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Direct Care Alliance, Inc.

Direct Care Alliance Policy Brief No. 1

Using Recovery Act Funds to Improve Direct Care Jobs and the Quality of Direct Care Services

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Direct care workers, including nursing assistants, home health aides, and personal and home care aides, constitute one of the largest and fastest growing sectors of the low-wage workforce. Strategies to improve the quality of these jobs can help promote economic recovery and expand the middle class. This policy brief provides an overview of direct care work and discusses how Recovery Act funds can be used to address some of the challenges faced by direct care workers. The charts at the end provide detail on the programs discussed.

An Overview of Direct Care Work

More than three million people are employed as direct care workers in the United States. They fall into three major categories: nursing assistants, home health aides, and personal and home care aides. These crucial workers help people perform basic daily activities. They provide medical care, from taking blood pressure and helping with range of motion exercises to cleaning out trachea tubes. They also provide emotional support, bringing stability, peace of mind, freedom, and positive energy into the lives of the people they support.

Nursing assistants generally provide care and some clinical services in institutional settings like nursing homes, hospitals, and assisted living facilities. The services provided by nursing assistants (and, therefore, their wages and benefits) are paid for primarily with Medicare and Medicaid funds.

Low Wages, High Turnover

... about three million workers were employed in direct-care occupations in 2006. Still, the current number of direct-care workers is insufficient to meet demand. .... A major factor in the deficit of direct-care workers is the poor quality of these types of jobs. Direct-care workers typically receive very low salaries, garner few benefits, and work under high levels of physical and emotional stress.

—Institute of Medicine (2008)

Home health aides have similar duties, but generally provide care in homes and are employed by home health agencies. Like nursing assistants, the services they provide are generally paid for with Medicare and Medicaid funds.

Personal and home care aides work in home settings. They mostly provide personal care, but may also provide clinical services. The services provided by personal and home care aides are generally not paid for with Medicare and Medicaid funds (except for services provided through Medicaid waivers). According to the Bureau of Labor Statistics, about one quarter of

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This is the first in a series of policy briefs about the direct care workforce in long-term care issued by the Direct Care Alliance (DCA). Editorial committee: Leonila Vega, Nancy Folbre, Eileen Appelbaum, Elise Nakhnikian. These papers were conceived at a meeting of labor economists, lawyers, long-term care researchers, and other experts convened by the DCA and funded by the Russell Sage Foundation.

The Direct Care Alliance

The Direct Care Alliance is the advocacy voice of direct care workers, by direct care workers, and for direct care workers in long-term care. We empower workers to speak out for better wages, benefits, respect, and working conditions, so more people can commit to direct care as a career. We also convene powerful allies nationwide to build consensus for change.

personal and home aides are self-employed.[1]

According to the most recent occupational projections of the Bureau of Labor Statistics, an additional 1 million direct care jobs will be created between 2006 and 2016. The three direct care occupations are all among the top ten in terms of the number of jobs they will add between 2006 and 2016—together they will account for one out of every four jobs created by the top 10 growth occupations. In percentage terms over this period, personal and home care aides and home health aides are projected to be the second and third fastest-growing occupations in the United States, with both projected to grow by about 50 percent.

Direct care jobs typically pay low wages and often provide limited employment benefits.

Why It Pays to Invest in Direct Care Workers

Using Recovery Act funds to invest in direct care workers is a highly effective way of simulating the economy, both directly and indirectly.

The President has made it clear that job creation is one of his top priorities, and direct care work is one of the nation's fastest growing occupations. Despite the economic downturn, we must attract many more direct care workers as the baby boomers age, and improving wages, benefits, training, and working conditions is the best way to make these important jobs more attractive.

Supporting the development of this workforce helps states avoid future headaches in the form of unmet demand. It also helps employers stabilize their workforces and save money currently spent on turnover. Low wages and poor working conditions fuel high annual turnover rates—more than 70 percent in nursing homes, and between 40 and 60 percent in home care agencies—that cost long-term care employers at least $5 billion annually.[5]

What's more, studies have shown that raising the wages of low-wage workers stimulates the economy more than giving raises or tax cuts to the wealthy, since the money is used to purchase basic necessities. The nation's direct care workers already spend $56 billion a year on goods and services.[6]

- The $11.14 median hourly wage for nursing assistants is roughly two-thirds of the median wage for men in the United States. The median wages for home health aides and personal and home care aides are even lower: $9.62 and $8.89 respectively.
- The median wage for all female direct care workers ($9.26 in 2006) is about 70 percent of the median wage for all female workers ($13.46).[2]
- About half of female direct care workers live in families with low incomes (below twice the federal poverty line), and one in five live in families with incomes below the poverty line.[3]
- About one out of every four direct care workers lack health insurance.

Given this combination of low compensation and rapid growth in jobs, it comes as no surprise the demand for direct care workers outstrips the supply. A synthesis of recent reports on direct care workforce shortages found a median vacancy rate of 8 percent for all direct-care jobs and a 16 percent vacancy rate for part-time ones.[4]

Effective deployment of direct care workers can help reduce overall health expenditures by averting hospitalization and institutionalization in nursing homes. Unfortunately, short-sighted efforts to contain public spending by keeping direct care wage rates low restricts the supply of new workers and contributes to high turnover rates within the profession.

Market forces alone cannot ensure that an increased supply of direct care workers will be available to meet increased demand for their services. Absent large-scale reform, direct care jobs will continue to be poorly rewarded, and it will become even more difficult to recruit and retain direct care workers.

How Recovery Act Funds Can Help

In its final report, issued in April 2008, the Institute of Medicine's Committee on the Future Health Care Workforce for Older Americans identified three broad strategies that can be used to improve the quality of direct care jobs:

➢ Increasing the wages and benefits provided to direct care workers

[1] PHI *Who are Direct-Care Workers?* fact sheet, January 2009. http://www.directcareclearinghouse.org/download/NCDCW%20Fact%20Sheet-1.pdf
[2] Kristin Smith and Reagan Baughman, Low Wages Prevalent in Direct Care and Child Care Workforce, Carsey Institute, University of New Hampshire.
[3] Ibid.
[4] See National Direct Service Workforce Resource Center and others, A Synthesis of Direct Service Workforce Demographics and Challenges Across Intellectual/Developmental Disabilities, Aging, Physical Disabilities, and Behavioral Health, November 2008, p. 10.
[5] See the PHI fact sheet *Eldercare/Disability Services: Untapped Engine for Job Creation and Economic Growth*, http://www.directcareclearinghouse.org/download/PHI%20FactSheetNo2.pdf
[6] Ibid.

- Enhancing the quality and quantity of education and training of direct care workers;
- Improving the work environment.

The Recovery Act includes funds that could be used for each of these strategies.

INCREASING WAGES AND BENEFITS

The Recovery Act includes two temporary new funding streams that could be used to increase wages and benefits for direct care workers: 1) an increase in the amount of state Medicaid expenditures that are paid for by the federal government; and 2) a portion of funds provided through the Act's State Fiscal Stabilization Fund.

Temporary Increase in the Federal Medical Assistance Percentage (FMAP): The Act increases the federal share of funding for Medicaid by an estimated $87 billion. This enhanced funding is available for Medicaid expenditures incurred by states between October 1, 2008, and December 31, 2010. These funds could be used by a state to finance an increase in reimbursement rates that must be used to increase the wages of direct care workers, known as a "wage pass through." About half of the states already have such a policy in place. The most effective policies also set a wage floor for direct care workers. For example, in 2006 the District of Columbia raised hourly reimbursement rates and directed that about two-thirds of the increase go toward higher wages.[7] At the same time, the District implemented a wage floor of $10.50 an hour for home care workers.

State Fiscal Stabilization Fund: The Act provides $53.6 billion in grants to governors for state fiscal relief. Most of this funding is reserved for education, but $8.8 billion can be used for other governmental purposes, including increases in the wages and benefit of direct care workers. These funds could be used, for example, to finance the state costs of a wage pass-through program for direct care workers.

Although the allowable uses of both of these sources of funding clearly encompass using them to increase the wages and benefits of direct care workers, there are practical considerations that will limit the extent to which these funds can be used for new initiatives in many states. In states with substantial budget deficits,

Acronyms

AoA: Administration on Aging
CFDA: Catalog of Federal Domestic Assistance
CFR: Code of Federal Regulation
DOL: Department of Labor
FMAP: Federal Medicaid Assistance Percentage
FY: Fiscal Year (unless otherwise noted, this is the federal fiscal year, which starts in October).
HHS: Department of Health and Human Services
OSHA: Occupational Health and Safety Administration
PHSA: Public Health Services Act
TAA: Trade Adjustment Assistance
WIA: Workforce Investment Act
WIB: Workforce Investment Board

Strategies to Improve Direct Care Work and Recovery Funding that Can Be Used to Implement Them

IMPROVING PAY AND BENEFITS

- Enhanced Federal Medical Assistance Payments
- State Fiscal Relief Funds

EDUCATION AND TRAINING

- Workforce Investment Act Programs: Adults, Dislocated Workers/Displaced Homemakers, and Youth
- Worker Training and Placement in High Growth and Emerging Industry Sectors

DEMONSTRATION AND INNOVATION, INCLUDING CULTURE CHANGE INITIATIVES

- Prevention and Wellness Fund—Evidence-based Clinical and Community-based Prevention and Wellness Strategies
- Comparative Effectiveness Funding
- Funding for Enforcement of Worker Protection Laws and Regulations, including Wage Protections and Health and Safety Standards
- Various Federal-Level Administrative Funds

[7] See Dorie Seavey and Vera Salter, Paying for Quality Care: State and Local Strategies for Improving Wages and Benefits for Personal Care Assistants, AARP Policy Institute (2006) http://assets.aarp.org/rgcenter/il/2006_18_care.pdf.

these funds will go to closing those deficits. Thus, the greatest potential for using these funds to increase wages and benefits for direct care workers will be in states with small or no deficits.

Another practical consideration is the time-limited nature of these funding streams. The enhanced Medicaid funding ends on December 31, 2010, and the State Fiscal Stabilization Funds are available for obligation through September 30, 2011. States that use these funds to increase the wages and benefits of direct care workers will need to plan carefully to ensure that increases are substainable after federal funding returns to normal levels.

IMPROVING EDUCATION AND TRAINING

The Recovery Act includes very substantial increases in funding for job training and workforce investment programs. Most of these funds can be used to provide additional education and training for direct care workers between now and June 2010.

In particular, the Recovery Act provides $250 million for a new competitive grant program—Worker Training and Placement in High Growth and Emerging Industry Sectors—administered by the U.S. Department of Labor. In awarding these funds, DOL must give priority to projects that prepare workers for careers in the health care sector.

The Act also increases funding for the nation's two main job training and workforce investment funding streams for adults, boosting the WIA Adult program and the WIA Dislocated Worker/Displaced Homemaker program by nearly 50 percent and more than 80 percent respectively between now and June 2009.

Both of these programs are federally funded but administered largely at the local and state levels by state and local Workforce Investment Boards. These bodies have primary responsibility for how the additional WIA funds they receive are spent.

WIA Adult funds can be used to provide a broad range of training and other employment and supportive services to all adults 18 and older. WIA is generally a universal program, but the Recovery Act place a priority on using the new funds to provide training and services to low-income individuals and beneficiaries of public assistance.

WIA Dislocated Worker and Displaced Homemaker funds can also be used to provide a broad range of training, employment and supportive services, but are limited to adults who meet the law's definitions of dislocated worker (most commonly, someone who has been terminated or laid off, including certain self-employed workers) or displaced homemaker (a homemaker who is no longer supported by another family member).

The increase in WIA funding provides an opportunity to ensure that

Direct Care Work: The Three Major Occupational Categories

	Nursing Assistants	Home Health Aides	Personal and Home Care Aides
Related Job Titles	Certified nursing assistant (CNA), geriatric aide, orderly, hospital attendant	Nurse's aide, CNA	Personal care attendant, personal care assistant, direct support professional, home attendant
Employment (2006)	1,447,000	787,000	767,000
Median Hourly Earnings (2007)	$11.14	$9.62	$8.89
Health Uninsurance Rate (Women)	Hospital Aides: 13 percent Nursing Home Aides: 24 percent	30 percent	40-50 percent
Typical Employers	Nursing and residential care facilities (52 percent) Hospitals (29 percent)	Home health care and social-assistance agencies	Home care agencies Individual and family services organizations Private households

state and local Workforce Investment Act programs provide services and training to direct care workers and their supervisors. Workforce development policies should also support efforts to improve the quality of direct care jobs

FUNDING INNOVATION

Job satisfaction for direct care workers is closely tied to organizational culture, including the respect and autonomy they are granted on the job. A variety of strategies have been developed that aim to improve relationships between direct care workers and supervisors, increase the recognition that direct care workers receive for improving the quality of care, and increase workers' autonomy and involvement in decision-making processes.[8]

Two funding streams in the Recovery Act could be used for innovative projects that implement or evaluate such strategies.

Prevention and Wellness Fund. The Act provides $650 million for "evidence-based clinical and community-based prevention and wellness strategies" authorized by the Public Health Service Act. Such strategies must deliver specific, measurable health outcomes that address chronic disease rates. HHS, which has considerable discretion in determining how these funds will be used, must provide a plan to Congress on their proposed uses by the middle of this May. The Administration on Aging is currently working with HHS to develop recommendations on how these funds may be used.

Comparative Effectiveness Research. The Act provides $1.1 billion to the U.S. Department of Health and Human Services for "comparative effectiveness" research to determine which treatments work best for which patients and the costs and benefits of various options. These evaluations typically involve specific medical techniques or drugs, but $400 million of the overall appropriation provided to HHS may be used for research that compares the effectiveness of "items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions," a definition that encompasses direct care services.

Both funding streams could be used for direct care services that aim at increasing the mental and physical health of long-term care recipients by empowering the direct care workers who provide the bulk of their hands-on care. A key component of the Green House® approach[9] to long-term care, for example, involves broadening the role of direct care workers, providing them with substantially more training than is currently required for CNAs, and increasing their compensation. Preliminary research finds improvements in quality of life and certain clinical outcomes for Green House residents. In New Jersey, advocates are recommending the use of comparative effectiveness funds to promote the concept that better quality jobs lead to more consistent, higher-quality care.

In addition, the Recovery Act provides HHS, DOL and other agencies with

[8] For more on these strategies, see the National Clearinghouse on the Direct Care Workforce best practices database, http://www.directcareclearinghouse.org/practices/index.jsp

[9] For more on Green House, see The Green House Concept, http://www.ncbcapitalimpact.org/default.aspx?id=148

How to Use the Internet to Find Out More About a Particular Program or Funding Source

1) Read the description of the program in the Catalog of Federal Domestic Assistance available at www.cfda.gov

2) Go to the website of the federal agency that oversees the program—you'll want to look at both the Recovery Act page maintained by the agency (all agencies are required to have one) and the page for the program itself.

3) Go to Recovery.gov to see if they have any information on the program or funding source.

4) Go to Grants.gov—within 20 days after enactment, agencies must post synopses of funding opportunity announcements there; and within 30 days of enactment, the Grants.gov synopsis must link to the full announcement on the agency website.

5) Read the Agency's "Recovery Program Plan." By May 1, federal agencies must have one in place for each program named in the Recovery Act.

additional administrative funding, and the authority to transfer up to 1 percent of funds received to other programs or appropriations accounts within the agency that received Recovery Act funds. This gives HHS and DOL flexibility to develop new federal initiatives aimed at improving the quality of direct care work.

REDUCING ON-THE-JOB INJURIES

Direct care workers are four times more likely than workers in general to suffer a non-fatal occupational injury or illness. These injuries are typically related to interacting with patients and overexertion. The Occupational Safety and Health Administration (OSHA) has taken various steps to address this problem, including developing ergonomic guidelines for nursing home workers and operating a National Emphasis Program in 2002-2003 targeting occupational injuries in nursing and personal care facilities.[10]

The Act provides the federal Department of Labor with $80 million to enforce worker protection laws and regulations, including OSHA standards. These funds could be used by DOL to reduce the rate of occupational injuries experienced by direct care workers.

Recovery II: Additional Federal-Level Improvements and Investments in Direct Care Work

Economists increasingly agree that Congress will need to pass additional economic recovery legislation in the coming months. Such a package should include additional improvements and investments in direct care work. Direct care worker advocates might request:

- Enhanced federal Medicaid funding for home care and other community-based services that is tied directing to improving the wages and benefits of direct care workers;
- A federal-level minimum hourly wage floor for direct care workers who provide care through publicly funded programs; and
- Dedicated funding for the education and training of direct care workers.

Recovery Act Programs and Funding that Could Help Improve Direct Care Jobs

Key to Our Charts

Program	Funding	Uses	Resources/ Comments
Program Name (or Appropriations Account) **The federal agency** administering the program. **Statute:** A citation to the section or sections of the United States Code that authorize and govern the program. **Regulations:** The section or sections of the Code of Federal Regulations that apply to the program or funding. **CFDA Number:** The Catalog of Federal Domestic Assistance, a federal government publication available at www.cfda.gov, is a basic reference guide to federal funding available to states and local governments, non-profit and other entities, and individuals. If a program has a CFDA number, you can go to the guide for further information about it.	The first number is the amount of new funding the Recovery Act provides for the program. The column also includes: 1) The type of funding, usually either a formula grant or competitive grant; 2) General information on how funds will be allocated, if applicable and available; 3) Who is eligible to apply for the funding; and 4) The date through which the funding is available (if different from September 30, 2010, the date section 1603 of the Act makes all funds available until unless expressly provided otherwise) and any other notable information related to the timing of funding.	Allowable uses of the funds, and any notable restricted uses. Requirements, if any, related to allocation of funds among allowable uses or program purposes. For programs providing direct benefits or services to individuals (e.g., employment and training programs), who is eligible to receive them.	Additional information that can help shape implementation and advocacy efforts.

[10] See OSHA's National Emphasis Program—Nursing and Personal Care Facilities, July 17, 2002, http://www.osha.gov/OshDoc/Directive_pdf/CPL_2_2002-03.pdf.

Program	Funding	Uses	Resources/Comments
State Fiscal Stabilization Fund, Title XIV—Allocation for Public Safety and Other Government Services Department of Education	$8.85 billion Formula grant to states Funds are available for obligation at the state and local levels until September 30, 2011.	Almost no limitation on use of funds, which can be used for "government services."	In most states, this funding will be used to close budget deficits, typically by supplanting state funding for existing programs and services. In states with small or no deficits, however, these funds can be used to expand existing programs and services, or to create new ones. For distribution, see http://www.nea.org/assets/docs/StateFiscalStabilizationTable.pdf
Medicaid: Temporary Increase in FMAP Department of Health and Human Services, Center for Medicare and Medicaid Services	Increases federal share of funding for Medicaid by an estimated $87 billion. Three components: 1) Postpones decreases in FMAP scheduled for certain states; 2) Increases FMAP rate for all states by 6.2 percent; and 3) Provides additional assistance to certain high unemployment states. Increased funding available for Medicaid expenditures between October 1, 2008 and December 31, 2010. States must maintain Medicaid eligibility and enrollment policies ("eligibility, standards, and methodologies") that were in place as of July 1, 2008 (or restore those policies) to receive enhanced funding.	Expenditures authorized under Medicaid	For distribution of first installment of funding (for October 2008 to March 2009), see http://www.hhs.gov/recovery/statefunds.html
Enforcement of Worker Protection Laws Department of Labor	$80 million	Enforcing minimum wage, occupational health and safety standards, and other DOL-enforced worker protection laws and regulations.	

Program	Funding	Uses	Resources/Comments
Prevention and Wellness Fund—Evidence-based Clinical and Community-based Prevention and Wellness Strategies Department of Human Services, Office of the Secretary New Program	$650 million HHS Secretary may transfer funds to other HHS appropriation accounts of the Department of Health and Human Services, as determined by the Secretary to be appropriate. HHS must provide operating plan to Congress within 90 days of enactment and before obligating any funds.	Evidence-based clinical and community-based prevention and wellness strategies authorized by the Public Health Service Act, as determined by the Secretary, that deliver specific, measurable health outcomes that address chronic disease rates.	AoA press release notes they are "currently working with the Department to develop recommendations on how those funds may be used. The aging network has demonstrated over time that it can be an important strategic partner in delivering preventive services. In recent years, the network has played a significant role in implementing evidence-based prevention programs as well as interventions proven to improve the health of older Americans, reduce chronic disease, injuries and illness and lower long- term care costs.
Comparative Effectiveness Research Department of Human Services, Agency Healthcare Research and Quality New Program	$1.1 billion ($400 million to HHS Office of the Secretary, $300 million to Agency for Health Care Research and Quality, and $400 million for National Institutes of Health).	Funds allocated to HHS Office of the Secretary must be used to accelerate the development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies, through efforts that include conducting, supporting, or synthesizing research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions. Funds allocated to AHRQ are to carry out titles III and IX of the Public Health Service Act, part A of title XI of the Social Security Act, and section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Funds allocated to NIH are to conduct or support comparative effectiveness research under section 301 and title IV of the Public Health Service Act	The newly formed Federal Coordinating Council for Comparative Effectiveness Research will help coordinate research and guide investments in comparative effectiveness research funded by the Recovery Act.

Program	Funding	Uses	Resources/Comments
Workforce Investment Act (WIA)—Adult Program Department of Labor, Employment and Training Administration **Purpose:** Improve the quality of the workforce and enhance the productivity and competitiveness of the nation's economy by providing workforce investment activities that increase the employment, retention, and earnings of participants, and increase occupational skill attainment by the participants. **Authorizing Statute:** Title I-B of the Workforce Investment Act (WIA) **Regulations:** 20 CFR Parts 660 to 663 **CFDA:** 17.258	$500 million Formula grants to states States must allocate 85% of funds to Local Workforce Investment Boards (LWIBs). Remaining 15% is reserved for administration and statewide activities. Responsibility for determining use of WIA funds in each state is split between the state's Workforce Investment Board and local WIBs. Funds available for obligation immediately and remain available until June 30, 2011. States must submit a modification of their WIA State Plan by June 30, 2009. Plan modifications are subject to the same public review and comment requirements that apply to the development of the original plan.	Adult (18 and older) employment and training activities under the Workforce Investment Act (WIA). Funds can be used for "supportive" services, including transportation, childcare, dependent care, housing and needs-related payments, if an individual needs them to participate in the program.	See the U.S. Department of Labor's Guidance Letter 14-08 for policy guidance on the implementation of this and other Recovery Act provisions related to WIA. WIA provides three levels of service: 1) *Core*—including outreach, job search and placement assistance, and labor market information; 2) *Intensive*—more comprehensive assessments, development of employment plans and counseling and career planning; and 3) *Training*—occupational and basic skills training. Although WIA is generally a universal program (i.e., not means-tested), low-income individuals and recipients of public assistance must receive priority for *intensive* services and *training* (according to guidelines developed by state and local governments). Moreover, the Recovery Act places a priority on using these new funds to provide services generally to low-income individuals and public assistance recipients. Local boards are generally required to provide training through "individual training accounts," but Recovery Act funds may be used to contract directly with an institution of higher education or other eligible training provider, if the board determines it would facilitate the training of multiple individuals in high-demand occupations.

Program	Funding	Uses	Resources/Comments
WIA—Dislocated Workers and Displaced Homemakers Department of Labor, Employment and Training Administration **Purpose:** Employ dislocated workers and displaced homemakers **Statute:** Title I-B of WIA. **Regulations:** 20 CFR Part 663 **CFDA:** 17.260	$1.25 billion Formula grants to states. See Appendix for estimated state allocations. States allocate funds to local workforce investment boards by formula prescribed by the governor. Funds available for obligation immediately and remain available until June 30, 2010.	Employment and training activities (see above) for dislocated workers and displaced homemakers. A dislocated worker is someone who meets any of the following criteria: 1) terminated or laid off, or has received a notice of termination or layoff from employment; 2) eligible for or has exhausted unemployment insurance; 3) demonstrated an appropriate attachment to the workforce, but not eligible for unemployment insurance and unlikely to return to a previous industry or occupation; 4) terminated or laid off or received notification of termination or layoff from employment as a result of a permanent closure or substantial layoff; 5) employer has announced that facility will close within a 180 days; or 6) self-employed, but unemployed as a result of general economic conditions or natural disaster; or A displaced homemaker is a homemaker who is no longer supported by another family member.	See the U.S. Department of Labor's Guidance Letter 14-08 for policy guidance on the implementation of this and other Recovery Act provisions related to WIA. Recovery Act funds may be used to contract directly with an institution of higher education or other eligible training provider, if the board determines it would facilitate the training of multiple individuals in high-demand occupations
WIA—Dislocated Workers National Reserve Department of Labor, Employment and Training Administration **Purpose:** Provide national emergency grants to re-employ dislocated workers in high unemployment and high poverty areas. **Statute:** Section 173 of WIA **Regulations:** 20 CFR Part 671 **CFDA:** 17.260	$200 million Project grants. Applicants may include states, outlying areas, local workforce boards, and non-profit and private organizations whose purpose is to provide targeted services to eligible beneficiaries. Funds available for obligation immediately and remain available until June 30, 2010.	"National emergency grants" for dislocated worker employment and training services in "high unemployment" and "high poverty" areas.	Recovery Act funds may be used to contract directly with an institution of higher education or other eligible training provider, if the board determines it would facilitate the training of multiple individuals in high-demand occupations.

Program	Funding	Uses	Resources/Comments
WIA—Youth Department of Labor, Employment and Training Administration **Purpose:** To help low-income youth acquire the educational and occupational skills, training, and support needed to achieve academic and employment success and transition to careers and productive adulthood. **Statute:** Title I-B of the Workforce Investment Act of 1998, Subtitle B **Regulations:** 20 CFR Part 664 **CFDA:** 17.259	$1.2 billion Formula grants to states. Funds available for obligation immediately and remain available until June 30, 2010.	Youth activities, including summer jobs for youth. May not be used for Youth Opportunity Grants. Recovery Act changes the age for an "eligible youth" from 14-21 to 14-24. Funds must be used to provide services to low-income youth who: 1) are deficient in basic literacy skills, or 2) require additional assistance to complete an education program or secure and hold employment. Also eligible are youth who fall into one of the following categories: school dropout, homeless, runaway, foster child, pregnant or a parent, offender.	See the U.S. Department of Labor's Guidance Letter 14-08 for policy guidance on the implementation of this and other Recovery Act provisions related to WIA.
Worker Training and Placement in High Growth and Emerging Industry Sectors Department of Labor, Employment and Training Administration New program.	$250 million Competitive grants awarded by DOL. DOL must give priority to projects that prepare workers for careers in the health care sector. Funds available for obligation immediately and remain available until June 30, 2010.		Funds may be used to contract directly with an institution of higher education or other eligible training provider, if the board determines it would facilitate the training of multiple individuals in high-demand occupations.

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