RESULTS OF THE 2005 NATIONAL SURVEY OF STATE INITIATIVES ON THE LONG-TERM CARE DIRECT-CARE WORKFORCE

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Paraprofessional Healthcare INSTITUTE

NATIONAL CLEARINGHOUSE on the Direct Care Workforce

DCWA Direct Care Workers Association of North Carolina

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ACKNOWLEDGEMENTS

The 2005 national survey and report were developed as a collaboration between the National Clearinghouse on the Direct Care Workforce, which is a program of the Paraprofessional Healthcare Institute (PHI), and the Direct Care Workers Association of North Carolina (DCWA-NC). This report was co-authored by workforce consultants Susan Harmuth and Susan Dyson.

I. BACKGROUND INFORMATION

The National Clearinghouse on the Direct Care Workforce and the Direct Care Workers Association of North Carolina (DCWA-NC) collaborated to survey states about direct-care workforce issues. Our 2005 survey updates and expands upon information collected from states in prior surveys and examines public policy actions taken by states to strengthen the direct-care workforce. Specifically, the purpose of our survey was to:

1) Obtain an updated assessment from states as to whether direct-care worker vacancies are currently a serious workforce issue;
2) Determine what initiatives states have taken in 2005 to address these vacancies;
3) Determine whether or not states reimburse Medicaid funded long-term care services on a case-mix basis;
4) Determine the degree to which states are, or are considering, tying reimbursement to outcomes associated with direct-care workforce and/or quality of care initiatives;
5) Compile additional information from states that use a uniform methodology to track turnover rates of direct-care workers in long-term care settings including tracking methods and trends;
6) Update individual state charts of known public policy actions taken since the first survey conducted in 1999;
7) Compile 2005 state unemployment and 2003 state wage data, which have been weighted by job type; and
8) Provide listing and summary of national, state, and regional direct-care worker member associations.

The Paraprofessional Healthcare Institute (PHI)

PHI works to improve care quality in long-term care by improving job quality for direct-care workers. Our goal is to strengthen the nation's direct-care workforce by advancing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy (www.paraprofessional.org). PHI's programs and initiatives include:

- The **National Clearinghouse on the Direct Care Workforce** (www.directcareclearinghouse.org), a resource center informing the movement to improve long-term care by improving job quality for direct-care workers.
- The **Direct Care Alliance** (www.directcarealliance.org), a national, practitioner-based coalition of long-term care consumers, direct-care workers, and concerned long-term care providers working together to ensure a stable, valued, and well-trained long-term care direct-care workforce.
- **Health Care for Health Care Workers** (HCHCW), a campaign to secure adequate, affordable health coverage for the direct-care workforce.
- The **Northern New England LEADS Institute** (Leadership, Education and Advocacy for Direct-care and Support Institute), which brings together 13 provider organizations with community-based organizations in Vermont, New Hampshire, and Maine to create long-term care environments that nurture workers and consumers.

Direct Care Workers Association of North Carolina (DCWA-NC)

This is the first report published by DCWA-NC, which is a 501(c) (3) membership organization for direct-care workers and other interested individuals and organizations. The mission of DCWA-NC is to improve the quality of care provided to health and long-term care consumers and their families through education, professional development and public awareness of direct-care workers.

In 2005, a supplemental set of questions was included to request information from states about back-up care requirements and/or best practice models for Medicaid-funded Personal Care Services (PCS). The supplemental set of questions constitutes part of a study commissioned from PHI by the AARP Public Policy Institute; findings from the supplemental survey will be published and released in early 2006 by the AARP Public Policy Institute.

II. METHODOLOGY

This is the fifth national survey on the direct-care workforce developed by PHI and the first by DCWA-NC. Surveys were sent to all state Medicaid agencies and State Units on Aging in October and November 2004; some were redirected to a more appropriate state entity for completion. Completed surveys were received between November 2004 and June 2005; clarification was sought as needed,

National Surveys of Direct-care Workforce Initiatives

Prior surveys were published by the National Clearinghouse and the North Carolina Department of Health and Human Services:

- 2003 - *Results of the 2003 National Survey of State Initiatives on the Long-Term Care Direct-care Workforce;*
- 2002 - *Results of the 2002 National Survey of State Initiatives on the Long-Term Care Direct-care Workforce;*
- 2001 - *Results of a Follow-up Survey to States on Career Ladder and Other Initiatives to Address Aide Recruitment and Retention in Long-Term Care Settings;*
- 2000 - *Results of a Follow-up Survey to States on Wage Supplements for Medicaid and Other Public Funding to Address Aide Recruitment and Retention in Long-Term Care Settings;* and
- 1999 - *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aides and Other Paraprofessional Aides.*

To view prior surveys, visit www.directcareclearinghouse.org, click on "Library" and then on "National Surveys of State Activities."

and authors consulted with respondents from prior years' surveys, where necessary. A total of 38 states responded to the survey, representing a 76 percent response rate. Some of the surveys that were submitted were only partially completed and any responses contained in those surveys have been included. The response rate in 2005 is lower than in prior years; reasons for the lower response rate may include: staffing turnover in the agencies contacted to respond to the survey, staffing constraints, length of the survey instrument, or the timing of the survey—given that it was an election year.

Survey Responses

Responses were received from State Medicaid agencies, Units on Aging, regulatory or licensing agencies, developmental disability entities, or other appropriate agencies.

38 states responded to the 2004 survey, representing a 76 percent response rate. Surveys were not received from: **Alaska, Illinois, Indiana, Massachusetts, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Tennessee,** and **West Virginia**. Responses from states that submitted partial data have been included where possible.

Response rates to prior national surveys on the direct-care/nurse aide workforce were:

- 1999 (92%)
- 2001 (86%)
- 2002 (86%)
- 2003 (88%)
- 2005 (76%)

Note: The 2000 survey was targeted only to states that implemented wage passthrough payments for direct-care workers and is not included in the above response rate summary.

A summary of results from the 2005 survey is available in **Table 1**; detailed comments are described in **Table 2.** A snapshot of each state's existing or enacted direct-care worker initiatives is presented in individual charts in **Appendix A,** reflecting information collected from this and prior national surveys. Information provided in prior years remains in the individual charts as a historical record, however, new information or changes to prior comments obtained from the 2005 survey are reflected in bold typeface.

Data Caveat: All analyses and percentages reported are based on the 38 states responding to this survey.

III. NATIONAL STATISTICS ON THE DIRECT-CARE WORKFORCE

Employment Growth:
Of states that responded to the survey, most continue to indicate that vacancies among direct-care workers exist. This is not surprising given the growth in demand nationally for direct-care workers as projected by the US Bureau of Labor. Between 2002 and 2012, the Bureau of Labor projects employment growth of direct-care workers to more than double (33.8 percent) the projected growth in overall employment nationally (14.8 percent). Both home health aides and personal and home care aides are considered two of the fastest growing occupations, in terms of percentage growth in the United States over the period 2002 to 2012.

Wage Rates:
The national average of median hourly wages for the three major categories of direct-care workers (1) nurse aides, orderlies and attendants; 2) home health aides; and 3) personal and home care aides) has increased from $7.97 in 1999 to $8.70 in 2002. This represents a 9.2 percent increase over the four-year period, for an average annual increase of 2.3 percent. Wage rates for direct-care workers in 2003 are presented at right.►

National Wage Data for Direct-Care Workers, 2003

Job Category	Median Hourly Wage
Nurse Aides, Orderlies and Attendants	$9.80
Home Health Aides	$8.85
Personal and Home Care Aides	$8.19
Average median wage across three categories *(*not weighted)*	$8.95*

See **Table 3** for state unemployment data from 2002 to 2005. Also included in **Table 3** are average median hourly wages, by state, across direct-care worker categories from 1999 to 2003.

IV. NATIONAL ECONOMIC OUTLOOK

Over the last year, the overall economic outlook has improved. The national unemployment rate continues to fall, dropping to 5.2 percent in April 2005, one of the lowest rates since September 2001. Individual state unemployment rates vary considerably, with seven with unemployment rates at, or in excess of, 6.0 percent in April 2005. **Michigan** was the only state with an unemployment rate above 7.0 percent.

Information collected during the 2005 survey continued to show that, generally, vacancies of direct-care workers continued to be a serious workforce issue for most states. This trend has continued since the first survey conducted in 1999 and in subsequent surveys conducted during both strong and declining economic periods. It is worth noting that the severity of direct-care worker vacancy rates did diminish for some states: In 2004, 76 percent of the 38 states responding to the survey indicated that vacancies were very serious or serious, compared to 92 percent of states in 1999 and 88 percent in 2003. Some of the decline may be attributed to the improvement in the economy. However, responses received from states re-affirm that the economy is not the primary factor impacting serious vacancies of direct-care workers.

Bureau of Labor Statistics

The US Bureau of Labor employment projections for 2002 to 2012 can be viewed at http://stats.bls.gov/news.release/ecopro.toc.htm

States with lowest unemployment rates in April 2005:

- **Hawaii** (2.9%), **North Dakota** (3.2%), **Vermont** (3.3%), **New Hampshire** (3.4%), and **Wyoming** (3.5%);

States with highest unemployment rates in April 2005:

- **Michigan** (7.0%), **Mississippi** (6.8%), **Alaska** (6.7%), **Oregon** (6.5%), and **South Carolina** (6.5%).

Repeating trends found in previous surveys, both the state with the highest unemployment rate as of April 2005 (**Michigan** at 7.0 percent) and the state with the lowest unemployment rate (**Hawaii** at 2.9 percent) reported serious direct-care workforce vacancies.

As reported in the December 2004 "Fiscal Survey of States" published by the National Governor's Association and the National Association of State Budget Officers, the general fiscal health of states improved in 2004 compared to 2003, as illustrated by a reported 3 percent increase in general revenue spending over 2003. In addition, state appropriation levels for 2005 reflected a projected 4.5 percent increase in spending over 2004. It is worth noting, however, that the 4.5 percent growth rate projected for 2005 is inclusive of one-time expenditures from a variety of sources such as funding reserves/surpluses and efforts by states to reduce property taxes through one-time payments to local government entities. Other indicators pointing to the improved fiscal health of states include the fact that only 3 states reported enacting "negative growth budgets," compared to 21 states in 2003. Additionally, almost every state in 2004 minimally-exceeded its expected revenue collections, which has not been the case in recent years.

December 2004 Fiscal Survey of States

To see the full report published by The National Governor's Association and The National Association of State Budget Officers, go to www.nasbo.org

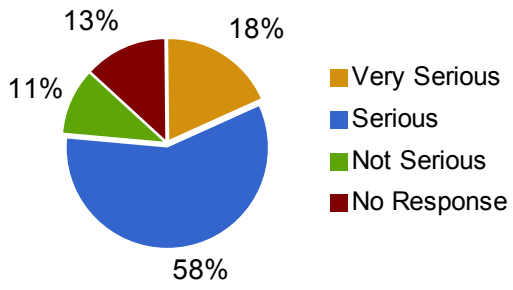
In spite of this improved fiscal picture for states, not surprisingly, the above report indicated that growth in Medicaid spending continues to be a major area of concern for states in spite of efforts to contain program costs. This may have implications for direct-care workforce policy initiatives by states, given the comparatively high level of public spending for long-term care from Medicaid funds compared with other public funding streams. In 2003, 23 states reported shortfalls between Medicaid reimbursement and allowable Medicaid costs, compared to 18 states in 2004.

V. SURVEY FINDINGS

A. Serious Workforce Issue

The percentage of states reporting that direct-care vacancies are a serious workforce issue continued to decline since 1999, yet three-quarters of states responding in 2004 still consider it a serious issue. Of responding states, 29 (76.3 percent) consider current vacancies a serious issue (seven consider it very serious); four states (10.8 percent) did not consider it serious and five states (13.5 percent) did not respond to the question *[Figure 1]*.

Figure 1.
State Responses to Seriousness of Direct-Care Worker Vacancies



Note: Percentages based on states responding to survey (n=38)

Available Reports, Research Studies, and Public Awareness Campaigns on Direct-care Workforce Shortages

- Ohio's "Make Care Your Career" campaign (www.careerincaring.com);
- Wisconsin's Council On Long Term Care Reform report (www.wcltc.state.wi.us);
- Pennsylvania's Direct Support Professional website (www.maxassociation.org);
- Arizona's Citizens Taskforce on the Long Term Care Workforce report (www.governor.state.az..us); and
- Michigan's "Voices from the Front: Recruitment and Retention of Direct-care Workers in Long Term Care Across Michigan" (www.miseniors.net).

B. State Initiatives and Activities to Address the Vacancies:

For states that reported direct-care vacancies as a serious issue (includes states that responded with very serious or serious), 20 of the 29 (68.9 percent) undertook some type of major initiative in 2004.

The most common types of initiatives reported by these 20 states were:

- Direct-Care Worker Career Advancement Initiatives (nine states, 31.0%);
- Task Force or Commission Formation by eight states (eight states, 27.6%);
- Public Awareness Campaign (seven states, 24.1%);
- Research Studies (seven states, 24.1%);
- Quality Improvement Initiatives (seven states, 24.1%);
- Wage or Benefit Enhancement (five states, 17.2%); and
- Other Type of Initiatives (eight states, 27.6%).

States that reported undertaking activities or initiatives and indicated vacancies were not serious or unknown (**Arizona** and **Vermont**) are not included in the percentages above.

State Initiatives to Address Direct-care Workforce Shortages

In the 29 states that considered the shortage serious, major initiatives were undertaken by the following states. [Names of states in brackets are those that responded that the direct-care shortage was not serious or unknown, but which also undertook an initiative]:

- Wage and benefit enhancement – **MD, MT, NY, WA, WY, [VT]**
- Public awareness campaign – **IA, KS, LA, MT, NC, OH, PA,**
- Direct-care worker career enhancement – **GA, IA, KS, LA, MN, MT, NC, PA, WY, [VT]**
- Formation of task force or commission – **CT, KS, LA, MI, OH, OK, PA, WI** [AZ]
- Research study – **IA, LA, ME, MI, OK, PA, WY**
- Quality improvement initiative – **IA, KS, LA, MI, PA, VA, WY, [VT]**
- Other – **FL, KS, MD, NC, OH, VA, WA, WY** [AZ]

C. Case-Mix Reimbursement:

Of those reporting, 23 states (60.5 percent) reported that one or more Medicaid long-term care services are reimbursed on a case-mix basis. Of these, nearly all (22) reimburse using case-mix in nursing facilities, three reimburse for personal care services (**Hawaii, Maine,** and **Minnesota**), three in home care settings (**Hawaii, Minnesota,** and **Texas**), and two in assisted living facilities (**Maine** and **Minnesota**).

Case-Mix Reimbursement

States that reimburse Medicaid long-term care services on a case-mix basis include:

- **Colorado, Delaware, Georgia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, Nevada, New York, North Carolina, Ohio, Pennsylvania, South Dakota, Texas, Utah, Vermont, Virginia, Washington** and **Wyoming**.

Of those states that reported using case-mix reimbursement, only six states responded to having quality improvement (QI) requirements associated with the case-mix structure for one or more settings. These include **Georgia, Iowa, Louisiana, Maine, South Dakota,** and **North Carolina** (QI requirements under development). Two states reported that quality improvement requirements are directly related to direct-care workers. Direct-care staff retention is a QI requirement in **Iowa; Louisiana** utilizes several QI requirements including federal CNA standards, use of certified medication assistants in ICF/MR group homes, and provider standards for payment for waiver-enrolled direct-service providers. In fact, all long-term care facilities and waiver programs require quality assurance and improvement programs in Louisiana. North Carolina reports that it is expected that direct-care workforce items are likely to be included in the QI program tied to case-mix reimbursement.

D. Use of Civil Monetary Penalty Funds:

Relatively few states (eight, 21.1 percent) reported utilizing civil monetary penalty funds directly to support direct-care workers or culture change related initiatives. The Iowa Caregivers Association received funding from **Iowa's** penalty funds to support its CNA Recruitment and Retention project and to provide scholarships for direct-care workers to attend its annual education conference. A dining assistant program for nursing home residents is being piloted in **Michigan** using penalty funds. Funds in **Kansas** are used for education of un-licensed nursing home staff; nursing facilities in **Mississippi** can apply for grants funded through penalties to be used for educational programs that will benefit nursing facility residents.

BJBC *Insights* Article on Civil Monetary Penalty Funds

Insights, Number 7, Summer 2005 includes an article titled "States Use Penalty Money for Direct Care Worker Recruitment and Retention." The report is available at: http://www.bjbc.org/page.asp?pgId=165

North Carolina's Win-a-Step-Up program is partially supported by civil monetary penalty funds. The program rewards direct-care workers with bonuses or wage increases for completing training and meeting retention commitments. **NC** also used fine monies to make Coaching Supervision training available to nursing facility staff and to develop a geriatric nurse aide curriculum. The Resident Trust Fund uses penalty monies to fund culture-related activities in **Louisiana**. While **Maryland** has used funds in prior years to initiate the Wellspring program in several nursing facilities, funds in 2005 were not used directly for direct-care workers or culture change. Monies in **South Carolina** are used to sponsor educational activities or grants for nursing facilities to embrace culture change.

Hawaii does not currently use its civil monetary penalty funds for direct-care or culture change initiatives; however, it is currently developing guidelines for future use of the funds, which may include staff training to improve nursing resident care.

E. Licensure of Home Care Provider Agencies

Of responding states, 31 (81.5 percent) reported license, registration, or regulation requirements for some or all home care provider agencies.

- Of those responding yes, 12 (38.7 percent) regulate all agencies that provide hands-on care in the home, whether at skilled and/or paraprofessional levels of care (listed in box at right); and
- Of those responding yes, 18 states (58.1 percent) regulate Medicare/Medicaid certified home health agencies only.

Regulation of Home Care Provider Agencies

States that license or regulate all agencies that provide hands-on care in the home include:

- **Alabama, Arkansas, Colorado, Connecticut, Florida, Georgia, Kentucky, Louisiana, Maine, Minnesota, New Jersey, New York, North Carolina, Oklahoma, Texas, Virginia, Washington**, and **Wyoming.**

Eight states reported training requirements for home health or personal care aides above the federal standard of 75 hours: **Florida, Maine, Maryland, Minnesota, New Jersey, South Carolina, Washington,** and **Wyoming**. A handful of these states have additional training for the care of specific patient populations. Both **Florida** and **Minnesota** require additional training for employees who will have direct contact with residents who have Alzheimer's or a related disorder.

F. Strategies to Address Lack of Affordable Health Insurance for Health Care Workers:

Nine states (23.7 percent) reported having (or having future plans to develop) strategies to address health care worker insurance.

- States that currently have strategies include **Maine**, whose Dirigo Health program makes affordable health insurance coverage available to small businesses and individuals. **New York** currently has a small Home Care Worker Rate Demonstration Project. A small pilot in **Virginia** through a Direct Service Worker grant offers health insurance through its child health program.

- States that are developing or planning strategies include **Arizona**, whose Long Term Care Workforce Taskforce is expected to recommend approaches to making health insurance more affordable for direct-care workers. **Iowa** conducted a wage and benefit survey of direct-care workers and its BJBC Coalition is currently reviewing options to ensure that direct-care workers are covered. A workforce demonstration project in **Maine** is evaluating direct-care worker recruitment, which includes an effort to enroll workers in Dirigo Health. A planning project in **Michigan** is seeking to extend health insurance to all citizens in the state.

Health Insurance Coverage Study

The Direct-care Workers Association of North Carolina will conduct an analysis of potential health insurance / mini medical plans that might be considered for inclusion as an optional benefit of association membership.

G. Data Collection on Health Insurance Coverage by Occupation

Few states reported collecting, or having the capacity to collect health insurance coverage by occupation: **Florida, Maryland, Michigan, Minnesota, Pennsylvania, Washington,** and **Wyoming**.

- **Florida** collected data on the uninsured through telephone surveys and focus groups through its Task Force for Access to Affordable Health Care for Floridians;

- Both **Wyoming** and **Minnesota** have collected insurance coverage information in the past.

H. Tying Outcomes to Reimbursement:

Since last year's survey, the numbers of states that reported implementation, or plans for implementation of outcomes-based reimbursement plans increased. In 2005, states were surveyed on whether they have, or are considering, tying outcomes to reimbursement. In addition to **Iowa**, which indicated in the 2003 survey that such efforts had been implemented, **Arizona**, **Georgia, and Michigan** also began outcomes-based reimbursement. Both **Georgia** and **Arizona** are considering expanding or revising existing efforts.

Policy Actions that Tie Outcomes to Reimbursement in Long-Term Care Settings

States that tie outcomes to reimbursement include:

- **Arizona, Georgia, Iowa**, and **Michigan**

States that are considering tying outcomes to reimbursement include:

- **California, Kansas, Minnesota, Nevada, North Carolina, Vermont,** and **Wyoming**

In April 2005, a ***Better Jobs, Better Care*** Practice and Policy Report, entitled "Linking Payment to Long-Term Care Quality: Can Direct-care Staffing Measures Build the Foundation?" was released. The report:

- Looks at federal and state initiatives to link performance to payment and other non-financial incentives to long-term care providers across settings;
- Examines the potential such incentives might hold for achieving improved quality and performance outcomes given the evidence as to the contribution of direct-care workers, nurses and other hands-on care providers to quality care outcomes; and
- Can be viewed in full at http://www.bjbc.org

Arizona's efforts to tie outcomes to reimbursement are limited to a handful of managed-care long-term care nursing facilities, which have begun tying reimbursement to quality outcomes. **Georgia's** contracts with providers of care for the developmentally disabled are currently set on a pay-for-performance basis. However, a recent audit revealed that the current methodology is ineffective, and alternative outcomes-related reimbursement methods are being evaluated. **Michigan** uses a cost-based reimbursement methodology to tie outcomes to reimbursement. As reported in **Iowa** in the 2003 survey, effective July 1, 2002, certain nursing facilities can qualify for up to a 3 percent reimbursement increase (of the direct-care and non-direct-care component median rates) for meeting up to ten specific quality assurance accountability measures. The percentage increase awarded is based on total points earned. Facilities must achieve at least 3 points (on a scale of 12) to qualify for any increased reimbursement.

Seven other states responded that they are planning or considering tying outcomes to reimbursement (18.9 percent). Strategies include:

- **California** is examining using facility-specific rates and higher reimbursement in order to improve quality.

- **Kansas** is aggressively pursuing implementation of a nursing home-quality incentive reimbursement provision in FY 2006. The provision would include seven factors:
  i. Case-mix adjusted nurse staff ratio;
  ii. Low operating expense (administration and plant operations);
  iii. Low direct-care employee turnover rate;
  iv. High employee retention rate;
  v. High occupancy rate;
  vi. High Medicaid occupancy rate; and
  vii. Low number of survey deficiencies (with no substandard care deficiencies).

  Future provisions in **Kansas** may also include a resident satisfaction factor in the methodology.

Better Jobs Better Care

Better Jobs Better Care is a 4- year, $15.5 million, national research and demonstration program funded by the **Robert Wood Johnson Foundation** and **The Atlantic Philanthropies** with direction and technical assistance provided by the **Institute for the Future of Aging Services, American Association of Homes and Services for the Aging**.

The Paraprofessional Healthcare Institute is the national technical assistance provider to the BJBC program.

- **Minnesota** is seeking to enact a quality, price, and cost-based system of rate setting. The proposed value-based reimbursement system would consider recognition of legitimate costs, encourage efficiency and quality, reduce rate disparities, provide incentives for delivering high quality services and achieving good patient outcomes, and provide the legislature with a means to manage overall expenditures. The Value-Based Nursing Facility Reimbursement System (VBR) will pay for services based on target price, quality, efficiency, and facility costs. Complete information is available at www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_020477.pdf

- **Nevada** is considering adjusting reimbursement for nursing facilities by using the accuracy rate in the completion of the Minimum Data Set.

- In **North Carolina**, a broad-based Partner Team is developing the NC New Organizational Vision Award (NC NOVA), with funding from a BJBC Demonstration grant. NC NOVA is a voluntary "raise the bar" special licensure program for home care agencies, adult care homes, and nursing facilities. The program encompasses four major areas: 1) supportive workplaces; 2) training; 3) balanced workloads; and 4) career development. Up to 60 organizations will pilot the criteria, review it, and determine process beginning July 2005. Statewide implementation is planned for 2007. The ultimate goal of the NC NOVA designation is to provide a reimbursement differential for entities attaining the special licensure award.

- **Vermont's** efforts to tie outcomes to reimbursement have been sidelined while the state addresses its budget situation and the implementation of its 1115 Long Term Care Waiver.

- **Wyoming** is planning to tie quality of care issues with reimbursement, along with adjusting contracted rates for value-added services.

I. Direct-Care Workforce Turnover and Methodology

In addition to the ten states that reported in the 2003 survey that they collect and analyze data on direct-care workers for one or more long-term care settings, **Vermont** becomes the 11th state reporting turnover data collection (for a total of 28.9 percent of 38 states responding to our survey).

Four of the 11 states (36.4 percent) reported collecting direct-care worker turnover data from two or more settings (**Maryland, North Carolina**, **South Carolina,** and **Wisconsin**). Six states (54.5 percent) reported collecting data from nursing facilities only (**California, Florida, Kansa, Minnesota, Texas,** and **Vermont**). **Wyoming** collects data for developmentally disabled adults.

Data on direct-care worker turnover reported in the 2005 survey have been combined with previous turnover reported in last year's survey and are presented below.

1. **California** has the longest history for collecting turnover data, yet did not report any new results for 2005. Turnover trend results in nursing facilities reported in the 2003 survey are presented below.

States Collecting Turnover Data

Combining responses from the 2003 and 2005 survey, 11 states report collecting turnover data using a uniform methodology. States that collect turnover, by setting include:

California – NF
Florida – NF
Kansas – NF
Maryland – HC, RH
Minnesota – NF
North Carolina – NF, HC, AC
South Carolina – NF, HC
Texas – NF
Vermont – NF
Wisconsin – NF, DD
Wyoming – RH

Legend:
NF – nursing facilities
HC – home care
AC – adult care homes
RH – residential habilitation
DD – developmentally disabled

California Nursing Facility Turnover Trend Data, FY 2000 - 2002

Fiscal Year	*All Employees*	*Nursing Employees*	*Nurse Assistants*
2000-01	68.6%	74.2%	78.7%
2001-02	67.0%	74.7%	77.1%

Methodology: Turnover rate equals the total number of employees per year divided by the average number of employees per year.

2. Turnover data for 2004 in **Florida** reveals a decline in turnover rates in nursing facilities from prior years.

Florida Nursing Facility Turnover Trend Data
2001 - 2004

Year	*Nursing Assistants*
2001	43.0%
2002	41.3%
2003	44.9%
2004	37.7%

Methodology: Turnover rate is calculated quarterly; the annual rate is the cumulative sum of the quarterly rates. Calculated as the total number of terminations or separations experienced during the quarter, excluding terminations of employees in three-month probationary period, divided by the number of staff employed at the end of the period.

3. Kansas implemented a new collection methodology for turnover data in its nursing facilities. Overall nursing home turnover has decreased 7 percent from CY 2002 to CY 2003, while nurse aide turnover decreased 10 percent over the same period.

Kansas Nursing Home Turnover Trend Data, 2003

Year	*Nurse, Med, Restorative Aides*	*LPNs*	*RNs*
2003	85.2%	59.6%	52.5%

Methodology: Divide total number of employees terminated by the average number of employees for the year, which is determined by averaging the beginning and ending number of staff reported.

4. Maryland collects turnover data for persons with developmental disabilities who receive home care or residential habilitation services. Data for 2004 show a continued improvement in turnover rates for both aides and first line supervisors. Detailed reports on turnover data in Maryland are available at www.dhmh.state.md.us/csrrc/annual_report.htm.

Maryland Home Care and Residential Habilitation Services
Turnover Data, 2001 - 2004

Year	*Aides*	*First Line Supervisors*
2001	48%	29%
2002	45%	28%
2003	41%	21%
2004	37%	18%

Methodology: Number of employee terminations during the year divided by the number of positions.

5. Minnesota collects turnover data in nursing facilities for RNs, LPNs, CNAs, TMAs, mental health workers, social workers, activity staff, and other direct-care staff. While turnover rates for RNs and LPNs have remained fairly stable since 2000, turnover rates for CNAs in nursing facilities have consistently declined over the last four years.

Minnesota Nursing Facility Turnover Trend Data, 2000 - 2003

Year	*CNAs*	*RNs*	*LPNs*
2000	69%	32%	30%
2001	65%	32%	31%
2002	56%	31%	30%
2003	51%	32%	31%

Methodology: Number of employees at the beginning of the period (October 1), number hired/transferred/leaving/transferred out and the number employed at the end of the reporting year (September 30).

6. North Carolina is in its fourth year of collecting turnover data in its nursing homes, adult care homes, and in-home care settings. In 2003, both nursing facilities and home care agencies saw an increase in direct-care turnover rates over 2002 rates, while adult care home turnover rates decreased. North Carolina will soon expand data collection on staff turnover to include directors of nursing, lead supervisors, and administrators.

North Carolina Direct-Care Turnover Trend Data, 2000 - 2003

Year	*Nursing Facilities*	*Adult Care Homes*	*Home Care Agencies*
2000	103%	119%	53%
2001	102%	113%	50%
2002	95%	115%	37%
2003	105%	109%	49%

Methodology: Total Separation = [(Full time quits + part time quits + full time fires + part time fires) / (Full time fully staffed + part time fully staffed)] x 100.

7. South Carolina has been collecting turnover data from approximately 39 of 200 nursing facilities as part of a 36-month grant beginning in 2003. Results will not be available until completion of the project; however, there has been some drop in participating nursing home grantees submitting data. Additionally, the Department of Health and Human Services collects home care data from worker registration sheets. However, statewide statistics cannot be compiled, due to completion and accuracy issues.

8. Texas collects turnover data from nursing facilities on nurse aides, RNs, directors of nursing, and Licensed Vocational Nurses (LVNs). However, no statewide analyses of these data exist and therefore no trend data are available to report.

9. Vermont only recently began collecting direct-care turnover data in nursing facilities and it is too early to report trend results. Vermont calculates turnover from the total number of W2s, minus (employees on payroll on December 31 plus number of vacancies) divided by (number of employees on payroll on December 31 plus number of vacancies).

10. Wisconsin collects turnover data for both full- and part-time aides in nursing facilities and in facilities for the developmentally disabled. Rates are also collected by type of ownership (government, nonprofit, and for-profit). Wisconsin also collects rates for RNs and LPNs in nursing facilities.

Wisconsin Turnover Rates in Nursing Facilities, 2001 - 2003

Year	*Nursing Assistants*		*LPNs*		*RNs*	
	Full-time	*Part-time*	*Full-time*	*Part-time*	*Full-time*	*Part-time*
2001	72%	n/a	35%	n/a	22%	n/a
2002	55%	n/a	32%	n/a	16%	n/a
2003	43%	61%	32%	44%	26%	33%

Methodology: Number of hired in current year divided by total number of employees, multiplied by 100 (by category).

Wisconsin Nurse Aide Turnover Rates by Facility and Ownership Type, 2003

Ownership	*Nursing Facilities*		*Facilities for Developmentally Disabled*	
	Full-time	*Part-time*	*Full-time*	*Part-time*
All	43%	61%	24%	33%
Government	10%	41%	5%	26%
Nonprofit	43%	51%	46%	36%
For-profit	57%	84%	16%	39%

11. Wyoming reports a significant decline in direct-care turnover rates in settings that care for the developmentally disabled. Legislated wage increases over the last three years have played a large role in reducing turnover of direct-care workers. Additionally, service providers are in compliance for collecting and reporting wages, benefits, and turnover each year. Several other initiatives, such as more site review interaction, increased training, and Annual Dinner for Direct Service Professional Awards, have also played a positive role in reducing turnover.

Wyoming Developmentally Disabled Facility Turnover Trend Data 2002 - 2004

Year	*Direct-Care*
2002	52%
2003	35%
2004	32%

Results of Workforce Turnover in Wyoming

Wyoming's $30 million initiative to raise the average hourly wage of direct-care workers serving the developmentally disabled likely had a significant impact on turnover. Other positive, but harder to measure, factors reported that likely contributed to reduced turnover include increased training, more site interaction, the Governor's Annual Dinner for Direct Service Professional Awards, and a web page for recruitment and retention. The Internet College for Direct Service Support statewide training, and Department of Labor apprenticeship programs have also been positive.

J. Questions and Topics for Future Surveys

Several states offered suggestions for new topics or lines of questioning for the next national survey on state direct-care workforce initiatives:

- A comparison of cost and quality measures between in-house and contracted direct-care staff.
- Consumer-directed programs and consumer flexibility for negotiation of wages, benefits, or other employment terms. Additionally, have consumer-directed programs had any effect on workforce recruitment and retention?
- State procurement processes to improve wages and benefits.

VI. DIRECT-CARE WORKER MEMEBERSHIP ASSOCIATIONS

The number of national, state, and regional membership associations for direct-care workers has continued to increase. While several associations were in existence during the 1990's, there has been significant growth in the number of associations that have been founded since 2000. There are approximately 14 known worker associations as of July 2005, and one under development. While size of membership in the associations varies greatly, the presence of organizations specifically aimed at supporting and acknowledging direct-care workers is a positive benefit for the profession as a whole.

The mission and goals of these associations include providing education and support to direct-care workers, improving quality of care, elevating professional standing and recognition, or advocacy and outreach. Some associations provide membership only to direct-care workers; others offer a range of memberships to workers, provider organizations, and supporters of direct-care workers.

Of the known direct-care worker associations:

- Four are national organizations: the National Association for Directcare Workers of Color (NADCWOC), the National Association of Geriatric Nursing Assistants (NAGNA), the National Network of Career Nursing Assistants (CNAP), and the National Family Caregivers Association.

- Eight are state organizations: the Direct Caregiver Association (DCGA-**Arizona**), the **Connecticut** Association of Personal Assistants (CTAPA), the **Florida** Association of Nurse Assistants (FANA), the **Iowa** Caregivers Association (ICA), the **Maine** Personal Assistance Services Association (Maine PASA), the Direct Care Workers Association of **North Carolina** (DCWA-NC), the **Virginia** Association of Professional Nursing Assistants (VAPNA), and the **Vermont** Association of Professional Care Providers (VAPCP).

- ❖ Two are regional organizations limited to a city or county regions: Schuylkill County Direct Care Worker Association (**Pennsylvania**), and Support Providing Employees' Association of **Kentucky** (SPEAK), which empowers direct-support professionals in the Louisville metropolitan area. An advisory committee has convened in **Pennsylvania** to consider development of a statewide association for direct-care workers and the necessary requirements if the development of the association were to proceed.

The cost to a direct-care worker to join one of these professional associations is minimal. Several associations provide membership free of charge or by donation; others charge up to $30 per year. Funding for the associations come from a wide variety sources: public and private grants, membership dues, donations, placement fees, and educational programs. Many of the associations operate as nonprofit, 501 (c) (3) organizations.

A more detailed summary of these associations, including membership information, founding date, financial support, staffing structure, and contact information is available in **Table 4.**

VII. UPDATE ON NATIONAL BETTER JOBS, BETTER CARE (BJBC) PROJECTS

We present more recent information on five states that have been granted a BJBC grant below:

Better Jobs Better Care Grantees

To see an overview of planned activities for each demonstration grantee, as well as an overview of the 12 research projects funded, go to http://www.bjbc.org.

A. **Iowa** – Under the leadership of the Iowa CareGivers Association (ICA), BJBC-Iowa has completed several policy/research studies, including: a Direct Care Worker Wage and Benefit Study; a Health Care Coverage Feasibility Study; consumer focus groups; and a synthesis of Certified Nurse Aide, Long Term Care Nurse, and Administrator Needs Assessment Survey findings. In addition, the BJBC Coalition has been successful in their legislative efforts to expand the Iowa Nurse Aide Registry to accommodate all classifications of direct-care workers; on June 14, 2005, Governor Vilsack signed legislation authorizing $80,000 for this expansion. In addition, the Coalition was successful in securing legislation to create a Direct-care Worker Education Task Force to be administered by the Iowa Department of Public Health. Planned project initiatives underway in nursing homes and home care agencies participating in the demonstration project include providing technical assistance, training, and mentoring of person-centered care. The project also includes strategies to increase health insurance coverage for the direct-care workforce. For more information about the Iowa BJBC demonstration project, go to: http://www.iowacaregivers.org (click on "Programs and Reports).

B. **North Carolina** – The North Carolina Foundation for Advanced Health Programs, working with a broad based Partner Team, has developed a voluntary special licensure program, NC NOVA (North Carolina New Organizational Vision Award). NC NOVA, a "raise the bar" set of workplace culture change initiatives, covers four major focus areas: 1) supportive workplaces, which covers orientation, peer mentoring, Coaching Supervision, reward and recognition, worker empowerment, and management support; 2) training; 3) career development; and 4) balanced workloads. To date, 60 pilot sites have been selected (approximately 20 nursing homes, 20 adult care homes, and 20 home care agencies). The pilot project will run from July 2005 to August 2006. A provider information manual has been developed which details NC NOVA criteria, general review, and determination processes. Measurement instruments and procedures are being finalized. Any necessary changes to the criteria, measurement protocols, or instruments, etc. will be made following the pilot, with statewide implementation expected for 2007. For more information about NC NOVA see: http://www.dhhs.state.nc.us/ltc (click on "Workforce Issues and Initiatives," then click on "Initiatives," then click on "Better Jobs, Better Care.")

C. **Pennsylvania –** The Center for Advocacy for the Rights and Interests of the Elderly (CARIE), is leading a multi-stakeholder group to implement policy, training, and practice interventions impacting direct-care workers. Accomplishments to date include: pilot testing underway in 36 long-term care related organizations of workplace design strategies to enhance support of direct-care workers (under the local leadership of six regional long-term care coalitions); and pilot testing of a six-module, universal core curriculum emphasizing person-centered care across the long-term care spectrum. Better Jobs, Better Care-PA (BJBC-PA) has created a statewide Direct Care Worker Advisory Committee to promote a

strong voice by direct-care workers on all BJBC-PA committees, and is considering launching a state direct-care worker association. The BJBC-PA coalition has incorporated, and has filed for status as a 501(c) (3) organization to ensure on-going collaborative efforts to improve jobs for direct-care workers. The Board of this new organization is diverse; 25 percent of members are direct-care workers. For more information about this project, contact: reever@carie.org.

D. **Oregon –**Under the leadership of the Oregon Technical Assistance Corporation (OTAC), the Oregon BJBC coalition is implementing an array of policy, practice, training, and workforce diversity strategies pertaining to direct-care workers and supervisors. Key accomplishments to date include: LEAP (Learn, Empower, Achieve, Produce) conducted train-the-trainer training for eight leadership sites; contract nurses employed by the Office of Seniors and People with Disabilities; mentoring programs implemented to varying degrees in all eight leadership sites; and conversations facilitated between the Oregon State Board of Nursing, the Home Care Commission, the Seniors and People with Disabilities department, and other leading stakeholders about key systems change efforts. For the next three years, the project is partnering with the Quality Improvement Organization to implement the Centers for Medicare and Medicaid Services (CMS) scope of work relating to Person Centered Care and culture change in nursing homes. It is also working with the Oregon Consortium for Nursing Education, with input from the leadership sites, to develop the baccalaureate-nursing curriculum to include an increased emphasis on nursing supervision and management skills. Additionally, project staff and representatives from the leadership sites are participating in strategic planning efforts for an Oregon Pioneer Network Coalition to support the transformation of long-term care in Oregon. For more information about this project, see: http://www.otac.org (click on "Policymakers").

E. **Vermont -** The Community of Vermont Elders (COVE), a consumer advocacy organization, is the lead agency for Vermont's BJBC Project. Accomplishments at the midway point of the demonstration include supporting growth and development of the Vermont Association of Professional Care Providers (VAPCP), a nonprofit membership organization sponsored by COVE. VAPCP is dedicated to advancing the professional growth, employment opportunities, and quality of life for people who provide personal care and support services in all home, community, and healthcare settings. The project began efforts to adapt Vermont's "Gold Star" program to other long-term care settings. Gold Star is a voluntary, direct-care worker-focused self-assessment and culture change process for nursing home facilities. It also developed a training framework, which will lead to a universally-recognized certificate and basic training curriculum for Personal Care Attendants, and is in the planning stages to deliver and provide access for this training. Steps to develop courses of "Special Focus" for direct-care workers in palliative care and dementia care are underway; the project has provided all-site and site-specific technical assistance and support for culture change in three nursing homes, three residential care homes, three home health agencies and five adult day centers. Vermont's BJBC project has also collaborated with the Northern New England LEADS Institute (Leadership, Education and Advocacy for Direct-care and Support Institute) and VAPCP to create a long-term care workforce policy group to advance direct-care issues in Vermont based policy arenas. For more information about Vermont's BJBC initiatives, see www.vermontelders.org.

IX. CONCLUSION

Consistent with every year since 1999—the first year this national survey examining state public policy initiatives was conducted, the vast majority of responding states indicated that direct-care worker vacancies and turnover continues to be a **serious** issue. However, the percentage of states indicating the problem as "serious" has dropped each year, from a high of 88 percent in 1999 to 74 percent in this survey.

In spite of improving economies, there continues to be significant new policy and practice activity across states to address worker vacancies and turnover, both in the short- and long-term. Reported state initiatives reported reveal an increased emphasis on peer mentoring programs for direct-care workers and building coaching

US and State Fiscal Health in 2004

The fiscal health of the nation and states was generally improved in 2004 over 2003 with decreased pressures from revenue shortfalls. It is worth noting, however, that states continue to struggle with growing Medicaid expenditures in spite of the improving economy and various actions by states over the past several years to better control program growth and/or costs. (Source: *Fiscal Survey of States*; June 2005, National Governor's Association and National Association of State Budget Officers).

In spite of a less than stellar economy, states have continued to find ways to move forward with direct-care workforce policy/practice initiatives.

supervision skills among supervisors of direct-care workers. Many states also initiated strategies to achieve more comprehensive, organizational culture change to be used as a mechanism to help address recruitment and retention of direct-care workers and improve quality. Efforts to develop direct-care worker associations continue: Two new state associations were established in 2004 (in Kentucky and Vermont) and efforts are underway for developing an association in Pennsylvania. States also continue to implement research studies to help guide policy and practice decisions on direct-care workforce issues and/or to improve the quality of care provided.

While only eight states currently use civil penalty monetary funds to benefit direct-care workers or culture change initiatives, it is likely that this number will increase. States that do allocate funds toward direct-care workers have seen substantial benefits in promoting direct-care professions, professional training, and career advancement. Many states are still facing tight budget situations, and monies for extra initiatives and programs are hard to come by; using civil penalty funds for direct-care initiatives may act as an important supplement.

Both the survey responses and other national initiatives and publications pertaining to the direct-care workforce highlight a growing trend and interest in providing incentives and/or rewards to long-term care providers for meeting certain outcomes that exceed standard regulatory requirements. The increased attention to pay-for-performance is not new to hospitals and other acute care providers, who have had to make substantial clinical and technological changes to meet patient safety, quality outcomes, and patient satisfaction measures. However, pay-for-performance is more recent in the long-term care arena.

Linking Quality with Incentives

For a more detailed review of efforts to give incentives to long-term care providers for improved quality, see the report entitled: Linking Payment to Long-Term Care Quality: Can Direct-care Staffing Measures Build the Foundation? (April 2005). The report, a Better Jobs Better Care Practice and Policy Report published by the Institute for the Future of Aging Services, can be viewed at: http://www.bjbc.org. Click on "BJBC Publications," then click on the report link under "Practice and Policy Reports."

As reported in an April 2005 report published by the Institute for the Future of Aging Services (IFAS), there is growing interest in developing measures that are more closely tied to workforce and/or staffing related measures (e.g. training, leadership, organizational culture, teamwork, and job satisfaction) given the critical role workforce and staffing issues play in quality care. A bill recently introduced in the US Legislature, HR 1381, The Medicare Nursing Facility Pay-for-Performance Act of 2005, would require all nursing facilities to report, on a quarterly basis, their performance on several quality measures, including facility staffing and staffing mix. Additional payments would be paid to nursing facilities that rank within the top 20 percent of facilities in quality. Three other pay-for-performance bills have also been introduced into Congress; all have been referred to committee. For a detailed overview of national and state initiatives in this area (both past and more recent) as well as a discussion about considerations for design, implementation and evaluation of incentive or pay for performance programs, the full IFAS report can be viewed at: http://www.bjbc.org.

TABLE 1 Summary of State Responses to the 2005 Survey of State Initiatives of the Long-Term Care Direct-Care Workforce

STATE

Survey Question	ALABAMA	ALASKA	ARIZONA	ARKANSAS	CALIFORNIA	COLORADO	CONNECTICUT	DELAWARE	FLORIDA	GEORGIA	HAWAII	IDAHO	ILLINOIS	INDIANA	IOWA	KANSAS	KENTUCKY	LOUISIANA	MAINE	MARYLAND	MASSACHUSETTS	MICHIGAN	MINNESOTA	MISSISSIPPI	MISSOURI	MONTANA	NEBRASKA	NEVADA	NEW HAMPSHIRE	NEW JERSEY	NEW MEXICO	NEW YORK	NORTH CAROLINA	NORTH DAKOTA	OHIO	OKLAHOMA	OREGON	PENNSYLVANIA	RHODE ISLAND	SOUTH CAROLINA	SOUTH DAKOTA	TENNESSEE	TEXAS	UTAH	VERMONT	VIRGINIA	WASHINGTON	WEST VIRGINIA	WISCONSIN	WYOMING	Yes	No	Unknown	No Response	TOTAL
1) Serious Workforce Issue?																																																							
a) Very Serious	N	#	N	N	U	N	N	U	N	Y	Y	N	#	#	N	Y	N	N	Y	N	#	Y	N	N	U	N	#	N	#	U	#	N	N	#	N	N	#	N	#	N	N	#	Y	N	U	N	N	#	N	Y	7	26	5	12	50
b) Serious	N	#	N	Y	U	Y	Y	U	Y	N	N	N	#	#	Y	N	Y	Y	N	Y	#	N	Y	N	U	Y	#	Y	#	U	#	Y	Y	#	Y	Y	#	Y	#	Y	Y	#	N	Y	U	Y	Y	#	Y	N	22	11	5	12	50
c) Not Serious	Y	#	Y	N	U	N	N	U	N	N	N	Y	#	#	N	N	N	N	N	N	#	N	N	Y	U	N	#	N	#	U	#	N	N	#	N	N	#	N	#	N	N	#	N	N	U	N	N	#	N	N	4	29	5	12	50
2) Undertake major initiative to address shortage in 2004?	U	#	Y*	U	U	U	Y*	U	Y*	Y*	U	N	#	#	Y*	Y*	U	Y*	Y*	Y*	#	Y*	Y*	U	U	Y	#	U	#	U	#	Y	Y*	#	Y*	Y*	#	Y*	#	U	N	#	U	U	Y*	Y*	Y*	#	Y*	Y*	22	2	14	12	50
If yes, what type of initiative:																																																							
a) Wage & Benefit Enhancement	-		N	-	-		N		N	N	-	-			N	N	-	N	N	Y		N	N	-	-	Y		-		-		Y	N		N	N		N		-	-		-	-	Y	N	Y		N	Y	6	-	-	-	
b) Public Awareness Campaign	-		N	-	-		N		N	N	-	-			Y	Y	-	Y	N	N		N	N	-	-	Y		-		-		N	Y		Y	N		Y		-	-		-	-	N	N	N		N	N	7	-	-	-	
c) Career Advancement Program	-		N	-	-		N		N	Y	-	-			Y	Y	-	Y	N	N		N	Y	-	-	Y		-		-		N	Y		N	N		Y		-	-		-	-	Y	N	N		N	Y	10	-	-	-	
d) Task Force or Commission	-		Y	-	-		Y		N	N	-	-			N	Y	-	Y	N	N		Y	N	-	-	N		-		-		N	N		Y	Y		Y		-	-		-	-	N	N	N		Y	N	9	-	-	-	
e) Research Study	-		N	-	-		N		N	N	-	-			Y	N	-	Y	Y	N		Y	N	-	-	N		-		-		N	N		N	Y		Y		-	-		-	-	N	N	N		N	Y	7	-	-	-	
f) Quality Improvement Initiative	-		N	-	-		N		N	N	-	-			Y	Y	-	Y	N	N		Y	N	-	-	N		-		-		N	N		N	N		Y		-	-		-	-	Y	Y	N		N	Y	8	-	-	-	
g) Other	-		Y	-	-		N		Y	N	-	-			N	Y	-	N	N	Y		N	N	-	-	N		-		-		N	Y		Y	N		N		-	-		-	-	N	Y	Y		N	Y	9	-	-	-	
3) Reimburse Medicaid long-term care services on a "case-mix" basis?	N	#	N	N	N	Y	U	Y	N	Y	Y	N	#	#	Y	Y	Y	Y	Y	N	#	N	Y*	Y	U	N	#	Y	#	N	#	Y	Y	#	Y	N	#	Y	#	N	Y	#	Y	Y	Y	Y	Y	#	N	Y*	23	13	2	12	50
If yes, what setting:																																																							
a) Nursing Facility	-		-	-	-	Y	-	Y	-	Y	Y	-			Y	Y	Y	Y	Y	-		-	Y	Y	-	-		Y		-		Y	Y		Y	-		Y		-	Y		Y	Y	Y	Y	Y		-	N	22	-	-	-	
b) Personal Care Services	-		-	-	-	N	-	N	-	N	Y	-			N	N	N	N	Y	-		-	Y	N	-	-		N		-		N	N		N	-		N		-	N		N	N	N	N	N		-	N	3	-	-	-	
c) Assisted Living	-		-	-	-	N	-	N	-	N	N	-			N	N	N	N	Y	-		-	Y	N	-	-		N		-		N	N		N	-		N		-	N		N	N	N	N	N		-	N	2	-	-	-	
d) Home Care	-		-	-	-	N	-	N	-	N	Y	-			N	N	N	N	N	-		-	Y	N	-	-		N		-		N	N		N	-		N		-	N		Y	N	N	N	N		-	N	3	-	-	-	
4) Are QI requirements associated with case-mix reimbursement?	-	#	-	-	-	N	-	N	-	Y	U	-	#	#	Y*	N	N	Y*	Y	-	#	-	N	N	-	-	#	N	#	-	#	N	Y*	#	N	-	#	N*	#	-	Y	#	N	N	N	N	U	#	-	U	6	-	-	-	
5) Use civil monetary penalty funds for DC worker or culture change initatives?	N	#	N	N	U	N	U	N	N	N	N*	N	#	#	Y*	Y*	N	Y*	N	Y*	#	Y*	N	Y*	U	N	#	N	#	U	#	N	Y*	#	N	N	#	N	#	Y*	N	#	N	N	N	N	N	#	N	N	8	26	4	12	50
6) Are provider agencies required to be licensed or registered?	Y	#	Y*	Y*	U	Y*	Y*	Y	Y*	Y	U	Y*	#	#	N	U	Y	Y*	Y*	Y*	#	Y	Y	N*	U	Y	#	Y*	#	Y*	#	Y*	Y*	#	Y*	Y*	#	Y*	#	Y	N	#	Y*	Y*	Y	Y*	Y	#	Y*	Y*	31	3	4	12	50
If yes, which agencies:																																																							
a) All Agencies that Provide Hands-On Care in Home	Y		N	Y		Y	Y	N	Y	Y	-	N			-	-	Y	Y	Y	N		N	Y	-	-	N		N		Y		Y	Y		N	Y		N		N	-		Y	N	N	Y	Y		N	Y	18	-	-	-	
b) Medicare/Medicaid Certified Home Health Agencies	-		Y	-		-	-	Y	-	-	-	Y			-	-	-	-	-	N		Y	-	-	-	Y		Y		-		-	-		Y	-		Y		Y	-		-	Y	Y	-	-		Y	N	12	-	-	-	
c) Other	N		N	N		N	N	N	N	N	-	N			-	-	N	N	N	Y		N	N	-	-	N		N		N		N	N		N	N		N		N	-		N	N	N	N	N		N	N	1	-	-	-	
7) Training requirements above federal 75 hrs for home health or personal care aides in home settings?	N	#	N*	N	U	N	N	U	Y*	N	U	N	#	#	N	U	N	N	Y*	Y*	#	N	Y*	N	U	N	#	N	#	Y*	#	N	U	#	N	N	#	N	#	Y*	U	#	N	U	N	N	Y*	#	N	Y*	8	22	8	12	50
8) Current (or future) strategies to address lack of affordable health insurance for health care workers?	N	#	Y*	N	U	N	U	U	N	N	U	N	#	#	Y*	Y	N	N	Y*	N	#	Y*	N	N	U	N	#	N	#	U	#	Y*	U	#	N	N	#	Y	#	N	N	#	N	N	N	Y*	Y	#	N	N	9	22	7	12	50
9) Collect data (or have capacity) on health insurance coverage by occupation?	N	#	N	N	U	U	U	N	Y*	N	U	N	#	#	N	U	N	N	N	Y	#	Y	Y*	N	U	N	#	N	#	U	#	N	U	#	N	N	#	Y	#	N	N	#	N	N	N	N	Y	#	U	Y*	7	22	9	12	50
10) Collect turnover data for DC workers?	N	#	N	U	Y	N	U	N	Y*	N	U	U	#	#	N	Y*	N	N	N	Y*	#	N	Y*	N	U	N	#	N	#	U	#	N	Y*	#	N	N	#	N	#	Y	N	#	Y	N	Y	N	N	#	Y*	Y*	11	21	6	12	50
If yes, what setting:																																																							
a) Home Care	-		-	-	N	-	-	-	N	-	-	-			-	N	-	-	-	Y		-	N	-	-	-		-		-		-	Y		-	-		-		Y	-		N	-	N	-	-		N	N	3	-	-	-	
b) Assisted Living	-		-	-	N	-	-	-	N	-	-	-			-	N	-	-	-	N		-	N	-	-	-		-		-		-	N		-	-		-		N	-		N	-	N	-	-		N	N	0	-	-	-	
c) Nursing Facilities	-		-	-	Y	-	-	-	Y	-	-	-			-	Y	-	-	-	N		-	Y	-	-	-		-		-		-	Y		-	-		-		Y	-		Y	-	Y	-	-		Y	N	9	-	-	-	
d) Personal Care	-		-	-	N	-	-	-	N	-	-	-			-	N	-	-	-	N		-	N	-	-	-		-		-		-	N		-	-		-		N	-		N	-	N	-	-		N	N	0	-	-	-	
e) Other	-		-	-	N	-	-	-	N	-	-	-			-	N	-	-	-	Y		-	N	-	-	-		-		-		-	Y		-	-		-		N	-		N	-	N	-	-		Y	Y	4	-	-	-	
11) Tie outcomes to reimbursement?	N	#	Y*	U	N	N	U	N	N	Y*	U	U	#	#	Y	U	U	N	N	N	#	Y	U	N	U	N	#	N	#	U	#	N	U	#	N	N	#	U	#	N	N	#	N	N	N	N	N	#	N	N	4	23	11	12	50
12) Considering tying outcomes to reimbursement?	N	#	-	U	Y*	U	U	U	N	-	U	U	#	#	U	Y*	N	N	N	N	#	N	Y*	N	U	N	#	Y*	#	U	#	U	Y*	#	N	N	#	U	#	N	U	#	N	N	Y*	N	N	#	N	Y*	7	-	-	-	-

Legend		
	#	No survey received in 2004
	-	Not applicable

TABLE 2. Detailed State Comments from the 2005 Survey of State Initiatives of the Long-Term Care Direct-Care Workforce

STATE	COMMENTS (As reported by States in Survey Responses)
ALABAMA	No additional comments.
ALASKA	No response.
ARIZONA	*Major Initiatives to Address Vacancies:* Increased awareness for tracking direct-care workforce issues, particularly with growing aging population. Arizona Health Care Cost Containment System (HCCCS) will adjust HCBS fees and service rates for Medicaid nursing facilities in October 2005; new fees and rates will consider workforce issues. The Governor formed a Citizens Taskforce on the Long Term Care Workforce (report available at http://www.governor.state.az.us/).The Governor also launched an Aging 2020 initiative (http://www.governor.state.az.us/eo/2004_07.pdf), requiring most state agencies to develop a plan for addressing the needs of the rapidly growing population of older Arizonans over the next 15 years; report, when complete will be available at (http://www.governor.state.az.us/). *Licensure/Regulation of Home Care Providers:* A significant majority of Medicaid in-home services are provided by agencies that are not required to be licensed or certified, including attendant care, personal care, and homemaker. State Citation - R9-10, Article 11 (Home Health Agencies); www.azsos.gov/public_services/Title_09/9-10.htm *Training Requirements Above 75 Hours:* Only nurse aides listed on the Certified Nursing Assistant Registry must have more than 75 hours of training. The registry is technically for nursing facility nurse aides, who must have completed at least 120 hours of training. *Health Insurance Coverage Strategies:* The Long Term Care Workforce Taskforce is expected to recommend that the State consider approaches to making affordable health insurance available to direct-care workers. However, it is not known if these recommendations will be followed. *Tying Outcomes to Reimbursement:* A limited number of long-term care nursing facilities (managed care organizations) have begun tying reimbursement to quality outcomes.
ARKANSAS	*Licensure/Regulation of Home Care Providers:* [Ark Code-Ann 20-10-701 et seq.].
CALIFORNIA	*Efforts to Tie Outcomes to Reimbursement:* May have facility specific rates and higher reimbursement in order to improve quality (AB1629).
COLORADO	*Licensure/Regulation of Home Care Providers:* Facilities and providers of home health, personal care, and homemaker services that serve Medicare and/or Medicaid clients must be federally certified, but not licensed. State Citation - 10CCR2505-10, § 8.520; § 8.485, § 489 and § 8.401.
CONNECTICUT	*Major Initiatives to Address Vacancies:* Creation of an Allied Health Workforce Policy Board to address health care workforce vacancies. The report and recommendations are due January, 2006. *Licensure/Regulation of Home Care Providers:* State Citation - CGS § 19a-491.
DELAWARE	No additional comments.
FLORIDA	*Major Initiatives to Address Vacancies:* The implementation of SB 1202 has been delayed, in part due to turnover issues. *Licensure/Regulation of Home Care Providers:* State Citation - § 400.464, Florida Statutes; § 464.203, Florida Statutes. *Training Requirements Above 75 Hours:* Home health aides employed by home health agencies and nurse registries must initially complete two hours of HIV/AIDS training and one hour of in-service training every two years thereafter. Aides must obtain and maintain CPR certification. Aides employed by Medicare and Medicaid home agencies must complete 12 hours of in-service training annually. Long-term care facility employees who have direct contact with Alzheimer's residents (or residents with a related disorder), must receive written information about interacting with such persons and must receive initial training (overview of dementia, communication, etc.) within three months of employment. Additional training within nine months of employment is required (management of behaviors, promoting independence, etc). CNAs must complete a minimum 18 hours of in-service training annually. Every two years, CNA training includes HIV/AIDS, infection control, domestic violence, medical record documentation, CPR, resident rights, medical error prevention and safety, etc. *Data Collection of Health Insurance Coverage:* A project funded through a Health Resources and Services Administration State Planning Grant is studying the uninsured and developing proposals for extending coverage to all who are uninsured in Florida. The Task Force for Access to Affordable Health Care for Floridians collected data on the uninsured via telephone survey and focus groups. *Turnover Data Results:* 2002 (41.32 percent); 2003 (44.88 percent); 2004 partial year (27.89 percent).

TABLE 2 Continued. Detailed State Comments from the 2005 Survey of State Initiatives of the Long-Term Care Direct-Care Workforce

GEORGIA	*Major Initiatives to Address Vacancies*: The Governor's Council on Developmental Disabilities, in collaboration with both the Department of Adult and Technical Education and Healthcare Georgia Foundation, piloted a training curriculum for direct support professionals, including field training, in three technical colleges. *Efforts to Tie Outcomes Tied to Reimbursement:* Currently, contracts with developmental disability providers are on a pay for performance basis. However, a State audit found the current system ineffective and alternatives are being examined.
HAWAII	*Use of Civil Monetary Penalty Funds:* The Office of Health Care Assurance is working with the Division of Human Services to develop guidelines for future use of these funds. They may be used for staff training to improve resident care.
IDAHO	*Licensure/Regulation of Home Care Providers:* State Citation - Idaho Code TrHC 39, Chapter 24.
ILLINOIS	No response.
INDIANA	No response.
IOWA	*Major Initiatives to Address Vacancies*: The Iowa CareGivers Association (ICA), with funding from the Iowa Department of Elder Affairs, hosted the 11th Annual Iowa CareGivers Month Campaign to increase public awareness of the need for, and importance of, direct-care workers. ICA, with funds from the Department of Public Health's Center for Health Workforce Planning, developed and piloted a direct-care worker leadership training program. Iowa's BJBC program revised ICA's direct-care worker mentor program to pilot with BJBC LTC provider organizations. The BJBC Coalition published several surveys: (1) A CNA Wage and Benefit Report, (2) A Nursing Home Administrator Needs Assessment Survey and Correlation to CNA and LTC Nurse Needs Assessment Surveys, and (3) A Direct Care Worker Health Insurance Feasibility Study. The Iowa Foundation for Medical Care (IFMC) assists providers in improving care related to publicly reported quality measures (pain, pressure ulcers, depression, acute care hospitalizations, surgical wounds, etc) and IFMC will be working with providers to implement organizational culture change. *Quality Improvement Initiatives Related to Direct-Care Workers:* One quality indicator is staff retention. *Use of Civil Monetary Penalty Funds:* ICA received funding from civil monetary penalty funds to support Year 2 of its CNA Recruitment and Retention Project, and to support direct-care worker scholarships to attend ICA's Education Conference in 2004-05. *Health Insurance Coverage Strategies:* Conducted a direct-care worker wage and benefit survey and a direct-care worker health care feasibility study through the Iowa BJBC project. The Coalition is in the process of reviewing various options and seeking ways to ensure that direct-care workers have health care coverage. *Efforts to Tie Outcomes to Reimbursement:* Iowa has implemented ten accountability measures that are calculated annually. If a facility meets three or more of the measures, it qualifies for an enhanced add-on to its per diem.
KANSAS	*Major Initiatives to Address Vacancies:* Promoting Excellent Alternatives in Kansas (PEAK) nursing homes promotes culture change, including staff empowerment. PEAK-ED contract with Kansas State University promotes culture change through education materials; an outcomes research-module on staff empowerment has been completed. Several pilot project collaborations are underway: a Person Center Care Pilot and Workforce Retention Pilot (The Kansas Foundation for Medical Care Quality Improvement Organization), Workforce Development Collaborative (The Kansas Association of Homes and Services for the Aging). A Nursing Home Medicaid Reimbursement Quality Incentive Factor details points for staff turnover, retention, and staffing ratios. The Kansas Department on Aging (KDOA) grants funded from the Civil Monetary Penalty Fund provides education for un-licensed nursing home staff; the KDOA grants from the Partnership Loan Program Interest develop a culture change toolchest. *Use of Civil Monetary Penalty Funds:* Funds provide education for un-licensed nursing home staff. *Turnover Data Results:* Overall nursing home turnover decreased 7 percent from CY2002 to CY2003. Nurse aide turnover decreased 10 percent over the same time period. *Efforts to Tie Outcomes to Reimbursement:* Aggressively pursuing implementation of a nursing home quality incentive reimbursement provision in FY 2006. The seven factors being considered include: a case-mix adjusted nurse staff ratio; a low operating expense (administration and plant operations); a low direct-care employee turnover rate; a high employee retention rate; a high occupancy rate; a high Medicaid occupancy rate; and a low number of survey deficiencies with no substandard care deficiencies. In the future, a resident satisfaction factor may be added.
KENTUCKY	No additional comments.

TABLE 2 Continued. Detailed State Comments from the 2005 Survey of State Initiatives of the Long-Term Care Direct-Care Workforce

LOUISIANA	*Major Initiatives to Address Vacancies:* Taskforce and Research activities include the Louisiana DD Council, Consumer Task Force Initiatives, and Real Choice Grant Subcommittee for HCBW. LTC facilities utilize CNAs through a State Registry that verifies that workers meet criteria for certification and continued employment in nursing facilities. *Quality Improvement Initiatives Related to Direct-care Workers:* Examples include annual nursing facility Medicare/Medicaid surveys; federal CNA requirements for nursing facilities; Certified Medication Assistants used in ICF/MR Group Homes; Consumer Direction in the New Opportunities Waiver with fiscal agent oversight; and provider standards for payment for waiver-enrolled direct-service providers. All LTC facilities and waiver programs require QA/QI programs, including support coordination agencies and direct service providers. *Use of Civil Monetary Penalty Funds:* Civil monetary penalty funds collected from nursing facilities are partially directed to the Resident Trust Fund for culture-related activities. *Licensure/Regulation of Home Care Providers:* State Citations - LRS: 28:380-451 (HCBW PCA/Personal Care, Family Supports, Household Supports, Day and Night Supervision, and Case Management); LRS: 46:1401-1424 (In Home Respite); LRS: 46:1402-1424 (Center-Based Respite); LRS: 40-2116.32 (Home Health Agencies).
MAINE	*Major Initiatives to Address Vacancies:* At the request of the legislative Joint Standing Committee on Health and Human Services, and in conjunction with the Bureau of Elder and Adult Services, the Direct Care Worker Coalition prepared an updated wage, benefit, and training analysis for presentation to the committee in March 2004. *Licensure/Regulation of Home Care Providers:* State Citations - MRSA Title 22, Chapter 419 (Home Health Agencies); MRSA Title 22 §1717 (Personal Care Agencies); MRSA Title 22, Chapter 1664 (Assisted Housing). *Training Requirements Above 75 Hours:* CNAs are required to complete 150 hours of training. *Health Insurance Coverage Strategies:* Dirigo Health is a program that makes affordable health insurance coverage accessible to eligible small businesses and individuals. A CMS Workforce grant (under 2003 Real Choices Systems Change Grant) will demonstrate and evaluate the impact of two direct-service worker recruiting interventions in community programs, one of which is to increase health coverage for workers and their families through enrollment in Dirigo Health.
MARYLAND	*Major Initiatives to Address Vacancies:* Organized free CPR and First Aid classes to help provider applicants meet qualification requirements; sponsored small training sessions and worker appreciation initiatives at local health department. A wage enhancement in FY 2005 devotes $17 million to fund a third year initiative to increase wages for direct-care workers who serve the developmentally disabled. *Use of Civil Monetary Penalty Funds:* Funds have been used to help start the Wellspring program in ten nursing facilities. However, 2004 funds were not used to support direct-care workers or culture change initiatives. *Licensure/Regulation of Home Care Providers:* Home health agencies and residential service agencies must be licensed (Maryland's Medicaid program also requires home health agencies to be Medicare-certified and licensed, and requires residential service agencies to be licensed); personal care agencies do not require licensure. State Citations – COMAR 10.07.10 and COMAR 10.09.04 (Home Health); COMAR 10.07.05, COMAR 10.09.53 and COMAR 10.09.69 (Residential Service). *Training Requirements Above 75 Hours:* CNAs must have 60 hours of classroom and 40 hours of clinical training. Home health aides have CNA certification and must obtain 12 hours of in-service training one year prior to certification renewal. No training requirements for personal care aides. *Turnover Data Results:* According to the Community Services Reimbursement Rate Commission, the turnover for aides working with the developmentally disabled was 41 percent in 2003 and 37 percent in 2004. For complete details, see: www.dhmh.state.md.us/csrrc/annual_report.htm
MASSACHUSETTS	No response.

TABLE 2 Continued. Detailed State Comments from the 2005 Survey of State Initiatives of the Long-Term Care Direct-Care Workforce

MICHIGAN	*Major Initiatives to Address Vacancies*: The Michigan Direct Care Workers Initiative released a study, "Voices from the Front: Recruitment and Retention of Direct Care Workers in Long Term Care Across Michigan." Findings reported demographics (average age of direct-care worker is 42, most have high school diploma and some college), and job-related information (most entered the field to help people and work in health care, or enjoy working with older people; most left the field because of low pay, not feeling valued, or personal health concerns). For staff that worked in nursing homes, many left the field because of high patient-to-staff ratios, the inability to provide quality care, or because of unsafe conditions; for staff that worked in home health, many left because of low pay, too few hours, or dissatisfaction with work schedule. The Michigan Medicaid Long Term Care Taskforce released a report, "Modernizing Michigan Medicaid Long Term Care" which examines and evaluates the state's long-term care system. Report available at www.ihcs.msu.edu/ltc/Reports/Final_LTC_Task_Force_Report.doc *Use of Civil Monetary Penalty Funds:* Funds are being used to pilot and evaluate a dining assistant program for feasibility for nursing home residents in FY2005; other programs may be considered in the future. *Health Insurance Coverage Strategies:* A Health Resources Service Administration grant for $900,000 is being used for a Planning Project for the Uninsured to extend health insurance to all citizens of Michigan. The project has four goals: 1) create a responsive and effective governance structure; 2) collect data to expand knowledge base on uninsurance issues; 3) utilize data collection efforts to extend access to health insurance; and 4) disseminate a final report on processes and outcomes to the Governor and DHHS. *Data Collection of Health Insurance Coverage:* The Michigan Report on Characteristics of Health Insurance Coverage is available at www.michigan.gov/documents/uninsured_78098_7.pdf *Tie Outcomes to Reimbursement:* Michigan uses a cost-based reimbursement methodology to tie outcomes to reimbursement.
MINNESOTA	*Major Initiatives to Address Vacancies*: Scholarship program for workers in nursing homes. *Training Requirements Above 75 Hours:* At least eight hours of additional training are required for the care of Alzheimer's patients. *Use of Civil Monetary Penalty Funds:* Ideas have been considered but not enacted. *Case-Mix Reimbursement:* Use Reimbursement Utilization Groups (RUGs) methodology in homes. *Data Collection of Health Insurance Coverage:* The Health Economics program in the Department of Health has conducted surveys of health insurance coverage by occupation in the past. *Turnover Data Results:* It appears that CNA turnover is declining, perhaps by the economy. Results from the last four years (year ending September 30): CNA turnover 69 percent (2000), 65 percent (2001), 56 percent (2002), and 51 percent (2003). *Calculate Turnover Methodology:* Uses number of employees at the beginning of the period (October 1), number of hired/transferred/leaving/transferred out, and the number employed at the end of the period (September 30). *Efforts to Tie Outcomes to Reimbursement:* Seeking to enact a quality, price, and cost-based system of rate setting. More information available at www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_020477.pdf
MISSISSIPPI	*Use of Civil Monetary Penalty Funds:* Nursing facilities have the opportunity to apply for civil penalty grant funds to be used for educational programs that will benefit, directly or indirectly, the residents in the nursing facility. *Licensure/Regulation of Home Care Providers:* Only nurse aides working in long-term care facilities that participate in the Medicaid and Medicare programs must be certified; this includes distinct- part certified units in hospitals. ICF/MRs, home health agencies, hospices, personal care homes (residential living), and personal care homes (assisted living) are required to have qualified aides, but do not need to be certified.
MISSOURI	Unable to complete 2004 survey.
MONTANA	No additional comments.
NEBRASKA	No response.

TABLE 2 Continued. Detailed State Comments from the 2005 Survey of State Initiatives of the Long-Term Care Direct-Care Workforce

NEVADA	*Licensure/Regulation of Home Care Providers:* State Citation - Nevada Administrative Code 449.749-449.768, Nevada Revised Statute 632.2856. *Efforts to Tie Outcomes to Reimbursement:* Division staff complete verification reviews in nursing facilities to assure appropriate assessment of care needs. Based on these reviews, the accuracy rate in the completion of Minimum Data Set for Nursing Facilities may be used to adjust reimbursement in the future.
NEW HAMPSHIRE	No response.
NEW JERSEY	*Licensure/Regulation of Home Care Providers:* State Citation - NJAC 8:42 (Home Health Agency); NJAC 13:45B (Health Care Service Firm). *Training Requirements Above 75 Hours:* Home health aides receive 76 hours of training.
NEW MEXICO	No response.
NEW YORK	*Licensure/Regulation of Home Care Providers:* State Citation - ten NYCRR 766. *Health Insurance Coverage Strategies:* Home Care Worker Rate Demonstration Project.
NORTH CAROLINA	*Major Initiatives to Address Vacancies:* Two videos were developed (one recruitment, one public education) as tools highlighting the importance of direct-care workers in the delivery of long-term care. A pilot was initiated to test training curricula and a related toolbox for the Medication Aide job category in nursing facilities, adult care homes, and other settings. Similar development on a Geriatric Aide category was also initiated and is expected in 2005. NC New Organizational Vision Award (NC NOVA) is being developed through a BJBC demonstration grant funded by The Robert Wood Johnson Foundation and The Atlantic Philanthropies; NC Foundation for Advanced Health Programs is the grantee. Since July 2003, a broad based Partner Team has been working to develop expectations and criteria for this voluntary "raise-the-bar" program, which focuses on workplace culture change to improve direct-care worker retention and job satisfaction. Four areas of NC NOVA are 1) supportive workplaces (orientation, peer mentoring, coaching supervision, management support, reward and recognition); 2) training; 3) balanced workloads; and 4) career development. Direct Care Workers Association of NC (DCWA-NC) received its advance ruling for 501 (c) (3) status in early 2004. *Quality Improvement Initiatives Related to Direct-Care Workers:* Development of quality improvement options related to case-mix reimbursement are under development but options specifically related to direct-care workforce initiatives are expected. *Use of Civil Monetary Penalty Funds:* Monies are used to support NC's "Win A Step Up" program, which is a collaborative effort between the NC Department of Health and Human Services and the UNC Institute on Aging. The program rewards direct-care workers (financial and other incentives) who complete certain training and fulfill a related retention commitment. Participating employers provide a bonus and/or wage increase when the worker completes the requirements. Coaching supervision will be added as a training option for direct-care supervisors in this program. (http://www.aging.unc.edu/research/winastepup/index.html) *Licensure/Regulation of Home Care Providers:* State Citation - G.S. 131 E-136 (3). *Turnover Data Results:* In 2003, turnover rates were 105 percent in nursing homes, 109 percent in adult care homes, and 49 percent in home care. *Efforts to Tie Outcomes to Reimbursement*: NC NOVA is in development; a pilot of the domains and criteria developed will begin summer 2005. Once implemented statewide (2007), there are plans to establish reimbursement differentials to entities that receive NC NOVA special licensure designation. The NC NOVA partner team will be working in 2005 - 2006 to determine ways to assess the impact of NC NOVA on retention, job satisfaction, care, etc. Additional information at www.dhhs.state.nc.us/ltc, click on "Workforce Issues and Initiatives," then on "Initiatives," then on "Better Jobs, Better Care."
NORTH DAKOTA	No response.

TABLE 2 Continued. Detailed State Comments from the 2005 Survey of State Initiatives of the Long-Term Care Direct-Care Workforce

OHIO	*Major Initiatives to Address Vacancies:* A direct-care worker public awareness campaign, "Make Care Your Career" was launched in June 2004, which included brochures, billboards, a website (www.careerincaring.com), and collaboration with state workforce programs. The Ohio Health Care Workforce Advisory Council published a report in June 2004 (www.golenbuckeye.com/wfreport2004.pdf). In development phase is the credentialing of four levels of direct-care workers through competency assessment, which will include competencies in specialized areas of care, including drug and alcohol services, mental health, MR/DD, Alzheimer's, and traumatic brain injury. Curricula and training materials are in development, as are advocacy efforts toward legislative authorization for credentialing. *Licensure/Regulation of Home Care Providers:* Ohio requires agencies to be certified to provide services, and requirements are specific to each service that is provided.
OKLAHOMA	*Major Initiatives to Address Vacancies:* A new methodology for calculating state Medicaid program reimbursements by implementing specific rates based on direct-care staffing expenditures is being developed. *Licensure/Regulation of Home Care Providers:* State Citation - Title 63 Oklahoma Statures 2001 § 1-1960 et seq.
OREGON	No response.
PENNSYLVANIA	*Major Initiatives to Address Vacancies*: Training sessions to nursing leaders and line supervisors, to improve the work environment and retention of direct-care workers; mentor demonstration projects for direct-care workers; initiatives to retain direct support professionals during the first 90 days (Direct Support Professional website for ideas and resources available at www.maxassocation.org); career development and career ladders through LEAP (Learn, Empower, Achieve, Perform) for CNAs; CNA professional empowerment projects; rural direct-care worker dementia training project; work culture shifts through team building in adult day services; published *Frontline Care* - a magazine for direct-care workers in long term care; direct-care worker recruitment and training including appreciation and awards events; development of direct-care associations and activities. *Quality Improvement Initiatives Related to Direct-Care Workers:* The current case-mix index is based solely on the cost of care and acuity adjustments. The Commonwealth is beginning discussions with the nursing facility industry to consider including direct-care turnover rate/retention rate and training in the index. *Licensure/Regulation of Home Care Providers:* State Citation - 28 PA Code Subsection 201 (Nursing Facilities); 28 PA Code Part fourSubpart F Chapter 601 (Home Health).
RHODE ISLAND	No response.
SOUTH CAROLINA	*Use of Civil Monetary Penalty Funds:* Funds are used to sponsor educational activities and provide grants to nursing facilities that embrace culture change. *Training Requirements Above 75 Hours:* CNAs are required to have 80 hours of training.
SOUTH DAKOTA	No additional comments.
TENNESSEE	No response.
TEXAS	*Licensure/Regulation of Home Care Providers:* Regulation includes agencies receiving Medicaid reimbursement for personal care services. State Citation - Health and Safety Code Chapter 142 (Home and Community Support Services), Section 142.02 (License Required).
UTAH	*Licensure/Regulation of Home Care Providers:* State Citation - UCA 26-21, R432-700.
VERMONT	*Major Initiatives to Address Vacancies:* The Department of Aging and Independent Living and the Department of Employment and Training are partners in a BJBC grant. The nursing home Gold Star Initiative is a project among 12 nursing homes; the Department of Aging and Independent Living. Annual nursing home quality awards are now tied to participation in the Gold Star Initiative. Under the BJBC grant, the Gold Star initiative will be expanded to home health agencies and adult day centers. *Efforts to Tie Outcomes to Reimbursement:* The State budget situation and implementation of the 1115 LTC Waiver have prevented further efforts to tie outcomes to reimbursement. *Calculate Turnover Methodology:* Total # of W2s, less (employees on payroll on Dec 31 plus # of vacancies) divided by (employees on payroll on Dec 31 plus # of vacancies). CMS does not specify staffing requirements other than for RN eight hours a day, seven days a week and LPN on each tour of duty.

TABLE 2 Continued. Detailed State Comments from the 2004 Survey of State Initiatives of the Long-Term Care Direct-Care Workforce

VIRGINIA	*Major Initiatives to Address Vacancies:* Through a Real Choice Systems Change Grant and Direct Service Worker Grant, the Medicaid agency offers additional training to direct-service workers and supervisors. *Licensure/Regulation of Home Care Providers:* Home health licensure is provided through the Virginia Department of Social Services, Division of Licensed Programs. *Health Insurance Coverage Strategies:* A small pilot demonstration through a Direct Service Worker grant offers insurance through the child health program, but this is not a statewide initiative.
WASHINGTON	*Major Initiatives to Address Vacancies:* Several initiatives have been undertaken to address the vacancies, including negotiations during the 2004 legislative session via union contract for individual providers who work in the home ($0.50 per hour wage increase, workers compensation insurance and health benefits). The Home Care Quality Authority received a federal workforce demonstration grant designed to strengthen and stabilize the in-home care workforce and ensure quality services are provided to consumers. Four Referral and Workforce Resource Centers were established throughout Washington to provide services including: referral registry, peer mentoring, professional development and apprenticeship opportunities, and training for consumers in their roles as employers. *Training Requirements Above 75 Hours:* All aides are required to attend 30 hours of training on care provision and injury prevention.
WEST VIRGINIA	No response.
WISCONSIN	*Major Initiatives to Address Vacancies:* The Wisconsin Council on Long Term Care Reform formed a committee on direct-care workforce issues in 2004. The Committee's report will be released in July 2005 and made available at www.wcltc.state.wi.us/CDCcharge.htm. A draft report is available. *Licensure/Regulation of Home Care Providers:* Personal care agencies are certified for Medicaid, but not licensed. Only counties and Independent Living Centers are eligible to become Personal Care Agencies. Licensed Home Health Agencies also provide some personal care. s. 50.49 (Home Health Agencies). *Turnover Data Results*: Turnover rates have declined in some categories; the extent to which this is related to the economy is not known. Turnover rates for 2003 for aides in Nursing Facilities for full time aides (43 percent) and part time aides (61 percent). Turnover rates for 2003 for aides in Facilities for the developmentally disabled for full-time aides (24 percent) and part-time aides (33 percent). Turnover rates in both types of facilities for both full- and part-time aides were lower in government facilities.
WYOMING	*Major Initiatives to Address Vacancies:* A wage passthrough of $30 million was appropriated in July 2002 to increase average wages of direct-care staff for adult waiver and developmentally-disabled preschool programs. The Wyoming Health Care Commission was created for a limited time by the legislature to study solutions for health care problems, including workforce issues. Some initiatives were enacted including loan repayment, a website, and an Internet College. *Case-Mix Reimbursement:* For developmentally disabled sites only, Wyoming uses a method called DOORS, which provides each program participant with an individual budget that considers living arrangements, work settings, prior services, and functional and medical information. More information is available at http://ddd.state.wy.us. *Licensure/Regulation of Home Care Providers:* State Citation - W.S. 35-2-901; W.S. 35-2-902. *Training Requirements Above 75 Hours:* An additional 16 hours of training is required for home health aides. *Data Collection of Health Insurance Coverage:* The Department of Employment previously conducted employer benefit surveys. *New Settings for Turnover Data Collection:* Turnover data is now collected in 30-day residential developmentally-disabled sites. *Turnover Data Results:* For developmentally-disabled sites, there has been a significant decline in turnover from 52 percent in Fall 2001 to 32 percent in Fall 2004. *Efforts to Tie Outcomes to Reimbursement:* Additional efforts are being considered to tie quality of care issues with reimbursement. Additionally, contracted rates for added value and possible Medicaid rule revision regarding recovering for quality of care issues are being considered.

TABLE 3. State Unemployment Data and State Wage Data for Direct-Care Workers

STATE	Unemployment Rate - April 2002	Unemployment Rate - February 2003	Unemployment Rate - November 2003	Unemployment Rate - April 2005	Average of Median Wages Across All 3 Categories 1999	Average Median Hourly Rate Across All 3 Categories 2000	Average of Median Wages Across All 3 Categories 2001	Average of Median Wages Across All 3 Categories 2002	Home Health Aides - Median Hourly Wage 2003	Nursing Aides, Orderlies, Attendants - Median Hourly Wage 2003	Personal Care & Home Care Aides - Median Hourly Wage 2003	Weighted Median Hourly Wage Across All 3 Categories 2003
Alaska	6.0%	5.5%	5.8%	6.7%	$6.97	$7.31	$7.39	$7.62	$7.85	$8.03	$6.99	$7.87
Alabama	6.5%	7.0%	7.5%	4.4%	$10.81	$11.50	$11.42	$12.11	$12.17	$13.37	$10.66	$12.16
Arizona	5.8%	5.7%	4.8%	5.0%	$8.01	$8.45	$8.73	$8.79	$8.68	$9.73	$8.45	**NA**
Arkansas	5.2%	4.9%	6.0%	4.9%	$6.46	$6.81	$7.12	$7.33	$7.57	$7.99	$6.50	$7.74
California	6.4%	6.6%	6.4%	5.4%	$8.22	$8.54	$8.90	$9.16	$8.90	$10.43	$8.50	$9.72
Colorado	5.6%	5.5%	5.6%	5.2%	$8.04	$9.09	$9.43	**NA**	**NA**	$10.64	$8.42	$9.95
Connecticut	3.5%	5.0%	5.0%	4.9%	$10.33	$11.08	$11.07	$11.23	$11.54	$12.68	$9.52	$12.02
Delaware	3.8%	3.7%	4.1%	3.9%	$8.43	$8.41	$8.95	$9.11	$9.85	$11.40	$7.10	**NA**
Florida	5.2%	5.2%	4.7%	4.2%	$7.95	$8.26	$8.52	$8.68	$8.49	$9.53	$8.42	$9.13
Georgia	4.6%	4.5%	4.2%	5.0%	$7.16	$7.67	$7.90	$7.92	$8.08	$8.33	$7.61	$8.18
Hawaii	4.6%	3.0%	4.1%	2.9%	$9.36	$8.70	$8.99	$8.83	$9.96	$11.05	$6.63	**NA**
Idaho	5.6%	5.3%	5.1%	4.0%	$7.28	$7.58	$7.86	$8.06	$8.06	$8.71	$7.67	$8.46
Illinois	6.1%	6.5%	6.7%	5.9%	$7.83	$7.80	$8.12	$8.30	$8.27	$9.62	$7.37	$8.98
Indiana	4.9%	4.9%	5.0%	5.4%	$8.09	$8.64	$9.05	$9.28	$9.62	$9.70	$8.80	$9.51
Iowa	3.4%	4.0%	4.2%	4.5%	$7.92	$8.20	$8.56	$8.83	$9.01	$9.75	$8.31	$9.34
Kansas	4.4%	4.6%	4.7%	5.2%	$7.78	$8.12	$8.42	$8.69	$8.72	$9.36	$8.45	$9.04
Kentucky	5.3%	5.6%	5.5%	5.6%	$7.40	$7.78	$7.97	$8.25	$8.58	$9.14	$7.59	$8.94
Louisiana	5.6%	5.7%	5.5%	5.1%	$6.41	$6.80	$6.75	$6.91	$7.34	$6.84	$6.47	$6.83
Maine	4.2%	4.6%	4.9%	4.7%	$7.70	$8.44	$8.69	$8.88	$8.75	$9.69	$8.52	$9.16
Maryland	5.2%	4.2%	4.2%	4.3%	$8.29	$8.65	$9.14	$9.46	$8.67	$11.45	$8.77	$10.61
Massachusetts	4.4%	5.3%	5.4%	4.7%	$9.10	$9.89	$10.39	$10.66	$10.69	$11.93	$9.96	$11.40
Michigan	6.0%	6.6%	7.0%	7.0%	$8.31	$8.78	$9.04	$9.25	$8.92	$10.70	$8.39	$9.78
Minnesota	4.3%	4.3%	4.6%	4.0%	$8.99	$9.55	$9.92	$10.10	$9.83	$11.14	$9.65	$10.36
Mississippi	6.6%	6.0%	5.0%	6.8%	$6.75	$7.39	$7.24	$7.44	$8.01	$7.49	$6.83	$7.52
Missouri	5.2%	4.7%	5.0%	5.6%	$7.25	$7.64	$7.96	$8.17	$8.15	$8.88	$7.92	$8.57
Montana	4.7%	4.0%	4.3%	4.4%	$7.23	$7.46	$7.82	$8.14	$8.31	$8.57	$7.80	$8.31
Nebraska	3.6%	3.5%	3.6%	3.9%	$8.09	$8.71	$9.05	$9.18	$9.21	$9.74	$8.28	$9.61
Nevada	5.8%	5.0%	4.5%	4.0%	$8.46	$8.82	$9.22	$9.41	$9.20	$11.18	$7.97	**NA**
New Hampshire	4.1%	3.8%	4.3%	3.4%	$8.63	$9.52	$9.74	$9.92	$10.28	$10.95	$8.47	$10.26
New Jersey	5.5%	5.7%	5.5%	4.2%	$9.06	$9.56	$9.82	$10.00	$9.69	$10.97	$9.57	$10.45
New Mexico	6.0%	5.8%	6.0%	6.0%	$7.16	$7.73	$7.96	$8.28	$8.59	$8.97	$8.84	**NA**
New York	5.9%	6.1%	6.1%	4.9%	$8.91	$9.25	$9.50	$9.74	$8.89	$12.85	$8.27	$10.11
North Carolina	6.6%	5.8%	6.2%	5.3%	$7.53	$7.86	$8.20	$8.36	$8.12	$9.16	$8.03	$8.67
North Dakota	3.1%	3.6%	3.2%	3.2%	$7.47	$7.81	$8.06	$8.30	$8.18	$9.00	$8.14	$8.70
Ohio	5.7%	6.0%	5.7%	6.1%	$7.97	$8.43	$8.76	$8.94	$8.85	$9.98	$8.29	$9.51
Oklahoma	4.0%	5.1%	5.3%	4.5%	$7.29	$7.17	$7.43	$7.65	$7.94	$8.16	$7.20	$7.98
Oregon	7.9%	7.3%	7.3%	6.5%	$8.17	$8.85	$9.22	$9.40	$8.96	$10.27	$9.23	$9.69
Pennsylvania	5.6%	6.2%	5.2%	4.9%	$8.21	$8.63	$8.87	$9.17	$9.15	$10.30	$8.25	$9.66
Rhode Island	4.2%	5.1%	4.9%	4.7%	$10.20	$9.93	$10.56	$10.77	$10.69	$11.07	$11.27	$11.00
South Carolina	6.0%	6.2%	6.9%	6.5%	$7.47	$7.89	$8.13	$8.27	$8.19	$8.45	$8.06	$8.32
South Dakota	3.2%	3.3%	3.3%	3.7%	$7.57	$8.06	$8.18	$8.36	$8.58	$8.83	$8.03	$8.69
Tennessee	5.6%	4.7%	5.7%	5.8%	$7.51	$7.98	$8.09	$8.39	$8.32	$8.97	$7.95	$8.69
Texas	5.8%	6.6%	6.3%	5.5%	$7.52	$6.69	$6.88	$7.11	$6.96	$8.28	$6.35	$7.19
Utah	5.9%	5.3%	4.9%	4.9%	$7.91	$8.25	$8.38	$8.65	$9.08	$9.20	$8.01	$9.01
Vermont	3.9%	4.0%	4.0%	3.3%	$7.66	$8.41	$8.60	$9.09	$9.13	$10.14	$8.31	$9.49
Virginia	4.2%	4.1%	3.6%	3.6%	$7.10	$7.59	$7.89	$8.14	$8.46	$9.19	$7.07	$8.72
Washington	6.8%	6.8%	6.8%	5.5%	$8.14	$8.71	$9.06	$9.26	$8.71	$10.78	$8.53	$9.70
West Virginia	5.9%	5.9%	5.6%	5.2%	$6.47	$6.66	$6.87	$7.19	$6.97	$8.08	$6.73	$7.49
Wisconsin	5.7%	5.3%	5.0%	4.5%	$8.16	$8.75	$9.12	$9.35	$9.49	$10.27	$9.09	$9.87
Wyoming	3.9%	4.1%	4.0%	3.5%	$7.68	$7.54	**N/A**	$8.15	$8.00	$9.20	$8.08	$8.85
US*	**5.7%**	**5.8%**	**5.9%**	**5.2%**	**$7.97**	**$8.21**	**$8.50**	**$8.70**	**$8.85**	**$9.80**	**$8.19**	**NA**

Source: Average Median hourly wages for 1999, 2000, 2001 and 2002 reflect the average of each of the three major categories of direct care workers included in this chart as obtained from the US Bureau of Labor Statistics - State Occupational Employment and Wage Estimates for the years indicated. For 2003, a **weighted** average was calculated for the three job categories for each state based on a weighted average of the median hourly wages for each job category as published by the Bureau of Labor for May 2003. Note that there was no median hourly wage available for one or more job categories in some states. In these cases, the absence of these data is denoted by an "**NA**" (for not available). Unemployment data (national and state) also obtained from the Bureau of Labor Statistics.

TABLE 4. Direct-Care Worker Professional Associations

Region	Name	Date Founded	Member Types (See Legend)	Members	Fees	Financial Support	Tax Status	Staffing	Brief Description	Contact Information
US	National Association for Directcare Workers of Color (NADCWOC)	2002	D; I; A; C	n/a	$10/yr for direct-care workers	Membership dues; city, state, and private donations; government grants	501(c)(3)	All volunteer	Deliver quality care services to elderly and disabled individuals by training minority workers	John Booker ☎ (574) 289-9326 ✉ j.booker@directcareworkersofcolor.org www.directcareworkersofcolor.org
US	National Association of Geriatric Nursing Assistants (NAGNA)	1995	D; A; C	30,000 CNAs	n/a	n/a	n/a	n/a	Improving quality of care, elevating professional standing and performance of nursing assistants	Lori Porter and Lisa Cantrell ☎ (417) 623-6049 ✉ lporter@nanga.org ✉ lcantrell@nagna.org www.nagna.org
US (with multiple state and regional chapters and networks)	National Network of Career Nursing Assistants (CNAP)	1977	I; F; C; O	6,000 members;	$25/yr for nursing assistants; can be waived	Members, grants, workshops, sponsors, in-kind donations	501(c)(3)	2 paid staff; volunteer staff	Education and peer support to nursing assistants; sponsors Career Nursing Assistants' Day/Week; National 20 Year Club; Nursing Assistants Authors Press; National Male Nursing Assistant Taskforce.	Jeni Gipson ☎ (330) 825-9342 ✉ cnajeni@aol.com www.cna-network.org
US	National Family Caregivers Association	1993	D; C; O	20,000	Free for current caregivers	Primarily through grants and donations	501(c)(3)	5 paid staff, three volunteer staff	Provides support, education, and empowerment for family caregivers.	☎ 800-896-3650 ✉ info@thefamilycaregiver.org www.thefamilycaregiver.org
AZ	Direct Caregiver Association (DCGA)	2000	D; H	10 providers; 145 caregivers	$25/yr for caregivers	Public and private grants; donations; tuition, membership and placement fees	501(c)(3)	6 paid staff	Training, continuing education, and recognition of DC workers	Judy Clinco ☎ (520) 325-4870 ✉ Tom@directcaregiver.org www.directcaregiver.org
CT	Connecticut Association of Personal Assistants (CTAPA)	2001	n/a	n/a	n/a	Grant from CT Council on Developmental Disabilities	n/a	n/a	Elevate job of personal assistants; develop competent workforce; support education and advocacy.	Debbie Barisano ☎ (860) 643-6452 ✉ info@ctapa.org www.ctapa.org
FL	Florida Association of Nurse Assistants (FANA)	1997	D; F; C; R; S; O	278 members	$30/yr for nurse assistant	Membership dues, educational programs, fundraising	Nonprofit	1 part time paid staff; 2-4 volunteer staff	Promotes continuing education, career information, and skill enhancement. Includes DC workers.	Terry Carleton-Bucher ☎ (863) 318-8495 ✉ fana202@verizon.net www.cwcreate.com/fana/
IA	Iowa Caregivers Association (ICA)	1992	D; I	2,000 direct-care members	Suggested Contribution of $10-$100	Iowa BJBC grant	501(c)(3)	3.5 paid staff, one FTE for BJBC, contracts	Network of services for direct-care, home health and nursing aides.	Di Findley ☎ (515) 241-8697 ✉ iowacga@ao.com www.iowacaregivers.org
KY	Support Providing Employees' of Kentucky (SPEAK)	2004	D; H	240 caregivers; eight providers	Free; in-kind	3-year grant from Centers for Medicare and Medicaid Services; private and public donations; contractual agreements	Nonprofit	2 paid FTEs	Supports direct support professionals in Louisville region. Offers networking, training, mentoring. and recognition opportunities.	Jeff King ☎ (502) 459-0205 x120 ✉ jking@sevencounties.org www.dspspeak.org

TABLE 4 Continued. Direct-Care Worker Professional Associations

Region	Name	Date Founded	Member Types (See Legend)	Members	Fees	Financial Support	Tax Status	Staffing	Brief Description	Contact Information
ME	Maine Personal Assistance Services Association (PASA)	2002	D; O	375 direct-care members	Free at this time	Workforce Contracts with Univ. of Southern Maine and State of Maine	501(c)(3)	1 part-time	Training, empowerment, improve quality of jobs for DC workers.	Roy Gedat ☎ (207) 890-0773; ✉ rggedat@exploremaine.com; www.mainepasa.org Elise Scala ☎ (800) 268-6612 ✉ scala@usm.maine.edu
NC	Direct Care Workers Association of North Carolina (DCWA-NC)	2003	D; S; A; C	1,045 members	$10/yr for worker	Real Choice Grant from Centers for Medicare and Medicaid Services	501(c)(3)	3 paid part-time staff	Improve quality of care through education, professional development and public awareness of DC workers	J. McQueen ☎ (919) 715-0828 ✉ janet.mcqueen@ncmail.net www.dcwa-nc.org
PA	Caregivers Achieving Recognition and Enrichment (CARE)	In development								Tamara Dunlap ☎ (717) 626-6884 ✉ tamaradunlap2003@yahoo.com
PA	Schuylkill County Direct Care Worker Association	2002	Direct-care worker	Approx. 30 members	Free	Original funding through PA Intra-Governmental Council on Long Term Care	n/a	2 volunteer staff	Provides outreach to DC workers for professional support in northwestern PA	Lori Michael ☎ (570) 739-1600 ✉ jlskm@losch.net Eileen Kuperavage ✉ ekuperavage@co.schulykill.pa.us
VA	Virginia Association of Professional Nursing Assistants (VAPNA)	1997	D	100	$25/yr	Membership dues, donations	n/a	1 part-time	Summit for nursing assistants including private citizens, promote position of nursing assistants. Promote quality healthcare for consumers and professional development for CNAs.	Lorrene Maynard ☎ (757) 595-1483 ✉ professionalcna@hotmail.com
VT	Vermont Association of Professional Care Providers (VAPCP)	2004	D; A	64 members	$15/yr for worker; $25 for associate	Original funding from CMS Real Choice grant; seeking new grants to supplement membership dues	501(c)(3) pending	1 paid part-time staff	Professional growth, education, employment opportunities, and quality of life for caregivers.	Marc Comtois ✉ vapcp@vermontelders.org www.vermontelders.org ☎ (888) 865-2683

Legend
Membership Types
A = associate or affiliate
C = corporation or business
D = direct-care worker, nurse assistant/aide, caregiver
F = facility
H = healthcare provider
O = other (friend, sponsor)
R = retired
S = student

APPENDIX A

Charts of Statewide Initiatives

ALABAMA

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders)	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Follows federal staffing regulations.		

ALASKA

Note: Incomplete Data. No Response to 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • None - other than general Advocacy Plan to move toward tying reimbursement to certification.	**Benefits** • The Foraker Group is working with a number of social service agencies to establish an insurance pool.	(Includes career ladders) • Annual conference for direct-service staff. • Training for newly hired front-line supervisors. • Direct-service staff training (aging/disability services)—Department of Labor grant to the Center for Human Development at the University of Alaska Anchorage.	• Work group established, 1999.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
Regulation [07 AAC 012.275] • RN 7days/wk day shift; five days/wk night shift; LPN on un-staffed RN shifts.	• Community Pass Grant to implement strategies to increase recruitment and retention of personal assistants. • Alaska Mental Health Trust Authority funding to implement recruitment and retention strategies.	

ARIZONA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Rates increased 5.5 percent for nursing facilities and 11.6 percent for in-home caregivers (primarily paraprofessionals) and alternative residential settings. • Providers required to passthrough proportional amounts to direct-care workers for wages AND/or benefits. • No wage/benefit passthrough requirements in 2003. • **No wage/benefit passthrough requirements for 2004 or 2005.**	**Benefits**	(Includes career ladders)	• Caregiver Wages and Workforce Development, an ad -hoc committee initiated in August 2001 to define critical policy concerns and emerging issues around long-term care and care giving. Seeks to develop cost effective strategies to promote and encourage caregiver workforce development that supports and strengthens family and informal care giving. Report to be submitted to President of the Senate. Workgroups on the committee include Funding, Reimbursement, and Collaboration, and Recruitment and Retention. **Not active at this time (2005).** • A Governor-appointed Citizens Taskforce on the LTC Workforce will issue recommendations on issues to strengthen the LTC workforce. • The Governor also initiated an Aging 2020 initiative, which requires most state agencies to develop a plan to address the needs of the rapidly growing population of the older Arizonans over the next 15 years. Report forthcoming.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Follows federal staffing regulations.		• Community Based Services and Settings Report issued in 2000, updates expected in 2002. Reports on the data, trends, and findings from two major long-term care home- and community-based programs, Medicaid LTC and non-Medicaid LTC. A copy can be viewed at www.ahcccs.state.az.us/Publications/reports • Network Development and Management Plan–a requirement of all Medicaid Managed Care contracts effective October 2001. Identifies status of network at all levels (institutional, acute, alternative residential, HCBS, etc) to include gaps, interventions, evaluations of interventions and coordination. **This requirement continues and is effective in ensuring managed care organizations continuously address network needs. It is now part of the Medicaid Managed Care requirements.**

ARKANSAS

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders) • Recruitment of Welfare to Work recipients. • Act 1465 (HB2165) Act to Establish an Arkansas Legislative Commission on Nursing to review issues of education, recruitment and retention of nurses. • Act 787 Graduate nursing student loans and scholarships. • Act 1664 includes nursing schools as approved institutions in academic scholarship program.	• Governor's Integrated Services Taskforce (GIST) seeks to identify methods to better attract, screen, and retain workers in healthcare, 2001.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
Act 1397, 2001 • Three tiers of minimum staffing ratios for direct-care staff**.** Final tier implemented October 1, 2003. Direct-care staff ratios are currently 1:6 for the day shift, for which there shall be a 1:40 nurse-to-resident ratio; 1:9 for evening shift, for which there shall be a 1:40 ratio of nurse to resident; 1:14 for night shift, for which there shall be a 1:80 nurse-to-resident ratio.	• Community Pass Grant to develop advertising campaign and materials for recruiting direct-support professionals to provide community based services. • Real Choice Grant to identify successful strategies to recruit and retain in-home workers, including efforts that focus on wages, benefits, training, and establishment of a career path; establish a worker registry.	• Cost-based methodology that is responsive to increased staffing levels and salary increases for direct-care workers (considered in reimbursement rate calculation). • Act 635 - Quality Assurance Fee for nursing home operators based on number of patient days per month. Pooled into Medicaid fund ($3 federal match).

CALIFORNIA

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Supplemental rate adjustment for covered employees' increases in salaries, wages, or benefits for period 2-1-02 through 7-31-04. Wage passthrough legislation also passed in 1999 and 2000 for SNF and ICF (DD, DD-H, and DD-N) as an add-on to per diem rates.	**Benefits**	(Includes career ladders) • May 2002 – Governor announced $10.5 million grant to support training for certified nurse aides with the goal of increasing the workforce by 2,000 within the next 20 months.	• AB 1731, (Stat of 2000) established the Skilled Nursing Facility (SNF) Financial Solvency Advisory Board to: advise the director on matters of financial solvency affecting the delivery of services in SNFs; develop solvency licensing requirements and standards relative to the operation of SNFs; and periodically monitor/report on the implementation and results of solvency licensing requirements and standards. Board has met three times in 2003, with an anticipated fourth meeting in December 2003.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
Welfare and Institutions Code 14110.7 • SNF – 3.2 hrs/pt day • SNF special – 2.3 hrs/pt day • ICF – 1.1 hrs/pt day • ICF/developmentally disabled – 2.7 hrs/pt day AB 1731, (Stat of 2000) directed the Department to determine the need and provide subsequent recommendations for any increase of the minimum number of nursing hours per patient day in SNFs.		• AB 1731, (Stat of 2000) amended existing law (HANDS Code 1417.4) to establish the Quality Awards Program for nursing homes. Nursing homes selected by criteria established by the Department could receive up to $1500 per employee as staff bonuses. Initial distribution of funds occurred in January 2003. • The University of California Los Angeles, School of Public Policy and Social Research, Los Angeles, CA received a Better Jobs, Better Care Applied Research and Evaluation Grant. To view a project description see: www.bjbc.org/page.asp?pgID=79

COLORADO

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders)	• Established Task Forces to examine quality of care issues and aide retention, 2000.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
Code of Colorado Regulations 1011, Chapter 5, Part 7 • 2 hrs per/patient per day		• Quality of Care Incentive Payments to assess retention and expertise in facilities.

CONNECTICUT

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Increase in reimbursement rate.	**Benefits**	(Includes career ladders)	• LTC Planning Committee has identified workforce issues and is working on solutions, 2001. • Olmstead Planning Committee has initiatives and recommendations on workforce issues, 2001. • **Creation of an Allied Health Workforce Policy Board to address health care workforce shortages; report and recommendations due January 2006.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
CT Public Health Code Sec. 19-13-D8t Chronic/convalescent home: • Licensed Personnel - 0.47hr/pt (day shift); 0.17 hr/pt (night shift) • Licensed and Un-licensed Personnel – 1.4hrs/pt (day shift); 0.5hrs/pt (night shift) Rest home: • Licensed Personnel .23hr/pt (day shift); 0.08hr/pt (night shift) • Licensed and Un-licensed Personnel - 0.7hr/pt (day shift); 0.17hr/pt (night shift)	• Nursing home transition grant	• Connecticut College, New London, CT, received a *BJBC* Applied Research and Evaluation grant: Making Consumer-Directed Homecare a Good Job. To view a project description, see: www.bjbc.org/page.asp?pgID=79/

DELAWARE

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders) • SB20, 1999 - New "Senior CNAs" job level, role model and resource (increased from 75 to 150 hrs advanced training and competency test).	• Established work group, 1999. • Delaware Nursing Home Residents Quality Assurance Commission released a report, *Efficacy of the Minimum Nursing Staffing Levels under Eagle's Law: Quality of Care, Labor Trends, and Nursing Home Cost and Availability* in December 2001, assessing the effects of SB 115's minimum staffing ratios and hours.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
SB 115 "Eagle's Law" • 3 phases of minimum nursing direct-care staffing hours and ratios of direct-care staff by shift and position (RN, LPN, CNA) o Phase one - 3hrs/ day (3/01) o Phase two – 3.28hrs/day (1/02) o Phase three – 3.68 hr/day (proposed 5/03)		

FLORIDA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders) • Florida Edloan to provide low-interest loans to make education in nursing professions accessible and affordable. • Florida Board of Nursing has developed new rules to better govern the practice, discipline, education, and testing of CNAs. There are new rules on standards for training, standardized curriculum, testing and competency evaluation, in-service training, and disciplinary guidelines.	• 1999 Task Force of Department of Elder Affairs researched and reported recruitment, training employment, and retention of CNAs in nursing homes http://elderaffairs.state.fl.us • Task Force on Availability and Affordability of Long Term Care, Informational Report February 16, 2001 - University of South Florida, Florida Policy Exchange Center on Aging. www.fpeca.cas.usf.edu

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
Senate Bill 1202 (2001 Fla. Legislature) • CNA – 2.3 hr/pt day beginning 1/1/02 Licensed nursing staff – 1.0 hr/pt day beginning 1/1/02. • Increase to 2.6 hrs by January 1, 2003 and to 2.9 hrs by January 1, 2004. No facility below one CNA per 20 residents. **The increase to 2.9 hrs has been delayed by the Legislature (SB 1202).** • Licensed Nurses: one hour direct-care per resident per day; never less than one per 40 residents.		• Include nurse-aide issue as part of overall labor shortage in low-wage jobs. • Florida statute requires turnover data to be collected from nursing facilities. Statute stipulates reporting protocols and calculation method (section 400.141(15)(b). • Florida's nurse aide workforce issues are being reviewed as part of a multi-state review by Harvard University, John F. Kennedy School of Government, and the Malcolm Wiener Center for Social Policy.

GEORGIA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • HR 275 - A Resolution to direct and require that the Department of Community Health adopt certain reimbursement methodologies for nursing facilities. • Established a case-mix based reimbursement methodology for long-term care providers.	**Benefits**	(Includes career ladders) • New training curriculum for additional career responsibilities and increased compensation for paraprofessionals. • Dementia training to nursing home staff. • Articulation efforts between the Department of Technical and Adult Education and the University System of Georgia are underway. • **The Governor's Council on Developmental Disabilities piloted a direct support professional curriculum in three technical colleges.**	• Established Health Care Workforce Policy Advisory Committee to monitor conditions of the health care workforce and make recommendations on action impacting the workforce, 2001. • Study report, *Code Blue: Workforce in Crisis,* issued in May, 2001. www3.state.ga.us/departments/dch/v4/top/shared/con_dhp/dhp_publications/healthcare_workforce_final.pdf

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
GA DHR Rules, Ch. 290-5-8-0.04 • 2hr/pt day • Medicaid Level I, II facilities 2.5hr/pt day	• Nursing Home Transition Grant to conduct a workforce development pilot project in 18 counties, identifying barriers and opportunities to increase direct-care workers and community services. • Communities for Independent Living demonstration project.	• Data collection regarding vacancy rates and average turnover time through GA Division of Health Planning Annual Survey.

HAWAII

Note: Incomplete survey in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits** 4. Required health benefits.	(Includes career ladders)	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
DHR 11-94-23 7. SNF – one RN 24/7 8. ICF – one RN day shift; licensed nurse for medication administration		

IDAHO

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • **$13.72/hour for Medicaid payments.** • All employees must be employed by an agency. • Nursing facilities have own wage scales and benefit packages.	**Benefits** • None – though Medicaid agencies may provide benefits.	(Includes career ladders)	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE

IDAPA16.03.02200,02
• SNF:
  • 59 residents; 2.4 hrs/pt day (may not include Director of Nursing [DON], may include nursing supervisor)
  • 60 residents; 2.4 hrs/pt day (may not include DON or supervisor)
• NF:
  • 1.8hr/pt day (DON, super, charge)
		• Uniform reimbursement rates across funding streams for similar home- and community-based services.

ILLINOIS

Note: Incomplete Data. No Response to 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Homemaker reimbursement rate increased from $10.56 to $11.06 per hour effective 1/1/03. • ADS reimbursement rate increased from $5.52 to $6.02 per hour effective 1/1/03 and to $7.02 per hour effective 7/1/03. • Note that reimbursement rates are paid to contracted providers. Direct-care worker hourly wages depend upon provider agencies. However, per state statute and administrative rule, a minimum of 73 percent of the Homemaker rate must be spent on direct-service worker related costs, such as wages, insurance, retirement, workers compensation, etc.	**Benefits** • Benefits paid to direct-care workers are at the discretion of each contracted provider agency.	(Includes career ladders) • Community Care Program Administrative Rule requires the following minimum training for homemaker workers: (a) 15 hours of initial pre-service training for new employees; and (b) three hours per calendar quarter of face-to-face in-service training. • Minimum training requirements also exist for homemaker supervisors and ADS workers.	• None known to be currently active.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Community Care Program Administrative Rule requires "homemaker staff to meet the needs of all cases referred for the provision of homemaker services." ADS minimum ratio of full-time staff: Staff Clients 2 1 to 12 3 13 to 20 4 21 to 28 5 29 to 35 6 36 to 45 77IL Administrative Code, CH1, Sec. 300.1230 • SNF: 2/5 hr/day (20 percent licensed nurse time • IC: 1.7 hr./day (20 percent licensed nurse time)		

INDIANA

Note: Incomplete Data. No Response to 2002, 2003 or 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders)	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
410 IAC 16.2-3.7-17 • Licensed nurse care - 0.5hr/pt day		

IOWA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • State funding for Iowa CareGivers Association to research and develop nursing facility case-mix reimbursement system (Medicaid providers) for financial incentives for direct-care workforce salaries.	**Benefits** • **The Iowa BJBC Grant Program, led by ICA, conducted the DCW Wage and Benefit Survey and the DCW Health Care Feasibility Study; considerations for next steps are underway.**	(Includes career ladders) • **ICA Direct Care Worker Mentor Program.** • **ICA Direct Care Worker Leadership Training Program.** • **Iowa BJBC Coalition will be conducting a direct-care worker education survey in 2005 in which workers, administrators, DONs, and supervisors will be surveyed regarding direct-care worker education standards.**	• Established Task Force in 2001 to address the nurse/nurse aide shortage. Created the Office of Health Care Personnel to track health care worker trends and implemented various recruitment and retention initiatives. • Iowa CareGivers Association's CNA Recruitment and Retention Pilot Project 1998-2000 report, Iowa CNA Wage and Benefit Survey 2001, and the Direct Care Forum 2002 report can be viewed at www.iowacaregivers.org. • **Legislation passed in 2005 to establish a Direct-care Worker Education Task Force in the Department of Public Health.** • **National Governors Association Iowa Workgroup.** • **Iowa Long Term Care Coalition.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
IAC 58.11(2) • 2 hr/day (20 percent qualified nurse)	• **Cash and Counseling Grant.** • **Assuring Better Child Health and Development II.** • **Iowa Self-Advocacy and Leadership for Youth with Disabilities.** • **Project for Assistance in Transition from Homelessness.** • **Performance Partnership Block Grant for Adults with SMI and Children with SED.** • **Co-Occurring Substance Related and Mental Disorder Policy Academy.** • **State Mental Health Data Infrastructure Grant.** • **Iowa Family Support Initiative.** • **Improving Transition Outcomes for Youth with Disabilities.** • **Aging and Disability Resource Connection.** • **Project Seamless.** • **Medicaid Infrastructure Grant.** • **Supplemental Security Income, Youth Transition Process Demonstration.**	• Quality of life pilot for direct-care workforce. • Mandated data collection efforts on nurse aide recruitment and retention. • Iowa CareGivers Association, the first direct-care worker association in Iowa. Goal is to partner with providers, educators, policymakers, advocates, labor, and others to develop a network of support, recognition, education, and advocacy. • Quality Indicators/incentive package for which facilities can receive incentive payments for various quality assurance measures including staff retention, resident satisfaction, Alzheimer's unit, etc. • Series of direct-care worker public forums held with AARP. • Iowa CareGivers Association awarded a BJBC demonstration grant. More information is available at: www.iowacaregivers.org or www.bjbc.org. • **11th Annual CareGivers Month Campaign to increase public awareness of direct-care workers.**

KANSAS

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Dollar amount WPT for wages, benefits, or new hires (nursing homes only). • WPT extended to 07/01for direct-care and support workers. • Quality Enhancement WPT funded during SFY00, 01, but ended July 1, 2001.	**Benefits**	(Includes career ladders) • **KDOA grants from Civil Monetary Fund to provide education to un-licensed direct-care staff.** • **KDOA grant from Partnership Loan Program interest to develop deep culture change toolkit.** • **Promoting Excellent Alternatives in Kansas (PEAK) Nursing Homes to promote culture change.** • **PEAK-ED contract with Kansas State University for education modules and research.**	• **Person Center Care Pilot Project by Kansas Foundation for Medical Care, the Quality Improvement Organization.** • **Workforce Retention Pilot Project by Kansas Foundation for Medical Care, the Quality Improvement Organization.** • **Workforce Development Collaborative sponsored by the Kansas Association of Homes and Services for the Aging.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
KS Admin Regulations 28-39-154 • 2hr/pt day • 1:30 nursing personnel to residents		• Analysis of turnover data for direct-care staff related to wage passthrough efforts for participating facilities. • **Aggressively pursuing the implementation of a nursing home quality-incentive reimbursement provision in state FY2006. Seven factors will be considered:** **1. Case-mix adjusted nurse staff ratio;** **2. Low operating expense (i.e. administration and plant operating costs);** **3. Low direct-care employee turnover rate;** **4. High employee retention rate;** **5. High occupancy rate;** **6. High Medicaid occupancy rate; and** **7. Low number of survey deficiencies with no substandard care deficiencies.** • **At a future date, a factor for resident satisfaction may be added.**

KENTUCKY

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • State facilities pay $9.00 p/hr. Other facilities pay $5.15 p/hr. upon hire with $1.00 raise to those passing a nurse aide state competency test.	**Benefits** • Facilities pay for medication aide certification courses.	(Includes career ladders)	• SCR 39 - Established Task Force to study methods to promote and enhance the provision of quality care in long-term care facilities and the quality of home- and community-based services, 2001. • Final report of the Task Force on Quality Long Term Care, 2002 available at www.lrc.state.ky.us/lrcpubs/Rm493.pdf

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• No minimum staffing standard	• Real Choice Grant to develop and implement seven curricula to train community-based direct-service, supervisory, and administrative staff to be available via state's Virtual University System.	

LOUISIANA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) 4. SB 71 - Investment earnings from Medicaid Trust Fund for Elderly to be used for wage enhancement for direct-care workers in certified nursing homes. 5. Case-mix reimbursement methodology for nursing facilities effective 1/1/03 provides for nursing wage and staff enhancement add-on.	**Benefits**	(Includes career ladders) • Nursing Home and Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) providers are being trained on reporting regarding Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin, as well as on the on-line submission of these reports. • Nursing facilities are reimbursed the allowable cost of provider-based certified nursing assistant education, per cost report audit.	• **Louisiana DD Council; Consumer Task Force Initiatives.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
LA Licensure Standards, Sec. 9811 • 1.5hr/pt day • Medicaid NH ratios: *Intermediate Care* • 2.35 hrs p/day *Skilled Care* • 2.60 hrs/day • Licensed nurse working 24 hours/day • New rules are being developed regarding staffing requirements for nursing facilities. This is due to the implementation of a case-mix reimbursement methodology. In the interim, the standard has been set at 2.5 nursing hours per resident per day (nursing hours include RN, LPN and CNA).	• A workforce development initiative was undertaken and is being implemented as part of the Real Choice Systems Change Grant. • Through the System Change Planning process, the Work Force Development Project has a subcommittee that includes culture, training, career ladders, recruitment/retention, wages and benefits, and other initiatives. • **Real Choice Grant Subcommittee for HCBW.**	• SB 445 (2001) – Requires Department of Health and Hospitals to establish case-mix reimbursement methodology for Medicaid-funded nursing home care, based on inclusion of certain criteria (acuity based system, achievement of quality outcomes, incentives to encourage admission of heavy care patients, recruit qualified employees, etc.). • Case-mix reimbursement methodology for Medicaid funded nursing facilities implemented on 1/1/03. • New Home- and Community-Based Services Waiver Program Standards for Participation for providers have been developed and published in the Louisiana Register Vol. 29, No. 09 (9/30/03). • New prospective payment system for Adult Day Health Care implemented. • **SCR 145 of 2004 Legislature requested review, evaluation, and recommendations necessary for workforce development and wage parity across all Long Term Care Systems.** • **Governor's Health Reform Initiatives in Long Term Care established action steps to address system capacity related to the direct-care workforce:** **1. Establish a Registry for direct-care workforce.** **2. Incorporate a training curriculum for direct-care workers.** 3. **Address person-centered alternatives to assure training and oversight for direct-care workers using non-complex nursing tasks.**

MAINE

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Chapter 358PL01 • 3 percent WPT (nursing facilities only) FY02. • 2.5 percent hike in wages/benefits (2002 WPT) for home care workers. 6. $0.50 per hour increase in reimbursement rates for home care workers FY00.	**Benefits** • **Dirigo Health makes affordable health insurance coverage accessible to eligible small business and individuals.**	(Includes career ladders) • Increases/changes in training • 24-hour Medication Administration course for CNAs under RN delegation. Allows CNAs to administer medications to home care clients. • 40 hours training required for all Personal Care Assistants within 90 days of hire (except consumer-directed programs). • Develop core curriculum for CNA, PCA, and Residential Care Specialist training.	• **Direct Care Worker Coalition prepared and presented an updated wage, benefit, and training analyses to the Joint Standing Committee on Health and Human Services, 2004.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
10-144 CMR 110, Ch. 9 • 1:8 (Day shift) • 1:12 (Eve shift) • 1:20 (Night shift) PL Ch. 731 • 1:5 day shift • 1:10 eve shift • 1:15 per rule making	• 10/03 grant awards: QA/QI in HCBS; Independence Plus Initiative; Money Follows the Person; ADRC Resource Center; Demonstration to Improve the Direct Service Workforce. • Current/in progress Quality Choice Grant (ends September 2004) established Maine PASA, a direct-care worker associationto provide benefits, support, continuing education, and advocacy for members.	• **Home-based care and homemaker services accounts were converted to "non-lapsing" accounts to stabilize enrollment of consumers and preserve service plans in Maine's Part I budget, passed in March 2004.**

MARYLAND

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • In FY02, $20m was added to nursing home reimbursement to improve compensation (wages or benefits) and staffing levels for direct-care workers. An additional $20m was added in FY03 (SB 794, 2000). • Undertaking a multi-year effort to bring wages of community workers who serve people with developmental disabilities into parity with their counterparts in State Residential Centers (SB 432, 2001)**. In FY05, added nearly $17 million to fund the third year of this initiative.**	**Benefits** • For both initiatives, the goals are improved retention, improved ability to recruit new workers, and, ultimately, improved quality of care.	(Includes career ladders) • **Grant funds have supported local initiatives to provide training or reward/recognition programs for providers in the State Plan personal care program.** • **Organized free CPR and First Aid classes to help provider applicants meet qualification requirements.**	• The Statewide Commission on the Crisis in Nursing addresses the state nursing shortage, 2000. • Nursing Home Report Card Steering Committee, 1999. • Oversight Committee on Quality of Care in Nursing Homes, 2000. • **Community Services Reimbursement Rate Commission, 1996.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE

Code of MD Regulations 10.07.02
• Comprehensive Care Facilities:
  ○ 1 FT RN (2-99 residents)
  ○ 2 FT RNs (100-199 residents)
  ○ 3 FT RNs (200-299 residents)
  ○ 4 FT RNs (300-399 residents)
• Ratio no less than 1:25 for nursing personnel.
	• Real Choice Systems Change Grant includes $60k over three years to fund and promote 'job fairs' to recruit potential HCBS waiver personal care providers, complete paperwork, and meet qualifications. Includes free CPR/First Aid training and reduced cost criminal background checks. **Recent events have added mini-seminars on topics such as injury prevention.**	• Developmental Disabilities Administration and Community Services Reimbursement Rate Commission survey providers annually and have collected turnover data using the same methodology since 2000. To view most recent report see: www.dhmh.state.md.us/csrrc/annual_report.htm

MASSACHUSETTS

Note: Incomplete Data. No Response to 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • $0.19 wage increase over mandated average wage of $9.42/hr. for home care workers (SFY 2002). • $35m WPT for CNAs in nursing facilities (SFY 2001). • SFY2002 includes $40m for WPT for aides.	**Benefits**	(Includes career ladders) • $5 million for Extended Care Career Ladder Initiative (ECCLI) strategy to improve quality of care ○ Pilot career ladder model providing skill upgrade training and promoting to higher job levels • $1m for CNA training scholarship funding (FY01). • SFY 2002 includes: ○ $100k for supervisory training for nursing home administrators and managers. ○ $1m entry level training scholarships for direct-care workers (including ESL and Adult Basic Education). ○ $5m for career ladder efforts for nursing homes.	• SFY 2002 includes establishment of Commission to study future of LTC and LTC workforce and establishment of Advisory Council on Quality of Care in nursing homes to address staffing, recruitment, retention, workforce development, budget, policy, etc.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
105 CMR 150.007 • *Level I Care* – 2.6hr/pt day (0.6hr by licensed personnel) • *Level II Care* – 2hr/pt day (0.6hr by licensed personnel) • *Level III Care* – 1.4hr/pt day (0.4hr by licensed personnel) ○ Level IV Care – 1-20beds (1:10 day shift); 20+beds (1 responsible person 24/7)		▪ Boston University School of Public Health received a BJBC Applied Research and Evaluation grant: *Organizational Cultural Competence Assessment: An Intervention and Evaluation.* To view the project description see: www.bjbc.org/page.asp?pgID=79 ▪ Brandeis University, Schneider Institute for Health Policy in Waltham, MA received a BJBC Applied Research and Evaluation grant: *Improving Institutional Long-Term Care Residents and Workers: The Effect of Leadership, Relationships, and Work Design.* To view the project description see: www.bjbc.org/page.asp?pgID=79

MICHIGAN

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Had wage passthrough for numerous years and tracked turnover data. • State average wage for a certified nursing assistant is $9.80.	**Benefits** • **HRSA grant is being used for Planning Project for the Uninsured to extend health insurance to all citizens.**	(Includes career ladders) • Additional training and testing for nurse aides. • **Office of Services to the Aging contracted with Community Services Network of Michigan, and in collaboration with Michigan State University (MSU) with technical support from MSU Extension Service, to develop a home management skills curriculum for direct-care workers. It is currently being piloted and evaluated in northern-lower Michigan.**	• In FY 2003, Bringing the Eden Alternative to Michigan (BEAM) implemented the Health Care Worker Recruitment and Retention Project with grant from Office of Services to the Aging. BEAM contracted with MSU to assess recruitment, training, and retention methods of certified nursing assistants. • **In FY 2004, the Michigan Direct Care Workforce Initiative Coalition released a study by MSU, "Voices from the Front: Recruitment and Retention of Direct Care Workers in Long Term Care Across Michigan." Findings show that direct-care workers enjoy their careers and working with older people. However, many leave the field due to low pay, not feeling valued, not enough hours, and the inability to provide quality care: see** www.miseniors.net. • **Michigan Medicaid Long Term Care Taskforce released "Modernizing Michigan Long-Term Care;" see** http://www.ihcs.msu.edu/ltc/Reports/Final_LTC_Task_Force_Report.doc

4. STAFFING RATIOS	5. CMS LTC SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
MI Dept of Public Health Rules Sec. 333.27120a • 2.25hr/pt day • 1:8 Morning shift • 1:12 Afternoon shift • 1:15 Night shift	• The Systems Change grant has a consumer cooperative initiative that would give consumers and families greater control over direct-care services. • Michigan's PASS grant includes a second-year goal related to improving the direct-care workforce. Plans for that work are being revised at time of press.	• AARP Michigan Long Term Care Stakeholder Group convened to develop policy recommendations. • **Governor appointed a Medicaid Long Term Care Task Force to develop policy recommendations for change within all long-term care settings. Report expected in FY 2005.** • **The Department of Community Health formed a Home Care Authority, "Quality Care Community Council Development," which is piloting a public authority model for community-based care services in Lansing. The purpose is to strengthen personal care services by improving access to, and support for, qualified workers.** • **Operation ABLE of Michigan received and is implementing a BJBC Applied Research and Evaluation Grant: *Older Workers in Direct Care: A Labor Force Expansion Study.* To view a project description, see:** www.bjbc.org/page.asp?pgID=79 • **Received grant to address health insurance coverage for all uninsured Michigan residents.**

MINNESOTA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Percentage WPT (80 percent of rate increase earmarked for wages/benefits; all LTC facilities). • 3 percent increase in reimbursement rate to all LTC facilities (FY 2001); 2/3 of nursing home increase must be used as WPT for employees. • **Rates cut for 2003.** • **Payment rates frozen for 2004-05.**	**Benefits** • SF 1077 introduced to create long-term care employee health insurance assistance program. • DHS required to seek all waivers to obtain matching SCHIP funds, to develop LTC employee health insurance. • Loan forgiveness and repayment programs to aid in recruiting employees to LTC. • **No action on first two; third still in effect.**	(Includes career ladders) • State approval for feeding assistants in nursing facilities. • $.25 p/day increase in nursing home rates to fund beginner and advance CNA training (FY 2001). **Scholarship program preserved, which fully funds facility costs for scholarships to non-admin workers for tuition, books, supplies, necessary fees, etc. Education must advance employees in the facility or in a career in LTC.** • Collaboration with community college system to provide web-based training for CNAs. • Healthcare Education-Industry Partnership Commission (HEIP) on the Emerging Worker has pilot projects to develop specialized training and community support to expand career pathways for immigrants, refugees, people in transition, and under-prepared students. • FY 2001-2003 Strategic Plan of the HEIP available at: www.heip.org	• State level Long-Term Care Task Force established 2000 to propose curriculum changes, distance learning, and increase provider rates. • Final report, *Reshaping Long-Term Care in Minnesota*, *2001*, available at www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_005812.hcsp • New DHS Commissioner discontinued LTC Task Force in March 2003 and was replaced with plans to hold legislative briefings, and use website to communicate with LTC stakeholders. • **In 2004-05, the Legislature required a study of LTC financing. Report completed in January, 2005; see:** www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_025734.hcsp

1. STAFFING RATIOS	2. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	3. OTHER INITIATIVES NOT COVERED ABOVE
MN Statutes Annotated Sec. 144A.04; MN Rules Sec. 4658.0510 • Greater of 2hrs/pt day *or* 0.95hr/standardized resident day. • DHS charged by Legislature in 2001 to develop case-mix reimbursement system for nursing facility services (report due Jan 2004). Study on staffing standards (minimum staffing requirements) will make recommendations regarding staffing in 2005 session. • **In 2004-05 staffing standards study completed but does not recommend change from required 2.0 hours of nursing staff per resident day.**	• Community Pass Grant to develop a consumer-initiated partnership and support network (CIPS) to enable consumers to assess each other's supports (i.e. family, neighbors) to provide personal care services and back-up systems. **Ongoing.** • **Grant is no longer available and efforts are aimed toward phase-in of Consumer Directed Community Supports (CDCS) in all waivers (2004-05).**	• Hardship waiver to allow family members to provide personal care under certain circumstances. • Many providers experimenting with universal worker concept to enhance satisfaction in LTC (some funded through the Bush Foundation). • **Will implement consumer directed care services waiver as a choice with all community waivers in the next year; expected to bring in non-traditional workers to LTC (i.e. family, neighbors, PCAs, etc).**

MISSISSIPPI

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders) • Career ladders for homemakers and personal care aides.	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
MS Code Annotated, 43-11-201.1 • 2.8 hrs/pt day FY00		

MISSOURI

Note: Incomplete survey in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Dollar amount WPT (home care only). • $.52 reimbursement increase to be used for home care direct staff wages and benefits (FY 2001).	**Benefits**	(Includes career ladders) • Expanded scope of CNA duties to include ostomy care and pulse-oximetry probe placement.	• Established Workgroup/Task Force, 1999.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Follows federal standard.		• Uniform reimbursement rates across funding streams for similar home- and community-based services. • Failure to comply with wage increase and reporting requirements could result in possible revocation of provider's Medicaid status. • Nursing Home Residential Care Facility Employee Award program.

MONTANA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Percentage WPT (all LTC facilities). • Wage increases of $0.50 p/hr (FY 2000); $0.68 p/hr (FY 2001); $0.92 p/hr (FY 2002); estimated $0.36 p/hr (FY 2003) for Medicaid funded personal care. • **2004 one time direct-care bonus.**	**Benefits**	(Includes career ladders) • Welfare to work initiatives; recruitment and retention. • Advanced training for CNAs at vocational technical institutions (one semester training and one semester practicum) leading to LPN (starting Fall 01). • Specialty training for home care attendants.	• Task Force with Systems Change Grant, 2001. • Governor's Blue Ribbon Task Force on healthcare worker shortages, 2001.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
Administrative Rules of MT 16.32.361 • Different requirements depending on shift and # of beds. • Example-Day Shift: o RN eight hrs (4-70 beds) o LPN eight hrs (41-75 beds) o Aide four hrs (9-15 beds); eight hrs (16-20 beds) and increase in four-hour increments for each additional four beds • For full summary of requirements, see: www.nccnhr.org/govpolicy/51_162_468.CFM	▪ Community Integrated Personal Assistance developing awareness campaign of direct-care issues, refining training issues.	• Compare FY 2001 wage plan with FY 2000 wage plan. • Audits by CPA firms to verify that wage passthroughs were handled appropriately. • HB2 directing department to complete comparative study of direct-care jobs in the community.

NEBRASKA

Note: Incomplete data. No response from Nebraska to the 2002, 2003, or 2005 Surveys

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders)	• Established Workgroup/Task Force.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Follows federal standard.		

NEVADA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders) • Expanded scope of CNA duties to include pulse-oximetry probe placement.	• Established Workgroup/Taskforce to address shortage issues, 2001. • **Nevada State Council on Personal Assistance Service, 2001 and ongoing to recommend standards of care.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• No specific staffing ratios: Medicare/Medicaid certified nursing facilities must comply with federal staffing requirements. • Freestanding nursing facilities must spend 94 percent of the median on direct-care staff (CNA, LPN, and RN) or recoupment will be made annually during cost reporting.	• Community Pass Grant to demonstrate and determine the efficacy of training and hiring adults with developmental disabilities as personal assistants through supported employment model. • **Money Follows the Person Systems Change Grant – devising online training system for Personal Care Attendants.**	• **Current Legislative initiative to license Personal Care Provider Agencies and set minimum standards for care attendants.**

NEW HAMPSHIRE

Note: Incomplete Data. No Response to 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Increased reimbursement rate (Medicaid). Legislation failed and the initiative has not been readopted.	**Benefits**	(Includes career ladders) • HIB grants for nursing career development. • Nursing Bridge Program: public private collaboration to promote nursing as a progression and grants for education.	• Direct Care Workforce Development Committee, 2001. • Legislative Study Committee, 2001.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Unknown	• Community Pass Grant to better support consumer directed personal care workforce to increase retention; develop and implement back-up personal care coverage models.	• Culture Change Training program. • Licensed Nursing Assistant Recognition Day.

NEW JERSEY

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Higher reimbursement rates for shift differentials. • Rate increases for Personal Care Assistants and Homemaker Services for selected services and waiver programs (new unit rates became effective July 2001).	**Benefits** • New Jersey FamilyCare program (2001 launch) allows health access through low premiums in managed care. • Additional subsidized health care coverage through employer sponsored plans meeting conditions for employed New Jersey FamilyCare eligibles. • Increase in Medicaid (traditional and waivers and NJ FamilyCare Plan A, fee for service reimbursement for PCA and homemaker services).	(Includes career ladders) • Recruitment of Welfare to Work recipients. • Working with local workforce investment boards and One Stop Centers to build available labor pools. • Medication aide training program.	• Report issued by the Forum Institute for Public Policy, *The Nursing Workforce Shortage: Impacts on Health and Medical Care in New Jersey* www.forumsinstitute.org/publs/index.html

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
NJAC 8:39-25.1 through 25.4 • 2.5 hrs/day (extra time for complex patients)	• Real Choice Grant to develop/pilot a personal care assistant registry and rapid response back-up system; develop training for front line staff and case managers on benefits of consumer directed care.	• Caregiver Assistance Programs allow family and friends to receive reimbursement as caregivers in selected situations – decreases demand on nursing workforce. • Jersey Assistance for Community Caregiving (JACC) provides in-home services and supports for individuals. JACC is intended to supplement and strengthen the capacity of caregivers as well as to delay or prevent placement in a nursing facility.

NEW MEXICO

Note: Incomplete Data. No Response to 2003 or 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • New Mexico's Personal Care Option program raised the bar for salaries paid to direct-care staff (currently $9 per hour). This is influencing salaries in other program areas by moving direct-caregivers more toward a "livable wage."	**Benefits**	(Includes career ladders) • New Mexico has recently taken steps to standardize the way in which Nurse Aides can become certified and maintain their certifications. These changes also allow CNAs from non-Medicaid facilities throughout the state to utilize the same standardized process, making it easier for CNAs to remain certified.	• New Mexico currently has two Quality Cabinet sub-committees focusing on recruitment, retention, career ladder development, minimum staffing, and other issues related to direct-caregivers. The State Legislature recently passed a memorial in both houses that will study these areas and report back to the body by November 2002.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• New Mexico is currently in the middle of a Quality Cabinet subcommittee process to make recommendations on staffing.		• Medicaid has two advisory bodies that focus planning and funding on the state's most urgent health care needs, the Medicaid Advisory Council and the Medicaid Long-Term Care Advisory Committee.

NEW YORK

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits** • Sec 107, Ch. one of Laws of 1999 created Home Care Worker Rate Demonstration providing $203m for 3.5 years to home care agencies to enhance aide health benefits. • In 2000, the Health Care Reform Act authorized a demonstration project between the Department of Health, the NYC Human Resources Administration, and the 1199 National Benefit Fund to improve the process of providing Medicaid payments for health insurance under COBRA.	(Includes career ladders) • Health Care Reform Act of 1996 established the Workforce Retraining Initiative supporting retraining of eligible health workers to assist in transition to new jobs within healthcare, or train workers to meet the requirements of an existing position. ($15m available 1997-98; $30m added in 2000). **Extended through 2007.** • Hospitals receiving more than $1m in funding from the Community Health Care Conversion Demonstration Program are required to spend at least 25 percent on workforce retraining projects; those facilities receiving less than $1m must spend at least 10 percent on retraining. This requirement resulted in $60m allocated toward training in the first year.	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Follows federal standard.		• Uniform reimbursement rates across funding streams for similar home- and community-based services. • Cornell University, Cornell Gerontology Research Institute, Ithaca, NY received a BJBC Applied Research and Evaluation grant: The Retention Specialist Program: Testing a Model Workplace Innovation. To view a project description, see: www/bjbc.org/page.asp?pgID=79

NORTH CAROLINA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits** NC Health Choice for Children materials (state children's health insurance) sent to newly listed CNAs; plans to expand informational campaign to other paraprofessional aide workers.	(Includes career ladders) • Established incentive program to improve aide job skills, job satisfaction, and performance, and improve recruitment and retention of nurse aides in nursing homes. Program continues in nursing homes using civil penalty fine money - Win-A-Step-Up program (NC Dept. of Health and Human Services and the Institute on Aging). • Developing "Geriatric Nurse Aide" curricula for Nurse Aide I's interested in additional training/career advancement. • Medication administration staff and supervisors in adult care homes must complete clinical skills competency evaluation and pass written exam within 90 days of requirement. (6 hrs of CEs in medication administration required annually). • NC Board of Nursing and Dept. of Health and Human Service co-sponsoring a workgroup to develop a medication aide job category. • **Train-the-trainer coaching supervision sessions conducted through a cooperative arrangement with the Paraprofessional Healthcare Institute to develop trained coaches to offer training through the community college system, area health education centers, and other venues across NC.**	The NC Institute of Medicine's Long Term Care Task Force published recommendations to reform NC's long-term care system; including recommendations on paraprofessional and professional workforce, 2001. Report available at www.nciom.org/ltcfinal.pdf

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
NC Administrative Code, Title 10, 03H.2303 • 2.1 hrs/pt day. H736 (2001) • All licensed adult care homes/nursing homes must publicly post number of direct-care staff and supervisors on shift.	• $1.6m Real Choice grant underway; focuses on paraprofessional workforce initiatives. Major components include: career ladder efforts, review to identify policies that contribute to institutional care bias, public education/awareness efforts, development of direct-care worker association, and development of consumer directed care model. • **C-PASS grant to address policy and practice issues related to consumer directed care.**	• Annual standardized collection and analysis of basic turnover data on direct-care workers in home care agencies, and nursing and adult care homes initiated in 2001. • Increased Medicaid reimbursement for Personal Care services provided in adult care homes; considered increased medication administration competency (2000). • **Direct Care Workers Association of North Carolina (DWA-NC) established in 2003:** www.dcwa-nc.org. • **Independence Plus Medicaid waiver approved by CMS to pilot consumer directed care through several Community Based Waiver Programs for Disabled Adults.** • **NC Foundation for Advanced Health Programs received a BJBC demonstration grant – for project description see:** www.bjbc.org/Page.asp?sectionID=3 • **UNC-Chapel Hill's Cecil G. Sheps Center for Health Services Research received a BJBC Applied Research and Evaluation grant. For a project description see**: www.bjbc.org/page.asp?pgID=79

NORTH DAKOTA

Note: Incomplete Data. No Response to 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • $1.50 per hour wage and/or benefits increase for all nursing facility employees for both Medicaid and private-pay resident categories (2001) HB 1196. • $.87 per hr. wage increase for ICR/MR and DD waiver service employees, effective July 1, 2003.	**Benefits** • $1.50 per hour wage AND/or benefits increase for all nursing facility employees for both Medicaid and private-pay resident categories (2001) HB 1196. • 3 percent increase in allowed fringe benefit percentage for ICR/MR and DD waiver service employees effective July 1, 2003.	(Includes career ladders) • Working with the Department of Labor and the Department of Commerce on career ladder initiatives.	• North Dakota Health Practitioner Workforce Coalition, 2001.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Follows federal standard.		• HB 1196 passed a nursing loan repayment and scholarship program.

OHIO

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES and COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders) • Identifying key core skill competencies for direct-care workers across systems of care, work settings and consumer populations to develop standardized requirements and institute state credential for workers. • **Four levels of key skill competencies for direct-care workers have been identified and endorsed by a multi-disciplinary panel of experts. Competencies will serve as foundation for development of model curricula and a statewide credential process for direct-care workers.** • **Statewide credential process will help establish meaningful career paths for direct-care workers wishing to move into a health care profession. It will also serve as the foundation of career ladders within the direct-care work arena.**	• Health Care Workforce Shortage Task Force (HB94). • **Ohio Health Care Workforce Advisory Council (advises Governor's WIA Policy Board) completed its work in 2004 and issued a report with recommendations aimed at alleviating the current and predicted future shortages of health care workers, including direct-care workers. Report available at** www.goldenbuckeye.com/wfreport2004.pdf

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
ORC 3701-17-08 *Revised rule effective 10/20/01* • RN as full-time DON. • 2.75 hrs/per resident per day of direct-care and services. (2hrs by nurse aide; .2hr RN, remainder by nurse aide, nurses, activity aides, OT, PT, dieticians, social workers). • 1 aide to 15 residents all shifts. • RN on call whenever no RN on duty.	• Ticket to Work Initiative.	• Developed and distributed materials on health care careers (including direct-care workers) for One-Stop Centers throughout state including training requirements, training centers, etc. • Developed a "best practices" web page. • The Margaret Blenkner Research Institute, Benjamin Rose- Cleveland, OH, received a BJBC Applied Research and Evaluation Grant: *The Impact of Job Preparation, Ongoing Education and Training on Job Satisfaction and Commitment Among Front-Line Workers and Their Supervisors.* To view a project description see: www.bjbc.org/page.asp?pgID=79 • **Hosted four regional conferences on workforce retention during 2004.** • **Implemented public education/recruitment campaign, "Make Your Career" to improve public image of direct-care workers and recruit workers into direct-care careers across work settings and consumer populations.** • **Developed and launched** www.careerincaring.com **web site.**

OKLAHOMA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Authorizes wage/benefit adjustment for LTC facility direct-care staff. • $6.65 minimum wage for specified positions (HB 2019 FY 2000). • DHS rate increase for personal care in-home services.	**Benefits**	(Includes career ladders) • PSA available for radio and television to recruit direct-care workers for in-home care. • 1-800 number available for information on how to become a direct-care worker.	• **2004 - Task force to develop a new methodology for calculating state Medicaid Program reimbursements by implementing specific rates based on expenditures related to direct-care staffing.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• LTC Facilities staffing ratio from HB 2019 are Day Shift 1:7, Eve Shift 1:10, Night Shift 1:17 • Effective 9/1/03, HB 2218, if funding is available: Day shift 1:6, Eve shift 1:8, Night shift 1:15 or 24 hour staffing of 2.86 hours/resident; • 16 beds or less ICF/MR Staffing ratio is Day 1:4, Evening 1:4; and Night 1:8 with a minimum of two staff at all times. • **2004 current staffing ratios: Day, 1:7; Evening, 1:10; Night, 1:17.**	• DHS received a systems change grant for home- and community-based services. Stakeholder and planning meetings have been going on for almost a year.	• Pilot program to enhance quality of life for direct-care workforce and reduce turnover.

OREGON

Note: Incomplete Data. No Response to 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Increased reimbursement rate for in home care providers.	**Benefits** • Health Insurance (April 2004). • Worker's Compensation (April 2004). • Paid leave (July 2003).	(Includes career ladders) • Delegation of medication administration duties by licensed nursing personnel to un-licensed workers in all care settings.	• Governor's Task Force on the Future of Services to Seniors and People with Disabilities addresses some workforce issues, 2001.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
OR Administrative Rules 411-86-100 • Day Shift 1:10 • Eve Shift 1:15 • Night Shift 1:25	• Real Choice Grant to develop statewide recruitment efforts for personal care assistants.	• Health Care Sector Employment Initiative (OR Workforce Investment Board) targets CNAs and RNs. • Oregon Technical Assistance Corporation of Salem, OR received a BJBC demonstration grant. For description of project see: www.bjbc.org/Page.asp?sectionID=3

PENNSYLVANIA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES and COMMISSIONS
Wages (includes wage passthroughs) Direct Care Worker Initiative Plans include sign-on and longevity bonuses, and shift differentials.	**Benefits** • Education about health plan eligibility for low-income workers. • Resource guide for direct-care workers. • Bonuses to cover travel expenses or to workers who serve in hard-to-serve areas. • Training bonuses. • AAA Direct Care Worker Initiative Plan provides childcare, transportation, profit sharing, uniform allocation.	(Includes career ladders) The AAA Direct Care Worker Initiative Plan funds: • Specialized training including supervisory skills, one day seminars, best practices; • Life Skills including communication, conflict resolution, attire; • Mentoring assistance; • Tuition assistance and basic skills at vocational schools, community colleges, through CareerLink. • Critical Job Training Grants and departmental funding (FY02-03) used to address high demand jobs. Over 60 percent of funding went to direct-care and health care initiatives; used for career ladders, entry level and CNA training, continuing education and skill building. • **Rural direct-care dementia training project**	• Established Council on Long Term Care to highlight workforce problems from provider-caregiver perspective. • Direct Care Work Group working on development of apprentice program; funding decisions on past practices and plans for recruitment and retention; targeting COLA increase toward raises. • **Three** reports about DC worker shortages from PA's Intra-Governmental Council on Long Term Care issued: *Frontline Workers in Long Term Care:* www.pgc.org/PRI/projects/PA_LTC_workforce/PA_LTC_workforce_report.pdf; *In Their Own Words: Pennsylvania's Frontline Workers in Long Term Care:* www.aging.state.pa.us/aging/LIB/aging/20/363/report_care.pdf; and *In Their Own Words, Part 2:* www.aging.state.pa.us/aging/lib/aging/InTheirOwnWords.indd.pdf. • **Established DCW Group, co-sponsored with Workforce Investment Board.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
PA Administrative Code, Title 28, Ch. 211 2.7 hrs/day – skilled patients 2.3hrs/day – intermediate care patients Summary at www.nccnhr.org/govpolicy/51_162_468.CFM		• Conducted follow-up focus groups with direct-care workers; report pending. • Received $1.5m for demonstration projects targeting direct-care workers. • AAA Direct Care Worker Initiative Plan funds direct-care projects (bonuses, training, benefits, marketing). • Direct-care marketing campaign, recognition day, public awareness, and technical assistance. • BJBC grant awarded to the Center for Advocacy for the Rights and Interests of the Elderly to design and test comprehensive core-training package for direct-care workers, as well as the effectiveness of innovative workplace practices. Details: www.bjbc.org/Page.asp?sectionID=3 • Direct Care Worker Initiatives funding through Dept. of Public Welfare's Office of Social Programs and Office of Mental Retardation and Department of Aging continues (Began FY 2001/2002). Available to local and county-based agencies or AAA for workforce initiatives. **This continues to be funded.** • Inter-Governmental Council on Long-term Care administered Inter-Governmental Transfer Grants to support direct-care worker association, and demonstrations with lessons from direct-care initiatives. • PA Council on Independent Living awarded the Personal Assistance Services (PAS) Priority Backup Study to examine best practices and procedures for establishing a back-up system for PAS related to employment of people with disabilities. It is critical to the Ticket to Work Medicaid Infrastructure Grant. • **Published *Frontline Care*, a magazine for direct-care workers in long term care.** • **Direct Care Worker Association in development.**

RHODE ISLAND

Note: Incomplete Data. No Response to 2003 or 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Dollar amount WPT (home care only). • Increased funds for direct passthrough for direct-care workers passed in state FY 2002 budget. • Bonuses tied to increased performance by providers and staff. • Shift differential. • HB6100 Sub. A, Sec. 13 - 4.8 percent rate adjustment for nursing homes applied to labor cost center and used for direct-care compensation or staff increases.	**Benefits** • RITE-CARE 1994 (Medicaid waiver provides access to health insurance for low-income families with children); RITE-SHARE 2000 (premium assistance in employer sponsored health insurance coverage for RITE-CARE eligible families with employer sponsored health insurance).	(Includes career ladders) • AOA Alzheimer's Demonstration project, Partners in Care, includes advanced training for certified nursing assistants with financial incentive.	• Established Workgroup/Task Force – proposes development of, and training for, career ladders and extending WPT compensation for non-nursing home providers. • Study report of the RI Long Term Care Coordinating Council, *Long Term Care Plan for Rhode Island, 1995-2000* • The Governor's Advisory Council on Health's Nursing and Allied Health Subcommittee's report on nurse aides, 2001.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
	• AOA Alzheimer's Demonstration Grant, Partners in Care, includes a model for Family Directed Respite care using non-traditional workers. • Community Pass Grant to design and implement consumer directed personal assistant services program to expand pool of care providers, among other outcomes.	• Additional hourly reimbursements in seven areas (shift differentials, client satisfaction, patient acuity, provider accreditation, continuity of care, employee satisfaction). • Increased reimbursement rates tied to in-service training, meeting state accreditation, Joint Commission accreditation, in-service standards excessive of state standards by 20 percent, and shift differential.

SOUTH CAROLINA

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Dollar Amount WPT (Home care only). • Certified Nursing Assistant add-ons to be used for hiring, increasing wages, or benefits ($4.5m in 1999, $5.8m in 2000). Facilities must submit documentation that add-ons spent on CNAs or reimburse for funds received.	**Benefits**	(Includes career ladders) • Recruitment of Welfare to Work recipients.	• SB140 (2001) SC Area Health Education Consortium to include in health profession needs assessment, the problem of recruitment and retention of nurses/nurse aides in SC nursing homes and hospitals. Report *Nurses and Nurses Aides Workforce in South Carolina Nursing Homes and Hospitals,* issued Dec 2001. • *Nursing Home Quality Study, Focus Group Results*, conducted with SC Nursing Facility Quality Improvement Committee and USC School of Public Health issued October 2001. • Un-licensed Assistive Personnel Task Force, 2000.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
SC Dept of Health and Environmental Control Regulation 61-17 • Shift one – 9:1 • Shift two – 13:1 • Shift three – 22:1		• Certified Nursing Assistants Conference. • Eden Coalition. • Quality Initiative grants (2002**) –** one reporting requirement for recipients of these grants is monthly submission of data, which includes information on facility's turnover rate. • Home care agencies and individuals provide worker registration sheets to DHHS with start and termination dates for workers to calculate agency specific turnover rates.

SOUTH DAKOTA

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders)	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Follows federal standard.		

TENNESSEE

Note: Incomplete Data. No Response to 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders)	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
TN Code, Ch. 1200-8-6-.04 • 2hrs/day (0.4hrs licensed nursing).		

TEXAS

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Rate Enhancement Program - The Community Care Attendant Compensation (CCAC) Rate Enhancement, implemented in 2000, includes a spending requirement for participating community care providers. Provider chooses level of attendant compensation spending participation and receives additional (i.e., enhanced) compensation. **If the minimum requirement is not met, provider must repay the state the unused enhanced funding.** • Consumer Directed Services (CDS) allow consumers of certain Medicaid Waivers and Community Care attendant programs to manage their own **attendant care**, including rate of pay and benefits. **Consumers must manage their spending within their allocated service budget.**	**Benefits** • The CCAC attendant compensation includes employee benefits/insurance, workers' compensation and mileage reimbursement for business use of personal vehicles. • CDS allows consumers to decide on a number of benefits including bonuses for longevity or performance, insurance, retirement, etc.	(Includes career ladders) • The CCAC encourages community care providers to increase attendant compensation through additional career ladder implementation. • CDS allows consumers to train their own attendants and create career ladders.	• **Task Force chaired by the Texas Health and Human Services Commission, includes state agencies, providers, advocates, and consumers and provides guidance for the CDS initiative.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
TX Administrative Code, Title 25, Part I, Ch. 145; TX Dept of Human Services, Sec. 19.1001,2 • **Nursing facilities - one licensed nurse: 20 residents or 0.4hrs licensed nursing care/pt day.** Can increase their reimbursement by increasing the ratio of staff-to-resident as outlined below: The Nursing Facility Enhanced Direct Care Staff Rate, implemented May 2000, includes a direct-care staffing requirement for nursing facilities choosing to participate in program and a spending requirement for every Medicaid nursing facility. **In Sept. 2003, the spending requirement applies only to facilities choosing to participate in receiving enhanced funds.** • Staffing requirement allows a nursing facility to choose staffing level of participation, and receives additional direct-care staff funding. If minimum staffing requirement for awarded level of participation is not met, facility must repay **enhanced funds associated with the unmet level(s) to the state.** • Spending requirement places minimum spending level for direct-care rate component of facility's total rate component by TILE. If facility does not meet minimum spending level, must repay difference to DHS. **As of September 2003, the spending requirement is limited to enhancement funds paid to participants.**	The Texas Council for Developmental Disabilities and the Department of Human Services began evaluating systems change grants May 2002. Strategies include: • Recruitment efforts targeting traditionally underemployed workers (older workers, full time volunteer participants, people with disabilities, non-English speaking individuals, and welfare-to-work participants). • Development of college courses with fieldwork credit for supervised personal assistance experiences. • Coordination of efforts to develop and promote a professional association for personal attendants at a local or regional level, to increase retention of those currently-employed in the field, and recruit and train new attendants. • Formation of partnerships with public and/or private workforce agencies or home health organizations to train and place personal assistants. • Utilization of marketing strategies for recruitment efforts in a local or regional area.	• Data collection regarding wages, benefits, other aide issues. • The "Wellspring" type model was piloted from 2000-01, in 13 nursing homes to impact quality of care, corporate culture, aide retention, etc.

UTAH

No Additions Made in 2005

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders)	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Unknown	• Real Choice grant to examine Systems Change.	• Independent Living Initiatives.

VERMONT

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Amended State Statute 1956 - Portion of provider tax on nursing homes and home health agencies earmarked for wage increases of workforce in setting.	**Benefits** • Increase consumer and provider awareness about eligibility for health insurance for low-income workers (Health Access Program). • Most home health agencies and nursing homes offer health insurance to full-time Nursing Assistants.	(Includes career ladders) • **Gold Star program now in place in 12 nursing homes. Training for new dementia specialists very successful. Annual nursing home quality awards tied to participation in Gold Star Initiative.** • **BJBC grant – training program set up for personal care attendants.** • **LNA II training program developed.**	• Established Task Force/Workgroup to address paraprofessional workforce shortage (2001). • Study report issued (2001). • **Original Workforce Taskforce is winding down and the remaining policy initiatives are being turned over to the Vermont Healthcare Workforce Partnership (a larger group focused on the staffing needs across the healthcare system) and the BJBC partners.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Follows federal standard.	• Real Choice Grant to develop a paraprofessional association and implement other workforce-related recommendations. • **2004 – the Vermont Association of Professional Care Providers has formed a nonprofit organization, developed a mission statement, goals, and a board and is actively recruiting members:** http://www.vermontelders.org.	• Community of Vermont Elders awarded BJBC demonstration grant (2003) for description of project see: www.bjbc.org?Page.asp?sectionID=3 • Vermont Health Care Association and Vermont Department of Aging and Disabilities collaborated to develop a "Gold Star" designation program for nursing facilities. The program focuses on best practices for nursing home recruitment and retention of direct-care workers (December 2003).

VIRGINIA

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Dollar amount WPT (all LTC facilities). • WPT to be rolled into reimbursement rates.	**Benefits** • **Small pilot demonstration through a Direct Service Worker grant offers insurance through the child health program (not statewide initiative).**	(Includes career ladders) • Increases/changes in training (minimum training for nurse aide up to 120hrs from 80hrs). • HB 1778 - Mandated development of regulations leading to career advancement certification for CNAs. • SB564 (2000) - Board of Health established scholarship and loan repayment program from Nursing Scholarship Fund to eligible students who agree to work in LTC facility for specified period of time; includes nurse aide programs. • HB 1778 (2000) – Calls for establishment and accompanying regulations for certification for advanced competencies for nurse aides to provide career advancement opportunity for successfully completing requirements.	• Established Workgroup/Task Force, 2000.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
• Follows federal standard.	• **Through a Real Choice Systems Change Grant (and a Direct Service Worker Grant), the Medicaid agency offers additional training to direct-service workers and supervisors.**	• Mandated data collection efforts on aide recruitment and retention (VA Board of Nursing). • HB 1249 (2000) – Registry of certified nurse aides consistent with federal requirements (may include regulations standards for authority of LPNs to teach nurse aides).

WASHINGTON

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Base Rates for nursing homes, adult family homes, and boarding homes were increased in 2001 to base provider rates in order to provide wage support to low-income direct-care workers. • **State minimum wage exceeds federal wage ($7.35 as of 1/1/05).** • **In-home care workers received ($0.50) wage increase to $8.93 via union contract.**	**Benefits** • Some of increase in base rates was used to increase benefits and bonuses. • **In-home care workers received workers compensation and health care benefits via union contract.**	(Includes career ladders) • Proposed changes in requirements for non-certified aides effective 2002 include: mandatory orientation on special topics prior to hands-on care for employees of boarding homes, adult family homes, and Medicaid home care. • Required standard basic training and training in dementia, mental illness, and developmental disabilities for boarding home administrators and caregivers. • **Required safety training.**	• Revised Code of Washington 74.39A230 established the Home Care Quality Authority Board (HCQA) to regulate and improve the quality of long-term, in-home care services by recruiting, training, and stabilizing the workforce of individual providers, 2001. • **HCQA completed development of referral registry database for consumers and workers of in-home care services.** • Workforce Training and Education Coordinating Board work group on health care shortage issues established 12 Workforce Development councils to analyze and development initiatives for local regions. See: www.wtb.wa.gov. • Proposed Health Care Workforce Commission would develop strategic plan for ensuring an adequate supply of health personnel. • Home Care Issues Group.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
Washington Administrative Code title 388-97-115 • Nursing homes must ensure a sufficient number of qualified nursing personal are available on a 24-hour basis, seven days per week to provide nursing and related services. • Nursing home must have: o RN on duty directly supervising resident care a minimum of 16 hours per day, seven days per week. o RN or LPN on duty directly supervising resident care the remaining hours, seven days per week.	• Welfare to Work through a collaborative program of three separate departments within the state, called WorkSource. Provides training, limited schooling, job supports, childcare, interpersonal job skill building, clothing, and transportation costs. • Personal Assistant Recruitment and Retention Grant: Client employer focused program to improve supervisory skills and create workforce availability initiated in 2002. • **Home Care Quality Authority received Workforce Demonstration Grant to create four Referral and Workforce Resource Centers designed to conduct referral registry operations, peer mentoring, professional development, apprenticeship and consumer training from 01/2005 – 12/2006.**	• PARR Project to build a qualified direct-care workforce sufficient to meet the needs of adults with chronic and disabling conditions. • Center for Health Workforce Studies and the University of Washington received a grant to study shortages in health care workers in the long-term care arena in five states.

WEST VIRGINIA

Note: Incomplete Data. No Response to 2005 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs)	**Benefits**	(Includes career ladders)	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
64 CSR 13 • 2hrs/pt day (0.4hrs licensed nurse time) • For full summary of requirements, go to www.nccnhr.org/govpolicy/51_162_468.CFM	• Nursing Facility Transition Grant to develop Consumer Oversight Commission to provide input on process to increase community supports - including attendant services and in-home health care.	• HB 2506 (2001) – Provides protection to health care workers who report concerns about quality of care, services, conditions, waste, or other wrongdoing to government agencies. Reported information to remain confidential with certain exceptions.

WISCONSIN

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Nursing home wage passthrough rate increase to be used for wages, benefits, or to increase staff hours, SFY 1999-2000. • Personal care worker wages increased in 2001 from $12 to $15 funding with intent for increase to benefit workers (not a wage passthrough).	**Benefits** • Health insurance for low-income families available through Badger-Care program.	(Includes career ladders) • Formal guidelines and parameters for testing and training un-licensed workers to work as medication aides; recognized worker category in nursing homes, community based residential facilities, and hospice. • Increase minimum training hours (presently 75 hrs); develop personal care worker competency testing. • Wisconsin Alzheimer's Institute developed worker education, training, and assistance program to improve quality of care in long-term care facilities.	• Workforce Development Workgroup, in conjunction with redesigning the Long-Term Care system, formed to identify strategies to meet increasing demands for direct-care workers. Recommendations and report issued 2000. • The Department of Workforce Development has appointed a "Select Committee on Health Care Workforce Development" primarily to strategize on ways to solve the workforce shortage problem in acute care settings. • **Interagency Select Committee on Health Care Workforce Development has focused primarily on ways to solve the workforce shortage problem in acute care settings and nursing homes. More focus is now directed to other long-term care settings.** • **Direct Care Workforce Issues Committee formed by the WI Council on Long Term Care Reform to develop recommendations on public policy affecting the LTC direct-care workforce. Report available at:** www.wcltc.state.wi.us/CDCcharge.htm

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
WI Statutes, Ch. 50.04 • Intensive SNF Care – 3.25hrs/pt day (0.65hrs RN or LPN) • SNF Care – 2.5hrs/pt day (0.5hrs RN or LPN) • Intermediate or Limited Nursing Care – 2hrs/pt day (0.4hrs RN or LPN)	**Systems Change Grant – LTC Workforce Planner position provides policy direction and program planning relating to recruitment, retention of viable workforce in LTC. Also disseminates viable models, develops new methods of addressing problems, and proposes policy or legislation to implement. Identifies training approaches supporting workers.**	• **The Wisconsin Long Term Care Workforce Alliance is a broad coalition of stakeholders across the LTC spectrum (workers, state and county agencies, providers, and educational institutions) to enhance role and status of long-term care workers and raise awareness within community and with policy makers.** **www.wiworkforcealliance.com/index.htm** • Bureau of Aging and Long Term Care Resources made available limited Community Options Programs (COP) and COP-Waiver funds for workforce projects serving community long-term participants. Existing projects include training underemployed persons, mentoring programs, LTC worker-owed Cooperatives, and recruitment and retention for LTC organizations. • Wisconsin Aging Network sponsors Caregiver of the Year and Cornerstone of Year (supervisor or organization) award. • Wisconsin Caregiver Association (WCGA) promotes dignity of care professionals through advocacy, education, and collaboration with other organizations to improve professional status. **WCGA is now defunct.**

WYOMING

Additions Made in 2005 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES AND COMMISSIONS
Wages (includes wage passthroughs) • Dollar amount voluntary WPT for all front line workers (nursing homes only). • WPT funds of $30million appropriated effective July 1, 2002 will increase average wages of direct-care staff for adult waiver program and preschool programs for developmentally-disabled children.	**Benefits**	(Includes career ladders) • Direct Support College contract signed and schedule to be available in early 2004.	• Report to the Joint Appropriations Committee, *Study of Nonprofessional Direct Care Staff Recruitment, Retention, and Wages* issued December 2001. http://ddd.state.wy.us • **Wyoming Health Care Commission, created by the Legislature, to study solutions for health care problems in the State, including workforce issues.**

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
WY Regulations • SNF Care - 2.25hrs/pt day • ICF Care – 1.5hrs/pt day		• The Developmental Disabilities Division (DDD) in joint participation with provider agencies across the state have created the "Want Your Job to Make A Difference?" campaign that is focused on recruitment and retention of direct-support professionals. The committee associated with this effort actively researches issues and trends in pursuing their goals. • Since 2002, the DDD surveys providers of Residential Services for the Adult DD Waiver program to collect data on turnover rates for habilitation aides using a uniform methodology. Data is also collected on wages, benefits, retention, etc.