

Results of a Follow-Up Survey to States on Career Ladder and Other Initiatives to Address Aide Recruitment and Retention in Long-Term Care Settings

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Background Information

In September 1999 the North Carolina Division of Facility Services, a division within the Department of Health and Human Services, published a paper entitled: *"Comparing State Efforts to Address the Recruitment and Retention of Nurse Aides and Other Paraprofessional Aide Workers."* The paper examined public policy efforts being undertaken by states to address aide recruitment and retention. In November 2000, a follow-up survey was published entitled *"Results of a Follow-Up Survey to States on Wage Supplements for Medicaid and Other Public Funding to Address Aide Recruitment and Retention in Long-Term Care Settings."*

This third paper is a follow-up to states on recent career ladder initiatives. Given the rapidly changing environment relative to aide recruitment and retention efforts, the survey was sent to all states as opposed to only those states that indicated they were working on career ladder issues in the 1999 survey. We also used this opportunity to request information about other recent (since 2000) state level initiatives intended to address aide recruitment and retention.

In addition to the survey findings, Attachment #3 is included which provides comparative state data related to unemployment rates (April '99, April '01 and June 2001); 1999 state median wage data for three major categories of aide workers; annualized median aide wages as a percent of state per capita income; and the state median hourly wage for all workers. Attachment #4 contains Bureau of Labor Statistics projections of direct care worker growth, by state, between 1998 and 2008.

Methodology

The NC Division of Facility Services developed a survey to collect information from all 50 states on state-level career ladder initiatives for nurse aides and other paraprofessional health care workers. Surveys were sent to state Medicaid agencies and State Units on Aging; some surveys were then redirected to the appropriate state entity to respond. Data was collected between May and July of 2001. The survey also

All three publications are available via the Division of Facility Services web site <http://facility-services.state.nc.us> (click on the "For Providers" box, then scroll down to "Documents of Interest").

Questions related to new initiatives since 2000 were intended to build upon state survey information compiled by the Paraprofessional Healthcare Institute in 2000 for their National Clearinghouse on the Direct Care Workforce. (<http://www.directcareclearinghouse.org>).

- *43 states responded to the survey representing a response rate of 86%.*
- *Responses were provided by either the state Medicaid Agency, State unit on Aging or other appropriate state entities.*

gathered data pertaining to other state initiatives since June 2000 such as increased wages/benefits, efforts to improve access to health insurance, and the establishment of study commissions to examine workforce issues. Follow-up calls were made to states to clarify information provided. Information reflected in this document is based on information reported by states.

(Note: Attachment #1, Table I provides a summary of various state-level initiatives, Table II contains detailed state notes based on survey responses from states. Attachment #2 lists the key state-level initiatives underway in states.)

Survey Findings – Career Ladder Initiatives

Survey results reveal a wide variety of state-level career ladder developments targeted toward paraprofessional direct care workers.

- Of the 43 states responding to the survey, 10 (23%) have proposed or implemented strategies for skill enhancement that would support establishing a career path for aides.
 - Three states, Minnesota, Montana, and Nevada are/have considered developing training curricula that will enable CNAs to qualify as LPNs.
 - o Long term care advisory councils in Minnesota (measure is included in pending legislation) and Nevada have recommended development of a new curriculum to enable CNA's to become LPN's. Minnesota also reports state approval for feeding assistants in nursing facilities.
 - o Montana has coordinated with vocational technical institutions to provide, starting Fall 2001, advanced training for CNAs – one semester of training plus one semester practicums - leading to a LPN.
 - Delaware passed legislation in 1999 (SB 20) establishing a new job level for CNA's known as "Senior CNA's." The state is currently drafting regulations for this new program. The Senior CNA is to act as a role model and resource person for entry-level CNAs. No decision has yet been made on whether there will be a pay differential for this new job classification.
 - Maine has recently developed a 24-hour medication administration course that will allow CNAs who successfully complete the course to perform certain medication administration tasks in home care settings provided the tasks have been delegated by a RN. Maine is also considering integrating training for Personal Care Aides and Residential Specialists to give this workforce more job flexibility.

- No responses were received from Arizona, Connecticut, Illinois, Maryland, South Dakota, West Virginia or Wyoming.

The 10 states that have proposed or implemented state-level career ladder strategies are:

Delaware, Maine, Massachusetts, Michigan, Minnesota, Montana, Nevada, North Carolina, Virginia, and Wisconsin.

Note: Oregon has long permitted licensed nursing personnel to delegate medication administration duties to unlicensed workers in all care settings. In addition, New Jersey reports having a medication aide training program in place for residential settings for a number of years.

Delaware: CNAs who wish to pursue designation as a Senior CNA need to complete 50 hours of advanced training and pass a competency test. Training modules will address Leadership Training and Mentoring skills, Dementia Training, and Advanced Geriatric Nursing Assistant Training.

North Carolina: Effective February 15, 2000, staff responsible for administering medications in adult care homes (medication aides) and their supervisors must successfully complete a clinical-skills competency evaluation. Medication

- North Carolina has developed a study guide for Medication Aides working in adult care homes and requires clinical and written competency evaluation for medication aides in these settings. North Carolina also plans to develop at least one new job category that would be an add on to the basic Nurse Aide training program and would recognize the unique skills required of Nurse Aides that work in long-term care facilities (e.g. dealing with dementia, depression) as well as training related to other job growth skills such as mentoring, effective communications, etc.).
- Last year, Wisconsin issued a formal set of guidelines and parameters for testing and training unlicensed workers to enable them to work as medication aides. This is a recognized worker category only in Nursing Homes, Community Based Residential Facilities (one type of assisted living) and for hospice.
- In 2001, Virginia passed legislation (HB 1778) that mandates the development of regulations leading to career advancement certification for CNAs.
- Using a five million-dollar appropriation in the FY 2001 budget, Massachusetts has developed an initiative to create and sustain recruitment and retention strategies as a core part of an overall quality of care enhancement program.
- Wisconsin is currently examining avenues to develop a career ladder approach to CNA training methods—additional hours of training will lead to a Nurse Aide II job category.
- Michigan has formed a Staffing Workgroup that is currently working on recommendations put forth by the state's Long Term Care (LTC) Workgroup (report issued in 2000) relating to direct care staffing issues. One of the chief recommendations is encouraging collaboration with community colleges to develop career ladders for LTC workers.

aides and their supervisors must also pass a written exam within 90 days of successfully completing the clinical skills competency requirement. Six hours of continuing education in medication administration is required annually for medication aides and supervisors. These requirements were put in place to improve the competency of staff responsible for administering medications and reduce medication errors in adult care home facilities. (The requirement does not apply to persons authorized by their state occupational license to administer medications.)

Massachusetts's Extended Care Career Ladder Initiative (ECCLI) is part of a multifaceted strategy to improve and sustain quality of care. The FY 2001 budget has allotted five million dollars for the ECCLI and the money has been disbursed to thirteen nursing facilities through a statewide competitive grant process. An additional \$5 million in funding has been proposed in the 2002 budget. A major component of the initiative in 2001-02 is to allow nursing facilities to pilot a progressive, structured career ladder model that provides skill upgrade training and promotes successful candidates to higher job levels. The state has contracted with academic institutions for future research into these pilots for the purpose of developing a statewide career development standard.

Other Key State Level Initiatives (since June 2000) Reported by States

- Analysis of survey results further indicates that several key recruitment and retention efforts (non-career ladder initiatives) are underway in 18 (42%) of the 43 states that responded to the survey. These measures include instituting Task Forces to study the issue and propose statewide recommendations, efforts to provide access to health insurance coverage, increasing minimum training requirements and scope of duties performed by CNAs, providing training scholarships and facilitating internet-based training. Specific findings include the following:

States that have commissioned task forces and study committees since June 2000 include: Colorado, Georgia, Iowa, Kansas, Michigan, Missouri, Nevada, North Carolina, Oregon, Pennsylvania, Rhode Island, Virginia, Vermont, and Wisconsin.

Maine is considering establishing a commission to study the healthcare workforce shortage. New York is considering funding a state level analysis of direct care worker jobs, results of

- An overarching trend that has emerged through the analysis is the establishment of state-level Task Forces and/or Study Commissions since June 2000 in 14 states (32%). Most of the studies were focused on examining the breadth and depth of the direct care workforce shortage and to develop broad solutions to resolve the problem. *(Results of the 1999 survey indicated that 13 states had/were planning to implement a Task Force at that time).*
- Five states (11%) have targeted efforts to provide/improve access to health insurance for paraprofessional workers. New Jersey's Family Care program, launched in 2001, enables health access through low premiums in a managed care plan. Efforts are underway in Pennsylvania and Vermont to increase consumer and provider awareness about eligibility for health plans for low-income workers. Recently passed legislation in Georgia (HB 470) authorizes the Department of Community Health (DCH) to provide access to health insurance for the uninsured and underinsured, a measure that the DCH intends to extend to paraprofessional health care workers. As of July 2000, Rhode Island established a public/private partnership to help low-income families with children access employer sponsored health care coverage known as RITE SHARE. In an effort to increase awareness about health insurance options, North Carolina sends out a flyer to newly listed CNAs. The flyer provides information about the state's children's health insurance program known as Health Choice for Children. Plans are being developed to expand this informational campaign to other paraprofessional aide workers.
- Six states (14%) are either considering or implemented measures that increase reimbursement rates for providers that exceed established minimum requirements (such as accreditation, in-service education beyond required hours, implementation of mentoring programs, etc.) for paraprofessional workers.
 - o Arkansas has recently tied higher reimbursement rates for nursing facilities to higher direct care staffing levels. The staffing level is a new variable the state is considering in its reimbursement rate calculation. In addition, legislation was passed in 2001 (Act 1397 of 2001) establishing minimum staffing ratios for direct care staff in nursing facilities.
 - o Georgia has recently passed a resolution (HR 275) directing the Department of Community Health (DCH) to tie increased reimbursement rates for providers exceeding established minimum requirements. The parameters of this measure are yet to be defined by the DCH.

which will be used to revise the current training program and foster job mobility.

Study reports have been issued by Georgia, Michigan, North Carolina, Pennsylvania, Rhode Island, and Vermont.

Rhode Island provides access to health insurance coverage for low-income families with children through a Medicaid waiver program known as "RITE-CARE" (established in 1994). In July 2000, Rhode Island established a public/private partnership known as "RITE-SHARE" which enables RITE – CARE eligible families with access to employer sponsored health care (that meets certain requirements) to participate in employer sponsored health insurance coverage through a premium assistance program from RITE-SHARE. To participate, employer offered health care coverage must meet certain scope of service, co-payment limit and cost-effectiveness test requirements. As of August 2001, 40 employers are signed up for the RITE-SHARE program.

New Jersey also has a program that subsidizes health care coverage costs through employer sponsored plans that meet certain conditions for employed individuals eligible for New Jersey's FamilyCare insurance program. Like Rhode Island, certain conditions must be met for persons eligible for FamilyCare to obtain coverage through their employer plan.

In Vermont, most home health agencies and nursing homes offer health insurance to full-time Nursing Assistants.

Other health coverage initiatives:

- Colorado and Minnesota are looking into measures to provide health care access to direct care workers. Colorado is exploring the possibility of establishing outreach to nursing facility workers for enrollment into the state's Children's Health Insurance Program (CHIP). Legislation was introduced in

- o Maine reported they would need to consider higher reimbursement rates for Medicaid and other public funded services that include use of medication aides.
- o Minnesota has passed a \$0.25 per day (FY 2001) increase in nursing home rate to pay for all kinds of beginner and advanced training for CNAs. For instance, providers can finance courses taken by CNAs to obtain a LPN or RN degree.
- o October 2000, North Carolina increased Medicaid reimbursement rates for Personal Care Services provided in adult care homes. While not specifically recognizing medication aides in adult care homes as a special category, the increased rate took the new competency requirements into consideration along with other factors.
- o Starting September 1999, Rhode Island has tied increased reimbursement rates for home-care providers (only for those paid under state Medicaid and state-only funded home care program for low-income persons) to the following criteria: 1) in-service training; 2) meeting state accreditation criteria; 3) in-service hours excessive of state standards by 20%; and 4) shift differential (for evenings, nights, weekends, and state holidays).
- 13 states (30%) are either considering or have implemented measures to increase worker wages.
 - o Arkansas has enacted a direct wage pass through (Act 635, Year 2001) for nursing home workers via a reimbursement rate increase tied to the number of direct care staff employed in nursing facilities.
 - o Maine passed additional funding in the 2000 legislative session to enable a 3% hike in wages/benefits (in form of a pass-through) for home care workers.
 - o Massachusetts recently implemented a \$35 million wage pass-through (funded through the FY2000 budget) for CNAs in nursing facilities.
 - o Minnesota's FY01 budget directs a 3 percent increase in reimbursement rates to all long term care facilities. In the case of nursing homes, 80 percent of the increase must be used as a pass-through for nursing home employees.
 - o Missouri's FY01 budget has designated a \$0.52/hour increase in wages and benefits for all direct care workers.
 - o Montana has established a wage increase of 0.68/hour for FY01, \$0.92/hour for FY02, and an estimated 0.38/hour for

Minnesota in 2001 (SF1077) which would create a long-term care employee health insurance assistance program.

- *Michigan and Montana are encouraging provider groups to establish purchasing cooperatives for providing health benefits.*

- *North Carolina's Department of Health and Human Services and Department of Insurance will convene a meeting in October 2001 for long-term care related provider associations to provide information about various group purchasing arrangements that are available to improve access to health insurance for this workforce.*

Iowa is planning to experiment with a "case mix" reimbursement system for nursing facilities in an effort to develop financial incentives related to direct care workers' salaries. State funding has been granted to the Iowa Caregivers Association for research and development in this area.

FY03 for Medicaid funded home care provided by aides. - o New Jersey's current budget proposal includes a measure to increase the reimbursement rate for community Medicaid personal care assistant services. - o North Dakota has authorized (2001 legislature) the equivalent of \$1.50/hour increase in wages and/or benefits for all employees of nursing facilities including CNAs for both Medicaid and private-pay resident categories. - o Pennsylvania is working on a proposal to target a 2% COLA towards raises for nurse aides (can also be used for other aide recruitment and retention efforts). - o Rhode Island has recently passed legislation (2001-HB6100 Sub. A, Sec. 13) that amends the nursing home principles of reimbursement to require an increase in the <i>labor cost center</i> to enable a direct-care worker compensation pass-through for nursing home workers. Legislation has been introduced to obtain a similar compensation pass-through for home care workers. - o Vermont has recently passed legislation (amending State Statute 1956 – Health Care Trust Fund) to impose a provider tax on nursing homes and home health agencies. The legislative intent is to earmark a portion of net provider tax funds raised for wage increases for workers in these facilities/agencies. - o Washington passed legislation that grants a \$0.50 p/hour increase for Medicaid services to go directly to in-home care providers as well as .50 p/hour increase for low-income residential care workers (e.g. boarding homes, adult family homes) and a .45 p/patient day increase to raise wages of low income worker wages in nursing homes. - o Wisconsin allotted increased funding in 2001 to personal care agencies with the legislative intent for increase in personal care worker wages. - Three states (7%) (Maine, Washington, and Wisconsin), have increased minimum training requirements for direct care workers in an effort to improve worker skills and enhance quality of care provided. - o Since July 2000, Maine requires all PCAs to complete 40 hours of training within 90 days of hire, except those in consumer-directed programs. - o Training requirements for all <i>non-certified aides</i> in Washington have been changed this year and will be implemented in March 2002. The changes are as follows:	<i>States proposing or implementing measures to increase wages and benefits:</i> <i>Arkansas, Maine, Massachusetts, Minnesota, Missouri, Montana, New Jersey, North Dakota, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin.</i> <i>With regard to implementing a wage pass through/labor enhancement type increase, additional states reporting this type of initiative since the 2000 survey conducted by the Division of Facility Services include: North Dakota, Pennsylvania and Wisconsin.</i> <i>Rhode Island has seven cost centers in the state's principles for nursing home reimbursement. The labor cost center deals with staffing except management and administration. The legislation provides for a 4.8% rate adjustment, which includes a \$3.71 Medicaid interim per diem increase for nursing homes to be applied to the labor cost center and used for direct care compensation or staff increases.</i> <i>In Washington, there is no penalty for non-compliance by residential or nursing home settings for not passing reimbursement increases for wages on to workers. The Department is, however, required to test the extent to which funds appropriated were used for intended purpose.</i>
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1) new employees require a mandatory orientation to specific topics before providing hands-on personal care, when employed in boarding homes, adult family homes, and Medicaid home care; and 2) boarding home administrators and caregivers require, as a condition of licensure, standard basic training and training in three specialty areas- dementia, mental illness, and developmental disabilities- as appropriate to needs of residents.

- o Wisconsin is currently reviewing proposals to increase minimum training hours (currently 75 hours) and to develop personal care worker competency testing.

- Several states have undertaken measures that, in our analysis, could not be grouped into one of the previously listed categories including:

- o Maine has approved (2000) state funding to increase staffing ratios in nursing homes.
- o Massachusetts's FY01 budget has allocated one million dollars to fund CNA training scholarships. To date, more than a thousand individuals have been trained and are/will be working in long term facilities across the state.
- o Michigan has allocated \$7.4 million for long term care innovation grants of which \$1.7 has specifically been targeted for staff development and training initiatives.
- o Minnesota is considering working with the community college system to provide web-based training for CNAs that will enable these workers to be trained at home and/or in facilities.
- o Missouri and Nevada have recently expanded scope of duties of CNAs to include ostomy care and pulse-oximetry probe placement. In last year's legislative session, Washington amended rules pertaining to allowable tasks in its formal nurse delegation to unlicensed caregivers' program (going from a specific list to no list – a RN judgement policy).
- o Wisconsin funds the Community Options Program that helps county and local governments to implement special workforce projects, and undertakes worker appreciation initiatives through activities such as the "Caregiver of the Year" award. Wisconsin's Department of Health and Family Services is proposing language to allow single task workers (resident assistants) to work in facilities other than certified nursing homes.

Note: In 1999, Virginia increased minimum nurse aide training hours from 75 to 120.

Minnesota also recommended that training be responsive to needs of immigrants, older workers, etc.

While not a state administered activity, it is worth noting that a statewide Caregiver Association has been established in Wisconsin, which is supported by foundation funding and in-kind contributions. It is also worth noting that the Wisconsin Alzheimer's Institute has developed a worker education, training and assistance program. The program is intended to improve quality of care through improved worker retention in long-term care facilities. An evaluation

Conclusion

Worker shortages continue to be a serious problem in many states. As expected, these shortages continue in spite of a slowing national economy. States continue to take action in an effort to improve recruitment and retention efforts to help achieve a more stable, skilled and satisfied direct care workforce. Numerous states are taking action through a variety of different strategies. Major categories of action taken and/or being considered by states include efforts to: improve wages/benefits; broaden the pool of potential workers; develop career path/advancement options and/or new service delivery models (i.e. medication aides, consumer directed care models); increase minimum training requirements to enhance worker skills; improve access to health insurance coverage; and increase public education and awareness regarding the importance of this workforce in the delivery of long-term care.

Keeping abreast of state action taken to address this workforce issue; tracking the successes and any barriers encountered related to various strategies implemented; data collection and analysis will all be important to considering the impact of various strategies over time in terms of the stability/growth of this workforce.

Acknowledgements

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of the program will be conducted by the University of Wisconsin at Madison's Center for Health Policy and Program Evaluation.

As reported by the National Conference of State Legislatures, the Health Care workforce issue was among the top five issues identified by Chairs of State Legislative Health Committees for 2001. Shortages of specific health workers including nurses and nurse aides was included in the top ten issues.

(Survey conducted by the Health Chairs Project and the Henry J. Kaiser Family Foundation)

While not the only factor, wages (and benefits) paid to this workforce are a major factor in recruitment and retention. In 1999, the median hourly wage for the three major categories of direct care workers across all 50 states was \$7.97.¹ This compares to a median hourly rate of \$8.91 for barbers or \$8.38 for file clerks.

Wake Forest University School of Medicine's Office of Health Policy Development, in conjunction with the North Carolina Institute of Medicine, conducted a conference with a national focus in September 2001 in Winston-Salem, NC to recommend a series of priorities that should be considered with regard to addressing professional and paraprofessional long-term care workforce issues. A report summarizing these deliberations as well as priorities needing to be addressed is expected to be published at some point in the future.

¹ State by state median hourly wage data for each of the 3 direct care categories considered (1 nurse aides, orderlies, attendants, 2. personal and home care aides; 3. Home Health Aides) was obtained from the US Bureau of Labor Statistics. Median hourly wages for the 3 categories were then averaged to get a state average of the median hourly wages then an average across all 50 states of the median average was calculated to arrive at the \$7.97 amount.

Update on North Carolina

Update on Department of Health and Human Services Kate B. Reynolds Foundation funded initiatives:

- Another analysis of the State's Nurse Aide Registry data is currently underway. The analysis will compare 2001 Registry data (active and inactive aides) with Bureau of Labor employment data. The first analysis was based on 1998 data and showed that registered aides no longer working in the field were earning considerably higher wages and had more stable employment than their counterparts who were still working as aides. The first analysis entitled: "Where Have All the Nurse Aides Gone" is available via (<http://facility-services.state.nc.us>).

The University of North Carolina at Chapel Hill's Institute on Aging is conducting the analysis. The Institute on Aging has applied for Grant funding from AARP to support the development of a data protocol other states could use to analyze Nurse Aide Registry data in conjunction with Bureau of Labor data.

- Pilot projects linking financial and other incentives to training and continued employment:
The final phase (Phase II) of the pilot has been completed. In Phase II, two different bonus structures were offered to participating agencies/facilities. The first option provided a "sign on" bonus for participating aides who agreed to continue in the pilot and complete the remaining training programs. No completion bonus would be offered. The second bonus option included both the "sign on" bonus and a "completion bonus" that would be matched by the employer up to \$75. Four of six of the participating pilot agencies agreed to offer the matching bonus.
- The Division of Facility Services will continue training and financial incentive efforts (similar to those used in the pilot project) to address recruitment and retention of nurse aides employed in nursing homes. Civil penalty fine monies will be used to help support this effort. Civil penalty fine monies will also be used to develop a new worker category for nurse aides in nursing homes (such as Geriatric Nurse Aide II) to provide a career advancement opportunity for nurse aides who want to continue to work in nursing homes but do not want to become licensed personnel.
- Seven training modules developed by the NC Division of Facility Services in response to training gaps identified by nurse aides and in-service training coordinators have been piloted and evaluated. These training materials will be made available via CD ROM in 2002. The training programs will also be modified as appropriate

As of August 3, 2001 there were 213,372 Nurse Aides on North Carolina's Nurse Aide Registry. Of these, 59% were inactive and 41% were active (have worked as a Nurse Aide at least one day within a two year period).

North Carolina's unemployment rate has increased from just 2.8% in April of 1999 to 5.3% in July 2001. Shortages of nurse aides and other direct care workers persist in spite of the increase in the state's unemployment rate.

Final evaluation results on the impact of training and incentives on aide job performance and satisfaction will be completed by October 2001.

for use in assisted living and/or home care settings.

- North Carolina's Nurse Aide Registry program is mailing out information about North Carolina's Children's Health Insurance Program known as "Health Choice for Children" to all newly registered Nurse Aides.

Other Actions

- The North Carolina General Assembly appropriated \$500,000 to the Department of Health and Human Services for State Fiscal Year 2001 to develop, implement, and evaluate on-site internet training or other innovative training programs to improve recruitment and retention of nurse aides in nursing homes. Language implementing the legislation called for the Community College System to work with nursing home providers on this effort. As a result of this funding, the North Carolina Community College System has worked with the North Carolina Health Care Facilities Association to:

Develop and pilot new training programs geared toward improving retention including:

- a nurse management and supervisory training program for RN's in nursing homes to help enable them to better utilize Nurse Aide staff, build teams and manage work place conflict
- a training program to develop nurse aides in nursing homes as mentors for newly hired nurse aides

In addition, recruitment tools have been developed including:

- development of 2 Public Service Announcements for television use and use by facilities at job fairs and for other recruitment activities
- brochures, postcards and posters have also been developed for use by facilities, community colleges, high schools, supermarkets, churches, libraries, etc. to support public education and awareness and recruitment

The Department of Health and Human Services has submitted a "Real Choice" grant proposal to Centers for Medicare and Medicaid Services. Efforts to address direct care workforce issues is one of four major grant components. If funded, workforce related activities will include: development and implementation of an education and media campaign to promote direct care worker jobs; review of policies for home and community based services that rely on direct care workers to incorporate opportunities for consumer directed care and develop associated tools, supports and accountability requirements; develop a model career ladder for personal care assistants based on levels of competence; develop a mentoring program for home and community based direct care workers; examine options for improving benefits to this workforce; examine wages/benefits, training, rate setting methodologies, etc.

Table 1: Results of National Survey on State-level Career Ladder Initiatives for Nurse Aides and Other Paraprofessional Aides

State	State-level Career ladder Initiatives (Existing/ being considered)	New Job Categories developed	Efforts to expand scope of duties	Web-based training	Increased reimbursement for exceeding minimum standards or requirements	Other career ladder efforts	Changes in Training Requirements (since 2000)	Efforts to increase wages/ benefits (since 2000)	Health insurance efforts (since 2000)	Studies/ task forces (since July 2000)
Alabama	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Alaska	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	NR									
Arkansas	No	No	No	No	Yes (See Notes)	NR	NR	Yes	No	No
California	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Colorado	No	No	No	No	Yes (See Notes)	NR	NR	NR	Yes (See Notes)	Yes
Connecticut	NR									
Delaware	Yes (See Notes)	No	No	No	No	No	No	No	No	No
Florida	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Georgia	No	No	NR	NR	Yes (See Notes)	No	No	No	Yes	Yes
Hawaii	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Idaho	No	No	No	No	No	NR	No	No	No	No
Illinois	NR									
Indiana	No	No	No	No	No	No	No	No	No	No
Iowa	No	No	No	No	Yes (See Notes)	No	No	No	No	Yes
Kansas	No	NR	NR	NR	NR	NR	No	Yes (See Notes)	No	Yes
Kentucky	No	NR	NR	NR	NR	NR	NR	NR	NR	NR

State	State-level Career ladder Initiatives (Existing/ being considered)	New Job Categories developed	Efforts to expand scope of duties	Web-based training	Increased reimbursement for exceeding minimum standards or requirements	Other career ladder efforts	Changes in Training Requirements (since 2000)	Efforts to increase wages/ benefits (since 2000)	Health insurance efforts (since 2000)	Studies/ task forces (since 2000)
Louisiana	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Maine	Yes (See Notes)	No	Yes	No	Yes (See Notes)	No	Yes (See Notes)	Yes (See Notes)	No	No
Maryland	NR									
Massachusetts	Yes (See Notes)	No	No	No	No	NR	NR	NR	NR	No
Michigan	Yes (See Notes)	No	No	No	No	No	No	No	Yes (See Notes)	Yes
Minnesota	Yes (See Notes)	Yes (See Notes)	No	Being considered	Yes	NR	NR	Yes	Yes (see Notes)	No
Mississippi	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Missouri	No	No	Yes (See Notes)	No	No	No	No	Yes	No	Yes
Montana	Yes (See Notes)	No	No	No	No	No	No	Yes	Yes (See Notes)	No
Nebraska	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Nevada	Yes (See Notes)	No	Yes (See Notes)	No	No	No	No	No	No	Yes
New Hampshire	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
New Jersey	Yes (See Notes)	No	No	No	No	No	No	Yes	Yes	No

State	State-level Career ladder Initiatives (Existing/ being considered)	New Job Categories developed	Efforts to expand scope of duties	Web-based training	Increased reimbursement for exceeding minimum standards or requirements	Other career ladder efforts	Changes in Training Requirements (since 2000)	Efforts to increase wages/ benefits (since 2000)	Health insurance efforts (since 2000)	Studies/ task forces (since 2000)
New York	No	No	No	No	No	No	No	No	No	No
North Carolina	Yes (See Notes)	No	No	No	Yes (See Notes)	No	No	No	Yes (See Notes)	Yes
North Dakota	No	No	No	No	No	No	No	Yes (See Notes)	No	No
Ohio	No	No	No	No	No	No	No	No	No	No
Oklahoma	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Oregon	Yes	No	No	No	No	No	No	No	No	Yes
Pennsylvania	No	No	No	No	No	No	No	Yes	Yes	Yes
Rhode Island	No	No	No	No	Yes	No	No	Yes	No	Yes
South Carolina	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
South Dakota	NR									
Tennessee	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Texas	No	No	No	No	No	No	No	No	No	No
Utah	No	NR	NR	NR	NR	NR	NR	NR	NR	NR
Vermont	No	No	No	No	No	No	No	Yes	Yes (See Notes)	Yes
Virginia	Yes (See Notes)	No	No	No	No	No	No (See Notes)	No	No	Yes
Washington	No	No	No	No	No	No	Yes (See Notes)	No	No	No
West Virginia	NR									
Wisconsin	Yes	No	No	No	No	Yes	Yes	Yes	No	Yes
Wyoming	NR									

Table 2: Notes from Survey Results

Arkansas:	Effective March 2001, Act 635 of the 2001 legislature imposes a Quality Assurance Fee on nursing home operators based on number of patient days per month. Revenue generated is pooled into the state's Medicaid fund with each dollar matched with almost three federal dollars. The same Act establishes a wage pass-through that directs the increased federal revenue towards worker wages and benefits by means of increased reimbursements to nursing facilities with higher direct care staff numbers.
Colorado:	The state general assembly recently passed legislation that grants \$5.4 million as quality of care incentive payments for the purpose of assessing degree of staff retention and expertise in facilities. Future incentive payments may be tied to degree of staff retention in the nursing facilities. The legislation also requires establishing a task force to study quality of care issues. Another task force has been appointed to study aide retention. The state is exploring the possibility of establishing outreach to nursing facility workers for enrollment in the CHIP program.
Delaware:	Passed legislation in 1999 that created a voluntary Senior CNA program to encourage career growth and satisfaction for CNAs.
Georgia:	In March 2001, the State General Assembly passed HR 275, a resolution directing the Department of Community Health (DCH) to tie increased reimbursement rates to providers exceeding established minimum requirements (for aide staff receiving in-service education beyond required hours, for accreditation, etc.). Efforts are underway to study and possibly duplicate in several nursing facilities a new training curriculum that provides additional career responsibilities and increased compensation to paraprofessional workers. A recently passed regulation grants state funds to provide dementia training for nursing home staff. The DCH also aims to extend HB 470 -- a bill that authorizes the DCH to provide health insurance coverage to underinsured and uninsured -- to long-term care and healthcare workers.
Iowa:	In an effort to increase nurse aides salaries, state funding has been provided to the Iowa Caregivers Association to research and develop a new (case-mix) reimbursement system to nursing facilities participating in the Iowa Medicaid program.
Kansas:	Quality enhancement wage pass-through program was instituted in July, 1999, and extended to July 2001. Nursing facilities elect to participate in the program that targets increasing salaries/benefits for direct care and support service workers in long term care. The Long-Term Care legislative task force will be addressing the workforce shortage issue over the next five years.
Maine:	The Board of Nursing has agreed to allow RNs to delegate certain medication administration functions (aide should be working with patient on consistent basis, no injections or PRN medicines would be allowed) in home care setting to CNAs who complete medication administration course. Increased reimbursement from Medicaid and probably other funding sources for such workers under consideration. The state legislature has also approved additional funding to increase minimum staffing ratios in nursing homes and to raise wages for home care workers. Since July 2000, all PCAs are required to complete 40 hours of training within 90 days of hire, except those working in consumer-directed programs. Under consideration is the establishment of a commission to study the health care workforce shortage.
Massachusetts:	The state funded (FY 2001) Extended Care Career Ladder Initiative (ECCLI) provides competitive funding to nursing facilities to implement skill upgrade training to paraprofessional workers and to develop and demonstrate models for long-term workforce sustainability. Further, state funded CNA training scholarships have been instituted. A \$35 million wage pass-through, established in the FY2000 budget to fund wage increases for CNAs, has been implemented.
Michigan:	The July 2000 report released by the state's Long-term Care workgroup suggests several recommendations related to staffing issues, chief among which are strategies to increase the worker pool, achieve worker retention, and encourage local collaboratives to create a registry that matches available registered workers to employment opportunities. The state has instituted a staffing workgroup of state officials and providers to implement

	the above recommendations. The state is encouraging provider groups to establish purchasing co-operatives to provide health coverage for direct care staff.
Minnesota:	State level long term care task force of January 2000 has proposed: 1) an 'additive' curriculum be developed to enable CNAs to train as LPNs, 2) all training be web-based for easy access at work sites and training be more responsive to needs of immigrants and older workers, and 3) provider rates in all settings be increased and, for nursing home workers, 80% of the increase be earmarked for wage increases. Current legislation provides for \$0.25/day/person increase in nursing home rate to pay for training. State agencies are seeking legislative approval to provide subsidized health insurance for direct care workers.
Missouri:	Effective January 2001, direct care staff wage rate has increased by \$ 0.52/hour. Nursing aides' duties have been expanded to include ostomy care. While a Governors Commission was established to address workforce issues under the previous administration, there is some uncertainty regarding the stance of the current administration on long-term care workforce issues.
Montana:	Advanced training for CNAs leading to LPN targeted to begin Fall 2001. Legislative initiatives include a \$ 0.68 hourly rate increase for FY01, \$0.92 for FY02, and an estimated \$0.38 increase for FY03. A providers committee is exploring methods to establish purchasing cooperative to provide workers with health insurance coverage.
Nevada:	The Board of Nursing's advisory committee is looking into an advanced CNAs program that will serve as a bridge towards LPN qualification. Curriculum has been revised to include pulse-oximetry probe placement training. A long-term care roundtable is being convened to address shortage issues.
New Jersey:	State FY budget proposes rate increase for community Medicaid PCA services. Access to affordable health care is made possible by low premiums available through the recently established New Jersey Family Care program.
New York:	Proposal to fund state level job analysis that will be used to revise training program that will foster job mobility.
North Carolina:	Effective 2000, personal care aides in adult care homes can work as medication aides after passing competency test and getting their skills validated by a licensed nurse or pharmacist. The increased competency required by medication aides has been given some consideration in the reimbursement increase recently granted by the state. The state sends out flyers to newly listed CNAs informing them about available health insurance options for their families under the program for low-income workers' children.
North Dakota:	The State has authorized an \$1.50 increase in wages and benefits of all nursing facilities' employees for both Medicaid and private-pay resident categories.
Oregon:	State rules permit licensed nursing personnel to delegate duties such as medication administration under certain conditions to unlicensed workers. The newly instituted Homecare Commission has proposed legislation to improve skills and working conditions of aides.
Pennsylvania:	A recently completed study commissioned by the Intra-governmental Council on Long Term Care issues highlights workforce problems from a provider and caregiver perspective. The state's Direct Care Work Group is working on proposals to 1) develop an apprenticeship program in conjunction with various stakeholders, 2) tie plans for added funding to county MH/MR providers with the organizations' past practices and future plans concerning enhanced recruitment and retention, and, 3) target the 2% COLA increase towards raises.

Rhode Island:	The CY2001 study report released by the Long-Term Care Coordinating Council (LTCC) proposes development of and training for career ladders. Since September 1999, increased reimbursement rates have been tied to in-service training, meeting state accreditation, Joint Commission accreditation, in-service standards excessive of state standards by 20%, and as a shift differential. 2001 legislation creates wage pass-through for nursing home direct care workers by requiring an increase in the labor cost center of reimbursement principles. The LTCC report proposes extending this compensation pass-through to provide for a COLA for non-nursing home long-term care providers.
Vermont:	Recently completed a detailed study of staffing issues that proposes, among other recruitment and retention efforts, exploring career ladder options for CNAs and PCAs. There is legislative intent to use money raised through provider taxes on nursing homes and home health agencies towards increasing wages and benefits. Efforts are currently underway to increase awareness among personal care aides regarding eligibility into Vermont's Health Access Program. Flyers are sent out to PCAs through Home Care Agencies or through fiscal intermediaries in case of PCAs hired by individuals.
Virginia:	House Bill 1778 of the 2001 legislature requires the Board of Nursing to establish an advanced certification for nurse aides with a goal of providing avenues for professional advancement and expands scope of CNA duties. A study on workforce issues was conducted in Sept 2000 by the Joint Commission on Healthcare. Currently, state wide data on paraprofessionals is being collected by the VA Board of Nursing. In 1999, minimum nurse aide training hours was increased to 120.
Washington:	Training requirements for non-certified aides were changed March, 2001, to be implemented March 2002, as follows: 1) required orientation to specific employees in boarding homes, adult family homes, and Medicaid home-care before providing hands-on personal care; 2) required standard basic training and training in three specialty areas –dementia, mental illness, and developmental disabilities- for all caregivers as a condition of licensure. In the last legislative session, the state amended rules pertaining to allowable tasks that could be delegated to unlicensed caregiver. The list went from a "Specific list" to "No list/ RN Judgement" policy.
Wisconsin:	The state is currently reviewing proposals to 1) enhance the minimum training hours (currently 75), 2) Include a career ladder approach –additional hours of training resulting in a Nurse Aide II category, and 3) develop personal care worker competency testing methods. A multi-disciplinary group has recently been appointed to act as an advisory group on proposed training enhancements. In 2000, increased funding was allotted to personal care agencies with legislative intent for increase in wages for personal care workers. In the same year, the state issued guidelines and parameters for training and testing unlicensed caregivers to enable them to work as medication aides. Health insurance for these low-income workers and their families is available through the state-established Badger-Care program (started in 1999). Statewide initiatives promote activities such as instituting the 'Caregiver of the Year Award' to recognize and appreciate long-term care workers. The Wisconsin Caregiver Association mentors caregivers. Further, the state-funded Community Options Program helps local county governments to implement special workforce projects. The Worker Education, Training and Assistance Program, developed by the Wisconsin Alzheimer's Institute, targets improving quality of care by increasing retention of staff and employee and consumer satisfaction.

Table I – A Snapshot of Existing and Proposed State-level Career Ladder Efforts and Other Key Trends in Various States

Major Career Ladder Initiatives	
1) CNA to LPN training	MN, MT, NV
2) Medication Aide	ME, NC, NJ OR, WI
3) Skill upgrade training	MA, VA, WI
4) Others : a) Voluntary CNA program b) Collaboration with community colleges to create a career ladder	DE MI
Other Key Initiatives (since 2000)	
1) Establishment of task forces/study commissions since June 2000	CO, GA, IA, KS, MI, MO, NV, NC, OR, PA, RI, VA, VT, WI
2) Health insurance efforts	GA, NC, NJ, PN, VT
3) Increased reimbursement tied to on-site training, accreditation, etc.	AK, GA, ME, MN, NC, RI
4) Case-mix reimbursement	IA
5) Higher wage rate/ wage pass-through	AK, ME, MA, MN, MO, MT, NJ, ND, PA, RI, VT, WA, WI
6) Increased minimum training requirements	ME, WI, WA
7) Others: ▪ CNA training scholarships ▪ Web-based training ▪ Increased scope of duties (other than medication aide) ▪ State funding to increase staffing ratios ▪ LTC innovation grants ▪ Funding support to local governments and worker appreciation efforts	▪ MA ▪ MN ▪ MO, NV, WA ▪ ME ▪ MI ▪ WI

State Comparative Wage Data 1999 - Median Wages												
State		Unemployment Rate April 1999	Unemployment Rate -- April 2001	Unemployment Rate -- June 2001	Home Health Aides - Median Hourly Wage - 1999	Nursing Aides, Orderlies, Attendants (Median Hourly -1999)	Personal Care & Home Care Aides (Median Hourly)	Average of Median Wages Across All 3 Categories -1999	State Median Hourly Wage, 1999 Source: Economic Policy Institute	Percent of Average of Median Hourly Wages to State Median Hourly Wage - 1999	Ave. Annual Per Capita Income 1999 source: US Bureau of Economic Analysis	Percent of Per Capita Income Represented by Average of Annualized Median Hourly Wages for Aide Categories
Alabama		4.6	5.3	4.5	\$7.42	\$7.22	\$6.27	\$6.97	\$10.88	64%	\$22,972	63.11%
Alaska		5.9	5.8	5.8	\$10.30	\$11.81	\$10.31	\$10.81	\$13.90	78%	\$28,629	78.51%
Arizona		4.4	4.3	4.4	\$7.96	\$8.40	\$7.67	\$8.01	\$10.96	73%	\$25,173	66.19%
Arkansas		4.4	4.2	4.9	\$6.42	\$6.67	\$6.29	\$6.46	\$9.84	66%	\$22,233	60.44%
California		5.7	4.8	5.1	\$8.54	\$8.40	\$7.72	\$8.22	\$12.41	66%	\$29,856	57.27%
Colorado		3.0	2.5	2.9	\$8.30	\$8.84	\$6.98	\$8.04	\$12.99	62%	\$31,533	53.03%
Connecticut		3.4	2.2	2.5	\$10.54	\$11.15	\$9.30	\$10.33	\$15.12	68%	\$39,543	54.34%
Delaware		3.3	3.3	3.2	\$9.16	\$9.10	\$7.04	\$8.43	\$12.33	68%	\$30,701	57.14%
Florida		4.3	3.9	4.0	\$8.00	\$8.14	\$7.72	\$7.95	\$10.64	75%	\$27,781	59.55%
Georgia		3.9	3.9	3.6	\$7.28	\$7.25	\$6.95	\$7.16	\$11.31	63%	\$27,324	54.50%
Hawaii		5.5	5.2	4.4	\$8.66	\$10.60	\$8.81	\$9.36	\$11.96	78%	\$27,533	70.69%
Idaho		4.7	5.0	4.8	\$7.74	\$7.69	\$6.42	\$7.28	\$10.39	70%	\$22,871	66.24%
Illinois		3.9	5.4	5.2	\$8.72	\$7.99	\$6.78	\$7.83	\$12.43	63%	\$31,138	52.30%
Indiana		2.5	2.9	3.4	\$8.44	\$8.12	\$7.72	\$8.09	\$11.69	69%	\$26,157	64.36%
Iowa		2.7	2.7	2.8	\$7.90	\$8.13	\$7.73	\$7.92	\$11.01	72%	\$25,598	64.36%
Kansas		3.4	3.5	3.8	\$7.79	\$7.89	\$7.67	\$7.78	\$10.89	71%	\$26,705	60.62%
Kentucky		4.3	4.3	4.0	\$8.18	\$7.71	\$6.30	\$7.40	\$10.82	68%	\$23,227	66.24%
Louisiana		5.1	4.9	5.3	\$6.92	\$6.17	\$6.14	\$6.41	\$10.02	64%	\$22,839	58.38%
Maine		3.6	3.1	3.3	\$7.89	\$8.23	\$6.99	\$7.70	\$11.01	70%	\$24,582	65.18%
Maryland		3.9	3.6	3.7	\$8.09	\$9.12	\$7.65	\$8.29	\$14.06	59%	\$32,517	53.01%
Massachusetts		2.9	3.2	3.4	\$9.72	\$9.93	\$7.65	\$9.10	\$13.45	68%	\$35,527	53.28%
Michigan		4.0	4.6	4.9	\$8.15	\$9.15	\$7.62	\$8.31	\$12.51	66%	\$28,104	61.48%
Minnesota		2.1	3.9	3.5	\$8.90	\$9.66	\$8.41	\$8.99	\$13.45	67%	\$30,742	60.83%
Mississippi		4.6	5.0	4.3	\$7.49	\$6.81	\$5.95	\$6.75	\$10.12	67%	\$20,686	67.87%
Missouri		3.2	3.8	4.1	\$7.37	\$7.51	\$6.88	\$7.25	\$11.89	61%	\$26,404	57.14%
Montana		5.4	4.7	4.3	\$7.60	\$7.71	\$6.39	\$7.23	\$9.77	74%	\$21,997	68.40%
Nebraska		2.5	3.0	2.9	\$8.41	\$8.40	\$7.46	\$8.09	\$10.43	78%	\$27,047	62.21%
Nevada		4.1	4.9	4.5	\$8.87	\$9.59	\$6.91	\$8.46	\$11.16	76%	\$31,004	56.73%

New Hampshire	2.4	2.9	3.0	\$8.66	\$9.78	\$7.45	\$8.63	\$12.78	68%	\$31,325	57.30%
New Jersey	4.5	4.2	4.5	\$8.68	\$10.11	\$8.39	\$9.06	\$14.08	64%	\$35,612	52.92%
New Mexico	6.3	5.3	5.7	\$7.44	\$7.42	\$6.62	\$7.16	\$10.76	67%	\$21,836	68.20%
New York	5.0	4.3	4.4	\$7.97	\$10.92	\$7.84	\$8.91	\$12.77	70%	\$33,901	54.67%
North Carolina	2.8	4.9	4.9	\$7.60	\$7.88	\$7.11	\$7.53	\$11.15	68%	\$26,417	59.29%
North Dakota	2.6	2.6	2.6	\$7.48	\$7.58	\$7.35	\$7.47	\$9.92	75%	\$23,273	66.76%
Ohio	4.3	3.9	4.2	\$7.91	\$8.30	\$7.69	\$7.97	\$12.06	66%	\$27,171	60.99%
Oklahoma	4.2	2.7	3.1	\$8.28	\$6.80	\$6.80	\$7.29	\$10.35	70%	\$22,958	66.08%
Oregon	5.3	5.2	5.3	\$8.03	\$8.75	\$7.73	\$8.17	\$11.98	68%	\$26,958	63.04%
Pennsylvania	4.2	4.3	4.7	\$7.86	\$8.98	\$7.79	\$8.21	\$11.96	69%	\$28,619	59.67%
Rhode Island	3.1	4.4	4.7	\$9.14	\$9.12	\$12.35	\$10.20	\$12.18	84%	\$29,335	72.35%
South Carolina	4.2	4.3	4.4	\$7.21	\$7.42	\$7.77	\$7.47	\$11.25	66%	\$23,538	65.98%
South Dakota	2.4	2.5	2.5	\$7.55	\$7.73	\$7.43	\$7.57	\$10.05	75%	\$25,041	62.88%
Tennessee	4.1	4.3	4.3	\$7.86	\$7.72	\$6.95	\$7.51	\$10.33	73%	\$25,548	61.14%
Texas	4.7	4.0	4.6	\$9.74	\$6.77	\$6.04	\$7.52	\$10.82	69%	\$26,834	58.26%
Utah	3.0	3.5	3.6	\$7.82	\$7.99	N/A	\$7.91	\$11.08	71%	\$23,276	70.64%
Vermont	2.6	3.1	3.0	\$8.08	\$8.21	\$6.68	\$7.66	\$11.61	66%	\$25,845	61.62%
Virginia	2.7	2.7	2.7	\$7.20	\$7.75	\$6.35	\$7.10	\$12.24	58%	\$29,794	49.57%
Washington	4.5	5.8	5.9	\$7.95	\$8.85	\$7.61	\$8.14	\$13.33	61%	\$30,380	55.71%
West Virginia	6.8	5.1	5.2	\$6.30	\$6.82	\$6.29	\$6.47	\$9.95	65%	\$20,921	64.33%
Wisconsin	3.1	4.2	4.3	\$8.01	\$8.90	\$7.57	\$8.16	\$11.84	69%	\$27,370	62.01%
Wyoming	4.5	3.5	3.7	\$7.74	\$7.73	\$7.57	\$7.68	\$10.41	74%	\$26,363	60.59%
United States*	4.4	4.5	4.5	\$8.21	\$8.29	\$7.50	\$7.97	\$11.87	67%	\$28,546	58.06%

Definitions of Job Titles used by US Bureau of Labor Statistics 1999 State Occupational Employment and Wage Estimates. Median hourly wages by state for job categories below from same source.

Home Health Aides: Provide routine, personal healthcare, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the home of patients or in a residential facility.

Nursing Aides, Orderlies, and Attendants: Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, or move patients, or change linens. Exclude "Home Health Aides" and Psychiatric Aide's".

Personal and Home Care Aides: Perform a variety of tasks at places of residence. Duties include keeping house and advising families having problems with such things as nutrition, cleanliness, and household utilities. Exclude Nursing Aides and Home Health Aides.

Note: Median Hourly data for US from same source -- (national median wage data and state data not computed using exactly same methodology -- methodologies for calculations available on Bureau of Labor web site.)

Per Capita Personal Income - Source for Personal Per Capita Income Data: US Bureau of Economic Analysis, Per capita personal income updated as of May 2001 for 1999. Definition of Personal Per Capita Income: "Income received by all persons from participation in production, from government and business transfer payments, and from government interest. Personal income is the sum of net earnings by place of residence, rental income of persons, personal, personal interest income, and transfer payments. " For calculation methodologies (state, national) see Bureau of Economic Analysis website.

Unemployment Data - state and national data source: US Bureau of Labor Statistics

State	Nursing Aides, Orderlies, Attendants				Personal and Home Health Aides			Total Additional Aides Projected to be Needed between 1998 - 2008
	1998 Employment	Projected 2008 Employment	Percent Change		1998 Employment	Projected 2008 Employment	Percent Change	
Alabama	19,700	24,850	26%		8,450	13,900	64%	10,600
Alaska	1,050	1,400	32%		NA	NA	NA	NA
Arizona	14,150	18,750	32%		7,800	12,550	61%	9,350
Arkansas	17,200	25,350	47%		5,600	8,750	56%	11,300
California	88,500	107,900	22%		36,900	54,400	47%	36,900
Colorado	13,950	18,200	31%		8,750	15,500	77%	11,000
Connecticut	25,600	29,450	15%		12,050	15,650	30%	7,450
Delaware	4,150	5,350	29%		1,800	2,450	37%	1,850
Florida	62,350	83,450	34%		31,400	46,500	48%	36,200
Georgia	NA	NA	NA		NA	NA	NA	NA
Hawaii	4,200	4,950	19%		NA	NA	NA	NA
Idaho	5,300	7,150	34%		2,100	3,250	56%	3,000
Illinois	52,750	61,850	17%		NA	NA	NA	NA
Indiana	26,200	34,950	33%		10,150	16,500	63%	15,100
Iowa	18,750	22,250	19%		5,050	7,350	46%	5,800
Kansas	16,050	20,250	26%		11,000	14,400	31%	7,600
Kentucky	NA	NA	NA		NA	NA	NA	NA
Louisiana	23,900	29,350	23%		9,450	10,600	12%	6,600
Maine	9,900	11,850	20%		5,950	8,900	50%	4,900
Maryland	NA	NA	NA		NA	NA	NA	NA
Massachusetts	40,100	46,350	16%		22,550	31,450	40%	15,150
Michigan	45,350	49,900	10%		27,100	35,100	30%	12,550
Minnesota	31,050	35,300	14%		20,150	30,200	50%	14,300
Mississippi	13,950	16,700	20%		4,250	6,500	53%	5,000
Missouri	37,500	44,350	18%		14,700	19,550	33%	11,700
Montana	4,950	6,150	24%		3,950	5,300	35%	2,550
Nebraska	11,200	14,050	26%		2,200	3,100	39%	3,750
Nevada	2,850	4,250	49%		2,150	3,550	65%	2,800
New Hampshire	6,200	7,950	28%		NA	NA	NA	NA
New Jersey	40,350	48,250	20%		23,800	38,250	61%	22,350
New Mexico	7,950	10,450	31%		5,200	7,250	39%	4,550
New York	105,950	129,050	22%		126,700	165,400	31%	61,800

State

Nursing Aides, Orderlies, Attendants				Personal and Home Health Aides			Total Additional Aides Projected to be Needed between 1998 - 2008
1998 Employment	Projected 2008 Employment	Percent Change		1998 Employment	Projected 2008 Employment	Percent Change	
North Carolina	43,750	62,150	42%	24,400	36,850	51%	30,850
North Dakota	6,350	7,900	25%	1,650	2,250	38%	2,150
Ohio	65,450	81,550	25%	31,000	49,650	60%	34,750
Oklahoma	19,900	26,050	31%	8,650	14,950	72%	12,450
Oregon	12,450	14,400	15%	6,150	11,900	93%	7,700
Pennsylvania	75,550	92,400	22%	25,750	35,650	38%	26,750
Rhode Island	9,100	11,150	23%	4,450	5,900	34%	3,500
South Carolina	14,100	19,300	37%	2,950	5,100	74%	7,350
South Dakota	5,900	7,350	25%	1,500	2,100	41%	2,050
Tennessee	26,250	32,800	25%	8,900	11,450	28%	9,100
Texas	91,250	112,550	23%	73,850	90,200	22%	37,650
Utah	5,850	8,750	49%	2,600	4,100	57%	4,400
Vermont	2,750	3,550	29%	2,150	2,750	30%	1,400
Virginia	27,750	38,600	39%	14,850	25,800	74%	21,800
Washington	24,000	30,500	27%	21,750	29,550	36%	14,300
West Virginia	8,800	10,150	15%	8,850	10,700	21%	3,200
Wisconsin	38,650	45,600	18%	16,150	23,650	47%	14,450
Wyoming	NA	NA	NA	NA	NA	NA	NA
United States	1,359,250	1,684,250	24%	743,000	1,176,100	58%	758,100

Source: State Occupational Projections for 1998 and 2008 as published by the Bureau of Labor Statistics, U.S. Department of Labor. State Employment Security Agencies develop state projections published by the Bureau of Labor Statistics.

Note: Bureau of Labor projections as published on their web-site combine Personal and Home Care Aides and Home Health Aide projections into a single category.

Total Additional Aides Needed is a calculated field which combines the additional aides projected for the two categories included (1.Nursing Aides, Orderlies, and Attendants and 2. Personal and Home Health Aides).

