SECTION 1009 REPORT

RECRUITMENT AND RETENTION CHALLENGES FOR THE WORKFORCE DELIVERING THE MOST FREQUENTLY USED SUPPORTS AND SERVICES

2016

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I. Executive Summary

After months of discussion and review of available data, the Workgroup on the Direct Support Workforce (hereinafter called, "the Workgroup") mandated by the Michigan Legislature[1] has concluded that the critically important frontline workforce delivering face-to-face supports and services to the state's residents with intellectual and developmental disabilities, mental illness, or substance use disorders is not stable. Employers, including individuals using self-determination as well as organizational employers are not able to recruit or retain a qualified, competent workforce. In order to fulfill the service and support delivery requirements of both the state's Mental Health Code and the Medicaid program and ensure the ability to comply with the Centers for Medicare and Medicaid Services Home and Community Based Services rules, additional state investments and new state policies and practices are needed to secure the dignity, well-being, independence and community involvement of people living with disabilities.

Within its diverse membership, the Workgroup reviewed relevant information and data on workforce recruitment and retention. This information included the large numbers of job vacancies across the state, the high staff turnover rates, the current inability to provide supportive services due to staff shortages, the closure of supportive service organizations and programs because of staff shortages, and reports from beneficiaries on the pain of losing relationships and trust when direct support staff move to a higher paying job. Medicaid beneficiaries speak openly of a high "quality of life"—to pursue employment, education, and inclusion—that is not possible without a stable, competent direct support workforce.

The needed workforce is not small and the jobs require complex skills and knowledge. The direct support workforce currently provides the majority of Medicaid funded behavioral health services and these services comprise a growing proportion of the overall Medicaid funded behavioral health services.

The Workgroup concludes that immediate actions are needed to address the current and worsening staffing challenges and that other state policy changes are needed in the long-term. The Workgroup's unanimous recommendations are:

Immediate Actions Needed to Improve Wages and Benefits

The Michigan Legislature and Governor need to make additional investments into all the named Medicaid covered supports and services to assure that:

Direct support staff earn a starting wage of at least $2.00 per hour above the state's minimum wage. These investments and the starting wage rate should increase as the state's minimum wage increases and should include the mandatory employer costs (FICA, worker's compensation, etc.) associated with employment.

[1] P.A. 84 of 2015, Article X, Section 1009

1. Direct support staff earn paid leave time at the minimum rate of 1 hour for every 37 hours worked (i.e., 10 days a year for full-time employment).

- The Michigan Department of Health and Human Services (MDHHS) should use its contractual authority to set Medicaid payment and reimbursement rates that provide sufficient funding to provide and maintain a starting wage rate of at least $2.00 per hour above the state's minimum wage, associated employer costs, and paid time off to the direct support workforce.
- The Michigan Department of Health and Human Services and each Prepaid Inpatient Health Plan (PIHP) shall collect and publish data on the size, compensation, and stability (turnover rates and job vacancies) of the direct support staff providing the identified supports and services at least annually. The collected data shall be used to assess the impact of the funded wage increases on the wages paid, direct support staff turnover rates, job vacancies, service delivery, and the adequacy of the direct support workforce.

Long Range Solutions to Improve Workforce Stability

- Develop and fund a promotional campaign to build public awareness and appreciation of people with disabilities and those who chose a career to support them. The campaign should build off the system's mission of inclusion and stigma elimination. MDHHS, the PIHPs, employers, direct support staff, and people with disabilities should participate in the creation and execution of the campaign.
- Expand the existing MDHHS funded matching services registry for Home Help beneficiaries to include all Medicaid beneficiaries using the self-determination option to address the difficulties (conducting criminal background checks, advertising, recruiting, etc.) individuals using self-determination have in finding direct support staff.
- Change Michigan's current laws and policies on criminal background checks to include a "rehabilitation review" similar to those authorized in 17 other states in order to increase the potential pool of applicants for direct support careers. Implementing a review process would allow people with a disqualifying criminal conviction to demonstrate that they no longer represent a threat to people needing supports and services or to their property.
- Provide publicly financed tuition reimbursement or incentives to direct support workers who are actively studying to become psychologists, behavior specialists, nurses, therapists and other health care occupations that serve people with intellectual and developmental disabilities, mental illness, and substance use disorders in order to increase the number of people interested in doing direct support work. This effort will also improve the frontline skills and broaden the experiences of other health care occupations serving these populations.
- Legislatively require the creation of a workgroup to identify the wide ranging initial competences, skills, and aptitudes needed by the direct support staff and to provide recommendations for a training and credentialing program to assure a competent direct support workforce.

II. Legislative Charge to the Workgroup

In the FY 2015-2016 appropriations boilerplate for the MDHHS, the Michigan Legislature requested an examination of the workforce recruitment and retention challenges faced in delivering a list specific services used by people with intellectual and developmental disabilities, mental illness and substance use disorders. (P.A. 84 of 2015, Article X, Section 1009, See Appendix Item 1) The section requested MDHHS to convene a workgroup of stakeholders to develop suggestions and recommendations to address the identified challenges.

In 2015, a broad array of statewide and local groups focused on the needs and interests of Medicaid beneficiaries sought to inform their state elected leaders on the issues of frontline staffing shortages, staffing turnover, and the changing costs of staffing. All of these groups expressed concerns about the impact of these issues on the dignity, well-being, and independence of people with disabilities using Medicaid funded services. The present Workgroup was created to examine those concerns.

MDHHS established a diverse stakeholder workgroup comprised of people living with disabilities, representatives of agencies delivering the services highlighted by the legislative language, Community Mental Health Services Programs (CMHSPs), agencies focused on the interests of workers, and Pre-paid Inpatient Health Plans (PIHPs). A list of the workgroup members is attached as Appendix Item 3.

The Legislature asked the Workgroup to focus on four specific Medicaid funded services provided by direct support staff: community living supports, personal care, respite services, and skill building. In keeping with the legislature's intent, the appointed Workgroup included in its review for recommendations, other similar services: supported/integrated employment services, out-of-home non-vocational habilitation, prevocational services, and Home Help in the workgroup's discussions. These additional Medicaid funded services provide vital supports and services. Home Help services, for example, include a wide array of personal care services for the target populations that can be used to compliment a named service like community living supports. Definitions for all nine service types are outlined in Appendix Item 2.

Background on these Medicaid-funded services and supports and the workforce

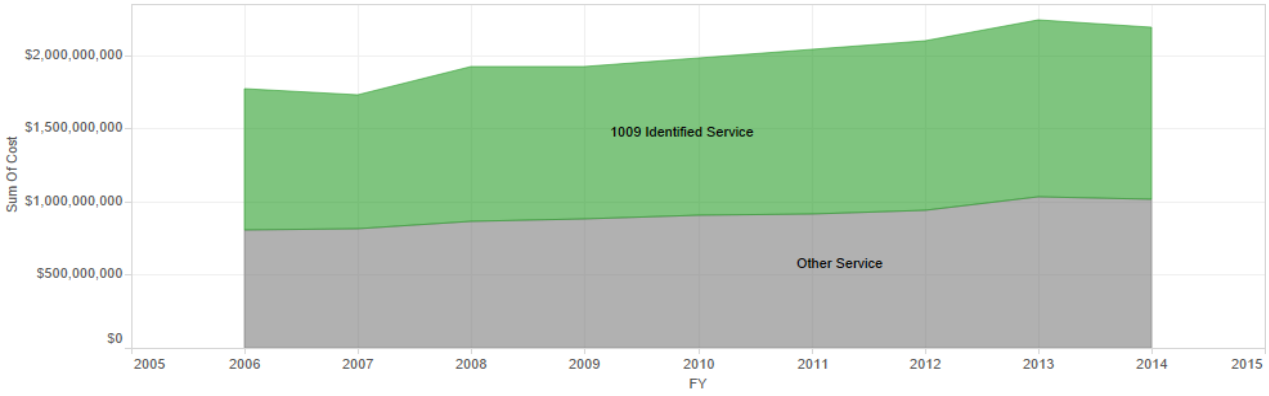
As a national leader, Michigan was one of the first states in the country to close its state-run institutions for individuals with disabilities. In their place, a community-based supports and services delivery system was built and that system continues to grow today. Self-determination and independent living models are core and growing elements of this support and service system. This delivery system is largely possible through the advocacy of people with disabilities, the leadership of state and county governmental agencies and provider organizations, and the work of frontline direct support employees.

Michigan's Medicaid budget allocates approximately $2.5 billion to provide behavioral health supports and services. In data reviewed by the Workgroup, the direct care related behavioral

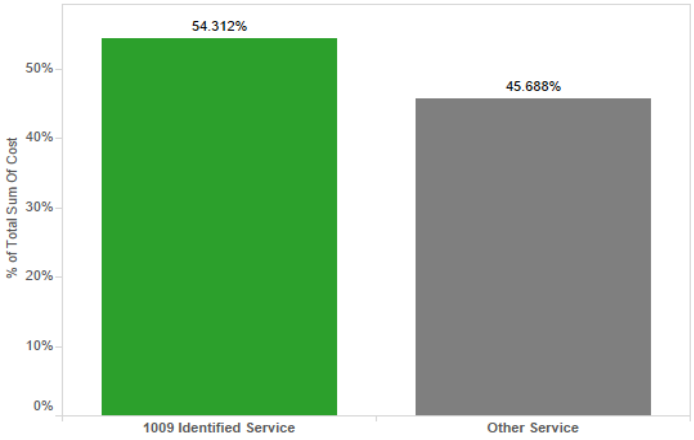
health Medicaid services represent the majority of face-to-face services used and needed by Medicaid beneficiaries. Table 1 below is a comparison of the annual expenditures on the identified direct care delivered services and supports in relation to overall expenditures. The trend lines in the table demonstrate that the amount of funding designated to these services is growing.

Table 1 – A Comparison of the Annual Expenditures For Direct Care Related Services to All Services

Statewide Total Annual Service Cost



FY06-14 Service Cost % of 1009 Services



Section 1009 Identified Services

Unlicensed CLS
H2015 15 Minutes
H0043 Per Diem

Licensed Residential
H2016 Community Living Supports Per Day
T1020 Personal Care Per Day

Respite
T1005 15 Minutes
H0045 Per Day
S5150 15 Mins
S5151 15 Mins
T2036 Per Day
T2037 Per Session

Skill Building
H2014 Per 15 Minutes

Supported Employment
H2023 Per 15 Minutes

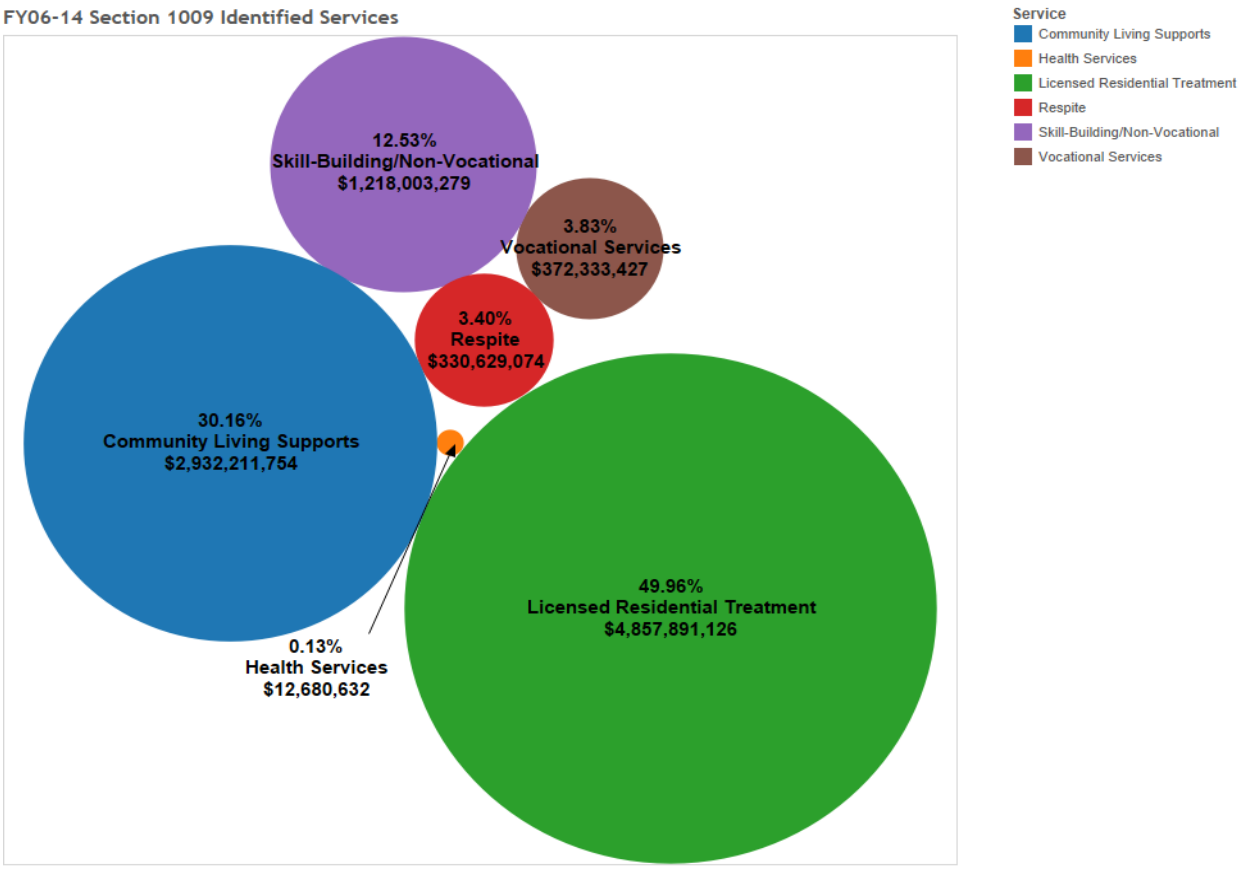
Pre-Vocational
T2015 Per Hour

*All codes summarized to include modifiers.

Source: 404 Data FY06-14

Table 2 illustrates the gross amount of expenditures from FY06 through FY14 for the identified direct care related services and supports that were included in the Section 1009 Workgroup's analysis. The table demonstrates the respective amount expended on each of the identified services for FY06 through FY14.

Table 2

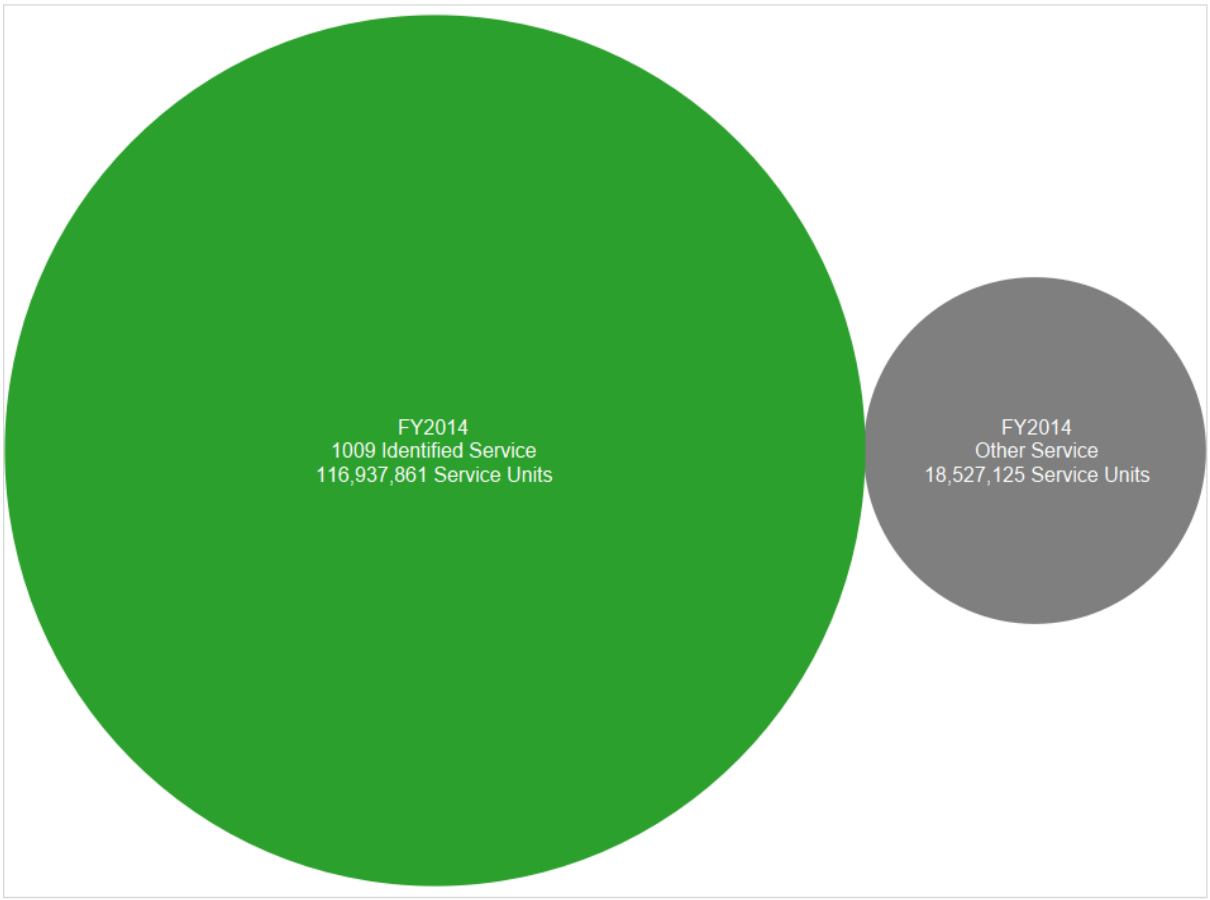


Source: FY06-14 404 Data

Table 3 compares the gross numbers of units of the identified services provided during FY14 with all other Medicaid covered services provided.

Table 3

1009 Units Vs Other Service Units



Total statewide FY2014 Section 1009 identified and other service units.

Source: 404 Data FY06-14

Overall, 193,347 Michigan residents used Medicaid behavioral services in FY 2014. Approximately 88,736 individuals received one or more of the identified behavioral health services each year. A substantial number of these Medicaid beneficiaries are also using Medicaid's Home Help program to receive supports which are necessary to allow them to continue to live in their communities. The Medicaid beneficiaries who receive these identified services and supports range in age from newborns to 102 years old and live in every Michigan town and community. Many of these individuals have intellectual and/or developmental disabilities caused by congenital birth impairments, various infections and diseases, a variety of head and other trauma caused by accidents, unanticipated reactions to medications, and medical procedures gone wrong. Others are individuals with severe mental illness or children with severe emotional disturbance.

These supports and services are provided in every Michigan community and serve Michigan residents through one of two ways. Hundreds of small companies, usually non-profits, and funded by the local public community mental health agency deliver the supports through its hired staff. Or, the Medicaid beneficiary acts as their own employer hiring, screening, training, and supervising his/her staff using a budget created in conjunction with the community mental health agency. This delivery option to self-direct one's own services is a choice increasingly exercised by Medicaid beneficiaries.

The legislatively identified Medicaid funded supports and services are delivered in individuals' homes and apartments, work places, congregate residential settings, schools and colleges, and throughout communities as people with disabilities live lives as fully participating, valued members of this society.

The direct support workforce, delivering the identified Medicaid funded services, play critical roles in securing a "great qualify of life, safety, and independence" called for by the Michigan Mental Health and Wellness Commission. An estimated, 44,000 people in Michigan are employed in direct support positions that serve as the foundational element for the delivery of needed Medicaid behavioral health supports and services.

The Workgroup relied on survey data to learn more about the direct support workforce size, compensation, and stability.[2] The workforce appears evenly divided between full-time and part-time employees. The average starting wage for direct support staff is $8.69 per hour resulting in a weekly take home paycheck of about $260 for full-time employment. Experienced direct support staff in Michigan earn an average $9.62 an hour and take home a weekly amount of about $275 a week.

Wages for direct support employees has fallen significantly behind their counterparts in the health care sector. According to the state's Michigan Labor Market Information, nursing assistants in Michigan earn on average $13.25 per hour in May 2014.[3]

[2] Explanation of Partnership for Fair Caregiver Wages's survey. Appendix Item 4 is a copy of their fact sheet.
[3] www.milmi.org

This wage disparity exists in spite of considerable overlap between the roles of direct support employees and nursing assistants. In fact, a comparison of the essential functions of the two occupations reveal that the training requirements needed for direct support staff actually exceeds that of nursing home nursing assistants. In addition, direct support staff have more required competencies, job responsibilities, and risks. Direct support staff are expected to play a significant role in teaching new skills, are trained to assist individuals with physician prescribed medications and are expected to carry out non-aversive techniques to manage instances of physical aggression or disruption on the part of individuals served, to name a few of the differences. See Appendix Item 5.

The same survey of Michigan provider agencies conducted in 2015 found an annual average of 37% turnover rate among agency employed staff and 2,600 unfilled jobs among the responding Medicaid funded employers. In February 2016, Kent county employers reported a 20% vacancy rate; they were attempting to hire over 200 direct support staff. Similarly, 15 of the 85 jobs serving beneficiaries using self-direction were not filled. [4]

A 2012 survey of employers providing the identified services found that paid time off was offered to full-time direct support staff by 70% of the responding employers. Only 30% of employers offer paid time off to their part-time direct support staff, who represent half of their employees. [5]

Direct support staff serving beneficiaries using the self-determination option cannot be offered any paid time off under current Medicaid policies.

The job is rewarding as described here by the people who have been doing it for decades:

> *"In my home I have six staff and five subs who currently work under me. All of them have been with me for more than a year. Some have been working with developmentally disabled individuals as long as I have (37 years). We are African, African American, Asian, and white. We are young college students, single moms, and middle aged fuddy-duddies. And when I asked all of them why they do what they do they simply reply "I like it". This work tends to grab a hold of you. It tends to redevelop who you are. I even know a teacher who after teaching all day comes and work for us."* See Appendix Item 6.

The job can be physically, mentally, and emotionally challenging while also requiring exceptional judgment and skills in supporting another individual to live a full life. Examples of frequently used language of some of the job descriptions reviewed by the workgroup are helpful in understanding the complexity, breadth, and importance of the work of direct support staff:

- Working knowledge of each individual's plan of service and associated documentation requirements and standards.
- Provides Community Living Support services and/or Respite services under the direction of the client and/or authorized guardian or representative.

[4] Conversations and emails with Network180 staff in February, 2016.

[5] "Findings from a Survey of Community Mental Health Provider Organizations: Understanding Michigan's Long Term Supports and Services Workforce," a report for the Michigan Office of Services to the Aging by PHI, March 2013, http://phinational.org/sites/phinational.org/files/surveys-focus-groups/cmh-provider-survey.pdf

- Provides skill development related to activities of daily living by assisting, reminding, observing, guiding or training the beneficiary.
- Transports those served in personal vehicles to appointments, shopping, social activities, etc., as per each individual's person-centered plan.
- Investigates possibilities for social and recreational activities and encourages/supports and advocates for the participation of those served.
- Physically capable of lifting and transferring, potentially large wheelchair users, safely with assistance. Ensure that team members do not lift any individual weighing in excess of fifty pounds, except in emergency situations, without assistance.
- Maintain a current knowledge and ability in the use of all lifts where applicable. This includes, but is not limited to, Arjo, Hoyer and van lifts and all accessories used in the operation of transferring and transportation of individuals.
- Successfully complete in-home training in the operation of the vans used in transportation of individuals. And, be able to operate appliances, lawn mowers, snow blowers, and to use appropriate techniques, dictated by safety.
- Assist all individuals daily, as needed, in their personal appearance and hygiene by assisting the individual in bathing, brushing teeth, personal grooming, selecting clothing and dressing.
- Successfully complete CMH medication and home training procedures. Following full clearance as a Med Passer, ensure that medications are administered and documented as written.
- Maintain a current knowledge of each individual's medication and administer individual's medication as assigned by the Home Supervisor.
- Sweeping, Loading dishwasher, Vacuuming, Scrubbing toilets and showers, Washing dishes, Snow removal, Yard care, Laundry chores and clothing care, Operating and refueling vehicles and various cleaning tasks. *See samples of direct support Job Descriptions in Appendix Item 7.*

As two experienced direct support staff summarized the responsibilities of a direct support Position.

"This is an important job, not a starter job or a stepping stone job. The people we serve are important people who play an important role in our society." [6]

[6] From a written statement by two current direct support staff. Names are being withheld.

The initial qualifications for a direct support position are comprehensive and notable. Many people in the state have difficulty meeting these frequently required initial job qualifications outlined in the table below.

Common Direct Support Worker Job Qualifications	
18 years of age	High school diploma or GED
Pass a criminal background check	Pass a drug screening
Language skills	Reasoning ability
Mathematical skills	Computer skills
A cell phone that can be used for work	Good driving record
Good moral character	Lifting or exerting—physical demands
Demonstrate warmth, respect, empathy, genuineness with people with disabilities	Physical exam, free of communicable disease, including a TB test
Successful completion of training	Three personal references
An insured car to transport beneficiary	

As outlined in the attached state policies, initial training and preparation to work as a direct support worker are currently grounded in basic safety issues, including first aid, CPR, and implementing the individual beneficiary's plan of service as well as training in chapter 7 of the Mental Health Code on recipient rights, abuse and neglect, dignity and respect, confidentiality, and incident reporting. See Appendix Items 8 & 9. From those modest beginnings, other training requirements come into play from the Department of Licensing and Regulatory Affairs under the licensing requirements for adult foster care homes. More training requirements come from the Office of Safety and Health Administration (OSHA) and the federal Office of Civil Rights. See Appendix Item 9. In addition, the MDHHS has a 1,600 page training guide posted in its website that is widely used in the field.

Training requirements are different across the different waiver programs serving people with disabilities. As a result, a direct support worker may need to meet different training requirements to provide the same payment service code, on the same day, to two individuals who are serviced by two different Medicaid waivers.

Employers estimate that 75 to 120 hours of training are required before a direct support worker is ready for unsupervised work with most Medicaid beneficiaries. Employers also report difficulties in accessing training sessions required by the state, a community mental health board, or a PIHP and some employers seek the ability to train their own staff.

In many parts of the state, direct support workers and their employers complain that PIHPs or community mental health boards will not accept or acknowledge training credentials that a workers bring from another PIHP or CMHSP. Frequently, experienced direct support workers are required to go through the same training session again which wastes time and money.

This issue is described in the field as a "lack of reciprocity." The redundant training is explained or justified as a lack of knowledge of the other course, a lack of teaching abilities of the other course, or a disagreement with the actual competencies taught by others in the state funded system.

Some workgroup members would like to see a statewide training and credentialing system for direct support staff similar to the federally defined training program for certified nursing home aides. This would include a defined minimum set of competencies, a model training curriculum, issuance of a certificate/license that is recognized by all employers, and a statewide database of

people who have been found competent to be a direct support worker through testing and skills assessment. http://www.michigan.gov/lara/0,4601,7-154-63294_74190---,00.html

III. Challenges in Recruiting and Retaining Direct Support Staff

The workgroup spent considerable time identifying challenges faced by both agency employers and beneficiaries using self-direction in recruiting and retaining direct support staff. While these groups are distinctly different kinds of employers, they face the same core challenges. The recruitment and retention challenges named by the workgroup members are presented here by topic areas.

Wages and compensation

- Low wage rates are the primary challenge. Many of the other challenges would not exist if competitive, adequate wages were offered. The amount a direct support worker clears working 40 hours a week at minimum wage is less than $250 a week after state and federal taxes and Social Security contributions. Appendix Item 10.
- Wages are not competitive and do not attract qualified workers with the needed skills or attitude. Target, Wal-Mart, and Costco start employees at higher wages.
- Wages are not aligned with the job responsibilities and expectations.
- Lack of consistent work schedules/hours in serving beneficiaries cause applicants and employees to seek more stable, predictable employment opportunities.
- Competition for workers varies by region; some counties offer many other better paying jobs.
- Too many part-time jobs; people need more income and hours.
- Wage rates have been flat, but the workload keeps increasing. There are fewer people on a shift and staff with less training are working.
- Lack of universal paid sick time puts workers and participants at risk. Without paid time off, burnout increases, as well as stress, which leads to injuries.

Recruitment Challenges

- The applicant pool across the state is getting smaller and most new applicants possess fewer competencies or qualifications.
- Applicants who are willing to work for the low wages paid, often do not meet the criteria for employment (driving record, high school diploma, criminal background checks, passing an employment physical including a drug and alcohol screen or the right attitude for this work).
- The geographical location of service areas and Medicaid beneficiaries are often a challenge to find qualified applicants, especially in rural areas.
- Younger people have left or are leaving rural areas of the state due to a poor economy and job prospects.
- The criminal background check process reduces the pool of qualified applicants. The past convictions of some applicants do not always reflect the job applicant today. As a result people who are interested are turned away from these careers.
- Beneficiaries who hire their own direct support employees find it difficult to complete full background checks.
- Beneficiaries who choose to self-direct their own services have challenges in recruiting and finding people who want to do this type of work.

- It is frequently hard to find the right staff to provide the needed care. Making the best match of staff to beneficiaries to deliver highly personal, intimate services is challenging.

Retention Challenges

- Providing these services and supports is a hard job. There are much easier jobs with better wages available.
- Personal risk is a concern. There are serious consequences to participants if employees don't do their job or if they make a mistake.
- Job descriptions imply a significant financial up front burden on the worker. Employees need a phone, car, driver's license etc.
- Some, but not all, employer cultures show a lack of respect and dignity for the worker in considering scheduling issues they may have.
- High employee turnover leads to burnout, excessive overtime, injuries, and job vacancies which result in even more workers leaving the job.
- There is a minimal advancement potential or lack of job mobility or career ladder for long staying staff.
- Lack of schedule flexibility for workers with children.
- The physical demands of the job can be difficult for older workers.
- Increase in personal risk in the work environment (e.g., fewer workers on the shift, fear in doing this job).
- Increased emphasis on documentation does not align with what the employee signed up for. Many prefer to serve as caregivers, not record keepers.

Training Challenges

- Training reciprocity does not exist. Trained, experienced workers often have to take repetitive training classes when they move to a new county or employer.
- There is a lack of resources for professional development for supervisors. More training resources are needed to show appreciation and to build relational, communication and conflict resolution skills.
- It is a constantly changing work environment, therefore it is difficult to adapt and keep up with evolving training needs.
- Training requirements require a lot of flexibility in the worker's schedule to get to all the training sessions because required classes are not offered conveniently. Training courses are often offered only in person and not online. This means that the schedules of college students cannot be accommodated.
- Training requirements are confusing. They come from multiple sources, including state and federal law; PIHP and CMHSP requirements, as well as what's needed to implement an individual beneficiary's plan of service.
- Most trainings are provided classroom lecture style and not delivered in a format most conducive to the learning style of employees who have chosen to be caregivers. Interactive and hands on training would be more effective in many cases.

Public Funding System

- Uncertainty of Medicaid budgets and revenue at both state and local levels make it difficult for PIHPs, CMHSPs, or employers to plan and grow wages and benefits. See Appendix Item 11 for the MOKA employer mandatory costs for a job paying a wage rate of $8.50 per hour and one paying $9.91 an hour.

- The move to "Fee for Service" payment models increased competition among providers. This placed cost pressure on controlling the largest section of budget - direct care wages and fringes.
- "Fee for Service" does not support giving the best care. It leads to providers/employers competing for the lowest cost to get cases, which in turn, does not support competitive wages and benefits.
- Medicaid is the payer for these supports and services. Other payers are not available to cover these costs.
- Home Help does not have sufficient administrative resources to run the program effectively. Beneficiaries cannot find Home Help providers and Home Help providers who want more hours cannot find beneficiaries.
- Home Help providers quit or stay away because of challenges to get paid, lack of predictable work hours, low wages, and the lack of paid sick time.

IV. Why Action is Needed Now

The difficulties that Medicaid-funded agencies and beneficiary employers have in attracting and retaining a competent direct support workforce produces negative outcomes and consequences for beneficiaries, their employers, direct support staff, the system of supports and services, and the state of Michigan. The workgroup concludes that the direct support workforce is woefully understaffed, rendering the Medicaid funded supports and services delivery system unstable. This instability has led to declines in access and quality of the supports and services delivered, and these additional outcomes:

- Residential services needed by beneficiaries have not opened or have closed because sufficient staffing cannot be found.
- A disturbing number of direct support positions across the state are vacant every day.
- Some providers report they are making contingency plans for the time when there is not overtime or staff to deliver needed services.
- If needed services are to be delivered in the face of high turnover rates and job vacancies, more and more overtime is assigned to available staff.
    - Overtime, while welcomed by many low wage workers, is more expensive to employers and largely ignored by payment structures.
    - Overtime puts additional stress and risk of injury to beneficiaries and workers who are working double shifts or 50, 60, 70 hours a week
    - Too much overtime or injury results in turnover or job vacancies that can result in more overtime.
- Better paying, less stressful jobs are available and growing in Michigan's private sector (retail, food services, etc.) as the state's economy has improved.
- In short, the present delivery system of community supports and services employing direct support employees is not sustainable without legislative action and policy changes.

Medicaid beneficiaries know, experience, and mourn the negative outcomes and consequences of direct support staff who leave them for higher paying jobs. In the words of two men relying on Medicaid supports and services:

"We have been living in an AFC home for about 4 ½ years now. During these last 4 ½ years we have had to rely on staff for numerous things such as helping us get ready in the morning, cooking, shopping, transportation, and help with our medical care.

We love the staff that take care of us, they have become like a family to us. We spend all of our time with the staff. They are there for our Birthdays and Holidays at times that our family is not.

It is really hard when a staff that we care about leaves and goes to a better paying job. It is hard for us when we have new staff coming into the home.

Some things are private like showering and getting dressed or medical things and it can be difficult for us. It is hard when we have someone we don't know very well come into our home to work, and we don't know them very well. It is staffs' job to help us in a very personal way.

Each time a new staff comes in we have to start fresh with building a relationship with them before we are comfortable with them helping us. We are trusting the staff with our lives every day.

Staff is expected to give us our medicines to help us feel better and if they give us the wrong medications we could get sick.

It is really hard for us when our favorite staff find a new job that pays more money, and leave us. If they were paid better to take care of us, they wouldn't leave.

We love our staff, they make us happy when we are sad. They help us with medications and food. They help us go places that we wouldn't be able to go without their help." [7]

V. Recommendations to Address Direct Workforce Challenges

After months of discussion and review of available data, the workgroup on the direct support workforce mandated by the Michigan Legislature[8] has concluded that the critically important frontline workforce delivering face-to-face supports and services to the state's residents with intellectual and developmental disabilities, mental illness, or substance use disorders is not stable. Employers, including individuals using self-determination as well as organizational employers are not able to recruit and retain a qualified, competent workforce. In order to fulfill the service and support requirements of both the state's Mental Health Code and the Medicaid program, additional state investments and new state policies and practices are needed to secure the dignity, well-being, and independence of people living with disabilities.

Within its diverse membership, the workgroup reviewed information and data on the large numbers of job vacancies across the state, the high staff turnover rates, the current inability to provide supportive services due to staff shortages, supportive service organizations and programs

[7] Statement received by the Workgroup from Medicaid beneficiaries whose names have been withheld.
[8] P.A. 84 of 2015, Article X, Section 1009

that are closing because of staff shortages, and the pain of losing relationships and trust when direct support staff move to a higher paying job. Medicaid beneficiaries speak openly of a high "quality of life"—to pursue employment, education, and inclusion—that is not possible without a stable, competent direct support workforce.

The needed workforce is not small and the jobs require complex skills and knowledge. The direct support workforce currently provides the majority of services funded by this segment of the Medicaid budget. And, their share of the Medicaid budget is growing.

The workgroup concludes that immediate actions are needed to address the current and worsening staffing challenges. And, other state policy changes are needed in the long-term. The Workgroup's unanimous recommendations address both immediate and long term recommendations.

Immediate Actions needed to improve wages and benefits

- The Michigan Legislature and Governor need to make additional investments into all the named Medicaid supports and services to assure that:
    1. Direct support staff earn a starting wage of at least $2.00 per hour above the state's minimum wage. These investments and the starting wage rate should increase as the state's minimum wage increases and should include the mandatory employer costs (FICA, worker's compensation, etc.) associated with employment.
    2. Direct support staff earn paid leave time at the minimum rate of 1 hour for every 37 hours worked (i.e., 10 days a year for full-time employment).

- The Michigan Department of Health and Human Services should use its contractual and statutory authorities to set Medicaid payment and reimbursement rates that provide sufficient funding to provide and maintain a starting wage rate of at least $2.00 per hour above the state's minimum wage, associated employer costs, and paid time off to the direct support workforce.

- The Michigan Department of Health and Human Services and each Prepaid Inpatient Health Plan (PIHP) shall collect and publish at least annually data on the size, compensation, and stability (turnover rates and job vacancies) of the direct support staff providing the identified supports and services. The collected data shall be used to assess the impact of the funded wage increases on the wages paid, direct support staff turnover rates, job vacancies, service deliver, and the adequacy of the direct support workforce.

The Federal Bureau of Labor Statistics pegs the average wage for all jobs in Michigan at $16.70 per hour and nursing assistants are paid, on average, over $13.00 per hour. (www.bls.gov) According to a recent survey by the Partnership for Fair Caregivers Wages, the average starting wage for direct support staff is $8.69. Direct support positions are not economically attractive and are competing with retail jobs that start at $10 and $11 an hour.

Agency and individual employers are struggling to fill job vacancies. Direct support jobs come with many requirements—criminal background check, drug screening, a car and phone to use for work, observation skills, math and documentation skills, ability to life 30 pounds or more, night and holiday shifts, ability to administer medications, and more.

Current wages are not aligned with the job skills or responsibilities that are outlined in the examples of job descriptions in Appendix Item 7.

Survey data[9] indicates that a large number of agency and individual employers are not providing paid sick time to direct support staff. With wages so low, many direct support staff come to work "sick" rather than miss a day's pay. As a result, the Medicaid beneficiaries they support and serve are exposed to contagious illnesses or injury.

Professionals in human resources explain that "offering paid sick leave is actually cost-effective, enhancing recruitment, retention and morale and reducing the impact of presenteeism, or people showing up to work even when they are ill."[10]

Long Range solutions to improve workforce stability

1. ***Develop and fund a promotional campaign to build public awareness and appreciation of people with disabilities and those who chose a career to support them.***

The campaign should build off the system's mission of inclusion and stigma elimination. MDHHS, the PIHPs, employers, direct support staff, and people with disabilities should participate in the creation and execution of the campaign.
There are numerous successes and positive stories of individuals with disabilities that could be crafted to both educate and change attitudes of community members. There are likewise many individual employees who demonstrate the passion, commitment and resilience which would inspire others to pursue careers supporting Michigan citizens with disabilities.

The recommended campaign could include the following activities, again including people with disabilities in the design, development, and implementation of the campaign.

- ✓ Speaking engagements with target groups
- ✓ Press releases centered around positions value to community and consumers
- ✓ Local TV news reports that center on value to community and consumers
- ✓ Appearances on local radio and television talk shows
- ✓ Promotion at job fairs and high school and college career days
- ✓ Promote internships to colleges with a possible link to earning college credits

[9] "Findings from a Survey of Community Mental Health Provider Organizations: Understanding Michigan's Long Term Supports and Services Workforce," a report for the Michigan Office of Services to the Aging by PHI, March 2013, http://phinational.org/sites/phinational.org/files/surveys-focus-groups/cmh-provider-survey.pdf
[10] "The Importance of Sick Pay in Human Resources Management," by Tia Benjamin, MBA. http://smallbusiness.chron.com/importance-sick-pay-human-resources-management-33867.html

- ✓ Involve local public officials in the marketing plan
- ✓ Radio public service announcements

2. ***Expand the existing MDHHS funded matching services registry for Home Help beneficiaries to include all Medicaid beneficiaries using the self-determination option to address the difficulties (conducting criminal background checks, advertising, recruiting, etc.) individuals using self-determination have in finding direct support staff.***

Implementing this recommendation would improve the ability of self-directing Medicaid beneficiaries and direct support staff looking for more hours of work to connect by expanding the Department's Home Help matching services registry. The Home Help matching services registry funded by Michigan Department of Health and Human Services (MDHHS) is housed at the Michigan Public Health Institute (MPHI) and currently only serves Home Help beneficiaries. This matching service registry includes a criminal background check. The registry is a place for screened direct support workers to find Medicaid beneficiaries who need an additional worker or a new worker to provide supports and services. An expanded and improved matching services registry would assist beneficiaries who want to use the self-direction delivery options and would help direct support workers find participants and more hours of work. Please note that the Workgroup's wage and paid leave time recommendations apply to Home Help providers as well. Implementation of this recommendation helps prevents wage disparities if the matching services registry is open to all Medicaid beneficiaries using self-direction.

3. ***Change Michigan's current laws and policies on criminal background checks to include a rehabilitation review process similar to those authorized in 17 other states.***

Michigan's current criminal background checks process unnecessarily restricts the applicant pool that is available to work for agencies and for beneficiaries using the self-direction service option. Current state laws and Medicaid policies ban employment in direct support occupations for a specified number of years after an individual has served any prison or jail sentence, successfully completed parole, and taken other steps to rehabilitate their suitability for employment.

Implementing a review process would allow people who currently have a disqualifying criminal conviction to demonstrate that they do not represent a threat to people needing supports and services or their property. Like 17 other states, Michigan should support changes in state laws and Medicaid policies to implement a robust, effective rehabilitation review process that allows people seeking direct support employment to demonstrate that they do not pose a threat to personal safety or property. This process is especially helpful to individuals, who want to do direct support work, and who have been convicted of offenses that occurred long ago and have since avoided any additional contact with the criminal justice system. Rehabilitation review processes can increase the pool of applicants that can be employed at an employer's discretion.[11] See Appendix Item 12 for the rehabilitation appeals policies of Illinois and Wisconsin.

[11] SOURCE: Criminal Background Checks Protections for Long-Term Care Workers, by the National Employment Law Project, Sept 12, 2011. States that have a "rehabilitation review process" for people working in long-term supports and services are Alabama, Arizona, Florida, Idaho, Illinois, Iowa, Kentucky, Massachusetts, Minnesota, Mississippi, New Jersey, New Mexico, New York, Oklahoma, Utah, Vermont, and Wisconsin.

4. ***Provide publicly financed tuition reimbursement or incentives to direct support workers who are actively studying to become psychologists, behavior specialists, nurses, therapists and other health care occupations that serve people with intellectual and developmental disabilities, mental illness, and substance use disorders in order to increase the number of people interested in doing direct support work.***

This effort will also improve the frontline skills and broaden the experiences of other health care occupations serving these populations.

5. ***Legislatively require the creation of a workgroup to identify the wide ranging initial competences, skills, and aptitudes needed by the direct support staff and to provide recommendations for a training and credentialing program to assure a competent direct support workforce.***

The training and preparation of direct support staff before beginning a job, as well as the ongoing skills building and knowledge development required as staff continue in the field, have a substantial impact on the recruitment and retention of direct support staff. Good training helps to retain staff and supports high quality service provision. Inadequate training too often results in staff leaving a job and can result in harm or injury to participants.

In a service delivery system that annually trains thousands of new direct support staff working for hundreds of employers to serve thousands of individuals living and working in a huge number of settings, the training program is unavoidably complex, confusing, and inefficient. The workgroup's discussions of direct support staff identified some of those complexities and their impact on recruitment and retention. The workgroup felt that a thorough exploration of the training required or needed by direct support staff, as well as specific training related recommendations fell outside of the scope of the workgroup's charge and merited creation of a specific workgroup focused on that purpose.

6. ***Expand the scope of the Governor's Award of Excellence initiative to include direct support workforce and health care employers.***

Governor Rick Snyder and MPRO annually name various kinds of health care organizations within Michigan as Award of Excellence recipients. The awards recognize health care providers for their dedication to improving health care quality and patient safety in Michigan. The community mental health system of services and workforce challenges have not been part of the Governor's Awards of Excellence program. A new category should be added for Community Living Supports provision to focus on these populations and on workforce achievements made by employers and their direct support staff. Those achievements could include significant reductions in direct support staff turnover or increases in direct support staff retention, improvements in wage and benefits packages, and resulting improvements in the quality of supports and services. See: http://www.mpro.org/#!governors-award-of-excellence/co7m

VI. Conclusion

Every member of the workgroup is grateful that the Legislature and Governor supported the creation of this opportunity to identify the workforce recruitment and retention challenges faced in serving people with intellectual and developmental disabilities, mental illness, or substance use disorders. The workgroup has provided consensus, unanimous recommendations for the state's legislative and policy makers to consider. The Workgroup would like to conclude by advising that it is especially urgent that additional public funds be invested now to increase the compensation of frontline direct support staff in order to address current instabilities and the inevitable harm to vulnerable populations our state has promised to serve and protect.

VII. Appendices

APPENDICES

APPENDIX ITEM 1

P.A. 84 of 2015, Article X, Sec. 1009. (1) The department shall work with PIHP network providers to analyze the workforce challenges of recruitment and retention of staff who provide Medicaid-funded community living supports, personal care services, respite services, skill building services, and other similar supports and services. The department workgroup must consider ways to attract and retain staff to provide Medicaid-funded supports and services.

(2) The department workgroup must include PIHP providers, CMHSPs, individuals with disabilities, and staff.

(3) The department shall provide a status report on the workgroup's suggestions to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget director, making note in the report when the participants outlined in subsection (2) reached consensus on the workgroup's suggestions and when the participants outlined in subsection (2) had points of difference on the workgroup's suggestions.

APPENDIX ITEM 2

Supports and Services Provided by the Direct Support Workforce

As Identified by the Section 1009 Workforce Workgroup

[Support and service definitions extracted from the Medicaid Provider Manual (version 1.1.2016) And the Adult Services Manual (version 1.1.2016]

Supported Employment (HSW)	Supported employment is the combination of ongoing support services and paid employment that enables the beneficiary to work in the community. For purposes of this waiver, the definition of "supported employment" is: • Community-based, taking place in integrated work settings where workers with disabilities work alongside people who do not have disabilities. • For beneficiaries with severe disabilities who require ongoing intensive supports such as job coach, employment specialist, or personal assistant. • For beneficiaries who require intermittent or diminishing amounts of supports from a job coach, employment specialist or personal assistant. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training, job coach, employment specialist services, personal assistance and consumer-run businesses. Supported employment services cannot be used for capital investment in a consumer-run business. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting or for any services that are the responsibility of another agency, such as Michigan Rehabilitation Services. FFP may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as: • Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; • Payments that are passed through to users of supported employment programs; or • Payments for vocational training that is not directly related to an individual's supported employment program.

	Transportation provided between the beneficiary's place of residence and the site of the supported employment service, or between habilitation sites (in cases where the beneficiary receives habilitation services in more than one place), is included as part of the supported employment and/or habilitation service. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for work activity or supported employment services provided by Michigan Rehabilitation Services (MRS). Information must be updated when MRS eligibility conditions change.
Supported/Integrated Employment Services (b3)	NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years. Provide job development, initial and ongoing support services, and activities as identified in the individual plan of services that assist beneficiaries to obtain and maintain paid employment that would otherwise be unachievable without such supports. Support services are provided continuously, intermittently, or on a diminishing basis as needed throughout the period of employment. Capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this service. Supported/ integrated employment must be provided in integrated work settings where the beneficiary works alongside people who do not have disabilities. Coverage includes: • Job development, job placement, job coaching, and long-term follow-along services required to maintain employment. • Consumer-run businesses (e.g., vocational components of Fairweather Lodges, supported self-employment) • Transportation provided from the beneficiary's place of residence to the site of the supported employment service, among the supported employment sites if applicable, and back to the beneficiary's place of residence. Coverage excludes: • Employment preparation. • Services otherwise available to the beneficiary under the Individuals with Disabilities Education Act (IDEA).
Out-of-home Non-vocational Habilitation (HSW)	Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the beneficiary resides. Examples of incidental support include:

	• Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community. • When necessary, helping the person to engage in the habilitation activities (e.g., interpreting). Services must be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's plan of service. These supports focus on enabling the person to attain or maintain his maximum functioning level, and should be coordinated with any physical, occupational, or speech therapies listed in the plan of services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.
Prevocational Services (HSW)	Prevocational services involve the provision of learning and work experiences where a beneficiary can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the beneficiary and his/her care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a beneficiary's employability in integrated, community settings. Competitive employment and supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required prerequisite for competitive employment or receiving supported employment services. Prevocational services should enable each beneficiary to attain the highest possible wage and work which is in the most integrated setting and matched to the beneficiary's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including, but not limited to: • ability to communicate effectively with supervisors, co-workers and customers; • generally accepted community workplace conduct and dress; • ability to follow directions; • ability to attend to tasks; • workplace problem solving skills and strategies; • general workplace safety; and • mobility training. Support of employment outcomes is a part of the person-centered planning process and emphasizes informed consumer choice. This process specifies the beneficiary's personal outcomes toward a goal of productivity, identifies the

	services and items, including prevocational services and other employment-related services that advance achievement of the beneficiary's outcomes, and addresses the alternatives that are effective in supporting his or her outcomes. From the alternatives, the beneficiary selects the most cost-effective approach that will help him or her achieve the outcome. Beneficiaries who receive prevocational services during some days or parts of days may also receive other waiver services, such as supported employment, out-of-home non-vocational habilitation, or community living supports, at other times. Beneficiaries who are still attending school may receive prevocational training and other work-related transition services through the school system and may also participate in prevocational services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational system's responsibility, e.g., after school or on weekends and school vacations. Prevocational services may be provided in a variety of community locations. Beneficiaries participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment situation. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for work activity or supported employment services provided by Michigan Rehabilitation Services (MRS). Information must be updated when MRS eligibility conditions change. Prevocational services may be provided to supplement, but may not duplicate, services provided under supported employment or out-of-home non-vocational habilitation services. Coordination with the beneficiary's school is necessary to assure that prevocational services provided in the waiver do not duplicate or supplant transition services that are the responsibility of the educational program. Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services. Assistance with personal care or other activities of daily living that are provided to a beneficiary during the receipt of prevocational services may be included as part of prevocational services or may be provided as a separate State Plan Home Help service or community living supports service under the waiver, but the same activity cannot be reported as being provided to more than one service.

	Only activities that contribute to the beneficiary's work experience, work skills, or work-related knowledge can be included in prevocational services.
Skill Building Assistance (b3)	NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years. Skill-building assistance consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community settings. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS). Information must be updated when the beneficiary's MRS eligibility conditions change. Coverage includes: • Out-of-home adaptive skills training: Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services incidental to the provision of that assistance, including: ➢ Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where adaptive skills training is provided in the community. ➢ When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting). Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings. • Work preparatory services are aimed at preparing a beneficiary for paid or unpaid employment, but are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able to join the general workforce, or are unable to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

	Activities included in these services are directed primarily at reaching habilitative goals (e.g., improving attention span and motor skills), not at teaching specific job skills. These services must be reflected in the beneficiary's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives. • Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence. Coverage excludes: • Services that would otherwise be available to the beneficiary.
CLS (HSW)	Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are: • Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with: ➢ Meal preparation; ➢ Laundry; ➢ Routine, seasonal, and heavy household care and maintenance (where no ➢ other party, such as a landlord or licensee, has responsibility for provision of these services); ➢ Activities of daily living, such as bathing, eating, dressing, personal hygiene; and ➢ Shopping for food and other necessities of daily living. • Assistance, support and/or training the beneficiary with: ➢ Money management; ➢ Non-medical care (not requiring nurse or physician intervention); ➢ Socialization and relationship building; ➢ Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence); ➢ Leisure choice and participation in regular community activities;

	➢ Attendance at medical appointments; and ➢ Acquiring goods and/or services other than those listed under shopping and non-medical services. • Reminding, observing, and/or monitoring of medication administration. The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings. If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times

	when the child or adult would typically be in school but for the parent's choice to home-school.
CLS (B3)	NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years. Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.). Coverage includes: • Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities: ➢ meal preparation ➢ laundry ➢ routine, seasonal, and heavy household care and maintenance ➢ activities of daily living (e.g., bathing, eating, dressing, personal hygiene) ➢ shopping for food and other necessities of daily living CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment. • Staff assistance, support and/or training with activities such as: ➢ money management ➢ non-medical care (not requiring nurse or physician intervention) ➢ socialization and relationship building ➢ transportation from the beneficiary's residence to community activities, among

	➢ community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded) ➢ participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting) ➢ attendance at medical appointments ➢ acquiring or procuring goods, other than those listed under shopping, and non-medical services • Reminding, observing and/or monitoring of medication administration • Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports. CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times

	when the child or adult would typically be in school but for the parent's choice to home-school.
Respite Care (HSW)	Respite care services are provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. • "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). • "Intermittent" means the respite service does not occur regularly or continuously. • The service stops and starts repeatedly or with periods in between. • "Primary" caregivers are typically the same people who provide at least some unpaid supports daily. • "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports or other services of paid support or training staff should be used. The beneficiary's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver. Respite services may be provided in the following settings: • Waiver beneficiary's home or place of residence. • Licensed foster care home. • Facility approved by the State that is not a private residence, such as: ➢ Group home; or ➢ Licensed respite care facility.

	• Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS. Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.
Respite Care (b3)	Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff. • "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). • "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between. • "Primary" caregivers are typically the same people who provide at least some unpaid supports daily. • "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). • Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the

	Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.) Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid. Respite care may be provided in the following settings: • Beneficiary's home or place of residence • Licensed family foster care home • Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility) • Home of a friend or relative chosen by the beneficiary and members of the planning team • Licensed camp • In community (social/recreational) settings with a respite worker trained, if needed, by the family • Licensed family child care home Respite care may not be provided in: • day program settings • ICF/IIDs, nursing homes, or hospitals Respite care may not be provided by: • parent of a minor beneficiary receiving the service • spouse of the beneficiary served • beneficiary's guardian • unpaid primary care giver Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.
Personal Care in Licensed Specialized Residential Settings	Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing his own personal daily activities. Services may be provided only in a licensed foster care setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS. Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services, and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks himself/herself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in an Adult Foster Care setting licensed and certified by the state under the 1987 Department of Mental Health Administrative Rule R330.1801-09 (as amended in 1995).

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.
- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

APPENDIX ITEM 3

Section 1009 Workgroup Membership Roster

Name	Geographic Area	Group Represented
Robert Spruce	Wayne	Individuals with disabilities
Angel Irvin	Ingham	Individuals with disabilities
David Taylor	Oakland	Individuals with disabilities
Tim Joy	Oakland	Provider Organization, North Oakland Residential
Tom Zmolek	Muskegon	Provider Organization, MOKA
Joe Manary	NW Michigan	Provider Organization, Summertree Residential
Nick Ciaramitaro	Statewide	Staff Representative, AFSCME
Tameshia Bridges Mansfield (served until 2/1/2016)	Statewide	Staff Representative, PHI Midwest
Hollis Turnham	Statewide	Staff Representative, PHI Midwest
Leslie Thomas	Middle counties of lower peninsula	Mid-State Health Network PIHP
James Colaianne	Southeast MI	CMH Partnership of Southeast Michigan PIHP
Lynn Bowman	Upper Peninsula	Northcare PIHP
Ruth Sprague	Kent County	Network 180 CMHSP
Lisa Anderson	Northeast Michigan	Northeast Michigan CMHSP
Ron Hocking	Detroit-Wayne	Detroit-Wayne Mental Health Authority
Tom Renwick	Statewide	MDHHS- Behavioral Health and Developmental Disabilities Administration
Vendella Collins	Statewide	MDHHS – DD Council
Belinda Hawks	Statewide	MDHHS- Behavioral Health and Developmental Disabilities Administration

Direct Support Employer Survey Results

Employers Can't Attract Direct-Support Workers with Current Reimbursement Rates

Results of a Survey by the Partnership for Fair Caregiver Wages

In the spring of 2014, the Michigan Legislature passed a law to increase the standard minimum hourly wage, via annual increases, from $7.40 to $9.25 by January 1, 2018. The Legislature did not provide any additional funding for the wages of direct-support workers, the employees of state-funded programs that care for and support some of the most vulnerable people in our state.

An estimated 44,000 direct-support jobs are funded through Medicaid appropriations to support and serve people with intellectual and developmental disabilities, mental illnesses, and substance use disorders. Employers of these workers depend on Medicaid funding provided through the Michigan Department of Health and Human Services, and unlike other businesses, have little or no ability to increase revenues to meet increased staff costs.

Even before the increases in the minimum wage, staffing shortages tied to low wage rates were creating soon-to-be-crisis-level consequences.

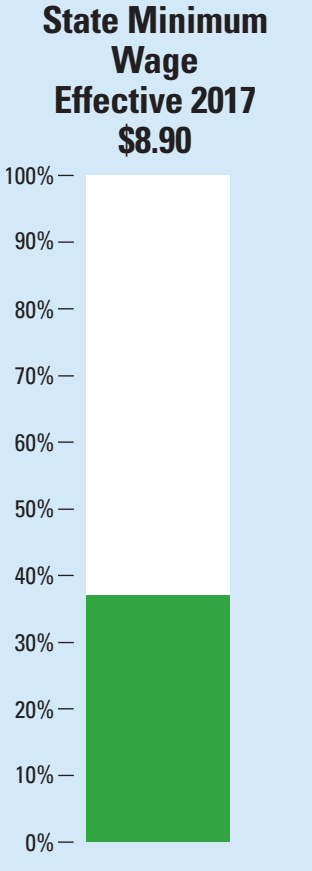
New survey paints a stark picture.

A recent survey (see page 4) sponsored by the Partnership for Fair Caregiver Wages highlights the challenge employers face in meeting the new minimum wage requirements.

The average starting wage for direct-support workers is $8.69 per hour, but 28 percent of state Medicaid-funded employers pay a starting wage of less than $8.50 per hour, the state minimum wage as of January 1, 2016. The majority pay an average starting wage of less than $8.90 per hour, the minimum wage scheduled to go into effect on January 1, 2017.

An estimated 44,000 direct-support jobs are funded through Medicaid appropriations to support and serve people with intellectual and developmental disabilities, mental illnesses, and substance use disorders.

Only 37 percent of employers have a starting wage at $8.90 per hour or above



The Partnership for Fair Caregiver Wages is a coalition of state-wide organizations advocating for persons with disabilities, direct support staff, and employers as well as regional community mental health boards and individual employers. This coalition is seeking sufficient public dollars to raise the wages of direct support staff in Medicaid-funded programs supporting people with intellectual and developmental disabilities, mental illness, and substance use disorders. For more information, please contact Hollis Turnham at hturnham@PHInational.org or Robert Stein at rstein@miassistedliving.org.

Direct Support Employer Survey Results

Uncompetitive wages result in high turnover and many unfilled jobs.

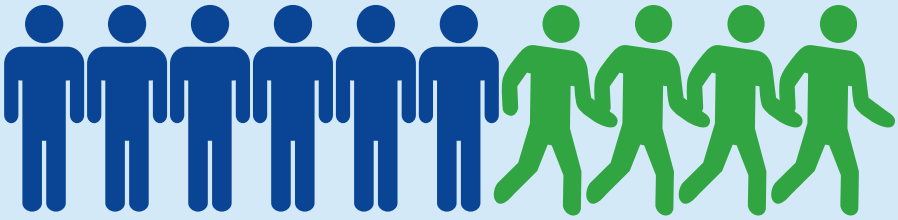
An ever-changing stream of staff due to high turnover and unfilled jobs destroys the continuity of supports and services and undermines the quality of support for people with disabilities.

In one week, surveyed employers reported over 2,600 vacant jobs meant to support and serve people with disabilities.

The average annual turnover rate was 37 percent, though a sizeable number of employers report much higher rates. Almost half of responding employers (48 percent) have a turnover rate higher than the average, ranging from 38 to 97 percent.

High Turnover

Among those surveyed, a 37 percent turnover rate = loss of 6,308 employees in a single year.



100% = 17,409

The labor market has changed.

With the recent change in the state minimum wage, these state-funded direct-support jobs are now "minimum wage jobs." This makes these challenging jobs even less attractive to workers who may find better wages in retail or food service.

The reality is that major retailers are raising their minimum wages to attract and retain employees. Michigan's direct-service providers are competing for labor with companies like Target, Walmart and Costco, all of whom have announced their intention to increase starting wages.

To ensure that their state-funded programs caring for vulnerable residents can compete for workers, other states are stepping up to increase wages. Maine, for example, increased reimbursement for home and community-based providers from $15 to $25 per hour, and required that 85 percent of the increase go to the home care aides who deliver services.[1] New York has created a wage floor of $10 per hour for its home care workers (the state minimum wage will be $9 per hour at the end of 2015),[2] and Oregon will pay state-funded personal care aides $14 per hour in 2016.[3]

Hourly Wages

Michigan Direct Support v. Major Retailers

Direct Support Employer Survey Results

Employers simply can't compete.

As this new survey shows, the vast majority of employers of direct-support staff cannot afford to raise starting wages to $8.90 per hour—or higher—to compete in the open job market with such behemoths as Walmart, Target, and others.

Just over one third of providers are considering discontinuing some services, identifying staffing shortages and insufficient reimbursement rates as the primary reason for doing so.

Potential workers are already choosing other employment where they can earn the same or a better wage with much less responsibility than that of a front-line caregiver. If publicly funded employers can't afford to pay more than the minimum wage, they will not be able to provide the caregiving services that Michigan residents need.

Direct-Support Workers Earning Poverty Wages

The average hourly wage for all direct-support workers is $9.52 per hour (including new and incumbent workers). With full-time hours, these workers earn just $19,801 annually, an amount just below the living wage earnings for a single person to live self-sufficiently ($20,761), and less than half that required to raise a child as a single parent ($44,322).[4] But notably, half the workforce works less than full-time, reducing their annual earnings.

Data shows that over half of Michigan's direct-care workers (including direct-support workers, home health aides, and nursing assistants) rely on public assistance, including food and nutritional assistance, Medicaid, and housing assistance to support their families.

Direct-support workers provide vital services to Michigan's families, but they don't earn enough to be self-sufficient themselves.

Solutions needed to stabilize support services.

State policies must change so that employers can recruit and keep skilled direct-support workers to support the independence of people with developmental disabilities, mental illness, and substance use disorders.

The Partnership is asking for a $1 per hour, per year wage increase for fiscal year 2017, 2018, and 2019 that will place starting and current wages at $10–$12 per hour.

By increasing the wage rate for direct-support workers, Michigan will demonstrate that caregiving is "not a minimum wage job" but is instead an important part of supporting and strengthening Michigan families and communities.

2,600 direct-support workers are needed *now*

Endnotes

1 Maine PCAs Will Receive Wage Increase (July 22, 2015). Found at: **http://phinational.org/blogs/maine-pcas-will-receive-wage-increase**

2 Home Care Worker Wage Parity Frequently Asked Questions (FAQs) (January 2014). Found at: **https://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-01-17_faq_information.pdf**

3 Oregon PCAs Could Earn $15/Hour by 2017 (September 3, 2015). Found at: **http://phinational.org/blogs/oregon-pcas-could-earn-15hour-2017**

4 **Dr. Amy K. Glasmeier** (2015). Living Wage Calculation for Michigan. **Massachusetts Institute of Technology**. Found at: **http://livingwage.mit.edu/states/26**.

About the Survey

The Partnership for Fair Caregiver Wages sponsored the survey of employers with the Michigan Assisted Living Association. The vast majority of the responding employers provide residential services (86 percent), community living supports (74 percent), and personal care (68 percent) to people with intellectual and developmental disabilities (96 percent) and mental illness (68 percent).

The response provides statewide representation of Medicaid-funded providers, with the majority of respondents working in Wayne, Oakland, and Macomb counties.

The 121 responding providers employ 17,409 direct-support workers, across the state. Half of direct-support workers work full-time.

For more information contact

Hollis Turnham at hturnham@PHInational.org
Robert Stein at rstein@miassistedliving.org

APPENDIX ITEM 5

Comparison

Nursing Assistant and Direct Support Staff

Competency and Job Functions

A comparison of the essential functions of nursing assistants and direct support staff shows a wide overlap of responsibilities even though nursing assistants earn a significantly higher average wage in Michigan.

Essential Job Functions	Certified Nurse Assistant (CNA)	Direct Support Staff
Personal care functions including:	Yes	Yes
a. Bathing (bed, tub, shower or sponge bath)	Yes	Yes
b. Skin Care	Yes	Yes
c. Toileting (bedpan, urinal, commode and/or toilet)	Yes	Yes
d. Grooming (shampoo, nail care & shaving)	Yes	Yes
e. Oral Hygiene (denture care)	Yes	Yes
f. Assist with dressing and undressing	Yes	Yes
2. Assists with feeding of residents.	Yes	Yes
3. Measuring and recording intake and output.	Yes	Yes
4. Weigh residents using upright, chair and bed scale.	Yes	Yes
5. Assists in turning and positioning of residents.	Yes	Yes
6. Proper transfer techniques.	Yes	Yes
7. Demonstrates appropriate knowledge for safe use of medical equipment (cane, crutches, walkers, Hoyer Lift, side rails, brace, splints, oxygen).	Yes	Yes
8. Helps keep residents' rooms clean and supplied.	Yes	Yes
9. Make and change beds (unoccupied and occupied).	Yes	Yes
10. Transports residents, supplies and equipment as needed.	Yes	Yes
11. Assists nurses and other personnel as needed.	Yes	Yes

12. Ambulate residents who require minimal assistance.	Yes	Yes
13. Simple, non-sterile dressings.	Yes	Yes
14. Perform skin assessment and notify RN of any abnormalities in skin integrity.	Yes	Yes
15. Applies heat or cold compresses as directed by a RN.	Yes	Yes
16. Answer residents calls and takes appropriate action.	Yes	Yes
17. Collects and labels specimens (urine, stool, sputum).	Yes	Yes
18. Measures and records vital signs/weights and reports variations in vital signs to RN/Supervisor/Care Team.	Yes	Yes
19. Immediately reports any changes in client's condition or incidents to the RN/Supervisor/Interdisciplinary Team	Yes	Yes
20. Participates in case conferences (or Person Centered Planning) with other members of the healthcare team as appropriate	Yes	Yes
21. Maintains confidentiality in relation to all clients, healthcare staff and documentation.	Yes	Yes
22. Meets annual in-service requirements in accordance with Agency policy and state regulations.	Yes	Yes
23. Maintains and enhances skill through attending appropriate staff development training	Yes	Yes
24. Appearance is professional and complies with agency dress code.	Yes	Yes
25. Maintains a cooperative manner towards client/family and all members of the healthcare team.	Yes	Yes

In addition to the many overlapping personal care roles, direct support staff are often expected to demonstrate a higher level competence in teaching skills, managing challenging behaviors,

administering medications, transportation, and meal preparation. These expectations of training and competence exceed those carried out by their higher paid CNA peers as shown in the chart below.

Variances in Job Descriptions and Duties

Essential Job Functions	Nursing Assistant	Direct Support Staff
Trained in MANDT, NAPPI or other forms of non-aversive physical intervention techniques.	No	Yes
Expected to intervene with approved non-aversive techniques to decelerate instances of severe aggression, property destruction or disruption by individuals served.	No	Yes
Trained and expected to administer physician prescribed medications and treatments.	No	Yes
Trained to implement programs designed by professional disciplines (Behavioral Therapists, psychologists, occupational therapists, speech therapists	Some	Yes
Expected to **teach new skills** to individuals served in areas of independent living, life choices, relationship building, employment related skills, etc.	Some	Yes
Transport vulnerable individuals in accessible handicap equipped vehicles, often times in adverse weather.	No	Yes
Plan and prepare meals for individuals served based on special dietary requirements.	No	Yes

APPENDIX ITEM 6

Impact of Direct Support Staff Job Vacancies

I am a home supervisor in a (name of home removed) home and I've been asked to write a letter regarding the current staff shortage and how it is affecting the consumers we have in our homes. I have been working and/or volunteering with the developmentally disabled individuals since I was fifteen years old (thirty-four years). I simply enjoy what I do. It is what I am.

Currently in my home we have five full time shifts and one part time shift open. This leaves my assistant and me scrabbling to cover two hundred twenty-one hours each week. We spend more time worrying about open shifts, calling subs, and covering open shifts than performing our own duties.

Not having any first shift staff leaves me and my assistant to cover direct care shifts and complete our duties at the same time. Not giving the consumers the attention they truly deserve. At times we have to reschedule consumer appointments that have already been rescheduled. We have to cancel one on one volunteer work because the staff to consumer ratio is inadequate and we can't even find a manager from another home to help out because they're in the same position. Next week alone I have eleven appointments I don't know how we are going to make them.

I've had staff that has had to cut their hours because they've had to pick up a second or even a third job. I have staff that have had to cut their hours due to the stress of the job and the improper staff to consumer ratio. Many times a week I give someone a ride to work or home because their car has broken down and they can't afford to get it fixed.

Over the holidays we had a situation where I came in to work at my normal time 7am to 3pm. I had volunteered to work a third shift for an employee and planned on going home to get some rest before the shift started. Shortly before the end of my first shift I had staff call in sick for 2nd shift and 3rd shift. This had me working my normal first shift, second shift, and the third shift I volunteered for. From 9pm to 9am the next morning by myself (totally inappropriate and unsafe). At the last minute we found someone who came in from 9pm to 9am. During the night one first shift staff called in sick. This meant I could possibly be at work until 4pm the next day. Thankfully in the end someone volunteered to come in four hours early. In total I had to work thirty-one hours straight awake.

In my home I have six staff and five subs who currently work under me. All of them have been with me for more than a year. Some have been working with developmentally disabled individuals as long as I have. We are African, African American, Asian, and white. We are young college students, single moms, and middle aged fuddy-duddies. And when I asked all of them why they do what they do they simply reply "I like it". This work tends to grab a hold of you. It tends to redevelop who you are. I even know a teacher who after teaching all day comes and work for us. She says it's therapeutic and that it doesn't seem like work.

APPENDIX ITEM 7

4 different sample direct support job descriptions

MOKA Job Description for Residential Supports, DSP Job Description, 604 Training Specialist, Job Description for SD

SUMMERTREE RESIDENTIAL CENTERS, INC.

JOB DESCRIPTION: DIRECT SUPPORT PROFESSIONAL (DSP)

SUMMARY OF POSITION:

The DSP must be honest and must care about the individuals we serve. The DSP is a member of a direct care team. The team is primarily responsible for the well-being and safety of the individuals. Duties include the physical ability to assist individuals in their activities of daily living, including ambulation or wheelchair mobility, lift usage, van transportation, and emergency evacuation. The DSP must also be active in the implementation of Person Centered Plans, schedules and maintaining the home environment by performing assigned shift responsibilities.

DIRECTLY RESPONSIBLE TO:

Home Supervisor and/or Assistant Home Supervisor

ESSENTIAL FUNCTIONS OF POSITION:

1. **Training:** Attend and successfully complete approved contract agency training within the timeframe specified. CPR and First Aid will be completed prior to first shift. Successfully complete in-home training and required annual update training.
2. **Consumer Advocacy:** Ensure effective individual and team advocacy for all persons served. Assist in transportation and ensure the safety of individuals to community activities as assigned. Ensure that individuals present as normal a profile to the community as possible. Maintain current knowledge of procedures and accept responsibility for immediately reporting suspected recipient rights violations per policy guidelines.
3. **Policy Administration:** Assist individuals in living a quality life as outlined in their Person Center Plan. Record clear, concise and accurate documentation of information relevant to each individuals Person Center Plan. Consistently carry out programs, both formal and informal as written per each Person Center Plan. Maintain a consistently positive attitude toward team members, and individuals served and their programs and goals. Follow the guidelines for accurately documenting data on individual programs on the daily and/or monthly summaries. Maintain current knowledge of individuals and accept responsibility for accurately filling out house paperwork e.g.; daily log, incident reports, individual's family contact log, and any other forms necessary to the operation of the home.
4. **Safety:** Maintain a clear understanding and ability to carry through on emergency home procedures for fires, tornadoes, accidents, and other serious incidents affecting individual welfare. Readiness for emergency procedures requires that a DSP be able to move individuals to safety. This generally requires a DSP be able to lift at least fifty pounds. Maintain a clear understanding and appropriately utilize correct notification procedures involving medical emergencies and other serious incidents. Actively and consistently, at all times, maintain knowledge of and practice infection control procedures as written per the home guidelines.

5. **Physical Requirements:** Physically capable of lifting and transferring, potentially large wheelchair users, safely with assistance. Ensure that team members do not lift any individual weighing in excess of fifty pounds, except in emergency situations, without assistance. Maintain a current knowledge and ability in the use of all lifts where applicable. This includes, but is not limited to, Arjo, Hoyer and van lifts and all accessories used in the operation of transferring and transportation of individuals. Successfully complete in-home training in the operation of the vans used in transportation of individuals.

NOTE: Although the essential functions of this position are dynamic, the current job description is an accurate view of the essential functions. Reasonable accommodations are always considered and may override the physical demands for a qualified individual with a disability.

PHYSICAL DEMANDS:

Medium Work: exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than 0 to 10 pounds of force constantly to move objects.

- **Walking**—moving about on foot is required on a frequent basis.
- **Sitting**—remaining in a normal seated position is required on an occasional basis.
- **Push/Pull**—on an occasional basis must be able to push/pull with arms with a force of approximately 20 to 50 pounds.
- **Stooping/Kneeling/Crouching**—is required on a rare basis regarding some of the general laborer duties.
- **Reaching**—reaching is required on a frequent basis.
- **Handling**—working with the hand or hands such as holding, seizing, grasping, or turning is required on a frequent basis.
- **Fingering**—picking, pinching, or otherwise working primarily with fingers rather than the whole hand or arm is required on an occasional basis.
- **Talking**—expressing or exchanging ideas by means of the spoken word is required on a frequent basis.
- **Hearing**—perceiving sounds by the ear is required on a frequent basis.
- **Near Acuity**—clarity of vision at 20 inches or less is required on a frequent basis.
- **Depth Perception**—three-dimensional vision with the ability to judge distances on spatial relationships is required on a frequent basis.
- **Color Vision**—(identify and distinguish colors) are required on an occasional basis.

SPECIFIC DUTIES:

1. Maintain an attendance record as defined by the personnel policy guidelines. Attend and participate in mandatory monthly staff meetings. Attend mandatory in-service training meetings as required by the Home Supervisor. Establish and maintain courteous, cooperative and

professional relationships with co-workers, supervisors, individuals and their families or guardians.

2. Assist all individuals daily, as needed, in their personal appearance and hygiene by assisting the individual in bathing, brushing teeth, personal grooming, selecting clothing and dressing.
3. Successfully complete CMH Medication and home training procedures. Following full clearance as a Med Passer, ensure that medications are administered and documented as written. Maintain a current knowledge of each individual's medication and administer individual's medication as assigned by the Home Supervisor.
4. Maintain and ensure the quality and safety of the home and grounds by following written checklists of the shift responsibilities. Report any perceived safety concerns in and around the home ensuring the safety of the individuals and other associates. Assist in meal preparation and clean-up following the guidelines established by infection control and Summertree Residential Centers, Inc. Follow dietary guidelines, as written in meal preparation.
5. Perform any other adjunct duties as assigned by the Residential Manager, Home Supervisor or Assistant Home Supervisor.

QUALIFICATIONS:

1. Ability to read, write and comprehend information at the level of a high school graduate.
2. Medical exam inclusive of a negative TB test, and drug test, which certifies that the candidate is able to assist individuals in their activities of daily living, transportation, emergency evacuations, etc.
3. Two references, one work related.

AGREEMENT:

I understand, agree to perform and be held accountable for the aforementioned duties to the best of my ability. I recognize that the failure to effectively perform these duties could result in the termination of my employment with Summertree Residential Centers, Inc.

SIGNATURE: _____DATE:_____

JOB DESCRIPTION: #604 TRAINING SPECIALIST

COMMUNITY MENTAL HEALTH AUTHORITY
103 West US-2
Wakefield, Michigan 49968
(906) 229-6100

JOB DESCRIPTION

Position: TRAINING SPECIALIST (604)

FLSA: Non Exempt

Bloodborne Pathogens Exposure Control Classification: A (High risk)

Educational level normally associated with the requirements of this position:

High School diploma/G.E.D. required

License/Certification Required:

Successful completion of DCH approved Training Modules, American Red Cross Certification in Standard First Aid & Adult CPR and a valid driver's license is required.

Experience Required:

None required.

Other Requirements:

Employees must be at least 18 years of age and must undergo a complete Pre-employment physical examination including a TB test (or chest x-ray if required) and backscreen at the employer's expense to ensure that the employee is free of debilitating communicable disease and physically capable of performing the work assigned without posing a direct threat to themselves or others, including clients of Community Mental Health entrusted to their care.

All employees in this job category are required to establish/maintain a telephone at their primary residence.

Supervision Received: Program Director/designee, may also work under indirect supervision of a Team Leader

Supervision Given: None

Special Skills Required:

1. Physical condition adequate for work performance.
2. Ability to maintain 100% confidentiality of information including staff, consumer, family and agency transactions.

3. Ability to demonstrate empathy, respect, genuineness, warmth and caring for individuals with disabilities and/or mental illness.

JOB SUMMARY:

The Training Specialist performs duties related to care, welfare, supervision and training of developmentally disabled and/or mentally ill consumers and the management and maintenance of the physical settings of the programs. The Training Specialist shall abide by the rules and regulations of the personnel policies, practices and procedures of the Gogebic County Community Mental Health Services Board and the Michigan Department of Mental Health.

Training Specialists will be providing services in diverse environments to include residential and day programs, and community situations. There may be exposure to loud human voices, body fluids, basic household cleaning chemicals, kitchen and other appliances, as well as food preparation risks such as use of sharp objects or high temperatures in ovens and stoves. Some service consumers smoke, may have verbally or physically aggressive behavior or require a significant amount of assistance to complete their own personal care.

All staff have the responsibility to be educated about and actively support: 1) culturally competent, recovery based practices 2) person-centered planning as a shared decision making process with the individual, who defines his or her own life goals and is assisted in developing a unique path toward those goals 3) a trauma informed culture of safety to aid consumers in their recovery process.

I. ESSENTIAL JOB FUNCTIONS:

The exact functions of the Training Specialist are dictated by the needs of the consumer being served. The range of functions could include the following:

A. MEDICAL AND HEALTH SERVICES

1. The Training Specialist will assist in supervision of medication needs of consumers. Must be able to follow exact directions, count medications, and document pertinent information. May need to supervise or provide specialized procedures such as insulin injections, use of glucose testing equipment, etc. after required training, and under general supervision.

2. The Training Specialist must complete training and be competent in basic first aid procedures as appropriate. Must be able to assess needs and provide first aid under the supervision of management personnel utilizing Universal Precautions at all times.

3. The Training Specialist must be aware of changes in physical status of consumers and be able to respond to medical emergencies. Use skills of observation to assess the changing needs of consumers. Be competent in responding to medical emergencies including seizures or other episodes

B. SOCIAL AND RECREATIONAL SERVICES

1. The Training Specialist must be capable of transporting consumers to community activities. Be able to drive and escort consumers during travel into the community. Exercise good judgement and safety skills while driving or escorting consumers in the community. Must have a valid drivers license.

2. The Training Specialist must assist in use of wheelchairs, transfer procedures, and operation of wheelchair lifts, hoyer lifts, or other adaptive devices. Be able to physically assist consumers to enable mobility in the home or program and to access the community.

3. The Training Specialist must provide companionship, direction and supervision to service consumers while on duty both at home or program and in the community. Be sensitive to the needs, preferences and choices of the consumer.

C. NUTRITION AND FOOD

1. The Training Specialist may be required to assist in all areas of food preparation. Must be able to follow menus, recipes and use appliances and utensils in the preparation and service of meals.

2. The Training Specialist must follow nutritional guidelines accurately. Must follow through on individual dietary restrictions. Must be able to read instructions and follow through with accuracy. Must follow safety procedures in all aspects of food preparation.

3. The Training Specialist must follow safety and health procedures in food storage and clean up.

D. TRAINING IN PERSONAL CARE

1. The Training Specialist must be able to provide personal care to consumers as dictated by individual need. The Training Specialist must be capable to assist and supervise in all activities of daily living which may include: Bathing, Hair Care, Oral Care, Shaving, Toileting, Feeding Dressing, Transferring, and Use of incontinence products.

2. Facility care and chore responsibilities may include:

Sweeping, Loading dishwasher, Vacuuming, Scrubbing toilets and showers, Washing dishes, Disinfecting program areas Snow removal, Yard care, Laundry chores and clothing care, Operating and refueling vehicles, Various cleaning tasks.

These activities require the Training Specialist to be able to operate appliances, lawn mowers, snow blowers, and to use appropriate techniques, dictated by safety.

E. RESPONSE TO BEHAVIORAL CRISIS

The Training Specialist will provide appropriate support and intervention to individual consumers during verbal and physical behavioral episodes. Must be physically capable of providing nonviolent physical intervention to individuals following the formal and sanctioned procedures taught by the training team.

F. DOCUMENTATION

The Training Specialist must accurately communicate in verbal and in written form required information and data. Must exercise adequate language skills, writing skills, and listening skills to provide required information. Documentation must be completed according to agency policy.

G. MONEY MANAGEMENT

The Training Specialist will assist consumers in purchasing goods and services in the community. Must have functional math skills to guide in making purchases and handling money.

H. EMERGENCY RESPONSE

The Training Specialist must complete training and utilize skills to respond to emergency situations appropriately.

I. ADMINISTRATIVE AND OTHER EMPLOYMENT RESPONSIBILITIES

1. Attend training and in-services as directed and required.

2. Fill in and submit time cards and time sheet required as directed.

3. Report to work as scheduled.

4. Be responsible for all practices and procedures in calling in or requesting vacation pay, sick days and other time off.

5. Exhibit behaviors and communication skills consistent with teamwork efforts of the program.

6. Cooperate with supervisors in evaluating and improving performance.

7. Other related duties assigned by Program Supervisor and Department Director.

8. Participate in Total Quality Improvement Process as necessary.

This job description is not an employment agreement or contract. Management has the exclusive right to alter this job description at any time without notice.

revised 7/00

Job Description for Self-Directing Participant

Date	
Employee Name	
Consumer Name	
Position/Title	Community Living Support/Respite Provider

I. POSITION SUMMARY

Provides Community Living Support services and/or Respite services under the direction of the client and/or authorized guardian or representative.

II. STANDARD REQUIREMENTS

- Must be at least 18 years of age at the time of hire.
- Must obtain a criminal records clearance from Community Mental Health Agency.
- Has completed the training required by Community Mental Health.
- Is knowledgeable of consumer rights and ensures confidentiality of data.
- Is knowledgeable of the individualized service plan for the consumer and provides support to the consumer according to the service plan.

II. ESSENTIAL FUNCTIONS

A. Provides skill development related to activities of daily living by assisting, reminding, observing, guiding or training the beneficiary with**:**

a. Meal preparation

b. Laundry

c. Activities of daily living, such as bathing, eating, dressing, personal hygiene.

d. Routine, seasonal, and heavy household care and maintenance

e. Shopping for food and other necessities of daily living.

f. Skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities.

B. PERFORMS OTHER RELATED DUTIES AND RESPONSIBILITIES AS DEEMED NECESSARY.

APPENDIX ITEM 8

Department of Health and Human Services Training Requirements

Related to the Services Evaluated by the Section 1009 Workforce Workgroup

The excerpts below describe the requirements outlined in the contract between MDHHS and the PIHPs, including the training requirements associated with these supports and services.

All providers must be: at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien). Licensed professionals must act within the scope of practice defined by their licenses. "Supervision" is defined by the Occupational Regulations Section of the Michigan Public Health Code at MCL§333.16109 and, as appropriate, in the administrative rules that govern licensed, certified and registered professionals.

Aide - Individual is able to perform basic first aid procedures and is trained in the beneficiary's plan of service, as applicable. Aides serving children on the Children's Waiver and the Waiver for Children with Serious Emotional Disturbance (SEDW) must also be trained in recipient rights and emergency procedures. Additionally, aides serving children on the Children's Waiver must be employees of the CMHSP or its contract agency, or be an employee of the parent who is paid through the Choice Voucher arrangement. For BHT/ABA services Behavior Technicians must also complete training in the curriculum outline in the Registered Behavior Technician (RBT) task list, but are not required to register with the BACB upon completion in order to furnish services.

Source: http://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf

Community Mental Health Required Training
October 2016

Type of Training	Description	Initial	Annual	Other	Required by	Target Audience
LEP	Limited English Proficiency Procedures; i.e. I Speak cards, TTY services, etc. working with individuals with limited English abilities those with hearing impairments.	X	X		DHHS Contract	All staff
Cultural Competency and Diversity	Includes language, dress, traditions, notions of modesty, eye contact, health values, help-seeking behaviors, work ethics, spiritual values, attitudes regarding treatment of mental illness and substance abuse, concepts of status, and issues of privacy and personal boundaries. Also includes; ethnicity, race, religion, age, gender and disabilities of the population served.	X	X		DHHS	All staff
PCP/self determination	Person and family centered services based on strengths, needs abilities, preferences, desired outcomes and cultural background of the person or family serviced	X		Every 2yrs (best practice)	DHHS	All staff
Recipient Rights	Recipient Rights Chapter 7 of MH Code; includes Abuse Neglect, Dignity and Respect, Confidentiality, Incident Reports and other aspects of this rule. (DHHS recommends annual training at this time.)	X	X		MH Code DHHS	All staff
HIPAA	Privacy and Security Acts, breach notifications and business associate responsibilities.	X	X		HHS/OCR	All staff
Regulatory Corporate Compliance	General laws and regulations governing compliance issues in the health care organization. Review of Ethics and Code of Conduct Policy	X	X		OIG DHHS	All staff
Deficit Reduction Act	Federal and State False Claims and Whistles Blower's Acts, Qui Tam and Medicaid Fraud, Waste and Abuse	X	X		OIG DHHS	All staff
Infection Control	Blood-borne pathogens, universal precautions and control of infectious and communicable disease (TB, etc.)	X	X		DHHS	All staff
Safety Training	Fire precautions, crisis management, emergency procedures, severe weather and evacuation, transportation/driving procedures and environmental safety.	X	X	Every 2 yrs (best practice)	OSHA	All staff
CPR and First Aide	Cardiopulmonary Resuscitation and First Aid	X		X Remain certified (2yrs)	DHHS	Assigned staff (day program, residential and those providing services)

Community Mental Health Required Training
October 2016

CPI	Crisis Intervention, information and techniques used in working with consumers with challenging behaviors, or a potential violent situation.	X (all staff)	X (assigned staff)		DHHS	Assigned staff (day program, residential and those providing direct services)
Grievance and Appeals	PIHP and CMH Appeals processes, adequate and advance notices, and grievance procedures and local dispute resolution.	X		Every 2 yrs (best practice)	DHHS	All staff
CDTS (24 hours)	Children Diagnosis and Treatment Specific training. This can include CAFAS (initial and then update every 2 yrs)		X		DHHS	All professional staff serving children
Advance Directives	Psychiatric Advance Directives (can be incorporated into person-centered planning curriculum).	X (all staff)		Every 2 yrs (best practice for assigned staff)	DHHS	Assigned professionals and Para-professionals
Residential Curriculum Group Home Training	Approved by DHHS – includes (but not limited to) role of direct care staff, interventions for maintaining and caring for an individual's health (personal hygiene, infection control, food preparation, nutrition, special diets and recognizing signs of illness), basic first aid and CPR, medication administration, environmental emergencies, recipient rights, non-aversive techniques for prevention and treatment of challenging behaviors.	X			DHHS	
Plan of Service	Evidence that staff are fully capable of implementing each individual's plan of service	X (assigned staff)	On-going with each new POS			All staff assigned to provide direct services to consumer(s).

References used: DHHS Contract, Mental Health Code, Michigan Medicaid Manual, HHS, OIG and OCR.

Note: This list does **NOT** include items required by internal clinical protocols, administrative policy manual, credentialing/human resources procedures and/or accreditation standards.

APPENDIX ITEM 10

Illustration of Take Home Pay for Direct Support Workers
January 1, 2016

$8.50	Hourly minimum wage rate as of January 1, 2016
$1.45	Federal Income Tax @ 17%
$0.53	Social Security @ 6.2%
$0.36	State Tax @ 4.25%
$6.16	**Take Home pay per hour @ $8.50 gross pay per hour**

$6.16 @ 40 hours per week = $246.40 net pay per week

$6.16 @ 29 hours per week = $178.68 net pay per week

$10.50	Hourly wage rate increase to $10.50 per hour
$1.79	Federal Income Tax @ 17%
$0.65	Social Security @ 6.2%
$0.45	State Tax @ 4.25%
$7.61	**Take Home pay per hour @ $10.50 gross pay per hour**

$7.61 @ 40 hours per week = $304.40 net pay per week

$7.61 @ 29 hours per week = $220.69 net pay per week

Deductions/taxes do not include city taxes or health care coverage employee contributions.

APPENDIX ITEM 11

MOKA's Illustration of Employer Costs for Hourly Direct Support Staff

Hourly Minimum Wage (hypothetical)*	Single $ 8.50	
Mandatory Fringes		
FICA (Employer Share)	$ 0.65	7.65%
Health Insurance (employer share)	$ 0.98	11.50%
Workers' Compensation	$ 0.24	2.80%
Unemployment Tax	$ 0.02	0.25%
Subtotal Mandatory Fringes	$ 1.89	22.20%
Optional Fringes (to attract		
Paid Leave or PTO	$ 0.46	5.43%
Pension Plan	$ -	0.00%
401(k) or 403(b) Employer Match**	$ 0.17	2.00%
Short Term/Long Term Disability	$ 0.09	1.00%
Term Life Insurance	$ 0.02	0.22%
Tuition Reimbursement	$ 0.05	0.63%
Subtotal Optional Fringes	$ 0.79	9.28%
Total All Fringes***	$ 2.68	31.48%
Total Wages and Fringes	$ 11.18	
	Single	
MOKA Average DC Wage Rate*	$ 9.91	
Mandatory Fringes		
FICA (Employer Share)	$ 0.76	7.65%
Health Insurance (employer share)	$ 1.14	11.50%
Workers' Compensation	$ 0.28	2.80%
Unemployment Tax	$ 0.02	0.25%
Subtotal Mandatory Fringes	$ 2.20	22.20%
Optional Fringes (to attract		
Paid Leave or PTO	$ 0.54	5.43%
Pension Plan	$ -	0.00%
401(k) or 403(b) Employer Match**	$ 0.20	2.00%
Short Term/Long Term Disability	$ 0.10	1.00%
Term Life Insurance	$ 0.02	0.22%
Tuition Reimbursement	$ 0.06	0.63%

Subtotal Optional Fringes	$ 0.92	9.28%
Total All Fringes***	$ 3.12	31.48%
Total Wages and Fringes	$ 13.03	

* = Does not include overtime calculation.

*** = Does not include training or recruitment costs.

State of Illinois
Illinois Department of Public Health

Facts About The

WAIVER APPLICATION FOR HEALTH CARE WORKERS

Illinois Department of Public Health

Health Care Worker Registry, 525 W. Jefferson St., Fourth Floor, Springfield, IL 62761
Phone 217-785-5133 Fax 217-524-0137 E-mail DPH.HCWR@Illinois.gov

You must complete a waiver application and have a fingerprint criminal history records check requested by the Department through a contracted livescan vendor. No other background check will be accepted. Please check our Web site at http://www.idph.state.il.us/nar for a full list of disqualifying offenses and a waiver application. After the Department receives your waiver application, you will be sent instructions for having your fingerprints collected.

The Health Care Worker Background Check Act, an Illinois state law, prevents many health care employers from hiring an individual who has certain criminal convictions as a direct care worker and, in long-term care facilities, from being hired as a worker who has or may have access to residents, their living quarters or their financial, medical or personal records (access worker).

A waiver does not change your criminal record but it does allow an employer to hire you as a direct care worker or an access worker in long-term care.

Many considerations are taken into account when reviewing a waiver application.

- Except in the instance of scheduled payments of court-imposed fines or restitutions, you must have met all obligations to the court and the terms of your parole (i.e. fines must be paid and parole, probation or mandatory supervised release successfully completed).
- You must have satisfactorily completed a drug and/or alcohol recovery program if you were ordered to as part of the judgment.
- Your age at the time of the offense, your work history, your criminal history in Illinois and other states, the amount of time since your last conviction, the severity of your conviction, and the circumstance surrounding your conviction, as well as other evidence that you provide are all considered in determining whether a waiver is granted.
- You are less likely to have a waiver granted if you have several convictions in recent years or if your offenses were violent crimes. There are three categories of disqualifying offenses: Offenses that are always disqualifying except through the appeal process; offenses that may be considered for a rehabilitation waiver without a waiver application being submitted; and offenses that may be considered for a waiver by submitting a waiver application and additional required information.

4. You may have been convicted and not sent to jail. An individual may be fined, given probation or conditional discharge and it still be considered a conviction. If you are unsure whether an arrest or charge became a conviction, contact the circuit clerk of the county in which you were arrested.

5. If granted a waiver it is in effect until you are convicted of another disqualifying offense, which causes the waiver to be automatically revoked. Health care employers must check the Health Care Worker Registry (http://www.idph.state.il.us/nar) to see if you have met any training requirements, have any administrative findings and to determine if you have disqualifying offenses or a waiver. No other source of information (i.e. a waiver letter, certificate of achievement, etc.) may be accepted. The information on the registry is the only means a health care employer may use to verify that the worker is eligible for employment.

THE WISCONSIN CAREGIVER PROGRAM MANUAL

for

Entities Regulated by the Division of Quality Assurance

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
Office of Caregiver Quality

P-00038 (02/2016)

Issued July 2000
Revised June 2001
Revised March 2005
Revised August 2006
Revised April 2009
Revised October 2013
Revised April 2015

CHAPTER 5 REHABILITATION REVIEW PROCESS

5.1.0 REHABILITATION REVIEW PURPOSE

s. 50.065(5)
DHS 12.03(18)

All caregivers with an offense on the Offenses List:

- Criminal conviction,
- Finding of misconduct entered on the Wisconsin Caregiver Misconduct Registry, or
- Finding of child abuse or neglect finding,

may request a Rehabilitation Review with the Department. An approval through the Rehabilitation Review process allows a caregiver to work in a state-regulated facility, such as a state licensed hospital, home health agency, or community-based residential facility.

The Rehabilitation Review is an opportunity for a caregiver to provide clear evidence that a repeat of the conduct that led to their conviction is not likely and that clients will remain safe under their care.

Federal regulations require that nurse aides with a finding of caregiver misconduct be permanently barred from working in any capacity in federally regulated nursing homes and may be barred from working in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The Rehabilitation Review process cannot change this permanent bar.

5.1.1 Offenses Affecting Caregiver Eligibility

The Offenses List includes serious convictions, as well as governmental findings, that require the person to apply to the Department for a Rehabilitation Review to be eligible to work as a caregiver, to receive regulatory approval, or to reside in an entity regulated by DHS. (See **Other Resources – 4.)**

5.2.0 REHABILITATION REVIEW PROCEDURES

DHS 12.12(2)(a)

A caregiver or a non-client resident who has:

- Committed a crime on the Offenses List,
- A finding of misconduct entered on the Wisconsin Caregiver Misconduct Registry, or
- A child abuse or neglect finding,

may apply for a Rehabilitation Review to seek approval to work as a caregiver, obtain regulatory approval, or reside in an entity regulated by DHS.

DHS 12.12(2)(b)

Entities are required to give employees information on Rehabilitation Review eligibility criteria and on how to obtain the application. DQA must give this information to a person seeking regulatory approval or non-client residency. (See ***Rehabilitation Review Process of Wisconsin's Caregiver Program,*** DQA publication, P-63160.)

5.2.1 Application Procedures

DHS 12.12(3)

The applicant must complete and sign ***a Rehabilitation Review Application,*** EXS form F-83263, with attachments (see **Other Resources - I** or **https://www.dhs.wisconsin.gov/caregiver/forms.htm**) and submit them to the DHS Office of Legal Counsel. Incomplete applications will be denied unless good cause exists for failure to submit a complete application.

Upon receipt of a complete application, DHS will notify the applicant by mail when and where the Rehabilitation Review Panel will meet. The applicant may be asked to provide additional information.

5.2.2 Panel Review Meeting

DHS 12.12(4)

Although the applicant is not required to appear at the Rehabilitation Review Panel meeting, the applicant's appearance is recommended. Panel members may ask questions to facilitate decision making and the applicant will have an opportunity to answer their questions.

As applicable, the Rehabilitation Review Panel will consider the following:

- Personal reference checks and comments from employers, persons, and agencies familiar with the applicant and statements from therapists, counselors, and other professionals
- Evidence of successful adjustment to, compliance with, or proof of successful completion of parole, probation, incarceration, or work release privileges
- Proof that the person has not had subsequent contacts with law enforcement agencies leading to probable cause to arrest or evidence of noncompliance leading to investigations by other regulatory enforcement agencies
- Any pending or existing criminal or civil arrest warrants, civil judgments, or other legal enforcement actions or injunctions against the person
- Any aggravating or mitigating circumstances surrounding the crime, act, or offense
- Evidence of rehabilitation, such as public or community service; volunteer work; recognition by other public or private authorities for accomplishments or efforts or attempts at restitution; demonstrated ability to develop positive social interactions; and, increased independence or autonomy of daily living
- The amount of time between the crime, act, or offense and the request for Rehabilitation Review and the age of the person at the time of the offense
- Whether the person is on the sexual offender registry under s. 301.45, Wis. Stats., or on a similar registry in another jurisdiction
- A victim's impact statement, if appropriate
- Employment history, including evidence of acceptable performance or competency in a position, and dedication to the person's profession
- The nature and scope of the person's contact with clients in the position requested
- The degree to which the person would be directly supervised or working independently in the position requested
- The opportunity presented for someone in the position to commit similar offenses
- The number, type, and pattern of offenses committed by the person
- Successful participation in or completion of recommended rehabilitation, treatment, or programs
- Unmet treatment needs
- The applicant's veracity

5.2.3 Review Panel Decision

DHS 12.12(5)(a)

After the meeting, the Rehabilitation Review Panel will decide whether sufficient evidence of rehabilitation exists. Each application is handled on a case-by-case basis. The panel will issue one of the following written decisions:

- ***Approved.*** If the Panel finds sufficient evidence of rehabilitation, the panel will approve the Rehabilitation Review application and may specify conditions or limitations that apply to the approval.
- ***Denied.*** If the Panel does not find sufficient evidence of rehabilitation, the decision will provide the reasons for denial and inform the applicant of his/her right to file an appeal within 10 days of the decision.
- ***Deferred.*** The Panel may defer a final decision for up to six months to gather additional information or for other reasons.

A Rehabilitation Review approval does not ensure that the applicant will be hired by an entity or receive permission to reside at an entity.

DHS 12.12(2)(a)1

Caregivers who are denied approval may not reapply for one calendar year after the date of denial.

5.3.0 CONTACT INFORMATION

Individuals, who have questions about the Rehabilitation Review process, who would like more information, or who need assistance in completing the application should contact DHS or their DHS designated tribal authority.

5.3.1 DHS Regulated Entities

Persons seeking Rehabilitation Review approval for employment, contracted services, regulatory approval, or non-client residency in a DHS regulated entity may contact:

Department of Health Services
Office of Legal Counsel
One West Wilson Street, Room 651
P.O. Box 7850
Madison, WI 53707-7850
(608) 266-8428

5.3.2 Tribal-operated DHS Regulated Entities

Persons seeking Rehabilitation Review approval for employment, contracted services, or non-client residency in tribal-operated, DHS regulated entities may contact the appropriate DHS designated tribal authority.