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Training TANF Recipients and Low-Income Populations for Long-Term Care Paraprofessional Jobs

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CONTENTS

TABLES

EXECUTIVE SUMMARY

Attracting and retaining paraprofessional employees—specifically, nurse aides and home health aides—to care for the elderly, disabled, and chronically ill is a growing concern to program administrators in the long-term care (LTC) industry and to policymakers in the health care arena generally. Broad demographic and economic factors combined with issues internal to the LTC industry (such as low wages, few benefits, and the physically and emotionally demanding nature of the work) are creating a shortage of paraprofessional workers that is expected to increase dramatically over the next several years as baby boomers begin to enter their sixties. At the same time, recipients of cash assistance from the Temporary Assistance for Needy Families (TANF) program are seeking opportunities to move from welfare to work within an environment marked by work requirements and time limits on receipt of aid. Welfare reform legislation in 1996 required states to engage a substantial proportion of their TANF caseloads in work or work-related activities for 30 hours per week, and recent proposals for reauthorization of the legislation would require states to engage an even larger share of their caseloads for 40 hours per week. To meet the new requirements, states will likely look for innovative strategies to help recipients find employment.

The LTC industry's need for workers and TANF recipients' need for jobs could be mutually beneficial if (1) the characteristics of TANF recipients are well-matched to the requirements of the paraprofessional jobs in demand; (2) available LTC jobs offer the hours and pay that TANF recipients need to move toward self-sufficiency; and (3) workforce development programs can create routes to the LTC industry that are accessible, attractive, and easily navigable for TANF recipients. An earlier report presented findings on the suitability of TANF recipients for employment in the LTC industry and the characteristics of LTC jobs based on analyses of survey data from three states and the District of Columbia. This report presents findings from a qualitative analysis of five programs that train TANF recipients and similar low-income populations for paraprofessional jobs in the LTC industry to assess the feasibility of and challenges embedded in such efforts. The programs included in the study are located in the District of Columbia; Tucson, Arizona; Dakota County, Minnesota; Bronx, New York; and Richmond, Virginia.

Most of the programs observed in the study provide participants with job readiness or life skills instruction in the classroom, some provide hands-on learning opportunities through a job shadow or work experience component, and all either provide directly or pay for nurse aide or home health aide training lasting between 3 and 13 weeks. While they had common goals, there were many differences in program structure. For instance, each of the five programs was operated by a different type of organization—a private for-profit organization; a hospital; a technical college; a worker-owned collaborative; and a housing authority. Some recruited TANF recipients directly and others indirectly. And, programs relied on a variety of funding sources to support activities including local TANF funds, grants from federal agencies such as the Department of Labor and the Department of Housing and Urban Development, contributions from private organizations involved in program efforts, and foundations. Despite these structural differences, the programs experienced some common challenges in implementing training and collectively offer a number of important lessons about the components of LTC training programs that could be important when targeting TANF recipients and other low-income individuals:

Implementation Challenges

- Training individuals with multiple barriers for LTC jobs is difficult; most programs have had to institute stringent selection criteria to achieve success.
- The "work-first" philosophy that is inherent in many TANF programs can impede program efforts.
- Few participants have taken advantage of the advanced training opportunities that programs offer.

Lessons Learned

- Successful linkages may be more likely when the training provider and employer are the same entity; at the very least, strong partnerships between training providers and employers are critical.
- A job shadowing or work experience component exposes program participants to the realities of paraprofessional LTC jobs and employers to a qualified pool of job candidates.
- Programs must be resourceful in identifying and accessing multiple funding streams.
- Linkages with the TANF system can provide funding for program participants as well as access to a host of supportive services.
- Retention must be a central component of program efforts.
- Dedicated staff who are fully committed to the program's mission ensure program stability and performance.

While the study findings offer important information about different ways in which LTC training programs may be structured, they are based on qualitative data and cannot answer questions about the effectiveness of programs on participant outcomes such as employment and retention, earnings, and self-efficacy or self-esteem. Before policy-makers and program administrators invest resources in wide scale efforts to link TANF with the LTC industry, it may be wise to first design, implement, and evaluate smaller-scale demonstration projects. Demonstration projects can provide evidence of the added value of individual program components, answer questions about overall program effectiveness, and help policy-makers and administrators design the most optimal programs in the most cost-efficient manner. Short of experimental evaluations, it could be useful to examine the feasibility of a program to support current, former, and potential TANF recipients already in LTC jobs with an array of TANF funded services, such as specialized case management or extended childcare and transportation assistance. Another non-experimental study could examine the job performance and retention rates of training program graduates vis-à-vis other LTC employees through a series of surveys to assess any differences in the groups of employees while controlling for demographic and background characteristics.

I. INTRODUCTION

Attracting and retaining paraprofessional employees to care for the elderly, disabled, and chronically ill is a growing concern to program administrators in the long-term care (LTC) industry and to policymakers in the broader health care arena. Broad demographic and economic factors combined with issues internal to the LTC industry are creating a shortage of paraprofessional workers that is expected to increase dramatically over the next several years. At the same time, recipients of cash assistance from the Temporary Assistance for Needy Families (TANF) program are seeking opportunities to move from welfare to work within an environment marked by strict work requirements and time limits on receipt of aid. Welfare reform legislation in 1996 required states to engage a substantial proportion of their TANF caseloads in work or work-related activities for 30 hours per week, and recent proposals for reauthorization of the legislation would require states to engage an even larger share of their caseloads for 40 hours per week. To meet the new requirements, states will likely look for innovative strategies to help recipients find employment—and the LTC industry may present such an opportunity.

The LTC industry's need for workers and TANF recipients' need for jobs could be mutually beneficial if (1) the characteristics of TANF recipients are well-matched to the requirements of the paraprofessional jobs in demand; (2) available LTC jobs offer the hours and pay that TANF recipients need to move toward self-sufficiency; and (3) workforce development programs can create routes to the LTC industry that are accessible, attractive, and easily navigable for TANF recipients. In an effort to assess the suitability of TANF recipients for such jobs and the feasibility of training recipients for such jobs, the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (DHHS), contracted with Mathematica Policy Research, Inc., (MPR) to conduct the Study of TANF Recipients as Long-Term Care Workers. An earlier report from the study presented findings on the suitability of TANF recipients for employment in the LTC industry based on analyses of survey data from three states and the District of Columbia and concluded that over half of the TANF caseload meets the basic requirements for LTC jobs.[1] This report presents findings from a qualitative analysis of five programs that train TANF recipients and similar low-income populations for paraprofessional jobs in the LTC industry to assess the feasibility of and challenges embedded in such efforts.

A. THE CRISIS IN LONG-TERM CARE

Demand for paraprofessional LTC employees—specifically, Certified Nurse Aides (CNAs) and home health aides—is increasing substantially. In 2003, there were 1,925,530 workers employed as nursing aides, orderlies and attendants or as home health aides (BLS, 2003). By 2012, Bureau of Labor Statistics (BLS) estimates project a need for 2,577,000 workers in these areas, an increase of 34 percent (Hecker 2003). Demand for paraprofessional LTC workers is expected to grow most substantially in home health care services because as the baby boom generation ages, the nation will experience an unprecedented increase in the size of the elderly population and trends indicate that a growing proportion of elderly individuals is choosing to remain in their own homes rather than move

[1] See Kirby et al. (2004)

into nursing homes. As a result of these trends, the BLS estimates indicate that personal and home care assistance will be the fourth-fastest growing occupation by 2006 (Stone and Wiener 2001).

While there is great demand for paraprofessional LTC workers, several factors are limiting their supply. These factors are primarily economic and result from the internal characteristics of LTC jobs and the external influences of local economies. Paraprofessional LTC jobs tend to pay low wages and offer few benefits. Wage estimates generally range between $7.00 and $9.00 per hour. In 1999, the mean hourly wage of all direct care positions—including nurse aides, orderlies, attendants, home health care aides, and personal and home care aides—was $8.59 (Scanlon 2001). And, in 1999, 25 and 32 percent of nurse aides and home health aides, respectively, had no health insurance coverage compared with 16 percent of all workers (Scanlon 2001). Moreover, paraprofessional LTC jobs tend to be both physically and emotionally demanding. For all these reasons, the desirability of these jobs varies with the vigor of the local economy; the relative availability of other entry-level jobs can make attracting and maintaining LTC workers competitive.

Many initiatives have been suggested or implemented to address the mismatch between supply and demand in the LTC industry. These supply-side solutions focus on either: (1) increasing the attractiveness of paraprofessional LTC jobs through wage supplements, increased fringe benefits, or developing career ladders; or (2) identifying and developing new pools of paraprofessional LTC workers.

B. THE TANF PROGRAM AND POLICY CONTEXT

TANF recipients are required to work or participate in work-related activities now more than ever before. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) afforded states flexibility in providing assistance to low-income families with children but mandated that a sizeable percentage of these families be involved in work or work-related activities. In fact, Congress specified a minimum state participation rate for all TANF families and a separate rate for two-parent families. Congress also specified the types of activities in which families must participate and the minimum number of hours per week they must participate—a total of 30 for adults in single parent families and 35 for adults in two-parent families—in order to count toward the state's rate. States face financial penalties for failing to meet their participation rates.

When TANF began in 1997, the minimum work participation rate, as set by Congress in PRWORA, was 25 percent for all families and 75 percent for two-parent families. For each subsequent year through 2002, it rose steadily until reaching 50 percent for all families and 90 percent for two-parent families. However, for each percentage point that a state's average monthly caseload drops below its average monthly caseload for fiscal year 1995, the minimum work participation rate is reduced by one percentage point.[2] In fiscal year 2002, the most recent year for which participation data are available nationwide, almost all states met the federal participation requirements, in many cases because this caseload reduction credit lowered the minimum rate to considerably below 50 and 90 percent or because states had waivers allowing them to deviate from federal program rules and requirements. However, most state waivers have now expired, and

[2] The caseload decline must not be as a result of changes in state or federal policy in order to count toward the caseload reduction credit.

Congressional proposals for the reauthorization of the TANF legislation call for raising the minimum participation rates and eliminating the caseload reduction credit. As a result, states will likely have to find new ways of engaging recipients in work or work-related activities.

Training TANF recipients for paraprofessional jobs in the LTC industry may be one new way of engaging recipients, and in fact, some TANF policies may facilitate training and job retention. First, one of the activities that may count toward the state participation rate is short-term vocational education, limited to 12 months in a lifetime. CNA and home health aide training is typically no more than six to eight weeks in duration, so TANF recipients participating in such training could count toward the state's participation rate. In addition, most state TANF programs offer supports to recipients participating in work or training programs, such as childcare, transportation assistance, health coverage through Medicaid, and resources to defray the cost of uniforms, equipment, or other work expenses. Case management services are also generally available to recipients throughout their stay on TANF. Once recipients are employed, policies to disregard a portion of their earnings in calculating TANF benefits enable recipients to keep more of what they earn and transitional Medicaid and childcare assistance, along with continued access to Food Stamp benefits for those who are income-eligible, can ease their transition from welfare to work.

There are other TANF policies and practices, however, which may impede the ability of recipients to train for, obtain, and retain paraprofessional LTC jobs. First, despite the fact that participation in vocational education may be counted in the calculation of the state participation rate, many TANF programs discourage education and training and place substantially more emphasis on immediate attachment to employment and activities intended to lead directly to employment, such as job search. Some programs require TANF applicants to participate in job search activities even before accepting them onto the caseload, a practice that prolongs entry into training. Others require that TANF recipients spend a part of every week in a work experience or community service activity, which precludes recipients from participating in training programs that hold classes every weekday.

C. STUDY METHODOLOGY

The primary objective of the Study of TANF Recipients as Long-Term Care Workers was to identify programs that train TANF recipients and similar low-income populations for paraprofessional LTC jobs (specifically, CNA and home health aide jobs), to examine how these programs operate, and to identify lessons for other sites interested in implementing similar programs. By researching the TANF and LTC literature and talking with experts in both fields, we identified five programs that have attempted to establish effective links between TANF recipients moving toward employment and the LTC labor market. In selecting study sites, we sought to include a range of programs that have experienced both successes and challenges designing and implementing paraprofessional LTC training for welfare recipients and similar populations. We also strove to achieve geographic diversity as well as diversity in program approaches.

The programs included in the study are located in the District of Columbia (DC); Tucson, Arizona; Dakota County, Minnesota; Bronx, New York; and Richmond, Virginia. Each operates in a different demographic, economic, and TANF policy environment. Programs in three of the sites—DC, the Bronx, and Richmond—draw participants strictly from urban areas while the programs in Tucson and Dakota County draw participants from both urban and rural areas. Local unemployment

rates range from 3 to 12 percent, and local TANF caseloads ranged from a low of 4,500 in Richmond in 1999 to a high of 55,000 in the Bronx in 2001. In two of the five sites, local TANF programs are guided by a strict "work-first" philosophy that values immediate employment and activities that lead directly to employment instead of or before education and training, while TANF programs in the other sites offer recipients more flexibility in fulfilling their participation requirements with a range of activities, including education and training. Table I.1 presents some key characteristics of the study sites.

We conducted in-depth, in-person, two-day visits to each of the selected sites in the winter and spring of 2004. The purpose of the visits was to gather information from a variety of sources in order to create a comprehensive picture of program policies, practices, and procedures as well as the contexts in which training programs operate and were developed. Using semi-structured guided discussion techniques, we interviewed program administrators and staff (including CNA or home health aide instructors), TANF case managers and state and/or local TANF administrators, employers in the LTC industry, and any other relevant program stakeholders. Chapter II of this report provides a brief overview of each program's approach, and Chapter III presents common challenges that sites experienced in implementing LTC training for TANF recipients and other low-income populations as well as lessons that can be drawn from their experiences. Finally, Chapter IV summarizes key findings from the study and discusses implications of the findings for future research.

TABLE I.1

SITE CHARACTERISTICS

Program Name	Program Acronym	Location	Positions for which Program Participants are Trained	Local Unemployment Rate in 2002	Local Average Starting Hourly Wage for Position	Local TANF Caseload	TANF Program Approach Toward Work and Training*
VMT Long Term Care Management, Inc.	VMT	Washington, DC	CNA Home Health Aide	3.1%	$8.75 - 10	11,000 (in 2004)	Flexible approach
Learn, Earn, Advance, and Prosper	LEAP	Tucson, AZ	CAN	7.7%	$6 – 9	5,950 (in 2004)	Flexible approach
Healthcare Occupations Preparation	HOP	St. Paul, MN*	CAN	3 –4.5%	$10	7,800 (in 2004)	Strict work-first approach
Cooperative Home Care Associates	CHCA	Bronx, NY	Home Health Aide	12.3%	$5.15 – 7	55,000 (in 2001)	Strict work-first approach
Hope for Healthcare	HH	Richmond, VA	CAN	3.7%	$8.50 – 13	4,500 (in 1999)	Flexible approach

** In programs with a strict work-first approach, TANF recipients typically participate in an established series of activities focused on securing unsubsidized employment. In Minnesota and New York, these include job search followed by work experience. In programs with a more flexible approach, TANF recipients typically participate in a range of activities best suited for their individual circumstances.

* Includes Dakota and Ramsey counties.

II. PROGRAM DESIGN AND DEVELOPMENT

The study sites all set out to train TANF recipients and other low-income individuals for paraprofessional LTC jobs, but each used a different approach to do so. For instance, each of the five programs was operated by a different type of organization—a private for-profit organization; a hospital; a technical college; a worker-owned collaborative; and a housing authority. Some recruited TANF recipients directly and others indirectly. Some provided classroom and clinical training only, while others combined training with work experience and supportive services. And, the programs experienced varying degrees of success. This chapter discusses each site's general approach to training TANF recipients and other low-income populations for paraprofessional LTC jobs. It highlights key aspects of program design—such as organizational structure, recruitment, services, and supports—and describes how and why programs developed as well as the outcomes they have achieved to date. Table II.1 presents key aspects of program structure and Table II.2 compares state training requirements for relevant LTC positions with specific program requirements.

A. VMT LONG-TERM CARE MANAGEMENT, INC. (VMT)

VMT Long Term Care Management, Inc. (VMT), provides job readiness instruction, CNA or home health aide training, and job search assistance to TANF recipients in Washington, DC. Providing services to TANF recipients is a small part of VMT's overall operations.

Organizational Structure. VMT is a private, for-profit organization whose mission is to provide solutions on managing and staffing LTC facilities in the Washington, DC metropolitan area. Originally incorporated in 1988, it is composed of four distinct, yet interrelated, components—(1) a management agency, which staffs and manages all aspects of two nursing homes owned by the DC government; (2) a nursing school, which offers a 12- month Licensed Practical Nurse (LPN) course beginning 4 times per year, a 3-week CNA course monthly, and a 2-week home health aide course according to demand (all courses are open to the general public); (3) a home health aide placement agency, which places aides in response to the staffing needs of health care providers and consumers; and (4) a corporate division, which houses general administration, accounting, marketing, and the TANF department responsible for providing employment services to TANF recipients throughout the city.

Program Development and Rationale. VMT began providing services to TANF recipients as a community service. In July 2000, VMT was awarded a competitively bid contract from the DC Department of Human Services (DHS) to provide employment services to TANF recipients throughout the city on the basis of its historical success placing low-income individuals in jobs and its strong relationships with employers in the same fields in which it offered training. DHS reimburses VMT 100 percent of the work-related costs (such as books, uniforms, and licensing exams) it incurs for TANF recipients up to $250 per recipient. In addition, DHS reimburses VMT for daily stipends that it provides to program participants and gives VMT bonuses for each participant who enters employment, maintains a job for one month, maintains a job for three months, maintains a job for six months, and/or maintains a job for at least one month and earns at least $7.50 per hour.

TABLE II.1

PROGRAM STRUCTURE

Program	Primary Sponsoring Organization	Positions for which Participants are Trained	Targets TANF Recipients	Key Program Activities	Current Sources of Funding	Program Inception	Program Enrollees from Inception through 2004 Visit	Program Graduates from Inception through 2004 Visit	Approximate Direct Costs Per Participant
VMT*	Private, for-profit organization	CNA HH aide	Directly	Job readiness course CNA/HH aide training Job search	TANF funds	July 2000	Approximately 200	n/a	n/a
LEAP	Hospital	CNA	Directly	Job shadow Work experience/GED prep Life skills course Employment at TMC CNA training	TANF funds, DOL YO funds, TMC operating budget	1998	210	144	$3700
HOP	Technical college	CNA	Directly	Pre-vocational class training Job shadow Peer mentoring Job club CNA training	TANF funds	April 2003	35	27	$3500
CHCA	Worker-owned cooperative	HH aide	Indirectly	HH aide training On-the-job training Peer mentoring Employment at CHCA	TANF funds, Foundations	1985	1,652**	1,285**	$3500-$4000 +
HH	Housing authority	CNA	Indirectly	Job readiness course CNA training Job search	HUD HOPE VI grant, RRHA funds, Care Advantage	June 2001	Approximately 205	191	$800-$1000

* Program enrollees from inception through 2004 visit includes all TANF program participants at VMT—that is, those who did and did not pursue CNA or home health aide training. The number of program graduates and approximate direct cost per participant is not available for VMT.

** Since mid-1998 when CHCA formally began tracking program data.

TABLE II.2

TRAINING REQUIREMENTS

Program	Positions for which Participants are Trained	Minimum Hours of Training Required by State for Relevant Position*	Hours of Training Provided by Program	Other State Requirements for Relevant Position (either for certification or employment in a LTC facility)**	Additional Requirements for Acceptance into Program
VMT	CNA*** Home health aide	180	180	Criminal background check (with no disqualifying crimes) 4th grade reading level on TABE PPD or chest x-ray Identification card	None
LEAP	CNA	120	136	Criminal background check (with no felony convictions)	Drug screen 4th grade reading level on TABE 8th grade math level on TABE Proof of transportation Proof of childcare
HOP	CNA	75	Varies by course	Criminal background check (with no disqualifying crimes)	TANF recipient 6th grade literacy level on CASAS Proof of transportation Proof of childcare Current immunizations Current TB test results
CHCA	Home health aide	75	154	Criminal background check (with no disqualifying crimes) 8 hours of supervision by an RN Demonstrated clinical skill set	Drug screen
HH	CNA	120	160	Criminal background check (with no disqualifying crimes)	High school diploma or GED Drug screen TB screen Proof of childcare

* In addition, all states require CNA trainees to pass a competency exam.

** In addition, interviewees at VMT, LEAP, and HOP reported that virtually all employers in the state require a high school diploma or GED for CNAs.

*** Relevant positions described elsewhere in the table are limited to CNAs.

Recruitment. There are four main avenues through which TANF recipients may learn about and become enrolled in VMT: (1) referral from DHS; (2) referral from another DC employment services vendor (VMT is one of nine and the only one that provides CNA training); (3) referral from a family, friend, or neighbor; and (4) referral from a LTC employer. The vast majority of program participants are referred to VMT by family, friends, and neighbors and come specifically for the CNA or related training opportunities the organization provides. However, VMT serves TANF recipients both with and without interest in health care.

Program Services and Paraprofessional Training. After attending a two-hour orientation session, TANF recipients typically participate in a four-week job readiness course. The course focuses on soft skill development and job preparation activities such as resume writing and interviewing. Those who are not interested in health professions then participate in job search or are referred to other vocational training providers in the city. Those who are interested in CNA training must take and pass the TABE test at the 4th grade level before entering the nursing school's CNA course (7 of the maximum 35 slots in a CNA course are reserved for TANF recipients). The course is three weeks long, provides exactly 180 hours of training as mandated by DC law, and combines clinical training at a nursing facility in the city, clinical training in a laboratory at VMT, and classroom training. Traditionally, VMT's nursing school has also offered a two-week home health aide training course, but has not done so recently due to lack of interest. After training, participants engage in independent job search activities and VMT periodically holds job fairs. Informally, graduates of the CNA training course have priority over other applicants for job openings in the two nursing facilities managed by VMT, but VMT provides no guarantee of employment or direct job placement services.

Supportive Services and Incentives. As at all DC employment service vendors, all TANF recipients at VMT receive $10 per day for each day they participate for at least four hours. Stipends are intended to cover the cost of transportation, but are paid in checks so participants may spend them how they wish. All TANF recipients are also entitled to a childcare voucher provided by a specially designated office within DHS. Finally, DHS provides financial bonuses to TANF recipients who obtain and maintain a job. Recipients receive $100 for obtaining a job, $200 for remaining employed for 30 days, $300 for remaining employed for 90 days, and $150 for remaining employed for 6 months (recipients may receive up to $750 total).

Program Successes and Outcomes. VMT's TANF department staff estimate that 200 TANF recipients have been through VMT's CNA or home health aide training since the program began in July 2000. They estimate that about 20 percent of those who began the program are currently working in the LTC field. The other 80 percent either drops out of training, does not pass the certification exam, or chooses to go into a different field. One of VMT's greatest strengths is that it maintains strong relationships with various LTC employers—it manages two LTC facilities in the city and contracts with others for clinical training for its CNA students—and is in the process of networking with other employers to develop an employer bank.

B. LEARN, EARN, ADVANCE, AND PROSPER (LEAP)

The Learn, Earn, Advance, and Prosper (LEAP) program—housed at TMC Healthcare in Tucson, Arizona—provides on-the-job training, life skills instruction, job placement, and advanced

training opportunities for TANF recipients and low-income youth interested in health care careers. LEAP does not offer CNA training directly to new program participants; rather CNA training is available only after participants have graduated from the program and have been employed at TMC for six months. In addition, LEAP focuses on providing training and employment in more of an acute care than LTC setting.

Organizational Structure. TMC Healthcare is a nonprofit hospital system in southern Arizona, which operates one of the 300 largest hospitals in the country as well as a smaller, newly acquired hospital. Its overall operating budget is over $200 million per year and its larger hospital employs over 3,000 staff and serves more than 30,000 inpatients and 122,000 outpatients yearly. The Workforce Development component within TMC's Public Policy Division operates LEAP, which accounts for a very small portion of TMC's overall operating budget.

Program Development and Rationale. TMC began serving TANF recipients as a result of its interest in shaping the codification of the 1996 federal welfare legislation in Arizona. This interest developed from its desire to fulfill its vision and mission as a nonprofit organization of supporting the well-being of the community. As a large employer with a variety of entry-level and advancement opportunities, TMC realized it was well situated to implement an employment program for welfare recipients and to formulate a partnership between the community, business, and government that was in the spirit of the new legislation. TMC's motivation wasn't purely altruistic, however. As a large employer, it spent substantial resources recruiting and hiring, but experienced a non-trivial amount of staff turnover. Management perceived that implementing a program to train and hire individuals from a targeted pool to fill hospital vacancies, particularly in nursing, would be a benefit to TMC. While TMC created LEAP in 1998 largely as a community service, over time the program became a part of TMC's overall workforce development efforts.

Initially, TMC absorbed 100 percent of the costs of the program. Realizing, however, that in order to make enhancements and ensure that LEAP would be sustainable TMC would have to tap into available public funding, it applied for a combination of TANF and Department of Labor Welfare-to-Work funding through a request for proposals from the state. TMC was awarded a contract from the Arizona Department of Economic Security (DES) in July 1999. Under that contract, DES reimbursed TMC $1,200 per TANF recipient (or a prorated amount for TANF recipients who did not complete the program). The reimbursement covered only about one-third of TMC's costs, which were approximately $3,700 per participant. Recently, TMC expanded its program to serve low-income, out-of-school youth as well.

Recruitment. Only two types of individuals may enroll in LEAP—TANF recipients and low-income, at-risk youth (ages 18-21) who meet Workforce Investment Act criteria for out-of-school youth. TANF recipients must be referred by a DES case manager. Case managers screen recipients for their interest in health care and motivation to complete the program and try to refer only those who have transportation and childcare in place as well as few, if any, barriers to work. In 2002, administrators revised the admission criteria (by requiring minimum math and literacy skill levels) to more closely match employers' requirements for CNA positions.

Program Services and Paraprofessional Training. In the first week of the program, participants spend two days in orientation and three days shadowing hospital staff to learn about positions in radiology, medical records, food service, housekeeping, and transportation. They can

request to shadow other positions as well, including CNA positions. Participants spend four days per week over the ensuing 10 weeks in on-the-job training in one of the five designated areas for shadowing (they cannot do on-the-job training in a CNA position because they do not yet have the requisite skills or training to do to the hands-on work that is required during this phase of the program). They spend one day per week in a life skills class that focuses on workplace etiquette, goal setting, identifying and resolving barriers, attitude and self-esteem, organizational and communication skills, parenting and family issues, and anger management. In addition, GED classes are mandatory for all LEAP participants without their high school degrees and take place during a portion of the on-the-job training component. During the last two weeks of the program, participants apply for jobs at TMC (or elsewhere if no jobs at TMC are available) with the assistance of program staff. Though jobs are not guaranteed, all LEAP graduates who have sought positions at TMC to date have been hired. TMC will cover the cost of CNA training only after graduates have been employed at TMC for six months.

Supportive Services and Incentives. TANF participants enrolled in LEAP are eligible for a range of standard DES supportive services, such as five dollars per day for transportation, vehicle assistance (for example, vehicle insurance or registration), a uniform or clothing voucher, childcare assistance, medical and dental coverage, counseling services, tools or equipment, and a $2,000 allowance for post-employment education. In addition, the LEAP program provides participants with breakfast and lunch coupons. A monthly support group is also available to all LEAP graduates. Finally, TMC provides training, including CNA training, to employees who want to further their education. Specifically, TMC pays for tuition and books for employees to become nurses and radiology and surgical technologists. To be eligible, participants must be employed at TMC for at least six months, work at TMC at least 24 hours per week, and have a high school diploma or GED, adequate TABE scores, and no criminal background.

Program Successes and Outcomes. Between the program's inception and July 2004, 210 individuals had enrolled in LEAP (the majority of whom were TANF recipients), and 144 had graduated. Of those, at least 120 are currently employed (48 within TMC and 72 elsewhere). Though exact numbers are not available, most graduates are employed in an acute care rather than LTC setting. Among those ever employed after graduation, 85 percent maintained their jobs for 3 months, 78 percent maintained their jobs for 6 months, and 65 percent maintained their jobs for 1 year. Approximately 4-5 of the 144 LEAP graduates have participated in the CNA training offered by TMC to date. Enrollment in CNA training has been low because classes are only offered in the evenings when it is particularly difficult to find childcare and when graduates are either tired from working the first shift or are busy working the second shift. Another contributing factor is that, originally, LEAP was not intended to focus exclusively or even primarily on nursing; TMC asked DES to refer TANF recipients who were interested in health care careers, but not necessarily limited to nursing careers. In the face of the looming nursing shortage, the program recently has been trying to shift its focus more toward nursing. In addition to its program outcomes, one of LEAP's greatest strengths is that it is not exclusively dependent on particular sources of government funding. TMC has and is willing to invest dollars from its own operating budget and program administrators seek out appropriate sources of public and philanthropic funding as needs arise.

C. HEALTHCARE OCCUPATIONS PREPARATION (HOP)

The Healthcare Occupations Preparation (HOP) program provides five weeks of pre-vocational classroom training and three weeks of job shadowing at a work site to TANF recipients in two counties in Minnesota—Dakota and Ramsey—who are interested in health care positions. It pays for CNA training for interested participants who complete the up-front eight-week component, but does not provide it directly.

Organizational Structure. The HOP program is housed within the Employment and Training Center (ETC) of Dakota County Technical College (DCTC). DCTC serves over 12,000 students per year and, since its establishment in 1971, has formed partnerships with a number of businesses and industries to train students for skilled professions. The ETC has been a contracted service provider for workforce development programs operated by the county and state for over 16 years.

Program Development and Rationale. Between 2000 and 2002, a division of the state Department of Employment and Economic Development awarded seven grants to "alleviate worker shortages in the health care and human services industries and to increase opportunities for current and potential direct care employees to qualify for advanced employment in the health care and human services fields through training and education." The grants were funded jointly by the state legislature and TANF. Grantees were required to provide an in-kind match, to include in their consortia at least one educational institution and one eligible employer, and to train TANF recipients or eligibles exclusively. DCTC's ETC applied for and was awarded a three-year, $400,000 grant in November 2002, and HOP began in April 2003. There are three health care employer partners in HOP, and two of the three have LTC facilities as part of their service structure. DCTC's grant application was a natural extension of its previous workforce development efforts in other fields.

Recruitment. All HOP participants must be TANF recipients, and all referrals to the program come from Dakota and Ramsey County TANF job counselors. To participate in the program, recipients must: have a GED or high school diploma; pass the CASAS skills test or other literacy test at 6th grade level; have transportation and childcare in place; and have current immunizations and TB test results. Job counselors are asked to screen recipients for other things as well, such as expressed an interest in a health care career; no limitations for lifting, bending or standing; reasonable chance of passing a criminal background check; and no—or controlled—mental health/chemical dependence issues.

Program Services and Paraprofessional Training. At its core, HOP is an eight-week job preparation program. The first five weeks consist of pre-vocational classroom training in five areas—career exploration, work readiness skills, basic health care skills, reading and study skills, and computer skills. In the ensuing three weeks, participants shadow health care workers at one of DCTC's three employer partners to gain more exposure to the health care field and the world of work and to give employers an opportunity to see participants in a work setting and evaluate them informally. During this time, participants receive mentoring from an employee at the work site. After completing this component, participants are free to enroll in any job-specific training program available in the county, but HOP will pay only for the cost of CNA training. HOP provides structured job search and job placement assistance to graduates through job club activities that are offered twice a week. There is no guarantee of employment once vocational training is complete,

however, employer partners have agreed informally to treat HOP participants as "first source" job applicants for positions in both LTC and acute care settings.

Supportive Services and Incentives. Childcare assistance is available to all TANF recipients through the Department of Human Services (DHS). DHS and the Department of Employment and Economic Development also pay for bus passes or gas cards (equivalent to about $60/month) as well as car repairs. The HOP grant can cover the cost of clinical uniforms. Financial aid for job-specific training (other than CNA training) is available for TANF students who are eligible for Pell Grants, which generally will cover the cost of tuition in a public post secondary institution. In addition, DCTC and other technical colleges offer scholarships for eligible students on a somewhat limited basis. Though not a source of financial support, HOP provides mentoring to increase the likelihood that participants succeed at and stay on the job. An independent consultant from DCTC trains mentors at each employer partner who are typically dedicated front-line workers with no other supervisory responsibilities. Mentoring is available during and after the job shadow component.

Program Successes and Outcomes. In the first year of the program, there were 5 HOP classes, and 35 participants had enrolled in the program in total. Twenty-seven completed the up-front 8-week course, and 17 went on to complete CNA training. Of those, 4 are currently working as CNAs and 3 are working in other health care positions. One of HOP's greatest strengths is that it is housed in a technical college with a strong history of working with welfare recipients and business partners and a track record for teaching soft skills development. This experience has proven critical in understanding and adapting to sweeping policy and program changes that were implemented in the state TANF program soon after HOP began.

D. COOPERATIVE HOME CARE ASSOCIATES (CHCA)

Cooperative Home Care Associates (CHCA) recruits, trains, and hires low-income individuals for home health aide positions and provides home care services to elderly and disabled residents in the Bronx and upper Manhattan in New York City. It is both a training provider and employer.

Organizational Structure. CHCA is a private for-profit home care agency whose mission is to create high-quality home health aide jobs for low-income women, to empower those women with greater skills and confidence, and to improve the quality of practice in the home health care industry. It was founded on the belief that to provide quality care, home care workers must have quality jobs, training and support. To create that type of work environment, CHCA is organized as an employee-owned cooperative—owned and controlled by the home health aides. CHCA currently employs about 750 workers and trains 200-300 home health aides each year.

Program Development and Rationale. CHCA grew out of a small, private economic development program designed to create jobs through the formation of cooperative, or worker-owned, firms. The goal of this economic development program was to assist low-income people obtain easier access to decent jobs in a variety of industries. Over time, the program came to focus on home health care for two key reasons—first, the industry was growing rapidly in the advent of new Medicare regulations governing reimbursement for home health care, and second, there existed a substantial pool of workers, although they were undervalued, under-trained and underpaid. From its inception in the mid-1980s, the twin goals of CHCA were to provide quality jobs and quality care.

In this vein, it established a progressive salary scale and generous benefits package and built substantial supports and a focus on worker retention into its training model. As a result, CHCA spends substantial resources training and retaining aides—approximately $3,500 to $4,500 per enrollee for up-front training and supports plus $600 to $700 per worker per year for development and supportive services.

CHCA originally operated with funding it received from foundations, contracts with private health care providers, and later from the Job Training Partnership Act. In 2002, it received a 2-year $1.4 million grant from the state Department of Health (DOH) under a program funded by TANF and intended to support LTC training programs and capacity building initiatives in hospitals, home care agencies, and nursing homes. DOH reimbursed CHCA quarterly for all expenses incurred for individuals it could certify as TANF eligible. When CHCA's grant expired in 2004, it submitted a winning proposal to Service Employees International Union 1199 to become a LTC training provider under the grant the union had with DOH through 2006.[3] The union currently reimburses CHCA approximately $2,000 per TANF eligible participant for expenses incurred through home health aide certification; it does not cover the expense of any post-employment activities or supports. CHCA covers its additional training and retention expenses primarily with foundation funding.

Recruitment. Seventy percent of people who come to CHCA are referred by someone already in training or at work at CHCA. CHCA does limited targeted recruitment from social service agencies, but does no recruiting directly from TANF offices or participant lists (though historically, 70-80 percent of participants have been and currently 40 percent are TANF recipients). Those who are interested in enrolling in CHCA's training program must attend an orientation session, submit an application, and complete a one-on-one interview with an administrative staff member. CHCA does not require a high school degree or its equivalent (and does not require applicants to pass a literacy test), but requires a clean drug screen before entering training and a criminal background check before employment.

Program Services and Paraprofessional Training. CHCA provides an average of 154 hours of classroom training (substantially more than the minimum state requirement) and offers 8 training cycles per year—4 in English and 4 in Spanish. Instructors follow the state DOH curriculum, but add to it a variety of customized training modules. On the last day of training, participants take part in a support group to learn from and support their peers as they enter the field (a second support group is held two weeks after the start of employment, and a third is held after the third month of employment). Immediately after classroom training, participants begin three months of probationary employment at CHCA, which is considered on-the-job training. During this time, participants are assigned peer mentors to help ease their transition. After probation, during which participants receive 8 hours of in-home supervision by a Registered Nurse (RN), they receive their certificates and are hired by CHCA as regular-status employees. All employees are eligible for worker-ownership and unionization.

Supportive Services and Incentives. CHCA provides an array of supports and incentives to help its participants maintain employment and advance in the workplace. During training, CHCA

[3] The union originally had a 2-year grant with DOH—from 2002 through 2004—but negotiated a 2-year extension through 2006.

provides participants with a metro card for public transportation. During employment, CHCA offers a benefits package that is worth $2.13 per hour which includes medical, dental, disability, and life insurance as well as vacation pay and earned leave time. It also provides aides with a 401(K) to which CHCA contributes approximately one percent of individuals' salaries (regardless of whether employees contribute to the plan or not), provides referrals to credit union membership and emergency childcare assistance, and provides dividends each year (to aides who work at least 30 hours per week) according to the number of hours worked that can average as much as $200 a year. After three years of employment at CHCA, the organization guarantees aides full time work—that is, 30 hours per week. In addition, CHCA uses a salary scale to reward continued employment. An employee's starting base wage increases automatically after one, three, five, seven, and nine years of employment.

CHCA also provides opportunities for personal and professional growth. All worker owners have the opportunity to serve on the CHCA Board, and all employees have the opportunity to serve on the Worker Council, a group of 20 home health aides who sit under the Board to communicate Board decisions and issues under consideration to the aides. All employees may also participate in CHCA's Policy Action Group, which works on affecting relevant public policy—through lobbying legislators and other efforts—in both Albany and Washington, DC.

Program Successes and Outcomes. The vast majority of those who enroll in CHCA's training program complete it and are hired as home health aides at CHCA. In 2002, 296 individuals enrolled in the program, and 249 completed training and were hired; 113 of the 249 were TANF certified participants. In 2003, 247 individuals enrolled, and 188 completed training and were hired; 145 of the 188 were TANF-certified participants. The majority of hires also retain their jobs for extended periods. Typically, about 85-90 percent of new hires are still working at CHCA 90 days later; about 75 percent are still working at CHCA 180 days later; about 60 percent are still working at CHCA one year later; and about 55 percent are still working at CHCA two years later. Among those who leave CHCA before each milestone, about 20 percent are working elsewhere. Perhaps CHCA's greatest strength is the innovation it brings to the home care industry in terms of organizational structure, wage and benefit structure, and personal and professional growth opportunities

E. HOPE FOR HEALTHCARE (HH)

Hope for Healthcare (HH) provides job readiness and CNA training primarily to residents of public housing developments in Richmond, Virginia. Though housed within the Richmond Redevelopment and Housing Authority (RRHA), it is the result of a partnership between RRHA, Care Advantage, Inc., and the YMCA of Greater Richmond.

Organizational Structure. RRHA is the largest housing authority in Virginia, serving approximately 4,000 households through its public housing program and 2,900 families through its subsidized housing voucher program. Its partners in the HH effort are Care Advantage, a for-profit health care staffing agency that matches CNAs, LPNs, and RNs to temporary nursing positions, and the YMCA of Greater Richmond, a nonprofit charitable organization that provides wellness, childcare, youth sports, and education programs in the community. Care Advantage pays for HH's CNA instructor, the YMCA provides space for HH's training, and RRHA covers all other program expenses and provides support and outreach services to residents.

Program Development and Rationale. In 1997, RRHA and the city of Richmond were awarded a $26.9 million HOPE VI grant from the U.S. Department of Housing and Urban Development (HUD) to revitalize Richmond's Blackwell community. Part of this effort entailed providing residents with access to education, job training, and employment. A survey of Blackwell community residents, funded by the grant, revealed residents' interest in the nursing field. As a result, RRHA contacted Care Advantage in the hope that it might sponsor several residents for a local CNA training program. Instead, motivated by the needs of LTC employers who faced severe labor shortages and the needs of RRHA residents who sought training for relatively high-paying professions with benefits and advancement opportunities, Care Advantage agreed to develop (in concert with RRHA) an entirely new CNA training program to serve the needs of RRHA residents specifically. It hired a nurse consultant to work with RRHA to develop the training program, combining Care Advantage's understanding of the nursing field with RRHA's understanding of the strengths and needs of its residents. The YMCA joined the effort because it viewed the initiative as consistent with its mission to serve the Richmond community. The three organizations did not develop formal agreements for planning and implementation; rather, motivation and organizational support allowed the partnership to move forward without formal contracts and bureaucracy.

Recruitment. The majority of HH participants have been referred to the program by RRHA Resident Service Advisors (RSAs) responsible for providing support services for the residents of the particular housing community where they live. Participants also hear about the program from family and friends who have either been involved in HH themselves or know someone who has been involved, or they see an RRHA advertisement (RRHA uses brochures, posters, and other program newsletters to publicize HH). In addition, some participants are referred from Care Advantage or a LTC facility where they are employed (generally as uncertified patient companions). Initially, HH was composed entirely of RRHA residents, but program staff suggested that bringing in several outside participants, particularly those with some experience in health care, would improve the quality of the class and ensure a class size of about 10, even if fewer RRHA residents enrolled. There are several prerequisites for selection into the program, including a high school diploma or GED, passing a drug test, a criminal background check, and TB screening. Proof of childcare is also required (to minimize the likelihood that participants will miss classes due to unreliable care) as is an interview with program staff.

Program Services and Paraprofessional Training. HH begins with an orientation session and professional development series the week prior to CNA training. It covers goal setting, motivation, job search skills, basic computer skills, completing job applications, resume development, interviewing skills, job retention techniques, money and credit management, and professional etiquette. Participants then go on to CNA training, which consists of four weeks (or 96 hours) of classroom instruction and two weeks (or 64 hours) of clinical training at a nursing home. At the start of each class, more "mature" students are assigned to serve as mentors to younger students, assisting classmates in networking and building a sense of group identity and support. Originally, RSAs provided extensive job development and job search assistance to training graduates. However, when HOPE VI funds expired in October 2003, RSAs were reassigned to other positions within RRHA. RRHA staff are now in the process of identifying other funding sources to replace the outreach and job development functions RSAs originally provided.

Supportive Services and Incentives. Before the grant expired, Hope VI funds paid for childcare for HOPE VI residents; the Department of Social Services (DSS) has always paid and continues to pay for childcare for TANF recipients. In addition, Hope VI funds covered transportation and childcare for Hope VI residents until their first paycheck arrived; DSS covers these services for up to one year for TANF recipients who are newly employed. Before the grant expired, RSAs acted as case managers providing substantial support to program participants. Now, program staff provide limited support and referrals to other agencies. In addition, RRHA encourages participants to take part in the Family Self-Sufficiency program, a HUD-sponsored initiative that allows residents who begin working to place the additional money that they would otherwise have to pay in higher rent into an escrow account that they can later use for homeownership, purchase of a car, tuition payments for further education, or for similar investments in their self-sufficiency.

Program Successes and Outcomes. In the 2½ years HH has been in operation, 191 participants have graduated from the program. About 5 to 10 percent of students were expelled or dropped out in that time, indicating a 90 to 95 percent retention rate. Of the program graduates, 2 have become RN students, 19 are LPN students, 2 are practicing LPNs, and it is estimated that at any given time, 90 percent of graduates are employed in CNA positions. Since the start of the program, about 10 percent of HH graduates have been hired by Care Advantage specifically. In addition, at any given time, there is a waiting list of approximately 80 people for program services. Perhaps HH's greatest strength is the cooperation among partners and the dedication of its staff. Under the HOPE VI grant, the program's outreach services (through RSAs and other marketing initiatives) were also extremely successful.

III. IMPLEMENTATION CHALLENGES AND LESSONS LEARNED

The sites included in the study experienced some common challenges in implementing training programs and collectively offer a number of important lessons even though they used different approaches to train TANF recipients and other low-income populations for paraprofessional LTC jobs. This chapter first presents common implementation challenges, citing specific examples and potential solutions. It then presents lessons based upon programs' experiences that program administrators and policy makers may find useful when considering the design and implementation of LTC training programs for low-income populations.

A. IMPLEMENTATION CHALLENGES

Designing and implementing a LTC training program for TANF recipients and other low-income populations may be a daunting task, particularly for organizations that have little experience in that field or with those populations. Among the programs included in the study, CHCA was the only one with a lengthy history of working both in the LTC field and with public assistance recipients. HH was the Richmond Redevelopment and Housing Authority's and HOP was Dakota County Technical College's first experience designing a training program in the LTC field. LEAP was TMC Healthcare's first and its contract with the Department of Human Services was VMT's first experience designing a training program specifically for TANF recipients. While the programs experienced a range of successes, all experienced a myriad of challenges as they entered uncharted territory. The most common challenges are discussed below.

Training individuals with multiple barriers for LTC jobs is difficult; most programs have had to institute stringent selection criteria to achieve success.

Though the programs highlighted in this study are specifically targeted to TANF recipients and other low-income populations, many individuals in these groups are not appropriate for employment in paraprofessional LTC jobs and thus screened out from training. In fact, an earlier report for this study estimated that two in every five TANF recipients has low potential for employment in paraprofessional LTC jobs.[4] Some—for instance, those with certain prior criminal convictions, typically felony convictions—are automatically disqualified from employment in paraprofessional LTC jobs by state law and thus not accepted into training. Though not specifically mandated by state law, most LTC employers require CNAs to have a high school or equivalent degree, so individuals lacking this credential are typically not accepted into training either. Programs tend to officially screen out individuals with other serious barriers as well, such as substance abuse or mental health problems, in an effort to increase the likelihood of participant success and quality patient care in a field that can be stressful and emotionally draining. In addition, most programs require individuals to pass a physical health exam before accepting them into training due to the physically demanding nature of the jobs. Paraprofessional LTC jobs require assisting patients in activities of daily living such as bathing and dressing, which may require physically helping patients out of bed and assisting

[4] See Kirby et al. (2004)

them in their movement. CNA positions, in particular, require long hours of standing or walking as well as exposure to hazardous chemicals and infectious bodily fluids.

Most programs included in the study, however, go beyond screening out individuals who may not be appropriate for paraprofessional LTC jobs and are more selective about who they accept into training. For example, three of the four programs that provide CNA training aim to accept only those applicants who provide proof of reliable childcare and/or transportation in an effort to reduce the risk of logistical problems that can disrupt program attendance and, ultimately, patient care. Many also have extensive application processes, designed to mimic employment application processes and identify the most motivated and capable applicants. For example, at HH, applicants must (1) submit a written application including a personal statement about their goals and expectations, (2) complete a one-on-one interview during which they are evaluated on their responses, behavior and dress, and (3) submit letters of reference. At LEAP, applicants are also required to submit an application, complete an in-person interview, and submit three references. During the interview, applicants are asked about their achievements and work and volunteer history, and given situational questions to respond to. Selection is based on previous experience (especially in health care), how applicants present themselves, the availability of reliable childcare and transportation, and TABE test results. While CHCA does not specifically screen out applicants other than those with positive drug screens or disqualifying criminal convictions, it bases its selection of applicants on their goodness of fit for the profession. Goodness of fit is judged by an applicant's personality, ethics, and prior care-giving experience.

Together, these disqualification and selection criteria have resulted in a group of program participants who are likely more skilled and have fewer personal challenges relative to TANF recipients as a whole and have excluded a set of somewhat less qualified recipients who might, with a greater level of support, be successful in training and subsequent employment. Administrators of the HH program in Richmond call the latter group the "middle third" of the low-income population—those who might benefit from the program, but do not qualify under current eligibility rules. In fact, programs across the study sites have adopted strict selection criteria and attempt to exclude "the middle third" for a number of reasons.

First, programs screen out applicants with specific individual barriers or with multiple barriers to reduce staff burnout. The LEAP program, for example, operates with a very small staff who do not have the time, resources, or training to address the intensive service needs of participants with serious and multiple barriers. Staff are already struggling to address the needs of participants with domestic violence issues. Administrators and staff alike report that domestic violence is an issue that is not immediately apparent, affects the vast majority of LEAP participants, and often results in low self-esteem and other mental health problems as well as poor physical health (for example, being overweight). Handling this issue alone has been overwhelming for staff, and administrators fear that accepting individuals with more apparent barriers would increase staff stress, undermine staff confidence, and be emotionally draining. Despite additional program capacity and will among administrators and staff to serve as many people as possible, concerns about burnout have reinforced the need for strict selection criteria. Administrators and staff recognize that, as a result, LEAP is increasingly becoming a program that looks for the "best and the brightest" among its eligible populations.

Second, programs screen out applicants with certain barriers to make the most efficient use of program resources and maximize program results. For instance, administrators of the HH program in Richmond believe that it is most efficient to invest in participants who are highly motivated and most likely to succeed. They are reluctant to spend resources on those likely to drop out and prefer to invest their limited funds in a way that is most likely to reap positive returns. Administrators noted that it was particularly important to maximize participants' likelihood of success in the program's early years in order to help HH establish a good reputation among potential applicants, referral sources, and employers. They even highlight HH's extensive screening and selection process in marketing efforts with employers, suggesting that HH can save employers substantial resources they otherwise would have to spend recruiting and screening applicants since HH already does the screening and produces a highly qualified and appropriate pool of potential employees from which employers can draw directly.

Workforce development programs in the health care arena, and particularly in home health care, face the challenge of balancing the need and desire to create employment opportunities for low-income individuals with the need to protect a vulnerable consumer population. While it is certainly true that some TANF recipients—such as those with substance abuse problems or physical or mental health problems—may not be appropriate for employment in the LTC industry, programs could probably reach a bit deeper into the caseload and serve a somewhat broader group. To serve a larger proportion of TANF recipients and low-income individuals and avoid the need to "cream," programs might seek out additional resources that would enable them to hire more staff (particularly staff with specialized expertise in domestic violence and related issues), further train current staff, and ensure links to consistent childcare and transportation assistance. In addition, programs might consider adding a GED component so that those lacking a high school education are not precluded from participation. In LEAP, for instance, GED classes are mandatory for all participants without their high school degree and take place during a portion of the 10-week on-the-job training component (typically, 2 mornings or afternoons per week).

The "work-first" philosophy that is inherent in many TANF programs can impede program efforts.

Since the mid-1990s, "work-first" has been the dominant philosophy in welfare-to-work programs. In a work-first environment, programs focus on engaging TANF recipients in employment immediately or in activities that are intended to lead directly to employment rather than encourage recipients to meet their federal participation requirements through a range of activities. In addition, they rarely allow education and training as the principal up-front activity. The philosophical and practical shift away from education and training can have significant consequences for programs designed to train TANF recipients for paraprofessional LTC jobs.

First, it can result in recruitment problems and low enrollment in programs that rely on referrals from TANF case managers. In the "work-first" environment, TANF case managers are often discouraged from or reluctant to refer recipients to any education and training activity, regardless of its content, duration or potential outcomes. This includes even short-term job training programs—like the LTC training programs highlighted in this study—which do in fact count toward the federal participation rate calculation. This problem has been particularly salient in the HOP program, which relies exclusively on referrals from TANF program case managers. When Minnesota's TANF

waiver expired in October 2003, the state felt increased pressure to meet its federal participation rate in the absence of flexibility to disregard from the calculation those recipients who were subject to the terms of the waiver.[5] In response to this pressure, the legislature now requires counties to meet a state-defined participation rate that is even higher than the required federal participation rate, and penalizes counties up to five percent of their TANF block grant for failing to meet the participation rate and the state self-sufficiency support index (which requires counties to reduce their TANF caseloads). In return, Dakota and Ramsey counties, which once encouraged recipients to participate in a range of activities, now place most recipients in job search for six weeks followed by unpaid work experience for those who are unsuccessful in finding employment. Case managers are reluctant to refer recipients to any kind of training, even in conjunction with job search, given the new political environment and pressures. As a result, referrals to HOP—a pre-vocational training program that leads to vocational training—have been extremely low to date. Instead of the 144 referrals per year that HOP expected, the program has had 5-6 referrals per month.

Second, the "work-first" philosophy can result in a substantial delay in program entry among TANF recipients who are interested in and appropriate for LTC training, but may be characterized as job-ready. This has been a problem for CHCA since the early to mid 1990s when New York City implemented one of the earliest models of a "One-Stop Center" as a pilot project. At the time, CHCA had a contract to train participants in the Job Training Partnership Act (JTPA) program. When the city implemented the One-Stop Center, it mandated that all JTPA contractors use its services. This forced individuals who wanted to participate in CHCA's training to first complete the One-Stop Center's intake procedures, which were designed to place to individuals deemed "work-ready" into immediate employment. As a result, many who likely would have succeeded in training and been guaranteed employment at CHCA were either held up for months or denied access to the program completely. Similarly, in March 1998, the city began converting all welfare offices into Job Centers that emphasize "work first." All eligible applicants entering a Job Center are assisted in exploring and pursuing alternatives to welfare. Those who are assessed as able to work are required to engage in full time job search. Those who do not find employment and begin receiving welfare participate in the Work Experience Program (WEP), which provides structured work assignments in government and not-for-profit agencies throughout the city. Participants work a maximum of three days per week at their WEP assignment, and spend two days per week with professional job developers and/or in education, training, and job search activities designed to help them achieve self-sufficiency. In this environment, TANF recipients who are interested in becoming CNAs or home health aides have limited opportunity to pursue training.

A potential solution to the challenges presented by the "work-first" philosophy inherent in many TANF programs is to educate TANF administrators and staff about the ways in which LTC training programs can promote rapid entry into the labor force, and seeking multiple sources of referrals. Educating TANF administrators and staff on the short-term nature of LTC training may help administrators and staff recognize that training can count toward the federal participation rate and holds promise of leading to quick employment outcomes (most home health aide and CNA training programs last five to eight weeks). One way to educate administrators might be to bring them together with LTC employers who can relay their needs, the availability of jobs after training, and the

[5] Prior to welfare reform in 1996, many states applied for and received waivers from federal law to implement innovative policies and service delivery strategies.

benefits of industry training. At CHCA, administrators have encouraged employment services staff to develop relationships with TANF case managers who can exempt TANF recipients accepted into CHCA's training program from participation in WEP. Programs might also need to be creative in ensuring that they do, indeed, meet federal participation guidelines. For instance, in response to policy changes brought about by the loss of Minnesota's TANF waiver, HOP program administrators worked diligently with the county to certify HOP's eight-week program as a community work experience activity so that it could count toward federal participation requirements and that TANF recipients would not be required to participate in an additional core work activity while in HOP.

In addition, programs might be better served by relying on multiple sources of referrals to maintain adequate levels of enrollment. This would help to sustain program participation and operations through changes in the political tide. When referrals from the welfare system in New York City were low, CHCA encouraged word of mouth referrals and began targeted recruitment from other social service agencies and community-based organizations. When referrals from the welfare system in Tucson were low, LEAP expanded its reach to low-income youth in the region's One-Stop system. In contrast, HOP has not tapped into referral sources other than the TANF system and continues to be under-subscribed. Alternatively, policy-makers and administrators might consider ways to integrate TANF recipients into existing programs designed for broader populations rather than design programs specifically for recipients and then broaden their reach in response to recruitment challenges.

Few participants have taken advantage of the advanced training opportunities that programs offer.

Four of the five programs in the study offer participants opportunities to pursue additional education and training, yet few participants have taken advantage of these opportunities to date. LEAP participants who have worked at TMC Healthcare for at least six months may pursue training for CNA, Patient Care Technician (PCT), LPN, RN, and various medical technician positions at TMC's cost in exchange for a commitment to remain employed at TMC for two years. Remedial training to acquire prerequisites is also offered. To date, only 4-5 out of 144 LEAP graduates have participated in CNA training along with a few who have participated in medical technician training. At VMT, participants may enroll in the nursing school's LPN course at no cost through a Blanket Purchase Agreement (BPA) from the city government. Though exact numbers are not available, to date, only a handful of VMT's approximately 200 enrollees have pursued BPAs for this purpose. At CHCA, union members are eligible for union-sponsored LPN training as well as remedial training to acquire prerequisites. Training is at no cost to CHCA employees, but employees must work 80 hours per month for 6 out of 12 months to be eligible. Though exact numbers are not available, to date, few CHCA employees have enrolled in this training. At HH, the Richmond Redevelopment Housing Authority supports program graduates who want to advance to LPN or RN careers by offering scholarships and assisting with federal aid applications. To date, 2 of the program's 191 graduates have become RN students, 19 are LPN students, and 2 are practicing LPNs. There are a number of reasons why few program participants have taken advantage of these opportunities.

First, many program participants are not aware that the opportunities exist. At VMT, many TANF recipients want to become LPNs and know that the nursing school offers the course, but do not know that the city will cover the cost of training. At CHCA, home health aides are informed

about the benefits of unionization immediately after their three months of probationary employment (or on-the-job training), but the extent to which education and training opportunities are stressed during these informational sessions is not clear and most aides receive little follow-up information. Though a union organizer distributes informational material in CHCA's lobby every Friday, the only aides who are on site at CHCA at that time are the minority whose paychecks aren't directly deposited.

Second, advanced education and training is often not very accessible to program participants and graduates. LEAP graduates, for instance, find it difficult to access training because, though many classes are offered on site at TMC, most are only offered in the evenings when it is difficult to find child care and when graduates are either tired from working the first shift or are busy working the second shift. In addition, program participants may not have the prerequisites for advanced nursing classes (that is, no high school diploma or GED or low TABE scores) and therefore see training as a lengthy commitment beginning with remedial education classes. This is particularly a problem for LEAP and CHCA participants, since neither program requires applicants or participants to have a high school diploma or GED. At VMT, despite a high rate of interest in nursing, many program participants leave the health care field before even attempting to access additional training. In Washington, DC, there is often a lag of between two and six months between graduation and administration of the CNA certification exam (reasons are largely unknown to program staff and employers, though some suggest that there are too few testing facilities and opportunities). Some graduates take other jobs during this time that pay higher than a position for a CNA with no certification and never return to the LTC field. Others leave the field because they are not able to pass the exam; participants' skills tend to get rusty and confidence tends to wane during the lag between graduation and the exam.

To encourage more participants to take advantage of advancement opportunities, programs might take measures to better educate participants about opportunities and ease access to training. Participants should be informed about opportunities not only at program entry, but also periodically throughout their participation. For example, HH, which has the highest rate of take-up in advanced training courses, discusses career opportunities during orientation and assists participants with scholarship and financial aid applications for RN and LPN courses throughout the program.[6] Participants might also be motivated by their peers; programs might consider inviting former welfare recipients or others who started in entry-level positions and have gone through additional training in the field to talk with participants about their experiences. Easing access to training essentially means making training more convenient. LEAP has taken one step toward easing access by offering CNA and other training programs on site, and the union with which CHCA is affiliated is considering offering training at CHCA rather than the union site, which is a farther distance for most workers. Programs that cannot offer training on site might consider providing transportation to and from the training location as well as childcare at the training location during class time. Programs might also be well served by offering classes during daytime as well as evening hours.

In addition, programs might think creatively about providing advancement opportunities within home health aide or CNA positions—a sort of career lattice rather than career ladder. For instance,

[6] Take-up rates in HH might also be relatively high, however, because HH is the only program that requires applicants to have a GED or high school diploma, so all participants in this site enter the program with the prerequisites for RN and LPN courses.

an affiliate of CHCA recently received a grant to develop a model in which home health aides receive additional training in a particular specialty area and, upon completion, receive a certificate of specialization and pay increase for using their enhanced skills to provide a higher level of support to consumers. Specialty areas include effectively supporting consumers with physical disabilities, hospice and palliative care, dementia care, effectively assisting consumers with mental illnesses, and peer mentoring and each requires up to 40 additional hours of classroom training. In some cases, additional training to enhance skills within the home health aide or CNA context might be more achievable for program participants and graduates than training for more advanced job titles.

B. LESSONS LEARNED

Through their experiences designing and implementing LTC training for TANF recipients and other low-income populations, the programs included in the study have identified a number of factors that either have contributed to their success or were important to consider in weighing the costs and benefits of various program features. Many of these are not necessarily specific to LTC training programs per se, but are more widely applicable to training programs for low-income populations in any field. However, all can be seen as lessons for program administrators and policy makers interested in linking TANF recipients to paraprofessional jobs in the LTC industry.

Successful linkages may be more likely when the training provider and employer are the same entity; at the very least, strong partnerships between training providers and employers are critical.

In two of the five programs included in the study—LEAP and CHCA—the training provider and employer were the same entity, and in the remaining three programs, strong relationships existed between the training provider and LTC employers in the region. When the training provider and employer are the same entity, a seamless transition can occur between training and employment, thus capitalizing on the momentum that program participants have upon graduation from training and ensuring that successful participants do not stagnate or get lost in the system. Building strong relationships when the training provider and employer are not the same entity can ease participants' access to available jobs. Employers that are connected to and invested in programs might consider participants as "first-source" job applicants, have opportunities to get to know participants during training, and ensure that participants have the most up-to-date information about available job openings. Either structure enables programs and employers to work together to ensure that training meets employers' needs and that participants graduate from training with a keen understanding of employers' unique work place environments and prepared with the specific skills that specific employers require. Either structure might also enhance commitment among former program participants to employers, thereby reducing the staff turnover that results in part from competition within the local LTC industry.

The study sites used a variety of methods to involve employers in their efforts at various stages of program development and implementation. In HH, a for-profit health care staffing agency was asked to provide limited financial support for the program. Motivated by the needs of LTC employers that—like itself—faced severe labor shortages as well as the needs of the community, it became a key player in the design of the program as a result. Administrators of HOP involved each of the area LTC employers early by soliciting their help in designing the program's LTC training curriculum to meet their needs. The employers also provide the sites for the job shadowing

component of the program. Though VMT does not offer a job shadowing or work experience component, it has recruited LTC employers to provide sites for clinical CNA training. Many program graduates are subsequently hired by these employers, which get to know them during their clinical training. A separate division of VMT also manages two regional LTC facilities, so training program participants informally have priority, or at least advantage, over other applicants for available jobs there. Finally, VMT holds job fairs and is in the process of establishing an employer bank by networking with employers to encourage them to recruit from VMT in place of—or in addition to—their standard recruitment practices. In their conversations with employers, program administrators stress the availability of tax breaks for hiring TANF recipients and promote the program as offering a pool of pre-screened and qualified workers who have the soft skills, as well as technical skills, necessary to succeed on the job.

According to program administrators at LEAP, a more subtle way to encourage private-sector employers to provide government-sponsored training is to limit the burden of funding/grant program administration and paperwork by relying on fiscal intermediaries so that employers can focus on providing services. For example, as LEAP and TMC administrators sought government support to bring youth into the program, they found it much more palatable to contract with a community-based organization (CBO) that provides payroll and other services for youth in internships and training programs, than directly with the county. Reimbursement for youth in LEAP flows from the county to the CBO to TMC; as such, the CBO has responsibility for the vast majority of program administration and reporting, leaving time and energy for TMC's limited LEAP staff to focus on providing services.

A job shadowing or work experience component exposes program participants to the realities of paraprofessional LTC jobs and employers to a qualified pool of job candidates.

Three of the five programs included in the study—HOP, LEAP, and CHCA—incorporate a job shadowing or work experience component immediately before job search or employment. All consider this component an essential part of participants' training—HOP and LEAP so that participants can gain in-depth exposure to the health care field and hone in on a career goal, and CHCA so that participants can refine their skills and gain the confidence to become regular status employees. However, each of these programs recognizes that job shadowing and work experience can be overwhelming and anxiety producing—particularly for those who have not had previous experience in the health care field or in the labor market in general—and that participants need peer support during this time. As such, each offers support groups or mentoring for participants during this time. LEAP participants take part in a support group one morning every week during the 10-week work experience component, and participants at HOP and CHCA are mentored by employed peers during the 3-week job shadowing and 3-month work experience components, respectively. At CHCA in particular, mentors provide information to other program staff periodically about problems that have arisen and about additional supports that participants might need.

Job shadowing and work experience not only benefit program participants, but also benefit prospective employers. They enable employers to observe and evaluate trainees in terms of their technical skill set, soft skills (such as motivation and workplace etiquette), and personal characteristics. At LEAP and CHCA, there is a strong expectation, if not a guarantee, that the employer providing the work experience placements will hire the participants. Here, the benefit of

observing and evaluating participants is being able to identify areas where they can use additional support and training before permanent hire and being able to identify where best they might fit into the organization so as to capitalize and build on their strengths. At HOP, where the employers hosting job shadowing have informally agreed to treat HOP participants as "first-source" job applicants though in no way guarantee employment, the benefit of observing and evaluating participants is to screen potential employees and inform hiring decisions.

Programs must be resourceful in identifying and accessing multiple funding streams.

Tapping into multiple sources of funding can reduce the risk of programs folding when individual funding streams dry up. Two of the programs included in the study—HOP and VMT—rely exclusively on one source of funding—TANF—to support all program activities, and the future of these programs is questionable as a result. Funds for HOP are limited and may be spent over a three-year period only. Program administrators have not yet considered what will become of the program when the funds run out or the grant period expires. VMT's contract with the DC Department of Human Services (DHS) was a 12-month contract with 4 1-year options. Each year, VMT must resubmit a bid in order for DHS to exercise a new 1-year option. When the contract expires completely at the end of the five-year period (which will occur in July 2005), VMT will have to go through a new competitive bidding process in response to a new DHS request for proposals, and there is no guarantee that a contract will be awarded.

By contrast, programs that rely on multiple sources of funding have some recourse when grants expire or public budgets are cut. For instance, when the Department of Housing and Urban Development Hope VI funds and Housing Authority Division of Housing Operations and Resident Services "drug elimination" funds that supported the HH program began to expire, the program had to cut much of its outreach and supportive services. However, the program has sufficient funds from Care Advantage to continue the core components of the program (namely, the professional development course and CNA training) for another year while program administrators seek foundation or other funding to restore the supplementary components of the program.

Tapping into multiple sources of funding can also expand the array of program services and protect programs from being beholden to a specific set of rules or requirements set forth by specific funders. For instance, LEAP initially relied on one source of funding (the operating budget of the hospital system sponsoring the program), but one year after implementation administrators realized that in order to make enhancements and ensure that LEAP would be sustainable, they would have to tap into available public funding. Through an RFP from the state, the hospital system applied for a combination of TANF and Department of Labor (DOL) Welfare-to-Work funding to help support the program. It later tapped into DOL Youth Opportunities funding to expand the reach of the program to youth. CHCA's first primary source of public funding was JTPA's Title IIB. However, when mandatory intake and assessment procedures for JTPA contractors became incongruous with CHCA's approach, CHCA dropped its contract with JTPA and elicited funding from foundations which did not impose specific procedural requirements on the program. Currently, CHCA uses a combination of private foundation funding and public grant funding—most recently from TANF, WIA, and the Perkins Act—to provide an array of pre- and post-employment services to its participants.

Linkages with the TANF system can provide funding for program participants as well as access to a host of supportive services.

All but one of the programs included in the study relied on TANF funding to support program staff and activities; two of the programs relied on TANF funding exclusively. In addition to supporting program-specific activities, contracting with the agencies that administer TANF afforded LTC training programs access to TANF program staff and services to further support program participants. One area in which this has been particularly useful is case management. For instance, the Department of Economic Security (DES) in Tucson has one dedicated case manager who handles all TANF recipients participating in LEAP. Each week, this case manager attends LEAP's Life Skills class to distribute supportive service vouchers to participants and address their needs and personal issues, such as childcare, punctuality, or family problems. Having DES staff who are specifically trained for this role address these issues with participants relieves some of the burden from LEAP staff. LEAP also relies on DES to conduct in-depth assessments—including mental health screens, vocational assessments, and TABE testing—for program participants, which result in cost savings to the program. Similarly, HOP relies on the state Department of Human Services to conduct mental health and substance abuse screens and to provide treatment services when they are required. Though none of the programs made extensive use of other TANF-related services, theoretically programs that contract with agencies administering TANF also have access to the job search/job development resources embedded within that system.

Perhaps more importantly, program participants who are TANF recipients can lay claim to the range of financial supportive services—such as transportation stipends, childcare subsidies, uniforms and other equipment for employment—that TANF agencies provide. Relying on TANF agencies to provide these supports saves programs substantial resources. For example, by nature of their TANF receipt, all program participants at VMT receive $10 per day from the city's Department of Human Services (DHS) for each day they participate in employment services for at least four hours; stipends are intended to cover the cost of transportation. They are also entitled to a childcare voucher, which can be used at any approved provider, administered by a specially designated office within DHS. Finally, DHS provides financial bonuses to TANF recipients who obtain and maintain a job. They receive $100 for obtaining a job, $200 for remaining employed for 30 days, $300 for remaining employed for 90 days, and $150 for remaining employed for 6 months (recipients may receive up to $750 in total). TANF participants enrolled in LEAP are eligible for a range of standard DES supportive services allocated from the TANF program budget. These include, but are not limited to, five dollars per day for transportation, vehicle assistance (for example, vehicle insurance or registration), uniform or clothing vouchers, childcare assistance, eye examinations and glasses, housing assistance, relocation assistance, funding for professional licenses, and tools or equipment.

Retention must be a central component of program efforts.

Most programs in the study last between 5 and 12 weeks, and most program administrators agree that it is misguided to expect participants to become self-sufficient in this time. In the experiences of administrators and staff, participants' barriers do not end when participants become employed. Some barriers that have previously been addressed may resurface, and others may become exaggerated as participants adjust to the demands and stresses of the LTC workplace. For this reason, HOP and CHCA have invested in post-employment peer mentoring and counseling, and LEAP has invested in post-employment support groups for former program participants. A key

component of CHCA's retention strategy also includes an emphasis on advancement opportunities, pay increases, and full-time employment, as lack of stability and predictability in hours and wages is often another major contributor to attrition in the LTC workforce. In addition, many of the participants in the programs included in the study had prior training and/or experience in health care, but reported in focus groups leaving the field because of personal issues. This suggests that supportive services to help participants remain employed in the LTC field, such as case management and continued childcare or transportation assistance, might help to reduce employee turnover (and thus ensure more continuity in patient care) and help programs avoid spending scarce training resources on individuals who have previously been trained.

Dedicated staff who are fully committed to the program's mission ensure program stability and performance.

The programs included in the study have been blessed with a small group of extremely dedicated and talented leaders who initially framed and have fought to sustain the mission and performance of the programs. CHCA, LEAP, and HH were the brainchildren of specific individuals with extensive experience in the health care field who creatively developed programs from scratch to fulfill an unmet need in the low-income and LTC communities. While the VMT and HOP programs were developed in response to RFPs from the TANF agencies in their respective vicinities, both programs were shaped by people with extensive experience developing business relationships and preparing low-income individuals for technical jobs. In all of the programs, continuity among the administrators and staff has been a key element of providing comprehensive services and producing desirable outcomes; to date, programs have experienced very little turnover among administrators or staff.

IV. CONCLUSION

The purpose of this study was to assess the feasibility of creating workforce development programs to help TANF recipients and similar low-income individuals obtain and maintain paraprofessional LTC jobs. The study was motivated on one hand by the crisis in the LTC industry caused by the mismatch between the supply of and demand for paraprofessional workers, and on the other hand, by the increasing need among states to develop innovative strategies to help TANF recipients find employment. Data for the study were collected from site visits to five LTC training programs currently in operation across the country. This chapter summarizes the key findings from the study and presents implications for future research.

The study findings suggest that not only is it feasible to create workforce development programs to help TANF recipients and similar low-income individuals obtain and maintain paraprofessional LTC jobs, but in fact there are many different ways to design and implement such programs. Each of the five programs included in this study, for example, was operated by a different type of organization—a private for-profit organization; a hospital; a technical college; a worker-owned collaborative; and a housing authority. Some recruited TANF recipients directly and others indirectly. Some provided classroom and clinical training only, while others combined training with work experience or job shadowing and supportive services. And, programs relied on a variety of funding sources to support activities, including local TANF funds, grants from federal agencies such as the Department of Labor and the Department of Housing and Urban Development, contributions from private organizations involved in program efforts, and foundations.

The findings also suggest, however, that designing and implementing LTC training programs for TANF recipients and other low-income individuals can present a number of challenges. Some of the more common challenges include serving individuals with severe and multiple barriers, working within the framework of the "work-first" philosophy underlying many TANF programs, and encouraging participants to take advantage of advancement opportunities that programs have to offer. And, there are many important issues to consider in determining funding and recruitment strategies and in weighing the costs and benefits of various program components, such as work experience or job retention.

While the study findings offer important information about different ways in which LTC training programs may be structured and funded, they are based solely on qualitative data collected during site visits to programs and cannot answer questions about how effective programs are on participant outcomes such as employment and retention, earnings, and self-efficacy or self-esteem. Before policy-makers and program administrators invest resources in wide scale efforts to link TANF with the LTC industry, therefore, it may be wise to first design, implement, and evaluate smaller-scale demonstration projects. Demonstration projects can help refine policy and program choices and provide evidence of how individual program components do or do not help to achieve positive participant outcomes. They also can answer questions about program effectiveness and value and can help policy-makers and administrators design the most optimal programs in the most cost-efficient manner.

REFERENCES

Hecker, Daniel E. Occupational Employment Projections to 2021, Monthly Labor Review. Washington, DC: U.S. Bureau of Labor Statistics, February 2004.

Kirby, Gretchen, LaDonna Pavetti, Jeffrey Max, and Jesse Gregory. "TANF Recipients as Potential Long-Term Care Workers: As Assessment of the Prospects in the District of Columbia, Illinois, Maryland, and South Carolina." Washington, DC: Mathematica Policy Research, Inc., November 2004.

Scanlon, W. "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides is a Growing Concern." GAO-01-750T. Testimony before the Committee on Health, Education, Labor and Pensions, U.S. Senate. Washington, DC: U.S. General Accounting Office, May 2001.

Stone, Robyn I. and Joshua M. Wiener. "Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis." Washington, DC: The Urban Institute and the American Association of Homes and Services for the Aging, October 2001.

U.S. Bureau of Labor Statistics (BLS). "Occupational Employment Statistics." Washington, DC, May 2003.