Background and White Paper Summary

The Office of Medical Assistance Programs (OMAP) within the Pennsylvania Department of Human Services (DHS) provides oversight of the managed care delivery system that serves children and adolescents who receive pediatric home health care (i.e., in-home shift nursing or home health aide services). In the past three years, there has been a fluctuating number between 7,600 and 8,000 unduplicated children and adolescents annually who receive these pediatric home health care services. In 2019, OMAP began a special initiative to re-envision how pediatric home health care was delivered to these children and their families and how they were supported in that process. Across a series of collaborative large-scale workshops and smaller workgroup meetings, OMAP along with home health agencies, managed care organizations, family members, and advocates, developed a public white paper with 13 recommendations across 5 areas to improve the system of care – Service Coordination; Going Home Transition and Discharge Planning; Caregiver and Nurse Relationship and Co-Training; Behavioral and Physical Health Coordination; and Nurse Recruitment and Retention.

5 Workgroup Areas

This update to the white paper summarizes how the collaborators within the pediatric shift care initiative have moved from 13 visionary recommendations to on-the-ground changes within Pennsylvania's managed care delivery system. The efforts continue to focus on improving Pennsylvania's pediatric shift care model to better serve patients, families, home health care workers, and managed care organizations.

Implementation Phase 1: Strategic Planning

The 13 recommendations from the stakeholder-developed white paper received support from DHS executive leadership in early 2021 and OMAP was charged with implementing the recommendations. OMAP team began to conduct strategic planning on how to implement each of the recommendations, including brainstorming and prioritizing based on several factors, such as monetary resources needed, scope of OMAP control, and timeframe. The implementation team also conducted research on peer-states to determine if programs or initiatives like those recommended were delivered in other states. Lastly, the team also reached out to subject matter experts that were both part of and not part of the workgroups to gain additional insight on how best to operationalize some of the white paper recommendations within the existing Pennsylvania system. The initial efforts focused largely on establishing a Patient-Centered Medical Home program that was focused specifically on children with medical complexity (CMC) and connecting nursing schools with home health agencies to improve the local workforce pipelines. This groundwork of moving from visionary recommendations to on-the-ground implementation proved to be invaluable for what came next.

Implementation Phase 2: American Rescue Plan Act of 2021 (ARPA) Initiatives

Within a few months of conducting the initial implementation planning, the Centers for Medicare and Medicaid Services (CMS) announced the opportunity for enhanced funding for home and community-based services (HCBS) for Medicaid members through the American Rescue Plan Act of 2021 (ARPA). As part of the larger spending plan across all DHS program offices, OMAP was able to incorporate items into the spending plan that addressed nearly all the white paper recommendations, with multiple strategies for some of the recommendations (see Pennsylvania Department of Human Services-Quarterly Update-HCBS). The spending plan was vetted through the stakeholders of the collaborative initiative through an open comment period and received CMS approval. The OMAP implementation team pivoted and focused their efforts on implementing the items within the spending plan, keeping in contact with the original stakeholders involved in the initiative. Below is a summary of the ARPA-related initiatives that align with one or more of the recommendations from the white paper.

Medical Homes for CMC

The new Patient Centered Medical Home (PCMH) Pediatric Nursing Care (PNC) program began January 2023 and is being delivered through managed care organizations. It leverages the American Academy of Pediatrics medical home applied to CMC to improve comprehensive coordination of care for children receiving pediatric shift care by providing existing PCMH providers (typically primary care providers) start-up funds and enhanced rates to establish and deliver whole-person, family-centered case management and team-based care planning.

Caregiver Support and Training Hubs

The new Pediatric Complex Care Resource Center (PCCRC) program is expected to launch early 2024 and will support families of CMC and their healthcare providers, such as home health agencies. The regionally based centers will provide education and training for specific needs and help families and providers navigate the various systems and resources that are available to support them. PCCRC services will be delivered through the existing regional network of eight Health Care Quality Units (HCQUs). The services will include:

- **Pediatric Coach**: A new position at the HCQU will have three core functions:
    1. ***Caregiver Support and Intervention:*** The Pediatric Coach will provide personalized support and intervention for caregiver teams as they work together and collaborate around the needs of the child. This may include providing problem solving, conflict resolution, and negotiating the bridge between meeting familial, social, and medical goals. They may also work individually with family members to empower them to successfully advocate and communicate needs, priorities, and concerns to the larger team.
    2. ***Learning Customization and Facilitation:*** The Pediatric Coach will provide education and training support to the caregiver team that will be targeted to meet each child's specific needs in a way that empowers each child's team to support them in the best way possible. They will facilitate training courses by leveraging PCCRC curriculum developed for the MyODP learning platform (described below) and customize course

content where applicable. Course instruction will be provided in a variety of modes including classroom-based, small group, and individualized training in the home.

3. ***Family Advisory Workgroup Facilitation:*** The Pediatric Coach will develop, schedule, and host ongoing regional family advisory workgroups aimed at supporting families caring for CMC. The purpose of the workgroups is to give families an opportunity to provide insight and feedback on services being utilized.

- **Teleconsulting**: A toll-free telephone line operated by a call center will be available 7am-9pm, seven days a week (excluding Federal Holidays) that will help caregivers (parents, family members, home health aides, nurses, etc.) to receive answers to non-medically-related questions, such as navigating the service system, insurance, peer family support, supporting the child in the home environment, and service referrals. Warm hand-offs will be made as often as possible to referred resources (i.e., the caller can be transferred to a resource without hanging up).
- **Family Facilitator:** An extension of an existing program within the Office of Developmental Programs to support children's transitions from facilities/hospitals to community settings and to support the diversion of children's placements in congregate care settings. The expansion of the program will increase capacity from one position severing the entire Commonwealth to six regionally based positions.
- **Online Training Platform:** Development of new self-paced learning courses on various home-care topics targeted for CMC caregiver teams (e.g., family members, medical personnel, home health agency staff, managed care organizations). OMAP is collaborating with the University of Pittsburgh to develop curricula and deliver through the existing MyODP online learning platform. The process for developing and deploying the courses will follow recognized principles of effectively addressing disparity, equity, inclusion and belonging (DEIB). Courses will focus on fundamentals of supporting CMC receiving in-home care, including education focused on supporting behavioral health needs; using durable medical equipment (DME) in individual home environments; improving advocacy efforts through inclusion in family/community systems; ensuring safe and efficient life transitions; and improving collaboration through relationship building amongst caregiver teams.

Strengthen the Home Health Workforce

- **Shadow Training Payments:** Home health agencies are now reimbursed for new in-home nurses to shadow and train with nurses currently assigned to an in-home case. Directed payments made to managed care organizations to pay these nurses while they train improves the quality of training and prepares nurses to more competently and confidently staff cases, thus improving retention and quality of care.
- **Retention Payments:** Home health agencies are now reimbursed to provide retention bonuses to in-home nurses who remain with an agency and provide in-home nursing for a year. Payments are direct through managed care organizations. This addresses workforce deficits by attracting and retaining qualified nurses.
- **Pay-for-Performance:** Managed care organizations are developing programs to make incremental improvement incentive payments to home health agencies and primary care providers who serve CMC with uncovered, authorized shift care hours and meet goals related to improved clinical and social outcomes.

- **Parents/Families as Paid Family Caregivers:** Managed care organizations have revised their home health aide authorization procedures to ensure that legally responsible relatives (LRRs) of CMC who meet home health aide qualifications and are employed by an enrolled home health agency can be paid for services delivered.

Expand Health Information Technology

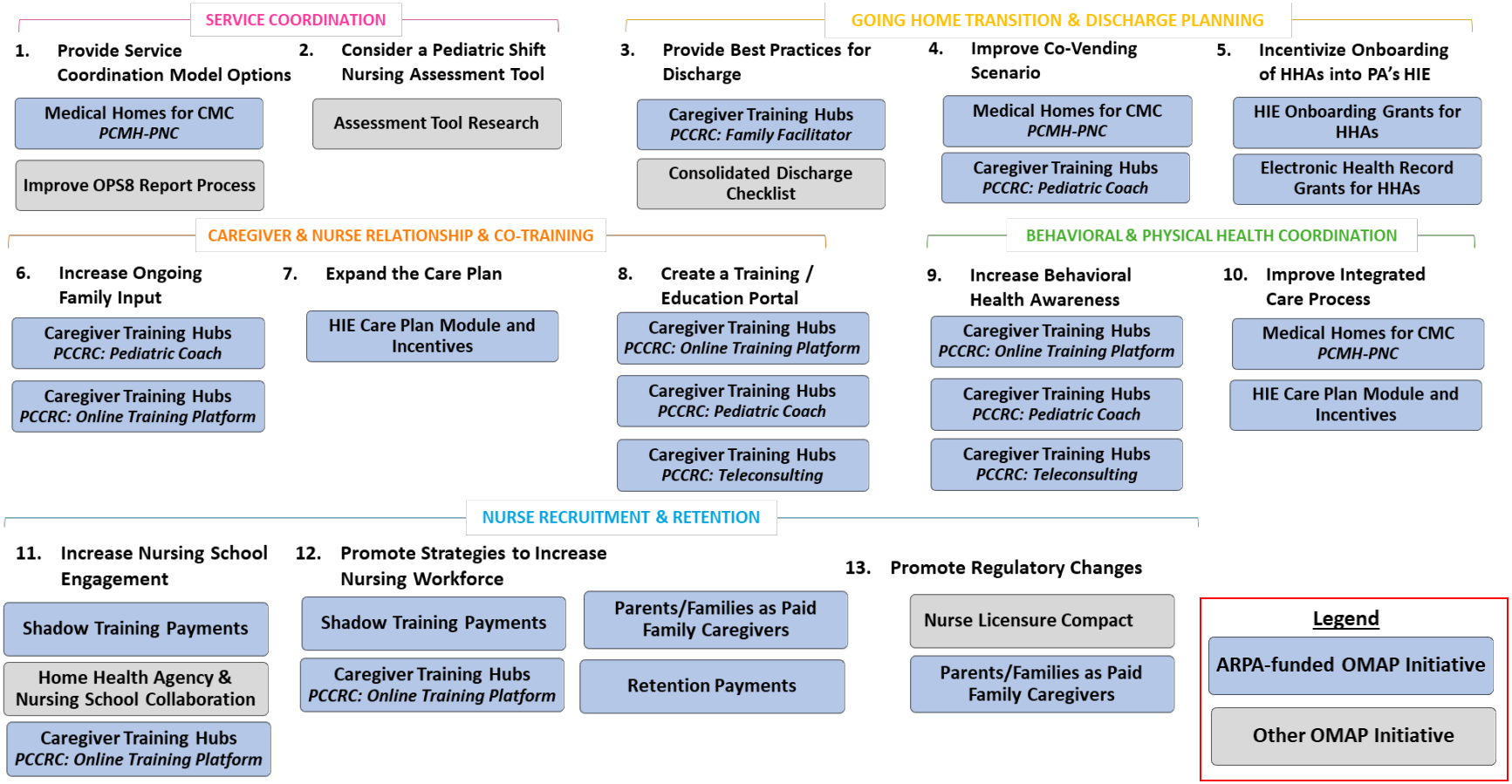
- **Health Information Exchange Onboarding Grants for Home Health Agencies:** One-time onboarding grants were made available to connect home health agencies to the Pennsylvania Patient and Provider Network, the Commonwealth's Health Information Exchange (HIE), which allows for sharing of patient information among providers. These grants delivered to Health Information Organizations allowed 37 home health agencies to onboard and represents an investment in technology infrastructure that will enhance care coordination.
- **Electronic Health Record Grants for Home Health Agencies:** One-time grants were made available to home health agencies to obtain interoperable electronic health record (EHR) technology that will allow them to connect their EHR to the Pennsylvania Patient and Provider Network and afford the opportunity to use these EHRs in a meaningful way to improve care for CMC.
- **HIE Care Plan Module and Incentives:** The new Pennsylvania Patient and Provider Network was enhanced with a Care Plan Module to improve care coordination and care management activities by increasing the ability to share care plans across providers. Key elements in shared care planning are person-centered goal setting and engaging caregivers in the creation and maintenance of a comprehensive care plan.

Looking Forward

The efforts of numerous individuals and organizations involved in the pediatric shift care initiative over the past four years has resulted not only in collaborative and innovative strategic planning but has also resulted in real-world changes to Pennsylvania's pediatric shift care delivery model to better serve patients, families, home health care workers, and MCOs. With implementation of several of the above efforts well underway, OMAP is turning to tracking outcomes and executing evaluations of how these efforts have made impacts. The initiative continues to grow as OMAP welcomes additional partners to the collaboration who bring new ideas and expertise to improve care to the CMC living in Pennsylvania, with a continued focus on the primary areas of concern and associated recommendations made within the collaboratively developed white paper.

Appendix: Alignment with Recommendations

The below graphic summarizes how ongoing OMAP efforts align with the 13 original recommendations developed by the five workgroups that were made public in the white paper. Many efforts are addressing recommendations across the five topic areas and the efforts listed here are not exhaustive.



Pediatric Shift Care Nursing

Dear Secretary Miller,

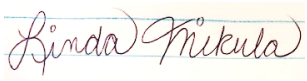
We are pleased to present the results of a stakeholder-driven initiative that has sought to improve Medicaid service delivery for some of Pennsylvania's most vulnerable children – children living with complex medical conditions that are receiving in-home pediatric shift care nursing.

The attached white paper represents the product of over a year of collaborative work with over 120 stakeholders and includes several recommendations for your consideration to improve the provision of pediatric shift nursing services in Pennsylvania's Medicaid program.

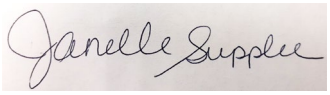
We appreciate your department's focus on this critical issue and look forward to the opportunity to continue our work together to implement these recommendations.

Sincerely,

The Pediatric Shift Care Nursing Initiative Co-Chairs





Linda Mikula, Gateway Health; Teri Henning, Pennsylvania Homecare Association; Kristin Michener, Interim Healthcare of Pittsburgh; Luis Rivera, Maxim Healthcare Services; Patrice Faust, Aetna Better Health; Janelle Supplee, CritiCare Lancaster

The Pediatric Shift Care Nursing Initiative team is also grateful to Shannon Gutwald, Harmony Home Healthcare; Meg Stellini, Aveanna Healthcare; and OMAP's Katrina Becker and Jeanne Funk for stepping in to serve as co-chairs for this initiative.

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Improving Pennsylvania's Pediatric Shift Care Nursing Through Collaboration

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From the Commonwealth of Pennsylvania's Office of Medical Assistance Programs

I am pleased to present the results of a stakeholder-driven initiative that has sought to improve Medicaid service delivery for some of Pennsylvania's most vulnerable children – children living with complex medical conditions that are receiving in-home pediatric shift care nursing. This white paper reflects the outcomes from extensive collaborative efforts with multiple stakeholder groups, including families and caregivers, home health agencies, managed care organizations (MCOs), health systems, and state agencies. This effort would not have been possible if it were not for the willingness of these stakeholders to engage in open, honest, and meaningful discussions to better understand one another's perspective of the issue and to reach consensus on what could be accomplished to improve the current state of service delivery. Over the last year, they have given generously of their time, participating in meetings and workshops that took them away from their "regular" jobs. I am grateful that they were willing to roll up their sleeves and do the work, which has led to recommendations that are more balanced and more reasoned.

The recommendations and ideas captured in this white paper are the result of thoughtful discussions and sharing of personal experiences. I would like to personally thank the family members who contributed across all the workgroups and who shared their personal stories that provided unique insights during our discussions that would not otherwise be possible. Working across organizational boundaries has provided all participants of this initiative the opportunity to learn new perspectives and build and foster existing connections and relationships.

While we have accomplished a significant amount of work over the past year, we realize we are on a journey of ongoing collaboration to improve Pennsylvania's pediatric shift care nursing model to better serve patients, families, home health care workers, and MCOs. We look forward to re-engaging our stakeholder partners to continue collaborative efforts to implement the forward-thinking recommendations and ideas presented in this white paper.

Thank you,

Sally A. Kozak, MHA, RN

Deputy Secretary, Office of Medical Assistance Programs

Table of Contents

Executive Summary

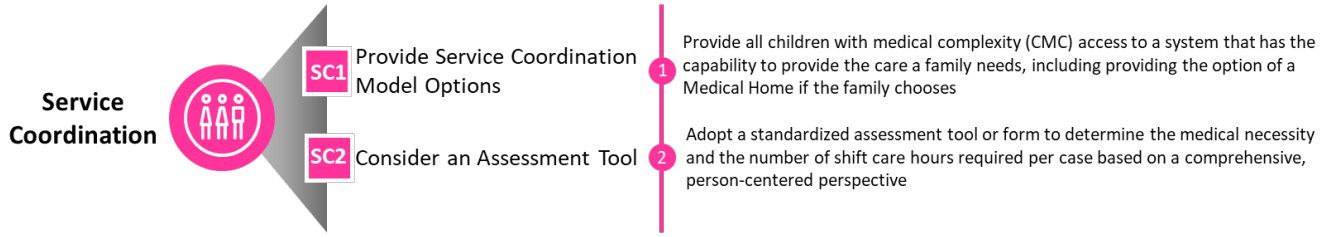
The Office of Medical Assistance Programs (OMAP) within the Pennsylvania Department of Human Services (DHS) provides oversight of the managed care delivery of pediatric shift care nursing services. There are approximately 10,000 unduplicated children in Pennsylvania who receive pediatric shift care nursing services throughout the course of a year, and approximately 4,000 children on a given day. OMAP collaborated with home health agencies and MCOs on this initiative with the purpose of improving Pennsylvania's pediatric shift care nursing model to better serve patients, families, and home health care workers. This initiative was driven by cross-organization stakeholder collaboration through in-person and virtual workshops. Ideas generated from the workshops were further developed by five stakeholder workgroups that consisted of family members, MCOs, home health agencies, and other pediatric shift care nursing stakeholders. The topics addressed by the workgroups were:

1. **Service Coordination**
2. **Going Home: Transition and Discharge Planning**
3. **Caregiver and Nurse Relationships & Co-Training**
4. **Behavioral Health and Physical Health Coordination**
5. **Nurse Recruitment and Retention**

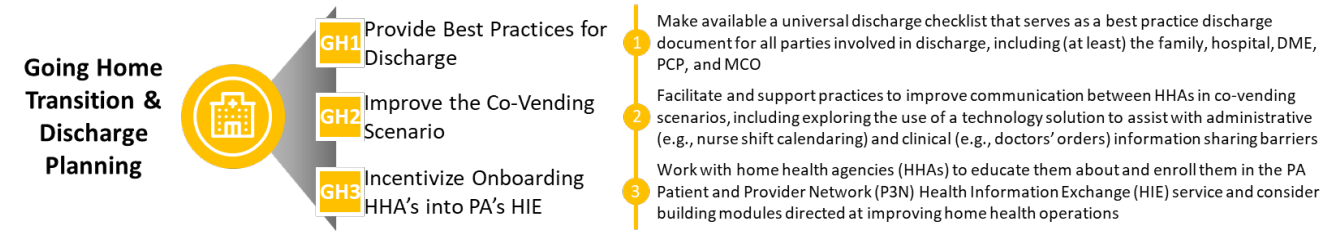
Each workgroup developed problem statements related to their topic scope and met for a total of over 60 virtual meetings to refine and finalize 13 recommendations to address the identified problems. Each recommendation is interrelated with the others and ultimately advances the goal of improving pediatric shift care nursing services. The five workgroups, the diverse stakeholders, and the final recommendations are united in the purpose to improve Pennsylvania's pediatric shift care nursing home health model to better serve patients, families, home health workers, and MCOs. All children in Pennsylvania, regardless of where they live or what diagnosis they have, deserve the care they need so they can live life to their fullest potential.

A summary of the recommendations is included below in Figure 1 and described in further detail in subsequent sections of this white paper.

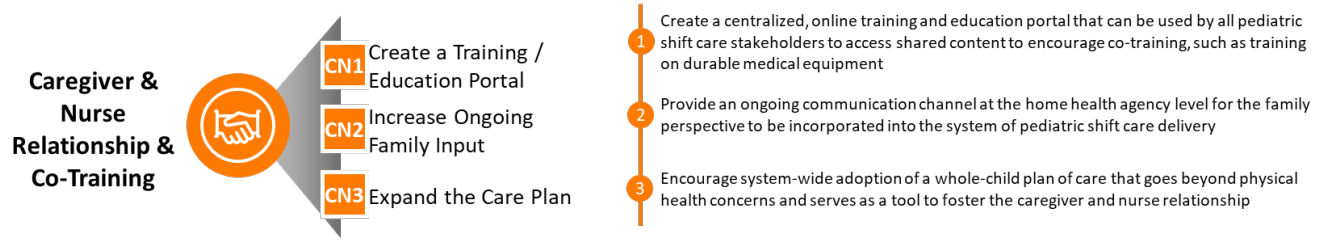
Service Coordination Recommendations Summary



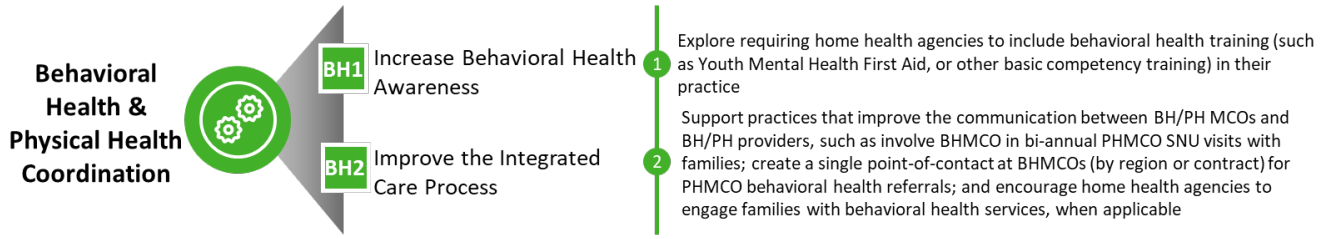
Going Home Transition and Discharge Planning Recommendations Summary



Caregiver and Nurse Relationship and Co-Training Recommendations Summary



Behavioral Health and Physical Health Coordination Recommendations Summary



Nurse Recruitment and Retention Recommendations Summary

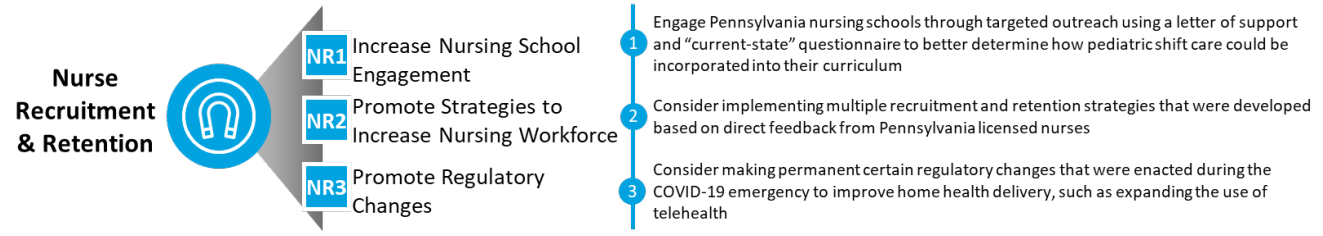


Figure 1 – Workgroup Recommendations

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Introduction

The following section is an overview of the research conducted as a part of this effort, as well as additional context on the overall mission of the initiative, the stakeholders involved, and the charter developed by the overall workgroup.

National Landscape of Pediatric Shift Care Nursing in Medicaid

Pediatric Shift Care Nursing can be defined as private duty nursing care offered to children with complex medical needs at home in shifts, aiming to offer high quality at-home care while easing the burden on caregivers. In support of OMAP's efforts to reimagine the pediatric shift care nursing model for Pennsylvania, extensive research was conducted to gain an understanding of the national landscape for pediatric shift care nursing services provided through Medicaid programs. This research involved a broad literature review of academic and trade journals, peer state model review, a survey sent to all State Medicaid directors, and in-depth interviews with Medicaid teams from four key states. A summary of this research is provided below in Figure 2.

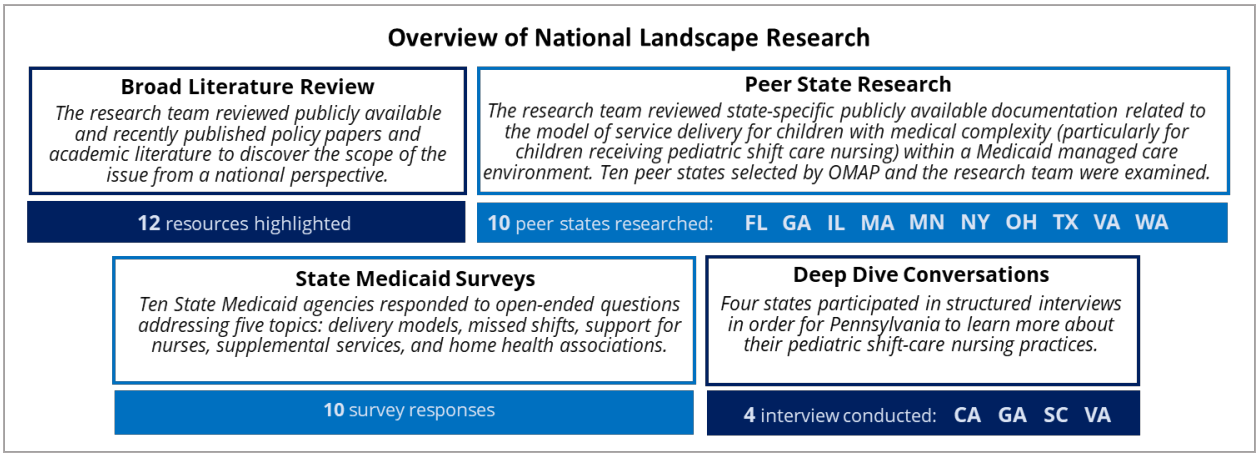


Figure 2 – National Landscape Research

The national landscape research showed that state Medicaid agencies across the country are embracing the emerging challenge of determining how to provide pediatric shift care nursing services. Many states face the same challenges of workforce shortages and identified service coordination as the keystone of an effective strategy. Against this common background of state challenges and efforts, there is not a proven "one best way" to administer care to CMC in Medicaid. However, there are several innovative strategies that states have implemented shown in Figure 3, below.

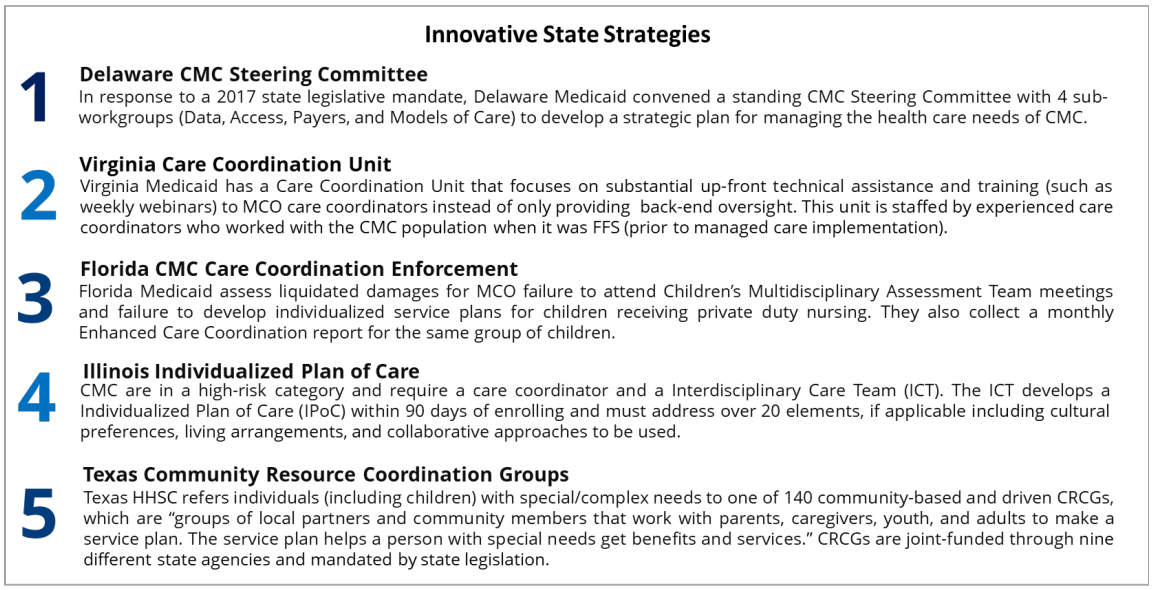


Figure 3 – Innovative State Strategies

In addition to these innovative strategies, a set of emerging practices were identified through a survey sent to all state Medicaid directors and follow-up interviews with Medicaid leadership from four states. These emerging practices respond to common challenges of workforce limitations and are strategies that have been recently implemented or are under consideration. Additional details are provided in Figure 4 below.

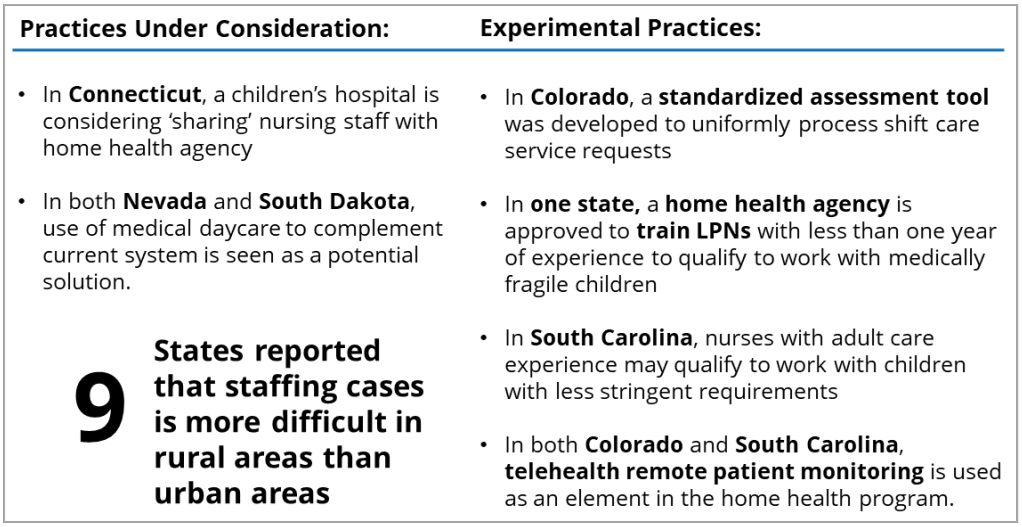


Figure 4 – Emerging State Practices

An in-depth view of the leading state best practices research is included in Appendix A.

A recent and similar scan of state practices was completed by the National Academy for State Health Policy (NASHP), which analyzed six states' approaches to providing home health services to CMC enrolled in Medicaid.[1] Five of six states analyzed used Medicaid managed care to deliver services; the sixth state used fee-for-service. They integrated their findings into six key strategies and conclusions that align with both the findings of the research and the outcomes of the workgroups (discussed later in this report):

- **Prioritize efforts to address provider shortages;**
- **Seek regular feedback from families;**
- **Leverage the benefits of cross-sector and stakeholder collaboration;**
- **Adjust service delivery models to increase capacity;**
- **Strengthen oversight to improve quality and access to services; and**
- **Customize fee-for-service and managed care approaches to improve access.**

Current State of Pediatric Shift Care Nursing Delivery in Pennsylvania

Most of the CMC who receive shift care nursing services under Medicaid are eligible under Pennsylvania's PH-95 Medicaid program. Within this program, about 95% of the children receive services through managed care; private duty nursing (i.e., shift care nursing) accounts for nearly $100 million in annual expenditures for this population.[2] Children with medical complexity often have multiple life-limiting conditions with no unifying diagnosis and an unclear prognosis, as well as are at high risk[3].

There are eight MCOs contracted with DHS to manage physical health service delivery for Medicaid enrollees, which are contracted with over 360 home health agencies within Pennsylvania to provide home health services, including pediatric shift care nursing. The home health agencies are the core service delivery entity to provide in-home physical health services to CMC. These children also receive services from a pediatrician or family medicine practice as well as multiple specialists. Their pediatrician or specialist may serve as their primary care physician (PCP). Some PCPs within Pennsylvania are formally designated as Patient Centered Medical Homes (PCMHs)[4], however it is not currently a requirement for CMC to be connected to a PCMH. Providers who are designated as a PCMH currently do not receive a higher reimbursement rate to serve as a PCMH.

[1] National Academy for State Health Policy (2020). State Approaches to Providing Home Health Services to Children with Medical Complexity Enrolled in Medicaid. Retrieved from: https://www.nashp.org/state-approaches-to-providing-home-health-services-to-children-with-medical-complexity-enrolled-in-medicaid/

[2] Pennsylvania Department of Human Services (2019). Medical Assistance for Children with Disabilities, 2017 Report. Retrieved from: https://www.dhs.pa.gov/docs/Publications/Documents/Highlighted%20Reports/PH-95%20Report%202017%20Final.pdf

[3] Children with Medically Complexity (CMC) (2020). Retrieved from: https://pediatrics.aappublications.org/content/145/3/e20192241

[4] Pennsylvania Department of Health (2020). PA Medical Home Initiative. Retrieved from: https://www.health.pa.gov/topics/programs/Pages/Medical-Home-Program.aspx

Role of Pediatric Extended Care Centers (PECCs)

The option of using pediatric extended care center (PECC) services to supplement pediatric shift care nursing services is an additional element of the service landscape for CMC. In Pennsylvania, PECCs are an aspect of the managed care landscape, meaning that beneficiaries can use these services without participating in a waiver program. As PECCs are covered under managed care, MCOs are required to pay for these services if daytime shift care nursing hours cannot be filled. However, the managed care network adequacy requirements do not include PECCSs. Therefore, PECCs cannot replace shift care nursing services but can supplement these services for beneficiaries in Pennsylvania's HealthChoices program.

The map in Figure 5 below shows PECCs across the commonwealth of Pennsylvania, including the approximate drive time to each one (up to 60 minutes)[5].

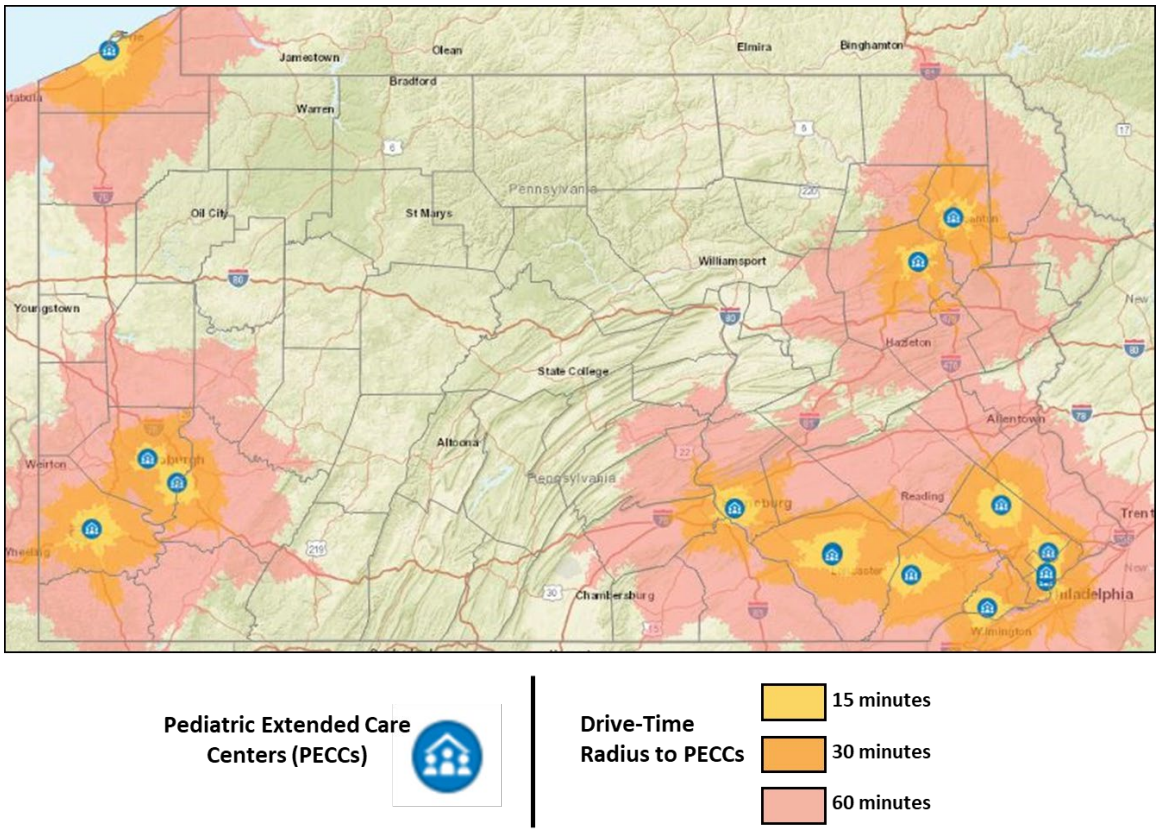


Figure 5 – PECC Accessibility Map

In Pennsylvania, PECCs are regulated by the Department of Health (DOH) in accordance with Pennsylvania Act 54 of 1999, commonly referred to as the Prescribed Pediatric Extended Care Centers Act.[6] To expand access to high-quality PECC services, OMAP is collaborating with DOH leaders to

[5] SAIS PA Department of Health, Health Care Facilities (2020). Retrieved from: http://sais.health.pa.gov/commonpoc/content/publiccommonpoc/CommonPOCSelect.asp?formSubmitted=normalformSearch

[6] Pennsylvania General Assembly (1999). Act 54 of 1999, Prescribed Pediatric Extended Care Centers Act. Retrieved from: http://www.legis.state.pa.us/WU01/LI/LI/US/HTM/1999/0/0054..HTM

evaluate requirements for establishing and operating PECCs. Specifically, collaboration will focus on achieving consistent, high-quality services. As these efforts continue, the role of PECCs in the Pennsylvania shift care nursing landscape may evolve and supplement additional shift care nursing hours when needed.

Pennsylvania Medicaid Managed Care and HealthChoices Background

For several decades, the Commonwealth of Pennsylvania has been a leader of health care delivery reform. The Commonwealth has provided some form of managed care to the Medical Assistance (Medicaid) population since the 1970s.

DHS is committed to providing Pennsylvanians enrolled in Medicaid managed care programs high quality services. Pennsylvania currently operates a statewide, fully capitated Medicaid managed care program, called the HealthChoices program, that includes eight physical health managed care organizations (PH-MCOs) and five separate behavioral health managed care organizations (BH-MCOs) operating under the CMS-approved 1915(b) waiver authority. Ninety-seven percent (97%) of the over 3 million individuals in Pennsylvania's Medicaid program are enrolled in a managed care program.

The HealthChoices program follows DHS's mission, vision, and set of core values that reflect Pennsylvania's commitment to providing high quality health care to the individuals served by Medicaid managed care programs. DHS's Mission and Vision are provided below in Figure 6[7].

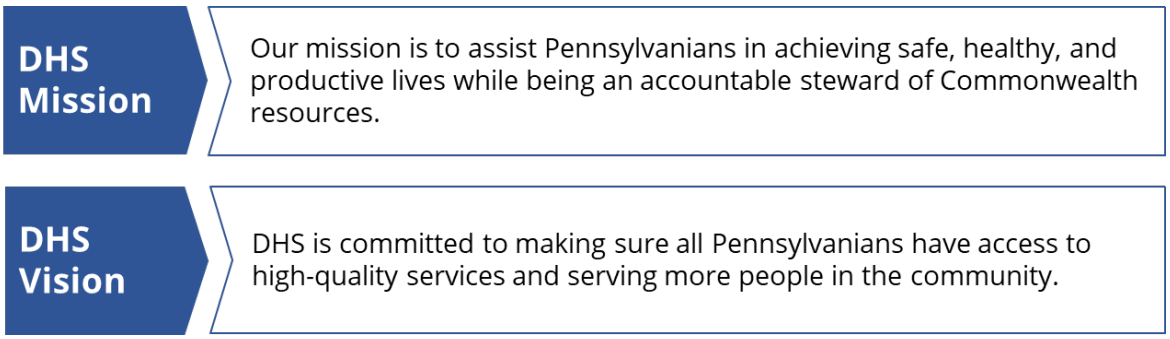


Figure 6 – DHS Mission and Vision

Initiative Background and Timeline

OMAP convened an inaugural Pediatric Shift Care Nursing Home Health Workshop in June 2019. This workshop was the beginning of a collaborative initiative focused on making improvements to the way care is provided to CMC receiving shift care nursing services in the HealthChoices program[8]. During the inaugural workshop, representatives from OMAP, the HealthChoices physical health MCOs, HHA staff, the Pennsylvania Coalition of Medical Assistance MCOs, and the Pennsylvania Home Care Association came together to collaborate and deeply understand the current state of staffing pediatric shift care nursing services. The discussion, ideation, and prioritization that occurred during this workshop guided the strategic direction of the initiative and developed the Mission, Purpose, and Objectives included in Figure 7.

[7] PA Department of Human Services' (DHS) Mission (2020). Retrieved from: https://www.dhs.pa.gov/about/DHS-Information/Pages/Learn-About-DHS.aspx

[8] Definition source: http://www.healthchoices.pa.gov/info/about/

Pediatric Shift Care Nursing Initiative Mission Statement

Mission

Serve as the catalyst for stakeholder collaboration that results in the exploration and development of actionable solutions to five key areas of Pennsylvania's pediatric shift care nursing home health model.

Pediatric Shift Care Nursing Initiative Purpose Statement

Purpose

Improve Pennsylvania's pediatric shift care nursing home health model to better serve patients, families, home health care workers, and MCOs.

Figure 7 – Pediatric Shift Care Nursing Initiative Mission and Purpose

Pediatric Shift Care Nursing Initiative Objectives

- Identify current issues and challenges faced by HHAs and MCOs in pediatric shift care nursing (i.e. missed shifts in difficult cases, including defining "difficult cases" and "missed shifts")
- Identify gaps in service coordination between MCOs and HHAs and develop solutions to bridge those gaps
- Identify gaps in training for families and nurses and create necessary training solutions for families and nurses upon discharge and ongoing home care
- Identify issues related to nurse recruitment and retention and design initiatives to address those challenges
- Identify challenges and solutions in supporting behavioral health needs for CMC and their families

This strategic direction guided the creation of five workgroups (Figure 8) that align with priority areas for improvement as well as the creation of a schedule of quarterly workshops to be held throughout the coming year. The five workgroups met for the first time during the second workshop held in September 2019 (see Figure 9 below). During this first workgroup meeting, each workgroup brainstormed and developed a workgroup vision and problem statements that were directly related to their workgroup topic. They also developed steps that the workgroup members could take to address the problem statements.

Figure 8 – Five Focused Workgroups

Following the September workshop, each workgroup met virtually to continue work on addressing their problem statements and to develop deliverables. During these virtual meetings, each workgroup had the opportunity to hold discussions on the deliverables they were working on, review research and information gathered by workgroup members, and receive feedback on work completed. Between virtual meetings, workgroup members worked on meeting workgroup goals by researching leading practices, talking to/surveying others in their or adjacent organizations, drafting deliverables, and communicating with other workgroup members via email. This additional effort outside of the virtual

meetings afforded workgroup members the opportunity to have productive conversations during virtual meetings and in-person workshop meetings.

During the January 2020 workshop the workgroups met in-person to continue to refine their deliverables and recommendations, and they also received feedback on their efforts from members of the other workgroups. The workgroups continued to meet virtually until mid-March 2020 when the workgroups meetings were paused due to the COVID-19 pandemic. The workgroups reconvened virtually beginning in June 2020 and finalized their deliverables and recommendations over the next two months. The final workshop was held virtually in July 2020. The workshop cadence is shown in Figure 9 – Initiative Workshop Timeline. During the final workshop, the workgroup co-chairs shared their workgroup's finalized recommendations to the other workgroup members. Immediately following the workshop, all workgroup members received the opportunity to vote on all workgroup recommendations and to provide any additional commentary (see Cross-Workgroup Recommendations). Executive summaries of all four workshops are included in Appendices B-E.

Figure 9 – Initiative Workshop Timeline

Stakeholders Involved

Numerous individuals and organizations were involved in each workshop and workgroup, culminating in the development of multiple recommendations and deliverables. Those involved throughout the process included families and caregivers, HHAs, physical and behavioral health MCOs, health systems, state agencies, and other groups that play a role delivering services to CMC. Families and caregivers of CMC played an integral part in this initiative. The invitation was extended to family representatives and caregivers beginning with the January 2020 workshop. At the start of the initiative it was necessary to first coordinate and unify the HHAs and MCOs, in preparation for introducing the family and caregiver groups. Within their integral role, families and caregivers participated in all workgroups, starting in January 2020, and provided vital feedback and personal stories. They helped to shape the recommendations to be patient-centered and provided insight that led to recommendations and ideas that may not have otherwise been discovered and discussed.

Figure 10 provides a comprehensive listing of each organization or entity involved in driving the progress of the initiative.

Figure 10 – Initiative Stakeholders

Service Coordination

During the September 2019 workshop, the Service Coordination (SC) workgroup focused on evaluating how service coordination could go beyond the current state to reinforce that children are receiving the care they need, maximizing available resources. They also considered:

- Why shifts are missed
- What role a care coordinator should play
- Who should be responsible for each aspect of service coordination
- Who builds and manages care plans
- Who should be requesting services

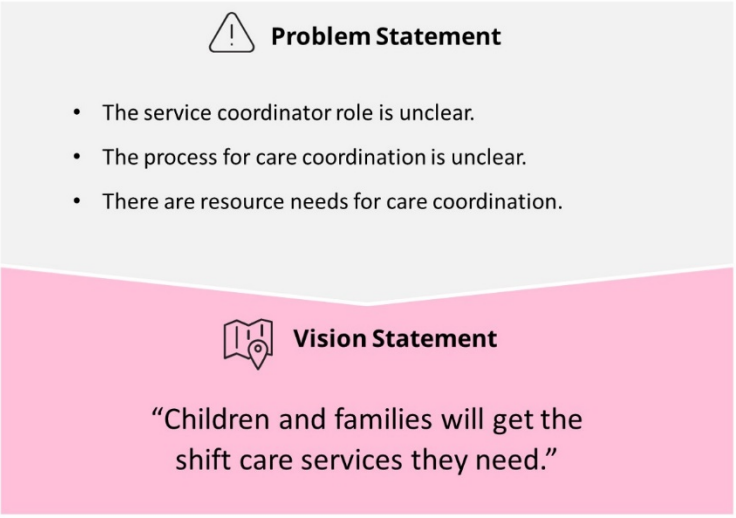


Figure 11 – Service Coordination Problem Statement and Vision

After the group discussion, the workgroup agreed upon draft problem and vision statements, shown in Figure 11.

Improving service delivery for CMC is a challenge that many state Medicaid programs are currently focusing their attention. Service coordination is at the center of this challenge. Many states are leaning towards "high-touch" care coordination to meet the needs of this population, such as regular face-to-face meetings, creating comprehensive care plans, and providing real-time support to in-the-field care coordinators. Example peer state strategies are described in Figure 12. Research into programs in other states revealed that several states are using five strategies to provide service coordination to children with medical complexity (CMC):

1. **The state has a unique MCO for CMC with a specific care plan**
2. **The state has enhanced service coordination requirement language in contracts with physical health MCOs**
3. **The state uses Title V funding for ongoing (not one-time) care coordination for CMC**
4. **The state uses a managed long-term services and support (MLTSS) contract for CMC**
5. **The state uses one or more HCBS 1915c waiver programs with enhanced service coordination requirements for CMC**

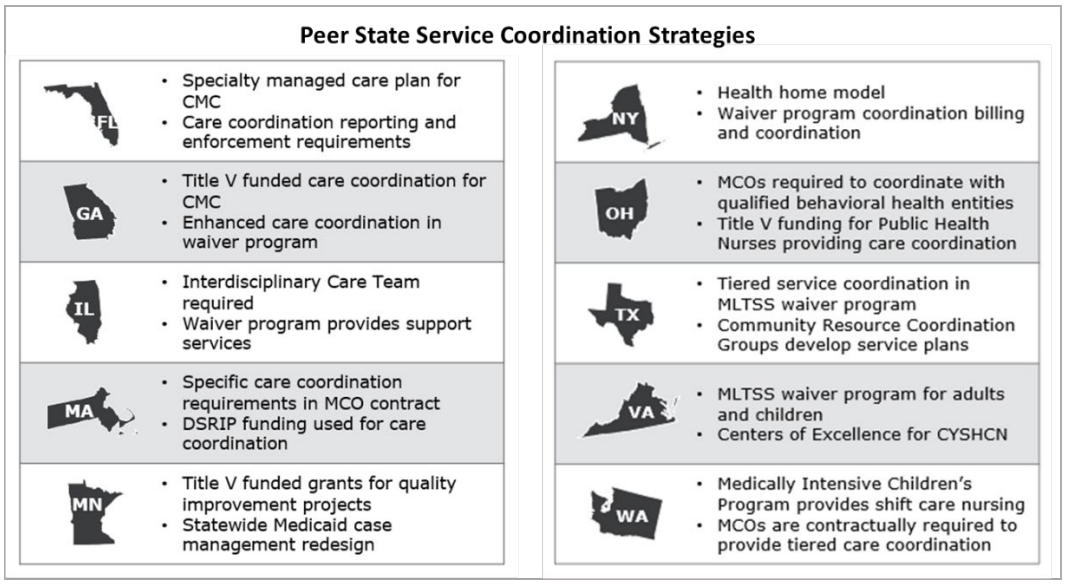


Figure 12 – Peer State Service Coordination Strategies

Workgroup Representation

Figure 13 shows the organizations and stakeholder groups that were a part of the Service Coordination workgroup throughout the initiative.

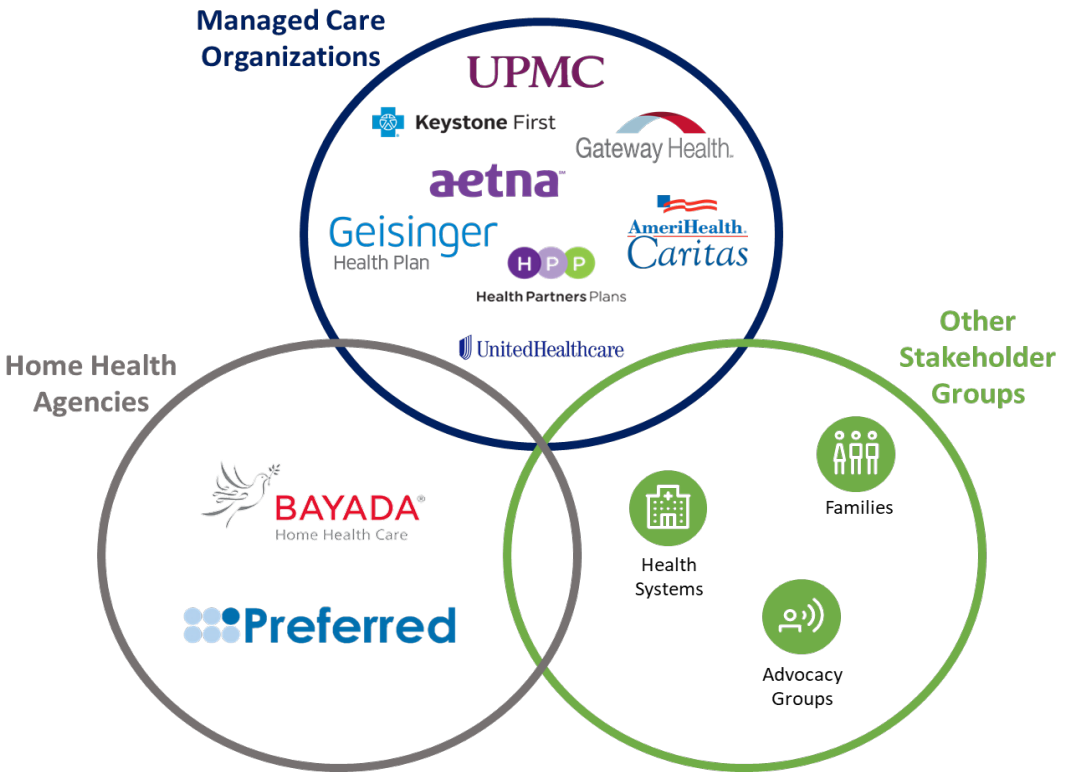


Figure 13 – Service Coordination Workgroup Representation

Key Activities

The chart included with Figure 14 displays participation by stakeholder group in the key meetings of the Service Coordination workgroup throughout the initiative.

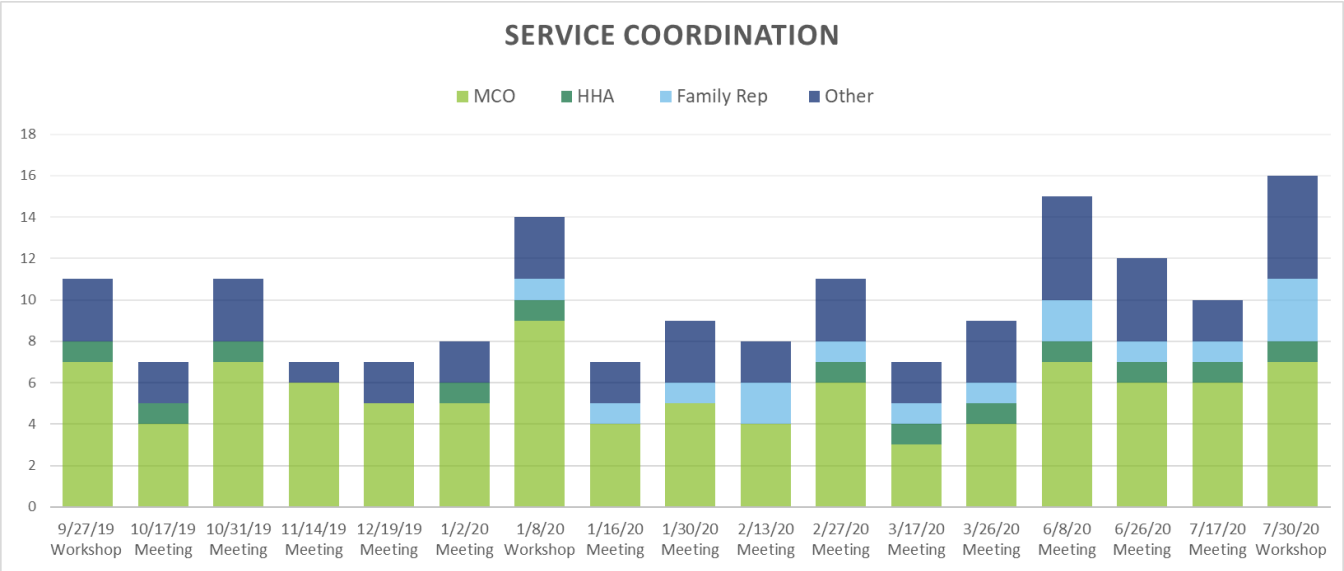


Figure 14 – Service Coordination Workgroup Key Activities

The Other category includes individuals representing hospitals and DHS.

Service Coordination Deliverables and Recommendations

SC1 - Recommendation #1: Provide Service Coordination Model Options

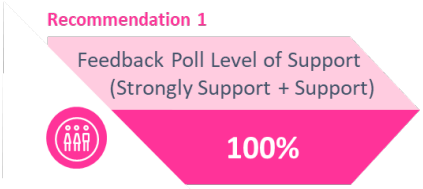


Figure 15 – SC1 Feedback Poll Results

The workgroup recommends that all CMC have access to a system that has the capability to provide the care a family needs, including providing the option of a Medical Home if the family chooses. This recommendation received unanimous support across workgroups as shown in Figure 15.

The workgroup recommends two model options for consideration:

1. **Service Coordination through the Medical Home Model**
2. **Service Coordination through MCOs**

A subgroup of the Service Coordination group, focused on MCO members in a Medical Home, specifically recommends all CMC should have access to comprehensive coordination of care through a Medical Home. Pediatric Medical Homes provide comprehensive coordination of care for healthcare services and other services such as Early Intervention, education, and social determinants of health. CMC with medical homes may have better outcomes. MCOs may assist families in identifying a medical home for their child. Approved Medical Home practices could receive a supplement for their work to

provide comprehensive care coordination for each CMC in their practice. This payment to Medical Homes would aim to encourage more pediatric practices to become approved Medical Homes.

A second subgroup of the Service Coordination group, focused on MCO members not in a Medical Home, recommends the MCO serve as the service coordinator in partnership with the PCP/Specialist for MCO members where a Medical Home is not available, or when a family chooses to not have a medical home.

If a family chooses not to have a Medical Home to coordinate their care, their MCO would act as their primary service coordination entity. All families should have access to a Medical Home, but the service coordination decision should be driven by family choice. The workgroup discussed that MCOs could assist families with identifying potential Medical Homes as well as bolster their Medical Home provider network by incentivizing physician offices to become certified Medical Homes and leverage enhanced compensation to provide service coordination.

The workgroup reached this recommendation by exploring the problem of lack of clarity in the roles and processes for service coordination of pediatric shift care nursing cases. The workgroup conducted several information gathering activities to capture new insights and perspectives on this issue. First, the workgroup collected current-state information from MCOs related to care management case load ratios and staffing structures for the pediatric shift care nursing populations. Second, the workgroup developed a list of questions that explored how service coordination is performed for other vulnerable populations and asked these questions to representatives from the Office of Long Term Living, the Office of Developmental Programs, and the Pennsylvania Elks Home Service Program[9]. Third, the workgroup developed an additional set of questions to ask pediatricians and specialists who provide care to a high volume of CMC.

The workgroup used the information collected through these activities to inform the recommendations for an ideal model of service coordination with an emphasis on physical health services. The workgroup established five key elements of service coordination, shown in Figure 16, that should be represented in any model.

[9] Pennsylvania Elks Home Service Program overview. Sourced from: https://paelkshomeservice.org/

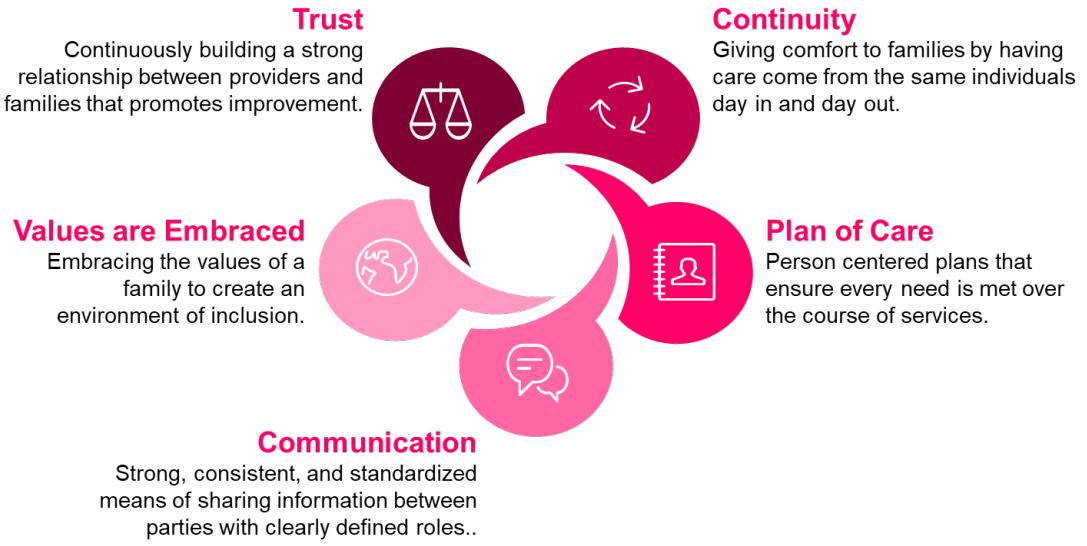


Figure 16 – Key Elements of Service Coordination

The workgroup discussed the intent behind each key element and defined the role of the service coordination entity and the care coordinator for each element in further detail, as described in Figure 17.

Figure 17 – Detailed Key Elements of Service Coordination

The workgroup also examined seven essential activities of a system of coordination of care, services, and supports for children and youth with special health care needs developed by members of the Imagine Different Coalition.[10] The workgroup members defined the key activities in the two service coordination models, which include 1) screening and identification; 2) outreach and informing; 3) assessment; 4) individual planning; 5) case management; 6) assistance accessing services and supports; and 7) monitoring, follow up and oversight. The exercise gave the workgroup the opportunity to work through the details of the role of the Medical Home and MCO in pediatric shift care nursing cases with a Medical Home, as well as the details of the role of the MCO and non-medical-home PCP/specialists in pediatric shift care nursing cases without a Medical Home. Some of the key items discussed regarding the role of the MCO included:

- **With a Medical Home**
    - **The MCO's Special Needs Unit (SNU) serves as the entry point to a Medical Home if a child is not currently connected to one. The MCO identifies Medical Home options for the family and provides service coordination when there is no Medical Home, or the family does not choose to use a Medical Home.**
    - **The MCO would provide some level of case management and reporting even when a member is receiving care in a Medical Home. The MCO remains responsible for managing all the member's services and for addressing issues that arise and are brought to their attention. Instead of deferring these issues to the Medical Home, the MCO would work with the Medical Home to resolve.**
- **Without a Medical Home:**
    - **The MCO conducts at least the minimum number of face-to-face meetings per state contract requirements – such as in-home or at the PCP/specialist office – with child/family at discretion of case manager and family.**
    - **The MCO could utilize multiple member assessments to inform the MCO case manager case ratios and number of FTEs required to cover the number of children in the plan.**

Full details of the seven activities for both models are provided in role checklists found in Appendix F.

SC2 - Recommendation #2: Consider a Pediatric Shift Care Nursing Assessment Tool

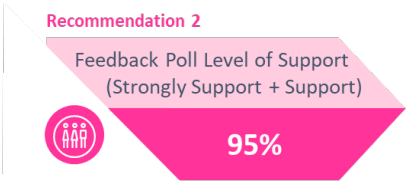


Figure 18 – SC2 Feedback Poll Results

The workgroup recommends that the pediatric shift care nursing delivery system adopt a standardized assessment tool or form to determine medical necessity and the number of shift care nursing hours required per case based on a comprehensive, person-centered perspective. This recommendation gained broad support across all workgroups based on the feedback poll with 95% support, shown in Figure 18. The workgroup explored multiple assessment forms both within and outside of shift care nursing services. Two examples stood out and have similarities regarding the comprehensive information collected, such as ambulation/ADLs, transportation to appointments, school information, caregiver work schedule, behavioral health, and environmental care. Regardless of the form used, the workgroup noted that the success of the assessment form is dependent on the quality and

[10] Imagine Different Coalition (2016). Who We Are. Retrieved from: http://www.imaginedifferent.org/what-we-do

comprehensiveness of the response. If a standardized form were to be adopted, an initial and ongoing training on how to best complete the form may help overcome this challenge. The workgroup also felt that piloting a standardized assessment would be best, rather than initial full rollout.

The workgroup also reviewed and discussed the Colorado Medicaid Pediatric Home Assessment Tool, which determines the level of CNA and RN-LPN services through a comprehensive assessment and scoring system.[11] Workgroup members suggested that this form is comprehensive, but may result in very different hours recommended than what is currently prescribed, as it was piloted with a current case. The workgroup felt that a calculation or score is difficult to capture the unique home environments and schedules that vary from family to family, and over time within families. A human interpretation of any assessment is important.

What's Next

Based on the work and recommendations of the Service Coordination workgroup, the recommended next steps could include:

- **All CMC should have access to a system that has the capability to provide the care a family needs, including providing the option of a Medical Home if the family chooses. In order to operationalize this recommendation, there are two additional assumptions:**
    - The HealthChoices agreement could be updated to include a requirement the MCOs are required to offer a Medical Home for families as an option. For example, in a geographic region where a Medical Home is not within a reasonable distance from a family, the MCO could work with nearby providers to help obtain the Medical Home designation.
    - There is an assumption that enhanced care coordination will require additional funding. Where additional funding is required, the MCO can help offset these costs and/or funding needs could be secured to support care coordination activities within Medical Homes.
- **Standardized assessment tool adoption across all MCOs and Medical Homes. Once the comprehensive assessment tool is developed and implemented, OMAP could provide all users ongoing training materials around how to best utilize the tool in a standardized manner.**

[11] Colorado Medicaid (2014). Colorado Medicaid Pediatric Home Assessment Tool. Retrieved from: https://www.colorado.gov/pacific/sites/default/files/Pediatric%20Assessment%20Tool%202.0%20F4%2001292014.pdf

Going Home Transition and Discharge Planning

During the September 2019 workshop, the Going Home and Discharge Planning (Going Home) workgroup focused on identifying issues in the lack of standardized processes and shared goals in the discharge process. They decided that it was of utmost importance to prepare and train both the family and the nurse from the HHA for the child's arrival home. The workgroup made plans to gather information on pediatric shift care nursing discharge processes throughout the state to inform future processes with the hope of identifying hospital systems that excel at certain aspects of the process. Together the information could help inform an "ideal" discharge process. This ideal process would assist families in transitioning home with confidence in their ability to care for their child and would decrease the need to return to the hospital due to a lack of knowledge. Communication between all parties (e.g., family, hospital, HHA, physicians, durable medical equipment providers, MCOs) throughout the entire discharge process is key to allowing all parties to be informed, are part of the plan for discharge, and have clear expectations and plans, including a plan for when a situation goes off track. After discussion, the workgroup reached agreement on problem and vision statements, as shown in Figure 19.

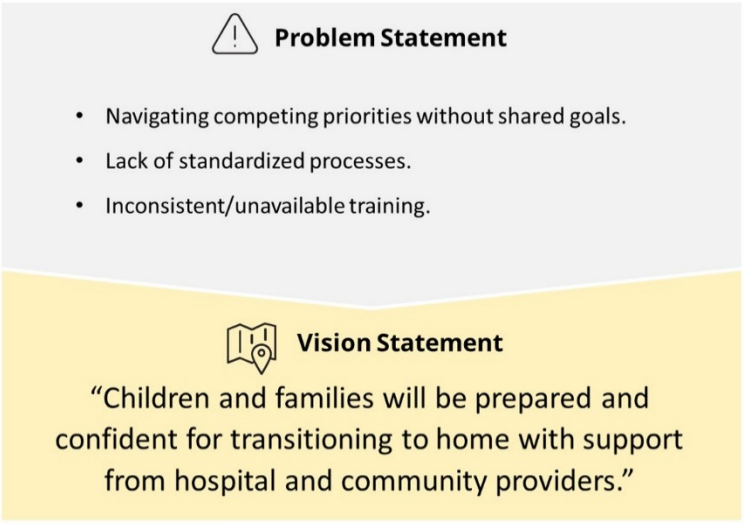


Figure 19 – Going Home Problem Statement and Vision

Workgroup Representation

Figure 20 depicts the organizations and stakeholder groups that were a part of the Going Home workgroup throughout the initiative.

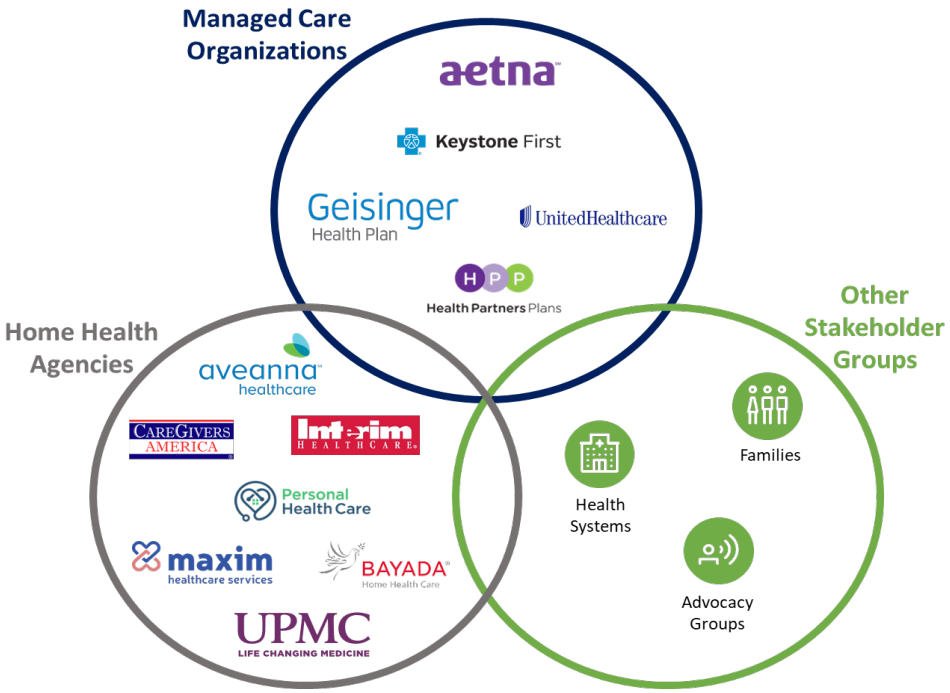


Figure 20 – Going Home Workgroup Representation

Key Activities

The chart in Figure 21 below displays key activities by stakeholder group for the Going Home workgroup throughout the initiative.

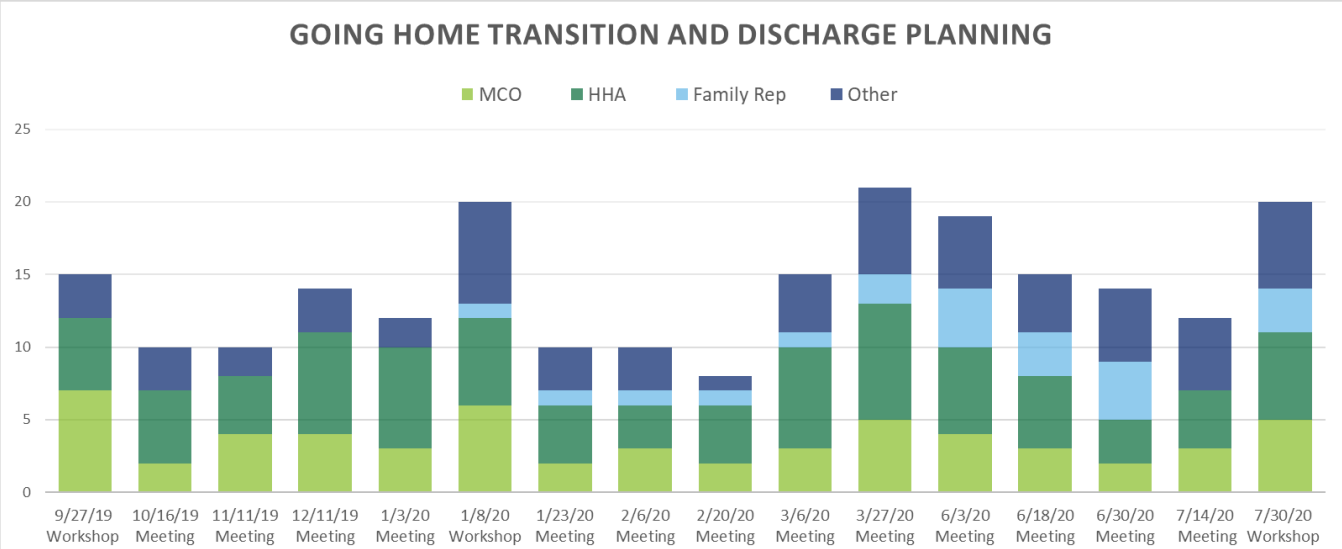


Figure 21 – Going Home Workgroup Key Activities

The Other category includes individuals from hospitals, the Pennsylvania Health Law Project, and DHS.

Going Home Deliverables and Recommendations

GH1 - Recommendation #1: Provide Best Practices for Discharge

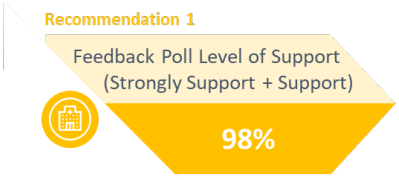


Figure 22 – GH1 Feedback Poll Results

The workgroup recommends communicating and encouraging a set of best practices for discharge. This recommendation received exceptional support across all workgroups, at 98% support via the feedback poll, as shown in Figure 22.

To facilitate this work, the workgroup initiated two workstreams to identify how to improve the discharge process:

The first workstream focused on encouraging on-the-ground coordination efforts between hospitals, HHAs, and MCOs for pediatric shift care nursing cases approaching discharge. Several workgroup members located in the southeast and southwest regions of the Commonwealth discussed coordinating a pilot discharge care conference with potential upcoming discharge cases. The conference would include all parties involved in the discharge of the child, including the family, hospital, HHA, and MCO to discuss care coordination plans for discharge and to promote early engagement by the home health agency and MCO. The goal of the pilot discharge conferences was to test the model, understand what works well and what does not, and share that experience with the workgroup. The workgroup used this feedback for discussions related to the second workstream.

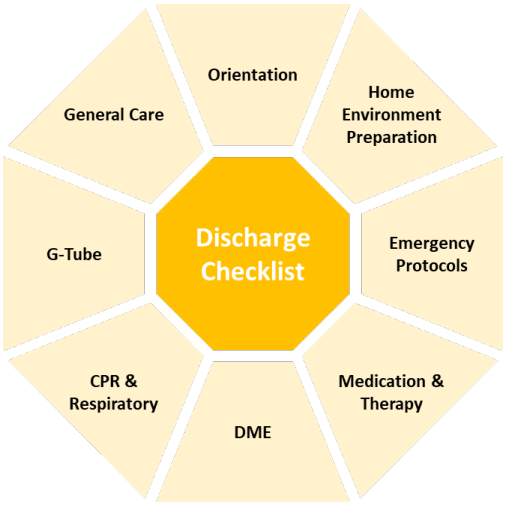


Figure 23 – Discharge Checklist Domains

The second workstream focused on developing a universal discharge checklist by collecting and analyzing current discharge documents and checklists used by hospitals that handle most pediatric shift care nursing discharge cases. The purpose of the universal discharge checklist is to serve as a "best practice" resource for all stakeholders to reference. The workgroup categorized checklist items into different domains, shown in Figure 23. During the discussions, the workgroup also identified several items that were missing from existing checklists to include in the universal checklist. For example, the workgroup identified the importance of undergoing practice scenarios with the family to educate them on what to do during specific situations. The detailed, proposed discharge checklist is included in Appendix G.

Additionally, the workgroup discussed emergency protocols to provide the family with the knowledge and resources necessary to make clinical judgements in challenging situations. The format of commonly used red-yellow-green asthma action plans were cited as an example that could be adapted to situations that require

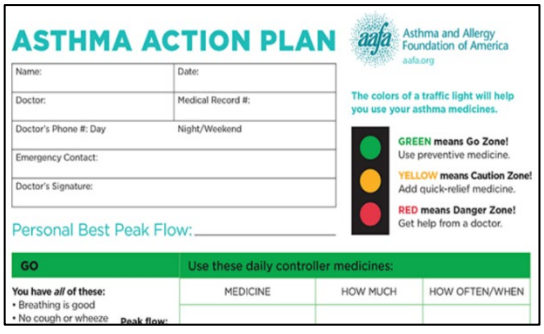


Figure 24 – Example Asthma Action Plan

quick clinical judgement when working with CMC. An example asthma action plan is shown in Figure 24[12].

The workgroup also generated ideas for improving the discharge process by listening to the experiences of the workgroups and reaching out to families who were recently discharged. Families expressed that the two biggest concerns were with the durable medical equipment (DME) company setting up the home environment and covering night shifts. The workgroup reached out to DME companies and performed additional research on DME best practices to identify what information was needed and most valuable to include in a universal checklist related to home preparation, before coming home, communication with the home health agency, and day of discharge.

Lastly, through the research, the workgroup found a comprehensive discharge "change package" developed by the Ohio Perinatal Quality Collaborative in partnership with the Ohio Department of Medicaid called *Improving Transition from NICU to Home for Infants Requiring Complex Care*.[13] The workgroup discussed how this comprehensive package could be a long-term goal for adaptation and adoption in the Commonwealth.

[12] Asthma and Allergy Foundation of America (2020). Retrieved from: https://www.aafa.org/asthma-treatment-action-plan/
[13] Ohio Perinatal Quality Collaborative (2018). Improving Transition from NICU to Home for Infants Requiring Complex Care. Retrieved from: https://opqc.net/sites/bmidrupalpopqc.chmcres.cchmc.org/files/NICU%20Grads/Change%20Package/OPQC%20NICU%20Graduates%20Change%20Package.pdf

GH2 - Recommendation #2: Improve the Co-Vending Scenario

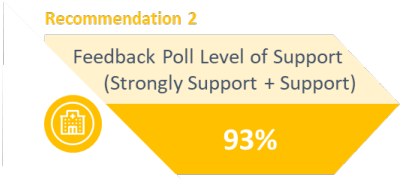


Figure 25 – GH2 Feedback Poll Results

The workgroup is recommending strategies to improve the co-vending scenarios in Pediatric Shift Care Nursing, where multiple HHAs are providing services for a single family. This recommendation received strong support across workgroups in the feedback poll with 93% support, as shown in Figure 25. Co-vending makes continuity of care challenging. Based on MCO-reported data, the workgroup discovered that at least 1 in 6 pediatric shift care nursing cases at one point in time are co-vend scenarios. The workgroup discussed co-vending and identified obstacles to successful delivery of co-vending scenarios, shown in Figure 26. Most obstacles pointed to a breakdown in communication on administrative/scheduling as well as in clinical services. This led to a focus on the need to identify an efficient, streamlined, and standardized practice for communication between co-vending agencies, the MCO, and the family.

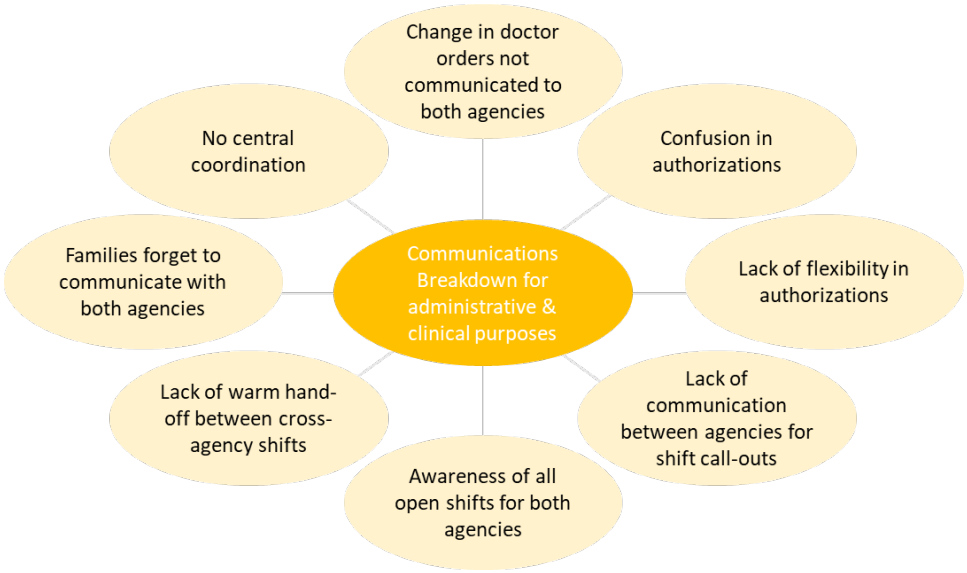


Figure 26 – Obstacles to Co-Vending

The workgroup also identified leading practices that home health agencies and MCOs have discovered when operating in co-vending scenarios, shown in Figure 27. Many of these leading practices mirrored the obstacles – fostering continual communication of both administrative and clinical information between all parties. The workgroup agreed that a technology solution, such as shared calendaring and shared electronic medical records, would assist with overcoming the obstacles and implementing best practices.

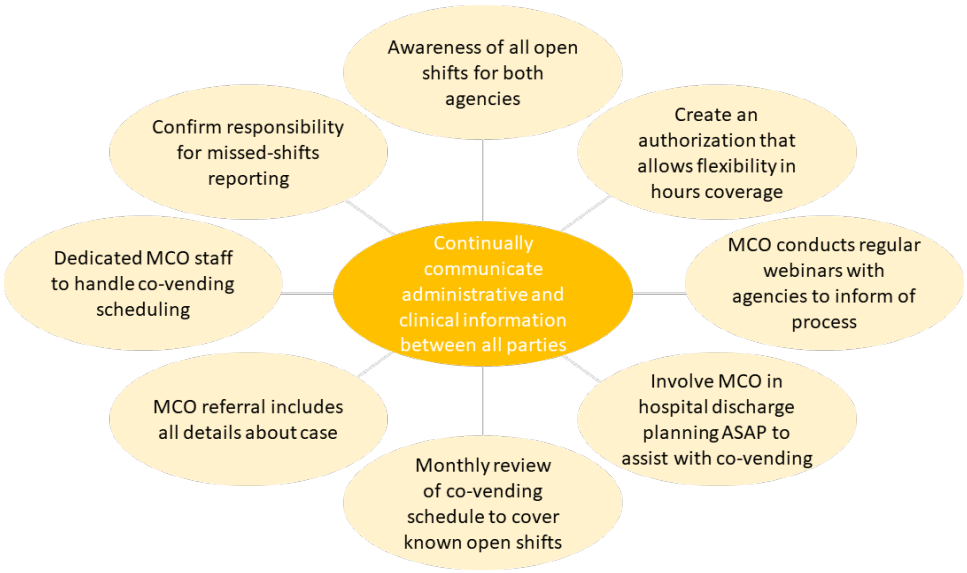


Figure 27 – Leading Practices for Co-Vending

GH3 - Recommendation #3: Incentivize Onboarding Home Health Agencies into Pennsylvania's Electronic Health Information Exchange

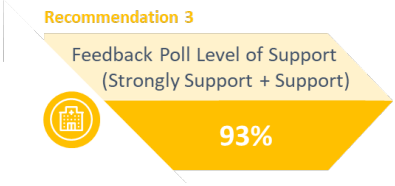


Figure 28 – GH3 Feedback Poll Results

The workgroup recommends offering incentives for Home Health Agencies that onboard into Pennsylvania's Electronic Health Information Exchange. This recommendation received notable support across all workgroups at 93% support in the feedback poll, as shown in Figure 28.

The workgroup discussed how the secure health information exchange, PA Patient and Provider Network (P3N) service of OMAP's eHealth Partnership Program can improve both the discharge process and the co-vending process using electronic health information exchange. Connecting HHAs, hospitals, and MCOs via P3N would help break down data-sharing silos and provide transparency and accountability for care team members. It would also likely remove some of the administrative burden from families and caregivers. The workgroup recommends that OMAP explore providing incentives for home health agencies to join the P3N program; however, there are multiple considerations that the workgroup discussed regarding onboarding home health agencies and the capacity of the P3N to improve operations:

- **Would the P3N support a centralized calendaring system for co-vending scenarios, both for discharge and ongoing cases? Would this system support a filtering and tiering structure where agencies would be able to easily find agencies/nurses that may support their need?**
- **Would the P3N support a centralized discharge checklist where multiple responsible parties could "check-off" their tasks?**
- **How "real-time" is the information in the P3N? Would it be fast enough to find nurses to cover call-out shifts?**
- **How are past records stored?**
- **Who from a home health agency would have access to the P3N?**

- **What are the ongoing costs to home health agencies and how are they structured? Do they increase with the number of cases enrolled and/or the number of staff gaining access?**

Addressing these considerations, along with monetary incentives, would likely result in increased home health agency enrollment. The workgroup also discussed another course of action to increase enrollment, by requiring agencies to enroll in the P3N if they want to be part of a co-vending case.

What's Next

Based on the work and recommendations of the Going Home Transition and Discharge Planning workgroup, the recommended next steps could include:

- **Adopt a universal discharge checklist to be completed through collaboration with the hospital, family, HHA, and MCO. The Health Choices Agreement language could be amended to require use of the universal discharge checklist, and the same requirement could be defined in the agreement between MCOs and HHA's.**
- **Create and distribute a best practices document to enable an efficient, streamlined, and standardized practice of communication between co-vending agencies, the MCO, and the family.**
- **Provide incentives for HHAs to join the P3N and share information to assist in coordination of co-vending teams. In order to operationalize this recommendation, P3N should be engaged to discuss and understand the questions above regarding onboarding home health agencies and the capacity of the P3N to improve operations.**
- **As a long-term goal, develop a comprehensive package, such as the Ohio Perinatal Quality Collaborative Change Package, for adaptation and adoption in the Commonwealth.**

Caregiver and Nurse Relationship and Co-Training

During the September 2019 workshop, the Caregiver and Nurse Relationships and Co-Training (Caregiver/Nurse) workgroup focused on identifying issues related to communication barriers between caregivers and nurses. Poor communication results in a misunderstanding of boundaries and expectations for both caregivers and nurses. The workgroup decided to explore HHA meet-and-greet policies to identify possible standardization. The workgroup also discussed the importance of providing appropriate training for nurses and caregivers to handle specific pediatric shift care nursing cases. This includes being knowledgeable of different types and models of DME that may differ from household to household. The workgroup decided to explore the current and future desired state of training within pediatric shift care nursing. The problem statement and vision statement developed by the workgroup are shown in Figure 29.

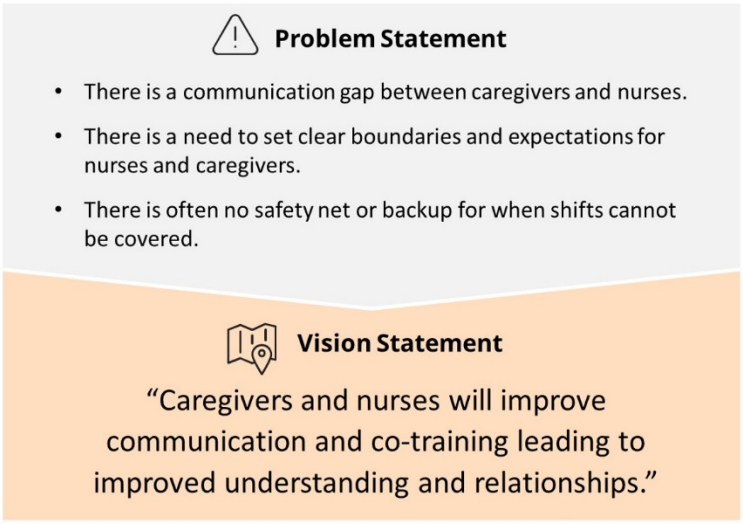


Figure 29 – Caregiver/Nurse Relationship Problem Statement and Vision

Workgroup Representation

Figure 30 shows the organizations and stakeholder groups that were a part of the Caregiver/Nurse workgroup throughout the initiative.

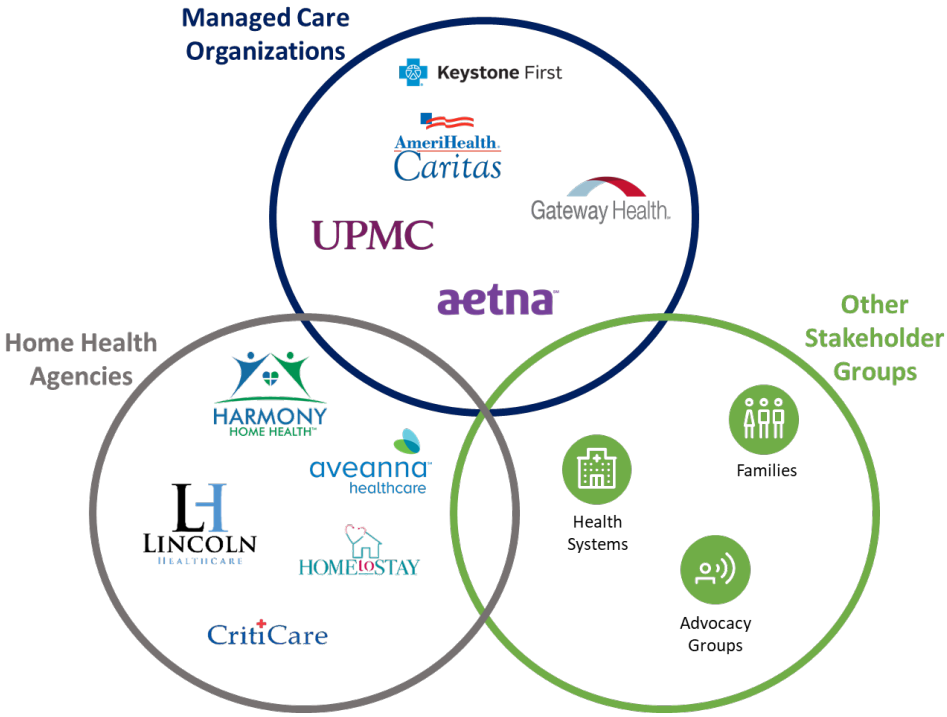


Figure 30 – Caregiver/Nurse Relationship Workgroup Representation

Key Activities

The chart in Figure 31 below displays attendance and key activities by stakeholder group for the Caregiver/Nurse workgroup throughout the initiative.

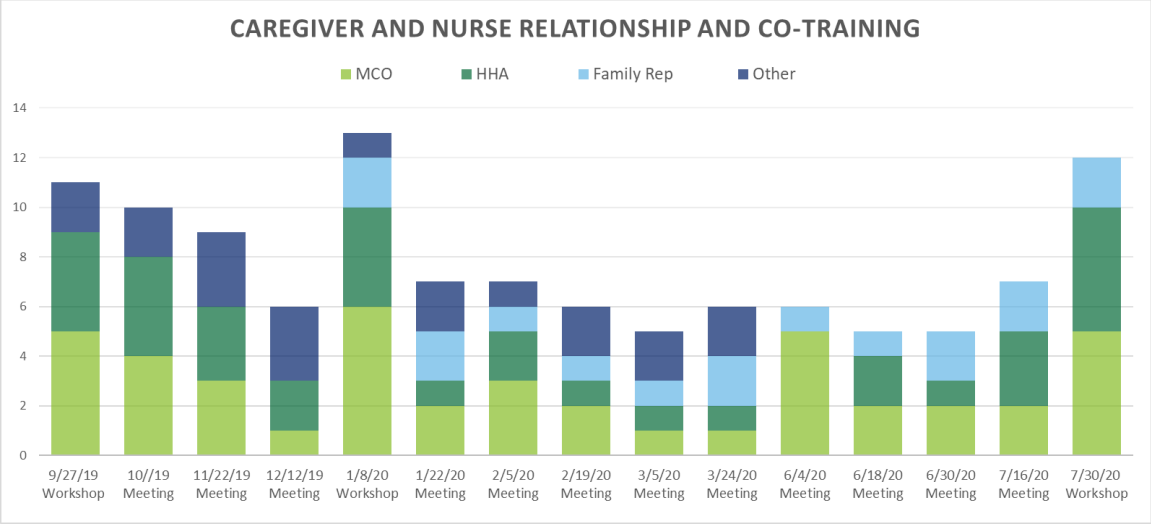


Figure 31 – Caregiver/Nurse Relationship Workgroup Key Activities

The Other category includes individuals representing hospitals and DHS.

Caregiver/Nurse Deliverables and Recommendations

CN1 - Recommendation #1: Create a Training/Education Portal

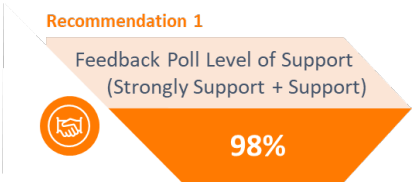


Figure 32 – CN1 Feedback Poll Results

The workgroup recommends developing a training/education portal to provide increased support for HHAs, caregivers, and MCOs with building relationships and expanding their knowledge. This recommendation received strong support across all workgroups with 98% support via the feedback poll, as shown in Figure 32. In order to operationalize this recommendation, the workgroup envisions this portal could be managed by DHS/OMAP and could mirror the Office of Development Programs' MyODP training portal, shown in Figure 33. Workgroup members reviewed the MyODP portal and discussed potential usability and functionality of the recommended portal.

Figure 33 – Sample MyODP Training Portal

They developed the following suggestions:

- **Allow users to submit content for consideration or suggest edits to existing training and resources**
- **Allow multi-tiered access – allow user accounts and general public access; possibly connect to COMPASS as all families enrolled in Medical Assistance have an account**
- **Incorporate the ability for nurses to obtain CEU credits**
- **Allow for resources and documents to be downloadable so users can modify to fit their needs**
- **Create active engagement by sending portal announcements on new content**
- **Consider multiple languages**

The workgroup also discussed the type of content for the portal. The workgroup recommends that the portal contain both resource documents as well as links to training opportunities (such as self-paced or in-person trainings, videos, or simulations). The content could be organized by the user-type (such as family, nurse, or MCO). Users should have access to all content; however, multi-tiered, role-based access allows for a more seamless user experience and navigation of content. The workgroup developed two resource documents to serve as examples of educational materials for HHAs that could be housed on the portal. These documents could be downloaded by portal users from home health agencies and tailored to meet specific agency guidelines. The first is a Meet-and-Greet pamphlet intended to assist agencies with standardizing the initial meeting between shift care nurses and the families. Following the specific guidelines for a meet-and-greet helps the relationship have a solid starting point with communication of boundaries and expectations. The second is a tip sheet that home health agencies could use to develop policies that provide support for nurses in developing positive relationships with families. An example of a resource document is a list of agencies and contact information across Pennsylvania and the resources and assistance they offer (e.g., developmental

disability, social services, behavioral health, etc.). Examples of both the Meet-and-Greet pamphlet and the Agency Tip Sheet are included Appendix I and J, respectively.

The workgroup also developed and distributed a training survey to members of all workgroups to collect content for the portal. The survey asked respondents to provide information on existing trainings and educational resources relevant to pediatric shift care nursing. The full list of existing trainings and resources, gathered from the survey, can be found in Appendix H. The ability to identify trainings that afford nurses the opportunity to obtain CEU credits would be valuable. The survey also asked respondents to identify training needs for both nurses and families, as well as opportunities for co-training (i.e., having nurses and families attend the same training).

Responses to the survey are categorized and summarized below.

Nurse Training Needs:

Beginning Shift Care Nursing Service – training to prepare nurses who are transitioning from other types of nursing to home care setting and to establish expectations for the work

Relationship Building – training to equip nurses with soft skills needed when interacting and setting boundaries with families

Family Training Needs:

Level Setting – training to prepare families on what to expect with home care providers entering their home

Aging-Out – training to prepare families for the aging-out transition to a new program upon the child's twenty-first birthday

Nurse/Family Co-Training Needs:

Providing Care – training to prepare nurses and families for the specific medical complexities of specific children, such as training on DME simulations (e.g., ventilators), medications, emergency scenarios, and behavioral health topics

CN2 - Recommendation #2: Increase Ongoing Family Input

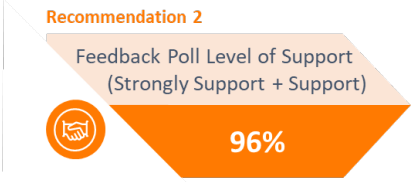


Figure 34 – CN2 Feedback Poll Results

The workgroup recommends an ongoing communication channel at the HHA level for the family perspective to be incorporated into the system of pediatric shift care nursing delivery. This recommendation gained broad support across all workgroups with 96% support via the feedback poll, as shown in Figure 34.

The workgroup highlighted it is also important for families new to the system to have the ability to receive peer family member support when requested to hear and learn from experienced voices. One such program is the Family Council Model, a pilot program operating at one Pennsylvania HHA that recruits volunteer family members receiving care from that agency as peer educators and advisors to both new families and the home health agency administration. The goal of the model is to build better relationships in the nurse-family-agency triad. The program is completely voluntary, and the participating family signs a release and waiver to work with a peer family. The

program provides valuable peer-to-peer connections for families newly transitioning a CMC to the home. The peer can help families by:

- **Preparing them for meet-and-greets with agency nurses**
- **Properly preparing their home environment for bringing their child home**
- **Recommending the family work with the agency to complete a patient-centered care plan so that nurses are better equipped to care for their child**
- **Assisting the family with overcoming roadblocks, such as communicating with the HHA when the family has a concern with a nurse**

The Family Council Model also supports the HHA as they provide valuable patient-centered insight into current and proposed agency policies. The Family Council also serves as a valuable training source for incoming nurses – the council can provide nurses the family perspective, identify themselves as a resource for the new nurse, assist with developing a nurse profile to be sent to families ahead of their meet-and-greet, and identify areas of additional training that may be of interest or helpful to the new nurse.

The use of peer volunteers in supporting families with CMC has been piloted and used in other Medicaid programs. For example, hospital systems in Ohio have recruited "graduate family representatives," who have experienced the transition to home with a medically complex child within the last 2 to 5 years, to serve as a peer resource for new families making the transition.[14]

The workgroup recommends that OMAP explore options for scaling such a program to HHAs across the Commonwealth. One option could be for OMAP or the MCOs to offer financial incentives to participating agencies who implement and effectively maintain a Family Council. Agency participation could be monitored by MCOs through either required reporting or during provider relation meetings, where agencies share specific family input that has been considered by the agency. The program does not need to be large, as even a small agency could support a few family representatives who could assist new families coming into the agency. Subsidizing start-up costs for small agencies may also be helpful. Second, agencies with an active and effective Family Council could receive public recognition from MCOs and OMAP for serving as a model for other agencies, which could make the agency appealing to new families. Lastly, a program like the Family Council Model could be scaled as a broader program that is not agency-specific. For example, peer support services are a well-established service under Pennsylvania's behavioral health HealthChoices program, and there is a potential opportunity to emulate that service for the pediatric shift care nursing population in physical health HealthChoices.[15] A detailed view of the recommended Family Council Model is included in Appendix L.

[14] Ohio Perinatal Quality Collaborative (2018). Improving Transition from NICU to Home for Infants Requiring Complex Care. Retrieved from: https://opqc.net/sites/bmidrupalpopqc.chmcres.cchmc.org/files/NICU%20Grads/Change%20Package/OPQC%20NICU%20Graduates%20Change%20Package.pdf

[15] Pennsylvania Department of Human Services (2020). Peer Support Specialist Services. Retrieved from: https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/Peer-Support-Services.aspx

CN3 - Recommendation #3: Expand the Care Plan

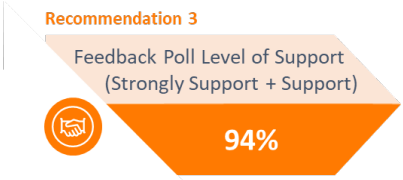


Figure 35 – CN3 Feedback Poll Results

The workgroup recommends the system adopt an expanded care plan that goes beyond the child's physical health concerns and rather is a whole-child plan of care. This recommendation received substantial support with 94% support via the feedback poll, as shown in Figure 35.

The current 485 Care Plan is a document that facilitates a patient's order for home care and contains the assessments and interventions that the nurse and/or therapist is expected to perform during the time caring for the patient. The workgroup discussed a tool that is being piloted by PA Families Need Nurses Now[16] for home health agencies to use at their discretion to support nurses in a whole-child/family-centered approach to care. The tool affords nurses the opportunity to become familiar with a family and their home environment – beyond what is offered in the regulatory 485 form – before the nurse enters the home, which better prepares them to care and support the child and family. The tool is to be completed by a family and supplied to the HHA, who would supply it to the nurse, or potential nurse, designated for the family. The tool covers multiple categories of information to support relationship building between nurses and families. Examples are provided below, the full tool can be found in Appendix K, and a quote highlighting the benefits of a whole-child plan of care is provided in Figure 36. The categories covered in this tool are:

- **Household/Family (such as pets, sleep schedules, household allergies, etc.)**
- **Home as a Workspace (such as attire, parking, trash protocol, food, etc.)**
- **Routines (such as bedtime, school, playtime, etc.)**
- **Mobility (such as capacity to sit or stand, orthotics, devices, etc.)**
- **Travel (such as car seats, go-bags, etc.)**
- **Communication and Social Engagement (such as communication style, favorite activities, etc.)**
- **Behavior Considerations (such as cries, vocalizations, anxiety, rewards and consequences, etc.)**
- **Academic Support (such as recommendations from school, learning goals, etc.)**
- **Family Goals (such as shared mealtimes, future expectations for child, etc.)**
- **Emergency Protocols (such as fever intervention, power outages, fire plan, etc.)**
- **Contacts (such as caregiver and emergency, DME, doctors, specialists, etc.)**

MCOs could encourage parents to work with the agency to complete the form and include it in the authorization packet. The workgroup also discussed the utility of using Pennsylvania's electronic Health Information Exchange program, the P3N, to house the tool either within the under-development care plan module, or within a newly developed module. This would support collaboration between HHAs that are serving the same family and provide consistency across HHAs. If possible, it would be ideal if families were able to complete the form electronically and have their responses on the tool stored directly into a

[16] PA Families Need Nurses Now overview. Retrieved from: https://www.pafamiliesneednursesnow.org/

module within the P3N. Families should also be able to update their responses, as home environments and personal preferences change over time.

Beyond the 485: Whole-Child Plan of Care
"In caring for a medically complex child in the home, shift nurses go well beyond the scope of the "485" Medical Plan of Care. Home care nurses are constantly engaging their patients on every level: social, emotional, cognitive, behavioral, etc. While they may technically be scheduled to support a child medically, it is short-sighted to ignore the important role these professionals play in each of their patient's ongoing development across domains. Additionally, it is important to remember that home care nurses often provide this care "beyond the 485" to several children, in a different home/workspace, and while navigating varying dynamics of multiple families day in and day out. Creating tools and resources for home care agencies to effectively collect and implement more robust whole-child/family-centered care allows a nurse to enter a new patient's home better prepared to care for and support each child in their individual environment." ~ **PA Families Need Nurses Now**

Figure 36 – Beyond the 485 Care Plan

What's Next

Based on the work and recommendations of the Caregiver and Nurse Relationship Support and Co-Training workgroup, the recommended next steps could include:

- **Create and maintain a training and education portal for HHAs, caregivers, and MCOs, similar to the Pennsylvania MyODP portal.**
- **Expand the Family Council Model pilot to more than one agency to test efficacy as well as streamline. Once matured, if applicable, encourage this model across the state.**
- **Expand the 485 Care Plan to address a whole-child plan of care. Encourage families to work with the HHA to complete the plan and encourage MCOs to require this form as part of the authorization packet.**
    - This Caregiver and Nurse Relationship recommendation is aligned with both the Service Coordination and Going Home workgroup recommendations. The Service Coordination workgroup recommends a care coordination model (SC1) and a comprehensive assessment tool (SC2). The Going Home workgroup recommends utilizing P3N where the expanded, whole-child plan of care could be housed for enhanced data sharing and ultimately, enhanced care coordination (GH3).

Behavioral Health / Physical Health Coordination

During the September 2019 workshop, the Behavioral Health/Physical Health Coordination (BH/PH) workgroup discussed the importance of addressing overall health as a concept; rather than focusing on physical or behavioral health, focusing on whole-person health. This led to the workgroup identifying challenges in a lack of education and exposure between the physical health and behavioral communities, with neither being able to understand all the concepts and 'speak each other's language.' This further led the workgroup to focus on exploring ways to improve education and communication, such as providing pediatric shift care nurses with information in order to guide families in need of behavioral health services, and to promote the use of a common care plan that addresses both physical health and behavioral health concerns in a single plan. The agreed upon problem statement and vision statement for the Behavioral Health and Physical Health Coordination workgroup are provided in Figure 37.

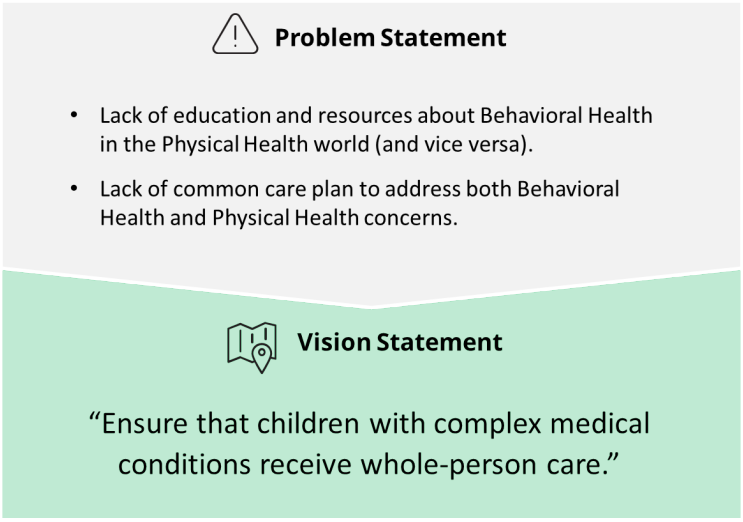


Figure 37 – Behavioral Health/Physical Health Coordination Problem Statement and Vision

Workgroup Representation

Figure 38 shows the organizations and stakeholder groups that were a part of the BH/PH workgroup throughout the initiative

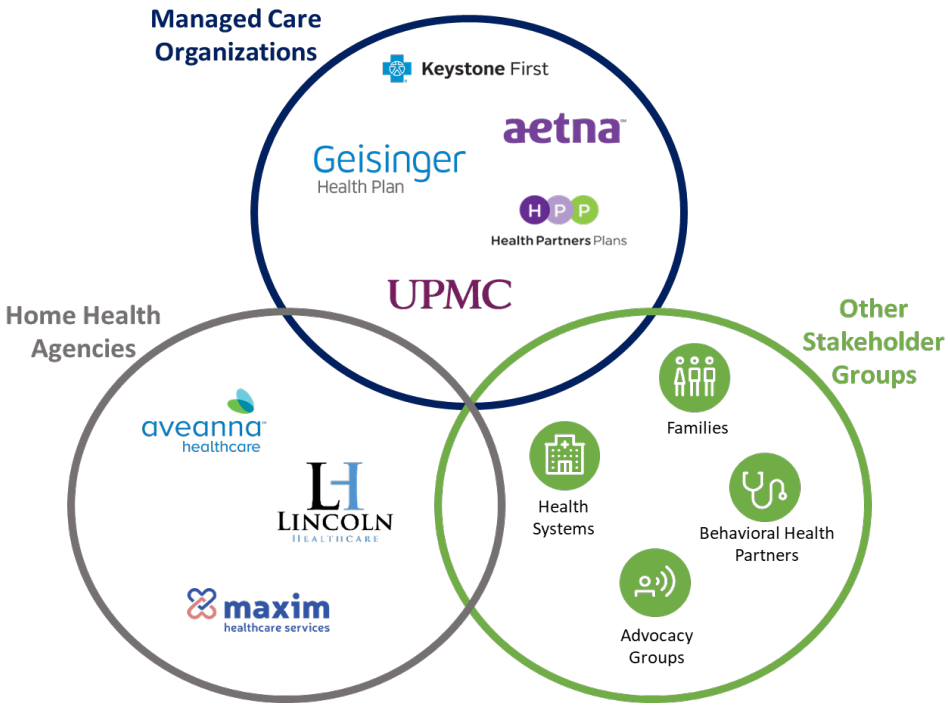


Figure 38 – Behavioral Health/Physical Health Coordination Workgroup Representation

Key Activities

The chart included in Figure 39 displays key activities by stakeholder group for the Behavioral Health/Physical Health Coordination workgroup throughout the initiative.

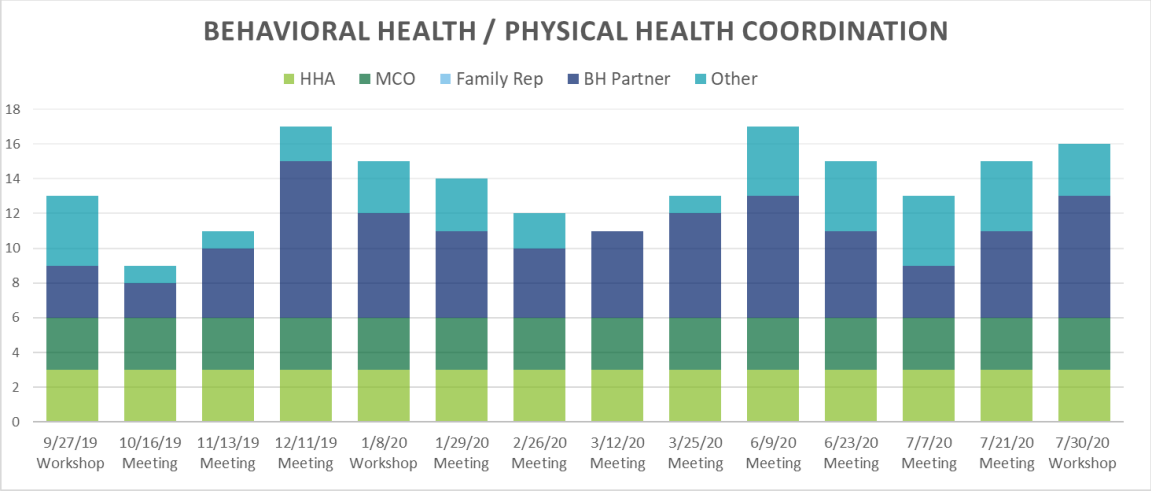


Figure 39 – Behavioral Health/Physical Health Coordination Workgroup Key Activities

The Other category includes individuals representing DHS.

BH / PH Deliverables and Recommendations

BHPH1 - Recommendation #1: Increase Behavioral Health Awareness

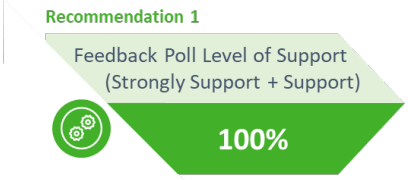


Figure 39 – BHPH1 Feedback Poll Results

The workgroup discussed the importance of increasing awareness of behavioral health within the pediatric shift care nursing home health field. This recommendation received unanimous support across workgroups shown in the Figure 39. The behavioral health resources and information included in the recently published resource guide called, "*The Care We Share: A Family Guide to In-Home Pediatric Care*[17]*"* did not include reference to behavioral health. There was consensus among workgroup members that HHA nurses currently lack basic knowledge to adequately respond to the common behavioral health scenarios within the pediatric shift care nursing population. The workgroup members compiled the common behavioral health diagnoses and behaviors that are experienced with this population, shown below in Figure 40. While these diagnoses and behaviors are complex, the goal is to have home health nurses recognize and be comfortable with behavioral health needs while administering care for CMC.

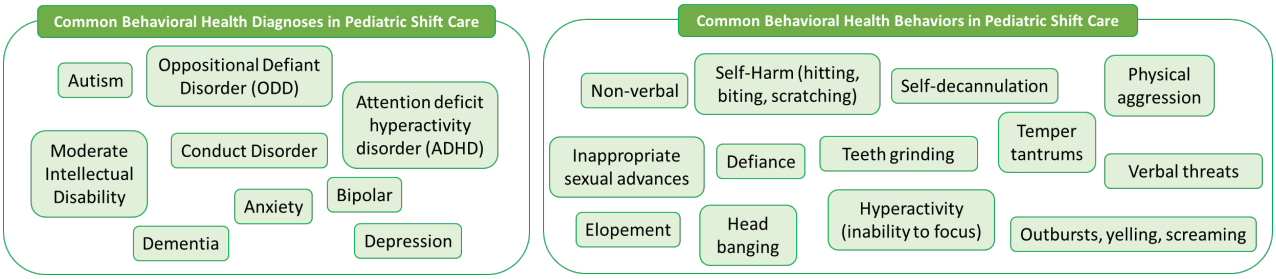


Figure 40 – Common Behavioral Health Diagnosis and Behaviors

The workgroup discussed two recommended strategies to increase behavioral health awareness. The first strategy is to support training for HHAs and Physical Health MCOs that provides basic information and skills for working with children with behavioral health needs. One such training is Youth Mental Health First Aid (YMHFA)[18] which is a nationally renowned training that teaches how to identify, understand, and respond to signs of behavioral health concerns. YMHFA is a one-day course that is provided by a certified MHFA trainer. The workgroup conducted an inventory of current MHFA trainers within Pennsylvania, and 95% of counties that responded have one or more certified MHFA trainers working within their county. Many times, these trainers might be able to provide the training at little to no cost to individuals located within their county. The workgroup also discussed the possibility of engaging the Pennsylvania Homecare Association to have association staff become YMHFA trainers. Members of the association would be able to have their pediatric shift care nurses, as well as other staff, become certified YMHFA-trained through the association. An initial phase could focus on training existing home health staff throughout the state and a second phase could focus on requiring incoming staff to take the YMHFA. In addition, a "virtual" YMHFA course is under development due to the changes

[17] Pennsylvania Homecare Association (2020). The Care We Share: A Family Guide to In-Home Pediatric Care. Retrieved from: https://www.pahomecare.org/the-care-we-share-a-family-guide-to-in-home-pediatric-care

[18] National Council for Behavioral Health (2020). Youth Mental Health First Aid. Retrieved from: https://www.mentalhealthfirstaid.org/population-focused-modules/youth/

caused by the COVID-19 crisis, that may prove to be more accessible for those in the already dispersed home health nursing field.[19]

The workgroup also discussed the importance of supplementing YMHFA with self-paced Autism awareness trainings given the high incidence of Autism in pediatric shift care nursing cases with behavioral health diagnoses. According to the CDC, about 1 in 54 children have been identified with autism spectrum disorder (ASD)[20]. For example, The Pennsylvania Bureau of Autism in the Office of Developmental Programs has compiled the comprehensive *Lifespan Autism Instruction, Training, Education, and Resource Navigation (LATERN)* resource guide with links to self-paced Autism-related courses and trainings.[21] The guide is divided by core areas of knowledge and tiered levels of trainings needs. Additionally, the Autism Navigator developed by the Autism Institute at the Florida State University College of Medicine has free and license-based Autism courses designed for caregivers as well as medical professionals.[22]

To increase behavioral health awareness in the pediatric shift care nursing field across the state, the workgroup agreed to encourage home health agencies to include the previously mentioned basic behavioral health trainings within their annual competency examinations of nurses as required by Pennsylvania home care regulations.[23] Such basic training may also be part of clinical orientations for both nurses and home health aides. The workgroup discussed the rollout of such requirements through a value-based funding or pay-for-performance arrangement, such that funding would be provided if a certain percentage of home health staff meet the basic behavioral health competency requirement. This could be accomplished through a staggered implementation approach; for example, for the first year the requirement might make sense to be voluntary, the second year could require 50% of staff be trained, and the third year could require 70% of staff be trained, and so on.

The second strategy to increase behavioral health awareness is to encourage Physical Health MCOs to include behavioral health resource information on their care management outreach letters or as an appendix in authorization letters. The Office of Mental Health and Substance Abuse Services (OMHSAS) maintains a contact list for the Child and Adolescent Service System Program (CASSP) coordinators for each county within the state (see Appendix M). The CASSP coordinators can assist caregivers with understanding the range of behavioral health services offered within their county and how to access those services.

While the workgroup focused primarily on strategies to increase behavioral health awareness in the physical health sector, the workgroup recognized the importance of behavioral health providers understanding the medical complexities of the children they serve that are receiving pediatric shift care nursing services. This could include providing background on some of the chronic conditions and the

[19] National Council for Behavioral Health (2020). Coming Soon: Virtual Option for Mental Health First Aid. Retrieved from: https://www.mentalhealthfirstaid.org/2020/04/coming-soon-virtual-option-for-mental-health-first-aid/
[20] Centers for Disease Control and Prevention (2020). Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years – Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2016. Retrieved from: https://www.cdc.gov/mmwr/volumes/69/ss/ss6904a1.htm?s_cid=ss6904a1_w
[21] Pennsylvania Office of Developmental Programs (2019). LANTERN: Lifespan Autism Instruction, Training, Education, and Resource Navigation. Retrieved from: https://paautism.org/wp-content/uploads/2019/10/LANTERN-Edition-2.pdf
[22] Autism Navigator, LLC (2020). Autism Navigator Courses for Families and Professional. Retrieved from: https://autismnavigator.com/courses/#everyone
[23] Pennsylvania Department of Health Title 28 Part IV Subpart H §611: Home Care Agencies and Home Care Registries. Retrieved from: https://www.health.pa.gov/topics/Documents/Facilities%20and%20Licensing/Chapter611.pdf

related DME that is in the home. This may help make in-home behavioral health providers feel more comfortable in the home environment.

BHPH2 - Recommendation #2: Improve the Integrated Care Process

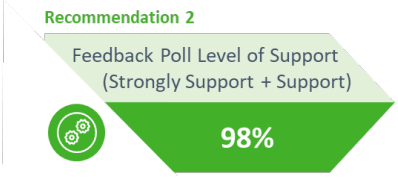


Figure 41 – BHPH2 Feedback Poll Results

The purpose of integrating care is to provide each pediatric shift care nursing case with whole-health care. The workgroup believes that improving the integrated care process involves improving communication at the agency level – between HHAs and behavioral health agencies – and MCO level – between physical health MCOs (PHMCOs) and behavioral health MCOs (BHMCOs). This recommendation received strong support across all workgroups at 98% via the feedback poll as shown in figure 41.

The workgroup categorized their discussion into two different types of communication: clinical discussions and data sharing. The workgroup considered the PHMCOs' Special Needs Units (SNUs) as playing a key role in improving communication related to clinical discussions. The SNUs currently complete behavioral health training in addition to trainings on how to coordinate with BHMCOs. Many families do not realize that they have behavioral health coverage and have limited knowledge of behavioral health services. Due to this, the SNUs should make behavioral health awareness and education as part of the PHMCO SNU semi-annual home visits and make referrals to the child's BHMCO during those visits if needed. If behavioral health services are already involved, the SNU could try to involve the BHMCO and/or behavioral health service provider at semi-annual home visits. The HealthChoices agreement language could be revised to include these new recommendations as part of the home visit process, allowing flexibility given the differences in county-level contracts and behavioral health delivery models. Lastly, the workgroup discussed recommending the use of behavior checklists, screenings, or assessments by home health nurses or clinical supervisors, and decided against the use of such tools by physical health providers. The workgroup agreed that identification and suggestion of a referral is the best course of action.

The workgroup agreed that the data sharing type of communication could be improved by adapting the Integrated Care Plan (ICP) process that is currently used to foster collaboration between PHMCOs and BHMCOs for adult members with serious mental illness to pediatric shift care nursing cases with behavioral health needs. The pediatric shift care nursing cases targeted for the ICP process could be those with common behavioral health diagnoses and behaviors that the workgroup discussed. The ICP process could start with creating a single point-of-contact at BHMCOs (by region or contract) for PHMCO behavioral health referrals. Creating this referral pathway is a small but impactful first step to establishing an ICP process. Data sharing between the PHMCOs and BHMCOs (such as physical and behavioral health hospitalizations utilization data) on shared pediatric shift care nursing cases would be an additional longer-term component to adapt, as would generating an ICP document.

At the agency level – between HHAs and behavioral health agencies – the workgroup discussed how HHAs could proactively ask specific and pointed behavioral health questions to caregivers during intake and 60-day clinical reviews. These questions would specifically ask about behavioral health concerns and services and would not be general questions such as "is anything else going on with your child?". HHAs could also encourage caregivers to sign releases of information for currently connected behavioral health services, as it affords the HHA the opportunity to obtain a child's crisis plan (when available).

Such a plan would assist nurses in understanding what specifically to do for a child when they begin to exhibit behaviors leading to a crisis. These crisis plan responses are not clinically focused, but rather are actual steps that caregivers – as well as nurses – can carry out (e.g., provide them some space, give them a stuffed animal or an iPad, etc.).

The workgroup discussed a long-term goal to improve the integrated care process would be to utilize Pennsylvania's electronic health information exchange (P3N) to facilitate data and information sharing across MCOs and providers, both physical health and behavioral health. This platform could be used to share important integrated care documents, such as the crisis plan mentioned earlier, and enable all parties involved in the child's PH and BH care to be synchronized, if they are enrolled in the P3N program.

What's Next

Based on the work and recommendations of the Behavioral Health and Physical Health Coordination workgroup, the recommended next steps could include:

- **Encourage HHAs to include basic behavioral health trainings in their annual competency examinations of both nurses and home health aides. MCOs could require this in their contracts with providers.**
    - This Behavior Health/Physical Health recommendation aligns with the Caregiver/Nurse recommendation to provide a training portal (CN1). The required behavioral health training could be made available within the training portal.
- **Explore methods to support the delivery of YMHFA training to home health agencies, such as engaging the Pennsylvania Homecare Association to serve as a centralized trainer. The workgroup recommends engaging the Pennsylvania Homecare Association to recommend having association staff become YMHFA trainers. Then, members of the association would be able to train their pediatric shift care nurses and staff to become certified YMHFA-trained.**
- **Include behavioral health awareness and education part of the PHMCO SNU semi-annual home visits.**
- **Adapt the Integrated Care Plan (ICP) process that is currently used for adult cases to pediatric shift care nursing cases with behavioral health needs.**
    - This Behavioral Health/Physical Health recommendations aligns with both Caregiver/Nurse and Service Coordination workgroup recommendations. An ICP aligns with the Caregiver/Nurse recommendation to expand the care plan beyond the 485 in order to encompass a whole-child plan of health (CN2). An ICP also aligns with the Service Coordination recommendation to provide access to comprehensive coordination of care (SC1).
- **Create a single point of contact at BHMCOs by HealthChoices zone (or county) for PHMCO behavioral health referrals.**
- **Create a list of behavioral health questions to be used by home health agencies at intake and 60-day clinical reviews.**
- **As a long-term goal, utilize the P3N to facilitate sharing of data, ICPs, and the child's crisis plan.**
    - This Behavioral Health/Physical Health recommendation aligns with both Caregiver/Nurse and Going Home workgroup recommendations. The Caregiver/Nurse workgroup recommends expanding the care plan, which encompasses the ICP as well as the child's crisis plan, all of which can be accessible via the P3N (CN3). The Going Home workgroup recommends both a universal discharge checklist and incentivizing onboarding of HHAs into the P3N (GH1 and GH3,

respectively). Both Going Home recommendations support the facilitation of sharing data and the development of an ICP focused on whole-child health.

Nurse Recruitment and Retention

During the September workshop, the Nurse Recruitment and Retention (NRR) workgroup focused on identifying the most prominent issues that arise while recruiting new nurses into the pediatric shift care nursing field as well as retaining the current nurses. The agreed upon problem statement and vision statement are included in Figure 42. With this problem statement and future vision in mind, the workgroup developed eight categories that captured primary challenges: Marketing and Stigma; Codes of Conduct; Administrative Pressures; Challenging Homes; Scheduling and Authorization; Nursing School Collaboration; Collaboration; and Education. Each category had unique concerns that impact recruitment and/or retention. The workgroup developed plans to research these concerns in more depth to develop recommendations based on the findings.

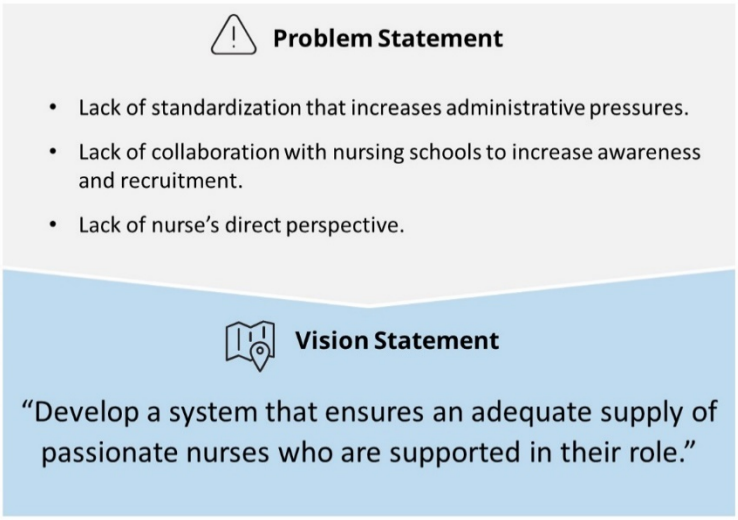


Figure 42 – Nurse Recruitment and Retention Problem Statement and Vision

Workgroup Representation

Figure 43 shows the organizations and stakeholder groups that were a part of the Nurse Recruitment and Retention workgroup throughout the initiative.

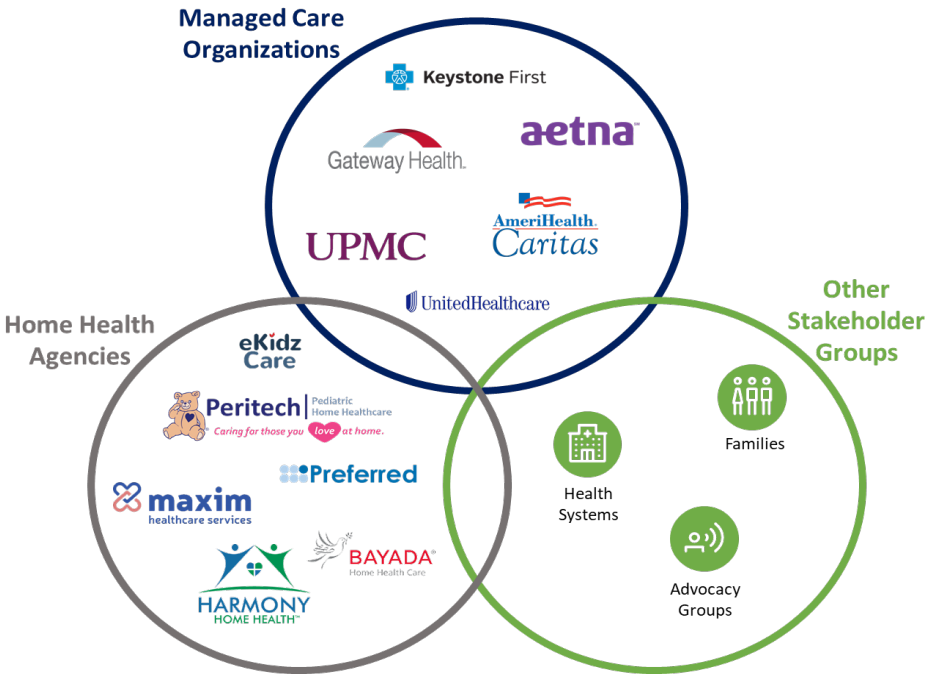


Figure 43 – Nurse Recruitment and Retention Workgroup Representation

Key Activities

The chart in Figure 44 below displays key activities by stakeholder group for the Nurse Recruitment and Retention workgroup throughout the initiative.

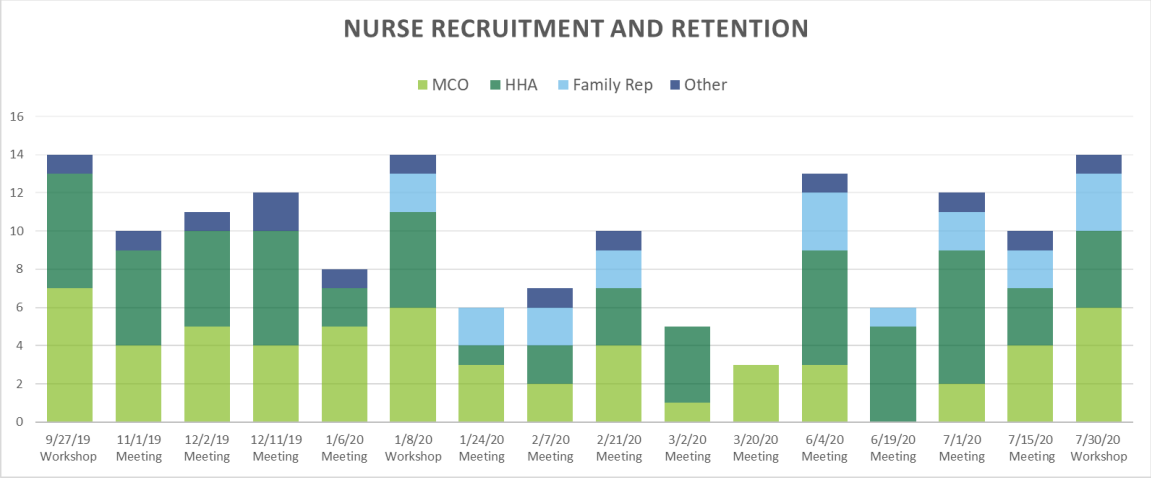


Figure 44 – Nurse Recruitment and Retention Workgroup Key Activities

The Other category includes individuals representing hospitals, homecare associations, and DHS.

NRR Deliverables and Recommendations

NRR1 - Recommendation #1: Increase Nursing School Engagement

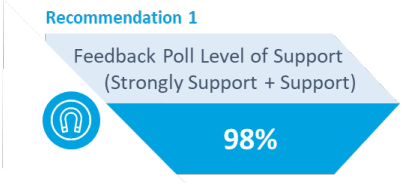


Figure 45 – NRR1 Feedback Poll Results

In recent years, Pennsylvania has experienced a significant increase in the volume of children requiring pediatric shift care nursing services. At the same time, HHAs across the Commonwealth have faced increased vacancies, high turnover, and difficulties in recruiting LPNs and RNs to provide these critically necessary services. The workgroup identified the need for pediatric shift care nursing stakeholders – OMAP, HHAs, and MCOs – to formally engage nursing schools as a top priority to address the nursing staff deficit. This recommendation gained strong support across all workgroups at 98% support via the feedback poll as shown in Figure 45.

While some HHAs and MCOs are informally engaging nursing schools to increase new-nurse awareness of pediatric shift care nursing, there is no coordinated effort to engage most (if not all) nursing schools in Pennsylvania. The workgroup members identified at least 110 nursing school programs in Pennsylvania that graduate nurses who could be the future of pediatric shift care nursing (see Appendix R for details). Unfortunately, many nursing schools do not typically prepare their graduates to manage in-home care for CMC, especially those that are technology-dependent.[24] Engaging nursing schools to create formal collaborations with OMAP, HHAs, and MCOs to build these specific skills has proven to provide benefits for schools as well as for service providers.[25]

To support nursing school engagement, the workgroup developed two approaches and related materials that OMAP may use to initiate the engagement. First, the workgroup recommends that OMAP initiate the process of formal collaboration with Pennsylvania nursing schools by conducting the first outreach. The workgroup developed a draft letter of support that OMAP can use to approach nursing schools about collaborating on shift care nursing education (see Appendix O for a copy of the letter). The letter succinctly details the issue of the lack of shift care nurses and the collaborative efforts that pediatric shift care nursing stakeholders have undertaken to address the issue. It invites nursing schools to be a part of the collaborative solution and to formally provide their support for this critically important nursing service.

Second, the workgroup recommends that OMAP send a "current-state" questionnaire to nursing schools across Pennsylvania (see Appendix N for a copy of the questionnaire). This questionnaire assists in determining the scope of nursing programs as they relate to pediatric shift care nursing and identify areas that could be expanded upon to provide nursing graduates with the skills and knowledge they need to be able to obtain employment in pediatric shift care nursing.

After discussing strategies for engagement, the workgroup concluded that conducting a phased-in approach to nursing school engagement may provide the best return. The workgroup recommends that OMAP connect with the Office of the Chancellor of the Pennsylvania State System of Higher Education (PASSHE) to begin discussions on how state-owned nursing schools could form a collaboration with pediatric shift care nursing stakeholders. This initiative would align well with aspects of PASSHE's System

[24] Foster, C. C., Agrawal, R. K., & Davis, M. M. (2019). Home health care for children with medical complexity: workforce gaps, policy, and future directions. Health affairs, 38(6), 987-993.
[25] Ibid.

Redesign, an effort to fundamentally transform its education and business models. For example, within the system redesign efforts, PASSHE identified a Workforce Readiness Team that is charged to "Identify discipline specific competencies that map to career specific competencies for students preparing to enter the workforce should obtain to prepare them for employment and future growth." [26] It appears likely that they may welcome the opportunity to partner with HHAs. In addition, the PASSHE Collaborative Team, also formed as a result of the system redesign efforts, is focused on cross-institutional delivery of academic programs, which could assist with disseminating pediatric shift care nursing curriculum recommendations across nursing schools throughout the PASSHE system.[27]

NRR2 - Recommendation #2: Promote Strategies to Increase Nursing Workforce

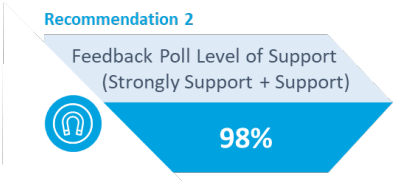


Figure 46 – NRR2 Feedback Poll Results

The workgroup recommends promoting strategies to increase the nursing workforce. This recommendation received exceptional support across all workgroups with 98% support via the feedback poll as shown in Figure 46.

In order to fully develop this recommendation, the workgroup determined that capturing the direct feedback of nurses – both working within pediatric shift care nursing and those not working in pediatric shift care nursing – would be valuable in understanding which strategies would increase recruitment and retention. To this end, family member stakeholders associated with the workgroup – and who are also part of the Imagine Different Coalition – drove the development of a questionnaire to capture what drew nurses to the field of pediatric shift care nursing, and why they continue to stay in the field or why they left the field. With the assistance of OMAP leadership, the questionnaire was delivered electronically to all licensed nurses in the Commonwealth. Over 900 responses were received over the course of a month. Slightly more than half of the respondents indicated that they were currently providing in-home care in Pennsylvania. There was largely an even split between RN and LPN respondents, and the majority of either group had more than 10 years' experience in their role. Responses to the questionnaire provided the workgroup substantial insight on what recruitment and retention strategies might provide the best return. In particular, the questionnaire included two open-ended questions to identify motivators for pediatric shift care nurse retention and things that could attract additional nurses to pediatric shift care nursing. Nearly half the respondents indicated that pay was both a motivator and an attractor, as shown in the word cloud graphic in Figure 47.

Figure 47 – Nursing Workforce Survey Word Cloud

[26] PASSHE (2020). System Redesign Phase 2: Workforce Readiness Team. Retrieved from: https://www.passhe.edu/SystemRedesign/Pages/TeamWorkforce.aspx
[27] PASSHE (2020). System Redesign Phase 2: Collaborative Team. Retrieved from: https://www.passhe.edu/SystemRedesign/Pages/TeamCollaborative.aspx

This confirmed the beliefs of the workgroup and aligns with numerous policy recommendations from different sources.[28] Comprehensive results from the questionnaire can be found in Appendix P. Highlighted findings are included in the graphs below (in Figure 48) including the demographics of respondents and the reasons respondents are interested in providing home nursing care.

Figure 48 – Nursing Workforce Survey Sample Results

Based on the review and discussion of the survey results, the workgroup developed a slate of 17 nurse recruitment and retention strategies. The workgroup voted on which strategies they do or do not support. The strategies that received unanimous support include providing transportation benefits for nurses, changing HHA operations to improve the workplace, and encourage OMAP to work with Labor and Industry to declare home health nursing a critical workforce shortage. The table below (Figure 49) details each strategy and the level of workgroup support, with the most supported strategies being listed at the top and the least supported at the bottom. The full results are available in Appendix Q.

[28] Simpser, E., & Hudak, M. L. (2017). Financing of pediatric home health care. Pediatrics, 139(3), e20164202.; Foster, C. C., Agrawal, R. K., & Davis, M. M. (2019). Home health care for children with medical complexity: workforce gaps, policy, and future directions. Health affairs, 38(6), 987-993.

Strategy Topic	Strategy Description	Workgroup Members Support	Workgroup Members Do Not Support
Benefits	OMAP to establish guidelines for travel reimbursement for case locations beyond a specific range (e.g., 20 miles), and for those with significant parking expenses (including contractors)	100%	0%
Benefits	OMAP to establish guidelines for reimbursement of taxi/Uber/Lyft rides to certain locations where the nurse has a reasonable concern for personal safety	100%	0%
Partnerships	OMAP to work with Labor and Industry to declare home health nursing a critical workforce shortage to provide funding to nursing schools to increase the capacity for nurse education	100%	0%
HHA Operations	Explore creating a health insurance pool for better benefits at better rates	100%	0%
HHA Operations	For new cases, the clinical manager will visit the location to find parking and create a strategic plan for the nurse's safety	100%	0%
HHA Operations	Utilize the characteristics of people who choose home shift nursing in recruitment efforts - characteristics are autonomy, independence, flexibility, and valued purpose	100%	0%
HHA Operations	Explore strategies to acknowledge the importance of employed nurses' work	100%	0%
Partnerships	OMAP to use a licensed nurse contact list from the PA Licensing Bureau to send a pediatric shift care recruitment message to nurses across the state	91%	0%
Partnerships	OMAP to work with American Association of Critical-Care Nurses and National Association for Practical Nurse Education and Service to establish a critical care credential for home health	91%	0%
Payment Arrangement	OMAP to establish shift differential rates for pediatric shift care nurses for high acuity cases (such as trach/vent)	91%	9%
Payment Arrangement	OMAP to establish LPN and RN pay rates	82%	18%
Payment Arrangement	OMAP to establish differential or higher rates for pediatric shift care nurses with specific certifications (such as critical care certification)	82%	18%
Payment Arrangement	OMAP to establish guidelines for paying pediatric shift care nurses (including contractors) for time taking required CEUs	73%	18%
Benefits	OMAP to establish guidelines for provision of health insurance to pediatric shift care nurses (including contractors)	73%	27%
Benefits	OMAP to establish guidelines for providing paid leave to pediatric shift care nurses (including contractors)	73%	27%
Regulatory	OMAP to permit independent nurse practice and Medicaid billing in pediatric shift care nursing, similar to the Wisconsin Professional Homecare Providers (wisconsinphp.org)	64%	18%
Payment Arrangement	OMAP to establish guidelines for paying pediatric shift care nurses (including contractors) for when shifts are canceled and/or cases are hospitalized	55%	36%

Figure 49 – Nursing Strategies Survey Results

NRR3 - Recommendation #3: Promote Regulatory Changes

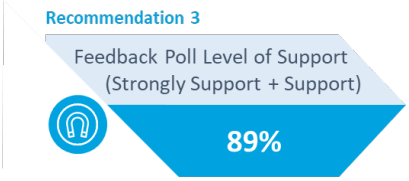


Figure 50 – NRR3 Feedback Poll Results

The workgroup recommends promoting regulatory changes that may work to improve pediatric shift care nursing. This recommendation received broad support across workgroups with 89% support via the feedback poll, as shown in Figure 50.

To further develop this recommendation, the workgroup reviewed, discussed, and voted on five regulatory and legislative recommendations prepared by the Pennsylvania Homecare Association that are linked to supporting nurse recruitment and retention. The top four of the five recommendations are related to certain COVID-19 emergency provisions that were put in place and would improve home health delivery if continued. The table below provided in Figure 51 provides the topic, the level of workgroup support, and details for each of the five recommendations.

Topic	Survey Question	Survey % Data	
Strong Support			
Expanding Telehealth for Home Health	Adopt and implement expanded use of and reimbursement for telehealth and remote patient monitoring, as permitted by federal law and regulations.	Support	90%
		Do Not Support	10%
Allowing Interstate Home Health Nursing	Support the passage of SB 655, authorizing Pennsylvania to join the Nurse Licensure Compact	Support	90%
		Do Not Support	10%
Moderate Support			
Expand Scope of Practice for Ordering Home Health	Review and expand scope of practice rules in Pennsylvania to implement federal rules/expansion with respect to ordering and overseeing home health.	Support	80%
		Do Not Support	20%
"Legally Responsible" Individuals	Expand the ability (through a waiver or other vehicle) to pay qualified, "legally responsible" individuals for personal care services.	Support	70%
		Do Not Support	30%
Weak Support			
Relax Medicare Certification for Pediatric Home Health Agencies	Amend state plan to allow home health agencies that do not bill Medicare to be Medicare-certified OR accredited by a nationally recognized accrediting organization.	Support	50%
		Do Not Support	20%
		Other	30%

Figure 51 – Nursing Regulatory Survey Results

What's Next

Based on the work of the Nurse Recruitment and Retention workgroup, the recommended next steps could include:

- **Present a letter of commitment signed by Secretary Miller to nursing schools to collaborate on improving home health curricula. Include a nursing school survey to determine the scope of existing programs and identify potential areas for improvement and expansion.**
- **Create a communication channel with the Office of the Chancellor at PASSHE to understand feasibility of adopting a standardized home health-focused curriculum within the state-wide academic planning.**
- **Work with other state partners to address the nursing shortage, including Labor and Industry to declare a critical workforce shortage.**
- **Explore additional nursing benefits, including creating a health insurance pool across agencies and creative pay arrangements to increase nurse pay**
- **Consider and support strategic regulatory changes including the passage of the nurse licensure compact, PA Senate Bill 655, and the expansion of telemedicine within the Medicaid program.**

Cross-Workgroup Recommendations

During the overall Pediatric Shift Care Nursing initiative, common themes appeared from the five workgroups. These common threads are centered around care plans, training, and the adoption of the P3N. The recurring theme to improve pediatric shift care nursing centered around coordinated care that encompasses the whole child, with the necessary training, data sharing, and technology tools to facilitate and enhance the level of coordinated care. This theme is an example of how the stakeholder collaboration served as a catalyst for actionable solutions to improve Pennsylvania's pediatric shift care nursing home health model to better serve patients, families, home health care workers, and MCOs.

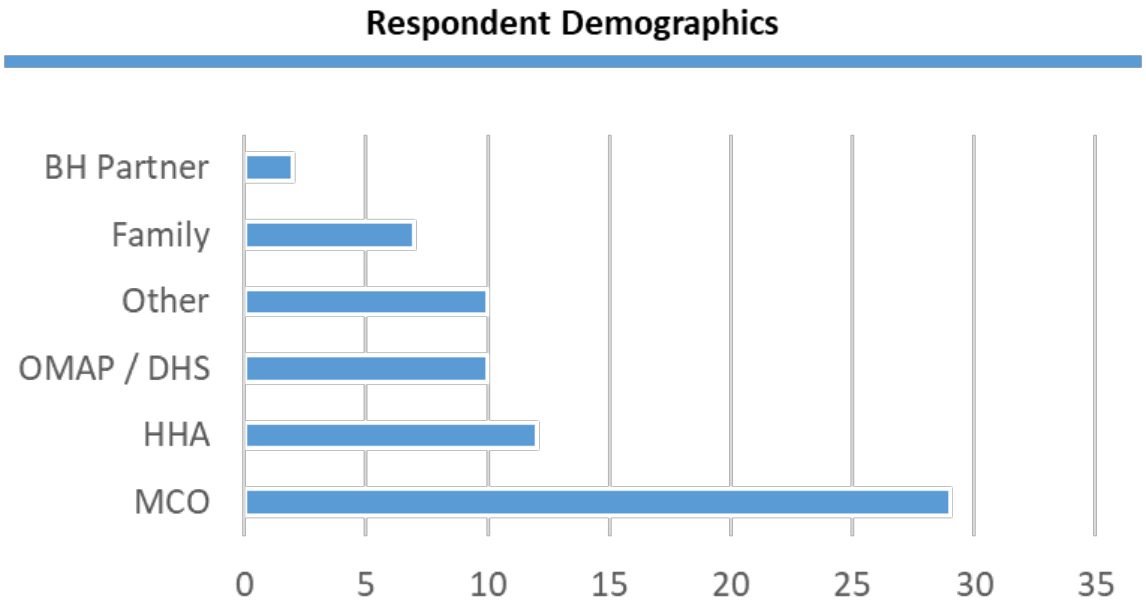
To further foster collaboration and communication among the five workgroups, during the July 2020 workshop, all workshop attendees had the opportunity to review the final recommendations from each workgroup. Members were given the opportunity to provide comments, ask questions, and discuss the recommendations with the workgroup chairs from all the workgroups.

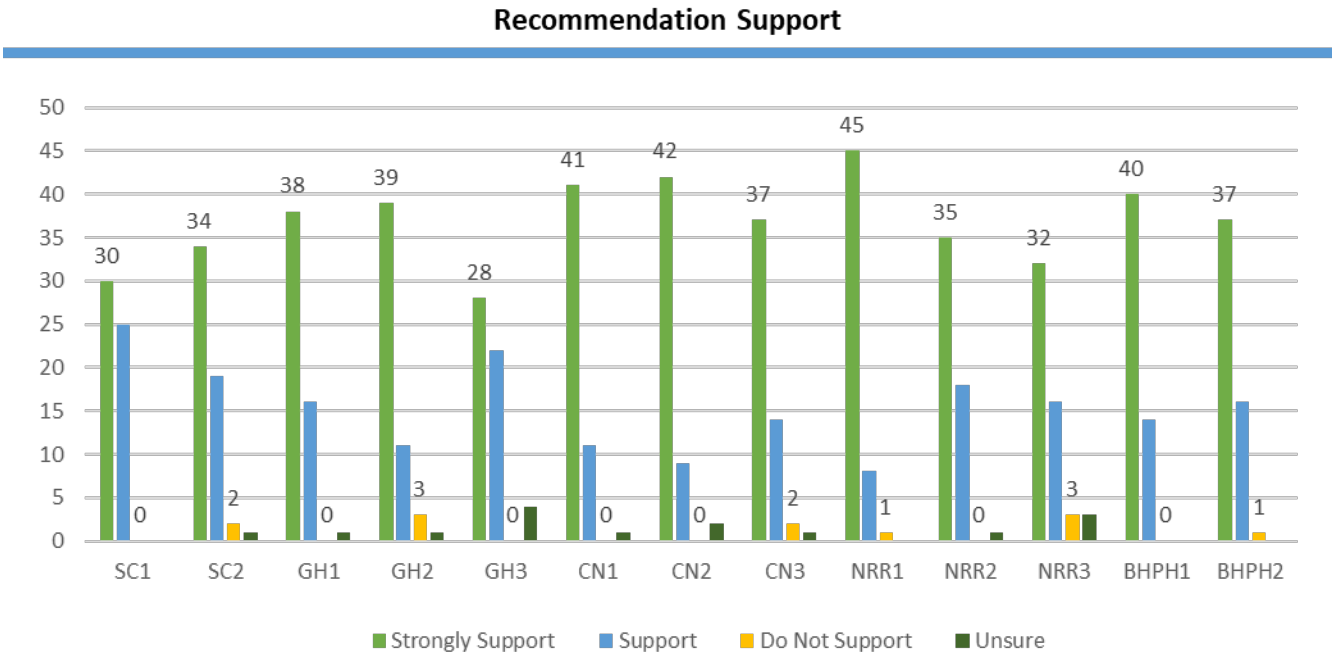
Throughout the July 2020 workshop, there were recurring feedback themes on the workgroup recommendations. Comments for consideration during implementation of the pediatric shift care nursing strategies include:

- **Service Coordination**
    - **Attendees discussed the clarifying point that no matter the Service Coordination model selected by the family (with or without a Medical Home), the MCO must still meet contractual obligations and the Medical Home does not exclude MCO involvement.**
    - **Attendees discussed the clarifying point that a standardized assessment tool would not cause denied requests or delays. The goal of the assessment tool is to be used for information gathering.**
- **Caregiver / Nurse Relationship**
    - **Attendees discussed the Family Council Model and recommended an additional opportunity for the Family Council to be independent, rather than tied to a specific agency.**
- **Behavioral Health and Physical Health Coordination**
    - **Attendees discussed the opportunity to not only increase behavioral health awareness for physical health providers, but also conversely, provide physical health training to behavioral health providers and MCOs.**
- **Going Home Transition and Discharge Planning**
    - **Attendees discussed the additional data sharing and integration opportunities available with the Electronic Visit Verification (EVV) system per the CARES Act.**
- **Nurse Recruitment and Retention**
    - **Attendees discussed the benefits of "education pods" to address educational needs regarding care specific to individual children, as well as the potential efficiencies associated with a "team nursing" strategy in order to help ensure consistency in the delivery of care for individuals.**

Following the final virtual workshop, attendees were invited to vote, via an online, anonymous feedback poll, on each recommendation using one of three voting options: 1) Strongly support; 2) Support; 3) Do Not Support and 4) Unsure.

The feedback poll received an exceptional response rate of 88% and all 13 recommendations received broad support. The aggregate results and highlights of the feedback poll are shown below in Figure 52.





Highlights

Top recommendations with the highest votes of Strongly Support:

- NRR1: Encourage Nursing Schools to Increase Home Health Education
- CN2: Increase Ongoing Family Input
- CN1: Create a Training/Education Portal

Top recommendations with highest overall Support votes (Strongly Support + Support):

- GH1: Provide Best Practices for Discharge
- BHPH1: Increase Behavioral Health Awareness

Unanimous support with all Strongly Support and Support votes:

- SC1: Provide Service Coordination Options
- BHPH1: Increase Behavioral Health Awareness

Clarification for Non-Support Votes

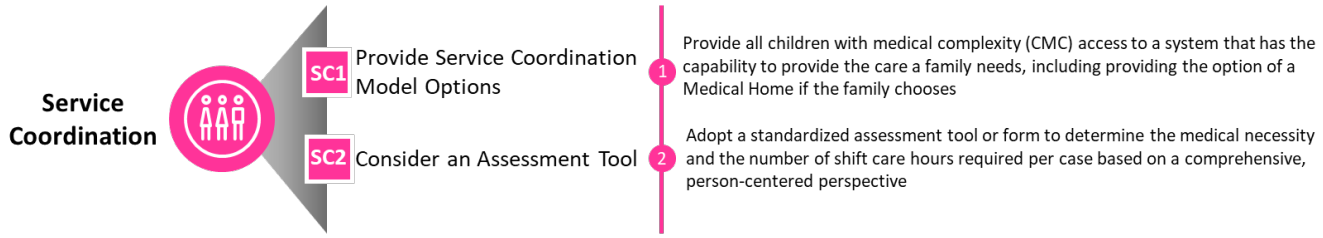
- Respondents were most **Unsure** about GH3 - **Incentivize Onboarding HHAs into the HIE**
  - Respondents cited unfamiliarity with the HIE platform as the primary driver of uncertainty
- Respondents voiced the most **Do Not Support** for two recommendations: NRR3 - **Consider Regulatory Changes** to Support Recruitment and Retention, and GH2 - **Improve the Co-Vending Scenario**
  - In both scenarios, the common reason cited for Non-Support was that respondents did not feel these recommendations directly addressed the problem of nurse availability

Figure 52 – Aggregate Feedback Poll Results

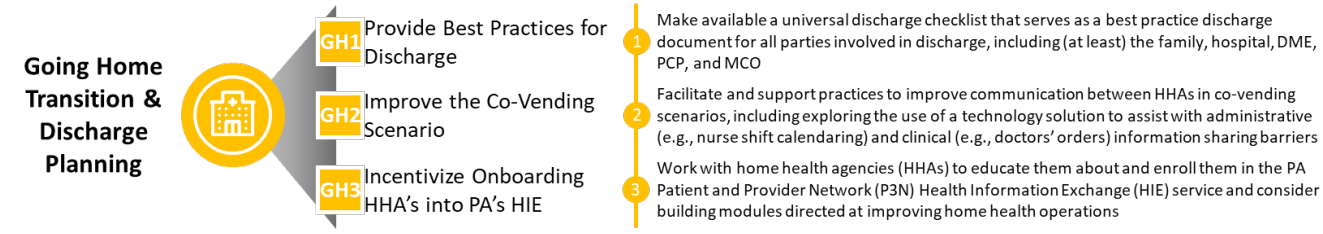
Conclusion

This collaborative initiative led by OMAP and carried out by numerous stakeholders in the field of pediatric shift care nursing resulted in several ideas and recommendations to improve the way pediatric shift care nursing services are managed and delivered in Pennsylvania (see Figure 1 below). The multiple quarterly workshops and virtual workgroup meetings brought together a diverse group of stakeholders and facilitated the development of stronger relationships and understanding. These relationships and the shared understanding will continue to support the delivery of pediatric shift care nursing through the implementation and adoption of these recommendations and others, and the continued evolution of the model of pediatric shift care nursing both across Pennsylvania and outside of it.

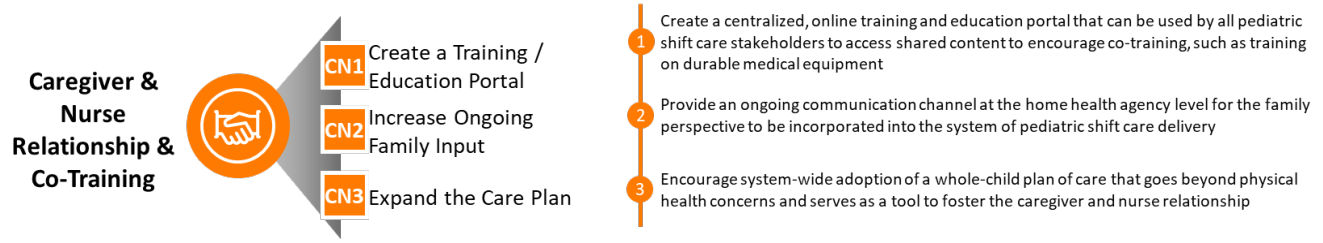
Service Coordination Recommendations Summary



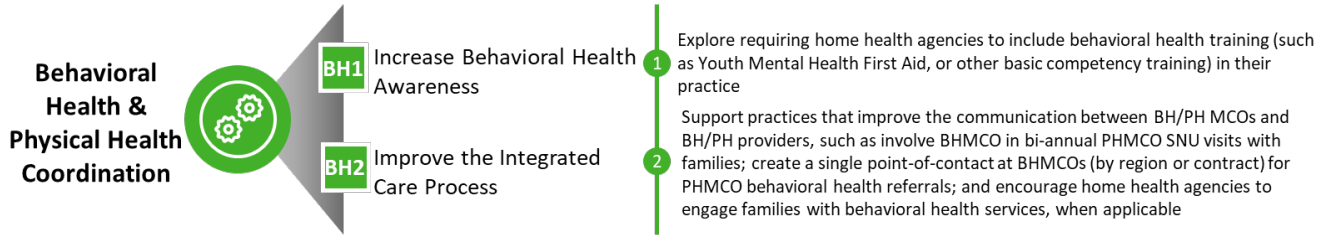
Going Home Transition and Discharge Planning Recommendations Summary



Caregiver and Nurse Relationship and Co-Training Recommendations Summary



Behavioral Health and Physical Health Coordination Recommendations Summary



Nurse Recruitment and Retention Recommendations Summary

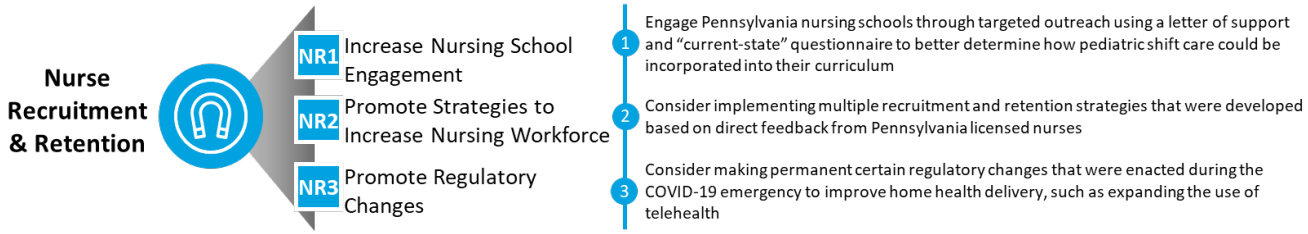


Figure 1 – Workgroup Recommendations

Acknowledgements

Pennsylvania's Department of Human Services would like to thank all the dedicated individuals who participated in workgroup discussions and meetings that led to the development of the content for this white paper. Special thanks to the individuals below who have served as a co-chair for one of the five workgroups. The co-chairs that served on each of the five workgroups is shown below in Figure 53.

Workgroup	Chair(s)	Organization
Service Coordination	Linda Mikula	Gateway Health
Service Coordination	Katrina Becker	OMAP
Nurse Recruitment & Retention	Shannon Gutwald	Harmony Home Healthcare
Nurse Recruitment & Retention	Teri Henning	Pennsylvania Homecare Association
Going Home Transition	Kristin Michener	Interim Healthcare of Pittsburgh
Going Home Transition	Luis Rivera	Maxim Healthcare Services
Behavioral Health & Physical Health	Meg Stellini	Aveanna Healthcare
Behavioral Health & Physical Health	Patrice Faust	Aetna Better Health
Caregiver & Nurse Relationship	Jeanne Funk	OMAP
Caregiver & Nurse Relationship	Janelle Supplee	CritiCare Lancaster

Figure 53 – Pediatric Shift Care Nursing Workgroup Co-Chairs

Pennsylvania's Department of Human Services would also like to thank all the workgroup members that invested their time and talents in this initiative. Over 120 participants represented the following organizations across the five workgroups. Initiative stakeholder organization are displayed in Figure 10.

Figure 10 – Initiative Stakeholders

Acronym Glossary

Acronym	Definition
ADL	Activities of Daily Living
ASD	Autism Spectrum Disorder
BH	Behavioral Health
BHMCO	Behavioral Health Managed Care Organization
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CASSP	Child and Adolescent Service System Program
CDC	Centers for Disease Control
CEU	Continuing Education Unit
CMC	Children with Medical Complexity
CNA	Certified Nursing Assistant
CRCG	Community Resource Coordination Group
DHS	Department of Human Services
DME	Durable Medical Equipment
DOH	Department of Health
EVV	Electronic Visit Verification
FFS	Fee For Service
FTE	Full Time Equivalent
HHA	Home Health Agency
HIE	Health Information Exchange
ICP	Integrated Care Plan
ICT	Interdisciplinary Care Team
IPoC	Individualized Plan of Care
LATERN	Lifespan Autism Instruction Training Education, and Resource Navigation
LPN	Licensed Practical Nurse
MCO	Managed Care Organization
NASHP	National Academy for State Health Policy
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Services
P3N	PA Patient and Provider Network
PASSHE	PA State System of Higher Education
PCMH	Patient Centered Medical Homes
PCP	Primary Care Physician
PECC	Pediatric Extended Care Center
PH	Physical Health
PHMCO	Physical Health Managed Care Organization
RN	Registered Nurse
SNU	Special Needs Unit
YMHFA	Youth Mental Health First Aid

Appendix

General Resources

Appendix A- State Practices Research

Pediatric Shift Care Nursing Home Health State Practices Research - *An Overview*

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The **Office of Medical Assistance Program (OMAP)** is taking steps *to improve Pennsylvania's Medicaid Managed Care delivery model of pediatric shift-care nursing for children with medical complexities (CMC).* In support of this effort, a team of researchers conducted a four-pronged project to identify **national trends**, **key considerations**, and **innovative practices** in pediatric shift-care nursing.

Approach

Broad Literature Review	Peer State Research	State Medicaid Surveys	Deep Dive Conversations
The research team reviewed publicly available and recently published policy papers and academic literature to discover the scope of the issue from a national perspective.	*The research team reviewed state-specific publicly available documentation related to the model of service delivery for children with medical complexity (particularly for children receiving pediatric shift care nursing) within a Medicaid managed care environment. Ten peer states selected by OMAP and the research team were examined.*	*Ten State Medicaid agencies responded to open-ended questions addressing five topics: delivery models, missed shifts, support for nurses, supplemental services, and home health associations.*	*Four states participated in structured interviews in order for Pennsylvania to learn more about their pediatric shift-care nursing practices.*
12 resources highlighted	**10** peer states researched: FL GA IL MA MN NY OH TX VA WA	**10** survey responses	**4** interview conducted: CA GA SC VA

Integrated Findings

Improving service delivery for CMC is an emerging challenge
Many state Medicaid programs have just begun to focus efforts on exploring challenges and assessing their current system

States are facing similar challenges
Addressing workforce shortages in shift-care nursing; measuring outcomes of shift-care; tailoring long term services and supports for pediatrics

There is not a proven "one-best-way" to administer care to CMC in Medicaid
The national landscape is a mosaic of FFS, waiver, traditional and specialized managed care, and LTSS programs

Service coordination is at the center of the issue
Many states are leaning towards "high-touch" methods to ensure success, such as regular face-to-face meetings, creating comprehensive care plans, and providing real-time support to in-the-field care coordinators

Innovative State Practices

1. **Delaware CMC Steering Committee**
In response to a 2017 state legislative mandate, Delaware Medicaid convened a standing CMC Steering Committee with 4 sub-workgroups (Data, Access, Payers, and Models of Care) to develop a strategic plan for managing the health care needs of CMC.

2. **Virginia Care Coordination Unit**
Virginia Medicaid has a Care Coordination Unit that focuses on substantial up-front technical assistance and training (such as weekly webinars) to MCO care coordinators instead of only providing back-end oversight. This unit is staffed by experienced care coordinators who worked with the CMC population when it was FFS (prior to managed care implementation).

3. **Florida CMC Care Coordination Enforcement**
Florida Medicaid assess liquidated damages for MCO failure to attend Children's Multidisciplinary Assessment Team meetings and failure to develop individualized service plans for children receiving private duty nursing. They also collect a monthly Enhanced Care Coordination report for the same group of children.

4. **Illinois Individualized Plan of Care**
CMC are in a high-risk category and require a care coordinator and a Interdisciplinary Care Team (ICT). The ICT develops a Individualized Plan of Care (IPoC) within 90 days of enrolling and must address over 20 elements, if applicable including cultural preferences, living arrangements, and collaborative approaches to be used.

5. **Texas Community Resource Coordination Groups**
Texas HHSC refers individuals (including children) with special/complex needs to one of 140 community-based and driven CRCGs, which are "groups of local partners and community members that work with parents, caregivers, youth, and adults to make a service plan. The service plan helps a person with special needs get benefits and services." CRCGs are joint-funded through nine different state agencies and mandated by state legislation.

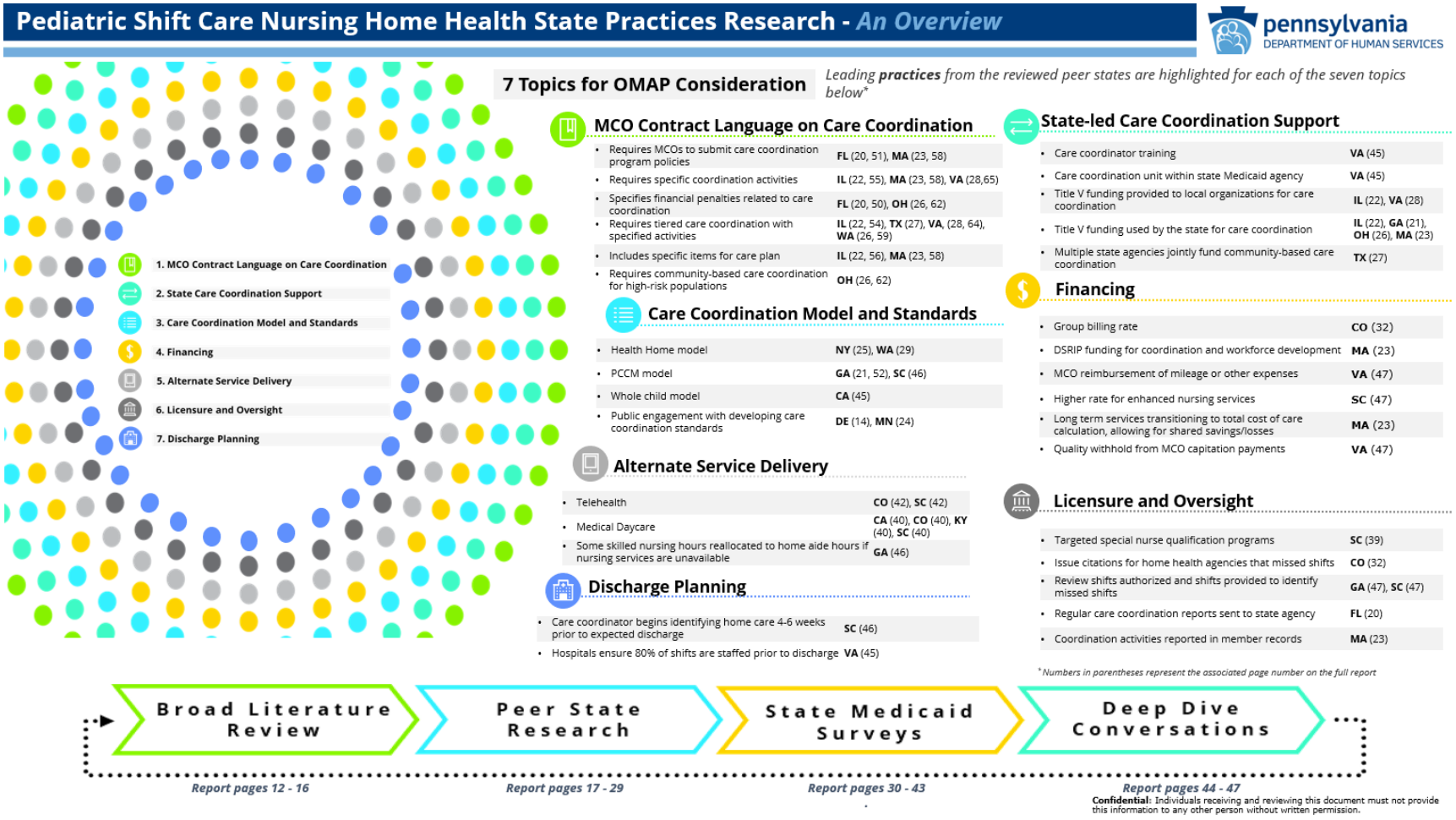
> *"**Children with medical complexity (CMC) are an extraordinary group of children**—with the most extraordinary families—who are striving to live with the rarest and most severe, functionally limiting, complicated, and life-threatening health problems of all. CMC are one of the smallest, yet fastest growing, populations of children, and they have an enormous impact on the healthcare system."*

Berry, J. G. (2015). What Children with Medical Complexity, Their Families, and Healthcare Providers Deserve from an Ideal Healthcare System. Lucile Packard Foundation for Children's Health.

> *"Collaboration among key stakeholders (patients, families, providers, payers, and policy makers) is needed to address the gaps in care and create best practice guidelines to ensure the delivery of high-value care for CMC."*

Pordes, E., et. al., (2018). Models of Care Delivery for Children with Medical Complexity. Pediatrics.

Confidential: Individuals receiving and reviewing this document must not provide this information to any other person without written permission.



Pediatric Shift Care Nursing Home Health State Practices Research - *An Overview*

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Broad Literature Review

The literature review identified national trends in efforts to improve care for children with medical complexity.

Delaware Health and Social Services (general)

Delaware's Plan for Managing the Health Care Needs of Children with Medical Complexity

- Delaware Medicaid convened a **CMC Steering Committee** to develop a strategic plan
- Multiple recommendations include creating **specific network requirements** for CMC MCO enrollees, and using data to assist with improving **nursing shortage**, as well as to explore **episodes of care** to identify gaps

National Academy for State Health Policy (general/service coordination)

Toolkit: National Standards for Children and Youth with Special Health Care Needs

- Provides standards that define the core components of a comprehensive, **coordinated**, and **family-centered system of care** for CYSHCN
- Describes how states have implemented the standards in **Medicaid managed care** programs
- Provides organizational and **system assessment tools** and national **quality measures** for CYSHCN

Health Affairs Journal (general)

Home Health Care For Children With Medical Complexity: Workforce Gaps, Policy, And Future Directions (2019)

- Discusses workforce and payment **challenges**
- Provides **recommendations** for **payment reform**, incorporating home health with child-focused hospitals to increase nurse support, increasing **home health telehealth**, and aligning practices with adult LTSS

Peer State Research

Peer state research identified relevant contract language and program structures relating to Medicaid coverage for children receiving shift care nursing.

Service Coordination (SC) models and programs:

Model		Peer States
State has a unique Managed care plan and MCO for CMC with SC requirements		FL
State has enhanced SC requirement language in contracts with regular MCOs		FL, IL, MA, OH, WA
State uses Title V funding for ongoing care coordination for CMC (not one-time visits)		GA, IL, MA, OH, VA
State utilizes MLTSS program for CMC		NY, TX, VA
State utilizes one or more HCBS 1915c waiver program for CMC with enhanced SC	Fee-for-service delivery	GA, IL, MN, OH
	Managed care delivery	IL, NY, TX, VA

Key State Findings:

FL
- Specialty managed care plan for CMC
- Care coordination reporting and enforcement requirements

GA
- Title V funded care coordination for CMC
- Enhanced care coordination in waiver program

IL
- Interdisciplinary Care Team required
- Waiver program provides support services

MA
- Specific care coordination requirements in MCO contract
- DSRIP funding used for care coordination

MN
- Title V funded grants for quality improvement projects
- Statewide Medicaid case management redesign

NY
- Health home model
- Waiver program coordination billing and coordination

OH
- MCOs required to coordinate with qualified behavioral health entities
- Title V funding for Public Health Nurses providing care coordination

TX
- Tiered service coordination in MLTSS waiver program
- Community Resource Coordination Groups develop service plans

VA
- MLTSS waiver program for adults and children
- Centers of Excellence for CYSHCN

WA
- Medically Intensive Children's Program provides shift care nursing
- MCOs are contractually required to provide tiered care coordination

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Pediatric Shift Care Nursing Home Health State Practices Research - *An Overview*

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State Medicaid Surveys

The State Medicaid surveys assessed similar challenges faced across states as well as innovative responses.

State Spotlights

Regulatory Highlight:

Colorado shared regulatory approaches to improving shift care nursing in home health services.

- Providers can use a **group rate for billing** when RN and LPN services are provided during the same shift.
- The Department of Public Health and Environment surveys home health providers for compliance with regulations requiring that all shift care nursing shifts be filled, which can lead to **agency licensure citation if shifts are unfilled**.
- Home health agencies can use **telehealth to collect health data from patients** with select diagnoses for later review by an agency nurse.

Care Coordination Highlight:

South Carolina highlighted the role of the care coordinator in many areas of the shift care nursing model.

- All waiver enrollees are assigned **an RN care coordinator**, who is required to make **monthly contact and complete quarterly home visits**. Care coordinators are employed by contracted providers and overseen by the state.
- The **care coordinator monitors service delivery**, and in situations when agencies do not fill all shifts, the coordinator will work with the family to resolve the situation or identify another provider.
- The care coordinator is also responsible for **coordination of medical daycare services** and care during a hospital-to-home transition.

Practices Under Consideration:

- In **Connecticut**, a children's hospital is considering 'sharing' nursing staff with home health agency
- In both **Nevada** and **South Dakota**, use of medical daycare to complement current system is seen as a potential solution.

9 **States reported that staffing cases is more difficult in rural areas than urban areas**

Experimental Practices:

- In **Colorado**, a **standardized assessment tool** was developed to uniformly process shift care service requests
- In **one state**, a **home health agency** is approved to **train LPNs** with less than one year of experience to qualify to work with medically fragile children
- In **South Carolina**, nurses with adult care experience may qualify to work with children with less stringent requirements
- In both **Colorado** and **South Carolina**, **telehealth remote patient monitoring** is used as an element in the home health program.

Deep Dive Conversations

Deep dive conversations led to clarification on specific aspects of Medicaid provision of shift care nursing.

State Spotlights

Virginia implemented a **technical-assistance-based** Care Coordination Unit staffed by prior care coordinators – they train/support MCO care coordinators, answer questions sent to a dedicated helpdesk email address, and hold "coffee talk Tuesdays" webinars for asking open/anonymous questions

- All members in the waiver must a have a "back-up" plan to ensure member needs are met
- Hospitals ensure 80% of pediatric shift-care nursing shifts are covered before discharging a child with CMC

South Carolina provides care coordination for all children receiving shift care nursing through the **family's choice of an RN Care Coordinator** or a **pediatrician in a PCCM model**

- **RN care coordinators** are located throughout the state and are required to make monthly contact and hold quarterly face-to-face meetings with the recipient
- **Care coordinators** begin identifying home health services 4-6 weeks prior to a child's expected hospital discharge and assist the family in discharge planning
- Some providers implemented specialized training programs for home health nurses transitioning from care for adults to pediatric care
- **Care coordinators review claims** to **ensure appropriate number of shift care nursing hours** are provided

- **California** Medicaid has a "no wrong door" policy for addressing questions and concerns, with the home health agencies frequently serving as intermediaries.
- **Georgia** Medicaid members have the choice to move skilled nursing hours to non-skilled home aide hours if skilled nursing shifts are unable to be filled, but a home aide could fill the shift.

States were specifically asked about their funding structure and monitoring of missed shifts

What funding strategies do you use for shift-care nursing?

- Higher capitated rate (PMPM) for technology-dependent children who receive shift-care nursing
- Quality withhold based on MCO performance (e.g., Virginia withholds 1% from each MCO that has the potential to earn it back)
- Shift differential rate payments based on distance of travel and/or time-of-day

How do you monitor missed shifts?

- States indicated that they do not have a process for ongoing reporting and monitoring of missed shifts
- Annual comparison of authorized against billed hours to determine missed shifts
- Member concerns with missed shifts are received through member complaints

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Workshop Deliverables

Appendix B- June 2019 Workshop Executive Summary

Pediatric Shift Care Nursing Home Health Workshop

Workshop Overview

On **June 20th**, 2019, the PA Department of Human Services hosted the inaugural pediatric shift care nursing workshop. The goal of the workshop was to **identify existing barriers** and **explore solutions** that would transform the way care is being provided to children with complex medical needs at home.

Participant Demographics

07 **Managed Care Organizations**
A total of 47 representatives

12 **Home Health Agencies**
34 representatives in total

30 **OMAP Facilitators**
Participation from DHS and OMAP staff members

Opening Remarks

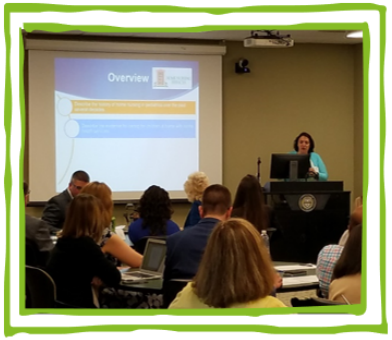
- Care for children involves the entire ecosystem surrounding them
- A better **care management plan** is necessary to support nurses while on their shifts
- Need to learn from existing care models and create one for pediatric care
- **Make** home health **attractive** to nurses

\- Sally Kozak,
Deputy Secretary, DHS

Keynote Address

Dr. Renee Turchi took the audience on a journey from the history of home nursing to the present issues and then to the potential future solutions. Key highlights from her address:

- **Understanding circumstances** of the families
- Medical home as a neighborhood
- Using **telehealth** to support families and nurses
- Developing **curriculum** for nurses and families
- **Working together** as a team



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Pediatric Shift Care Nursing Home Health Workshop

Panel Discussion

This session had 2 panels:
- MCOs - Home Health Agencies

Some of the **unique solutions** discussed are shown below

- Shift Care Welcome Kit
- Use of data analytics
- Parent Caregiver Model
- Working with LPM program
- Home Health Sim Lab

Open Discussion

The brainstorming session involved:
- Ideation: Participants visited two stations (**Collaboration**, **Leading Practices**) to add their ideas to the posters
- Solution Prioritization: Participants voted for their top 3 themes on each poster

6 themes emerged from the ideation session

- Sharing Best Practices
- Enhanced Family Support
- Marketing Branding
- Standardization Technology
- Trainings
- PH + BH Collaboration

Closing Remarks

Deputy Secretary Sally Kozak concluded the workshop by reminding everyone the need to solve this issue together.

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Appendix C- September 2019 Workshop Executive Summary

DHS Pediatric Shift Care Nursing Home Health Initiative – *An Overview*

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Purpose Improve Pennsylvania's pediatric shift care nursing home health model to better serve patients, families, home health care workers, and MCOs.

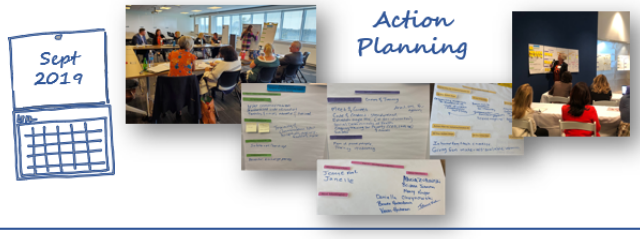
Mission Serve as the catalyst for stakeholder collaboration that results in the exploration and development of actionable solutions to five key areas of Pennsylvania's pediatric shift care nursing home health model.

> *"In order to fix some of the issues we're seeing, we will need to question the way we do things and the reasons why we do them that way."*
> ***-DHS Deputy Secretary Sally Kozak***

Completed Quarterly Workshops

DHS convened an **inaugural workshop** with MCO and Home Health Agency stakeholders involved in the care of HealthChoices members receiving pediatric shift care nursing.

The discussion, ideation, and prioritization that occurred during the inaugural workshop led to the identification of **five workgroups** that align with priority areas for improvement. The workgroups developed work plans during the workshop.



Workgroups & Future Quarterly Workshops

Workgroups are comprised of and driven by representatives from MCOs and Home Health Agencies. The **goal of each workgroup** is to create a deliverable fitting to its topic by **July 2020**, such as best practice guidelines or standardized pediatric shift-care materials (e.g., checklists, welcome kits).

Workgroups are tasked with **working towards their identified deliverables over the next nine months**. They will report on their progress to the full stakeholder group at the January and April quarterly workshop, with the goal of presenting the final deliverable(s) at the July workshop.

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DHS Pediatric Shift Care Nursing Home Health Initiative – *Workgroups at a Glance*

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Service Coordination

Workgroup Problem Statements

- Service coordinator role is not clear
- Process for care coordination is not clear
- Resource needs for care coordination

Current Activities/Initiatives

- Exploring stratified service coordination case load ratios
- Gathering service coordination information from other programs (e.g., ODP, Elks Nurses)
- Connecting with high-volume physicians and specialty providers to gain their perspective on service coordination

Going Home Transition & Discharge Planning

Workgroup Problem Statements

- Lack of consistency in the discharge process
- Unrealistic expectations of families that they are properly trained
- Lack of consistency in training

Current Activities/Initiatives

- Exploring the barriers and obstacles of discharge
- Exploring current training offerings related to discharge
- Developing a resource repository of discharge materials (e.g., checklists, workflows, training)

Caregiver & Nurse Relationship Support & Co-Training

Workgroup Problem Statements

- Lack of communications between caregivers and shift care team (e.g., setting boundaries and expectations)
- Establishing a safety net

Current Activities/Initiatives

- Compiling a "meet and greet" pamphlet that covers caregiver/nurse relationship topics (e.g., boundaries, expectations, home safety)
- Compiling a "home health agency tip sheet" to include policy recommendations

State Practices Research: Service Coordination

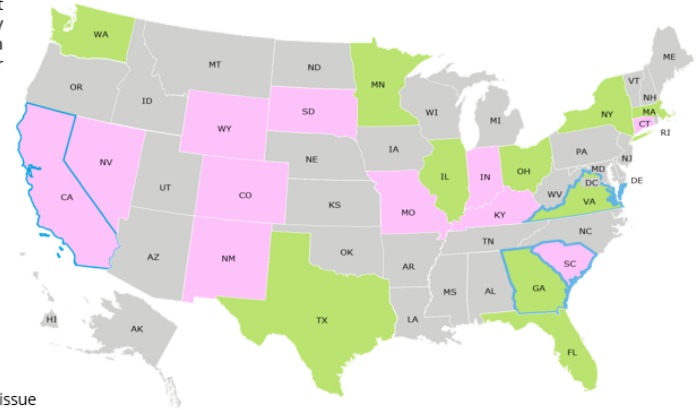
In support of this initiative, a team of researchers conducted a four-pronged project to identify **national trends**, key considerations, and innovative practices in pediatric shift-care nursing, with a particular **focus on service coordination**.

Integrated Findings

- Improving service delivery for CMC is an emerging challenge
- There is not a proven "one-best-way" to administer care to CMC in Medicaid
- States are facing similar challenges
- Service coordination is at the center of the issue

Research Approaches

Peer State Research | Deep Dive Conversations | State Medicaid Surveys



Behavioral Health & Physical Health Coordination

Workgroup Problem Statements

- Lack of common care plan
- Lack of communication between all stakeholders
- Lack of behavioral health training in home health agencies

Current Activities/Initiatives

- Exploring the availability of MH First Aid training for home health workers
- Developing an integrated care plan based on existing integrated plans
- Compiling information on behavioral health training currently offered by home health agencies

Nurse Recruitment & Retention

Workgroup Problem Statements

- Lack of system to ensure adequate supply of nurses
- Need to ensure spots in nursing school to explain home care as an option
- Need to ensure education for the specialty of pediatric home care

Current Activities/Initiatives

- Initiated subgroups to address five key initiatives: 1) Marketing and Stigma; 2) Nursing School Collaboration; 3) Challenging Homes; 4) Codes of Conduct; 5) Administration Pressures
- Subgroups are developing action plans

Executive Summary

On January 8, 2020, the Pennsylvania Department of Human Services hosted the third Pediatric Shift Care Nursing Home Health Quarterly Workshop.

Participant Demographics

79 stakeholders

- 29 **Managed Care Organization** attendees
- 22 **Home Health Agency** attendees
- 16 **DHS Staff** including OMAP, OMHSAS, and the Secretary's Office
- 8 **Parent/Family** representatives and advocates
- 4 **Behavioral Health Partners**

Opening Remarks

- Executive Assistant to the OMAP Deputy Secretary Gwen Zander welcomed **parent/family representatives** to the workshop and emphasized the importance of their perspectives to the work of this collaborative effort. She also emphasized how the work of the workgroups can influence **HealthChoices Agreement language**.
- Special Assistant to the DHS Secretary Nancy Thaler discussed the current DHS initiative of assisting families of children with complex medical needs to **transition their child to community care**. She highlighted the importance of the role of **care coordination** within this process.

Colorado Medicaid Presentation

This presentation was a learning opportunity intended to spur discussion by providing workshop attendees a first-hand account of **how another state is addressing delivery of pediatric shift care**. Colorado discussed their Accountable Care Collaborative and **Pediatric Assessment Tool (PAT)** and answered questions from attendees.

Health First COLORADO
Colorado's Medicaid Program

Workgroup Meetings

All of the five workgroups had the opportunity to meet in-person to reflect on what they've accomplished since the September workshop and where they want to be by the April quarterly workshop. Workgroup efforts were reported to all attendees and feedback was provided.

Workgroups will be working diligently over the next 3 months before the April quarterly workshop to further their work on their identified deliverables.

Executive Summary

On July 30, 2020, the Pennsylvania Department of Human Services hosted the fourth and final Pediatric Shift Care Nursing Quarterly Workshop.

Welcome and Opening Remarks

Office of Medical Assistance Programs (OMAP) Chief of Staff Gwen Zander **welcomed workshop representatives**. As this is the final workshop, **DHS OMAP Deputy Secretary Sally Kozak** reflected on how far this initiative has come over the past year and thanked attendees for their effort, hard work, and dedication of the workgroups.

Time for Change...

- ✓ Every recommendation represents months of hard work and deliberation
- ✓ Each recommendation builds upon each other and ultimately advances the goal of improving pediatric shift care nursing services
- ✓ Feedback poll voting results will be communicated to DHS; The results of the feedback poll will impact which recommendations will be adopted
- ✓ DHS will be carefully considering each of the recommendations
- ✓ Once decisions are made, changes will start to be made to improve the care for children with complex needs receiving pediatric shift care nursing services

"Because you were willing to participate in this initiative, our recommendations are more balanced and more reasoned. We know some conversations were hard and there was not always consensus, however, we were united in our purpose of ensuring that all children in Pennsylvania regardless of where they live or what diagnosis they have, get the care that they need and deserve so that they can live life to their fullest potential." – Sally Kozak, DHS OMAP Deputy Secretary

Gallery Walk

Workshop attendees were divided into five breakout groups where a virtual gallery walk took place. Each breakout group contained representation from each of the five workgroups. The chairs of each workgroup circulated between the rooms to present their respective workgroup posters that summarize workgroup recommendations. The gallery walk allowed for feedback, open discussion, and opportunity for endorsement from the workgroup participants on all the recommendations.

Participant Demographics

83 *stakeholders*

- ✓ 31 Managed Care Organization attendees
- ✓ 19 Home Health Agency attendees
- ✓ 11 DHS Staff including OMAP, OMSAS, and the Secretary's Office
- ✓ 7 Parent / Family representatives and advocates
- ✓ 8 Behavioral Health Partners
- ✓ 7 Other representatives (DOH and Hospitals)

Pennsylvania In-Home Nursing Survey Report Results

A survey was sent out to all RNs and LPNs across the state who are currently, or have formerly, provided pediatric in-home nursing services, and results were shared in the workshop. The survey was a shared project between the Imagine Different Coalition and PA Office of Medical Assistance Programs.

Workgroup Deliverables

Service Coordination

Appendix F- Model Role Checklist

ROLES AND RESPONSIBILITIES FOR SERVICE COORDINATION MODELS

Overall goal of the Service Coordination Workgroup:

All children with medical complexity (CMC) should have access to a system that has the capability to provide the care a family needs, including providing the option of a Medical Home if the family chooses.

Option 1: MCO Members in a Medical Home

All children with medical complexity (CMC) need comprehensive coordination of care and should have a Medical Home. Pediatric Medical Homes provide comprehensive coordination of care for healthcare services and other services such as Early Intervention, education, social determinants of health. CMC with medical homes have better outcomes. Furthermore, MCOs should assist families identify a medical home for their child. Approved Medical Home practices should receive a supplement for their work to provide comprehensive coordinated care for each CMC in their practice. This payment to Medical Homes attempts to encourage more pediatric practices to become approved Medical Homes.

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	Approved Medical Home
1. Screening and identification **a. Potential current and future need for care, services, or supports for health, development, socio-emotional well-being, behavior, education, habilitation, and family life** **b. Potential current and future need for coordination**	● ***Primary – MCO/SNU serves as entry point to Medical Home if child is not currently connected; identify Medical Home options for the family and ensure service coordination is provided when there is no Medical Home, or the family does not choose to use a Medical Home.*** ● Supplementary role **● When a new child is enrolled, current requirement is that the MCO/SNU conducts outreach (via phone or mail) to introduce her/himself and explain the role of the MCO in assisting their child to get the care and services they need, and to follow-up on the screening conducted by Medical Home PCP for needs, services, and service gaps.** **● SNU screening supplements Medical Home screening and serves as safety net screening that DOES NOT duplicate the Medical Home screening.** **● Responsible for obtaining completed PCP screening and ensuring that all members are connected to a Medical Home; communication between MCO and medical home occurs once identified**	● **Primary role** ● The role of a medical home as defined by Bright Futures, the American Academy of Pediatrics and the Maternal Child Health Bureau. A core performance measure is that all children are connected to a medical home and have their screenings completed by the appropriately trained clinicians. ● The Medical Home team in the PCP office has active family engagement and includes front staff, referral coordinators, nurses, CRPPs/PA, physicians, social workers, community health workers, and others in the office and the family as a leader. PCP within the Medical Home (pediatrician, family practitioner, CRNP, specialist, etc.) conducts the screening as they have direct contact with child ● Physicians and PCMHs are required to use 10-question screening tool that captures SDOH needs ● As part of existing vendor agreement with MCO, the Medical Home will share necessary parts of screening with MCO

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	Approved Medical Home
2. Outreach and informing **a. Anticipate needs** **b. Available as well as possible care, services, or supports**	● Supplementary role **● SNU provides "safety net" support to Medical Home to ensure that there are no gaps in services and that all identified needs are met** **● Level of outreach varies on case-by-case basis and depends on needs and case situation (see #5)**	● Primary role **● Service care coordinator within Medical Home conducts high touch "front-line" outreach at a level that ensures care integration (see #5) and meeting needs across all medical, social, educational, family, quality of life, developmental, psychosocial, medical equipment, cultural effectiveness, supporting the needs of the family and is the constant in their life until and through their transition to adult oriented systems.**
3. Assessment **a. Comprehensive** **b. Child needs (inclusive of all needs, not just health)** **c. Family needs** **d. Need for case management**	● Supplementary role **● SNU obtains and reviews the comprehensive assessment from a systems-level perspective to ensure Medical Home is addressing all needs** ● MCO should utilize assessments to inform MCO case manager case ratios and number of FTEs required to cover the number of children in the plan.	● Primary role **● Medical Home responsible for driving the comprehensive assessment that informs care plan.** **● Medical Home manages and maintains the care plan and the PCP Medical Home works with the family on goal setting and revisits this as a working document available across all settings.** **● Responsible for ensuring that all care integration partners are aware of their role in the care plan**

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	Approved Medical Home
4. Individual planning **a. Single, proactive, comprehensive across all needs** **b. Interdisciplinary team-based with members with specialized expertise** **c. Family-centered principles and practices**	● Supplementary role **● SNU is part of the discussion during planning driven by Medical Home** **● MCO utilization management team collaborates with the Medical Home on meeting the needs of the child through negotiation of medical necessity and level of authorizations while considering case specific SDOH concerns (beyond what is in the 485)** **● SNU assists the family and the Medical Home on establishing medical necessity and with filing an appeal** **● SNU responsible for maintaining communication with Medical Home for all cases**	● Primary role **● Medical Home to work collaboratively with child/family, HHA, and other care integration partners to develop family-centered care plan and is responsible for signing off on all orders for home nursing every 60 days and writing LOMN for nursing services to be initiated and maintained.** **● Integrates all the care integration into a living document** **● Expected outcome – ensuring that all care integration partners are on the same page and have the correct and same plan of care that is being carried out in an integrated fashion** **● Includes how the skill set of the HHA nurse(s) fits the need of the child and how this relates to covering all shifts** **● Medical Home initiates the letter of medical necessity (and renewal letters) for submission to the MCO and revises when necessary** **● Medical Home maintains the medical orders and initiation and maintenance of services**

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	Approved Medical Home
5. Case management **a. Assure all elements of comprehensive plan are adequately addressed** **b. Coordinate between/across all settings/providers of care, services, and supports**	● Supplementary role **● Goal of ensuring that Medical Home provides the MCO/SNU an updated Medical Home screening, assessment, and care plan to afford the MCO/SNU the opportunity to fill in service gaps when needed** **● The MCO should expect to have to carry out some level of case management and reporting despite member being in a Medical Home. The MCO is still responsible for managing all the members services and for addressing issues that arise and are brought to their attention and are not to defer to the Medical Home. If the issue is a concern relevant to the Medical Home the MCO would work with the Medical Home to resolve.**	● Primary role **● High-touch role to ensure care integration – integration of services across all systems that aligns with the child's care plan/map (e.g., medical, social, education, legal, therapeutic, DME, nursing, mental/behavioral health, etc.)** **● Coordinates supplementary coordinators (such as MCO case manager, HHA supervisors/managers, DME, early intervention, behavioral health, education, etc.)** **● Care integration initiated at in-person meeting and continues between in-person meetings**
6. Assistance accessing services and supports **a. Proactive, facilitating, researching, locating, linking, arranging, obtaining, advocating** **b. Formal and informal** **c. EPSDT/Medicaid and non-Medicaid and community resources**	● Supplementary role **● SNU assists Medical Home with addressing SDOH needs when requested by the Medical Home – provides a safety net in complicated cases/situations (i.e., when the Medical Home hits a wall and doesn't know where/how to connect)**	● Primary role **● Medical Home uses the 10-question SDOH screening tool and comprehensive assessment to link to services to address the identified needs and supports family in environment of trust and caring across the life course** **● Engages the MCO/SNU when unable to make needed linkages to services or does not have knowledge of how to address the need**
7. Monitoring, follow up, and oversight **a. At individual and child level:** **i. Sufficient in scope, intensity, periodicity, frequency, and continuity to evaluate the effectiveness of all elements of the comprehensive plan**	**● Primary role is at the systems level (activities listed under b)** ● Responsible for determining the adequacy of the system of services that children are (or are not) receiving. ● Continually reviews and analyzes data from authorizations and utilization and	**● Primary role is at the individual level (activities listed under a)** ● Responsible for determining the level of support at the child/family level is adequate.

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	Approved Medical Home
ii. Ongoing contact, in-person visits, analysis, satisfaction determination **b. At the system level:** **i. Sufficient in scope, intensity, periodicity, frequency, and continuity to evaluate the effectiveness of all elements of the system of coordination** **ii. Develop and maintain adequate provider network.** **iii. Develop contracts and interventions for inadequate performance.** **iv. Monitor provider performance** **v. Intervene in patterns of authorized but unmet services** **vi. Quality improvement strategies**	conducts experience surveys from families and providers to ensure needs are being met – takes a proactive approach, does not rely on complaints, grievances, and appeals to determine adequacy ● Ensures child/family is satisfied with the system of services ● Ensures child/family is satisfied with the Medical Home ● Ensure authorized services are being delivered ● Assures adequacy of the provider network **● Assists Medical Home when needs arise (such as finding specialist within MCO network)**	● Drives outreach to MCO to gain support when needed (such as finding specialists within MCO network) ● Garners constant and consistent feedback from families about experience with care coordination, family centered care and experience in the office and across systems with the entire medical home team.

Option 2: MCO Members not in a Medical Home

For MCO members where a Medical Home is not available, or when a family chooses to not have a medical home, the MCO could act as the service coordinator in partnership with the PCP / Specialist.

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	PCP/Specialist
1. Screening and identification **a. Potential current and future need for care, services, or supports for health, development, socio-emotional well-being, behavior, education, habilitation, and family life** **b. Potential current and future need for coordination**	● Primary role **● Stratifications and authorizations in place for shift care nursing to start** **● Proactively establish a liaison between MCO inpatient case managers and in-network NICU and pediatric hospitals to ensure cases are identified early assign a case to case management when shift care nursing case identified** **● Cases identified via outreach from discharge planners at hospital, but does not always occur (do not have control over hospitals); attempt to establish a chain of notification from in-network NICU and pediatric hospitals** ● For members who do not receive shift care nursing services as the result of an inpatient admission referrals can be made through direct contact with the SNU so that case management and care coordination can be initiated ● MCO/SNU serves as entry point to Medical Home if child is not currently connected. MCO to identify Medical Home options and details around what options exist if a family does not want to choose a Medical Home.	● Supplementary role **● PCP would not identify cases.** **● There would be communication with the PCP and/or ordering physician to ensure there is an understanding of the shift care nursing services and the care team involved with the child and family**
2. Outreach and informing **a. Anticipate needs** **b. Available as well as possible care, services, or supports**	**● Shared role** ● MCO conducts proactive outreach via phone and mail to family	**● Shared role** ● PCP may need to provide additional detail on history and

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	PCP/Specialist
	● Outreach may also be made to community partners, schools, service agencies, home health agencies and other medical providers as the family agrees to the MCO conducting that outreach	medical and social needs as part of information gathering (such as triggers for chronic conditions and potential variations in the treatment plans)
3. Assessment **a. Comprehensive** **b. Child needs (inclusive of all needs, not just health)** **c. Family needs** **d. Need for case management**	**● Shared role** **● Currently two different assessments (and nursing roles) conducted at MCO: 1) determine level of shift care nursing services, UM nurse; and 2) determine level of case management, CM nurse** **● MCO should collect assessments from the child's team and integrate (when available)** **● CM assessment gathers information about the child's interdisciplinary team (e.g., PCP, specialists, school, Headstart, EI, etc.) – like creating a care map** ● The 2 assessments are combined to create a larger assessment of member's holistic needs so that shift care nursing hours work to support the child in optimal functioning and involvement in medical social education and family activities ● MCO should utilize assessments to inform MCO case manager case ratios and number of FTEs required to cover the number of children in the plan.	**● Shared role** ● PCP conducts clinical medical assessment that informs clinical care plan ● PCP may also be collaborating with specialists that are involved in the members care to inform assessment
4. Individual planning **a. Single, proactive, comprehensive across all needs** **b. Interdisciplinary team-based with members with specialized expertise**	**● Shared role** **● MCO CM care plan details checking wellness, resources and family goals**	**● Shared role** ● PCP creates clinical care plan and provides

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	PCP/Specialist
c. Family-centered principles and practices	**● MCO will receive PCP care plan only if it's provided as part of the UM process (HHA may submit it for medical necessity determination for service authorization)** **● MCO to facilitate sharing of care plans between MCO and PCP when able** **● MCO to reconcile differences between multiple care plans to ensure integration of care**	to HHA to incorporate into their care plan
5. Case management **a. Assure all elements of comprehensive plan are adequately addressed** **b. Coordinate between/across all settings/providers of care, services, and supports**	● Primary role **● Proactively connect with the PCP to communicate to the PCP the child's care team** **● MCO conducts at least the minimum number of face-to-face meetings per state contract requirements – such as in-home or at the PCP/specialist office – with child/family with varying levels of frequency as needed at discretion of case manager and family (i.e., not as "high-touch" as a Medical Home)** **● Comprehensive CM requires buy-in and agreement from the caregiver – the level of CM support will depend on the level of need and desire of the caregiver and may change at different times depending on the member's unique situation** **● Offer varying categories of engagement and CM support** ● Family may prefer that CM work only with them or may prefer that CM collaborates with all partners in the care plan and provide updates to the family ● The key is to be flexible and continually assess the needs and level of involvement and interaction that fits the specific situation **● MCO to initiative team meetings when needed to involve the entire care team –**	● Supplementary role **● PCP would respond to MCO with requests for information** ● PCP may also be engaged to talk with family about accepting care to avoid a readmission or about a change in the level of care nurse to aide or aide to nurse so that the care aligns with the care needs and what the agency can support

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	PCP/Specialist
	● Serve as primary driver when making transition from hospital to home – DME equipment, what does MA cover, how can we get it assistance if not covered Schedule appointments with specialists **● If the nurse shifts aren't available, the MCO CM identifies additional supports by assessing alternatives to have the shifts covered such as additional agencies, advertising, medical day care, hiring families when appropriate and encouraging families to set up meet and greets with prospective staffing**	
6. Assistance accessing services and supports **a. Proactive, facilitating, researching, locating, linking, arranging, obtaining, advocating** **b. Formal and informal** **c. EPSDT/Medicaid and non-Medicaid and community resources**	● Primary role **● MCO engages the caregiver and assesses gaps in care, including issues related to SDOH – such as assistance with utilities – and will alert PCP so gap can be closed at next appointment** **● MCO attempts to understand where the family needs assistance and where the MCO can ease the burden – scheduling appointments, transportation to appointments, household safety concerns, assistance with understanding home delivered meds that are prepackaged for the day, etc.**	● Supplementary role **● PCP would inform the MCO (with family approval) when needs are identified and gaps in care are evident**
7. Monitoring, follow up, and oversight **a. At individual and child level:** **i. Sufficient in scope, intensity, periodicity, frequency, and continuity to evaluate the effectiveness of all elements of the comprehensive plan** **ii. Ongoing contact, in-person visits, analysis, satisfaction determination** **b. At the system level:** **i. Sufficient in scope, intensity, periodicity, frequency, and continuity to evaluate the effectiveness of all elements of the system of coordination** **ii. Develop and maintain adequate provider network.**	● Primary role **● Face to face visits with member/ family, may be done in multiple settings and even with the home health agency.** ● MCO may host/ attend interdisciplinary meetings with family and all members of the care team to review plan of care and/or discuss additional needs, including SDOH and how they can be addressed ● MCO provides incentives to agencies to have additional shifts covered – MCO may offer	● Supplementary role **● PCP is encouraged to use the point of contact at the health plan to address concerns that family may present to them or to identify and discuss changes to the treatment plan**

Essential elements of a system of coordination of care, services, and supports for CYSHCN	Responsible entity for children with medical complexities	
	MCO/SNU	PCP/Specialist
iii. Develop contracts and interventions for inadequate performance. **iv. Monitor provider performance** **v. Intervene in patterns of authorized but unmet services** **vi. Quality improvement strategies**	enhanced rates to home care agency to cover travel or coverage of night shifts as ● Have more than one agency provide coverage of hours ● MCO uses missed shifts reports to identify trends and opportunities with provider networks ● MCO works with agencies for timely reporting of missed shifts so additional strategies can be identified ● MCO encourages families to contact CM when there are changes in staffing patterns	

Going Home Transition and Discharge Planning

Appendix G- Consolidated Discharge Checklist

The purpose of this document is to not recommend as a requirement, but more as a "best practice" checklist that is available to stakeholders.

Week 1	
Topic	Task
Orientation	Identify 2 primary care providers
	Make family aware of goals and expectations; Review trach rehab
	Orient family to unit and routine
Home Environment Preparation	Identify home health agency to staff the case
	Identify if this is a co-vending case
	Train nurses to be staffed on the case
	Organize a meet & greet between family and nurses
	Assist family with keeping track of all the vendors and specialists
	Determine transportation
	Assist the family with connecting to a Medical Home (when available) or a pediatrician who is able and comfortable to handle the case given the medical complexities
	Assist family with developing clinical judgements (i.e. when to call the doctor)
	Teach family how to troubleshoot the ventilator
	Make parents aware of home emergency protocols, such as using scenario planning with different clinical situations, determine which hospital to go to in an emergency, etc. Consider using red-yellow-green action planning templates: - Asthma discharge tool: https://resphealth.org/wp-content/uploads/2017/07/theCHICAGOasthmaDischargeTool.pdf - Asthma action plan: https://www.aafa.org/asthma-treatment-action-plan/
Care	Participate in hands-on care
CPR	View CPR DVD
Respiratory	Review emergency supplies to be kept at the bedside
	Teach trach size
	Teach vital signs and respiratory assessment
	Obtain bag to be used for GO BAG
	Obtain GO BAG contents and emergency supplies

Topic	Task
DME	Has DME been determined?
	Has DME been ordered?
	Has DME been set up in the house? And caregivers taught how to use DME?

Week 2	
Topic	Task
Home Environment Preparation	Conduct Meet-and-Greet with the pediatrician who will be the PCP and/or Medical Home
	Help family think through the day-to-day home care, such as where will the child sleep, where will the child spend time during the day, what are the electrical needs and which rooms in the house can meet those needs, what level of air conditioning will be required, etc.
	Work with family to help them understand who to call for which issues (such as the nursing agency versus the DME company)
	Work with family to develop home bathing plan, such as how to keep all lines and tubing in place if they plan to bath the child in bed, in tubby, on kitchen counter, etc.
Care	Complete four-hour independent care session
CPR	Discuss need for cardiac monitor
Respiratory	Observe trach change
	Review contents of GO BAG to ensure accuracy
	Verbalize normal/abnormal site appearance
	Change ties
	Clean stoma
	Identify type, size, and length of trach
	Verbalize reason for trach change
	Verbalize understanding of reason and use of cuff in trach
	Demonstrate inflation/deflation of cuff
	Verbalize reasons for suctioning
	Complete independent suctioning
	Verbalize reason for chest physiotherapy
	Complete chest physiotherapy if indicated
	Verbalize reasons for respiratory treatments, bag valve mask, and medications

Topic	Task
Respiratory	Verbalize reason for coffalator, if indicated
	Teach trach emergencies
	Verbalize understanding of oxygen entrainment
	Verbalize emergency supplies needed at bedside (suction, suction catheter, sterile water, ambu bag, oxygen source, spare trachs, trach key)
G-Tube	Verbalize normal and abnormal Gtube sites
	Complete Gtube care
	Review Gtube feeding, set up, and emergency care, including formula type and strength, and what to do if G-tube comes out

Week 2	
Medications	Review medication schedule
	Verbalize understanding of medications and purpose
	Demonstrate proper technique to draw up and administer medications
Therapy	Attend therapies 2-3X/week to learn handling, positioning, developmental activities, and use of adaptive equipment
	Bring in car seat
	Obtain stroller and/or adaptive stroller
	Assist in bathing, dressing, diaper changes of patient
	Verbalize importance of keeping portable equipment charged
	Initiate car seat/stroller tolerance
	Initiate mobility trials, such as strategies to transfer child with all lines and tubing attached or briefly disconnected
	Initiate passy-muir valve
	Demonstrate comfort in handling patient
DME	Initiate home equipment trials once durable medical equipment representative is at bedside

Week 3	
Topic	Task
Home Environment Preparation	Review with the family who to call for different post-discharge questions and needs
	Hospital to complete a follow-up call to family at 24 hrs. post discharge to see if everything is going well, and remind family to call PCP/Medical Home for questions (i.e., ensure a warm handoff was completed)
	Notify the family's local fire, EMS, and police when bringing home a vent dependent child so they can assist in an emergency
Care	Complete eight-hour independent care session
	Complete combined 24-hour care session
CPR	View CPR video again
	Perform CPR demonstration
Respiratory	Participate in trach change
	Demonstrate use of coffalator, if indicated
	Verbalize handling of trach emergencies (mucus plug/obstruction, accidental decannulation, water in trach, unable to place trach)
	Demonstrates competence in handling oxygen
	Performs independent trach change and review frequency of changes
	Ventilator - Complete Durable Medical Equipment Ventilator class
	Ventilator - Verbalize reason for ventilator alarms and how to troubleshoot alarms
	Ventilator - Demonstrate and verbalize understanding of ventilator circuitry, filters, and settings on both home and travel ventilator
	Ventilator - Demonstrate use of fisher pakel humidification
G-Tube	Demonstrate Gtube feeding and set up, including formula type, strength, and recipe
	Caregiver shows independence with oral feeding
	Demonstrate proper preparation of formula
	Perform Gtube change
Medications	Competence drawing up medication
	Competence administering medication
	Competence in medication use/purpose
	Shows independence with medications and feeding

Topic	Task
Therapy	Attend therapies 2-3X/week to learn handling, positioning, developmental activities, and use of adaptive equipment
	Verbalize understanding of passy-muir valve purpose and trial - wearing schedule
	Demonstrate independence with passy-muir valve use, if indicated
	Verbalize supplies needed for traveling (such as suction machine, suction catheter, ambu bag, oxygen source, multi-dose inhaler, etc.)
	Increase sitting time stroller/car seat
	Confirm patient passes two-hour car seat test
	Demonstrate independence with taking patient on or off unit safely in kid cart
	Complete car transfer with patient
	Demonstrate independence with bathing and dressing patient

Caregiver and Nurse Relationship and Co-Training

Appendix H- Training Repository (Training Survey Results)

Existing Trainings

Organization	Training	Topic	Stakeholder	Website
MCO	Shift Care Nursing Welcome Kit	Information for families regarding shift care nursing services	Family	No
	UHC on Air Ops 8	Online training on how to complete Ops 8 report	Agency	Not provided
Children's general medical and surgical facility	Trach/vent training, feeding tube education, training on equipment families will use in the home, pulse ox and oxygen training, central line, etc.	Families of medically fragile children to transition from the hospital to home; Also, nurses of HHA to provide training on trach/vent patients to assist with transition from the hospital to home.	Family	Not provided
DHS	Autism training	Autism	Family and Nurses	https://paautism.org/wp-content/uploads/2019/10/LANTERN-Edition-2.pdf
DHS	ODP training programs	Various	All	https://www.myodp.org/course/index.php?categoryid=213
	Autism	Autism	All	https://paautism.org/about-us/
DHS	Autism training	Autism	Family and Agency	http://www.eita-pa.org/autism/autism-navigator-ei/
Hospital	My Learning Center video trainings	These videos are meant for non-medical homecare providers and family caregivers, but could still help add to the family's training for tasks that are not medical in nature	Family	https://learningcenter.pahomecare.org/
MCO	I believe each agency does their own intensive training and orientation	Not provided	Not provided	Not provided
MCO	UHCOnline - OPPS 8 Training	Training reviews requirements for OPPS 8 reporting	Home Health Agencies	Not provided

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Training Needs

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
MCO	The difference in hospital nursing compared to Home health	None needed	Has been excellent in our meeting hearing the thoughts of the parents of the children	Making any changes & updates available to both	Not provided	Not provided	Not provided
Home Health Agency	Yes, there are needs but didn't provide details	Yes, there are needs but didn't provide details	Yes, there are needs but didn't provide details	Yes, there are needs but didn't provide details	Not provided	Not provided	20-29 hours
MCO	Yes, it seems that nurses do not often feel fully prepared for in-home care or need extra support with some of the additional challenges that come with working in someone's home (such as maintaining boundaries).	Families report that they feel unprepared to care for their children at home, and we observe that they often have a misunderstanding of the role of in-home nursing care.	I think joint trainings would be a good opportunity to help families and professionals build relationships and clarify roles.	None at this time	Not provided	Not provided	Not provided
Behavioral Health Partner	I believe nurses could benefit from training about behavioral health, behavior management, psychiatric medications	How the child's medical and behavioral health needs may be interfering and interacting with each other.	Behavioral health interventions for the child	- Working with children who are non-verbal and have both medical and behavioral health needs - Functional behavioral Assessments (FBA) - Autism	Not provided	Not provided	Not provided
MCO	Need more training on BH diagnosis and how to handle behaviors	What to expect....	None needed	Not provided	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
MCO	More hands-on training via sim labs. Training in the hospital when child is still inpatient.	Availability of sim labs to provide refresher training.	When the child is being discharged home for the first time and any new extensive treatments being added to the plan of care.	Building an internet portal site to share all available trainings to parents and nurses.	Not provided	Not provided	Not provided
MCO	Trach/Vent care; diagnoses of patients receiving Shift Care nursing services; infection control	The "want" vs. the actual needs of the child/family: we have found that families try to "keep up with the Joneses" and want their child to have more hours than necessary or needed due to meeting another child with complex or catastrophic medical needs and finding out that child has 24/7 services. Families also need training on how their treatment of Shift Care staff will impact the staffing of their child's case. If they are cordial and welcoming to the staff and treat staff with respect, families will find there will be a great reduction in missed shifts even if their child has complex medical or high-acuity needs.	Equipment for use in the home for Shift Care nursing; expectations regarding Shift Care nursing services.	The trainings should be held on a routine basis.	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
Home Health Agency	There should be free online course materials that nurses and/or agencies can utilize to advance the training for home health care nurses. Home health agencies should take the time to properly train the nurses for the patients they will care for.	None needed	Whenever new equipment is introduced into the child's plan of care	Home health agencies should take the time to properly train the nurses for the patients they will care for. With in-depth training on assessment and emergency scenarios. Also, any emergency drugs in the child's plan of care and equipment the child needs.	We have never had a hospital offer to train a nurse from our agency. Sometimes families don't want a nurse that needs additional training, they only want nurses with experience.	10-19 hours	30+ hours
Home Health Agency	None needed	The families need to understand the roles of the nurse. Appropriate things to request of the nurse vs. inappropriate. The need to MD orders. Maintaining boundaries.	None needed	Not provided	Not provided	10-19 hours	30+ hours
Home Health Agency	More training needed to prepare nurses for trach/vent and g tube feeding and care.	Families often feel the nurse is going to take the place of them totally and are not using them to fill the needs of the family to work, and sleep. Many families are requesting almost 24 hours per day care.	In certain instances, families may be taught different than others and each child has specific needs. Also, each MD may have different orders and specific ways of doing things.	Not provided	It has never been offered to us.	10-19 hours	20-29 hours
DHS	All nurses can use a refresher or update on pediatric even if you are a pediatric shift care nurse.	Many families say they wish there were more training opportunities for them.	Especially when it is a topic that involves both nurses and families such as dealing with a difficult family or dealing with a difficult nurse.	Not provided	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
MCO	Additional education is always valuable to staff members.	Families being more knowledgeable is a benefit.	Same as above	not at this time	Not provided	Not provided	Not provided
DHS	Transitioning from acute care to home based shift care nursing; setting patient/family/nurse boundaries/limits; dealing with difficulty families; MH/BH issues in non-verbal and medically complex children	Vent/trach care - in particular how to care for trach that comes out (it's not as big an emergency for established trach as families believe); why it's important to let the nurse do their job according to how they were trained and per agency policy	Roles and responsibilities; relationships and limit settings; joint training on how to do the child's care including equipment	Not provided	Not provided	Not provided	Not provided
Behavioral Health Partner	I think Mental Health First Aid for youth would be a good training for nurses who may encounter mental health issues when they go into a home	None needed	None needed	Not provided	Not provided	Not provided	Not provided
MCO	None needed	I think it would be beneficial for families who are initiating shift care nursing services for the first time	I think it would be beneficial for nurses and families to be on the same page. The family would be able to voice any concerns they have as well as the nurses able to do the same	Not provided	Not provided	Not provided	Not provided
DHS	Though I am a nurse I would never consider going into Pediatric Homecare as I am not current on the skills and equipment related.	I feel that the opportunity to develop rapport and relationships between family and skilled caregivers is an opportunity	I spoke to this in above question	No	Not provided	Not provided	Not provided
Hospital	I think that additional training for home health nurses would increase the ability to staff medically complex cases in the home.	None needed	None needed	Not provided	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
MCO	There is a lack of available trach/vent certified nursing in the central PA area https://www.bayada.com/pediatrics/simulation-training-lab.asp https://www.bayada.com/pediatrics/upload/simulation-lab-flyer.pdf	Yes/No - depends on specific agency and their intake process-i.e. expectations, boundaries, etc....I feel like the initial clinical assessment and intake process is different with every provider. This questionnaire for families to ask nurses during meet and greets was on Bayada Pediatrics' website - https://www.bayada.com/pediatrics/upload/choosing-a-home-health-provider-child.pdf	Ex. client is coming home from an IP stay with new technology and parents are being trained in hospital, it would be great if nurse could also be present during this "end of discharge planning"	Not provided	Not provided	Not provided	Not provided
MCO	Yes, there are needs but didn't provide details	None needed	None needed	Not provided	Not provided	Not provided	Not provided
Family/Parent	We need more nurses to be trained to care for kids with central lines, mitochondrial disease, and POTS.	None needed	When the child comes home from hospital with new equipment it is a good idea to train both.	I do not.	Not provided	Not provided	Not provided
Home Health Agency	Many of the nurses that come to our agency report working on highly skilled clients with minimal to no training.	Many families are being discharged without adequate training from CHOP, St. Christopher's and Dupont. CMS & CHAP regulations state that there must be a trained caregiver in the home, and we must put the willingness and availability of that caregiver on the Plan of Care.	To clarify that the care provided by the SN must comply with DOH, CMS and Accreditation standards, while the care provided by the parents does not, but should.	Yes, facilities should provide realistic training in the facility that mimics the home setting, i.e. trach changes with portable suction, not hospital wall suction.	No	1-5 hours	10-19 hours

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
Home visiting program	The families program serves (TACHP) consistently reports having to train home health nurses on how to care for their child properly, especially for children who are trac-vent dependent.	Trainings could be offered by the home health agency on appropriate expectations, interaction, and trainings with assigned nurses prior to start.	Getting to know one another, appropriate expectations, and child nuances.	Incentives.	Not provided	Not provided	Not provided
Parent; Non-clinical nurse	As the parent of a child (diagnosed with infant acute lymphoblastic leukemia, inpatient 250 days, and with home health support for med administration several times), and as someone working with families whose children are dependent on technology to support and enhance their lives (ventilators, tracheostomies, various types of feeding tubes, speech support, etc.), it has become increasingly clear to me that pediatric home shift nurses are frequently in need of more training for the complex needs of their patients and families. Parents must learn an inordinate amount of medical information and be medical providers as well as breadwinners and parents in the home. It is an incredibly demanding position to be in - and having to additionally train and support nurses on how to use equipment should not be among the parent's duties. Nurses should be	Families need to know what they can and cannot expect from pediatric home shift nursing services as soon as diagnosis occurs. They need to be able to plan, and to understand their rights and responsibilities. Every family should be sent home from the hospital thoroughly trained on the equipment & meds they are expected to be able to manage. For example, in the hospital I was given a 1-hour training on how to place an NG tube for my infant, but we did not end up getting discharged at that time. It was ultimately several months later that we were discharged with the NG tube. When I asked for a refresher, I was told insurance only pays for one hour of training. So, as a parent I had to courageously rely on my frazzled, sleep-deprived memory to hopefully insert the NG tube correctly for the first time because I was denied the training, I felt I needed. It was awful.	Shift nursing at home of kids with complex medical needs should be approached as a team - family and nurses together. Everyone should work together to provide safe, seamless care for the child. Misinformation, different training, differently taught technique, different expectations of role, etc. all can contribute to care mistakes and unnecessary damage to patients.	As a parent, I am currently administering yet another new med to my daughter at home. This one is a subcutaneous infusion over an hour. My daughter is now 3 1/2 and she and I are both "over" needles and doing this at home. We are tired of all that we have been through. The one thing that has helped is a nurse navigator was assigned to us at our hospital - she has been outstanding checking in with me, being supportive, offering helpful suggestions, following up with home care or any area of service	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
	comfortably knowledgeable and equipped to handle a large variety of situations in a variety of homes and should be able to provide families the support their need.			that is missing or incomplete. She has been validating and empowering, and kind. The access to someone dedicated to our experience, and who is knowledgeable about our health and treatment journey, who cares and is empathetic and readily available has been an invaluable and helpful addition to our experience - and it's all over phone or via email!			
MCO	I think there are some soft skills training that could occur and some trainings on how to set limits as well as how to be interactive with sensory deficits or non- verbal children.	What the services are, how they should be used, the difference between personal and professional relationship. When families should utilize their MCO as their advocate.	None needed	Maybe have a collaborative where folks get together and out together a clinical curriculum for parents.	Not provided	Not provided	Not provided
DHS	None needed	Many families are unaware of the resources in the community. If families are having difficulty obtaining shift nursing services due to complexities of the child, what are the resources or a contact list of available agencies in the	Even though families may feel that they are providing better care than the nurse providing the care, the person may not have had updates on the most recent procedures or training. To ensure that the family is	Families may take the initiative to not follow appropriate training guidelines	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
		rural areas. To be aware of any changes in practice in pediatric shift care nursing.	adequately trained to care for the child.				
MCO		I think that peer supports and or agency staff that specialize in preparing families for care in the home would be helpful. As a larger group we are trying to develop some training for the families that we manage with shift care nursing, especially 1st time shift care nursing recipients.	it would be extremely helpful if the in-facility trainings for families would be able to be attended by the shift care nurses or a representative from the agency (supervisor?). It would be great if both the family member and the shift care nursing provider was learning the same techniques and able to ask clarifying questions- together.	A "global" FAQ (frequently asked questions) document for families would be a great opportunity to ensure that the family and the agency have a feel for what all comes along with shift care nursing and the oversight of the services.	Not provided	Not provided	Not provided
MCO	Issues related to family dynamics.	Expectations.	May assure everyone is on the same page.	Not provided	Not provided	Not provided	Not provided
MCO	Yes, there are needs but didn't provide details	Yes, there are needs but didn't provide details	None needed	Not provided	Not provided	Not provided	Not provided
Home Health Agency	None needed	None needed	Prior to discharge from acute care or transition care	Not provided	Availability of staff and families; liability risk of training another agency nurse - not a typical practice. No current contract/liability waiver in place.	6-9 hours	10-19 hours

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
Nurse; Social worker; Navigator; Parent	Nurses are being sent to homes without specific care for that child.	How to handle handling having a nurse in your home assisting with your child. Boundaries is a huge issue	That would be great knowledge is power the more information on both ends the better care for the child	Nursing having follow through, importance of working your shifts once committed by nurse, complacency in the home and boundaries	Not provided	Not provided	Not provided
Community Patient Navigator; Social work	Handled medical equipment and to have knowledge in different cultures	Family health care right	Responsibilities and communication	Empathy, advocacy and support training	Not provided	Not provided	Not provided
Home Health Agency	Working within the home environment. Caring for a trached/vented child in the home setting. Caring for diabetic children / pumps in the home setting. IV care in the home setting. Sharing a case with multiple providers/agencies.	Making your home a safe and enjoyable environment for a nurse. How to best communicate with caregivers/agencies in your home. Regulatory responsibilities of home health agencies. Rights/Responsibilities of Parents/Family in relation to home care. When more than one provider/agency is providing care in your home.	None needed	Training/Ed focused on understanding one another's position	No	1-5 hours	6-9 hours
DHS	None needed	Throughout the life span of the child, the family always needs information/training on their child's conditions, how to plan for the future and how best to advocate for their child.	Probably but I can't name any	Three websites sponsored by the DHS Office of Developmental Services www.myodp.org - a website with information and	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
DHS				training. Registering with My ODP will activate notices of training. https://paautism.org/ - website with information and training on AUTISM https://www.myodp.org/mod/page/view.php?id=7699 - the link on MY ODP to the eight Health Care Coordination Units which all have training related to health care			
Hospital	Training on specific equipment and manufacturers to broaden their awareness of different DME configurations	Coping with their new lifestyle and helping them feel that they are not as isolated as they might think	When new equipment is added to the home	Not provided	Not provided	Not provided	Not provided
DHS	Preparing them more for difficult family dynamics as well as BH factors.	Realistic expectations of shift care nursing providers in their home and appropriate ways to address any identified issues.	Developing a way to provide an introduction of the case and provide a personal picture of the family life to providers to better prepare. And then creating a method for families and shift care nursing providers to create an agreement of sorts for what the agreed upon expectations would be.	This is unrelated to training but a reminder that we need to be careful not to only refer to "nurses" all of this should also include Home Health Aides as they are part of many of the cases.	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
MCO	The need to enhance motivational interviewing skills and development of family centered care planning with a life course framework is much needed.	None needed	Transition to home - particularly for tech-dependent children	Peer-based models of training and support	Not provided	Not provided	Not provided
MCO	I believe we may need to expose the concept to new graduates who would need on hands training for the complex cases, being new to the field they would not have the experience that would be needed to care for the individuals.	Any additional training for families would be an added bonus, it would enable them to be better advocates of what is needed for the patient.	I believe there is a better understanding of what the nurse/family roles would be.	Not provided	Not provided	Not provided	Not provided
MCO	None needed	I feel families need trained on what to expect. Meet and greets with nurses, what it is like to have someone in your home on good and bad days... understanding what the physician ordered	None needed	Not provided	Not provided	Not provided	Not provided
DHS	A general overview of Pediatric shift care nursing duties, requirements, and trainings prior to working with members who are chronically medically compromised.	Families need to have a basic understand what tasks the shift care nurse is able to perform. What the expectations or responsibilities the family has regarding care for the member.	Both Families and Nurses need to meet to set the stage on the expectations of both parties.	No	Not provided	Not provided	Not provided
MCO	I think it is more of a discussion of expectations to be met by the nurses providing pediatric shift care nursing services rather than additional "training". Such as what would need to be done in an emergent situation;	Once again, I think it is more of a discussion of expectations to be met by the families receiving pediatric shift care nursing services rather than additional "training". Families need to have a "real" discussion of what is, and is	None needed	Once again, I think it is more of a "real" discussion to be had of expectations to be met by the nurses providing pediatric shift care nursing	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
MCO	what providing pediatric shift care nursing "really" entails in a positive light.	not, acceptable behavior, language, and providing other duties (frivolous requests) to the nurses not related to providing nursing care/services.		services, and the families receiving pediatric shift care nursing services rather than additional "training".			
MCO	None needed	Families need to understand what the responsibilities of the nurses are and what their responsibility is in communicating with the nurses.	Post discharge after a long hospitalization.	Not provided	Not provided	Not provided	Not provided
Other - Advocate	I have heard the loss of the home vent program (VACHP) meant the loss of a lot of training programs for nurses who work with kids on vents. I believe more training is needed at the nursing school level and creation of a "home health track" would be appropriate to help remedy at least some of the nursing shortage for home care.	None needed	Training on relationship building and what to expect from the parent-nurse relationship/dynamics.	Partner with children's hospitals to create home vent simulation labs and allow nurses to be "certified" in home health care, or vent care, or some combination, prior to entering field.	Not provided	Not provided	Not provided
MCO	None needed	None needed	None needed	No	Not provided	Not provided	Not provided
MCO	Pediatric Shift Care and Home Health Nursing care as concepts of care in Nursing Schools	Families need to better understand how consistency and their home environment will attract / retain nursing staff for their child's care.	Consideration of how to support each other and maximize staffing needs for the child	Rotation for Resident Physicians in Peds - to better understand how to request attainable nursing care and how to explain concept to potential families. Career Fairs and	Not provided	Not provided	Not provided

Organization	Nurses	Families	Both Nurses and Families	Other Suggestions	Barriers encountered when coordinating joint training	Estimated training hrs. home health AIDES receive prior to working shift unsupervised	Estimated training hrs. home health NURSES receive prior to working a shift unsupervised
MCO				Webinars available for H.S. / College Guidance Counselors.			
Home Health Agency	Simulation lab scenarios Shadow training in facilities opportunities	Scenario based emergency Car travel practice and emergency scenarios	Scenario based that could include client specific practices example would be if the child needs oxygen and bagging for trach changes	Provide YouTube videos of how-to scenarios Shadow training Family support networking	No experience of joint training	6-9 hours	30+ hours
MCO	None needed	None needed	None needed	Not provided	Not provided	Not provided	Not provided

Appendix I- Meet and Greet Pamphlet

This pamphlet is currently in a draft state

FAMILY EXPECTATIONS

- Treat agency staff with dignity and respect
- Discovery or possession of the following could be grounds for dismissal of services pending an investigation and review of the situation:
  - Violence
  - Illegal drug use
  - Dangerous and disrespectful behavior
- The family is responsible for notifying the Care Managers of the following:
  - Changes to client's care, medications, treatments that differ from what the nurse and agency have been doing, whether these changes are ordered by a doctor or by family's choice
  - Upcoming appointments/ hospitalizations/surgeries, etc that would affect the client's care or the nurses schedule

About the pamphlet

This pamphlet is to be used as a resource by Home Health Agencies and families during their initial meeting between assigned home health nurses and families to help foster strong relationships.

OTHER RESOURCES

Care We Share
https://www.pahomecare.org/the-care-we-share-a-family-guide-to-in-home-pediatric-care

PEDIATRIC SHIFT CARE
NURSING HOME HEALTH

MEET & GREET

What Nurses Can and Can't Do

Nurses **CAN**...

- Provide care (medical advice, medical care, and medical attention) to assigned client

Nurses **CAN'T**...

- Watch other kids, deal with family issues, clean the house, do laundry, etc.
- Provide care for other individuals in the home

FAMILY PREFERENCES

Discussion Topics:

- Techniques/toys/object preferences
- Signs of pain/illness
- Cultural/religious practices
- Nurse's attire
- Nurse's belongings
- Parking
- Discipline and consequences
- Report to parents
- Household rules (rooms that are off limits, areas where food can be eaten, smoking/vaping habits, treatment of pets, shoes)
- Entering the home (knock, doorbell, walk-in)
- Boundaries
- Bathroom usage
- Supply room (i.e. paper towels)
- Kitchen usage (refrigerator, microwave, dining room)
- Laundry and trash
- Nighttime calls
- Non-emergencies
- Communication of care
- Security blanket

COMMUNICATION

Provide contact information so nurses know who they can reach out to if they are doing something new or working with a new piece of equipment and need additional help.

Include contact information for issues regarding scheduling

Include contact information for the clients DME and Supply company

Include contact information for the specific care manager working the case that the nurse is assigned as well the number to the on call person so they never feel as though they can't get ahold of someone.

PCP with phone number, Pharmacy with number and pharmacy with number any other contact information that would be patient specific.

Appendix J- Agency Tip Sheet

This Tip Sheet is currently in a draft state

Pediatric Shift Care Nursing Home Health Agency

Tip Sheet

This document is a resource for Home Health Agencies to help foster strong relationships with family members and caregivers.

COMMUNICATION WITH FAMILY

- Provide family with information on nurse's education, training, experience, and background
- Ask the family how they would like care to be administered, while adhering to the plan of care
  - After a few shifts, follow up with the family and ask how you are doing and if there is anything they would like done differently

Child's Care Plan: Daily Routine including therapies, Naptime or Quiet Time; Favorite activities/toys/; favorite foods if permitted; favorite TV shows or games if permitted; does child enjoy being read to or can he/she read with assistance? Child's favorite clothing items/shoes; Child's Likes/Dislikes.

NURSE EXPECTATIONS

- Meet and Greet with the family is best practice
- Cell phones are for emergency use only and should not be used for personal use during work hours
- No posts regarding your patient on any social media platform (i.e. Facebook, Instagram, Twitter)
- Each agency must review scheduling policies and practices with each nurse

Incentives: scheduling "pods"; if all the nurses on the case can get shifts covered maybe the agency can offer some kind of incentive/bonus for that month?

WHAT NURSES CAN AND CANNOT DO

- Make AGENCY TIP SHEET clear about nurse ability to transport client (ex. Nurse is able to accompany family to/from medical appt but provide clarity as to whether nurse is able to transport member solo.) Example-a provider I work with will not transport members who have seizure disorders in the car alone because of the liability-if member seizes nurse then cannot address b/c nurse is busy driving
- Discuss Plan for reaching family re: Call-offs, Running Late.
- GUIDELINES FOR PROPER COMMUNICATION OF CALL-OFFS (have a policy and communicate it to the parents, clearly relay them to the nurses); Minimum time for prior notice to family/agency that there is a call-out

PROFESSIONAL BOUNDARIES

- Maintain a professional relationship with families and families are encouraged to support this relationship
- No entering into any dual relationships (no relationships with family members of client while providing care for the member, no babysitting other children in the home, no interaction on social media)
- Nurses cannot be invited to family events/vacations outside of their scheduled shifts, unless otherwise specified by agency
- Do not accept or solicit any of the following: gift, gratuity, favor, loan, or any other item of value.

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Pediatric Shift Care Nursing Home Health Agency

Tip Sheet

HOME SAFETY

General Household Safety

- Keep stairs, halls, and exits free from clutter
- Arrange furniture to allow freedom of movement in high traffic areas
- Wipe up spilled liquids/grease immediately!
- Maintain proper ventilation when working with cleaning agents
- Keep knives and other sharp utensils out of reach of children
- Know the location of your main electrical switch, gas and water valves; know how to close valves
- Keep power tools and other hazardous machinery disconnected and switches locked
- Store cleaning supplies in a clearly labeled bottle in a separate area that is out of reach of children

Fire Safety

- Develop a fire safety plan for the entire family with 2 ways to exit each room
- Install smoke detectors near sleeping areas with at least one smoke detector on each floor
- Chimneys serviced regularly to avoid creosote buildup
- Heaters, stoves, fireplaces should never be left unattended while in use; use safety guards/screens in front of heaters/fireplaces; service heaters/pipes once per year
- Do not smoke in bed
- Do not pour water on grease fires! Turn down the heat and smother with a glass lid if it occurs on the stovetop
- Never leave cooking food or burning candles unattended
- Keep flammable substances away from heat sources and children
- If you or a family member use oxygen, use the oxygen concentrator away from heat and open flames; NO SMOKING signs should be posted in the oxygen use area

First Aid

- Keep a well-supplied first aid kit in an easy to reach area
- Keep emergency numbers by the phone: poison control, police, fire, ambulance
- Find out if there are "911" services available in your area

Bathroom Safety

- Light switch should be near the entrance of the bathroom
- Tubs and showers should have textured surfaces to avoid falls
- Area rugs should have nonskid backing
- Check water temperature with your hand before getting in tub/shower
- Never leave a child alone in the bathtub
- Ground fault outlets installed near sink area
- Keep all medicines out of reach of children, clearly labeled, and in their original containers; check expiration dates
- Discard razor blades properly

Electrical Safety

- Keep all electrical cords in good condition and replace any broken or frayed cords
- Do not run extension cords under rugs or furniture—run them along walls
- Don't overload electrical outlets by using multiple outlet adaptors!
- Cover unused outlets with plug covers or electrical tape
- Keep all electric appliances away from tub/sink
- Make sure electrical system is adequate from utilizing medical equipment (ventilators, oxygen); arrange for battery or generator backup when necessary
- Label switches and have instructions inside fuse box in case of an accidental breaker trip

OTHER RESOURCES

Care We Share magazine: https://www.pahomecare.org/the-care-we-share-a-family-guide-to-in-home-pediatric-care

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Beyond the 485: Whole-Child Plan of Care

A resource to encourage agencies, nurses, and families to partner in a whole-child, family-centered approach to care

In caring for a medically complex individual in the home, shift nurses go well beyond the scope of the "485" Medical Plan of Care. Home care nurses are constantly engaging their patients on every level: social, emotional, cognitive, behavioral, etc. While they may technically be scheduled to support a child medically, it is short-sighted to ignore the important role these professionals play in each of their patient's ongoing development across domains. Additionally, it is important to remember that home care nurses often provide this care "beyond the 485" to several patients, in a different home-workspace, and while navigating varying dynamics of multiple families day in and day out. Tools and resources to effectively collect and implement more robust whole-child/family-centered care allows a nurse to enter a new patient's home better prepared to care for and support each child in their individual environment.

Categories/Info to consider when creating a Beyond the 485: Whole-Child Plan of Care:

- **Household / Family**
  - **List of other household members**
  - **Pets**
  - **Household allergies/restrictions (e.g. fragrance sensitivities, peanut allergies, etc.)**
  - **Preferences around religion/culture**
  - **Other household members' sleep schedules, etc.**
  - **Peak bathroom times (e.g. Mom needs the shower between 8-8:30am)**

- **Home as a Workspace**
  - **Nurse attire (e.g. scrubs only? Plain clothes?)**
  - **Parking info**
  - **Entering home (e.g. knock first or just enter?)**
  - **Alarm system, door locking preference, etc.**
  - **Shoes allowed in house? Alternative plan?**
  - **Electronics use (e.g. earbuds in 1 ear while child sleeps, etc.)**
  - **Use of appliances (Refrigerator, microwave, oven, Keurig, etc.)**
  - **Laundry preferences (e.g. rinse soiled items in tub, use bathroom hamper for wet items, etc.)**
  - **Trash protocol**
  - **Supply locations**

- **HVAC system use / preferences**
- **Where/when nurse should eat / food delivery info**
- **How/what/when to give report to parent/caregiver**
- **Is there a Communication Log?**

- **Nap / Bedtime Routines**
  - **Where/When/How long does child sleep**
  - **Where is bedding/when to change it?**
  - **Stuffed animals/books/music?**

- **School routine (if applicable)**
  - **Instructions for school prep / packing**
  - **Transportation info**
  - **Expectation for nurse involvement at school**

- **Daytime routine (at home)**
  - **Wake time, naps, etc.**
  - **Scheduled therapies**
  - **Play time, tv time, tablet time, etc.**

- **Hygiene Routines / Incontinence Care**
  - **Bath routine (e.g. items to use/not use, allergies/restrictions)**
  - **Teeth brushing routine**
  - **Recommended diaper change frequency / ointment info**

- **Nutrition**
  - **How/When is child fed**
  - **Food options / allergies**
  - **Favorite foods**

- **Mobility**
  - **Does child sit/stand unsupported?**
  - **Ortho concerns or other precautions?**
  - **Orthotics use (if applicable)**

- **When/how to encourage movement/mobility**
- **Adaptive seating / mobility devices**

- **Travel info**
  - **Car safety (e.g. car seat, tie downs, etc.)**
  - **What to bring**

- **Communication and Social Engagement Supports**
  - **How does child communicate (e.g. verbally, expressively, comm device, etc.)?**
  - **Preferences around sibling/peer play/contact**
  - **Does child receive Speech services? Can that team make recs for the nurses?**
  - **Favorite activities (e.g. being read to, making silly faces, coloring, etc.)**
  - **TV / Tablets / Other Devices**

- **Behavior Considerations / Concerns / Support**
  - **Different cries or other vocalizations to note**
  - **Anxious or stress related behaviors/what helps?**
  - **Rewards/Consequences**
  - **Adverse behaviors of note and responses (e.g. smacking self / response block)**
  - **Does child receive Behavior-based interventions? Can that team make recs for the nurses?**

- **Cognitive / Academic Support**
  - **What learning goals does child have? Can school/EI make recs for the nurses?**

- **Family Goals**
  - **What personal goals do you have as a family (e.g. go more places, more shared mealtimes, child attend school, etc.)**
  - **Where do you see your child in 1 year, 5 years?**
  - **How could nurses support those goals?**

- **Emergency Protocols**
  - **Preferred fever intervention (e.g. when to alert caregiver, give meds, etc.)**
  - **Power Outage (e.g. alert caregiver, alternative location)**
    Fire or another immediate-exit emergency plan

- **Contacts**
    - **Caregiver contact info**
    - **Emergency contact (if caregiver is unavailable or having an emergency)**
    - **Therapists**
    - **DME Company(s)**
    - **Doctors / Specialists**

- **Additional Info**
    - **Anything else that is relevant to family around the care of their child**

POSSIBLE FORMAT TEMPLATE:

Household / Family
○ List of other household members ○ Pets ○ Household allergies/restrictions (e.g. fragrance sensitivities, peanut allergies, etc.) ○ Preferences around religion/culture

Home as a Workspace
○ Nurse attire (e.g. scrubs only? Plain clothes?) ○ Parking info ○ Entering home (e.g. which door? knock first or just enter?) ○ Alarm system, door locking preference, etc. ○ Shoes allowed in the house? Alternative plan? ○ Electronics use (e.g. earbuds in 1 ear while child sleeps, etc.) ○ Use of appliances (Refrigerator, microwave, oven, Keurig, etc.)

Appendix L- Family Council Model Summary

Family Council

1) Overview:

The family council model was created to be a resource for both families utilizing the agency and all agency staff. The family council helps families identify areas of concern/need & locate the best possible resource/solution and helps the agency staff locate resources and solutions for families facing extenuating circumstances, whether it's community-based resources, peer-to-peer support, or fostering positive relationships between the staff and the families.

Some areas of concern the council could directly assist with:

1) **New-family training/experience**- when a new family is brought into the agency, a family council representative(s) could meet the family at their convenience to share the council as a resource, help them identify any questions or concerns they have, offer experience about homecare and expectations, and help foster an open-communication style with the office staff.
    a) Example- identify medical supplies needed and which DME will be servicing those supplies, share resources on organizing the supplies and the home for nursing care, identify and share support groups or other willing families for support, offer peer-to-peer support while they begin their services, and/or offering peer support while they meet with the clinical manager and nurses for the first time to help identify important questions to ask and information to supply.
2) **Families facing extenuating circumstances**- if a nurse, staff member, or family member feels extenuating circumstances are adding roadblocks to either the care the child is receiving or the relationship between the staff and the family, the family council can be brought in to help identify those roadblocks and resources/solutions for those roadblocks.
    a) Example- families cancelling nurses due to transportation concerns. The council could help identify community transportation and present the options to the family and help initiate the solution.
    b) Example- families going through personal stress are having a hard time communicating with nurses about their needs. The council could have a representative meet with the family to find out how they could help mediate the situation and recommend any additional solutions that could ease the tension.
3) **New Nurse training**- the family council should be utilized to present at every new nurse training. The council would help prepare the nurse from the family perspective, identify themselves as a resource for the new nurse, prepare the

nurse's profile to be sent to families ahead of their orientations, and identify areas of additional training that may be of interest or helpful to the new nurse.

a) Example- the council identifies the nurse has never worked in homecare before, so it may be beneficial to do an extra orientation with the council focusing solely on the nuances of homecare
b) Example- the council identifies the nurse has worked in a hospital setting, but never worked with small children before, so the council may recommend additional orientation/experiential opportunity with small children

4) **Policy/Procedure updating-** the family council can offer their feedback and suggestions to any new policies and procedures being considered for the office
5) **Relationship building**- families may feel more comfortable discussing questions and concerns with a peer on the council, which will afford the council the opportunity to head off any roadblocks before it impairs the relationship with the nurses or the office. Conversely, the nurses will have an opportunity to seek family council input and assistance in locating resources or peer support for their families, thereby improving their work environment and the relationship with the families.

2) Structure

- The families are nominated by each clinical manager to try to best represent the families of that office at large
  - i) The diversity of the group is important and should be representative of the families utilizing the agency- example: trach/vent family, central line family, gtube family, intellectual disability family, Autism family, complex medical family, etc. It is also important to consider representation of cultures, socioeconomic status, and locations throughout the service region in order to create a group of families who will best be able to represent the entire serviced population.
  - ii) It is helpful if families selected also have diversity in services they utilize, hospitals/physicians seen, and have knowledge of what is available within their own communities- though this is not always feasible for everyone
  - iii) All family council members will submit clearances and sign HIPAA forms.
  - iv) All serviced families will be notified about the council, their functions, and asked to sign a document stating they have been notified and are aware the family council is a resource for them
- Council will meet monthly, either via electronic platform or in person when safe and feasible, accompanied by at least 1 clinical manager or other staff person and the office director, with a nurse representative.
  - i) The first 30 minutes of the meeting are open to any family who wants to attend and express questions, comments, or concerns. If the matter is private, the family can ask for any office staff to step out, while they discuss the matter with

the family panel, or they may submit their question to a council member to be discussed anonymously.

(1) The council members will assist families immediately if possible, otherwise, their information will be collected to allow the board to gather resources, discuss with appropriate entities, and then offer their recommendations at a later date.

ii) The next 30 minutes of the meeting are open only to office staff. All nurses and staff members are encouraged to come forward to discuss any questions, comments, or concerns they have.

(1) Staff are not to identify a family by name or any medical specifics that could reveal the identity of the family. If a time comes where it is helpful to the council to know more about the family, the clinical manager can approach the family and ask them to sign a waiver for only pertinent information to be released to the council. (Example- if a family is having a hard time getting community services they need for transportation, the council having access to their address and specific needs would be necessary to assist them, so the family would have the option of authorizing the release of that information to the council in order to provide them with resources. A family is ALWAYS able to decline this option but would be encouraged to meet with the council or members of the council on their own.)

(2) The council should assist the staff immediately if possible, otherwise, information will be collected to allow the council to gather resources, discuss with appropriate entities, and then offer their recommendations at a later date.

iii) The final 30-60 minutes of the meeting are for council discussion/training/resource sharing.

(1) The council will discuss any past business still open, set an action plan for new business, and give an update on the action plan to the clinical manager and director in attendance.

(2) The council should have a guest speaker/training presentation as often as possible. Utilizing community resources to come in to make connections for families and explain what is available is a vital resource for the council to be able to assist families.

(3) A resource list should be kept by the secretary and saved in a shared space for all council members to be able to access

- The council can be scaled up or scaled back based on interest/availability and agency size. Even having a few family representatives will allow the agency to provide new families and nurses with peer-to-peer support and experienced voices.

Behavioral Health/ Physical Health Coordination

Appendix M- CASSP Coordinators Survey

Behavioral Health Training for Home Health Agencies

Audience: CASSP coordinators

The Pennsylvania Office of Medical Assistance Programs (OMAP) is collaborating with physical health managed care organizations, home health agencies, and families of children with medical complexity to improve the delivery of pediatric shift care nursing in Pennsylvania. As part of that effort, the collaborative is exploring how to improve the behavioral health training received by home health care staff. We would greatly appreciate taking five minutes of your time to complete the below survey about Mental Health First Aid and other behavioral health training opportunities within your area. Thank you!

1. Name
    a. Open response
2. Email address
    a. Open response
3. What county or county-joinder office do you work within?
    a. Drop down list (with "Other" and open response)
4. What is your position/title?
    a. Open response
5. Does your office have certified a Mental Health First Aid trainer(s) that provides Mental Health First Aid training (MHFA) within your county/county-joinder?
    a. Yes, my office has a trainer(s) for Adult Mental Health First Aid
    b. Yes, my office has a trainer(s) for Youth Mental Health First Aid
    c. Yes, my office has a trainer(s) for both Youth and Adult Mental Health First Aid
    d. No, my office has no trainer(s)
6. (if a, b, or c to 5) Are these MHFA trainings provided on a regular basis or by request?
    a. Regular basis
    b. By request
    c. Regular basis and by request
7. (if a or c) Would the MHFA trainings that are offered on a regular basis be open to home health agency staff that work with children with behavioral health needs? If so, how would agency staff enroll?
    a. Open response
8. (if b or c) How would a home health agency make a request to provide a MHFA training? Please provide any contact information that would be helpful
    a. Open response
9. What is the average cost per person to attend a MHFA training?
    a. Open response
10. How long is a typical MHFA training session?
    a. Banded response: half-day, full day, longer than full day
11. How many individuals can attend one MHFA training session?
    a. Banded response: 1-10, 11-20, 21-30, 31-40, 41-50, 51+

12. Are you aware of any certified Mental Health First Aid trainers that provide Mental Health First Aid training (MHFA) within your county/county-joinder area that are not affiliated with your office?
    a. Yes, there is a trainer(s) for Adult Mental Health First Aid
    b. Yes, there is a trainer(s) for Youth Mental Health First Aid
    c. Yes, there is a trainer(s) for both Youth and Adult Mental Health First Aid
    d. No, there are no trainer(s)
    e. I am not aware of any additional trainer(s)
13. (if a, b or c) Please provide the name and contact information of the trainer(s).
    a. Open response
14. Do you have any additional recommendations for obtaining introductory behavioral health training for home health agency staff? This could include local or non-local resources.

Dear [NAME]:

Through the direction of Sally Kozak, Deputy Secretary, Office of Medical Assistance Programs, a coalition of managed care organizations, Home Health Agencies, and Health Care providers have been meeting to discuss the challenges that face pediatric home health nursing and how we can all work together to address these challenges. As a leader in Pennsylvania's healthcare community, you are aware of the significant challenges we face related to nursing recruitment and retention in Pennsylvania, and particularly in pediatric home health nursing. In recent years, we have experienced a significant increase in the volume of individuals requiring home health services in Pennsylvania. At the same time, home health agencies across Pennsylvania have faced increased vacancies, high turnover, and difficulties in recruiting LPNs and RNs to provide these critically necessary services.

Below is a link to a questionnaire that is being sent to nursing schools across Pennsylvania to determine the scope of their program as it relates to pediatric home health and to identify areas that could be expanded upon to provide nursing graduates with the skills and knowledge they need to be able to obtain employment in pediatric nursing in general and home health specifically. Your input is valuable to assist us in this endeavor and we request your response by [DATE].

Survey Link: https://www.surveymonkey.com/r/MR3KXTG

Thank you in advance for helping us address the nursing shortage that is impacting the lives of so many vulnerable Pennsylvania families.

Sincerely,

Pennsylvania Office of Medical Assistance Programs

Pediatric Shift Care Nursing Home Health Initiative Team

Appendix O- Nursing School Letter of Support

Dear Pennsylvania Nursing School Partners,

As you know, Governor Wolf remains focused on strengthening Pennsylvania's ability to protect vulnerable populations. A key part of this ability is collaborating with healthcare education partners to address shortages of healthcare providers who work with vulnerable populations. One such vulnerable population is children receiving shift care nursing services. In recent years, we have experienced a significant increase in the volume of individuals requiring shift care nursing services in Pennsylvania, growing from about 3,000 in 2013, to more than 5,100 in 2018. At the same time, home health agencies across the Commonwealth have faced increased vacancies, high turnover, and difficulties in recruiting LPNs and RNs to provide these critically necessary services.

Recently, the Pennsylvania Department of Human Services Office of Medical Assistance Programs (OMAP), convened a coalition of healthcare stakeholders – including Medicaid managed care organizations, home health providers, families receiving pediatric shift care nursing, OMAP administrators, and others – to recommend possible solutions to improve pediatric shift care nursing in Pennsylvania and to respond to critical caregiver shortages. The coalition recommended that the Department partner with nursing schools throughout the state to understand how to best increase nursing students' exposure to and experience with home health, including potential additions to curriculum and practical experience requirements.

To that the end, the Department is seeking your interest and engagement in connecting on this important issue. We invite you to attend a partner videoconference call where we will describe our efforts to date in more detail and will look to gain your thoughts on this matter.

We look forward to speaking with you further and to working together to increase awareness of and interest in employment in shift care nursing services, a critically important healthcare service that helps to protect some of Pennsylvania's most vulnerable.

Sincerely,

Appendix P- Nursing Workforce Survey Results

Q1 - Do you have experience providing direct pediatric in-home nursing care in in Pennsylvania (PA)?	Count	Percent
No, have never worked in family's homes providing direct pediatric home nursing care in PA	441	30.25%
Not currently, have done so in the past	432	29.63%
Yes, am doing so currently	492	33.74%
(blank)	93	6.38%
Grand Total	**1458**	

QN.a. - Why did you choose a type of nursing other than pediatric in-home nursing care? Please check ALL that apply - Selected Choice	Count	Percent
Interested in a different kind of nursing	185	10.48%
Prefer work with a team	76	4.31%
Uneasy with supportive technology	17	0.96%
Receive better pay in other roles	63	3.57%
Prefer work with older patients	124	7.03%
Prefer more predictable work schedules	63	3.57%
Was unaware of this form or nursing	29	1.64%
Other: please tell us	155	8.78%
(blank)	1053	59.66%
Grand Total	**1765**	

Q1_1 - Tell us about your experience - RN	Count	Percent
Am currently	376	25.79%
No experience	49	3.36%
Was formerly	95	6.52%
(blank)	938	64.33%
Grand Total	**1458**	

Q1_2 - Tell us about your experience - LPN	Count	Percent
Am currently	376	25.79%
No experience	73	5.01%
Was formerly	87	5.97%
(blank)	922	63.24%
Grand Total	**1458**	

Q2_1 - How many years in each role? - Years as an RN	Count	Percent
0	56	3.84%
1-3	56	3.84%
4-7	52	3.57%
8-10	40	2.74%
More than 10	333	22.84%
(blank)	921	63.17%
Grand Total	**1458**	

Q2_2 - How many years in each role? - Years as an LPN	Count	Percent
0	70	4.80%
1-3	68	4.66%
4-7	98	6.72%
8-10	59	4.05%
More than 10	256	17.56%
(blank)	907	62.21%
Grand Total	**1458**	

Q3 - What first got you interested in providing home nursing care? (CHECK ALL THAT APPLY) - Selected Choice	Count	Percent
Want to help children stay at home	482	16.76%
Personally know someone with special health care needs	218	7.58%
Other: please tell us	132	4.59%
Needed a job	197	6.85%
More autonomy than in a hospital/facility	412	14.33%
Like to work with families	447	15.54%
Like the flexibility	651	22.64%
I get to use a wide variety of skills	337	11.72%
(blank)	559	19.44%
Grand Total	**2876**	

Q4 - What are your plans to continue providing home nursing care? (Select the one that best matches your feelings) - Selected Choice	Count	Percent
Am retired with no plans to work again	34	2.33%
Am retired, would consider returning to this type of care	32	2.19%
I am retired, would consider doing a different kind of nursing	19	1.30%
OK for now, but not a career	75	5.14%
Other. Please tell us	225	15.43%
Plan to continue- see as my career	362	24.83%
Want to change careers	23	1.58%
Want to do a different kind of nursing now	110	7.54%
(blank)	578	39.64%
Grand Total	**1458**	

Q5 - ASPECTS OF CARE. For each item, please indicate how much you LIKE / DISLIKE each aspect of pediatric home care.	Helping a child with complex medical needs have as regular a life as possible		Being a key resource to families about their child's health	
	Count	Percent	Count	Percent
DISLIKE a great deal	6	0.41%	6	0.41%
DISLIKE moderately	8	0.55%	24	1.65%
LIKE a great deal	704	48.29%	596	40.88%
LIKE moderately	132	9.05%	226	15.50%
(blank)	608	41.70%	606	41.56%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**

Q5 - ASPECTS OF CARE. For each item, please indicate how much you LIKE / DISLIKE each aspect of pediatric home care.	Using my skills to make clinical judgments about child's health		Working with families to plan for their child's care	
	Count	Percent	Count	Percent
DISLIKE a great deal	5	0.34%	17	1.17%
DISLIKE moderately	18	1.23%	37	2.54%
LIKE a great deal	618	42.39%	565	38.75%
LIKE moderately	212	14.54%	232	15.91%
(blank)	605	41.50%	607	41.63%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**

Q5 - ASPECTS OF CARE. For each item, please indicate how much you LIKE / DISLIKE each aspect of pediatric home care.	Having long term relationships in my role as a nurse	
	Count	Percent
DISLIKE a great deal	11	0.75%
DISLIKE moderately	33	2.26%
LIKE a great deal	589	40.40%
LIKE moderately	219	15.02%
(blank)	606	41.56%
Grand Total	**1458**	**100.00%**

Q5 - ASPECTS OF CARE. For each item, please indicate how much you LIKE / DISLIKE each aspect of pediatric home care.	Using my skills to make clinical judgments about child's health		Working with families to plan for their child's care	
	Count	Percent	Count	Percent
DISLIKE a great deal	5	0.34%	17	1.17%
DISLIKE moderately	18	1.23%	37	2.54%
LIKE a great deal	618	42.39%	565	38.75%
LIKE moderately	212	14.54%	232	15.91%
(blank)	605	41.50%	607	41.63%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**

Q7_1 - CHALLENGES. To what degree does each item below NEGATIVELY IMPACT your work satisfaction?	Neighborhoods that feel unsafe		Families who don't understand my role as a nurse		Homes where things happen that make me uncomfortable	
	Count	Percent	Count	Percent	Count	Percent
-10	179	12.28%	122	8.37%	191	13.10%
-9	61	4.18%	37	2.54%	71	4.87%
-8	73	5.01%	65	4.46%	96	6.58%
-7	50	3.43%	68	4.66%	63	4.32%
-6	42	2.88%	68	4.66%	49	3.36%
-5	75	5.14%	113	7.75%	92	6.31%
-4	38	2.61%	38	2.61%	44	3.02%
-3	41	2.81%	65	4.46%	45	3.09%
-2	41	2.81%	58	3.98%	44	3.02%
-1	55	3.77%	63	4.32%	53	3.64%
0	65	4.46%	53	3.64%	38	2.61%
(blank)	738	50.62%	708	48.56%	672	46.09%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**	**1458**	**100.00%**

Q7_1 - CHALLENGES. To what degree does each item below NEGATIVELY IMPACT your work satisfaction?	Limited physical space to provide care for the child		Language barriers	
	Count	Percent	Count	Percent
-10	60	4.12%	67	4.60%
-9	25	1.71%	22	1.51%
-8	51	3.50%	31	2.13%
-7	51	3.50%	37	2.54%
-6	53	3.64%	35	2.40%
-5	96	6.58%	84	5.76%
-4	68	4.66%	38	2.61%
-3	82	5.62%	59	4.05%
-2	76	5.21%	64	4.39%
-1	86	5.90%	91	6.24%
0	68	4.66%	108	7.41%
(blank)	742	50.89%	822	56.38%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**

Q8 - Again, to what degree does each item below NEGATIVELY IMPACT your work satisfaction?	Feeling undervalued by my employer		Last minute emergency assignments		Receiving my work schedules late	
	Count	Percent	Count	Percent	Count	Percent
-10	165	11.32%	64	4.39%	87	5.97%
-9	47	3.22%	17	1.17%	35	2.40%
-8	73	5.01%	36	2.47%	52	3.57%
-7	64	4.39%	34	2.33%	40	2.74%
-6	41	2.81%	30	2.06%	30	2.06%
-5	80	5.49%	73	5.01%	65	4.46%
-4	39	2.67%	45	3.09%	37	2.54%

Q8 - Again, to what degree does each item below NEGATIVELY IMPACT your work satisfaction?	Feeling undervalued by my employer		Last minute emergency assignments		Receiving my work schedules late	
	Count	Percent	Count	Percent	Count	Percent
-3	46	3.16%	63	4.32%	39	2.67%
-2	54	3.70%	83	5.69%	63	4.32%
-1	51	3.50%	87	5.97%	84	5.76%
0	74	5.08%	108	7.41%	111	7.61%
(blank)	724	49.66%	818	56.10%	815	55.90%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**	**1458**	**100.00%**

Q8 - Again, to what degree does each item below NEGATIVELY IMPACT your work satisfaction?	No pay when child is hospitalized		Insufficient notice about changes in care plans		No pay when shadowing to learn a child's care	
	Count	Percent	Count	Percent	Count	Percent
-10	296	20.30%	87	5.97%	198	13.58%
-9	52	3.57%	33	2.26%	42	2.88%
-8	49	3.36%	64	4.39%	50	3.43%
-7	46	3.16%	42	2.88%	35	2.40%
-6	39	2.67%	31	2.13%	27	1.85%
-5	59	4.05%	86	5.90%	64	4.39%
-4	29	1.99%	45	3.09%	27	1.85%
-3	33	2.26%	42	2.88%	32	2.19%
-2	30	2.06%	74	5.08%	26	1.78%
-1	37	2.54%	71	4.87%	50	3.43%
0	60	4.12%	85	5.83%	89	6.10%
(blank)	728	49.93%	798	54.73%	818	56.10%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**	**1458**	**100.00%**

Q9 - RANK ORDER. Please place them in order of most important to you, following in descending order to the item that is least important to you.	Doing meaningful work		Continuity with a child / family		Getting enough assignments	
	Count	Percent	Count	Percent	Count	Percent
1	227	15.57%	92	6.31%	26	1.78%
2	102	7.00%	130	8.92%	51	3.50%
3	125	8.57%	97	6.65%	68	4.66%
4	110	7.54%	116	7.96%	77	5.28%
5	67	4.60%	119	8.16%	93	6.38%
6	78	5.35%	108	7.41%	132	9.05%
7	52	3.57%	88	6.04%	151	10.36%
8	43	2.95%	54	3.70%	206	14.13%
(blank)	654	44.86%	654	44.86%	654	44.86%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**	**1458**	**100.00%**

Q9 - RANK ORDER. Please place them in order of most important to you, following in descending order to the item that is least important to you.	Support from my agency		Opportunities for growth		Benefits	
	Count	Percent	Count	Percent	Count	Percent
1	55	3.77%	33	2.26%	41	2.81%
2	86	5.90%	53	3.64%	142	9.74%
3	128	8.78%	68	4.66%	82	5.62%
4	124	8.50%	68	4.66%	76	5.21%
5	142	9.74%	86	5.90%	116	7.96%
6	117	8.02%	118	8.09%	89	6.10%
7	101	6.93%	178	12.21%	100	6.86%
8	51	3.50%	200	13.72%	158	10.84%
(blank)	654	44.86%	654	44.86%	654	44.86%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**	**1458**	**100.00%**

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Q9 - RANK ORDER. Please place them in order of most important to you, following in descending order to the item that is least important to you.	Pay		Good "match" in assignments	
	Count	Percent	Count	Percent
1	222	15.23%	108	7.41%
2	132	9.05%	108	7.41%
3	114	7.82%	122	8.37%
4	117	8.02%	116	7.96%
5	84	5.76%	97	6.65%
6	65	4.46%	97	6.65%
7	45	3.09%	89	6.10%
8	25	1.71%	67	4.60%
(blank)	654	44.86%	654	44.86%
Grand Total	**1458**	**100.00%**	**1458**	**100.00%**

Appendix Q- Nursing Strategies Survey Results

Strategy Topic	Strategy Description	Workgroup Members Support	Workgroup Members Do Not Support
Benefits	OMAP to establish guidelines for travel reimbursement for case locations beyond a specific range (e.g., 20 miles), and for those with significant parking expenses (including contractors)	**11**	**0**
Benefits	OMAP to establish guidelines for reimbursement of taxi/Uber/Lyft rides to certain locations where the nurse has a reasonable concern for personal safety	**11**	**0**
Partnerships	OMAP to work with Labor and Industry to declare home health nursing a critical workforce shortage to provide funding to nursing schools to increase the capacity for nurse education	**11**	**0**
HHA Operations	Explore creating a health insurance pool for better benefits at better rates	**11**	**0**
HHA Operations	For new cases, the clinical manager will visit the location to find parking and create a strategic plan for the nurse's safety	**11**	**0**
HHA Operations	Utilize the characteristics of people who choose home shift nursing in recruitment efforts - characteristics are autonomy, independence, flexibility, and valued purpose	**11**	**0**
HHA Operations	Explore strategies to acknowledge the importance of employed nurses' work	**11**	**0**
Partnerships	OMAP to use a licensed nurse contact list from the PA Licensing Bureau to send a pediatric shift care recruitment message to nurses across the state	**10**	**0**
Partnerships	OMAP to work with American Association of Critical-Care Nurses and National Association for Practical Nurse Education and Service to establish a critical care credential for home health	**10**	**0**
Payment Arrangement	OMAP to establish shift differential rates for pediatric shift care nurses for high acuity cases (such as trach/vent)	**10**	**1**
Payment Arrangement	OMAP to establish LPN and RN pay rates	**9**	**2**
Payment Arrangement	OMAP to establish differential or higher rates for pediatric shift care nurses with specific certifications (such as critical care certification)	**9**	**2**
Payment Arrangement	OMAP to establish guidelines for paying pediatric shift care nurses (including contractors) for time taking required CEUs	**8**	**2**
Benefits	OMAP to establish guidelines for provision of health insurance to pediatric shift care nurses (including contractors)	**8**	**3**

Strategy Topic	Strategy Description	Workgroup Members Support	Workgroup Members Do Not Support
Benefits	OMAP to establish guidelines for providing paid leave to pediatric shift care nurses (including contractors)	**8**	**3**
Regulatory	OMAP to permit independent nurse practice and Medicaid billing in pediatric shift care nursing, similar to the Wisconsin Professional Homecare Providers (wisconsinphp.org)	**7**	**2**
Payment Arrangement	OMAP to establish guidelines for paying pediatric shift care nurses (including contractors) for when shifts are canceled and/or cases are hospitalized	**6**	**4**

Strategy Topic	Strategy Description	Workgroup Members Support	Workgroup Members Do Not Support
Benefits	OMAP to establish guidelines for travel reimbursement for case locations beyond a specific range (e.g., 20 miles), and for those with significant parking expenses (including contractors)	**100%**	**0%**
Benefits	OMAP to establish guidelines for reimbursement of taxi/Uber/Lyft rides to certain locations where the nurse has a reasonable concern for personal safety	**100%**	**0%**
Partnerships	OMAP to work with Labor and Industry to declare home health nursing a critical workforce shortage to provide funding to nursing schools to increase the capacity for nurse education	**100%**	**0%**
HHA Operations	Explore creating a health insurance pool for better benefits at better rates	**100%**	**0%**
HHA Operations	For new cases, the clinical manager will visit the location to find parking and create a strategic plan for the nurse's safety	**100%**	**0%**
HHA Operations	Utilize the characteristics of people who choose home shift nursing in recruitment efforts - characteristics are autonomy, independence, flexibility, and valued purpose	**100%**	**0%**
HHA Operations	Explore strategies to acknowledge the importance of employed nurses' work	**100%**	**0%**

Strategy Topic	Strategy Description	Workgroup Members Support	Workgroup Members Do Not Support
Partnerships	OMAP to use a licensed nurse contact list from the PA Licensing Bureau to send a pediatric shift care recruitment message to nurses across the state	**91%**	**0%**
Partnerships	OMAP to work with American Association of Critical-Care Nurses and National Association for Practical Nurse Education and Service to establish a critical care credential for home health	**91%**	**0%**
Payment Arrangement	OMAP to establish shift differential rates for pediatric shift care nurses for high acuity cases (such as trach/vent)	**91%**	**9%**
Payment Arrangement	OMAP to establish LPN and RN pay rates	**82%**	**18%**
Payment Arrangement	OMAP to establish differential or higher rates for pediatric shift care nurses with specific certifications (such as critical care certification)	**82%**	**18%**
Payment Arrangement	OMAP to establish guidelines for paying pediatric shift care nurses (including contractors) for time taking required CEUs	**73%**	**18%**
Benefits	OMAP to establish guidelines for provision of health insurance to pediatric shift care nurses (including contractors)	**73%**	**27%**
Benefits	OMAP to establish guidelines for providing paid leave to pediatric shift care nurses (including contractors)	**73%**	**27%**
Regulatory	OMAP to permit independent nurse practice and Medicaid billing in pediatric shift care nursing, similar to the Wisconsin Professional Homecare Providers (wisconsinphp.org)	**64%**	**18%**
Payment Arrangement	OMAP to establish guidelines for paying pediatric shift care nurses (including contractors) for when shifts are canceled and/or cases are hospitalized	**55%**	**36%**

Appendix R- Nursing School Contact List

Nursing School	Type	Location	General Phone	Contact Name	Title	Phone	Email
Alvernia College		Kingwood, PA	888-ALVERNIA	Deborah A. Greenawald, Ph.D., RN	Department Nursing Chair	N/A	N/A
				Priscilla Price	Nursing Department Secretary	610-796-8217	priscilla.price@alvernia.edu
Bloomsburg University	PASSHE	Bloomsburg, PA	570-389-4000	Susan Fetterman	Department Nursing Chair	N/A	N/A
				Deby Krum	Nursing Department Secretary	N/A	N/A
				GayAnne Spezialetti	Nursing Department Secretary	N/A	N/A
Brandywine School of Nursing		Gary, PA	610-383-8000	N/A	N/A	N/A	N/A
Bucks County Community College	Community College	Ottumwa, PA	215-968-8000	Virginia Nanni	coordinator LPN	215-968-8046	virginia.nanni@bucks.edu
Butler County Community College	Community College	Butler, PA	N/A	Christy Streeter	Dean	(316)322-3140	cstreeter1@butlercc.edu
				Beth Eagleton	Associate Dean	316.323.6223	eeagleton@butlercc.edu
				Kerri Smith	Administrative Assistant	316.322.3140	ksmith@butlercc.edu
California University	PASSHE	California, PA	724-938-4000	Dr. Donna Caruthers	Chairperson and Assistant Professor	N/A	caruthers@calu.edu
Career Technology Center - School of Practical Nursing		Scranton, PA	570-346-8471	Mrs. Laura Kanavy	Director, Practical Nursing	N/A	lkanavy@ctclc.edu
Carlow University		Pittsburgh, PA	800.333.2275	Lynn George, PhD, RN, CNE	Dean, Nursing Department Chair	412.578.6115	legeorge@carlow.edu
Cedar Crest College		Allentown, PA	800-360-1222	Wendy J. Robb	Dean of the School of Nursing	N/A	wjrobb@cedarcrest.edu
Central PA Institute of Science and Technology		Pleasant Gap, PA	814.359.2793	Debbie Couturiaux	Practical Nursing Coordinator	814-359-2793 Ext. 265	dcouturiaux@cpi.edu
Central Susquehanna Intermediate Unit - LPN Career Center		Milton, PA	570-523-1155	Candy Feaster	N/A	570-768-4960	cfeaster@csiu.org
				Timothy B. Campbell	PhD, RN, Director	N/A	timothy.campbell@csiu.org
Chester County Intermediate Unit		Downingtown, PA	484-593-5950	Nancy Haughton	practical nursing program		NancyH@cciu.org
Cheyney University of Pennsylvania	PASSHE	Cheyney, PA	610-399-2275	Biology Dept - Pre-Nursing			-

Nursing School	Type	Location	General Phone	Contact Name	Title	Phone	Email
Citizens School of Nursing		Tallahassee, PA	(724) 337-5090	Lynne Rugh, MSN, RN	Director, School of Nursing	N/A	N/A
Clarion County Career Center		Shippenville, PA	814-226-5857, ext. 160	N/A	N/A	N/A	N/A
Clarion University of Pennsylvania	PASSHE	Clarion, PA	814-393-1252	Deborah J. Kelly, DNP, RN, CHPCA	Chair, Nurse Administrator	N/A	dkelly@clarion.edu
Clearfield County Career and Technology Center		Clearfield, PA	1-814-765-5308	Cheryl Krieg MSN, RNC-OB	Nursing Program Director	814-765-4047	ckrieg@ccctc.edu
Community College of Allegheny County	Community College	Fennimore, PA	N/A	Amber Reed	Director of Nursing Admissions	412.237.4556	Areed@ccac.edu
Community College of Beaver County	Community College	Muscle Shoals, PA	724-480-2222	Sally Fitzgerald	N/A	800-335--222	sally.fitzgerald@ccbc.edu
			800-335-0222				
Community College of Philadelphia	Community College	Philadelphia, PA	215-751-8000	N/A	N/A	N/A	N/A
Conemaugh School of Nursing		Johnstown, PA	814-534-9000	Leah Patton, BS, CST	Academic Admissions Coordinator, Conemaugh School of Nursing	(814) 534-9492	lpatton@conemaugh.org
Crawford County Area Vocational-Technical School		Meadville, PA	(814) 724-6024	Rebecca Parker	Nursing	N/A	rparker@crawfordctc.org
Delaware County Community College	Community College	Media, PA	610-359-5353	Dr. Faye Meloy	Dean Division of Allied Health, Emergency Services & Nursing	610-359-5181	AHN@dccc.edu
				Ms. Genny Cavanagh	Assistant Dean Division of Allied Health, Emergency Services & Nursing		
Delaware County Technical School - Practical Nursing Program		Morton, PA	610-938-9000	Kathleen McNamara	N/A	N/A	Kmcnamara@dciu.org
DeSales University		Center Valley, PA	610-282-1100	N/A	Division of Nursing	610.282.1100 ext. 1271	nursing@desales.edu
District 1199C Training		Philadelphia, PA	215-568-2220	Karen Poles	LPN program		kpoles@1199ctraining.org

Nursing School	Type	Location	General Phone	Contact Name	Title	Phone	Email
Drexel University		Philadelphia, PA	215.895.2000	Anthony Angelow PhD, CRNP, ACNPC, AGACNP-BC, ACNP-BC, CEN, FAEN	Chair, Advanced Practice Nursing, Nurse Practitioner and DNP Programs and Assistant Clinical Professor	267.359.5587	ama435@drexel.edu
Duquesne University		Pittsburgh, PA	412.396.600	Mary Ellen Glasgow, PhD, RN, ANEF, FAAN	Dean and Professor	412.396.6554	glasgowm@dug.edu
East Stroudsburg University	PASSHE	East Stroudsburg, PA	(570) 422-3211	Laura Waters	Department Chair Nursing	(570) 422-3569	lwaters@esu.edu
Eastern Center for Arts & Technology		Willow Grove, PA	215-784-4800	N/A	Contact Practical Nursing	215-784-4800, extension 451	lingersoll@eastech.org (Cduell@eastech.org)
Edinboro University of Pennsylvania	PASSHE	Edinboro, PA	814.732.2000	Dr. Thomas White	Department Chair	814.732.2695	twhite@edinboro.edu
Falcon Institute of Health and Science		Bethlehem, PA	610-253-2527	Kassidy Lax			Kassidy@falconihs.com
Fayette County Area Vocational - Technical School		Uniontown, PA	724-437-2721	N/A	Nursing Program	724-437-2724	N/A
Fortis Institute		Scranton, PA	570-558-1818	Kim Pilker	Nursing		kpilker@fortisinstitute.edu
Frankford Hospital School of Nursing		Trevose, PA	1-877-808-2742	N/A	Nursing Main Line	215-710-3510	N/A
Franklin County Career &Technology Ctr		Chambersburg, PA	717-263-9033	Janyce Collier			janyce.collier@franklinctc.com
Gannon University		Erie, PA	(814) 871-7000	N/A	School of Nursing	814-871-7240	admissions@gannon.edu
Greene County Career &Tech. Ctr		Waynesburg, PA	724-627-3106	Judy Swauger	Nursing		swaugerj@greenectc.org
Great Lakes Institute of Technology		Erie, PA		Bailey Shaffer	Nursing		baileys@glit.edu
Greater Altoona Career& Technology Ctr		Altoona, PA	814-946-8450	Rebecca Kelly	Nursing		becky.kelly@gactc.edu
Greater Johnstown Career & Tech. Ctr		Johnstown, PA	814-266-6073	Kelly Hoffman	Nursing		khoffman@gjctc.org
Gwynedd-Mercy College		Gwynedd Valley, PA	800-342-5462	N/A	N/A	N/A	N/A
Hanover Public School District - Practical Nursing Program		Hanover, PA	(717) 637-2111	N/A	N/A	N/A	admin@practicalnursingonline.com
Harcum College		Bryn Mawr, PA	610-525-4100	N/A	N/A	N/A	N/A
Harrisburg Area Community College	Community College	Harrisburg, PA	800-ABC-HACC	Trudy Bauer	N/A	N/A	tlbauer@hacc.edu

Nursing School	Type	Location	General Phone	Contact Name	Title	Phone	Email
Holy Family University		Philadelphia, PA	215-637-7700	N/A	School of Nursing	267-341-3293	SNAHP@holyfamily.edu
				Cynthia A. Russell	Dean of the School of Nursing	N/A	crussell@holyfamily.edu
Huntingdon County Career and Technology Center		Mill Creek, PA	(814) 643-0951	Jessica McCorkle	N/A	N/A	jmccorkle@hcctc.org
Immaculata University		Moon Township, PA	1-610-647-4400	N/A	N/A	N/A	N/A
			1-877-42 TODAY				
Indiana County Technology Center		Indiana, PA	724-349-6700	Diana Rupert	Nursing program LPN		drupert@ictc.edu
Indiana University of Pennsylvania	PASSHE	Indiana, PA	724-357-2100	N/A	Nursing Department	724-357-2557	N/A
Jameson School of Nursing		New Castle, PA	412-647-8762	N/A	School of Nursing	724-936-3941	forlettatl@upmc.edu
			800-533-8762				-
Jefferson County - DuBois AVTS		Reynoldsville, PA	(814) 653.8265	Brenda Hodge	Nursing program	N/A	bahodge@jefftech.us
Kutztown University of Pennsylvania	PASSHE	Kutztown, PA	610-683-4000	N/A	N/A	N/A	N/A
Lancaster County Career& Tech Ctr.		Willow Street, PA	717-464-7050	Josie Campbell	Nursing		jcampbell@lancasterctc.edu
La Roche College		Pittsburgh, PA	412-367-9300	N/A	N/A	N/A	N/A
La Salle University		Philadelphia, PA	215.951.1000	Kathleen Czekanski, Ph.D., R.N., CNE	Dean, Associate Professor in Nursing	215.951.1432	czekanski@lasalle.edu
				Meredith Kneavel, Ph.D.	Associate Dean, School of Nursing and Health Sciences	215-951-1530	kneavel@lasalle.edu
Lebanon County Career & Tech. Center				Michelle Achey			machey@lcctc.edu
Lehigh Carbon Community College	Community College	Schnecksville, PA	610-799-2121	Tina Van Buren	N/A	N/A	tvanburen@lccc.edu
Lenape Technical School		Ford City, PA	724-763-7116	Kim Smith	Nursing		domskim@lenapepnp.com
Lincoln Tech		Allentown, PA/Philadelphia, PA		Michelle Davis			mdavis@lincolntech.edu
Lock Haven University	PASSHE	Lock Haven, PA	(570) 484-2027	Marie Fair	Academic Secretary - Department of Nursing	(814) 768-3450	lhunursing@lockhaven.edu
Luzerne County Community College	Community College	Nanticoke, PA	1-800-377-5222	Deborah Vilegi Payne	Dean of Health Sciences	570-740-0232	N/A

Nursing School	Type	Location	General Phone	Contact Name	Title	Phone	Email
Mansfield University	PASSHE	Mansfield, PA	570.662.4000	Dr. Susan Lanzara	Department Chair	570-662-4628	slanzara@mansfield.edu
				Jocelyn Brion	Administrative Assistant	N/A	jbrion@mansfield.edu
Marywood University		Scranton, PA	570-348-6211	N/A	Nursing Department	570-348-6275	jnotari@maryu.marywood.edu
Mercer County Career Center		Mercer, PA	724-662-3000	Mary Jane Peters	Nursing		mpeters@mercerccc.org
Mercyhurst University		Erie, PA	814-824-2000	N/A	Nursing Program	814-725-6144.	N/A
Messiah College		Mechanicsburg, PA	717-766-2511	Kim Fenstermacher, Ph.D., CRNP	Chief Nursing Administrator; Assistant Dean of Nursing	717-691-6029	KFenstermacher@messiah.edu
				Beth Aumen	Administrative Assistant to the Chair, Department of Nursing	717-691-6029	nursing@messiah.edu
Mifflin Juniata Career & Technology Center		Lewistown, PA	717-447-0394	Alicia Lentz	Nursing Program	(717) 248-3933 Ext. 5831	alentz@academynursing.com
Millersville University - Department of Nursing	PASSHE	Millersville, PA	717-871-4636	N/A	Nursing Program	717-871-4274	nursing@millersville.edu
Misericordia University		Dallas, PA	(570) 674-6400	Annette M. Weiss, PhD, RN, CNE	Assistant Dean of Nursing	570-674-6358	aweiss@misericordia.edu
Montgomery County Community College	Community College	Blue Bell, PA	215-641-6300	N/A	N/A	N/A	N/A
Moravian College		Bethlehem, PA	1 800.441.3191	Dr. Dawn M. Goodolf	Nursing Department Chair	(610) 861-1660	nursing@moravian.edu
Mount Aloysius College		Cresson, PA	814.886.4131	Nicole Custer	Chairperson, Department of Nursing	814-886-6394	ncuster@mtaloy.edu
Neumann College		Aston, PA	610-459-0905	Kathleen Hoover	Nursing Dean	610-558-5560	hooverk@neumann.edu
				Beverly Whitton	Nursing - Secretary to the Dean	610-558-5561	whittonb@neumann.edu
Northampton Community College	Community College	Bethlehem, PA	610.861.5300	Mary Jean Osborne	Nursing		mosborne@northampton.edu
Northeastern Hospital School of Nursing		Philadelphia, PA	215-926-3000	N/A	School of Nursing	215-898-4502	N/A
Northern Tier Career Center		Towanda, PA	(570) 265-8111	Maggie Johnson RN, MSN	Coordinator	N/A	mjohnson@ntccschool.org

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				Tina Mathers	Secretary	N/A	tmathers@ntccschool.org
Ohio Valley General Hospital School of Nursing		Kennedy Township, PA	1.877.771.4847	N/A	School of Nursing	412-777-6204	sgvory@ohiovalleyhospital.org
Penn Commercial Business & Tech school		Washington, PA	724-222-5330		Practical Nursing Coordinator		reckert@penncommercial.edu
Pennsylvania College of Technology		Williamsport, PA	570.320.2400	Jo Miller	Nursing		jlm74@pct.edu
Pennsylvania State University		University Park, PA	814-865-4700	N/A	Dean of Nursing Office	814-863-0245	N/A--does not have LPN program
Philadelphia University		Philadelphia, PA	1-877-533-3247	Marie Ann Marino	Dean & Professor, Jefferson College of Nursing	215-503-3720	Marie.Marino@jefferson.edu
Pittsburgh Technical College		Oakdale, PA	412-809-5100	Teresa Barbour/Kaitlin Cobourne	Nursing	412-809-5100	barbour.teresa@ptollege.edu cobourne.kaitlin@ptcollege.edu
Prism Career Institute		Philadelphia, PA	1-888-966-8146	Sharon Gordon	Nursing		sgordon@prismcareerinstitute.edu
The Rapha School		Home, PA	724-397-2365	Sharon Laney	Nursing		sharonlaney@theraphaschool.com
Reading Area Community College	Community College	Reading, PA	610-372-4721	Stacia Visgarda	HEALTH PROFESSIONS - Associate Dean	N/A	svisgarda@racc.edu
Robert Morris University		Moon Township, PA	412-397-3000	Jessica L. Kamerer, EdD, MSN, RNC-NIC	Nursing Department Head	N/A	kamerer@rmu.edu
Roxborough Memorial Hospital School of Nursing		Philadelphia, PA	215.483.9900	N/A	School of Nursing	215-487-4344.	N/A
Schuylkill Technology Center				Kim O'Neil	Nursing		oneik@stcenters.org
Sharon Regional Health System		Sharon, PA	724-983-3911	N/A	School of Nursing	724-983-3865	N/A
Slippery Rock University	PASSHE	Slippery Rock, PA	800.778.9111	Mary Ann Thurkettle	Chairperson and Associate Professor	724.738.4568	maryann.thurkettle@sru.edu
				Tanya Turner	Department Secretary	724.738.2065	nursingdepartment@sru.edu
Shippensburg University of Pennsylvania	PASSHE	Shippensburg, PA	(717) 477-1401	In association with Thomas Jefferson via SU Biology Dept			biology@ship.edu

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St. Francis University		Loretto, PA	814.472.3000	Dr. Rita Trofino	Associate Dean, School of Health Sciences, Nursing Department Chairperson, Professor	814.472.3027	rtrofino@francis.edu
St. Lukes Hospital School of Nursing		Bethlehem, PA	1-866-STLUKES	N/A	School of Medicine	484-526-8875	templestlukes@sluhn.org
Susquehanna County Career & Tech Ctr.		Springville, PA	570-278-9229	Denise Gieski	Nursing		denise.gieski@scctc-school.org
Temple University		Philadelphia, PA	215-707-4686	Nancy L. Rothman	Department Chair	215-707-5436	rothman@temple.edu
University of Pennsylvania		Philadelphia, PA	(215) 898-8281	José A. Bauermeister, PhD, MPH	Chair of the University of Pennsylvania School of Nursing's	(215) 898-9993	bjose@upenn.edu
University of Pittsburgh		Pittsburgh, PA	412-624-4586	Jacqueline Dunbar-Jacob PhD, RN, FAAN	Dean - Distinguished Service Professor of Nursing	412-624-7838	dunbar@pitt.edu
University of Scranton		Scranton, PA	1-888-SCRANTON	Kim Subasic, PhD, MS, RN, CNE	Department Chair	570-941-6223	kimberly.subasic@scranton.edu
Unied Career Institute		Irwin/Mt. Braddock, PA	724-515-2440/724-437-4600	Pamela Hughes	Nursing		phughes@piht.edu
Venango County Area Vocational Technical School		OIL CITY, PA	814-677-3097	N/A	Practical Nursing Program	(814) 493-6590	kkauffman@vtc1.org
		Warren, PA				(814) 406-0075	ckellogg@vtc1.org
Villanova University		Villanova, PA	610-519-4500	Donna S. Havens	Dean and Professor of the M. Louise Fitzpatrick College of Nursing.	(610) 519-4902	donna.havens@villanova.edu
Washington Hospital School of Nursing		Washington, PA	(724) 225-7000	Jamie Lynn Golden, RN, MSN, CNE	Director, School of Nursing	N/A	N/A
Waynesburg College		Waynesburg, PA	1.800.225.7393	N/A	N/A	N/A	N/A
West Chester University	PASSHE	West Chester, PA	610-436-1000	N/A	Nursing Program Director	610-436-2219	N/A
Western Area Career &Tech center				Lisa Balint			lbalint@wactc.net

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Western Pennsylvania Hospital School of Nursing		Tarentum, PA	412-578-5538	N/A	N/A	N/A	N/A
Westmoreland County Community College	Community College	Westmoreland, Fayette and Indiana counties	724-925-4000	N/A	N/A	N/A	infocenter@westmoreland.edu
Widener University		Chester PA	1-888-WIDENER	Anne M. Krouse, PhD, MBA, RN-BC	Dean of Nursing	(610) 499-4214	amkrouse@widener.edu
Wilkes-Barre Area Career & Tech. Ctr.		Plains Township, PA	570-822-4131	Gail Holby	Nursing		gholby@wbactc.org
Wilson College		Chambersburg, PA	717-264-4141	N/A	N/A	N/A	N/A
York College of Pennsylvania		York PA	717.846.7788	Dr. Janet L. Powell	Interim Dean - School of Nursing and Health Professions	717.815.2290	N/A
				Allison Malachosky	Executive Assistant	717.815.2290	amalacho@ycp.edu
York County School of Technology - Adult Nursing Education		York PA	717-741-0820	Vickie Hake or Frances Bietsch	Adult Nursing Secretary	717-747-2135	vhake@ytech.edu or francesbietsch@ytech.edu