

AVAILABILITY OF  
CLINICAL WORKFORCE  
FOR NURSING HOMES

---

REPORT TO THE GENERAL ASSEMBLY

2020

VIRGINIA DEPARTMENT OF HEALTH  
OFFICE OF LICENSURE AND CERTIFICATION

**PREFACE**

---

The Virginia Department of Health (VDH) is submitting this report in response to the legislative mandate in Chapter 932 of the 2020 Acts of Assembly, which directed VDH to convene a work group to study and make recommendations on the availability of the clinical workforce in nursing homes. The legislative mandate requires VDH to submit its report “to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions on or before November 15, 2020.”

**MEMBERS OF THE WORK GROUP**

**Heather K. Anderson, MPH** – Director, Division of Primary Care and Rural Health, Office of Health Equity, Virginia Department of Health

**Todd Barnes** – Administrator, Virginia Veterans Care Center, Virginia Department of Veteran Services

**Alaysia Black Hackett, Exec. JD, MPA** – Special Assistant to the Chief Diversity Officer, Office of Diversity, Equity, and Inclusion, Office of the Governor

**Karen Brimm, MA** – Community Services Manager, Virginia Department for the Deaf and Hard of Hearing

**Jewell Bronaugh** – Commissioner, Virginia Department of Agriculture and Consumer Services

**Elizabeth A. Carter, PhD** – Director, Healthcare Workforce Data Center, Virginia Department of Health Professions

**Alicia Cundiff** – Government Affairs Specialist, SpottsFain Consulting

**Lionel DeCuir** – Deputy Director, Dignity for the Aged

**Kurt Elward, MD, MPH** – Senior Advisor, Virginia Department of Medical Assistance Services

**Meaghan Green** – Special Assistant to the Chief Workforce Advisor, Office of Governor Ralph Northam

**Erin Hines** – Facility Activity Coordinator, Dignity for the Aged

**Susan Hines** – Facility Activity Coordinator, Dignity for the Aged

**Christina Holloway** – Owner, Beach Health and Wellness

**Judy Jackson** – Virginia Department for the Blind and Vision Impaired

**W. Scott Johnson, Esq.** – Hancock, Daniel & Johnson, P.C.

**The Honorable Jennifer A. Kiggans** – Senator, Senate of Virginia

**Bob Kukich** – Treasurer, Dignity for the Aged

**Sam Kukich** – Director, Dignity for the Aged

**Joani Latimer** – State Long-Term Care Ombudsman, Virginia Department for Aging and Rehabilitative Services

**Heather Legere, MSW, LNHA** – Assistant Administrator, Virginia Veterans Care Center, Department of Veterans Services

**Vivienne Pierce McDaniel, DNP, MSN, RN** – Diversity, Equity, and Inclusion Chair, Virginia Nurses Association

**Dana Parsons** – Vice President and Legislative Counsel, LeadingAge Virginia

**Kathryn Paxton** – Policy Analyst, Office of Policy, Planning, and Research, Department of Agriculture and Consumer Services

**April Payne** – Vice President of Quality Improvement, Virginia Health Care Association | Virginia Center for Assisted Living

**Eric Raff** – Director, Virginia Department for the Deaf and Hard of Hearing

**Charlette Ridout, RN, MS, CNE** – Deputy Executive Director, Board of Nursing, Virginia Department of Health Professions

**Barbara Seymour, BSW, HCCS** – Division of Aging and Disability Services, Virginia Department of Medical Assistance Services

**Randall Stamper** – Assistant Vice Chancellor, Virginia Community College System

**Corie Tillman Wolf, JD** – Executive Director, Board of Long-Term Care Administrators, Virginia Department of Health Professions

**STAFF TO THE TASK FORCE**

**Rebekah E. Allen, JD** – Senior Policy Analyst, Office of Licensure and Certification, Virginia Department of Health

**A. Carole Pratt, DDS** – Senior Advisor and Confidential Assistant for Policy, Governmental and Regulatory Affairs, Virginia Department of Health

**Brenden Rivenbark** – Senior Policy Analyst, Governmental and Regulatory Affairs, Virginia Department of Health

**TABLE OF CONTENTS**

**Preface**..... **i**  
     Members of the Work Group ..... i  
     Staff to the Task Force ..... ii  
**Table of Contents**..... **iii**  
**Executive Summary** ..... **v**  
**Introduction** ..... **1**  
     Study Mandate ..... 1  
     Work Group Activities ..... 1  
         *July 6 Meeting*..... 1  
         *July 20 Meeting*..... 1  
         *August 4 Meeting*..... 2  
         *August 17 Meeting* ..... 2  
         *August 31 Meeting* ..... 2  
         *September 25 Meeting* ..... 2  
         *September 30 Meeting* ..... 2  
         *November 9 Meeting* ..... 2  
     Report Outline ..... 2  
**Virginia’s Clinical Workforce for Nursing Homes** ..... **4**  
     State of the Workforce ..... 4  
     CMS Five-Star Ratings for Workforce..... 6  
**Policy Recommendations** ..... **8**  
     Education-Related Recommendations ..... 8  
         *Service Learning and Volunteerism*..... 8  
         *Student Outreach*..... 10  
         *Educational Funding*..... 11  
     Wage-Related Recommendations ..... 12  
         *Financial Relief Programs*..... 12  
         *Minimum Wage* ..... 12  
         *Medicaid Reimbursement*..... 14  
     Workforce-Related Recommendations ..... 16  
         *Supporting Persons with Disabilities* ..... 16  
         *Supporting Veterans*..... 17  
         *Other Recommendations*..... 18  
**Appendix A – Chapter 932 of the 2020 Acts of Assembly** ..... **20**  
**Appendix B – Acronyms and Abbreviations**..... **21**  
**Appendix C – Work Group Meeting Minutes** ..... **23**  
     July 6, 1:00 P.M. .... 23  
     July 20, 1:00 PM..... 24  
     August 4, 1:00 P.M. .... 25  
     August 17, 1:00 P.M. .... 26  
     August 31, 1:00 P.M. .... 28  
     September 25, 1:00 P.M. .... 29  
     September 30, 1:00 P.M. .... 30  
     November 9, 9:00 A.M. .... 31  
**Appendix D – Summary of Written Comments from the Public** ..... **33**  
     July 6 Meeting ..... 33  
     July 20 Meeting ..... 33  
     August 4 Meeting..... 33

August 17 Meeting .....	34
August 31 Meeting .....	35
September 25 Meeting.....	35
September 30 Meeting.....	35
November 9 Meeting.....	35
<b>Appendix E – Stakeholder Voting Record on Work Group Recommendations .....</b>	<b>36</b>
<b>Appendix F – Stakeholder Explanations of Opposition to Specific Recommendations .....</b>	<b>42</b>
Recommendation #1 .....	42
Recommendation #2 .....	42
Recommendation #3 .....	42
Recommendation #4 .....	42
Recommendation #5 .....	42
Recommendation #6 .....	42
Recommendation #7 .....	43
Recommendation #8 .....	43
Recommendation #9 .....	43
Recommendation #10 .....	43
Recommendation #11 .....	43
Recommendation #12 .....	43
Recommendation #21 .....	43
Recommendation #22 .....	44
Recommendation #23 .....	44
Recommendation #25 .....	44
Recommendation #26 .....	44
Recommendation #27 .....	45
Recommendation #28 .....	45
Recommendation #30 .....	45
Recommendation #31 .....	45
Recommendation #32 .....	45
Recommendation #33 .....	45
Recommendation #34 .....	45
<b>Appendix G – Stakeholder Comments on Work Group Draft Report .....</b>	<b>47</b>
Dignity for the Aged.....	47
Office of the Chief Workforce Advisor .....	48
Office of the State Long-Term Care Ombudsman .....	48
Virginia Department of Health Professions .....	48
Virginia Health Care Association   Virginia Center for Assisted Living .....	50
<b>Appendix H– Service Learning Requirements by Jurisdiction .....</b>	<b>51</b>
<b>Appendix I– Nursing Home Staffing Requirements by Jurisdiction .....</b>	<b>66</b>
<b>Appendix J– CNA Responses to Dignity for the Aged .....</b>	<b>73</b>

## EXECUTIVE SUMMARY

---

As a condition of state licensure, nursing homes are required to provide a sufficient number of nursing staff to meet the assessed nursing care needs of its residents. Similarly, for those nursing homes participating in the Medicare and Medicaid programs, federal regulations require facilities to have sufficient nursing staff to address the number, acuity, and diagnoses of residents. The clinical workforce in Virginia—particularly certified nurse aides (CNAs) and licensed practical nurses (LPNs)—has declined in recent years; as a result, all medical care facilities, including nursing homes, have an increasingly smaller pool of qualified applicants from which to hire. The availability of the clinical workforce directly impacts the quality of care provided to nursing home residents.

The General Assembly directed the Virginia Department of Health (VDH) to convene a work group of key stakeholders in order to “review and make recommendations on increasing the availability of the clinical workforce for nursing homes in the Commonwealth.” VDH convened a work group that met eight times between July and November 2020. The work group received numerous informational presentations and received extensive written and oral comments. Through its discussions and deliberations, the work group focused in particular on the following issues and topics within the context of the study mandate:

- Education
- Wages
- Expansion of the existing workforce

*Education.* The work group identified the need to strengthen the educational pipeline that leads to careers not just in the clinical workforce, but specifically the clinical workforce in nursing homes. Some recommendations developed by the work group may be mutually exclusive (e.g., the multiple service learning options), but the work group felt that adoption of any one option would be beneficial to increasing the availability of the clinical workforce in nursing homes. The following recommendations are made:

1. Permit, but not require, local school boards to offer graduation credit for service learning in clinical care in long term care settings. Service learning is an instructional strategy that combines meaningful hands-on service to and for the benefit of the community with curriculum-based learning meeting specified objectives defined by the local school board in consultation with the Virginia Department of Health Professions (DHP) and VDH
2. Statewide offering of optional graduation credit for service learning in clinical care in long term care settings. Service learning is an instructional strategy that combines meaningful hands-on service to and for the benefit of the community with curriculum-based learning meeting specified objectives defined by the Virginia Board of Education (VBOE) in consultation with DHP and VDH
3. Statewide offering of optional Fairfax County Public Schools model of hours-based service learning (i.e., required for students in grades 6, 8, and 12, with optional diploma seal if additional hours are completed) in clinical care in long term care settings. Service learning is an instructional strategy that combines meaningful hands-on service to and for the benefit of the community with curriculum-based learning meeting specified objectives defined by the VBOE in consultation with DHP and VDH
4. Require changes to nursing home regulations to permit volunteerism in nursing homes, with supervision that includes orientation and training for volunteers consistent with the tasks assigned, recording the type of tasks and time worked, and method by which a volunteer may contact supervisor for immediate assistance
5. Require changes to nursing home regulations to permit service learning in nursing homes, with supervision that includes orientation and training consistent with the tasks assigned, recording the type

of tasks and time worked, and method by which a learner may contact supervisor for immediate assistance

6. Establish education and outreach programs for middle school and high school students to promote career pathways in long term care
7. Funding for tuition of the Advanced Certification for CNAs upon conclusion of pilot program
8. Expand eligibility of Nurse Loan Repayment Program in Va. Code § 32.1-122.6:04 (also known as the Mary Marshall Nursing Scholarship) to include CNAs
9. Fund the Nursing Scholarship and Loan Repayment Fund in Va. Code § 54.1-3011.2

*Wages.* The work group also recognized that one of the major challenges facing the current clinical workforce is low wages, which leads to difficulty in adequately staffing nursing homes, which in turn leads to burnout of existing staff. Some recommendations developed by the work group may be mutually exclusive (e.g., the multiple pay-for-performance programs), but the work group felt that adoption of any one option would be beneficial to increasing the availability of the clinical workforce in nursing homes. The following recommendations are made:

10. Establish financial relief program to support direct care nursing home employees by covering a percentage of childcare or dependent care costs
11. Establish financial relief program to support direct care nursing home employees by covering a percentage of transportation costs to include public transportation costs
12. Establish financial relief program to support direct care nursing home employees by covering a percentage of living costs, which may include housing, transportation, childcare or dependent care, utilities, or other categories of expenses as determined by the General Assembly
13. Increase wages for CNAs proportional to regional living wage standards, with living wage standards derived from United For ALICE project data aggregated according to the local workforce board region
14. Increase wages for CNAs proportional to regional living wage standards, with living wage standards derived from Massachusetts Institute of Technology (MIT) Living Wage Calculator aggregated according to the local workforce board region
15. Increase minimum wage proportional to regional living wage standards, with living wage standards derived from United For ALICE project data aggregated according to the local workforce board region
16. Increase minimum wage proportional to regional living wage standards, with living wage standards derived from MIT Living Wage Calculator aggregated according to the local workforce board region
17. Rebase the Medicaid reimbursement rate annually based on regionalized living wage standards (derived from United For ALICE project data aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program
18. Rebase the Medicaid reimbursement rate annually based on regionalized living wage standards (derived from MIT Living Wage Calculator aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program
19. Rebase the Medicaid reimbursement rate triennially based on regionalized living wage standards (derived from United For ALICE project data aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program
20. Rebase the Medicaid reimbursement rate triennially based on regionalized living wage standards (derived from MIT Living Wage Calculator aggregated according to the local workforce board region)

and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program

21. Pay for performance program through the Virginia Department of Medical Assistance Services (DMAS) to provide additional reimbursement to facilities meeting minimum staff-to-resident ratios and meeting minimum quality of care standards as determined by DMAS, with such threshold ratios for additional reimbursement increasing every biennium for three biennia
22. Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum staff-to-resident ratios and meeting minimum quality of care standards as determined by DMAS, with such threshold ratios for additional reimbursement beginning at 12-to-1 and increasing to 6-to-1 over for four biennia
23. Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum hours of nursing care per resident, with such threshold hours for additional reimbursement increasing every biennium for three biennia
24. Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum hours of nursing care per resident and meeting minimum quality of care standards as determined by DMAS, with such threshold hours for additional reimbursement beginning at 3.5 hours and increasing to 4.1 hours over for three biennia

*Expansion of the existing workforce.* The work group examined ways to expand the clinical workforce in nursing homes, both now and in the future, by investigating means and methods to incentivize the inclusion of veterans, persons with disabilities, and other groups. The work group also looked at ways to incentivize the existing clinical workforce to remain in nursing homes. The following recommendations are made:

25. Creating a workforce program similar to Virginia Values Veterans (V3) Program for people with disabilities to increase employment opportunities and promote economic development by training and certifying organizations in disability workforce best practices
26. Require changes to nursing home regulations to permit care by non-credentialed individuals in the Military Medics and Corpsmen (MMAC) program
27. Civilian credentialing/licensing reciprocity so state regulatory bodies recognize civilian equivalency of certain military allied health specialties
28. Civilian educational credits for statewide standardized recognition of military medical education and awarding of equivalent credit hours
29. Funding for awareness campaign for MMAC Program and the healthcare employment opportunities provided by the program
30. State version of the federal work opportunity income tax credit for private-sector businesses that hire individuals who have consistently faced significant barriers to employment, as determined by the General Assembly
31. State income tax credit for CNAs, LPNs, and registered nurses (RNs) working at licensed nursing homes and certified nursing facilities
32. State income tax credit for for-profit nursing homes based on expenditures aimed at providing access to employees with disabilities
33. Tax relief program for not-for-profit nursing homes that would allow them to offset part of their payroll tax for expenditures aimed at providing access to employees with disabilities
34. Direct Joint Commission on Health Care to conduct a study on direct care staff recruitment and retention, workplace culture improvements, and internal leadership development in nursing homes



## INTRODUCTION

---

The Division of Long Term Care Services in the Virginia Department of Health’s (VDH) Office of Licensure and Certification (OLC) is the unit responsible for the state licensure and inspection of nursing homes<sup>1</sup> and for conducting federal surveys of certified nursing facilities.<sup>2</sup>

A certified nursing facility is one that has chosen to participate in the Medicare and/or Medicaid programs, and therefore, be subject to the conditions of participation (COPs) for those programs. Certified nursing facilities must comply with federal COPs and state licensure regulations. Nursing homes are not subject to federal COPs. As of October 27, 2020, there are 283 nursing homes and 275 certified nursing facilities in Virginia. Eight nursing homes are currently licensed, but not participating in Medicare and/or Medicaid; all residents of these non-participating nursing homes fund their care through private pay arrangements.

Resident care in nursing homes and certified nursing facilities is provided primarily by certified nurse aides (CNAs), licensed practical nurses (LPNs), and registered nurses (RNs). Each nursing home and certified nursing facility must have sufficient clinical staff to meet the needs of each resident.<sup>3</sup>

## STUDY MANDATE

The General Assembly, in Chapter 932 of the 2020 Acts of Assembly, directed the Virginia Department of Health (VDH) to convene a work group of key stakeholders in order “review and make recommendations on increasing the availability of the clinical workforce for nursing homes in the Commonwealth” (Appendix A).

## WORK GROUP ACTIVITIES

In response to the legislative mandate, the Office of Licensure and Certification (OLC) in VDH convened a 32-member work group representing a broad range of perspectives and expertise. The work group held eight meetings during 2020: on July 6, July 20, August 4, August 17, August 31, September 25, September 30, and November 9.

### JULY 6 MEETING

The work group reviewed the mission of the Chapter 932 work group set forth by the 2020 General Assembly. In addition, the current state of Virginia’s nursing home workforce was reviewed and a preliminary road map for the work group was produced. The work group discussed opportunities to leverage civic engagement requirements in public schools as a means to market the value of nursing home jobs and the need to explore additional policy recommendations to enhance the nursing home workforce.

### JULY 20 MEETING

The work group revised the Chapter 932 work group road map to focus on educational pipelines, training curriculum, student debt, payer mix, reimbursement rates, and financial incentive programs. Virginia’s public school service learning requirements were reviewed in addition to multiple various workforce development and

---

<sup>1</sup> Va. Code § 32.1-123 defines nursing home as “any facility or any identifiable component of any facility licensed pursuant to this article in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care of two or more non-related individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.”

<sup>2</sup> Va. Code § 32.1-123 defines certified nursing facility as “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 as a Medicare or Medicaid provider, or both, pursuant to § 32.1-137.”

<sup>3</sup> See 12VAC5-371-210(B) and 42 C.F.R. § 483.35.

student loan repayment programs. Members of the public implored the work group to focus on the drivers of poor nursing home quality outcomes, such as low nurse aide wages and regulatory accountability.

#### AUGUST 4 MEETING

The work group discussed opportunities to enhance nursing home staff curricula for special populations by developing courses that focus on engaging with residents who are blind, deaf, and/or hard of hearing as well as the need to develop programs for blind, deaf, and/or hard of hearing staff. Programs supporting the integration of veterans into the civilian health care workforce were discussed as were the payer mix for Virginia's certified nursing facilities, full-time equivalents (FTEs), labor costs, revenues, profit margins, and reimbursement rates. Tax incentive programs that nursing homes can further leverage to support staffing recruitment and retention were presented.

#### AUGUST 17 MEETING

William A. Hazel Jr., MD provided an overview of the Claude Moore Scholars Healthcare Education Program, which provides funds to public school systems and institutions of higher education to develop and maintain Career and Technical Education (CTE) programs and Medicaid staff discussed Medicaid rate setting, sources of funding, and incentive programs. Meaghan Green, the Special Assistant to Governor Northam's Chief Workforce Advisor, presented on nursing and other long-term care facility workforce trends as well as opportunities to recruit the workforce impacted by the COVID-19 pandemic into high-need long-term care settings. The work group reviewed resident and staffing demographics of Virginia's nursing homes as well as the payer mix for residents. Additionally, the financial and operational impacts of COVID-19 on Virginia's nursing homes and potential opportunities to address workforce gaps, including temporary nurse aide training programs, FastForward Virginia, and scholarship programs.

#### AUGUST 31 MEETING

The work group reviewed research conducted by VDH staff highlighting strategies other states have utilized in mandating staffing ratios in nursing homes and data comparing ratios reported to the U.S. Centers for Medicare and Medicaid Services (CMS), hospitalizations per 1,000 long-stay resident days, CNA hourly mean wages, total CNA workforce, employment per 1,000 jobs, and Medicaid expenditures per aged enrollee. Additionally, potential work group recommendations as submitted by members were reviewed.

#### SEPTEMBER 25 MEETING

The work group conducted an initial review of the 17 recommendations that had been produced by the work group to date. It was requested by the work group that revisions be made to the draft recommendations and that another meeting be held to finalize recommendations.

#### SEPTEMBER 30 MEETING

Each of the 32 potential recommendations produced by the work group were put forward for final review and revision, after which time recommendation voting instructions were provided.

#### NOVEMBER 9 MEETING

The work group reviewed the draft report and recommendations in addition to next steps for report submission.

### **REPORT OUTLINE**

Following the discussion of the study mandate and the activities of the clinical workforce work group, the report provides an overview of Virginia's clinical workforce and the current regulatory and statutory

requirements for staffing. A description of other states' minimum nursing home staffing requirements is included. The report also describes the star rating system utilized by the CMS and the specific ratings related to the clinical workforce.

---

**VIRGINIA’S CLINICAL WORKFORCE FOR NURSING HOMES**

---

**STATE OF THE WORKFORCE**

As noted in the Introduction, the clinical workforce needs for Virginia’s nursing home residents rely primarily upon a mix of CNAs, LPNs, and RNs. The Virginia Department of Health Professions (DHP), which is composed of the numerous boards responsible for licensing and oversight of health professionals, routinely surveys health professionals when they renew their licenses and certifications. This surveying function is carried out by DHP’s Healthcare Workforce Data Center (HWDC). The HWDC produces white papers and numerous data products, such as the profession reports that provide a statewide look at the healthcare workforce on a profession-by-profession basis. The HWDC produces regular reports on the 62 professions regulated by DHP and the most recent profession reports are from 2019.

HWDC’s *Virginia’s Certified Nurse Aide Workforce: 2019* report indicated that there are 60,272 CNAs in Virginia, representing 50,584 FTEs.<sup>4</sup> It is estimated that 56,870 CNAs worked at least part of the year in the state or intend to return to work as a CNA in the future.<sup>5</sup> Nursing homes employ 29% of the state’s CNAs as their primary place of employment and 18% as a secondary place of employment.<sup>6</sup> When compared with data from five years ago, there has been a 2% decline in the number of CNAs in the state.<sup>7</sup> However, in spite of this decline, the number of CNAs who are actively in the workforce has increased by 7%, boosting the number of FTEs by 12%.<sup>8</sup> CNAs in Virginia are 94% female and their median age is 38, down from 39 five years ago.<sup>9</sup>

The rate of involuntary unemployment over the past five years has fallen dramatically from 9% to 3%.<sup>10</sup> Three quarters of CNAs receive at least one employer-sponsored benefit including 54% who have access to health insurance.<sup>11</sup> The median hourly wage for Virginia’s CNAs has increased from \$11-\$12 five years ago to \$13-\$14 per hour in 2019.<sup>12</sup> The pay rate ranges from less than \$7.50 per hour to over \$15 per hour.<sup>13</sup> A comparison of the hourly pay rate between 2014 and 2019 is show below in Figure 1.

---

<sup>4</sup> FTEs are defined as those persons working 2,000 hours per year or 40 hours per week for 50 weeks. Elizabeth A. Carter, ed., “Virginia’s Certified Nurse Aide Workforce: 2019” (Healthcare Workforce Data Center, October 2019), <https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/nurse/1401CNA2019.pdf>, 4.

<sup>5</sup> Ibid, 2.

<sup>6</sup> Ibid, 13.

<sup>7</sup> Ibid, 2.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid, 2.

<sup>13</sup> Ibid, 10.

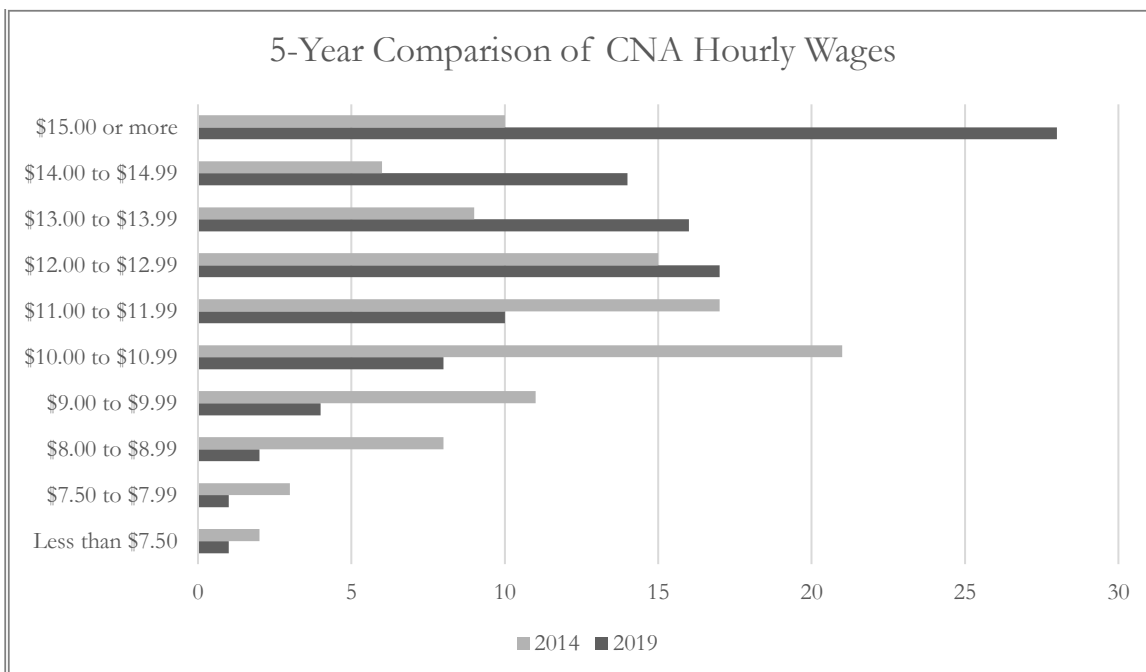


Figure 1: 5-Year Comparison of CNA Hourly Wages<sup>14</sup>

HWDC’s *Virginia’s Licensed Practical Nurse Workforce: 2019* report indicated that Virginia has licensed 29,500 LPNs, representing 23,974 FTEs.<sup>15</sup> It is estimated that 26,725 LPNs worked at least part of the year in the state or intend to return to work as an LPN in the future.<sup>16</sup> Long-term care facilities or nursing homes employ 26% of the state’s LPNs as their primary place of employment with 33% reporting these facilities as a secondary place of employment.<sup>17</sup> When compared with data from five years ago, there has been a 5% decline in the number of licensed LPNs in the state resulting in a 4% decrease in the LPN workforce and a 4% decrease in FTEs.<sup>18</sup> LPNs in Virginia are 95% female and their median age is 46.<sup>19</sup>

The median debt burden of an LPN is \$20,000 to \$30,000, up from \$10,000 to \$20,000 five years ago.<sup>20</sup> The median annual income is \$40,000 to \$50,000, which is an increase from \$30,000 to \$40,000 five years ago.<sup>21</sup> Pay ranges from less than \$20,000 annually to \$100,000 or more.<sup>22</sup> The rate of involuntary unemployment for LPNs over the same period has fallen from 3% to 2%.<sup>23</sup> Seventy-nine percent of LPNs have access to at least one employer-sponsored benefit including 62% who have health insurance.<sup>24</sup>

<sup>14</sup> Ibid and Elizabeth A. Carter, ed., “Virginia’s Certified Nurse Aide Workforce: 2014” (Healthcare Workforce Data Center, January 2015), [https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/nurse/1401CNA\\_2014.pdf](https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/nurse/1401CNA_2014.pdf), 10.

<sup>15</sup> Elizabeth A. Carter, ed., “Virginia’s Licensed Practical Nurse Workforce: 2019” (Healthcare Workforce Data Center, October 2019), <https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/nurse/0002LPN2019.pdf>, 1.

<sup>16</sup> Ibid, 2.

<sup>17</sup> Ibid, 16.

<sup>18</sup> Ibid, 2.

<sup>19</sup> Ibid, 16.

<sup>20</sup> Ibid, 2.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid, 8.

<sup>23</sup> Ibid, 2.

<sup>24</sup> Ibid.

HWDC's *Virginia's Registered Nurse Workforce: 2019* report indicated that Virginia has 112,053 RNs representing 81,369 FTEs.<sup>25</sup> It is estimated that 94,384 RNs worked at least part of the year in the state or intend to return to work as an RN in the future.<sup>26</sup> Long-term care facilities or nursing homes employ 4% of the state's RNs as their primary place of employment and 6% as a secondary place of employment.<sup>27</sup> The number of RNs licensed in Virginia has increased by 11% over the last five years, representing a 14% increase in the RN workforce and a 13% increase in FTEs.<sup>28</sup> RNs in Virginia are 93% female and their median age is 46,<sup>29</sup> falling from 48 five years ago.<sup>30</sup>

The median debt burden of an RN is \$30,000 to \$40,000, an increase from \$20,000 to \$30,000 five years ago, and the median annual income is \$60,000 to \$70,000 which is an increase from \$50,000 to \$60,000 during the same time.<sup>31</sup> Pay ranges from less than \$10,000 to more than \$120,000 annually.<sup>32</sup> The rate of involuntary unemployment for RNs over the same period has fallen from 2% to 1%.<sup>33</sup> Eighty-four percent of RNs have access to at least one employer-sponsored benefit, including 66% who have health insurance through their employer.<sup>34</sup>

### CMS FIVE-STAR RATINGS FOR WORKFORCE

CMS has created for the public the Nursing Home Compare site that provides information about every certified nursing facility in the country.<sup>35</sup> This comparison function includes the Five-Star Quality Rating System, which assists residents, families, and caregivers to more easily compare nursing homes and to obtain answers about them.<sup>36</sup> The Five-Star Quality Rating System rates each nursing home with one to five stars, with five stars representing above average quality ratings and one star representing those below average. Each nursing home is assigned a single rating overall with separate ratings for health inspections, staffing, and quality measures.<sup>37</sup>

The Nursing Home Compare Five-Star Quality Rating System user's guide describes, in relevant part, how it evaluates staffing:<sup>38</sup>

---

<sup>25</sup> Elizabeth A. Carter, ed., "Virginia's Registered Nurse Workforce: 2019" (Healthcare Workforce Data Center, October 2019), <https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/nurse/0001RN2019.pdf>, 1.

<sup>26</sup> *Ibid.*, 2.

<sup>27</sup> *Ibid.*, 16.

<sup>28</sup> *Ibid.*, 2.

<sup>29</sup> *Ibid.*, 5.

<sup>30</sup> *Ibid.*, 2.

<sup>31</sup> *Ibid.*

<sup>32</sup> *Ibid.*, 8.

<sup>33</sup> *Ibid.*, 2.

<sup>34</sup> *Ibid.*

<sup>35</sup> "Medicare Nursing Home Compare Overview." U.S. Centers for Medicare and Medicaid Services, 2020. <https://www.medicare.gov/NursingHomeCompare/About/howcannhchelp.html>.

<sup>36</sup> "What Information Can I Get About Nursing Homes?" U.S. Centers for Medicare and Medicaid Services, 2020. <https://www.medicare.gov/NursingHomeCompare/About/nhcinformation.html>.

<sup>37</sup> *Ibid.*

<sup>38</sup> U.S. Centers for Medicare and Medicaid Services. 2015. "Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide." <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/usersguide.pdf>.

*Staffing - Measures based on nursing home staffing levels: Ratings on the staffing domain are based on two measures: 1) Registered nurse (RN) hours per resident per day; and 2) total nurse staffing (the sum of RN, licensed practical nurse (LPN), and nurse aide) hours per resident per day. Other types of nursing home staff, such as clerical or housekeeping staff, are not included in the staffing rating calculation. The staffing measures are derived from data submitted each quarter through the Payroll-Based Journal (PBJ) System...*

Section 6106 of the Patient Protection and Affordable Care Act amended the Social Security Act to require certified nursing facilities to electronically submit direct care staffing information based on payroll and other auditable data.<sup>39</sup> The data, when combined with census information, can then be used to report on the level of staff in each nursing home, as well as employee turnover and tenure, which can impact the quality of care delivered.

Current Virginia regulatory requirements for nursing home staffing defines the nursing supervisor and their duties and requires the facility to provide qualified nurses and CNAs on all shifts in sufficient number to meet the assessed needs of all residents.<sup>40</sup> Likewise, CMS’s staffing COP<sup>41</sup> requires certified nursing facilities to “have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population...” There are other jurisdictions that have more specific requirements (Appendix I). As of the date of this report, out of the 286 certified nursing facilities in Virginia,<sup>42</sup> on the staffing metric, 40 received 1 Star indicating much below average, 84 received 2 Stars indicating below average, 66 received 3 Stars indicating average, 53 received 4 Stars indicating above average, and 35 received 5 stars indicating much above average. A visual representation of this distribution is shown below in Figure 2.

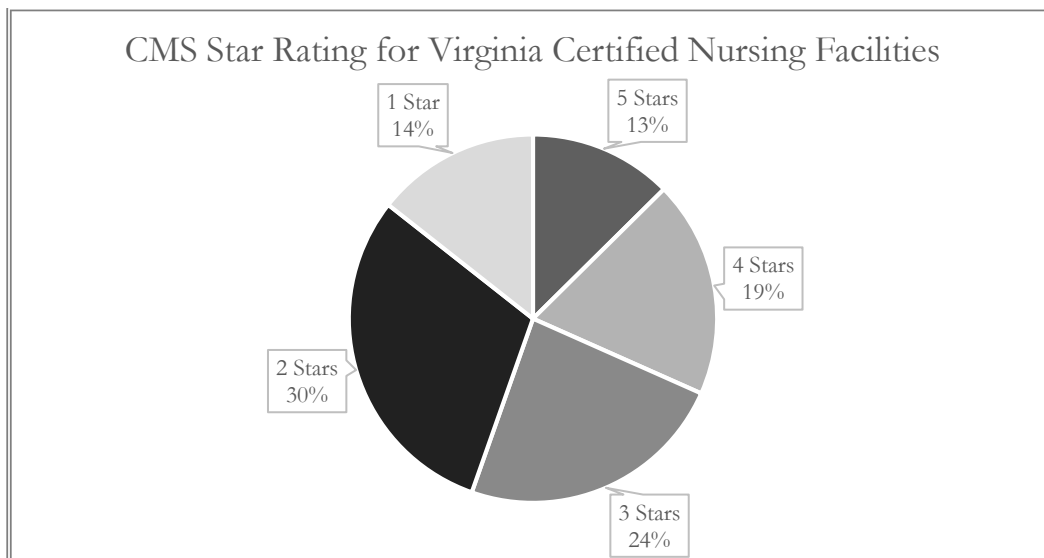


Figure 2: CMS Star Rating for Virginia Certified Nursing Facilities

<sup>39</sup> See Patient Protection and Affordable Care Act of 2010, H.R. 3590, 111th Cong. § 6106 (2010) and 42 C.F.R. § 483.70(q).

<sup>40</sup> See 12VAC5-371-210.

<sup>41</sup> See 42 C.F.R. § 483.35.

<sup>42</sup> Two facilities were too new to rate and 20 facilities did not have data available regarding staffing

## POLICY RECOMMENDATIONS

---

The work group considered 34 potential recommendations, of which 21 were adopted with an outright majority vote of Support and 13 were adopted after abstention votes were accounted for.<sup>43</sup> Each stakeholder organization or agency was afforded one vote per recommendation, and a recommendation was approved for inclusion in the work group’s report if a simple majority voted in support of the recommendation. The results of the stakeholders’ votes may be found in Appendix E. If a stakeholder opposed a recommendation, the stakeholder was also given the opportunity to explain its opposition in writing; these written comments are reproduced, in full, in Appendix F.

No recommendation received a majority “Oppose” vote, though there are several recommendations where the majority vote was “Abstain”; those recommendations that received a majority “Abstain” vote were otherwise supported by a majority of the stakeholders. The outcome of each vote is indicated beside the recommendations, with “Y” indicating a yes vote, “N” indicating a no vote, and “A” indicating an abstention.

### EDUCATION-RELATED RECOMMENDATIONS

The work group recognizes that part of the clinical workforce shortage in nursing homes is due to a less-than-robust pipeline of potential direct care workers. To address this pipeline issue, the work group examined topics that could expose students to the career opportunities in direct care work in the long term care and financial barriers in education to either enter the workforce or to advance with additional learning opportunities.

#### SERVICE LEARNING AND VOLUNTEERISM

A majority of jurisdictions have adopted service learning as either a requirement or an optional credit for graduation (Appendix H). Service learning is different from volunteerism or community service in that service learning is part of a structured curriculum with specified objectives.

Service learning is distinguished from community service or other volunteerism in that it is tied to curriculum and standards, either set at the state or local level. Service learning is often framed as an instructional strategy to increase student achievement, increase student civic engagement, prepare students for the workplace, or some combination of all three.<sup>44</sup> The work group discussed various service learning implementations by jurisdiction. A small minority of jurisdictions<sup>45</sup> set service learning requirements as a graduation requirement for all students. Many more jurisdictions have service learning as an optional jurisdiction-wide graduation credit that all students can pursue, with varying degrees of discretion granted to local school boards to set standards and objectives for service learning.

A final option for service learning gives discretion to local school boards to both offer the graduation credit and to set standards and objectives for service learning. This option has already been implemented by Colorado, Florida, Iowa, Rhode Island, Tennessee, and Wisconsin. Half of these states utilize the service learning requirement as potential endorsement on the high school diploma or academic award, whereas the other half utilize it as a potential graduation requirement. In Virginia, Fairfax County Public Schools (FCPS) has launched an hours-based service learning model and is documenting its students’ successful completion of the program

---

<sup>43</sup> Stakeholders were given the options of “Support”, “Oppose”, or “Abstain” when voting on individual recommendations. Some recommendations received more Abstain votes than Support or Oppose votes, but once the Abstain votes were accounted for, the recommendations received more Support than Oppose votes.

<sup>44</sup> Baumann, Paul. “50-State Comparison: Service-Learning/Community Service as a Strategy for Fostering Student Outcomes.” Education Commission of the States. National Center for Learning and Civic Engagement, January 1, 2014. <http://ecs.force.com/mbdata/mbquest3RTE?Rep=SL1303>.

<sup>45</sup> See Md. Code Regs. 13A.03.02.06 and D.C. Mun. Regs. tit. 5-E § 2203.



through the electronic x2vol software.<sup>46</sup> This program calls for a minimum number of service hours in Grades 6, 8, and 9 through 12,<sup>47</sup> as outlined below:

- Grade 6: 5 hours
- Grade 8: 15 hours
- Grades 9–12: 40 hours, though students are encouraged to spread out this requirement so that they are completing 10 hours annually.

By completing these hours, FCPS offers a FCPS service learning cord.<sup>48</sup> FCPS also offers a diploma seal for excellence in civics education for those high school students completing more than 50 hours.<sup>49</sup> FCPS’s service learning is built upon the principles of connection with curriculum, authenticity, intentionality, reflection, impact to the community, and applicability to the student’s interests and career goals.<sup>50</sup>

The work group discussed all of the service learning models and as part of that discussion, rejected consideration of a statewide requirement for service learning as too prescriptive and restrictive. The service learning recommendations that the work group voted upon are mutually exclusive; for example, Recommendation 1 leaves service learning to the discretion of local school boards whereas Recommendation 2 does not and instead gives the student the choice to pursue the optional graduation credit. The work group recognizes this incompatibility, but based on the votes, felt that the recommendations below represent a spectrum of choices that the General Assembly may utilize if it wishes to implement service learning in Virginia.

The work group also discussed that if a service learning recommendation were to be adopted by the General Assembly or in the alternative, the General Assembly wished to encourage volunteerism by students and other members of the community in nursing homes, the nursing home regulations would need to be updated as outlined in Recommendations 4 and 5 below.

<i>No.</i>	<i>Recommendation</i>	<i>Voting Result</i>
1	Permit, but not require, local school boards to offer graduation credit for service learning in clinical care in long term care settings. Service learning is an instructional strategy that combines meaningful hands-on service to and for the benefit of the community with curriculum-based learning meeting specified objectives defined by the local school board in consultation with DHP and VDH	11Y - 1N - 5A
2	Statewide offering of optional graduation credit for service learning in clinical care in long term care settings. Service learning is an instructional strategy that combines meaningful hands-on service to and for the benefit of the community with curriculum-based learning meeting specified objectives defined by the Virginia Board of Education (VBOE) in consultation with DHP and VDH	11Y - 1N - 5A
3	Statewide offering of optional Fairfax County Public Schools model of hours-	9Y - 1N - 7A

<sup>46</sup> “Service Learning.” Fairfax County Public Schools, 2020. <https://www.fcps.edu/activities/service-learning>.

<sup>47</sup> Ibid.

<sup>48</sup> “Service Learning.” W.T. Woodson High School, 2020. <https://woodsonhs.fcps.edu/student-life-activities/service-learning>.

<sup>49</sup> This diploma seal is available to any Virginia high school student who completes 50 or more volunteer hours, in addition to other criteria. “Graduation (Diploma) Seals of Achievement.” Virginia Department of Education, 2020. [https://www.doe.virginia.gov/instruction/graduation/diploma\\_seals/index.shtml](https://www.doe.virginia.gov/instruction/graduation/diploma_seals/index.shtml).

<sup>50</sup> “Service Learning.” Fairfax County Public Schools, 2020. <https://www.fcps.edu/activities/service-learning>.

	based service learning (i.e., required for students in grades 6, 8, and 12, with optional diploma seal if additional hours are completed) in clinical care in long term care settings. Service learning is an instructional strategy that combines meaningful hands-on service to and for the benefit of the community with curriculum-based learning meeting specified objectives defined by the VBOE in consultation with DHP and VDH	
4	Require changes to nursing home regulations to permit volunteerism in nursing homes, with supervision that includes orientation and training for volunteers consistent with the tasks assigned, recording the type of tasks and time worked, and method by which a volunteer may contact supervisor for immediate assistance	10Y - 2N - 5A
5	Require changes to nursing home regulations to permit service learning in nursing homes, with supervision that includes that includes orientation and training consistent with the tasks assigned, recording the type of tasks and time worked, and method by which a learner may contact supervisor for immediate assistance	12Y - 1N - 4A

#### STUDENT OUTREACH

During the work group’s meetings, representatives from LeadingAge Virginia<sup>51</sup> and the Claude Moore Charitable Foundation<sup>52</sup> spoke about the importance of early engagement with students to cultivate and encourage interest in long term care settings. LeadingAge Virginia described its efforts with a poster campaign pilot program for elementary students, based on the successful “Careers that Love You Back” poster campaign created by LeadingAge Ohio,<sup>53</sup> which promotes student awareness of 21 careers in the aging services workforce sector. The pilot program consists of both posters and a teacher’s guide that has sample lesson plans, classroom activities, and other engagement recommendations.<sup>54</sup> Dr. William H. Hazel, Jr. with the Claude Moore Charitable Foundation also spoke about the Claude Moore Scholars Program, which “provides local school systems with grant funds to establish healthcare education programs for high school students that will meet local, regional, and state-wide workforce needs.”<sup>55</sup> Since LeadingAge Virginia’s work was presently a pilot program aimed at elementary students and the Claude Moore Scholars Program was involved in seven school districts,<sup>56</sup> the work group discussed and considered the need for statewide education and outreach programs promoting long term care careers to address the gaps between these two existing efforts.

<sup>51</sup> LeadingAge Virginia is an association of not-for-profit aging services organizations serving residents and clients through life plan/continuing care retirement communities, senior housing, assisted living, nursing homes, adult day centers and home and community based services.

<sup>52</sup> The Claude Moore Charitable Foundation is an organization that supports programs and partnerships aimed at increasing academic competence and encouraging leadership abilities, with an emphasis on the underprivileged.

<sup>53</sup> “Careers That Love You Back.” LeadingAge Ohio, 2019, [leadingageohio.org/aws/LAO/pt/sp/posters](http://leadingageohio.org/aws/LAO/pt/sp/posters).

<sup>54</sup> *A Teacher’s Guide to Careers That Love You Back*. LeadingAge Ohio, 2019, [leadingageohio.org/aws/LAO/asset\\_manager/get\\_file/328050?ver=5831](http://leadingageohio.org/aws/LAO/asset_manager/get_file/328050?ver=5831).

<sup>55</sup> “Public School Systems K-12.” Claude Moore Charitable Foundation, 2020, <https://claudemoorefoundation.org/claude-moore-scholars-program/k-12-school-systems/>

<sup>56</sup> The school systems that the Claude Moore Charitable Foundation is currently partnered with are Loudoun County Public Schools, Fairfax County Public Schools, Winchester City Public Schools, Petersburg City Public Schools, Chesterfield County Public Schools, Halifax County Public Schools, and Prince William County Public Schools.

<i>No.</i>	<i>Recommendation</i>	<i>Voting Result</i>
6	Establish education and outreach programs for middle school and high school students to promote career pathways in long term care	12Y - 1N - 4A

#### EDUCATIONAL FUNDING

Part of the work group’s discussion involved funding for education opportunities of the clinical workforce. Representatives from LeadingAge Virginia spoke about its grant-funded educational pilot program consisting of both clinical and classroom coursework for CNAs that helps them meet the criteria to apply for the Advanced Nurse Aide certification. This program has been developed in collaboration with Blue Ridge Community College (BRCC) and Sunnyside Retirement Community, and in consultation with DHP’s Board of Nursing.<sup>57</sup> Thirty students will receive scholarships to take the course through BRCC, broken down as ten students over three semesters.<sup>58</sup> This educational program is designed to teach CNAs additional skills to improve care and well-being of nursing home residents and to create a career path and advancement ladder for better staff retention and to decrease burnout.

As noted, the scholarship for this program is grant funded, specifically through the Civil Monetary Penalty (CMP) Fund. The CMP Fund is a collection of monetary penalties that CMS may impose against certified nursing facilities, for either the number of days or for each instance a facility is not in substantial compliance with one or more Medicare and Medicaid COPs. Regardless of jurisdiction, CMP funds are used for projects that directly benefit individuals residing in a certified nursing facility through protecting and improving residents’ quality of life and care. However, the CMP Fund projects cannot exceed three years, and LeadingAge Virginia representatives explained that while they would like to expand the pilot program to other educational institutions, presently additional funding for full or partial scholarships has not been secured.

Representatives from Virginia Board of Nursing and VDH’s Office of Health Equity touched upon the fact that two statutory educational funding programs already exist. The Nurse Loan Repayment Program, which is also known as the Mary Marshall Nursing Scholarship, was established by Chapter 188 (2001 Acts of Assembly). This program is funded by fees collected by DHP’s Board of Nursing and both LPNs and RNs may apply for the scholarship. CNAs are presently not eligible for this scholarship program.<sup>59</sup>

The Nursing Scholarship and Loan Repayment Fund was established by Chapter 699 (1991 Acts of Assembly). Unlike the Mary Marshall Nursing Scholarship, CNAs are already eligible to partake in this program, per the amendments in Chapters 240 and 254 (2000 Acts of Assembly). These 2000 amendments expanded eligibility to RNs, LPNs, and CNAs who agree to work in Virginia long-term care facilities.<sup>60</sup> However, the Nursing Scholarship and Loan Repayment Fund is not fee-funded and is instead reliant on appropriations from the General Fund. Presently, there are no General Fund appropriations for this program, which means there is no money available to distribute.

<i>No.</i>	<i>Recommendation</i>	<i>Voting Result</i>
7	Funding for tuition of the Advanced Certification for CNAs upon conclusion of pilot program	10Y - 1N - 6A

<sup>57</sup> “Advanced Certified Nurse Aide Program.” LeadingAge Virginia, 2020. <https://leadingagevirginia.org/mpage/AdvancedCNAHome>.

<sup>58</sup> Due to the COVID-19 pandemic, the start of the program has been delayed to March 2021.

<sup>59</sup> See Va. Code § 32.1-122.6:04(A).

<sup>60</sup> Per 12VAC5-507-10, ““Long-term care facility” means a certified nursing facility or nursing home as defined in § 32.1-123 of the Code of Virginia.”

8	Expand eligibility of Nurse Loan Repayment Program in Va. Code § 32.1-122.6:04 (also known as the Mary Marshall Nursing Scholarship) to include CNAs	12Y - 1N - 4A
9	Fund the Nursing Scholarship and Loan Repayment Fund in Va. Code § 54.1-3011.2	11Y - 1N - 5A

**WAGE-RELATED RECOMMENDATIONS**

The work group also focused on topics relevant to those persons already part of the clinical workforce in nursing homes. These topics included low wages for direct care staff, particularly CNAs, and how the low wages were tied to Medicaid reimbursement rates. The work group also considered topics touching upon what other financial relief could be offered to direct care staff that was not wage-specific.

**FINANCIAL RELIEF PROGRAMS**

Meaghan Green with the Office of the Chief Workforce Advisor discussed trends and opportunities for the long-term care workforce with the work group. She also presented wage data showing that in many Virginia communities CNAs make less than living wages. Her presentation led to the conclusions that pay increases, incentives, and additional workforce supports would boost nursing home staff recruitment and retention. As part of that discussion, Ms. Green indicated that financial relief programs that target dependent care or childcare, transportation, and other expenses could be a solution to the challenges faced by the nursing home workforce during the COVID-19 pandemic. Based on Ms. Green’s presentation and the discussion that followed, the work group voted upon three recommendations related to financial relief, with Recommendation 12 placing the discretion on the General Assembly to decide the categories of expenses to be targeted by a proposed financial relief program.

<i>No.</i>	<i>Recommendation</i>	<i>Voting Result</i>
10	Establish financial relief program to support direct care nursing home employees by covering a percentage of childcare or dependent care costs	9Y - 1N - 7A
11	Establish financial relief program to support direct care nursing home employees by covering a percentage of transportation costs to include public transportation costs	9Y - 1N - 7A
12	Establish financial relief program to support direct care nursing home employees by covering a percentage of living costs, which may include housing, transportation, childcare or dependent care, utilities, or other categories of expenses as determined by the General Assembly	7Y - 2N - 8A

**MINIMUM WAGE**

In a letter to the work group from the Virginia Health Care Association/Virginia Center for Assisted Living—which is Virginia’s largest association representing long term care—President and CEO Keith Hare called attention to wages and underfunding of nursing services by Virginia Medicaid.<sup>61</sup> He stated that addressing these concerns will be critical to arriving at meaningful solutions to nursing home staffing.<sup>62</sup> He also noted that

<sup>61</sup> Hare, Keith. Letter to The Honorable Jennifer Kiggans, Dr. Carole Pratt, and Rebekah Allen. “Ch. 932 (2020 Acts of Assembly) Work Group.” Richmond, VA, August 4, 2020.

<sup>62</sup> Ibid.

wages are a major portion of nursing care costs with more than 60% of Virginia’s nursing home residents relying on Medicaid for their care.<sup>63</sup> Mr. Hare also made a presentation to the work group about an overview of resident and staffing data from the association’s membership along with payer mix for residents.

The work group spent much time discussing the wage situation for direct care staff both before and after the presentations by Mr. Hare and Ms. Green (noted in the prior section above). While recommendations addressing the relationship between Medicaid reimbursement and wages are discussed in the next section, the work group discussed other recommendations that would directly impact wages. As Ms. Green had noted during her presentation, CNAs in Virginia often receive wages that are less than the living wage for the region in which they live. The work group discussed recommendations that would mandate a minimum wage and how to regionalize that wage amount. The work group examined the living wage data available for Virginia from both United for ALICE<sup>64</sup> and the Massachusetts Institute of Technology (MIT) Living Wage Calculator.

United for ALICE is a United Way program that provides statistics, tools, and data available for every Virginia locality on living wages.<sup>65</sup> According to United for ALICE’s most recent report, 39% of Virginia households struggled to make ends meet, with 10% of households living below the Federal Poverty Level and 29% were ALICE, which means they are “above the FPL, but not enough to afford basic household necessities.”<sup>66</sup> United for ALICE provides three basic budgets—Household Survival, Senior Survival, and Household Stability<sup>67</sup>—for each Virginia locality and the wage needed to cover the budget.

The MIT Living Wage Calculator similarly breaks down data for Virginia by locality, allowing stakeholders and policymakers to estimate a community’s or region’s estimated cost of living based on usual expenses and allowing employers to determine a wage that will meet the standard of living.<sup>68</sup> The MIT Living Wage Calculator splits out living wage calculations according to the number of children in the household and the number of working adults. The work group did not find one data source to be superior to the other, but felt that specifying the data source in the recommendation was important, so two versions of the wage recommendations were voted upon

While the work group formulated recommendations specific to CNAs, there was concern that such a narrow recommendation may face significant political headwinds. In light of this, the work group also voted upon broader minimum wage proposals that were still regionalized according to data from either United for ALICE or the MIT Living Wage Calculator.

The work group chose to base its regions on the local workforce boards that oversee local workforce development areas (LWDAs). There are 15 LWDAs in Virginia,<sup>69</sup> which are overseen by local workforce boards that are appointed by the County Executive to align employment and training programs into a comprehensive system.<sup>70</sup> In collaboration with the Virginia Employment Commission and Virginia Career Works, they help collect the latest market information including wage data, local area unemployment statistics, and occupational employment statistics, among other data.

---

<sup>63</sup> Ibid.

<sup>64</sup> “ALICE” is defined as Asset Limited, Income Constrained, Employed.

<sup>65</sup> “ALICE Project – Virginia.” United Way of Northern New Jersey. 2020. <https://www.unitedforalice.org/virginia>.

<sup>66</sup> Abrahamson, Andrew, Ashley Anglin, Catherine Connelly, Max Holdsworth, Dan Treglia, and Stephanie Hoppes. 2020. “ALICE in Virginia: A Financial Hardship Study.” United for ALICE. United Way of Northern New Jersey. [https://www.unitedforalice.org/Attachments/AllReports/2020ALICEReport\\_VA\\_FINAL.pdf](https://www.unitedforalice.org/Attachments/AllReports/2020ALICEReport_VA_FINAL.pdf)

<sup>67</sup> Ibid, 2.

<sup>68</sup> Glasmeier, Amy K. “About the Living Wage Calculator.” Massachusetts Institute of Technology. 2020. <https://livingwage.mit.edu/>

<sup>69</sup> “Local Workforce Development Areas.” Virginia Employment Commission, 2020. <https://virginiaworks.com/Portals/200/Publications/LWDAs/Maps/LWDA%20Regions.pdf>

<sup>70</sup> “FAQ.” Virginia Career Works, 2020. <https://virginiacareerworks.com/faq/>.

<i>No.</i>	<i>Recommendation</i>	<i>Voting Result</i>
13	Increase wages for CNAs proportional to regional living wage standards, with living wage standards derived from United For ALICE project data aggregated according to the local workforce board region	9Y - 1N - 7A
14	Increase wages for CNAs proportional to regional living wage standards, with living wage standards derived from MIT Living Wage Calculator aggregated according to the local workforce board region	7Y - 0N - 10A
15	Increase minimum wage proportional to regional living wage standards, with living wage standards derived from United For ALICE project data aggregated according to the local workforce board region	7Y - 1N - 9A
16	Increase minimum wage proportional to regional living wage standards, with living wage standards derived from MIT Living Wage Calculator aggregated according to the local workforce board region	5Y - 0N - 12A

#### MEDICAID REIMBURSEMENT

As mentioned earlier in this report, Medicaid reimbursement makes up a significant portion of many nursing homes' payer mix and has a direct impact on what wages can be paid to staff. Several representatives from the Virginia Department of Medical Assistance Services (DMAS)—which is Virginia's Medicaid agency—presented to the work group about how Medicaid reimbursement is determined. DMAS sets rates using the Nursing Facility Price-Based Methodology<sup>71</sup> and several data sources. The current per diem rate that a facility receives for a resident funded by Medicaid is broken down into approximately 47% direct costs, 44% indirect costs, 9% capital costs, and less than 1% each for nurse aid training and criminal records checks.<sup>72</sup> The direct costs include costs for direct care staff. DMAS rebases (i.e., recalculates) rates triennially using cost data; all reimbursement rates are prospective, which means that providers are responsible for managing a resident's cost of care.

In discussions about what recommendations the work group would consider for voting upon, the work group felt that data regarding what constitutes a regionalized living wage for direct care staff should be one of the data sources that DMAS looked to when it rebased its rates. Similar to the above discussion, no strong preference was expressed for United for ALICE or the MIT Living Wage Calculator, so both are included as options below. The work group also discussed the frequency of rebasing the nursing home rates. The rates are presently rebased every three years and a recommendation, if adopted by the General Assembly, on that same time interval would be easier for DMAS to administer. However, the work group also recognized that cost of living can be quite variable, especially with economic conditions like the Great Recession of 2008 and the economic downturn associated with the COVID-19 pandemic; in light of this variability, the work group also voted recommendations that would require rebasing to be annual.

The work group also discussed ways to incentivize nursing homes to both provide higher wages to direct care staff and to encourage higher staffing levels, as the work group received several public comments including comments from Erin Hines, a work group member, about the burnout and attrition of current direct care staff. Staffing levels have been mandated in several other jurisdictions, either in the form of minimum resident-to-staff ratios or in the form of minimum hours per resident day (HPRD) (Appendix I). While attempts have been made in prior legislative sessions to mandate minimum staffing in nursing homes, those bills have been

<sup>71</sup> See 12VAC30-90-44.

<sup>72</sup> Criminal records checks are mandated by Va. Code § 32.1-126.01 for all compensated employees.

unsuccessful in part because some stakeholders argue that there is insufficient clinical workforce for all nursing homes to be able to hire enough staff to meet the proposed minimums and in part because nursing homes do not receive high enough Medicaid reimbursement to offer competitive salaries. The work group voted on several recommendations—some with specific suggested staffing minimums and others that leave the staffing minimums to the discretion of the General Assembly—that were paired with a pay for performance program through DMAS to provide additional reimbursement for nursing homes that could meet minimum staffing and quality of care outcomes. In all cases, the recommendations that the work group voted on used a multi-biennial progression to increase what the minimum staffing requirements are. DMAS previously had a pay for performance program for certified nursing facilities in the early 2000s that was discontinued in part due to the requirement that DMAS audit 100% of facilities.

It should be noted that these recommendations would only benefit those nursing homes that are both licensed and certified.

<i>No.</i>	<i>Recommendation</i>	<i>Voting Result</i>
17	Rebase the Medicaid reimbursement rate annually based on regionalized living wage standards (derived from United For ALICE project data aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program	8Y - 0N - 9A
18	Rebase the Medicaid reimbursement rate annually based on regionalized living wage standards (derived from MIT Living Wage Calculator aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program	7Y - 0N - 10A
19	Rebase the Medicaid reimbursement rate triennially based on regionalized living wage standards (derived from United For ALICE project data aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program	8Y - 0N - 9A
20	Rebase the Medicaid reimbursement rate triennially based on regionalized living wage standards (derived from MIT Living Wage Calculator aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program	7Y - 0N - 10A
21	Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum resident-to-staff ratios and meeting minimum quality of care standards as determined by DMAS, with such threshold ratios for additional reimbursement increasing every biennium for three biennia	8Y - 2N - 7A
22	Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum resident-to-staff ratios and meeting minimum quality of care standards as determined by DMAS, with such threshold ratios for additional reimbursement beginning at 12-to-1 and increasing to 6-to-1 over for four biennia	7Y - 1N - 9A

23	Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum hours of nursing care per resident, with such threshold hours for additional reimbursement increasing every biennium for three biennia	7Y - 1N - 9A
24	Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum hours of nursing care per resident and meeting minimum quality of care standards as determined by DMAS, with such threshold hours for additional reimbursement beginning at 3.5 hours and increasing to 4.1 hours over for three biennia	6Y - 0N - 11A

**WORKFORCE-RELATED RECOMMENDATIONS**

The work group also looked to the wider workforce and what barriers might exist to their entry into either the health professions, the nursing home clinical workforce, or both. As part of these discussions, the work group heard from representatives of the Virginia Department of Veterans Services (DVS), the Virginia Department for the Blind and Vision Impaired (DBVI), the Virginia Department for the Deaf and Hard of Hearing (VDDHH) as to what they perceived as stumbling blocks to joining the nursing home clinical workforce.

**SUPPORTING PERSONS WITH DISABILITIES**

Representatives from DBVI and VDDHH spoke at length about the barriers that persons with disabilities face when seeking employment. They touched upon that though there are federal laws protecting persons with disabilities and the need for employers to make reasonable accommodations, the mere act of getting hired can be a barrier due to potential employers being uncertain about what accommodations would be needed and how they would accomplish those accommodations. Contemporaneous to these presentations was DVS’s presentation about the Virginia Values Veterans (V3) program. The V3 programs helps employers develop and implement long-term strategies and nationally recognized best practices in recruiting, hiring, and retaining veterans.<sup>73</sup> The work group discussed and included as a recommendation to be voted upon that would create a similar program for employers hiring persons with disabilities.

On the topic of accommodations and potential employer hesitance about hiring persons with disabilities, DBVI and VDDHH representatives did discuss that there is the Disabled Access Credit, a federal income tax credit for small businesses that incur expenditures for the purpose of providing access to persons with disabilities.<sup>74</sup> A similar tax credit is not currently available at the state-level and because of how the Internal Revenue Service (IRS) defines “small business,”<sup>75</sup> it is very unlikely that any nursing home in Virginia would qualify for the credit; additionally, no not-for-profit nursing home would be eligible for an income tax credit since they are exempt from federal income taxes under subsection 501(c) of the IRS tax code.<sup>76</sup> The work group discussed voting on a recommendation that included a state income tax credit for for-profit nursing homes that would otherwise mirror the Disabled Access Credit and a similar program for not-for-profit nursing homes structured as a partial offset for payroll taxes.

<sup>73</sup> “Virginia Values Veterans (V3) Program.” Virginia Department of Veterans Services, 2021. <https://dsv3.com/>.

<sup>74</sup> “Tax Benefits for Businesses Who Have Employees with Disabilities.” U.S. Internal Revenue Services, 2021. <https://www.irs.gov/businesses/small-businesses-self-employed/tax-benefits-for-businesses-who-have-employees-with-disabilities>.

<sup>75</sup> An eligible small business is one that earned \$1 million or less or had no more than 30 full time employees in the previous year. Ibid.

<sup>76</sup> “Federal Tax Obligations of Non-Profit Corporations.” U.S. Internal Revenue Services, 2021. <https://www.irs.gov/charities-non-profits/federal-tax-obligations-of-non-profit-corporations>.



<i>No.</i>	<i>Recommendation</i>	<i>Voting Result</i>
25	Creating a workforce program similar to DVS's V3 Program for people with disabilities to increase employment opportunities and promote economic development by training and certifying organizations in disability workforce best practices	12Y - 1N - 4A
32	State income tax credit for for-profit nursing homes based on expenditures aimed at providing access to employees with disabilities	6Y - 2N - 9A
33	Tax relief program for not-for-profit nursing homes that would allow them to offset part of their payroll tax for expenditures aimed at providing access to employees with disabilities	9Y - 2N - 6A

### SUPPORTING VETERANS

DVS also presented to the work group about the Military Medics and Corpsmen (MMAC) Program, which recruits, reviews, and refers veterans to healthcare employers statewide.<sup>77</sup> Veterans provide the MMAC team with their educational and career goals, which the MMAC team uses to help facilitate their transition to the Virginia's civilian healthcare workforce. The MMAC team matches veterans to partner healthcare employers<sup>78</sup> in the region of Virginia requested by the veteran and utilizes a multi-pathway approach to account for a veteran's general scope of practice, how recently the veteran has engaged their general scope of practice, non-clinical experience, and operational or management experience.

As part of this presentation, DVS representatives spoke to the barriers currently facing the MMAC. Since state nursing home regulations may prohibit care for non-credentialed veterans participating in the MMAC program, DVS suggested that the work group consider recommending that the nursing home regulations be amended, which could require a statutory change. DVS representatives also pointed out that CMS does recognize the civilian equivalency of certain military allied health specialties. While DHP does recognize substantially equivalent military education and training of medical professionals as appropriate,<sup>79</sup> the extent to which the training/education is recognized or applied to requirements for licensure depends upon the profession, the licensure qualifications, and the nature of the military education/training. DVS representatives also noted that it faces challenges raising awareness, including in nursing homes, of the MMAC program and other DVS employment programs. The work group considered these recommendations and voted on them, as indicated below

<i>No.</i>	<i>Recommendation</i>	<i>Voting Result</i>
26	Require changes to nursing home regulations to permit care by non-credentialed individuals in the MMAC program	9Y - 3N - 5A
27	Civilian credentialing/licensing reciprocity so state regulatory bodies recognize civilian equivalency of certain military allied health specialties	11Y - 1N - 5A
28	Civilian educational credits for statewide standardized recognition of military medical education and awarding of equivalent credit hours	11Y - 1N - 5A

<sup>77</sup> "Military Medics and Corpsmen (MMAC) Program." Virginia Department of Veterans Services, 2021. <https://www.dvs.virginia.gov/education-employment/military-medics-corpsmen-mmec-program>.

<sup>78</sup> These partners include major health systems in Virginia and Virginia state agencies.

<sup>79</sup> See Va. Code § 54.1-118.

29	Funding for awareness campaign for MMAC Program and the healthcare employment opportunities provided by the program	11Y - 0N - 6A
----	---------------------------------------------------------------------------------------------------------------------	---------------

OTHER RECOMMENDATIONS

In addition to the state tax incentives discussed above in the “Supporting Persons with Disabilities” subsection, the work group further discussed the federal Work Opportunity Tax Credit (WOTC). The WOTC is available to employers for hiring individuals from certain targeted groups who have consistently faced significant barriers to employment.<sup>80</sup> The target groups include:<sup>81</sup>

- Temporary Assistance for Needy Families (TANF) recipient
- Qualified veteran<sup>82</sup>
- Qualified ex-felon<sup>83</sup>
- Designated community resident<sup>84</sup>
- Vocational rehabilitation referral
- Summer youth employee
- Supplemental Nutrition Assistance Program (SNAP) recipient
- Supplemental Security Income recipient
- Long-Term Family Assistance recipient
- Qualified long-term unemployment recipient<sup>85</sup>

As part of the discussions surrounding how the recommendation should be written and voted upon, the work group decided that the qualifying groups of disadvantaged persons should be left to the General Assembly’s discretion.

The work group also discussed a state income tax credit for CNAs, LPNs, and RNs, who work at licensed nursing homes and certified nursing facilities. As part of the licensure process, VDH OLC collects the federal employer identification number (FEIN) on its nursing home applications; similarly, DHP collects health care

---

<sup>80</sup> “Work Opportunity Tax Credit.” U.S. Internal Revenue Service, 2021. <https://www.irs.gov/businesses/small-businesses-self-employed/work-opportunity-tax-credit#:~:text=The%20Work%20Opportunity%20Tax%20Credit,faced%20significant%20barriers%20to%20employment>

<sup>81</sup> Ibid.

<sup>82</sup> A “qualified veteran” is a veteran who is (a) receiving assistance under the SNAP (food stamps) for at least 3 months during the first 15 months of employment; (b) unemployed for a period totaling at least 4 weeks (whether or not consecutive) but less than 6 months in the 1-year period ending on the hiring date; (c) unemployed for a period totaling at least 6 months (whether or not consecutive) in the 1-year period ending on the hiring date; (d) disabled and entitled to compensation for a service-connected disability hired not more than one year after being discharged or released from active duty in the U.S. Armed Forces; or (e) disabled and entitled to compensation for a service-connected disability who is unemployed for a period totaling at least six months (whether or not consecutive) in the one-year period ending on the hiring date.

<sup>83</sup> A “qualified ex-felon” is a person hired within a year of being (a) convicted of a felony or (b) released from prison from the felony.

<sup>84</sup> A “designated community resident” is a person who, on the date of hire, (a) is at least 18 years old and under 40, (b) resides within an Empowerment zone, Enterprise community, or Renewal community, and (c) continues to reside at the locations after employment.

<sup>85</sup> A “qualified long-term unemployment recipient” is a person who has been unemployed for not less than 27 consecutive weeks at the time of hiring and received unemployment compensation during some or all of the unemployment period.

practitioners’ social security numbers. This information could be supplied to the Virginia Department of Taxation to aid in validating information from taxpayers claiming this credit.

Dignity for the Aged<sup>86</sup> presented information to the work group about feedback it received from 100 CNAs regarding their self-reported reasons for considering leaving or actually leaving the clinical workforce. Out of 100 CNAs, 59% reported low wages, 51% reported burnout or understaffing, 41% reported physical issues, 33% reported lack of appreciation, and 15% reported co-worker issues (Appendix J). The work group discussed a potential recommendation for the Joint Commission on Health Care to conduct a study on related nursing home workforce matters, such as workplace culture and internal leadership development, to further address retention and recruitment.

<i>No.</i>	<i>Recommendation</i>	<i>Voting Result</i>
30	State version of the federal work opportunity income tax credit for private-sector businesses that hire individuals who have consistently faced significant barriers to employment, as determined by the General Assembly	6Y - 3N - 8A
31	State income tax credit for CNAs, LPNs, and RNs working at licensed nursing homes and certified nursing facilities	9Y - 1N - 7A
34	Direct Joint Commission on Health Care to conduct a study on direct care staff recruitment and retention, workplace culture improvements, and internal leadership development in nursing homes	11Y - 1N - 5A

---

<sup>86</sup> Dignity for the Aged is an advocacy group founded to improve the lives of those in elder care facilities.

---

**APPENDIX A – CHAPTER 932 OF THE 2020 ACTS OF ASSEMBLY**

---

*Availability of Clinical Workforce for Nursing Homes Study Mandate*

Be it enacted by the General Assembly of Virginia:

1. § 1. That the Department of Health shall convene a work group to review and make recommendations on increasing the availability of the clinical workforce for nursing homes in the Commonwealth. The work group shall include representatives from the Virginia Health Care Association, the Virginia Center for Assisted Living, Dignity for the Aged, the Virginia Nurses Association, LeadingAge Virginia, and other stakeholders as appropriate. The Department shall collaborate with the Department of Health Professions, the Governor's Chief Workforce Development Advisor, and other state agencies as appropriate. The Department shall report all recommendations to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions on or before November 15, 2020.

**APPENDIX B – ACRONYMS AND ABBREVIATIONS**

---

This is a listing of the acronyms and abbreviations appearing throughout the report and its appendices.

ALICE – asset limited, income constrained, employed

BRCC – Blue Ridge Community College

CMP – civil monetary penalty

CMS – U.S. Centers for Medicare and Medicaid Services

CNA – certified nurse aide

COP – condition of participation

CTE – career and technical education

DBVI – Virginia Department for the Blind and Vision Impaired

DHP – Virginia Department of Health Professions

DMAS – Virginia Department of Medical Assistance Services

DVS – Virginia Department of Veterans Services

FTE – full-time equivalent

HPRD – hour per resident day

HWDC – Healthcare Workforce Data Center in DHP

IRS – Internal Revenue Service

LPN – licensed practical nurse

LWDA – local workforce development area

MIT – Massachusetts Institute of Technology

MMAC – Military Medics and Corpsmen

OLC – Office of Licensure and Certification in VDH

PBJ – Payroll-Based Journal

RN – registered nurse

VBOE – Virginia Board of Education

VDDHH – Virginia Department for the Deaf and Hard of Hearing

GA Report – Availability of Clinical Workforce for Nursing Homes, 2020

VDH – Virginia Department of Health

V3 – Virginia Values Veterans

**APPENDIX C – WORK GROUP MEETING MINUTES**

---

**JULY 6, 1:00 P.M.**

Due to COVID-19, this meeting was conducted in an all-virtual environment.

**Members Present:** Judy Jackson, Karen Brimm, Eric Raff, Joani Latimer, Kathryn Paxton, Charlette Ridout, Elizabeth Carter, Sam Kukich, Lionel DeCuir, Senator Jen A. Kiggans, Melissa Andrews, Alicia Cundiff, Randall Stamper, W. Scott Johnson, Susan Hines, Erin Hines, Barbara Seymour.

**VDH Staff Present:** Joseph Hilbert, A. Carole Pratt, Rebekah Allen, Mylam Ly.

**Call to Order**

Dr. Pratt called the meeting to order at 1:05 p.m.

**Introductions**

Ms. Allen welcomed those in attendance to the meeting. Ms. Allen then started the introductions of the work group members and VDH staff present.

**Review of Agenda**

Ms. Allen reviewed the agenda.

**Public Comment Period**

Ms. Allen opened the meeting for the Public Comment Period. There were no speakers signed up.

**Proposed Work Group Roadmap**

Dr. Pratt, Senator Kiggans, and W. Scott Johnson provided an introduction and background for the Chapter 932 work group.

- Dr. Elizabeth Carter provided an overview of the current nursing workforce in Virginia.
- Melissa Andrews provided an overview of LeadingAge’s national initiatives to support nursing home workforce recruitment and retention.
- Representatives for Dignity for the Aged want the group to explore causes for workforce shortages and whether or not requirements for staffing ratios will mitigate drivers of workforce shortages, such as burnout.

**Initial Discussions on Educational Pipeline**

- The work group reviewed the current pipeline for nurses providing care in Virginia’s nursing homes, barriers to recruitment and retention, and additional training needs of Virginia nursing home staffing workforce.
- The work group discussed opportunities to partner with K-12 schools to educate students on the opportunities to work in nursing homes as well as leveraging civic engagement requirements to provide exposure to employment opportunities in nursing homes.

**Discussion of Next Steps**

- Ms. Allen will be researching civic engagement requirements for Virginia’s K-12 schools.
- VDH staff will begin researching nursing home staffing ratios in other states.
- VDH will work with DHP to review CNA disciplinary data.

- VDH will work with VHCA to determine if there are any relevant data to explore as a result of CNA exit surveys.
- VDH will work with partners to understand if there are other data to determine why CNAs are leaving nursing home settings.
- VDH staff will research opportunities to include leadership development competencies in CNA training programs.

### **Other Business**

There was no other business discussed.

### **Adjourn**

Meeting adjourned at 2:54 p.m.

The meeting recording is available at: [https://youtu.be/\\_edjZDVqZ9c](https://youtu.be/_edjZDVqZ9c)

### **JULY 20, 1:00 PM**

This meeting was a hybrid with some members gathering at the Perimeter Center (9960 Mayland Drive, Henrico, VA 23233) and others attending virtually.

**Members Present:** Alaysia Black Hackett, Megan Healy, Joani Latimer, Kathryn Paxton, Elizabeth Carter, Corie Tillman Wolf, Todd Barnes, Sam Kukich, Bob Kukich, Erin Hines, Susan Hines, Senator Jen A. Kiggans, Christina Holloway, Dana Parsons, Alicia Cundiff, W. Scott Johnson, Vivienne McDaniel, Barbara Seymour, Lionel DeCuir.

**VDH Staff Present:** Heather Anderson, A. Carole Pratt, Rebekah Allen

### **Call to Order**

Dr. Pratt called the meeting to order at 1:05 p.m.

### **Introductions**

Ms. Allen welcomed those in attendance to the meeting. Ms. Allen then started the introductions of the work group members and VDH staff present.

### **Review of Agenda**

Ms. Allen reviewed the agenda.

### **Public Comment Period**

Ms. Allen opened the meeting for the Public Comment Period. Written comments were submitted to Ms. Allen and Dr. Pratt. There were 4 speakers signed up:

- Kathy Schroeder stated that Virginia's nursing home ranking of 36th nationwide is due to lack of enforcement to facilities and the lack of support to CNAs.
- Patricia Vannucchi stated that she has not been allowed to see her mother since the beginning of the COVID-19 pandemic, and she fears that the lock down of the facility and staffing shortages are exacerbating her mother's illnesses.
- Ms. Niak stated that her mother has lost weight and is pleading for help during virtual face to face meetings and that the staff is struggling to keep up with the needs of residents.



- Deborah Buchanan stated that the challenges faced by nursing homes are not specific to one facility and that staffing ratios can be to blame. In addition, poor treatment of residents is causing poor outcomes and premature death.

### **Review of Work Group Roadmap and Revisions**

As a follow up to the work group's first meeting, focus area for the work group will be educational pipelines, training curriculum, student debt, payer mix, reimbursement rates, and financial incentive programs.

- Key drivers of recruitment and retention are salary and wages, benefits, staffing ratios, advancement opportunities, and leadership opportunities.

### **Initial Discussions regarding Curriculum and Educational Debt**

- Ms. Allen presented on Virginia's K-12 service learning requirements as well as those in other states across the nation.
- Dr. Pratt presented on rural health workforce development programs in Virginia.
- Ms. Allen presented on opportunities to support training programs of special needs populations.
- Heather Anderson presented on Virginia's State Loan Repayment Programs.

### **Discussion of Next Steps**

- Ms. Allen and Dr. Pratt will be working with DVS and DBVI to finalize curriculum recommendations for special needs populations as well as programs to help veterans transition into the civilian workforce.
- The group will prepare to discuss financial incentive programs for nursing home staffing recruitment and retention.
- A discussion of payer mix for nursing homes will be prepared.

### **Other Business**

There was no other business discussed.

### **Adjourn**

Meeting adjourned at 4:01 p.m.

The meeting recording is available at: <https://youtu.be/MB08lSmuozU>

**AUGUST 4, 1:00 P.M.**

Due to Executive Order 69 that declares a state of emergency due to Hurricane Isaias, this meeting was conducted in an all-virtual environment.

**Members Present:** Judy Jackson, Karen Brimm, Joani Latimer, Kathryn Paxton, Charlette Ridout, Elizabeth Carter, Corie Tillman Wolf, Todd Barnes, Bob Kukich, Erin Hines, Susan Hines, Tyler Edmonds, Christina Holloway, Dana Parsons, Alicia Cundiff, W. Scott Johnson, Vivienne McDaniel, Randall Stamper, Meaghan Green, Lionel DeCuir, Barbara Seymour.

**VDH Staff Present:** Heather Anderson, A. Carole Pratt, Rebekah Allen

### **Call to Order**

Dr. Pratt called the meeting to order at 1:05 p.m.

### **Introductions**

Ms. Allen welcomed those in attendance to the meeting. Ms. Allen then started the introductions of the work group members and VDH staff present.

#### **Review of Agenda**

Ms. Allen reviewed the agenda.

#### **Public Comment Period**

Ms. Allen opened the meeting for the Public Comment Period. Written comments were submitted to Ms. Allen and Dr. Pratt. There were 2 speakers signed up. Both were unable to provide their statements due to technical difficulties.

- W. Scott Johnson spoke to remind the group that they are charged with finding workforce solutions and that all have the same goal of finding mechanisms for supporting nursing home staff and nursing home residents.

#### **Suggestions for Health Care Curriculum and Career Pathways for Special Needs Populations**

Karen Brimm and Judy Jackson presented on the need to train workforce who are deaf or hard of hearing and those serving those that are deaf or hard of hearing, including cultural competency.

#### **Suggestions for Transitions to Civilian Careers in Health Care and Nursing Homes**

Todd Barnes presented on programs to help veterans transition to health care careers in nursing homes, including leveraging the MMAC Program, Virginia Transition Assistance Program (VTAP), and V3 Program.

#### **Initial Discussions on Health Care Financing - Payer Mix, Reimbursement Rates, and Financial Incentive Programs**

Ms. Allen presented on the payer mix for Virginia's certified nursing facilities, full-time equivalents, labor costs, revenues, profit margins, and reimbursement rates. Ms. Allen also presented on Virginia's tax incentive programs that nursing homes can further leverage to support staffing recruitment and retention, including the Work Opportunity Tax Credit (WOTC) and Disabled Access Credit. Ms. Allen provided an overview of Virginia's nursing home Medicaid participation.

#### **Discussion of Next Steps**

- Ms. Allen will be scheduling the next meeting to ensure there are no conflicts with the 2020 General Assembly August Special Session.

#### **Other Business**

There was no other business discussed.

#### **Adjourn**

Meeting adjourned at 3:54 p.m.

The meeting recording is available at: <https://youtu.be/uY33AkY401w>

**AUGUST 17, 1:00 P.M.**

Due to COVID-19, this meeting was conducted in an all-virtual environment.

**Members Present:** Meaghan Green, Judy Jackson, Joani Latimer, Charlette Ridout, Elizabeth Carter, Corie Tillman Wolf, Kurt Elward, Barbara Seymour, Randall Stamper, Todd Barnes, Bob Kukich, Sam Kukich, Erin

Hines, Susan Hines, Senator Jen A. Kiggans, Melissa Andrews, Alicia Cundiff, April Payne, W. Scott Johnson, Vivienne McDaniel, Lionel DeCuir.

**VDH Staff Present:** Heather Anderson, A. Carole Pratt, Rebekah E. Allen.

### **Call to Order**

Dr. Pratt called the meeting to order at 1:05 p.m.

### **Introductions**

Ms. Allen welcomed those in attendance to the meeting. Ms. Allen then started the introductions of the work group members and VDH staff present.

### **Review of Agenda**

Ms. Allen reviewed the agenda.

### **Public Comment Period**

Ms. Allen opened the meeting for the Public Comment Period. Written comments were submitted to Ms. Allen and Dr. Pratt. There were 3 speakers signed up.

- Erin Hines highlighted the perceived disconnect between long-term care facility administrators and CNAs.
- Sam Kukich implored the working group to focus on key drivers of nursing home staffing challenges, including staffing ratios.
- Susan Hines discussed the need to increase recruitment efforts and mandate staffing ratios for Virginia’s nursing homes.
- Lionel DeCuir spoke to the need to increase the amount of direct care provided to residents of long-term care facilities in Virginia

### **Claude Moore Scholars**

Dr. William A. Hazel Jr. M.D. provided an overview of the Claude Moore Scholars Healthcare Education Program, which provides funds to public school systems and institutions of higher education to develop and maintain Career and Technical Education (CTE) programs and is interested in partnering with Virginia stakeholders to develop and expand healthcare workforce pipeline programs.

### **Medicaid Rate Setting and Sources of Virginia Medicaid Funding**

Sonja Lee-Austin and Sara Benoit presented on nursing facility Medicaid reimbursement in Virginia, including how rates are set and adjusted.

### **DMAS & Medicaid Incentive Programs**

Terry Smith, Tim Catherman, and Evelyn Hardwick presented on DMAS’ various training and incentive programs, including trauma-resilience training for CNAs, curriculum development for Advanced Certification of CNAs, and peer mentoring programs.

### **Workforce Development Programs**

Meaghan Green presented on nursing and other long-term care facility workforce trends as well as opportunities to recruit the workforce impacted by the COVID-19 pandemic into high-need long-term care settings. Meaghan Green also presented wage data, indicating that in many communities, CNAs make less than living wages in Virginia and on Virginia’s career pathways and workforce development programs. Key takeaways from reviewing trend data and lessons learned from the trend analysis are that pay increases, innovative benefit incentives, and additional workforce supports are needed to improve nursing home staff recruitment and retention.

### **Recruitment & Retention: Medicaid Funding, Recommendations for Workforce, and Pathways for Implementation**

Keith Hare provided an overview of the resident and staffing demographics representing the Virginia Health Care Association’s membership as well as the payer mix for Virginia’s nursing home residents. Mr. Hare also reviewed the financial and operational impacts of COVID-19 on Virginia’s nursing homes and potential opportunities to address workforce gaps, including temporary nurse aide training programs, FastForward Virginia, and scholarship programs.

### **Discussion of Next Steps**

- VDH will be preparing a presentation on staffing ratios in preparation for the next work group meeting.
- VDH will work to distribute meeting minutes to work group members.

### **Other Business**

There was no other business discussed.

### **Adjourn**

Meeting adjourned at 3:35 p.m.

The meeting recording is available at: <https://youtu.be/UyZBKwWcUwY>

**AUGUST 31, 1:00 P.M.**

Due to COVID-19, this meeting was conducted in an all-virtual environment.

**Members Present:** Judy Jackson, Karen Brimm, Charlette Ridout, Corie Tillman Wolf, Todd Barnes, Heather Legere, Sam Kukich, Randall Stamper, Erin Hines, Susan Hines, Lionel DeCuir, Senator Jen A. Kiggans, Melissa Andrews, Dana Parsons, Alicia Cundiff, April Payne, W. Scott Johnson, Vivienne McDaniel, Joani Latimer, Steve Ankiel, Elizabeth Flaherty.

**VDH Staff Present:** Heather Anderson, A. Carole Pratt, Rebekah E. Allen, Brenden Rivenbark

### **Call to Order**

Dr. Pratt called the meeting to order at 1:05 p.m.

### **Introductions**

Ms. Allen welcomed those in attendance to the meeting. Ms. Allen then started the introductions of the work group members and VDH staff present.

### **Review of Agenda**

Ms. Allen reviewed the agenda.

### **Nursing Home Staffing and Supporting the Development of Virginia’s Nursing Home Workforce**

Brenden Rivenbark provided an overview of research conducted that highlights strategies other states have utilized in mandating staffing ratios in nursing homes. While not every state was analyzed, data comparing ratios reported to CMS, hospitalizations per 1,000 long-stay resident days, CNA hourly mean wages, total CNA workforce, employment per 1,000 jobs, and Medicaid expenditures per aged enrollees were produced for California, Illinois, Maine, Florida, Virginia, the District of Columbia, and nationally.

### **Review of Recommendations Discussed to Date**

Ms. Allen reminded the work group of the Chapter 932 mandate set forth by the General Assembly and highlighted potential recommendations provided by work group members to-date.

**Discussion of Next Steps**

- Ms. Allen will continue to draft recommendations for the work group to discuss during the next meeting.
- Ms. Allen will work with DMAS to understand necessary budget language that would ensure that any additional funding provided for nursing homes be allocated to direct staffing expenditures.

**Other Business**

There was no other business discussed.

**Public Comment Period**

Ms. Allen indicated that no speakers signed up for public comment.

**Adjourn**

Meeting adjourned at 3:54 p.m.

The meeting recording is available at: <https://youtu.be/3dYpmDkwjM>

**SEPTEMBER 25, 1:00 P.M.**

Due to COVID-19, this meeting was conducted in an all-virtual environment.

**Members Present:** Meaghan Green, Karen Brimm, Joani Latimer, Kathryn Paxton, Charlette Ridout, Elizabeth Carter, Corie Tillman Wolf, Todd Barnes, Heather Legere, Lionel DeCuir, Tyler Edmonds, Christina Holloway, Dana Parsons, April Payne, Vivienne McDaniel, Sam Kukich, W. Scott Johnson, Judy Jackson, Barbara Seymour.

**VDH Staff Present:** A. Carole Pratt, Rebekah E. Allen.

**Call to Order**

Dr. Pratt called the meeting to order at 1:05 p.m.

**Roll Call**

Ms. Allen welcomed those in attendance to the meeting. Ms. Allen then started the introductions of the work group members and VDH staff present.

**Review of Agenda**

Ms. Allen reviewed the agenda.

**Public Comment Period**

Ms. Allen opened the meeting for the Public Comment Period. Written comments were submitted to Ms. Allen and Dr. Pratt. There was 1 speaker signed up.

- Sam Kukich stated that she was concerned about the prioritization of money over quality of care for nursing home residents.

**Review of Recommendations To Be Voted Upon**

Ms. Allen presented the 17 recommendations that have been produced by the work group to date for review, revision, and voting. It was requested by the work group that revisions be made to the draft recommendations and that another meeting be held within the next week to finalize recommendations. On the topic of wages, the work group reviewed average CNA wages to that of the average cost of living as reported by the United Way's ALICE research.

#### **Discussion of Next Steps**

- The work group will convene one more time to vote on recommendations prior to VDH's drafting of the Chapter 932 work group, which will be reviewed and voted upon in November.

#### **Other Business**

There was no other business discussed.

#### **Adjourn**

Meeting adjourned at 2:37 p.m.

The meeting recording is available at: <https://youtu.be/FOjuJfKvM9U>

### **SEPTEMBER 30, 1:00 P.M.**

Due to COVID-19, this meeting was conducted in an all-virtual environment.

**Members Present:** Judy Jackson, Karen Brimm, Kathryn Paxton, Charlette Ridout, Elizabeth Carter, Corie Tillman Wolf, Sam Kukich, Erin Hines, Susan Hines, Lionel DeCuir, Dana Parsons, Alicia Cundiff, April Payne, Vivienne McDaniel, Barbara Seymour.

**VDH Staff Present:** Heather Anderson, A. Carole Pratt, Rebekah E. Allen.

#### **Call to Order**

Dr. Pratt called the meeting to order at 1:05 p.m.

#### **Introductions**

Ms. Allen welcomed those in attendance to the meeting. Ms. Allen then started the introductions of the work group members and VDH staff present.

#### **Review of Agenda**

Ms. Allen reviewed the agenda.

#### **Public Comment Period**

Ms. Allen opened the meeting for the Public Comment Period. Written comments were submitted to Ms. Allen and Dr. Pratt. There were 3 speakers signed up.

- Ms. Kukich voiced her concerns that there were no meeting minutes provided and felt there was a lack of transparency due to the lack of communication in meeting cancellations and lack of sharing of group members' contact information. Additionally, there was a concern that work group members' recommendations or opinions were being ignored.
- Erin Hines feels that the topic of supporting the current CNA workforce has been purposefully ignored during the work group process.

- Susan Hines voiced concern that the work group has failed to address the quality concerns being reported in many of Virginia’s nursing homes.

### **Review of Recommendations To Be Voted Upon**

Ms. Allen provided an overview of the voting rules for the recommendations to be put forth by the work group. Additionally, each of the 32 potential recommendations produced by the work group were put forward for final review and revision.

### **Discussion of Next Steps for Work Group Report**

- Work group members will be sent a final copy of recommendations by October 2nd and a link for a Google Form ballot by October 9th.
- Votes on recommendations are due for submission by 11:59 p.m. October 19th.
- The draft Chapter 932 work group report will be distributed to members by November 2nd.
- The final meeting of the work group will be held on November 9th to discuss the draft Chapter 932 work group report.
- The final draft of the Chapter 932 work group report will be sent to work group members and VDH’s Deputy Commissioner for Governmental and Regulatory Affairs for filing.

### **Other Business**

There was no other business discussed.

### **Adjourn**

Meeting adjourned at 4:07 p.m.

The meeting recording is available at: <https://youtu.be/BbBvseLf1QU>

## **NOVEMBER 9, 9:00 A.M.**

Due to COVID-19, this meeting was conducted in an all-virtual environment.

**Members Present:** Joani Latimer, Kathryn Paxton, Charlette Ridout, Corie Tillman Wolf, Barbara Seymour, Sam Kukich, Senator Jen A. Kiggans, Alicia Cundiff, W. Scott Johnson, Vivienne McDaniel, Lionel DeCuir.

**VDH Staff Present:** Heather Anderson, A. Carole Pratt, Rebekah E. Allen, Brenden Rivenbark.

### **Call to Order**

Dr. Pratt called the meeting to order at 9:03 a.m.

### **Introductions**

Ms. Allen welcomed those in attendance to the meeting. Ms. Allen then started the introductions of the work group members and VDH staff present.

### **Review of Agenda**

Ms. Allen reviewed the agenda.

### **Public Comment Period**

Ms. Allen opened the meeting for the Public Comment Period. Written comments were submitted to Ms. Allen and Dr. Pratt. There was one speaker signed up.

- Ms. Kukich expressed her concern that the work group focused on workforce development needs rather than those of the current nursing home workforce.

**Feedback on “Preface” and “Introduction”**

- No feedback was given.

**Feedback on “VA Clinical Workforce for Nursing Homes”**

- No feedback was given.
- Ms. Allen provided an overview of Report acronym definitions.

**Feedback on “Education-Related Recommendations”**

- No feedback was given.

**Feedback on “Wage-Related Recommendations”**

- No feedback was given.

**Feedback on “Workforce-Related Recommendations”**

- No feedback was given.

**Feedback on “Appendices”**

- Meeting minutes will be updated based on feedback.
- Minutes should have reflected real time feedback.
- A more concise report may be most effective.
- National nursing home rating reports would be valuable points of reference.

**Other Business**

- Dr. Pratt thanked work group members for effort, time, and contributions to work group efforts.
- Senator Kiggans thanked work group members for effort, time, and contributions to work group efforts.
- Final report feedback is due by the end of November 11, 2020.
- The feedback template will be resent to the work group.

**Adjourn**

Meeting adjourned at 9:58 a.m.

The meeting recording is available at: <https://youtu.be/eA8OvY-3AH8>



---

**APPENDIX D – SUMMARY OF WRITTEN COMMENTS FROM THE PUBLIC**

---

**JULY 6 MEETING**

No written comments were received.

**JULY 20 MEETING**

*Brenna Bebel*

Ms. Bebel requested that Virginia establish minimum staffing ratios for nursing homes.

*Deborah Buchanan*

Ms. Buchanan requested that the work group focus on staffing ratios, adhere to the requirements set forth in the Omnibus Budget Reconciliation Act of 1987, and sufficient and effective regulation and enforcement of facilities.

*Elizabeth Caine*

Ms. Caine requested that Virginia establish minimum staffing ratios for nursing homes.

*Eleanor Charnock*

Ms. Charnock requested that the work group address the poor quality of care in nursing homes as a result of insufficient staffing.

*Lionel DeCuir*

Mr. DeCuir implored the work group to hold regulators of nursing homes accountable for poor outcomes experienced by nursing home residents and information for sites that rank nursing homes based on quality.

*Marc Fortunato*

Mr. Fortunato expressed his concern that insufficient staffing in nursing homes has led to the poor quality of care received by a loved one in a Virginia facility.

*Kathy Schroeder*

Ms. Schroeder shared her concerns that long-term care administrators have too much power with little accountability and that staff interacting directly with residents have few supports to do their job adequately.

*Patricia Vannucchi*

Ms. Vannucchi wished to know how it was possible that facilities could still be so short staffed when they were provided an enhanced Medicaid benefit during the pandemic. Ms. Vannucchi also expressed her concern with the perceived lack of proper infection control and compassionate care practiced by nursing home staff.

**AUGUST 4 MEETING**

*Lynn McNelis*

Ms. McNelis requested that the work group mandate nursing home staff to resident ratios.

*Cindy Bocrie*

Ms. Bocrie shared her experiences as a nurse and working in a nursing home to request that Virginia support the expansion of a companion work force in nursing homes to support CNAs with resident activities of daily living.

*Michele Reed*

Ms. Reed requested that Virginia establish minimum staffing ratios for nursing homes.

*Laura Duval*

Ms. Duval requested that Virginia require basic parameters such as socialization, the number of CNAs, and better wages to enhance quality in nursing homes.

*Janet Slavett*

Ms. Slavett requested that the work group mandate nursing home staff to resident ratios.

*Kathy Schroeder*

Ms. Schroeder voiced her frustration that the work group was focusing on nursing home staffing pipelines rather than challenges facing nursing homes today.

*Marc Fortunato*

Mr. Fortunato voiced his frustration that the work group was focusing on nursing home staffing pipelines rather than challenges facing nursing homes today.

*Cheryl Waldrup*

Ms. Waldrup requested that the work group mandate nursing home staff to resident ratios.

*Linda Talbot*

Ms. Talbot, a former CNA, requested that Virginia increase wages for CNAs.

*Laura Ortiz*

Ms. Ortiz requested that the work group mandate nursing home staff to resident ratios.

*Deborah Buchanan*

Ms. Buchanan requested that Virginia increase the number of CNAs working in Virginia to increase the quality of care.

*Joani Latimer*

Ms. Latimer expressed concern that the work group's extensive focus so far on pipeline/recruitment issues may limit getting to the real root of the workforce shortages, retention and recruitment. These factors include low wages, morale, understaffing, and workplace culture.

#### **AUGUST 17 MEETING**

*Charlette Ridout*

Ms. Ridout shared a positive story of her father's experience in his nursing home in Richmond. She also shared information pertaining to the suspension of 18VAC90-26-20(B)(1)(e) until December 31, 2020.

*Keith Hare*

Mr. Hare explained that the historic nursing home staffing challenges are multifaceted and that establishing staffing mandates do not address the complex educational and cultural layers that drive staffing shortages.

*Sam Kukich*

Ms. Kukich shared perspectives of CNAs she has spoken with about barriers to recruitment and retention, which include pay, burnout, cost of education, benefits, lack of ratios, lack of integration with the care team, lack of training by the facility, and poor communication from leadership.

*Lionel DeCuir*

Mr. DeCuir shared links to sites that rank nursing homes based on quality of care, including CMS. Mr. DeCuir also requested that the work group focus on mandatory staffing ratios in nursing homes.

*Erin Hines*

Ms. Hines shared the results of a survey she conducted with CNA colleagues, which indicated that many of the respondents felt that facility leadership did not meaningfully engage staff.

#### **AUGUST 31 MEETING**

*W. Scott Johnson*

Mr. Johnson shared national survey data reporting financial hardships faced by nursing homes due to COVID-19.

*Sam Kukich*

Ms. Kukich shared research she conducted indicating that poor nursing home quality can be attributed to private equity ownership of nursing homes.

*Erin Hines*

Ms. Hines shared the results of a survey she conducted with CNA colleagues, which indicated that many of the respondents felt that CNAs leave the industry because of low pay, burnout, cost of education, benefits, lack of ratios, lack of integration with the care team, lack of training by the facility, and poor communication from leadership.

*Susan Hines*

Ms. Hines requested that the work group mandate nursing home staff to resident ratios.

#### **SEPTEMBER 25 MEETING**

*Sam Kukich*

Ms. Kukich shared information from a CNA who had contacted her regarding the justification for no longer serving as a CNA, which was attributed to high burnout as a result of low staffing supports and high demands. Ms. Kukich also shared the story of her mother's experience in a nursing home, of which she attributed quality challenges to poor staffing ratios and tools for success. It was also noted that meeting minutes had not yet been provided to the work group and that more communication would be valuable to the mission of the work group.

#### **SEPTEMBER 30 MEETING**

*Sam Kukich*

Ms. Kukich reiterated her desire for the work group to focus on nursing home staffing ratios rather than other solutions to support the future workforce and mentioned that numerous private citizens had contacted her to express their concerns about quality of care in nursing homes. Ms. Kukich also provided service learning guidance from the Virginia Department of Education.

#### **NOVEMBER 9 MEETING**

*Kathy Schroeder*

Ms. Schroeder voiced her concern about the lack of materials provided prior to the Work Group meetings and displeasure that the drafted recommendations serve as a reward system for facilities that provide low quality care rather than requirements to increase the quality of care.

---

**APPENDIX E – STAKEHOLDER VOTING RECORD ON WORK GROUP RECOMMENDATIONS**

---

1. Permit, but not require, local school boards to offer graduation credit for service learning in clinical care in long term care settings. Service learning is an instructional strategy that combines meaningful hands-on service to and for the benefit of the community with curriculum-based learning meeting specified objectives defined by the local school board in consultation with DHP and VDH
  - a. Support: 11
  - b. Oppose: 1
  - c. Abstain: 5
  
2. Statewide offering of optional graduation credit for service learning in clinical care in long term care settings. Service learning is an instructional strategy that combines meaningful hands-on service to and for the benefit of the community with curriculum-based learning meeting specified objectives defined by the VBOE in consultation with the DHP and VDH
  - a. Support: 11
  - b. Oppose: 1
  - c. Abstain: 5
  
3. Statewide offering of optional Fairfax County Public Schools model of hours-based service learning (i.e., required for students in grades 6, 8, and 12, with optional diploma seal if additional hours are completed) in clinical care in long term care settings. Service learning is an instructional strategy that combines meaningful hands-on service to and for the benefit of the community with curriculum-based learning meeting specified objectives defined by the VBOE in consultation with the DHP and VDH
  - a. Support: 9
  - b. Oppose: 1
  - c. Abstain: 7
  
4. Require changes to nursing home regulations to permit volunteerism in nursing homes, with supervision that includes orientation and training for volunteers consistent with the tasks assigned, recording the type of tasks and time worked, and method by which a volunteer may contact supervisor for immediate assistance
  - a. Support: 10
  - b. Oppose: 2
  - c. Abstain: 5
  
5. Require changes to nursing home regulations to permit service learning in nursing homes, with supervision that includes that includes orientation and training consistent with the tasks assigned, recording the type of tasks and time worked, and method by which a learner may contact supervisor for immediate assistance
  - a. Support: 12
  - b. Oppose: 1
  - c. Abstain: 4

6. Establish education and outreach programs for middle school and high school students to promote career pathways in long term care
  - a. Support: 12
  - b. Oppose: 1
  - c. Abstain: 4
  
7. Funding for tuition of the Advanced Certification for CNAs upon conclusion of pilot program
  - a. Support: 10
  - b. Oppose: 1
  - c. Abstain: 6
  
8. Expand eligibility of Nurse Loan Repayment Program in Va. Code § 32.1-122.6:04 (also known as the Mary Marshall Nursing Scholarship) to include CNAs
  - a. Support: 12
  - b. Oppose: 1
  - c. Abstain: 4
  
9. Fund the Nursing Scholarship and Loan Repayment Fund in Va. Code § 54.1-3011.2
  - a. Support: 11
  - b. Oppose: 1
  - c. Abstain: 5
  
10. Establish financial relief program to support direct care nursing home employees by covering a percentage of childcare or dependent care costs
  - a. Support: 9
  - b. Oppose: 1
  - c. Abstain: 7
  
11. Establish financial relief program to support direct care nursing home employees by covering a percentage of transportation costs to include public transportation costs
  - a. Support: 9
  - b. Oppose: 1
  - c. Abstain: 7
  
12. Establish financial relief program to support direct care nursing home employees by covering a percentage of living costs, which may include housing, transportation, childcare or dependent care, utilities, or other categories of expenses as determined by the General Assembly
  - a. Support: 7
  - b. Oppose: 2
  - c. Abstain: 8
  
13. Increase wages for CNAs proportional to regional living wage standards, with living wage standards derived from United For ALICE project data aggregated according to the local workforce board region
  - a. Support: 9
  - b. Oppose: 1
  - c. Abstain: 7

14. Increase wages for CNAs proportional to regional living wage standards, with living wage standards derived from Massachusetts Institute of Technology Living Wage Calculator aggregated according to the local workforce board region
  - a. Support: 7
  - b. Oppose: 0
  - c. Abstain: 10
  
15. Increase minimum wage proportional to regional living wage standards, with living wage standards derived from United For ALICE project data aggregated according to the local workforce board region
  - a. Support: 7
  - b. Oppose: 1
  - c. Abstain: 9
  
16. Increase minimum wage proportional to regional living wage standards, with living wage standards derived from Massachusetts Institute of Technology Living Wage Calculator aggregated according to the local workforce board region
  - a. Support: 5
  - b. Oppose: 0
  - c. Abstain: 12
  
17. Rebase the Medicaid reimbursement rate annually based on regionalized living wage standards (derived from United For ALICE project data aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program
  - a. Support: 8
  - b. Oppose: 0
  - c. Abstain: 9
  
18. Rebase the Medicaid reimbursement rate annually based on regionalized living wage standards (derived from Massachusetts Institute of Technology Living Wage Calculator aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program
  - a. Support: 7
  - b. Oppose: 0
  - c. Abstain: 10
  
19. Rebase the Medicaid reimbursement rate triennially based on regionalized living wage standards (derived from United For ALICE project data aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program
  - a. Support: 8
  - b. Oppose: 0
  - c. Abstain: 9

20. Rebase the Medicaid reimbursement rate triennially based on regionalized living wage standards (derived from Massachusetts Institute of Technology Living Wage Calculator aggregated according to the local workforce board region) and mandating rate increases are passed on to direct care workers by implementing a wage pass-through program
  - a. Support: 7
  - b. Oppose: 0
  - c. Abstain: 10
  
21. Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum staff-to-resident ratios and meeting minimum quality of care standards as determined by DMAS, with such threshold ratios for additional reimbursement increasing every biennium for three biennia
  - a. Support: 8
  - b. Oppose: 2
  - c. Abstain: 7
  
22. Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum staff-to-resident ratios and meeting minimum quality of care standards as determined by DMAS, with such threshold ratios for additional reimbursement beginning at 12-to-1 and increasing to 6-to-1 over for four biennia
  - a. Support: 7
  - b. Oppose: 1
  - c. Abstain: 9
  
23. Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum hours of nursing care per resident, with such threshold hours for additional reimbursement increasing every biennium for three biennia
  - a. Support: 7
  - b. Oppose: 1
  - c. Abstain: 9
  
24. Pay for performance program through DMAS to provide additional reimbursement to facilities meeting minimum hours of nursing care per resident and meeting minimum quality of care standards as determined by DMAS, with such threshold hours for additional reimbursement beginning at 3.5 hours and increasing to 4.1 hours over for three biennia
  - a. Support: 6
  - b. Oppose: 0
  - c. Abstain: 11
  
25. Creating a workforce program similar to Virginia Values Veterans (V3) Program for people with disabilities to increase employment opportunities and promote economic development by training and certifying organizations in disability workforce best practices
  - a. Support: 12
  - b. Oppose: 1
  - c. Abstain: 4

26. Require changes to nursing home regulations to permit care by non-credentialed individuals in the MMAC program
  - a. Support: 9
  - b. Oppose: 3
  - c. Abstain: 5
  
27. Civilian credentialing/licensing reciprocity so state regulatory bodies recognize civilian equivalency of certain military allied health specialties
  - a. Support: 11
  - b. Oppose: 1
  - c. Abstain: 5
  
28. Civilian educational credits for statewide standardized recognition of military medical education and awarding of equivalent credit hours
  - a. Support: 11
  - b. Oppose: 1
  - c. Abstain: 5
  
29. Funding for awareness campaign for MMAC Program and the healthcare employment opportunities provided by the program
  - a. Support: 11
  - b. Oppose: 0
  - c. Abstain: 6
  
30. State version of the federal work opportunity income tax credit for private-sector businesses that hire individuals who have consistently faced significant barriers to employment, as determined by the General Assembly
  - a. Support: 6
  - b. Oppose: 3
  - c. Abstain: 8
  
31. State income tax credit for CNAs, LPNs, and RNs working at licensed nursing homes and certified nursing facilities
  - a. Support: 9
  - b. Oppose: 1
  - c. Abstain: 7
  
32. State income tax credit for for-profit nursing homes based on expenditures aimed at providing access to employees with disabilities
  - a. Support: 6
  - b. Oppose: 2
  - c. Abstain: 9
  
33. Tax relief program for not-for-profit nursing homes that would allow them to offset part of their payroll tax for expenditures aimed at providing access to employees with disabilities
  - a. Support: 9



- b. Oppose: 2
  - c. Abstain: 6
34. Direct Joint Commission on Health Care to conduct a study on direct care staff recruitment and retention, workplace culture improvements, and internal leadership development in nursing homes
- a. Support: 11
  - b. Oppose: 1
  - c. Abstain: 5

---

**APPENDIX F – STAKEHOLDER EXPLANATIONS OF OPPOSITION TO SPECIFIC RECOMMENDATIONS**

---

**RECOMMENDATION #1**

*Dignity for the Aged*

The time, effort and cost associated with setting up this program is not worth the effort or guarantee an increase of the clinical workforce, never mind benefit the elderly who are currently dying. Family members currently are not allowed to help their own relatives due to restrictions in nursing homes. The service learning would require staff to supervise, and most nursing homes are already understaffed.

**RECOMMENDATION #2**

*Dignity for the Aged*

The time, effort and cost associated with setting up this program is not worth the effort or guarantee an increase of the clinical workforce, never mind benefit the elderly who are currently dying. Family members currently are not allowed to help their own relatives due to restrictions in nursing homes. The service learning would require staff to supervise, and most nursing homes are already understaffed. There is no guarantee of Return on Investment – the pay is so low, and the environment so unprofessional and stressful, it would not take these kids much time to know that this field is not one they would want to obtain employment,

**RECOMMENDATION #3**

*Dignity for the Aged*

The time, effort and cost associated with setting up this program is not worth the effort and would not benefit the elderly who are currently dying. Family members currently are not allowed to help their own relatives due to restrictions in nursing homes. The service learning would require staff to supervise, and most nursing homes are already understaffed. There is no guarantee of Return on Investment – the pay is so low, and the environment so unprofessional and stressful, it would not take these kids much time to know that this field is not one they would want to obtain employment,

**RECOMMENDATION #4**

*Dignity for the Aged*

The nursing home regulations are not currently even enforced!!! Resident Rights, BASIC Standards for Care are ignored, why in the world would we change regulations that protect the elderly, when they are not getting the care that they are paying for now?

*Virginia Department for the Blind and Vision Impaired*

DBVI supports the concept of regulating the use of volunteers in long term care facilities, however, it does not support a requirement for the use of volunteers.

**RECOMMENDATION #5**

*Dignity for the Aged*

The nursing home regulations are not currently even enforced!!! Resident Rights, BASIC Standards for Care are ignored. The Nursing Home IS FOR THE RESIDENT – do not hire anyone who is not qualified!!!

**RECOMMENDATION #6**

*Dignity for the Aged*

There are plenty of programs available to promote career pathways in long term care, we do not need children to start filling the vacancies that adults should be applying for, especially when we do not pay qualified adults a decent wage. It would not take very many visits to a nursing home to find out that the job is thankless and even more so when they can be paid more at a Fast Food restaurant with less stress.

**RECOMMENDATION #7**

*Dignity for the Aged*

As was discussed in our meetings, this pilot program would only include a very small percentage of CNAs. Some of the discussion also conveyed that many Nursing Homes would not want to pay an increase salary for Advanced Certification for CNAs, so the program would set CNAs up for expectations and pay that would not be made available to them in the workplace. Why offer a pilot program?

**RECOMMENDATION #8**

*Dignity for the Aged*

Most CNA training programs are not expensive and in some cases are paid for by organizations if applicant [*sic*] agrees to work at their facility.

**RECOMMENDATION #9**

*Dignity for the Aged*

The workforce area that needs to be focused on is the CNAs. THEY carry the load, THEY are understaffed, THEY are not paid a wage that can support them, emphasis MUST be on increasing their pay for daily life and increasing staff to prevent burn out - which would help increase the workforce.

**RECOMMENDATION #10**

*Dignity for the Aged*

The very fact that a “Financial Relief Program” is recommended is a clear message that the CNAs need an increase in their salary. Why should they have to grovel and ask for financial relief, why not give them the dignity they deserve and pay them a decent wage?????

**RECOMMENDATION #11**

*Dignity for the Aged*

If a CNA cannot provide for their own transportation to work, it seems obvious that their wages need to be increased. It is not like they are taking an airplane to work. So why not increase their pay so they can provide for themselves, why must they make so little that they need to beg for money to get to work? The very fact that a “Financial Relief Program” is recommended is a clear message that the CNAs need an increase in their salary. Why should they have to grovel and ask for financial relief, why not give them the dignity they deserve and pay them a decent wage?????

**RECOMMENDATION #12**

*Dignity for the Aged*

Just pay them a respectable wage so they can pay for their own living costs, how would you feel if you had to beg? No wonder the workforce is dwindling, it is obvious. More programs don't support them, better wages do! Could you live on \$24,000 a year or less?

**RECOMMENDATION #21**

*Virginia Department for the Blind and Vision Impaired*

DBVI does not support this recommendation due to the mandate additional payments based on minimums, not the optimum performance.

*Virginia Health Care Association | Virginia Center for Assisted Living*  
Oppose staff-to-resident ratios

**RECOMMENDATION #22**

*Virginia Health Care Association | Virginia Center for Assisted Living*  
Oppose staff-to-resident ratios

**RECOMMENDATION #23**

*Office of the State Long-Term Care Ombudsman*

While we support a Pay for Performance model to incentivize facilities to improve the level of staffing, we believe that the criteria should include not only meeting the staffing threshold, but also meeting basic quality of care [*sic*] standards at the same time.

**RECOMMENDATION #25**

*Dignity for the Aged*

The issue with caring for the elderly requires competent professionals. People with disabilities can be helpful, however in a long term facility or nursing home, liability could be a risk that result in harm or death to a resident.

**RECOMMENDATION #26**

*Dignity for the Aged*

Enforce the Nursing Home regulations!!! Residents are abused, neglected and dying due to no enforcement of the regulations, too many slip through the cracks and are not provided proper care.

*Virginia Department of Medical Assistance Services*

Not clear as to meaning of "non-credentialed", question if speaking about military members that have no healthcare background or experience. This would be a concern.

*Virginia Nurses Association*

Virginia law mandates that nurse aides complete 120 hours of training and that the training be provided by a nurse aide school approved by the Virginia Board of Nursing. To work as a nurse aide in a nursing home an individual must be certified, except for the time allotted a new graduate of a nurse aide education program prior to completing the National Nurse Aide Assessment Program ([https://www.aeseducation.com/healthcenter21/what-is-the-nnaap-ex am-how-do-you-prepare-students-for-it](https://www.aeseducation.com/healthcenter21/what-is-the-nnaap-ex-am-how-do-you-prepare-students-for-it)). A veteran in the MMAC program will not meet the requirements to become a certified nurse aide in the state of Virginia which falls under certification by examination or certification by endorsement. Please see 18VAC90-25-71 Certification by examination and 18VAC90-25-72 Certification by endorsement found in the Virginia Board of Nursing Regulations Governing Certified Nurse Aides (<https://www.dhp.virginia.gov/media/dhpweb/docs/nursing/leg/CNA020620.pdf>)

After reading the qualifications for the MMAC program shown below, it does not appear that a veteran would qualify by certification by examination or certification by endorsement nor would it benefit a long-term care facility, if the individual requires constant monitoring by an already short of staff facility:

Pathway One – MMAC – Qualified: If you are a recently discharged Combat Medic/68W, Corpsman or Medical Technician/4N0X with less than 12 months since last practicing hands-on clinical care you may be

MMAC-Qualified. MMAC has Memos of Agreement (MOA) with 10 major healthcare systems in Virginia. The MMAC Partner Healthcare Systems (PHS) MOA allow MMAC-Qualified applicants to continue to practice clinical procedures under supervision while gaining the education and credentialing required in civilian healthcare. Only Virginia offers this option.

Additionally, there are no geriatric residents in the military that would allow a veteran to obtain the required experiences. While these individuals may be skilled in recognizing sudden changes in the status of a geriatric patient's condition, they may not be skilled in providing the type of care geriatric residents require on a daily basis.

**RECOMMENDATION #27**

*Dignity for the Aged*

Everyone should have the same standards PERIOD

**RECOMMENDATION #28**

*Dignity for the Aged*

Everyone should have the same standards period. Working with seniors is much different than military medical education and takes away from key qualifications.

**RECOMMENDATION #30**

*Dignity for the Aged*

Absolutely NOT. There are enough problems with theft, abuse and neglect, people need to fill the position because they have the proper skill set and compassion necessary to care for the elderly!

**RECOMMENDATION #31**

*Dignity for the Aged*

As discussed in several meetings, increase their pay where they need it, a tax credit does nothing for day to day living

**RECOMMENDATION #32**

*Dignity for the Aged*

We need qualified individuals working in Nursing Home facilities – the job involves physical fitness, mental and educationally sound individuals. As per discussions, A [sic] deaf or blind person would not be capable of helping elderly individuals in this line of work.

**RECOMMENDATION #33**

*Dignity for the Aged*

We need qualified individuals working in Nursing Home facilities – the job involves physical fitness, mental and educationally sound individuals. As per discussions, A [sic] deaf or blind person would not be capable of helping elderly individuals in this line of work

**RECOMMENDATION #34**

*Dignity for the Aged*

We have enough information from studies to fill a library the size of the Pentagon. We do not need to waste one more dime on a study. In a nutshell, CNAs are leaving the field. They are not treated like professionals, they don't make enough money to provide for their basic needs, they are taking care of 20, 30 or more patients which is impossible, they are overwhelmed, stressed out, burned out and no one cares enough

to pass a bill to establish ratios so they can do the job they were hired to do, which is care for the elderly in a way that provides some dignity to the elderly and the workers. Get it together and pass a bill to mandate ratios of 1 CNA to 6 residents! Think of your parents, friends or even yourself residing in a nursing home with no one to answer your call button, sitting in your own waste for hours. We have all the data we need, if you need more, please contact me at: [skukich2002@yahoo.com](mailto:skukich2002@yahoo.com).

*Virginia Health Care Association | Virginia Center for Assisted Living*

Oppose any JCHC study as that basically is another study of this study that VDH just did.

---

**APPENDIX G – STAKEHOLDER COMMENTS ON WORK GROUP DRAFT REPORT**

---

Stakeholders were offered the opportunity to provide feedback and suggestions on the draft work group report.

**DIGNITY FOR THE AGED**

<https://nursinghomesabuseadvocate.com/WATCHLIST/>

Above is the link for the Nursing Home Watch List that Lionel De Curr [sic] provided several times to the panel. I have attached a document with a listing of the 50 homes<sup>87</sup> that are on the Nursing Home Watch List from Virginia. I included one of the Nursing Homes as an example<sup>88</sup> to include in the Work Group Report as requested in today's meeting. The Watch list document with the 3 supporting documents should be included in the Appendices as Appendice [sic] I. Nursing Home Watch List.

As requested during today's meeting, please add this document<sup>89</sup> as another Appendices. The link will provide a well defined quick look at the specifics. I have also attached a document to include in the report that would allow members of the GA a quick explanation for reference.

Virginia Details [<https://www.familiesforbettercare.com/index.php/report-cards/details/va>]

The following documents<sup>90</sup> should be inserted into the report under Virginia's Clinical Workforce For Nursing Homes under the subtitle of State of Workforce. This information directed much of the conversation and was presented by Erin Hines concerning the shortages of CNAs. Including this information will provide a much more accurate picture of why there are shortages in the workforce.

I believe in adding this information<sup>91</sup> with a paragraph concerning panel discussion and public comments you already recieved [sic], should be included in the report under the title of CMS Five Star Ratings for Workforce as it will give more meaning to fact that Virginias [sic] ranking is quite low (36th) place as well as having a grade of D due to understaffing - if further information is needed, they may access the Appendice [sic] I previously send [sic] to be included.

I would recommend that this graphic<sup>92</sup> which was discussed at length in meetings, be inserted under the CMS Five Star Ratings for Workforce - under staffing - for the General Assembly to view actual data to address the application of how staffing affects care. A note for further investigation can be included in the paragraph to refer them to the Appendice [sic] for further information if needed. Including this will provide real life content for insight and perspective.

---

<sup>87</sup> Dignity for the Aged provided screenshots of the first 50 results from this webpage <https://nursinghomesabuseadvocate.com/watchlist/?ws=Hampton%2C+VA&distance=100&sortby=> and a screenshot of the webpage <https://nursinghomesabuseadvocate.com/nursing-homes/coliseum-convalescent-and-rehabilitation-center/>.

<sup>88</sup> Dignity for the Aged provided multiple screenshots of the webpage <https://nursinghomesabuseadvocate.com/nursing-homes/newport-news-nursing-rehab/>.

<sup>89</sup> Dignity for the Aged provided a screenshot of the webpage <https://www.familiesforbettercare.com/index.php/report-cards/details/va>.

<sup>90</sup> Dignity for the Aged provided materials that are reproduced in Appendix J.

<sup>91</sup> Dignity for the Aged provide a screenshot of the webpage <https://www.familiesforbettercare.com/index.php/report-cards/details/va>.

<sup>92</sup> Dignity for the Aged provided a screenshot of the webpage <https://nursinghomesabuseadvocate.com/nursing-homes/newport-news-nursing-rehab/>.

**OFFICE OF THE CHIEF WORKFORCE ADVISOR**

The Office of the Chief Workforce Advisor provided 20 technical changes to address typographical errors, sentence structure, and clarification of information and materials presented by Meaghan Green.

**OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN**

For Join [sic] Latimer’s affiliation, it is correct except for agency name, which should read Va. Department for Aging and Rehabilitative Services

Remove Gail Thompson from the list, as she indicate [sic] she was an initial point of contact only, and did not participate in the work group.

*Financial Relief Programs*

*Regarding Recommendations # 10, 11, and 12*

While our program does not specifically oppose these recommendations in that we would not wish to thwart any measure that provides meaningful support/financial relief for our direct care staff, we have some reservations about Recommendations 10 – 12 as the mechanism for that relief. In some ways, recommendations 10 -12 offer only partial relief at best and may actually become the stopgap measure that prevents our getting to one of the primary roots of the problem – the lack of a true living wage and appropriate benefits for our direct care staff.

Putting into place the kind of partial ‘propping up’ embodied by # 10-12 may actually defer and ultimately undermine the potential for a solution that substantively addresses the problem. To pay our CNAs rock-bottom wages while ‘propping up’ their situation with some relief ‘around the edges’ could be a detrimental and dangerous policy. Rather than paternalistically offering ‘benevolences’ in a sense, we need to fairly compensate our workforce, respecting and supporting their management of their living costs once they actually can make a living.

*Supporting Persons with Disabilities*

While it may not be appropriate for inclusion in the report, I do wish to register a general concern with the recommendations in this category. I would assume that all of the work group members would be supportive of measures that eliminate barriers for persons with disabilities to meaningful employment. I believe that our disabled citizens represent an insufficiently tapped national treasure that might well positively infuse our struggling long-term care workforce. Eliminating such barriers for these individuals is a moral imperative and an important public policy goal. At the same time, unless policies of this sort are enacted in concert with significant improvements in the quality of long-term care workforce jobs, we may do harm to our disabled citizens, essentially ‘throwing them into the fire.’

*C. Summary of Written Comments from the Public*

I think the following better captures the thrust of my written comments (Aug 4):

Joani Latimer expressed concern that the work group’s extensive focus so far on pipeline/recruitment issues may limit getting to the real root of the workforce shortage (low wages and morale, understaffing, workplace culture), which has as much or more to do with retention as recruitment.

**VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS**

*State of the Workforce*



Page 11, paragraph 2<sup>93</sup>

The paragraph refers to “licensed” CNA’s, which may cause some confusion since CNA’s are not licensed, they are “certified.” We would recommend deleting the term “licensed” before “CNA” on lines 2 and 6 of paragraph 2.

*Student Outreach*

Page 18, “*Student Outreach*”

The sentence under this heading/this section appears to be incomplete.

*Supporting Veterans*

Pages 25-26, “*Supporting Veterans*”

Paragraph 2 on page 26 contains the following statements:

*DVS representatives also pointed out that neither CMS nor Virginia’s regulatory agencies recognize the civilian equivalency of certain military allied health specialties; similarly, there is no standard recognition of military medical education or awarding of equivalent credit hours.*

Virginia’s health regulatory agencies do recognize substantially equivalent military education and training of medical professionals as appropriate. The extent to which the training/education is recognized or applied to requirements for licensure really depends upon the profession, the licensure qualifications, and the nature of the military education/training.

Va. Code § 54.1-118 provides the following:

*§ 54.1-118. Qualifications for licensure, etc.; substantially equivalent military training and education.*

*A. Except as provided in this section, the regulatory boards within the Department of Professional and Occupational Regulation, the Department of Health Professions, or any board named in this title shall accept the military training, education, or experience of a service member honorably discharged from active military service in the armed forces of the United States, to the extent that such training, education, or experience is substantially equivalent to the requirements established by law and regulations of the respective board for the issuance of any license, permit, certificate, or other document, however styled or denominated, required for the practice of any business, profession, or occupation in the Commonwealth. To the extent that the service member’s military training, education, or experience, or portion thereof, is not deemed substantially equivalent, the respective board shall credit whatever portion of the military training, education, or experience that is substantially equivalent toward meeting the requirements for the issuance of the license, permit, certificate, or other document.*

*The provisions of this subsection shall not apply to the Board of Medicine in the regulation of the practice of medicine or osteopathic medicine. Nor shall this subsection apply to the Board of Dentistry in the regulation of dentists or oral and maxillofacial surgeons.*

---

<sup>93</sup> References to paragraphs and page numbers are for a prior draft and may no longer be accurate.

*B. The Board of Medicine may accept a service member's military training, education, or experience as an intern or resident in an approved facility to satisfy the requirement of one year of satisfactory postgraduate training as an intern or resident in a hospital or health care facility, provided the applicant for licensure (i) has been honorably discharged from active military service in the armed forces of the United States, (ii) is a graduate of a Board-approved institution, (iii) has successfully completed all required examinations for licensure, and (iv) applies for licensure within six months of discharge from active military service.*

*C. The Board of Dentistry may accept the military training, education, or experience of a service member provided the applicant for licensure (i) has been honorably discharged from active military service in the armed forces of the United States, (ii) has been in continuous clinical practice for four of the six years immediately preceding the application for licensure, (iii) holds a diploma or certificate of a dental program accredited by the Commission on Dental Accreditation of the American Dental Association, and (iv) has successfully completed all required examinations for licensure. Active patient care in the Dental Corps of the United States armed forces, voluntary practice in a public health clinic, or practice in an intern or residency program may be accepted by the Board to satisfy requirements for licensure.*

*D. Any regulatory board may require the service member to provide such documentation of his training, education, or experience as deemed necessary by the board to determine substantial equivalency.*

*E. As used in this section, "active military service" means federally funded military duty as (i) a member of the armed forces of the United States on active duty pursuant to Title 10 of the United States Code or (ii) a member of the Virginia National Guard on active duty pursuant to either Title 10 or Title 32 of the United States Code.*

**VIRGINIA HEALTH CARE ASSOCIATION | VIRGINIA CENTER FOR ASSISTED LIVING**

*Recommendation #12 – 16*

Support provided funding is provided by GA which would only cover Medicaid, so the cost would be passed through to the private pay residents.

*Recommendation #23*

Support in lieu of #22.

*Recommendation #24*

We fully agree in concept to a value-based payment arrangement whereby additional payment, relative to the normal Medicaid rate, be provided based on achievement of or progress toward quality measures. In fact, over a year ago we proposed that DMAS explore such an initiative by convening the Medicaid managed care organizations and our organization to “to determine which existing long-term care quality performance metrics should be measured; the methodology and thresholds for successful achievement or significant improvement under which a facility would qualify for an enhanced, add-on payment; the distribution formula for the enhanced payment; and, the funding mechanism to allow incorporation of the enhanced funding into MCO capitation rates, or in any other federally-approved mechanism for full distribution to eligible nursing facilities.” Our only concern with the recommendation as written is that while we do believe increased direct care hours will likely be an end product of the initiative, if not an explicit measure, we do not believe the measures should be formalized until the above process has taken place. However, we stand by the proposal and believe it is very much on line with the spirit of the recommendation.

**APPENDIX H – SERVICE LEARNING REQUIREMENTS BY JURISDICTION**

This chart outlines the high school graduation requirements or credit allowed toward graduation for service-learning per jurisdiction. Per the Education Commission of the States, many school districts have graduation requirements in addition to those required by the jurisdiction.<sup>94</sup>

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
<b>AK</b>	No	No	No
<b>AL</b>	No	No	No
<b>AR</b>	No	A student who has completed a minimum of 75 hours of documented community service in grades 9-12, as certified to the school by the service agency or organization, is eligible to receive one academic credit that may be applied toward graduation. The community service must be in programs or activities approved by the State Board of Education and the local school board and must include preparation, action, and reflection components. Local school boards are authorized to grant a waiver of this requirement with notice to the state board.  Ark. Code Ann. § 6-16-120 Code Ark. R. 005.08.1	No
<b>AZ</b>	No	No	No
<b>CA</b>	No	No	No
<b>CO</b>	No	No	School districts are required to consider and, if they deem it appropriate, adopt a policy to encourage students to engage in community service or service-learning and to recognize students' contributions to their

<sup>94</sup> Baumann, Paul. “50-State Comparison: High School Graduation Requirement or Credit toward Graduation — Service-Learning/Community Service.” Education Commission of the States. National Center for Learning and Civic Engagement, January 1, 2014. <http://ecs.force.com/mbdata/mbquest3RTE?Rep=SL1301>.

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
			<p>communities through community service or service-learning. A student who successfully meets the community service or service-learning program goals can earn recognition in the manner described in the policy. The policy should specify how the service is recognized on a student's diploma or transcript as an indication of the student's commitment to service within the community.</p> <p>Colo. Rev. Stat. Ann. § 22-32-137</p>
<b>CT</b>	No	<p>A local or regional board of education is authorized to offer one-half credit in community service, which qualifies for high school graduation credit. The community service must be supervised by a certified school administrator or teacher and consist of not less than 50 hours of actual service that may be performed at times when school is not regularly in session and not less than 10 hours of related classroom instruction. Community service does not include partisan political activities.</p> <p>Beginning with classes graduating in 2020, to graduate, students will be required to complete two credits in career and life skills electives, such as career and technical education, English as a second language, community service, personal finance, public speaking, and nutrition and physical activity.</p>	No

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
		Conn. Gen. Stat. Ann. § 10-221a	
<b>DC</b>	<p>Students are required to complete 100 hours of volunteer community service to graduate. The specific community service projects are established by the local education agency.</p> <p>D.C. Mun. Regs. tit. 5-E § 2203</p>	No	No
<b>DE</b>	No	<p>If a student in grades 9-12 performs at least 45 hours of voluntary community service for 2 semesters, the student will receive 1 Delaware Volunteer credit. The credit may be counted as an elective for graduation requirements if the service is approved by, and conducted under the supervision of, the school principal. To qualify for the credit:</p> <ul style="list-style-type: none"> <li>• The service must be performed outside of the hours during which the student is required to be at school. Service can be performed during the summer or other recess periods.</li> <li>• The organization or project with whom the service is performed must have its name submitted to a school guidance counselor by the Delaware Office of Tourism or the Department of Education.</li> <li>• The service cannot be of a political or advocacy nature.</li> </ul> <p>A student can only be awarded one Delaware Volunteer credit.</p>	No

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
		Del. Code Ann. tit. 14, § 8902A.	
<b>FL</b>	No	<p>Districts may award up to one-half elective credit for student completion of nonpaid voluntary community or school service work. Students choosing this option must complete a minimum of 75 hours of service in order to earn the one-half credit in either category of instruction. Credit may not be earned for service provided as a result of court action. District school boards that approve the award of credit for student volunteer service are required to develop guidelines regarding the award of the credit, and school principals are responsible for approving specific volunteer activities.</p> <p>Fla. Stat. Ann. § 1003.497</p>	<p>School districts are encouraged to include service learning as part of any course or activity required for high school graduation and to include and accept service-learning activities and hours in requirements for academic awards, especially those awards that currently include community service as a criterion or selection factor.</p> <p>Fla. Stat. Ann. § 1003.497</p>
<b>GA</b>	No	<p>Community Service I, II, III, and IV are elective courses that satisfy credit requirements for high school graduation.</p> <p>Ga. Comp. R. &amp; Regs. 160-4-2-.36</p>	No

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
<b>HI</b>	No	Beginning with the graduating class of 2016, <sup>95</sup> one of the six elective credits for graduation may include one elective credit for a senior project. The components of a senior project are: <ul style="list-style-type: none"> <li>• Research Paper</li> <li>• Project (career focus, service learning, or student personal interest)</li> <li>• Project Portfolio</li> <li>• Presentation to a panel</li> </ul>	No
<b>IA</b>	No	No	A school district or a nonpublic school may require a certain number of service-learning units as a condition for the inclusion of a service-learning endorsement on a student's diploma or as a condition of graduation.  Iowa Code Ann. § 256.18A
<b>ID</b>	No	No	No
<b>IL</b>	No	School districts are authorized to establish a volunteer service credit program under which students can earn credit toward graduation through performance of community service. The amount of credit given for program participation cannot exceed the amount given for completion of one semester of language arts, math, science, or social studies.  105 ILCS 5/27-22.3	No

<sup>95</sup> “Graduation Requirements.” Hawaii State Department of Education. <http://www.hawaiipublicschools.org/TeachingAndLearning/StudentLearning/GraduationRequirements/Pages/home.aspx>.

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
<b>IN</b>	No	<p>Students in grade 11 or 12 can earn academic credit toward the student’s minimum graduation requirements by completing approved community service or other volunteer service.</p> <p>Ind. Code Ann. § 20-30-14-1</p> <p>The State Board of Education is required to promulgate rules related to community service. Among the required rules are requirements that a student must perform at least 48 hours of service to earn one academic credit and that not more than two academic credits toward graduation may be awarded.</p> <p>Ind. Code Ann. § 20-30-14-9</p>	No
<b>KS</b>	No	No	No
<b>KY</b>	No	No	No
<b>LA</b>	No	No	No
<b>MA</b>	No	No	No
<b>MD</b>	<p>Students are required to complete either:</p> <ul style="list-style-type: none"> <li>• 75 hours of student service that includes preparation, action, and reflection components and that, at the discretion of the local school system, may begin during the middle grades; or</li> <li>• a locally designed program in student service that has been approved by the state Superintendent of Schools.</li> </ul>	No	No



<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
	Md. Code Regs. 13A.03.02.06		
<b>ME</b>	No	No	No
<b>MI</b>	No	No	No
<b>MN</b>	No	<p>A school board is authorized to offer, as part of a community education program with a youth development program, a youth service program that provides young people with opportunities to become involved in their community, develop individual capabilities, make career connections, seek support networks and services, become active citizens, and address community needs through youth service. The board may award up to one credit toward graduation for a pupil who completes the youth service requirements of the district.</p> <p>Minn. Stat. Ann. § 124D.19</p>	No
<b>MO</b>	No	<p>Local boards of education that maintain a high school are authorized to include service-learning as part of any course contributing to the satisfaction of credits necessary for high school graduation and to provide support for the use of service-learning as an instructional strategy at any grade level to address appropriate areas of current state educational standards for student knowledge and performance.</p> <p>Mo. Rev. Stat. § 170.037.3</p>	No
<b>MS</b>	No	No	No
<b>MT</b>	No	No	No
<b>NC</b>	No	No	No

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
<b>ND</b>	No	Two service learning courses listed in the high school career and technical supplementary services course codes for grades 9-12 are designed to help at-risk students make a smooth, successful transition from high school to the world of work and will allow students to earn elective credits toward graduation requirements. <sup>96</sup>	No
<b>NE</b>	No	No	No
<b>NH</b>	No	<p>If a district chooses to offer extended learning opportunities in middle school, the opportunities must be governed by a policy adopted by the local school board that specifies whether or not credit can be granted for extended learning activities, including, but not limited to, independent study, private instruction, team sports, performing groups, internships, community service, and work study.</p> <p>NH ADC ED 306.26</p> <p>If a district chooses to offer extended learning opportunities in high school as part of the required curriculum content, the opportunities must be governed by a policy adopted by the local school board that specifies that credits can be granted for extended learning activities, including independent study, private instruction, team sports, performing groups, internships, community service, and work study.</p>	No

<sup>96</sup> “Grades 9-12 Course Codes: Career and Technical Supplementary Services.” North Dakota Department of Public Instruction, July 2013. <http://www.dpi.state.nd.us/resource/corscode/2014pdf/specneeds14.pdf>.

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
		NH ADC ED 306.27	
<b>NJ</b>	No	<p>The 120-credit requirement for graduation may be met in whole or in part through completion of a range of experiences that enable students to pursue a variety of personalized learning opportunities. District boards of education are required to establish a process to approve individualized student learning opportunities, including service-learning experiences, that meet or exceed the core curriculum content standards.</p> <p>N.J. Admin. Code 6A:8-5.1</p>	No
<b>NM</b>	No	<p>School districts must offer student service learning as an elective in which students can earn credits toward the elective units required for graduation.</p> <p>N.M. Stat. Ann. § 22-13-1.1</p> <p>Among the items allowed for alternate demonstration of competency of high school exit requirements using standards-based indicators are community-based projects such as internships, service learning, pre-apprenticeship, or after-school job performance.</p> <p>N.M. Admin. Code § 6.19.7</p> <p>A career readiness alternative program of study leading to a diploma or conditional certificate of transition is available to students with an</p>	No

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
		<p>IEP. Course work includes a minimum of four units of career development opportunities and learning experiences that may include career readiness and vocational course work, work experience, community-based instruction, student service learning, job shadowing, mentoring, or entrepreneurship related to the student's occupational choices.</p> <p>N.M. Admin. Code § 6.29.1</p>	
<b>NV</b>	No	<p>High school students who successfully complete an approved community service project are allowed to apply not more than one credit received for the completion of the project toward the total number of credits required for graduation. The credit must be applied toward the pupil's elective course credits and not toward a course that is required for graduation from high school.</p> <p>Nev. Rev. Stat. 389.165</p>	No
<b>NY</b>	No	No	No
<b>OH</b>	No	<p>High school credit for a community service education course may be granted if approximately half of the course is devoted to classroom study of such matters as civic responsibility, the history of volunteerism, and community service training and approximately half of the course is devoted to community service.</p> <p>Ohio Rev. Code Ann. § 3313.605</p>	No

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
<b>OK</b>	No	<p>School districts are authorized to establish, as part of the curriculum, a youth community service program for secondary students that includes youth community service activities integrated with study and reflection on the experiences gained through youth community service activities. Students may receive elective credit for participating in a youth community service program as long as the outcomes of the program reflect the competencies outlined in the Oklahoma Learner Outcomes adopted by the State Board of Education. A student may perform youth community service activities for credit only under the sponsorship of an organization approved by the State Department of Education.</p> <p>Okla. Stat. Ann. tit. 70, § 11-108.2 West</p>	No
<b>OR</b>	No	<p>Students have the option of earning credit required for a diploma or a modified diploma by successfully completing classroom or equivalent work (e.g., supervised independent study, career-related learning experiences, project-based learning) in a course of at least 130 clock hours. The work must meet common curriculum goals and academic content standards.</p> <p>Or. Admin. R. 581-022-1131</p>	No
<b>PA</b>	No	No	No

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
<b>RI</b>	No	No	<p>The Department of Elementary and Secondary Education is required to encourage school districts to establish community service learning programs by developing a model program and appropriate guidelines for implementation of the model program. Local school districts may petition the Commissioner of Education for approval of community service learning programs, which may be used in partial fulfillment of the requirement for obtaining a high school diploma. The commissioner must develop criteria that school districts can use as a means of determining and recognizing community service learning activities for credit towards a high school diploma.</p> <p>R.I. Gen. Laws Ann. § 16-22-21</p>
<b>SC</b>	No	No	No
<b>SD</b>	No	<p>Students are required to complete at least one unit, in any combination, of approved career and technical education courses, a capstone experience or service learning, and world languages.</p> <p>S.D. Admin. R. 24:43:11:02</p>	No

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
<b>TN</b>	No	Local boards of education set the number of credit hours that may be earned by students who complete a minimum of 30 service hours in the course “Success Skills through Service Learning.” <sup>97</sup> A maximum of three credits may be earned in any one school year, and at least one credit must be earned in the related classroom experience. Credit is not awarded for paid service learning. <sup>98</sup>	Local boards of education are encouraged to consider requirements for students to complete a capstone experience. Capstone experiences may include, among other things, at least 40 hours of service learning or community service.  Tenn. Comp. R. & Regs. 0520-01-03-.06
<b>TX</b>	No	One-half to one credit is awarded for a family and community services course that is designed to involve students in realistic and meaningful community-based activities through direct service experiences. Students are provided opportunities to interact and provide services to individuals, families, and the community through community or volunteer services. Emphasis is placed on developing and enhancing organizational and leadership skills and characteristics.  19 Tex. Admin. Code § 130.249  One-half to one credit is awarded for the principles of hospitality and tourism course and the travel and tourism management course. Students must demonstrate leadership, citizenship, and teamwork skills required for success, and	No

<sup>97</sup> “Success Skills Through Service Learning.” Tennessee Department of Education. [http://www.tn.gov/education/ci/service/doc/SL\\_Grades\\_9-12.pdf](http://www.tn.gov/education/ci/service/doc/SL_Grades_9-12.pdf).

<sup>98</sup> “Work-Based Learning Policies, Procedures, and Resources.” Tennessee Department of Education, April 2013. <http://www.tennessee.gov/education/cte/wb/doc/WorkBasedLearningPoliciesApril2013.pdf>.

<i>Juris-diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
		they are expected to participate in community service activities.  19 Tex. Admin. Code § 130.222 19 Tex. Admin. Code § 130.225	
<b>UT</b>	No	No	No
<b>VA</b>	No	No	No
<b>VT</b>	No	No	No
<b>WA</b>	No	School districts are required to adopt a policy that is supportive of community service and provides an incentive, such as recognition or credit, for students who participate in community service.  WA ST 28A.320.193	No
<b>WI</b>	No	No	A school board may require a pupil to participate in community service activities in order to receive a high school diploma.  Wis. Stat. Ann. § 118.33
<b>WV</b>	No	Students in grades 9-12 must be provided structured, on-going experiences for career exploration, decision making, and career preparation. All students must participate in an experiential learning experience at some time in grades 9-12. If credit is granted for these experiences, content standards and objectives will be developed and approved at the local level. Experiential learning is defined as structured work-based, services-based, community-based, or research-based learning experiences.	No



GA Report – Availability of Clinical Workforce for Nursing Homes, 2020

<i>Juris- diction</i>	<i>Statewide Requirement</i>	<i>Credit toward graduation</i>	<i>Local districts discretion to adopt requirement</i>
		W. Va. Code R. § 126-42-5 W. Va. Code R. § 126-42-13	
<b>WY</b>	No	No	No

---

**APPENDIX I – NURSING HOME STAFFING REQUIREMENTS BY JURISDICTION**


---

This chart outlines the minimum staffing ratios and minimum direct care hours for licensed nursing homes per jurisdiction. Minimum direct care hours requirements are often presented as hours per resident day (HPRD).

<i>Juris-diction</i>	<i>Minimum Staffing Ratio</i>	<i>Minimum Direct Care Hours</i>
<b>AK</b>	<u>Day Shift</u> : 1 RNs to every 30 residents <u>Other Shifts</u> : 1 RN to every 60 residents  Alaska Admin. Code, tit. 7, § 12. 275	N/A
<b>AL</b>	N/A	N/A
<b>AR</b>	<u>Day Shift</u> : 1 direct care staff per 6 residents; 1 licensed nurse per 40 residents <u>Evening Shift</u> : 1 direct care staff per 9 residents; 1 licensed nurse per 40 residents <u>Night Shift</u> : 1 direct care staff per 14 residents; 1 licensed nurse per 80 residents  Ark. Code R. § 016.06-15-520.3.1	N/A
<b>AZ</b>	1 licensed nurse per 64 residents  Ariz. Admin. Code § R9-10-412(B)(3)	N/A
<b>CA</b>	N/A	3.5 HPRD, with a minimum of 2.4 HPRD by CNA  Cal. Code Regs., tit. 22, § 72329.2
<b>CO</b>	N/A	2.0 HPRD  10 Colo. Code Regs. § 2505-10-8-408
<b>CT</b>	N/A	<u>Day Shift</u> : 1.40 HPRD for licensed nurses and nurse aides, with 0.47 HRPD for licensed nurses <u>Night Shift</u> : 0.50 HPRD for licensed nurses and nurse aides, with 0.17 HRPD for licensed nurses  Conn. Agencies Regs., § 19-13-D8t(m)
<b>DC</b>	N/A	Minimum daily average of 4.1 HPRD, with 0.6 HPRD provided by an RN or advance practice RN and 0.2 HPRD provided by a physician, PA, or advanced practiced RN  D.C. Mun. Regs. tit. 22B, § 3211.4 – .5

<i>Juris-diction</i>	<i>Minimum Staffing Ratio</i>	<i>Minimum Direct Care Hours</i>
<b>DE</b>	<p><u>Day Shift</u>: 1 RN or LPN per 15 residents; 1 CNA per 7 residents</p> <p><u>Evening Shift</u>: 1 RN or LPN per 20 residents; 1 CNA per 10 residents</p> <p><u>Night Shift</u>: 1 RN or LPN per 30 residents; 1 CNA per 15 residents</p> <p>Del. Code tit 16, § 1162(e)</p>	<p>3.67 HPRD</p> <p>Del. Code tit 16, § 1162(e)</p>
<b>FL</b>	<p>1 CNA per 20 residents</p> <p>1 licensed nursing per 40 residents.</p> <p>Fla. Stat. § 400.23(3)(a)(1)(c) – (d)</p>	<p>Minimum weekly average of 3.6 HPRD combined licensed nurse and CNA staffing, with 2.5 HPRD for CNAs and 1.0 HPRD for licensed nurses</p> <p>Fla. Stat. § 400.23(3)(a)(1)(a) – (b)</p>
<b>GA</b>	N/A	<p>2.0 HPRD</p> <p>Ga. Comp. R. &amp; Regs. 111-8-56-.04</p>
<b>HI</b>	N/A	N/A
<b>IA</b>	N/A	<p>2.0 HPRD, or 1.7 HPRD if maximum medical assistance rate is reduced below the 74th percentile</p> <p>Iowa Admin. Code r. 481-58.11(2)(g)</p>
<b>ID</b>	N/A	<p>2.4 HPRD</p> <p>Idaho Admin. Code r. 16.03.02.200.02(d)</p>
<b>IL</b>	N/A	<p>3.8 HPRD for skilled care and 2.5 HPRD for nonskilled care, with at least 25% being provided by a licensed nurse and at least 10% being provided by an RN</p> <p>Il. Admin. Code tit. 77, pt. 300.1230(c) – (d)</p>
<b>IN</b>	N/A	N/A
<b>KS</b>	<p>1 licensed nurse per 30 residents</p> <p>Kan. Admin. Regs. § 28-39-154(a)(7)(B)</p>	<p>Minimum weekly average of 2.0 HRPD</p> <p>Minimum daily average of 1.85 HRPD</p> <p>Kan. Admin. Regs. § 28-39-154(a)(7)(A)</p>
<b>KY</b>	N/A	N/A
<b>LA</b>	N/A	<p>2.35 HPRD</p> <p>La. Admin. Code tit. 48, § 9823</p>
<b>MA</b>	N/A	N/A
<b>MD</b>	<p>1 nursing service personnel per 15 residents</p> <p>1 RN per 99 residents</p>	<p>3.0 HPRD</p> <p>Md. Code Regs. 10.07.02.19(B)</p>

GA Report – Availability of Clinical Workforce for Nursing Homes, 2020

<i>Juris-diction</i>	<i>Minimum Staffing Ratio</i>	<i>Minimum Direct Care Hours</i>
	Md. Code Regs. 10.07.02.19(A) and (D)	
<b>ME</b>	<p><u>Day Shift:</u> 1 direct-care provider per 5 residents and</p> <ul style="list-style-type: none"> <li>• 20 or fewer beds: 1 licensed nurse; or</li> <li>• Greater than 20 beds: 1 licensed nurse, with an additional licensed nurse for each 50 beds above 50 and with an additional RN for every 100 beds</li> </ul> <p><u>Evening Shift:</u> 1 direct-care provider per 10 residents and 1 licensed nurse per shift, with an additional licensed nurse for each 70 beds and with an additional RN for every 100 beds</p> <p><u>Night Shift:</u> 1 direct care provider per 15 residents and 1 licensed nurse per shift, with an additional licensed nurse for each 100 beds and with an additional RN for every 100 beds</p> <p>10 144 Me. Code R. 110 § 9.A.3 and .4</p>	N/A
<b>MI</b>	<p><u>Day Shift:</u> 1 nursing care personnel per 8 residents</p> <p><u>Evening Shift:</u> 1 nursing care personnel per 12 residents</p> <p><u>Night Shift:</u> 1 nursing care personnel per 15 residents</p> <p>Mich. Comp. Laws § 333.21720a(2)</p>	<p>2.25 HPRD</p> <p>Mich. Comp. Laws § 333.21720a(2)</p>
<b>MN</b>	N/A	<p>2.0 HPRD</p> <p>Minn. Stat. § 144A.04(7)(a); Minn. R. 4658.0510</p>
<b>MO</b>	N/A	N/A
<b>MS</b>	N/A	<p>2.8 HPRD</p> <p>Miss. Code R. § 45.4.1(1)</p>
<b>MT</b>	<p><u>Day Shift:</u></p> <ul style="list-style-type: none"> <li>• 4-8 beds: 1 RN</li> <li>• 9-15 beds: 1 RN and 0.5 CNA</li> <li>• 16-20 beds: 1 RN and 1 CNA</li> <li>• 21-25 beds : 1 RN and 1.5 CNAs</li> <li>• 26-30 beds : 1 RN and 2 CNAs</li> <li>• 31-35 beds : 1 RN and 2.5 CNAs</li> <li>• 36-40 beds : 1 RN and 3 CNAs</li> <li>• 41-45 beds : 1 RN, 1 LPN, and 3.5 CNAs</li> <li>• 46-50 beds : 1 RN, 1 LPN, and 4 CNAs</li> </ul>	N/A

<i>Juris-diction</i>	<i>Minimum Staffing Ratio</i>	<i>Minimum Direct Care Hours</i>
	<ul style="list-style-type: none"> <li>• 51-55 beds: 1 RN, 1 LPN, and 4.5 CNAs</li> <li>• 56-60 beds: 1 RN, 1 LPN, and 5 CNAs</li> <li>• 61-65 beds: 1 RN, 1 LPN, and 5.5 CNAs</li> <li>• 66-70 beds: 1 RN, 1 LPN, and 6 CNAs</li> <li>• 71-75 beds: 1 RN, 1 LPN, and 6.5 CNAs</li> <li>• 76-80 beds: 1 RN, 2 LPNs, and 6 CNAs</li> <li>• 81-85 beds: 1 RN, 2 LPNs, and 6.5 CNAs</li> <li>• 86-90 beds: 1 RN, 2 LPNs, and 7 CNAs</li> <li>• 91-95 beds: 2 RNs, 2 LPNs, and 6.5 CNAs</li> <li>• 96-100 beds: 2 RN, 2 LPNs, and 7 CNAs</li> <li>• 101+ beds: Individually determined</li> </ul> <p><u>Evening Shift:</u></p> <ul style="list-style-type: none"> <li>• 4-15 beds: 1 LPN</li> <li>• 16-20 beds: 1 LPN and 0.5 CNA</li> <li>• 21-30 beds : 1 LPN and 1 CNA</li> <li>• 31-35 beds : 1 LPN and 1.5 CNAs</li> <li>• 36-45 beds : 1 LPN and 2 CNAs</li> <li>• 46-50 beds : 1 LPN and 2.5 CNAs</li> <li>• 51-60 beds: 1 RN and 3 CNAs</li> <li>• 61-65 beds: 1 RN and 3.5 CNAs</li> <li>• 66-75 beds: 1 RN and 4 CNAs</li> <li>• 76-90 beds: 1 RN, 1 LPN, and 4 CNAs</li> <li>• 91-95 beds: 1 RN, 1 LPN, and 4.5 CNAs</li> <li>• 96-100 beds: 1 RN, 1 LPN, and 5 CNAs</li> <li>• 101+ beds: Individually determined</li> </ul> <p><u>Night Shift:</u></p> <ul style="list-style-type: none"> <li>• 4-20 beds: 1 LPN</li> <li>• 21-25 beds : 1 LPN and 0.5 CNA</li> <li>• 26-40 beds : 1 LPN and 1 CNA</li> <li>• 41-45 beds : 1 LPN and 1.5 CNAs</li> <li>• 46-60 beds : 1 LPN and 2 CNAs</li> <li>• 61-65 beds: 1 LPN, and 2.5 CNAs</li> <li>• 66-70 beds: 1 LPN and 3 CNAs</li> <li>• 71-80 beds: 1 RN and 3 CNAs</li> <li>• 81-85 beds: 1 RN, 1 LPN, and 2.5 CNAs</li> <li>• 86-100 beds: 1 RN, 1 LPN, and 3 CNAs</li> <li>• 101+ beds: Individually determined</li> </ul> <p>Mont. Admin. R. 37.106.605(1)<sup>99</sup></p>	

<sup>99</sup> Montana expresses staffing standards as minimum number of hours provided by each category of nursing staff per shift per licensed bed. For ease of comparison, these standards have been translated into the equivalent amount of FTE.

<i>Juris-diction</i>	<i>Minimum Staffing Ratio</i>	<i>Minimum Direct Care Hours</i>
<b>NC</b>	N/A	N/A
<b>ND</b>	N/A	N/A
<b>NE</b>	N/A	N/A
<b>NH</b>	N/A	N/A
<b>NJ</b>	N/A	2.5 HRPD for all residents and <ul style="list-style-type: none"> <li>• 0.75 HRPD for wound care</li> <li>• 1 HRPD for Nasogastric tube feedings and/or gastrostomy</li> <li>• 0.75 HRPD for oxygen therapy</li> <li>• 1.25 HRPD for tracheostomy</li> <li>• 1.5 HRPD for intravenous therapy</li> <li>• 1.25 HRPD for use of respirator</li> <li>• 1.5 HRPD for head trauma stimulation/advanced neuromuscular/orthopedic care</li> </ul> N.J. Admin. Code §§ 8:39-25.2(b) and 8:85-2.2(a)
<b>NM</b>	N/A	Weekly minimum average of 2.5 HRPD  N.M. Code R. § 7.9.2.51(F)(2)(a)
<b>NV</b>	N/A	N/A
<b>NY</b>	N/A	N/A
<b>OH</b>	N/A	2.5 HRPD  Ohio Admin. Code 3701:17-08
<b>OK</b>	<u>Day Shift:</u> 1 direct care provider per 7 residents <u>Evening Shift:</u> 1 direct care provider per 10 residents <u>Night Shift:</u> 1 direct care provider per 17 residents  Okla. Stat. tit. 63, § 1-1925.5(B)(3)	Depending on the state Medicaid reimbursement rate, 2.86 HRPD, 3.2 HRPD, 3.8 HRPD, or 4.1 HRPD  Okla. Stat. tit. 63, § 1-1925.5(B)(5)(a) and (F)(1) – (3)
<b>OR</b>	<u>Day Shift:</u> 1 CNA per 7 residents <u>Evening Shift:</u> 1 CNA per 9.5 residents <u>Night Shift:</u> 1 CNA per 17 residents  Or. Admin. R. 411-086-0100(5)(c)	1 RN hour per resident per week  Or. Admin. R. 411-086-0100(4)(a)
<b>PA</b>	1 licensed nurse per 20 residents at all times and <ul style="list-style-type: none"> <li>• <u>Day Shift:</u> <ul style="list-style-type: none"> <li>○ 150 or fewer residents: 1 RN</li> <li>○ 151 – 250 residents: 1 RN and 1 LPN</li> <li>○ 251 – 500 residents: 2 RNs</li> </ul> </li> </ul>	2.7 HRPD  28 Pa. Code § 211.12(i)

GA Report – Availability of Clinical Workforce for Nursing Homes, 2020

<i>Juris-diction</i>	<i>Minimum Staffing Ratio</i>	<i>Minimum Direct Care Hours</i>
	<ul style="list-style-type: none"> <li>○ 501 – 1,000 residents: 4 RNs</li> <li>○ 1,001 or more residents: 8 RNs</li> <li>• <u>Other Shifts:</u> <ul style="list-style-type: none"> <li>○ 150 or fewer residents: 1 RN</li> <li>○ 151 – 250 residents: 1 RN and 1 LPN</li> <li>○ 251 – 500 residents: 2 RNs</li> <li>○ 501 – 1,000 residents: 3 RNs</li> <li>○ 1,001 or more residents: 6 RNs</li> </ul> </li> </ul> <p>28 Pa. Code § 211.12(f)(1) and (g)</p>	
<b>RI</b>	N/A	N/A
<b>SC</b>	<p>1 licensed nurse per shift (except if there are 45 or more residents, there will be 2 licensed nurses on the Day Shift) and</p> <ul style="list-style-type: none"> <li>• <u>Day Shift:</u> 1 nonlicensed nursing staff per 9 residents</li> <li>• <u>Evening Shift:</u> 1 nonlicensed nursing staff per 13 residents</li> <li>• <u>Night Shift:</u> 1 nonlicensed nursing staff per 22 residents</li> </ul> <p>S.C. Code Regs. 61-17-605(A)(2) and (B)(1)</p>	N/A
<b>SD</b>	N/A	N/A
<b>TN</b>	N/A	<p>2.0 HPRD, with 0.4 HPRD from a licensed nurse</p> <p>Tenn. Comp. R. &amp; Regs. 1200-08-06-.06</p>
<b>TX</b>	<p>1 licensed nursing staff per 20 residents</p> <p>26 Tex. Admin. Code § 544.1002(a)(1)</p>	<p>0.4 HPRD</p> <p>26 Tex. Admin. Code § 544.1002(a)(1)</p>
<b>UT</b>	N/A	N/A
<b>VA</b>	N/A	N/A
<b>VT</b>	N/A	<p>Minimum weekly average of 3.0 HPRD, with 2.0 HRPD provide by licensed nurse aides</p> <p>Vt. Code R. 13-110-005.7.13(c)(3)(d)(1)</p>
<b>WA</b>	N/A	<p>3.4 HPRD</p> <p>Wash. Rev. Code § 74-42-360(2)</p>
<b>WI</b>	<p><u>Day Shift:</u> 1 RN irrespective of resident census</p> <p><u>Other Shifts:</u> 1 RN per shift in nursing homes with 75 or more residents</p> <p>Wis. Admin. Code DHS § 132.62(2)(b)(1)</p>	N/A

<i>Juris-diction</i>	<i>Minimum Staffing Ratio</i>	<i>Minimum Direct Care Hours</i>
<b>WV</b>	N/A	2.25 HPRD  W. Va. Code R. § 64-13-8.14.a <sup>100</sup>
<b>WY</b>	N/A	2.25 HPRD for skilled care and 1.5 HPRD for nonskilled care  048-003-011 Wyo. Code R. § 9(x)

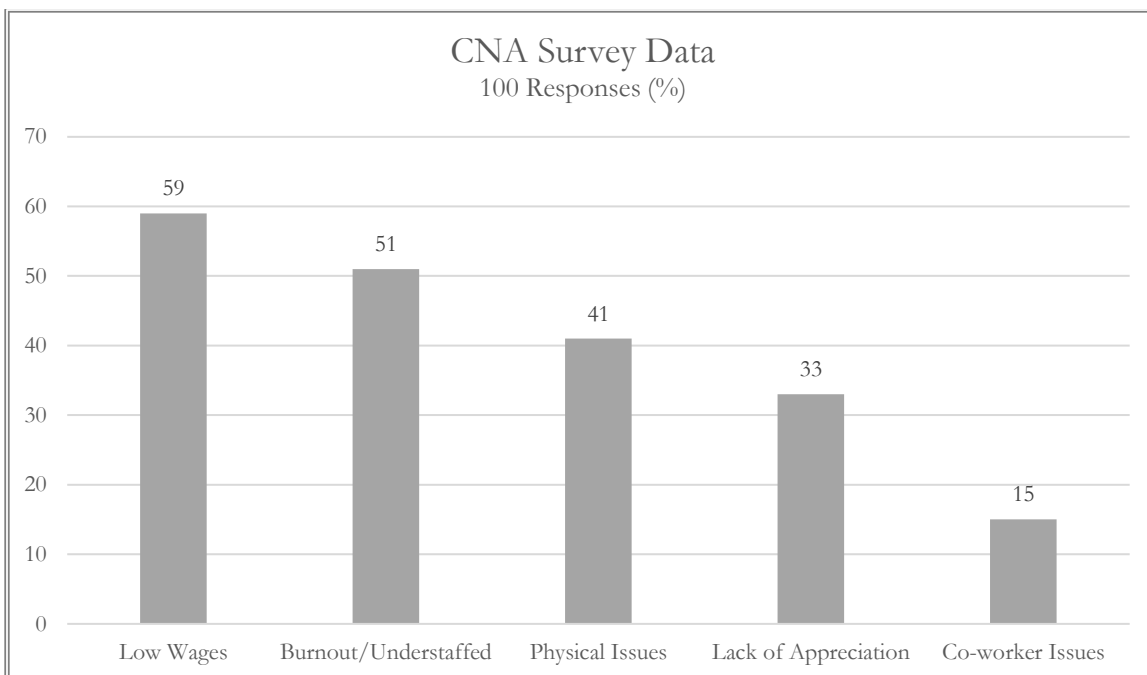
---

<sup>100</sup> West Virginia publishes a multi-page table in its regulations (Table 64-13A) that details individual staffing per day and hours per day by individual resident count so that nursing homes know the minimum care staff to employ to meet the prescribed minimum direct care hours. Due to the table’s length, it has not been reproduced in this appendix, but can be accessed at this link (<https://apps.sos.wv.gov/adlaw/csr/readfile.aspx?DocId=26551&Format=PDF>).



**APPENDIX J – CNA RESPONSES TO DIGNITY FOR THE AGED**

The following materials were provided to VDH staff by Dignity for the Aged and was prepared by a Dignity for the Aged member who had solicited this information from 100 CNAs via Facebook, in response to the question, “If you have ever considered leaving the CNA profession (or already have), what were your main reasons why?” Questions about the information presented in this Appendix should be directed to Dignity for the Aged.



**A Closer Look**

*Low Wages – 59%*

- CNA income in VA: \$14.61/hour or \$28,599/year
- Average income in VA: \$72,577/year
- Virginia ranks 31st in cost of living with 1st being most affordable
- Minimum wage in VA: \$7.25/hour and will rise over the next 2.5 years to \$12.00/hour
- For comparison: Target’s starting wage as of July 5 is \$15.00

*Burnout/Understaffed – 51%*

- Most CNAs report having to care for 20+ residents during a normal shift
- It is also common for CNAs to report times when they have had to care for 30 – 60 residents because of severe understaffing, callouts, etc.

*Physical Issues – 41%*

- 41 CNAs in this survey report consistent wear and tear on their body, back pain, knee pain, and foot pain
- Because of understaffing, it is often hard to find help for the very physical tasks that need more than one person

*Lack of Appreciation – 33%*

- 1/3 of the CNAs feel they are not appreciated by their administration and/or the nurses

*Co-Worker Issues – 15%*

- 15 of the CNAs cited workplace drama and lack of teamwork as a reason for leaving