HCAW Board Packet

June 16th, 2022

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HCAW June 2022 Board Meeting Agenda

Our Vision: We are inspired to position homecare services as a leader in healthcare in Washington State.

Date: 6/16		**Time:** 10:00 p.m.-11:00 a.m.	**Location:** GoToMeeting	
TIME	**TOPIC**	**DISCUSSION**	**ACTION PLAN**	**RESPONSIBLE**
10:00 a.m.	Call to Order	Welcome/Updates • Consent Agenda: May 2022 Minutes	Acceptance	Rachel / All
10:05 a.m.	Financial Reports	• May Financials: Update and Acceptance • Baird Account – Signer Approval Request • 2022-2023 Budget Planning	Acceptance Vote Review & Discussion	Brent / All
10:15 a.m.	Committee Reports	• Education & Annual Meeting Committee ○ Annual Conference Program Summary • Membership Committee • QAPI Committee	Discussion	Deb / Carissa Jason / Kelly Amber / Deb / Donna
10:35 a.m.	Legislative Updates	• Public Policy Report	Review and Questions	Leslie
10:50 a.m.	Clinical Updates	• Clinical Director Report	Review and Questions	Donna
10:55 a.m.	Strategic Plan	Review open items from strategic planning	Review and Discussion	All
11:00 a.m.	Adjourn/Action Items	*Our Mission: To promote the long-term growth and sustainability of in-home services in Washington State. HCAW provides leadership for consumers by unifying in-home services providers through public outreach, education, legislative advocacy and supporting practice standards.*		

Board Meeting Teleconference Minutes
Thursday, May 19, 2022

10:00 am-11:00 m

Our Vision: We are inspired to position homecare services as a leader in healthcare in Washington State.

ATTENDANCE

Board: Officers: President-Elect/Treasurer; **Brent Korte**, Secretary; Sheena Paylor Directors: Jason Darling, Lisa Shaw, Kelly Panijag, Shelly McDiarmid, Geoff Meinken, Amber Hahn-Keenan, Deb Strom

Staff: Leslie Emerick, Public Policy Director, Clinical Director: Donna Goodwin, Carissa Linnane, Executive Director

Not in Attendance: President; Rachel Manchester, Directors: Melinda Moore, Imee Nebres, Gina Anderson.

Meeting called to order at 10:04 am

CALL TO ORDER

Consent Agenda: April 2022 Minutes accepted

FINANCE REPORTS

Financial Reports:
Brent K. reviewed the financial summary as provided in the board packet. Preliminary review of conference financials including the PAC donations. **Motion to approve April financials accepted.**

EDUCATION & ANNUAL MEETING

Review of the 2022 HCAW Conference feedback. Attendees expressed the desire for better food and a better location. The board discussed Targeting later in the year for the 2023 Spring Annual Meeting.

Brent challenged the board to commit to attending the meeting. This is not just a venue change; 2023 will be a rebirth of this program. Because of COVID the culture is changing, and we need to strongly consider this when planning. When selecting our meeting date, the committee was asked to look at other offerings throughout the state and avoid conflicts.

MEMEBRSHIP

Review of the membership repot included in our packet. The committee recently met to discuss our membership application and due's structure. We looked a few other states and are working to condense the fee schedule. We have also produced an introductory fee for new agencies. We will be surveying our members to ensure they are paying the appropriate rate in 2023.

It was shared that the NAHC due's structure was revised recently due to the agency consolidation that has been taking place in the industry. Brent K. agreed to assist in this effort and share what he learned from participating in these discussions at the national level. The committee welcomes everyone to participate in the re-working of our application and due's structure.

PUBLIC POLICY REPORT

Complete report in board packet. Leslie advised that all PAC candidate contributions will be allocated by June. Heather Navarre is working with the PDN agencies to see if she can raise funds. We encourage everyone to contribute to our PAC.

Review of the budget bill and the decision packages for the next legislative session. The decision package is what the agency puts forward in session.

Outstanding issues from the legislative session – amendment that requests the DOH conduct a voluntarily survey to inform consideration of a Home Care Assessment. The purpose of this amendment is to draw down more federal funds to the state.

The Palliative Care topic is bigger than rulemaking. A lot of time is being spent developing a model to pay for this program. Stakeholder meetings will be held soon, and we will continue to keep you informed.

Leslie requested a formal motion to setup a QAPI Committee dedicated to improving our numbers and ranking in the WA state. Purpose: address areas where we can improve the metrics brought to light in our CON meetings. **Motion by Deb S. to create a Quality assurance Committee that report to the board at the same level as the education and membership committee approved. Amber H. and Deb S. will collaborate with Donna G. to develop a charter. Amber H. and Deb S. to setup a preliminary meeting to plan next steps.**

Leslie is working with PDN and Seattle Children's on how to get kids out of the hospital and back home.

CLINICAL DIRECTOR REPORT

Sima Rattler with CoImagine in New Mexico contacted us to ask if we would provide resources or an online seminar on Home Health VPB. The board need some additional context before deciding to commit organization resources to this effort.

Meeting Adjourned at 11:00am

ACTION ITEMS

All:

- Donate to the HCAW PAC and encourage others to do the same

Membership Committee:

- Continue work to update due's structure and member application

QAPI Committee:

- Deb & Amber - Setup a preliminary meeting to develop a charter

AME Committee:

- Identify the date and location of our 2023 Annual Spring Conference

Financial Report Notes - Brent Korte, Treasurer & Carissa Linnane, Executive Director Prepared June 9, 2022

- **Operational Health Snapshot**
  - YTD our income is at a net deficit of ($6,830). We are forecasted to meet miss our budget net income target for FY 21-22 due to the postponement of the OASIS Workshop training until July 2022.
  - PAC Income up to $4,320.

- **Balance Sheet**
  - Current Assets:
    - Columbia Checking: Balance $145,672, up $23,048 from the previous YTD.
    - Columbia Money Market/Savings: $ 65,691; about 1% growth from previous YTD.
    - Total Baird Investment Assets total: $152,523; account have seen a loss of ($2,482) from April 2022 but are still up by $26,060 from the previous YTD.
    - Prepaid Workshop and other prepaid expenses booked as expected; All 21-22 Member dues income has been booked as earned.
  - Accounts Receivables:
    - Outstanding Invoices: $17,426; Unpaid dues
- **P&L to Budget:**
  - INCOME:
    - PAC: YTD Donations Income $4,320.
    - Dues: Monthly deferred dues entries updated and booked based on 2022 member dues received.
    - Workshops & Seminars: – No changes from previous month.
    - Annual Conference:
      - Sponsorship & Exhibitors: Achieved 384% above our budget goal with a total of $11,531 raised.
      - Registration income: $27,559, 68% of our budget target.
  - EXPENSES:
    - All is ordinary through admin, advocacy, member retention, and organizational expenses
    - Workshops & Seminars: Technology: deferred expense entry RCTCLearn $1,800 YTD ($360 Monthly). A/V cost incurred for Zoom annual subscription and Webinar add on.
    - Annual Conference: See below.

2022 Annual Spring Conference Financial Breakdown

Income:
Registration $27,889
Sponsorship $11,531

Expenses:
Venue $24,282

- Room Block Attrition $4,600
- F&B + Room Rental $19,682

Audio Visual $7,763
Speaker: $7,135
Syllabus: $1,126

Net Income: ($887)

2022 OASIS Answers Workshop Financial Breakdown

Due to the postponement of the June OASIS Blueprint Workshop, we will see a projected financial loss of $15,680.

Projected Income: ($20,000)

Expenses: $4,320

Projected loss: ($15,680)

Home Care Association of Washington
Balance Sheet Prev Year Comparison
As of May 31, 2022

	Apr 30, 22	May 31, 22	May 31, 21	$ Change	% Change
ASSETS					
Current Assets					
Checking/Savings					
Baird Cash and Equivalents	38,450.71	38,626.53	33,970.00	4,656.53	13.71%
Bairds Investment Assets	116,379.76	113,897.14	92,493.21	21,403.93	23.14%
Columbia Checking 0944	157,534.68	145,672.65	122,623.95	23,048.70	18.8%
Columbia Money Mkt #0936	65,697.12	65,697.68	65,691.10	6.58	0.01%
PAC - Columbia #0951	2,037.54	4,320.14	579.81	3,740.33	645.1%
Paypal	0.00	0.00	0.00	0.00	0.0%
Total Checking/Savings	380,099.81	368,214.14	315,358.07	52,856.07	16.76%
Accounts Receivable					
Accounts Receivable	24,791.75	17,426.75	7,059.50	10,367.25	146.86%
Total Accounts Receivable	24,791.75	17,426.75	7,059.50	10,367.25	146.86%
Other Current Assets					
Prepaid Annual Meeting Expenses	750.00	750.00	750.00	0.00	0.0%
Prepaid Expenses	6,867.50	6,676.25	8,025.00	-1,348.75	-16.81%
Prepaid Insurance	1,416.28	1,285.86	1,548.32	-262.46	-16.95%
Prepaid Workshop Expenses	14,680.00	16,320.00	14,680.00	1,640.00	11.17%
Undeposited Funds	285.00	0.00	8,535.50	-8,535.50	-100.0%
Total Other Current Assets	23,998.78	25,032.11	33,538.82	-8,506.71	-25.36%
Total Current Assets	428,890.34	410,673.00	355,956.39	54,716.61	15.37%
TOTAL ASSETS	428,890.34	410,673.00	355,956.39	54,716.61	15.37%
LIABILITIES & EQUITY					
Liabilities					
Current Liabilities					
Accounts Payable					
Accounts Payable	2,151.60	22.70	377.62	-354.92	-93.99%
Total Accounts Payable	2,151.60	22.70	377.62	-354.92	-93.99%
Other Current Liabilities					
Deferred Dues					
Affiliate Dues	2,583.01	1,953.88	1,764.36	189.52	10.74%
Provider Dues	138,336.20	118,570.84	93,055.25	25,515.59	27.42%
Total Deferred Dues	140,919.21	120,524.72	94,819.61	25,705.11	27.11%
Deferred Workshop Income	-35,086.70	-35,086.70	-35,086.70	0.00	0.0%
Payable to HCAW PAC	0.00	0.00	-8,900.00	8,900.00	100.0%
Total Other Current Liabilities	105,832.51	85,438.02	50,832.91	34,605.11	68.08%
Total Current Liabilities	107,984.11	85,460.72	51,210.53	34,250.19	66.88%
Total Liabilities	107,984.11	85,460.72	51,210.53	34,250.19	66.88%
Equity					
Retained Earnings	94,498.77	94,498.77	-7,025.79	101,524.56	1,445.03%
Unrestricted Net Assets	237,544.50	237,544.50	237,544.50	0.00	0.0%
Net Income	-11,137.04	-6,830.99	74,227.15	-81,058.14	-109.2%
Total Equity	320,906.23	325,212.28	304,745.86	20,466.42	6.72%
TOTAL LIABILITIES & EQUITY	428,890.34	410,673.00	355,956.39	54,716.61	15.37%

Home Care Association of Washington
Profit & Loss Budget vs. Actual
July 2021 through May 2022

	May 22	Jul '21 - May 22	Budget	% of Budget
Ordinary Income/Expense				
Income				
PAC Contributions	850.00	3,834.00	0.00	N/A
MEMBERSHIP				
Affiliate Dues	104.13	3,432.95	3,200.00	107.28%
Provider Dues	15,525.36	175,035.10	180,000.00	97.24%
Total MEMBERSHIP	15,629.49	178,468.05	183,200.00	97.42%
OPERATING				
Job Target/Career Board	0.00	238.50	1,300.00	18.35%
Total OPERATING	0.00	238.50	1,300.00	18.35%
PROGRAMMING				
Annual Meeting/Conv - Spring				
Sponsorships/Endorsements/Rebat	0.00	11,531.00	3,000.00	384.37%
Annual Meeting/Conv - Spring - Other	11,271.75	27,889.40	41,000.00	68.02%
Total Annual Meeting/Conv - Spring	11,271.75	39,420.40	44,000.00	89.59%
Conf Trade Show Booth	0.00	0.00	3,000.00	0.0%
OCS OASIS Partnership	0.00	164.90	1,500.00	10.99%
Workshops/Seminars	0.00	1,177.10	21,250.00	5.54%
Total PROGRAMMING	11,271.75	40,762.40	69,750.00	58.44%
Total Income	27,751.24	223,302.95	254,250.00	87.83%
Gross Profit	27,751.24	223,302.95	254,250.00	87.83%
Expense				
PAC Expenses	31.14	293.52	0.00	N/A
ADMINISTRATIVE				
Professional Fees				
Tax Return Prep	0.00	3,328.25	3,330.00	99.95%
Total Professional Fees	0.00	3,328.25	3,330.00	99.95%
Bank / Merchant Fees	717.14	2,869.96	2,900.00	98.96%
Business License	0.00	0.00	10.00	0.0%
Insurance	130.42	2,050.04	2,300.00	89.13%
Management	6,900.00	75,900.00	82,800.00	91.67%
Office Supplies	30.17	276.00	300.00	92.0%
Postage	1.00	111.50	350.00	31.86%
Printing/Copies	0.00	384.23	400.00	96.06%
Publications/Subscriptions	38.88	671.75	1,500.00	44.78%
Telephone	30.42	304.38	500.00	60.88%
Total ADMINISTRATIVE	7,848.03	85,896.11	94,390.00	91.0%
ADVOCACY				
Lobbyist Expenses	150.00	150.00	1,750.00	8.57%
Lobbyist/Legislative Consultant	4,000.00	47,700.00	44,400.00	107.43%
Policy & Advocacy	128.75	11,518.75	11,500.00	100.16%
Total ADVOCACY	4,278.75	59,368.75	57,650.00	102.98%
COMMUNICATIONS				
Website- Reg & Maint	22.86	3,152.86	2,400.00	131.37%

Home Care Association of Washington
Profit & Loss Budget vs. Actual
July 2021 through May 2022

	May 22	Jul '21 - May 22	Budget	% of Budget
Total COMMUNICATIONS	22.86	3,152.86	2,400.00	131.37%
LEADERSHIP				
Board Meetings	0.00	270.55	1,750.00	15.46%
Strategic Planning	0.00	650.00	1,500.00	43.33%
Total LEADERSHIP	0.00	920.55	3,250.00	28.33%
MEMBERSHIP SERVICE/RETENTION				
Clinical Director	2,500.00	27,500.00	30,000.00	91.67%
Clinical Director Expenses	0.00	0.00	500.00	0.0%
NAHC Dues/Other Memberships	62.50	750.00	1,500.00	50.0%
Public Relations/ Awards	0.00	62.67	250.00	25.07%
Total MEMBERSHIP SERVICE/RETENTION	2,562.50	28,312.67	32,250.00	87.79%
PROGRAMS				
Annual Mtg/Convention Spring				
A/V - Technology	0.00	7,763.72	8,300.00	93.54%
Food and Beverage	4,825.70	24,282.68	18,500.00	131.26%
Speaker	0.00	7,135.38	9,000.00	79.28%
Syllabus	1,125.97	1,125.97	2,500.00	45.04%
Total Annual Mtg/Convention Spring	5,951.67	40,307.75	38,300.00	105.24%
Workshops/Seminar Expense				
A/V-Technology	445.33	4,846.17	3,250.00	149.11%
Food and Beverage	0.00	0.00	2,000.00	0.0%
Lodging & Transportation	0.00	0.00	1,500.00	0.0%
Other Workshops/Seminar Expense	0.00	125.00	2,000.00	6.25%
Speaker	0.00	1,500.00	10,000.00	15.0%
Syllabus Copies	0.00	0.00	2,500.00	0.0%
Total Workshops/Seminar Expense	445.33	6,471.17	21,250.00	30.45%
Total PROGRAMS	6,397.00	46,778.92	59,550.00	78.55%
Total Expense	21,140.28	224,723.38	249,490.00	90.07%
Net Ordinary Income	6,610.96	-1,420.43	4,760.00	-29.84%
Other Income/Expense				
Other Income				
Interest & Dividends	177.71	2,919.42	750.00	389.26%
Gain/Loss on Investments	-2,482.62	-8,329.98	0.00	N/A
Total Other Income	-2,304.91	-5,410.56	750.00	-721.41%
Net Other Income	-2,304.91	-5,410.56	750.00	-721.41%
Net Income	4,306.05	-6,830.99	5,510.00	-123.97%

Home Care Association of Washington
Profit & Loss Prev Year Comparison
July 2021 through May 2022

	Jul '21 - May 22	Jul '20 - May 21	$ Change	% Change
Ordinary Income/Expense				
Income				
PAC Contributions	3,834.00	579.81	3,254.19	561.25%
MEMBERSHIP				
Affiliate Dues	3,432.95	1,365.28	2,067.67	151.45%
Provider Dues	175,035.10	197,706.82	-22,671.72	-11.47%
Total MEMBERSHIP	178,468.05	199,072.10	-20,604.05	-10.35%
OPERATING				
Job Target/Career Board	238.50	1,376.66	-1,138.16	-82.68%
Total OPERATING	238.50	1,376.66	-1,138.16	-82.68%
PROGRAMMING				
Annual Meeting/Conv - Spring				
Sponsorships/Endorsements/Rebat	11,531.00	2,700.00	8,831.00	327.07%
Annual Meeting/Conv - Spring - Other	27,889.40	3,318.33	24,571.07	740.47%
Total Annual Meeting/Conv - Spring	39,420.40	6,018.33	33,402.07	555.01%
OCS OASIS Partnership	164.90	0.00	164.90	100.0%
Workshops/Seminars	1,177.10	-215.00	1,392.10	647.49%
Total PROGRAMMING	40,762.40	5,803.33	34,959.07	602.4%
Total Income	223,302.95	206,831.90	16,471.05	7.96%
Gross Profit	223,302.95	206,831.90	16,471.05	7.96%
Expense				
PAC Expenses	293.52	0.00	293.52	100.0%
ADMINISTRATIVE				
Professional Fees				
Tax Return Prep	3,328.25	0.00	3,328.25	100.0%
Total Professional Fees	3,328.25	0.00	3,328.25	100.0%
Bank / Merchant Fees	2,869.96	1,094.30	1,775.66	162.26%
Insurance	2,050.04	751.26	1,298.78	172.88%
Management	75,900.00	55,800.00	20,100.00	36.02%
Miscellaneous	0.00	1,436.30	-1,436.30	-100.0%
Office Supplies	276.00	136.35	139.65	102.42%
Postage	111.50	299.75	-188.25	-62.8%
Printing/Copies	384.23	164.70	219.53	133.29%
Publications/Subscriptions	671.75	0.00	671.75	100.0%
Telephone	304.38	141.37	163.01	115.31%
Total ADMINISTRATIVE	85,896.11	59,824.03	26,072.08	43.58%
ADVOCACY				
Lobbyist Expenses	150.00	629.50	-479.50	-76.17%
Lobbyist/Legislative Consultant	47,700.00	44,400.00	3,300.00	7.43%
Policy & Advocacy	11,518.75	1,375.00	10,143.75	737.73%
Total ADVOCACY	59,368.75	46,404.50	12,964.25	27.94%
COMMUNICATIONS				
Website- Reg & Maint	3,152.86	499.00	2,653.86	531.84%
Total COMMUNICATIONS	3,152.86	499.00	2,653.86	531.84%

Home Care Association of Washington
Profit & Loss Prev Year Comparison
July 2021 through May 2022

	Jul '21 - May 22	Jul '20 - May 21	$ Change	% Change
LEADERSHIP				
Board Meetings	270.55	0.00	270.55	100.0%
Strategic Planning	650.00	0.00	650.00	100.0%
Total LEADERSHIP	920.55	0.00	920.55	100.0%
MEMBERSHIP SERVICE/RETENTION				
Clinical Director	27,500.00	22,688.75	4,811.25	21.21%
NAHC Dues/Other Memberships	750.00	125.00	625.00	500.0%
Public Relations/ Awards	62.67	372.20	-309.53	-83.16%
Total MEMBERSHIP SERVICE/RETENTION	28,312.67	23,185.95	5,126.72	22.11%
PROGRAMS				
Annual Mtg/Convention Spring				
A/V - Technology	7,763.72	8,350.00	-586.28	-7.02%
Food and Beverage	24,282.68	0.00	24,282.68	100.0%
Speaker	7,135.38	250.00	6,885.38	2,754.15%
Syllabus	1,125.97	0.00	1,125.97	100.0%
Total Annual Mtg/Convention Spring	40,307.75	8,600.00	31,707.75	368.7%
Workshops/Seminar Expense				
A/V-Technology	4,846.17	1,215.00	3,631.17	298.86%
Other Workshops/Seminar Expense	125.00	1,053.00	-928.00	-88.13%
Speaker	1,500.00	0.00	1,500.00	100.0%
Workshops/Seminar Expense - Other	0.00	-500.00	500.00	100.0%
Total Workshops/Seminar Expense	6,471.17	1,768.00	4,703.17	266.02%
Total PROGRAMS	46,778.92	10,368.00	36,410.92	351.19%
Total Expense	224,723.38	140,281.48	84,441.90	60.2%
Net Ordinary Income	-1,420.43	66,550.42	-67,970.85	-102.13%
Other Income/Expense				
Other Income				
Interest & Dividends	2,919.42	574.02	2,345.40	408.59%
Gain/Loss on Investments	-8,329.98	7,102.71	-15,432.69	-217.28%
Total Other Income	-5,410.56	7,676.73	-13,087.29	-170.48%
Net Other Income	-5,410.56	7,676.73	-13,087.29	-170.48%
Net Income	-6,830.99	74,227.15	-81,058.14	-109.2%

Home Care Association of Washington
A/R Aging Summary
As of June 15, 2022

	Current	1 - 30	31 - 60	61 - 90	> 90	TOTAL
Assured Home Health, Hospice & Homecare	0.00	0.00	0.00	0.00	1,200.00	1,200.00
Medline	0.00	0.00	0.00	2,745.00	0.00	2,745.00
Non Member	0.00	0.00	0.00	0.00	366.00	366.00
Providence	0.00	0.00	0.00	0.00	0.00	0.00
Providence Home Health	0.00	0.00	0.00	0.00	547.75	547.75
Providence Sound Homecare and Hospice	0.00	6,825.00	0.00	0.00	0.00	6,825.00
Providence VNA Home Health- C	0.00	0.00	0.00	0.00	9,330.00	9,330.00
QuickBooks Customer	0.00	0.00	0.00	0.00	0.00	0.00
Sandata Technologies	0.00	0.00	0.00	0.00	499.00	499.00
SimiTree	0.00	0.00	0.00	499.00	0.00	499.00
Sunrise Services	0.00	0.00	0.00	0.00	150.00	150.00
Wenatchee Home Health NW of Wenatchee	0.00	0.00	0.00	0.00	2,090.00	2,090.00
TOTAL	0.00	6,825.00	0.00	3,244.00	14,182.75	24,251.75

Statement Period: **MAY 1 - MAY 31, 2022**
Account Number: **8084-3137**
Account Solution: **Advisory - Baird Advisory Choice**
For more information, go to www.bairdwealth.com/retailinvestor

PREMIER CLIENT STATEMENT

ACCOUNT SUMMARY

	This Period May 1, 2022	*Year-to-Date January 1, 2022*
Beginning Balance	**$154,830.47**	**$164,795.34**
Cash Deposits		
Cash Withdrawals		
Income and Distributions	329.93	1,654.62
Other Transactions	-154.11	-154.11
Change in Value*	-2,482.62	-13,772.18
Total Assets: May 31, 2022	**$152,523.67**	**$152,523.67**

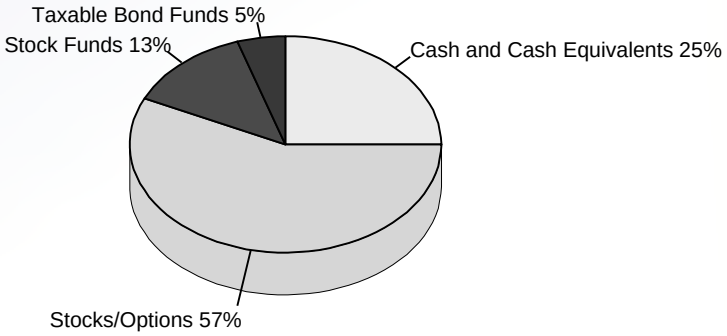
* Change in Value may include assets received in and/or delivered out.

INVESTMENT OBJECTIVE

Growth with Income

If you have any questions concerning your investment objective, or wish to make a change, please contact your Baird Financial Advisor.

ASSET ALLOCATION



HOME CARE ASSOCIATION OF WA
5727 BAKER WAY NW STE 200
GIG HARBOR WA 98332-5811

YOUR BAIRD FINANCIAL ADVISOR

Bill MacGeorge
Telephone: (206) 664-8850

Office Servicing Your Account
925 Fourth Ave Ste 3600
Seattle WA 98104

A Message from Baird

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Portfolio Bulletin Board

Contact your Baird Financial Advisor if you are interested in investment alternatives.

Account Protection

Assets in your Baird account are protected by SIPC, subject to applicable limits. Baird provides additional coverage in excess of SIPC limits through an insurance policy with Lloyd's of London. Your balances in the bank deposit account are insured by the FDIC subject to applicable limits. For more information on FDIC insurance, please see rwbaird.com/cashsweeps.

Robert W. Baird & Co. Incorporated
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ASSET SUMMARY

	Value as of May 31, 2022				Gains/(-)Losses		
						Realized	
	At Baird	Not at Baird	Total	% of Assets *	Unrealized	This Period	Year-to-Date
Cash	53.10		53.10	0.03%			
Money Market/Bank Deposit	38,573.43		38,573.43	25.29%			
Margin							
Cash and Cash Equivalents	**$38,626.53**		**$38,626.53**	**25.32%**			
Stocks/Options	86,435.02		86,435.02	56.68%	11,964.49		
Stock Funds	20,547.12		20,547.12	13.47%	7,022.86		
Preferred Stocks							
Balanced Funds							
Tax-Exempt Bonds							
Tax-Exempt Bond Funds							
Taxable Bonds							
Taxable Bond Funds	6,915.00		6,915.00	4.53%	-4,068.95		
Unit Investment Trusts							
Annuities							
Baird Capital							
Other Investments							
Portfolio Assets	**$113,897.14**		**$113,897.14**	**74.68%**	**$14,918.40**	**$0.00**	**$0.00**
Total Assets	**$152,523.67**		**$152,523.67**	**100.00%**	**$14,918.40**	**$0.00**	**$0.00**

INCOME & DISTRIBUTION SUMMARY **

		This Period	Year-to-Date
Dividends	Tax-Exempt		
	Taxable - Qualified	271.25	832.87
	Taxable - Non-Qualified	56.10	817.54
Interest	Tax-Exempt		
	Taxable	2.58	4.21
Capital Gain Distributions			
Return of Principal			
Other			
Total Income and Distributions		**$329.93**	**$1,654.62**

TAX INFORMATION SUMMARY

		This Period	Year-to-Date
Accrued Interest Paid	Tax-Exempt		
	Taxable		
Accrued Interest Received	Tax-Exempt		
	Taxable		
Gross Proceeds			
Federal Withholding			
Foreign Taxes Paid			
Margin Interest Charged			

* Please note "% of Assets" figures are shown gross of any amounts owed to Baird and/or net short positions.

** Certain distributions made in the current year that are reported in the prior year and/or receiving securities whose fair market value is taxable as a dividend may cause a difference in totals between the Income and Distribution Summary and Activity Summary tables.

ASSET DETAILS

This section shows the cash, cash equivalents and/or securities in your account. It reflects market values as of the close of business, May 31, 2022.
Please note, unrealized gain/loss is being prepared for informational purposes only and should not be used for tax preparation without the assistance of your tax advisor.
Cumulative Investment Return on funds and unit investment trusts is provided for informational purposes only to assist you in comparing the total current value of your position with your total amount invested, excluding reinvestment activity. Cumulative Investment Return may be misstated if any cost information is inaccurate or if you have sold part of your position since your original investment.

CASH AND CASH EQUIVALENTS

Any balances reflected in this section held in a bank deposit account or in shares of money market mutual funds may be liquidated on your order and the proceeds returned to your account or remitted to you. We encourage you to visit www.rwbaird.com/cashsweeps and to speak to your Financial Advisor about alternatives for your idle cash as there may be material differences in yield and other important factors to consider (e.g. liquidity, safety) when choosing the best solution to meet your needs.

	Current Value	*Cost*	*Unrealized Gain/(-)Loss**	*Anticipated Annualized Income*	*Current Yield %*
CASH	53.10	53.10			
FDIC INSURED DEPOSIT MULTI-BANK	38,573.43	38,573.43		38.57	0.10%

Net yield from 05/01/22 - 05/31/22 was 0.10%.

Deposits are insured by the FDIC up to $1,250,000 per depositor (or $2,500,000 for joint accounts).

Program Banks	*Current Value*
CITIBANK, N.A.	38,573.43

Total Cash and Cash Equivalents	**$38,626.53**	**$38,626.53**		**$38.57**	**0.10%**

PORTFOLIO ASSETS

	Symbol/CUSIP Bond Rating+	*Quantity*	*Current Price*	*Average Unit Cost*	*Current Value*	*Cost*	*Unrealized Gain/(-)Loss**	*Anticipated Annualized Income*	*Current Yield %*
Stocks/Options									
ABBVIE INC	ABBV	80	147.3700	97.0486	11,789.60	7,763.89	4,025.71	451.20	3.83%
ALASKA AIR GROUP INC	ALK	100	48.2600	65.5800	4,826.00	6,558.00	-1,732.00	N/A	N/A
DIVERSIFIED HEALTHCARE TRUST SBI	DHC	300	2.2700	23.6135	681.00	6,334.57***	-5,653.57	12.00	1.76%
EXPEDIA GROUP INC	EXPE	55	129.3300	128.5516	7,113.15	7,070.34	42.81	N/A	N/A
ALERISLIFE INC	ALR	20	1.4100	3.7100	28.20	74.20	-46.00	N/A	N/A
RMR GROUP INC CL A	RMR	3	30.0200	11.8900	90.06	35.67	54.39	4.80	5.33%
RAYTHEON TECHNOLOGIES CORP	RTX	93	95.1200	82.4149	8,846.16	7,664.59	1,181.57	204.60	2.31%
SIX FLAGS ENTERTAINMENT CORP NEW	SIX	150	29.3500	56.0749	4,402.50	8,411.24***	-4,008.74	N/A	N/A

ASSET DETAILS continued

	Symbol/CUSIP Bond Rating+	Quantity	Current Price	Average Unit Cost	Current Value	Cost	Unrealized Gain/(-)Loss*	Anticipated Annualized Income	Current Yield %
Stocks/Options continued									
STARBUCKS CORP	SBUX	125	78.5000	14.2369	9,812.50	1,779.61	8,032.89	245.00	2.50%
UNITED PARCEL SERVICE INC CL B	UPS	60	182.2500	115.9950	10,935.00	6,959.70	3,975.30	364.80	3.34%
U S BANCORP DE NEW	USB	165	53.0700	43.2977	8,756.55	7,144.12	1,612.43	303.60	3.47%
VERIZON COMMUNICATIONS INC	VZ	150	51.2900	51.2033	7,693.50	7,680.50	13.00	384.00	4.99%
WEYERHAEUSER CO	WY	290	39.5200	24.1176	11,460.80	6,994.10	4,466.70	208.80	1.82%
Total Stocks/Options					**$86,435.02**	**$74,470.53**	**$11,964.49**	**$2,178.80**	**2.52%**
Stock Funds									
WASHINGTON MUTUAL INVESTORS CL A REINVESTMENTS	AWSHX	362.703	56.6500	37.2875	20,547.12	13,524.27	7,022.86	313.77	1.53%
Total Stock Funds					**$20,547.12**	**$13,524.27**	**$7,022.86**	**$313.77**	**1.53%**
Taxable Bond Funds									
TEMPLETON GLOBAL INCOME FUND	GIM	1,500.000	4.6100	7.3226	6,915.00	10,983.95***	-4,068.95	646.50	9.35%
Total Taxable Bond Funds					**$6,915.00**	**$10,983.95**	**-$4,068.95**	**$646.50**	**9.35%**
Total Portfolio Assets					**$113,897.14**	**$98,978.75**	**$14,918.40**	**$3,139.07**	**2.76%**
Total Assets					**$152,523.67**	**$137,605.28**	**$14,918.40**	**$3,177.64**	**2.08%**

\+ Bond ratings of securities displayed on your statement were obtained from various rating services. There is no guarantee with respect to the accuracy of this information.

* Please note, "Unrealized Gain/(-)Loss" does not equal the total current value minus the total cost if any value or cost amounts are missing.

*** The original cost of this security has been adjusted to reflect principal payments, return of capital or amortization/accretion based on our records and/or provided by you.

ACTIVITY SUMMARY

Type of Activity	*Activity*	*This Period*	*Year-to-Date*
	Opening Balance - Cash and Cash Equivalents	**$38,450.71**	**$37,200.11**
Buy and Sell Transactions	Assets Sold/Redeemed		
	Assets Bought		-74.09
Cash Deposits and Withdrawals	Deposits		
	Withdrawals		
Income and Distributions	Dividends	327.35	1,650.41
	Interest	2.58	4.21
	Capital Gain Distributions		
	Return of Principal		
	Other		
Margin Interest	Margin Interest Charged		
Cash Management Activity	Debit Card Activity		
	ACH/ATM Activity		
	Checks You Wrote		
Other	Asset Based Fees	-154.11	-154.11
	Other Transactions		
	Closing Balance - Cash and Cash Equivalents	**$38,626.53**	**$38,626.53**

ACTIVITY DETAILS

SUBACCOUNT ACTIVITY

Date	*Activity*	*Quantity*	*Price*	*Description*	*Total*	*Cash*	*Money Market*	*Margin*
	Opening Balance			**Total Opening Balance**	**$38,450.71**	**$54.30**	**$38,396.41**	**$0.00**
05/02/22	Purchase			FDIC INSURED DEPOSIT		-54.30	54.30	
05/02/22	Dividend			VERIZON COMMUNICATIONS INC	96.00	96.00		
05/03/22	Purchase			FDIC INSURED DEPOSIT		-96.00	96.00	
05/16/22	Dividend			ABBVIE INC	112.80	112.80		
05/17/22	Purchase			FDIC INSURED DEPOSIT		-112.80	112.80	
05/19/22	Dividend			DIVERSIFIED HEALTHCARE TRUST SBI	3.00	3.00		
05/19/22	Dividend			RMR GROUP INC CL A	1.20	1.20		

ACTIVITY DETAILS continued

Date	*Activity*	*Quantity*	*Price*	*Description*	*Total*
05/20/22	Purchase			FDIC INSURED DEPOSIT	
05/25/22	Asset Based Fee			FIA FEE BILL VAL 148,040.00 05/24/22 THRU 06/30/22	-154.11
05/26/22	Sale			FDIC INSURED DEPOSIT	
05/27/22	Dividend			STARBUCKS CORP	61.25
05/31/22	Interest			FDIC INSURED DEPOSIT	2.58
05/31/22	Asset Bought-Reinv			FDIC INSURED DEPOSIT	
05/31/22	Purchase			FDIC INSURED DEPOSIT	
05/31/22	Dividend			TEMPLETON GLOBAL INCOME FUND	53.10
	Closing Balance			**Total Closing Balance**	**$38,626.53**

SUBACCOUNT ACTIVITY continued

Cash	*Money Market*	*Margin*
-4.20	4.20	
-154.11		
154.11	-154.11	
61.25		
2.58		
-2.58	2.58	
-61.25	61.25	
53.10		
$53.10	**$38,573.43**	**$0.00**

INTERESTED PARTIES AND/OR SUPPORTING REPRESENTATIVE(S)

Your Supporting Representative(s) is (are):

ROBERT W BAIRD & CO INC
ADVISORY SERVICES

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Visit our Web site at www.rwbaird.com. Clients enrolled in Baird Online can access updated Account Information, Baird Research and Investing Tools including the latest market information, portfolio tracking and more. Please contact your Baird Financial Advisor with questions regarding Baird Online, your account or this statement.

June 8, 2022

HCAW June 2022 Public Policy Report

Prepared by Leslie Emerick, HCAW Public Policy Director

Legislative Landscape

The 2022 Election Campaign season has started and our primary in WA State is on August 2, with ballots mailed out on July 15th. The General Election is on November 8th. There will be quite a bit of turn-over in the legislature next year and changes in the health care committees, especially with Rep. Eileen Cody retiring. She was the longest running House member, a nurse, and the Chair of the House Health Care Committee for many years. She was a strong advocate for home care, home health, hospice and palliative care and will be greatly missed!

It is fairly quiet in Olympia as state agencies are gearing up for rulemaking from bills and budget provisos that passed this last session. Short sessions typically do not address major or controversial changes to state law, but this year was an exception, with nursing unions and their partners in the Legislature attempting to pass strict hospital staffing mandates, criminal justice reforms and new funding for health care, homelessness, and the environment. State agencies will be figuring out over the interim how to spend that money and implement the two new apprenticeship bills. Agencies are putting together their financial Decision Packages to submit to the Governor for his budget that will be introduced in early December before the session starts.

As you may remember, this year's Supplemental Budget included nearly $50 million for health care workforce development, creating more slots in nursing programs, investing in simulation training equipment, providing grants to nurses who supervise students, offering loan repayment for nurse educators and expediting the nurse licensing process. This will take at least a year or more to really start rolling out into our communities to build the pipeline for more certified nursing assistants and nurses into the workforce, but it's a good start!

HCAW Political Action Committee (PAC): Please donate to the HCAW PAC for this election cycle. Many of you created lasting relationships with legislators this year during our In-Home Services Days and your support for their campaigns can make a big difference and helps open doors for us. Final approval for contributions will be soon, so please don't delay if you plan to contribute! Go to: Home Care Association of Washington - Donate to the PAC (wildapricot.org)

WA state hospitals 'remarkably strained' by COVID-19 community spread: A June 6, 2022, article in The Olympian newspaper reports that our WA State Hospital Association officials warned Monday that facilities are heading toward the bad old days COVID-19 cases peaking and there is

high spread in the community again straining our hospital capacities. Read more at: https://www.theolympian.com/news/coronavirus/article262204287.html#storylink=cpy

Health Care Authority (HCA)

Palliative Care Benefit for Medicaid, PEBB, SEBB: I spoke with Cynthia Rivers at the Health Care Authority who is the lead on the Palliative Care Benefit Project. She says that HCA is forming their internal task force to work on the palliative care benefit project. The main issue for HCA is how to do the billing for palliative care. Their focus in the beginning will not be on agency rulemaking, but how to construct the palliative care benefit and pay for it. Actual filing for the rule will probably happen later in the year as the agency sees what it will need to change in rule.

The state invested $250,000 of the general fund for fiscal year 2023 to design a standardized payment methodology for a palliative care benefit for the state Medicaid program and the employee and retiree benefits programs. HCA may contract with a third party to design the palliative care model and complete the work required. We are looking forward to seeing who get hired and when this work will begin!

Pediatric Palliative Care Rates: Pediatric palliative care Medicaid Reimbursement rates have not moved for over 15 years. We need a rate increase to improve utilization of this benefit. HCAW will be working with WSHPCO, the Health Care Authority and the Governor's office to discuss a rate increase for Medicaid Pediatric Palliative Care rates. We are working on a date and time to meet.

Pediatric Health listserv now available: HCA recognizes that they historically have not had a listserv specific to pediatric policy and program updates. To ensure providers serving the pediatric population have access to updates and information relevant to their services, HCA has created a Pediatric Health topic in response to a variety of projects impacting children and youth on Apple Health. This may be of help to our private duty nursing agencies. To stay informed on the projects listed below and other topics relevant to pediatric care, subscribe to the Pediatric Health topic.

Department of Health (DOH)

Death with Dignity Study: Fred Hutchison Cancer Research Center is reaching out to hospice providers regarding participating in a survey around barriers to the state's Death with Dignity Act. ESSB 5693 Budget Bill appropriated $200,000 of the state fund for 2023 to the institution to conduct a study, in consultation with DOH and with approval from the Washington state institutional review board, of the ability of Washington residents to make use of the rights established in chapter 70.245 RCW to achieve full access to the Washington death with dignity act. The institution and department shall enter into a signed data sharing agreement for the purpose of the study. Pursuant to RCW 42.56.070, 42.56.360, and 70.245.150, the data sharing agreement must specify that data shared or obtained in the course of this study are not subject to public disclosure.

The study shall review the extent to which there are barriers to achieving full access to the Washington death with dignity act.

COVID -19 Guidance: DOH has consolidated all healthcare guidance into one document. They hope this will make it easier to maintain consistency with the recommendations as well as make it easier to find the appropriate recommendations. Guidance was updated to clarify language and to maintain consistency. Three substantive changes in recommendations are:

- Healthcare workers should wear eye protection for all patient encounters when working in areas with substantial to high community transmission. (pg. 42)
- Nursing home residents who are not up to date with COVID-19 vaccines should be placed in quarantine on returning to the nursing home if out of the nursing home for more than 24 hours. No recommendation for quarantine of residents in non-nursing home LTCFs on admission or returning to the facility following a visit in the community.(pg. 56)
- The Risk Assessment is not included in the DOH guidelines. Facilities do not need to complete a risk assessment with residents who wish to go on community visits.

Please see Interim recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings. Feel free to reach out to HAI-COVID@doh.wa.gov with any questions.

Winding Down State COVID-19 related Emergency Rules/Waivers: DOH is gathering input on how best to unwind waivers that were established by Governor Proclamation to support the health care system's response to the COVID-19 pandemic. We are at a point in the pandemic where we are seeing less stress on the health care system and more stability overall due to increased testing and access to a vaccine. Because of this, it's time to begin thinking about whether there are waivers that were put in place through a Governor proclamation to support health care's response to COVID-19 that are no longer needed. There is no timeframe established for ending the COVID-19 waivers or the state of emergency. The information you provide will help the department and the Governor's office understand the current landscape and plan for the future.

Donna and I met with Christie Spice, Assistant Director of Health Quality Assurance Systems, the division that has oversight of In-Home Services agencies, to discuss how to ramp down after the state of emergency ends for our In-Home Services patients. The department come up with a list of all the emergency rules that impact in-home services agencies so we know specifically what will be ending when the state of emergency is officially declared over. If you or your agency has any specific concerns, please let us know ASAP. We have expressed concerns about hospices that are operating out of their CON area under the waivers and how they will wind down care for those patients, especially in rural areas of the state.

Governor Proclamations

20-32.11 COVID-19: Department of Health – Health Care Workers

- Allowed Secretary of Health to extend license renewal periods

- Suspended continuing education and training requirements for certain professions
- Waived certain medical assistant supervision requirements and restrictions on working
- Altered delegation agreement requirements (physician assistants, nursing assistants)
- Waived restrictions on practice of retired active licensees for certain professions
- Waived rules that restrict the practice of health care provider volunteers

20-36.10 COVID-19: Department of Health – Health Care Facilities and Hand Sanitizer

- Waived Certificate of Need requirement for surge capacity projects

Actions Taken

Since the first proclamations were issued several policy actions have occurred to decrease the reliance on waivers. Examples of these actions include:

Legislation

- ESHB 1120 allowed DSHS and DOH to set alternative time frames for nursing assistant and home care aide training and certification – emergency rules in place
- ESHB 1196 allowed audio-only telemedicine

Secretary Waiver

- WSR 20-10-061 Washington State Department of Health Guidance and Exemptions from Certain In-Person and On-Site Requirements for Home Care, Home Health, and Hospice Agencies and Washington State Patrol Fingerprint Background Checks

Emergency Rules

- WAC 246-980-030, 040, 065 Home Care Aide training and certification timelines. DSHS also has emergency rules reflecting the same adjusted date of hire/timeline for training and certifications. These emergency rules are authorized by ESHB 1120 and as such will be withdrawn when not needed.
- WAC 246-335-510, 545, 610, 645 In Home Services Agencies allowing supervision via telemedicine. Permanent rulemaking is in progress.
- WAC 246-840-010 – Waiving certain nursing CE requirements and allowing LPNs to practice as Nursing Technicians
- WAC 246-841-405 - Nursing Assistants training flexibility including volunteer experience

Permanent Rules

- WAC 246-335-510 Home Health allowing Physician Assistants to order Home Health. This permanent rule replaced emergency rules and also implemented a federal CARES Act change. This became effective March 28, 2021.

- Chapter 246-335 WAC making emergency rules permanent, implementing ESHB 1196 audio only telemedicine, addressing a rule petition related to remote supervision, and incorporating recent CMS flexibilities for Medicare patient supervision. This removes requirements that supervisory visits must occur during an on-site visit. Permanent rules may complete fall/winter 2022.
- WAC 246-980-010 definitions to redefine "date of hire" according to ESHB 1120.
- Chapter 246-841 WAC – Chapter update incorporating emergency rules for Nursing Assistants

Next Steps: DOH will share your input with the Governor's office to plan the exit from COVID-19 health care waivers. Please subscribe for email or text alerts based on your topic preference at Washington State Department of Health (govdelivery.com).

DOH Health Equity Rules: DOH is holding a series of rules workshops to implement ESSB 5229. In 2021, state legislators passed ESSB 5229 directing DOH to make rules for health professionals to take health equity continuing education. They previously held listening sessions to listen and engage with individuals who have lived experience of health inequities and racism, as well as providers, advocacy groups, and associations. At this time, they are considering between 2-6 hours of training every 4 years but have not settled on the exact number yet. If you have questions or comments, please contact: healthequityimplementation@doh.wa.gov.

Home Health and Hospice Telemedicine Supervisory Visits: This rulemaking will help our private duty nursing agencies but may not have an impact on Medicare certified home health and hospice unless federal telehealth rules change. We are waiting for further rulemaking.

- In-Home Services WSR 21-20-084.PDF
- WSR 21-16-096.pdf

Hospice CON Rulemaking: DOH hosted a meeting on May 25, 2022, to discuss hospice rules workshops starting in 2022. See: CN Rules Kick-Off Presentation (wa.gov) Here is a link posted on the DOH CON Website: Initial proposed draft changes to WAC 246-310-290(8)(e) (PDF).

The DOH first rulemaking workshop has been scheduled for Tuesday, June 14, 2022, and is scheduled to begin at 2pm. The meeting will begin at 2pm and may end early depending on the amount of feedback. We have budgeted an hour for this meeting and will be seeking feedback on the two specific rule change: WAC 246-310-290(8)(e) and WAC 246-310-720(2)

The agenda (attached) and Zoom link will be posted to the CN Program's Rules Activity website soon. Email CNRulemaking@doh.wa.gov if you have any questions.

Workshop_06142022.pdf

- **Future workshops:** June 22, 2022 – Begins at 10am
- **Future listening sessions:** August 2022

Home Health Certificate of Need Rulemaking: Probably not until 2023. In the meantime, HCAW has hired Marc at Berg Data to review current data for Home Health CON in WA State and will make some recommendations to the board.

In-Home Services Rules: DOH plans to update the In-Home Services Rules. No date set yet.

Palliative Care Roadmap Still Available!! We received good news from Pat Justis that DOH found grant money to reprint the roadmap. It's still posted on DOH Rural Health webpage, as well as the WA Rural Palliative Care Initiative portal To order: https://prtonline.myprintdesk.net/DSF/

Palliative Care-Rural Health Integration Advisory Team (PC-RHIAT): This is a workgroup that helps provide tele-consults for patients and their providers and helps set up community support for palliative care efforts in rural areas. For more information on their efforts go to: https://waportal.org/partners/home/washington-rural-palliative-care-initiative

SEIU Gets Funding for a Study to Increase Taxes on Home Care to Gain higher Federal Reimbursements: We did have one dangling issue from the last session regarding a budget proviso that slipped through at the end of session from Senator Warnick (R) of the Ellensburg-Moses Lake area that was apparently suggested by SEIU. It took them two months to get me that information…so perhaps they were a little embarrassed that they did not reach out to us! This is only a study at this time and the additional fees would need to be approved by the legislature! It may be a bill or budget proviso next year at which time we can take a position.

DOH is to conduct a voluntary survey (expected to cost $17,000 GF-S) to gather non-identifiable baseline information about the home care industry that would inform future consideration of a possible home care assessment of the same type that is already used to obtain more federal Medicaid dollars for the state with the current assessments for hospitals and nursing homes DOH is supportive of the amendment but wasn't able to get it into either the House or Senate versions of the Operating Budget. John Hilger confirmed that he has been assigned to do the study at DOH!

Nursing Care Quality Assurance Commission (NCQAC)

Pediatric Certified Nursing Assistant: I am working with Leslie Elder at Seattle Children's Hospital (SCH) on ways to expand care for medically fragile children in our state. Currently around 20 or more children are backed up in hospitals around the state because there is not enough private duty nursing to care for these kids in their homes. Meetings start next week with SCH to talk about how to develop an expanded program and perhaps even pay parents with appropriate training to take shifts with their child with in certain specified boundaries and receive payment.

RN and LPN Nurse Licensure Increase: The NCQAC is doing rulemaking with increased licensure fees up to 20% for LPNs and RNs. This will help to hire new employees to process licenses that got very backed up during the pandemic and was taking up to 6-7 weeks to process. This does not impact certified nursing assistants, but they are under review for fees with DOH.

CR-102 Proposal Announcement: DOH filed a CR-102, Proposed Rule as WSR 22-10-104, for WAC 246-840-990, Fees and Renewal Cycle with the Nursing Care Quality Assurance Commission (NCQAC) is proposing fee increases for registered nurses (RNS), licensed practical nurses (LPNs), and advanced registered nurse practitioners (ARNPs).

RCW 43.70.250 requires that the costs of licensing each profession be fully borne by members of that profession. The department is proposing rules to ensure that profession fees are enough to cover the cost of licensing. The proposed fee change is necessary to cover the cost of a database solution to replace an outdated licensing system, for staffing to continue nurse license processing within legislated timelines, and staffing to address an increased workload associated with nursing assistants and the long-term care crisis.

Submit written comments by June 13, 2022 to the Department of Health online rules comment webpage. Attend an online rules hearing on June 13, 2022, at 2:00 p.m. Register in advance for the rules hearing: https://us02web.zoom.us/webinar/register/WN_dYNOpgEZTVqsB5ZC0MvMig
For information, please contact: Ross Valore, Policy Analyst DOH, HSQAfeerules@doh.wa.gov

LPN Apprenticeship Pilot Steering Committee Meeting: This group is an extension of the multiple years of work on the LTC Workforce Steering Committee. I am an official member of this workgroup and will continue to offer ideas from our association membership. The last meeting was on May 20,2022. This project is sponsored by the NCQAC and DOH. They are starting out with a pilot project in skilled nursing facilities (SNF).

Labor and Industries (L & I)

L&I filed a Preproposal Statement of Inquiry (CR-101) on May 13, 2021: (WSR 21-11-051) and initiated the permanent rulemaking process for rules related to infectious diseases, to include when there is an outbreak subject to a public health emergency under a national or state declared state of emergency. This emergency rule supersedes WSR 22-01-047 filed on December 7, 2021.
Effective date: April 6, 2022 Expiration date: August 4, 2022

CR-103 Emergency Adoption, Adoption Language

Ongoing Public Policy Meetings

WA State Senior Citizens Lobby: I attend the monthly meetings where they are now reviewing bills that impact seniors in the state legislature. Bill Moss, Assistant Secretary of DSHS/ALTSA is retiring and Bea Rector has been giving an update on what is happening with policy at DSHS. This group has been a great advocate for hospice and palliative care legislative initiatives.

Dementia Action Collaborative: There was new legislation that passed in 2022 to continue the efforts of the DAC and update the state Dementia Plan. They will be changing around people who are currently Governor Appointments to the committee. I have been participating in the states Dementia Collaborative for several years but am not sure if I will make the cut. I will continue working on a various committees to make sure that they continue to include a hospice and palliative care representative on the collaborative.

WA State Telemedicine Collaborative: I participate in these meetings to follow issues closely related to providing telemedicine services in the home.

By Carolyn C. Foster, Rishi K. Agrawal, and Matthew M. Davis

Home Health Care For Children With Medical Complexity: Workforce Gaps, Policy, And Future Directions

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ABSTRACT With the medical and surgical advances of recent decades, a growing proportion of children rely on home-based care for daily health monitoring and care tasks. However, a dearth of available home health care providers with pediatric training to serve children and youth with medical complexity markedly limits the current capacity of home health care to meet the needs of patients and their families. In this article we analyze the workforce gaps, payment models, and policy challenges unique to home health care for children and youth with medical complexity, including legal challenges brought by families because of home nursing shortages. We propose a portfolio of solutions to address the current failures, including payment reform, improved coordination of services and pediatric home health training through partnerships with child-focused health systems, telehealth-enabled opportunities to bridge current workforce gaps, and the better alignment of pediatric care with the needs of adult-focused long-term services and supports.

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Home health care for children and adolescents is an understaffed health care model that does not meet the current needs of patients and families. Increasingly, pediatric patients are surviving conditions that were untreatable decades ago. While applaudable, hospital-based medical advances that have saved children from previously fatal conditions have not been matched with adequate home and community-based medical care, which leaves many parents to manage complicated medical care for their children at home alone, struggling to stay employed and healthy themselves. The primary challenge of the pediatric home health care crisis is to develop a trained and adequately compensated workforce to meet the needs of children and their families. In this article we analyze the policy context for this workforce gap. We also propose opportunities to address the current failures in providing a home health workforce for children and youth.

The origins of home health care for this special population are unique. In the early 1980s a child named Katie Beckett required a breathing machine to live, but she was institutionalized in a hospital because nursing care that would allow her to live at home with her family was financially inaccessible. Bipartisan legislation in the wake of her case, as well as the subsequent passage of the Americans with Disabilities Act of 1990, as interpreted by the US Supreme Court in its 1999 decision in *Olmstead v. L.C.*,[1] expanded access to Medicaid home and community-based services waivers that provided long-term services and supports for a broad array of children and adults with disabilities and a consequent reduction in institutional care.[2]

With medical advances that increase the likelihood of surviving a childhood disease, the medical needs of children with medical complexity are extending well into adulthood.[3] Parents report increased need to forgo employment to care for their children with medical needs.[4–6] Medicaid

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spending for children with medical complexity disproportionately goes to hospital care (47 percent) instead of home health care (2 percent).[7] This continues to raise the possibility that a more effective system of home health care could reduce hospital use for this population.[7,8]

Policy Governing Home Health Care For Children

Although federal law has established a base of expected long-term services and supports, a complex state-by-state patchwork of policy governs the provision of home health care services to American children.[2] The *Olmstead* decision[1] provides an "integration mandate" for states to develop policies that promote the inclusion of people with disabilities so that they can live at home and in the community, rather than in institutions such as acute care hospitals. Children with Medicaid also are entitled to home health care services—including private duty nursing ("home nursing")—through the Early and Periodic Screening, Diagnostic, and Treatment provisions of the Medicaid statute of 1967. Consequently, long-term services and supports are infrequently covered by private health insurance, given that there are pathways for families with higher incomes to gain Medicaid coverage for them through home and community-based services waivers, Section 1115 waivers, and other state-specific Medicaid mechanisms.[9]

Despite the goal of expanding options for long-term services and supports through these laws, substantial problems persist in accessing home-based care for children and youth. States vary widely in their use of waivers, which generally offer standard Federal Medical Assistance Percentage rates as compared with the enhanced federal match present in other state programs such as the Children's Health Insurance Program.[10] Reimbursement rates to states have been flat despite inflation, which translates to flat payment rates to home health agencies and their workforce. At least fourteen states have instituted pediatric waiting lists for Section 1915(c) home and community-based services waivers, which leads to eligible patients not receiving services.[11]

While children and youth with medical complexity have been traditionally excluded from Medicaid managed care, a recent National Academy for State Health Policy fifty-state long-term services and supports review noted that one-quarter of states now provide them to children through Medicaid managed care programs.[12] According to the report, eleven of the fourteen states that provide managed care long-term services and supports use a risk-based system, most commonly enrolling children into a comprehensive single managed care program that includes behavioral and physical health services. The remaining three states have stand-alone programs that focus only on long-term services and supports and behavioral health. While most shifts to managed care within Medicaid for children and youth with medical complexity have not been studied formally, there is some evidence that managed care may decrease health care expenditures for this group.[13]

Pediatric Home Health Care Workforce Challenges

Consequently, there is substantial variation across states in the extent to which children are in home and community-based versus long-term care settings (that is, nursing facilities).[14] For patients able to access home nursing, the number of hours granted for a given patient may range from 20–30 hours a week to total coverage (24/7). Even when hours are approved for Medicaid payment, families often have difficulty finding home nurses, which leads to either prolonged hospitalizations or exhausted family caregivers.[15,16]

Thus, the current home health care "system" for children depends substantially on cost shifting to families, with vital but informal labor provided by family caregivers—typically mothers.[4–6] Parents of chronically ill children are less likely to work more than twenty hours per week and more likely to participate in casual than in regular employment compared to parents with otherwise healthy children.[6] A national survey of family caregivers of children with a rare disease reported that 52 percent of family members had to go to part-time work or cut hours, 42 percent took a leave of absence, 31 percent turned down a promotion, 23 percent lost a job benefit, and 21 percent gave up working or retired early to meet the care needs of their children.[5]

Children with severe chronic lung conditions exemplify the challenges of workforce training for the pediatric home health care workforce. A study in Pennsylvania noted that families reported inadequate workforce nursing skills in respiratory assessment, airway care, and emergency preparedness.[17] Unlike adults, who may be able to provide some level of self-care alone or with a personal care assistant, children typically must have medication and respiratory care administered for them, which requires clinical training and higher pay. Such children typically receive liquid medications through a tube in their stomach and require minute-to-minute lung monitoring. Nurses with intensive care experience are often most comfortable caring for

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Home health care for children and youth with medical complexity illustrates the problem of an underfunded mandate.

such patients, but they receive substantially lower wages for home-based care. While new nursing school graduates sometimes work home health care shifts to broaden their skill set, nursing schools typically do not prepare graduates to care alone for technology-dependent children.

Moreover, no uniformity exists in how home health care agencies document and receive the orders necessary to maintain their services.[18] Documentation is often still paper based, with agencies using different templates—including for key information such as medication reconciliation.[18] Even when agencies use electronic health records, electronic ordering is often not available, which can lead to discrepant and out-of-date paper orders and can frustrate ordering physicians, home nurses, and families alike.[18]

Collectively, such fragmentation—coverage mandates varying by state, the need for and unavailability of a specialized workforce, and multiple and onerous documentation requirements—leaves home health care isolated from typical health care delivery streams for children and youth. The need for specialized, highly skilled, and integrated home health labor to care for these medically complex children also collides with a national shortage of home health care providers.[19,20] State scope-of-practice laws differ regarding who may provide what level of home health care. Where only registered nurses are eligible, workforce options are especially limited.

Pediatric Home Health Care Workforce Payment

Home health care for children and youth with medical complexity illustrates the problem of an underfunded mandate. In the current era of constrained state budgets, there is no evidence base to guide eligibility criteria for state-based waivers and thus no guidance to determine the need for long-term services and supports. States therefore have a fiscal incentive to keep thresholds sufficiently high to control utilization. Fee-for-service payment structures that emphasize procedural and higher-acuity care have discouraged investment in long-term services and supports for decades, which has exacerbated this problem.[21]

Consequently, low Medicaid payments de facto support a workforce of low-wage home health workers. Median hourly wages for home health care services in 2017 were $33.77, compared to an average of $36.45 for inpatient care nationally. Of note, these figures mostly rely on Medicare payment and do not take into account locally prevailing wages.[22] For example, through conversations with home health care agencies, we have found that pediatric home health agencies in the Chicago area can offer only about $26 per hour for a private-duty nurse to provide home care to a Medicaid beneficiary, regardless of experience, compared to about $36 per hour that an entry-level nurse could earn at a hospital. Pay for home nursing care in less urban areas may be as low as about $19–$21 per hour, compared with roughly $23–$38 per hour for hospital nursing care. Notably, in Illinois, the education system pays nurses for the hours that a patient is in school at a higher rate (about $55 per hour), which motivates home health providers to prefer patients who can attend school.

As a result, there are few incentives for home health workers with the requisite training and experience to serve in the pediatric home setting instead of taking higher-paying hospital-based jobs.[20] Compassion fatigue, burnout, and the difficulties of navigating professional boundaries in the home are additional challenges reported by pediatric home nurses.[23,24] To sustain their business model, home health agencies that specialize in children often need to balance private-pay and Medicaid patients in an effort to recruit and retain high-quality workers, which leads to perceived inequitable access for socioeconomically disadvantaged families.

Family advocates have used various legal challenges to compel states to provide long-term services and supports for their children.[25–29] A class-action lawsuit in Washington State brought by the Northwest Justice Project against the state health care authority that was decided in 2016 identified low wages as a key contributor to the lack of home nursing for eligible children and specified necessary increases in such wages.[29] Additional suits in Illinois, Texas, Georgia, and Florida highlight how families are resorting to litigation to address inadequate access.[25–29]

Ramifications of the lack of skilled home health workers for children ripple throughout the health care system, as children's hospitals

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struggle to discharge children with medical complexity. In some locations, scarce and costly pediatric intensive care beds are being used for de facto long-term care because of a lack of home nursing coverage and pediatric postacute care options.[15,19] In a recent prospective multicenter study in Minnesota of 185 children who required home nursing, 57 percent of hospital discharge delays were directly attributable to lack of home health care, accounting for 1,454 hospital days.[15] Hospital costs resulting from these delays totaled $5.72 million, compared to the estimated $769,326 that it would have cost to care for the children at home. In an analysis at our institution, we also found that hospital discharge delays due to the private duty nursing shortage lead to months of unnecessary hospital days and millions of dollars in avoidable hospital charges in the aggregate.[30] Home health agencies, in turn, lose revenue when patients are hospitalized and sometimes drop patients as clients when a hospitalization is prolonged. Staff nurses are then reallocated to other clients so that the agencies can remain financially viable.

Transitional and long-term care facilities may offer opportunities for training and transitional support for families before patients are discharged home. States differ, however, in allowing these services. One example of a facility is Almost Home Kids, an Illinois pediatric community–based health care center that provides a supportive, educational alternative to the hospital for children with medical complexity and their families before the children go home and when the families need respite.[31] States vary, however, in their definitions, licensure, and regulations of such facilities, which affects the available out-of-home options for children and youth nationally.[32]

Recommendations For Policy And Program Changes

While the challenges to providing high-quality home health care are multifaceted, policy and program approaches can alleviate workforce gaps and expand access to home health care for children and benefit families, payers, and providers. Accessible, high-quality home health care has the potential to improve health outcomes in a patient- and family-centered fashion and reduce the use of emergency and hospital care. A combination of payment reform, improved pediatric home health training opportunities through partnerships with child-focused health systems, telehealth-enabled opportunities to bridge current workforce gaps, and the consideration of dynamics in home health care for adults can address fundamental vulnerabilities in the current system.

PAYMENT REFORM State payment for pediatric home-based care should be competitive with that for other forms of skilled nursing care. Payment increases—perhaps tapping fiscal sources that are tied to higher Federal Medical Assistance Percentage rates, depending on state circumstances—could include the stratification of rates for higher-complexity cases and, in areas of shortage, to provide incentives for nurses to care for patients most at risk for prolonged hospitalizations. For example, care of patients who required continuous respiratory care would be reimbursed at a higher rate than care for patients who only need to be given medication every few hours. Paid caregiving for trained family members, which is not permitted in most states, could further expand the workforce while mitigating the financial impact on families. Since home health agencies usually deduct administrative fees from state payments before paying nursing staff, allowing families to contract directly with nurses instead of through agencies could offer a higher, more enticing wage to home nurses.

Calls for higher wages for Medicaid-reimbursed home care services can be expected to be met with skepticism from policy makers. However, given that children with medical complexity have intensive medical needs and frequent exacerbations of chronic health conditions, investment in higher-quality home health care would be a cheaper option than the repeated or prolonged hospitalizations that currently occur.[7,33] Instead of viewing home health care as a drain on state budgets, the Minnesota multicenter study suggests that states should consider it as a tool to prevent hospitalizations and facilitate more timely discharge when hospitalizations occur.[15] Furthermore, states could phase in increases in home health care payment over a period of time, moving toward a goal of hourly nursing wages in the home setting that approximate wages in the inpatient setting.

The potential role and impact of managed care on pediatric long-term services and supports are unknown. The National Academy for State Health Policy issue brief noted that only four states—Delaware, Tennessee, Virginia, and Texas—specify network adequacy standards for pediatric long-term services and supports.[12] To achieve managed care goals, states should carefully review network adequacy and consider competitive payment for home nursing in their managed care contracts to shift care from expensive hospital settings to less costly care delivery settings, such as the home. Evaluations of network adequacy must consider more than single-year savings and direct costs to states. Instead, they should include longer-term effects such as

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An improved evidence base is needed for what constitutes accessible high-quality pediatric long-term services and supports.

lost family wages (that is, taxable income) from family caregivers who were forced to leave their own employment to fill workforce gaps.

INTEGRATION OF HOME HEALTH WITHIN CHILD-FOCUSED HEALTH CARE SYSTEMS With the advent of accountable care organizations and value-based payment arrangements between payers and health care systems, creating systems that align inpatient, ambulatory, and community services has gained appeal. Hospitals—including children's hospitals—are increasingly penalized for readmissions, the origins of which may be based in the home, where hospitals traditionally have little influence.

We propose more formal collaborations between child-focused hospitals, academic institutions, home health agencies, and nursing education programs to create a robust pool of nurses in pediatric home health care and manage patient care. Pediatric hospitals can help shape how to train nurses and clinical nursing assistants to have the right skill levels matched to levels of patient need, step in to modify the level of nursing care when gaps occur, supplement home health agency oversight with supervisory support, and work with patients' primary care physicians and primary care medical homes to coordinate home-based care between emergency department and hospital visits. Among successful examples of targeted nursing education are the Trach Safe Emergency Airway Management Course at Seattle Children's Hospital and Nitty Gritty Nursing: Improve Your Community Nursing Skills for Children Who Are Medically Fragile and Technology Dependent at our institution. Alternatively, the University of Massachusetts Medical School's Community Case Management program keeps children and adults out of institutional care through coordinating care and helping families navigate the administrative hurdles involved in long-term services and supports coverage. Through such partnerships and programs, child-focused health institutions can fulfill their own patient care goals and attend to fiscal constraints without fully incorporating the home health business model, if desired. Home health agencies would similarly benefit from a better-trained workforce and greater coordination with child-focused health systems in their service areas.

Another needed advancement is the development of uniform order forms and documentation for home health care, including electronic ordering, to facilitate timely and accurate orders for home care providers (that is, there is a need for interoperative health care records). Ideally, such as system would enable home nurses to review the orders for correctness in a timely manner to enact necessary changes to care at home to minimize error and expedite care, especially after a hospital discharge.

As the value-based payment system expands, pediatric hospitals that do not already offer home care programs may wish to do so, by capitalizing on their already highly trained workforce as a way to better monitor the care that is being provided at home.

ADVANCING COMPLEX HOME-BASED CARE THROUGH TELEHEALTH Incorporation of telehealth in the home health care of children with medical complexity also can link institution-based specialists with home nurses to monitor patient status, manage symptoms, and adjust care in real time. Videoconferencing and remote home monitoring of clinical parameters such as respiratory physiology and blood sugar offer tools to link children's families, health care providers, and home health care staff.[34] These examples of telehealth tools are increasingly vital, especially for children and youth with medical complexity who live in remote or otherwise underserved areas or who are difficult to transport. They can sustain success in home-based care and avert hospitalizations.

Telehealth may also provide a bridge to address workforce shortages, by supporting nurses without pediatric experience—and potentially even nonclinical aides or extended family caregivers—to care safely for more patients at home through videoconferencing with pediatric specialists and home health agency nursing supervisors.[35,36] One successful model has already demonstrated a decrease in clinic and emergency department visits through direct support of family caregivers for children with home breathing machines.[35] Importantly, as telehealth increasingly includes remote patient monitoring, the home health care workforce will require appropriate training and education to leverage the maximum benefit of these clinical tools, which have been shown to be feasible and highly rated by families.

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ALIGNMENT WITH HOME-BASED CARE FOR ADULTS Children with medical complexity and technology dependence are living longer as a result of technological advances, so their numbers and the demand for a home health care workforce are increasing.[2] In addition, as adults live longer, they also will require more home-based care. Combined, these two trends will have a substantial economic impact on family caregivers and the demand for paid caregiving. In 2015 an estimated 43.5 million US adults had provided unpaid, health-related care to an adult or child in the prior twelve months, providing an average of 24.4 hours of care per week.[37] It will be essential to align pediatric care with adult care by including pediatric health care professionals in federal and state long-term services and supports policy working groups and on home health care agency boards.

Better alignment with adult care to address the need for more pediatric home health care services must also be linked to the need for quality measures for such care. While some metrics exist to evaluate home health care delivery for adults, there are no equivalent measures for pediatric home health care. The Centers for Medicare and Medicaid Services' Home Health Compare has no pediatric-specific items,[38] and national surveys on home health care typically do not include children.[39] Therefore, state managed care contracts for long-term services and supports lack pediatric-specific measures to evaluate the quality of care provided.[12] It will be essential for pediatricians to be involved in the development or adaptation of government-based, home health care–focused quality measures in the near future and in the creation and implementation of Medicaid network standards. Consideration of children in national metrics is necessary to ensure that pediatric home health care services are of good quality and commensurate to their cost.

An improved evidence base is needed for what constitutes accessible high-quality pediatric long-term services and supports. Future surveys and data reporting requirements in this area should include patients younger than age eighteen to enhance our understanding of pediatric utilization nationally and by state, to understand how state-based waiver eligibility affects utilization. Future research should include rigorous evaluation of the current state of home nursing quality, including the development of pediatric-specific measures that take into account the family context, to support future interventions designed to improve access and training.

Conclusion

Home health care for children and youth with medical complexity in the United States is a patchwork of policies and programs that does not currently meet the medical needs of many patients; unnecessarily prolongs hospitalizations; and relies on an insufficient, inadequately trained workforce. Although there are no formal metrics of quality for pediatric home health, it is evident from several national surveys that family caregivers are frequently shouldering enormous burdens that lead them away from their own gainful employment and create social, emotional, and financial hardship.

There are, however, immediate opportunities to address some of these workforce issues through more competitive payment, better training, and better coordination of services among child-focused hospitals and health systems and home health nursing services. In addition, wider use of telehealth can create efficiencies. Finally, with an improved evidence base, there would be opportunities to better align pediatric and adult home health care services—particularly in terms of network adequacy and quality measurement. While supportive public policies exist, additional policy-based solutions will be required to ensure that adequate, affordable, and measurably high-quality home health care services are available to children and adults. ■

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Home Care Association of Washington

Clinical Director Report – June 2022 Board Meeting

Report for May 2022

Social worker payment for Medicaid home health:

HCAW was successful in getting Apple Health to cover social work visits. See links for billing guide and fee schedule:

https://www.hca.wa.gov/assets/billers-and-providers/Home-Health-Services-bg-20220401.pdf

home-health-20220101.xlsx (live.com)

Please let us know if you are having trouble getting paid for this. Has your agency provided social visits to Medicaid patients? Have you successfully billed for this and been paid?

Certificate of Need rules for Home Health: Certificate of need rules for home health review still pending. No date yet. Leslie and I have had preparatory meetings with Marc Berg with a focus on educating board members and other participants regarding current rule and methodology. The current numeric methodology allows for a substantial number of additional agencies statewide. In addition, as a state we are not performing as well as we could on many metrics.

Private Duty Home Care Deserves Provider Relief

The *CARES Act* Provider Relief Fund has been a lifesaver to thousands of health care providers across the country. Through the fund distributions, the Department of Health and Human Services (HHS) has been able to stabilize access to care during the Public Health Emergency and help preserve the health care infrastructure for the post-pandemic future. We very much appreciate Congressional action creating the fund and the swift actions taken by HHS to prioritize the distribution of the funds.

The National Association for Home Care & Hospice strongly believes direct relief funds should be provided to personal care home care providers, and we are advocating directly to congressional leadership on this issue. NAHC firmly believes Congress must take immediate steps to provide funds to an essential part of our health care system that, to date, has not received this crucial support. Home care companies that serve...

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Choose Home Care Act 2021, S. 2562/H.R. 5514

The Choose Home Care Act of 2021, S. 2562/H.R. 1544 is a cost-effective and patient preferred home-based extended care benefit as a supplement to the existing home health benefit that supports patients to leave the hospital and recover at home with a mix of expanded skilled nursing, therapy, personal care, telehealth services and more. In this way, eligible patients can choose to recover at home in a safe home environment with appropriate (NAHC). You can read more at the NAHC fact sheet available here: ChooseHome_PQHHNAHC_062321[7][2].pdf This key piece of federal legislation continues into the 2022 legislative session. There are approximately 50 legislators who have signed on as co-sponsors. However, none of the WA state legislators have done so. See links below.

Cosponsors - H.R.5514 - 117th Congress (2021-2022): Choose Home Care Act of 2021 | Congress.gov | Library of Congress

https://www.congress.gov/bill/117th-congress/senate-bill/2562/cosponsors?q=%7B%22search%22%3A%5B%22choose+home+care%22%2C%22choose%22%2C%22home%22%2C%22care%22%5D%7D&r=1&s=1