

Joined in Our Calling:
**People Who Serve,
People Who Care**



A Direct Care Workforce Shortage Resources Report
December 2003

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Foreword

Those who provide hands on care for young children, people of advanced age and infirmity, and people with developmental disabilities become, in a sense, the hands of God. Bathing and feeding serve as metaphors for ways in which our Creator sustains us, and as we assist those who are unable to do these things for themselves, we use God's gifts to us to serve others.

Direct care workers in the health and human services industry are critical to that industry's web of interdependent relationships. They often perform difficult physical tasks with people who depend on them for assistance to make their circumstances livable. This work can be thankless and exhausting. It is work that often requires odd shifts, weekend work and extreme patience. Furthermore, these hands-on caregivers are usually employed through state government reimbursements which set salary levels that are often at—or slightly above – the minimum wage.

Sadly, direct care workers lose heart when they experience the low priority that our society assigns to their important service. Even though many develop personal bonds with those for whom they care, they often cannot support their own families by continuing to do this type of work. Turnover rates are high as they subsequently seek employment in less demanding environments.

Lutheran social ministry organizations serve children, elderly and persons with developmental disabilities. These services are financed by reimbursements from federal, state and local governmental agencies. Despite constant efforts to ensure high quality care for these vulnerable populations, Lutheran social ministry organizations struggle daily to recruit, train, and retain direct care workers, without whose hands and hearts such care would be impossible.

Because those who serve and those who are served merit better than our current situation provides, the Evangelical Lutheran Church in America's Division for Church in Society (ELCA-DCS) provided a research grant to Lutheran Services in America (LSA). It was in partial fulfillment of a DCS goal to deepen and expand the ELCA's efforts to eliminate poverty. LSA, in turn, conducted research and produced this document intended for use by several distinct groups.

- Lutheran social ministry organization staff who manage and boards that govern Lutheran social ministry organizations will find information about initiatives for training and retaining their direct care workforce, nationally and state-by-state.
- Congregation members, seeking to link with others in their advocacy initiatives for children, the elderly and people with developmental disabilities can find a wealth of information to help them speak out for fair, just wages for direct caregivers.

Joined in Our Calling invites broad advocacy participation and sketches out initiatives and experiments underway in many places. It also points to programs and benefits that may provide short run improvements. A shift in public policy could provide encouragement for people to consider direct care giving as a fulfilling career option. Together, we believe that we can work to overcome the shortage of direct care workers by addressing the issues of just wages, benefits and working conditions in care-giving agencies.

Note: Information specific to **Nursing-Home** aides, **Home-Care** aides, and **Child Care** aides is highlighted by displaying those phrases in bold in the text.

I. Introduction

Lutheran health and human service ministries employ direct-care aides in at least three job settings, with three corresponding job titles:

- In nursing homes, the general title is *Nursing-Home Aides*. Those with this title perform different work than Certified Nursing Assistants (CNAs), who must pass a medical course.
- In private homes and other community-based settings which serve elderly and people with disabilities, the typical title is *Direct Support Professional, Home-Care Aides* or personal-care attendants. These aides lack the medical skills required for staff of Medicare-certified Home Health Agencies.
- In daycare and foster care facilities, the title is *Child Care Aides*.

Generally, Aides are not licensed or credentialed; instead they receive on-the-job training which usually includes first aid and infection control but not other medical or professional skills. Aides receive relatively low wages, nationally averaging about \$8 per hour, and often lack health insurance and other benefits as well as job-advancement opportunities. The main, though not sole, cause of this situation is the shortage of funding for these jobs. Examples include inadequate Medicaid payment rates and the financial limitations of low-income parents needing childcare.

Because Aide positions are compensated at low rates, they often have high vacancy and turnover rates. Low compensation rates also make it difficult for Lutheran health and human service ministries to obtain the qualified staff required to help needy clients. Although recent high unemployment has reduced the aide shortage, this shortage will grow in the future because medical advances and the aging Baby Boom generation are rapidly increasing the number of people who need continuing assistance. The federal Department of Labor estimates that by 2010, an additional 600,000 full-time-equivalent aides will be needed to fill existing vacancies and respond to growing needs.

Direct support professionals, especially those in community-based settings which serve people with disabilities, are often credentialed and have formal training.

Long-term solutions to the aide shortage will require substantially increased governmental funding and reimbursement. While that seems unlikely in the near future, aide clients, providers, and aides themselves need help now.

This report has three purposes:

- The first is to summarize specific aide-workforce initiatives state-by-state because most initiatives operate at the state rather than national level.
- The second is to discuss considerations in implementing initiatives by state. Appendix 1 provides details on the many specific approaches that states use in their initiatives.
- The third is to identify currently-available materials designed to train and retain direct-care aides. Training materials and state initiatives often focus on only one or two job settings, reflecting each type of aide's specific job tasks and payment sources.

This report highlights in bold the particular types of settings to which the training programs and state initiatives apply. But because all aide jobs have similar aspects, activities focused on one aide type often have applicability to others.

Appendix 2 identifies current **national informational resources** and **federal legislative proposals**. Although virtually all current initiatives operate at the state or service-provider level, the information in this Appendix may be useful to social ministry organizations wishing to begin their own programs, apply to participate in state initiatives, or consider federal proposals that may affect long-term workforce planning.

Although this document was written in Fall 2003, the Evangelical Lutheran Church in America (ELCA) and Lutheran Services in America (LSA) plan to update it periodically. For additions or suggestions for those updates, please contact Lisa Carr, director of Public Policy for LSA at 202/626-7945 or by e-mail at lcarr@lutheranservices.org.

II. State Initiatives Designed to Address Recruitment, Training and Retention Issues

Definitions of State Initiatives Types

State initiatives, detailed in Appendix 1, are classed as:

Benefits Buy-in - refers to subsidized health insurance premiums/other subsidized benefits;

Focused Recruitment - means recruitment efforts focused on certain demographic groups or on expanding the labor pool by encouraging clients' relatives, friends or neighbors as to serve as aides;

Job Registries - include formal statewide registries, job fairs and other recruitment methods;

Recognition and Support initiatives - are those such as award programs and job mentoring;

Training - includes statewide training standardization, career ladders and scholarships;

Wage Adjustments - refers to Medicaid payment rate adjustments designed to increase aide wages or other compensation; and

Other Initiatives - refers to miscellaneous low-frequency initiatives not fitting into prior categories, and includes brief notes on potential but currently unused approaches.

State-specific information on each category is found in Appendix 1 below. The states with the most extensive initiatives are Massachusetts, Minnesota and Wisconsin; several states have no known initiatives.

Most initiatives apply to only one or two of the three major types of aides. Although such focused initiatives may well help the targeted sector (e.g. nursing homes), they may also exacerbate aide shortages in other sectors. Further, many initiatives are funded through special authorities (e.g. grants) and may therefore be in effect for limited periods or apply only to parts of a state or to aide services rendered to certain types of clients.

A. Benefits Buy-In

Approximately half of all direct-care aides lack employer-based health insurance because their employers do not offer it or employees cannot afford the premiums. Lack of insurance poses not only a financial risk to these aides but also may harm client care if sick, uninsured aides expose clients to communicable diseases or if their untreated illnesses cause them to lose work time and backup staff is unavailable.

Health insurance buy-in initiatives subsidize premiums for direct-care aides, who are allowed to enroll in state-sponsored plans such as Medicaid, the state employees' plan(s) or a special statewide providers' group-purchasing insurance plan. Although there are clear policy reasons to expand the number of aides with health insurance, in states where some aide providers already offer employer-paid health insurance, an equity question is raised if a buy-in applies only to aides working for providers that do not offer insurance. Also in this Benefits category are a

few initiatives that provide non-health benefits (e.g. commuting subsidies). Not included in this category are state efforts that, while not subsidizing health premiums, only advise aides about low-cost insurance plans that may be available.

The seven states using Benefits Buy-In initiatives are California, Michigan, Minnesota, New Jersey, New York, Pennsylvania and Wisconsin.

B. Focused Recruitment

This category includes recruitment either

- focusing on certain demographic groups, or
- expanding the labor pool by using clients' relatives, friends and neighbors as aides.

First, because 90 percent of aides are non-elderly women, it may be helpful to use women's organizations as recruitment vehicles. But during the next decade, projections are that the number of non-elderly women will be a stable population while the need for aides will grow by 600,000. At the same time, alternate job opportunities for women will expand. Thus, some initiatives have focused on other demographic groups such as recent immigrants, college students, and unemployed recipients of welfare and other governmental benefits.

Although certain aide-provider organizations have focused on recent immigrants or college students, no statewide initiatives have included those groups, perhaps due to certain potential disadvantages (e.g. immigration visa restrictions; immigrants' possible limited English fluency; student mobility), although generic training (e.g. English fluency) may be available under Training initiatives (see Training category below).

State initiatives in this category have targeted unemployed recipients of governmental programs, usually "welfare" (TANF) recipients, though sometimes including people with disabilities covered under the federal Ticket to Work and Work Incentives Improvement Act (TWWIA), the federal Workforce Investment Act (WIA) or similar state vocational programs. Paraprofessional Health Institute's (PHI) analysis of using welfare recipients as aides is available at http://www.paraprofessional.org/publications/WTW_An_Employer's_Dispatch_from_the_front.pdf.

The second type of initiative in this category – called "client-directed services" – expands the labor pool by encouraging clients' relatives, friends and neighbors to serve as aides, pursuant to state and federal (HHS/CMS) approval, and is used by approximately 25 states to allow certain Medicaid recipients with disabilities (or their parents/guardians) to receive financial vouchers in lieu of agency-provided community aide services, and to use this funding to hire a person of their choosing, who becomes a self-employed aide.

Because some aides chosen under these plans are family members, neighbors or friends, drawing from this non-traditional labor pool will reduce the shortage of agency-employed aides, thus helping ease the shortage of aides for clients unable or unwilling to use this voucher approach. (Some states use other names - such as "self-directed services" or "cash and counseling" – to describe this approach, and use non-Medicaid funds to operate them; the federal Department of Veterans Affairs has a similar program for eligible veterans.)

Although some aide-provider agencies perform administrative functions for these aides (e.g. payroll distribution and income/payroll tax collection), their use raises several policy concerns. For example, in New Jersey, legislation has been introduced by the Senate Co-

President and the Speaker of the Assembly to replace all traditional aide-service providers with four regional “Quality Home Care Councils” which would oversee self-directed services for 15,000 Medicaid clients.

The 15 states using focused recruitment initiatives are California, Florida, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New York, Oregon, Pennsylvania, South Carolina, Texas, Wisconsin and Washington.

C. Job Registries

Traditional recruitment methods, such as newspaper ads, are relatively expensive and inefficient for recruiting aides. This is due to high turnover and to the bulk of potential aides being middle-aged women who may have only limited attachment to the formal labor force. Thus, statewide aide job registries and recruitment via methods such as job fairs sponsored by women’s social groups or multi-agency Internet job “pool” listings may be useful. As a condition of Medicaid funding, states currently must maintain registries for nursing (but not other types of) aides.

Nevertheless, in nursing aide registries, up to half of those listed are not actively seeking aide positions, either because they are now working in unrelated higher-wage jobs or because they are not currently seeking employment.

The two states using Job Registries (beyond those for nursing aides) and similar initiatives are Maryland and New Jersey.

D. Recognition and Support

These initiatives include award programs and job coaching/mentoring. Their purposes are to encourage aides to pursue excellence and to offer emotional as well as technical support for aides’ difficult job duties. They may also include general “training” on advanced topics. The greatest use of mentoring has been in the childcare sector, where the aides receiving mentoring are usually termed protégés. The mentors, who are either experienced aides or aide supervisors, may receive additional compensation for their coaching, and the protégés may receive additional compensation or career-ladder opportunities.

Although applicable to all types of aides, these initiatives seem particularly important for home-care aides because of the lack of peer interaction available in nursing facilities and childcare centers. Some aide providers have long used recognition and support initiatives, but statewide programs make these initiatives available to many more aides.

A more general type of recognition initiative is to “professionalize” aides’ job titles. For instance, some providers refer to home-care aides as “direct-support professionals” while some child care aides are called “child care teachers.” Although no state initiatives have tested the impact of such title changes, anecdotal evidence suggests that while such titles may help employee morale, they also may be confusing to the public.

The four states using Recognition and Support initiatives are Iowa, Missouri, Pennsylvania and Wisconsin.

E. Training, Including Standardization, Career Ladders and Scholarships

In order to minimize injuries to their clients and themselves, meet the terms of their employers' Workers Compensation and liability insurance policies, and obtain third-party payments, aides require training on topics such as infection control, lifting techniques and paperwork completion. But because this training is usually not standardized, a trained aide who changes employers or job settings (e.g. nursing home to home care), or moves job locations from one state to another, is usually required to complete additional training. This training is often a costly, duplicative process that delays the aide from providing client care on the new job. This may be avoided when standardized training is provided.

Except in nursing homes, the direct-care job hierarchy traditionally has been "flat" (e.g. 10 or 20 "aides" with varying amounts of experience all report to one "aide supervisor"). So there have been few ways for aides to advance to jobs with higher compensation and more responsibility. Advancement also may be discouraged because it creates another aide vacancy.

Thus, the purpose of career ladder programs is to offer formal advancement paths. The two most frequent initiatives are training of nursing aides to become CNAs, and (in both nursing-home and some community-based settings) creation of specialized jobs such as "feeding aide" or "medication aide" where permitted by Medicaid rules and state Nursing Practice Acts. This category also includes formal apprenticeship programs for home-care and child-care aides under U.S. Department of Labor auspices. State scholarship programs usually apply either to training nursing aides to become CNAs (because the aides' employers may not be financially able to pay for such training) or to offering generic skills such as English fluency or high-school equivalency training (20 percent of all aides, and up to 50 percent of home-care aides, lack high school or GED certificates).

Another approach, training high school students for aide positions, is available in some school districts for "vocational" (non-college-preparatory) students but is not known to be used in any statewide initiative. Although this seems a rather obvious approach (at least where vocational classes are available), recent high-school graduates may not be sufficiently mature to perform aide functions, especially those of home-care aides.

The 19 states using Training initiatives are Georgia, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Texas, Virginia, Washington and Wisconsin.

F. Wage Adjustments

These are legal rules set by state programs (usually Medicaid) requiring employers of aides in nursing homes (general Intermediate Care Facilities/Intermediate Care Facilities for the Mentally Retarded) and-or home care programs to channel a certain amount (usually 100 percent) of a reimbursement rate increase directly into aides' compensation (wages/benefits), and usually allow state audits to determine providers' compliance.

These payment increases, generally in the form of so-called "wage pass-throughs," are made by state legislatures on an ad hoc basis, rather than being automatically linked to inflation or average local wages. Funding may be specified either as a fixed hourly wage or as a lump sum per client-service-hour (or other factor). These may be used either to raise all aides' hourly wages or to focus on specific incentives such as subsidized health insurance premiums or to shift

differentials or one-time “retention” bonuses. States may either allow providers to choose whether to participate or mandate participation in such initiatives.

PHI’s analysis of wage pass-through initiatives (available for review on the paraprofessional website at <http://www.paraprofessional.org/publications/WorkforceStrategies1.pdf>) concludes that they appear somewhat effective in reducing turnover, but that factors such as low funding amounts and uncertainty about the long-term availability of funding impede their effectiveness. As an example, Illinois enacted a wage pass-through for Medicaid home-care aides in 1989 but, in spite of occasional payment increases, inflation-adjusted Medicaid aide payment rates are now lower than when the pass-through was enacted.

Apart from the adequacy of the total funding level, the most important factor in pass-throughs’ effectiveness appears to be the amount of flexibility allowed providers in distributing that funding. For instance, some providers have declined to participate in hourly wage pass-throughs because of associated uncompensated costs for increased payroll taxes and record keeping, while other providers have used flexible pass-through funding to increase compensation in ways other than an across-the-board hourly wage increase.

Other, more focused, types of wage adjustments include:

- Increased Medicaid payment rates (thus potentially raising aides’ compensation) for providers scoring relatively high on measures such as their clients’ average medical acuity (“case mix”) or client-reported satisfaction,
- Explicit shift differentials for evening/weekend work;
- Driving-time or mileage-allowance payments for community aides with substantial distances between clients;
- Uniform payment rate for home-care aides regardless of type of Medicaid coverage (home-care aides are paid under a variety of Medicaid legal authorities),
- Wage “parity” between home-care aides and similar jobs in state institutions for people with developmental disabilities, and
- Implementation or elimination of sub-state Medicaid aide payment rates. This last approach is intended to address intra-state payment equity (e.g. cost-of-living differences between urban and rural areas) but creates perceived losers as well as winners regardless of whether sub-state or statewide rates are set.

A final approach supported by some faith-based advocacy groups and labor unions is a “living wage” mandate set by local governments. It requires most or all employers that contract with local government to pay at least a specified hourly wage to every worker. While this may be helpful in some instances, this approach may have three drawbacks regarding aide jobs:

- Many aides’ wages are slightly higher than those set by these local laws;
- Even when aide jobs are subject to these laws, no additional funding is paid to their employers, forcing affected non-profit providers to cut other essential activities;
- These laws do not apply to self-employed individuals, so that aides hired directly by clients under “client-directed” programs do not benefit.

Because these laws are imposed on a local basis, they are not tracked in this report.

The 29 states using Wage Initiatives are Arizona, California, Colorado, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Missouri,

Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Washington, Wisconsin and Wyoming.

G. Other Initiatives

This category, by way of encompassing low-frequency initiatives that do not fit into any other category, consists of:

1. Cost-subsidized background checks for aide job applicants,
2. Federal HHS “System Change Grants” that pursue a variety of generic initiatives for home-care aides that do not fit into other categories, and
3. Client-to-aide minimum staffing ratios.

Regarding this last approach, minimum staffing ratios are required for nursing homes’ professional and quasi-professional nursing personnel (RNs, LPNS, CNAs) but have been little used for aides, probably because they would increase Medicaid costs. But if aides are currently overworked and adequate additional funds were provided for increased staffing, aide retention should increase. Yet even if funds were available, setting appropriate ratios would be difficult for aides who serve clients with many different conditions or who must travel varying distances to reach multiple home-based clients.

Although no state is known currently to use initiatives involving technology (i.e. using machines or other non-human means to take the place of, or assist in, certain aide tasks), such initiatives appear to hold promise. For instance, handheld computers can reduce paperwork, while mechanical lifts to transfer clients to and from their beds can reduce aides’ lifting injuries. Such technologies thereby provide more (or safer) aide time for client care. Perhaps there are two reasons that no states have implemented such initiatives.

- First, Medicaid programs often do not cover medical equipment such as mechanical lifts, so states may be concerned about setting what they view as costly precedents, especially when a piece of equipment would be home-based and thus help only one client.
- Second, technology involving computers is not only relatively expensive, it also requires that aides be computer-literate. No state initiative is known to promote volunteerism, probably because volunteer aides pose challenges including limited reliability, relatively high training costs, and liability-coverage concerns.

Nevertheless, volunteers could supplement aides by performing adjunct duties (as with hospital auxiliaries and candy strippers). For instance, volunteers could perform housekeeping, cooking and shopping functions for home-based clients.

Finally, it is possible that clients who sued states based on legal theories such as lack of equal protection (e.g. home-care aide services being inferior to facility-based aide services, due to home-care aides’ lower wages) could lead to court decisions ordering Medicaid and other payment rate increases, thereby attracting and retaining more aides. But this process would be uncertain, lengthy and costly (absent pro bono legal counsel), and thus is not detailed here. For information on current topical litigation, see <http://www.hsri.org/docs/litigation062903.PDF>.

The seven states using Other Initiatives are Alaska, Georgia, Michigan, North Carolina, Oklahoma, Pennsylvania and Wisconsin.

III. Implementing Initiatives in Your State

The question for those who have multiple initiatives available in their state is “How does one choose the one that is best for our situation?”

Because recruitment and training for each new aide costs \$2,000-\$5,000, any initiative that reduces aide turnover is potentially cost-effective. However, most initiatives being undertaken in states today are still being evaluated for efficiency and effectiveness. Our limited data suggests that much of their success rate may be affected by such factors as local labor-markets. You may find yourself in the situation of discovering that while each initiative type might yield some benefit, each taken alone may have drawbacks. Furthermore, taking the approach that combining different initiatives could yield larger total benefits may be offset by being this procedure being financially less efficient than focusing on a single initiative.

Increased compensation (wage adjustments and health insurance) will probably yield the most substantial and immediate benefits. Though most aides are dedicated to their work, they face economic realities that may compel them to accept higher compensation in other fields when those jobs become available. Wage adjustments are known to have reduced annual turnover rates by as much as 10 percent in as little as one year. Compensation initiatives tend to be the most financially expensive. Though full scale funding for such initiatives may be unavailable, relatively small amounts of funding may be effective when applied to focused recruitment or recognition and support initiatives. For most initiatives, having your social ministry organization act in conjunction with other providers of services can be an efficient implementation approach.

If, on the other hand, you decide to pursue grant funding or other non-statewide funding sources, you will need to work with consultants or have in-house staff develop the plan. *Organizations such as Paraprofessional Healthcare Institute (www.paraprofessional.org) and WorkforceEngage (www.workforceengage.com) are among those who can provide consulting expertise on aide recruitment and retention.

For Further Information, contact Lisa Carr, director of Public Policy for Lutheran Services in America at 202/626-7945 or e-mail lcarr@lutheranservices.org.

*Note that the ELCA and LSA do not endorse any specific aide training or consulting service.

IV. Materials to Recruit, Train and Retain Direct-Care Aides

A. Printed Materials

1. Overviews of Aide Recruitment, Training and Retention

- *Recruiting Quality Health Care Para-professionals*, Paraprofessional Healthcare Institute (PHI), 26 pages, August 2000. Audience: **Nursing-Home and Home-Care Provider Human Resources and Training Directors**. Available at www.paraprofessional.org or single printed copy free from PHI; contact PHI for bulk order terms.
- *The Cooperative Home Care Associates: A Case Study of a Sectoral Employment Development Approach*, Aspen Institute, 86 pages, February 2002. Audience: **Nursing-Home and Home-Care** Provider Chief Executives, Human Resources Directors, and Training Directors. Available at www.paraprofessional.org or single printed copy free from PHI; contact PHI for bulk order terms.
- *Living Our Promises, Acting on Faith: Successful Practices for Nursing Facilities*. Catholic Health Association, 36 pages, 2002. Audience: **Nursing-Home** Provider Human Resources and Training Directors. Available through <http://www.chausa.org>
- *Taking on Turnover: An Action Guide for Child Care Center Teachers and Directors*. Center for Childcare Workforce, Undated. Audience: **Child Care** Provider Chief Executives, Human Resources Directors, and Training Directors. Available for \$19.95 on the CCW website at http://www.ccw.org/tpp/pubs/bestsell.html#taking_on.
- *Creating Better Child Care Jobs: Model Work Standards for Teaching Staff in Center-Based Child Care*. Center for Childcare Workforce, 2003. Audience: **Child Care** Provider Chief Executives, Human Resources Directors, and Training Directors. Available when published at http://www.ccw.org/tpp/pubs/bestsell.html#taking_on

2. Recruitment

- *Finding and Keeping Direct Care Staff*. PHI & Catholic Health Association, 54 pages, 2003. Audience: **Nursing-Home and Home-Care** Provider Human Resources Directors, Aide Supervisors and Provider Training Directors. Available at www.paraprofessional.org or single printed copy free from PHI; contact PHI for bulk order terms. Note: this publication is similar to the PHI/Catholic Health Association's Finding and Keeping Direct Care Staff: Employer of Choice Strategy Guide for Catholic-Sponsored Long-Term Care and Home Care Providers.

- *Recruiting Quality Health Care Para-professionals.* PHI, 26 pages, August 2000. Audience: **Nursing-Home and Home-Care** Provider Human Resources Directors. Available at www.paraprofessional.org or single printed copy free from PHI; contact PHI for bulk order terms.
- *Removing the Revolving Door: Strategies to Address Recruitment and Retention Challenges.* Institute on Community Integration, 2001. Audience: **Nursing-Home and Home-Care** Provider Human Resources Directors (for use with supervisors). Available - \$65.00 for a package which includes Facilitator Guide and Learner Guide, from the Institute on Community Integration. <http://ici.umn.edu/products/curricula.html#para>.
- *The Power of Diversity: Supporting the Immigrant Workforce.* Institute on Community Integration, 2001. Audience: **Nursing-Home, Home-Care and Child Care** Provider Human Resources Directors (for use with supervisors). Available - \$68.00 for a package which includes the Facilitator Guide and Learner Guide from the Institute on Community Integration, <http://ici.umn.edu/products/curricula.html#para>.
- *The Right People for the Job: Recruiting Direct-Care Workers for Home- and Community-Based Care.* PHI & MEDSTAT, 8 pages, Fall 2002. Audience: **Home-Care** Provider Human Resources Directors. Available at www.paraprofessional.org or single printed copy free from PHI; contact PHI for bulk order terms.

3. Training

- *Nurse Aide Training.* Department of Health and Human Services, Office of Inspector General, November 2002. Audience: **Nursing-Home** Provider Chief Executives and Training Directors. Available at <http://oig.hhs.gov/oei/reports/oei-05-01-00030.pdf>.
- *U.S. Department of Health and Human Services.* August 2002 Audience: **Nursing-Home** Provider Chief Executives and Training Directors. Available at Direct Care Clearing House http://www.directcareclearinghouse.org/download/OIGrpt_state_CNA_training_prgms.pdf.
- *Working for Quality Child Care: Good Child Care Jobs = Good Care for Children.* Center for the Childcare Workforce, Undated. Audience: **Child Care** Direct-Care and Training Staff, Especially Aide Supervisors. Available - \$19.95 on the CCW website at http://www.ccw.org/tpp/pubs/bestsell.html#taking_on.
- *A Guide To Creating An Employer-Based Home Health Aide Training Program.* PHI, 2001 Audience: **Home-Care** Aide Supervisors and Provider Training Directors. Available at www.paraprofessional.org or single printed copy free from PHI; contact PHI for bulk order terms.
- *Community Support Skill Standards: Tools for Managing Change and Achieving Outcomes.* Human Services Research Institute (HSRI), 1996. Audience: **Home-Care Aides for Clients with Developmental Disabilities.** Available from HSRI, 2336 Massachusetts Avenue, Cambridge, Massachusetts 02140; 617-876-0426; <http://www.hsri.org>. (for a description, see <http://www.nadsp.org/training/csss.html>).

- *Supporting Students with Disabilities in Inclusive Schools: A Curriculum for Job-Embedded Paraprofessional Development.* Institute on Community Integration, 2002. Audience: Trainers of **Child Care Aides** for Children with Disabilities. Available - \$35.00 from the Institute on Community Integration, <http://ici.umn.edu/products/curricula.html#para>.
- *Strategies for Paraprofessionals Who Support Individuals with Disabilities (6 Modules).* Institute on Community Integration, 1999. Audience: **Home-Care Aides for Clients with Disabilities.** Available for between \$15 and \$25 (each module) for the teacher's edition and between \$10 and \$15 for the student edition from the Institute on Community Integration, <http://ici.umn.edu/products/curricula.html#para>

4. **Retention: Recognition and Support Initiatives**

- *Workforce Strategies 2: Introducing Peer Mentoring in Long-Term Care Settings.* PHI, 8 pages, May 2003. Audience: **Nursing-Home and Home-Care Aide Supervisors and Provider Training Directors.** Available at www.paraprofessional.org or single printed copy free from PHI; contact PHI for bulk order terms.
- *Creating a Culture of Retention: A Coaching Approach to Paraprofessional Supervision.* PHI, 22 pages, 2001. Audience: **Nursing-Home and Home-Care Aide Supervisors and Provider Training Directors.** Available at www.paraprofessional.org or single printed copy free from PHI; contact PHI for bulk order terms.
- *The Peer Empowerment Program (PEP): A Complete Toolkit for Planning and Implementing Mentoring Programs Within Community-Based Human Services Organizations.* Institute on Community Integration, 2001. Audience: **Home-Care Provider Training Directors (for use with aides and supervisors).** Available for a cost of \$37.00 (for a package which includes Program Coordinator Guide, Facilitator Guide, and Learner Guide) from the Institute on Community Integration. <http://ici.umn.edu/products/curricula.html#para>.

B. Audio-Video Materials

- *Bethesda Lutheran Homes and Services* offers an extensive list of professionally-produced VHS **Home-Care** aide-training videotapes with particular reference to clients with developmental disabilities. Please visit the website, <http://www.blhs.org/resources/developStaff/catalog/>, for a current catalog with prices and ordering information. Among the tapes of interest is a 10-tape VHS set on Daily Living Skills including topics such as Bathing, Oral Hygiene, and Documentation (\$400 for the set or \$45 each).
- *The Institute on Community Integration* offers a 30-minute VHS videotape, *Helping Hand: An Introductory Video to a Career in Direct Service*, for \$30 (to place an order, go to <http://ici.umn.edu/products/curricula.html#para>). It is focused on Home-Care aides but may be useful in other settings.
- *Mosaic (formerly Bethphage and Martin Luther Homes - not the ELCA video magazine)* offers a free 13-minute introductory **Nursing-Home and Home-Care** aide

Internet video, available at <http://www.bethphage.org/video/HR/index.html> (requires Windows Media Player).

- *The Iowa Caregivers Association*, a group of clients, aide providers, and paid and family-member aides, offers a 10-minute \$60 VHS video, *A Career in Caring*, to show prospective **Nursing-Home and Home-Care** aides what these jobs involve. For more information, see <http://www.iowacaregivers.org/video.html>.

C. On-Site Training

Several organizations offer fee-based “in service” training at providers’ offices or other locations across the country. Bethesda’s training includes basic **Home-Care** aide skills and are offered for a base price of \$1,200 plus the speaker’s travel expenses. Most other organizations either focus on advanced topics or concern aides’ supervisors or human resources directors. Organizations offering such training include *Child Care Resource Center*; call 617-547-1063 for more information or visit the website at <http://www.blhs.org/resources/developStaff/workshops/default.asp>.

D. Internet-Based Training

The College of Direct Support, operated by the University of Minnesota and other partners, offers many Internet-based aide courses at 6th-to-8th grade reading levels, with a focus on **Home-Care aides for clients with developmental disabilities**. Fees are based on the number of site users and courses selected, so the courses are generally accessed through aides’ employers. (See <http://www.collegeofdirectsupport.com/courses.htm> for a course list.)

APPENDIX 1: Current State-Specific Initiatives in States Served by Lutheran Social Ministries

Known involvement by Lutheran social ministries is mentioned below. It is difficult to determine the extent to which these organizations are participating in their state-based initiatives, and it does appear that such participation is limited.

Alabama

- No initiatives

Alaska

- *Other* (generic systems change grant for **Home-Care** aides).

Arizona

- *Wage Adjustment* (pass-through for **Nursing-Home** aides and **Home-Care** aides).

California

- *Benefits Buy-in* (low-premium health insurance to **Home-Care** aides, who are paid under the county-based Title XX Social Services Block Grant funding, known as the In Home Support Services program (IHSS), rather than through Medicaid; *Focused Recruitment* (client-directed **Home-Care** aides via IHSS; *Training* (**Nursing-Home** aide-to-CNA upgrades; stipends for **Child Care** aides who successfully complete certain training courses); *Wage Adjustment* (pass-through for **Nursing-Home** aides; wage adjustment for **Child Care** aides).

Colorado

- *Wage Adjustment* (pass-through for **Home-Care** aides; **Nursing-Home** aide retention bonuses).

Delaware

- No initiatives

District of Columbia

- No known initiatives (District did not report on surveys).

Florida

- *Focused Recruitment* (client-directed **Home-Care** aides); *Wage Adjustment* (pass-through for wages/benefits for **Nursing-Home** aides).

Georgia

- *Training* (career ladder for **Nursing-Home** aides); *Wage Adjustment* (nursing-home case-mix rate adjustment); *Other* (federal HHS systems change workforce-development grant for moving nursing-home clients in 18 counties to community settings; may expand **Home-Care** aide supply).

Idaho

- *Wage Adjustment* (uniform payment rate for **Home-Care** aides regardless of type of Medicaid coverage).

Illinois

- *Wage Adjustment* (pass-through for **Home-Care** aides); Bethesda offers aide Training to local providers of **Home-Care** aide services (for details, see <http://www.blhs.org/resources/developStaff/workshops/default.asp>).

Indiana

- No initiatives

Iowa

- *Recognition and Support* (**Nursing-Home** aide quality of life project); *Wage Adjustment* (payment bonuses for low **Nursing-Home** aide turnover and high nursing-home client satisfaction).

Kansas

- *Wage Adjustment* (pass-through for **Nursing-Home** and **Home-Care** aides authorized but currently unfunded).

Kentucky

- *Training* (standardized training for **Home-Care** aides via Internet).

Maryland

- *Job Registries* (federal HHS systems change grant for job fairs to recruit **Home-Care** aides); *Training* (federal HHS systems change grant for free CPR/first aid training for **Home-Care** aides); *Wage Adjustment* (pass-through for nursing aides; wage parity for **Home-Care** aides with state institutional aides); *Other* (federal HHS systems change grant for subsidized criminal background checks for prospective **Home-Care** aides).

Massachusetts

- *Focused Recruitment* (welfare recipients for **Nursing-Home** and **Home-Care** aides); *Training* (CNA training scholarships and other career-ladder initiatives for **Nursing-Home** aides; funds for **Nursing-Home** aide supervisors' expanded training; high-school equivalency and English fluency scholarships for **Nursing-Home** aides – a report on the success of these projects may be ordered by visiting the Direct Care Clearing House website at www.directcareclearinghouse.org/r_art_det.jsp?res_id=53910); *Wage Adjustment* (pass-through for **Nursing-Home** and **Home-Care** aides; uniform payment rate for **Home-Care** aides regardless of type of Medicaid coverage; increased reimbursement rates for **Child Care** aides). A state needs-assessment analysis by PHI is available at <http://www.paraprofessional.org/Sections/Publications.htm>.

Michigan

- *Benefits Buy-in* (state encouragement of **Nursing-Home** and **Home-Care** provider health insurance group-purchasing cooperatives to reduce employee costs; special HMO-style program for low-wage workers including **Child Care** aides); *Focused Recruitment* (client-

directed **Home-Care** aides); *Training* (career-ladder development and additional training for **Nursing-Home** aides; also, Lutheran Social Services of Michigan partnered with others to obtain a \$24,336 state **Nursing-Home** aide recruitment grant; two nursing homes also recently received Workforce Investment Act funding to upgrade staff skills); *Wage Adjustment* (pass-through for **Nursing-Home** aides); *Other* (identification of untapped funding for uniforms, transportation and family childcare for **Nursing-Home** aides). (A 2003 needs study is available by visiting the Direct Care Clearing House website at www.directcareclearinghouse.org/download/MI%20Care%20Gap%20Publicn.pdf and a state needs-assessment analysis by PHI is available at <http://www.paraprofessional.org/Sections/Publications.htm>.)

Minnesota

- *Benefits Buy-in* (enrollment of **Nursing-Home**, **Home-Care** and **Child Care** aides who are low-income parents, and of their children and spouses, in the State Children's Health Insurance Program); *Focused Recruitment* (client-directed **Home-Care** aides); *Training* (feeding-assistant career ladder option for **Nursing-Home** aides; *CNA certification training*; training of potential aides who need assistance to obtain high-school equivalency and/or English fluency; Bethesda offers aide training to local providers of **Home-Care** aide services; for details, see <http://www.blhs.org/resources/developStaff/workshops/default.asp>); *Wage Adjustment* (pass-through for **Nursing-Home** aides); *Other* (job satisfaction enhancement projects funded through Bush Foundation and other sources). A state needs-assessment analysis by the University of Minnesota is available at <http://www1.umn.edu/coa/Peopling/Peopling%20Report%202001.pdf>.

Mississippi

- *Training* (career ladders for **Home-Care** aides).

Missouri

- *Recognition and Support* (recognition awards for **Nursing-Home** aides and other nursing-home staff); *Training* (**Home-Care** aide apprenticeship training program under auspices of U.S. Department of Labor); *Wage Adjustment* (pass-through for **Home-Care** aides; uniform payment rate for **Home-Care** aides regardless of type of Medicaid coverage).

Montana

- *Focused Recruitment* (welfare recipients for **Nursing-Home** and **Home-Care** aides); *Training* (specialty training for **Home-Care** aides); *Wage Adjustment* (pass-through for **Nursing-Home** and **Home-Care** aides; merit-pay awards for **Child Care** aides).

Nebraska

- No initiatives

Nevada

- *Focused Recruitment* (federal HHS systems change grant for adults with developmental disabilities to become **Home-Care** aides).

New Jersey

- *Benefits Buy-in* (low-premium enrollment of **Nursing-Home** and **Home-Care** aides in NJ Family Care health plans); *Focused Recruitment* (welfare recipients to become **Nursing-Home** and **Home-Care** aides; client-directed **Home-Care** aides - legislation has been introduced by the Senate Co-President and the Speaker of the Assembly to replace all traditional aide-service providers with four regional “Quality Home Care Councils” that would oversee self-directed services for 15,000 Medicaid clients; this is opposed by the state’s hospital, home-care provider and nurses’ associations); *Job Registries* (registry for **Home-Care** aides); *Training* (**Nursing-Home** aide career ladder for medication aide); *Wage Adjustment* (pass-through and shift-differential pay for **Home-Care** aides).

New Mexico

- *Training* (**Nursing-Home** aide training standardization); *Wage Adjustment* (pass-through for **Home-Care** aides).

New York

- *Benefits Buy-in* (funding to enhance benefits for **Home-Care** aides; New York City demonstration of COBRA continuation health coverage under Medicaid buy-in for **Nursing-Home** and **Home-Care** aides covered by the SEIU/Local 1199 National Benefit labor union fund); *Focused Recruitment* (welfare recipients); *Training* (funds to train **Nursing-Home** and **Home-Care** aides to meet requirements of their existing jobs e.g. English fluency); *Wage Adjustment* (Nassau County has a salary enhancement initiative for **Child Care** workers).

North Carolina

- *Training* (**Nursing-Home** aide career ladders to medication aide and to geriatric nursing aide; **Home-Care** aide career ladder to medication aide in adult care homes; standardized training for **Nursing-Home** aides; federal HHS systems change grant for developing career ladders for **Home-Care** aides); *Wage Adjustment* (increased payment rates for **Home-Care** aides working in adult care homes and for **Child Care** aides); *Other* (incentive programs for **Child Care** aides and **Nursing-Home** aides).

North Dakota

- *Training* (generic work to develop **Nursing-Home** and **Home-Care** aide career ladders); *Wage Adjustment* (pass-through for wages/benefits for **Nursing-Home** aides; applies to both Medicaid and self-pay payments).

Ohio

- No statewide initiatives; *Training* (Bethesda offers aide training to local providers of **Home-Care** aide services; for details, see <http://www.blhs.org/resources/developStaff/workshops/default.asp>).

Oklahoma

- *Wage Adjustment* (higher minimum wage for **Nursing-Home** aides); *Other* (**Nursing-Home** aide quality-of-life program).

Oregon

- *Focused Recruitment* (federal HHS systems change grant for increasing **Home-Care** aide recruitment); Training (medication administration functions available to qualified **Nursing-Home** and **Home-Care** aides); *Wage Adjustment* (pass-through for **Home-Care** aides).

Pennsylvania

- *Benefits Buy-in* (AAA Direct Care Worker **Nursing-Home** and **Home-Care** aide plan to fund transit, childcare, uniforms, etc.); *Focused Recruitment* (welfare recipients for **Nursing-Home** and **Home-Care** aides); *Recognition and Support* (state Recognition with monetary bonuses; quality-of-life demonstration programs for **Nursing-Home** and **Home-Care** aides); *Training* (tuition assistance for generic educational needs of **Nursing-Home** and **Home-Care** aides); *Wage Adjustment* (sign-on and longevity bonuses; shift differentials; bonuses for travel costs and for serving in underserved locales for **Nursing-Home** and **Home-Care** aides); *Other* (state funding for various workforce development projects for **Nursing-Home** and **Home-Care** aides). (A state needs-assessment analysis by PHI is available at <http://www.paraprofessional.org/Sections/Publications.htm>.)

South Carolina

- *Focused Recruitment* (client-directed **Home-Care** aides; welfare recipients for **Nursing-Home** and **Home-Care** aides); *Wage Adjustment* (pass-through wages for **Home-Care** aides; similar lump-sum funding for **Nursing-Home** aides may no longer be in effect).

South Dakota

- No known initiatives (state did not report on surveys).

Tennessee

- No known initiatives (state did not report on surveys).

Texas

- *Focused Recruitment* (client-directed **Home-Care** aides; welfare recipients for **Home-Care** aides; people with disabilities for **Home-Care** aides; under-employed persons such as older and non-English-speaking workers for **Home-Care** aides); *Training* (Bethesda offers aide training to local providers of **Home-Care** aide services; for more information and details, see <http://www.blhs.org/resources/developStaff/workshops/default.asp>); *Wage Adjustment* (pass-through for **Home-Care** aides, which may be spent for benefits, transit allowances, Workers' Compensation premiums, as well as wages).

Utah

- No initiatives

Virginia

- *Training* (increased minimum training level for **Nursing-Home** aides; training scholarships for persons agreeing to serve as **Nursing-Home** aides for minimum periods); *Wage Adjustment* (pass-through for **Nursing-Home** aides).

Washington

- *Focused Recruitment* (client-directed **Home-Care** aides; welfare recipients for **Home-Care** aides); *Training* (mandated training in dementia, mental illness and developmental disabilities for **Nursing-Home** aides and for **Home-Care** aides in adult family homes and boarding homes); *Wage Adjustment* (increased payment rates for **Nursing-Home** aides and for **Home-Care** aides in adult family homes and boarding homes; funds may be used for benefits as well as wages).

West Virginia

- no report

Wisconsin

- *Benefits Buy-in* (health insurance through state Badger Care plan for **Nursing-Home** and **Home-Care** aides); *Focused Recruitment* (welfare recipients for **Child Care** aides); *Recognition and Support* (several statewide awards and mentoring programs for **Nursing-Home**, **Home-Care** and **Child Care** aides); *Training* (training **Nursing-Home** and **Home-Care** aides as medication aides; increased basic training for **Nursing-Home** and **Home-Care** aides; Bethesda offers aide training to local providers of Home-Care aide services; for information and details, see <http://www.blhs.org/resources/developStaff/workshops/default.asp>); *Wage Adjustment* (pass-through for **Nursing-Home** and **Home-Care** aide; lump-sum funding for **Home-Care** aides; wage adjustment for **Child Care** in aides); *Other* (federal HHS systems change grant for hiring **Home-Care** aide workforce planner; state funding for Community Options Programs for 32 county-level projects involving **Home-Care** aide workforce development; summary available by visiting <http://www.dhfs.state.wi.us/aging/Genage/initiatives.pdf>. Also, The CCW publication, *Recruiting and Retaining Low-Income Child Care Workers in Wisconsin*, is available free at <http://www.ccw.org>.

Wyoming

- *Wage Adjustment* (pass-through for **Nursing-Home** aides and for **Home-Care** aides serving adults with disabilities or children with developmental disabilities in pre-school programs). State reports on the “dramatic” positive impact of the adjustment are available at to <http://ddd.state.wy.us/Documents/wagedoc.htm> and <http://ddd.state.wy.us/Documents/JAC1102.htm>.

APPENDIX 2: National Informational Resources and Federal Legislative Proposals

A. National informational Resources

Although the focus of this report is on actually implementing recruitment, training and retention initiatives, background information on the nature of the aide shortage may be useful in documenting the need for initiatives.

1. Nursing Home and Home Care Aide Shortage

- U.S. Department of Health and Human Services (HHS) and the U.S. Department of Labor (DoL), have provided a requested Report to Congress entitled “The Future Supply of Long Term Care Workers in Relation to the Aging Baby Boom Generation,” May 14, 2003 (see aspe.hhs.gov/daltcp/reports/ltcwork.pdf for a downloadable “printed” version or aspe.hhs.gov/daltcp/reports/ltcwork.htm for a text-only version). Among the recommendations of this important report is outreach to faith-based groups to obtain volunteers for family and respite caregivers, and the report includes statistics on both current and future aide needs by type of setting as well as state-initiative information.
- Twenty-four HHS reports on home-care aides are available at the following web address <http://aspe.os.dhhs.gov/daltcp/sitemap.shtml>, scrolling down to “Personal Assistance/Care Services” and clicking on that term. HHS also is involved in providing material for a similar site, www.hcbs.org. A related HHS information source is the Proceedings of a March 3-5, 2003, HHS/CMS conference (cosponsored by the National Association for State Health Policy) on community services for people with disabilities, is available for downloading at <http://www.nashp.org/CMSconference2003>.
- The North Carolina Department of Health and Human Services has published an excellent series of national surveys of state activities including “Results of the 2002 National Survey of State Initiatives on the Long-Term Care Direct Care Workforce” and a 2001 report on aide career ladder initiatives. You can visit their website at <http://facility-services.state.nc.us>.
- The Paraprofessional Healthcare Institute (PHI) is the leading topical “think tank,” providing both background information and some training materials (for PHI’s training materials, see the last section of this Report). PHI’s June 2003 publication, “Personal Assistance Services and Direct-Support Workforce: A Literature Review,” is particularly valuable for providers wishing to submit grant funding applications, and this publication also includes a list of potential allies (e.g. consumer organizations). PHI also has published need-assessments and case studies of aide shortages in California, Michigan, Massachusetts and Pennsylvania. A list of PHI’s publications, most of which are without charge, is available at <http://www.paraprofessional.org>. In addition, PHI operates a program for the

dissemination of information from other sources, the National Clearinghouse on the Direct Care Workforce and staffs the Direct Care Alliance an advocacy group representing consumers, providers, and aides. (For more information, visit <http://www.directcareclearinghouse.org> or <http://www.workforcealliance.org/>.) PHI also has been involved in preparing reports for other groups, such as the Citizens for Long Term Care's Long-Term Care Financing and the Long-Term Care Workforce Crisis: Causes and Solutions study issued in 2002.

- Several other “think tanks,” academic institutions, and national advocacy groups have published information and recommendations on specific aspects of the aide shortage, such as how the shortage is affecting the elderly and nursing homes. Of most interest among recent publications are those by the Institute for the Future of Aging Service (see website at <http://www.futureofaging.org/Publications.asp?area=3>), an organization funded by the American Association of Homes and Services for the Aging (AAHSA). This group's affiliate - Better Job, Better Care (BJBC, <http://www.bjbc.org/>) is a clearinghouse for aide workforce development grants from multiple sources including HHS/CMS. The Institute for the Future of Aging also has partnered with the Urban Institute to issue “Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis” (http://www.urban.org/UploadedPDF/Who_will_Care_for_Us.pdf). For clients with developmental disabilities, a good source is <http://www.hsri.org/>.

2. Child Care Aide Shortage

- Because child care aides serve a different population than nursing and home-care aides, national (and state) initiatives tend to focus specifically on them. The leading source of information on the child care aide shortage is an affiliate of the American Federation of Teachers, the Center for the Child Care Workforce (CCW, <http://www.ccw.org>). Among the Center's useful publications are “Then and Now: Changes in Child Care Staffing, 1994-2000” (available by visiting website at <http://www.ccw.org/tpp/pubs/then&now.html>) and a number of training manuals (see Training resources at end of this Report).
- The Child Welfare League of America (CWLA) also has published research on the childcare aide shortage (see <http://www.cwla.org/programs/r2p/rrnews0209.pdf> for summary of information; for an annotated bibliography, see <http://www.cwla.org/programs/r2p/bibliowf.pdf>). CWLA also administers a Freddie Mac Scholarship Program, which is designed to highlight and support the continued education of exceptional direct care workers from member agencies (for details, please visit <http://www.cwla.org/members/memscholarship.htm>).
- Although there is a general shortage of child care aides, it is even more acute for children with disabilities. Federal law guarantees appropriate assistance for such children in educational settings but not in day-care or after-school centers. Thus day care can be a “weak link” that impedes parents of these children from obtaining employment, and might even thwart the child's educational progress.

B. Federal Legislative Proposals

Note: For information on introduced bills noted below, go to <http://thomas.loc.gov>, type the bill number, e.g. H.R. 123, in the computer screen box marked “Bill Number” and press Enter.

- *“New Freedom” Initiative.*
 - In response to the Supreme Court’s Olmstead decision requiring that people with disabilities receive Home-Care aide and other community-based, rather than institutional services, whenever possible, President George W. Bush has proposed a federal government-wide “New Freedom” Initiative focused on people with disabilities (see <http://www.cms.hhs.gov/newfreedom>). Some of its proposals are being implemented through existing executive authority (see references to “Systems Change Grants” under “State Initiatives” above) but others require implementing legislation. The President’s most recent proposal, “Money Follows the Person,” would provide 100 percent federal funding for one year for Medicaid recipients that a state moves from institutional settings (e.g. nursing homes) to community-based settings, at a Fiscal 2004 cost of \$350 million and a 5-year total cost of \$1.75 billion. At the time this report was written, this proposal has not yet been introduced in legislative form.
- *Direct Support Professional Recognition Resolution.*
 - The Direct Support Professional Recognition Resolution, S. Con. Res. 21 and H. Con. Res. 94 would “express the sense of the Congress” that community living for people with MR/DD “is at serious risk because of the crisis in recruiting and retaining direct support professionals” such as Home-Care aides. Although passage of this resolution does not compel federal spending or other activity, it is the first time that Congress as a whole acknowledged the direct-care aide crisis.
- *Medicaid Community-Based Attendant Services and Supports Act (MiCASSA).*
 - This bill, S. 971 and H.R. 2032, is commonly known by its acronym, MiCASSA. It would change Medicaid law to guarantee certain recipients - those whose disabilities entitle them to a nursing-home level of care - access to Home-Care aide and other community-based services in lieu of nursing-home residence. Its supporters argue that it would increase the compensation—thus the supply—of home-care aides, as relevant recipients would not require Medicaid funds for food and lodging in nursing homes. Instead, such expenses would be paid by family members in their homes or by other programs such as HUD housing assistance. Arguably, that would leave more Medicaid funds available for aide services. This bill’s primary supporters are advocates for non-elderly adults with disabilities. Although it purportedly would reduce long-term Medicaid spending, it would increase such spending in the short term due to transition costs and thus has not been seriously considered for passage.
- *Aide Criminal Background Checks.*
 - Currently, there is no nationwide criminal background check system directly available to providers in order to screen prospective Nursing-Home, Home-Care or Child Care aides, and existing background check systems can be costly and

untimely to use. Among other provisions, the Senior Safety Protection Act, H.R. 208, would direct the Secretary of HHS and the Attorney General to establish a more efficient background check system that provides for more immediate determination of the criminal status of prospective long-term care staff. No short-term action on this bill is expected. Several other bills would, among many other provisions, facilitate a national criminal background check system but not provide subsidized funding for its use by aide services' providers.

- *Child Protection Workforce Services Act.*
 - The Child Protection Workforce Services Act, H.R. 2437 would provide grants to State child welfare systems (i.e. abuse, neglect and foster care agencies) to improve quality standards and outcomes, increase the federal portion of staff training funds paid to private child-welfare agencies, and authorize the forgiveness of loans made to certain students who become child welfare workers. Although this bill applies to workers serving only at-risk children rather than all Child Care aides, it could be a procedural model for workers serving other children as well. No action on this bill is expected in the near term.
- *Family Caregiver Initiatives.*
 - Although most federal and state initiatives attempt to increase the supply of Nursing-Home and Home-Care aides, reducing the shortage also could be addressed by reducing the demand for paid aides. Thus, if the situation of unpaid family caregivers were improved, the need for aides should decline. So the Family Caregiver Relief Act, S. 1214, would provide tax incentives for family caregivers. Similarly, the Lifespan Respite Care Act, S. 538/H.R.1083, which has passed the Senate, would authorize funding for family caregiver respite services, which would be awarded on a competitive basis to states, large cities within states, and statewide respite-care groups. Services eligible for payment include training of paid aides to provide respite-care services for clients with disabilities when the client's regular family caregiver takes a respite.
- *Medicaid and Aide Workforce Proposals Not Yet Introduced as Bills.*
 - A variety of proposals, discussed by federal policymakers and advocates, have not yet been introduced as Congressional bills. These include the Quality Care, Quality Jobs (QCQJ) proposal to authorize flexible state grants to increase the supply of Nursing-Home and Home-Care aides, which is supported by some faith-based and provider groups such as ANCOR, and Republican plans to provide states with greater flexibility in covering long-term care services, which might result in changes such as that envisioned by MiCASSA but also might result in substantial reductions in eligibility and benefits for Medicaid recipients needing aide services.

C. Discussion of National Initiatives

Although the aide shortage is a national problem, because regulation and reimbursement of aide services historically has been a state (or personal) responsibility, there is a dearth of federally-funded multi-state initiatives. Indeed, the “Boren Amendment,” a 1980 federal law requiring that state Medicaid payment rates cover costs “which must be incurred by efficiently and economically operated facilities” -- such as nursing homes’ costs to recruit and retain sufficient qualified **Nursing-Home** aides—was repealed in 1997 at state governments’ request because it had been used in lawsuits successfully compelling states to raise Medicaid payment rates. Likewise, virtually all current federal and private aide-workforce grants apply to specific states or to private entities for projects in individual states.

For-profit employers that provide aide services have access to certain tax incentives (e.g. Work Opportunity Tax Credits) if they hire people with certain characteristics, such as welfare recipients. Although tax advantages are not available to Lutheran health and human service providers, to the extent that for-profit aide providers use such incentives to draw from non-traditional labor pools, that may help non-profit providers recruit from traditional labor pools.

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8765 West Higgins Road
Chicago, Illinois 60631
Phone: (800)638-3522
www.elca.org/dcs/



700 Light Street
Baltimore, MD 21230
800-664-3848
www.lutheranservices.org