Report of the Governor's Commission on Long Term Caregivers

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Acknowledgements

The Governor's Commission on Long Term Caregivers (COC) would like to thank all of the agencies and organizations whose time and effort helped to facilitate the research for this report.

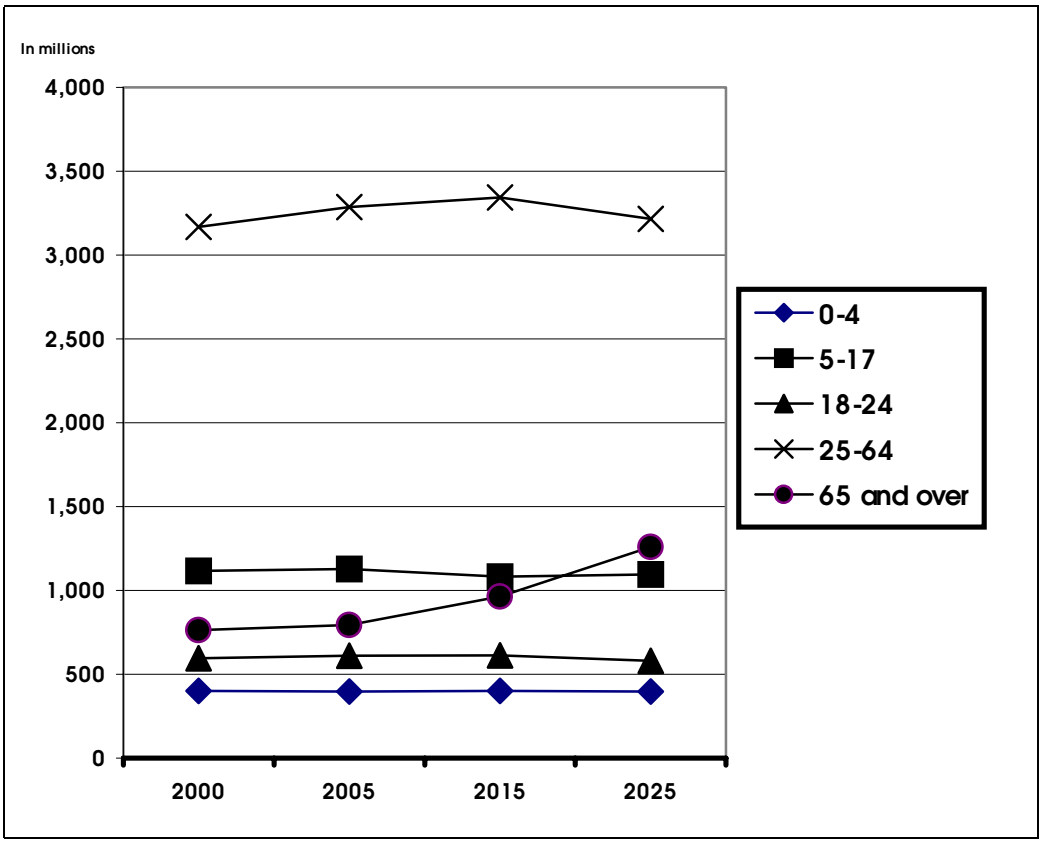
Along with primary research and published sources, the report draws on focus groups and interviews with key informants. Almost all members of the COC took significant time for interviews with the consultant, and they also helped by providing valuable contacts in the field. In addition, COC members assisted in arranging focus groups with their boards or their membership. Special thanks for focus groups go to the Indiana Association for Area Agencies on Aging, the Indiana Association for Home and Hospice Care, the Indiana Association for Homes and Services for the Aging, and the Indiana Health Care Association. Ivy Tech State College greatly assisted by setting up focus groups with LPN students and CNA students at their Indianapolis campus. In several cases, COC members also made their staff available to the COC consultant to answer technical questions related to laws, rules and regulations about facility- or community-based long term care. Indiana State Department of Health staff in the Division of Long Term Care and the Division of Acute Care were especially helpful in this regard. Indiana Family and Social Service Administration staff provided insight into Medicaid reimbursement programs and other matters under their purview. The COC also appreciates the efforts of all Indiana nursing program directors who responded to the COC's questionnaires on program capacity and curriculum.

The COC is grateful to Claudia H. Siegel, MA, MPA, who served as consultant to the COC, conducted the research and wrote the report.

Report of the Governor's Commission on Long Term Caregivers

Executive Summary

All over the nation, people are coming to terms with increasing demand for long term care services, much of it driven by growth in the aging population. If demographic data are correct, demand will continue to climb. By 2025, Indiana's 65 and older population is expected to increase to over 1.2 million from its current 753,000, making it the second-largest age group in the state. Within this population group, it is estimated that at least 60 percent of people 75 and older will require some type of long term care.



Indiana's Projected Population Growth, by Age Group, 2000-2025[1]

Developing a workforce to respond to long term care demand presents a considerable challenge, and adapting the care delivery process to accommodate consumer choice adds to the complexity of the endeavor. However, within this challenge, there is enormous opportunity. The growing need for long term care represents an amazingly stable source of jobs long into the future. When compared to recent problematic fluctuations in other economic sectors, long

[1] Based on data from US Bureau of the Census, Series A Projections.

term care presents a favorable alternative. Indiana should harness the expanding demand for long term care services, fostering employment while providing compassionate and professional caregiving to vulnerable populations.

The Role of the Governor's Commission on Long Term Caregivers (COC)

The Governor's Commission on Long Term Caregivers (COC) was authorized by statute in 2001 and convened in 2002 to review information and data related to long term caregivers, evaluate the adequacy of the state's training programs, and make recommendations to increase the supply of long term caregivers.[2] The group consisted of representatives drawn from the private sector (long term care services industry, grassroots senior citizen advocacy groups, professional associations, and private educational institutions) and the public sector (the Governor's Office, and state agencies dealing with human services, workforce development, health, secondary and higher education, and health professions licensing).[3]

In this report, the COC sets out a new path for Indiana related to long term caregivers. In recent years, Indiana's principal focus has been on stemming costs for the populations needing long term care. The regenerative opportunities in terms of job creation, economic development, promoting an ethic of service and celebrating the lives of those who have gone before have largely been ignored. The Commission asks the state's leaders and the long term care provider community to change their focus and to collaborate in an all-out effort to look at both sides of the balance sheet when it comes to long term care.

On one side of the balance sheet are the costs of caring for the populations that need long term services. On the other side of the balance sheet are the dollars that every person and business employed in long term care contribute to the state, directly through taxes but also indirectly by pursuing their lives and livelihoods in Indiana. The totals on each side of the balance sheet are related phenomena, linked by a human equation. A dollar's cost on the long term care side is a dollar's investment in a working person and her/his family, in capital projects, in localities throughout the state, in activities related to other products of the health care industry, and in responsible regulation that improves quality. Most importantly, that dollar is an investment in someone who spent a lifetime investing in Indiana.

Every stakeholder in the long term care discussion, whether public or private, has to take responsibility for maintaining a healthy balance sheet. This will require changes in vision, in communication, and in practice. Providers and state agencies need to regard long term care as a collaborative effort to maintain or elevate the quality of life for consumers whose days and/or physical resources are limited. Caregivers need to earn decent wages and have ample staffing support. They should also have opportunities to pursue additional education and be made to feel that their contribution is valued.

This report is a beginning: it sets out the basic scaffolding needed to increase the supply and stability of the long term care workforce, with the goal of enhancing the overall economic

[2] The authorizing statute for the COC defines "long term caregivers" as "certified nurse aides, licensed practical nurses, and registered nurses employed in health facilities, home health care, and other community-based settings."

[3] See Appendix A for the statute creating the COC, and Appendix B for a list of the COC's membership.

stability of Indiana. The report will not answer every question, but it will propose some strategies for working toward the answers.

Report Overview

Chapter I discusses existing state initiatives in education, workforce development and service delivery that can serve as building blocks for a new approach to long term caregiver supply.

Chapter II reviews available information about Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nurse Aides (CNAs), Qualified Medication Aides (QMAs), and Gerontological Advanced Practice Nurses. It also discusses what information Indiana is lacking and suggests ways to collect the necessary data. The chapter also includes perspectives from providers and caregivers about barriers to long term caregiver supply.

Chapter III (The Home Care and Home Health Care "Side of the House") gives an overview of the caregiver supply issues in home care and home health care, along with other factors affecting access to care in the community.

Chapter IV (Ways to Boost Indiana's Long Term Caregiver Supply) examines strategies that have been used elsewhere to respond to long term caregiver supply problems, including increases in wages and benefits, valuing the caregiver (management improvements and caregiver appreciation), better orientation and training, and opportunities for advancement. The chapter also discusses the variety of ways in which other states have utilized minimum staffing ratios, and describes the current national debate on single task workers.

Chapter V (Conclusion and Recommendations) contains a discussion of the five strategies suggested by the COC's authorizing statute, and then sets out the COC's recommendations for building a comprehensive approach to Indiana's long term caregiver supply. The recommendations are also included below.

The Appendices to the report give an array of quantitative and qualitative information concerning Indiana's long term caregiver supply, including Indiana population data, caregiver supply data, information on nursing program curricula and capacity, types of home care and home health care agencies, national and state level wage information related to long term caregivers, and a summary table of other states' initiatives on long term caregiver supply and retention.

Governor's Commission on Long Term Caregivers: Recommendations

- **Access and Service**
- **Data**
- **Education**
- **Recognition and Appreciation**
- **Workplace**

Recommendations have been grouped according to their general area, and the areas are arranged alphabetically. There is no priority order within each group.

Access and Service

- The Family and Social Service Administration should expedite its approval and payment process under Medicaid waiver programs and CHOICE. It needs to meet with Area Agencies on Aging, home health care providers, home care providers and representatives of those in need of services to discuss strategies for improvement. It should consider using the same process as CHOICE to manage the Medicaid waiver programs. This process allows Area Agencies on Aging to negotiate contracts with local providers for the delivery of services. The Area Agencies are then responsible for ensuring the quality of services provided. However, the quality of Area Agencies across the state is not uniform, and the Family and Social Services Administration will need to adopt and enforce quality measures to assure consumer satisfaction.

- The Family and Social Services Administration and the Indiana State Department of Health should continue to work together diligently to resolve as quickly as possible any regulatory conflicts that may arise because of their different roles and perspectives in health care delivery. The Governor's Commission on Home and Community-based Services should evaluate the roles and interactions of these agencies in facilitating consumer access to community-based care, and make recommendations for procedures that will minimize consumer difficulty, enhance quality, expedite care delivery, and fulfill regulatory requirements.

- Indiana home health care associations should conduct a confidential survey of their membership to assess whether home care providers and home health care agencies are serving Medicaid waiver and CHOICE clients, and to provide more information on barriers to taking these clients. The results of the surveys should be made available to the Family and Social Services Administration so that it can devise remedies for the problems identified, including low Medicaid waiver rates and transportation costs.
- The Governor's Commission on Home and Community-based Services should explore the feasibility of a PACE grant (Program of All-Inclusive Care for the Elderly) with existing centers of geriatric excellence in the state. The PACE program is a capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. It utilizes a comprehensive medical and social service delivery system that includes a multidisciplinary team approach in an adult day health center. This is supplemented by in-home and referral services based on participants' needs. There are 15 states with at least one PACE (or pre-PACE) site in place, and some states, like Pennsylvania, have more than one. Some states have set up health professions student rotations at their PACE site(s), and Indiana should make every effort to implement an interdisciplinary training program at the proposed site.

- The Indiana State Department of Health Local Liaison Office should explore utilizing state and federal funding to establish nurse-managed clinics in long term care facilities, similar to the model of the Rural Health Clinic Training Centers. These clinics would provide primary care for persons who are elderly or disabled, and help to train students in multiple health disciplines with a focus on Health Occupations Education students, nursing students (RN and LPN), nurse practitioner students, CNA students, social work students, home health aides, Qualified Medication Aides, and personal attendants. These clinics should also make every effort to actively involve the three Indiana nursing programs that have received private or federal grants to enhance geriatric curriculum, and should also work to involve family practice residency programs in their region.

Data

- The Indiana Department of Workforce Development should convene an interagency task force consisting of the Indiana State Department of Health, the Indiana Department of Education, the Indiana Commission for Higher Education, the Indiana Health Professions Bureau, the Family and Social Services Administration and the Indiana Health Care Professional Development Commission to link data related to long term caregivers, including RNs, LPNs, CNAs, QMAs, registered home health aides and personal attendants. The linked information should be aggregated in such a way as to provide information that will assist in the development of recruitment, retention and career lattice programs for these professions. Possible sources of funding include: federal Preventive Health Block Grant funds; federal funds received by the Family and Social Services Administration for Nursing Home Transition, Real System Change, Community Pass, or workforce development; and Department of Workforce Development federal workforce development funds.

- The General Assembly should fund the Indiana Health Care Professional Development Commission (HCPDC), so that the Indiana State Department of Health can hire staff for the HCPDC's activities. This interdisciplinary body was created by resolution in 1995 and is the only state entity to give sustained and comprehensive attention to Indiana's health professions shortages. Under the HCPDC, the Department of Health should continue and expand its surveys of health professionals through the Health Professions Bureau's license renewal process, both paper and electronic. Without fail, the Department of Health and the Health Professions Bureau should collaborate on a comprehensive survey of all nursing groups (including LPNs) that includes a full-scale nursing articulation study. The Health Care Professional Development Commission should work with the Health Professions Bureau to improve its database so that information on the educational background of Indiana health care professionals is easily accessible. The Health Care Professional Development Commission should also work with the Family and Social Services Administration and the private sector to try to project Indiana's service needs and their impact on health professions in the future. Additional funding sources should also be explored.

- The General Assembly should give the Indiana State Department of Health appropriate statutory authority to develop rules requiring CNA training programs to provide

information on the number of successful completers by year of completion, and should also require CNA testing sites to provide information on the numbers sitting for the CNA examination, as well as those passing the examination, by training site. The General Assembly should also allocate to the Department of Health appropriate funding for these additional responsibilities.

- The nursing home associations and home health care associations should partner with the Family and Social Services Administration and the Indiana State Department of Health to develop a vacancy and turnover questionnaire to regularly gather information on vacancy and turnover rates for different types of positions across all long term care providers, both facility and community-based. The questionnaire could be developed by adapting surveys used in other states. The results of these questionnaires should be made available to the public in printed form and on the web at least annually. The results should be used to help the Health Care Professional Development Commission and the Department of Workforce Development project future needs for health care professionals, including long term caregivers.

- The Family and Social Services Administration should continue its efforts to develop and implement a standard methodology for determining the number of persons in need of Medicaid waiver and CHOICE services, by type of service need. The waiting lists for these programs should be updated at regular intervals and shared with the public. FSSA should aggregate service need data from the waiting lists and transmit this information to the Department of Workforce Development, the Indiana Health Care Professional Development Commission and the Indiana State Department of Health for workforce projection estimates.

Education

- The Department of Workforce Development, the Department of Education, the Commission for Higher Education, and the Indiana Career and Post-Secondary Advancement Center should work together more closely to enhance the development and expansion of the Health Occupations Education program in ways that relate to long term care, both in community-based and facility-based settings. The mission of Health Occupations Education is to provide students an academic base on which to build a career in health care. In academic year 2001-02, over 4,000 students took courses that in some way related to the health care industry. There is enormous potential for Health Occupations Education to contribute to Indiana's health professional supply, particularly in the area of long term care. The agencies named in this recommendation should facilitate partnerships throughout the state between Health Occupations Education programs and higher education institutions, health care facilities, and home health care agencies. They should make every effort to develop private and public sources of financial aid for Health Occupations Education students (e.g. approach Indiana's community foundations); develop faculty recruitment and faculty-sharing arrangements among health care providers, Health Occupations Education programs, local and regional health workforce development efforts, and higher education health-related programs; and encourage articulation between secondary Health Occupations Education programs and health-related higher education programs.

- Nursing home foundations and nursing home owners should set aside some of their funds to assist Health Occupations Education students in nursing assistant classes with the cost of transportation, uniforms, name tags, and shoes during their training. This will help to create a connection between these students and long term care. The funds could be distributed by Health Occupations Education program directors to students in need of assistance.

- CNA testing logistics and requirements should be available to the public. The Indiana State Department of Health should post on the web contact information for CNA training and testing, so that this information can be easily accessed by all seeking to be CNAs. The Indiana State Department of Health should also ask for input from CNA training providers, including educational institutions such as Ivy Tech, on "Frequently Asked Questions," so that the agency can develop answers to these questions and post them on the Department of Health website in an appropriate location.

- The Governor should as soon as possible write a letter to Indiana Congressional representatives expressing support for modifying the federal regulation that currently suspends CNA training at nursing homes under certain conditions. The letter should ask Indiana's delegation to do everything they can to revise this regulation in appropriate ways. The Governor's Office should solicit suggestions about the wording of the letter from nursing home associations and the Indiana State Department of Health.

- Higher education institutions and long term care employers should review their programs for responsiveness to the needs of the working student. Higher education institutions should make financial aid information readily available and provide financial aid counseling for students. They should also implement more part-time nursing articulation programs and develop other strategies that make it comfortable for health care workers at all levels to obtain additional education. The Commission for Higher Education should encourage these higher education efforts. For their part, employers should re-evaluate tuition reimbursement programs that require front-funding of tuition costs by students and full-time employment. The majority of students participating in focus groups for this study were working their way through school in either a CNA program or a LPN program. They described financial hardship, late notification of class and clinical rotation schedules, difficulties in accessing child care, and exhaustion created by simultaneously pursuing a full-time education and a full-time job.

- Indiana nursing programs at every level should review their curriculum to assure that they are providing adequate didactic and experiential learning related to the populations requiring long term care, and the systems and settings that deliver long term care. Programs should measure their curriculum against the model curricula developed by national organizations such as American Nurses Association, National League of Nursing/Kellogg Foundation, Association for Gerontology in Higher Education, the National Institute on Aging and other groups. Nursing programs should seek to give undergraduate and graduate students didactic and clinical experiences with aging

populations across a variety of care environments. Directors of nursing programs should instruct their faculty to learn more about long term care delivery systems in facilities and communities so that they can provide accurate information to their students about the opportunities for delivering compassionate and cost-effective care in these environments.

- The Indiana Board of Nursing and the Indiana Commission for Higher Education should look into the type of geriatric and long term care curriculum being provided at Indiana nursing programs. Research for this report raised questions about the nature of the current curriculum and whether adequate attention is being given to geriatrics and long term care. Since RNs and LPNs will be in management positions in long term care facilities, home health care agencies, and other long term care delivery settings, they should understand the populations they will be dealing with, the staff they will be managing, and the challenges posed in various long term care settings. In view of the changing demographics of the nation and the state, the Board of Nursing should evaluate the National Council Licensure Examination (NCLEX) to determine whether it includes sufficient material on geriatrics and long term care. If the NCLEX is found to be deficient by the Board in these areas, the Board should write to the appropriate bodies asking that the situation be rectified as soon as possible.

- Long term caregivers need appropriate support from other professions involved in the care delivery system. Coordination and collaboration among disciplines enhance effective service and consumer satisfaction. The Commission for Higher Education should consider a review of geriatric and long term care curriculum provided to students in social work, medicine, dentistry, dental hygiene, occupational therapy, physical therapy, and other therapy disciplines, to ensure adequacy of content and the incorporation of a collaborative approach to caregiving.

- The Governor and General Assembly should use every means available to encourage Indiana nursing programs to develop partnerships with long term care facilities and home health care agencies for the creation or expansion of learning opportunities within the nursing curriculum related to geriatrics and long term care delivery systems; continuing education opportunities for nursing home and home health care staff (including CNAs, home health aides and personal attendants); and grant applications under the federal Nurse Reinvestment Act and other federal or privately-funded grant programs.

- One of the chief bottlenecks for nursing supply in Indiana is the nursing faculty shortage. This is likely to worsen in the next few years as current nursing faculty retire or leave for higher-paying jobs in the private sector. The Indiana Health Care Professional Development Commission (HCPDC) and the Commission for Higher Education should carry out a faculty vacancy survey of Indiana nursing programs to determine current and future need for faculty, and utilize all available Indiana nursing studies. They should also review faculty development programs in other states and compile information on available grants and other initiatives for nursing faculty development, recruitment and retention. The HCPDC and the Commission for Higher Education should also develop recommendations for the most cost-effective ways for the state to fund higher nursing faculty salaries and more faculty positions, with

particular attention to those nursing programs with waiting lists. They should also recommend ways of monitoring any additional funds received by institutions to assure that these are used for the intended purposes. This information should be set out in a report as quickly as is feasible. The report should be shared with the Governor, the General Assembly, Indiana nursing programs and the general public.

- The Indiana General Assembly should give top priority to the funding recommendations of the nursing faculty development study once the study has been completed.

- The Indiana State Department of Health and the Department of Workforce Development need to convene a Direct Care Task Group that includes representatives of providers who use CNAs (preferably representatives who work with direct care workers every day, such as directors of nursing, LPNs and human resource directors), home health care agencies, CNAs, CNA educators, the State Ombudsman, a local ombudsman, and consumers. The Task Group should consider whether CNA training hours need to be increased; whether additional content should be included in training that relates to stress reduction, mental health, and other skill development areas; and the most effective ways to expand accessibility of CNA training and testing. The Task Group should review the changes made by other states to CNA curriculum and credentials, and consider whether the state should create an advanced category of direct care worker with specific continuing education requirements. This category would entitle the direct care worker to additional compensation and to add appropriate credential initials after her/his name that denote completion of the required number of continuing education hours. This would be in addition to and different from the Qualified Medication Aide. The Direct Care Task Group should also make recommendations to the Governor and the General Assembly about appropriate ways for the state, provider associations, and local communities to promote the field of direct care and to recognize the service of direct care workers.

Recognition and Appreciation

- The Governor's Office and General Assembly should create an annual Caregiver Recognition Week and call upon the state Chamber of Commerce, local chambers of commerce, community foundations, long term care providers (facility- and community-based), and educational institutions with programs to train direct care workers and long term care nurses to develop community, regional and statewide activities celebrating direct care workers (including CNAs, registered home health aides, personal attendants and homemakers), and long term care and home health care nurses. The Governor and General Assembly should also create recognition awards in cooperation with area agencies on aging, home care agencies, home health care agencies, and nursing homes for individual direct care workers so that the essential contributions of these health care personnel will be appropriately and regularly acknowledged.

Workplace

- The Department of Workforce Development needs to continue to utilize Advance Indiana funds to promote regional skills alliance forums among long term care providers in all areas of the state to create a collaborative rather than competitive climate for long term caregiver training, recruitment and retention. These regional skills alliances should also be encouraged to formulate collaborative training projects that will be supported by Advance Indiana.

- Within the regional workforce development system, alliance activities need to include a compilation of "Best Practices" in management to promote retention of long term caregivers and brainstorming about the way to generate interest in long term caregiving. Members of the regional workforce system should reach out to employees, colleges, Health Occupations Education programs, churches and other appropriate entities for ideas on how to promote long term caregiving as a career and how to honor long term caregivers in their communities.

- The Department of Workforce Development should chair a work group consisting of educators, long term care providers (facility- and community-based), and direct care staff representatives (facility- and community-based), to discuss the formulation of a Career Lattice, which sets out vertical and horizontal career paths across the continuum for the advancement of workers from housekeeping positions to RNs. The lattice should articulate specific educational requirements for vertical movement but it should also set out the recommended additional competencies for lateral movement and continuing education for direct care workers and licensed personnel. The notion of a lattice, rather than a ladder, is fundamental to success. Long term care does not need more hierarchy.

- Long term care provider associations should make every effort to encourage their members to distribute information to their staffs on Hoosier Healthwise, the state's Children's Health Insurance Program. The Indiana State Department of Health should also distribute information on the program through its provider newsletters, its website, and the CNA, QMA and home health aide registries, as has been done in other states. The Family and Social Services Administration should provide Hoosier Healthwise materials to all Area Agencies on Aging to distribute to contracted providers under Medicaid waiver and CHOICE programs. This might help increase access to children's health insurance for the children of direct care workers who otherwise may not have it.

- The nursing home associations, the Family and Social Services Administration, and the Indiana State Department of Health may need to review the minimum staffing ratios and wage passthrough methodologies adopted by other states, and consider how these might be beneficial to Indiana. They should also develop appropriate quality measures that will be incorporated into the nursing home evaluation for purposes of assuring that any increase in Medicaid nursing home rates will be used for wage or benefit increases or other activities that will improve staffing ratios and quality of care. Any proposed staffing ratio methodology should incorporate consideration of adequate funding, case mix sensitivity, and local labor market variations. A strong monitoring system should be enacted alongside any increase, to make sure that the funding goes exactly where the Commission on Caregivers believes it should go: into the pockets of nursing and direct

care staff. If facilities and agencies cannot document this to the state's satisfaction, they should be required to pay back any funds received as part of the initiative and should also be assessed financial penalties. This should not be construed as a recommendation for minimum staffing ratios, but rather research into staffing alternatives.

- As with nursing home rates, Medicaid rates for home care and home health care waiver services are too low. At their current levels, they discourage providers from taking eligible clients. They also make it difficult for providers who accept waiver clients to pay a decent wage, offer adequate benefits, and reimburse transportation costs. The rates should be increased in such a way as to remove the disincentive for delivering waiver services and to encourage development and retention of a high quality workforce for community-based care. The Governor's Commission on Home and Community-Based Services or one of its task forces, should work with home care providers, home health care agencies, Area Agencies on Aging, and the Family and Social Services Administration to develop a waiver and CHOICE rate methodology that ties the payment of a higher Medicaid waiver rate to a provider's offering a basic standard package of wages, benefits, and travel reimbursement.

- The Governor's Commission on Home and Community-Based Services Transportation and Employment Task Force should consider the transportation and employment issues of direct care workers needed for community-based care. Transportation inadequacies in rural areas should be given special attention.

Chapter I

Long Term Care Workforce Development: Challenges and Opportunities

All over the nation, people are coming to terms with increasing demand for long term care services, much of it driven by growth in the aging population. If demographic data are correct, the demand for these services will continue to climb. By 2025, Indiana's 65 and older population is expected to increase to over 1.2 million from its current 753,000, making it the second-largest age group in the state (see Appendix C, Charts 1 and 2). Within this population group, it is estimated that at least 60 percent of people 75 and older will require some type of long term care.[4]

Elderly persons are not the only ones in need of these services, however. Nationally, about 12.8 million Americans reported long term care needs in 1995, if measured by the need for assistance with activities of daily living or instrumental activities of daily living.[5] About 57 percent of these people were over 65, another 42 percent were younger adults, and about 3 percent were children. It is estimated that a substantial portion of them rely on unpaid caregivers for their assistance, but a significant number, especially among seniors, rely on nursing home care.[6]

In Indiana, it was estimated in 1998 that there were 978,099 persons over age 60, 240,000 of whom experienced some limitation in two or more activities of daily living. Another 136,000 Hoosiers under age 60 were limited in these activities.[7] As of May 2002, there were about 40,159 persons receiving long term care in nursing homes, about 68 percent of them requiring state assistance. There were another approximately 37,000 persons being served in the community who qualified for state-assisted long term care services. Current population statistics show that a much greater percentage of Indiana's rural counties have higher proportions of elderly persons than urban counties: 90 percent of the state's rural counties have 12 percent or more of their population in the 65 and older age bracket, compared to 66 percent of the state's urban counties (see Appendix D).[8] Indiana must take this into account as it plans for the future, since rural counties frequently do not have the human resources, transportation infrastructure or developed health care delivery systems of urban counties.

Developing a workforce to respond to long term care demand presents a considerable challenge, and adapting the care delivery process to accommodate consumer choice adds to the

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[4] Indiana Association of Homes and Services for the Aging, "The Staffing Crisis in Indiana's Continuing Health Care System, A Comprehensive Analysis and Recommendations" (Indianapolis, Indiana), 2001, p. 12.
[5] Activities of daily living (ADLs) include such things as bathing, dressing, eating or other personal care, and instrumental activities of daily living (IADLs) include meal preparation, cleaning, shopping, medication management and money management.
[6] Stone R, Weiner J, Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis, (Washington, D.C.) 2001, pp. 10-11.
[7] Indiana Family and Social Services Administration (FSSA), "Community-Integrated Personal Assistance Services and Supports Grant,", p. 1, http://www.in.gov/fssa/servicedisabl/olmstead/passnar.html.
[8] The Indiana State Department of Health definition of "rural" has been used. This means that a county has not been designated as part of a Metropolitan Area by the federal government, and the county's largest city has a population of less than 10,000. By this definition, there are 42 rural counties in Indiana.

complexity of the endeavor. However, within the challenge, there is enormous opportunity. The growing need for long term care represents an amazingly stable source of jobs long into the future. When compared to recent problematic fluctuations in other economic sectors, long term care presents a favorable alternative. Unlike the chase after out-of-state corporations, long term care workforce development involves the state investing in itself to take care of its own, simultaneously promoting an ethic of service and creating networks that promote career advancement and economic growth. Indiana should harness the expanding demand for long term care services, fostering employment while providing compassionate and professional caregiving to vulnerable populations.

Statewide Activities

To a degree, individual providers, educational institutions, regions and counties, and some state agencies are already moving toward a more progressive view of long term care as a source of jobs and professional advancement. State leadership needs to take its cue from these constituents: their approach is the key to Indiana's long term caregiver supply and its economic future.

Secondary Education

Pioneering efforts to increase the caregiving workforce are already taking place at the secondary educational level. In 2001-02, vocational program enrollments in health-related areas were up to 4,054 (see Appendix E). As the overall numbers increase, the Indiana Department of Education (DOE) is working to revamp its nursing assistant curriculum so that even more students will pursue this particular educational path. They have added material on home health, infant and child care, and public health to the standard curriculum to fill out the picture on health care career options. DOE has also encouraged Health Occupations Education (HOE) teachers to establish partnerships with nursing homes in which the schools will teach the 30 classroom hours required for Certified Nurse Aide (CNA) training, while selected nursing homes will be responsible for the 75 clinical hours and the state testing for CNA certification. With 41 nursing assistant programs at high schools or career centers around the state, there are real opportunities for providing exciting experiences that will interest students in long term caregiving. These experiences will be enhanced by the recent implementation of Career Academies at some Indiana high schools. These academies will create learning communities within the schools focused on different topic areas, including Medical and Allied Health. Through the Career Academies, students with similar interests will have the chance to learn from each other and from area employers in their field.

In another promising development, high schools and Ivy Tech campuses have established agreements allowing students to count some of their high school HOE courses toward a degree or technical certificate from Ivy Tech. Schools in Columbus, Fort Wayne, Gary, Indianapolis, Kokomo, Lafayette, Muncie, South Bend, and Terre Haute are involved in this initiative, which includes courses ranging from general health occupations curriculum to nursing assistant, child development, early childhood education, medical records management, dental assisting, medical terminology, CPR and medical ethics. This type of arrangement effectively gives high school students additional incentive to pursue a career in caregiving.

Higher Education

Further along the caregiving path, Indiana higher educational institutions are implementing efforts to assist nurses who wish to enhance their skills and further their careers. Recent years have seen the development of articulation agreements between Ivy Tech and multiple other Indiana higher education institutions, including IUPUI, Ball State, University of Southern Indiana, Indiana State University, Purdue-West Lafayette and Purdue-Calumet. These agreements ease the way for associate degree registered nurses (RNs) to earn their bachelor's nursing degree. Ivy Tech has its own programs to articulate licensed practice nurses (LPNs) to RNs through associate degree programs, and there are also agreements in place with IU to facilitate LPN advancement.

Some Ivy Tech campuses have gone even further in smoothing the career path for their graduates. For example, Ivy Tech-Kokomo and IU-Kokomo concluded an educational "escrow agreement" in 1999 that allows currently enrolled students and graduates of the Ivy Tech's LPN program to directly transfer the credits from their one-year technical certificates toward associate and bachelor's degree programs at IU-Kokomo. The agreement differs from traditional transfer arrangements in that IU-Kokomo will transfer all the technical certificate credits toward the more advanced degrees following an 8-week transition course, rather than looking at each course in the technical certificate program separately. It will take less than one year for LPNs qualifying for the escrow arrangement to be eligible for the Indiana State Board of Nursing licensure examination as a RN. Ivy Tech-Kokomo and IU-Kokomo are also collaborating with hospitals and long term care facilities in Fulton, Cass, Miami, Wabash, Howard and Tipton counties in a Department of Labor Technical Skills grant proposal that would expand training programs in nursing (CNA), respiratory therapy, radiological technology, and surgical technology.

Department of Workforce Development

Additional partnerships between health care facilities and educational institutions are being fostered by the Indiana Department of Workforce Development (DWD). Through its Advance Indiana program, DWD has actively assisted health care providers throughout the state in upgrading the training level and professional credentials of caregivers, resulting in greater expertise for employers, better care for Hoosiers, and higher-paying jobs for employees. In Southwest Indiana, DWD is helping 5 health care employers articulate 18 current employees into LPN positions by sharing the cost of training with the employers. At the end of the project, the employers will have 18 additional nurses to help deliver care and the new nurses will be earning as much as $3.00 more per hour than in their previous positions. They will also be able to go on to earn an associate degree if they desire.

In East Central Indiana (Blackford, Delaware, Henry, Jay and Randolph counties), Advance Indiana is providing half the support for training 52 individuals in care delivery: 17 technicians, 27 LPNs, 6 associate degree nurses and 2 bachelor's level nurses. The effort will benefit 24 different employers (facility-based long term care, home health care, acute care, hospice care, and individual physician providers), increase annual wages for participants by $3,000-$6,000, and involve both Ivy Tech and Ball State. DWD has also assisted in supporting Ivy Tech training for direct care staff who will provide help to individuals with developmental disabilities. There is a similar project in the southeast region of the state.

In Indianapolis, DWD is assisting in training for Clarian Health System and St. Francis Hospital for acute care RNs and surgical technicians, and in Hancock county, they are helping with the costs of training radiological technicians and associate degree nurses in acute care settings.

Indiana Family and Social Services Administration (FSSA)

Like DWD, FSSA has begun to train individuals for the health care workforce and in addition, is also exploring new ways to deliver long term care. With regard to workforce development, FSSA's IMPACT program has supported training costs for Temporary Assistance to Needy Families (TANF) recipients who wish to work in health care and whose training is undertaken by individual health care employers around the state, including nursing homes. Under the IMPACT program, contract dollars can go for training costs, job placement and supportive services (the cost of a uniform, car repair or transportation reimbursement). According to FSSA and local IMPACT consultants, a number of individuals have been trained as CNAs this way. Unfortunately, FSSA tracks these dollars by individuals, not by type of training or employment, and so it is difficult to determine how many individuals have undergone health workforce training of some sort and whether they have remained in their positions. It would help to be able to track the use of state and federal dollars by industry, as well as to learn more about how these new trainees fared in their jobs.

FSSA is also assisting selected health care employers in upgrading their workforce. The agency has recently embarked on a project with Clarian Health in Indianapolis to train CNAs to meet the staffing needs of Clarian Health and other area health facilities. Those eligible for the program will be entry-level employees of Clarian hospitals and outpatient facilities, employees of hospitals or health care facilities serving as CNA training affiliates or people seeking Clarian employment or its affiliates. The program has educational and background requirements, and much of the training will take place in the unit where trainees will ultimately work. Participants will earn a training wage of $7.00/hr while enrolled, and their salary will be increased upon completion of the program. Clarian expects to train about 10 students every 6 weeks and to have 5 six-week sessions per year, for a projected total of 50 graduates per year. While this is the first attempt by FSSA to work with a single employer in the health care field for sustained production of employees, the agency has expressed interest in expanding this type of effort, provided employer involvement is as assured as in Clarian's case. According to FSSA, this involvement is a key element for success.

FSSA is heavily involved in another health-care related effort: expanding long term care in the community for individuals who are elderly or disabled.[9] The agency has written several federal grants to support this effort, including grants related to Community-Integrated Personal Assistance Services and Supports (Community PASS), Nursing Facility Transition, and Real Systems Choice. The objective of the grants is to offer consumers who are elderly and disabled

[9] This initiative is principally the result of the 1999 decision in Olmstead v. L.C., in which the U.S. Supreme Court decided that states might be in violation of the Americans with Disabilities Act if they provide care to people with disabilities in institutional settings even though they could be appropriately served in a home or community-based setting. While the subject matter of the case specifically concerned individuals with disabilities, the decision has implications for all populations in need of long term care, including the elderly.

more long term care choices than institutionalization, and to transition some residents living in facilities back into the community to receive services through Indiana's Medicaid waiver and Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program. To provide input into this effort, the Governor has created a Commission on Home and Community-Based Services, with 5 task forces (Transitions, Community Personal Assistance Services and Supports (PASS), Children at Risk, Transportation and Employment, Housing) and a Consumer Advisory Committee. Needless to say, training professionals to deliver care in a community setting presents both a challenge and an opportunity in terms of health workforce development.

The Role of the Governor's Commission on Long Term Caregivers (COC)

The excitement of the initiatives described above has yet to be reflected in the state's overall approach to long term caregiving and those who provide it, however. In recent years, Indiana's principal focus has been on stemming costs for the populations needing long term care. The regenerative opportunities in terms of job creation, economic development, promoting an ethic of service and celebrating the lives of those who have gone before have largely been ignored. Put more directly: taking care of the growing numbers of people who are aging and disabled has been approached in recent years as a costly burden, both in terms of dollars and regulation. This has created tension between government and providers, and led to an atmosphere in which cost-cutting and regulation have threatened to entirely obscure caregiving itself. Local resources have been strained and access to care has diminished, as static or growing waiting lists for Medicaid waiver and CHOICE demonstrate.

In this report, the COC sets out a new path for Indiana related to long term caregivers, and asks the state's leaders and the long term care provider community to collaborate in an all-out effort to look at both sides of the balance sheet when it comes to long term care. On one side of the balance sheet are the costs of caring for the populations that need long term services. On the other side of the balance sheet are the dollars that every person and business employed in long term care contribute to the state, directly through taxes but also indirectly by pursuing their lives and livelihoods in Indiana. The issues in long term caregiving can best be negotiated by looking at the totals on both sides of the balance sheet as related phenomena, linked by a human equation. A dollar's cost on the long term care side is a dollar's investment in a working person and her/his family, in capital projects, in localities throughout the state, in activities related to other products of the health care industry (e.g. pharmaceuticals, medical devices, etc.), and in responsible regulation that improves quality. Most importantly, that dollar is an investment in someone who spent a lifetime investing in Indiana.

Every stakeholder in the long term care discussion, whether public or private, has to take responsibility for maintaining a healthy balance sheet. This will require changes in vision, in communication, and in practice. Providers and state agencies need to regard long term care as a collaborative effort to maintain or elevate the quality of life for consumers whose days and/or physical resources are limited. An essential part of that collaboration requires that caregivers earn decent wages and have ample staffing support. It also requires that caregivers have opportunities to pursue additional education and feel that their contribution is valued.

This report is a beginning: it sets out the basic scaffolding needed to increase the supply and stability of the long term care workforce, with the goal of enhancing the overall economic

stability of Indiana. Implementation of the COC's recommendations will require further discussion and action related to data, economic and social infrastructure, educational opportunity and continuing advancement, and potential roles for stakeholders. The report will not answer every question, but it will propose some strategies for working toward the answers. Where this report ends is where the real work begins, and everyone has a part to play.

Chapter II

What We Know and Don't Know about the Long Term Caregiver Workforce[10]

As the previous chapter details, Indiana has initiatives at the state, local and regional levels to promote health occupations and career paths related to long term care. However, these efforts need additional data, inter-programmatic links, and sustained support to be successful.

While there is no question that Hoosiers needing either community-based or facility-based long term care will increase in future years, there is too little information on how many professionals should be trained to address consumer needs. The COC found that Indiana has information for some professions and occupations that are crucial to the individuals needing long term care, but there is a great deal missing. Data are lacking on the "supply side" of the equation (numbers of professionals actively giving care, and the numbers actually coming into the workforce from the state's training programs), and also on the demand side (current vacancies in long term care facilities, home health care agencies and home care agencies, and anticipated need, as well as what these workers desire in a job setting). This chapter describes available information on RNs, LPNs, CNAs and Qualified Medication Aides (QMAs), and highlights what Indiana needs to know to plan for the future.

Registered Nurses (RNs)[11]

While long term care facilities do not make extensive use of RNs for the delivery of hands-on care, the RN role in long term care delivery is crucial, whether the care is facility or community-based. In nursing homes, RNs are found in staff leadership and management positions, including that of the Director of Nursing, and they play a significant role in resident assessment. For home health and hospice care, RNs are a vital component in terms of supervision and case management. A number of home health agencies or hospital-based home health units are headed by RNs. As Indiana's long term care population grows, adequate numbers of well-trained RNs need to assume these leadership and supervisory positions.

Findings from the Indiana Registered Nurse Survey

Indiana has extensive information on its registered nurse (RN) population for 1997, thanks to the survey efforts of the Indiana Health Care Professional Development Commission (HCPDC), funded by the Indiana State Department of Health.[12] This information will be updated in the coming year based on the RN survey conducted in 2001. The 1997 data

[10] The authorizing statute for the COC defines "long term caregivers" as "certified nurse aides, licensed practical nurses, and registered nurses employed in health facilities, home health care, and other community-based settings." See Appendix A for a copy of the authorizing statute.

[11] In Indiana, completion of either an associate degree in nursing (2-year degree) or a bachelor of science in nursing degree (4-year degree) counts toward licensure as a RN, along with other licensing requirements.

[12] See Indiana Health Care Professional Development Commission (HCPDC), Indiana Registered Nurse Survey, 1997 (Indianapolis, Indiana), 2000. An essential partner in the RN survey effort in addition to the HCPDC was the Indiana Health Professions Bureau (HPB). The survey was conducted using the license renewal process for RNs. The RN survey was repeated in a modified format in 2001, and the data will be forthcoming in the next year.

showed a potential deficit of RNs in general, with a higher probability of shortage in long term care facilities/units.

The 1997 survey also showed that an active license does not necessarily reflect a practicing professional. Of the 69,893 persons possessing an active Indiana RN license in 1997, about 89 percent responded to the RN survey (62,230). Of those who responded, only 38,721 (62 percent) were actively practicing nursing in Indiana. Retired and temporarily inactive RNs comprised 8,992 (14 percent) of respondents, another 2,410 (4 percent) were employed in health care but not in nursing, and another 692 (1 percent) were employed in areas not related to health care or nursing. Yet another 6,838 (11 percent) were employed in nursing in locations other than Indiana.[13]

As for RNs in long term care, the 1997 RN survey noted that 6,699 RNs (17 percent) were working in some type of long term care environment, including home and hospice care, compared to 22,480 (59 percent) in acute care settings.[14] If ages and education of RNs across settings are compared (see Appendix F), it is clear that in 1997, long term care facilities and/or units were staffed with nurses who were significantly more likely to be diploma or associate degree RNs, and who were also much more likely to be approaching retirement age (55 or over) than RNs in acute care or home and hospice care. These data appear to confirm the anecdotal information derived from COC focus groups and interviews indicating a shortage of RNs in long term care facilities in recent years. A more precise measure of the shortage, however, can only be derived through a statewide vacancy survey. Currently, Indiana has no such tool, either for long term care facilities or home health and hospice care. As the state's population ages, it will be crucial to understand where and at what levels vacancies are occurring.

Indiana Licensing Data

Even though Indiana lacks data to profile RN vacancies in long term care delivery, there is compelling evidence that Indiana must immediately respond to the nursing shortage on all levels. Data indicate that fewer new RNs are being licensed each year, both through examination and through endorsement (see Appendix G).[15] Licensing data from the HPB show that between 1990 and 2001, RNs licensed by examination (a proxy measure indicating in-state education) peaked in 1994, when 2,776 RNs were licensed this way. In 2001, 1,696 were licensed by examination, a drop of 39 percent. RNs licensed by endorsement (a proxy measure for practicing RNs who come from out-of-state) reached a peak in 1993, when 1,738 obtained an Indiana RN license through endorsement. In 2001, 1,494 were licensed in this manner, a drop of 14 percent. If these trends continue, Indiana will become increasingly dependent on outside sources for its RN supply. With a nationwide nursing shortage, this is definitely not to the state's advantage.

[13] HCPDC, Indiana Registered Nurse Survey, 1997, pp. 3-6, 10, 11.
[14] HCPDC, Indiana Registered Nurse Survey, 1997, p. 29.
[15] Licensure by exam indicates that the candidate satisfactorily completed a state-accredited program of registered nursing that requires a high school diploma, or an equivalent nursing education program in a foreign country, and passage of the National Council Licensure Examination (NCLEX). Licensure by endorsement indicates that nurses currently licensed in other states, Canada, or other foreign countries met the endorsement requirements in these respective categories of the Indiana State Board of Nursing.

Sources of Indiana's RNs

Indiana has in the past derived the bulk of its RNs from in-state educational institutions. Data from the 1997 survey indicate that almost 78 percent of all RNs practicing in Indiana in 1997 received their basic nursing education from an Indiana program, including diploma nursing programs that are now defunct.[16] In recent years, however, it has been difficult for Indiana nursing programs to graduate enough nurses to fill all available positions. As noted by focus group participants and persons interviewed for this report, nurses are now utilized in a wide variety of areas in addition to direct health care, and this has considerably increased demand. Nursing programs may strive to meet these needs, but they are constrained by a lack of resources and what some nurse educators describe as a general lack of interest in nursing as a career and/or a lack of qualified candidates. Nonetheless, data collected by the COC indicate that at least 14 of Indiana's associate degree nursing programs (ASN/ADN) and 3 of Indiana's bachelor of science in nursing (BSN) programs have waiting lists and need additional resources to accommodate all qualified candidates (see Appendix H and I). Licensed practical nursing (LPN) programs have even more extensive waiting lists of qualified candidates (see Appendix J).

In recent years, a number of BSN programs in the state have developed transitional tracks to enable associate degree RNs to gain a BSN. At least 16 BSN programs now have these types of tracks.

But there are important questions that we cannot answer at this point: how many RNs from Indiana nursing programs actually enter the workforce and how long do they remain working as nurses? Given the figures from the 1997 Indiana Registered Nurse Survey, it appears that a significant proportion of nurses have left the nursing field. How extensive have these losses been in recent years, and to what are they due? The Indiana Commission for Higher Education has data on the RN graduates of public institutions (and some private) in its database. It would be possible to link these data with HPB and RN survey data to get a good sense of how many graduates go on to practice nursing and how many have remained in the nursing workforce over time and in what types of settings. While a small-scale analysis of this type may be incorporated in the HCPDC's 2001 RN survey, a large scale examination of these trends would be extremely helpful for the state.

[16] HCPDC, Indiana Registered Nurse Survey, 1997, p. 34.

Perspectives on the RN Shortage in Long Term Care

Persons interviewed for this report and focus group participants often commented on the shortage of licensed nurses, both RNs and LPNs. Some also voiced concern about the training of RNs with regard to long term care. In some provider focus groups, there was a feeling that the state's nursing programs did not adequately expose students to facility-based long term care or home health care, or that the experiences provided were too diffuse to actually teach much about the populations needing long term care, the various settings in which long term care is provided, and the regulations governing different long term care delivery systems. As one nursing consultant in the field put it, "You need to let students get acquainted with the nursing home environment, develop a relationship with a patient over time, and acquaint them with what to expect. It is a great environment to learn continuity of care." She contrasted this type of longitudinal learning experience with one that exposed nursing students to long term care late in their education and consisted of a rotation only one day a week. Another informant commented that, "Educational institutions need to have educators familiar with long term care and the regulations. They also should teach that acute care nurses and long term care nurses are equal."

Discussions with some nurse educators, as well as discussions in the literature, raise curricular concerns as well.[17] At least one associate degree nursing program in the state launched a full-scale curriculum revision with the goal of elevating NCLEX pass rates. Because the NCLEX apparently has relatively little geriatric content, a decision was made to entirely eliminate geriatrics from the ASN program, in spite of projections that approximately 46 percent of all registered nurses will give direct care to elderly persons. Both the federal government and private foundations are seeking to remedy the curriculum deficit in geriatrics by offering grants for the enhancement of geriatric curriculum and/or faculty development. At least three Indiana BSN programs have qualified for these grants: University of Indianapolis and Marian College have received federal grants, and Valparaiso University has received a grant from the John A. Hartford Foundation.[18]

Other provider focus group participants echoed the importance of training RNs in the nursing home environment from a recruitment perspective. One nursing home administrator commented on the number of exceptional quality facilities and the fact that nursing home nurses can make a significant positive impact on the lives of residents. This administrator indicated that the most effective recruiting tool was RN students' word of mouth after having a good firsthand experience: "students who work in our building . . . . decide 'Wow, it wasn't

[17] US Department of Health and Human Services, Health Resources and Services Administration, A National Agenda for Geriatric Education: White Papers (Rockville, Maryland), 1995, pp. 181-183.

[18] Both the University of Indianapolis and Marian College received Geriatric Nursing Knowledge and Experience in Long Term Care Facilities grants, which are designed to help schools of nursing provide hands-on clinical training for senior nursing students caring for elderly individuals (see http://newsroom.hrsa.gov/releases/2002releases/nursegrants.htm). Valparaiso University's Hartford Foundation grant has as its objectives the implementation of an interfaith community-based curriculum for baccalaureate nursing students, integration of more geriatric nursing content throughout the courses each semester, the addition of a 3-credit required course in gerontological nursing to be taken during the junior or senior year, and the development of workshops for faculty to assist them in enhancing gerontological content and meaningful experiences for students. Other Hartford awardee initiatives can be viewed at http://www.themeasurementgroup.com/JAHFundergraduate.htm.

what I thought it would be like.'" In general, nursing home administrators felt that partnerships with nursing programs were crucial for recruiting future staff. They also observed, however, that nursing homes did not often have resources comparable to those of hospitals for sponsoring faculty positions within nursing programs or mounting aggressive recruitment campaigns. This is because nursing homes have a much higher Medicaid census than hospitals and therefore have far tighter budgetary constraints.[19]

Some administrators felt that nursing program curriculum was weighted in favor of acute care, and that there was little chance of recruiting RNs without an opportunity to expose them firsthand to long term care. Some also cited statements made to students by nursing program faculty to the effect that if they went into long term care, they would "lose their nursing skills." As one provider representative pointed out, long term care may not offer the excitement of an acute care environment but it does offer abundant opportunities to exercise nursing skills such as patient assessment and counseling, as well as case management. Another provider pointed out that nursing programs had yet to realize the informatics and case management potential of the Minimum Data Set (MDS) system used by the federal Centers for Medicare and Medicaid Services (CMS) to monitor costs and quality in the nursing home setting.

Nursing home administrators interviewed for this report were quick to acknowledge that facility-based long term care was not for every RN. Long term care RNs have to know how to value people; handle stress; be good managers, problem-solvers and communicators; and feel proud of their work in spite of colleagues' criticism of their choice of long term care. They also have to know how to handle the general public, and even families who may not appreciate how important and challenging it is to make persons who are elderly and/or disabled feel respected, comfortable and cared for. Administrators were also aware that their ability to match acute care RN salaries was limited, given the limited reimbursement sources for long term care. Based on data from the 2000 federal National Sample Survey of Registered Nurses, it is fair to say that RN salaries in long term care are anywhere between 31 percent and 12 percent below those in acute care, depending upon the position.[20] As one nursing home administrator put it (herself a RN), "If an RN goes into long term care, it isn't for the money."

Educators, for their part, indicated that experiences in long term care facilities, while invaluable in some respects, sometimes could have a downside. If students encounter a short-staffed facility, where staff find it difficult to meet residents' needs in a timely way, or where staff feel pressured from paperwork, and/or unappreciated by administration, families and surveyors, the staff can convey a negative impression to a student. Some educators felt that it was a good idea to teach basic nursing skills in a long term care setting, exposing nursing students to long term care while teaching basic nursing skills. Other educators felt that many of the elderly in nursing homes present complex cases that are beyond the rudimentary knowledge of beginning nursing students.

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[19] According to the FSSA Office of Medicaid Policy and Planning, there was a statewide average nursing home Medicaid census of 67.9% as of May 2002. According to the Indiana Hospital&Health Association, 13.7 percent of 2001 hospital discharges were Medicaid patients.

[20] US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, The Registered Nurse Population, Findings from the National Sample Survey of Registered Nurses, March 2000, Table 26, "Annual Average Earnings of Registered Nurses Employed Full-time in Their Principal Nursing Position, by Field of Employment and Type of Position," p. 64.

RN Education in Long Term Care and Geriatrics

The COC's curriculum questionnaires show that of the state's 25 ASN/ADN programs, 8 require long term care curriculum in the classroom, while 16 require clinical curriculum in this area (Appendix I). Whether the classroom and/or clinical curriculum is a block experience or integrated throughout is unknown unless programs specified this on their questionnaire. Given provider and professional comments on the importance of a block and/or longitudinal experience, as opposed to a more intermittent experience, this may be an important follow-up question. Eighteen programs use a long term care setting to teach basic nursing skills. Few programs incorporate a clinical experience in home health care, however.

It also should be noted that some of the ASN/ADN programs have transitional tracks that allow LPNs to obtain the ASN/ADN degree more easily. In the case of some of these programs, the ASN/ADN program counts the LPN's long term care curriculum toward the ASN/ADN, and therefore does not repeat the long term care experience.

Based on the questionnaire responses, it appears that the most pressing need at ASN/ADN programs is for more clinical faculty, followed by more academic faculty, and then more clinical training locations. Programs also cite the need for more classroom space, among other requirements.

In terms of BSN programs, the COC's questionnaires show that almost all responding programs incorporate long term care/geriatrics in their classroom hours, although one program was careful to distinguish between curriculum content in geriatrics as opposed to long term care (see Appendix H). All but 5 of the 20 BSN programs responding to the COC's curriculum questionnaire require a clinical experience of some kind. As with the ASN/ADN programs, it is unknown whether this is a block experience or a rotation integrated with other experiences. Fifteen of the BSN programs incorporate a home health care experience as well, generally in the later years of the program.

Like the ASN/ADN programs, some of the BSN programs cite needs for academic and clinical faculty, as well as additional clinical training locations. Additionally, some programs note shortages of classroom space and lab space. The proportion of BSN programs with waiting lists of qualified candidates was far smaller than that of ASN/ADN programs.

Licensed Practical Nurses (LPNs)

Little is known about the LPN population in Indiana. While the Health Professions Bureau (HPB) had a database of 24,164 active licenses in 1999, the Bureau of Labor Statistics projected in 2000 that the total number of LPNs employed statewide was 18,830, which is substantially less than the number of active licenses.[21] As of July 2002, the HPB database showed that 26,651 persons possessed a current Indiana LPN license. No funding has been made available for a LPN survey similar to that conducted for RNs, so there are no hard state-level data related to actual numbers of practicing LPNs, or the types of settings in which they

[21] Licensing figures from May 1999 HPB database. Bureau of Labor Statistics data from http://stats.bls.gov/oes/2000.

practice. Based on interviews, focus groups, and the national literature, it is fair to conclude that nursing homes rely a great deal on LPNs, although hospitals report using greater numbers of these professionals in recent years to make up for the shortage of RNs. Fewer LPNs tend to be employed in home health care.

What we do know is that, like the RN population, the number of persons seeking an Indiana LPN license each year is declining. LPNs licensed by examination peaked in 1993 at 1,419. In 2001, 964 LPNs were licensed by examination, a drop of 32 percent. LPNs licensed by endorsement reached a high of 458 in 1993, but in 2001, only 326 were licensed in this way, a decline of 29 percent (see Appendix G.)

Sources of Indiana LPNs

According to the Indiana Health Care Professional Development Commission's 1999 Annual Report, the principal source of LPNs in recent years has been Ivy Tech. Using HPB data, the HCPDC concluded that about 71 percent of the LPNs licensed from 1993-1999 were educated by Ivy Tech, with the other 29 percent coming from Vincennes University, the Anderson School of Practical Nursing, J. Everett Light School of Practical Nursing, Horizon Career College, Marion Community College, St. Anthony Medical Center (Crown Point) and the Kokomo School of Practical Nursing (which has now been taken over by the Ivy Tech-Kokomo program). Private and community colleges in neighboring states also contribute to Indiana's supply of LPNs.[22]

Based on COC questionnaires sent to all LPN programs in the state, there are waiting lists of qualified candidates at a number of LPN programs, ranging from a high of 157 at Ivy Tech-Columbus to a low of 2 at Vincennes (see Appendix J), and totaling over 500 qualified candidates. Of the 19 LPN programs responding to the COC's capacity survey, 13 report waiting lists, and 3 report that while no waiting list is maintained, excess candidates are put into the next applicant pool or reapply.

Program directors attribute the waiting lists to shortages of teaching resources, including academic and clinical faculty, a lack of classroom space, clinical training sites, and lab space. Put simply, Indiana LPN programs do not have the resources to produce more LPNs, despite escalating demand on the part of providers.

LPN Student Perspectives

Other reasons for LPN waiting lists emerged from focus groups of current LPN and CNA students at Ivy Tech conducted by the COC researcher. According to CNA students who wish to attain the RN someday, the LPN is a necessary step in their academic advancement. For these students, supporting their families is a paramount consideration, and virtually none of them could think about being full-time students without significant financial aid. Their intent is to work as CNAs while training to be LPNs, and then to work as LPNs to support their ASN education. This approach was validated by the responses of the LPN student focus group, many of whom were working as CNAs in nursing homes to pay for school and family expenses. Both

[22] Indiana Health Care Professional Development Commission (HCPDC), 1999 Annual Report (Indianapolis, Indiana), 1999, p. 21.

groups commented on the lack of financial aid for students wishing to pursue nursing or other health-related career paths, and they also commented on the difficulty of obtaining what little scholarship funding was available.

Students also spoke about the challenges of working and going to school full-time. Some described the lack of adequate and affordable day care, others talked about the necessity of having to cram for LPN examinations because there was no part-time option in the LPN program they were attending. A number of them were sincerely distressed that they were making lower grades than they thought themselves capable of but they felt they had no choice but to work their way through their education. One LPN student described her typical week as 5 days spent in school with two 12-hour shifts on the weekend as a CNA at a nursing home. She wondered aloud where she was supposed to find the time to study, with so little time left after job responsibilities and her family obligations. Students voiced frustration that Food Stamps, day care and health insurance seemed to be available for welfare-to-work populations, but nothing seemed to be available for working people who wanted to advance themselves. Other students noted that while tuition reimbursement programs were sometimes available from employers, students nonetheless were expected to fund their education "up-front" and then be reimbursed according to the grades they made. Furthermore, it was required that one remain a full-time employee while getting the additional education. This meant carrying a full workload and a full class load. Almost all students agreed that educational institutions needed to better inform students about financial aid opportunities.

Students also described difficulties with scheduling work around their clinical rotations, and remarked that educational institutions needed to realize that employed students, particularly those with children, needed sufficient notice as to class schedules and clinical rotation schedules so that they could make the necessary work and child care adjustments. Since many of the LPN students were working as CNAs in nursing homes, their absence from work for a clinical rotation elsewhere created a hardship for the facility and the residents unless sufficient notice was received.

It should also be noted that the majority of the LPN students in the focus group intended to go beyond the program in which they were enrolled. Most wished to become RNs (associate degree level) but some aspired to Master's degrees in nursing.

LPN Education in Long Term Care and Geriatrics

All LPN programs responding to the COC's questionnaire require classroom and clinical hours in long term care (see Appendix J). However, just as with the RN programs, the nature and extent of the long term care/geriatrics curriculum may vary from program to program. Some programs may have block classes and experiences, while others may have a more integrated curriculum. Some may require significant long term care/geriatric curriculum and others may require as little as one 3 credit course, with more time given to obstetrics/pediatrics, even though LPNs are probably used with greater frequency by long term care providers than providers of other services. This may be changing, however, with Indiana hospitals' increased recruitment of LPNs.

A few LPN programs offer experiences in home health care, usually as a selective or elective, but some appear to require such an experience (see Appendix J). A focus group of

home health care providers from around the state felt that LPN students were not always well-prepared for home health care. Some providers felt that educational preparation was lacking, that students did not have adequate assessment skills, lacked knowledge regarding drugs and had too little experience doing basic tasks like giving a bath. Others felt that perhaps the quality of student was not what it was 10 years ago. Some felt that in the past, more was expected of LPN students in terms of skills but that it had now been "hammered into them" that a RN must supervise everything they do. In their view, LPN programs had followed suit in their curriculum because they are training LPNs for the current environment. It was observed that the academic world needed to learn something from the reality of the work world. Some members of the focus group observed that access to care was affected by the willingness to do certain tasks and a knowledge of how to do them.

The group also touched on the idea that because the LPN was sometimes perceived as simply a transitional step to the RN, LPN programs might be providing less training for licensed practical nursing as a career in itself, with its own special tasks and skills. They particularly noted that in home health care, the LPN trained for pediatric ventilator cases is highly valued and difficult to find in urban areas like Indianapolis.

Nursing Faculty Shortage: Jamming the Pipeline

The COC questionnaire data (Appendices H-J) leave no doubt that one of the things jamming the nursing education pipeline in Indiana is a shortage of nursing faculty.

Indiana Nursing Programs in Need of Faculty, 2002

	Need Academic Faculty	Need Clinical Faculty	Total Programs Responding to COC Capacity Questionnaire	Total Programs
BSN	11	12	20	20
ADN/ASN	15	17	24	25
LPN	14	13	19	22

Easing the faculty shortage would allow Indiana nursing programs to admit and train greater numbers of students. Some health care providers (usually hospitals) have formed partnerships with RN programs that allow the provider's RNs to function as RN nursing program faculty without cost to the program. For nursing homes, and home health care agencies not attached to a hospital, this type of faculty subsidy is a difficult proposition, however. Yet long term care must replenish its nurses, and they must be educated in the systems that deliver long term care as well as the populations requiring it.

Ivy Tech is particularly hard-hit by the nursing faculty shortage. Over the past two years, the Ivy Tech system has applied for National League of Nursing (NLN) accreditation for its ASN/ADN and LPN programs. The NLN requires that academic faculty in both types of programs possess a Master's degree in nursing. Faculty with these credentials are hard enough to come by, but at Ivy Tech's current salary levels, filling these positions is even more difficult. Ivy Tech's current strategy is to hire faculty with a bachelor's degree and then put them on a track to earn the Master's, with the goal of completing the degree within 5 years. Because of the new requirement, some faculty have already been lost. Ivy Tech is hoping to cultivate partnerships with the health care industry to fill some of these positions, but has so far concentrated on linking with acute care facilities. Long term care facilities and home health care agencies should work to forge links with Ivy Tech as well.

Although Indiana is currently experiencing significant budget shortfalls, it should make every effort to fund additional faculty positions and raise faculty salaries for nursing programs at public institutions at all levels. For their part, nursing programs around the state should embrace grant opportunities that assist with faculty and/or curriculum development initiatives and career advancement, especially as they relate to geriatrics or long term care.

Congress has recently made nurse recruitment and retention (including nursing faculty) a priority with the passage of the Nurse Reinvestment Act. The Act encompasses a number of initiatives, including a loan program to encourage the education of nursing faculty; a National Health Services Corps type of program that would pay for nursing education in exchange for a service commitment; grants to expand baccalaureate nursing programs; grants for career ladder

programs that include all levels of nursing personnel, including CNAs, home health aides, and LPNs (but not personal care attendants); and grants to develop programs in geriatric education that include training, continuing education and faculty development. The entities eligible for geriatric education grants include a health care facility, a program leading to certification as a CNA, a facility/nursing school partnership, or a facility/CNA program partnership. While the Act has yet to be funded, Indiana should be ready to take advantage of these programs by starting to build its own nurse reinvestment strategies.

Certified Nurse Aides (CNAs)

Among RNs, LPNs, and CNAs, it is CNAs who are the most directly involved in the adequate daily functioning of those utilizing long term care. According to the Indiana Nursing Facility Statistical Report dated 8/16/02, produced by FSSA and based on Medicaid cost reports, nursing aides and orderlies are the chief staffing resource for long term care facilities.[23] In terms of statewide normalized case mix-adjusted nursing hours per resident day, CNAs and orderlies logged 1.70 hours per resident day compared to a little over 0.77 hours per resident day for LPNs, about 0.31 hours per resident day for RNs, and 0.12 hours per resident day for Directors of Nursing. In other words, CNAs spent over twice as much time as LPNs in direct nursing care per resident day, and over 5 times as much as RNs.

COC focus groups and interviews confirmed the essential role of CNAs in long term care, and also confirmed their apparent shortage throughout the state. Yet, in spite of their pivotal place in the care of persons who are elderly and disabled, Indiana has no profile of the population pursuing this occupation. The Indiana State Department of Health maintains a CNA registry, which contains current employment and personal information on all persons who have successfully completed the CNA training and testing program. It would be possible to link the CNA data to other data (for example, DWD data) in order to learn more about CNA activity levels, work locations, and job longevity. Other states have done this type of analysis so that they can devise recruitment and retention incentives for CNAs.

CNA Training Requirements

In order to be a CNA in Indiana, an individual most complete 30 hours of approved CNA classroom training and 75 hours of clinical rotation in an approved clinical site, and s/he must pass the CNA test administered by the state-approved testing entity, Professional Resources, Inc., or by the approximately 30 other sites approved by ISDH for testing.[24] Students successfully completing the CNA course of study do not have to take the CNA test immediately. They have up to 24 months after completion of the course to sit for the examination. Out-of-state nurse aides who are currently registered and in good standing in their home state's CNA registry must pass the Indiana examination, and may have to complete a skills examination as well, depending upon the facility that is hiring them. Student nurses who have graduated but who do not pass the state nursing boards may become registered CNAs

[23] FSSA, Office of Medicaid Policy and Planning, "Semi-Annual Compilation of Nursing Facility Statistical Reports" (produced by Myers and Stauffer LC), 8/16/02, Section 2.

[24] After August 1, 1999, facility-based and non-facility-based training programs were not allowed to test their own students, except for a limited number of vocational schools that received approval for test administration before that date.

if they successfully complete both the written and skills examination. Student nurses who are currently enrolled in a nursing program, who have successfully completed the "Fundamentals of Nursing" course with a grade of C or above, may become registered CNAs after successfully completing the written examination and, depending upon the hiring facility, passing the skills examination.

Many nursing homes in Indiana have approval from the state to train their own CNAs. Federal law requires that approval must be withdrawn for a period of two years if a facility is found to have provided substandard quality of care; demonstrated an inability to provide required nursing care; has been assessed a federal civil money penalty in excess of $5,000; or has had a denial of payment for new admissions due to untimely correction of problems cited in a survey.[25] Nursing homes feel that this is an unduly harsh penalty that further impacts the quality of care at a nursing home because it has the potential to further reduce staff.

CNA Supply Data

As of late June, there were 104,885 CNAs on the CNA registry maintained by ISDH, 32,082 of whom are considered active. However, the "active" designation is defined by federal law, and the activity level is set so low (proof of having worked at least one 8-hour shift in the past 24 months in a state-licensed health facility, home health agency, hospice or hospital), that it is virtually useless in determining which CNAs are actively working. A CNA's name even remains on the list when there have been findings that result in the CNA's being barred from working in a licensed health facility. In cases such as this, the CNA's name on the registry is marked with a "FINDING" label and her/his name is posted to a public list so that consumers and providers can be made aware of the CNA's status. As of July 2002, there were about 570 CNAs who are listed as barred from working in a licensed health facility.[26] In contrast to the registry, the Bureau of Labor Statistics estimates the number of actively employed nursing aides, orderlies and attendants in Indiana (not including home health aides or personal attendants) to be 28,450.

ISDH data indicate that Indiana has averaged about 6,538 CNA registrants per year for the period 1997-2001 (see Appendix K). We do not know how this compares with the number of persons who have stopped working as CNAs during each year, although we do know that the total of new registrants 1997-2001 (32,689) exceeds that of active registrants (32,082). At this point, we also cannot compare the number of those successfully completing CNA training with those who pass the examination and who are therefore on the registry. Hence, no conclusions can be drawn about whether the numbers coming onto the registry are balancing those no longer active, or whether all of the persons who could possibly be certified as CNAs pursue certification. While training sites are supposed to keep data for up to 5 years on students successfully completing training, the COC's attempts to gain a sample of training numbers were unsuccessful, and there is apparently no central place where even simple data, such as the number of successful completers of CNA programs, are kept. We also cannot know at this

[25] The federal regulations are described in the Centers for Medicare and Medicaid Services State Operations Manual, Section 7536, at http://www.cms.hhs.gov/manuals/pub07pdf/part-07.pdf.

[26] The list may be accessed on the ISDH website: http://www.in.gov/isdh/regsvcs/ltc/badcna/cnafind.htm. According to participants in provider focus groups, the list of barred CNAs does not necessarily include all persons who have criminal backgrounds, nor does it include those who have flunked workplace drug tests required for employment.

point how many hours per week registered CNAs are working, and in what types of settings. The CNA registry may be an appropriate tool for collecting and storing this type of information.

It would be possible to conduct a survey of CNAs using the ISDH registry data, or Indiana could emulate other states whose registries have collaborated with workforce development efforts by linking CNA registry data with other employment-related data to more completely profile the CNA population. This has helped these states to craft programs enhancing recruitment and retention of CNAs. Given the "unknowns" about CNAs and the discrepancy between state and federal numbers, further research is needed. A CNA analysis would assist nursing homes, home health care agencies, ISDH, FSSA and DWD in knowing more about this crucial workforce.

CNA Profile

Although Indiana has yet to profile its CNA population, national studies and those conducted by other states tell us something about this essential workforce, and what might increase supply and retention of good CNAs.

CNAs, according to the Bureau of Labor Statistics (BLS), are among the occupations that "provide basic patient care under direction of nursing staff. [They] feed, bathe, dress, groom, or move patients, or change linens."[27] But this minimalist description of the CNA's responsibilities does not adequately capture the importance of these caregivers in the lives of those for whom they care, and the challenges they face. In addition to helping with much of the basic sustaining activity in a vulnerable individual's life, the CNA is required to deal with individuals who may be mentally or physically challenged, developmentally disabled, psychologically impaired, and/or chronically ill. Statistics indicate that they work within an industry that is among the top in workplace injuries: 16.5 per 100 full-time CNAs had occupational injuries in 1996 compared with 6 per 100 for other service workers.[28] A 1992 federal Department of Labor document stated that on a single shift, a CNA might perform up to 40 unassisted lifts and transfers of patients weighing as much as 260 pounds. While the situation may have improved in recent years with the increasing use of mechanical lifts, further information is needed on Indiana's nursing home injury rates.[29]

According to some state studies, a significant proportion of CNAs work two jobs, with the second job frequently being a caregiving job as well.[30] Depending upon the sector of long term care in which they work, CNAs may be called upon to deal with a variety of care responsibilities. Research from North Carolina indicates that those working in nursing homes do more direct patient care tasks on a daily basis than those CNAs in other settings or home health. On the other hand, home health CNAs do more housekeeping tasks than either nursing

[27] Definition from BLS, http://state.bls.gov/oes
[28] Stone R, "Long Term Care: Workforce Issues in a Changing Society," presentation for the American Society on Aging, 2002 Summer Series on Aging.
[29] US Department of Labor, Brief to OSH Review Commission (filed May 1 1996), as cited by Service Employers International Union (SEIU), Caring Till It Hurts, 1997, p. 12.
[30] North Carolina Department of Health and Human Services, Division of Facility Services and the North Carolina Institute on Aging, "WIN A STEP UP Findings Brief #9: Comparing Nursing Assistants Working in Nursing Homes, Adult Care Homes and Home Health/Home Care Agencies," p. 3.

home CNAs or those in other settings. The most difficult case mix seems to belong to CNAs in nursing homes, however, who reported a greater frequency of caring for residents with cognitive impairments or behavior problems, and providing emotional support to residents and their families.[31]

Judging from national data, the CNA is typically a middle-aged single mother with a low level of education, living at or just below the poverty level. In urban areas, a larger proportion of CNAs may be African-American, Asian or Hispanic.[32] Interviews with some Indiana nursing home directors of nursing and home health care providers anecdotally confirmed this portrait, but it also gave a more diverse aspect to the CNA population. CNAs may include seasonal employees who perform outside labor during the spring and summer months, but who work as CNAs during the winter. They may also be factory workers who have been laid off, some of whom may return to factory work when factory wages rise above the CNA wage. Some ultimately may not return to factory work because they find employment as a CNA more reliable and rewarding, particularly if there is a career ladder or advancement path made available to them. CNAs may also be high school students who have participated in their high school's Health Occupation Education (HOE) program or in an Indiana Career Center program, and passed the state CNA certifying examination.[33] Some of these students may choose to remain CNAs; others may work their way through college as CNAs and go on to other fields or remain in health care. One director of nursing reported that a number of her CNAs have been high school HOE students who then work their way through college as CNAs, forming lasting relationships with nursing home residents.

CNA Perspectives and Concerns

For both recruitment and retention purposes, Indiana needs to know the demographic, social or educational characteristics of its CNA population. But it is even more important to understand what motivates someone to choose direct caregiving in the first place. In a recent Pennsylvania study, members of the direct care workforce drew a distinction between two different groups of direct care workers: those who go into caregiving because they want to help people and those who need a job, any job. The Pennsylvania caregivers also stated that depending upon the attitude of the caregiver, quality of care was noticeably affected. In the Pennsylvania study, direct caregivers were asked to profile what made a good caregiver. Here is what they said:

- Compassionate
- Dedicated

[31] "WIN A STEP UP Findings Brief #9", p. 2.
[32] Stone R, "Long Term Care: Workforce Issues in a Changing Society," presentation for the American Society on Aging, 2002 Summer Series on Aging.
[33] Some of these students will choose to remain CNAs and others will go on to a health care career, most likely nursing. They are encouraged to do so by articulation agreements with local Ivy Tech campuses that allow students to earn 7.5 credits toward a health program at Ivy Tech if they earn their CNA at one of the state's Career Centers. Some Career Center directors report a significant increase in enrollment in CNA programs in the past year. In the Fort Wayne area, for example, a Career Center director stated that there were 70-80 applicants for 30 CNA training slots. There is some feeling that there would be even more student interest if articulation between CNA and LPN programs were further streamlined. In any event, the pool of persons who work as CNAs is more diverse than it might originally appear from the national literature.

- Empathetic
- Good listener
- Patient
- Positive attitude
- Professional
- Reliable
- Respectful
- Sense of humor
- Team player
- Thick-skinned[34]

An Iowa study (also based on caregiver focus groups) noted that the top reason CNAs stayed on the job "is their dedication to their residents or clients and their co-workers," and that their job satisfaction is strongly connected with how they are treated by their supervisors.[35] In both the Iowa and Pennsylvania studies, another highly significant factor influencing job satisfaction and retention was short-staffing.[36]

These CNA perspectives from other states were echoed by a focus group of Indiana LPN students who are currently working as CNAs. They liked long term care, and felt strong connections with the residents they cared for. Some remarked on the advantage of knowing which patients they would be caring for and the routine of the care. Several also agreed heartily with the statement made by one that "a lot of facilities in this city are overworked and understaffed and after awhile that gets depressing. . . if I don't have adequate staff, I can't give this person the care they deserve. To me this is a statewide problem." Another remarked, "Every CNA may be working with 8-11 patients and you have to get all of those patients cleaned, fed, dressed, etc. Do the math—that's less than 10 minutes per patient. Is there anybody who can get ready in 10 minutes? No. The staff ratio is a huge problem." The CNAs felt that there needed to be minimum staffing ratios to resolve the situation. They also felt that ISDH surveyors were ignoring an obvious issue and focusing on the technicalities of regulation, rather than on the elephant in the tent. "There are a lot of technical rules," said one, "but when it comes to employment and the people there, and who is working and the kind of job they are doing, they left a whole area out. If you are going to be that intense on these technical things, then be that intense on the help and the patient ratio." A number of the focus group participants said that short-staffing was the reason they would probably not remain in long term care. When asked whether they would consider staying in long term care if the staff ratio improved, all of them replied affirmatively.[37]

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[34] Pennsylvania Intra-Governmental Council on Long Term Care, In Their Own Words, Pennsylvania's Frontline Workers in Long Term Care (Harrisburg, Pennsylvania), 2001, p. 14. Hereinafter cited as "PA Council." Focus group participants for the Pennsylvania study consisted of long term care workers in both facility-based and community-based settings.

[35] Iowa Caregivers Association, Certified Nursing Assistant Recruitment and Retention Pilot Project Final Report (Des Moines, Iowa), 2000, p. 7. Hereinafter cited as "Iowa Caregivers."

[36] PA Council, p. 14, Iowa Caregivers, p. 7.

[37] Indiana does not currently have minimum staffing ratios. Instead, it adheres to the federal guideline which states that "the determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psycho-social well-being,"

Short-staffing has implications in terms of career advancement through education, as well. One LPN program director noted on her program survey that she preferred not to articulate CNAs to LPNs because her job was to teach students how to do things right, and the CNAs she had encountered had learned to take shortcuts because of short-staffing. In her estimation, it took significant time to help CNAs re-learn how to do things.

The focus group also talked about the significance of their relationship with supervisors. They commented that the LPN to CNA relationship is very important and that if the LPN lacked management skills, there would be problems. Others added that if administration was a problem, this would also find its way down to every level of the facility.

Qualified Medication Aides (QMA)

Another important direct care provider in Indiana is the Qualified Medication Aide. The QMA program was originally established and administered by the Indiana Department of Education in 1977, but was transferred to ISDH in 1986. The program was set up to provide education for unlicensed persons so that they could administer medications in long term care facilities.[38] In 1991, a requirement was put in place that all QMAs had to be CNAs.[39] Since 1991, for the most part, a QMA is a CNA who has undergone an additional 100 hours of training, consisting of 60 hours of classroom instruction and 40 hours of a supervised practicum, at a site approved by ISDH. Of the 20,607 QMAs who are currently on the QMA registry, 9,167 were CNAs as of late June 2002. There are also 56 persons who are registered both as a QMA and a home health aide, whom ISDH surmises probably came onto the registry prior to the 1991 CNA requirement. There are 403 persons who have triple registration as a CNA, a QMA and a home health aide, indicating that they are trained for different settings, but it is unknown what types of jobs these triple-listed individuals have.

A list of approved QMA training sites may be found on the ISDH website, and includes licensed long term care facilities, accredited schools of nursing, Indiana vocational schools governed by the Indiana Department of Education or North Central Accreditation, and non-facility based programs.[40] As of July 5, 2002 there were 146 QMA training sites throughout the state. After successfully completing the QMA training program, students must pass an examination and demonstrate specific competencies before they are registered as a QMA. Nursing students who have graduated but who do not pass the state nursing board exam may function as QMAs after successfully completing the competency evaluation with a minimum score of 80 percent. Nursing students who have completed a pharmacology course with a grade of "C" or above may also function as QMAs if they successfully complete the QMA practicum and the competency evaluation test.

In the 2002 session of the Indiana General Assembly, the legislature passed a bill that would permit ISDH to promulgate rules that would specify how QMAs can be removed from

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Centers for Medicare and Medicaid Services State Operations Manual, pp. 135.7-135.8. According to ISDH, surveyors are required to look at staffing ratios only after quality of care problems have been discovered.

[38] Indiana State Department of Health, "Indiana QMA Instructor Course," July 2001, p. 4.

[39] This does not apply to psychiatric aides at state hospitals, who are required to take the QMA course and become QMAs although they do not have to become a CNA first.

[40] http://www.in.gov/isdh/regsvcs/ltc/qumatdir/qmatweb.htm. Training site information is updated monthly.

the registry. ISDH has begun the rule promulgation process. The proposed new rule requires annual recertification and in-service education for all QMAs if they wish to remain on the registry. The proposed rule also requires that facilities use only registered QMAs, and authorizes ISDH to remove facilities from the training list that do not fulfill certain requirements, including having a pattern of excessive failure rates on the QMA competency evaluation test. If the proposed rule is adopted, ISDH may also revoke QMA certification from an individual in case of disciplinary infractions. The proposed rule further provides that persons certified as a QMA in another state may petition for exemption from training, provided they pass the competency evaluation test with a minimum score of 80 percent.

There are a large number of persons listed as QMAs who are inactive, but it is difficult to estimate just how many. There are over 20,000 names on the registry, but the numbers of active QMAs will not be known until ISDH purges those who do not qualify under the proposed rule. On average, about 289 new QMAs have registered annually between 1997 and 2001 (see Appendix K).

As with CNAs, it would be very helpful to have information on active numbers of QMAs, activity levels, types of activities, work locations, salary and benefit levels, and demographic characteristics in order to tailor appropriate retention and articulation programs.

Gerontological Advanced Practice Nurses

In recent years, advanced practice nurses have been assuming a more prominent role in health care delivery. This is true for long term care as well, although the number of advanced practice nurses in long term care in Indiana is not abundant. The table below shows that although there are a number of advanced practice nurses in Indiana, long term care is not a major practice area in most cases except for gerontological clinical nurse specialists and gerontological nurse practitioners.[41]

	Number	LTC a Major Practice Area
Gerontological Clinical Nurse Specialists	37	12
Gerontological Nurse Practitioners	39	11
Adult Nurse Practitioners	259	10
Family Nurse Practitioners	220	3

Survey data also reveal that for those advanced practice nurses who cite long term care as a major practice area, their practice setting was more likely to be in a private physician's office or a hospital rather than in a nursing home. None responded that their practice setting was in a home health agency.

Nursing home administrator focus group participants remarked on the importance of advanced practice nurses in long term care, particularly gerontological nurse practitioners. They wished for greater numbers of graduates and the ability to pay these professionals what they are worth. As the acuity, age and number of elderly persons increases, long term care settings will

[41] The Indiana Registered Nurse Survey, 1997 provides a profile of advanced practice nurses who met the state's requirements for prescriptive authority. The figures used here are derived from the self-reported certification questions on the survey combined with other survey data.

need to have ready access to expert advice that in turn can be easily communicated to nursing staff. Focus group participants remarked that advanced practice nurses in a long term care setting often eased communication gaps between physicians and nurses.

Currently, there are only 2 gerontological nurse practitioner programs in the state (Indiana Wesleyan University and University of Indianapolis). Only IUPUI has an adult clinical nurse specialist track that allows for a concentration in the older adult.

National foundations, particularly the Hartford Foundation, have been active in encouraging the training of advanced practice nurses for long term care. There is no doubt that Indiana would benefit greatly from additional support for these programs.

Chapter III

The Home Care & Home Health Care "Side of the House"

While much less is known about the workforce in home care and/or home health care, the direct care workers in this arena must be considered, particularly as Indiana moves to enhance consumer choice for citizens who are elderly or disabled.

Data indicate that there is considerable demand for these services: as of late June, FSSA reported unduplicated waiting lists as follows:

CHOICE	12,000 (Estimated)
Aged and Disabled Medicaid Waiver	2,339
Assisted Living Medicaid Waiver	9
Autism Medicaid Waiver	316
Developmental Disabilities Medicaid Waiver	3,473
Medically Fragile Children Medicaid Waiver	222
Traumatic Brain Injury Medicaid Waiver	80

However, FSSA acknowledges that the waiting list estimates are not necessarily accurate. The waiting lists are compiled from Area Agency on Aging data entered through the INSITE system. Although Area Agencies purge the lists, some as frequently as twice a year, there is no requirement that they do so at set intervals. It should also be noted that the waiting list numbers by themselves give no specific information as to the actual services needed by persons on the lists, although this information is collected. In order to be able to project demand for health professionals, aggregated data on required services must be developed and shared.[42]

The waiting list numbers are also to some degree artificially low because of Indiana's tight eligibility requirements for all Medicaid waiver programs except Developmental Disabilities. In many states, the eligibility for Medicaid waiver programs is the same as Medicaid nursing home eligibility: 300 percent of SSI.[43] In Indiana, this is the eligibility level for only the Developmental Disabilities waiver and Support Services for Persons with Developmental Disabilities. Otherwise, Medicaid waiver eligibility is limited to 100 percent of SSI, which comes out to about $545 monthly, or an annual income of $6,540. If all Medicaid waiver programs used the more generous Developmental Disabilities eligibility levels, it is likely that the waiver waiting lists would expand significantly, dwarfing the ability of Indiana home care and home health care providers to deliver these services.

Home Care Providers and Home Health Care Agencies in Indiana

The table in Appendix L sets out the various types of entities that deal with home care and/or home health care in Indiana. In terms of workforce supply and its relation to access, it is

[42] FSSA uses another database, Indiana's Prioritization of Urgency of Need for Services (IPUNS) to prioritize needs.

[43] SSI (Supplemental Security Income) is a federal program in which benefits are paid to individuals who are poor and disabled.

important to remember that only certain types of entities are permitted to provide certain types of services based on state and/or federal regulations or reimbursement policies. These regulations and policies may also affect the kinds of personnel they can use to deliver these services, which in turn has implications for workforce composition.

Unlicensed providers can only deliver home care services, meaning services that do not require a skill, such as housekeeping, grocery shopping, personal shopping and bill assistance. They are not allowed to provide hands-on care except minimal assistance with personal care. A licensed home health care agency can provide both unskilled and skilled services, but for purposes of Medicaid waiver programs, it can provide only unskilled services. If the licensed home health care agency is also a Medicare and Medicaid certified home health agency (dually certified), it must adhere to the Medicare Conditions of Participation, which contain additional requirements about the types of personnel that can be used and what they can do.

It is difficult to determine the number of unlicensed home care providers, since no state agency keeps track of these numbers. Yet these providers are essential to community care in Indiana because they provide some of the most basic services that help preserve independence, such as personal care attendant services and homemaking. Licensed home health care agencies are easily quantified. According to the ISDH facility licensure database, there are 245 licensed home health care agencies in Indiana. Of these agencies, 72 are state-licensed only; 160 are both licensed and Medicare/Medicaid-certified (dually certified); 11 are licensed and only Medicaid-certified; and 2 are licensed and only Medicare-certified. Some of the 72 state-licensed only agencies are the side of Medicare/Medicaid-certified providers that deliver services outside of the Medicare Conditions of Participation, which require the use of certain professionals to deliver home health care under Medicare and Medicaid.

Registered Home Health Aides

As the table in Appendix L indicates, home health care agencies use RNs, LPNs, and the therapy disciplines. They also use registered home health aides. Because they are essential to the functioning of licensed home health care agencies and Medicare and Medicaid certified agencies, the number and distribution of registered home health aides is important for Indiana. According to ISDH, as of May 23, 2002, the home health aide registry contained 7,727 aides, 5,731 of whom were considered active. Appendix K contains information on newly registered home health aides per year since 2000, because legislation requiring registered home health aides to register with ISDH was passed only in 1999. The first year of registration (2000) would necessarily be greater than all others since those who were already home health aides would have activated their registration at that time. Because home health aide registration is so recent, an average of new registrants per year cannot be calculated at this time.

Registered home health aides are required by federal law to have 75 hours of training. The student must spend at least 16 of these hours in supervised practical training, or pass a competency test. Training may be provided by any licensed home health agency except one that is not in good standing according to federal criteria. Training must be provided by or under the supervision of a registered nurse who has had at least 2 years of nursing experience, at least one of which must be in the provision of home health care. According to state law, if a licensed home health care agency wishes to continue using a registered home health aide, the

aide must have 12 hours of in-service education per year and undergo an annual performance evaluation.

As in the case of CNAs, very little is known about this population in terms of activity levels, types of activities (except in terms of general descriptions about the limitations of the care they can deliver), demographic composition or job longevity. It would be possible to find out some of this information using by linking home health aide registry data with other databases. More research is needed on registered home health aides, because the COC's focus group research indicates that there are shortages. It is also clear that the training levels of registered home health aides may differ: some home health agencies require that their registered home health aides be CNAs before being trained in home health, although this is not mandatory.

Personal Care Attendants

The Bureau of Labor Statistics (BLS) estimates that "Personal and Home Care Aides" number 371,280 nationally and 6,590 in Indiana.[44] However, the job description for a personal care attendant may vary depending upon the kind of agency providing attendant care services or the reimbursement program that pays for these services.

Training requirements for personal care attendants are somewhat unclear as well. According to FSSA, home care providers and home health agencies are assumed to have some type of training program in place. In the past, if an individual wanted to qualify as a personal care attendant for purposes of the CHOICE or Medicaid waiver programs, s/he had to undergo training according to a curriculum outline provided by FSSA. It was up to the individual to flesh out the outline, send the curriculum to FSSA for approval, and pay for their own training. Some entities, such as Ivy Tech, once had a curriculum for personal care attendants, but at least in Ivy Tech's case, the training was discontinued because of lack of demand. Currently, according to FSSA, only the Area Agency on Aging in Bloomington is offering an approved Attendant Care training module for individuals who wish to obtain training. FSSA has recently decided that if an individual can show proof of having been trained as a CNA, LPN or RN, those credentials will be accepted.

Focus group participants from home health care agencies and those who contract with them cited confusion with regard to the requirements for personal care attendants and the curriculum that is used to train them. This seems to be an unclear area between ISDH, which oversees regulation of home health care, and FSSA, which pays for home health care through several different programs. According to ISDH, ISDH and FSSA are now in the process of putting together a group to look at this and other issues related to home health care so that regulations can be clarified. Given the importance of personal care attendants to individual independence, this type of discussion should be encouraged.

[44] The BLS job description for Personal and Home Care Aide is "assist elderly or disabled adults with daily living activities at the person's home or in a daytime non-residential facility. Duties performed at a place of residence may include keeping house. . . . May provide meals and supervised activities at non-residential care facilities. May advise families, the elderly, and disabled on such things as nutrition, cleanliness, and household utilities."

Self-directed Care: A New Wrinkle[45]

The role of unlicensed caregivers has taken on new significance in Indiana because of recently enacted legislation that allows state payment under the CHOICE and Medicaid waiver programs for certain types of self-directed care, provided certain conditions are met.[46] The unlicensed caregiver under this legislation is known as a "Personal Services Attendant."[47] The Division of Disability, Aging and Rehabilitative Services is developing a registry for personal services attendants who may assist an individual in her/his self-directed care.

Various focus group participants and informants had mixed opinions on the self-directed care legislation. Some saw it as an opportunity to get more care in the community, while others questioned whether enough funds were available to pay for assisting all persons who would prefer self-directed care to facility-based care or care through an unlicensed home care provider or home health care agency. Still others remarked on the irony that FSSA would be paying more to untrained individuals for delivering care than they paid to trained professionals who provide care through an agency that also monitors the quality of the care and is required to adhere to state licensing standards. Some focus group participants also observed that licensed personnel (e.g. RNs) within agencies could not teach certified personnel (e.g. registered home health aides) to do some of the invasive procedures required for home health care, but under recent self-directed care legislation, a layperson could teach another layperson to do these procedures. This apparent contradiction may arise out of considerations of risk assumption more than anything else, however.

Some informants have adopted a "wait and see" attitude toward self-directed care, applauding the effort for greater self-determination but voicing concerns about quality and the possible diversion of personnel from agencies to individuals, which would exacerbate the shortage situation. Regulatory agencies such as ISDH point out that it will be difficult to monitor performance of personnel who are hired to perform self-directed care since the state lacks an error tracking process at this point.

A number of states have enacted self-directed care statutes in recent years, but implementation is too recent to predict the effects. Some informants speculate that the legislation may encourage some people to enter the health care workforce, and feel that this would not be a bad result. A focus group of home health care providers agreed that only time will tell.

Homemakers

[45] "Self-directed care" is defined in IC 12-10-17-6. According to ISDH, self-directed care is not provided through any agency. The client needing care hires and trains the person(s) caring for her/him. This person is called a "personal services attendant" (PSA). Home health care agencies may assist the individual hiring the personal services attendant with the financial aspects of filing paperwork and taxes. In such cases, however, the client is not considered to be a patient of the agency.

[46] SB215, passed in 2001, and HB1252, passed in 2002.

[47] According to Indiana code, a personal services attendant "means an individual who is registered to provide attendant care services under this chapter and who has entered into a contract with the individual and acts under the individual's direction to provide attendant care services that could be performed by the individual if the individual were physically capable." (IC 12-10-17-8).

Like personal care attendants, these workers are needed by home care and home health care, but according to informants, they are in short supply. This seems to be true particularly in urban areas where homemakers charge $20-$25 for cleaning someone's home, a rate far higher than that paid by Medicaid waiver programs. In rural areas, focus group participants reported that homemakers are somewhat easier to find. Informants explained that another difficulty with homemaking services is that FSSA, under the Medicaid waiver and CHOICE programs, seemed reluctant or slow to approve cleaning agencies that provide this type of work, yet these are sometimes the only entities that can provide services at the price the state is willing to pay. Some home health care providers noted that staff entering through a homemaking position might be able to move up into CNA and registered home health aide positions, if the opportunity is made available, and they successfully complete the training. This helps the agency, the worker and the individual needing care.

Other Home Health Care Workforce Needs

In addition to the personnel mentioned above, home health care informants described the need for RNs and all of the therapy disciplines, particularly physical therapists. They also described a shortage of clinical managers: RNs who can supervise case managers and do quality assurance for home health care. This requires a thorough knowledge of home health care rules and regulations, something that several informants stated is rare in the nursing community. Clinical social workers (Master's of Social Work) are also difficult to recruit, particularly in rural areas.

Additional Issues Related to Home Care and Home Health Care in Indiana

According to the information ISDH collects, it would appear that every county in Indiana is served by home health care agencies, and some counties appear to be served by a great many (see Appendix M).[48]

However, according to COC focus groups and informants, the information in Appendix M does not accurately capture coverage of the state for home health care services. Persons on Medicaid waiver and those in rural areas have a much harder time accessing home health care services than those who are insured, private pay or covered by Medicare, or those who are in urban areas.

Slow contractor approval for certain types of services, and issues arising from regulatory questions or conflicts may also interfere with easy access.

Medicaid Waiver Rates

As with nursing homes, Medicaid waiver rates are far too low to make it cost effective for home health care agencies to provide services. Focus groups and interviews conducted for this report indicate that a number of home health care agencies have simply stopped taking Medicaid waiver clients, and others take them only selectively as other revenue streams allow, such as private pay or CHOICE, both of which pay far better than Medicaid waiver for the same services. While there are approximately 243 providers in Indiana who could provide some type of Medicaid waiver and/or CHOICE services, interviews and focus groups indicated that a significant number are probably not taking these clients. A comprehensive anonymous survey of home health and home care providers should be conducted to determine real access to services for Medicaid and CHOICE clients, and the changes needed to improve participation.

It should be noted that OBRA 1997 caused a number of home health agencies in the state to abandon home health care and home care, which would have affected coverage in any event. The state's reimbursement levels, combined with the shortage of personnel, has further affected access. Focus groups participants involved in home health care felt that if the state intends to make community-based continuing care a viable alternative, it must pay enough for providers to adequately compensate current staff and attract more to these jobs.

Transportation

Delivery of care in the community inevitably involves transportation costs. However, Medicaid waiver rates are the same throughout the state, no matter how far an agency might have to travel to deliver services. Focus groups and informants knowledgeable about home health care observed that since agencies have to pay for a registered home health aide's time, whether spent in travel or care delivery, clients close to an agency's home base (usually in an urban or semi-urban area) are more likely to get service than those in outlying areas, particularly those that are rural. In addition, focus group participants pointed out that mileage and car

[48] The ISDH definition of "rural" has been used. This means that a county has not been designated as part of a Metropolitan Area by the federal government, and the county's largest city has a population of less than 10,000. By this definition, there are 42 rural counties in Indiana.

maintenance costs for community-based direct care staff are burdensome. These costs should either be considered in Medicaid waiver rates for clients at a distance from an agency, or they should be reimbursed separately. The higher proportions of elderly persons in many of the state's rural counties means that these counties may need more home health care services in future years (see Appendix D). At this point, there is no incentive for agencies to accept these clients.

The state may have the best of intentions in assisting consumers to stay at home, and this may also help the state cut costs for institutionalization. However, the well-being of vulnerable citizens will be jeopardized if the necessary services are unavailable or inaccessible, especially in the state's rural areas.

Slow Payment and Slow Contractor Approval

Slow payment of Medicaid waiver claims and slow approval of community-based service providers were also noted by focus group participants as factors affecting the willingness to take Medicaid waiver clients. Focus group participants stated that slow approval seems to particularly afflict non-home health providers such as housekeeping services, many of whom find the Division of Disability, Aging and Rehabilitative Services application cumbersome and complex. Provision of basic homemaking services is a key component to helping people stay independent and in their own homes. Participants felt that FSSA should expedite the application and approval process for these non-health providers.

Complexities of Regulation and Reimbursement

FSSA and ISDH each have important roles to play in the realm of home health care. FSSA pays for services in the community through CHOICE and Medicaid waiver programs. ISDH is responsible for enforcing federal and state laws, rules and regulations that delineate which providers can deliver certain types of services and how they are to be delivered. Unfortunately, reimbursement regulations and those governing the practice and delivery of care are not always consistent because they approach care delivery from different perspectives and with different purposes in mind. The multi-dimensional complexity of the laws, rules, and regulations may create a confusing situation for providers in the field. Focus group participants and informants wished for greater clarity and consistency in areas where FSSA and ISDH regulation intersect, particularly where two different home health care agencies are sharing the same client.

For example, a client may be receiving certain home health care services from a certified Medicare home health agency that are paid for by Medicare. Since Medicare is a federal program, the care delivered by the Medicare home health agency is governed by federal regulations. The same client may also be receiving different services from a different provider under CHOICE, which is a state-funded program administered according to FSSA regulations. The CHOICE provider's contract would be through the Area Agency on Aging, which is the state entity that monitors CHOICE providers in its region. Questions may arise as to whether federal regulations govern the relationship between the Medicare home health agency and the CHOICE provider, what types of personnel can provide the state-funded CHOICE services, and who should be handling the coordination and quality monitoring of services between the two different providers. This example involves two different funding programs, but providers

in the field also state that questions exist even where two different programs are not involved but where FSSA case managers or insurance company case managers may have made referrals to two different agencies for the provision of different services.

It is important that ongoing discussions among FSSA, ISDH and the home health care provider community work out these sorts of issues. ISDH reports that it is putting together a group to look at conflicts between laws, rules and regulations. ISDH also reports that it is meeting regularly with representatives of the home health care sector. As more care moves into the community, regulatory barriers and conflicts will need to be discussed and resolved quickly so as to promote access to care. The Governor's Commission on Home and Community-Based Services should assist with this effort.

Chapter IV

Ways to Boost Indiana's Long Term Caregiver Supply

Wages and Benefits

In focus groups and interviews, provider informants commented time and again that one of the biggest obstacles to recruitment and retention of direct care workers is wages. Appendix N (Tables 1-4) sets out hourly and annual wages for CNAs, home health aides, personal attendants and LPNs, based on BLS data from 2000, by Indiana Metropolitan Statistical Area (MSA). The table also compares these wage levels to the current poverty level and the 1998 Indiana Self-Sufficiency Annual Wage for different family sizes. Put simply, the annual wages paid to CNAs and other direct care workers are too low. As noted above, the average CNA has a family and is often a single mother, yet CNA median annual wages in 2000 in most Indiana communities were anywhere from 110 percent of the poverty level to 138 percent of the poverty level for a family of 3, and anywhere from below the poverty level to 115 percent of the poverty level for a family of 4. CNA wages were nowhere near the self-sufficiency level for a family of 3 (adult and 2 children), even using the 1998 self-sufficiency standard. No separate wage figures were available for rural areas unless they were encompassed by a MSA, but it is likely that wage levels are even lower than those in MSAs. Some of the regional FSSA IMPACT consultants who were interviewed for this report described CNA wages as low as $7.00 per hour, for an annual wage of $14,560.

In terms of registered home health aides, salaries are even lower than those of CNAs: CNAs may earn anywhere from $7.95 to $11.08/hour (median hourly wage), whereas registered home health aides earn $7.53-$9.76/hr (median hourly wage) (see Appendix N, Table 2). Members of a home health care provider focus group remarked on the low reimbursement for Medicaid waiver services and CHOICE, saying that they could not meet their costs and pay the caregiver under the current rates. As one put it, "We are very concerned that our aides be able to make a decent wage, and we want a quality person in there. We are entrusting our patients, our clients and families' lives to someone who is to go into their home and care for them."

A number of COC provider informants also registered strong opinions about the necessity of providing decent benefit packages to CNAs and other direct care professionals, and the chilling effect of low Medicaid rates on their ability to offer this type of incentive. This seemed to be more true of nursing homes than home health care agencies, perhaps because home health care agencies, like hospitals, are less dependent upon Medicaid dollars. Members of a home health care provider focus group related that they had made a great effort to get benefits for their registered home health aides, tying eligibility for insurance to the number of hours worked. However, they indicated that in some cases, registered home health aides requested that instead of insurance benefits, they preferred to receive a dollar or two more per hour.

Given the prevailing salaries of CNAs, registered home health aides, and other direct care workers, their children would be eligible for Hoosier Healthwise, the state's Children's Health Insurance Program. Some provider informants described vigorous efforts on their part to inform and counsel their direct care workers to apply for the program. Others simply

referred them to the local Division of Family and Children office for information, but did not actively assist their application. Using the ISDH registries, it would be possible to mail information on Hoosier Healthwise to all CNAs and registered home health aides, as has been done in other states. The state could also provide Hoosier Healthwise materials to all Area Agencies on Aging to distribute to contracted providers under Medicaid waiver and CHOICE programs. This might help increase access to children's health insurance for those who otherwise may not have it. Direct care workers are, after all, providing an essential service to the state by caring for some of Indiana's most vulnerable populations. The provider associations could also encourage their members to do everything possible to inform their staffs about Hoosier Healthwise if they have not already done so.

Past Efforts to Increase Wages and Benefits

Indiana has made only modest efforts to provide additional compensation for direct care workers, largely owing to budget shortfalls. In October 2001, it provided a 4.5 percent increase for direct care staff in the CHOICE, Social Service Block Grant, and Medicaid waiver programs for attendant care, homemaker, respite care and home health services. The increase was intended to go toward wage increases, training opportunities or enhanced benefits. However, there was no requirement that the funds be spent this way, and neither area agencies on aging nor FSSA are aware of any effort to monitor whether funds were spent as intended. There was no commensurate increase given to nursing home staff, although Medicaid nursing home rates have risen slightly in recent years, from an average of $92.21 per day per Medicaid resident in 1999 to $102.78 in 2002, including all therapies. According to FSSA, there has been no requirement that any part of these increases be dedicated to increasing staff salaries.

Valuing the Caregiver

There is no doubt that the future will bring caregiver shortages, given the shrinking pool of workers who have traditionally cared for persons who are aged and disabled. Indiana must implement policies that encourage the recruitment of a stable and qualified long term care workforce for the future. Effective retention strategies are an essential part of these policies because, as one Indiana provider put it, "My best recruitment policy is to do things that help retain the workers I have."

While wages and benefits are important in securing quality long term caregivers at all levels, some studies have probed whether this is the most important factor for long term caregiver retention and attraction of new workers to the field. These studies, combined with insights from COC focus groups and interviews, indicate that there are other aspects of the workplace that can make a significant difference and are of equal and sometimes greater priority than wages and benefits.

Importance of Good Leadership: Administrators, Managers and Supervisors

A recent federal study on long term care included an examination of nursing staff turnover in three states. The study compared high-turnover nursing homes with low-turnover

nursing homes in the same market.[49] One of the chief findings of the comparison study was that management and supervision were significantly different between the two types of facilities. In low turnover facilities, administrators and supervisors gave recognition, meaning and feedback that allowed licensed nurses as well as direct care staff to feel that their work was valued and valuable. These facilities were marked by managers who "built on the intrinsic motivation of workers in the field." They knew their staff by spending time on the floor; they were willing to help out in difficult situations; they included direct care staff in committee meetings dealing with residents' status and well-being. In some cases, they even honored their staff's attachments to residents by letting them conduct brief services at the bedside when the resident died, respecting the bond that had formed between caregiver and resident. They also respected the family obligations of their staff, bending within certain limits when staff required time off for family reasons.

In some of the interviews and focus groups conducted for this report, Indiana nursing home administrators and directors of nursing spoke about the leadership practices that had helped them to reverse high turnover rates at their facilities. One director of nursing spoke of the importance of making sure her staff knew she would never ask them to do something she would not do herself. She described assisting CNAs in everything from difficult care situations to making beds to helping with incontinent patients, and noted that this fostered a real sense of teamwork and cooperation throughout the facility. She also remarked that this was not a lesson she had always known, but it was one of the most important she had learned in her 18 years as director of nursing. She has included CNAs, the housekeeping staff and the maintenance person on the facility's Falls Committee, and spoke of the wealth of patient information these personnel have provided. Her intent was to put CNAs on the Behaviors Committee as well. As in the federal study, she appreciated and recognized the intrinsic motivation of good CNAs, those who "care about the elderly, and [who] are not so concerned about themselves," and she sought to encourage this spark with additional education and responsibility. Perhaps the most telling observation about her leadership style was that, as director of nursing, "you [sometimes] have to eat humble pie" and "admit you made a mistake."

An Indiana nursing home administrator spoke about the 200 percent turnover rate among CNAs when he first came to his facility. He conducted an employee satisfaction survey and found that only 17 percent were satisfied with their jobs. This administrator stressed that his first task was to let employees see his values, the chief one being people. He started by inviting all the staff to his home for dinner and recreation. He pointed out that the important thing was to meet people "where they are at, not where you are," and that his philosophy was to appreciate people for their strengths and help them to develop them. He implemented policies that demonstrated care and compassion for his staff, including a "Magical Moments" program, where every month, staff are formally recognized for the extra caring that they give residents; "Back to School" packages for his CNAs' children; an employee assistance program that in part consists of stress management; and support for more professional education. He also emphasizes daily appreciation for staff, and every quarter, he gives away a DVD player to a

[49] US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report, December 2001, Chapter 5, "What a Difference Management Makes! Nursing Staff Turnover Variation Within a Single Labor Market." The three states chosen were Kansas, Wisconsin and California, because these three states collect individual nursing classification turnover figures. Hereinafter cited as "What a Difference".

CNA, which he observed is far cheaper than taking out employment ads. He has also implemented a financial assistance program funded from gift shop proceeds. The satisfaction level at his facility is now 77 percent and the turnover rate has dropped to 75 percent. He observed that while not all of his staff are happy, "the community is not about happiness all the time, it's about discussing and problem-solving," and it is important to involve CNAs in the process. At his facility, they serve on the recruitment/retention committee, the safety committee, and they are involved in resident care team deliberations, although he feels their involvement in the latter needs to be increased. The staffing coordinator is a CNA, and the administrator hires the RNs himself.

Indiana home health care providers have put similar retention programs in place as well. One provider described her bonus program for home health aides: for every 1,000 hours of home health care work, the aide receives a $250 bonus. This provider promotes from within, includes registered home health aides in benefit programs, and also provides for tuition reimbursement.

Direct care workers in the federal study remarked on the importance of good management at all levels, not just at the top. When asked what made a good nurse supervisor, directors of nursing in low turnover facilities and CNAs agreed that it was a willingness to be very involved with direct resident care, "They have to be able to make the aide feel a partner, whose opinion is valued," said one director of nursing at a low turnover facility. A CNA in the federal study also observed about a particular charge nurse, "She talks to us at our level. She does not try to be the heavy boss. She listens to us. We respect her and she respects us. She believes in us, she knows that we're OK." At one high turnover facility, the research team found a low turnover unit and did additional research as to the reason why. There was a particular charge nurse who believed (as she put it) "all people are equally valuable, we just have different jobs to do."[50] An Indiana director of nursing expressed it well: "The nursing hierarchy has to break down in the nursing home. We need to do just what they do. They work hard, and we need to help them."

According to the federal study, managers at both high and low turnover nursing facilities believe there is a pressing need for management and leadership training for charge nurses and LPN supervisors. So did CNAs, interestingly, and part of what constituted good management and leadership was holding staff accountable for doing a good job. As one CNA stated in the federal study, when asked about what makes a good supervisor, "Abide by the rules, and be stern. Make sure people do their jobs. Put your foot down sometimes. They have authority, but they don't use it. . . . . Some people come and go, sometimes because the supervisors don't know how to talk to people—as if they are not human, as if we don't mean anything."[51] Accountability matters, but being held accountable does not mean being treated disrespectfully or harshly.

A large part of what long term caregivers described as "good leadership and management" is really respect and appreciation. Here is what Pennsylvania direct care workers, including home health care workers, said:

[50] "What a Difference", p. 26.
[51] "What a Difference", p. 24.

- Just say thank you when I've done a good job
- Pitch in and help us when things are going crazy
- Tell us you can't do without us
- Acknowledge my presence
- Say hello
- Ask me how things are going
- Give me feedback
- Recognize when we work mandatory overtime
- Provide snacks occasionally
- Ask my opinion about the consumer
- Admit if you make a mistake
- Present a certificate of recognition for going "above and beyond"
- Give us small gift certificates
- Help defray transportation costs
- Recognize good performance in newsletters[52]

Better Orientation and Training

One of the continuing themes in interviews, focus groups and the literature is the importance of orientation and continuous training, and the effect these have on retention. In Indiana, CNAs are required to have the federal minimum number of hours of training before they take the CNA examination. Some nursing home administrators and directors of nursing feel that more is required, and they have created programs within their facilities to provide new CNAs and nurses with guidance and mentoring so that they do not feel, "thrown to the wolves," as one CNA put it, when they come on to the job.

Statistics indicate that the highest turnover occurs within the first few days or weeks that CNAs and/or nurses are hired. One of the keys to retention seems to be making the learning curve less steep and making sure that there are knowledgeable and accessible guides along the way. Adequate training is a quality of care issue as well. The Indiana Long Term Care Ombudsman 2001 Annual Report cites lack of sufficient training as a major long term care issue, second only to inadequate staffing levels.

An Indiana director of nursing described the changes she had to make at her facility during a period when CNAs were hard to find. The facility was, in her words, "eating its own," and this was expensive. The director of nursing estimated that it took anywhere from $800-$1,000 to train a CNA not counting additional staff time that must be paid until the necessary numbers of CNAs are trained and in place (some estimates run as high as $1,200 when all is said and done). Long-time CNAs were not helping new ones and there was a clear hierarchy among the staff, which intimidated the younger employees. The director of nursing implemented a mentoring program, and chose a LPN to lead it who understood the importance of working with the new staff until they were comfortable in their situation. The director of

[52] Pennsylvania Intra-Governmental Council on Long Term Care, In Their Own Words, Pennsylvania's Frontline Workers in Long Term Care (Harrisburg, Pennsylvania), 2001, p. 24. Hereinafter cited as "PA Council."

nursing pointed out that in a mentoring job, it was best to have someone who was aiming for something beyond their present position because this inspires those whom they mentor.

The same type of orientation approach was implemented with new nurses, with some variations. New nurses are brought into multiple team meetings so they can become familiar with all that is going on in the facility and learn the culture of dialogue that helps things to work well. The director of nursing also provides special experiences for the nurses from time to time, such as asking them to work on special projects, like researching the Eden alternative, or giving them the opportunity to rotate into different settings for a break in their routine. She has also set up an in-service for the nurses to deal with their feelings when families get angry. The director of nursing also established a program to pay for CNAs' college education that was different from tuition reimbursement: the facility paid for CNAs' additional education and then asked them to work an hour for each dollar spent, with no interest. If the CNA leaves before her/his obligation is discharged, they have to pay back the cash up front.

In the federal study, one human resources director at a low turnover facility said that the orientation in her facility was 30 days before CNAs were given their own assignment. Another manager described the use of an assessment tool to gauge strengths and weaknesses and to determine where the CNA might need some review of the basics (vital signs, how to assess residents and what to report). Still another commented "You can put aides on the floor immediately, they don't feel good, they don't know what to expect, they quit. Then you spend more money on training and keep on [temporary] agency [staff]."[53]

In Iowa, a study of direct caregivers utilized two interventions at selected facilities to see if these would influence retention: a CNA mentoring program and a career ladder program. The study measured retention rates at facilities implementing these programs against those where no mentoring or career ladder programs were implemented. The facilities with interventions had an average length of service during the study period of approximately 19 months compared to the non-intervention facilities' average length of service of approximately 10 months. In follow-up surveys with the staff at each type of facility, job satisfaction was higher at facilities implementing the interventions.[54]

In Pennsylvania direct caregiver focus groups, orientation and training were subjects for discussion as well, and these groups of caregivers viewed training and orientation as critical to retention. From their perspective, the first few weeks were crucial in determining whether new workers would attempt to make the job work for them. The most important element was hands-on training that enabled caregivers to handle real-life situations. One caregiver commented, "Someone is whipping your butt while you're trying to change them. . . the dummy you trained on didn't do that." Caregivers in home-based care felt that orientation was important as well: new clients meant new issues, and replacing one caregiver with another required a transition period for the caregiver and consumer to become acquainted.[55]

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[53] "What a Difference", p. 42.
[54] Iowa Caregivers Association, Certified Nursing Assistant Recruitment and Retention Pilot Project Final Report (Des Moines, Iowa), 2000, pp. 36-40. Hereinafter cited as "Iowa Caregivers."
[55] PA Council, p. 22.

Opportunities for Advancement: Formal and Informal Career Ladders

A number of the states attempting to respond to long term caregiver shortages have implemented career ladders for direct care workers to assist them in gaining more skills, credentials and better-paying jobs, usually within the long term care field. Eight states have developed or are developing formal career ladder programs and some, such as Massachusetts, have provided substantial funding for these efforts.

In Indiana, some long term care providers, facility and community-based, have developed their own informal career ladders by setting up internal or external training arrangements for direct care and/or homemaking staff. In the case of one Indiana home health care agency, homemakers who show promise are paid their same hourly wage to attend CNA classes at a neighboring nursing home that has an approved CNA program. When homemakers complete the CNA program, the home health care agency then gives them the additional training required to be a registered home health aide, and they then move into a better paying position, still in home health care. Some nursing homes provide training programs for their CNAs to become QMAs, increasing their salaries accordingly, and they sponsor something similar to a graduation ceremony that recognizes the additional achievement.

As noted in the first chapter of this report, some of the state's nursing programs are reaching out to CNAs to help them articulate upward as far as they would like to go. A similar effort needs to be made with registered home health aides. A number of key informants and focus group participants for this report were adamant that Indiana nursing programs should do much more outreach to nursing home personnel in terms of educational opportunities and continuing education. There was also strong feeling that nursing programs need to better educate themselves about the realities of long term care, so that they can fairly represent it to their students. Nursing programs, the nursing home associations, and the home health associations need to work together on behalf of partnerships that will foster a quality nursing workforce for the populations needing long term care.

Minimum Staffing Ratios

As noted in earlier sections, Indiana is not the only state concerned about its long term caregiver shortage. Over the past several years, about 35 states have initiated efforts to develop effective recruitment and retention strategies related to health care personnel in long term care (see Appendix O). Some states such as North Carolina have done a series of studies related to workforce shortages throughout the nursing profession, and others, like Georgia, have done broader health workforce studies, only a portion of which concern RN, LPN and CNA shortages. National studies have been conducted as well to try to increase awareness about the current and impending shortage of caregivers and to devise solutions.

One of the strategies identified in a number of these reports is minimum staffing ratio requirements. Proponents argue that there is an identifiable staffing threshold in nursing homes below which quality of care is compromised. In a recent federal study, sample data from 10 states and over 5,000 facilities were analyzed, yielding optimum minimum staffing levels for short-stays and long-stays. For short-stay quality thresholds, a minimum of 2.4 CNA hours per resident day and 1.15 licensed nurse hours per resident day appear to make a difference. For long-stay quality improvement, the study specifies 2.8 CNA hours per resident day and 1.3

hours licensed nurse hours per resident day. Within each of these ratios, RN requirements were .55 hours per resident day for short-stay quality measures and .75 hours per resident day for long-stay quality measures.[56]

States have specified minimum staffing ratio requirements also. These vary widely. In some cases, nursing hours per patient day is used as the basis for calculation; in other cases, the requirement sets a given number of RNs per specified number of residents. In still other cases, the minimum requirement may be sensitive to shift, number of beds, and types of nursing personnel. In Delaware's case, the state conducted its own minimum staffing level study to determine whether legislation passed two years ago had made for quality improvements and found that facilities operating at or above the minimum of 3 direct care nursing hours per resident day (including some portion of nurse supervision hours) had significantly fewer deficiencies than facilities operating below the minimum.

In some states, the staffing levels have been enacted along with wage passthrough legislation or rate increases. This optimizes the ability of facilities to meet the requirement and keeps it from being an unfunded mandate. States enacting wage passthroughs have developed different ways of assuring that these funds find their way into workers' pockets, so that they are not used for overhead costs or shareholder dividends. Kansas analyzes turnover data for direct care staff related to the wage passthrough initiative; Montana requires audits to verify that wage passthroughs were handled as required; and Rhode Island includes employee satisfaction as one of its criteria for receiving additional hourly reimbursement. In Texas, an incentive approach is used: the staffing requirement permits a nursing facility to choose a staffing level of participation to receive additional direct care staff funding. If the level is not met, the facility must repay the unused enhancement funds to the state. There is also a minimum spending level requirement for direct care. In Iowa, the state has developed a "Quality Assurance" incentive package which gives facilities incentive payments for meeting certain quality assurance measures, one of which is staff retention.[57]

The federal study recommending minimum staffing levels recognized that some states or areas within states might have difficulty garnering the needed human resources to meet a minimum staffing requirement. In fact, it projected that 52 percent of all nursing homes would fail to meet all of the federal standards and 97 percent would fail to meet one or more. In view of these findings and the fact that the supply of nurses and direct care staff is unlikely to increase dramatically in the short term, the study recommends an alternative approach: requiring minimum expenditures for nurse staffing.[58] In this way, facilities could respond in the way they considered most efficient and best suited to labor market conditions in their area. A facility could choose among various strategies, including increasing overall numbers of staff, focusing on salary increases for directors of nursing, increasing wages for all existing staff, or they could pursue a mix of these strategies.

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[56] US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report, December 2001, "Overview of the Phase II Report: Background, Study Approach, Findings and Conclusions," p. 6. Hereinafter cited as "Overview."

[57] This discussion is based on Paraprofessional Health Care Institute and North Carolina Department of Health and Human Services Office of Long Term Care, Results of the 2002 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce, June 2002.

[58] "Overview," p. 10.

While it can be argued that minimum staffing requirements may present a challenge to fulfill no matter how they are formulated, it is also true that CNAs, the crucial workforce element of nursing homes, have identified short-staffing as one of the major reasons they leave a particular facility and leave the CNA workforce. Without some type of minimum staffing standard, as well as the funds to pay for additional staff, direct care supply problems will only get worse. Workers will not be attracted to a job where overwork and underpay is regarded as the norm. Improvement has to start somewhere.

Currently, Indiana has no minimum staffing requirements, and for some focus group participants and persons interviewed for this report, this is a serious problem. Working CNAs feel it is important that some type of state standard be developed and enforced. Some consumer-oriented informants desired minimum staffing ratios by shift and position rather than just by resident day, like the requirements enacted by Arkansas, Connecticut, Delaware, Maine, Massachusetts, and Michigan. Some nursing home administrators favor minimum staffing requirements as well, as long as there is a wage passthrough or a rate increase to help pay for the additional staffing.

Indiana should consider the types of minimum staffing requirements enacted by other states, corresponding wage passthrough or rate increases associated with the requirements, the monitoring procedures related to appropriate expenditure of funds, and measurement of quality improvements. If long term care is to rise to the level that caregiving and care-receiving Hoosiers deserve, the state must set standards upon which consumers and employees can rely. A quality workplace will help to generate a quality workforce.

Single Task Workers: An Ongoing Debate

In March 2002, CMS proposed a rule that would allow specially-trained feeding assistants to aid nursing home residents in eating and drinking, mainly at mealtimes. This would be a change from current federal policy, which requires that feeding be done by RNs, LPNs, CNAs or volunteers and/or family members. The proposed feeding assistants would not have to be trained as CNAs, but they would have to pass a state-approved training program that included curriculum on feeding techniques, assistance with feeding and hydration, communication and interpersonal skills, safety and emergency procedures (including the Heimlich maneuver), infection control, resident rights and recognizing changes in resident condition. The federal rule would also require that they be supervised by a RN or LPN.

Proponents of the rule, including nursing home associations, are convinced that these workers are needed in a tight labor market. Opponents of the change, among them labor unions and some nursing home reform advocacy organizations, argue that further fragmentation of nursing home tasks will increase the use of unskilled workers and that supervision will be diverted from CNAs to feeding assistants. In their view, management will assume that single task workers have lightened the CNA load, and pressure to increase CNA wages will lessen while CNA workloads expand. The ultimate result will be diminished quality of care and worsened morale.[59]

[59] See http://www.afscme.org/publications/issueb/ib0010.htm, and http://www.nccnhr.org/govpolicy/51_162_3227.

Some responding to the proposed rule feel that much would depend on the training required and whether this was determined federally or by each state. Some feel that the minimum CNA training requirements should be used, while others feel that less would suffice. Others have ventured to speculate on who might be recruited to do this activity, e.g. housekeeping staff or retired persons. Still others feel that the single task worker concept should be extended to other responsibilities, such as bed-making. Animated debate continues around the issue.[60]

[60] http://www.directcareclearinghouse.org/Sections/News.htm.

Chapter V

Conclusion and Recommendations

The statute authorizing the Commission on Caregivers (COC) asked the COC to consider the following:

- Welfare to work programs
- Worker recruitment and retention programs
- Immigration
- Linkages between training programs and the long term care and senior services industries
- Cross-training of nurse aides across the continuum of long term care services

COC members were surveyed as to their views on these suggested remedies. They were first asked to rate each by itself on a scale of 1 to 5, with 1 being the most effective and practical and 5 the least effective and practical, and they were also asked to rank the alternatives against each other. The survey of COC members was followed by discussions with each COC member about their rankings and their views on long term caregiver supply in Indiana.

Welfare to Work Programs

In both ranking exercises and in COC interviews there was a general consensus that welfare to work programs would not be an effective solution to Indiana's long term caregiver shortage. COC members pointed out that these programs were expensive and attrition is significant. Program participants require extended training time because long term care is not something that just anyone can do, let alone someone who is unfamiliar with work in general. Members also talked about the diminishing numbers of welfare to work participants, and the fact that a number of them require transportation and day care. COC members also observed that this type of program worked best in urban areas where the population was concentrated, but was less feasible in rural areas. Their general feeling was that Indiana needed a long term solution to long term caregiver supply.

Indiana's efforts to bring welfare to work populations into long term care have been modest, judging from interviews with FSSA staff in Indianapolis and around the state. In Indiana, IMPACT requires persons who are eligible for Temporary Assistance to Needy Families (TANF) and say they would like to become a CNA to research the type of work CNAs do. If possible, they are to shadow a CNA to see if this is what they really want. The IMPACT Family Case Coordinator or contracted provider then interviews the prospective employee again to see what effect the shadowing had on their choice. If the client wishes to proceed, the IMPACT Family Case Coordinator or the contracted provider makes the necessary training arrangements. The demand for this training has not been great. As one Indiana IMPACT consultant put it, "To be a CNA, you have to like people and have good people skills. A lot of the population we work with simply don't have this capacity." Nonetheless, some FSSA IMPACT consultants cite individual successes here. It was not feasible to gain information on how many TANF-eligible persons might have been trained as CNAs or whether they were still

in their jobs. Unfortunately, FSSA tracks each case individually and they are not cross-referenced as to the type of training or the job the individual was ultimately placed in.

Immigration

COC members were largely in consensus that immigration was not a feasible solution to long term caregiver supply. Members cited language barriers, cultural differences, fluctuating numbers, and immigrant composition as issues. While some of these barriers might eventually be overcome, members commented that some immigrants may be in the country only to work and send wages home, and that they might eventually return home themselves. Directors of nursing reported some success with immigrants from the Balkans in CNA positions, and LPN program directors in some parts of the state reported in 2001 that African immigrants (mainly male) were successfully completing LPN classes and licensure. Whether these populations will contribute significantly to the labor pool remains to be seen. In any event, COC members were clearly of the opinion that in terms of a future long term caregiving workforce, the state's money was best invested elsewhere.

Worker Recruitment and Incentive Programs

In a recent presentation, a national authority researching direct care staff shortages noted that nursing home administrators generally perceived direct care staff shortages as a recruitment problem, while direct care staff generally perceived them as a retention problem.[61] This speaks volumes about the different perspectives of two groups crucial to changing the long term caregiver supply picture.

COC member rankings placed worker recruitment and incentives closely behind cross-training and linkages as the most practical (achievable) and effective solution to long term caregiver shortages. Some members were adamant that while this was indeed an employer responsibility, reimbursement had to be raised before the problem could be solved. However, some Indiana focus group participants and informants, including nursing home administrators and directors of nursing, described effective retention practices that were not dependent on additional reimbursement. Furthermore, the research for this study and others indicates that increased reimbursement alone, even if linked to somewhat higher wages, might not have the desired retentive effect, especially if there are other undesirable aspects of the workplace that remain the same, such as short-staffing or poor management practices. Compiling and disseminating best practices for retention, combined with increased Medicaid reimbursement for achieving staffing level targets might help to stem recruitment and retention problems for long term care providers.

Linkages Between Training Programs and the Long Term Care and Senior Services Industries

Based on rankings and interviews, this remedy was the second-most favored by COC members, and almost tied with cross-training for first place. All COC members saw connections with educational institutions as important, although a number of them commented

[61] Stone R, "Long-Term Care: Workforce Issues in a Changing Society," presentation for the American Society on Aging, 2002 Summer Series on Aging.

on the lack of interest by higher education institutions in partnering with long term care. Some COC members also remarked that the long term care sector had been less than vigorous in forging the necessary connections. However, in focus groups and interviews, informants whose facilities currently serve as clinical sites for nursing programs talked about problematic perceptions and attitudes on the part of nursing faculty, and described a general lack of acquaintance with the field of long term care. Obviously, if linkages are to be effective, these perceptions and attitudes need to be discussed, and the realities need to be dealt with by all concerned.

In terms of direct care workers, a number of nursing homes serve as training sites for CNAs for their own benefit and for the benefit of nursing homes and home health care agencies in their immediate area. Data are not available at this time to evaluate the efficacy of this type of linkage as it relates to completion, pass rates, and proportions hired and retained. One nursing home administrator recounted that he had thought his facility was recruiting and retaining most of the people they trained in their own CNA program. Upon further investigation, he found this was not the case, and discovered that it was the lack of follow-up after the initial training that seemed to be responsible, indicating that a mere training connection was not enough. Another nursing home administrator who currently sponsors a CNA training program indicated that he was considering stopping the program. He found that with effective retention policies, almost all of which related to management practices, word of mouth was a more effective recruitment tool.

Cross-training of Nurse Aides Across the Continuum of Long Term Care Services

Cross-training of nurse aides was closely ranked with linkages as a preferred remedy to long term care giver supply. COC members expressed the view that as the needs of patients or residents changed, CNAs and registered home health aides should be able to respond. Cross-training and cross-tasking in different environments would also allow direct care workers some relief from stagnant routine. Some COC members noted that additional training was imperative if multi-tasked aides were to be used effectively and quality of care was to be maintained. It might be possible to develop additional categories of advanced CNA in addition to QMA to reflect additional skills acquired. In the home health care realm, cross-training is already occurring: CNAs who become registered home health aides move between home health and hospital environments, and are capable of following patients in both settings. One of the obstacles to cross-training and cross-tasking, however, is the rules and regulations governing different funding streams, such as Medicaid waiver programs. These need to be reviewed by FSSA in conjunction with Area Agencies on Aging, home health care providers, and ISDH to see where cross-training or cross-tasking conflicts arise.

Conclusion: Building a Comprehensive Approach

The COC has had only a short time to do its work, yet its deliberations are crucial for Indiana's future. The numbers of Hoosiers requiring long term care, whether in communities or facilities, will steadily grow. Just as these Hoosiers will need care, Hoosiers of all ages will need employment. Indiana should use the long term care needs of the state as a means to develop good, stable jobs and productive career paths while providing quality care.

The first step in the process is a change of attitude toward long term care and those who receive it. State government must lead the way. If an out-of-state corporation approached state leadership with the guarantee of thousands of jobs statewide whose multiplication was assured, it is likely that government would respond with incentives and encouragement, while expecting a return on its investment. State government should view long term care similarly. Since Indiana will inevitably have to spend significant sums on care for elderly and disabled persons, it should leverage as much as possible for these dollars. The state should raise Medicaid nursing home rates and Medicaid waiver rates, but these increases should be tied directly to caregiver compensation and agreed-upon quality measures.

Long term care facilities, home health care agencies, and other long term care providers should in return work to collaboratively collect turnover and vacancy information and to develop effective worker retention strategies. Indiana has some excellent examples of facility-based and community-based long term care, where good management practices, decent salaries and benefits, and staff appreciation and advancement programs have resulted in retention and mobility to higher paying jobs in the health care workforce. This report has drawn on interviews and focus groups that included some of these model employers.

National studies and studies in other states have set out the types of practices that help staff to feel valued and that also result in better care for residents and clients. The basic "take-home" message is quite simple: treat the resident/client as a consumer and treat the long term caregiver, including the direct caregiver, as a professional who provides essential life-sustaining services. The provider associations should do everything within their power to promote good management models, and use turnover and vacancy data in part to determine which providers might be in need of improvements. All providers need to review their management strategies and take responsibility for the implementation of practices that will retain nursing and direct care staff, and elevate the quality of care.

COC members feel that state agencies, long term care providers, and educational institutions need to do a better job of educating health care professional students and the public about long term care. Many of us will need caregiving at some point in our lives, whether because of disability or old age. Providing that care in a quality way is an honorable endeavor, and should be viewed as such. Improvement of working conditions, elevation of salaries and benefits, and employer respect and appreciation will help to bring this about, but public outreach is also an important component for success.

The following recommendations are designed to transform Indiana's long term caregiver deficit into a growth industry creating stable jobs, opportunities for advancement, and a better quality of life for elderly and disabled persons. Implementation of the recommendations might require the appointment of specific Task Groups. Another approach might be to delegate the different tasks to ongoing commissions or councils, such as the Commission on Excellence in Health Care or to the most appropriate commissions and task forces under the Governor's Commission on Home and Community-based Services.

Governor's Commission on Long Term Caregivers: Recommendations

- **Access and Service**

- **Data**
- **Education**
- **Recognition and Appreciation**
- **Workplace**

Recommendations have been grouped according to their general area, and the areas are arranged alphabetically. There is no priority order within each group.

<u>Access and Service</u>

- The Family and Social Service Administration should expedite its approval and payment process under Medicaid waiver programs and CHOICE. It needs to meet with Area Agencies on Aging, home health care providers, home care providers and representatives of those in need of services to discuss strategies for improvement. It should consider using the same process as CHOICE to manage the Medicaid waiver programs. This process allows Area Agencies on Aging to negotiate contracts with local providers for the delivery of services. The Area Agencies are then responsible for ensuring the quality of services provided. However, the quality of Area Agencies across the state is not uniform, and the Family and Social Services Administration will need to adopt and enforce quality measures to assure consumer satisfaction.

- The Family and Social Services Administration and the Indiana State Department of Health should continue to work together diligently to resolve as quickly as possible any regulatory conflicts that may arise because of their different roles and perspectives in health care delivery. The Governor's Commission on Home and Community-based Services should evaluate the roles and interactions of these agencies in facilitating consumer access to community-based care, and make recommendations for procedures that will minimize consumer difficulty, enhance quality, expedite care delivery, and fulfill regulatory requirements.

- Indiana home health care associations should conduct a confidential survey of their membership to assess whether home care providers and home health care agencies are serving Medicaid waiver and CHOICE clients, and to provide more information on barriers to taking these clients. The results of the surveys should be made available to the Family and Social Services Administration so that it can devise remedies for the problems identified, including low Medicaid waiver rates and transportation costs.
- The Governor's Commission on Home and Community-based Services should explore the feasibility of a PACE grant (Program of All-Inclusive Care for the Elderly) with existing centers of geriatric excellence in the state. The PACE program is a capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. It utilizes a comprehensive medical and social service delivery system that includes a multidisciplinary team approach in an adult day health center. This is supplemented by in-home and referral services based on participants' needs. There are 15 states with at least one PACE (or pre-PACE) site in place, and some states, like Pennsylvania, have more than one. Some states have set up health professions student rotations at their PACE

site(s), and Indiana should make every effort to implement an interdisciplinary training program at the proposed site.

- The Indiana State Department of Health Local Liaison Office should explore utilizing state and federal funding to establish nurse-managed clinics in long term care facilities, similar to the model of the Rural Health Clinic Training Centers. These clinics would provide primary care for persons who are elderly or disabled, and help to train students in multiple health disciplines with a focus on Health Occupations Education students, nursing students (RN and LPN), nurse practitioner students, CNA students, social work students, home health aides, Qualified Medication Aides, and personal attendants. These clinics should also make every effort to actively involve the three Indiana nursing programs that have received private or federal grants to enhance geriatric curriculum, and should also work to involve family practice residency programs in their region.

Data

- The Indiana Department of Workforce Development should convene an interagency task force consisting of the Indiana State Department of Health, the Indiana Department of Education, the Indiana Commission for Higher Education, the Indiana Health Professions Bureau, the Family and Social Services Administration and the Indiana Health Care Professional Development Commission to link data related to long term caregivers, including RNs, LPNs, CNAs, QMAs, registered home health aides and personal attendants. The linked information should be aggregated in such a way as to provide information that will assist in the development of recruitment, retention and career lattice programs for these professions. Possible sources of funding include: federal Preventive Health Block Grant funds; federal funds received by the Family and Social Services Administration for Nursing Home Transition, Real System Change, Community Pass, or workforce development; and Department of Workforce Development federal workforce development funds.

- The General Assembly should fund the Indiana Health Care Professional Development Commission (HCPDC), so that the Indiana State Department of Health can hire staff for the HCPDC's activities. This interdisciplinary body was created by resolution in 1995 and is the only state entity to give sustained and comprehensive attention to Indiana's health professions shortages. Under the HCPDC, the Department of Health should continue and expand its surveys of health professionals through the Health Professions Bureau's license renewal process, both paper and electronic. Without fail, the Department of Health and the Health Professions Bureau should collaborate on a comprehensive survey of all nursing groups (including LPNs) that includes a full-scale nursing articulation study. The Health Care Professional Development Commission should work with the Health Professions Bureau to improve its database so that information on the educational background of Indiana health care professionals is easily accessible. The Health Care Professional Development Commission should also work with the Family and Social Services Administration and the private sector to try to project Indiana's service needs and their impact on health professions in the future. Additional funding sources should also be explored.

- The General Assembly should give the Indiana State Department of Health appropriate statutory authority to develop rules requiring CNA training programs to provide information on the number of successful completers by year of completion, and should also require CNA testing sites to provide information on the numbers sitting for the CNA examination, as well as those passing the examination, by training site. The General Assembly should also allocate to the Department of Health appropriate funding for these additional responsibilities.

- The nursing home associations and home health care associations should partner with the Family and Social Services Administration and the Indiana State Department of Health to develop a vacancy and turnover questionnaire to regularly gather information on vacancy and turnover rates for different types of positions across all long term care providers, both facility and community-based. The questionnaire could be developed by adapting surveys used in other states. The results of these questionnaires should be made available to the public in printed form and on the web at least annually. The results should be used to help the Health Care Professional Development Commission and the Department of Workforce Development project future needs for health care professionals, including long term caregivers.

- The Family and Social Services Administration should continue its efforts to develop and implement a standard methodology for determining the number of persons in need of Medicaid waiver and CHOICE services, by type of service need. The waiting lists for these programs should be updated at regular intervals and shared with the public. FSSA should aggregate service need data from the waiting lists and transmit this information to the Department of Workforce Development, the Indiana Health Care Professional Development Commission and the Indiana State Department of Health for workforce projection estimates.

Education

- The Department of Workforce Development, the Department of Education, the Commission for Higher Education, and the Indiana Career and Post-Secondary Advancement Center should work together more closely to enhance the development and expansion of the Health Occupations Education program in ways that relate to long term care, both in community-based and facility-based settings. The mission of Health Occupations Education is to provide students an academic base on which to build a career in health care. In academic year 2001-02, over 4,000 students took courses that in some way related to the health care industry. There is enormous potential for Health Occupations Education to contribute to Indiana's health professional supply, particularly in the area of long term care. The agencies named in this recommendation should facilitate partnerships throughout the state between Health Occupations Education programs and higher education institutions, health care facilities, and home health care agencies. They should make every effort to develop private and public sources of financial aid for Health Occupations Education students (e.g. approach Indiana's community foundations); develop faculty recruitment and faculty-sharing arrangements among health care providers, Health Occupations Education programs,

local and regional health workforce development efforts, and higher education health-related programs; and encourage articulation between secondary Health Occupations Education programs and health-related higher education programs.

- Nursing home foundations and nursing home owners should set aside some of their funds to assist Health Occupations Education students in nursing assistant classes with the cost of transportation, uniforms, name tags, and shoes during their training. This will help to create a connection between these students and long term care. The funds could be distributed by Health Occupations Education program directors to students in need of assistance.

- CNA testing logistics and requirements should be available to the public. The Indiana State Department of Health should post on the web contact information for CNA training and testing, so that this information can be easily accessed by all seeking to be CNAs. The Indiana State Department of Health should also ask for input from CNA training providers, including educational institutions such as Ivy Tech, on "Frequently Asked Questions," so that the agency can develop answers to these questions and post them on the Department of Health website in an appropriate location.

- The Governor should as soon as possible write a letter to Indiana Congressional representatives expressing support for modifying the federal regulation that currently suspends CNA training at nursing homes under certain conditions. The letter should ask Indiana's delegation to do everything they can to revise this regulation in appropriate ways. The Governor's Office should solicit suggestions about the wording of the letter from nursing home associations and the Indiana State Department of Health.

- Higher education institutions and long term care employers should review their programs for responsiveness to the needs of the working student. Higher education institutions should make financial aid information readily available and provide financial aid counseling for students. They should also implement more part-time nursing articulation programs and develop other strategies that make it comfortable for health care workers at all levels to obtain additional education. The Commission for Higher Education should encourage these higher education efforts. For their part, employers should re-evaluate tuition reimbursement programs that require front-funding of tuition costs by students and full-time employment. The majority of students participating in focus groups for this study were working their way through school in either a CNA program or a LPN program. They described financial hardship, late notification of class and clinical rotation schedules, difficulties in accessing child care, and exhaustion created by simultaneously pursuing a full-time education and a full-time job.

- Indiana nursing programs at every level should review their curriculum to assure that they are providing adequate didactic and experiential learning related to the populations requiring long term care, and the systems and settings that deliver long term care. Programs should measure their curriculum against the model curricula developed by national organizations such as American Nurses Association, National League of

Nursing/Kellogg Foundation, Association for Gerontology in Higher Education, the National Institute on Aging and other groups. Nursing programs should seek to give undergraduate and graduate students didactic and clinical experiences with aging populations across a variety of care environments. Directors of nursing programs should instruct their faculty to learn more about long term care delivery systems in facilities and communities so that they can provide accurate information to their students about the opportunities for delivering compassionate and cost-effective care in these environments.

- The Indiana State Board of Nursing and the Indiana Commission for Higher Education should look into the type of geriatric and long term care curriculum being provided at Indiana nursing programs. Research for this report raised questions about the nature of the current curriculum and whether adequate attention is being given to geriatrics and long term care. Since RNs and LPNs will be in management positions in long term care facilities, home health care agencies, and other long term care delivery settings, they should understand the populations they will be dealing with, the staff they will be managing, and the challenges posed in various long term care settings. In view of the changing demographics of the nation and the state, the Board of Nursing should evaluate the National Council Licensure Examination (NCLEX) to determine whether it includes sufficient material on geriatrics and long term care. If the NCLEX is found to be deficient by the Board in these areas, the Board should write to the appropriate bodies asking that the situation be rectified as soon as possible.

- Long term caregivers need appropriate support from other professions involved in the care delivery system. Coordination and collaboration among disciplines enhance effective service and consumer satisfaction. The Commission for Higher Education should consider a review of geriatric and long term care curriculum provided to students in social work, medicine, dentistry, dental hygiene, occupational therapy, physical therapy, and other therapy disciplines, to ensure adequacy of content and the incorporation of a collaborative approach to caregiving.

- The Governor and General Assembly should use every means available to encourage Indiana nursing programs to develop partnerships with long term care facilities and home health care agencies for the creation or expansion of learning opportunities within the nursing curriculum related to geriatrics and long term care delivery systems; continuing education opportunities for nursing home and home health care staff (including CNAs, home health aides and personal attendants); and grant applications under the federal Nurse Reinvestment Act and other federal or privately-funded grant programs.

- One of the chief bottlenecks for nursing supply in Indiana is the nursing faculty shortage. This is likely to worsen in the next few years as current nursing faculty retire or leave for higher-paying jobs in the private sector. The Indiana Health Care Professional Development Commission (HCPDC) and the Commission for Higher Education should carry out a faculty vacancy survey of Indiana nursing programs to determine current and future need for faculty, and utilize all available Indiana nursing studies. They should also review faculty development programs in other states and compile information on available grants and other initiatives for nursing faculty

development, recruitment and retention. The HCPDC and the Commission for Higher Education should also develop recommendations for the most cost-effective ways for the state to fund higher nursing faculty salaries and more faculty positions, with particular attention to those nursing programs with waiting lists. They should also recommend ways of monitoring any additional funds received by institutions to assure that these are used for the intended purposes. This information should be set out in a report as quickly as is feasible. The report should be shared with the Governor, the General Assembly, Indiana nursing programs and the general public.

- The Indiana General Assembly should give top priority to the funding recommendations of the nursing faculty development study once the study has been completed.

- The Indiana State Department of Health and the Department of Workforce Development need to convene a Direct Care Task Group that includes representatives of providers who use CNAs (preferably representatives who work with direct care workers every day, such as directors of nursing, LPNs and human resource directors), home health care agencies, CNAs, CNA educators, the State Ombudsman, a local ombudsman, and consumers. The Task Group should consider whether CNA training hours need to be increased; whether additional content should be included in training that relates to stress reduction, mental health, and other skill development areas; and the most effective ways to expand accessibility of CNA training and testing. The Task Group should review the changes made by other states to CNA curriculum and credentials, and consider whether the state should create an advanced category of direct care worker with specific continuing education requirements. This category would entitle the direct care worker to additional compensation and to add appropriate credential initials after her/his name that denote completion of the required number of continuing education hours. This would be in addition to and different from the Qualified Medication Aide. The Direct Care Task Group should also make recommendations to the Governor and the General Assembly about appropriate ways for the state, provider associations, and local communities to promote the field of direct care and to recognize the service of direct care workers.

Recognition and Appreciation

- The Governor's Office and General Assembly should create an annual Caregiver Recognition Week and call upon the state Chamber of Commerce, local chambers of commerce, community foundations, long term care providers (facility- and community-based), and educational institutions with programs to train direct care workers and long term care nurses to develop community, regional and statewide activities celebrating direct care workers (including CNAs, registered home health aides, personal attendants and homemakers), and long term care and home health care nurses. The Governor and General Assembly should also create recognition awards in cooperation with area agencies on aging, home care agencies, home health care agencies, and nursing homes for individual direct care workers so that the essential contributions of these health care personnel will be appropriately and regularly acknowledged.

Workplace

- The Department of Workforce Development needs to continue to utilize Advance Indiana funds to promote regional skills alliance forums among long term care providers in all areas of the state to create a collaborative rather than competitive climate for long term caregiver training, recruitment and retention. These regional skills alliances should also be encouraged to formulate collaborative training projects that will be supported by Advance Indiana.

- Within the regional workforce development system, alliance activities need to include a compilation of "Best Practices" in management to promote retention of long term caregivers and brainstorming about the way to generate interest in long term caregiving. Members of the regional workforce system should reach out to employees, colleges, Health Occupations Education programs, churches and other appropriate entities for ideas on how to promote long term caregiving as a career and how to honor long term caregivers in their communities.

- The Department of Workforce Development should chair a work group consisting of educators, long term care providers (facility- and community-based), and direct care staff representatives (facility- and community-based), to discuss the formulation of a Career Lattice, which sets out vertical and horizontal career paths across the continuum for the advancement of workers from housekeeping positions to RNs. The lattice should articulate specific educational requirements for vertical movement but it should also set out the recommended additional competencies for lateral movement and continuing education for direct care workers and licensed personnel. The notion of a lattice, rather than a ladder, is fundamental to success. Long term care does not need more hierarchy.

- Long term care provider associations should make every effort to encourage their members to distribute information to their staffs on Hoosier Healthwise, the state's Children's Health Insurance Program. The Indiana State Department of Health should also distribute information on the program through its provider newsletters, its website, and the CNA, QMA and home health aide registries, as has been done in other states.

The Family and Social Services Administration should provide Hoosier Healthwise materials to all Area Agencies on Aging to distribute to contracted providers under Medicaid waiver and CHOICE programs. This might help increase access to children's health insurance for the children of direct care workers who otherwise may not have it.

- The nursing home associations, the Family and Social Services Administration, and the Indiana State Department of Health may need to review the minimum staffing ratios and wage passthrough methodologies adopted by other states, and consider how these might be beneficial to Indiana. They should also develop appropriate quality measures that will be incorporated into the nursing home evaluation for purposes of assuring that any increase in Medicaid nursing home rates will be used for wage or benefit increases or other activities that will improve staffing ratios and quality of care. Any proposed staffing ratio methodology should incorporate consideration of adequate funding, case mix sensitivity, and local labor market variations. A strong monitoring system should be enacted alongside any increase, to make sure that the funding goes exactly where the Commission on Caregivers believes it should go: into the pockets of nursing and direct care staff. If facilities and agencies cannot document this to the state's satisfaction, they should be required to pay back any funds received as part of the initiative and should also be assessed financial penalties. This should not be construed as a recommendation for minimum staffing ratios, but rather research into staffing alternatives.

- As with nursing home rates, Medicaid rates for home care and home health care waiver services are too low. At their current levels, they discourage providers from taking eligible clients. They also make it difficult for providers who accept waiver clients to pay a decent wage, offer adequate benefits, and reimburse transportation costs. The rates should be increased in such a way as to remove the disincentive for delivering waiver services and to encourage development and retention of a high quality workforce for community-based care. The Governor's Commission on Home and Community-Based Services or one of its task forces, should work with home care providers, home health care agencies, Area Agencies on Aging, and the Family and Social Services Administration to develop a waiver and CHOICE rate methodology that ties the payment of a higher Medicaid waiver rate to a provider's offering a basic standard package of wages, benefits, and travel reimbursement.

- The Governor's Commission on Home and Community-Based Services Transportation and Employment Task Force should consider the transportation and employment issues of direct care workers needed for community-based care. Transportation inadequacies in rural areas should be given special attention.

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Report of the Governor's Commission on Long Term Caregivers

Appendix A

Indiana Long Term Caregivers Commission Authorizing Statute

SECTION 20. [EFFECTIVE JULY 1, 2001] (a) As used in this SECTION, "commission" refers to the governor's commission on caregivers established by subsection(d).

(b) As used in this SECTION, "health facility" has the meaning set forth in IC 16-18-2-167.

(c) As used in this SECTION, "long term care caregivers" means certified nurse aides, licensed practical nurses, and registered nurses employed in health facilities, home health care, and other community-based-settings.

(d) The governor's commission on caregivers is established.

(e) The commission consists of the following members:

(1) The governor or the governor's designee, who shall serve as the chairperson.

(2) The state health commissioner (IC 16-19-4-2) or the commissioner's designee.

(3) The president of the Indiana state board of nursing (IC 25-23-1-5) or the president's designee.

(4) The secretary of family and social services (IC 12-8-1-2) or the secretary's designee.

(5) The chairman of the commission for higher education (IC 20-12-0.5-7) or the chairman's designee.

(6) The state superintendent of public instruction or the superintendent's designee.

(7) The commissioner of the department of workforce development (IC 22-4.1-3-1) or the commissioner's designee.

(8) The director of the department of commerce (IC 4-4-3-2) or the director's designee.

(9) The commissioner of the department of labor (IC 22-1-1-2) or the commissioner's designee.

(10) One (1) member appointed by the governor to represent each of the following organizations:

(A) The Indiana Association of Homes and Services for the Aging.

(B) The Indiana Health Care Association.

(C) The Indiana Association for Home and Hospice Care.

(D) The Indiana State Nurses Association.

(E) The Indiana Health and Hospital Association.

(F) The Indiana Home Care Task Force.

(G) The Indiana Association of Area Agencies on Aging.

(H) United Senior Action.

(I) The Indiana University School of Nursing.

(J) Ivy Tech State College.

(11) One (1) member appointed by the governor to represent a private postsecondary educational institution that offers nursing degrees.

(f) The commission shall do the following:

(1) Review data and information on the availability of and need for long term care

caregivers.

(2) Evaluate barriers to increasing the supply of long term care caregivers.

(3) Evaluate the adequacy of existing training programs in the state for long term care caregivers.

(4) Develop recommendations to increase the supply of long term care caregivers, including the following:

(A) Welfare to work programs.

(B) Worker recruitment and incentive programs.

(C) Immigration.

(D) Linkages between training programs and the long term care and senior services industries.

(E) Cross-training of nurse aides across the continuum of long term care services.

(F) Potential roles for various state agencies and educational institutions represented on the commission.

(g) Eleven (11) members of the commission constitute a quorum.

(h) The affirmative votes of at least eleven (11) members of the commission are required for the commission to take any action, including the approval of a final report.

(i) Each member of the commission who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b).

(j) The commission may contract with a private individual or organization to provide the staff support necessary for the operation of the commission, including conducting research and developing the report required under subsection (k).

(k) The commission shall submit a report to the governor and the legislative council not later than October 1, 2002.

(l) There is appropriated to the commission forty-nine thousand dollars ($49,000) from the state general fund to implement this SECTION, beginning July 1, 2001, and ending October 1, 2002.

(m) Funds appropriated under subsection (l) do not revert to the state general fund at the close of a state fiscal year but remain available to the commission through October 1, 2002.

(n) This SECTION expires October 2, 2002.

Report of the Governor's Commission on Long Term Caregivers

Appendix B

Members of the Governor's Commission on Long Term Caregivers (COC)

The governor or the governor's designee, who shall serve as the chairperson:
Beth Compton
Deputy Counsel and Executive Assistant for Health and the Environment

The state health commissioner or the commissioner's designee:
Liz Carroll
Assistant Commissioner for Health Care Regulatory Services

The president of the Indiana state board of nursing or the president's designee:
Laurie Peters, MSN, RN
Vice President, Indiana State Board of Nursing

The secretary of family and social services or the secretary's designee:
Jackie Pitman
Director, Bureau of Strategic Support Services
Division of Disability, Aging and Rehabilitative Services

The chairman of the commission for higher education or the chairman's designee:
Karen Rasmussen, PhD
Associate Commissioner for Planning and Policy Studies

The state superintendent of public instruction or the superintendent's designee:
Carolyn Wegner, MSN
Health Occupations Specialist.

The commissioner of the department of workforce development or the commissioner's designee:
Patrick J. Vercauteren
Deputy Commissioner of Policy and Evaluation

The director of the department of commerce or the director's designee:
Sharon T. Kendall
Manager, Existing Business Team
Business Development Division

The commissioner of the department of labor or the commissioner's designee:
John Griffin
Commissioner

One (1) member appointed by the governor to represent each of the following organizations:

The Indiana Association of Homes and Services for the Aging
Barbara Pantos, RN, MS
Outcome Liaison, Medical Division, Eli Lilly and Company

The Indiana Health Care Association
Faith Laird, RN
Vice President, Regulatory Affairs

Indiana Association for Home and Hospice Care
Rosanne Bordenkecher, MSN, RN
Director, Columbus Regional Hospital Home Services

The Indiana State Nurses Association
Christina Johns, BSN, RN, C
Regional Clinical Service Consultant

The Indiana Hospital&Health Association
Robert E. Morr Jr.
Vice President

The Indiana Home Care Task Force
Linda Simers, LPN

The Indiana Association of Area Agencies on Aging

Patricia Jewell
Executive Director
LifeSpan Resources, Inc.

United Senior Action

Jerry Swinehart

The Indiana University School of Nursing

Lillian Stokes, PhD,RN, FAAN
Associate Professor and
Director, Diversity and Enrichment

Ivy Tech State College

Kathleen Lee, MS, RRT
Division Chair for Health and Public Service
Ivy Tech State College - Central Indiana

One (1) member appointed by the governor to represent a private postsecondary educational institution that offers nursing degrees

Anita Hupy Siccardi, EdD, APRN, BC
Director of the Graduate Nursing Program
University of Indianapolis School of Nursing