National Survey on State Initiatives To Improve Paraprofessional Health Care Employment:

October 2000 Results On Nursing Home Staffing

For the past 18 months, the Paraprofessional Healthcare Institute (PHI) and the National Citizens' Coalition for Nursing Home Reform (NCCNHR) have been documenting states' activities around nursing home staffing. In fall 1999 and, again, in summer 2000, surveys were sent to ombudsmen's offices in all 50 states. Additional data was collected through follow-up phone calls and secondary sources.

The PHI/NCCNHR November 1999 report on state initiatives to improve staffing shows that 40 states have been addressing inadequate staffing levels in some way. These states have recognized that, as the HCFA staffing study released in July 2000 points out, inadequate staffing levels are directly affecting the quality of care received by residents.

Preliminary results from this most recent survey, released in October 2000, show that, in the 40 states that responded to the survey, advocates and providers, often working together, are pursuing a variety of solutions. Although many states are pursuing legislation that would mandate improved staffing-to-resident ratios, some are looking at a broader array of reforms to help providers recruit and retain a stable, well-trained workforce. Most notably, a large number of states are seeking to improve wages for CNAs. Those that are most forward looking are also seeking to improve benefits, training, and opportunities for advancement in order to compete for workers in the new economy. Massachusetts successfully passed a comprehensive bill that authorized funds for wage increases, pre-certification preparation and certification training, and career advancement demonstration projects.

Summary of Findings

Staffing Ratios Several states have fully adopted changes in staffing ratios, while others achieved legislative approval, but not final gubernatorial approval. Maine has adopted new staff-to-patient ratios for staff responsible for "hands-on patient care" (including all nursing staff): 1 to 5 for days; 1 to 10 for evenings; and 1 to 18 for nights. Oklahoma has approved ratios of 1 to 8, 1 to 12, and 1 to 17, respectively,

Tables:

beginning September 1, 2000. Further increases, mandated for 2001 and 2002 eventually achieve ratios of 1 to 6, 1 to 8, and 1 to 15. (The Oklahoma ratio includes activity, social services, and therapy staff as well as nursing staff until 2002, when the ratios must include only CNAs). California passed legislation mandating minimum threshold of 3.5 hours of hands-on care per patient per day by 2004, unless a study commission develops an alternative recommendation by that date. Delaware also passed legislation mandating that minimum hours be increased to 3.0 hours per patient per day for 2001; a study commission has recommended increases to 3.2 hours by December 2001 and to 3.67 hours by January 2003.

Advocates also introduced legislation to set higher staffing levels in Michigan, New Jersey, New York, and Washington, DC, but efforts failed this year. Rhode Island's proposal to improve ratios to 1 to 8, 1 to 12, and 1 to 20 stalled in this session. The Arkansas legislature passed a new standard of 1 to 8, 1 to 12, and 1 to 18, but the measure was derailed in July 2000 by lack of departmental funding. Arkansas advocates continue to push for implementation. Most staffing legislation includes a requirement to publicly post staff on duty, reflecting a long-standing consumer demand.

Wages and Benefits In 1999, Connecticut, California, Florida, Maine, Montana, Virginia, and Wisconsin passed wage increases for CNAs. During 2000, more than 20 states (California, Colorado, Delaware, Idaho, Iowa, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Mexico, Nevada, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, Texas, Utah, and Washington) introduced legislation to improve wages to direct-care workers, but many of the proposals either failed or were modest in scope. For example, Oklahoma's reform package set a minimum hourly wage for direct-care workers at $6.65.

Maryland and Minnesota took a more flexible approach to addressing low wages. Maryland passed legislation increasing Medicaid funding to the nursing cost-center by $10 million in both 2002 and 2003. These funds are not targeted specifically to CNAs-the funding can be used to enhance staffing levels, wages, or direct-care services. Minnesota's legislation offers even more flexibility. Rate increases can be used for compensation-related costs, including salaries, payroll taxes, and fringe benefits for all employees except managers and central office staff. An additional rate increase is also available for specific operating costs. In both Maryland and Minnesota, facilities have considerable flexibility in using the rate increases.

Wage pass-throughs are the most commonly proposed strategies to achieve wage increases. We are just learning the effects of different types of implementation on the actual dollars that CNAs receive. For example, in 1999, Virginia passed a package to improve CNA hourly wages by up to a $1/hour, but not all nursing homes applied for the increase. Because the legislation was poorly implemented and lacked accountability, many CNAs failed to benefit from the state authorization. Some states are asking nursing facilities to submit plans to their state Medicaid departments to define how they will use additional funds. Other states take a more standardized approach and determine exactly which staff are eligible and for what amount of increase. Some states have a clearly designated system for auditing these new funds, while others have not been as specific. (The North Carolina Division of Facilities Services will soon publish the results of their study of the efficacy of these different wage pass-throughs. See their most recent data at http://facility-services.state.nc.us/provider.htm.)

Only a few states offer any assistance with health insurance. CNAs benefit from state laws that address the health care needs of low-income workers in states such as Vermont and Hawaii. Vermont expanded a plan that allows individuals with incomes up to 300% of poverty to purchase prescription drugs at the Medicaid rate. Hawaii mandates that full-time workers receive medical coverage from their employers who must pay at least 50% of the premium. Although not yet extended to CNAs, Rhode Island has implemented a program to provide health care for child care workers through Medicaid. This model that could also work for low-wage health care workers. Most states, however, see health care as the responsibility of providers and have not begun to explore alternatives.

In truth, many direct-care workers have traditionally relied on health insurance and other benefits from the public assistance system. CNA wages have been so low that workers have been eligible for Medicaid to provide health insurance for themselves and their children. However, with the cutbacks generated by "welfare reform," more low wage and part-time workers are now left without any health insurance-from either their employer or the government-though their children are often eligible for their state's version of the Medicaid CHIP program. Research, however, indicates that many low-wage workers are not aware of this benefit and are not using it.

Training & Supervision Currently, the federal government requires 75 hours of training for CNA certification. About one-third of the states mandate additional hours of training, with California, Maine, and Oregon at the high end, requiring 150 hours.

Advocates for increased training point to recent data about nutrition, hydration, dementia care, worker injury rates, and turnover rates to illustrate the need for better, more comprehensive training.

Ten states are pursuing efforts to increase or improve the training for CNA certification. Several of those are requiring unspecified additional hours, while California and Oklahoma, among others, indicate that those additional hours should address dementia care. New York advocates sponsored a conference focused exclusively on CNA training requirements, urging that soft skills such as communication and problem solving also be included in the required curriculum. They have also been lobbying for 160 hours of mandated training.

Advocates in several states-Delaware, Massachusetts, and North Dakota-are actively promoting career ladders as another aspect of training. Other states, such as Louisiana are focused specifically on curriculum development.

In contrast to a general push for more training, one bill has been offered in Congress and others have been proposed in the states -West Virginia, for example-for single-task, minimally trained workers. Rather than promoting a solution, the use of single-task, untrained workers poses a risk to the health and well-being of residents while perpetuating the poor quality of direct-care jobs by offering part-time work for even lower pay without benefits.

Finally, more than one-third of the states are looking at ways to shape incentives to promote better management, supervision, and other improvements in the nursing home workplace culture. Nine states have been able to access Civil Monetary Penalty funds to support new programs on training, supervision, and management.

Emerging Coalitions Of the 40 states that responded to the survey, 30 report that their state has either an informal or formally appointed taskforce or commission looking at long-term care workforce issues. Most of these work groups are comprehensive in that they include workers, consumers, providers, and government representatives. The work group in Massachusetts is perhaps most inclusive because it also includes representatives from community colleges as well as the welfare reform and traditional workforce development constituencies.

Notably, the Massachusetts legislature recently passed a bill that provides the most comprehensive approach to addressing workforce issues in nursing homes. In

addition to a $35 million wage pass-through for CNAs, it includes $5 million for CNA career ladder grants, $l million for a scholarship program for certification training for new CNAs, and $1 million in training and adult basic education for prospective CNAs. The governor vetoed two proposals in the original bill: a study on health insurance for direct-care workers and a permanent Advisory Council on Nursing Home Quality to study and make recommendations on staffing levels and workforce issues. This new law is an important model for other states in its comprehensive approach to a multifaceted problem.

Conclusion

Seen as a whole, all these attempts by states are focused on finding ways to attract a stable, valued, and well-trained direct-care workforce for our nation's citizens who are elderly, ill, and living with disabilities. There is a shared recognition that improving the quality of care delivered to residents can only be achieved by enhancing the job quality of the frontline workforce. In some states, advocates are seeking to change a single aspect of the problem. In other states, successes in one year have lead to more improvements in subsequent years. Massachusetts, however, has taken a more comprehensive approach by addressing multiple issues in a single piece of legislation. Their success can be attributed to having created a strong, broad-based coalition that included consumers, workers, and providers who worked together to influence government officials. We must now track these changes over time to evaluate their effect on workforce stability and quality care.

State Activities to Increase CNA Wages

State	Efforts to increase wages in 2000	Efforts to increase wages in 1999	Designed through Legislation, Rate Setting, or Budget	Wage pass-through non-specific increase change in reimbursement formula	Description	Status	Accountability Voluntary or Mandatory
AL	N	N					
AZ	Y	N			Discussion of increase in wages through LTC Taskforce that will start again in fall 2000		
CA	Y	Y	Legislation and Budget	$50 M.Wage pass through in Governor's Aging with Dignity Budget. Includes 7.5% incr. for housekeepers, maintenanc,e admin. And direct care staff.	Increased wages and lower ratio	Passed	7/1/00 Medi-Cal will start program. Mandatory for providers.
CO	Y	N		Discussion of funding of benefits counselor to assist workers access public benefits such as child care, earned income tax program etc.	Coalition and Governor's panel		NA
D.C.	N	N		LTCOP advocating for wage pass-throughs		Discussing with local govt officials	To be determined. No specific time frame. Probably will be voluntary
DE	Y	N			Wage increase for C.N.A in state-owned N.H., not those in privately operated facilities.		
GA	N						
HI	N	N					
IA	Y				Industry efforts for	failed	

					wage pass through		
ID	Y	N	No organized effort, only market driven on individual facility basis				
IL	Y	Y	Legislation, Budget	PCW wage pass-through of $19 million in FY '01.	Effective 7/1/00 facilities will receive a 2.5% increase in Medicaid reimbursement. No specific requirements tied to increase.		
IN	N	N					
KY	Y	Y	Was proposal to pass-through wage increase	To be determined, but legislative session adjourned in 4/2000			Mandatory
LA	N	N					
ME	N	Y	Legislation	Wage pass through of $4M for C.N.A.s in NH, passed in 1999.	federal match of $533,000		Check is done at time of facility audit. Mandatory participation.
MD	Y	?	Budget	$10 M additional funds for both FY 2002 and 2003 for Medicaid nursing service cost centers.	Funds to be used for increase in hours to residents, increase staffing, increase wages, benefits or compensation to direct care personnel.	Passed	NH expenditures will be subject to audit and cost settlement by Dept. of Health and Mental Hygiene
MA	Y		$35 M wage pass through for CNAs in Medicaid facilities passed through budget, signed by governor.		Funds available for wages and benefits, not pool staff.		Accountability mandated. Details to be developed. Mandatory wage pass-through.
MI	Y	Y	Budget	Wage pass-through.	$.50/hour wage		

					pass-through for fy 2001. Contingent on each NF pay their C.N.A. at least $8.50 during post-probationary period.		
MN	Y	Y	Legislation	Divide increase into compensation costs (salaries, payroll taxes, fringe benefits for all employees except mgt, admin and central office staff) and operating costs.	Compensation costs for direct care staff increased by 3.63% in fy 2000.		Facilities must submit plan for increasing wages and operating costs, and post plan in employee room or give copy of plan to every employee. Raises can only be used for existing staff, not new staff. Facilities using funds differently- some for raises, some for benefits
MT	Y	Y	Rate Setting, Budget	Wage pass-through $2.14/day for all direct care workers.			Documentation of starting/ ending wages. Will audit select facilities to ensure. Voluntary participation.
NH	N	N					.
NM	Y	Y	Legislation	Wage pass-through.	Failed in committee		
NV	Y	Y	Legislation, Rate Setting, Budget				
NY	N	N					
NC	Y	N	Legis., Rate Setting, Budget	“labor enhancement” to be used for multiple items.	Being discussed by legislators and	Expect wage increases to be	DHHS to develop

					aging study commission.	implemented by Oct 2001.	safeguards for accountability. Not yet completed.
ND	Y	N			Task force on LTC appointed by governor has subcomm. looking at increasing wages for C.N.A. s, HHA., and career ladder	Legis. session begins Jan. 2001	Medicaid and private pay rates are same in ND
OK	Y	Y	Legislation and rate setting.		Wage pass-through. Increase to $6.65 hourly as minimum wage for C.N.A., effective 7 – 1-2000. All other staff receive $1.50 hour increase	Signed by governor 6-6-2000. Immediate implementation.	Staffing reports/cost reports/audits. Mandatory participation by providers.
RI	Y		Budget	Ongoing discussions with DHS re increases for C.N.A.s	Industry proposal earmarked for direct care staff. Not passed this year.		
SD	N	N		Non-specific incr. in rates	Task force convened in May to study rates currently being paid to facilities		
TN	DK	DK					
TX	Y	Y	Rate setting, Budget.	Change in reimbursement formula. 3.1% incr. in reimb. for FY 2000	.	Currently being implemented	Legis. requirement that increases targeted to staffing, with tracking through cost reports. Mandatory participation.

UT	Y	N	Increase in Medicaid rates for C.N.A. wages only			Slowly beginning	
VA	N	Y	Legislation	$1. hour wage pass through in 1999.			Was not equitably distributed. Not all staff received, not all facilities applied.
VT	N	Y –	Legislation, Rate setting.	Change in reimbursement formula.1999 statute allowed $4 M. from NH bed tax to improve wages and benefits for NH employees. Each NH receives pro- rata share of fund. Facilities can spend funds on any wage or benefit for all staff, except owners/administrators.	States must report to state 60 days after beginning of fy how they are using funds.	Some facilities used to increase wages of all staff, others use as signing bonuses to attract new staff.	States will use facility cost reports to determine if and how supplement was used. If not used for wages/benefits, supplemental payments treated like Medicaid overpayments and can be recouped. Supplement in effect until 2000 when all cost categories will be been rebased. Then supplement will be incorporated into base.
WA	Y	Y	Legislation	Change in reimbursement formulas. Wage pass-through of $.50 /hour/year for 2 years.		Accomplished.	2 year time frame for implementation. Mandatory participation.
WV	N	N		No formal increases proposed, but many facilities paying bonuses and	Discussing wage pass-throughs in ongoing		

				increased initial wages to increase staffing.	discussions with Bureau for Medical Services		
WI	Y	Y		Increase specifically for C.N.A.s not dietary and other support services passed in last biennial budget.			Some difficulties for facilities since funds could not be used for support services personnel.

State Activities to Improve Staffing Levels

State	No. hours of nurse staffing required	Efforts to change for CNA in 2000?	Efforts to change in 1999	Through Legislation, Regulation, or Budget	Description	Status
AL	?	N	N			
AZ	No ratios. Staff to meet the needs of residents.	Y		Legislation	To lower allowable age of CNAs to 16.	Legislation was included in ltc initiative that was a "strike all"
CA	3.2 hours per pt. day	Y	Y for CNA	C.N.A. through Budget, PCW through legislation	Increase wages and lower staff ratio per resident. Increase wages for PCW	Commission to make recommendations by 2004. If not, automatic deferral to 3.5 minimum
CO	2 hours per pt. day.	Y	Some for C.N.A., nothing for HHA, PCW		Discussion with legislators re staffing ratios	Nothing yet
D.C.	fed. requirement	Y	Y for C.N.A.	through regulation	NCCNHR recommended fixed staffing ratios	Regs. not yet finalized. staffing ratios may or not be accepted
DE	2.25 hours daily	Y.	Y for C.N.A., N for HHA, PCW	legislation	proposal for 3.0 contact hours per resident, year one, and 3.33 year two.	Passed 3.0 hours for 2001, with Medicaid funds appropriated. Commission to report by 12/1/01 to increase to 3.2 hours, and by 1/1/03 to increase to 3.67 hours.
GA	2.5 hours daily	Y	Y	legislation	Resolution passed to assign members to study committee to look at all ltc staffing.	Appointment of members
HI	No staffing ratios,	N	N	2 bills died. HI Nursing Assn concern re hospital increasing No. of C.N.A.	2 bills died. No real advocate for staffing ratios.	
IA	2 hours daily	N	N for C.N.A.,			

			HHA			
ID	Up to 59 residents .4 hours per resident day. Hours shall not include DON, but Supervising nurse may be counted. 60 + residents at 2.4 hours per resident day, and not include DON or supervising nurse.	N	N- C.N.A., HHA, PCW			
IL	"Staffing shall be based on the needs of the residents…" Ill. state code.	Y	Y-C.N.A.	Legislation	NCCNHR ratios.	Remained in committee.
IN	Sufficient to meet needs of residents	Y		Legislation	NCCNHR standards	Study commission assigned
KY	No specific number "adequate staff"	Y	Y – C.N.A.	Public committee meetings	NCCNHR ratios	Task force named by KY legislature to examine issues. will look at HHA, too
LA	2.6 skilled, 2.35 intermediate	Y	Y – C.N.A.	Legislation	same staffing ratio as AR law	Bill not pushed beyond introduction, but senator still interested. Will be raised in 2001
ME	1:8 day shift, 1:12 evening, 1:20 night	Y	Y – C.N.A., N- HHA	Legislation	Bill to enrich NH staffing ratios.. Sets up pilot projects to determine appropriate staffing ratios for mealtimes. Report due to legislature Jan. 2001, mandates Me. develop acuity based staffing ratios, with report to leg. 5/2001.	Bill passed with $1,336,000 in state funds, with matching fed. funds of $2,610,000 to increase minimum staffing ratios in NH to 1:5, 1:10, 1:18. Signed by governor in April 2000, P.L. chapter 731.
MD.	2 hrs. daily	Y	Y		NCCNHR standards	Bill went to study. Task force estabd. Legis. introduced in 2000
MI	2.25 hrs daily now (1:8, 1	Y	Y	Legislation to incl 3.0 hours per day	3.0 hrs direct resident. care a resident ratio cannot fall belov average during day	Legislation passed
MT	"meet the needs"	N	Y – C.N.A.,	Legislation		
NH		Y		Legislation	NCCNHR recommended	

					minimum.	
NJ	2.5 hrs. daily plus extra time for residents with complex needs	Y	Y	Legislation and, Regulations. Increased staffing levels with simplified calculations.	Legislation to stop overtime by nurses, C.N.A.s and other direct care workers	Passed both houses, but vetoed by governor.
NM	2.25 hrs. daily	Y	Y	Legislation	Staffing based on acuity. Include only staff who actually provide hands-on service. Medicaid recoupment when minimum standards unmet.	Legislation died in Senate.
NV		N				
NY	"sufficient staffing"	Y	Y	Legislation	NCCNHR ratios	Introduced in State Senate and State Assembly. Not passed.
NC	2.1 hours daily	Y	Y	Legis, Reg and Budget.	1999 increased staff on Special Care Units in adult care homes.	
ND	Fed. "meet res. needs"	N	N			
OH	3.2 hours daily	Y	?		As part of 5 year rule revision for all nursing homes, DOH established commission to look at different proposals. Study of proposal to increase to 4.0 hours daily care due in 8 months.	Public Health Council will report out in eight months. Advocates will revisit in 2001.
OK	1.75 hours daily	Y	Y	Legislation. Raise ratio required of direct care staff to residents. Penalty for facilities who understaff. Raise wages of direct care staff. More to	Not passed in 1999. Passed both houses in 2000, and governor signed.	Raise ratios to 1:8, 1:12, 1:17 by 8/31/01; to 1:7, 1:10, 1:16 by 8/31/02 and to 1:6, 1:8, 1:15 by 9//1/02. By 9/1/02 ratios to include only CNAs, not activities or social services. Legislation also raised all staff but administrators by $1/hour. With minimum wage in NF set at $6.65/hour.

				improve quality of care and quality of life.		
PA	2.7 hours daily	Y	Y	Auditor General's office has been studying issue.		
RI	1.9 hours daily	Y	Y	Legislation	NCCNHR ratios.	Will die in 2000 session. Looks good for 2001
TN	2 hours daily	Discussions	N	Legislation		
TX	?	Y	Y	Legislation	Similar to NCCNHR.	Unsuccessful 1999
UT	No ratio, just "sufficient to meet their needs"	Y	Y	Health Facility Committee.	Priority - Specific ratios for all staff and residents	Advocates must submit specific proposal
VA		N				
VT		N	N			
WA		Y	Y	Legislation.	NCCNHR recn.	Very little progress
WV	2 hrs. daily	Y	Y	Legislation, Regulation	AARP wants 2.75, licensure department requests 2.25. state Health Care Assn wants category of workers (valets) to assume increased responsibility without certif.	AARP proposal died in legislature. . Optimistic that 2.25 will be implemented.
WI	N	N				

State Training Activities to Prepare CNAs

State	No. hours of nurse staffing required	Efforts to change for CNA in 2000?	Efforts to change in 1999	Through Legislation, Regulation, or Budget	Description	Status
AL	?	N	N			
AZ	No ratios. Staff to meet the needs of residents.	Y		Legislation	To lower allowable age of CNAs to 16.	Legislation was included in ltc initiative that was a "strike all"
CA	3.2 hours per pt. day	Y	Y for CNA	C.N.A. through Budget, PCW through legislation	Increase wages and lower staff ratio per resident. Increase wages for PCW	Commission to make recommendations by 2004. If not, automatic deferral to 3.5 minimum
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DE	2.25 hours daily	Y.	Y for C.N.A., N for HHA, PCW	legislation	proposal for 3.0 contact hours per resident, year one, and 3.33 year two.	Passed 3.0 hours for 2001, with Medicaid funds appropriated. Commission to report by 12/1/01 to increase to 3.2 hours, and by 1/1/03 to increase to 3.67 hours.
GA	2.5 hours daily	Y	Y	legislation	Resolution passed to assign members to study committee to look at all ltc staffing.	Appointment of members
HI	No staffing ratios,	N	N	2 bills died. HI Nursing Assn concern re hospital increasing No. of C.N.A.	2 bills died. No real advocate for staffing ratios.	
IA	2 hours daily	N	N for C.N.A.,			

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ID	Up to 59 residents .4 hours per resident day. Hours shall not include DON, but Supervising nurse may be counted. 60 + residents at 2.4 hours per resident day, and not include DON or supervising nurse.	N	N- C.N.A., HHA, PCW			
IL	"Staffing shall be based on the needs of the residents…" Ill. state code.	Y	Y-C.N.A.	Legislation	NCCNHR ratios.	Remained in committee.
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Supervision and Management Strategies and Advocacy Activities on Behalf of CNAs

State	Describe	New funds available for new initiatives? (CMP)	Commission/Taskforce? Topic?	Studies?	Other Strategies?	Key Contact?
AL	Eden Alternative work group	N	Governor appointed committee of NH administrators and Aging Director	DK	N	
AK						Nancy Johnson, Arkansas Adv. For Nursing Home Reform, gjohnson@artelco.com; Alice Ahart, Ombudsman, alice.ahart@mail.state.ar.us
AZ		Y for training	Comprehensive Workforce Taskforce. Reinstated for next legislative session. Includes Dept. Health, Economic Security, AAAs, providers, Alzheimer's Assn, and others.	No study, but work will focus on workforce development and retention, funding, and other areas.	Tucson area coalition of providers, consumers and workers create job bank, continuing education, support etc. Judy Clinco, (520) 327-6351	Dawn Savattone, AAA and ombudsman, 602-264-2255.
CA		N	Y Workgroup includes State omb., DHS, CAHF, looking at Recruitment, trg. and retention	Conducting CNA survey. Recn. to Dir, DHS.	$25 million in state grants tfor training, recruitment and retention of caregivers	Susan DeMarois , Calif. Council of Alzh. Assn. 916-979-9131. Heather Martin, Lic. and Cert, 1800 Third St., Suite 210, Sacco. Ca 94234. 916-322-9912.
CO	CNA leadership day	N	Y. Formal panel soon to be announced, chaired by ED of state Health Care		Alz. training	Virginia Fraser, 303-722-0300. chgin28@aol.com

			Assn.			
D.C.	nominal efforts	DK	Y. Mayor's Health Policy Council, LTC Committee, DC LTC Coalition. Looking at: N.H. regs for DC, and assisted living	Nothing current	Implementing assisted living in D.C.	Beverly Bryant, DC ltc omb., 202-434-2140
DE	Office of State Omb. emphasize benefits of Eden Option, and promotes aqua therapy for ltc facilities	N	Y. Senior Victim Task Force in A.G. office established subcommittees to improve health and safety of NH residents. Ensure that NH staff do not have criminal history.	Not now	Develop systems that protect residents from abuse, neglect, and financial exploitation.	Tim Hoyle, Ombudsmen office, 302-577-4791, thoyle@state.de.us
GA	Eden alternative coalition	N	Y. Appointees to be from provider, worker, consumer, home care and state depts. of Labor, Human Resources, Community Health, Adult Education etc. .	Coalition of providers, Council on Aging, Alzheimer's Assn, Ombudsmen, AAA, Georgia Gerontological Society		Becky Kurtz. 888-454-5826. bakurtz@dhr.state.ga.us
HI			N	Hi does not have ltc worker shortage		John G. McDermott, Exec. Office on Aging, State of Hawaii, N. 1 Capital District, 250 South Hotel Street, Suite 109, Honolulu, HI, 96813-2831, 808-586-7268. jgmcderm@mail.health.state.hi.us
IA	Iowa Caregivers Assn. received funding to recommend how to recruit and retain CNAs through non-financial incentives (e.g.	Y. ICA study funded through CMP and medicaid dollars	ICA survey of CNAs and nurses. Also Commission with IA Healthcare Assn, Omb. office and IA Dept of Inspections and Appeals.	Looking at use of non-traditional workers. Not doing a study, or advocating rule changes, but intense recruitment efforts, PR and cultural changes	Co-sponsored with Alz.Assn. statewide meeting of stakeholders including: providers, officials from workforce devt, welfare to work, education, health, immigration and ltc,	Iowa Caregivers Assn, 1117 Pleasant St., Des Moines, IA, 50309. 575-241-8697. Iowacga@aol.com

	support, shared responsibility, etc.)			at facility level.	elected officials, consumers direct care workers and unions.	
ID		N	N		N	Cathy Hart, ID Comm. on Aging, P.O. Box 83720-0007, Boise, ID 83720-0007. Chart@icoa.state.id.us (208)334-3833.
IL	LTCOP is bringing Pioneers to IL to provide NF staff with concept and implementation strategies.	Y. IL DPH increasing assignment of monitors in homes. They can provide technical assistance to staff while in NF.	Y. looking at recruitment and retention of CNAs. Based on study will develop C.N.A. incentive program by 1/1/01.	No study yet. Due 1/1/01. Commission participants include: DPH, Il Health Care Assn, Life Services Network, Il Council on LTC, County NH Assn, organized labor, Il Community college board, Southern Il Univ. at Carbondale Dept of workforce Ed., Il State Bd. of Ed, Dept on Aging Omb.		Beverly Rowley, browley@ageo84r1.state.il.us. 217-785-3143.
IN	Conference promoting best practices, nonprofit assn.	Y – for training in restraint reduction	Y- task force. United Sr. Action, Alzheimers Assn, Nonprofit industry assn, consumers and omb.	Not that far along.		Paul Severance, United Sr. Action 1211 Hyatt Street, Indianapolis, IN 46221. pseverance@iquest.net.

	promoting culture change to membership.		program. Looking at all possibilities for improving staffing			46221. pseverance@iquest.net, 317-634-0872. or Doug Starks, Alz. Assn, 317 – 575-9620.
LA	Individual facility level: several facilities have or plan to "edenize".	N	Y, looking at training needs.	N	N	Dr. Bob Crow, 504-942-8201 Deborah Eley, Community Living Omb Program 225-925-8884
MA	Broad coalition achieved significant legislative goals	?	CORE (Coalition to Reform Eldercare) includes Alz. Assn., n.h. and h.h. provider assns., Elderly Legal Services, NASW, Paraprofessional Healthcare Institute.	PHI study on workforce crisis in ltc across settings. Published June 2000 in statewide meeting of stakeholders.	Legislative strategy incorporated unions, providers, workers, consumers, community colleges. Focus on workforce concerns across ltc sectors	Barbara Frank, PHI, 617-338-8478, bfrank1020@aol.com, Deb Thomson, Alz. Assn, 617-868-6718, Deborah.Thomson@Alz.org, Kathy Fitzgerald, Greater Boston Eldery Legal Services, 617-371-1270. kfitzgerald@gbels.org
ME	ME Health Care Assn launched, with partial state funding a "labor task force". Meets monthly, includes all stakeholders.		Y	Feb. 1999 study of all ltc workers by the Labor Task Force, convened by Me. Health Care Assn. Paid by ME. DOL, DHS and members of ME. Health Care Assn. Primary rec. to create career ladder for entry-level health care workers in Me.	May 2000 MHCA sponsored training for new supervisors in ltc settings to promote better mgt.	Catherine Valcourt, Legal Counsel for LTCOP, Paula Valente, Maine Care, 207-623-1146
MD			Y. Now being established. Aging health, industry, advocates. Looking at implementation of task force legislation.	Report findings to Senate and House by Dec. 1, 2000.		Patricia Bayliss, MD Dept of Aging, 410-767-1100. plb@marlooa.state.md.us

			Reconvene Medicaid Nursing Home Reimbursement study Group.			
MI	MI Office of Services to Aging committed to bringing Eden Alternative to MI. Second annual conference and celebration of C.N.A.s.	No	(incomplete)			Eileen Kostanecki, state budget 517-373-0370, Cindy Paul 517-373-8928.
MT		N	Y. AARP, AL providers, ombudsmen, QA and Senior and LTC divisions. Looking at ed/trg./staffing requirements for AL owners, mgrs, workers.	Not yet. due 2001.		Hilke Faber, AARP, 206-517-2319. hfaber@aarp.org, Barb Smith, SLTC/DPHHS, 406-444-4064. basmith@state.mt.us
NH	Eden altern. in several NF. Staffing Crisis Task Force discussing ways to promote culture change.	N	Y. DHHS identified human service workforce as top priority. Assigned workforce taskforce. Red Cross, Hlth Care Assn, VNA, HHA, prof. assn, Assn of Res. Care Homes, Div. of Elderly and Adult services, LTC Ombudsmen, Hosp. Assn etc	Looking at recruitment, retention, financing, image No study yet.	Health Care Assn planning pilot projects in several NF. Proposing state-wide award and recognition of CNAs representing each area of practice to heighten public awareness. SLTCO compiled Staffing Crisis I&R Packet for NF.	Rebecca Hutchinson, Dir. of NH Paraprofessional Healthcare Initiative, NH Community Loan Fund, 603-224-6669. Rhutchinson@nhclf.org
NM			Y. HOME coalition, Health Action New		Attempt to develop rel. with NM Hlth	Kay Bird,

			Mexico		Care Assn, DON	505-827-7645. kay.bird@state.nm.us Linda Sechovic, NM Hlth Care Assn 505-880-1088
NY	Pioneer Network, 1199 SEIU investing in helping NH in NYC start culture change. Working on changing supervision in NH	N – NY does not use CMP. Must go into Medicaid.	Y. provider association, NYS DOH, SEIU, Paraprofessional Healthcare Inst., CSEA, Nurses Assn. Looking at recruitment and turnover	Study underway by Paraprofessional Healthcare Institute. Due in early 2001. NYAHSA also has study.		Louis Bonilla, Paraprofessional Healthcare Institute 718-402-7766, Louis@paraprofessional.org, Cynthia Ruddder, Nursing Home Community Coalition of NYS, 212-385-0355, Pearl Granite, SEIU, 212-261-2297.
NC	Cultural change training with LTC Pioneers	Y for those promoting Eden alternative	Several in state. AAA, ombudsmen, regulators, providers, comm. colleges, advocates, hospitals etc.	Looking at recruitment, retention, benefits, training, wages, stress mgt. State Health Facilities Division completed study. Click here. Update due Fall 2000. Bob Konrad at UNC published study of registered C.N.A.s who no	Meeting with direct care staff in November .	Susan Harmuth, Division of Facility Services, 919-733-4139. Susan.harmuth@ncmail.net, Nancy Smith Hunnicutt, 828-251-6622. nancy@landofsky.org. , konrad@mail.schsr.unc.edu

				longer working in health care.		
ND	Health and LTC facilities, AARP, Dept of Human Serv, Med. Assn sponsored conference on managing, retaining staff.	N	Yes. Governor appointed Task Force on LTC Planning.	Report available in Sept.	Y. Voc tech colleges offer programs	Dave Zentr?? 701-328-3191, Carol Olson – DHS 701-328-2538. Fax: 328-2359)
OK		N	Legislative "Continuum of Care Committee", Ad Hoc Comm. of State Health Dept on Training for Nurse Aides, LTC Facilities Advisory Board.	Looking at continuum of care and easy access. Proposing: adequate reimbursement, increase staffing, increase trg. re dementia, mentoring program for C.N.A. after hired.	Coalition with omb. office and NH assn., C.N.A. of year award, held a few round table summits re pay and recruitment/retention problems, costs and requirements. C.N.A. trg. provided in voc-techs , and in facilities.	Eleanor Kurtz, DHS, 405-521-6734. elearnor.Kurtz@okdhs.org
OR			Or. Health Care Assn tried, failed to get task force funded in legisl. session. . Ballot measure for Nov. 2000 would create 9 member commission ensuring high-quality home care services for elderly, disabled receiving publicly-funded personal care.			Kathy Labady, Senior Disabled Services Division 503-945-6462

RI	Bilingual speaking and NH cooking for different populations	N	Y. Omb., Depts of Elderly Affairs, Human Services, Health, Nursing homes, home care, legislators, union Looking at short term problems.	RI Health Care Ass. With AAHSA affiliate did survey of C.N.A.s	Yes. pulling voc-tech into commission	
SD		N	Y. DOH, Medicaid, S.D. Health Care Assn. Looking at Rate setting in relation to workforce supply	First mtg. June 2000	unsure.	
TN						
TX			Y. TX Health and Human Services Comm, and TX Workforce Comm. Looking at welfare to work proposals to transition from welfare to independence.	Study due Jan. 2001	Y. stakeholder partnerships.	Susan Sycor. 512-438-3111. TX Dept of Human Svcs.
VA	Informal discussions re Eden alternative	N	Y. Joint Commission on Health Care of the VA General Assembly. Looking at Recruitment and retention incentives, reimb. issues, career devt, staffing ratios.	Study avail from JCHC, Old City Hall, 1005 E. Broad St., Suite 115, Richmond, VA 23219		Patrick Finnerty, JCHC, 804-786-5445, Lorrene Maynard,VAPNA, 757-244-2857.
VT		N	Dept of Aging and Disabilities, Dept of Ed. and Trg. looking at issue.		voc. tech	Joan Senecal, 103 S. Main St., State Dept of Aging and Disabilities. Waterbury, VT 05676 241-2400.
WA						
WV	Informally, WV HCA and Social work conference brought in Dr. Thomas. . Conversations among providers,	N	Y. Legislature in last session passed resolution to form committee to look at ltc issues. WV Interagency LTC panel comprised of WV Health Care Authority, WV Sr. Services, WV Office of Health Facility Licensure,	Primary issues: trg. improvement of staff, med. admin, pay scales, trg. in palliative care	Study due in June, 2000	WV Health Care Authority, 304-558-7000. hcawv.org Wm. Davis, Capital City Task Force, 124 Tiskelwah Ave. Elkview WV 25071

	ombudsmen and others to have licensure change regs that inhibit Eden approach.		Bureau of Med. Services, Dept of HHS, WVU. Ctr. on Aging, Bureau of Public Health, WV Health Care Assn, WV council of Home Health, WV state legislature provider orgs.			
WI	1999 was Year of LTC worker.	?	Governor appointed commission to study issue. Conference in 1999.	Study completed in 1999. Multi-stakeholder group continuing to meet .	Proposals include more training and funding.	Claudia Stein, Ombudsman office 608-264-9760