

**RESULTS OF THE 2003 NATIONAL SURVEY
OF STATE INITIATIVES ON THE
LONG-TERM CARE DIRECT-CARE WORKFORCE**

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Paraprofessional Healthcare Institute

and the

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The 2003 national survey and report are developed under the collaboration of the Paraprofessional Healthcare Institute (PHI) and the North Carolina Department of Health and Human Services (NCDHHS). This report was prepared by Susan Harmuth, Long Term Care Specialist with the NCDHHS Office of Long Term Care, and Susan Dyson, workforce consultant, who also worked on the 2002 survey.

I. BACKGROUND INFORMATION

The Paraprofessional Healthcare Institute (PHI) and the North Carolina Department of Health and Human Services (NCDHHS) have once again collaborated to survey states about direct-care workforce issues. The 2003 survey updates and expands upon information collected from states in prior surveys to examine public policy actions taken by states to strengthen the direct-care workforce. Specifically, the purpose of this 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 whether state budget constraints during 2003 had any effect on planned or existing direct-care worker initiatives, and/or whether the direct-care workforce was affected by Medicaid program changes;
- 3) Identify new direct-care workforce public policy actions taken by states since the June 2002 survey;
- 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 one or more long-term care settings regarding data tracking methods used, data trends, etc.; and
- 6) Update individual state charts of known public policy actions taken since the first survey conducted in 1999.

II. METHODOLOGY

This is the fourth national survey on the direct-care workforce developed by PHI and NCDHHS. Surveys were sent to all state Medicaid agencies and state Units on Aging in September 2003; some surveys were redirected to a more appropriate state entity for completion. Completed surveys were received between October and December 2003; clarification was sought as needed. Responses were received from 44 states, representing an 88% response rate.

A summary of results from the 2003 survey is available in **Table 1** and 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 conducted by PHI and NCDHHS. New information provided from the 2003 survey is reflected in bold type.

Data Caveat: All analyses and percentages reported are based on the 44 states responding to this survey.

The Paraprofessional Healthcare Institute (PHI)

PHI is a national organization dedicated to improving long-term care through improved jobs for direct-care workers. (www.PHInational.org). PHI initiatives include:

- ❖ The National Clearinghouse on the Direct-Care Workforce, which collects, analyzes, and disseminates information about the direct-care workforce (www.PHInational.org/clearinghouse)
- ❖ Affiliation with several worker-owned home care agencies and employee-centered training programs, employing nearly 1,000 direct-care staff.
- ❖ Sponsorship of the consumer-directed *Independence Care System* (ICS), a Medicaid managed care demonstration program for people with disabilities living in the community; and
- ❖ Technical assistance to the five coalitions selected as *Better Jobs Better Care* (BJBC) demonstration sites by The Robert Wood Johnson Foundation and The Atlantic Philanthropies — in partnership with the Institute for the Future of Aging Services (IFAS), which serves as the National Program Office for the BJBC initiative.

The North Carolina Department of Health and Human Services (NCDHHS)

NCDHHS has published four prior reports examining state efforts related to nurse aides and other paraprofessional aide workers:

- ❖ *Results of the 2002 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce;*
- ❖ *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* (2001);
- ❖ *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* (2000); and
- ❖ *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aides and Other Paraprofessional Aides* (1999).

All publications are available at the NC Division of Facility Services' website (facility-services.state.nc.us) under "For Providers" link).

III. NATIONAL STATISTICS ON THE DIRECT-CARE WORKFORCE

Employment Growth:

Many states continued to indicate that high rates of vacancies exist among direct-care workers occupations. 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%) the projected growth in overall employment nationally (14.8%).

Wage Rates:

The national average of median hourly wages for the three major categories of direct-care workers (nurse aides, orderlies, and attendants; home health aides; and personal and home care aides) has increased from \$7.97 in 1999 to \$8.70 in 2002. This represents a 9.15% increase over the four-year period for an average annual increase of 2.28%. Wage rates for direct-care workers in 2002 are presented below:

National Wage Data for Direct-Care Workers, 2002

	<i>Median Hourly Wage</i>
Nurse Aides, Orderlies, and Attendants	\$9.59
Home Health Aides	\$8.70
Personal and Home Care Aides	\$7.81
Average median wage across 3 categories	\$8.70

See **Table 3** for state unemployment data from 2001 to 2003. Also included in **Table 3** are average median hourly wages, by state, across direct-care worker categories from 1999 to 2002.

IV. NATIONAL ECONOMIC OUTLOOK

During calendar year 2003 the national unemployment rate peaked at 6.3% in June and dropped to 5.7% by December. When examining individual state unemployment rates, however, twelve states had unemployment rates at, or in excess of, 6.0% in November 2003. Of these, three states (**Alaska, Michigan, and Oregon**) had unemployment rates of 7.0% or higher.

Information collected during the 2003 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 2003, 79% of the 44 states responding to the survey indicated that high vacancy rates continue, compared to 88% of states in 1999 and 86% of states in 2002. Thus, the recent high unemployment rates may have contributed to improved vacancy rates in some states. It will be interesting to observe whether those workers who were attracted to enter (or re-enter) direct care during the recession because of limited job opportunities, remain in the field once the overall job market significantly improves.

Survey Responses

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

44 states responded to the 2003 survey, representing an 88% response rate.

Surveys were not received from: **Delaware, Indiana, Nebraska, New Mexico, Rhode Island and South Dakota.**

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

- ❖ 1999 (92%)
- ❖ 2001 (86%)
- ❖ 2002 (86%)
- ❖ 2003 (88%)

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

Wage Rates

State level wage and unemployment data are included in **Table 3**.

Bureau of Labor Statistics

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

However, responses received from states re-affirm that the economy is not the primary factor impacting serious vacancies of direct-care workers. Repeating trends found in previous surveys, both the state with the highest unemployment rate as of November 2003 (**Alaska** at 7.5%) and the state with the lowest unemployment rate (**North Dakota** at 3.2%) reported serious direct-care workforce vacancies.

In spite of the unemployment rate and continued slow job growth during 2003, there were clear signs an economic recovery was underway. Indications that state economies were improving were welcome news for states, which have struggled to balance their budgets over the past several years. A November 12, 2003 article in USA Today reported that state and local spending increases were annualized at 1% for the two consecutive quarters ending September 2003.¹ This growth rate represented the smallest growth spending during back-to-back quarters reported since 1952. In contrast, the good news for states during this same period was that revenue collection was picking up, increasing to a 9.2% annualized rate during these same two quarters. However, much of these increases was reportedly due to increased federal payments to states, a significant portion of which was one-time money to offset Medicaid costs, and increased tax collections.

The December 2003 Fiscal Survey of States published by the National Governors Association and the National Association of State Budget Officers confirmed that while the economy was improving, states continued to have difficulty balancing their budgets during State Fiscal Year 2003.² Medicaid is a major expense for states, and the report indicates that every state has taken at least one step to control Medicaid costs during State Fiscal Years 2002-2004. The report listed the following key actions:

- ❖ All 50 states either reduced or froze payments to provider organizations;
- ❖ All 50 states took steps to control prescription drug costs;
- ❖ 35 states reduced benefits;
- ❖ 34 states took steps resulting in reduced or restricted eligibility for services; and
- ❖ 32 states increased co-payments required by consumers.

Some of these actions have had a direct impact on direct-care workforce issues. Detailed Medicaid policy actions taken by states during the 2003 fiscal year are described in *Section D* below.

V. SURVEY FINDINGS

A. Serious Workforce Issue

Although the percentage of states considering direct-care vacancies to be a serious workforce issue has declined since 1999, over three-quarters of states responding in 2003 still consider it a major issue. Thirty-five (79.5%) states consider current vacancies a serious issue, eight (18.2%) states did not consider it serious, and 1 state (2.3%) did not answer this question.

¹ Cauchon, D. "States Getting Budgets Under Control." USA Today. November 12, 2003.

² National Governors Association and the National Association of State Budget Officers. *Fiscal Survey of States*. Washington, DC. December 2003.

Direct-Care Vacancies a Serious Issue

The percentages of states remarking that vacancies in the direct-care workforce as a serious issue has declined since 1999:

- ❖ 1999: 42 of 48 states (88%) stated vacancies were a serious workforce issue
- ❖ 2002: 37 of 43 states (86%)
- ❖ 2003: 35 of 44 states (79.5%)

States reporting that direct-care worker vacancies were not a serious issue (2003 survey) include:
Idaho, Illinois, Minnesota, Mississippi, Nevada, South Carolina, Utah, and West Virginia.

B. Economic Downturn and Impact on State Initiatives and Activities:

As evident in findings from prior years, the impact of the recession on state direct-care workforce initiatives continued in 2003. Of the 44 states responding, nine (20.5%) reported that funding for one or more direct-care worker initiatives was reduced or terminated and seven (15.9%) indicated that planned direct-care initiatives had been delayed. In total, 14 states (31.8%) had experienced reductions, terminations, or delays in direct-care workforce initiatives in 2003.³

Though the nation is starting to show signs of economic recovery, many states are still grappling with significant budget shortfalls and have had to face difficult decisions about sustaining funding for existing programs and initiatives.

Examples of state funding *reductions or terminations* in direct-care workforce programs include:

- ❖ Reduction or elimination of reimbursement rate adjustments (**California, Minnesota, Virginia**);
- ❖ Reductions in Medicaid waiver and community-based programs (**New Jersey, Texas**);
- ❖ Hiring freezes for vacant direct-care positions (**New Hampshire**);
- ❖ Elimination or reduction of in-home services hours or patient load (**Colorado, Michigan, Oklahoma**); and
- ❖ Cutting direct-care worker enhancement and training programs (**Minnesota**).

California, Minnesota, and Virginia all experienced reduction or elimination in planned reimbursement rates for nursing homes.

Simultaneously, many planned direct-care initiatives have been *delayed* because of the fiscal constraints facing many states. Seven of the 44 states responding to the survey (15.9%), have had to delay direct-care initiatives. Many of the initiatives have directly affected the direct-care workforce through delays in staffing ratio increases, proposed wage or benefit enhancements, or recruitment and retention programs. Some examples of delays include:

- ❖ An increase of 0.3 hours in CNA staffing ratios per resident in **Florida** has been delayed until early 2004.
- ❖ Although two of three increases in staffing levels in nursing facilities were delayed in 2002 in **Arkansas**, the delays were short and all scheduled increases have since been implemented.
- ❖ Funding increases for wages and benefits were dropped from **Wisconsin's** 2004-05 budget; **Maryland's** planned wage increase for community based workers serving the developmentally disabled was funded at 90%, but this state has plans to make up the remaining amount in future years.

C. Wage and Benefits Pass-Through:

Of the states responding to the 2003 survey, the majority (26 states, 59.1%) has funded a wage or benefit pass-through or similar increase benefiting direct-care workers within the last three years. Pass-throughs took the form of increasing hourly or minimum wages or reimbursement rates, funding benefit enhancements (including health insurance), or implementing activities aimed at recruitment and retention of direct-care staff.

- ❖ In 2001, **Arkansas** began a cost-based reimbursement methodology in nursing homes to encourage spending in direct care, primarily for salaries.

³ Some states answered yes to both the question of reduction or termination of funding and to the question of delayed initiatives.

Impact on State Direct-Care Initiatives and Activities

States indicating funding *reductions or terminations* for previously implemented direct-care initiatives include:

- ❖ **California, Colorado, Michigan, Minnesota, New Hampshire, New Jersey, Oklahoma, Texas, and Virginia.**

States experiencing a *delay* in planned direct-care initiatives were reported by:

- ❖ **Alaska, California, Florida, Maryland, Michigan, Missouri, and Wisconsin.**

Wage or Benefit Pass-Throughs

States that funded a wage and/or benefit pass-through over the last 3 years include:

- ❖ **Arizona, Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nevada, New Jersey, New York, North Dakota, Oklahoma, Oregon, Texas, Vermont, Virginia, Washington, and Wyoming.** (New respondents to the 2003 survey, Connecticut and Hawaii reported recent wage/benefit pass-throughs.)
- ❖ **Hawaii's** minimum wage is higher than national.

- ❖ In 2000, **Oregon's** Ballot Measure 99 created the Home Care Commission, which offered home care workers collective bargaining rights, resulting in guaranteed wage increases in 2003 and 2005.
- ❖ States reporting a rate increase in skilled nursing facilities, intermediate care facilities, developmental disabilities facilities, alternative care facilities, home care sites, and/or adult day care sites were **Arizona, California, Colorado, Connecticut, Illinois, Kansas, Louisiana, Maryland, Maine, Minnesota, Missouri, New York, North Dakota, Oklahoma, Texas, Vermont, Virginia, and Washington.**

D. Changes in Medicaid Coverage or Eligibility Impacting the Direct-Care Workforce:

Seventeen states (38.6%) have made changes in Medicaid coverage or eligibility that have likely affected the direct-care workforce. Six states made changes to its Children's Health Insurance Programs including reduced or frozen eligibility (**Alaska, Colorado, Texas**), enrollment caps (**Florida, Utah**) or reduction in benefits (**Pennsylvania**).

Reduction or tightening in eligibility of state Medicaid programs were seen in **Alabama** (eligibility reduced from 300% to 200% of poverty levels), **Florida** (reduced eligibility from 90% to 80% of the Federal benefit rate), **Colorado** (tightening of eligibility for home- and community-based services) and **Washington** (eligibility reduced in the Medicaid Personal Care program). All of **New Hampshire's** Medicaid programs have been reduced or level funded. Although not specifically indicated, many reductions were due to state economic shortfalls, including those in **Oregon** where reduction and elimination of priority levels (survival) were considered. Conversely, **Virginia** was one state that added services to its Medicaid program by including consumer-directed services in its AIDS waiver.

Changes in covered services were made in **Montana** (reduction in coverage for bathing and home-keeping tasks), **Connecticut** (limitations imposed on providers of podiatry and physical therapy), and both **Nevada** and **North Carolina**, which reduced hours for Personal Care services.

Although hourly rates for healthcare attendants in **Kansas'** Home and Community Based Services Frail Elderly and Physically Disabled waiver programs were reduced, the rates were restored in FY 2004. **Utah's** Aging waiver program reduced the number of hours for Personal Assistance.

Also of note is the reduction in eligibility standards for MinnesotaCare, **Minnesota's** health insurance program for Medicaid ineligibles, which also increased premiums.

Medicaid Coverage or Eligibility Changes

The following states have made changes to coverage or eligibility in the Medicaid program over the last year, likely affecting the direct-care workforce:

- ❖ **Alabama, Alaska, Colorado, Connecticut, Florida, Kansas, Minnesota, Montana, Nevada, New Hampshire, North Carolina, Oregon, Pennsylvania, Texas, Utah, Virginia, and Washington.**

E. Direct-Care Workforce Demonstrations:

Just over one-third of states responding to the survey (15; 34.1%) have initiated a state-funded or related direct-care workforce demonstration in the last year. Most of these demonstrations involved a recruitment or retention component. Such programs were introduced in **Alaska** (through the Alaska Alliance for Direct Service Careers), **Arkansas, Georgia, Maryland, Montana, North Carolina, Ohio, Pennsylvania, and West Virginia**.

- ❖ Several of **Florida's** healthcare initiatives affected direct-care workers including its Healthcare Worker pilot program, which provided home ownership opportunities for a variety of health care workers.
- ❖ **Georgia, Louisiana, Montana, North Carolina, and Pennsylvania** all received grants for direct-care pilot programs (Real Choice, Nursing Home Transitions, and/or *Better Jobs Better Care*).
- ❖ Public education and media campaigns promoting direct-care careers were developed in **Arkansas, Maryland, and Ohio**; Annual Direct Support Professional Banquets honoring direct service providers have been held in **Wyoming** since 2002.
- ❖ The **Wisconsin** Council on Developmental Disabilities convened several public hearings soliciting input from agencies, clients and families on the direct-care workforce and collected satisfaction surveys from the direct-care workforce in 2002. (Results can be found at wcdd.org/Retention_survey_report.pdf).

F. Tie Outcomes to Reimbursement:

A recent trend in public policy actions being taken by states to, at least in part, address direct-care workforce issues, are efforts that tie outcomes to reimbursement for one or more publicly funded long-term care provider settings.

The 2003 survey asked states whether they have, or are considering, tying outcomes to reimbursement. Nine of the 44 states responding (20.5%) said yes. Only Iowa has implemented such efforts while eight states are considering such action or have plans to implement one or more activities tying outcomes to reimbursement.

In **Iowa**, effective July 1, 2002, certain nursing facilities can qualify for up to a 3% reimbursement increase (of the direct-care and non-direct-care component median rates) for meeting up to 10 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.

Direct-Care Workforce Demonstrations

Fifteen states have initiated a state-funded or related direct-care workforce demonstration project in the last year.

- ❖ **Alaska, Arkansas, Florida, Georgia, Iowa, Louisiana, Maryland, Montana, North Carolina, Ohio, Pennsylvania, Virginia, West Virginia, Wisconsin, and Wyoming.**

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

- ❖ State that has implemented such actions: **Iowa**
- ❖ States considering or planning such actions: **Alaska, Kansas, Michigan, Minnesota, North Carolina, Vermont, Wisconsin, and Wyoming.**

❖ The **Iowa** accountability measures and associated point values include:

<i>Measure</i>	<i>Description</i>	<i>Points awarded</i>
1	Deficiency free survey	2*
2	Regulatory compliance	1*
3	Nursing hours provided	2
4	Resident satisfaction	1**
5	Resident advocate committee resolution rate	1
6	High employee retention rate	1
7	High occupancy rate	1
8	Low administrative cost	1
9	Special licensure classification	1***
10	High Medicaid utilization	1

Notes: * Cannot receive points for both Measures 1 and 2.

** Optional measure.

***Licensed for care of residents with chronic confusion or dementing illness.

❖ The increase awarded is based on the following point scale:

<i>Points Earned</i>	<i>Awarded Increase</i>
0-2	No additional reimbursement
3-4	1% of the direct-care and non-direct-care component medians
5-6	2% of the direct-care and non-direct-care component medians
7 or more	3% of the direct-care and non-direct-care component medians

❖ The increased reimbursement is not available for Medicare certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities.

❖ Results for the most recent fiscal year indicate that 14% of providers achieved the full 3% increase available; 34% of facilities received 2% additional reimbursement; 35% received 1% additional reimbursement; and 17% of providers received no additional reimbursement.

Efforts being considered or planned by states to tie outcomes to reimbursement include a variety of strategies. Efforts under consideration/development in various states include:

- ❖ **Alaska** is considering approaching the legislature to tie wage increases to nurse aide certification.
- ❖ **Kansas** is examining a variety of nursing home incentive programs and is specifically interested in several features of the Iowa program (described above).
- ❖ **Michigan** is considering tying low staff turnover to increased reimbursement for long-term care facilities.
- ❖ In **Minnesota**, a legislatively mandated and funded study is underway to redesign nursing facility reimbursement, with recommendations due to the legislature in January 2004. As part of this effort, consideration is being given to models that would provide incentive payments for quality improvement.
- ❖ Through a *Better Jobs Better Care (BJBC)* grant, the **North Carolina BJBC** coalition is developing a uniform set of expectations and criteria for statewide use, on a voluntary basis, across home care, adult care homes, and nursing facilities. For entities that meet the criteria, it may result in

special licensure designation. Expectations and criteria will address direct-care workforce issues such as: workplace culture, effective care teams, staff empowerment, coaching supervision, career ladder opportunities, and peer mentoring. The special licensure designation is intended to serve as the potential basis for awarding a differential reimbursement and/or eligibility for labor enhancement funds.

- ❖ Through a *Better Jobs Better Care* grant, the **Vermont BJBC** coalition plans to expand current quality award criteria to include workforce related measures for nursing homes and other long-term care providers. In addition, Vermont plans to develop a sustainable reimbursement structure in which direct-care staff development and support, working conditions, and recognition of direct-care workers' valued part of the care team are continued beyond the project period. It is also worth noting that the Vermont Health Care Association and Vermont Department of Aging and Disabilities collaborated to develop a "Gold Star" designation program for nursing facilities, a program that focuses on best practices for nursing home recruitment and retention of direct-care workers.
- ❖ Through their Careers in Caring Initiative, **Wisconsin** planned to tie reimbursement to consumer quality of life outcomes. However, this initiative was curtailed due to funding constraints.
- ❖ **Wyoming** plans to begin offering courses in early 2004 through the Direct Support College - an Internet training program for direct-support professionals serving adults with development disabilities. The state plans to financially sponsor a certain number of participants for training. Providers will be encouraged to increase wages for workers who complete one or more courses through the training program.

G. Used Prior Surveys

Many states are beginning to use the results of, and information from, surveys conducted by PHI and NC DHHS. Although only nine states (20.5%) responded yes to using prior national surveys, the results have been used for a variety of reasons. These include:

- ❖ As a means of generating new ideas for improving recruitment, retention, and recognition of the direct-care workforce;
- ❖ As a source of best practices and comparison against other states;
- ❖ As a way to share information with legislators, state agencies, and community organizations to substantiate need for direct-care initiatives, influence direct-care policy, and improve working conditions of direct-care staff;
- ❖ Using as a primary resource for writing grant applications; and
- ❖ Using as a motivator for media and public relations campaigns about the need for, and interest in the direct-care workforce.

Surveys have also been widely used at the national level to describe state public policy efforts.

Use Prior National Direct-Care Workforce Surveys

Nine states have used prior national surveys conducted by the Paraprofessional Healthcare Institute and the North Carolina Department of Health and Human Services:

- ❖ **Alaska, Florida, Minnesota, North Carolina, Ohio, Oklahoma, Pennsylvania, Wisconsin, and Wyoming.**

H. Turnover Methodology

Another area the 2003 survey examined was the extent to which states collect and analyze turnover data on direct-care workers for one or more long-term care settings using a uniform methodology. For those states that do collect turnover data, the 2003 survey also collected the number of years of data collection, the calculation methodology used, and any resulting trend data.

Nationally, discussion about the best method for calculating direct-care worker turnover rates in long-term care settings has occurred. Although states use different methodologies, the ability of individual states to collect turnover data in a systematic and longitudinal way is important to assess the stability of the direct-care workforce in settings in which data are collected. While many factors impact worker turnover, some outside the control of the provider, the ability to examine turnover data over time can potentially shed light on the impact of public policy or practice interventions implemented by a particular provider (e.g. wage pass-throughs, career advancement opportunities, etc.). For state policymakers, these data can also quantify the extent of the direct-care turnover problem in one or more long-term care settings.

Findings:

Ten of the 44 states (22.7%) collect direct-care worker turnover data from one or more long-term care settings using a uniform methodology. Of these, six (60.0%) reported collecting data for nursing facilities only (**California, Florida, Kansas, Minnesota, Texas, and Wisconsin**). One state, **Wyoming**, collects data for developmentally disabled adults served through its residential waiver program, and three states (30.0%; **Maryland, North Carolina and South Carolina**) collect data from two or more settings. Both **Maryland and North Carolina** report using the same methodology for calculating turnover across provider settings while **South Carolina** uses a separate methodology for nursing homes and home care.

With the exception of **North Carolina and Wyoming**, both of which currently only collect turnover data on direct-care staff, states collect turnover data for multiple job categories within a particular care setting.

A description of each state's turnover data collection efforts is shown below. Where available, a general statement about the calculation methodology used is also provided. Supplemental materials are provided in **Appendix B**.

1. **California** has the longest history for collecting turnover data from nursing facilities - 26 years. The state collects and reports turnover data on all employees, nursing employees and nurse assistants. Separate data collection for nursing employees and nursing assistants has only been calculated for two years. Prior to that, only turnover data for total employees in the facility were aggregated.

Nursing Facility Turnover Trend Data for California, FY2001-2002

Fiscal Year	All Employees	Nursing Employees	Nurse Assistants
12/31/01-12/30/02	67.0%	74.7%	77.1%
12/31/00-12/31/01	68.6%	74.2%	78.7%

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

States Collecting Turnover Data

The ten states that reported collecting turnover data using a uniform methodology include:

- ❖ **California** – NF
- ❖ **Florida** – NF
- ❖ **Kansas** – NF
- ❖ **Maryland** –HC, RH*
- ❖ **Minnesota** –NF
- ❖ **North Carolina** – HC, AC, NF
- ❖ **South Carolina** – HC, NF
- ❖ **Texas** –NF
- ❖ **Wisconsin** –NF
- ❖ **Wyoming** –RH for Adult DD Waiver

Legend

NF	Nursing facility
HC	Home care
AC	Adult care homes
RH	Residential habilitation

*Note: **Maryland** collects data from providers serving developmental disability clients receiving home care and residential services.

2. **Florida** has been collecting turnover data in nursing facilities using a uniform methodology for approximately three years. Requirements for the collection and calculation of turnover data are detailed in statute. Florida reports turnover rate data for Certified Nurse Aides, Registered Nurses, and Licensed Practical Nurses as follows:

**Trend Data for Nursing Facility Turnover in Florida
2001-2003**

Year	CNAs	RN/LPNs
2001	43.0%	43.6%
2002	41.3%	40.4%
2003 (3 Qtrs)	38.5%	30.5%

Methodology: Staff turnover must be reported for the most recent 12-month period ending on the last workday of the most recent calendar quarter prior to the date the information is submitted. The turnover rate must be computed quarterly; the annual rate is the cumulative sum of the quarterly rates. It is calculated as the total number of terminations or separations experienced during the quarter, excluding any employees terminated during a probationary period of 3 months or less, divided by the total number of staff employed at the end of the period for which the rate is computed, and expressed as a percentage (Section 400.141(15)(b)).

3. **Kansas** has collected turnover data from nursing facilities for 11 years and for 21 different job categories (see **Appendix B** for a table on nursing facility turnover rates for these categories for 2001). Kansas reports that it recently started a new collection methodology and as such, no trend data were reported.

Nursing Facility Turnover Rates for Kansas, 2001

Year	RNs	LPNs	Nurse, Med & Restorative Aides
2001	52%	63%	98%

Methodology: The new calculation methodology being used is to divide the 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** has been collecting turnover data for persons with developmental disabilities who receive home care and/or residential habilitation services for four years. Turnover data are reported for aides, service workers, first line supervisors, and drivers. The statistics for workers in residential habilitation settings are differentiated for live-in versus non live-in staff. Maryland also compares turnover data for state employed workers versus those working for other providers. A detailed report on turnover data for Maryland is available at www.dhmd.state.md.us/csrrc/white_papers/2002_B2.htm

Turnover Data for Home Care and Residential Habilitation Settings in Maryland, 2001

Year	Aides	First Line Supervisors
2001	48%	29%

Methodology: The calculation methodology used is based on the number of employee terminations during the year divided by the number of positions.

Collection of Turnover Data Across Settings and Job Categories

Six of the seven states collect turnover data for multiple job categories for each of the settings for which turnover data are collected.

North Carolina and **Wyoming** collect turnover data using a uniform methodology for direct-care workers only.

Alaska reports it will begin collecting turnover data using a uniform methodology in 2004. It reports having 1998 turnover data from developmental disabilities providers.

Michigan has collected turnover data from nursing facilities for approximately 10 years.

5. **Minnesota** has been collecting turnover data from nursing facilities for two years. Job categories include Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aide positions. In addition to turnover data, Minnesota also compiles data on retention rates, employees per bed and average length of employment.

Nursing Facility Turnover Trend Data for Minnesota, September 2000

Year	RNs	LPNs	CNAs
2000	32%	30%	62%

Methodology: The calculation methodology used for turnover is based on the number of employees leaving a position divided by the number of filled positions on October 1st.

6. **North Carolina** has been collecting turnover data for three years. A supplemental one-page form is included with the licensure renewal package sent annually to licensed home care agencies, adult care homes, and nursing facilities. Agencies and facilities are questioned about their perceived aide turnover problem. Other questions request the agencies' or facilities' perceived difficulty (or lack thereof) in hiring and retaining aides. A copy of the questionnaire sent to providers is included in **Appendix B**. The full report on annual turnover findings is available at: <http://www.aging.unc.edu>.

Trend Data for Direct-Care Turnover in North Carolina, 2000-2002

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

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. A more detailed description of calculations (total, voluntary, non-voluntary) is included in Appendix B.

7. **South Carolina** has recently begun collection of turnover data from home care agencies and nursing facilities. Data have only been collected for one year, and as a result, it has no trend data to report. Data are collected from home care agencies, which are responsible for submitting worker registration sheets with start dates and termination dates, enabling the Department of Health and Human Services to compile turnover data by agency. Turnover data are also collected monthly from the 39 nursing facilities that received a quality improvement grant in 2002. These facilities must submit turnover information on a monthly basis.
8. **Texas** has been collecting turnover data from nursing facilities for over ten years. In addition to collecting turnover data on Nurse Aides, Texas collects turnover data on Directors of Nursing, Registered Nurses, and Licensed Visiting Nurses. Providers report the number of staff employed in each job category during, and at the end of their cost-reporting period; these data are used to calculate turnover statistics for the facility. While these data are collected from providers, Texas reported that no statewide analysis data exists. Thus, there are no trend data to report. The instructions used by facilities to report turnover data and the form used to report the data are included in **Appendix B**.

Minnesota does not collect turnover data, but turnover data are collected biannually by two state-level long-term care provider associations.

Positive Findings:

Generally, states that are able to provide turnover data for multiple years show a decline in turnover of direct-care staff over a period of two to three years.

9. **Wisconsin** has been collecting turnover data from nursing facilities for 15 years. Data are collected for a variety of job categories including Registered Nurses, Licensed Practical Nurses, and Nurse Aides. These data are collected as part of a broader annual survey conducted of nursing facilities. To review turnover questions, see pages 6 and 7 of the following report: www.dhfs.state.wi.us/provider/pdf/90-99nhtrendsurvey.pdf. A report detailing annual survey findings for 2002 can be viewed at dhfs.wisconsin.gov/provider/pdf/02nh&r.pdf. Statewide turnover data (and retention data) are described for both full-time and part-time staff in nursing related job categories as well as by facility ownership type (i.e. governmental, non-profit, and proprietary). For specific information on nursing related turnover and retention data, see pages 22 and 23 of the 2002 report.

Trend Data for Nursing Facility Turnover in Wisconsin, 2001-2002

Year	RNs	LPNs	Nurse Aides
2001	22%	35%	72%
2002	16%	32%	55%

*Note: Turnover rates are shown for full-time staff.
Methodology: The calculation methodology used to calculate turnover is based on the number of hired (by category) in the current year divided by the total number of employees in that category, multiplied by 100.*

10. **Wyoming** reported that it has been collecting turnover data from providers of residential care services for adults in the developmental disabilities waiver program for two years. The turnover survey also includes information about wages paid and benefits provided to full-time employees.

Trend Data for Direct-Care Turnover in Wyoming, 2002-2003

Year	Direct Care
2002	52%
2003	37%

Note: Data are collected on direct-care workers employed with providers of Residential Services for Adult Developmental Disability Waiver clients.

11. It is also worth noting in **Michigan**, the Health Care Association of Michigan (HCAM) conducts a Wage and Personnel Survey biannually. As seen in the chart below, there were considerable drops in turnover across Registered Nurse, Licensed Practical Nurse, and Certified Nurse Assistant job categories between 2000 and 2002, which HCAM attributes to increased wages. The Michigan Assisted Living Association conducts a Mental Health Provider Wage and Benefit Survey for direct-care workers and managers. Data from these surveys are shown below.

**Turnover Data from the Health Care Association of Michigan
2000 and 2002**

Year	RNs	LPNs	CNAs
2000	33.4%	32.6%	64.0%
2002	25.7%	28.4%	48.5%

**Michigan Assisted Living Association's Mental Health Provider Survey
2000 and 2002**

Year	Direct-Care Workers	Residential Managers
2000	65%	22%
2002	53%	18%

VI. NATIONAL DIRECT-CARE INITIATIVES

As previously mentioned, direct-care workforce vacancies and turnover continue to receive visibility at the national level. A sample of major national efforts over the past year include:

- A. **US Department of Health and Human Services** - awarded approximately \$6 million in October 2003 for five demonstration projects specifically intended to support the recruitment and retention of direct-care workers.
 - Three of the demonstrations plan to make health insurance coverage available to direct-care workers. Each project will receive \$1.4 million over three years.
 - Two additional demonstration projects were funded at \$680,500 each for development of educational materials, training and mentoring programs, and other activities.
 - For more information about these projects see www.hhs.gov/news/press/2003pres/20031002.html
- B. **The Robert Wood Johnson Foundation and The Atlantic Philanthropies** together provided more than \$15 million to fund the national *Better Jobs Better Care (BJBC)* initiative in 2003.
 - The Institute for the Future of Aging Services (IFAS), American Association of Homes and Services for the Aging in Washington, DC, serves as the National Program Office for this effort. *Better Jobs Better Care* includes demonstration project funding to five lead agencies on behalf of state-based coalitions and funding to eight applied research and evaluation grantees. The overall goal of these demonstration projects is to implement policy and practice changes that will improve the ability to attract and retain high-quality direct-care workers to meet the needs of long-term care consumers in both home and community settings and facility-based settings.

Tracking State Efforts

It will be important to track state efforts to tie outcomes to reimbursement to:

- Determine the extent to which intended outcomes were achieved;
- Examine measurement methods used, and where possible; and
- Compare how those meeting outcomes and those that do not differ from the standpoint of quality of care indicators, turnover, and/or intended outcome criteria.

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

ASPE helped to facilitate the development of the *Better Jobs Better Care* demonstration and applied research program.

- The Paraprofessional Healthcare Institute in conjunction with IFAS provides technical assistance to *BJBC* grantees.
 - For more information about the *BJBC* initiative and grantees visit: www.bjbc.org
- C. **The Institute for the Future of Aging Services (IFAS)** - developed a working draft document entitled: *Measuring Long-Term Care Work: A Guide to Selected Instruments to Examine Direct-Care Work Experiences and Outcomes*.
- The guide provides a compilation of reviewed measurement instruments for potential use by individual providers/corporations, states, researchers, workforce development organizations and others to help identify direct-care workforce problems in various long-term care settings. It also assesses the effectiveness of strategies implemented to address identified direct-care problems. The measurement instruments (and sub-scales) focus on eleven key topics of specific relevance to direct-care worker retention and quality of care issues.
 - The guide includes information about the importance of using data to inform the decision-making and workforce improvement process. Issues to consider in planning, designing, collecting, analyzing and presenting data are also highlighted. Strengths and limitations of various measurement instruments and examples of formulas for calculating turnover, retention and other workforce rates are also included. The US Departments of Health and Human Services, and Labor support development of the guide.
 - A draft copy of the guide is available at the IFAS website: www.futureofaging.org
- D. **National Governors' Association** - Idaho Governor Dirk Kempthorne chose for his Chairman's Initiative *A Lifetime of Health and Dignity: Confronting Long-Term Care Challenges in America*.
- There are five focal points, including Community Based Care, Financial Planning and Consumer Role, Utilization of High Technology, Wellness and Disease Management, and Caregivers and the In-Home Workforce. As part of the Chairman's Initiative, Governors Guinn and Balducci are leading a subcommittee on Caregivers and the In-Home Workforce.
 - Additional information about the Chairman Kempthorne's Initiative can be found at: www.nga.org/chairman03/
 - To view an Issue Brief entitled *Rescuing the Health Workforce: Options for State Action*, published by the National Governors' Association for Best Practices— Health Policy Studies Division (January 2004), go to: www.nga.org/center/.
- E. **US Department of Labor** - the Department's Employment and Training Administration (ETA) has created a pilot "career lattice" apprenticeship program for Certified Nursing Assistants who work in both nursing homes and hospitals through a contract with the Council for Adult and Experiential Learning. The program, which creates advancement for CNAs, including progression to LPNs, is being developed in Chicago, Houston, Sioux Falls, St. Louis, and Seattle.

F. **Office of the Assistant Secretary for Planning and Evaluation (ASPE)** – has several national efforts underway.

1. *National Survey of Direct Care Workers* - ASPE has designed a national survey of nursing assistants in longterm care to examine wages, working conditions, workplace perceptions, job responsibilities, and the role of supervision. The survey will be fielded in summer 2004 in conjunction with the National Center for Health Statistics' National Nursing Home Survey. Analysis of the survey data is expected to be complete by December 2004.
2. *National Initiative to Improve the Recruitment and Retention of the Long-Term Care Paraprofessional Workforce* - is a multi-year collaborative effort under the leadership of ASPE and implemented through a contract with the Institute for the Future of Aging Services. Activities to date include:
 - Development of a promising practices database related to the recruitment and retention of direct-care workers by the Paraprofessional Healthcare Institute (PHI) and the Institute for the Future of Aging Services (IFAS);
 - Preparation of Issue Briefs authored by PHI and IFAS highlighting topics important to states and providers such as wage pass-throughs and on-the-job training; and
 - Development of a resource guide for measuring long-term care work. (Outlined in sub-section C above.)
3. *Coordination with Department of Labor on Apprenticeship and Training* - ASPE has been working with the Department of Labor's Employment and Training Administration (ETA) on possible apprenticeship programs to enhance training and create greater career ladders for direct-care workers. (See sub-section C above.)

VII. CONCLUSION

As expected, direct-care worker vacancies continue to be a major issue for most states. This situation has continued through both robust and recessionary economies. The percentage of states reporting that direct-care worker vacancies are a major workforce issue has varied less than 10% since 1999 from a high of 88% in 1999 to 86% in 2002 and 79.5% in 2003. The majority of states grappled with budget shortfalls in recent years and 14 states reported having to reduce, terminate, and/or delay direct-care workforce initiatives during 2003. However, in general, there continues to be considerable public policy activity on direct-care workforce issues at the state level as evidenced by the enclosed state charts.

In addition to state funded direct-care workforce initiatives, it is also important to note that over the past four or five years there have been significant increases in federal and private foundation funding available to states and/or individual providers in support of direct-care workforce initiatives. Sustaining momentum on direct-care initiatives that were established with federal and/or private foundation funding will undoubtedly be an important challenge for states whose efforts have relied heavily on outside resources. It will be important to track the degree to which initiatives implemented with time-limited federal and/or private foundation resources become institutionalized activities and/or serve as a building block for other initiatives in support of the direct-care workforce.

Seven states reported having to delay one or more planned direct-care worker initiatives in 2003. Generally, survey respondents were hopeful initiatives would get back on track when the states' budget situations improve.

Two public policy trends evident from the 2003 survey findings include an increasing number of states (10) reporting collection and compilation of direct-care turnover data for one or more long-term care settings using a uniform methodology. The ability to collect and analyze turnover data over time is helpful to states to assess the stability of the direct-care workforce in settings for which data are collected. Another trend identified is efforts by states to tie outcomes to provider reimbursement. While only one state has already implemented one or more strategies to tie outcomes to reimbursement, eight other states were considering such action or working on such strategies. The ability to tie outcomes effectively to reimbursement will undoubtedly hinge on states having the necessary data/evaluation systems in place to collect and analyze required data/information to verify the intended outcomes have occurred.

It will be important to watch how efforts to tie outcomes to reimbursement actually impact the quality of care provided, the size and stability of the direct-care workforce, and the ability to achieve any other intended outcomes. This trend can be expected to grow as state data collection and analysis efforts expand. As these early states implement and evaluate efforts to tie outcomes to reimbursement it will be helpful to share information with other states and communicate ideas about criteria and rationale used, measurement methods, barriers encountered, and comparison of applicable data for providers meeting the outcome measures implemented versus those who have not.

TABLE 1. Summary of State Responses to 2003 Survey (* Additional comments in Table 2)

State	Serious workforce issue	Direct care funding reductions or terminations	Planned direct care initiatives delayed	Wage/benefit pass-through within 3 years	Changes in Medicaid eligibility or coverage	Direct care workforce demonstrations	Tie outcomes to reimbursement	Use prior national surveys	Collecting uniform methodology on turnover data
ALABAMA	Y	N	N	N	Y*	N	N	N	N
ALASKA	Y	N	Y*	N	Y*	Y*	Y*	Y*	N
ARIZONA	Y	N	N	Y*	N	N	N	N	N
ARKANSAS	Y	N	N	Y*	N	Y*	N	N	N
CALIFORNIA	Y	Y*	Y	Y*	N	N	N	N	Y
COLORADO	Y	Y*	N	Y*	Y*	N	N	N	N
CONNECTICUT	Y	N	N	Y*	Y*	N	N	N	N
DELAWARE	No Response								
FLORIDA	Y	N	Y*	N	Y*	Y*	N	Y*	Y
GEORGIA	Y	N	N	N	N	Y*	N	N	N
HAWAII	Y	N	N	Y*	N	N	N	N	N
IDAHO	N	N	N	N	N	N	N	N	N
ILLINOIS	N	N	N	Y*	U	N	N	N	N
INDIANA	No Response								
IOWA	Y	N	N	N	N	Y*	Y*	N	N
KANSAS	Y	N	N	Y*	Y*	N	Y*	N	Y
KENTUCKY	Y	N	N	N	N	N	N	N	N
LOUISIANA	Y	N	N	Y*	N	Y*	N	N	N
MAINE	Y	N	N	Y*	N	N	N	N	N
MARYLAND	Y	N	Y*	Y*	N	Y*	N	N	Y
MASSACHUSETTS	Y	N	N	N	N	N	N	N	N
MICHIGAN	Y	Y*	Y*	Y*	N	N	Y*	N	N
MINNESOTA	N	Y*	N	Y*	Y*	N	Y*	Y*	Y
MISSISSIPPI	N	N	N	N	N	N	N	N	N
MISSOURI	Y	N	Y*	Y*	N	N	N	N	N
MONTANA	Y	N	N	Y*	Y*	Y*	N	N	N
NEBRASKA	No Response								
NEVADA	N	N	N	Y*	Y*	N	N	N	N
NEW HAMPSHIRE	Y	Y*	N	N	Y*	N	N	N	N
NEW JERSEY	Y	Y*	N	Y*	N	N	N	N	N
NEW MEXICO	No Response								
NEW YORK	Y	N	N	Y*	N	N	N	N	N
NORTH CAROLINA	Y	N	N	N	Y*	Y*	Y*	Y*	Y
NORTH DAKOTA	Y	N	N	Y*	N	N	N	N	N
OHIO	Y	N	N	N	N	Y*	N	Y*	N
OKLAHOMA	Y	Y*	N	Y*	N	N	N	Y*	N
OREGON	Y	N	N	Y*	Y*	N	N	N	N
PENNSYLVANIA	Y	N	N	N	Y*	Y*	N	Y*	N
RHODE ISLAND	No Response								
SOUTH CAROLINA	N	N	N	N	N	N	N	N	Y
SOUTH DAKOTA	No Response								
TENNESSEE	U	N	N	N	N	N	N	N	U
TEXAS	Y	Y*	N	Y*	Y*	N	N	N	Y
UTAH	N	N	N	N	Y*	N	N	N	N
VERMONT	Y	N	N	Y*	N	N	Y*	N	N
VIRGINIA	Y	Y*	N	Y*	Y*	Y*	N	N	N
WASHINGTON	Y	N	N	Y*	Y*	N	N	N	N
WEST VIRGINIA	N	N	N	N	N	Y*	N	N	N
WISCONSIN	Y	N	Y*	N	N	Y*	Y*	Y*	Y
WYOMING	Y	N	N	Y*	N	Y*	Y*	Y*	Y

Number of States Responding									
Yes	35	9	7	26	17	15	9	9	10
No	8	35	37	18	26	29	35	35	33
Unknown	1	0	0	0	1	0	0	0	1
No response to survey	6	6	6	6	6	6	6	6	6
Total	50	50	50	50	50	50	50	50	50

Table 2: Detailed State Comments from the 2003 Survey of State Initiatives of the Long-Term Care Direct-Care Workforce

State	COMMENTS (As reported by States in Survey Responses)
ALABAMA	<i>Medicaid Changes:</i> Medicaid has reduced eligibility from 300% to 200% of poverty.
ALASKA	<i>Delayed Initiatives:</i> A portion of the Alaska Alliance for Direct Service Careers, focused on generating support for increased wages and benefits, was put on hold. <i>Medicaid Changes:</i> Reduction in Alaska's children's health insurance program, Denali Kid Care, through increased eligibility requirements. Proposed regulations seek to reduce maximum allowable hours for personal care services (PCS). <i>Demonstrations:</i> The Alliance for Direct Service Careers, funded by the Alaska Mental Health Trust Authority, works to address recruitment and retention of direct-care workers in the fields of aging, disabilities, substance abuse, and mental health. <i>Survey Use:</i> Prior surveys have been used in the activities of the Alaska Alliance for Direct Service Careers.
ARIZONA	<i>Pass-through:</i> Increases in rates in nursing facilities (5.5%), assisted living facilities (11.7%), and in in-home settings (11.7%), which were directed at wage and/or benefit increases for direct-care workers.
ARKANSAS	<i>Pass-through:</i> A cost-based reimbursement methodology was implemented in January 2001 for nursing facilities to encourage spending in direct care, primarily for worker salaries. <i>Demonstrations:</i> The Division of Aging and Adult Services and the Division of Developmental Disabilities Services conducted a direct service worker recruitment campaign.
CALIFORNIA	<i>Funding Reductions and Terminations:</i> SB 26 X1 (2003) amended section of AB430 (2001) to make the previously added supplemental rate adjustment to Medi-Cal reimbursement (Wage Adjustment Rate Program - WARP) for some nursing facilities inoperative due to budget deficit for FY 2003-2004. Also statement of legislative intent to stop further rate adjustments to nursing facilities except for those approved prior to December 31, 2002. AB 1762 reinstated WARP to implement rate adjustments for February 1, 2002 to July 31, 2004. <i>Pass-through:</i> A wage pass-through was enacted in several settings by multiplying Medi-Cal resident days by the wage pass-through per diem amount. FY1999 – skilled nursing facilities (\$2.03); intermediate care facilities (\$1.13). FY2000 – skilled nursing facilities (\$4.82); intermediate care facilities (\$3.00); intermediate care facilities/developmental disabilities (\$4.97); intermediate care facilities/developmental disabilities-H (\$6.08); intermediate care facilities/developmental disabilities -N (\$7.72). <i>Turnover:</i> Collects turnover data for nursing facilities.
COLORADO	<i>Funding Reductions and Terminations:</i> Therapy services provided to adults by home health agencies were eliminated as a benefit. <i>Pass-through:</i> Rate increases recommended by 2000 50a Task Force ranged from 1% for skilled nursing visits, private duty RN/LPN, adult day care, and therapies to 12.5% for alternative care facilities. Rate increases for 2001 – 2002 ranged from 0% for therapies to 12.5% for alternative care facilities. For 2002 –2003, rate increases of 1% were passed for all service categories. <i>Medicaid Changes:</i> Enrollment in the CHIP program was frozen and eligibility for home- and community-based services was tightened.
CONNECTICUT	<i>Pass-through:</i> A 2% increase in home care settings was passed. <i>Medicaid Changes:</i> Co-pays for physician office visits for T19 recipients were initiated and provider limitations for podiatry and physical therapy were imposed.
DELAWARE	NO RESPONSE TO SURVEY
FLORIDA	<i>Delayed Initiatives:</i> The requirement to raise CNA staffing ratios from 2.6 hours to 2.9 hours of direct care per resident (to become effective January 1, 2004) was delayed until May 1, 2004. <i>Medicaid Changes:</i> Several changes to Florida's Medicaid program occurred including a CHIP enrollment cap, a reduction in eligibility from 90% to 88% of the Federal benefit rate, and a reduction in home health service fees. <i>Demonstrations:</i> The Governor's Office, the Department of Community Affairs, and the Department of Health announced a HealthCare Worker pilot initiative to provide affordable homeownership opportunities for nurses, CNAs and other health professionals. The Florida Board of Nursing developed new rules for the practice, discipline, education, and testing of CNAs. These rules provide standards for training programs, standardized curriculum, competency evaluation, and guidelines for disciplinary action. <i>Survey Use:</i> Information from prior surveys has been shared with legislative staff and others requesting information on workforce shortages. <i>Turnover:</i> Collects turnover data for nursing facilities.
GEORGIA	<i>Demonstrations:</i> A Nursing Home Transitions Grant for workforce development was initiated.
HAWAII	<i>Pass-through:</i> Hawaii's minimum wage increased to \$6.25.
IDAHO	No additional comments.

ILLINOIS	<i>Pass-through:</i> The hourly homemaker reimbursement rate for the Community Care Program increased from \$10.56 to \$11.06, effective January 2003. The hourly Adult Day Service reimbursement rate increased from \$5.52 to \$6.02, effective January 2003, and again to \$7.02 in July 2003. A portion of these rate increases is intended to boost workers' hourly wages.
INDIANA	NO RESPONSE TO SURVEY
IOWA	<i>Demonstrations:</i> New monitoring of adult day and assisted living facilities through Elder Affairs Department. <i>Tie Outcomes to Reimbursement:</i> Nursing facilities can qualify for additional Medicaid reimbursement if they achieve at least 3 points on 10 measures of accountability.
KANSAS	<i>Pass-through:</i> The two-year wage pass-through of \$4.1 million in 2000 and \$4.3 million in 2001 in nursing homes expired in June 2001. <i>Medicaid Changes:</i> The hourly rate for self-directed health care attendants in the Home and Community Based Services Frail Elderly and Physically Disabled waivers were reduced, but restored in FY 2004. <i>Tie Outcomes to Reimbursement:</i> Kansas is looking at various nursing home incentive programs to tie outcomes to reimbursement, including those in Iowa. <i>Turnover:</i> Collects turnover data for nursing facilities.
KENTUCKY	No additional comments.
LOUISIANA	<i>Pass-through:</i> Two pass-throughs were funded in Louisiana including an increase in rates to providers of Home and Community Based Services waivers from \$12 to \$14 per hour and a case mix reimbursement methodology for nursing facilities which includes a nurse wage and staffing enhancement add-on. <i>Demonstrations:</i> The state is working on a direct-care work force pilot project through the Real Choice System Change Grant.
MAINE	<i>Pass-through:</i> Hourly increases in rates for in-home CNAs and home health aides from \$16.44 to \$17.38, for in-home PCAs from \$14.20 to \$15.14, and adult care providers from \$7.20 to \$9.44.
MARYLAND	<i>Delayed Initiatives:</i> A planned wage increase for community-based workers serving the developmentally disabled was funded at 90% in FY 2003 but there are plans to make up the difference in future years. <i>Pass-through:</i> Two years of funding increases for direct-care workers in nursing homes totaled approximately \$60 million in FY 2002 and 2003. Additionally, \$16 million in wage increases for community-based workers who serve the developmentally disabled were passed in FY 2003. <i>Demonstrations:</i> The Developmental Disabilities Administration helped fund a recruitment and retention program for community providers. The Medicaid program helped facilitate a television campaign to recruit direct-care workers to nursing homes. <i>Turnover:</i> Collects turnover data for home care and residential habilitation facilities.
MASSACHUSETTS	No additional comments.
MICHIGAN	<i>Funding Reductions or Terminations:</i> The Michigan Choice Home and Community-Based waiver was reduced from 15,000 people in 2001 to 9,400 people in 2003 due to budget shortfalls. The \$7 million Long-Term Care Innovations Grants awarded in 2001 from Tobacco Settlement dollars were cut in April 2003 because of the state budget shortfall. <i>Delayed Initiatives:</i> A FY 2003 grant to bring the Eden Alternative to Michigan, aimed at recruitment and retention of direct-care workers, was reduced from \$349,000 to \$72,000. <i>Pass-through:</i> In FY 2000 Michigan offered a wage pass-through as part of a 5.4% inflationary allowance to nursing home providers for \$0.50 per hour. <i>Tie Outcomes to Reimbursement:</i> Michigan is considering tying low staffing turnover with increased reimbursement for long-term care facilities.
MINNESOTA	<i>Funding Reductions and Terminations:</i> A \$0.25 per day increase in nursing home rates to fund training was eliminated in the 2003 legislation. <i>Pass-through:</i> In 2001, two-thirds of a nursing home increase was directed at a wage pass-through. <i>Medicaid Changes:</i> MinnesotaCare, health insurance for Medicaid ineligible, reduced its eligibility standards and increased its premiums. <i>Tie Outcomes to Reimbursement:</i> A legislatively mandated and funded study is underway to redesign nursing home reimbursement. Models being considered include a formula that would provide incentive payment for quality improvement. Another study underway is looking at staffing standards for nursing homes. <i>Survey Use:</i> Prior surveys are shared with staff at the Department of Human Services. <i>Turnover:</i> Collects turnover data for nursing facilities.
MISSISSIPPI	No additional comments.
MISSOURI	<i>Delayed Initiatives:</i> A \$0.50 per hour reimbursement increase requested by the Division of Medical Services for in-home service provider agencies in FY 2003 was not approved by the legislature. <i>Pass-through:</i> The FY 2001 budget included an hourly rate increase of \$0.52 in home care settings for direct-care staff wages and/or benefits.
MONTANA	<i>Pass-through:</i> Wage pass-through incentives for direct-care workers included \$0.60 and \$0.59 per hour increases in 2001 and 2002 respectively. <i>Medicaid Changes:</i> Decrease in coverage for bathing and home keeping tasks.
NEBRASKA	NO RESPONSE TO SURVEY
NEVADA	<i>Pass-through:</i> New provider models were implemented in January 2001. A Personal Care Aide (PCA) Provider Agency was developed in which PCA providers are reimbursed at \$17 an hour and then pay PCA employees between \$8-11 per hour. A Personal Care Aide Intermediary Service Organization is reimbursed at \$16.50 per hour and then determines employee wages. Personal Care Aide Independent Contractors are reimbursed at \$14.50 an hour. <i>Medicaid Changes:</i> In July 2003 changes were made to the Personal Care Aide program. The maximum allowable number of PCA hours was reduced from 62.75 to 50.0 hours per week. Budgetary constraints and growth in caseload triggered this reduction. Recipients of PCA services also transitioned from Division of Aging (DAS) to the state plan population, allowing DAS recipients to receive additional services and doubling the number of PCA recipients.

NEW HAMPSHIRE	<i>Funding Reductions and Terminations:</i> Due to funding constraints, the legislature implemented a hiring freeze on many vacant direct-care positions. <i>Medicaid Changes:</i> All Medicaid programs have either been reduced or level funded. The home- and community-based care program for elderly and adult services program was level funded despite increased demand.
NEW JERSEY	<i>Funding Reductions and Terminations:</i> There have been reductions in Medicaid waiver programs (CAP, CCPED) and state programs (JACC, HCEP). <i>Pass-through:</i> Hourly wages for personal care assistants and homemaker services have increased.
NEW MEXICO	NO RESPONSE TO SURVEY
NEW YORK	<i>Pass-through:</i> Licensed home care services agencies, certified home health agencies, and nursing homes received a recruitment and retention pass-through for the direct-care workforce.
NORTH CAROLINA	<i>Medicaid Changes:</i> The maximum monthly number of hours for Medicaid in-home Personal Care Services were reduced from 80 to 60 hours in December 2002. The impact of this reduction on the direct-care workforce is unknown. <i>Demonstrations:</i> With funding from Real Choice grants, four consumer-directed care pilots were initiated. An Independence Plus waiver has also been approved by the Centers for Medicare and Medicaid Services related to the consumer directed care effort. <i>Tie Outcomes to Reimbursement:</i> The <i>Better Jobs Better Care</i> partner team is working to develop a voluntary, special licensure category for facilities (home care agencies, adult care homes and nursing facilities) that meet certain expectations and criteria related to the direct-care workforce. The project will likely address issues of workplace culture, effective care teams, staff empowerment, coaching supervision, peer mentoring, and career ladder opportunities. <i>Use of Surveys:</i> Survey information on state shortages, major initiatives, wage pass-through strategies, and others are shared with Long Term Care committees, commissions, and task forces. Survey findings are also used for conference presentations. North Carolina has used the findings to consult with other states that have implemented similar initiatives (direct-care associations, consumer directed care options, wage pass-throughs, curricula for new paraprofessional job categories, etc.). The information has also been incorporated into grant applications. <i>Turnover:</i> Collects turnover data for nursing facilities, adult care homes, and home care agencies.
NORTH DAKOTA	<i>Pass-through:</i> Nursing facilities received an hourly benefit enhancement of \$1.50 in July 2001. ICF/MRs and DD waiver service provider employees received a \$0.87 hourly wage increase plus a 3% increase in fringe benefits in July 2003.
OHIO	<i>Demonstrations:</i> Public education/recruitment campaign to improve the image of direct-care workers and increase recruitment into direct-care careers were initiated. Overall health care careers marketing materials for One-Stop Centers were developed. <i>Use of Surveys:</i> Survey findings have been used to substantiate the need for special state-sponsored initiatives to improve recruitment, training, recognition, retention, and working conditions of direct-care workers across settings, consumer populations, and Medicaid waiver programs.
OKLAHOMA	<i>Funding Reductions and Terminations:</i> Individual Advantage waiver plans were reassessed to reduce hours for in-home service if informal supports could replace the services. In the Developmental Disabilities Services Division, MR care plans were reviewed and overall services reduced, however, the unit cost remains unchanged. <i>Pass-through:</i> HB 2019 raised the minimum wage for direct-care staff in long-term care facilities to \$6.65 per hour. The minimum staffing levels per resident in long-term care facilities was also increased with a concurrent increase in the per diem rate. The Developmental Disabilities Services Division's Rates and Standards Committee passed a personal care rate increase with an expectation that the increase would be passed on to direct-care staff. <i>Survey Use:</i> Information from prior national surveys motivated the Department of Human Services to air television and radio advertisements on the need for direct-care workforce for elderly and disabled. In addition, a toll free telephone line was put in place providing information for those interested in direct-care careers.
OREGON	<i>Pass-through:</i> Ballot Measure 99 in 2000 created the Home Care Commission, offering home care workers collective bargaining rights. The first contract was ratified in 2003, guaranteeing a wage increase of \$0.40 an hour effective July 2003 and an additional increase of \$0.30 per hour in 2005. In addition, health insurance coverage and Workers Compensation will commence in 2004. Beginning July 2003, home care workers working 80 hours a month were entitled to 8 hours of paid leave. <i>Medicaid Changes:</i> By eliminating survival priority levels for long-term care services, long-term care caseloads were reduced. These levels determine eligibility for nursing facility services and home- and community-based services. In February 2002, legislative action eliminated service priority levels for lesser-impaired individuals. These actions were in response to budget shortfalls.
PENNSYLVANIA	<i>Medicaid Changes:</i> CHIP benefits were reduced, which affects direct-care workers who rely on the program for their children's health care. In addition a freeze in Adult Basic made it unavailable to new direct-care workers. <i>Demonstrations:</i> Direct-Care Worker initiative, <i>Better Jobs Better Care</i> grant and Intergovernmental Transfer Funded Demonstrations were initiated. <i>Survey Use:</i> Survey findings have been used to compare Pennsylvania with other states. Results have also been used to influence policy direction.
RHODE ISLAND	NO RESPONSE TO SURVEY
SOUTH CAROLINA	<i>Turnover:</i> Collects turnover data for nursing facilities and home care agencies.
SOUTH DAKOTA	NO RESPONSE TO SURVEY
TENNESSEE	No additional comments.

TEXAS	<p><i>Funding Reductions and Terminations:</i> 1.1% and 1.75% reductions were made to community-based programs and nursing facilities respectively for FY 2004 and 2005. Reductions were also made to the direct-care staffing and compensation enhancement program for nursing facilities and attendant compensation enhancement for community-based long-term care programs.</p> <p><i>Pass-through:</i> In FY 2002 and 2003, the Legislature appropriated approximately \$62.5 million over the biennium for wage increases for personal assistants in community-based long-term care programs, excluding programs for the mentally retarded. The Legislature also appropriated \$50 million to increase the quality of care in nursing facilities by increasing staffing of, and spending on direct-care staff (aides and nurses). Participating providers who fail to meet the spending requirements will be retroactively adjusted.</p> <p><i>Medicaid Changes:</i> The CHIP program is expected to reduce caseloads of approximately 125,000 children because of reduced eligibility.</p> <p><i>Turnover:</i> Collects turnover data for nursing facilities.</p>
UTAH	<p><i>Medicaid Changes:</i> The CHIP program implemented an open enrollment process to limit the number of new persons who could be served within the legislative appropriation for the year. The Aging waiver was amended to reduce number of hours for the covered Personal Assistance waiver service.</p>
VERMONT	<p><i>Pass-through:</i> Nursing homes received a pass-through for wage increases for all workers - \$6.8 million, \$8.7 million, and \$8.3 million in FY 2001, 2002, and 2003 respectively.</p> <p><i>Tie Outcomes to Reimbursement:</i> Vermont is still in the planning stages of <i>Better Jobs Better Care</i> initiatives.</p>
VIRGINIA	<p><i>Funding Reductions and Terminations:</i> The 2003 General Assembly reduced the increase in nursing home direct-care reimbursement for FY 2004 to 1% lower than it otherwise would have been.</p> <p><i>Pass-through:</i> In 2000, the General Assembly appropriated \$21.7 million for increased payments to nursing homes, with funds dedicated to nurse aide salaries. In July 2003, increases in reimbursement amounts for Personal Care services to provider agencies and hourly wages for personal attendants in the consumer-directed services became effective.</p> <p><i>Medicaid Changes:</i> Effective May 2003, the Medicaid program added consumer-directed services to the AIDS waiver.</p> <p><i>Demonstrations:</i> The Department of Medical Assistance Services contracted with the Virginia Geriatric Education Center to develop training materials for and provide training to personal care aides in the Home and Community Based waivers. The state is also collaborating with the Autism Program of Virginia to develop training materials for personal care aides working in Home and Community Based waiver settings with autistic patients.</p>
WASHINGTON	<p><i>Pass-through:</i> Wages were increased to individual providers and home care agency providers.</p> <p><i>Medicaid Changes:</i> Eligibility was reduced in the Medicaid Personal Care program.</p>
WEST VIRGINIA	<p><i>Demonstrations:</i> The Developmental Disabilities Council will be contracting with Human Services Research Institute to address issues of workforce capacity, recruitment and retention.</p>
WISCONSIN	<p><i>Funding Reductions and Terminations:</i> Indirect reductions in direct-care initiatives have occurred over several years. Rates for Home and Community Based Services for the developmentally disabled have been frozen for years.</p> <p><i>Delayed Initiatives:</i> A planned initiative to increase funding for wages and benefits via Home and Community Based Service waiver increase to be funded in part with federal intergovernmental transfer funds, was dropped from the 2004-2005 state budget.</p> <p><i>Demonstrations:</i> The Wisconsin Council on Developmental Disabilities, Bureau of Developmental Disabilities Services convened public hearings and workshops to solicit input from agencies, clients and families on direct-care workforce. A statewide survey of direct-care workers on job satisfaction was commissioned in 2002- findings available at wcdd.org/Retention_survey_report.pdf. The Center for Delivery Systems Development administered a direct-care worker retention survey to three major supportive home care providers with findings to be available in March 2004. The Bureau of Aging and Long Term Care Resources set aside a portion of the Community Options Program to fund a one-time Community Links project. The project focused on assisting and strengthening the direct-care workforce in settings through retention, training, recognition, coalition building, and a worker registry. Strategies are being developed to secure funding for health care worker job enhancements, similar to the Cooperative Care rural model.</p> <p><i>Tie Outcomes to Reimbursement:</i> The plan to tie reimbursement to consumers' quality of life outcomes, measured by the Wisconsin long-term care functional screen, has been curtailed due to funding constraints.</p> <p><i>Survey Use:</i> The national surveys have been a primary resource for grant writing and the information is regularly shared with case managers, means of generating ideas for Community Links projects.</p> <p><i>Turnover:</i> Collects turnover data for nursing facilities.</p>
WYOMING	<p><i>Pass-through:</i> A wage pass-through \$30 million for front line staff and supervisors providing services to the developmentally disabled became effective in July 2002. Funds could only benefit staff through wage and benefit increases. Statewide average wages were required to meet the \$10.23 mandate.</p> <p><i>Demonstrations:</i> Beginning in 2002, Wyoming has held the Annual Direct Support Professional of the Year awards banquet honoring eight or more direct service providers.</p> <p><i>Tie Outcomes to Reimbursement:</i> Plans to begin tying wages to courses offered through the Direct Support College are expected in early 2004.</p> <p><i>Survey Use:</i> The Developmental Disabilities Division, in joint participation with provider agencies across the state, created the "Want Your Job to Make a Difference" campaign which focuses on recruitment and retention of direct-support professionals.</p> <p><i>Turnover:</i> Collects turnover data for adults in developmental disabilities waiver program in residential care settings.</p>

TABLE 3. State Unemployment and Wage Rates for Direct Care Workers

STATE	Unemployment Rate				Median Hourly Wages, 2002			Average of Median Wages Across all 3 Categories				% Change 2001 - 2002
	Nov. 2001	Apr. 2002	Feb. 2003	Nov. 2003	Home Health Aides	Nursing Aides, Orderlies, Attendants	Personal Care & Home Care Aides	2002	2001	2000	1999	
ALABAMA	5.7%	6.0%	5.5%	5.8%	\$7.87	\$8.07	\$6.91	\$7.62	\$7.39	\$7.31	\$6.97	3.07%
ALASKA	5.7%	6.5%	7.0%	7.5%	\$12.06	\$13.57	\$10.71	\$12.11	\$11.42	\$11.50	\$10.81	6.10%
ARIZONA	5.6%	5.8%	5.7%	4.8%	\$8.58	\$9.60	\$8.18	\$8.79	\$8.73	\$8.45	\$8.01	0.61%
ARKANSAS	4.8%	5.2%	4.9%	6.0%	\$7.36	\$7.83	\$6.80	\$7.33	\$7.12	\$6.81	\$6.46	2.95%
CALIFORNIA	6.0%	6.4%	6.6%	6.4%	\$8.98	\$10.09	\$8.41	\$9.16	\$8.90	\$8.54	\$8.22	2.88%
COLORADO*	4.7%	5.6%	5.5%	5.6%	N/A	\$10.44	\$8.22	N/A	\$9.43	\$9.09	\$8.04	N/A
CONNECTICUT	3.2%	3.5%	5.0%	5.0%	\$11.40	\$12.62	\$9.68	\$11.23	\$11.07	\$11.08	\$10.33	1.48%
DELAWARE	3.0%	3.8%	3.7%	4.1%	\$9.49	\$10.86	\$6.99	\$9.11	\$8.95	\$8.41	\$8.43	1.86%
FLORIDA	5.0%	5.2%	5.2%	4.7%	\$8.40	\$9.24	\$8.39	\$8.68	\$8.52	\$8.26	\$7.95	1.88%
GEORGIA	4.4%	4.6%	4.5%	4.2%	\$8.06	\$8.22	\$7.48	\$7.92	\$7.90	\$7.67	\$7.16	0.30%
HAWAII	5.7%	4.6%	3.0%	4.1%	\$7.30	\$11.16	\$8.02	\$8.83	\$8.99	\$8.70	\$9.36	-1.85%
IDAHO	5.2%	5.6%	5.3%	5.1%	\$8.00	\$8.57	\$7.62	\$8.06	\$7.86	\$7.58	\$7.28	2.54%
ILLINOIS	5.8%	6.1%	6.5%	6.7%	\$8.44	\$9.34	\$7.11	\$8.30	\$8.12	\$7.80	\$7.83	2.13%
INDIANA	4.9%	4.9%	4.9%	5.0%	\$9.31	\$9.59	\$8.94	\$9.28	\$9.05	\$8.64	\$8.09	2.58%
IOWA	3.4%	3.4%	4.0%	4.2%	\$8.75	\$9.48	\$8.26	\$8.83	\$8.56	\$8.20	\$7.92	3.15%
KANSAS	4.1%	4.4%	4.6%	4.7%	\$8.75	\$9.09	\$8.23	\$8.69	\$8.42	\$8.12	\$7.78	3.25%
KENTUCKY	5.3%	5.3%	5.6%	5.5%	\$8.42	\$8.83	\$7.51	\$8.25	\$7.97	\$7.78	\$7.40	3.55%
LOUISIANA	6.3%	5.6%	5.7%	5.5%	\$7.47	\$6.82	\$6.44	\$6.91	\$6.75	\$6.80	\$6.41	2.42%
MAINE	4.2%	4.2%	4.6%	4.9%	\$8.74	\$9.57	\$8.34	\$8.88	\$8.69	\$8.44	\$7.70	2.26%
MARYLAND	4.3%	5.2%	4.2%	4.2%	\$8.58	\$11.08	\$8.72	\$9.46	\$9.14	\$8.65	\$8.29	3.54%
MASSACHUSETTS	4.3%	4.4%	5.3%	5.4%	\$10.58	\$11.57	\$9.82	\$10.66	\$10.39	\$9.89	\$9.10	2.60%
MICHIGAN	5.7%	6.0%	6.6%	7.0%	\$9.07	\$10.44	\$8.24	\$9.25	\$9.04	\$8.78	\$8.31	2.32%
MINNESOTA	3.8%	4.3%	4.3%	4.6%	\$9.65	\$11.05	\$9.59	\$10.10	\$9.92	\$9.55	\$8.99	1.75%
MISSISSIPPI	6.0%	6.6%	6.0%	5.0%	\$8.16	\$7.38	\$6.79	\$7.44	\$7.24	\$7.39	\$6.75	2.76%
MISSOURI	4.7%	5.2%	4.7%	5.0%	\$8.11	\$8.61	\$7.80	\$8.17	\$7.96	\$7.64	\$7.25	2.64%
MONTANA	4.5%	4.7%	4.0%	4.3%	\$8.30	\$8.42	\$7.71	\$8.14	\$7.82	\$7.46	\$7.23	4.09%
NEBRASKA	3.2%	3.6%	3.5%	3.6%	\$9.34	\$9.54	\$8.65	\$9.18	\$9.05	\$8.71	\$8.09	1.44%
NEVADA	6.5%	5.8%	5.0%	4.5%	\$8.70	\$10.95	\$8.59	\$9.41	\$9.22	\$8.82	\$8.46	2.10%
NEW HAMPSHIRE	3.9%	4.1%	3.8%	4.3%	\$10.38	\$10.86	\$8.52	\$9.92	\$9.74	\$9.52	\$8.63	1.85%
NEW JERSEY	4.7%	5.5%	5.7%	5.5%	\$9.55	\$10.81	\$9.64	\$10.00	\$9.82	\$9.56	\$9.06	1.87%
NEW MEXICO	5.9%	6.0%	5.8%	6.0%	\$8.59	\$8.74	\$7.52	\$8.28	\$7.96	\$7.73	\$7.16	4.11%
NEW YORK	5.4%	5.9%	6.1%	6.1%	\$8.71	\$12.38	\$8.14	\$9.74	\$9.50	\$9.25	\$8.91	2.56%
NORTH CAROLINA	6.1%	6.6%	5.8%	6.2%	\$8.23	\$8.91	\$7.94	\$8.36	\$8.20	\$7.86	\$7.53	1.95%
NORTH DAKOTA	2.4%	3.1%	3.6%	3.2%	\$8.03	\$8.68	\$8.19	\$8.30	\$8.06	\$7.81	\$7.47	2.94%
OHIO	4.7%	5.7%	6.0%	5.7%	\$8.77	\$9.75	\$8.30	\$8.94	\$8.76	\$8.43	\$7.97	2.02%
OKLAHOMA	4.0%	4.0%	5.1%	5.3%	\$7.86	\$7.95	\$7.13	\$7.65	\$7.43	\$7.17	\$7.29	2.92%
OREGON	7.4%	7.9%	7.3%	7.3%	\$8.92	\$10.30	\$8.97	\$9.40	\$9.22	\$8.85	\$8.17	1.88%
PENNSYLVANIA	5.0%	5.6%	6.2%	5.2%	\$9.14	\$10.15	\$8.21	\$9.17	\$8.87	\$8.63	\$8.21	3.38%
RHODE ISLAND	4.4%	4.2%	5.1%	4.9%	\$10.84	\$10.70	\$10.78	\$10.77	\$10.56	\$9.93	\$10.20	2.05%
SOUTH CAROLINA	5.5%	6.0%	6.2%	6.9%	\$8.24	\$8.39	\$8.17	\$8.27	\$8.13	\$7.89	\$7.47	1.64%
SOUTH DAKOTA	2.9%	3.2%	3.3%	3.3%	\$8.33	\$8.72	\$8.03	\$8.36	\$8.18	\$8.06	\$7.57	2.16%
TENNESSEE	4.6%	5.6%	4.7%	5.7%	\$8.41	\$8.79	\$7.96	\$8.39	\$8.09	\$7.98	\$7.51	3.71%
TEXAS	5.4%	5.8%	6.6%	6.3%	\$7.07	\$7.93	\$6.33	\$7.11	\$6.88	\$6.69	\$7.52	3.34%
UTAH	4.4%	5.9%	5.3%	4.9%	\$9.08	\$8.91	\$7.96	\$8.65	\$8.38	\$8.25	\$7.91	3.18%
VERMONT	3.7%	3.9%	4.0%	4.0%	\$8.92	\$9.92	\$8.42	\$9.09	\$8.60	\$8.41	\$7.66	5.62%
VIRGINIA	4.0%	4.2%	4.1%	3.6%	\$8.33	\$9.04	\$7.06	\$8.14	\$7.89	\$7.59	\$7.10	3.17%
WASHINGTON	7.0%	6.8%	6.8%	6.8%	\$8.72	\$10.49	\$8.56	\$9.26	\$9.06	\$8.71	\$8.14	2.17%
WEST VIRGINIA	4.6%	5.9%	5.9%	5.6%	\$7.10	\$7.80	\$6.67	\$7.19	\$6.87	\$6.66	\$6.47	4.61%
WISCONSIN	4.7%	5.70%	5.30%	5.00%	\$9.14	\$10.11	\$8.81	\$9.35	\$9.12	\$8.75	\$8.16	2.56%
WYOMING*	3.8%	3.9%	4.1%	4.0%	\$7.88	\$8.90	\$7.67	\$8.15	N/A	\$7.54	\$7.68	N/A
UNITED STATES	5.6%	5.7%	5.8%	5.9%	\$8.70	\$9.59	\$7.81	\$8.70	\$8.50	\$8.21	\$7.97	2.39%

Source: Median hourly wages in 2002 and 2001 for each of the three major categories of direct care workers included in this chart obtained from the US Bureau of Labor Statistics - Occupational Employment and Wage Estimates. Unemployment data (national and state) also from the Bureau of Labor Statistics.

Notes: The average of the median hourly wages for the 3 categories is calculated as was the average of median hourly wages shown for 2000 and 1999.

* No average hourly rate is calculated due to BLS having no median wage data indicated for at least one job category (i.e. no median hourly wage indicated for Personal Care Workers for Wyoming in 2001; and no median wage data for Home Health Aides in Colorado for 2002).

APPENDIX A: Kansas Nursing Facility Turnover Rates

KANSAS DEPARTMENT ON AGING

Nursing Home Turnover Data as of December 31, 2001

Total All Classifications	
Beginning # Employees	28,750
Employees Hired	23,035
Employees Terminated	22,176
Ending # Employees	29,609
Full Time Employees	20,555
Part Time Employees	9,054

Specific Classifications	Beginning			Ending No	Full Time	Part Time	Turnover
	No.	Hired	Terminated				
Administrators	349	120	125	344	325	19	36%
Co-Administrators	36	6	15	27	24	3	48%
Other Administrative	1,182	458	420	1,220	915	305	35%
Plant Operating	708	344	347	705	531	174	49%
Dietary	4,450	3,821	3,830	4,441	2,574	1,867	86%
Laundry	1,064	571	597	1,038	661	377	57%
Housekeeping	2,132	1,750	1,728	2,154	1,530	624	81%
Registered Nurse	2,384	1,264	1,249	2,399	1,654	745	52%
Licensed Practical Nurse	2,595	1,708	1,656	2,647	1,970	677	63%
Licensed Mental Health Tech	128	147	108	167	126	41	73%
Nurse, Med, Restor Aide	10,779	11,578	10,919	11,438	8,191	3,247	98%
Physical Therapist	166	107	83	190	105	85	47%
Speech Therapist	67	30	35	62	11	51	54%
Occupational Therapist	100	62	44	118	37	81	40%
Respiratory Therapist	21	8	13	16	12	4	70%
Psych Therapist	0	0	0	0	0	0	0%
Recreation Therapist	13	3	7	9	5	4	64%
Resident Activity	792	395	407	780	553	227	52%
Social Worker	438	152	142	448	357	91	32%
Medical Records	395	112	113	394	327	67	29%
Other Healthcare Salaries	951	399	338	1,012	647	365	34%
Total Classifications	28,750	23,035	22,176	29,609	20,555	9,054	76%

Patsy Samson
 KDOA, Program & Policy Commission
 NF/CARE Division

APPENDIX A: North Carolina Turnover Data Questionnaire

Staff Turnover Rate Information

Please complete the following information regarding aide (e.g., nurse aides, personal care aides and/or home management aides) turnover rates. This information is being requested to enable the Division of Facility Services and the Department of Health and Human Services (DHHS) to track turnover rates of aide workers in nursing homes, adult care homes and home care agencies. The information you provide by answering the questions below will be compiled and aggregated with other responses by type (i.e., nursing homes, adult care homes, home care agencies). By collecting and analyzing this data on an annual basis, the Department will be able to assess the size and stability of this workforce across long-term care settings as well as by specific care settings over time. **This information will not be filed as a part of the renewal application.**

Please complete the following questions:

For the period October 1, 2002 thru September 30, 2003 . . .

	Full-time	Part-time
1) How many aides at your facility/agency QUIT their job?	_____	_____
2) How many aides at your facility/agency were FIRED Or Terminated?	_____	_____
3) How many NEW aides were HIRED?	_____	_____
4) How many aide positions are budgeted?	_____	_____
5) How many aides did you have on your payroll as of September 30, 2003?	_____	_____
6) Do you feel that you have an <u>Aide Turnover</u> problem at your facility/agency?	Yes _____	No _____

If yes, check "Yes" to the item below that best reflects the extent of the aide turnover problem in your facility/agency?

We have a substantial turnover problem	Yes _____
We have a mild turnover problem	Yes _____

Circle one response for each question

	<i>Almost Impossible</i>	<u>Very Difficult</u>	<i>Slightly Difficult</i>	Not Difficult
7) How difficult has it been for your facility to find enough aides to fill vacant positions	1	2	3	4
8) How difficult has it been for your facility to retain aides?	1	2	3	4

Licensed as: _____ ACH _____ Nursing Home _____ Combination facility _____ Home care agency

Licensed bed capacity _____ (for facilities only)

Results of Turnover Data Collected in Prior Years

Turnover Rates	2000	2001	2002
Nursing Facilities	103%	102%	95%
Adult Care Homes	119%	113%	115%
Home Care Agencies	53%	50%	39%

[For questions please call Susan Harmuth (919) 733-4534]

APPENDIX A: North Carolina Turnover Calculation Methodology

Calculating Separation Rates for Facilities

This process uses data from the Staff Turnover Rate Information form (DFS-4029).

The following relevant data are available from the form:

- Full-time quits and Part-time quits (Question 1)
- Full-time fires and Part-time fires (Question 2)
- Full-time hires and Part-time hires (Question 3)
- Full-time fully staffed and Part-time fully staffed (Question 4)

Total Separation Rate

The formula for calculating total separation rate looks like this:

Total Separation = [(Full-time quits + Part-time quits + Full-time fires + Part-time fires) / (Full-time fully staffed + Part-time fully staffed)] x 100

- A. First, calculate the total number of NAs who have left their jobs for one reason or another. You will add all of the items from questions 1 and 2 to do this.
- B. Next, calculate the number of NAs you need to be fully staffed, by adding the numbers from question 4.
- C. Finally, divide the number you came up with in part A by the number from part B, and multiply the resulting number times 100.

APPENDIX A: Texas Turnover Calculation Methodology

Employee Turnover

Notes: Complete employee turnover information only for staff employed as DONs, RNs, LVNs, and Nurse Aides. Do not include any other positions. DONs should be categorized as RNs or LVNs, depending upon their licensure status. Medication Aides and Restorative Aides are not to be included in the employee turnover information.

Use whole numbers only (no decimal places).

The value reported for a specific staff type for "Staff Employed During The Cost-Reporting Period" should always be greater than or equal to the value reported for that staff type for "Normal Staffing At The End Of The Cost-Reporting Period."

The value reported for a specific staff type for "Normal Staffing At The End Of The Cost-Reporting Period" should always be less than or equal to the value reported for that staff type for "Staff Employed During The Cost-Reporting Period."

Items 425 - 428 (Staff Employed During the Cost-Reporting Period)

For each staff type indicated, count the number of Internal Revenue Service Forms W-2 your facility was required to file for the latest taxable calendar year.

Include only positions that were funded **throughout** the facility's cost-reporting year. If a position was eliminated or added during the cost-reporting period, do not include the employee filling that position.

Items 429 - 432 (Normal Staffing at the End of the Cost-Reporting Period)

For each staff type indicated, report the number of persons employed by your facility at the end of your cost-reporting period.

Include only positions that were funded throughout the facility's cost-reporting period. If a position was eliminated or added during the cost-reporting period, do not include that position.

Report in terms of the number of staff employed, not in terms of full-time equivalent positions (FTEs). For example, a part-time employee would be counted the same as a full-time employee (i.e., as "one"). If your staffing was below normal at the end of your cost-reporting period due to vacant positions, include job vacancies in your count. For staff whose salaries and wages were allocated to more than one facility, count that employee as one person for each facility. *For example*, if, at the end of your reporting period, your facility employed four part-time LVNs (each working 20 hours a week), two full-time LVNs (each working 40 hours a week), a full-time LVN shared with another facility in the same chain, and was advertising to fill a vacant full-time LVN position, you would report 8 on item 430 (LVNs).

APPENDIX A: TEXAS TURNOVER DATA QUESTIONNAIRE

2001 Cost Report Texas Nursing Facility	Employee Turnover & Square Footage	9 Digit NF Contract #

EMPLOYEE TURNOVER

Report Staffing only for the positions listed below. Do not include any other facility staff.

Staff Employed During the Cost-Reporting Period

425.	RNs	425.
426.	LVNs	426.
427	Nurse Aides	427.
428.	TOTAL Staff (sum 425 through 427)	428.

Normal Staffing at the End of the Cost-Reporting Period

429.	RNs	429.
430.	LVNs	430.
431.	Nurse Aides	431.
432.	TOTAL Staff (sum 429 through 431)	432.

NURSING FACILITY SQUARE FOOTAGE

440.	Square Footage of NF Resident Living Areas	440.
441.	Square Footage of Resident Common Areas	441.
442.	Square Footage of NF Non-Resident Areas	442.
443.	Total Nursing Facility Square Footage (sum 440 through 442)	443.

ALABAMA

No Changes Made in 2003

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

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> Follows federal staffing rules 		

ALASKA

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> • None - other than general Advocacy • Plan to move toward tying reimbursement to certification 	Benefits <ul style="list-style-type: none"> • Foreaker Group is working with a number of social service agencies to establish an insurance pool 	(Includes career ladders) <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Work group established, 1999

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
Regulation [07 AAC 012.275] <ul style="list-style-type: none"> • RN 7days/wk day shift; 5 days/wk night shift; LPN on unstaffed RN shifts 	<ul style="list-style-type: none"> • 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 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Rates increased 5.5% for nursing facilities and 11.6% for in-home caregivers (primarily paraprofessionals) and alternative residential settings. Providers required to pass through proportional amounts to direct-care workers for wages &/or benefits. <p>There are no current wage/benefit pass-through requirements (2003)</p>	<p>Benefits</p>	<p>(Includes career ladders)</p>	<ul style="list-style-type: none"> 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. 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 in 2003.
4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE	
<ul style="list-style-type: none"> Follows federal staffing regulations 		<ul style="list-style-type: none"> Community Based Services and Settings Report issued in 2000, updates 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.asp#Community%20Based%20Report <p>The community based report was updated may 2002. A copy can be viewed at the same link as noted above.</p> <ul style="list-style-type: none"> Network Development and Management Plan – 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. <p>This requirement continues. AHCCS finds this to be an effective approach to ensure the managed care organizations continuously address network needs.</p>	

ARKANSAS

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	Benefits	(Includes career ladders) <ul style="list-style-type: none"> 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 challenge scholarship program 	<ul style="list-style-type: none"> Governor's Integrated Services Taskforce (GIST) seeks to identify methods to better attract, screen, and retain workers in health care, 2001

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<i>Act 1397, 2001</i> <ul style="list-style-type: none"> Minimum staffing ratios for direct-care staff - three tiers. 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 ratio of nurse to resident; 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 ratio of nurse to resident 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Supplemental rate adjustment for covered employees' increases in salaries, wages, or benefits for period 2-1-02 through 7-31-04. <p>Wage pass-through 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.</p>	<p>Benefits</p>	<p>(Includes career ladders)</p> <p>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.</p>	<p>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.</p>

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>Welfare and Institutions Code 14110.7</p> <ul style="list-style-type: none"> 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 <p>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.</p>		<ul style="list-style-type: none"> AB 1731, (Stat of 2000) amended existing law (H&S 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 <i>Better Jobs Better Care Applied Research and Evaluation Grant</i>. To view a project description see: www.bjbc.org/page.asp?pgID=79

COLORADO

No Changes Made in 2003

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> Dollar amount WPT in home care settings (not mandatory) 	Benefits	(Includes career ladders)	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 2 hrs per/patient per day 		<ul style="list-style-type: none"> Quality of Care Incentive Payments to assess retention and expertise in facilities

CONNECTICUT

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> Increase in reimbursement rate 	Benefits	(Includes career ladders)	<ul style="list-style-type: none"> LTC Planning Committee has identified workforce issue, and is working on solutions 2001 Olmstead Planning Committee has initiatives and recommendations on workforce issues, 2001

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
CT Public Health Code Sec. 19-13-D8t <ul style="list-style-type: none"> Chronic/convalescent home: <ul style="list-style-type: none"> Licensed Personnel - .47hr/pt (day shift); .17 hr/pt (night shift) Licensed & Unlicensed Personnel – 1.4hrs/pt (day shift); .5hrs/pt (night shift) Rest home: <ul style="list-style-type: none"> Licensed Personnel .23hr/pt (day shift); .08hr/pt (night shift) Licensed & Unlicensed Personnel - .7hr/pt (day shift); .17hr/pt (night shift) 	<ul style="list-style-type: none"> Nursing home transition grant 	Connecticut College, New London, CT, received a <i>Better Jobs Better Care Applied Research and Evaluation grant: Making Consumer-Directed Homecare a Good Job.</i> To view a project description see: www.bjbc.org/page.asp?pgID=79

DELAWARE

No Response to 2003 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	Benefits	(Includes career ladders) <ul style="list-style-type: none"> SB20, 1999 - New "Senior CNAs" job level, role model & resource (increased from 75 to 150 hrs advanced training & competency test) 	<ul style="list-style-type: none"> Established work group, 1999 Delaware Nursing Home Residents Quality Assurance Commission released a report, <i>Efficacy of the Minimum Nursing Staffing Levels under Eagle's Law: Quality of Care, Labor Trends, and Nursing Home Cost and Availability</i> 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" <ul style="list-style-type: none"> 3 phases of minimum nursing direct-care staffing hours and ratios of direct-care staff by shift and position (RN, LPN, CNA) <ul style="list-style-type: none"> Phase 1 - 3hrs/ day (3/01) Phase 2 - 3.28hrs/day (1/02) Phase 3 - 3.68 hr/day (proposed 5/03) 		

FLORIDA

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	Benefits	(Includes career ladders) <ul style="list-style-type: none"> • Florida Nursing Edloan program 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. 	<ul style="list-style-type: none"> • 1999 Task Force of Department of Elder Affairs researched and reported recruitment, training employment, and retention of CNAs in nursing homes 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.usf.edu

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
Senate Bill 1202 (2001 Fla. Legislature) <ul style="list-style-type: none"> • 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 by January 1, 2003 and to 2.9 by January 1, 2004. No facility below 1 CNA per 20 residents • Licensed Nurses 1 hour direct care per resident per day with never less than 1 per 40 residents 		<ul style="list-style-type: none"> • 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, Malcolm Wiener Center for Social Policy.

GEORGIA

No Changes Made in 2003

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> 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 	<p>Benefits</p>	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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, <i>Code Blue: Workforce in Crisis</i>, issued in May, 2001 www3.state.ga.us/departments/dch/v4/to p/shared/con_dhp/dhp_publications/healthcare_workforce_final.pdf

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>GA DHR Rules, Ch. 290-5-8-0.04</p> <ul style="list-style-type: none"> 2hr/pt day Medicaid Level I, II facilities 2.5hr/pt day 	<ul style="list-style-type: none"> Nursing Home Transition Grant to conduct workforce development pilot project in 18 counties to identify barriers and opportunities to increase direct-care workers and community services Communities for Independent Living demonstration project. 	<ul style="list-style-type: none"> Data collection regarding vacancy rates and average turnover time through GA Division of Health Planning Annual Survey

HAWAII

No Changes Made in 2003

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	Benefits <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> SNF – 1 RN 24/7 ICF – 1 RN day shift; licensed nurse for medication administration 		

IDAHO

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> • \$13.40/hr. for Medicaid payments • All employees must be employed by an agency • Nursing facilities have their own wage scales and benefit packages. 	Benefits <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • SNF: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ 1.8hr/pt day (DON, super, charge) 		<ul style="list-style-type: none"> • Uniform reimbursement rates across funding streams for similar home and community-based services

ILLINOIS

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs) Homemaker reimbursement rate increased from \$10.56 to \$11.06 per hour effective 1/1/03.</p> <p>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.</p> <p>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% of the Homemaker rate must be spent on direct service worker related costs, such as wages, insurance, retirement, workers compensation, etc.</p>	<p>Benefits</p> <p>Benefits paid to direct-care workers are at the discretion of each contracted provider agency.</p>	<p>(Includes career ladders)</p> <p>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.</p> <p>Minimum training requirements also exist for homemaker supervisors and ADS workers.</p>	<p>None known that are currently active.</p>

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE												
<p>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:</p> <table border="0"> <tr> <td>Staff</td> <td>Clients</td> </tr> <tr> <td>2</td> <td>1 to 12</td> </tr> <tr> <td>3</td> <td>13 to 20</td> </tr> <tr> <td>4</td> <td>21 to 28</td> </tr> <tr> <td>5</td> <td>29 to 35</td> </tr> <tr> <td>6</td> <td>36 to 45</td> </tr> </table> <p>77IL Administrative Code, CH1, Sec. 300.1230</p> <ul style="list-style-type: none"> • SNF: 2/5 hr/day (20% licensed nurse time) • IC: 1.7 hr./day (20% licensed nurse time) 	Staff	Clients	2	1 to 12	3	13 to 20	4	21 to 28	5	29 to 35	6	36 to 45	<p>N/A</p>	<p>N/A</p>
Staff	Clients													
2	1 to 12													
3	13 to 20													
4	21 to 28													
5	29 to 35													
6	36 to 45													

INDIANA

No response to 2002 or 2003 survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	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 <ul style="list-style-type: none"> Licensed nurse care - 0.5hr/pt day 		

IOWA

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> 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 	<p>Benefits</p>	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> CareGivers Association and community colleges are partnering to provide a certified CNA Mentor Training program for advancement of CNAs 	<ul style="list-style-type: none"> 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

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>IAC 58.11(2)</p> <ul style="list-style-type: none"> 2 hr/day (20% qualified nurse) 		<ul style="list-style-type: none"> Quality of life pilot for direct-care workforce Mandated data collection efforts on nurse aide recruitment and retention Iowa CareGivers Association was the first statewide professional association for direct-care workers in the nation. Goal is to partner with providers, educators, policy makers, advocates, labor, and others to develop a network of support, recognition, education and advocacy. Activities include a series of direct-care forums, the CNA Recruitment and Retention Program, leadership training, research, information and referral. Quality Assurance incentive package - facilities can receive incentive payments for various quality assurance measures including staff retention, resident satisfaction, Alzheimer's unit, etc. Survey of Long-Term care nurses to determine concerns and needs of CNAs Iowa CareGivers Association awarded a <i>Better Jobs Better Care</i> demonstration grant. For description of project and stakeholder groups see: www.bjbc.org/Page.asp?sectionID=3

KANSAS

No Changes Made in 2003

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> • Dollar amount WPT for wages, benefits or new hires (nursing homes only) • WPT extended to 07/01 for direct-care and support workers • Quality Enhancement WPT funded during SFY00, 01, but ended July 1, 2001 	Benefits	(Includes career ladders)	<ul style="list-style-type: none"> • Established Long Term Care legislative task force to address worker shortage over next five years, 2001

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
KS Admin Regulations 28-39-154 <ul style="list-style-type: none"> • 2hr/pt day • 1:30 nursing personnel to residents 		<ul style="list-style-type: none"> • Analysis of turnover data for direct-care staff related to wage pass-through efforts for participating facilities is being considered

KENTUCKY

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> • State facilities pay \$9.00 p/hr. Other facilities pay \$5.15 p/hr. upon aides hire with \$1.00 raise after passing nurse aide state competency test. 	<p>Benefits</p> <ul style="list-style-type: none"> • Facilities pay for courses to become certified medication aide 	<p>(Includes career ladders)</p>	<ul style="list-style-type: none"> • 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 in-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
<ul style="list-style-type: none"> • No minimum staffing standard 	<ul style="list-style-type: none"> • Real Choice Grant to develop and implement 7 curricula to train community-based direct service, supervisory, and administrative staff to be available via state's Virtual University System. 	

LOUISIANA

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> SB 71 - Investment earnings from Medicaid Trust Fund for Elderly to be used for wage enhancement for direct-care workers in certified nursing homes Case mix reimbursement methodology for nursing facilities effective 1/1/03 provides for nursing wage and staff enhancement add-on 	<p>Benefits</p>	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> Nursing Home and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's) providers are being trained on reporting Abuse, Neglect, Misappropriation and Injuries of Unknown Origin, and 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. 	
4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE	
<p>LA Licensure Standards, Sec. 9811</p> <ul style="list-style-type: none"> 1.5hr/pt day Medicaid NH ratios: <p>Intermediate Care</p> <ul style="list-style-type: none"> 2.35 hrs p/day <p>Skilled Care</p> <ul style="list-style-type: none"> 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 & CNA). 	<ul style="list-style-type: none"> A workforce development initiative was undertaken and is being implemented for Louisiana as part of the Real Choice System 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. 	<ul style="list-style-type: none"> 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 was 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 has been implemented. 	

MAINE

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> • Chapter 358PL01 • 3% WPT (nursing facilities only) FY02 • 2.5% hike in wages/benefits (2002 WPT) for home care workers • \$0.50 per hour increase in reimbursement rates for home care workers FY00 	Benefits	(Includes career ladders) <ul style="list-style-type: none"> • 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 	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
10-144 CMR 110, Ch. 9 <ul style="list-style-type: none"> • 1:8 (Day shift) • 1:12 (Eve shift) • 1:20 (Night shift) PL Ch. 731 <ul style="list-style-type: none"> • 1:5 day shift • 1:10 eve shift • 1:15 per rule making 	<ul style="list-style-type: none"> • 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 “Personal Assistance Worker Guild” to provide benefits, support, continuing education and advocacy for members. 	

MARYLAND

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> 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 increase is planned for 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) 	<p>Benefits</p> <ul style="list-style-type: none"> For both wage enhancements, the goals are improved retention, improved ability to recruit new workers, and ultimately improved quality of care. 	<p>(Includes career ladders)</p>	<ul style="list-style-type: none"> 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

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>Code of MD Regulations 10.07.02</p> <ul style="list-style-type: none"> Comprehensive Care Facilities: <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Real Choice Systems Change Grant includes \$60k over 3 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 	<ul style="list-style-type: none"> 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.dhmf.state.md.us/csrrc

MASSACHUSETTS

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> \$0.19 wage increase over mandated average wage of \$9.42/hr. for home care workers (SFY 02) \$35m WPT for CNAs in nursing facilities (SFY 01) SFY 02 includes \$40m for WPT for aides 	<p>Benefits</p>	<ul style="list-style-type: none"> \$5 million for Extended Care Career Ladder Initiative (ECCLI) strategy to improve quality of care <ul style="list-style-type: none"> Pilot career ladder model providing skill upgrade training and promoting to higher job levels \$1m for CNA training scholarship funding (FY01) SFY 2002 includes: <ul style="list-style-type: none"> \$100k for supervisory training for nursing home administrators and managers \$1m entry level training scholarships for direct-care workers (including ESL & Adult Basic Education) \$5m for career ladder efforts for nursing homes 	<ul style="list-style-type: none"> 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
<p>105 CMR 150.007</p> <ul style="list-style-type: none"> <i>Level I Care</i> – 2.6hr/pt day (0.6hr by licensed personnel) <i>Level II Care</i> – 2hr/pt day (0.6hr by licensed personnel) <i>Level III Care</i> – 1.4hr/pt day (0.4hr by licensed personnel) <ul style="list-style-type: none"> <i>Level IV Care</i> – 1-20beds (1:10 day shift); 20+beds (1 responsible person 24/7) 		<ul style="list-style-type: none"> Boston University School of Public Health received a <i>Better Jobs Better Care Applied Research and Evaluation grant: <i>Organizational Cultural Competence Assessment: An Intervention and Evaluation.</i></i> 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 <i>Better Jobs Better Care Applied Research and Evaluation grant: <i>Improving Institutional Long-Term Care Residents and Workers: The Effect of Leadership, Relationships, and Work Design.</i></i> To view the project description see: www.bjbc.org/page.asp?pgID=79

MICHIGAN

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Had wage pass-through for numerous years and tracked turnover data. The state average wage for a certified nursing assistant is \$9.80. 	<p>Benefits</p>	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> Additional training and testing for nurse aides Contracted with Community Services Network of Michigan located in northern lower, west Michigan to improve the recruitment and retention of direct-care workers by offering training in three key areas designated by direct-care workers. The training is being provided in dementia, advanced dementia and stress and time management. 	<ul style="list-style-type: none"> In FY 2003, using the Eden Alternative methods and experience, BEAM, Inc. (Bringing the Eden Alternative™ to Michigan) implemented the Health Care Worker Recruitment and Retention Project with a grant from the Michigan Office of Services to the Aging (OSA). BEAM contracted with Michigan State University (MSU) to assess recruitment, training and retention methods of certified nursing assistants. The Michigan Direct Care Workforce Initiative Coalition, comprised of advocates, consumers, direct-care workers, providers and government representatives, convened to review the issues and will be presented with MSU's findings in October 2003. A conference detailing the findings is being planned for 2004.
4. STAFFING RATIOS	5. CMS LTC SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE	
<p>MI Dept of Public Health Rules Sec. 333.27120a</p> <ul style="list-style-type: none"> 2.25hr/pt day 1:8 Morning shift 1:12 Afternoon shift 1:15 Night shift 	<ul style="list-style-type: none"> 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. The plans for that work are being revised at this time. 	<ul style="list-style-type: none"> The AARP Michigan Long Term Care Stakeholder Group, which is comprised of advocates, direct-care workers, providers and government representatives, has convened to develop policy recommendations for short-and long-term change. Three work groups including the Long Term Care Workforce, Single-Point of Entry and Home and Community-Based Services meet to research the related issues and are in the process of making initial recommendations for public policy change. The Department of Community Health has formed a Home Care Authority Development Work Group to develop plans for piloting a public authority model for community-based care services. The purpose is to strengthen personal care services by improving access to and support for qualified workers. Operation ABLE of Michigan – Southfield, MI has received a <i>Better Jobs Better Care</i> 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 	

MINNESOTA

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Percentage WPT (80% of rate increase earmarked for wages/benefits; all LTC facilities) 3% increase in reimbursement rate to all LTC facilities (FY 01); 2/3 of nursing home increase must be used as WPT for employees <p>Rates cut for 04-05</p>	<p>Benefits</p> <ul style="list-style-type: none"> 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 long-term care employee health insurance Loan forgiveness and repayment programs to aid in recruiting employees to long-term care <p>No action on top two—third still in effect</p>	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> State approval for feeding assistants in nursing facilities \$.25 p/day increase in nursing home rates to fund beginner and advance CNA training (FY 01) Collaborating with community college system to provide web-based training for CNAs (and tailored to learner needs – immigrants, older workers, etc) 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 <ul style="list-style-type: none"> To view the FY 2001-2003 Strategic Plan of the HEIP view the following web site: www.heip.org 	<ul style="list-style-type: none"> State level Long-Term Care Task Force established 2000 to propose curriculum changes, distance learning and increase provider rates. Final report, <i>Reshaping Long-Term Care in Minnesota</i>, 2001 available at www.dhs.state.mn.us/agingint/lcttaskforce/MS-1781.pdf <p>LTC task force was discontinued in March 2003 by new DHS commissioner. Replaced with plans to hold legislative briefings, use website to communicate with LTC stakeholders</p>

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>MN Statutes Annotated Sec. 144A.04; MN Rules Sec. 4658.0510</p> <ul style="list-style-type: none"> Greater of 2hrs/pt day <i>or</i> 0.95hr/standardized resident day <p>MN Dept. Of Human Services charged by Legislature in 2001 to develop case mix reimbursement system for nursing facility services with report due by January 15, 2004. Staffing standards study being done with plans to make recommendations regarding staffing in 2005 session. Staffing Standards Study will affect minimum staffing requirements.</p>	<ul style="list-style-type: none"> Community Pass Grant to develop a consumer-initiated partnership and support network (CIPS) to enable consumers to assess each other's natural supports (i.e. family, neighbors) to provide personal care services and establish back-up systems. <p>This is ongoing</p>	<ul style="list-style-type: none"> Hardship waiver to allow family members to do personal care under certain circumstances Many providers experimenting with universal worker concept to enhance satisfaction in long-term care (some funded through Bush Foundation projects) Will be implementing consumer directed care services waiver as a choice within all community waivers in the next year—this is expected to bring in many nontraditional workers to LTC, e.g., family members, neighbors, PCAS.

MISSISSIPPI

No Changes Made in 2003

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	Benefits	(Includes career ladders) <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 2.8 hrs/pt day FY00 		

MISSOURI

No Changes Made in 2003

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> Dollar amount WPT (home care only) \$.52 reimbursement increase to be used for home care direct staff wages and benefits (FY 01) 	Benefits	(Includes career ladders) <ul style="list-style-type: none"> Expanded scope of CNA duties to include ostomy care and pulse-oximetry probe placement 	<ul style="list-style-type: none"> Established Workgroup/Task Force, 1999

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> Follows federal standard 		<ul style="list-style-type: none"> 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

No Changes Made in 2003

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> Percentage WPT (all LTC facilities) Wage increases of \$0.50 p/hr (FY 00); \$0.68 p/hr (FY 01); \$0.92 p/hr (FY 02); estimated \$0.36 p/hr (FY 03) for Medicaid funded personal care 	Benefits	(Includes career ladders) <ul style="list-style-type: none"> Welfare to work initiatives; recruitment and retention Advanced training for CNAs at vocational technical institutions (1 semester training and 1 semester practicum) leading to LPN (starting Fall 01) Specialty training for home care attendants 	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Different requirements depending on shift and # of beds E.g. Day Shift <ul style="list-style-type: none"> RN 8 hrs (4-70 beds) LPN 8 hrs (41-75 beds) Aide 4 hrs (9-15 beds); 8 hrs (16-20 beds) and increase in 4 hour increments for each additional 4 beds For full summary of requirements, go to www.nccnhr.org/govpolicy/51_162_468.CFM 	<ul style="list-style-type: none"> Community Integrated Personal Assistance developing awareness campaign of direct-care issues, refining training issues 	<ul style="list-style-type: none"> Compare FY2001 wage plan with FY2000 wage plan Audits by CPA firms to verify that wage pass-throughs were handled appropriately House Bill 2 - directing department to complete comparative study of direct-care jobs in the community.

NEBRASKA

Incomplete data. No response from 2002 or 2003 survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	Benefits	(Includes career ladders)	<ul style="list-style-type: none"> Established Workgroup/Task Force

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> Follows federal standard 		

NEW HAMPSHIRE

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> Increased reimbursement rate (Medicaid) - Legislation failed and the initiative has not been readopted. 	Benefits	(Includes career ladders) <ul style="list-style-type: none"> HIB grants for nursing career development Nursing Bridge Program: public private collaboration to promote nursing as a progression and grants for education 	<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Unknown 	<ul style="list-style-type: none"> Community Pass Grant to better support consumer directed personal care workforce to increase retention; develop and implement back-up personal care coverage models 	<ul style="list-style-type: none"> Culture Change Training program Licensed Nursing Assistant Recognition Day

NEW JERSEY

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> 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) 	<p>Benefits</p> <ul style="list-style-type: none"> 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) 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Report issued by the Forum Institute for Public Policy, <i>The Nursing Workforce Shortage: Impacts on Health and Medical Care in New Jersey</i> www.forumsinstitute.org/publs/index.html

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>NJAC 8:39-25.1 through 25.4</p> <ul style="list-style-type: none"> 2.5 hrs/day (extra time for complex patients) 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 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

No Response From 2003 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> 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 towards a "livable wage." 	<p>Benefits</p>	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> New Mexico has recently taken steps to standardize the way in which Nurse Aides can become 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. 	<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> New Mexico is currently in the middle of a Quality Cabinet subcommittee process to make recommendations on staffing 		<ul style="list-style-type: none"> 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

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS	2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS	
<p>Wages (includes wage pass-throughs)</p>	<p>Benefits</p> <ul style="list-style-type: none"> • Sec 107, Ch. 1 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. 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> • 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 2005. • Hospitals receiving more than \$1m in funding from the Community Health Care Conversion Demonstration Program are required to spend at least 25% on workforce retraining projects; those facilities receiving less than \$1m must spend at least 10% on retraining. This requirement resulted in \$60m allocated towards training in the first year. 	

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> • Follows federal standard 		<ul style="list-style-type: none"> • Uniform reimbursement rates across funding streams for similar home- and community-based services • Cornell University, Cornell Gerontology Research Institute, Ithaca, NY received a <i>Better Jobs Better Care Applied Research and Evaluation grant: The Retention Specialist Program: Testing a Model Workplace Innovation.</i> To view a project description see: www/bjbc.org/page.asp?pgID=79

NEVADA

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	Benefits	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> Expanded scope of CNA duties to include pulse-oximetry probe placement 	<ul style="list-style-type: none"> Established Workgroup/Task Force to address shortage issues, 2001

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> No specific staffing ratios: Medicare/Medicaid certified nursing facilities must comply with federal staffing requirements. Free-standing nursing facilities must spend 94% of the median on direct-care staff (CNA, LPN, and RN) or recoupment will be made annually during cost reporting. 	<ul style="list-style-type: none"> Community PASS Grant to demonstrate and determine the efficacy of training and hiring adults with developmental disabilities as personal assistants through supported employment model. 	

NORTH CAROLINA

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p>	<p>Benefits</p> <ul style="list-style-type: none"> 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 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> Program established to provide incentives to improve aide job skills, job satisfaction and performance; and improve recruitment and retention of nurse aides in nursing homes. Program is continuing for nurse aides in nursing homes using civil penalty fine money and known as the Win-A-Step-Up program which is administered as a joint effort of the NC Department 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 successfully complete clinical skills competency evaluation and pass written exam within 90 days of requirement. Six hours of continuing education in medication administration required annually. NC Board of Nursing and the Department of Health and Human Service co-sponsoring a work group to develop a medication aide job category. Coaching supervision train-the-trainer sessions conducted through a cooperative arrangement with the Paraprofessional Healthcare Institute to develop a cadre of trained trainers to offer this training in NC through the community college system, area health education centers and other venues. 	<ul style="list-style-type: none"> January 2001, the NC Institute of Medicine's Long Term Care Task Force published recommendations to reform NC's long-term care system; included recommendations on paraprofessional and professional workforce Report available at www.nciom.org/lctfinal.pdf

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>NC Administrative Code, Title 10, 03H.2303</p> <ul style="list-style-type: none"> 2.1 hrs/pt day <p>H736 (2001)</p> <ul style="list-style-type: none"> All licensed adult care homes/nursing homes must publicly post number of direct-care staff and supervisors on shift 	<ul style="list-style-type: none"> \$1.6million Real Choice grant currently underway. Grant will focus on paraprofessional workforce initiatives. Major components include: career ladder efforts, policy 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. 	<ul style="list-style-type: none"> Annual collection and analysis of basic turnover data on direct-care workers in nursing homes, adult care homes and home care agencies, using standard set of questions – initiated in 2001. Increased Medicaid reimbursement rates for Personal Care services provided in adult care homes; considered increased medication administration competency (2000). Direct Care Workers Association of North Carolina established in 2003 (DCWA-NC) 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 <i>Better Jobs Better Care</i> 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 <i>Better Jobs Better Care</i> Applied Research and Evaluation grant – for project description see: www.bjbc.org/page.asp?pgID=79

NORTH DAKOTA

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> \$1.50 per hour wage &/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 	<p>Benefits</p> <ul style="list-style-type: none"> \$1.50 per hour wage &/or benefits increase for all nursing facility employees for both Medicaid and private-pay resident categories (2001). HB 1196 3% increase in allowed fringe benefit percentage for ICR/MR and DD waiver service employees effective July 1, 2003 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> Working with the Department of Labor and the Department of Commerce on career ladder initiatives 	<ul style="list-style-type: none"> North Dakota Health Practitioner Workforce Coalition, 2001

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> Follows federal standard 		<ul style="list-style-type: none"> HB 1196 Passed a nursing loan repayment and scholarship program

OHIO

Additions Made to 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	Benefits	(Includes career ladders) <ul style="list-style-type: none"> Identifying key core skill competencies for direct-care workers across systems of care, work settings and consumer populations (e.g., nursing homes, MR/DD, home health, physically disabled, etc.) to develop standardized requirements and institute state credential for workers. 	<ul style="list-style-type: none"> Health Care Workforce Shortage Task Force (HB94) Ohio Health Care Workforce Advisory Council (advises Governor's WIA Policy Board)

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
ORC 3701-17-08 <u>Revised rule effective 10/20/01</u> <ul style="list-style-type: none"> 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:15 residents all shifts RN on call whenever no RN on duty. 	<ul style="list-style-type: none"> Ticket to Work Initiative 	<ul style="list-style-type: none"> Implementing public education/recruitment campaign to improve public image of direct-care workers and recruit workers into direct-care careers across work settings and consumer populations. Developing materials on health care careers (including direct-care workers) for One-Stop Centers throughout state including training requirements, training centers, etc. Developing a "best practices" web page. Planning a "best practices" in health care recruitment, training, retention and recognition conference late spring, 2004. The Margaret Blenkner Research Institute, Benjamin Rose, Cleveland, OH, received a <i>Better Jobs Better Care</i> Applied Research and Evaluation Grant: <i>The Impact of Job Preparation, Ongoing Education and Training on Job Satisfaction and Commitment Among Front-Line Workers and Their Supervisors</i>. To view a project description see: www.bjbc.org/page.asp?pgID=79

OKLAHOMA

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> • Authorizes wage/benefit adjustment for LTC facility direct-care staff • \$6.65 minimum wage for specified positions (HB 2019 FY2000) • DHS rate increase for personal care in-home services. 	Benefits	(Includes career ladders) <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • N/A

5. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> • LTC facilities staffing ratio from HB 2019 are: Day shift 1:7; Eve shift 1:10 and Night shift 1:17 • Effective 9/1/03, HB 2218, if funding is available: Day shift 1:6; Eve shift 1:8; and 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 2 staff at all times. 	<ul style="list-style-type: none"> • DHS receive a systems change grant for home and community-based services. Stakeholder and planning meetings have been going on for almost a year. 	<ul style="list-style-type: none"> • Pilot program to enhance quality of life for direct-care workforce and reduce turnover.

OREGON

Changes Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Increased reimbursement rate for in home care providers 	<p>Benefits</p> <ul style="list-style-type: none"> Health Insurance (April 2004) Worker's Compensation (April 2004) Paid leave (July 2003) 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> Delegation of medication administration duties by licensed nursing personnel to unlicensed workers in all care settings 	<ul style="list-style-type: none"> 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
<p>OR Administrative Rules 411-86-100</p> <ul style="list-style-type: none"> Day Shift 1:10 Eve Shift 1:15 Night Shift 1:25 	<ul style="list-style-type: none"> Real Choice Grant to develop statewide recruitment efforts for personal care assistants 	<ul style="list-style-type: none"> Health Care Sector Employment Initiative (OR Workforce Investment Board) targets CNAs and RNs Oregon Technical Assistance Corporation, Salem, OR received a <i>Better Jobs Better Care</i> demonstration grant. For description of project see: www.bjbc.org/Page.asp?sectionID=3

PENNSYLVANIA

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <p>Direct-Care Worker Initiative Plans:</p> <ul style="list-style-type: none"> • Use of sign-on and longevity bonuses, shift differentials 	<p>Benefits</p> <ul style="list-style-type: none"> • Educate consumers and providers about health plan eligibility for low income workers • Development of resource guide for direct-care workers • Geographic bonuses to cover travel expenses or reward workers willing to serve in hard-to-serve areas • Training bonuses • AAA Direct Care Worker Initiative Plan provides childcare, transportation, profit sharing, uniform allocation and other benefits 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> • The Area Agency on Aging Direct Care Worker Initiative Plan provides funding for: <ul style="list-style-type: none"> ○ Specialized training including supervisory skills, one day seminars, best practices, etc.; ○ Life Skills including communication, conflict resolution, attire, etc.; ○ Mentoring assistance; ○ Basic skills at vocational schools, community colleges, through CareerLink, and provide tuition assistance • Critical Job Training Grants in FY 02-03, coordinated with funding from multiple departments, for projects addressing in-demand occupations. Over 60% of funding went to direct care and other health care initiatives – and used for career ladders, entry level training, CNA training, continuing education and specialized skill building. 	<ul style="list-style-type: none"> • 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 towards raises • Two reports from Pennsylvania’s Intra-Governmental Council on Long Term Care’s reflect the direct-care worker shortage were issued in February 2001 <i>Frontline Workers in Long Term Care</i> www.pgc.org/PRI/projects/PA_LTC_workforce/PA_LTC_workforce_report.pdf and <i>In Their Own Words: Pennsylvania’s Frontline Workers in Long Term Care</i> www.aging.state.pa.us/aging/LIB/aging/20/363/report_care.pdf

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>PA Administrative Code, Title 28, Ch. 211</p> <ul style="list-style-type: none"> • 2.7 hrs/day – skilled patients • 2.3hrs/day – intermediate care patients • For full summary of requirements, go to www.nccnhr.org/govpolicy/51_162_468.CFM 		<ul style="list-style-type: none"> • Conducted follow-up focus groups with direct-care workers: www.directcareclearinghouse.org/download/InTheirOwnWords.indd.pdf • Requested and received \$1.5m for demonstration projects targeting direct-care workers. • AAA Direct Care Worker Initiative Plans funds numerous projects related to bonuses, training, benefits, and marketing for direct-care industry. • Marketing campaign includes focusing value on direct-care workers, Recognition Day with monetary bonuses, public awareness of home care and caregiving, technical assistance with CareerLink networks. • Center for Advocacy for the Rights and Interests of the Elderly, Philadelphia, PA received a <i>Better Jobs Better Care demonstration</i> grant. Grant will enable broad coalition of groups in PA to design and test comprehensive core-training package for direct-care workers across the continuum. Funding will also test effectiveness of innovative workplace practices such as peer mentoring, worker participation in decision-making, etc. For more detailed description see: www.bjbc.org/Page.asp?sectionID=3 • Direct Care Worker Initiatives funding through Dept. of Public Welfare’s Office of Social Programs and Office Mental Retardation and Department of Aging continues. Funding began in FY 01-02. Funds available to local and county-based agencies and Area Agencies on Aging to demonstrated a variety of workforce initiatives. • Inter-Governmental Council on Long-Term Care administering a new set of Inter-Governmental Transfer Grants (IGT) to be used to support a direct care worker association, and new demonstrations which pick-up on lessons learned in Direct-Care initiatives. • PA Council on Independent Living (PCIL) awarded the Personal Assistance Services (PAS) Priority Backup Study to examine best practices and procedures for the establishment of a priority, back-up system for personal assistance services as they relate to employment of people with disabilities. This study is a critical piece to PA’s Ticket to Work Medicaid Infrastructure Grant.

RHODE ISLAND

No Response from 2003 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Dollar amount WPT (home care only) Increased funds for direct pass-through for direct-care workers passed in state FY02 budget Bonuses tied to increased performance by providers and staff Shift differential HB6100 Sub. A, Sec. 13 - 4.8% rate adjustment for nursing homes applied to labor cost center and used for direct-care compensation or staff increases 	<p>Benefits</p> <ul style="list-style-type: none"> 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) 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> AOA Alzheimer's Demonstration project, Partners in Care, includes advanced training for certified nursing assistants with financial incentive. 	<ul style="list-style-type: none"> 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, <i>Long Term Care Plan for Rhode Island, 1995-2000</i> (www.ltgov.state.ri.us/longtermcare/lccmain.htm) The Governor's Advisory Council on Health's Nursing and Allied Health Subcommittee published a report on nurse aides, 2001
4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE	
	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Additional hourly reimbursements in 7 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%, and shift differential 	

SOUTH CAROLINA

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> 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. 	<p>Benefits</p>	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> Recruitment of Welfare to Work recipients 	<ul style="list-style-type: none"> 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 <i>Nurses and Nurses Aides Workforce in South Carolina Nursing Homes and Hospitals</i> issued Dec 2001. <i>Nursing Home Quality Study, Focus Group Results</i>, conducted with SC Nursing Facility Quality Improvement Committee and USC School of Public Health issued October 2001. Unlicensed Assistive Personnel Task Force, 2000

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>SC Dept of Health & Environmental Control Regulation 61-17</p> <ul style="list-style-type: none"> Shift 1 – 9:1 Shift 2 – 13:1 Shift 3 – 22:1 		<ul style="list-style-type: none"> 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. Bring South Carolina’s CNA registry in house.

SOUTH DAKOTA

No response from 2003 Survey

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

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> Follows federal standard 		

TENNESSEE

No Changes Received on Chart from 2003 Survey

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs)	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 <ul style="list-style-type: none"> 2hrs/day (0.4hrs licensed nursing) 		

TEXAS

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Rate Enhancement Program - The Community Care Attendant Compensation (CCAC) Rate Enhancement, implemented September 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 not met, provider must repay DHS the unused enhanced funding. Consumer Directed Service (CDS) allows consumers of certain Medicaid Waivers and Community Care attendant programs to manage their own care, including rate of pay and benefits. Consumers must provide details within their allocated service budget. 	<p>Benefits</p> <ul style="list-style-type: none"> The CCAC attendant compensation includes employee benefits/insurance, workers' compensation and mileage reimbursement for business use of personal vehicles. The CDS service allows consumers to decide on a number of benefits including bonuses for longevity or performance, insurance, retirement, etc. 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> The CCAC encourages community care providers to increase attendant compensation through additional career ladder implementation. The CDS Service allows consumers to train their own attendants and create career ladders. 	<ul style="list-style-type: none"> Task Force chaired by the Texas Health & Human Services Commission, includes state agencies, providers, and consumers, and has guided the CDS initiative, 2000.

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>TX Administrative Code, Title 25, Part I, Ch. 145; TX Dept of Human Services, Sec. 19.1001,2</p> <ul style="list-style-type: none"> In Nursing Home: 1 licensed staff: 20 residents OR 0.4hrs licensed care/pt day Nursing facilities 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 both a direct-care staffing requirement for nursing facilities choosing to participate in program and a spending requirement for every Medicaid nursing facility. Beginning September 1, 2003 the spending requirement applies only to facilities choosing to participate 	<ul style="list-style-type: none"> The Texas Planning Council for Developmental Disabilities and the Department of Human Services have begun evaluating systems change grants. Implementation to begin 5/1/02. Strategies may include: <ul style="list-style-type: none"> recruitment efforts targeting traditionally underemployed workers (i.e., older workers, participants in full time volunteer programs, people with disabilities, non-English speaking individuals, welfare-to-work participants) development of college courses offering field work credit for supervised personal assistance experiences 	<ul style="list-style-type: none"> 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.

<p>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 the awarded level of participation is not met, facility must repay the enhanced funds associated with the unmet level(s) to DHS.</p> <p>Spending requirement places minimum spending level for direct-care rate component of facility's total rate component by TILE. If facility does not meet the minimum spending level, must repay difference to DHS. As of September 1, 2003, the spending requirement is limited to enhancement funds paid to participants.</p>	<ul style="list-style-type: none"> o 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 to recruit and train new attendants o formation of partnerships with public and/or private workforce agencies or home health organizations to train and place personal assistants o utilization of marketing strategies for recruitment efforts in a local or regional area. 	
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UTAH

Additions Made in 2003 Appear in Bold

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

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> Unknown 	<ul style="list-style-type: none"> Real Choice grant to examine Systems Change 	<ul style="list-style-type: none"> Independent Living Initiatives

VERMONT

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Amended State Statute 1956 - Portion of provider tax on nursing homes and home health agencies earmarked for workforce wage increases 	<p>Benefits</p> <ul style="list-style-type: none"> 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 	<p>(Includes career ladders)</p>	<ul style="list-style-type: none"> Established Task Force/Workgroup to address paraprofessional workforce shortage, 2001 Study report issued, 2001

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> Follows federal standard 	<ul style="list-style-type: none"> Real Choice Grant to develop a paraprofessional association and implement other workforce related recommendations 	<ul style="list-style-type: none"> Community of Vermont Elders Montpelier, VT received a <i>Better Jobs Better Care</i> demonstration grant. For a 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

No Changes Made to Chart in 2003

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
Wages (includes wage pass-throughs) <ul style="list-style-type: none"> Dollar amount WPT (all LTC facilities) WPT to be rolled into reimbursement rates 	Benefits	(Includes career ladders) <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Established Workgroup/Task Force, 2000

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<ul style="list-style-type: none"> Follows federal standard 		<ul style="list-style-type: none"> 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

No Changes Made to Chart in 2003

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> 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 (\$6.90 as of 1/1/02). 	<p>Benefits</p> <ul style="list-style-type: none"> Some of increase in base rates was used to increase benefits and bonuses. 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Revised Code of Washington 74.39A230 established the Home Care Quality Authority Board to regulate and improve the quality of long-term in-home care services by recruiting, training, and stabilizing the workforce of individual providers, 2001. 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. 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
<p>Washington Administrative Code title 388-97-115</p> <ul style="list-style-type: none"> Nursing homes must ensure a sufficient number of qualified nursing personal are available on a 24 hour basis, 7 days per week to provide nursing and related services Nursing home must have: <ul style="list-style-type: none"> RN on duty directly supervising resident care a minimum of 16 hours per day, 7 days per week RN or LPN on duty directly supervising resident care the remaining hours, 7 days per week. 	<ul style="list-style-type: none"> 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 2002. 	<ul style="list-style-type: none"> 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 5 states.

WEST VIRGINIA

No Changes Made to 2003 Chart

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

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
64 CSR 13 <ul style="list-style-type: none"> • 2hrs/pt day (0.4hrs licensed nurse time) • For full summary of requirements, go to www.nccnhr.org/govpolicy/51_162_468.CFM 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Nursing home wage pass-through rate increase to be used for wages, benefits, or to increase staff hours SFY 99-00 Personal care worker wages increased in 2001 from \$12 to \$15 funding with intent for increase to benefit workers (not a wage pass-through) 	<p>Benefits</p> <ul style="list-style-type: none"> Health insurance for low-income families available through Badger-Care program 	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> Formal guidelines and parameters for testing and training unlicensed 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 	<ul style="list-style-type: none"> 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.
4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE	
<p>WI Statutes, Ch. 50.04</p> <ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> Systems Change Grant – LTC Workforce Planner position: <ul style="list-style-type: none"> provides policy direction and program planning relating to recruitment, retention of viable workforce in LTC. Disseminate viable models, develop new methods of addressing problems, and propose policy or legislation to implement. Identify training approaches supporting workers. 	<ul style="list-style-type: none"> Long Term Care Workforce Alliance to enhance role and status of long-term care workers and raise awareness within community and with policy makers 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, 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 mentoring program. 	

WYOMING

Additions Made in 2003 Appear in Bold

1. WAGE/BENEFIT ENHANCEMENTS		2. TRAINING AND OTHER INITIATIVES	3. TASK FORCES & COMMISSIONS
<p>Wages (includes wage pass-throughs)</p> <ul style="list-style-type: none"> Dollar amount voluntary WPT for all front line workers (nursing homes only) WPT funds of \$30 million appropriated effective July 1, 2002 will increase average wages of direct-care staff for adult waiver program and developmentally disabled children preschool programs 	<p>Benefits</p>	<p>(Includes career ladders)</p> <ul style="list-style-type: none"> Direct Support College contract signed and scheduled to be available in early 2004 	<ul style="list-style-type: none"> Report to the Joint Appropriations Committee, <i>Study of Nonprofessional Direct Care Staff Recruitment, Retention, and Wages</i> issued December 2001 ddd.state.wy.us

4. STAFFING RATIOS	5. SYSTEMS CHANGE GRANT WORKFORCE INITIATIVES	6. OTHER INITIATIVES NOT COVERED ABOVE
<p>WY Regulations</p> <ul style="list-style-type: none"> SNF Care - 2.25hrs/pt day ICF Care – 1.5hrs/pt day 		<ul style="list-style-type: none"> 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 which 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 are also collected on wages, benefits, retention, etc.