

# State Investment in Culture Change Toolkit

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The Institute for the Future of Aging Services (IFAS) is a policy research institute whose mission is to create a bridge between the practice, policy and research communities to advance the development of high-quality health, housing and supportive services for America's aging population. IFAS is the applied research arm of the American Association of Homes & Services for the Aging (AAHSA). AAHSA members help millions of individuals every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. AAHSA's commitment is to create the future of aging services through quality people can trust.

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# Introduction

Over the past decade, there has been increasing interest among providers, consumer advocates, policymakers and researchers in how to design and implement culture change elements to transform traditional institutional long-term care settings. Although much of the culture change philosophy had already been articulated in the Omnibus Budget Reconciliation Act of 1987 (OBRA), it took a group of progressive providers, consumers and others concerned about the lack of attention to the resident and “home” to create the “Pioneer Movement” that began to raise this issue as a policy and practice priority. The early pioneers developed approaches to systematically change the culture and practice of their facilities. Their efforts led to a network in the 1990s that addressed the needs and issues of older adults and advanced the culture change movement.

The Commonwealth Fund provided a grant to the Institute for the Future of Aging Services (IFAS), housed at the American Association of Homes and Services for the Aging (AAHSA), to examine and document the extent to which and in what ways states have engaged in promoting, encouraging and supporting culture change activities in nursing homes. The project focused on seven states that have been proactive in supporting culture change through a variety of policy and practice initiatives. The premise for the project is that the state government can help promote and support culture change efforts because they are major players in financing and regulating long-term care.

The goal of this toolkit is to help other states initiate or expand upon their culture change activities. The toolkit includes information about the importance of the state’s role in culture change and the factors that helped states support these types of initiatives. Additionally, it includes information and resources (documents, links to Web sites, etc.) on a variety of initiatives from each state that were part of the case study, as well as a few additional resources outside the case study states.

# How to Use the Toolkit

The State Investment in Culture Change project assessed how seven case study states—Georgia, Kansas, Massachusetts, Michigan, North Carolina, Oregon and Vermont—made financial and human resource investments to support culture change initiatives in nursing homes. The case study states developed programs and activities that can help guide other states interested in making similar investments. The research team has presented the findings from the case study at several conferences and meetings to share the lessons learned from these exemplar states. The presentations included representatives from the state government and educational institutions, providers and others involved in the different initiatives to share the experiences and how the state governments have invested and supported the activities. The goal is to provide other states with this information, so they can learn from these experiences, and to create a network among state governments and other key organizations. The profiled initiatives include a description to enhance awareness of the range of approaches and specific interventions that have been developed through state investments. Additionally, the initiatives include resources and contact information to help states initiate or expand on their culture change activities.

Each state initiative is outlined in a profile that provides:

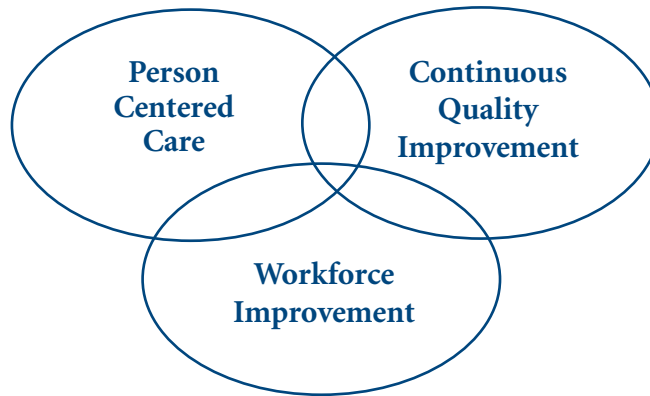
- ♦ A short description
- ♦ Resources, including Web sites and documents that provide more details about the program or activity
- ♦ Contact person

The toolkit also includes a list of contact people from each state. We encourage shared learning and the creation of a network across states. The list of key stakeholders are those who are part of the initiatives and are willing to share information about their programs and what they have learned through the process.

The *Appendix* provides additional tools and resources that were not included as part of the project but can be useful in the development of culture change programs.

# What Is Culture Change?

Over the years, the definition of culture change and the activities subsumed under its banner have evolved. There is consensus that culture change requires substantial organizational transformation, and nursing homes cannot achieve it through any one intervention. The analytic framework for culture change is that it has three strategic objectives: person-centered care, workforce improvement and continuous quality improvement.



- ♦ **Person-centered care**, initiated by the Pioneer Movement, focuses on reclaiming the concept of “home” and ensuring that all care and supports are person-centered.
- ♦ **Workforce improvement** initiatives address improving the recruitment and retention of a quality, stable nursing home staff at all levels to improve the quality of care and life for residents.
- ♦ **Continuous quality improvement** emphasizes the organization and systems, focuses on the process rather than the individual and promotes the use of objective data to analyze and improve practice.

This definition incorporates similar attributes identified by a group of experts and stakeholders and described in *Measuring Culture Change: Literature Review report* (Colorado Foundation for Medical Care, 2006).<sup>1</sup> The panel identified the following elements of culture change expected to be found in a nursing home that is “100 percent culture changed”:

- ♦ Residents direct care and all resident-related activities.
- ♦ The living environment is designed to be a home rather than an institution.
- ♦ There are close relationships between residents, family members, staff and the community.
- ♦ Work is organized to support and empower all staff to respond to residents’ needs and desires.
- ♦ Management enables collaborative and decentralized decision making.
- ♦ Systematic processes for continuous quality improvement are comprehensive and measurement based.

<sup>1</sup> Colorado Foundation for Medical Care (Quality Improvement Organization for state of Colorado) (2006). *Measuring Culture Change: Literature Review*. Final report submitted to the Centers for Medicare and Medicaid Services, Baltimore, MD.

# State Investment in Culture Change— How to Get Started

## Important Role of State Government in Culture Change

The culture change movement has been led by providers, worker associations, consumer advocates and researchers. The state government has not played a significant role in many states. Given the fact that states are major players in financing and regulating long-term care, including their responsibility for ensuring the delivery of quality services in nursing homes and for the development of the workforce in the health sector, it is in their best interest to help promote and support culture change efforts. They are the primary funders (through the Medicaid program and their own funds); they regulate nursing homes, home health agencies and assisted living; they set the standards for nurse and nursing assistant training; and they administer the ombudsman programs. They also control the Workforce Investment Act funds, passed down from the U.S. Department of Labor, which many community colleges and providers use to train direct care workers in long-term care. Consequently, they have a major, ongoing role to play in ensuring the quality of care and life that people receive in nursing homes and other settings. This includes their current and potential role in encouraging and supporting culture change and person-centered care delivery.

States have the potential and the responsibility to make important administrative, regulatory and legislative changes that will increase opportunities for culture change. This includes using their buying power to create incentives for providers (e.g., including culture change and workforce improvement elements in pay-for-performance reimbursement schemes). *The Results of the 2007 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce report* identified eight states that tie reimbursement rate enhancements to outcomes (PHI and the Direct Care Workers Association of North Carolina).<sup>2</sup> The increased payment rates are to workers in nursing homes or home health agencies. Some of these initiatives were legislated, while others were the result of departmental authority. On a less ambitious scale, state governments can provide grants to providers, worker associations and educational institutions interested in advancing culture change. Many already have invested in studies and commissions to examine problems and solutions and to raise public awareness of these issues.

## Features of Successful Implementation

A number of issues emerged across the states. The seven case study states have common features in the successful implementation of culture change activities. These help facilitate the long-term sustainability of the initiatives.

### Degree of Inter- and Intra-Departmental Coordination/Integration

The case study states varied in their level of integration across the different culture change programs and initiatives—workforce improvement, person-centered care and continuous quality improvement. In states with several compartmentalized and independent activities, it is not clear if and how the efforts work together. The different initiatives can diffuse the energy and focus among the agencies involved and the nursing homes.

Several states, however, have made efforts to examine the different activities and integrate the different objectives and goals to have a more unified approach. In addition, some states have used external grants to pull together diverse activities focused on the same type of issues. Better Job Better Care, for example, was a mechanism for North Carolina, Oregon and Vermont to coordinate various workforce initiatives. The competitive programs required that each state have a coalition of the key stakeholders to work together to initiate practice and policy changes as they related to direct care workers.

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<sup>2</sup>Paraprofessional Healthcare Institute and the Direct Care Workers Association of North Carolina (October 2007). *Results of the 2007 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce.*

Kansas demonstrated the most integrated approach to statewide culture change activity. This integration is due, in large part, to the executive branch's unique organizational structure. It is the only state the research team studied to

co-locate the regulatory, programmatic and financial functions related to aging services within the same department—the Kansas Department on Aging (KDOA). KDOA administers the Older Americans Act, the Medicaid program (including reimbursement) for nursing homes and home and community-based services and the regulatory oversight of all long-term care settings.

This move provided the opportunity for these two powerful influencers on nursing homes to collaborate in efforts to remove barriers and reward culture change. The secretary on aging has the ability to use the state Medicaid payments to nursing homes and the regulatory process to promote culture change. Although the intention of the move at the time was not to facilitate culture change, the creation of a unified agency played a key role in helping to create a broad culture change strategy in the state.

### **The Involvement of State and Local Workforce Development Funds**

Two key resources to address long-term care workforce improvement issues are the Department of Labor (or equivalent state-level agencies responsible for workforce development) and local Workforce Investment Boards (WIBs). Workforce development agencies have both federal and state resources dedicated to identifying new workers to meet state and regional demands and developing training programs, career ladders and career lattices for new and incumbent workers. They are also the conduits of substantial funds to the local WIBs to support implementation of workforce development programs. Many are increasingly targeting the health sector, and a few have focused specifically on the long-term care field.

The WIBs connect workforce training and development to local and regional engines of economic growth. WIBs have the potential to support efforts to improve the long-term care workforce and may even be a catalyst for efforts to customize recruitment and improve entry-level training. They also can support efforts to redesign jobs and revamp training and credentialing systems for direct care work.

### **Rethinking Regulatory Approaches**

One of the key impediments to culture change in nursing homes (often perceived, sometimes real) is the state regulatory process and the surveyors themselves. There is a perception that the field surveyors in particular do not value and understand culture change. In the research team interviews, some state agency staff and providers noted that while the director and upper management of the regulatory agency may be committed to culture change, the front-line surveyors and sometimes the middle managers have not been adequately educated about culture change and are not open to this type of transformation.

The relationship between state survey agencies and nursing homes has historically been contentious and, at times, adversarial. According to Walshe (2001)<sup>3</sup> the current American approach to enforcing nursing home regulation is often characterized by deterrence. In this approach, some nursing homes are seen as out to get away with what they can and, therefore, the regulatory agency needs to have formal, written regulations and significant sanctions to minimize practices that may harm residents and jeopardize quality. A number of stakeholders, particularly providers but also some government representatives, expressed concerns about strained relationships between nursing home operators and regulatory bodies and the potential for stifling innovation.

The research team found that some providers are hesitant to initiate change because of fear they will be penalized for making modifications, particularly in the physical design and staffing areas. On the other hand, many providers and state staff felt that regulations were not barriers, but that providers were just using this as an excuse to avoid change. Several of the case study states are reviewing their regulations to determine if they conflict with culture change and how they can be more supportive of these efforts.

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<sup>3</sup>Kieran Walshe, "Regulating U.S. Nursing Homes: Are We Learning from Experience," *Health Affairs*, November/December 2001; 20(6): 128-144

In response to these tensions, several states that we studied have begun to see their role differently and have added a new dimension to their regulatory approach. They have found ways to be both an enforcer of regulations and a provider of technical assistance to homes on how to implement culture change within the regulatory framework.

This assistance and education to nursing homes has focused on how to provide more person-centered care and how to develop a more empowered workforce. While not without its detractors, this complementary approach seems to be growing in momentum in the states that are exemplars in culture change.

### **Importance of Relationship Building across Stakeholders**

Changing the culture in a nursing home involves not only the physical transformation of the home, such as creating neighborhoods or installing home-style dining, but also the transformation of relationships at all levels. This study found that state efforts to encourage culture change also involve changing relationships—between the state staff in different agencies, between state officials and providers, and between provider associations and consumer advocates. Many of the state respondents reported that expanding their relationships with multiple stakeholders has been integral to successful culture change efforts.

Building a different kind of relationship with providers and others played an important role in how successful the state was in encouraging nursing homes to adopt culture change initiatives. Whether the state or the providers were the primary motivators or whether it was a combination of the two, in almost all the case study states, it took both to move culture change into the state.

It was often in the many day-to-day activities when states and providers really began working together and forging more open communication. Whether it was planning for joint provider-surveyor training or working together to apply for a major grant to improve the workforce, these connections were just as important, and maybe more so, than formal coalitions.

This study found that the state presence at the “coalition table” is critical to successful culture change efforts. State representatives can offer access to multiple state programs that affect different aspects of culture change (regulation, rate setting and reimbursement, workforce development). They can also help to identify potential funding sources.

State investment in culture change cannot be achieved in isolation. Building sustained relationships with stakeholders is essential to moving culture change throughout a state. When all of the “players” are working together on common issues, there is a greater probability that each stakeholder group will contribute to an overall culture change effort rather than each working on their respective silo projects.

## **Funding Mechanisms**

States can make significant financial investments in culture change activities using a variety of mechanisms, including Civil Monetary Penalty (CMP) dollars, legislative funding, Medicaid dollars and grants or contracts to outside organizations. Some states also have provided in-kind support that includes devoting part or all of a full-time equivalent position to this issue; allowing staff to participate in coalitions, taskforces etc.; providing office space for workshops and conferences; and other non-financial supports. In addition, some legislative efforts—while not tied to dollars—have mandated the state to conduct studies and/or modify policies to facilitate culture change practices.

### **Civil Monetary Penalties**

Civil Monetary Penalties are “fines the Centers for Medicare and Medicaid Services can impose on Medicare and Medicaid-certified nursing facilities that are found to be noncompliant with federal safety and quality of care standards” (Levinson, 2005).<sup>4</sup> This is one of the sanctions against nursing homes that resulted from the 1987 Nursing Home Reform Act. The federal and state regulatory agencies can issue these fines (The Commonwealth Fund,

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<sup>4</sup>Levinson, D. (2005). *Nursing Home Enforcement: Collection of Civil Money Penalties*. Department of Health and Human Services, Office of Inspector General.

2006).<sup>5</sup> Each state has rules on how to use the fines collected. One consideration is for states to require the CMPs be used for projects to improve the quality of care and life for nursing homes residents and staff. Within this quality context, many states have used this CMP mechanism to support culture change projects. The advantage of the CMP mechanism is that the fines represent a pool of available money to improve the quality of care and life in nursing homes. Perhaps the major disadvantage of this mechanism is the instability of the funding and, consequently, the inability of those receiving the funds to sustain projects that rely solely on this source of funding. In addition, the size of the funding pool may change depending on how the fines are calculated.

### **Legislative Efforts**

The case studies found that several states employed a legislative route to both create and fund programs that promote culture change in nursing homes. Of all the case studies, Massachusetts is the best example of how a state legislature can ensure a long-term investment in culture change efforts. The legislature not only invested significant dollars in workforce improvement and culture change over an extended period of time, but also worked with the executive branch to make the initiative a line item in the budget. Although less ambitious, other state legislatures have supported various aspects of culture change.

### **Medicaid**

Medicaid is the federal/state health care program for low-income individuals and the major public payer for services provided in nursing homes. States set the Medicaid reimbursement rate, and the methods for calculating this rate vary substantially from state to state, although most reimburse on a prospective basis. Several states have used Medicaid reimbursement to nursing homes as an incentive to improve the quality of care. In Michigan, for example, providers have received supplemental Medicaid dollars to implement culture change components in nursing homes. Georgia nursing homes receive a percentage increase in their Medicaid rates to support their standardized data collection and reporting. Kansas provides increased Medicaid reimbursement to nursing homes that have demonstrated improved quality of care and a healthy workplace.

### **Grants or Contracts**

In addition to funds provided through the CMP pool, some state agencies have awarded grants or contracts to provider associations to administer programs or to individual providers and consultants for the development of products or implementation of culture change activities. These types of investments are most dependent on the funding available from the state agency and typically have a specified time.

### **In-Kind Support**

Many state representatives have provided a significant amount of in-kind time toward the culture change initiatives. In most of the states, one or more staff persons represent their agencies on coalitions focused on workforce improvement and the development of person-centered care in nursing homes. In addition to the monetary value of the staff time, this participation from state agencies helps to guarantee that they will be a champion within the executive

branch to advocate for these activities, to help gain access to funds and to resolve regulatory and administrative challenges to program implementation.

State government representatives also are members of numerous steering committees, taskforces and workgroups that examine various culture change efforts and make recommendations to the executive and legislative branches. In addition, some state staff members have become trainers in person-centered care and have helped to expand the skills and knowledge of caregivers in the field. In a few cases, for example in Kansas, a full-time staff person has been dedicated to culture change efforts.

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<sup>5</sup> The Commonwealth Fund. (2006). *Funding for Innovation: A Review of State Practices with Civil Monetary Penalties. Opportunities to Improve Care with Recommendations for State and Federal Governments and Strategies for Stakeholders to Help Implement Recommendations.*

# **State Culture Change Initiatives**

## **Workforce Improvement Initiatives**

# Georgia Health Care Association Certified Nursing Assistant Career Ladder Program

## Description

A collaboration of several key stakeholders expanded a career lattice program for certified nursing assistants (CNAs). The stakeholders include:

- ♦ Georgia Department of Labor (DOL)
- ♦ U.S. Department of Labor Office of Apprenticeship
- ♦ Local Workforce Investment Act service delivery areas, each of which has a local Workforce Investment Board to administer local WIA activities
- ♦ Four or five employees who work for nursing home operators
- ♦ Council for Adult and Experiential Learning (CAEL)
- ♦ Georgia Alzheimer's Association
- ♦ Georgia Health Care Association (GHCA) (the for-profit association of long-term care providers in Georgia)

The group formed an advisory panel to decide how to run the program, and the Georgia DOL administers it. The program provides experienced CNAs with access to educational development leading to a specialty certificate and/or licensed practical nursing (LPN) certificate, as well as an apprenticeship certification.

Griffin Technical College provides the training. Online learning enables any CNA working for a nursing home to take advantage of the program. CAEL provided a \$96,000 grant, which was used for technical assistance, and the state came up with a match.

Tuition and books are paid for by a Helping Outstanding Pupils Educationally (HOPE) grant, which is available to Georgia residents who meet the criteria and can be used for any certificate program to cover tuition, HOPE-mandatory approved fees and a book allowance. The HOPE grant is funded through the state lottery. Nursing homes pay the difference of what is not covered by the HOPE grant and the application fee.

To be admitted to the program, an individual must be a CNA with a certificate who has been working in a nursing home for at least six months. CNAs who are approved can apply to Griffin Technical College and for a HOPE grant. If accepted by both, they are enrolled in an "advanced practice" certificate program that spans three quarters. Learning and online work can be done at the facility before or after work. The program requires a commitment from the CNAs.

Courses count toward an LPN program. CNAs can choose to apply for the LPN program at a local technical school or college based on successful completion of Phase I, or they can decide to continue in the career ladder program and advanced CNA career training by pursuing a specialty area certification such as dementia, nutrition/hydration, skin care or restorative care. The four specialty areas are not taught online. There is a 2,000-hour requirement, and participants receive 500 credit hours because they are already CNAs. Each specialty area is different, but they make up the 1,500 credit hours between the advanced practice and a single specialty area. GHCA developed a curriculum committee comprised of administrators of nursing homes and others involved in care.

When CNAs enroll in the program, they also are registered with the U.S. Department of Labor Office of Apprenticeship. When they finish, they have a certificate from Griffin Technical College, a specialty certificate (when they finish any of the four areas) and then a certificate from the DOL Office of Apprenticeship that they have competencies. Thus, the program gives them real credentials. When they finish the advanced practice, they also are entitled to a \$0.25 wage increase. When they finish the training areas, they receive another \$0.25 increase. To become an LPN, however, CNAs must find their own funding.

## Resources

Click on [program](#) for more information.

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# Kansas Workforce Enhancement Grants

## Description

The Workforce Enhancement Grants (WEG) provide funds to train unlicensed (and some licensed) nursing home staff. The Kansas Department on Aging (KDOA) administers the grants, which are funded with Civil Monetary Penalties (CMP) money.

The program is designed to improve quality of life and quality of care for residents in licensed nursing homes and long-term care units in hospitals. It provides grants that aid in the development of ongoing statewide educational and training programs for unlicensed and some licensed staff employed in these facilities.

The grants are offered to community colleges, businesses and aging services organizations to provide educational programs at no cost to these long-term care staff. The grant applications for training are often centered about culture change. Since the program's inception in 2004, over \$833,990 in grants have been awarded. From 2005-2007, almost 7,000 staff members were trained, representing over 80 percent of Kansas nursing homes.

Some of the training topics have included:

- ♦ Palliative care, including the role of hospice
- ♦ Person-centered care and culture change
- ♦ Certified nursing assistant involvement in care planning and delivery of service
- ♦ Fall prevention
- ♦ Pain management
- ♦ Working with residents with dementia and Alzheimer's
- ♦ Physiology of aging

KDOA contracted with the University of Kansas to evaluate the impact of the WEG education and training programs on nursing home quality of care, quality of life, culture change and staff retention. The study also evaluated the impact of the programs on the staff who were trained. The study's final report, released in August 2008, showed that WEG-participating facilities had a higher decrease in deficiencies from 2006-2007 than non-participating facilities. While demonstrating a direct cause and effect between WEG trainings and desired outcomes of quality of care, quality of life, resident-centered care and staff retention proved difficult, the data point to the positive impact of the WEG program. Training participants reported that WEG trainings had a direct effect on their practices, increased their job satisfaction, reduced turnover and improved the quality of care they provided, which all had a direct effect on resident quality of life.

## Resources

[Workforce Enhancement Grants](#)

Evaluation of the [program](#) information

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# Kansas Nursing Facility Quality and Efficiency Incentive Factor

## Description

The Nursing Facility Quality and Efficiency Incentive Factor is a component of the Kansas Medicaid nursing home rate-setting methodology and is a program that connects culture change and pay-for-performance.

The quality and efficiency factor was implemented to provide a monetary incentive encouraging quality care and efficiency in nursing homes. The incentive is a per diem add-on, ranging from \$1 to \$3, to their Medicaid per diem rate. Those nursing homes that exceed in five quality outcome measures—case-mix adjusted nurse staffing ratio, operating expense, staff turnover rate, staff retention rate and occupancy rate—are awarded points based on them. The total points for each provider determine the per diem incentive factor included in the provider's rate calculation.

Since the program began in 2005, approximately 38 percent of nursing home providers have received a quality incentive factor during each year of the program.

KDOA completed a case study in 2006 comparing [PEAK](#) nursing home winners with non-PEAK homes from 2002 to 2005, using the quality incentive factor. Overall, a higher percentage of PEAK homes (63 percent) were awarded this incentive compared to non-PEAK homes (36 percent).

## Resources

Click on [Nursing Facility Quality and Efficiency Outcome Incentive Factor](#) for more information.

Click on [PEAK winners to non-PEAK homes using the quality incentive factor](#) for information on the case study comparing PEAK and non-PEAK homes.

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# Massachusetts Extended Care Career Ladder Initiative

## Description

The Extended Care Career Ladder Initiative (ECCLI), a comprehensive workforce training program, is the career ladder grant component of the Massachusetts Nursing Home Quality Initiative, created by the state legislature in 2000. ECCLI is managed by the Commonwealth Corporation, a quasi-governmental entity.

ECCLI has its roots in a certified nursing assistant (CNA) career ladder pilot program funded by the U.S. Department of Labor. The legislation to fund ECCLI grew out of pressure from a broad-based coalition of stakeholders who wanted to improve the quality of care and quality of work life in nursing homes and home health agencies by addressing the high turnover of direct care workers. High turnover creates instability, negatively affecting the quality of care. Basic to this initiative was the idea that good care for consumers relies on good jobs and opportunities for direct care workers.

ECCLI funds are provided through a competitive, multiple-round grant program available to Massachusetts nursing homes and home health agencies to create career ladders and other training initiatives for their frontline direct care workers. ECCLI's primary goal is to enhance the quality and outcomes of resident/client care, while simultaneously addressing the dual problems of recruitment and retention.

In addition to the traditional nursing career tracks, workers are eligible for specialized training in person-centered care, dementia care and other specializations. Many of the providers also have used these funds to engage in more fundamental culture change at the organizational level.

Since 2000, ECCLI has helped more than 160 nursing homes and home health agencies train over 7,500 individuals. Over the past eight years, the state legislature has provided over \$22 million to fund the program. ECCLI is now a line item in the state budget, which moves the initiative from a discretionary project to one that has a greater likelihood of being sustained over time.

## Resources

[ECCLI information](#)

## Contact

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# Massachusetts Workforce Training Fund

## Description

In 1998, the state legislature established the Massachusetts Workforce Training Fund to provide grants and technical assistance to Massachusetts businesses to recruit, train and retain skilled employees.

The fund, administered by the Division of Career Services at the Massachusetts Department of Workforce Development, is financed by employers in Massachusetts through a surcharge to their unemployment insurance. The surcharge generates \$21 million for the fund each state fiscal year. The funds promote:

- Projects that will result in job retention, job growth or increased wages.
- Projects where training would make a difference in the company's productivity, competitiveness and ability to do business in Massachusetts.
- Projects where the applicant has committed to provide significant private investment in training during and after the grant.

Each potential grantee can apply to one of three grant programs that operate within the training fund. Each grant program is designed to serve the needs of different businesses and organizations. They include the:

- **General program** for any size company that wants to train employees in job-related skills through a program designed by the company. Training must be completed within a two-year contract. Maximum grant: \$250,000
- **Express program** that helps small employers (50 employees or less) and labor unions to provide training for employees. The program utilizes existing training courses where a pricing structure already exists. Training must be completed within a one-year contract. Maximum grant: \$15,000
- **Hiring incentive training grant program**, which assists companies in paying for training for new employees that meet certain criteria. The length of the grant is 12 months. Maximum grant: \$30,000

In addition to these three grant programs, a new **LPN/RN Program** has been created to address the shortage of LPNs and RNs in hospitals, nursing homes and other health care settings. The program pays for the courses, clinical instructor, books, tutoring and prep course for the licensing exam. The matching portion of the grant must include the cost of administering the program, limited paid time-off, mentoring support for those being trained and any student related fees, as well as any insurance, uniforms and exam fees. The employees must complete a LPN or RN program and graduate within two years. Maximum grant: \$250,000

Recently, the program has sought out more health care organizations to apply to the fund. Since 1999, WTF has awarded approximately \$2,646,410 in matching grants to nursing homes and other long-term care organizations—about 28 percent of the amount awarded to the health care sector. Over 1,100 long-term care staff members were trained with the help of these grants. Some of the activities initiated by nursing homes include holding English as a Second Language (ESOL) classes for their staff and trainings to improve customer service. And although the program was not initially designed to support culture change in nursing homes, a nursing home received \$100,000 to implement culture change in 2006.

## Resources

[Workforce Training Fund information](#)

## Contact

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# Massachusetts Workforce Competitive Trust Fund

## Description

The Workforce Competitiveness Trust Fund (WCTF) is an \$18 million grant program established and funded by the state legislature, overseen by the Executive Office of Labor and Workforce Development and administered by the Commonwealth Corporation, a quasi-governmental entity. The program is designed to enable a broad range of Massachusetts residents—including older workers, low-wage workers, low-income individuals, disabled citizens, vulnerable youth, incumbent workers and the unemployed—to gain access to employment, education and the skills necessary to move forward along a career path leading to economic self-sufficiency.

Since 2007, the WCTF has awarded over \$14.5 million in grants to support sectoral/regional workforce development partnership projects that help fill jobs in “critical” industries within a region while providing good jobs. Current programs are projected to reach over 6,800 workers. Since health care is considered a critical industry in virtually every region of the state, this program is an important resource to the long-term care field. In Round I of the grant awards in 2007, long-term care organizations were included in partnerships that received \$1,343,641, representing about 19 percent of the total funds awarded at the time. In Round II, one partnership that included long-term care organizations was awarded \$474,634, or seven percent of the total funds awarded at the time.

In one example, a collaborative of health care industry and health education organizations created a new online education model, the Health Care Learning Network™ (HCLNTM), which delivers health care industry-specific English language, basic academic and college preparatory coursework to frontline health care workers. As part of this project, three industry partners representing seven long-term care facilities will use the HCLNTM to address critical professional shortages and improve overall customer service. From the employee standpoint, this project will dramatically increase employee wages, allowing many direct care workers to become economically self-sufficient and move up the career ladder.

## Resources

[Workforce Competitive Trust Fund](#) information

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# Michigan Direct Care Workforce Initiative

## Description

The Michigan Office of Services to the Aging (OSA) supported BEAM, Inc. (Bringing the Eden Alternative to Michigan) in assessing recruitment, training and retention methods of certified nursing assistants and home health workers. The researchers at Michigan State University conducted the study. The results were released at a conference entitled the Michigan Direct Care Workforce Initiative (MDCWI) Conference. MDCWI members assisted with the release of the findings and have continued to address Michigan's direct care workforce issues since 2004.

MDCWI works to develop, propose, promote and improve programs, services and policies to ensure a high-quality, well-trained and respected long-term care workforce. It has a strategic plan with the goal to position long-term care workforce issues as key elements in Michigan's long-term care agenda.

There are various organizations dedicating staff time and resources to the MDCWI coalition. Many long-term stakeholders are involved, including advocates, consumers, educators, employers, government representatives, providers, researchers and unions. They have a committed core of 20 members who dedicate their time and resources to improve the recruitment, training and retention of direct care workers statewide. Many subcommittees have been created, including one that focuses solely on culture change. In addition, they are currently working to get additional money to help support MDCWI but have not started fundraising. However, that is part of the strategic planning.

## Resources

*Voices from the Front: Recruitment and Retention of Direct Care Workers in Long-Term Care in Michigan Report*

[Michigan Direct Care Workers Initiative Strategic Plan](#)

[MDCWI Member Directory—September 2008](#)

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# North Carolina Medication Aide

## Description

The medication aide began in 2002 and officially started in 2006 to create career advancement for certified nursing assistants. The North Carolina Department of Health and Human Services and North Carolina Board of Nursing convened a large group of stakeholders that included the nursing home industry, mental health, pharmacists, nurses and nurse educators. The core group included the Department of Facility Services, the Board of Nursing and representatives from the Department of Long-Term Care Services. The group had one taskforce focused on the development of the curriculum and a second taskforce focused on the competency evaluation. A Real Choice Systems Change grant was used to develop the job category. Legislation was passed in 2005 to create a class of medication aide workers. The legislation allowed the medication aide registry and competency to be used only in nursing homes. However, the legislation stated that Department of Facility Services could look at including providers in other settings.

The North Carolina Medication Aide Registry lists all health care personnel in North Carolina who have:

- ◆ Successfully completed a medication aide-training program approved by the North Carolina Board of Nursing (a 24-hour training program).
- ◆ Passed the state medication aide competency exam.
- ◆ Are listed on the Nurse Aide I Registry.
- ◆ Do not have substantiated findings listed on the Health Care Personnel Registry.

The medication aides administer medications and are responsible for ensuring the right dose, at the right time, for the right resident.

The listing on the Medication Aide Registry is valid for two years. Medication aides can renew within the two-year period through qualified work experience that meets the following criteria:

- ◆ Paid work.
- ◆ Work as a medication aide.
- ◆ Supervised by a registered nurse or qualified supervisor.
- ◆ A total of eight hours or more working as a medication aide during the 24-month registry listing period.

One of the initial challenges was resistance among licensed practical nurses (LPNs) and a small group of nurse educators. LPNs did not want the medication aides because they were concerned about the elimination of their jobs. There also was concern that the medication aides would increase the error rates. To address these concerns, the workgroup:

- ◆ Posted information about the position on Web sites.
- ◆ Held discussions with various concerned groups.
- ◆ Implemented a state-run pilot test to determine the impact of the medication aide. The research showed no increase in the error rates and positive nurse reaction because they had approximately four more hours per day for other job responsibilities.

Two other key challenges were working out the details of the program and the cost. Decisions had to be made about which medications non-licensed personnel could administer and the length of the course. The workgroup discussions helped resolve these issues.

The sustainability challenge is that the medication aide role is seen as career advancement for certified nursing assistants. It is not mandatory that organizations increase the pay for medication aides. If nursing homes do not appropriately reward medication aides, this could pose a problem. It is unknown the number of medication aides who receive a wage increase.

A total of \$35,000 in CMP dollars funded the pilots and evaluation. Current resources at the government agency support the registry, and no new funding was appropriated for this effort. A contractor under a no-cost contract to the state provides the state competency exam. The fees students pay to take the exam cover the total cost to administer it. A Real Choice Systems Change grant provided the funds for developing the curriculum.

## Resources

For more information about the Medication aide, visit the [North Carolina Medication Aide Registry Web site](#)

To read the legislation establishing the medication aide category, click on [131E-114.2](#) and [131E-270](#).

[Medication Aide Curriculum](#)

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# North Carolina Geriatric Aide

## Description

The geriatric aide, which began in 2008, is a career ladder effort that allows nurse aides to improve their knowledge, skills and marketability. The Office of Long-Term Care Services, the North Carolina Institute of Medicine and the Division of Facility Services, along with the nursing home industry, advocated for the geriatric aide position within nursing homes. It came about because of employer and worker needs identified by the North Carolina Institute of Medicine Long-Term Care Task Force. The goal is for the geriatric aides to be culture change agents and a resource for other nurse aides within the organizations.

In 2002, a stakeholder group came together to design the structure of the program. The training requires 100 hours of classroom and 40 hours of clinical training. The group determined the topics based on focus groups with nurse aides and input from educators and industry leaders in long-term care on the knowledge and skills for a geriatric aide. The curriculum focuses on innovative nurse aide care and clinical topics such as pressure ulcers, depression, dementia and challenging behaviors, mental health issues and death and dying. Each area incorporates person-centered care concepts. To become a geriatric aide, nurse aides are required to be listed on the Nurse Aide I Registry and complete the state-approved geriatric aide training program. Community colleges provide the training. Geriatric aides are listed on the North Carolina Geriatric Aide Registry, and there is no renewal process.

Initial funding came from a Real Choice Systems Change grant of \$50,000. The Office of Long-Term Care Services is the funding stream and contracted with consultants to develop the curriculum using \$30,000 in CMP funds. The registry is in place with support provided by existing staff and resources from the Division of Facility Services. The state will seek legislative appropriations to maintain the registry. The competency testing is a contract with the national vendor for the [medication aide program](#). There is no cost to the state because the vendor recoups the cost from the payment for each test. All nursing homes reimburse the nurse aides for training and testing costs.

## Resources

[Geriatric Aide Curriculum](#)

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# North Carolina Workforce Improvement for Nurse Aides: Supporting Training, Education and Payment for Upgrading Performance Program (WIN A STEP UP)

## Description

WIN A STEP UP was in response to a crisis in nurse aide retention. The state was seeing an alarming trend of a net reduction in the number of nurse aides on the registry. WIN A STEP UP was the first initiative the state undertook. It is a partnership between the state and the University of North Carolina Institute on Aging. The goal is to create a more competitive environment for nurse aides. WIN A STEP UP is a career ladder program that provides additional training with an increase in wages and a commitment by the participants to stay with the sponsoring agency for at least three months after completing the training. The incentives for the participating nurse aides are:

- ♦ A \$35 stipend for completing each module from WIN A STEP UP.
- ♦ A \$75 retention bonus upon completing the curriculum and retention commitment from WIN A STEP UP.
- ♦ A minimum \$0.25 per-hour pay increase or a \$75 retention bonus (or both), as specified in the contract from the employer.

The program has added supervisor training to encourage a better style of supervision and promote active listening to nurse aides.

The program has had three funding sources. Initial funding for the pilot program, 1999-2000, was a Kate B. Reynolds grant. The program has since been funded by CMP monies for a total of \$2,437,629 from 2002-2009. The Better Jobs Better Care program, funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies, funded the evaluation of the program. The state has contributed almost 60 percent of the cost of the program, with the employer share approximately 40 percent.

Since 2001, the program has enrolled over 2,400 frontline nurse aides, and each year the number of enrollees increases. In fiscal year 2008-2009, the program trained 98 nurse aides in 10 nursing homes, and 78 nurse aide supervisors received coaching supervision in 10 nursing homes. The program has demonstrated success. The retention rate for nurse aides has ranged from 74 percent to 85 percent. The evaluation showed lower turnover, higher quality of care and better teamwork among participating facilities compared to non-participating facilities.

## Resources

[WIN A STEP UP](#) information

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# North Carolina New Organizational Vision Award (NC NOVA)

## Description

North Carolina received a grant from the Better Jobs Better Care program, a \$15.5 million national initiative to improve the recruitment and retention of direct care workers funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies. As part of the grant, North Carolina developed a state-based coalition that included long-term care provider-related associations, state regulators, educators, researchers, consumers, direct care workers, supervisors and foundations. The coalition developed the NC NOVA program.

NC NOVA is a voluntary, specialty state license that recognizes providers for workplace excellence through their investment in their workers and improved workplace culture. NC NOVA standards fall under four major areas or domains: supportive workplaces, training, career development and balanced workloads. The domains identified for the NC NOVA designation are job practices known to contribute to high turnover in the direct care workforce.

The Carolinas Center for Medical Excellence (CCME), North Carolina's designated quality improvement organization, reviews applications to determine whether the providers have met the standards. The provider must have an operating license in good standing to apply for the NC NOVA designation. The reviewer team from CCME conducts an on-site review and interviews direct care workers and supervisors to ensure consistency between the information in the application and the programs at the organization.

The legislature established NC NOVA as a statewide program effective Jan. 1, 2007. The state helps to administer the program, track the license and advertise the program on the Web site. The goal is to tie NC NOVA to labor enhancement funds or some reimbursement differential. This is consistent with the workforce recommendations in the 2001 Institute of Medicine's Long-Term Care Task Force Report.

## Resources

[NC NOVA](#) information and related materials

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# Oregon Career Ladder and Certified Nursing Assistant (CNA) Level 2 Curriculum

## Description

The Oregon State Board of Nursing developed a career ladder curriculum and state-certification program for new long-term care CNA Level 2 positions. The purpose was to increase public safety by standardizing CNA training and duties, broaden CNA skills and knowledge base and provide recognition to CNAs. This is one of the few state-certified CNA 2 programs in the country.

There are currently three new CNA 2 categories: restorative care, acute care and dementia care. The restorative care curriculum and instructor qualifications were adopted in September 2004, the acute care curriculum and instructor qualifications were adopted in November 2005 and the dementia care curriculum and instructor qualifications were adopted in November 2006.

The program has a built-in competency testing feature. CNA 1s have three years from the time the curriculum is adopted by the state board to test for a CNA 2 position. If they test during this three-year window, CNA 1s do not have to complete the CNA 2 training program.

With the advent of the new CNA 2 positions, the state board also began maintaining a registry for each CNA 2 category for the benefit of both the CNAs and their potential employers.

## Resources

[CNA 2 categories](#) information

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# Vermont Nursing Home Gold Star Employer Program

## Description

The Nursing Home Gold Star Employer Program, which began in 2004, is designed to recognize nursing homes that employ best practices for recruitment and retention of caregivers, particularly direct care staff. It is a voluntary self-nomination program. The quality improvement model is based on research of effective practice and involves the formation of work teams, assessment of need, goal setting, documentation and submission to a member council.

The Gold Star Council, which includes representatives from the Vermont Health Care Association (the Vermont for-profit association representing long-term care providers), Office of Nursing Workforce, consumer and advocacy organizations, the Vermont Department of Labor and the Vermont Department of Disabilities, Aging and Independent Living selected the seven best practices based on evidence of their positive effect on recruitment and retention. The best practices were selected based on a survey of 43 nursing homes, a literature review and a focus group to expand on the survey results (20 participants). The workplace best practices include: staff recruitment, orientation, staffing levels and work hours, professional development and advancement, supervision training and practices, team approaches and staff recognition and support. A workbook was developed that includes the following information for nursing homes interested in applying for the Gold Star Program:

- ♦ Application process.
- ♦ Gold Star application kit, including self-assessment instruction and tools about a nursing home's current practices in each of the best practices categories and planning charts for specific best practices the home health agency plans to develop.
- ♦ Documentation forms for the steps taken and achievement of goals and agency data.
- ♦ Examples of best practice work plans.
- ♦ Application review process.

To win a Gold Star, nursing homes must conduct a self-assessment, select a best practice area and develop a work plan. After one year, a council review team reviews the nursing facility's progress through site visits and telephone interviews. The council awards Gold Star Employer Recognition based on achievement of designated goals or achievement of unanticipated goals that have measurable quality outcome improvements. The recognition is for one year. Council members provide technical assistance to those selected.

The state government expects facilities to publicize the Gold Star awards in their marketing to potential new employees and consumers. The program does not come with a financial reward. It is, however, a requirement for the Nursing Home Quality Award program that provides a \$25,000 reward to improve the quality of life for residents.

The Department of Disabilities, Aging and Independent Living provided a \$30,000 three-year grant to the Vermont Health Care Association to administer the program. Additionally, the state sponsors the conference that recognizes recipients of the Gold Star Employer Program (\$6,000 for each conference). The conference includes sessions on issues related to the program and break-out sessions to discuss different activities in the nursing facilities over the year. The Vermont Health Care Association received a second three-year grant not to exceed \$57,000.

The program has demonstrated modest improvements at the participating facilities. Since 2004, 74 nursing homes in Vermont participated, and 85 best practice projects were completed (two best practice projects were required per facility in 2004 and one subsequently). An evaluation of 14 nursing homes that completed the program in 2004 and 2005 showed that they were most often involved in activities that addressed team approaches, orientation and training and supervision training and practices. These facilities have better retention rates and lower turnover compared to nursing facilities that did not participate in the program. The turnover rate of participating organizations in 2007 was lower compared to those that have not participated (mean 47 percent versus 60 percent). Additionally, the staff vacancy rates were low for the participating facilities, ranging from zero to 40 percent in one facility. There was no association between the Best Practice category chosen to implement and the turnover rates or staff vacancy rates at the facility.

## Resources

To access the Gold Star Manual, visit the [Vermont Health Care Association Web site](#)

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# Vermont Direct Care Worker Registry

## Description

The Community of Vermont Elders, a consumer organization, and the Vermont Association of Professional Care Providers (VAPCP) co-convened a taskforce to examine the need and concept for a Vermont registry. With strong state representation from the Department of Disabilities, Aging and Independent Living and the Department of Labor, the taskforce examined the need and viability of the direct care workforce and assessed the needs and goals for the registry. The members recommended a statewide voluntary Web-based registry. The perceived benefits of the registry include:

- ♦ Providing an employment tool for direct care workers who do not have a network.
- ♦ Assisting consumers who are seeking employees by providing information such as background, experience and training, so they have a better chance for quality control.
- ♦ Providing data that the Department of Labor can use to gain a picture of the workforce.

The Vermont legislature provided financial support for the registry. It allocated \$100,000, of which \$60,000 is a one-time appropriation and \$40,000 is ongoing funding. The \$40,000 is in the base administrative line of the Department of Disabilities, Aging and Independent Living budget. The \$60,000 is a split of state (40 percent) and federal (60 percent) money.

## Resources

[Direct Care Workforce Registry Task Force Summary of Findings](#)

[The Appropriations for the Direct Care Worker Registry](#)

[Direct Care Worker Registry, Sealed Bid Request for Proposals](#)

[Vermont Direct Care Registry information](#)

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# **Person-Centered Care Initiatives**

# Kansas Organization Supports Culture Change— Under One Roof

## Description

Kansas has built an integrated approach to statewide culture change activity. This integration is due, in large part, to the executive branch's unique organizational structure. It is the only state the research team studied that co-locates the regulatory, programmatic and financial functions related to aging services within the same department—the Kansas Department on Aging (KDOA). KDOA administers the Older Americans Act, Medicaid (including reimbursement) for nursing homes and home and community-based services and regulatory oversight of all long-term care settings.

One of the most important features of this integration is that the state survey agency and state Medicaid office are literally under the same roof. Prior to 2003, the survey agency for nursing homes was housed in the Kansas Department of Health and the Environment. In 2003, the state legislature mandated that the survey agency be moved to KDOA. This was done partly to comply with the governor's blue ribbon commission on making government more efficient and partly to help KDOA put more focus on improving nursing homes. There was also a perception that the survey agency was operating in isolation from other aging departments and from the environmental department.

This move provided the opportunity for these two powerful influencers on nursing homes—the Medicaid office and the survey agency—to collaborate in efforts to remove barriers and reward culture change. The secretary on aging has the ability to use state Medicaid payments to nursing homes and the regulatory process to promote culture change. Although the intention of the move at the time was not to facilitate culture change, the creation of a unified agency played a key role in helping to create a broad culture change strategy in the state.

Kansas has a reputation for being very regulation oriented. The state was nationally known for strong enforcement and surveyors who took pride in their work. While KDOA was not going to lessen their strong enforcement, staff realized there needed to be room and incentive to encourage culture change initiatives.

## Resources

Visit the [Kansas Department on Aging Web site](#) and the [Kansas Department on Aging Culture Change in Long-Term Care Web site](#) for more information

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# Kansas Long-Term Care Division: Culture Change Assistance for Nursing Homes

## Description

The Kansas Department on Aging (KDOA), which uniquely houses both the state survey agency and state Medicaid office, also supports a unit that provides guidance and technical assistance to nursing homes on culture change. Kansas' technical assistance services were the most comprehensive in the seven states studied under the state culture change grant, with a formal structure and financial backing from KDOA.

These technical assistance services began in the 1980s with the creation of a single position for a nurse consultant, housed in the state survey agency, to provide regulatory education and consultation to nursing homes. The creators of this position felt that if providers viewed the position as separate from surveyors, they might be more willing to ask for help. The intent was to offer a place where providers can talk about culture change and regulations without fear of reprisals from state regulators.

That single position has grown into the Long-Term Care Division, which provides guidance and technical assistance to providers and consumers on how to initiate culture change within state regulations. The four professional staff members—consisting of two registered nurses, a registered dietitian and an environmental specialist—are all former surveyors. This team of consultants provides information to consumers, providers and the public on topics relating to long-term care and adult care homes. The topics include state and federal regulations, provision of care, resident rights, the resident assessment instrument, dietary standards, remodeling and construction.

Under this model, nursing homes can get individual advice and technical assistance about how to transition to person-centered care in practice and in their physical plant within the state regulations, without fear of recrimination from surveyors. The office has become invaluable in helping homes adopt culture change initiatives. Division staff report that 60 percent of calls today are from providers asking about regulations, culture change and problem solving.

Besides providing individual technical assistance, division staff members participate in various conferences around the state, present education programs on care practices and culture change initiatives and provide regulatory updates. The division also publishes a quarterly newsletter, *The Sunflower Connection*, for care providers, consumers and advocates, offering regulatory news and updates, educational opportunities, information and specific examples of how to incorporate culture change into aging services.

The division's other responsibilities include the development of state adult care regulations and conducting physical environment inspections of adult care homes following construction projects.

The division's budget for fiscal year 2008 was \$499,688.

## Resources

For more information, visit the [Kansas Department on Aging Culture Change in Long-Term Care Web site](#)

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# Promoting Excellent Alternatives in Kansas (PEAK)

## Description

Promoting Excellent Alternatives in Kansas (PEAK), which began in 2002, was the first major culture change program initiated by the state. Administered by the Kansas Department on Aging (KDOA), PEAK has two components—recognition and education. Outstanding nursing home culture change initiatives are recognized through an annual award program. Education modules on how to begin and sustain culture change are provided through resources and trainings to nursing homes in the state.

## Award Program

The award component recognizes nursing homes that have initiated significant culture change in their organizations. The measures used to judge the initiatives are based on the four culture change principles of the Pioneer Network: resident control, staff empowerment, home environment and community involvement.

At the start of the award program, nursing homes self-nominated. Now, KDOA has an independent review panel made up of representatives from the state's quality improvement organization, the Kansas Foundation for Medical Care, AARP, the area agencies on aging and others. State surveyors provide input into the selection process.

The panel reviews applications and selects promising ones for the next stage in the process—site visits. A travel team made up of review panel members visits each selected home, reviewing its culture change initiative. After the site visits, the panel picks the final award winners. The secretary of aging personally presents the award to the home in a special ceremony, and KDOA issues a press release on all winners. In 2008, the secretary presented the awards at the annual Governor's Conference on Aging Services, thereby sharing the winners' work with the entire aging community. In addition, the governor signed a proclamation declaring "PEAK Week."

The yearly PEAK Awards have been presented 59 times during the past seven years, with some homes winning more than once. CMP funds are used to provide small cash awards of \$300 to the winners.

## Education Program

KDOA has contracted with Kansas State University (KSU) to develop and deliver the education component of the PEAK program. KSU has developed culture change education modules, trains nursing home staff and providers on the modules and consults with providers on how to begin and sustain culture change. The modules and trainings have helped raise awareness of culture change, as has the exemplar providers that participate in the trainings and share their culture change journey with their fellow providers.

The modules currently available are:

- ◆ Culture Change
- ◆ Measuring Change
- ◆ Returning Control to Residents
- ◆ Family and Community
- ◆ Strengthening Staff
- ◆ Creating Home
- ◆ End of Life
- ◆ Activities
- ◆ Dining
- ◆ Dementia Activities
- ◆ Spirituality of Nursing Home Residents

Training modules still to be developed include Community in Nursing Homes and Sexuality in Nursing Homes. KSU also produced a booklet, *Pioneering Change in Kansas Nursing Homes*, which was distributed to all Kansas nursing homes and other parties involved in the nursing home professions.

## Resources

For general information about PEAK and the award program, including access to the applications, visit the [PEAK Initiative Web site](#)

For information on the educational component of PEAK and *Pioneering Change in Kansas Nursing Homes*, visit the [KSU Web site](#)

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# Kansas Partnership Loan Program

## Description

In 2000, the Kansas Partnership Loan Program was established to support the expansion of housing alternatives and services for older adults in Kansas. The program provides low-interest loans to aging services providers to help expand these alternatives, such as GREEN HOUSE© projects. The program focuses on rural communities lacking adequate housing options for seniors.

As of June 2008, the program had granted loans totaling \$5,638,491 to 10 housing projects with a total of 150 units. These loans supported the construction and long-term financing of various housing projects, including both licensed adult care homes and unlicensed senior housing. Unfortunately, the program currently does not have funds available to finance additional projects.

## Resources

For more information about the program, visit the [Kansas Department on Aging's Partnership Loan Program Web site](#)

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# Kansas Partnership Grant Program

## Description

The Partnership Grant Program provides matching grants for long-term care programs. The program is funded through the interest income the Kansas Department on Aging receives from the Partnership Loan Program.

Since its inception in 2000 through fiscal year 2008, the program has awarded or is committed to award \$489,609 to fund two projects. An early grant went to Steve Shield at Meadowlark Hills (a continuing care retirement community) to develop a nationally recognized culture change toolkit, *Household Matters*. The toolkit integrates materials and systems to help an organization implement and sustain culture change, with resident-directed service models and methods to improve and empower the workforce.

The state's two long-term care provider associations each received 200 toolkits to market and sell to nursing homes throughout the country. The net proceeds were used to fund culture change in Kansas nursing homes.

KDOA also awarded a grant to establish a long-term care home telehealth pilot project in southeastern Kansas. This proactive care model, involving technology and telecommunications, provides participants with chronic diseases the opportunity to take an active role in their health care by helping to identify the need for preventive intervention before situations become acute. A \$120,000 grant was awarded to Windsor Place At-Home Care in Coffeyville for the period of Feb. 1, 2007 through June 30, 2008. KDOA awarded a second grant of \$170,000 to extend the pilot to Oct. 31, 2009 and increase the number of participants. KDOA and the Kansas Health Policy Authority have signed a research contract with Kansas University Medical Center Research Institute to determine the effectiveness in terms of cost and quality of life for this type of care delivery system on a frail, elderly population living in a community environment.

## Resources

For more information on the Partnership Grant Program, visit the [Partnership Loan Program Web site](#)

[Household Matters information](#)

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# Massachusetts Resident Empowerment Program

## Description

The Massachusetts Department of Public Health (DPH) sponsors the Resident Empowerment Program, which began in 2000. This grant program uses Civil Monetary Penalties (CMP) money to fund innovative programs that enhance the quality of life for residents of Medicare- and Medicaid-certified nursing facilities. Quality of life includes those activities, events and environments that contribute to residents' emotional, physical and psychological well-being, contentment and satisfaction. The goals for both the 2007 and 2008 rounds of funding were person-centered care, focusing on the needs and preferences of the person rather than the organization or staff.

The maximum amount for each award is \$30,000. The proposals that come in from nursing homes are evaluated by DPH staff who weigh each proposal using the following measures; person-centered care, 50 percent; partnerships, 30 percent; and creativity, resourcefulness and succinctness, 20 percent.

Approximately \$300,000 has been awarded each year, for the past seven years, bringing the total to \$2.1 million. In 2006, some of the CMP money that didn't go to the grants was used to pay for a culture change conference (\$30,000) put on by the Massachusetts culture change coalition.

One unique proposal was generated by residents and families of a nursing home. They saw the need for a laundry center and approached the facility's staff for ideas on funding. The facility submitted a proposal to the resident empowerment program and received capital funds to build the laundry center. Another nursing home proposed and received money to purchase a new computer system called "It's Never Too Late," which connects residents with people all over the world.

## Resources

[Resident empowerment program](#) information

For information on previous requests for proposals explaining each year's criteria, visit the [Comm-PASS Web site](#) and search under "Search for solicitations."

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# Michigan Facility Innovative Design Supplemental (FIDS) Program

## Description

In 2006, the state champions had an idea to tap into state funding creatively for culture change activities. This idea began as a program to increase jobs in the construction sector. What they devised was a long-term care program that encouraged renovation and replacement of Michigan's nursing facility infrastructure. The Facility Innovative Design Supplemental (FIDS) program established several criteria for participation, including:

- ♦ A remodeling/renovation that includes 80 percent of rooms as private with attached bath and toilet and no rooms with more than double occupancy in the rest of the facility.
- ♦ A culture change contract for three years worth of training/activity from a state-approved culture change agent.
- ♦ An evaluation process administered by My InnerView.
- ♦ Full sprinkler coverage.
- ♦ Air-conditioning or a state-approved alternative.
- ♦ Compliance with the Certificate of Need Pilot Program.
- ♦ Continued culture change efforts to maintain funding.
- ♦ A cap of 75 homes.

One key aspect of this program is that it is budget neutral—construction is financed through private investment. An up to \$5 (per bed, per day) supplemental payment makes the building of new designs more affordable and attractive. This supplement was made available for the half-life of the facility (up to 20 years), and there was partial coverage of construction costs. The Federal Medicaid Assistance Percentages (FMAP matching) supports 55 percent of the cost of the supplemental payment.

A multi-disciplinary team comprised of representatives from the Michigan Department of Community Health (MDCH), Medical Services Administration (Medicaid), Bureau of Health Systems (BHS) (Survey and Certification), Health Facilities Engineering, Certificate of Need and Office of Services to the Aging administers the FIDS program. BHS is the lead agency. Unfortunately, no further rounds of FIDS funding are expected.

## Resources

[FIDS Bulletin](#)

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# North Carolina Coalition of Long-Term Care Enhancement

## Description

The North Carolina Coalition of Long-Term Care Enhancement started in 1996 with the original name of Eden North Carolina Long-Term Care Coalition. The section chief of licensure heard of Dr. William Thomas and the Eden Alternative, which was the motivation to start the coalition. The state worked closely with the for-profit association—the North Carolina Health Care Association—to create the coalition. It has approximately 25 members and includes the long-term care provider-related associations, assisted living and retirement communities, state and local regulators, North Carolina Horticulture Society, Division of Aging (ombudsman program), providers, state long-term care advocates, educators and others. The coalition meets monthly, and the state provides the space and takes minutes.

The coalition has a formal structure and by-laws. It considered becoming a not-for-profit but decided against it because it would limit the state's role in the coalition. The coalition has a different chairman each year, which has not been a representative from state government.

The coalition had two conferences for providers. CMP funds supported the first conference, and volunteer time and participant fees supported the second conference.

The coalition's key activity is its demonstration grant program. Initially, it was designed for nursing homes to implement the Eden Alternative; however, the focus has changed to the identification of other culture change groups and ideas, such as the Pioneer Network and Wellspring. A subcommittee from the coalition selects grant recipients, with two people reviewing each grant. They use a scoring system and if there are differences in the scores, a third person scores the applicant. The reviewers also consider the complaint history, survey results and risk/benefit of each applicant. There have been four rounds of grants, and each grant is for two years.

The CMP dollars support the demonstration grant program, and the state has provided a significant amount of in-kind time. The CMP support so far has been approximately \$1 million. The state's participation on the coalition has helped secure CMP money to fund the program.

## Resources

[North Carolina Coalition of Long-Term Care Enhancement Grantee Request for Application](#)

[North Carolina Coalition of Long-Term Care Enhancement Grant Press Release](#)

[North Carolina Coalition of Long-Term Care Enhancement Mission Statement](#)

[North Carolina Coalition of Long-Term Care Enhancement By-Laws](#)

[Proposed Committees of the North Carolina Coalition of Long-Term Care Enhancement](#)

[North Carolina Coalition of Long-Term Enhancement Membership Directory](#)

[North Carolina Coalition of Long-Term Enhancement Grantee Monitoring](#)

[Visit the North Carolina Coalition of Long-Term Enhancement Web site](#) for more information

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# Oregon Survey Agency/Nursing Home Culture Change Initiative

## Description

In 2005, state survey staff created the Survey Agency/Nursing Home Culture Change Initiative to help educate surveyors about culture change and set up nursing home/surveyor teams to work on culture change initiatives.

Interested nursing homes and surveyors were asked to apply for the teams as sign of their interest and commitment. The selection criteria for nursing homes included having a minimum two-year tenure for the administrator and director of nursing services, a clean compliance history (no ongoing problems) and an idea of where they were in their own culture change development.

The state received 18 applications from nursing homes and surveyors, and six teams made up of nursing home staff and a surveyor were selected in 2005. The state chose surveyors from the three regional surveyor offices, so they could share what they were learning with their colleagues.

To help jump-start the process, all six teams attended the Pioneer Network's institute on culture change held in Portland and set up their culture change teams soon after the conference. The team members often included the administrator, a licensed nurse representative, a direct care worker, a state surveyor and, in some cases, dietary and house-keeping staff. The surveyor attended the team meetings in person or via conference call. The role of the surveyor was to help the team understand the parameters of the regulations with regard to culture change. To avoid any conflict of interest, the surveyors who were part of a home's culture change team could not be part of their survey process.

The state investment included:

- ♦ Paying for the cost of the surveyors and one nursing home staff member to attend the Pioneer Network Institute.
- ♦ Making available a \$2,500 matching grant from the state's CMP funds to the nursing homes to develop culture change activities in either practice or policy, with the help of their team.

Once the teams were up and running, survey agency staff provided support through face-to-face meetings and follow-up phone calls.

Four teams in 2006 and two teams in 2007 submitted proposals for the state matching grant and were accepted by the review group. Their proposals included changes in dining allowing for more home-like meals for residents, expanding family-style dining to breakfast and recruiting volunteers to provide more activities to residents.

In 2007, the survey agency decided to invest in hiring a part-time consultant to provide team support. State staff members had tried to support the teams as part of their job but found the teams needed more consistent support to keep the momentum going. The consultant's responsibilities included conducting orientation for new team members, providing technical assistance about best practices for person-directed care, facilitating monthly conference calls with team members, organizing two day-long group meetings per year focused on technical assistance, offering best practices and sharing lessons learned and providing one in-service training per year to all surveyors on culture change.

In 2008, six additional culture change teams were established.

The program has helped bring about more understanding of culture change among the surveyors. The program lead observed that since surveyors often go in looking for what's wrong, this model is a wonderful opportunity for relationship building between nursing home staff and surveyors around culture change.

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# Oregon Survey Agency/Provider Forums

## Description

In 2005, the state survey agency set up a survey agency/provider forum that meets every other month to talk about regulations and build relationships and trust between surveyors and providers. It was a way to formalize discussions and collaborations that had taken place over several years between the state agency and providers.

About 20 individuals attend the bimonthly meeting, which include survey state agency staff, the for-profit and non-profit provider associations, nursing homes, home care agencies, surveyor managers and licensing staff. Individuals who sign up for the forum must give a one-year commitment to participate. If members miss one session, they are no longer allowed to participate.

During the meetings, which are run by survey agency staff, forum members discuss emerging issues and updates, develop an action plan at the beginning of each year and plan for one deliverable a year. One year, their work centered on the Informal Dispute Resolution (IDR) that occurs when surveyors give facilities 10 days to respond to a deficiency or sanction. Forum members reviewed the process, determined it was fair and didn't need to be changed. They did, however, choose to hold a series of trainings around the state for providers on how to prepare for an IDR. The next year, forum members developed an Innovative Practice Award for long-term care providers. Three providers were recognized for their work to enrich the lives of their residents through enrichment/activity programming that was a part of everyday life and that involved all staff and residents. Culture change and person-centered care practices were central to their work.

According to survey agency staff, the forums seem to be successful and have increased communication, trust and mutual understanding among members. The forums have become a safe place to have conversations between survey agency staff and providers.

## Resources

[Application for the Innovative Practice Award](#)

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# Oregon Best Practices Initiative in Person-Centered Care

## Description

In 2000, the Oregon Seniors and People with Disabilities (SPD) Division partnered with the Oregon Health and Science University's Hartford Center of Geriatric Nursing Excellence to promote culture change through the Best Practices Initiative (BPI). BPI was set up to address the gap between research findings and the use of these findings to improve practice in person-centered care. The initiative was implemented using an education and consultative model and emphasizing use of evidence-based practices. A kick-off educational summit on person-centered care was held in October 2002. To attend, long-term care facilities were required to identify and send teams that included a direct care worker and organizational leaders, such as the administrator or director of nursing. The summit featured best practices in person-centered care in bathing, dressing and dining. Thirty-nine facilities were represented.

Sixteen facilities sent in proposals to BPI for assistance in making changes in their practices. Ten were chosen and participated in three educational two-day retreats and received coaching support from BPI team members, made up of staff from the university and SPD. The coaches provided onsite consultation and phone support to the facilities. The participating facilities made significant changes in engaging residents, increasing choice and promoting relationships between direct care workers and residents.

Three exemplary facilities made significant practice changes that fully involved all staff, including the direct care workers. These three facilities later became part of the Better Jobs Better Care research and demonstration grant program.

Though BPI has formally ended, its concepts and learnings have continued on into new initiatives.

## Resources

Crandall, Lynda G., White, Diana L., Schuldheis, Sherrie, Talerico, Karen Amann, "[Initiating Person-Centered Care Practices in Long-Term Care Facilities](#)," *Journal of Gerontological Nursing*, Vol. 33, No. 11, November 2007

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# Oregon Philosophy Statement on Person-Centered Care for State Statutes and Regulations

## Description

The Oregon Better Jobs Better Care (BJBC) state demonstration project (2003-2006) focused significantly on promoting a person-centered model for long-term care. To that end, BJBC partners, which included staff from the Oregon Department of Human Services, developed a person-centered care philosophy statement, which the department then officially adopted.

This statement provides overall guidance to the department's work, including regulations. It defines person-centered care and person-directed care and offers suggestions for how a state and its partners can develop a system of care that is person-centered and person-directed.

The department already had laid some groundwork for person-centered care. In the mid 1990s, the Seniors and People with Disabilities (SPD) Division of the Department of Human Services was created to develop a seamless approach to elders and bring the Older Americans Act and survey process under one roof. Programs for the developmental disability community also were integrated into the SPD at that time. The fact that this community was much more consumer/person-directed in their care contributed to the acceptance of person-centered care for the elderly in the division.

## Resources

[Oregon Philosophy statement on Person-Centered Care](#)

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# Vermont Nursing Home Quality Award

## Description

The Nursing Home Quality Award program, which began in 2000, came out of a study that examined Vermont's Medicaid reimbursement methodology for nursing homes. The study redesigned the long-term care system, and nursing homes wanted to address the quality issue. The state government created a system to link increasing funds to quality improvement or culture change. Facilities are eligible if they participate in the Vermont Medicaid program and meet the following criteria:

- ♦ A score of five or less on the most recent health report; no deficiency with a scope and severity level greater than "D," with no more than two "D" level deficiencies in the general categories of Quality of Care, Quality of Life or Resident Rights. A "D level deficiency" is an isolated instance of a deficient practice with a potential for harm, but no actual harm has occurred.
- ♦ No substantiated complaints in the previous 12 months related to quality of care, quality of life or residents' rights.
- ♦ Gold Star provider designation.
- ♦ Participation in the approved Resident Satisfaction survey process (My Innerview), with results above the statewide average.
- ♦ Staff turnover below the state average.
- ♦ A Fire Safety deficiency score of five or less with scope and severity less than "E" in the most recent full survey.

The Division of Licensing and Protection ranks eligible facilities based on the basic criteria. The five top-ranking facilities for quality of care receive the award. If more than five facilities are equally qualified, then additional criteria (efficiency rankings) are used to determine the awardees. The efficiency rankings are based on the sum of the nursing, resident care and allowable costs per day from each facility's most recently settled Medicaid cost report. Costs per day are calculated using actual resident days for the same fiscal period.

The award started at \$50,000 and two years later was reduced to \$25,000. The money is used to improve the quality of life for residents in the nursing homes. One requirement is that the residents, through the Resident Council, have input on how to use the money.

## Resources

[Vermont's Nursing Home Quality Awards Criteria and Use of Funds](#)

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# Continuous Quality Improvement Initiatives

# Georgia Nursing Home Quality Initiative

## Description

The Georgia Nursing Home Quality Initiative, which began in 2003, focuses on raising the quality of care received by residents in the state's nursing homes. Key stakeholders—including the Department of Community Health, nursing home providers, AARP, the Georgia for-profit and not-for-profit associations, the quality improvement organization and the Alzheimer's Association—created the program to have one initiative that met the goals and objectives of all the state's different quality programs. They formed workgroups to focus on a different quality aspect. My InnerView was considered as a software package that could help measure quality. Based on the data collected by this system, they could then target trainings all over the state to address areas of low quality.

The group held district meetings and invited the administrator and director of nursing of each provider to attend the meetings to recruit organizations. The participating facilities collect data via My InnerView, a Web-based data entry program measuring a common set of key performance factors (clinical indicators, workforce performance metrics and satisfaction of employees, residents and family members). The information is analyzed and provided to the facilities monthly, enabling them to take quicker action to improve care and satisfaction. The Quality Initiative group gets aggregate quality indicator scores twice a year and, based on that data, the initiative addresses weak areas via trainings.

In the first year, the primary round of data went to the initiative's quality committee. The next year, the initiative focused on the weak parts, such as restraints and pressure ulcers. They also found that facilities were weak in leadership and supervisory skills. They started trainings with RNs, then opened it up to other supervisors. There were about 36 training courses total.

The group has had positive results. They have made significant improvements on restraints, and they have seen tremendous stories around resident and employee satisfaction. Some facilities have been able to keep turnover down and improve retention. However, there has not been as much improvement in pressure ulcers.

The state initially used \$600,000-\$700,000 of CMP funds to pay for the costs of implementing the initiative for the first three years, citing it as a quality exercise and quoting OBRA. Most of these funds went to training and paying for My InnerView.

To cover the rest of the money needed for trainings, each nursing home had to be willing to cover the cost for My InnerView. All facilities have paid for the program through June 2009; they are billed \$2,000 per year for the program. The Georgia Health Care Association (GHCA, the for-profit association for long-term care providers in Georgia) handles the money and pays My InnerView. A small amount is kept aside for the trainings. Participants have been charged \$2,000 every year from year one. If they meet the criteria—which includes attending the trainings, submitting the data monthly and participating in the family satisfaction survey—they get the money back. The entire program costs the average facility in Georgia \$200 per month. Approaching it in this way has kept the non-GHCA members involved, thus the initiative's far reach in the state.

As a partner, the state paid for the first year. After that, AARP contributed \$75,000 to train for leadership skills, and the state provided another year of funding. After three years, the state said it could not provide additional funding.

The second component of the initiative is the Georgia Nursing Home Incentive Model or Georgia's Quality Incentive Rate System. This initiative provides incentive payments to eligible facilities based on quality indicators. Started in 2007, the program is a collaboration between GHCA, My InnerView and the Centers for Medicaid and Medicare Services (CMS) and also involves the Department of Health and providers.

The facilities are required to meet the following criteria to participate:

- ♦ Participate in the Georgia Nursing Home Quality Initiative and submit monthly My InnerView data.
- ♦ Conduct a family satisfaction survey at least annually.
- ♦ Conduct an employee satisfaction survey at least annually.

Eligible facilities are scored on eight criteria based on the quality measures from My InnerView and CMS data. Facilities must receive three points from the following:

- ♦ At least one point from the CMS metrics (percent of high-risk long-stay residents who have pressure sores, percent of long-stay residents who are physically restrained, percent of long-stay residents who have moderate to severe pain and percent of short-stay residents who have moderate to severe pain).
- ♦ Exceeding the threshold of 85 percent or higher of “good” or “excellent” ratings on the family satisfaction question “would you recommend this facility?”
- ♦ Participation in the employee satisfaction survey.
- ♦ Above the state average on either RN/LPN stability or certified nursing assistant stability.

One additional point may be awarded for exceeding the threshold of another CMS metric not listed above. The total points awarded based on CMS metrics cannot exceed two.

Medicaid provides a quality add-on incentive to eligible facilities that meet the above criteria. The quality add-on equals a one-percent increase in the routine component of the Georgia daily Medicaid rate. Facilities are reviewed every 90 days to determine if they have met the requirements for additional quality payments.

Overall, approximately \$3.5 million has been invested so far, partially funded by the state, the facilities and AARP over the past three to four years.

## Resources

For information about the family satisfaction report and the Georgia Department of Community Health Nursing Home Incentive Model, visit [Georgia Health Care Association Web site](#)

[Press release on the Quality Initiative Program](#)

For more information about [My InnerView Web site](#) for more information about the surveys

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# North Carolina Family Satisfaction Surveys

## Description

The North Carolina Health Care Facilities Association, the association of for-profit providers in the state, established a two-year quality project to enhance the quality of care and life for the 42,000 residents in North Carolina. The association sought the project from the Division of Facility Services because it saw a gap in empirical evidence of family satisfaction in nursing facilities. The purpose of the project is to systematically collect and analyze data to develop and conduct initiatives, training, etc. to improve the quality of care and life for residents in nursing facilities. Nursing facilities enter data into My InnerView, a Web-based data entry and reporting program measuring a common set of key performance factors such as clinical indicators, workforce performance metrics and satisfaction of employees, residents and family members. The project started in April 2007.

The first component is annual surveys, through My InnerView, on family satisfaction of quality of life, quality of care, quality of service and overall satisfaction. The second component, derived from survey data, consists of internal and external quality improvement efforts. The state and individual nursing facilities can compare satisfaction results among nursing homes in North Carolina and other nursing homes in the nation that participate in My InnerView. The nursing homes can observe changes over time and make decisions based on the data. The comparative data helps to address quality issues that are important to the organization. In addition, information gained by the statewide summary report guides topic selections for training and education sessions. The educational sessions are available to all skilled nursing facilities in North Carolina.

The goal is for 75 percent of the licensed homes to participate in the program by submitting satisfaction surveys to participate in either or both of the learning sessions.

The two-year project is funded through \$288,360 in CMP monies.

## Resources

For information about the family satisfaction survey, visit the [My InnerView Web Site](#)

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# Vermont Statewide Resident Satisfaction Survey

## Description

In 2000, Vermont implemented a voluntary, statewide resident satisfaction survey, in which approximately half of the nursing homes participate. The survey is administered once a year and to short-term residents on discharge. Some of the survey measures include overall satisfaction and satisfaction with admissions, dining, rooms, maintenance, nurses, nurse aides, housekeeping, activities and finances.

The Department of Disabilities, Aging and Independent Living posts on its Web site the results of each individual facility compared to the state average, as well as the facilities that chose not to participate. Each facility is provided a comprehensive report, and the state works with facilities on the areas that need to be improved.

The Department of Disabilities, Aging and Independent Living supports the survey through a grant to the Vermont Health Care Association, which administers it. The grant is for one year, not to exceed \$50,000. Plans are to renew this grant annually.

The survey is a useful tool for providers to assess their progress and areas for improvement. Since the results are publicly available, it also can help consumers in selecting a nursing home.

## Resources

For information about the resident satisfaction survey, visit the [My InnerView Web site](#)

Visit the [Department of Disabilities, Aging and Independent Living Web site](#) for posting of the resident satisfaction survey results

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## Appendix—Resources Outside of Case Study States

# Advancing Excellence in America's Nursing Homes Campaign

## Description

Advancing Excellence in America's Nursing Homes is a coalition-based campaign to improve the quality of life for residents and staff in nursing homes. The campaign's coalition includes long-term care providers, caregivers, medical and quality improvement experts, consumers, government agencies and other quality-focused organizations.

The campaign:

- ♦ Monitors key indicators of nursing home care quality—both clinical quality and organizational improvement goals.
- ♦ Promotes excellence in caregiving.
- ♦ Acknowledges the critical role nursing home staff has in providing care.
- ♦ Recognizes the important role of consumers to the success of the campaign by contributing ideas and suggestions.

Participating nursing homes work on at least three of the eight measurable goals:

- ♦ Reducing high-risk pressure ulcers.
- ♦ Reducing the use of daily physical restraints.
- ♦ Improving pain management for longer-term nursing home residents.
- ♦ Improving pain management for short-stay, post-acute nursing home residents.
- ♦ Establishing individual targets for improving quality.
- ♦ Assessing resident and family satisfaction with the quality of care.
- ♦ Increasing staff retention.
- ♦ Improving consistent assignment of nursing home staff, so residents regularly receive care from the same caregivers.

The campaign shares the results of participating nursing homes through:

- ♦ National reports of summary data, such as real-time updates about enrollment, real-time progress on each of the campaign's eight measurable goals, an enrollment summary report, quarterly updates about progress on campaign goals and quarterly updates and progress towards campaign objectives.
- ♦ State reports on enrollment, progress on each of the campaign's eight measurable goals, an enrollment summary and quarterly updates for the clinical quality measure data.

## Resources

For more information about the campaign, visit the [Advancing Excellence Web site](#).

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# Consumer Directed Care and Nurse Practice Acts

## Description

This 50-state report, authored by Susan Reinhard, RN, PhD, examines the current state nurse practice acts and their implementing regulations to determine the extent to which they permit more consumer direction in home and community-based services. This review focuses on several key issues that might affect consumer directed care state policy and practice:

- ♦ Analysis of the statutory and regulatory language that pertains to delegation, including who may delegate, tasks that may be delegated, in what setting and with what supervision and training requirements. States can range from broad authority to narrow authority that limits delegation to certain tasks or settings.
- ♦ Examination of exemptions that permit nursing tasks to be performed by persons who are not nurses.
- ♦ Liability sections to determine nurses' accountability for delegation.

This report was prepared under contract #HHS-100-97-0008 between the U.S. Department of Health and Human Services (HHS), Office of Disability, Aging and Long-Term Care Policy (DALTCP) and the National Opinion Research Center.

## Resources

[Consumer Directed Care and Nurse Practice Acts Report](#)

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# Funding for Innovation: A Review of State Practices with Civil Monetary Penalties

## Description

The Long-Term Care Community Coalition, in partnership with the University of California, San Francisco and the National Citizens' Coalition for Nursing Home Reform, received funding from the Commonwealth Fund for a study on the use of Civil Monetary Penalties (CMPs) to improve nursing home care and quality of life. The goal of the project was to:

- ♦ Inform the public, consumer groups, government officials, ombudsmen and the nursing home industry about the practices and experiences of states' use of CMPs/fines.
- ♦ Encourage states to make greater use of CMPs/fines for projects.
- ♦ Identify the uses of funds from CMPs/fines for special projects that can be replicated to provide lasting and widespread improvements to resident quality of life.

The authors developed a CMP Action Plan that includes the summaries of the findings from the study with information on states' experiences with CMPs/fines and interviews with stakeholders, such as ombudsmen, advocates, providers and government officials. Additionally, the CMP Action Plan has recommendations for states and the Centers for Medicare and Medicaid Services on how to better use CMPs/fines.

## Resources

[Civil Monetary Penalties Report](#)

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# PHI National Clearinghouse on the Direct Care Workforce

## Description

PHI's National Clearinghouse on the Direct Care Workforce is a national online library that provides information on the direct care workforce. The clearinghouse has government and research reports, news, issue briefs, fact sheets, training manuals and how-to guides; a list of direct care worker associations; state-specific information on statistics, regulations and initiatives; and listings to other associations, resources and events. The information is on topics such as recruitment, career advancement and peer mentoring, supervision, national surveys of state activities, workplace culture and empowerment and caregiving practices.

One feature is the best practices database, which includes a profile of programs implemented by providers, educators, workers and community organizations to improve the recruitment, training and retention of direct care workers across all long-term care providers. Each profile includes a description of the program and links to additional information. PHI and the Institute for the Future of Aging Services (IFAS), with funding from the U.S. Department of Health and Human Services, developed the practice profiles. PHI and IFAS identified the practices through conversations with experts around the country and through broad distribution of a call for nominations. Those selected for inclusion have been in place for at least six months and can provide some quantitative or qualitative evidence of their results.

## Resources

[PHI National Clearinghouse Web site](#)

## Contact

National Clearinghouse on the Direct Care Workforce

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# Pioneer Network

## Description

The Pioneer Network is a national organization that advocates and seeks to change the culture of aging and long-term care of older adults in America. The Pioneer Network is a coalition of organizations and individuals from across the nation that:

- ♦ Advocates for public policy changes and creates communication, networking and learning opportunities.
- ♦ Builds and supports relationships and community.
- ♦ Identifies and promotes transformation in practice, services, public policy and research.
- ♦ Develops and provides access to resources and leadership.
- ♦ Hosts a national conference to bring together interested parties with a desire to propel this important work.

## Resources

Visit [Pioneer Network Web](#) site for more information

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# Results of the 2007 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce

## Description

PHI and the Direct Care Worker Association of North Carolina collaborated to survey states about direct care workforce issues. They sent surveys to all state Medicaid agencies and state units on aging and redirected to a more appropriate state entity for completion, if necessary. The first survey was in 1999, and this is the sixth national survey on the direct care workforce. The 2007 study examines public policy actions states have taken since the last survey in 2005 to strengthen the direct care workforce. The survey collects information on the follow topics:

- ♦ Whether the direct care worker vacancies are currently a serious workforce issue for each state.
- ♦ State initiatives taken to address shortages through establishment of wage pass-throughs, wage floors and/or rate enhancements.
- ♦ Which states have undertaken a study to investigate the costs of proposed wage and benefit initiatives mandated by their legislatures.
- ♦ Training and/or career advancement initiatives states support to improve the direct care workers and supervisors.
- ♦ Data states track and monitor to assess the adequacy and stability of their direct care workforce.
- ♦ Government structures, reports, research studies and/or public awareness campaigns for addressing long-term care.
- ♦ 2006 state wage data across the three major direct care job categories, as well as the weighted average wage across the three categories and 2006 unemployment information.

## Resources

To access the report, visit [PHI Clearing House Web Site](#)

## Contact

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# Rhode Island Department of Health Individualized Care Pilot

## Description

The Individualized Care Pilot is a project of Rhode Island's state survey agency, the Department of Health Office of Facilities Regulation. The Commonwealth Fund supported the project. The goal was to influence and promote individualized, resident-centered quality care in nursing homes via the regulatory process by:

- ◆ Piloting supplemental questions and observations as part of every standard federal recertification survey in Rhode Island between Nov. 1, 2007 and April 30, 2008.
- ◆ Conducting surveyor training to ensure familiarity with quality of life regulations and a variety of individualized care practices.
- ◆ Providing information and education about individualized, resident-centered care practices to nursing home staff in collaboration with its educational partner for the project, Quality Partners of Rhode Island, Rhode Island's quality improvement organization.

The project targeted three areas of individualized resident-centered care:

- ◆ Resident-directed choice, particularly regarding waking, sleeping and bathing schedules.
- ◆ Personalized environment regarding sound levels, personalized rooms, access to public/common areas, homelike bathrooms and dining alternatives.
- ◆ Staff-resident relationships that support quality care and quality of life via consistent assignment and the resident being known as a person whose concerns are sought after, known and responded to satisfactorily.

The project has four products:

- ◆ Surveyor training materials
- ◆ Survey prompts, probes and protocols
- ◆ Educational materials for providers regarding implementation of consistent assignment, resident-directed choice of waking times and noise reduction
- ◆ Recommendations to the Centers for Medicare and Medicaid Services

## Resources

For information about the program and to access the materials, visit the [Rhode Island Department of Health Web site](#)

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