The 2007 National Survey of State Initiatives on the Direct-Care Workforce:

Key Findings

Prepared by

PHI

and the

Direct Care Workers Association of North Carolina

PHI Quality Care THROUGH Quality Jobs

DCWA Hands at the heart of care

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The 2007 National Survey of State Initiatives on the Direct-Care Workforce

The 2007 national survey and report were developed collaboratively between PHI (formerly the Paraprofessional Healthcare Institute) and the Direct Care Workers Association of North Carolina (DCWA-NC).

PHI (**www.PHInational.org**) works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. Using our workplace and policy expertise, we help consumers, workers, employers, and policymakers improve eldercare and disability services by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect, and independence.

PHI sponsors two websites with additional resources on the direct-care workforce. For more information on PHI's policy advocacy and related resources, visit **www.PHInational.org/policy**. For a comprehensive library of resources related to the direct-care workforce, including previous state surveys, visit **www.PHInational.org/clearinghouse**.

The **Direct Care Workers Association of North Carolina** is a statewide, education-based organization for direct-care workers and others who share its mission and values. Those values include:

- Quality care, and the skill, individual attention, diligence, compassion, commitment and dedication necessary to make it happen;
- Professionalism, and the opportunity, advocacy, integrity and fairness that go with it;
- Effective communication, and the clarity that comes from listening with an open mind to what others say;
- Diversity, and the inclusion and active participation of people with different backgrounds and differing points of view; and
- Teamwork, and the respect that comes from working toward a common goal with a commitment to support the group's decisions.

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Highlights from the 2007 National Survey of State Initiatives

More than 3 million direct-care workers now provide critical support for elders and individuals with disabilities and chronic illnesses in the United States. Direct-care jobs are growing *more than three times faster* than the average occupation, and over the next decade, two jobs in particular—Personal and Home Care Aide and Home Health Aide—are expected to rank as the nation's second and third fastest-growing occupations. The *2007 National Survey of State Initiatives*, our sixth state-initiative overview since 1999, documents key trends in state workforce policy development efforts for direct-care workers in eldercare and disability services.

Increasing workforce instability. With unemployment at a low in 2007 and demand for long-term care services increasing significantly, 97 percent of states responding to the survey reported "serious" or "very serious" direct-care workforce shortages. This was the highest percentage in our survey's history.

More initiatives to improve wages and benefits. States continue to rely on wage pass-throughs to address the generally low level of direct-care worker wages and benefits. These payment-rate adjustments or targeted grants are intended to improve compensation for direct-care workers. In practice, however, their effectiveness is often minimal, serving, at best, as a modest cost-of-living increase. But experimentation with other approaches is growing. Both Montana and Louisiana implemented a wage floor specifying a minimum hourly wage to be paid to direct-care workers employed in certain publicly funded care programs. And Washington passed a parity bill that increases compensation for agency-employed home care workers equivalent to the salary and wage component of the statewide contract for individual providers.

Growing use of Medicaid payment policies to enhance workforce. A small but growing number of states are restructuring their reimbursement methods to create incentives for providers to invest in their direct-care workers. In particular, since 2005, five states have decided to reward favorable workforce-related outcomes—such as improved retention, lower turnover, and broader health care coverage—with increased payment rates. Two of the new state rate-enhancement policies apply to nursing homes (Kansas, Oklahoma); two apply to home-based care (Montana, Rhode Island); and one applies to programs for individuals with intellectual and developmental disabilities (New York).

Concern with better training. States are showing greater interest in both improving training programs for direct-care workers and in strengthening their training requirements. Several states have created training requirements for workers who are not covered by federal requirements, such as personal care assistants, home care aides, and assisted living aides. Others are considering standard or common training for all direct-care workers, regardless of setting (e.g., Pennsylvania, Iowa). In addition, with the growing emphasis on consumer-directed care, many states are beginning to consider providing training resources and other supports to help both consumers and the independent providers (i.e., non-agency workers) who provide them with services and supports.

Building interest in collecting and monitoring workforce data. While more states reported tracking some data related to aspects of their direct-care workforces, few reported using a

comprehensive approach to data collection across long-term care sectors that would support effective monitoring. Furthermore, no state currently collects a minimum set of data that could accurately inform policymakers about key workforce vital signs of size, compensation, and stability.

Background

The 2007 National Survey of State Initiatives on the Direct-Care Workforce examines public policy actions taken by states since 2005 to strengthen their direct-care workforces. The survey also provides an updated assessment from states as to whether direct-care worker vacancies and turnover are currently serious workforce issues.

Expanding upon information collected from states in prior surveys, the 2007 survey examines state efforts to improve direct-care worker compensation through the establishment of wage pass-throughs, wage floors, and reimbursement rate enhancement strategies. In addition, it provides information about training and career advancement initiatives for direct-care workers and their supervisors, and the extent to which states track and monitor data on the direct-care workforce.

Methodology

This is the sixth national survey on the direct-care workforce. Surveys were sent to all state Medicaid agencies and State Units on Aging in February 2007 and then, if necessary, redirected to appropriate state entities for completion. Between March and August 2007, 34 states returned completed surveys, for a response rate of 68 percent. Where necessary, survey administrators sought clarification from respondents and contacts that they provided. In addition, researchers consulted publicly available information at state websites.

Definitions used in this survey:

- **"Direct-care worker"** refers to the full spectrum of paraprofessional caregivers in long-term care who provide daily living services and supports to older persons, people with physical disabilities, those with intellectual and developmental disabilities, and people with chronic care needs. Job titles for these workers include: Nursing Aides, Nursing Assistants, Home Health Aides, Personal and Home Care Aides, Home Care Aides, Personal Attendants, and Direct Support Professionals.
- **"Setting"** refers to the eldercare or disability services venue in which a direct-care worker is employed. These range from institutional settings such as licensed and/or certified nursing homes, skilled nursing facilities, and large Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), to home and community-based settings. The latter include private homes, community residential settings such as congregate or group homes, assisted living facilities, adult foster care homes, small residential care facilities, and homes for the aged. Community-based settings also include venues in which respite, rehabilitative, or adult day services are delivered.

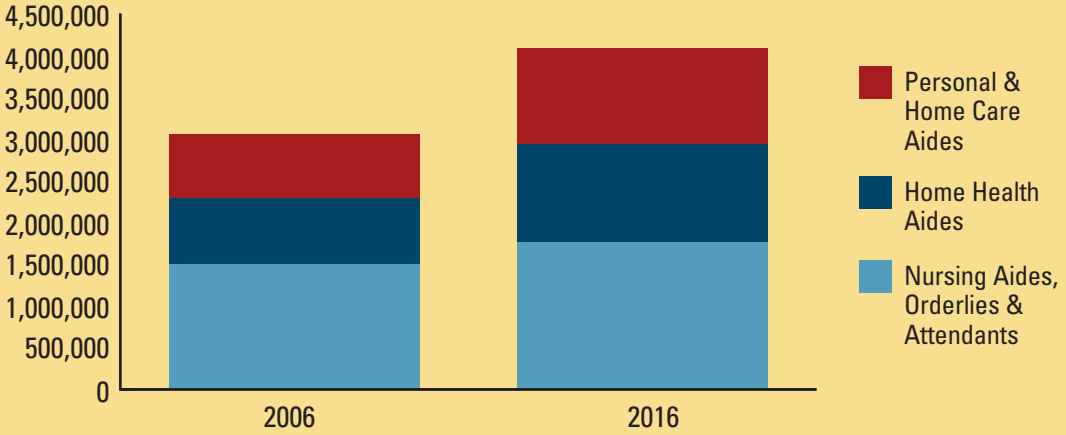
All analyses and percentages reported are based on the 34 states that fully or partially completed the survey. State information regarding specific initiatives and activities is included in this report when such descriptive information was provided in the state's survey response, or when other updates were obtained from publicly available information or from follow-up with state respondents and other contacts.

National Statistics on the Direct-Care Workforce

Growing Demand

In 2006, the direct-care workforce surpassed the 3 million mark. Projected demand calls for an additional 1 million new positions by 2016.

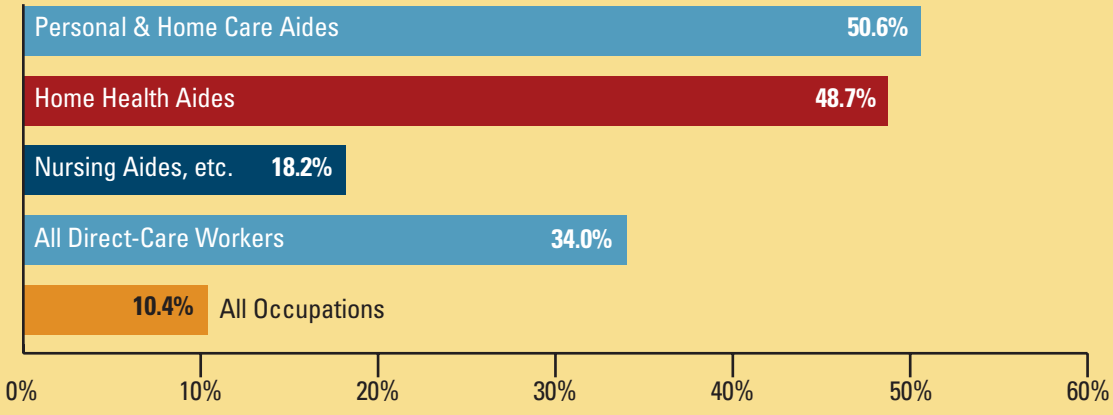
Figure 1:
Growing Direct-Care Workforce



Source: PHI (April 2008) *Occupational Projections for Direct-Care Workers, 2006-16*, PHI Facts No. 1, Bronx, NY: PHI.

Overall national demand for direct-care workers is projected to increase by 34 percent between 2006 and 2016, more than triple the projected growth rate in overall employment (10.4 percent).[1] Two direct-care occupations—Personal and Home Care Aides and Home Health Aides—are expected to be the second and third fastest-growing occupations in the country over the next decade, and are on the list of the top 10 occupations projected to register the largest numeric job growth across the entire economy.

Figure 2:
Projected Increase in Employment Demand, 2006–2016



Source: PHI (April 2008) *Occupational Projections for Direct-Care Workers, 2006-16*, PHI Facts No. 3, Bronx, NY: PHI.

Wages

In 2007, the national median hourly wage for all direct-care workers was approximately $10.22 (calculated as a weighted average across the three main occupational categories for direct-care workers).[2]

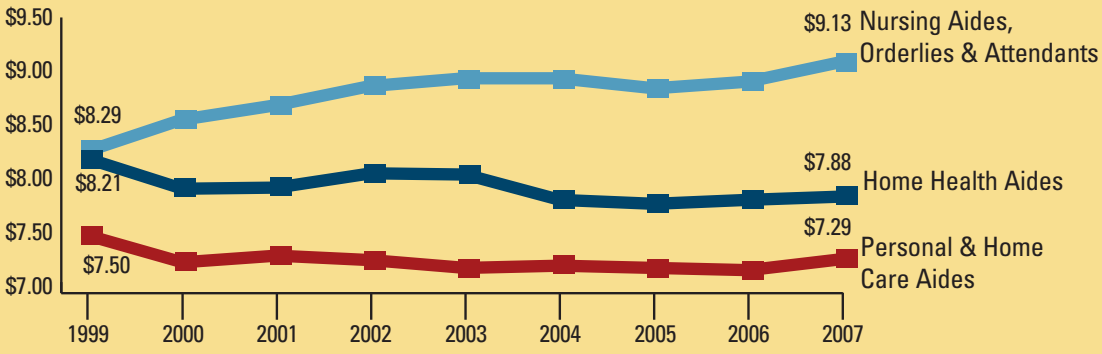
Table 1:
National Wages for Direct-Care Workers, 2007

Type of Direct-Care Worker	Median Hourly Wage
Nurse Aides, Orderlies & Attendants	$11.14
Home Health Aides	$9.62
Personal & Home Care Aides	$8.89
Weighted median wage across three occupations	$10.22

Source: Bureau of Labor Statistics, US Department of Labor, Occupational Employment Statistics Program, May 2007.

Inflation-adjusted wages for the direct-care workforce show that, over the past eight years, while Nursing Aides, Orderlies and Attendants have seen a modest increase in their real wages to just over $9 an hour (measured in 1999 dollars), real wages for Home Health Aides and Personal & Home Care Aides have both declined and are under $8 an hour.[3]

Figure 3:
Direct-Care Worker Median Wages Adjusted for Inflation (1999 dollars), 1999–2007

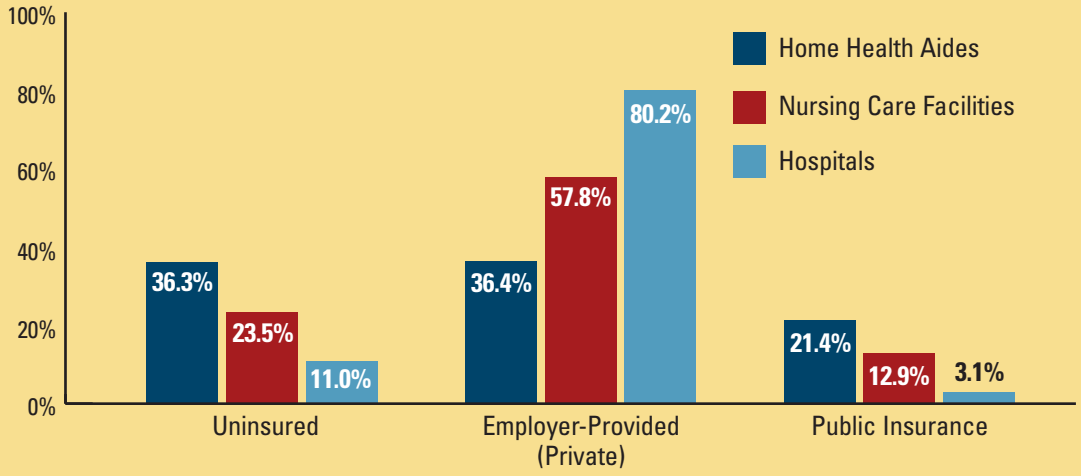


In 2006, in nearly 60 percent of states (or 29 total), average hourly wages for Personal and Home Care Aides were below 200 percent of the federal poverty line wage for individuals in one-person households working full time. Since the 200 percent poverty level is low enough to qualify households for many state and federal assistance programs, this means that in these states most Personal and Home Care Aides—certainly those who work part time and have children—are earning near-poverty level wages.[4]

Health Insurance Coverage

In 2007, about one in every four nursing home workers (23.5 percent) and 36 percent of direct-care workers employed in home health care lacked health coverage. In hospitals, only 11 percent of direct-care workers lacked health insurance.[5]

Figure 4:
Health Insurance Status of Direct-Care Workers by Setting, 2007



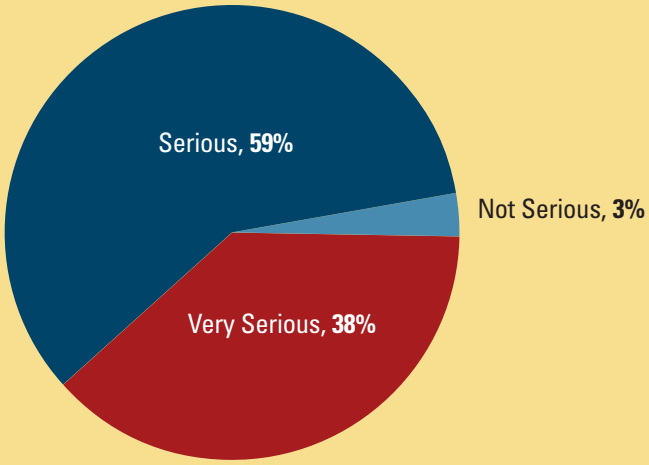
While two-thirds of Americans under age 65 receive health coverage through an employer, only about half of direct-care workers (53 percent) have employer-based coverage. But there are large disparities according to setting: only 36 percent of direct-care workers in home health report enrollment in employer-provided health coverage, compared with 58 percent of nursing home workers, and 80 percent of direct-care workers in hospitals. Finally, home health care workers are much more dependent on public coverage than nursing home or hospital direct-care workers; roughly one-fifth of home health care workers are enrolled in public plans.

Survey Findings

Workforce Stability as a Serious Workforce Issue

Of the 34 states that responded to the survey, all but one state (97 percent) ranked direct-care vacancies and/or turnover as a "serious" or "very serious" workforce issue. This is a substantial increase from 2005, when 76 percent of states indicated that vacancies and turnover were a serious or very serious issue. Of the 33 states that considered this problem serious in the 2007 survey, 13 considered it very serious. Only one state, Washington, ranked workforce stability issues as "not serious."

Figure 5:
State Rankings of Problem of Workforce Turnover & Vacancies, 2007



State Initiatives and Activities to Improve Direct-Care Compensation

A number of states reported pursuing efforts to improve direct-care compensation using policies and programs such as wage pass-throughs, wage floors, rate enhancements tied to workforce outcomes, and exploratory wage/benefit studies that gather information and data to help design policy responses and initiatives.

Wage Pass-Throughs. Wage pass-throughs refer to state-funded adjustments of payment rates or grant increases that have compensation-related cost requirements for direct-care staff, including a wage increase requirement. These increases sometimes are referred to as cost-of-living adjustments (COLAs), and their general intent is to enhance the compensation received by direct-care workers who are delivering services and supports under public eldercare and disability services programs.

Thirteen state respondents reported wage pass-throughs for at least one group of direct-care workers in at least one setting. In ten of these states, the pass-throughs resulted from legislation, while in the other three, the pass-throughs were due to departmental authority. Of the thirteen states, only six indicated that the wage pass-through was monitored through

mechanisms such as a COLA application process, reporting, audits, or onsite reviews of agency records.

Table 2:
States Reporting Wage Pass-Throughs Since 2005

State Wage Pass-Throughs & Related Monitoring	Number	States
States with wage pass-throughs for at least one group of direct-care workers or one setting since 2005	13	HI, LA, MA, MD, ME, MI, MN, MT, NJ, PA, RI, UT, WA
States indicating that wage pass-throughs are monitored	6	LA, MA, MI, MN, MT, NJ

The most infrequent type of wage pass-through was an across-the-board version, in which an equivalent increase was required to be delivered to direct-care workers across different long-term care settings. Important exceptions to this in the 2005-2007 period included Louisiana, Montana, and Washington. In both Louisiana and Montana, the wage pass-throughs were relatively comprehensive across sectors, with workers in different settings receiving the same increase. In Washington, parity legislation ensured that compensation increases awarded to independent providers under Medicaid home care programs were implemented within the agency home care network through vendor rate increases.

Wage Pass-Through: Selected State Detail

In 2007, **Louisiana** implemented a $2 per hour wage pass-through for a wide range of direct-care workers, of which $1.50 had to be directed to wages, and up to $0.50 could be used for benefits, payroll taxes, FICA, worker's compensation, unemployment insurance, and other employment-related expenses.

In **Maine**, a 2 percent COLA was granted in 2006 to direct-care staff in nursing facilities and selected residential care facilities (the COLA was received broadly by CNAs, RNs, LPNs, etc.). In 2007, nursing facilities again received a 2 percent COLA. A 3.8 percent COLA for workers in MR/DD was proposed in 2007, but did not pass. In 2007, the legislature passed a rate increase for the Homemaker Program that raised the rate from $17/hour to $18.75; the Office of Elder Services contracts with Home Care for Maine to provide the homemaker services, and it was understood that the rate increase would result in a pay increase for workers. By union contract, the agency agreed to increase worker wages for Personal Support Specialists and Homemakers to $10 per hour by January 2008 (pending legislative approval), an average increase of $0.75 per hour. This action was the result of the union's negotiations with the governor and the Department of Health and Human Services.

In **Massachusetts**, Medicaid nursing facilities had two wage-related reimbursement add-ons since the first part of this decade: one for CNAs and the other for all direct-care staff, including CNAs, RNs, LPNs, and Directors of Nursing for Medicaid nursing facilities. The add-ons could be spent on: a) increasing wages, hours, benefits and related employee costs, b) improving the staff-to-patient ratio in facilities, or c) recruitment and retention of nursing staff. In 2007, nursing facility rates were rebased, and starting in FY 2008, these add-ons were incorporated into the standard

rate and no longer are added on. On the home and community-based side, the Executive Office of Health and Human Services (EOHHS) continues to administer a Salary Reserve allocation according to the amounts appropriated in the state budget. Funds are distributed for the purpose of adjusting the wages, compensation, or salary of certain personnel earning less than $40,000 who are employed by human and social service agencies under contract with EOHHS and the Executive Office of Elder Affairs. Contractors are permitted to use up to 15 percent of their allocation to cover the employer portion of payroll and fringe benefit obligations directly associated with the salary increases.

In **Minnesota**, the legislature funded a COLA increase for a wide range of long-term care settings, totaling $20.5 million and $55.7 million, respectively, in 2006 and 2007. The COLA for nursing facilities was 1.87 percent and that for ICF/MRs and home and community-based services was 2 percent. A quarter of the COLA was unrestricted; the remaining 75 percent was to be allocated to staff compensation, and of that amount, two-thirds was targeted at wage increases.

In **Michigan**, the legislature appropriated a wage pass-through for Community Mental Health workers in FY 2007 totaling $10.4 million. These funds were to be used "for increasing the wages and the employer's share of federal insurance contribution act (FICA) costs of direct care staff by 2 percent per direct care worker in local residential settings and for paraprofessionals and other nonprofessional direct care workers in settings where skill building, community living supports and training, and personal care services are provided, effective October 1, 2006." However, the appropriation was insufficient to fund the full increase; the Department of Community Health committed an additional $7.3 million, of which $5.6 million was Medicaid funding subject to federal approval. In 2006, independent providers in the Home Help Program received their first wage increase in many years when the state increased their hourly wage floor from $5.15 to $7.00. It also raised wages already above that level by 50 cents per hour. At the time of the 2006 increase, the statewide average hourly wage paid to these workers was $6.07 per hour. In 2007, the minimum hourly wage was increased to $7.15; increases were not provided to those who received the 50 cents raise in the prior year.

In 2005, the **Montana** legislature authorized the distribution of $11.7 million in additional funds for the purpose of providing wage and benefit increases in 2006 to direct-care workers in nursing homes and community-based programs (aging, physical, and developmental disabilities) with the specific intent of raising the hourly wage by 75 cents and benefits by 25 cents per hour. These pass-throughs were sustained with no increase in 2007.

In **New Jersey**, community-based programs under the Division of Developmental Disabilities received COLAs in each of the past three years: 3.5 percent in 2005, followed by a 1 percent unrestricted COLA in 2006 and again in 2007. The 2005 COLA stipulated that if the provider paid for the health insurance of direct-care workers, then direct-care wages were to receive at least 50 percent of the COLA; if no health insurance was paid for, then 75 percent of the COLA was to be directed to direct-care wages. In 2007, home health care agencies received a COLA totaling $7.4 million through the Division of Disability Services.

In **Pennsylvania**, a 3 percent COLA in 2007 was earmarked for direct-care worker compensation in home and community-based programs other than those that serve individuals with intellectual and developmental disabilities. The stated purpose was "to help home and community-based programs for persons with physical disabilities recruit and retain staff."[6] Both agency- and consumer-directed workers were entitled to the COLA.

In 2006 and 2007, **Utah** instituted general staffing COLAs of 1 percent and 3.5 percent, respectively, for residential care workers and personal care workers in programs providing services to the elderly, persons with DD/MR, and persons with physical disabilities. In SFY 2008, a 2.5 percent COLA was approved for nursing home staff, and 6 percent COLA for staff working in residential care facilities and in programs providing personal care services to the elderly, persons with developmental disabilities, and persons with physical disabilities.

In **Washington**, hourly wage rates for 23,500 individual providers of in-home personal care services covered by a state collective-bargaining agreement for 2007-09 were due to increase by 30 cents per year, starting from a base of $9.43. In addition, these workers receive reimbursement for client-related travel in their personal vehicles, and differential pay when they serve as mentors or trainers. The health care contribution level for these workers was due to increase by 10 percent. For home care workers who are agency-employed, funding has been provided under a Parity Bill (HB 2333, effective July 2006) to provide for a wage and benefit increase that corresponds to the salary and wage component of the home care worker contract for individual providers. For health care coverage, the state reimburses agencies for up to the amount negotiated for health care coverage in the union contract for individual providers.[7]

Wage Floors. Wage floors specify a minimum hourly wage to be paid to direct-care workers. The minimum wages established by wage floors go above and beyond any state minimum wage law directed more broadly at low-wage workers.

Over the period 2005 to 2007, four states reported establishing a wage floor for direct-care workers in at least one long-term care setting. In two of those states—Louisiana and Montana—the wage floors were broadly based, extending across multiple settings.

Table 3:
States Indicating Establishment of Wage Floor by Setting

Setting	Pre 2005	2005–2007
At least one setting	OK, MA, ME, MI, NM	MT, LA, VT, WA
Multiple settings		LA, MT

As indicated in Table 4, states appear to be employing wage floors more in consumer-directed programs.

Table 4:
States Indicating Wage Floors by Service Delivery Model

Service Delivery Model	States
Agency-based service delivery models	LA, MT, NM, OK, WA
Consumer-directed service delivery models	LA, MA, ME, MI, MT, VT, WA

Wage Floors: Selected State Detail

Beginning in 2007, all direct-care workers in **Louisiana** were required to be paid a minimum of $6.65 per hour.

In **Massachusetts**, under the Personal Care Attendant (PCA) Program in which consumers hire their own workers, the PCA gross wage was set at $10.84 per hour. Workers in this program became unionized in November 2007, and a public authority model has been implemented in which the union representing the workers will engage in collective bargaining with the state in order to set compensation and establish other supportive resources such as a worker registry.

In July 2006 the **Michigan** legislature established a minimum $7.00/hour wage floor for the Home Help Program and gave a 50 cent/hour raise to personal care workers already making more than the $7.00/hour wage floor. In 2007, the wage floor was increased to $7.15. Wages had been frozen since 2003 at an average of $6.69 per hour.

In 2007, **Montana** departmental authority was used to establish a minimum wage of $8.50 per hour for CNAs and PCAs under programs operated by the Senior and Long Term Care Division, and of $8.00 per hour for direct-care staff who provide services under the Developmental Disabilities Program.

New Mexico has a pre-existing wage floor for Personal Care Attendants working in its Medicaid Personal Care Option (PCO) Program. As part of a cost containment effort, beginning in SFY 2005, the minimum wage rate of $8.50 per hour was lowered to $8.00. This rate applies to workers in both parts of the PCO program: the consumer-directed model and the consumer-delegated model (which is agency based).

Since 2000, **Oklahoma** has required a wage floor of $6.65 in all nursing facilities and private ICF/MR facilities receiving Medicaid payments. Payroll registers are randomly audited for specified employees, including RNs, LPNs, nurse aides, certified medication aides, social service staff, activities staff, housekeeping staff, and maintenance and laundry staff.

In **Vermont**, personal care attendants working in the Attendant Services Program and in 1115 Waiver settings in consumer/surrogate-directed settings were required to be paid $9.00 and $10.00 per hour, respectively, in 2007.

In **Washington**, base wages are specified for the 23,500 individual providers of in-home services who are covered by a collective-bargaining agreement. Under the 2007-09 contract, base wages were to increase by 30 cents/hour per year starting from $9.43.

Other Wage and Benefit Initiatives. Seven states reported conducting studies over the past three years to investigate the costs of proposed wage and/or benefit initiatives. Among the studies conducted were the following:

- **Louisiana** surveyed Medicaid-participating nursing homes in order to baseline staff hours, salaries, and contract payments by geographical area in June 2005. Later, the state compared the June 2005 data with similar data compiled in December 2005 in order to gauge the impact of Hurricane Katrina.
- In a March 2007 study, **Maine** estimated the cost of establishing a wage floor for home care workers at two levels ($8.50 and $10). It also considered providing health insurance to direct-care workers, as well as options for expanding the existing CNA registry.
- In 2007, **Utah** investigated contract provider rates under programs administered by the Division of Aging and Adult Services (DAAS) and the Division of Services for People with Disabilities.

In addition to mandated studies, states responding to the 2007 survey reported the following additional wage and benefit initiatives:

- In **Alaska**, a Workforce Development Initiative was created in 2006 by the Alaska Mental Health Trust Authority to focus on recruitment, retention, and training. Preceding it were numerous studies and reports of long-term care costs, workforce recruitment, and retention.
- **Iowa** reported two bills addressing the problem of providing affordable health insurance to all Iowans, including direct-care workers: HF790 allows small businesses to pool for health insurance, and HF909 created a Legislative Commission on Affordable Health Care Plans for Small Businesses and Families to make recommendations on improving health care access and affordability.
- In 2007, the **Montana** legislature passed an act requiring the Department of Public Health and Human Services to reimburse Medicaid personal assistance and private duty nursing agencies that provide health insurance coverage to workers. An enhanced Medicaid reimbursement rate for Medicaid-funded home care agencies was created for those agencies that provide health insurance to their direct-care employees and verify that the coverage meets certain established criteria.
- **New Hampshire** reported planning a workforce strategy to complement its Systems Transformation and Money Follows the Person initiatives. The state received technical assistance through the CMS Direct Service Workforce Resource Center (see box below) to develop that workforce strategy.
- **Utah** used technical assistance from the Direct Service Workforce Resource Center to analyze ways to improve its direct service worker marketplace.

The National Direct Service Workforce Resource Center

In 2006, the Centers for Medicare and Medicaid Services (CMS) established the Direct Service Workforce (DSW) Resource Center (www.dswresourcecenter.org). The Center makes data, policy, best practices, and other resources available to policymakers and other interested entities with the goal of improving the recruitment and retention of direct-care workers.

Each year, CMS selects up to five states to receive intensive technical assistance on direct-care workforce issues or initiatives of interest to the respective state. The Center's experts comprise representatives from The Lewin Group, Institute for Future of Aging Services, PHI, and the Research and Training Center on Community Living at the University of Minnesota.

Since 2006, technical assistance has covered a broad array of topics and needs:

- Assistance to plan or convene direct-care workforce stakeholder groups, and to draft consensus reports with recommendations for priority state initiatives.
- Identify best practice models of job design and supervision for direct-care workers employed by consumers managing their own services.
- Support the development of state training programs for workers and supervisors.
- Develop data/evidence-based outcome measures to assess impact of current or planned recruitment and retention strategies.

States awarded technical assistance

2006: AZ, LA, NY, SC, TX 2007: GA, NJ, NC, UT, WI 2008: DE, IN, MI, OH, VT

2009: Money follows the person grantees: CT, DC, HI, IA, LA, MI, ND, NE, NH, NJ, OH, OK, TX, WA

Reimbursement Rate Enhancements Tied to Job Quality. Rate enhancements refer to increased payment rates paid to providers that meet workforce-related performance goals, such as higher wage rates, provision of health insurance coverage, lower turnover, and higher retention.

Since 2005, six new states have indicated that they are tying increased payment rates to workforce-related outcomes. Of the six new states, three rate-enhancement programs apply to nursing homes (Kansas, Minnesota, Oklahoma), two to home-based care (Montana, Rhode Island), and one to programs for individuals with intellectual and developmental disabilities (New York). Rate enhancements in three states were legislated; in three other states they resulted from actions taken under departmental authority. Table 5 provides information on the specific performance requirement areas necessary to qualify for the designated rate enhancements.

Table 5:
States Reporting Rate Enhancement Programs Tied to Workforce

Workforce-related areas or outcomes	KS	OK	MN	MT	NY	RI
Turnover	X	X				
Retention	X	X				
Staffing ratios or hours		X				
Education & training			X			X
Health insurance				X	X	
Other Outcomes						X
High–acuity clients						X
Client satisfaction		X				
Continuity of care	X	X				
Agency accreditation		X		X		X

Workforce-Related Rate Enhancements: Selected State Detail

Since 2003, **Iowa**'s case mix payment system for Medicaid nursing homes has included ten Nursing Home Accountability Measures, including one relating to employee retention. Better performing facilities receive financial rewards in the form of an add-on to their Medicaid rates. In October 2006, the Department of Human Services completed an evaluation of the effectiveness of the state's nursing home accountability measures. DHS recommended expanding the accountability measures to include a more comprehensive set of performance indicators, such as nursing home quality indicators, resident quality of life, employee turnover, facility staff job satisfaction or morale, or innovative management practices or organizational change.

After aggressively pursuing quality incentive reimbursement provisions, **Kansas** implemented a rate enhancement in 2006 and 2007 for nursing homes. Facilities qualify if performance demonstrates lower nurse aide turnover, higher retention, and greater continuity of care.

Minnesota implemented an employee scholarship program that provides nursing homes with a rate adjustment to pay for an employee's training classes.

In **Montana**, legislation was passed in 2007 that provides funding for a provider rate increase for agencies that deliver Medicaid personal assistance and private duty nursing services when those agencies provide their employees with health insurance coverage that meets defined criteria. The program—"Healthcare for Montanans Who Provide Healthcare"—is scheduled to begin in January 2009 and is expected to expand coverage to approximately 1,000 home care workers who lack health coverage.

Oklahoma rewards nursing home facilities for their direct-care staff expenditures, paying a rate adjustment based on the relative expenditures of facilities for RNs, LPNs, and CNAs. In addition, beginning in 2007, the state established a new tiered reimbursement incentive program—Focus on Excellence—an incentive-based scoring system that offers enhanced rates ranging from 1 to 4 percent based on performance measures such as: quality of life; resident/family and employee satisfaction; CNA/LPN/RN turnover and retention; state survey compliance; level of person-centered care; clinical outcomes; and direct-care staffing hours.

In **Rhode Island**, the Enhanced Home Health Agency Reimbursement Program provides additional reimbursement when standards beyond minimal licensing are met. Additional enhancements can be achieved for: shift differentials (to improve access during off-hours), staff education, higher acuity clients, state accreditation, and national accreditation (JCAHO-CHAPS-COA).

In **New York**, two Health Care Enhancement Initiatives have been implemented by the Office of Mental Retardation and Developmental Disabilities (OMRDD), the first in 2006 and the second in 2007. (A third was launched in 2008.) These initiatives primarily provide additional funding to enable agencies to enhance health care-related benefits for their OMRDD employees, particularly their direct-care staff. Additional funding is built into the Medicaid reimbursement rate for those agencies that receive approval for their plans.

Texas has had rate enhancement programs in place since 2000 for both its Attendant Care Program and for its nursing facilities. Under both programs, when providers commit to pay their attendants or aides at a higher rate, they are given extra money to do so through an enhanced rate. Nursing facility providers can meet the enhancement requirement through additional staff time as well as higher staff compensation.

Training and Career Advancement for Direct-Care Workers

States continue to take a variety of steps to improve training for direct-care workers and to support opportunities for career ladders and lattices. Some states have expanded beyond the federal minimum requirements for certified nursing home and home health agency staff, or have instituted training requirements for direct-care workers who are not **certified nursing assistants** (CNAs) or **home health aides** (HHAs). Others have initiated efforts to identify core competencies for direct-care workers that are applicable across settings and programs. Still other states are investing in efforts to create career advancement opportunities for direct-care workers and to enhance supervisory training, including training for consumers who direct their own care under consumer-directed programs.

State-Required Entry-Level Training. Going beyond federal regulations, some states have chosen to require additional hours of classroom and clinical training for HHAs in certified home health agencies and CNAs in Medicare- and/or Medicaid-certified nursing homes.[8] As of 2007, 27 states and the District of Columbia had extended the minimum number of

training hours beyond 75 hours of instruction.[9] Minimum required hours range by state from 75—the federal minimum—up to 175 hours. Required clinical-training hours range from 16 to 100 hours, with 30 states requiring more than the federal minimum of 16 hours. Four states do not specify how many hours of required training must be spent in clinical practice. Depending on the training sponsor, the actual amount of total training time can exceed the federal and/or state minimum requirements.

CNAs and HHAs aside, there are no federal training requirements for other direct-care workers, such as **personal care assistants**, **direct support professionals**, **home care aides**, and **assisted living aides**. For states that offer Medicaid-funded personal care services, the State Medicaid Manual (Chapter 4, Section 4480, paragraph E) requires states to develop provider qualifications for personal care assistants. The manual does not list specific qualifications, but rather offers examples of areas where states may establish requirements including: criminal background checks or screens for attendants before they are employed; training for attendants; use of case managers to monitor the competency of personal care providers; and establishment of minimum requirements related to age, health status, and/or education.

Direct-care workers other than CNAs and HHAs typically rely on employer-developed training delivered post-hire. As services become more geographically dispersed, the task of training workers becomes more difficult and costly for their employers. In addition, in many states and organizations, workers are not reimbursed for mileage and/or are not paid to attend training.

Table 6 provides information on developments in state training requirements for direct-care workers during 2005 to 2007. Ten states reported establishing **training requirements for direct-care workers not covered by existing federal requirements** under the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). An additional five states reported that such requirements are under consideration.

Table 6:
Developments in State-Required Entry Training for Direct-Care Workers, 2005–07

Entry-Level Training Developments	Adopted	Under Consideration
Training requirements for workers not covered by federal OBRA requirements (e.g., personal care assistants, direct support professionals, home care aides, assisted living aides)	GA, KS, LA, ME, NC, NJ, RI, TX, VA, WA	AZ, IN, MD, UT, WI
Training for workers in consumer-directed programs	AL, LA, MT, NM, TX, WA	AZ, IN, MT, TX, UT, VT
Standard/common training for all direct-care workers regardless of care setting		AZ, IA, ME, OH, PA, VT, WA, WI

Other notable training developments include:

- With the growing emphasis on consumer-directed care, many states are beginning to consider providing **training resources and other supports to help both consumers and the independent providers** (i.e., non-agency workers) who provide them with services and supports. Of the states responding to the 2007 survey, six reported enacting training requirements for independent workers, and another six states reported interest in such requirements.
- Web-based national curricula for direct support professionals, available through the **College of Direct Support** and developed by the University of Minnesota's Institute on Community Integration at the Research and Training Center on Community Living, was being used for statewide training of direct support workers in eleven states.
- Eight states reported that they were considering or developing **standard or common training for all direct-care workers**. These initiatives aim to establish a basic "core" of direct-care competencies for workers providing services and supports across a wide range of settings.

Standardizing Training for all Direct-Care Workers: Selected State Detail

For many years, direct-care workers in **Georgia** not covered by OBRA training requirements have had to complete approximately 30 hours of training. The training includes CPR, first aid, seizure care, and proper documentation.

In 2005, the **Iowa** General Assembly (under HF 781) established the Direct Care Worker Task Force to make recommendations regarding employment and training of direct-care workers. In 2006, the Task Force issued recommendations to the governor, the Iowa General Assembly, and the Department of Health that called for the establishment of a direct-care worker classification based on function (not setting or population served) to allow for consistency and portability of employment and training. In addition, the Task Force recommended the development of a governing body, a single approved curriculum, and certification for all direct-care workers. During the 2007 legislative session, $75,000 was appropriated to DPH to create a Direct Care Worker Education governance entity to begin implementing the recommendations of the Task Force.

In 2005, **Louisiana** adopted legislation (ACT No. 306) that established training requirements for unlicensed direct service workers (DSWs) who are compensated through state or federal funds and who provide "personal care or other services and supports to persons with disabilities or to the elderly to enhance their well-being… [involving] face-to-face direct contact with the person." DSWs may be employed by an agency or be independent providers, including paid family caregivers. The legislation also requires the Department of Health and Hospitals to develop and maintain a Direct Service Worker Registry for individuals who have successfully completed the DSW training and competency evaluation as well as a criminal background check.

In **Pennsylvania**, the Department of Labor and Industry is working with other state departments through the Center for Health Careers to develop of a competency-based direct-care worker training and credentialing system. The state has supported the development and field-testing of an adult learner-centered 77-hour model curriculum designed for personal care attendants working for a variety of employers in the Commonwealth's long-term living system (home care agencies, assisted living residences, disability service agencies). The entry-level PCA training credential is being designed to articulate into an expanded 120-hour certification system for Nursing Assistants/Home Health Aides (CNA/HHA), with an additional 30 hours of site-specific training to be required of CNA/HHAs working in skilled nursing facili-

ties, home health agencies, hospice and acute care hospitals. The training and credentialing system is based on the philosophy of consumer self-determination and person-directed care, and recognizes a worker's ability to apply a set of related skills in performing critical work functions across a range of situations.

Texas has instituted training requirements for several positions, including adult day care aides, assisted living facility aides, aides working for Home and Community Support Services Agencies, and consumer-directed direct-care staff.

State-Approved Career Ladder and Advancement Programs. As shown in Table 7, twelve states reported adopting at least one sanctioned career ladder and/or advancement program for direct-care workers. In addition, five states reported that such programs are under consideration.

Table 7:
States Reporting Career Ladders & Advancement Programs

Career Ladder & Advancement Programs	Adopted	Under Consideration
DOL apprenticeship program for CNAs, HHAs, and/or DSPs	KS, WI	
Career path initiatives or training enhancement funds	KS, LA, MA, ME, PA	AK, NJ, OH
Specialty aide positions (e.g., medication aide, geriatric aide, senior aide)	KS, ME, NM, NC, OH, TX, UT, VA	CA, MI

Career Ladder & Advancement for Direct-Care Workers: Selected State Detail

Alaska is creating a comprehensive career lattice for direct support professionals through a collaboration of the Alaska Mental Health Trust Authority, the Center for Human Development, and the Department of Labor.

Through its Civil Money Penalty Fund, **Kansas** funds educational programs for licensed and unlicensed staff working in nursing facilities in order to improve quality of life and quality of care for nursing home residents. Specialty aide positions in Kansas include Nurse Aide Trainees, Certified Home Health Aides, Certified Medication Aide, and Paid Nutrition Assistant. The Kansas Apprenticeship Program for direct-care workers offers a multitude of classes ranging from 3 to 32 hours.

Louisiana makes available courses for direct support staff working in state-run ICF facilities through its state-funded Comprehensive Public Training Program, which provides facilities with enhancement funds.

Career ladder programs in **Maine** include the Mental Health Rehabilitation Technician series (established in 2002) and a CNA Medication Technician series, a training program in place since 2003 that requires an additional 24 hours of training.

In **Massachusetts**, the Extended Care Career Ladder Initiative (ECCLI), established in 2000, continues after facing termination in the state's FY 2007 budget. ECCLI's overarching goal is to improve the quality of long-term care by increasing the skills of direct-care workers, primarily through the development and implementation of career ladders. FY 2007 funding was set at $1.5 million.

Medication Aides in **North Carolina** must successfully complete a 24-hour training course and pass an exam before being placed on the Medication Aide Registry. North Carolina has developed a 140-hour Geriatric Aide Specialist curriculum. Once the curriculum is implemented statewide, Geriatric Nurse Aides are to be included in the state's Nurse Aide Registry.

The **New Jersey** Department of Labor, together with the Division of Developmental Disabilities, is applying for funding to be used for the training and advancement of CNAs and other direct-care workers. The New Jersey Direct Support Professional Workforce Development Coalition, which was formed in 2004, has begun a statewide process for credentialing direct support professionals at recognized levels of training and competencies that are connected to salary increases.

New Mexico offers a Medication Aide advancement program that resulted from a pilot program several years ago and was recently codified into the state's Nurse Practice Act. Additionally, a Hemodialysis Technician position was created via a pilot and codified into law in 2006.

Utah has developed a Certified Medication Aide (CMA) position and also a Geriatric Care Manager (GCM) program. The CMA slots above a CNA and below an LPN; the GCM slots above an LPN and below an RN.

State-Approved Training for Supervisors. Supervisors have a powerful impact on the lives of direct-care workers. A worker's relationship with her supervisor is often the most influential factor in determining whether she feels valued and respected in her work. It is also a key component of job satisfaction, intent to remain in the job, and the ability to adequately provide support and care. While recognition of the importance of effective supervision is increasing, planned and well-executed training programs for supervisors are not prevalent.

- Only one state responding to the 2007 survey—Texas—indicated that it has adopted state-approved training for direct-care supervisors [see Table 8]. Supervisory training requirements have been instituted for nurse supervisors and managers in adult day care, home and community support services agencies, and personal assistance services (PAS).
- North Carolina offers coaching supervision training to support providers seeking to attain NC NOVA special licensure designation.

Table 8:
States Reporting Approved Training for Supervisors

State-Sanctioned Training for Supervisors	Adopted	Under Consideration
Supervisory training for nurse supervisors/managers	TX	
Training for consumers directing their own workers		TX, WI

- With the growing emphasis on consumer-directed care, many states are beginning to consider providing training resources and other supports to help consumers effectively supervise the direct-care workers they hire. **Texas**, for example, reported that certification training for Support Advisors is currently under development. These advisors would be responsible for assisting consumers to train their direct-care staff in consumer-directed programs. **Iowa** reported receiving several grants to develop more educational training for consumers who direct their own services and supports so they can better hire and supervise their own direct-care staff.

Tracking and Monitoring Direct-Care Workforce Information

In the 2007 survey, fourteen states reported collecting some type of direct-care workforce data on a regular basis. This represents a substantial increase from the five states that reported on-going data collection efforts in the 2002 survey. The 2005 survey focused on state-collected turnover data for direct-care workers, and found that eleven states collected such data (along with other data in some cases) for one or more settings.

Although the uptick of states reporting data collection and workforce monitoring efforts is encouraging, data collection and monitoring for the direct-care workforce is still a relatively underdeveloped policy area for most states. Despite the greater number of states collecting data on their long-term care workforce, few of these efforts are comprehensive in their approach, either by taking a coordinated approach across settings or by tracking a comprehensive set of indicators within one major setting, such as nursing facilities.

Table 9 shows the types of workforce data collected by the fourteen states that provided details on the workforce information they gather. As the table indicates, data collection and workforce monitoring activities of these states are by no means comprehensive. Only one state reported collecting data on all six indicators identified in the survey, but not across all settings. Two additional states reported collecting data on at least four indicators, but not across all settings. Most states collected data on up to three indicators in one or two settings. Nursing facilities are where the bulk of states focus their data collection efforts, followed by ICF/MR settings.

In addition to the fifteen states shown in Table 9, three states—Georgia, Ohio and Utah—report that they have data and workforce monitoring plans under consideration or development.

Table 9:

States Reporting Collecting Workforce Indicators

States	Workforce Indicators						Settings
	No. of workers	Wages	Health insurance	Hours worked	Turnover/ vacancy/ retention	Injury rate	
AL	X	X	X				NF, HC, PC and state level
AZ	X						PC
CA	X	X			X		NF, ICF/MR
IN		X		X			NF, ICF/ MR
KS	X	X		X	X		NF
ME	X	x					NF
MN					X		NF
MT	X	X	X	X	X	X	Multiple-NF, ICF/MR, AL, PC, CD, not all indicators for all settings
NC					X		NF , HC, AL
NH	X	X		X			Multiple- NF, ICF/MR, HC, AD, AL, PC, not all indicators for all settings
OK		X			X		Multiple -NF, ICF/MR, HC, AD, AL, PC
TX	X	X		X	X		Multiple-NF, ICF/MR, HC, AD, AL, PC, not all indicators for all settings
VA		X		X			NF
WA	X	X	X		X		PC, CD, AL[10]

Legend: ICF/MR (intermediate care facility for the mentally retarded), NF (nursing facility), HC (home care), AD (adult day care), AL (assisted living/other residential facility), PC (personal care services), CD (consumer-directed programs).

Through the CMS-funded National Direct Service Workforce Resource Center (DSW-RC), a national consortium of experts on long-term care workforce issues recently issued a set of recommendations on state workforce monitoring and data collection for direct-care workers.[11] The report recommends that states collect a standard minimum data set on their direct-care workforce across long-term care settings that includes three basic elements: (i) numbers of direct service workers (full time and part time); (ii) stability of workforce (turnover and vacancies); and (iii) average compensation of workers (wages and benefits).

Conclusion: What's New in 2007?

The *2007 National Survey of State Initiatives on the Direct-Care Workforce* follows five previous surveys of its kind. Expanding upon information collected from states in prior surveys, the 2007 survey reveals rich information concerning state workforce policy development for direct-care workers in eldercare and disability services. Four developments in particular stand out:

- Deterioration in the stability of state-level direct-care workforce compared with 2005
- Growing numbers of state initiatives to improve wages and benefits for direct-care workers
- Expanded interest in efforts to improve state-level training systems for direct-care workers
- Increasing state interest in collecting and monitoring workforce data for use in more effective policy making

▶ Deterioration in the stability of state-level direct-care workforces compared with 2005

In 1999, 88 percent of the 42 states responding deemed the issue of direct-care vacancies and/or turnover "serious" (includes states indicating "very serious" or "serious" issue). In each subsequent survey (until 2007), the percentage of states reporting serious shortages dropped, reaching a low of 76 percent in 2005. The 2007 survey is the first since 1999 that the percentage has increased over the prior survey; and, in fact, at 97 percent the percentage exceeds the previous high of 88 percent reported in 1999.

The nation's low unemployment rate in 2007 was a likely factor contributing to the high percentage of states indicating turnover and/or vacancies as serious or very serious. But even in times of high unemployment, we can expect that the demand for direct-care workers will outpace supply, unless states take seriously the need to improve wages and benefits, training, and career pathways.

The most recent national occupational growth projections covering the decade 2006 to 2016 show that because of our rapidly aging population, more direct-care workers will be needed for our future economy than almost any other occupation. Direct-care jobs are expected to grow at three times the rate of the nation's overall growth in employment (34 percent growth for direct-care jobs compared with 10.4 percent for all occupations). Two direct-care occupations—Personal and Home Care Aides and Home Health Aides—are expected to be the second and third fastest-growing occupations in the country over the next decade, and are on the list of the top ten occupations projected to register the largest numeric job growth across the entire economy.

▶ Growing numbers of state initiatives to improve wages and benefits for direct-care workers

Across the country, direct-care wages lag far behind median wages for all occupations. In fact, for the direct-care jobs in greatest demand—those in home and community-based settings—wages often fall below 200 percent of the federal poverty level. The 200 percent poverty level is low enough to qualify households for many state and federal assistance programs. Nearly two-thirds of states (32) report average wages for Personal and Home

Care Aides below the 200 percent level; and in nearly 40 percent of states (19), average wages for Home Health Aides are below this level. States have a number of policy tools at their disposal for improving the competitiveness of direct-care compensation.

Wage pass-throughs remain the most widely used tool for addressing the generally low level of direct-care worker wages and benefits, although evidence concerning their effectiveness is minimal, with much depending on the size of the pass-through and the ability of the state to implement effective monitoring and accountability. Only about half of the states reporting wage pass-throughs for at least one setting indicate that the pass-through is in any way monitored.

Although the most common wage pass-throughs usually affect only one sector of the workforce, three states—Louisiana, Montana, and Washington—were unique in implementing increases across multiple settings.

Since 2005, several states have turned to other policy tools in order to improve direct-care worker compensation. Several states have implemented a **"wage floor" for direct-care workers** working in publicly funded care settings or programs.

Other states have implemented **enhanced rates for providers achieving various programmatic or other goals**, such as increased staff retention, lower turnover, greater continuity of care, and broader health care coverage for workers. Since 2005, five new states have indicated that they tie increased payment rates to outcomes. Rate enhancements in three states were legislated, while in two others they were the result of departmental authority actions. Of the five new states, two rate enhancements apply to nursing homes, two to home-based care, and one for programs for individuals with intellectual and developmental disabilities.

Another significant development in state efforts to improve wages and benefits is the **creation of public authorities** that serve as the employer of record for independent providers providing personal care services. Since 2005, a new authority has been created in Massachusetts, joining other authorities in California, Oregon, Washington, and Michigan. These authorities typically allow for collective bargaining regarding wages and benefits for these direct-care workers. PHI estimates that over 400,000 personal care workers across the United States are now covered through public authority arrangements that help them advocate for improved compensation, training, and other supports.

▶ Expanded interest in improving state-level training systems for direct-care workers

While new training initiatives have been reported by states in each of the previous surveys, the 2007 survey shows increasing interest on the part of states in a variety of initiatives to improve state training systems, strengthen requirements for direct-care workers, and support opportunities for career ladders and lattices.

Some states have expanded beyond the federal minimum requirements for certified nursing home and home health agency staff. Others have instituted training requirements for workers not covered by federal OBRA requirements (e.g., personal care assistants, home care aides, assisted living aides). Still others have implemented training for workers in consumer-directed programs, or are considering such training. Finally, Pennsylvania and Iowa are considering standard or common training for all direct-care workers regardless of setting, an approach that requires identifying core competencies applicable across settings and programs. Streamlining common core training requirements has the potential to

improve job mobility opportunities for direct-care workers and to create full-time work for workers who, as a result, have expanded opportunities for cross-setting employment.

Other training-related efforts include investing in efforts to enhance supervisory training, including training for consumers who direct their own care.

The emphasis on improved training suggests that states are recognizing several trends in eldercare and disability services. Of particular concern is rebalancing state expenditures toward home and community care. If consumers with greater care and support needs are to remain at home, then there is a need for better training for home-based workers—training that provides workers with the skills and competencies they need to deliver person-centered care without the benefit of on-site supervision or support. In addition, continuity of care is essential to quality; dead-end jobs, without career advancement opportunities, lead many workers to leave direct care in search for a more fulfilling career path. Finally, many states are aware that their training infrastructure is underfunded and fractured, lacking the capacity to train the large numbers of direct-care workers that will be needed over the next decade.

▶ Increasing state interest in collecting and monitoring workforce data for use in policy making

Data are essential to effectively build a business case to garner support for new public policy direct-care initiatives, calculate costs for certain initiatives, and sustain or increase support for existing initiatives, including efforts by an increasing number of states that tie outcomes to reimbursement. The 2007 survey shows that more states are routinely collecting/tracking data on at least one vital sign in one or more settings relevant to the direct-care workforce.

While these developments are notable, there is still considerable work to be done at the state level to expand regular data collection on the direct-care workforce. Very few states show a comprehensive approach toward data collection either in the type of information they are collecting or in the range of long-term care settings they cover. Almost none currently collect the minimum set of data required to inform policymakers and other stakeholders about workforce participation, workforce stability, and workforce compensation. According to the National Direct Service Workforce Resource Center, these three data elements are recommend as a set of minimum data measures that states need to track to make informed decisions about the magnitude of their workforce issues, design appropriate policy responses, and assess the impact of their policies.[12]

The *2007 National Survey of State Initiatives on the Direct-Care Workforce* shows that states are taking seriously the need to strengthen and stabilize their direct-care workforces in order to meet the needs of their aging populations and people with disabilities who rightly expect that, ten years after the passage of the Americans with Disabilities Act, adequate supports should be available for community living. Nonetheless, the survey, along with our additional research on occupational projections and wage trends, suggests that states have not fully addressed some key challenges. Wages remain low, training requirements inadequate, and data collection insufficient. With demand for direct-care workers growing for the foreseeable future—and given that states have primary responsibility for providing the resources for wages and training for this workforce—states will need to move quickly to avoid a serious caregiving crisis.

Endnotes

1 PHI (April 2008) *Occupational Projections for Direct-Care Workers, 2006-16*, PHI Facts No. 1, Bronx, NY: PHI. Available at: **http://www.directcareclearinghouse.org/download/BLSfactSheet4-10-08.pdf**

2 PHI (January 2009) *Who Are Direct-Care Workers?* PHI Facts No. 3, Bronx, NY: PHI. Available at: **http://www.directcareclearinghouse.org/download/NCDCW%20Fact%20Sheet-1.pdf**

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4 PHI (July 2008) *State Chart Book on Wages for Personal & Home Care Aides, 1999-2006*, Bronx, NY: PHI. Available at: **http://www.directcareclearinghouse.org/download/PHI_State_Chartbook_PHCA_Wages_99-06.pdf**

5 Statistics are based on PHI analysis of the U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic (ASEC) Supplement.

6 Office of Long Term Living, Bureau of Home and Community Based Services Directive, Commonwealth of Pennsylvania, Directive 2007-HCBS-003, August 7, 2007. Subject: Three Percent COLA.

7 See Washington State 59th Legislature, 2006 Regular Session, Substitute House Bill 2333. Available at: **http://www.leg.wa.gov/pub/billinfo/2005-06/Pdf/Bills/House%20Passed%20Legislature/2333-S.PL.pdf**

8 Federal regulations (42 CFR 483.152) require that a state-approved nurse aide training program must consist of a minimum of 75 hours of training, which includes at least 16 hours of supervised practical or clinical training under the direct supervision of a registered nurse (RN) or licensed practical nurse (LPN) and prior to direct contact with a resident or patient. Federal regulations also require that both CNAs and home health aides receive a minimum of 12 hours of in-service training during each 12-month period they are employed.

9 Institute on Medicine (2008) *Retooling for an Aging American: Building the Health Care Workforce*, Washington, DC: The National Academies Press, pp. 218-220.

10 **http://www.governor.wa.gov/ltctf/workgroup/20070926/NASDDSA_Revised_09_21_07.pdf**

11 S. Edelstein and D. Seavey (February 2009) *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection*, Report prepared for the National Direct Service Workforce Resource Center. Available at: **http://www.dswresourcecenter.org/tiki-download_file.php?fileId=13**

12 The Center's detailed descriptions of workforce indicators can be found in: Steve Edelstein and Dorie Seavey (February 2009) *The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection*, Report Prepared for the National Direct Service Workforce Resource Center. Available at: **http://www.dswresourcecenter.org/tiki-download_file.php?fileId=13**

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