen. Patty Schachtner, Lisa Schneider, Margie Steinhoff, Mo Thao-Lee, Rep. Chuck Wichgers; Michael Lauer Absent: Delores Sallis State Staff: Carrie Molke, DHS;Faith Russell, DHS; Lynn Gall, DHS; Andrew Evenson, DWD; Nikolai Kapustin (DHS) Guests:Guests: WisconsinEye, Mindy Ochs, Erin Fabrizius, Janet Stockhausen, Laura Nolan, Laura Rose, Sarah Barry, Kerry, Lisa Davidson, Anna Lezott, Sean Kirkby, Vicky Wedin… , MKoneke, Aaron Nelson, Monica Sundal, Kevin Coughlin, afabik (screen name), Diane Farsetta, Janet Zander, Forbes McIntosh, Tim Bireley, Lisa McComb
Date: 5/28/2020	Time Started: 10:00 am	Time Ended: 3:00 pm	
Location: Zoom video conference			Presiding Officer: Todd Costello and Lisa Pugh

Minutes

Minutes
Governor's Task Force on Caregiving
May 28, 2020

I. **OVERVIEW OF AGENDA**: Carrie Molke, Director, DHS Bureau of Aging and Disability Resources

- Primary focus of today's meeting is to take up the first set of policy proposals as selected by the Task Force co-chairs
- Update on the RFI for developing a Caregiver Registry
- Public Comments
- The meeting is being livestreamed by WisconsinEye to allow more members of the public to view the proceedings. The broadcast can also be viewed after the meeting on WisconsinEye.
- Meaning of today's poll votes by members:
  The meeting today is for the Task Force to start determining what proposals being put forth by members have enough support that they should be developed further over the course of the summer for possible inclusion in a recommendation to the Governor at the end of September. There is not time to conduct polls on all of the Task Force's proposals today – another meeting will be held in June.

- "Yes" – Member supports the concept and want it to be finalized over the summer for possible inclusion in the package of recommendations for the Governor.
- "No" – Member does not support the concept and would not want the policy included in the package of recommendations to the Governor.

Proposals being considered today are not final recommendations. If at least 19 task force members (a supermajority) approve a proposal, the concept will be further developed over the summer, incorporating comments from today as well as public input, which will be gathered following these meetings. Formal votes on a final package will be held in late August or early September, after which the final report for the Governor will be prepared. If a proposal receives fewer than 19 votes, it will be taken off the list for further consideration at this time. If the Task Force moves into a Phase II, some version of that proposal could be reconsidered.

II. PROPOSALS (https://gtfc.wisconsin.gov/content/draft-policy-proposals)

1. **Caregiver Assessment: TCare – Tailored Caregiver Assessment and Referral Proposal - (Jane Mahoney)**

   Proven to delay nursing home placement by identifying high risk caregivers who may need more support to continue in that role. Release an RFP for 2-4 consortiums made up of both Medicaid and non-Medicaid partners in rural and urban areas to pilot TCare for 1 year. Data will be collected and analyzed at the end of the pilot period. TCare is an evidence-based assessment approved by the Administration on Community Living. It is the only family caregiver assessment using an algorithm to triage services and supports to caregivers in the most need. It asks questions of the family or informal caregiver to assess their health and well-being, stress levels, challenges, skills needed to perform care, and their informal support system and strengths that enable them to provide care. The assessment identifies areas where the caregiver may need additional supports to keep them healthy and allow them to continue to provide care in the community setting, thus delaying the need for placement in a facility. The assessment is not meant to be a critique of the caregiver's ability; rather, the process itself can be therapeutic for the family caregiver as it may be the first time anyone has acknowledged the importance of their role as caregiver. A pre-screening tool is used by staff from any community agency who interacts with a family caregiver. High risk caregivers would be identified, then referred for the full TCare assessment. The full assessment would be completed by staff who will be trained and licensed to use TCare. Staff members could be ADRC staff, IRIS consultants, tribal and county aging unit staff and health care staff. New staff may be needed to oversee the pilot project. Is also a recommendation from the RAISE Family Caregiving Advisory Council.

   Question: Laverne Jaros: Is this tool for caregivers of children as well as caregivers of adults?
   Answer: What we saw didn't use it children, but there's no reason the Task Force couldn't include it recommending it for children's LTC programs as well.

Comment: Anne Rabin - Wants to make sure that the assessment is tied to respite and other services.
Responses: Jane Mahoney – TCare includes completing resource mapping before any referrals are made. It is not just an assessment for assessment sake. TCare is evidence-based and a prevention tool with a care plan that directs caregivers to the resources that will be the most helpful for them. Being assessed can be therapeutic for the caregiver because it may be the first time anyone has asked them, "How are YOU doing?"
Lisa Pugh: It is important that the Task Force be looking at all recommendations as part of a package. This proposal relates to a recommendation for ADRCs that the Task Force will be considering later, and the same is true on rate proposals for the LTC Medicaid and children supports systems.

Question: Adien Igoni - Are resources that family caregivers need right now there but not properly directly to them? Or will TCare identify what resources are lacking?
Answer: Jane Mahoney - Both. A triage of resources is part of the algorithm of TCare to direct caregivers to proper caregiver support resources instead of to a Medicaid funded facility.

Question: Michael Pochowski - Would this be a mandated assessment for a facilities or personal care agencies?
Answer: Jane Mahoney - No. This proposal would only be implemented by the pilots that agree to implement it.
Lisa Pugh: When caregiving is an expectation of a family member is when it is most likely that the TCare assessment would be done by an IRIS consultant, MCO or ADRC.

Question: Mo Thao-Lee - Is this a recommendation for a statewide use or for providers to use as a tool?
Answer: The recommendation is for a pilot in at least one rural and urban area, and to be implemented not just by a single agency but by a consortium. Anyone in the pilot site consortiums would be able to use the screener, but only trained TCare assessors can do the full assessment.

Poll Results:
Yes: 25
No: 0

2. **Legislative Change: Medical Leave Act Amendments (Helen Marks Dicks)**
Expand coverage in the Wisconsin Family Medical Leave act to include chronic conditions and caregiving responsibilities. Currently it covers serious health conditions under the care of the physician which seems to cover only acute conditions. Expan d the list of people covered to include grandparents, grandchildren, and siblings. Expand the examples of how care can be

used to include attending training and education on caregiving duties and responsibilities, discharge planning meetings, and care planning meetings. No additional state funding required for this change.

Question: Jane Bushnell -Would expansion be for all FMLA reasons or just caregiving?
Answer: Helen Marks Dicks – The proposals would apply across all categories.
Question: Jane Bushnell – Her concern about the "chronic diseases" addition is that workers do find ways to occasionally take time off or ask for intermittent FMLA. Would this change move the caregiving crisis in the wrong direction if the person is a paid caregiver who may leave their agency to provide care?
Answer: Helen Marks Dicks - The concern about abuse by employees is always a valid concern. But this change would help people who are taking care of people who aren't acutely ill but require ongoing support by allowing more people in the family to share in the support system. It would apply to all employees across all job sectors, not just the caregiving workforce.

Question: John Sauer - Caregivers working in facilities, if they have a grandparent for whom they are not primary support, would the extension of this benefit allow a caregiver who works in a facility time off to care for their grandparent if they are not the primary support person?
Answer: Helen Marks Dicks - This proposal spreads the duty and backup of caregiving a little so that there are more people available to give relief to the primary caregiver. It would also be useful to providers because the new language recognizing time needed to attend care planning meetings, which is a concern facilities. Some caregivers cannot be available to meet with providers. Remember that FMLA can be taken in small increments or large blocks of time. Right now, Wisconsin law does not require that the FLMA be paid, and this proposal does not change that. It will continue to be up to the employer to decide if an employee can use banked sick leave or vacation hours to cover the leave time.

Comment: Anne Rabin - Requested that individual with power of attorney or legal guardianship be added to the list of people who would be covered by the expanded FMLA proposal.

Poll Results:
Yes: 20
No: 5

3. **Legislative Change: WI Credit for Caring (Helen Marks Dicks)**
Create a nonrefundable individual income tax credit for qualified expenses incurred by a family caregiver to assist a qualified family member. To be qualified, a family member must be at least 18 years of age, and the person in need of care must require assistance with one or more daily living activities as certified by a physician and must be the claimant's spouse or related to the claimant. Subject to a number of limitations, a claimant may claim 50 percent of the costs of qualified expenses the claimant paid for in the year to which the claim relates. These expenses

include amounts spent to improve the claimant's primary residence to assist the family member, equipment to help the family member with daily living activities, and obtaining other goods or services to help the claimant care for the family member.
The maximum amount of credit that may be claimed each year is $1,000, or $500 if married spouses file taxes separately. If more than one claimant may file for a tax credit related to a family member, the amount of credit each may claim is based on the percentage of the family member's qualified expenses for which each claimant paid during the year. No credit may be claimed by a claimant whose Wisconsin adjusted gross income in the year to which the claim relates exceeds $75,000 if the claimant is single or is married and files separately, or $150,000 if the claimant is married and files jointly. Generally under the bill, qualified expenses may not include general food, clothing, transportation, or household repair costs, or amounts that are paid or reimbursed by an insurance company or the government. Because the credit is nonrefundable, it may be claimed only up to the amount of the claimant's tax liability.
The real value in this is that it delays placement. Estimated to cost $125 million per year. Would be a long term benefit to the state in Medicaid savings, but a big price tag in the short term.

Question: Lisa Schneider - Do we want to exclude people on IRIS from the tax credit?
Answer: Helen Marks Dicks - When bill drafters were trying to reduce the cost of this tax credit, it was geared more to people who were in the middle income groups and not already receiving other benefits. There was significant pushback to that idea. It is possible the proposal could be amended that way, but we left it including everybody in our proposal.

Poll Results:
Yes: 20
No: 5

4. **Legislative Change: The Care Act (Helen Marks Dicks)**
Legislation would ensure that a family caregiver is recorded when a loved one is admitted to the hospital. The caregiver is notified if that person is transferred to another facility or discharged back home. The facility would also have to provide an explanation and in-person/hands-on live instruction on medical tasks for caregivers. We believe it would reduce hospital readmissions, improve caregiver confidence/reduce stress, and improve the quality of care that is provided by caregivers.

Question: Helen Marks Dicks asked about getting public input on proposals beyond individuals who were invited to present to Task Force workgroups.
Answer: Carrie Molke – There will be opportunities in the future for public input.

Poll Results:
Yes: 21
No: 4

5. **Rates: Rate Band Proposal (Beth Swedeen)**
DHS should develop and implement by December 2021 a statewide rate band that: a. starts with worker wages; b. is transparent and consistent across programs and settings; c. has built-in increases based on Consumer Price Index (CPI) annually; and d. is developed with provider input from the beginning. The current "Look Back" model guarantees that services will be underfunded because it looks at what was spent instead of what services cost or what services were needed. Are not able to provide an accurate cost estimate at this time.

Comment: Jane Bushnell - Rate bands have been a great success in the LTC Children's Program. It provides the ability to give raises to workers that more adequately reflect care provided.

Question: Stephanie Birmingham - How does this proposal interface with the nursing home Medicaid reform proposal?
Answer: John Sauer - This is a separate proposal related to Family Care and some other programs but not the Medicaid fee for service programs. This one is about rates paid by Managed Care Organizations (MCOs) for the most part.

Question: Rep. Deb Kolste: Is the rate paid to MCOs or to the end provider?
Answer: Jane Bushnell - The children's program did the same type of rate band. It determined the actual reimbursement rate to the provider agency, but the band starts with looking at the worker cost and everything else that goes into what that band would be. It would be what the MCO pays to the provider agency.
Question: Rep. Deb Kolste - Will it be mandated to be paid to the end provider?
Answer: Lisa Pugh - There is still a negotiation between the MCO and end provider, but this sets a range for the rate of what is fair payment, which allows for individual variances for specialized services or considerations.

Question: John Sauer - Once the rate bands are established, is it also true that if the MCO and the provider enter negotiations it is possible in some circumstances to pay expenses in excess of the rate band if it is a unique and outlying situations?
Answer: Beth Swedeen and Jane Bushnell - Yes

Poll Results:
Yes: 25
No: 0

6. **Regulation & Compliance: DHS COVID-19 Statewide Health Emergency Guidelines (Mo Thao-Lee)**
Personal care agencies are facing many challenges, including an unprecedented workforce crisis

that is jeopardizing the health, safety and independence of older adults and people with disabilities. Over the past decade, we have become increasingly concerned about the stability of our community-based direct care provider network. More than 80 personal care agencies have closed or stopped providing Medicaid Personal Care in the past 6 years, and 24 Wisconsin counties have 5 or fewer personal care providers. Ongoing regulatory flexibility is needed to ensure the ongoing provision of critical in-home services while blunting the spread of COVID-19. Direct care providers have been taking steps throughout the COVID-19 outbreak to protect our workers, clients, and community members. Personal care agencies are facing a serious challenge to prevent the spread of disease while continuing to provide in-home long-term care services. We are asking our personal care workers to put themselves at risk by entering clients' homes during this public health emergency. They are truly on the frontlines of this pandemic as best practice is for individuals who do not require hospitalization to self-quarantine at home. The Wisconsin Department of Health Services (DHS) estimates that 17% of COVID-19 patients have required hospitalization. This means that more than three-quarters of patients have remained in their homes while ill. According to an April 2020 WI Personal Services Association (WPSA) Survey, 43% of agencies that responded have provided care to someone who was exposed to COVID-19. Hospitals and other medical providers across the state have reached out to personal care agencies about ways to use our in-home services to support COVID-19 patients. The proposal includes the following elements, which are intended to provide Medicaid Providers with clarity regarding regulatory changes that have been made during the COVID-19 public health emergency :

- Prevent DHS OIG From Conducting Audits and Recoupments During the Public Health Emergency.
- In addition, action should be taken to prohibit DHS OIG from including the public health emergency time frame in any future audit lookbacks.
- DHS should provide an official, comprehensive guidance document that includes a list of all temporary regulatory flexibility granted to community-based providers during the COVID-19 public health emergency.

Cost: there would not be a cost to the State of Wisconsin.

Question: Lisa Pugh - Are you saying there would be a prohibition of OIG and DQA recoupment during the COVID time, no matter what it was? This needs clarification in the proposal.
Answer: Adien Igoni: It is saying that the State responded very quickly and issued a variety of regulatory expectations related to COVID-19 very quickly. Given the emergency state, we would like a clear list of what these regulations are and in order for us to carry out the governor's mandate during a time when our employees had to put themselves in harm's way to provide this care, and that OIG should not pursue any recoupments during this emergency period. We are considered an essential part of meeting this emergency mandate, and it came at a considerable cost. No, this proposal is not asking for a free pass on fraud. Providers must be within the regulatory confines. What we are saying is that DHS and providers both responded quickly, which put demands on providers to meet those exceptions. Audits need to keep this in

mind - that messages were not always relayed as quickly to agencies as they needed to be able to adequately respond to them.

Question: Rep. Deb Kolste: Is this topic really in the preview of the Task Force?
Answer: Adien Igoni - We want to have a robust provider network. In order to do this, we need to address the low reimbursement rate and regulation by OIG. More so than any other industry out there, the home-based community provider network adapting to the COVID emergency meant they needed to take on new regulations and changes very quickly in a heavily regulated industry. It has been a difficult time for providers in this industry. They don't want auditors looking back and not remember that there were special circumstances during this period of time. It is not our intent to not deal with fraud.

Question: Stephanie Birmingham - Are you looking for a compilation of Forward Health to all be put together in one area?
Answer: Adien Igoni - Yes, we are requesting a list of regulatory changes issued during this time of emergency, and for it to be an official document from DHS so it will be legally binding. We understand that the speed at which these regulatory prescriptions were put out, not all agencies could have gotten hold of them at once. We are asking that when audits happen, that these circumstances have to be put into consideration. There needs to be a condition period allowing providers to deal with changes during COVID-19 pandemic, and also as we transform back to "normal."

Comment: Mo Thao-Lee – We were allowed to do virtual supervision and other cares, and we want to make sure that this is understood when all is said and done. And to know these allowances are recognized if we didn't follow provider certification rules as shown in Wisconsin Administrative Code Chapter 105. A guideline to go back to if by chance this type of emergency happens again.

Comment: Jane Bushnell - Suggested putting the dates in the document so an agency could pull it out during an audit.

Carrie Molke suggested this proposal could be discussed with DHS before sending something to governor, and Lisa Pugh explained that the membership will be voting on the original proposal before them today. Based on the results, it could be put back on a future agenda, if needed.

Poll Results:
Yes: 16
No: 7 (Does not move forward)

7. **Regulation & Compliance: DHS COVID-19 State-Wide Health Emergency Guidelines: Community-Based Residential Facilities Hiring (Mike Pochowski)**

On April 3, 2020 Governor Evers issued Emergency Order #21 which in part, suspended Wis. Admin. Code 83.16(2). This regulation requires resident care staff to be 18 years old. Under the order, "Resident care staff may be 16 and 17 years of age so long as they meet Wis. Admin. Code ch. DHS 83 training requirements, do not work alone, do not pass medications, and work under supervision." Wis. Admin. Code 83.16(2) is no longer suspended as of May 11, 2020. Many community-based residential facilities (CBRF) appreciated the flexibility to hire caregivers that were 16 and 17 years old given the caregiver crisis intensified during the COVID-19 pandemic. We are working to obtain data from CBRFs and the Department of Health Services/Bureau of Assisted Living to determine the pros and cons of the effectiveness of this regulatory flexibility. We would appreciate it if the Task Force would continue to entertain this regulatory proposal as we obtain more information. The Task Force would like to talk to the Bureau of Assisted Living to see how this went during this time because some facilities found this change useful to recruiting staff.

Question: Stephanie Birmingham – Is an explanation of expected supervisory oversight and liability for this age group included in this proposal?
Answer: Mike Pochowski – No. But training oversight and supervision would be needed. Workgroup is open to doing that but they did not have experts in that area to make recommendations. It makes sense that we could add that.

Question: Beth Swedeen - Could this be for IRIS, children's LTCS and community based programs as well? It makes sense for the children's program in particular to have a caregivers who is more of a peer.

Question: Rep. Deb Kolste: People interested in becoming CNAs are able take training through high schools. Is that what you're talking about? Someone working toward a CNA, or anyone? Do they need to have certain kinds of trainings?
Answer: Mike Pochowski – It would put in regulations that a 16 or 17 year old could work as a caregiver regardless if they are going toward a CNA license.

Comments:

- Jane Bushnell agreed with Beth that the proposal as written is too narrow because it only applies to CBRFs. However, the Task Force could move it forward knowing that it can be changed to be more inclusive of other programs if that means the difference between it going forward or being put aside until Phase II.
- Stephanie would be opposed as it currently stands solely focused on CBRFs.
- John Sauer is in favor, with the idea it could be broadened in the next few meetings.
- Lisa Pugh – There were some flexibilities due to COVID that allowed family members who couldn't previously be able to be paid. Perhaps that could be worked into it. Lisa suggested contacting Deb Rathermel at DHS to see what has been done.

- Mike Pochowski is open to including other categories but he doesn't know what those categories are or who to contact to find out. He asked for others to help modify the proposal so it can move forward.
- Adien Igoni - If the proposal were extended into other settings, what would the supervision requirement look like for a family home, for example? This is where there could be problems with expanding the settings.
- Carrie Molke - Those details would have to be developed.
- Mo Thao-Lee expressed concern that this age group may not be capable of dealing the complex health issues that some agencies have.
- Sen. Kathleen Bernier – Is this proposal in line with building the workforce that we are trying to achieve?

Poll Results:
Yes: 16
No: 9 (does not move forward)

8. **Statewide Caregiver Training: Statewide Direct Support Professional Training (Stephanie Birmingham)**

Develop a statewide best practice standard for training direct support professionals. The recommendation is to pilot a program that would include:

- A person-centered direct support professional training guide.
- A training guide allowing providers the flexibility to apply criteria to their existing training while meeting the needs of clients in both community- and facility-based settings.
- Alignment with regulations and statutes for different worker categories.
- A portable certificate for Direct Support Professionals with the option to upload to a registry.
- A three-tiered career ladder leading to CNA (Tier 3) by successfully completing Tier 1 and Tier 2 requirements and obtaining potential credit for prior learning and/or work experience.
- A web-based or e-learning training option. (Explore opportunities to incorporate WisCaregiver Career Program technology to support web-based access and testing capability).
- Communication with job centers to ensure they are aware of the Direct Support Professional certificate and career ladder.

Question: Jason Endres – How will this affect people who are on IRIS, the self-directed program? The training that most people working in IRIS is done by the individuals who hire them, and there really is no incentive for an IRIS worker to be educated any more.
Answers: Stephanie Birmingham - We do have, at least for provider agencies, some built-in cost incentives for providers who have gone through this proposed training in way of higher

reimbursement rates. We can look at IRIS, too.
Todd Costello – This proposal will support the IRIS ladder and support the professionalization of the workforce as a whole so IRIS caregivers can work in other settings and obtain CNA certification as well.
Lisa Pugh: This proposal goes back to the rate band discussion in that a person who has gone through this training would be paid a higher rate.

Carrie Molke: The DHS Division of Quality Assurance (DQA) has some concerns that federal regulations for CNAs may not allow credit for previous work experience. If this proposal moves forward, the Task Force may want to meet with DQA to discuss options for moving this forward as a viable proposal.

Question: Sen. Patty Schachtner: Is this a bridge to become a CNA, or is it saying that you can be less than a CNA and stay at that level? She is afraid it could be setting up a lower paid job force.
Answer: Stephanie Birmingham - It's up to the person. If they don't want to work toward becoming a CNA they don't have to. But it is an opportunity for those who do. And the person hiring workers can be assured that a person at a certain tier will have certain skills.

Question: Jane Bushnell - DHS would certify standardized curricula – Explain that? Concerned it could become so over-prescriptive that it could be a barrier to hiring caregivers.
Answer: Stephanie Birmingham – There are a lot of agencies that already have great training programs. This would enhance that by offering additional training that they may not have to offer. This proposal doesn't dictate who provides the training.

Comment: Lisa Schneider asked to be invited to the next meeting of this sub-group because it ties into some of the training the Respite Care Association of Wisconsin is working on. She feels that some things do need to be prescriptive. There is a chance to improve quality.

Question: Adien Igoni - We have a caregiver crisis in this state. I don't think it's because we're not training enough. It's because we don't pay enough for the most part. Training is already overseen by regulatory agencies that tell us if they think our training is good for the industry. Is there some redundancy to this proposal, or changes we should make to fix the problem at hand?
Answer: Mo Thao-Lee – Right now, all the different agencies, IRIS, personal care, family caregiver, home health care all have their own training. The idea behind this proposal is to identify what basic education and skills to train on so that you can have confidence that the person assigned to care for a particular person has the right skills.

Comment: Anne Rabin - Within IRIS, there is nurse delegated task training provided to IRIS participants.

Question: Elsa Diaz-Bautista - Do we have enough training, or are we hearing from people receiving care that they don't feel there is adequate training to receive the care they need?
Answers: Stephanie Birmingham - As someone who receives care under supportive home care, she finds that the training is quite lacking. The Task Force is the cream of the crop, and the agencies represented here are unique. But the agencies represented here are just the small portion of those that are doing training right. Unfortunately, she thinks there are a lot more agencies that aren't doing it as well, which is why training expectations need to be clear and robust.
Lisa Pugh - This is part of the professionalization of the caregiving workforce, being recognized as a direct support professional, and as someone who needs a way to increase their skills and improve their wage over time.
Todd Costello – Training also helps recruit individuals to the workforce by providing a career path they can follow.

Poll Results:
Yes: 21
No: 6

9. Rates: Medical Loss Ratio (MLR) (Lisa Pugh)

Include in the Family Care contract (Family Care, Family Care Partnership, PACE) a requirement for an 85% medical loss ratio. Direct that care management service expenses cannot be included in the service cost component of the calculation. Provides transparency to the capitated rate paid to how much goes to admin costs, claims cost, MCO profits and what is intended to be direct services to participants.

Question: Rep. Kolste - How does this proposal address the Task Force charges?
Answers: Lisa Pugh - The last time that the actuaries sat down to set rates for this year there was a directive to increase rates by 1%, recognizing the increasing costs of labor. But there was no requirement that the increase be passed down to providers, and many said they didn't see those rate increases to help them to increase worker pay.
John Sauer – Under this proposal, the overhead of the MCO can only be 15%. And 85% should go to the agency that is providing the care. This is the industry standard. Let's get the money to the people who are actually providing the care, which will be an opportunity to improve wages. Case management would no longer be considered a service, but part of administration.

Comment: Laverne Jaros - A lot of care managers would argue that they spend a lot of time doing administration instead of providing services. What I don't want to see happen is that they end up doing more because of this.

Question: Mo Thao-Lee - Are you proposing that, for example, some HMO Medicaid fee for services would be affected?
Answer: Lisa Pugh - No, this would only apply to Medicaid LTC programs, not fee for service.

Poll Results:
Yes: 24
No: 3

10. Recognition and Recruitment of Direct Support Professionals (Laverne Jaros)

There is evidence that targeted marketing campaigns can be effective tools to increase recognition and recruitment of direct support professionals. It is proposed that resources be allocated for the Wisconsin Department of Health Services to oversee a statewide marketing campaign, the development and dissemination of a marketing toolkit for local use, and grants for local pilots. The goals of these initiatives are to increase community awareness about the value of direct support professionals and activate individuals to apply for positions, including:

- Statewide Campaign - The WisCaregiver Career Marketing and Recruitment Campaign should be continued and adapted to include direct support professionals across the spectrum of long-term care. This would include the modification of, or addition to, the existing campaign's website, videos, posters, and brochures.
- Marketing Toolkit for Implementation by Local or Regional Organizations. There are many recognition and recruitment tools in existence, some of which are available for replication or modification.
- Local Pilots - Grants of $25,000 each should be made available to 4 local provider consortia or organizations to promote careers in long term support through social media.

Question: Stephanie Birmingham - Does it make a difference to use the terminology of "caregiver" or "direct support professional" with regard to WisCaregiver Career program?

Question: Lisa Pugh - Who is anticipated to be in charge of this? DHS? How much staff time would this require? Or is it meant to be a contacted out project?
Answer: Laverne Jaros – The sub-group is still trying to figure that out. It could be either. She discussed that question with Leading Age Minnesota re their project, but they may have underestimated how much time they spent on it. The group still needs to estimate how much time would be needed, if current staff are available, or if more staff would need to be hired.

Comment re chat: Kevin Coughlin - DHS owns a lot of videos from the WisCaregiver Career Program that could be leveraged for this project as well.

Question: Lisa Pugh - Is there science behind the $25,000 recommendation?
Answer: Laverne Jaros – The $25,000 figure was based on two counties having a social media marketing specialist and ads placed in Minnesota.

Poll Results:
Yes 19
No 8

Additional proposals to be considered at the June 11 Task Force Meeting

1. Background Check Policies
2. Rates: Nursing Home and Personal Care Payment Reform
3. ADRC Reinvestment/Caregiver Support
4. Rates: Direct Care Worker Fund
5. Regulation & Compliance: Regulatory proposals for pre- and post-COVID-19

III. CAREGIVER REGISTRY (Lisa Schneider)

The Registry sub-group worked with the DHS procurement office to develop and publish and Request For Information (RFI). Deadline for submissions was Tuesday the 26th and four responses were received. The ad hoc workgroup will develop a more thorough recommendation for the June meeting.

IV. WRAP UP AND NEXT STEPS

- Helen Marks Dicks would like to go back to original charges of the Task Force at the June meeting to make sure that nothing was dropped or that other things have become more relevant since then. DHS staff will update the crosswalk of proposals and the Governor's charge to the Task Force for the June meeting.

- A public input process will be held after the June meeting. Plan to do some webinars discussing the recommendations and asking for feedback in some manner.
    - Co-Chairs will reconvene the full Task Force at the end of August to finalize the proposals and discuss how public input might impact final recommendations.
    - For the webinars, it would be good to designate a scope for discussion.
    - In addition to the normal public meeting procedure, make special contact with the 300 people who applied to be on the Governor's Task Force because we know they are interested in the topic.
    - A date will be set for final revisions to proposals.
    - A number of ways will be established to contact interested partners who may want to solicit public input. Determine how many public forums are needed, and how to make it useful for the most to participate. It's hard to have a listening session with 500 individuals. One idea is to ask people to identify what issues they want to speak to before the session and work out the technology.
    - Need two or more of these public forums. Limit comments to 5 minutes.

- People can always send comments by email on the GTFC website.
- Co-chairs will work with DHS to come up with a plan for soliciting public input.
- Hope to have final Task Force vote and send recommendations to the Governor in September.
- Proposals that didn't pass will be set aside for now.
- Those who voted no on a proposal that passed, share with that sub-committees what changes could be made to make the proposal stronger and win your vote if there is a Phase II.
- Incorporate DHS feedback re proposals to make sure there aren't conflicting federal regulations or other unknown issues of concern.

V. PUBLIC COMMENT

- Jolene Faust, Home Care Association of America re the Caregiver Registry: It is very difficult when you have individuals signing up for a registry, especially one that is an Angie's List type of registry. There is such a large turnover in this industry, and families get frustrated trying to find someone who is still available because registries get outdated so fast. Costs associated with liability insurance and bonding and other things are also barriers.
- Mindy Oches: With Home Instead Senior Care in Janesville and the legislative chair for Wisconsin chapter of the Home Care Association. Any registry must emphasize privacy. See potential for harm if privacy of caregivers is not protected. They don't share even last names because some family members put undue pressure on caregivers, and there are domestic abuse victims who don't want to be found. She noted that the RFI issued asked for a way for agencies to list all employees. Doing this would produce more problems for them rather than be helpful as an agency. There are things agencies don't share with a person in need of care. She is ok with listing an agency name, but not staff names. Concerns over privacy violations could keep interested people from joining the care workforce/agency. (Also submitted a formal letter to the Task Force via the website.)
- Janet Stockhausen: A family member who has been listening in. Thanked the Task Force for their continued hard work!
- Anna Lazott: Owner of Right At Home Care and Assistance in the Madison area, and Home Care Association of America Board President. Hired caregivers and clients she represents are of vital importance to her. I care about my community and the people we serve and have some concerns about:

  1. Caregiver Registry: First priority needs to be making sure that it's up to date. If you compile this with people whose name, address, or willingness to serve clients is continually changing, it can cause burnout and frustration among families trying to hire someone. People are going to assume that the list of providers is approved by the State of Wisconsin with proper licensing and background checks. Those people have to be vetted out because a lot of people will follow "blindly" if a state entity is providing this information. We are dealing with an at-risk population who are already being taken advantage of by a lot of scammers. Any registry must be meaningful, useful, and provide info that keeps our family, friends, and neighbors safe.

2. Training proposal: Seems to be lack of clarity and redundancy. We are required to do training and have a training curriculum, as other facilities do. How would the state go about approving the content and keeping it up to date … and checking how it interacts with what we're already doing? I'd like to hear more about that. Keep up the good work!

- Erin Fabrizius: Wisconsin Personal Services Association – WPSA submitted a document with comments early in the process related to privacy concerns. (Stored on member SharePoint site)
- Aaron Nelson, Home Helpers Homecare in Southeast WI and the Fox Valley area. Requested an updated list of task force members. Also, is concerned about the missing voice of private duty/privately contracted caregiver representation on the Task Force. Sustainable employment is important, and for people working blocks of four hours and/or 1 hour, at a time isn't going to solve the problem. Need a robust sustainable solution.
- Tim Bierley: Runs a home care agency in the Milwaukee area: Home Health Workers of Greater Milwaukee. If you put together a registry, there are many things you have to keep track of – are the people listed current on their flu shots and TB tests? Data needs to be managed. Do they have reliable transportation and car insurance, and who is going to be checking on it? What about workers compensation? Once you put out a registry and it has the endorsement of the government, who is going to do the field supervision of making sure these individuals are going to their assignments on time and following the care plan for an individual? And who do they contact if things go badly? Childcare and transportation are the biggest needs workers have in order to reach their care assignments. It's a more complicated business than you might image. It's not just about the caregiver. It's about the family and the importance of the relationship there.

VI. Adjourned at 3:00 p.m.

Prepared by: Lynn Gall, DHS Office on Aging on 6/1/2020.

These minutes are in draft form. They will be presented for approval by the governmental body on: 6/11/2020