DEVELOPMENT OF A NURSING FACILITY QUALITY IMPROVEMENT PROGRAM USING CIVIL MONEY PENALTY FUNDS

Department of Medical Assistance Services

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EXECUTIVE SUMMARY

VIRGINIA'S QUALITY IMPROVEMENT PROGRAM FOR NURSING FACILITIES

Chapter 474 of the Virginia Acts of Assembly (2007 Session) amends §32.1-353.3 of the *Code of Virginia* (See Appendix A) to require:

- the Director of the Department of Medical Assistance Services (DMAS) to establish a Nursing Facility Quality Improvement Program; and,

- the Director of DMAS to provide a strategic plan and progress report to the Governor, Chairmen of the House Committees on Health, Welfare and Institutions, and Appropriations; the Senate Committees on Education and Health, and Finance; and the Joint Commission on Health Care no later than October 1, 2007.

This report is intended to fulfill this reporting requirement, specifically by providing recommendations on how the Commonwealth may use civil money penalty (CMP) funds collected from nursing facilities (NFs) that have been found to be out of compliance with Federal requirements to better the lives of the residents in nursing facilities. The proposed quality improvement program is a work in progress and will continue to be developed and refined over the next several months and years.

Section 1919 [42 U.S.C. 1396r],(h)(2)(A)(ii), specifies that "funds collected by a State as a result of imposition of such a penalty... shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds."

The federal law suggests the CMP revenues be applied to administrative expenses rather than direct care costs, although it is clear that states have broad latitude to determine which of these types of expenses best meets the needs of the residents. The Act permits each state to implement its own procedures with respect to the use of CMPs. However, this flexibility is limited by the requirement that CMP funds are to be focused on facilities that have been found to be deficient. The law does not specify when the NF must have been determined to be deficient to qualify for benefits under a state project funded by CMPs.

To address the new Code requirement for the development of a Nursing Facility Quality Improvement Program (QIP), the Department formed an interdisciplinary QIP Advisory Committee to discuss the issues and recommend an action plan. The committee included representatives from the Departments of Aging, Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), Health Professions, Health and Social Services, the

Alzheimer's Association, State Long-Term Care Ombudsman; Virginia Association for Home Care and Hospice, Virginia Coalition for the Aging, Virginia Health Care Association, the Tender Loving Care 4 Long Term Care Organization, the Virginia Association of Professional Nursing Assistants', Inc., the Virginia Association of Non-Profit Homes for the Aging, Virginia Health Quality Center, Lake Taylor Hospital, Westminster-Canterbury of the Blue Ridge, Legal Aid, Commonwealth Care of Roanoke, Inc., Virginia Poverty Law Center, Virginia Coalition for the Aging, Blue Ridge Legal Services, and the Virginia Office of Protection and Advocacy. (See Appendix B for the detailed list of participants.)

The Committee spent the summer of 2007 discussing the issues associated with quality improvement in nursing facilities. After this discussion, which included review of best practice models both nationally and within Virginia, the Committee agreed to pursue a quality improvement model similar to that utilized in North Carolina. The North Carolina program is described as a "meaningful and voluntary 'raise the bar' program pertaining to direct care staff recruitment and retention that would apply across long-term care related settings."

The Committee agreed with the North Carolina theory that the recruitment and *retention* of qualified nursing staff would lead to an improved living environment for residents of nursing facilities. Through focused attention on the development of supportive workplaces, balanced workloads, training and career advancement opportunities, the program expects to improve the retention of *quality* direct care workers, resulting in an enhanced quality of life for nursing facility residents.

This document is intended as a roadmap for an improved long-term care system. There are items that should and can be implemented now; however, appropriate performance benchmarks to measure future impact will need to be developed and implemented as part of this process. Other recommendations could be reasonably tied to key benchmarks and implemented in the future. It is important to note that the Advisory Committee recognized that many of the recommendations in this report will have associated costs. The measure of such costs must be weighed against the high costs of staff turnover, and the concomitant costs of recruitment and training of new staff as well as the high cost of heavy reliance on agency 'pool' staff to fill staffing gaps when there is high turnover. In addition, in determining the costs of any recommendations, the costs of potential additional administrative costs on the nursing facilities must be considered. The bottom line, however, is that all costs incurred for this program will remain within the amount of funds that have been collected through the Civil Money Penalty process from Virginia nursing facilities and/or will have been secured through grants.

THE VIRGINIA QUALITY IMPROVEMENT PROGRAM IN NURSING FACILITIES

INTRODUCTION

The Department of Medical Assistance Services (DMAS), as administrator of the state Medicaid program, maintains a fund comprised of civil money penalties (CMP) received from nursing facilities as a result of enforcement of federal survey requirements. Nursing facilities are required to undergo federal licensure and certification surveys on an annual basis. The purpose of the surveys is to ensure that nursing facilities are meeting the regulations for participation in the Medicare and Medicaid program. The survey process also ensures that residents are receiving adequate and quality care. Pursuant to federal regulations, such funds are to be used for the protection of the health or property of certified nursing facility residents.

The purpose of this report is to provide recommendations on how the Commonwealth might use CMP funds collected from nursing facilities (NFs) that have been found to be out of compliance with Federal quality of care requirements. In order to formulate recommendations, DMAS established an interdisciplinary Advisory Committee to provide guidance into the most appropriate use of CMP funds for the improvement of care in nursing facilities. The recommendations herein are proposed as the foundation for the Nursing Facility Quality Improvement Program (hereafter, QIP). This report will discuss the parameters set by the federal government for the use of CMP funds, the current application of CMP funds in Virginia, the recommendation of the QIP Advisory Committee and DMAS, and will present the strategic plan itself.

CMS-SANCTIONED USES OF CMP FUNDS

Federal and state law dictates certain quality standards for nursing facilities which are enforced through periodic onsite surveys. Remedies to address quality deficiencies uncovered during the survey depend on the severity of the deficiency identified:

- **Substantial Compliance:** The *Code of Federal Regulations* (42CFR§488.301) defines substantial compliance as a "level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm."
    - **Category 1 Deficiencies:** Classified as the facility being in "substantial compliance" with survey requirements. However, the facility needs to address and correct any identified deficiencies, typically by a plan of correction, state monitoring, and/or directed in-service training.
    - **Category 2 Deficiencies:** Classified as the facility not being in "substantial compliance" with survey requirements. Category 2 deficiencies involve denial of payment for new admissions, denial of

payment for all individuals imposed by CMS, and/or CMPs of $50-$3,000/day or a single instance of $1,000 to $10,000.

- **Category 3 Deficiencies:** Classified as the facility not being in 'substantial compliance' with survey requirements and are the most severe of the three categories. Deficiencies in this category directly affect the resident's behavior, facility practices, quality of life and quality of care. Remedies involve temporary management or termination of the provider agreement.

The imposition of swift and significant penalties when quality of care in NFs is deficient is an important component of enforcement of quality standards. When state enforcement systems work properly, CMPs can act as an influential deterrent to poor care. The provision of information to the public about fines levied plays a crucial role in maximizing their deterrent effect (Long-Term Care Community Coalition, 2006). Because CMP funds collected are state funds, the state may use the money for any project that directly benefits NF residents, within the scope of uses defined by federal regulations. Federal law cites several examples of uses for CMPs, including:

- Payment for the costs of relocation of residents to other facilities (state costs) when the current NF has not met the requirements to achieve or maintain substantial compliance; and,

- Maintenance of operations of a NF pending correction of deficiencies or closure.

The law generally suggests that CMP revenues be applied to administrative expenses rather than direct care costs, although it is clear that states have broad latitude to determine which of these types of expenses best meets the needs of the residents. National data indicates that states have used approximately 65 percent of CMP funds for survey and certification activities such as temporary management, relocation, and consultation; the remaining 35 percent of CMP funds were used for "special projects".

VIRGINIA'S USE OF CMP FUNDS

Previously, CMP funds in Virginia had for several years been used to fund the Certified Nursing Facility Education Initiative (CNFEI). CNFEI was a non-profit organization created pursuant to the *Code of Virginia*, § 32.1-353.4, established to provide early onsite training and assistance to certified nursing facilities that were found not in substantial compliance with long-term care requirements. Funding for services came from charges to NFs, general appropriations, and CMP funds. However, CNFEI was not self-sustaining and there was a lack of participation by the nursing facility community. The project disbanded in November 2006.

As of August 31, 2007, the total amount of assessed CMP funds for 2007 is $228,325. Of this amount, $37,677 has actually been collected by CMS from nursing facility providers. CMS gives providers opportunities to reduce the amount of funds levied based on whether or not a provider chooses to appeal a survey sanction. Providers do not have to initiate payment of the

CMPs until the appeals process is resolved. These processes may account for the difference between actual funds levied and funds collected.

RECOMMENDATION OF THE QIP ADVISORY COMMITTEE

The QIP Advisory Committee discussed several major issue areas for pursuing a nursing facility quality improvement program in Virginia (See Appendix C for a list of options reviewed). The Committee selected these areas based on the needs and challenges of Virginia's nursing facilities. In considering programs that would most benefit nursing facility residents through the use of the CMP funds, quality improvement initiatives in other states were reviewed. The purpose was to ensure that proven best-practice models were identified and replicated wherever possible. The Committee evaluated these programs in the context of improving the efficiency and quality of services to enhance nursing facility residents' quality of life and ability to enhance nursing staff's ability to perform their jobs with the knowledge and respect deserved. The Committee realized that the proposed quality improvement program is a work in progress and will continue to be developed and refined over the next several months and years.

To facilitate the discussion, a series of three meetings were held. In these meetings, the group heard presentations about quality improvement programs in other states and began the discussion of Virginia's needs. In the last meeting of the Advisory Committee, a representative of the North Carolina quality improvement program, Better Jobs Better Care, presented that state's program to the committee. A provider who successfully implemented the program also offered testimony to the benefits of the program.

The Committee was very interested in the connection between job satisfaction and quality care. Practices such as consistent staff assignments, flexible scheduling, peer mentoring, career ladder development, person-centered care, etc. have been shown to significantly improve workforce stability thereby improving the quality of care, and life, for residents.

North Carolina New Organizational Vision Award: Better Jobs Better Care

North Carolina's program was reviewed and chosen by the QIP Advisory Committee as the model to implement in Virginia. The Committee felt that aspects of this program were valuable and could be used to develop a program in the Commonwealth. The program in North Carolina began as a pilot program limited to 60 providers. The pilot program was successful and the program has now been expanded statewide. The intent of the North Carolina program is to be a "meaningful and voluntary 'raise the bar program' pertaining to direct care staff recruitment and retention that would apply across long-term care related settings."

The Committee agreed with the North Carolina theory that the recruitment and *retention* of qualified nursing staff would lead to an improved living environment for residents of nursing facilities. By focusing attention on structural disincentives for a stable workforce, the program expects to improve the retention of *quality* direct care workers, resulting in an enhanced quality of life for nursing facility residents.

North Carolina's program identified key structural factors that affect worker shortages:

- Low wages and few, if any, benefits;
- Lack of a career path;
- Physically demanding work;
- Lack of opportunity for meaningful input in patient care;
- Inadequate recognition and appreciation;
- Inadequate exposure to "real life job demands during training".

In an attempt to elevate or eliminate the structural factors listed above, the North Carolina program established four areas of focus:

1. Supportive Workplaces
2. Balanced Workloads
3. Training
4. Career Opportunities

By addressing concerns in these four areas, the North Carolina program expects that providers will experience improvement in staff relationships and communication, leading to increased retention of quality direct care workers to care for residents. In addition to the quality of life improvements experienced by the residents of the facility, a participating nursing facility will experience marketing and recruiting boosts from the "best practices" designation by an accrediting body that results from the facility's improved quality.

It is the intent that the special designation could be the starting point for providers to become eligible for a labor enhancement funding. The program is also intended to tie increased reimbursement rates to staff performance. North Carolina is still considering both of these options. Additionally, a career ladder for nurse aides has been created. Nurse aide trainees are provided with more hands on, real world experience to give them a realistic view of job requirements, accompanied by a mentoring program where an experienced nurse aide guides them along.

The North Carolina program is being funded through a demonstration grant. This funding is intended to allow the state to develop, pilot, and implement a uniform set of criteria and expectations for statewide use, on a voluntary basis, across home care, assisted living and nursing facilities. Providers who meet expectations and criteria receive a special licensure designation, North Carolina's New Organizational Vision Award (NOVA). This special designation (generally for two years) will be the basis for providers being eligible for enhanced funding or reimbursement.

In keeping with the Special Licensure Pilot Framework established by the NC program, the sixty participating organizations will be expected to:

- Attend an orientation meeting.

- Work toward implementing the NC NOVA requirements with expectation of submitting an application for NC NOVA review.
- Provide feedback as requested from NC NOVA Partner Team.

Outlined in Appendix D are more details regarding the areas and criteria established by the NC program.

Advisory Committee Recommendation: Pursue a model of culture change and recruitment and retention of long-term care nursing staff based on the North Carolina Model.

THE STRATEGIC PLAN

The Mission

The Virginia Quality Improvement Program Advisory Committee seeks to ensure an adequate supply of nursing staff in Virginia's nursing facilities through innovative recruitment and retention practices to meet the current and future need for care of one of the Commonwealth's most vulnerable populations.

The Committee has developed a strategic plan and recommendations for the Commonwealth that supports this mission. It is anticipated that, by using CMP funds towards the effort to recruit and retain quality nursing staff in Virginia's nursing facilities, nursing facility residents will receive improved care in a supportive, caring environment.

The QIP Advisory Committee supports the development of a *voluntary* and comprehensive incentive-driven model for workforce renewal using proven culture change principles based on the North Carolina model. The following strategic plan is proposed:

Goals and Objectives

GOAL ONE: Promote culture change in nursing facilities by encouraging nursing facilities to adopt proven operational practices and innovative strategies that strengthen the performance of nursing staff and improve the quality of care based on the "Better Jobs Better Care" demonstration grant.

- Objective One: Improve the quality of Virginia's nursing facilities by using CMP funds to develop a voluntary incentive-driven program to promote "culture change."

- Objective Two: Develop and maintain online resources offering technical assistance to nursing facilities on nursing recruitment and retention efforts. Include information on staff career advancement, mentoring, and trends.

GOAL TWO: Using the "Better Jobs Better Care" model, direct a portion of accumulated CMP funds specifically to recruitment and retention efforts of nursing staff in nursing facilities,

particularly of nursing assistants, that would provide positive inducements for nursing facilities to voluntarily implement culture change practices to improve workforce stability and care quality.

- Objective One: Develop, pilot, and implement a uniform set of criteria and expectations for statewide use, on a voluntary basis, for nursing facilities that address factors affecting the recruitment, retention, and job satisfaction of direct care staff. Consideration should be given to the reasons why nursing staff leave their jobs as demonstrated in long-term care research.

- Objective Two: Develop the "raise-the-bar" program pertaining to direct care staff recruitment and retention based on job practices known to contribute the high turnover and, by extension, workplace cultures where there is low turnover and high job satisfaction. These practices include supportive workplaces, balanced workloads, training, and career opportunities.

- Objective Three: Outline eligibility requirements for participation as a pilot site and criteria for attaining a special designation indicating that the facility is a participating facility. The program should allow for creative, innovative, and cost-effective approaches to achievement of identified measurable objectives based on sound "culture change principles.

Funding Estimates: At the present time, DMAS has a balance of CMP funds of more than $1,000,000 in addition to the CMP funds collected annually. Therefore, DMAS could use existing CMP funds for a one-time amount of $500,000 to $1,000,000, to begin the development and implementation of this project or to fund one of the suggestions discussed below. In addition, DMAS could supplement these funds by seeking grant funds.

ADDITIONAL FUNDING SUGGESTIONS

- ***Pay for Performance.*** The 2007 General Assembly (2007 Acts of the General Assembly, Chapter 847, Item 302.mmm) directed the Department of Medical Assistance Services to develop a pay for performance proposal for nursing homes. *"The proposal shall include the types of information that will be used to measure quality and the structure of the per diem reimbursement plan, (including the quality indicators that will be used and any payment levels on performance)."*

  While the Advisory Committee did not discuss the Pay-for-Performance initiative, the QIP should be a complementary program and ensure that all activities are coordinated between the two initiatives. Therefore, it may be appropriate to using a small portion of the accumulated balance of CMP funds to 'jump start' this project. The funding could be continued on a yearly basis in an amount determined by the Advisory Committee based on the yearly funds collected from providers who are assessed civil money penalties. This would provide sustainable funding for the QIP project, while providing enhanced incentives for pay for performance in nursing facilities.

- ***Base Funding Requirements for CMP Funds.*** The Advisory Committee may consider setting aside a base funding amount of $500,000 (from the accumulated balance) to offset costs of relocation of residents, maintenance of operation of a facility pending correction of deficiencies or closure, and/or reimbursement of residents for personal funds.

CONCLUSION

The greatest challenge in addressing quality of care issues in nursing facilities is staffing. Nursing recruitment and retention is creating heightened awareness of the problem and the subsequent risk inherent for nursing facility residents when staff turnover is great. Immediate action to improve Virginia's long-term care nursing recruitment and retention policies and practices, coupled with the opportunity to protect adults and provide needed services, will improve quality of care and life to vulnerable adults in the Commonwealth. With the implementation of the recommendations in this report, a coordinated effort among state agencies and other stakeholders, it is anticipated that nursing staff, particularly nursing assistants, will have a stronger voice in their jobs and increase job satisfaction.

The Virginia QIP Advisory Committee examined many different programs for the development and implementation of a quality improvement program. As the population continues to shift and the elderly and persons with disabilities require long-term care in growing numbers, the Committee believes that establishing a program to enhance nurse recruitment and retention in nursing facilities is only a beginning toward a better system of care for some of Virginia's most vulnerable citizens. Additional resources and funding must be put in place to bolster current programs and services, explore new avenues for providing long-term care, and increase awareness among the public about long-term care services.

The QIP Advisory Committee believes the Governor, General Assembly, state agencies, localities, and the private sector have an important role to play in supporting and funding many of these recommendations. In addition to the use of available CMP funds, the QIP Advisory Committee encourages the Commonwealth to continue to take advantage of federal grants and other funding opportunities to develop innovative pilot projects and other programs that support these recommendations. This will help Virginia maximize alternative funding streams and bolster the state's commitment to innovation in this area.

NEXT STEPS

DMAS will schedule, at a minimum, quarterly meetings of the Advisory Committee to begin addressing the tasks outlined in this report, including establishment of specific goals, creation of timelines, and the determination of the most appropriate use of CMP funds.

APPENDIX A

VIRGINIA QUALITY IMPROVEMENT PROGRAM IN NURSING FACILITIES

CHAPTER 474

An Act to amend and reenact §§ 32.1-353.1, 32.1-353.2, and 32.1-353.3 of the Code of Virginia and to repeal §§ 32.1-353.4 and 32.1-353.5 of the Code of Virginia, relating to the Certified Nursing Facility Education Initiative.

[H 2290]
Approved March 19, 2007

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-353.1, 32.1-353.2, and 32.1-353.3 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-353.1. Certified nursing facility education initiative; purpose.

The General Assembly finds that early identification of potential certified nursing facility deficiencies, coupled with the opportunity to correct any such problems, will improve quality of care and life to certified nursing facility residents in the Commonwealth. In order to implement the General Assembly's finding, early on-site training and assistance shall be provided ~~by a nonprofit organization~~ to certified nursing facilities that are found not in substantial compliance with long-term care requirements and that meet certain requirements as set forth ~~under any agreement as described in § 32.1-353.4~~ *in the Nursing Facility Quality Improvement Program developed pursuant to § 32.1-353.3.*

Creative and innovative approaches to the provision of long-term care services may also be explored. Such measures can best be accomplished by using the data, expertise, and knowledge of representatives of state government and representatives from the consumer, long-term care provider, and business communities. For this reason, the Board of Medical Assistance Services, assisted by the Department of Medical Assistance Services, shall administer the education initiatives for certified nursing facility care established by this chapter.

§ 32.1-353.2. Definitions.

As used in this chapter:

"Board" means the Board of Medical Assistance Services.

"Certified nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and § 32.1-137.

"Civil money penalty funds" means those funds collected by the Department of Medical Assistance Services for enforcement of certified nursing facility remedies pursuant to Title XIX of the Social Security Act.

"Director" means the Director of the Department of Medical Assistance Services.

~~"Nonprofit organization" means the nonprofit, tax exempt organization with the characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.~~

§ 32.1-353.3. Authorization to expend civil money penalty funds.

A. The Department of Medical Assistance Services, as administrator of the state Medicaid program, maintains a fund comprised of CMPs received from nursing facilities as a result of enforcement of federal survey requirements. Pursuant to federal regulations, such funds shall be used for the protection of the health or property of certified nursing facility residents. ~~The Director or his designee may enter into agreements with the nonprofit organization created pursuant to § 32.1-353.4 to spend any such funds, when in compliance with federal law, up to a total of $700,000. This discretionary authority shall in no way obligate the Director to enter into such agreements. Such funds shall be initially used to implement the nonprofit organization, but thereafter the nonprofit organization shall be self-sustaining.~~

B. In addition to the remedies specified in subsection A, the Director shall establish a Nursing Facility Quality Improvement Program in compliance with all applicable federal and state regulations designed to improve the health, safety, and welfare of residents in nursing facilities. The Director shall develop the Nursing Facility Quality Improvement Program in cooperation with affected state agencies, representatives of the nursing facility provider community, and advocacy groups.

2. That §§ 32.1-353.4 and 32.1-353.5 of the Code of Virginia are repealed.

3. That the Director shall provide a strategic plan and progress report to the Governor and the Chairmen of the House Committees on Health, Welfare and Institutions, and Appropriations; the Senate Committees on Education and Health, and Finance; and the Joint Commission on Health Care no later than October 1, 2007.

APPENDIX B

VIRGINIA NURSING FACILITIES QUALITY IMPROVEMENT PROGRAM ADVISORY COMMITTEE

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APPENDIX C

Other options QIP Advisory Committee Reviewed:

- Culture Change Models
  - Wellspring
  - Eden Alternative
  - Green House
  - I.D.E.A.S.
  - Michigan
  - Outcome Based
  - Pioneer
  - Quality Partners Rhode Island
  - Quality First Partners
  - My Innerview
  - Vital Research
  - Better Pay for Nurse Aide
- Advancing Excellence
- Best Practices
- Consistent Assignment
- Excellence and Educational Grant Awards

Other State Special Projects

Some states used their funds for targeted special projects. Some examples:

- New Jersey funded pressure ulcer projects, videos for CNAs, injury prevention, resident satisfaction surveys, medical error reporting.
- Delaware provided training workshops for facilities on restraints and pressure ulcers.
- Iowa presented information on CNA recruitment and retention initiatives, including a mentoring program where veteran CNAs received the opportunity to advance as peer mentors after completing the program. New CNAs paired with mentors experienced longer and more meaningful work experience through mentor experience.
- Ohio presented technical assistance programs to help improve quality of care.
- North Carolina implemented five programs for quality improvement initiatives, a university medication error study, and Eden Alternative and Pioneer Network program.
- Minnesota produced and distributed video and brochure on restraint use.
- Maryland provided quality improvement and technical assistance units, family council development, Wellspring projects, and pets-on-wheels.
- Michigan developed a special team for NF remediation and closures, a NF transition program, and evaluation of a NF dining assistant program.
- Florida conducted a university research project to identify the extent of mental illness among residents and to make recommendations for specialized staff training.

- Greater Indiana chapter of Alzheimer's Association sought CMP grant funding to offer training to all state's direct care workers on caring for residents with Alzheimer's or dementia.
- Kansas Association of Homes and Services for the Aging (KAHSA), with $97,000 in CMP funds, began training in March 2005 to help direct care workers improve their skills.
- South Carolina used $1 million in CMP money given to 39 nursing facilities through grants ranging from $5,000 to $22,000 for various projects, including Eden Alternative (works to deinstitutionalize culture and environment of nursing facilities and other LTC institution), quality improvement, and statewide CNA conferences.
- Kansas chose deficiencies that routinely hit the top 10 on surveys as focus of training (e.g.., falls, pressure sores, and range of motion). Training sessions were targeted to improve care giving skills in these areas and also show CNAs the regulatory foundation for surveys. One facility developed its own training program, which is now being disseminated with CMP funds. New hires are required to take the course. Nursing facilities report retention rates that have more than doubled.
- New Jersey, New Mexico, Florida, and Alaska are making an effort to broaden the pool of potential nurse aides by looking at former welfare recipients as potential nurse aides/
- Wisconsin, Iowa, and Oklahoma have funded or proposed pilot programs that focus on enhancing quality of life for direct care workers and decreasing staff turnover.
- Iowa used $100,000 in CMP money in FY 1999/2000 to fund a certified nursing and recruitment project. The project included a survey to determine why CNAs left the field. It also reviewed staff retention programs and interventions and a CNA mentor program. Over past 2 years, $70,000 has gone to fund scholarships for direct care workers to attend Iowa Caregivers Association's (ICA) annual education conference.

Appendix D

NC NOVA Manual

Areas and Criteria for NC NOVA Designation

Area 1: Supportive Workplaces

- Element 1: Orientation – structured, time-limited, initial training process by which an employer familiarizes new employees to organizational mission, policies and procedures and workplace environment.
- Element 2: Peer Mentoring – effective means for creating supportive workplace environment for new workers in terms of orientation, and for seasoned workers in terms of a career path opportunity.
    - Needs to be formal program that is clearly thought out and understood by all staff within the organization.
- Element 3: Coaching Supervision – an approach to supervision that relies on working with employees in a manner that centers on developing problem solving skills, the ability to think critically, prioritize and communicate effectively.
    - Criteria for NC NOVA Designation: prepare supervisors to use effective, respectful, team-building methods for leadership and management, which is a key element of a supportive workplace where employees feel valued and respected.
- Element 4: Management Support – management creates and supports a climate of mutual respect and responsiveness that values front-line care giving as a shared goal of direct care workers, clinical staff and non-clinical personnel throughout the organization.
- Element 5: Worker Empowerment – requires worker participation in planning and decision making about day-to-day and long range care practices and work environment.
    - Criteria for NC NOVA Designation: requires formal, well-understood mechanisms for worker participation in planning and decision-making about day-to-day and long range care practices and work environment.
- Element 6: Rewards and Recognition – address the needs and interests of the direct care workers themselves (may be monetary or non-monetary).
    - Managers should engage workers in participatory process to determine value and meaningful forms of recognition.

Area 2: Training

- A continuous undertaking that builds upon worker's demonstrated skills and strengthens their ability to thrive in a positive, problem-solving environment.
- In direct care settings, effective training should be characterized by:
    - Emphasis on strengthening person-centered services.
    - Respect for diverse backgrounds, training levels, and learning styles of individual workers.
    - Linkages with quality improvement initiatives and topics generated with input from front-line caregivers and administrators.
    - Involvement of experts outside of agency or facility, when necessary.
- Criteria for NC NOVA Designation: training initiatives targeted to direct-care workers under NC NOVA are expected to exceed minimum licensing requirements pertaining to continuing education for staff.

Area 3: Balanced Workloads

- Result from ongoing cooperation between management and direct care workers.
- Flexibility may be most important principle underlying this goal.
- Criteria for NC NOVA Designation: assumes an appropriate level of qualified staff, equipment, and supplies.

Area 4: Career Development

- Recommended elements for successful interventions: should be open, equitable, and accessible to all employees.

- Criteria for NC NOVA Designation: structured, incremental system that incorporates what are widely regarded as fundamental practices of human resources management and categorizes direct-care job titles, descriptions, qualifications, responsibilities, and pay ranges.

The Medical Review of North Carolina (MRNC) will be managing application, review, and determination process for NC NOVA special licensure for this project. Once applications have been submitted to NOVA trained MRNC staff will conduct pre-site visit, desk review of application, and evidence submitted by pilot applicant.

- Conducts conference call with applicant to clarify questions.
- Schedule on-site visit.
- Conducts an on-site review.
- Conduct post on-site review to compile all information and determine whether applicant has met requirements for NC NOVA special licensure designation.
- Notifies applicant by letter whether or not have met NC NOVA criteria.
- Division of Facility Services will mail NC NOVA special license to awardees following notification by MRNC
- All provider specific information collected will be destroyed after MRNC makes determination.

The eligibility criteria to apply for special licensure is a voluntary program for home care agencies, assisted living and nursing facilities. State provider associations, represented on the Partner Team, are responsible for selecting agencies to participate in pilot phase. Pilot sites must maintain good standing through process to receive designation. If the NF status is provisional, license revoked, or decertified by Medicare or Medicaid, the NF must contact MRNC to have application/review put on hold and may resume once license reinstated.