Direct Support Professional

Statewide Workforce Employment

Assessment Report

June 2003
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Prepared for:

Idaho Council on Developmental Disabilities

Prepared by:

CENTER ON DISABILITIES AND HUMAN DEVELOPMENT
live learn work play
University of Idaho College of Education

Ron Seiler, M.S. and Jolene Zajdel
129 West Third Street, Moscow, ID 83843
(208) 885-3559

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To the Reader

Direct Care Providers, the subject of this report, have a number of "labels" or job titles that have created some confusion about the appropriate terminology to use. In this report, the terms, Certified Nurses Assistant, Personal Care Attendant, Nurses Aide, Therapy Technician, Residential Counselor, Job Coach, and Psychiatric Technician, all refer to Direct Care Providers.

Executive Summary

Direct Service Providers (DSPs) provide day-to-day, person-to-person contact support and assistance to a wide range of individuals including people with disabilities or chronic illness and older persons. DSPs are found in a number of settings and they have a number of job titles such as Certified Nurses Assistant, Personal Care Attendant, Nurses Aid, Therapy Technician, Residential Counselor, Job Coach, Psychiatric Technician, and others. DSPs work in nursing homes, home health agencies, assisted living facilities, board and care facilities, adult day care or adult health centers, or group homes for individuals with mental illness or mental retardation. They can also be community-based providers such as area agencies on aging, hospice, or even transportation carriers.

Thirteen million people in this country need daily assistance with personal maintenance, hygiene, eating, and for those living at home a range of basic household tasks. About one-third of these long-term care consumers are aged 80 and over a population that is expected to grow by over 35% (from 7.8 million to 10.6 million) between 1994 and 2006. Seven in ten nursing home residents, and six in ten home care consumers, are women, making long term care very much a "women's health" issue.

Between 2000 and 2010, the U.S. Bureau of Labor estimates employment growth for DSPs will double (36.3%) as compared to the overall growth in employment among the general population. Eight hundred and seventy four thousand (874,000) new DSPs will be needed by 2010. In addition to job openings created by the increase in demand for these workers, replacement needs are expected to produce numerous openings. Clearly, these national data indicates there is a DSP workforce crisis in this country.

In 2002, the Idaho Council on Developmental Disabilities (DDC) established a DSP Task Force charged with examining how this crisis might be impacting Idaho. As a first step, and at the suggestion of the Task Force, the DD Council sponsored a study designed to identify critical issues that DSPs feel impact their profession. The results of the survey will be used to develop short and long-term strategies to address the issues identified in the study. The Council subcontracted with the Center on Disabilities and Human Development (CDHD) at the University of Idaho to conduct the study.

Members of the DSP Task Force identified four major categories considered important to DSPs: Salaries and Benefits; Recognition and Respect; Work Environment;and Information and Training. These categories formed the basic structure of the survey. A fifth section designed to collect background information about the person completing the survey was also included in the survey. The Task Force developed a set of general questions for each of these five areas. Based on this information, the CDHD developed a draft of the survey instrument. Revisions to the survey were made based on input from the DD Council staff and the DSP Task Force. It was then mailed to: Assisted Living facilities, Community Rehabilitation Providers, Developmental Disability Agencies, Group Homes, Home Care Providers, Hospitals, IFC-MRs, Mental Health Agencies, Nursing Homes, Residential Habilitation Facilities, Idaho State School and Hospital, and any other agency or individual who provides direct support services to individual with disabilities. Nearly 400 surveys were returned from individuals working in a number of businesses including: assisted living, community rehabilitation, developmental disability agencies, group homes, home care providers, IFC-MR, mental health agencies and nursing homes.

It is clear from a combination of business organizations that participated and the job titles reported in the survey, that DSPs in the state of Idaho provide a variety of services, including, transportation, health care, employment assistance/job coaching, financial management assistance, educational assistance and advocacy. These services are performed in a variety of settings including private homes, group homes, in the community, employment settings, hospitals and nursing homes. In essence, a person in a DSP position is required to have a variety of complex job skills.

Survey respondents were asked to identify three items that would assist in better job performance. The most commonly indicated issue was salary compensation. The second most commonly reported item was more training. Survey respondents were asked to identify training topics which would help them perform their job better. The most commonly reported training topic was specific disability training i.e., understanding the nature of their client's disability (including dual diagnosis and medications). Other common responses included: better communication and support from supervisors and co-workers, additional staff (less turnover), improved office space and equipment (including updated computers, updated computerized office processes) more consistent scheduling and more community activity options for clients.

The report concludes with a set of recommendations designed to address the issues found to be important to DSPs. The recommendations are based on the results of the DSP survey discussed below, but also reflects research findings generated by a literature review that was conducted as part of the DSP Initiative. In particular, the recommendations draw heavily from *Issues in the Direct Support Workforce and their Connections to the Growth, Sustainability and Quality of Community Supports: A Technical Assistance Paper of the National Project: Self-Determination for People with Developmental Disabilities*; [prepared by Amy Hewitt and K. Charlie Lakin, Research and Training Center on Community Living, University of Minnesota.

Possible Solution: Recruitment and Retention

- **Idaho should strive to attract people to the DSP "profession" by:**
    - Identifying specific skills and standards for DSPs;
    - Improving the public's perception of the DSP profession;
    - Increasing the awareness of educators and workforce development counselors about the DSP profession;
    - Requiring Idaho's welfare-to-work program, technical and community colleges, and school-to work programs to include DSP on their list of employment option;
    - Providing recognition and other incentives for service providers that have few vacancies and low turnover rates; and,

- Training service provider agency administrators on the use of organizational and management practices that have proven to be effective at reducing vacancies and increasing the retention of direct care professionals.

Possible Solutions: Training and Professional Development

- **Idaho should improve the capacity of DSPs to perform their job duties by:**
  - Implementing a "career ladder" education and training programs that offer career paths and other incentives for people to remain in direct support positions.
  - Financially rewarding direct-care professionals who complete additional education, demonstrate new skills, and remain in their positions for periods of more than a year.
  - Using distance learning and web-based training programs to improve the quality, consistency and access of training information for direct care professionals.
  - Providing training that addresses the topics identified in the survey, e.g., specific disability training (including dual diagnosis and medications); behavior modification techniques (including how to utilize positive and negative reinforcement, reward techniques, how to manage behavior interventions in public); and, communication skills, sign language, lifting and transfers, time management and stress management.
  - Funding tuition vouchers and community service benefits to assist DSPs in paying for education and training.

Possible Solutions: Wages and Benefits

- **Idaho should increase wages and improve benefits for DSPs by:**
  - Ensuring both federal and state agencies are committed to increasing the wages and benefits provided to DSPs;
  - Ensuring that direct support staff vacancy rates,retention and competence
  - should become a serious component of quality assurance; and,

- Requiring the DHW to collect ongoing data about DSP wages, benefits, vacancies, and turnover in order to know whether intended solutions are effective.

It is the hope of all the stakeholders that participated in this effort that the information contained in this report will be used as a springboard toward finding ways to ensure Idaho has a well-trained and well-supported DSP workforce. The barriers to accomplishing this goal are many, but the reward will be a strong community-based system of long-term care, where DSPs work together with self-directed consumers to achieve independence and full community integration.

I. Introduction

Direct Service Providers (DSPs) provide day-to-day, person-to-person contact support and assistance to a wide range of individuals including people with disabilities or chronic illness and older persons. DSPs are found in a number of settings and they have a number of job titles such as Certified Nurses Assistant, Personal Care Attendant, Nurses Aide, Therapy Technician, Residential Counselor, Job Coach, Psychiatric Technician, and others. DSPs work in nursing homes, home health agencies, assisted living facilities, board and care facilities, adult day care or adult health centers, or group homes for individuals with mental illness or mental retardation. They can also be community-based providers such as area agencies on aging, hospice, or even transportation carriers.

DSPs provide housekeeping and routine personal care services. They clean clients' houses, do laundry, and change bed linens. Aides may plan meals (including special diets), shop for food, and cook. Aides also may help clients move from bed, bathe, dress, and groom. Some accompany clients outside the home, serving as a guide and companion. Personal and home care aides also provide instruction and psychological support. They may advise families and patients on such things as nutrition, cleanliness, and household tasks. Aides also may assist in toilet training a child with significant disabilities, or just listen to clients talk about their problems.

The personal and home care aide's daily routine may vary. Aides may go to the same home every day for months or even years. However, most aides work with a number of different clients, each job lasting a few hours, days, or weeks. Aides often visit four or five clients on the

same day. Personal and home care aides generally work on their own, with periodic visits by their supervisor. They receive detailed instructions explaining when to visit clients and what services to perform. Many aides work part time, and weekend hours are common.

DSPs are individually responsible for getting to the client's home. They may spend a good portion of the working day traveling from one client to another. They are particularly susceptible inside and outside clients' homes to injuries resulting from all types of overexertion when assisting patients. Mechanical lifting devices that are available in institutional settings are seldom available in patients' homes.

In home care agencies, it usually is a registered nurse, a physical therapist, or a social worker who assigns specific duties and supervises personal and home care aides. Aides keep records of services performed and of clients' condition and progress. They report changes in the client's condition to the supervisor or case manager. Aides work in cooperation with other healthcare professionals, including registered nurses, therapists, and other medical staff.

According to the U.S. Labor Bureau (2000), DSPs account for 2 million jobs, or 20% of our nation's healthcare workforce. Of these, just over one million are nurse's aides (53%); 561,000 are home health aids (28%), and 371,000 are personal or home care assistants (19%). Over 90% of them are women aged 22 to 45—a demographic bracket that will see an absolute decline in size in the coming decade. They are disproportionately women-of-color — 30% of direct-care workers nationwide, and the majority of paraprofessionals in many urban centers. One fifth of all African-American women employed in the United States work within healthcare—most of them in these direct-care jobs. Table 1 displays the average hourly wage for each of these three groups as estimated by the U.S. Labor Bureau.

However, the Occupational Outlook Handbook, 2002-03 Edition, which is published by the U.S. Department of Labor, Bureau of Labor Statistics, uses a slightly different job classification system, and lists lower average pay rates for DSPs. The Handbook estimates: the median hourly earnings of personal and home care aides was $7.50 in 2000; the middle 50 percent earned between $6.43 and $8.53 an hour; the lowest 10 percent earned less than $5.74, and the highest 10 percent earned more than $10.13 an hour.

Table 1. Median Hourly Earning (U.S. Bureau of Labor, 2000).

Direct Care Provider Group	Hourly Wages
Nurses Aide	$8.89
Home Health Aide	$8.23
Personal and Homecare Provider	$7.50
Average Hourly Wage	**$8.21**

Median hourly earnings in the industries employing the largest numbers of personal and home care aides in 2000 are shown in Table 2.

Table 2. Median Hourly Earning (Bureau of Labor Statistics, 2002-03).

Job Classification	Hourly Wages
Residential care	$7.97
Job training and related services	$7.85
Nursing and personal care facilities	$7.82
Individual and family services	$7.75
Home health care services	$6.49

Between 2000 and 2010, the U.S. Bureau of Labor estimates employment growth for DSPs will grow by 36.3% as compared to the overall growth in employment among the general population. **Eight hundred and seventy four thousand (874,000) new DSPs will be needed by 2010**. In addition to job openings created by the increase in demand for these workers, replacement needs are expected to produce numerous openings. Turnover is high, a reflection of the relatively low skill requirements, low pay, and high emotional demands of the work. For these same reasons, many people are reluctant to seek these jobs. Therefore, persons who are interested in this work and suited for it should have excellent job opportunities, particularly those with experience or training as personal care, home health, or nursing aides.

In some States, this occupation is open to individuals with no formal training. On-the-job training is generally provided. Other States may require formal training, depending on State law. The National Association for Home Care offers national certification for personal and home care

aides. Certification is a voluntary demonstration that the individual has met industry standards. Successful personal and home care aides like to help people and do not mind hard work. They should be responsible, compassionate, emotionally stable, and cheerful. In addition, aides should be tactful, honest, and discreet because they work in private homes. Aides also must be in good health. A physical examination including State-mandated tests, such as those for tuberculosis, may be required. In some agencies, workers start out performing homemaker duties, such as cleaning. With experience and training, they may take on personal care duties.

Advancement for personal and home care aides is limited. Most employers give slight pay increases with experience and added responsibility. Aides usually are paid only for the time worked in the home. They normally are not paid for travel time between jobs. Employers often hire on-call hourly workers and provide no benefits.

Thirteen million people in this country need daily assistance with personal maintenance, hygiene, eating, and for those living at home, a range of basic household tasks. About one-third of these long-term care consumers are aged 80 and over, a population that is expected to grow by over 35% (from 7.8 million to 10.6 million) between 1994 and 2006. Seven in ten nursing home residents, and six in ten home care consumers, are women, making long term care very much a "women's health" issue.

The number of elderly people is projected to rise substantially. This age group is characterized by mounting health problems requiring some assistance. In addition to the elderly, there will be an increasing reliance on home care for patients of all ages. This trend reflects several developments: efforts to contain costs by moving patients out of hospitals and nursing facilities as quickly as possible; the realization that treatment can be more effective in familiar surroundings rather than clinical surroundings; and the development and improvement of medical technologies for in-home treatment.

Consumers consistently cite the quality of the paraprofessional workers with whom they are in contact on a daily basis as the primary determinant of their care quality. Consumers want a stable care giving workforce with whom they can develop ongoing relationships—and despair at caregiver turnover rates typical in home care (40-60% per year) and nursing homes (70-100%

per year). As the typical long term care consumer gets older, frailer, and more likely to suffer from dementia, he or she will need a more skilled direct-care workforce than the current one—which is now typically under-trained and inexperienced.

II. Purpose & Scope of the Direct Support Proposal Initiative

Issues related to DSPs have taken on national importance as the federal government strives to meet the needs of a rapidly aging population as well as implementing the Supreme Court's Olmstead decision. According to a report recently delivered to President Bush and the Congress entitled: *Delivering on the Promise: Preliminary Report, Federal Agency Actions to Eliminate Barriers and Promote Community Integration, Personal Assistance, Direct Care Services and Community Workers.*

"As the President's Executive Order is implemented and more people with significant disabilities live in home and community-based settings and enter the workforce, the already critical need for personal care assistants and other direct care staff and community service workers will become even more pronounced. A chronic inability to attract and retain dedicated people in these fields can be traced to the fact that traditionally across the country these workers earn very low pay, work long hours, and often receive no benefits. There is an urgent need to address the areas of recruiting, training, retaining, promoting, and improving the earnings/benefits of personal assistants and other community service workers."

The issues that are important to DSPs nationwide are: recruitment and retention; training, and earnings/benefits. However, it is uncertain to what degree national trends are impacting Idaho's DSPs. To find out, and in response to the growing importance of the DSPs in Idaho and nationwide, the Idaho Council on Developmental Disabilities sponsored a study designed to identify critical issues that DSPs feel impact their profession. The results of the survey will be used to develop short and long-term strategies to address the issues identified in the study. The DDC subcontracted with the Center on Disabilities and Human Development at the University of Idaho to conduct the study. The CDHD staff prepared this report in collaboration with many partners and is pleased to submit it to the Direct Service Provider Task Force and the public at-large for their consideration.

III. Methodology

The DSP Survey instrument was developed by the Center on Disabilities and Human Development in collaboration with DD Council staff and the DSP Task Force. Members of the DSP Task Force identified four major categories considered important to DSPs: salaries and benefits; recognition and respect; work environment; and information and training. A fifth section designed to collect background information about the respondent is also included in the survey. The Task Force developed a set of general questions for each of these five areas. Based of this information, the CDHD developed a draft of the survey instrument.

The draft of the instrument was disseminated to DD Council staff and the Task Force who reviewed it for accuracy, completeness and to ensure the questions would collect the desired information. The survey was revised based on this input and a final draft of the survey was completed.

The next step was to disseminate the survey to all of the relevant agencies. The Task Force members provided the CDHD with a mailing list representing each of the targeted agencies. The mailing list included: Assisted Living, Community Rehabilitation Providers, Developmental Disability Agencies, Group Homes, Home Care Providers, Hospitals, IFC-MRs, Mental Health Agencies, Nursing Homes, Residential Habilitation Facilities, Idaho State School and Hospital, and any other agency or individual who provides direct support services to individuals with disabilities. Surveys were distributed with a cover letter signed from the DDCouncil accompanied by a pre-addressed and pre-posted return envelope. The cover letter informed each survey participant of the purpose of the survey and that each survey would be treated confidentially. Survey participants were informed that they were eligible to participate in a drawing for a $100 gift certificate to Barnes & Noble. The survey was made available for downloading on the DD Council's website and was disseminated via several in-state conferences.

Surveys were distributed to agencies in February 2003 and supervisors were asked to distribute the surveys to their DSP staff. Approximately 4,500 surveys were mailed to the various agencies

and approximately 400 surveys were returned to the Council on Developmental Disabilities. The surveys were collected and the results are summarized below.

IV. Survey Analysis

1. Survey Respondents, Business Organizations, Job Titles & Work Responsibilities.

Surveys were returned from individuals working in a number of businesses including: assisted living, community rehabilitation, developmental disability agencies, group homes, home care providers, ICFs-MR, mental health agencies and nursing homes. Nearly two-thirds (63%) of the surveys were completed by individuals who work in either DD agencies or Nursing Facilities. Community rehabilitation workers (8%), Others (7%), Home Health Providers (6%), and individuals who work in ICF-MRs (5%) were the next largest groups of respondents. "Others" was comprised of a majority of target care coordinators. No surveys were received from the Idaho State School and Hospital, State Hospital North or State Hospital South.
Finally, less than one percent of survey respondents were employed in residential habilitation and hospitals.

Employers associate a variety of job titles with the type of work and services that DSPs provide. Generally, very few employers classify the job title as a DSP. Rather, Therapy Technician was the most common job title in the industry associated with the type of work performed by a DSP. Note, however, that individuals with Certified Nurses Assistant job titles were also frequent among the individuals who responded to the survey. Employers associate a variety of job titles with the type of work and services that DSPs provide. Generally, very few employers classify the job title as a DSP. Rather, Therapy Technician was the most common job title in the industry associated with the type of work performed by a DSP.

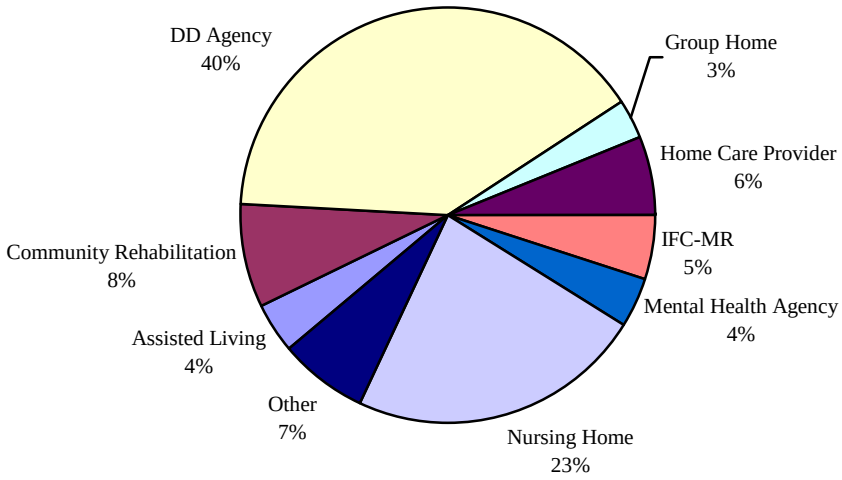


Figure 1. Business Organizations Represented in DSP Data Analysis

Employers associate a variety of job titles with the type of work and services that DSPs provide. Generally, very few employers classify the job title as a DSP. Rather, Therapy Technician was the most common job title in the industry associated with the type of work performed by a DSP. Note, however, that individuals with Certified Nurses Assistant job titles were also frequent among the individuals who responded to the survey. This title, perhaps, is the most standardized title associated with individuals who were targeted by this survey. Additional job titles reported in the survey include Aide, Bath Aide, Development Provider/Specialist, Employment Specialists, Home Care Provider/Aid, Life Instructor/Skills Coach, LPN, Professional Services Coordinator, Service Coordinator and TSC/ESC.

It is clear from a combination of business organizations that participated and the job titles reported in the survey, that DSPs in the state of Idaho provide a variety of services, including, transportation, health care, employment assistance/job coaching, financial management assistance, educational assistance and advocacy. These services are performed in a variety of settings including private homes, group homes, in the community, employment settings, hospitals and nursing homes. In essence, a person in a DSP position is required to have a variety of complex job skills. First, a DSP is most certainly required to have knowledge of disabilities and some level of knowledge about behavior management techniques. In addition to these most obvious employment requirements, some DSPs are required to provide assistance related to a

consumer's employment, finance and advocacy issues. There is a strong ethical component in the daily employment responsibilities of a DSP. DSPs may often be considered to have a fiduciary relationship with their clients.

2. Education and Motivation for DSP Employment

Nearly half of the survey respondents indicated that they have a high school education or GED equivalent. Seven percent of the survey respondents indicated that they were employed in the DSP field while working towards an associate's degree, bachelor's degree or specialized certification. Seven percent of survey respondents indicated that they had an associate's degree and almost 20% of the survey respondents indicated that they had a bachelor's degree. Twelve percent of the survey respondents indicated that they had completed a specialized certificate program and nearly all of those respondents indicated they were employed as a Certified Nurses Assistant.

Generally, the primary motivation for individuals to pursue DSP related employment fell into one of five categories. Thirty-nine percent of the survey respondents indicated their primary motivation for DSP employment was to begin a career. Seventeen percent of the survey respondents indicated that their primary motivation for DSP employment was for economic reasons. Eighteen percent of the survey respondents indicated their primary motivation for DSP employment was to gain experience in a related employment field. Twelve percent of the survey respondents indicated their primary motivation for DSP employment was based on a personal relationship with an individual with a disability. Finally, twelve percent of the survey respondents selected 'other' as their primary motivation for DSP related work. The most commonly referred to motivation for DSP related employment was a desire to improve the lives of consumers and their enjoyment of DSP related work.

3. Duration of Employment, Wages & Benefits

The average number of months in current position is approximately 32 months. This figure, however, may be misleading. The range of employment in current position ranges from 1 month to 312 months. The median is 21 months experience in their current position. The most frequent

response to the inquiry regarding duration of employment was 12 months and nearly one-third of the respondents indicated they had between one month and 12 months work experience in their current position.

Almost all respondents indicated they were compensated on an hourly basis. Almost half of the respondents indicated they were paid between $7.00 and $8.99 per hour. The lowest paid individual who responded to the survey indicated she was compensated at an hourly wage of $5.50. The exceptions for hourly compensation were the situations in which DSPs were paid on a case-by-case basis. This ranged from $20 to $50 per case per month. The survey did not gather any information that allowed for a comparison between different rates of compensation in different regions of the state. Chart 2 displays the information about the hourly wage of the DSPs who completed the survey.

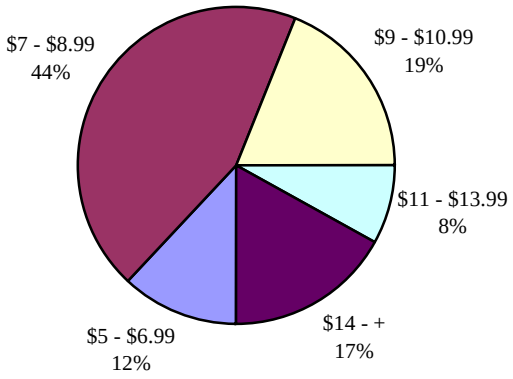
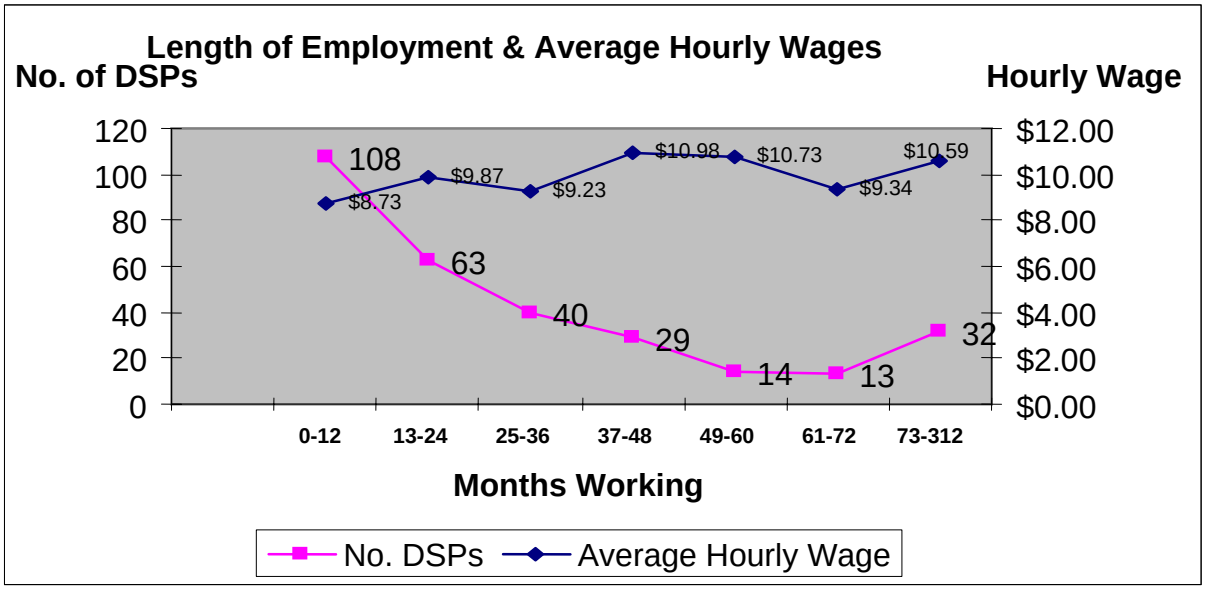


Figure 2. DSP Hourly Compensation

Approximately 25% of the respondents indicated they have a second job for the purpose of supplementing their income. Examples of a second job include the following: a second job in same field; home businesses; massage therapy; and, additional employment in the restaurant industry. Table 3 illustrates the work history as compared to the average hourly wage of the survey respondents.

Table 3. Work History Compared to Average Hourly Wages.



Approximately half of the respondents (162) reported that this was there first employment experience working as a DSP while the other 161 indicated they had previous experience working in the field averaging 8 years 13 months experience (Range = 7 months to 360 months).

Over eighty percent of the respondents indicated that they were eligible for some type of work benefit. As displayed in Table 4, the types of work benefits received by the DSPs who completed the survey varied widely. Survey respondents who received health, dental and/or vision insurance benefits stated this benefit was very valuable to them. Those who indicated they did not receive health insurance reported that paid vacation or paid time off was the most valued benefit. Approximately 57% of the survey respondents who were eligible for benefits indicated health insurance as their most valuable benefit.

Table 4. Salary and Benefits.

Salary Benefits	
Average Wage of those receiving benefits	$10.29
Average hours worked per week	35.37
Percent eligible for benefits?	
Yes	81.3%
No	18.7%
Types of benefits received:	
Dental Insurance	47.5%
Health Insurance	56.5%
Paid Vacation	66.9%
Paid Holiday	65.0%
Sick Leave	55.4%
Vision Insurance	20.1%
Professional Development	13.3%
Day Care	0.0%
Mileage Reimbursement	46.0%
Flexible Benefits	18.3%
Tuition Reimbursement	15.8%
401K (with employer contribution)	28.5%
Pension	5.8%
Employee Assistance Program	17.3%
Other (see Table 5)	
Most Valuable Benefit:	
Dental Insurance	6.2%
Health Insurance	51.1%
Paid Vacation	14.2%
Paid Holiday	1.8%
Sick Leave	1.3%
Vision Insurance	0.4%
Professional Development	0.4%
Day Care	0.0%
Mileage Reimbursement	1.3%
Flexible Benefits	0.0%
Tuition Reimbursement	0.9%
401K (with employer contribution)	2.2%
Pension	1.3%
Employee Assistance Program	0.0%
Other (flexibility)	0.4%
Additional Employment	21.0%

Table 5. Other Benefits.

Benefits
benefits from another job
cell phone
choose not to receive
company recently took all medical away
counseling
eligible but choose not to take benefits
flexibility/accrue PTO overtime
phone reimbursement
short/long term insurance
supplemental insurance.
workers comp/unemployment insurance

Table 6. Nature of Additional Employment.

Additional Employment	
Alternative care provider	janitorial
apartment. manager/odd jobs	store clerk
assisted living	massage therapist
audio/visual tech	motel desk clerk
CNA training	nurses aid
care provider in group home	nursing home aide
certified family home	sales
city parks and rec/home care	services
clean offices	speech/language teacher
community one on one	technology
community service/youth	various jobs
comp. software training	video rental store
cook	waitress
therapy aide	waitress
aide to disabled adults	work at home
home health	youth director
home-based	state institution
house cleaning	home school coordinator
house manager care	case management
in-home respite	massage therapist
Pastor	inventory
physical therapist	aide

4. Attitudes & Experiences about DSP Employment Experience

The following information was gathered from survey respondents reviewing a statement about their employment experience and selecting on a scale whether they strongly disagree (1), disagree (2), somewhat agree (3), agree (4) and strongly agree (5). Table 4 displays the responses to three questions about their initial employment experience. The questionnaire statement appears in the left hand column and the average (mean), standard deviation and the total number of responses (n) appears in the right hand column

Table 7. Initial Employment Experience.

Initial Employment Experience		Strongly Disagree 1	Disagree 2	Some-what 3	Agree 4	Strongly Agree 5
1	This position met my original expectations.	Mean=3.9	SD=.82	n = 299		
2	My new employee orientation and initial training prepared me to perform my job.	Mean=3.6	SD=.986	n = 300		
3	I was tested and evaluated on my initial orientation and training I received.	Mean=3.45	SD=1.12	n = 297		

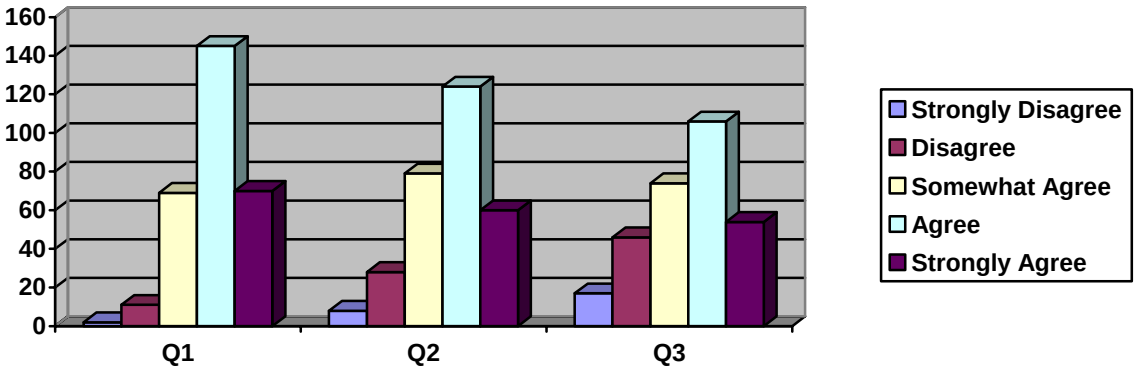


Figure 3. Mode Values for Employment Attitudes & Experiences on Initial Employment Experience

Table 8. Training and Professional Development.

Training & Professional Development		Strongly Disagree 1	Disagree 2	Some-what Agree 3	Agree 4	Strongly Agree 5
4	Periodically, my employer offers training to support my professional development.	Mean=4.1	SD=.93	n = 300		
5	I am tested and evaluated on my professional development training.	Mean=3.7	SD=.99	n = 298		
6	I can openly communicate with my supervisor about my training needs.	Mean=4.2	SD=.96	n = 299		
7	I feel qualified to meet the needs of the people I serve.	Mean=4.5	SD=2.9	n = 300		
8	At minimum, I receive performance reviews on an annual basis.	Mean=4.1	SD=.91	n = 293		
9	Performance reviews are helpful in developing my professional skills.	Mean=4.2	SD=.83	n = 297		
10	At minimum, I am considered for raises at least once per year.	Mean=3.7	SD=1.22	n = 290		
11	I receive helpful feedback about my job performance from the people I provide services to.	Mean=3.8	SD=.957	n = 299		
12	My employer solicits feedback from the people I provide services to.	Mean=3.8	SD=.86	n = 298		
13	I have the opportunity for career growth at my current employer.	Mean=3.39	SD=1.18	n = 300		

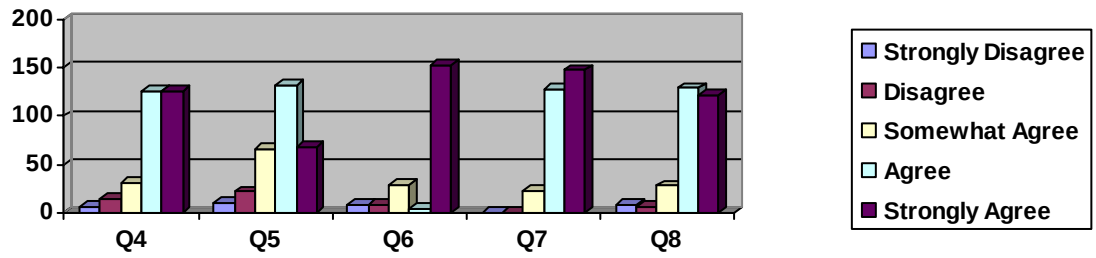


Figure 4. Mode Values for Employment Attitudes & Experiences on Professional Development Q4-Q8

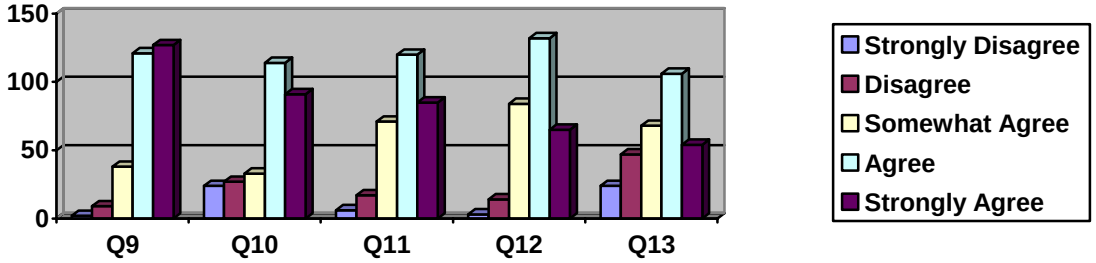


Figure 5. Mode Values for Employment Attitudes & Experiences on Professional Development Q9-Q13

Table 9. Work Environment.

Work Environment		Strongly Disagree 1	Disagree 2	Some-what Agree 3	Agree 4	Strongly Agree 5
14	I feel my work environment is safe.	Mean=4.2	SD=.78	n = 300		
15	I feel my work environment is sanitary.	Mean=4.16	SD=.83	n = 300		
16	For non-emergency situations, I feel I have adequate back-up support.	Mean=4.2	SD=.74	n = 300		

17	When encountered with an emergency situation, I have adequate support to handle the situation.	Mean=4.2	SD=.72	n = 301
18	My co-workers contribute to the overall safety of my work environment.	Mean=4.1	SD=.73	n = 299

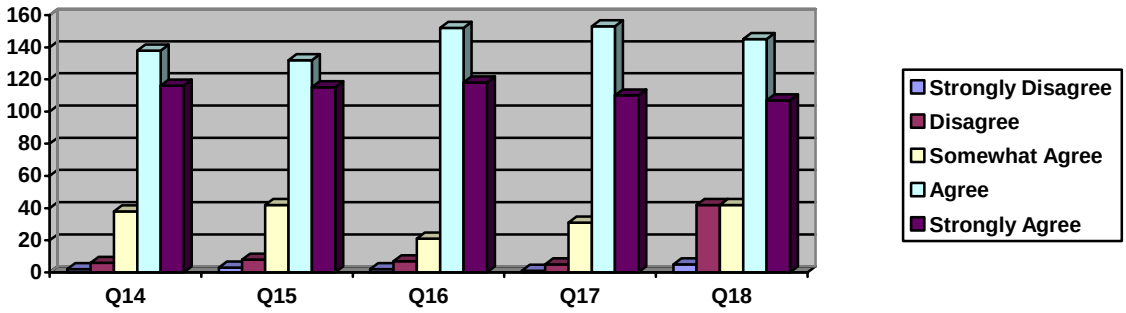


Figure 6. Mode Values for Employment Attitudes & Experiences on Work Environment Q14-Q18

Table 10. Recognition and Wages.

Recognition & Wages		Strongly Disagree 1	Disagree 2	Some-what Agree 3	Agree 4	Strongly Agree 5
19	The service I provide improves the lives of the people I serve.	Mean=4.5	SD=.58	n = 298		
20	I feel respected by my supervisor.	Mean=4.2	SD=.96	n = 301		
21	I feel respected by the people I provide services to.	Mean=4.2	SD=.74	n = 301		
22	My supervisor provides me with the necessary supplies I need to do my job well.	Mean=4.1	SD=.94	n = 301		
23	I feel my supervisor would be tactful in providing me with any feedback or discipline.	Mean=4	SD=.93	n = 299		
24	I feel I have job security in my current position.	Mean=3.7	SD=1	n = 301		
25	I am recognized for my work accomplishments.	Mean=3.7	SD=1.05	n = 301		
26	I am adequately compensated for the level of responsibility required by my position.	Mean=3.3	SD=1.1	n = 300		
27	I receive adequate time off.	Mean=4	SD=.9	n = 299		

Recognition & Wages		Strongly Disagree 1	Disagree 2	Some-what Agree 3	Agree 4	Strongly Agree 5
28	My job is rewarding in non-monetary ways.	Mean=4.3	SD=.75	n = 298		
29	I feel challenged by the work I do.	Mean=4.2	SD=.83	n = 299		
30	I enjoy my work.	Mean=4.4	SD=.69	n = 301		

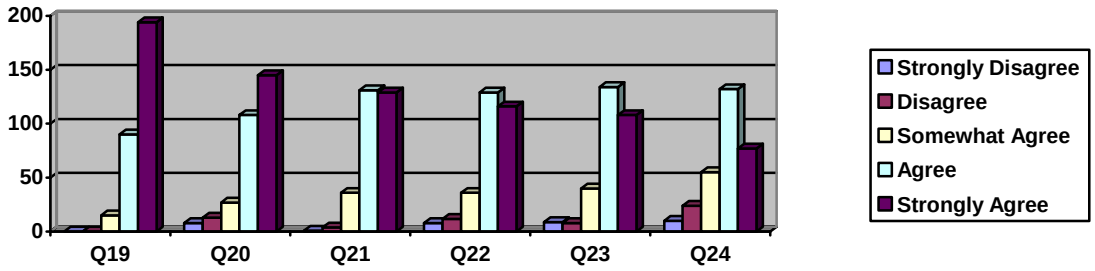


Figure 7. Mode Values for Employment Attitudes & Experiences on Recognition & Wages Q19-Q24

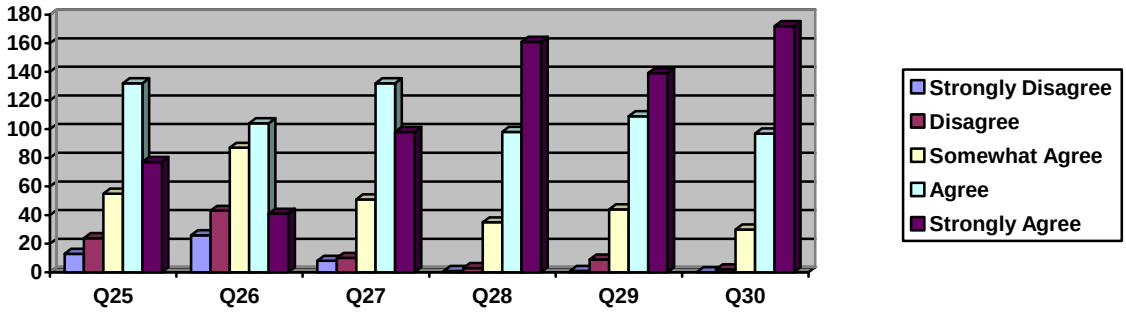


Figure 8. Mode Values Employment Attitudes & Experiences on Recognition & Wages Q25-Q30

V. Needs Identification

Survey respondents were asked to identify three items that would assist in better job performance. The most commonly indicated issue was salary compensation. The second most commonly reported item was more training. The following are among very frequent responses: better communication and support from supervisors and co-workers, additional staff (less

turnover), improved office space and equipment (including updated computers, updated computerized office processes) more consistent scheduling and more community activity options for clients.

Survey respondents were asked to identify three training topics that would help them perform their job better. The most commonly reported training topic was specific disability training i.e., understanding the nature of their client's disability (including dual diagnosis and medications). The second most requested training topic was behavior modification techniques (including how to utilize positive and negative reinforcement, reward techniques, how to manage behavior interventions in public). Other common responses included: communication skills, sign language, lifting and transfers, time management and stress management. Survey respondents indicated their training style preferences in the following order: (1) hands-on; (2) written materials; (3) Internet; and (4) lecture.

VI. Conclusions and Possible Solutions

Based on the best available information, there clearly is a DSP workforce crisis in this country and there is no reason to conclude that Idaho will be immune from this crisis. This crisis presents a significant challenge to the full community integration of persons with disabilities. According to Hewitt and Lakin (2001a):

> "Current difficulties in assuring adequate direct support staff recruitment, retention and competence are widely reported as the single biggest barrier to the growth, sustainability, and quality of community services for people with developmental disabilities (ANCOR, 2001; Colorado Department of Human Services, 2000; Hewitt, 2000; Lakin, Hewitt & Hayden, in press). There are longstanding challenges in efforts to provide sufficient high quality community supports to people with developmental disabilities (Lakin, & Bruininks, 1981; Braddock & Mitchell, 1992); but they are also ones of growing concern because the number of people demanding community services is increasing (Larson, Lakin & Hewitt, in press)."

In fact, given Idaho's demographic profile, i.e., the rapid increase in the aging of Idaho's general population that is expected to exceed the national average, it is easy to conclude that the looming crisis in the DSP workforce may be more severe in Idaho than in other parts of the country. Stakeholders in Idaho must generate far-reaching solutions to this crisis; and there is no time to waste. A coordinated response must come from not only members of the service provider community, but must also include federal and Idaho's state disability-related agencies. Again, Hewitt and Lakin (2001b) argue that:

> "Without involvement of all responsible entities, direct support staff recruitment, retention and training in community human services will be an increasingly insurmountable problem of growing significance to the opportunities of Americans with disabilities."

Below is a list of possible solutions for addressing the DSP workforce crisis in Idaho. The recommendations are based on the results of the DSP survey discussed above, but also reflects research findings generated by a brief literature review that was conducted as part of the DSP Initiative. In particular, the recommendations draw heavily from *Issues in the Direct Support Workforce and their Connections to the Growth, Sustainability and Quality of Community Supports: A Technical Assistance Paper of the National Project: Self-Determination for People with Developmental Disabilities*; [prepared by Amy Hewitt and K. Charlie Lakin, Research and Training Center on Community Living, University of Minnesota (see Appendix 2)]. The recommendations are interconnected, and in most cases, should be implemented simultaneously in order to be effective. For instance, recruitment and retention will improve when wages and benefits are improved, and retention will increase as more training and administrative support is provided, etc.

It is our hope that the information contained in this report will be used as a springboard toward finding ways to ensure Idaho has a well-trained and well-supported DSP workforce. The barriers to accomplishing this goal are many, but the reward will be a strong community-based system of long-term care, where DSPs work together with self-directed consumers to achieve independence and full community integration.

> *"If we want direct support professionals to walk in partnership toward self-determined lives; if we want people with developmental disabilities to share their*

dreams and hopes; if we want excellence, then we must promote continuity and competence of direct support professionals." (Taylor, 2001).

Possible Solutions: Recruitment and Retention

- **Idaho should strive to attract people to the "profession" of direct support by:**
    - Identifying specific skills and standards for DSPs;
    - Improving the public's perception of the DSP profession;
    - Increasing the awareness of educators and workforce development counselors about the DSP profession;
    - Requiring Idaho's welfare-to-work program, technical and community colleges, and school-to- work programs to include DSP on their list of employment options;
    - Providing recognition and other incentives for service providers that have few vacancies and low turnover rates; and,
    - Training service provider agency administrators on the use of organizational and management practices that have proven to be effective at reducing vacancies and increasing the retention of direct care professionals.

Possible Solutions: Training and Professional Development

- **Idaho should improve the capacity of DSPs to perform their job duties by:**
    - Implementing a "career ladder" education and training programs that offer career paths and other incentives for people to remain in direct support positions.
    - Financially rewarding direct-care professionals who complete additional education, demonstrate new skills, and remain in their positions for periods of more than a year.
    - Using distance learning and web-based training programs to improve the quality, consistency and access of training information for direct care professionals.

- Providing training that addresses the topics identified in the survey, e.g., specific disability training (including dual diagnosis and medications); behavior modification techniques (including how to utilize positive and negative reinforcement, reward techniques, how to manage behavior interventions in public); and, communication skills, sign language, lifting and transfers, time management and stress management.
- Funding tuition vouchers and community service benefits to assist DSPs in paying for education and training.

Possible Solutions: Wages and Benefits

- **Idaho should increase wages and improve benefits for DSPs by:**
  - Ensuring both federal and state agencies are committed to increasing the wages and benefits provided to DSPs;
  - Ensuring that direct support staff vacancy rates, retention and competence should become a serious component of quality assurance; and,
  - Requiring the DHW to collect ongoing data about DSP wages, benefits, vacancies, and turnover in order to know whether intended solutions are effective.

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Appendix 1: Survey Instrument

We are interested in your experiences and attitudes about your employment as a direct support professional. Please take a few minutes to complete this survey. In general, if you are presented with a checklist question or a scale next to a question, please check the answer that best corresponds to your answer. *As is the case with all the information we are collecting for our study, we will keep all the information you provide to us completely confidential.*

SECTION I: GENERAL INFORMATION

What type of business organization are you employed by?

___ Assisted Living
___ Community Rehabilitation Provider
___ Developmental Disability Agency
___ Group Home
___ Home Care Provider
___ Hospital
___ IFC-MR
___ Mental Health Agency
___ Nursing Home
___ Residential Habilitation
___ *Family* ___ *Non-Family*
___ Idaho State School and Hospital (ISSH)
___ State Hospital North (SHN)
___ State Hospital South (SHS)
___ Non-Paid Provider – *Please skip to Section IV*
___Other – *Please Indicate:*_____

What types of people to you most frequently work with?

___ Adults with Developmental Disabilities
___ Elderly (age 65+)
___ Adults with Mental Illness
___ Adults with Physical Disabilities
___ Adults with Traumatic Brain Injury
___ Other – *Please Indicate:*_____

What is your current position: _____

How long have you worked in your current position? _____ Years _____ Months

Is this your first employment experience in this field? ___ Yes ___ No

If not, please indicate how long you have been employed in this field? _____ *Years*

What was your *primary* motivation for seeking employment in this field?

___ Begin a Career ___ Personal Relationship

___ Economic Reasons ___ Gain Practical Experience for a Related Field

___ Other – *Please Indicate:*

What is your level of education?

___ GED ___ Associates Degree ___ Currently in High School

___ High School Diploma ___ Bachelors Degree ___ Currently in College

___ Specialized Certificate Program

___ Other – *Please Indicate:*_____

Have you had training or education that has prepared you to work in this field? ___ Yes ___ No

If yes, please describe your training: _____

SECTION II: SALARIES & BENEFITS

Are you paid an hourly, daily or weekly wage?_____

What is your hourly/daily wage in your current position? _____

On average, how many hours do you work per week? _____

Based on the number of hours you work, are you eligible to receive employment benefits?
___ Yes ___ No

If so, please indicate which benefits you receive?

___ *Dental Insurance* ___ *Day Care*
___ *Health Insurance* ___ *Mileage Reimbursement*
___ *Paid Vacation* ___ *Flexible Benefits Plan*
___ *Paid Holidays* ___ *Tuition Reimbursement*
___ *Sick Leave* ___ *401K (with employer contribution)*
___*Vision Insurance* ___ *Pension*
___ *Professional Development* ___ *Employee Assistance Program*
___ *Other, please indicate:*_____

*Which of these benefits is most valuable to you?*_____

Do you have additional employment for the purpose of supplementing your income?
___ Yes ___ No

If yes, please describe the nature of your work:_____

For scaled questions below, if you strongly agreed with the question, you might circle the number 5. If you agreed moderately you might circle number 4, if you neither agreed nor disagreed, you might circle through number 3. If you would like to make additional comments on a statement please do so by referencing the statement number and writing your comments on the following page. Again, we encourage you to provide us with your input, as your knowledge is essential to advancing the professional development needs of Direct Service Professionals.

	SECTION III: ATTITUDES & EXPECTATIONS	**Strongly Disagree**	**Disagree**	**Some-what Agree**	**Agree**	**Strongly Agree**
1	This position met my original expectations.	1	2	3	4	5
2	My new employee orientation and initial training prepared me to perform my job.	1	2	3	4	5
3	I was tested and evaluated on my initial orientation and training I received.	1	2	3	4	5
4	Periodically, my employer offers training to support my professional development.	1	2	3	4	5
5	I am tested and evaluated on my professional development training.	1	2	3	4	5
6	I can openly communicate with my supervisor about my training needs.	1	2	3	4	5
7	I feel qualified to meet the needs of the people I serve.	1	2	3	4	5

8	At minimum, I receive performance reviews on an annual basis.	1	2	3	4	5
9	Performance reviews are helpful in developing my professional skills.	1	2	3	4	5
10	At minimum, I am considered for raises at least once per year.	1	2	3	4	5
11	I receive helpful feedback about my job performance from the people I provide services to.	1	2	3	4	5
12	My employer solicits feedback from the people I provide services to.	1	2	3	4	5
13	I have the opportunity for career growth at my current employer.	1	2	3	4	5
14	I feel my work environment is safe.	1	2	3	4	5
15	I feel my work environment is sanitary.	1	2	3	4	5
16	For non-emergency situations, I feel I have adequate back-up support.	1	2	3	4	5
17	When encountered with an emergency situation, I have adequate support to handle the situation.	1	2	3	4	5
18	My co-workers contribute to the overall safety of my work environment.	1	2	3	4	5
19	The service I provide improves the lives of the people I serve.	1	2	3	4	5
20	I feel respected by my supervisor.	1	2	3	4	5
22	I feel respected by the people I provide services to.	1	2	3	4	5
23	My supervisor provides me with the necessary supplies I need to do my job well.	1	2	3	4	5
24	I feel my supervisor would be tactful in providing me with any feedback or discipline.	1	2	3	4	5
25	I feel I have job security in my current position.	1	2	3	4	5
26	I am recognized for my work accomplishments.	1	2	3	4	5
27	I am adequately compensated for the level of responsibility required by my position.	1	2	3	4	5
28	I receive adequate time off.	1	2	3	4	5
29	My job is rewarding in non-monetary ways.	1	2	3	4	5

30	I feel challenged by the work I do.	1	2	3	4	5
31	I enjoy my work.	1	2	3	4	5

SECTION IV: NEEDS IDENTIFICATION

Please list three things that you feel would help you do your job better.

1. _____ 2. _____
3._____

Please list three training topics that you feel would help you do your job better.

1. _____ 2. _____
3._____

Please rank your training style preferences by from 1 to 4, 1 being your most preferred and 4 being your least preferred method of training delivery:

___ Hands-On Training
___ Lecture
___ Internet Training
___ Written Materials

Please use the back of this survey to share with us any additional information you feel would be helpful in addressing the current employment and training issues for Direct Service Professionals. Place the survey in the attached postage-paid envelope and return.

We will keep all the information you provide to us completely confidential.

Appendix 2: Articles

Issues in the Direct Support Workforce and their Connections to the Growth, Sustainability and Quality of Community Supports

A Technical Assistance Paper of the National Project: Self-Determination for People with Developmental Disabilities

Prepared by: Amy Hewitt, PhD, Research Associate
K. Charlie Lakin, PhD, Senior Research Associate
Research and Training Center on Community Living
University of Minnesota
May 2001

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Introduction

Current difficulties in assuring adequate direct support staff recruitment, retention and competence are widely reported as the single biggest barrier to the growth, sustainability, and quality of community services for people with developmental disabilities (ANCOR, 2001; Colorado Department of Human Services, 2000; Hewitt, 2000; Lakin, Hewitt & Hayden, in press). Theses are longstanding challenges in efforts to provide sufficient high quality community supports to people with developmental disabilities (Lakin, & Bruininks, 1981; Braddock & Mitchell, 1992); but they are also ones of growing concern because the number of people demanding community services is increasing (Larson, Lakin & Hewitt, in press). As the difficulties of providing for an adequate and well-prepared workforce becomes more complex and multifaceted, so does the requirement of effective responses to these difficulties. The complexity of the current direct support workforce crisis, the effects of this crisis on various stakeholder groups and potential strategies to address them will be further explored throughout this paper. Relevant research, policy, reports and other resources related to these topics will also be summarized.

History and Nature of the Crisis

Concern about recruiting, retaining and training direct support professionals (DSPs) who can meet the needs for community support services for people with developmental disabilities is not new in the United States. Evidence of such concern can be found since the inception of community supports (Larson, Hewitt & Lakin, in press). Finding and keeping direct support staff and supporting their development of necessary skills, competence and attitudes have long been viewed as pervasive problems by service provider organizations. But these problems are becoming increasingly severe, threatening of the viability of community services, and challenging avowed commitments on the part of national, state, and local governments to assure access to community support for growing numbers of persons with developmental disabilities. What was once a problem viewed primarily as a service provider agency problem must today be viewed as a broad systems problem for which there are no easy solutions and in which all entities that have played a part in promising a place in the community for persons with developmental disabilities must play a role in addressing issues that threaten that promise. The move toward inclusive community supports away from institutional services has had serious effects on the nature of and problems associated with direct support. In June 1977 almost all people who received residential services did so in large institutional settings with 16 or more other people (207, 356); while in June 1999 only a small percentage were living in institutional settings (82, 718) (Prouty & Lakin, 2000). This shift has had an impact on the roles and expectations of the people who provide supports. Service settings have been transformed from relatively few locations primarily in rural areas in which 4 the service provider was often a primary employer to an enormously greater number of much smaller service settings most often in urban communities. In fact, between 1977 and 1999 the total number of service settings increased from 11,006 to 113,633 (Prouty & Lakin, 2000). These changes have brought geographic dispersion of DSPs, an increase in the number of DSPs needed to support people in their communities, and a marked shift from public to private employment opportunities for DSPs. Major changes have also occurred in the expectations and roles of direct support professionals (Taylor, Bradley & Warren, 1996). DSPs were in previous decades primary caretakers who under the direction of on-site supervisors carried out structured programs of health, safety, training and basic care. Today, in addition to meeting peoples' basic health, safety and care needs, DSPs have responsibilities to support people to develop and achieve their own personal goals, to balance risks with choices, to connect with peers, friends and family members, and to be full and active citizens in their communities. They carry out these expanded responsibilities with less supervision and increasingly while working alone. These expanded responsibilities and the increased isolation of DSPs have not been accompanied by increased qualifications, education or training. As a result, many DSPs report that their training has been insufficient to prepare them for their job responsibilities (Hewitt, Larson & Lakin, 2000; Test, Solow & Flowers, 1999; Hewitt, 1998). Changes in the U.S. economy, labor market and the demographic make up of our country have contributed to the workforce problems in the developmental disabilities service system. The typical direct support worker is a female between the ages of 27 and 39 (Larson, Hewitt, & Lakin, 1994). Between 1976 and 1986 as the rapid expansion of community services was just beginning, the number of people between the ages of 20 and 44 grew by about 20 million. Staff turnover in those years was not appreciably higher than today, but replacement staff were plentiful. Since 1986 the number of people in this age group grew by only 7 million people and is currently expected to decline by 2 million people by the year 2006 (Fullerton, 1999). As the demographic pool from which DSPs are

traditionally selected is declining, the need for more workers is steadily increasing. As the U. S. population ages and other persons with disabilities stake their claim to community supports, the demand for human service workers also increases. The U.S. Bureau of Labor statistics projects there will be a 58% increase in demand for home health aides and a 53% increase in the demand for community human service workers between 1998 and 2008 (Fullerton, 1999). Low unemployment and a booming economy exacerbate the workforce challenges faced by community human services providers. Today, with unemployment rates are as low as 2% in some communities and on average 4% nationally in May 2000 (U.S. Census Bureau, 1999), human services join service industries as a whole in struggling to find workers. Unlike most of the competing service industries human services are unable to keep pace with prevailing wages because they cannot increase prices which are set by government and they can not substantially increase productivity because of the highly interpersonal role of direct support.

Direct Support Professionals

Direct support professionals have a variety of job titles; in fact in a recent study conducted in North Carolina over 155 titles were assigned to people in direct support roles (Test, Solow & Flowers, 1999). DSPs have complex jobs that require complex skills, knowledge and ethical judgment (National Alliance for Direct Support Professionals, 2001; Taylor, 2000; and O'Brien & O'Brien, 1992). They support people to participate fully in their families, communities and social lives. They assist people with personal care, health care, transportation, advocacy, financial management and other areas in which a person might need assistance (Hewitt & O'Nell, 1998; Jaskulski & Ebenstein, 1998; Taylor, Bradley & Warren, 1996; and O'Brien & O'Brien, 1992). The Community Support Skill Standards (CSSS) define the direct support role as, "…to assist the individual to lead a self-directed life and contribute to his/her community; and encourage attitudes and behaviors that enhance inclusion in his/her community (Taylor, Bradley & Warren, 1996)." Direct support professionals work in a variety of settings, including people's own homes and their family homes, group homes, employment settings, recreation programs, and institutional settings (Hewitt, O'Nell, & Larson, 1996). The exact number of DSPs working in the United States supporting people with developmental disabilities is unknown because current labor statistics do not adequately define, identify and count these positions. It is estimated that there were about 110,000 full-time equivalent (FTE) positions in state operated institutions and 400,000 FTE positions in community residential settings in 2000 (Larson, Lakin, & Hewitt, in press). It is also estimated that between 90,500 and 125,000 DSPs work in vocational programs (Larson, Hewitt & Anderson, 1999). The Bureau of Labor Statistics (1999) reports that there were 746,000 homemaker and home health aide jobs in the United States. DSPs work in both full time and part time positions and are often are required to work shifts that cover 24 hours a day, seven days a week and 365 days per year. Most direct support professionals are females (Hewitt, Larson & Lakin, in press; Bachelder & Braddock, 1994; Braddock & Mitchell, 1992; Lakin & Bruininks, 1981), below the age of 39 (Colorado Department of Human Services, 2000; Test, Solow & Flowers, 1999; Larson, Hewitt & Lakin, 1994), and have at least some college with as many as a third of DSPs having college degrees (Hewitt, Larson & Lakin, 2000; Test, Solow & Flowers, 1999; Larson, Lakin & Bruininks, 1998). Growing numbers of DSPs across the country are from diverse cultural, ethnic and linguistic backgrounds and many are recent immigrants to the United States (Ebenstein, 1998; Sedlezky, Hewitt, O'Nell, Sauer & Larson, 2001).

Recruitment Challenges

Administrators in community service settings report that direct support professional recruitment is a significant challenge (Cohen, 2000; Hewitt, Larson & Lakin, 2000; Barry Associates, 1999; Test, Solow & Flowers, 1999). Recent studies have found a 17% DSP vacancy rate in Alaska (Johnston, 1998) and an 8% vacancy *"My daughter has consistently received about 50% of the in-home and PCA hours she is authorized." --Parent* 6 rate in Minnesota (Hewitt, Larson & Lakin, 2000). There are a number of reasons for the growing recruitment challenge including an increased demand for workers, a reduced number of people in the traditional demographic "pool" supplying DSPs, and persistently low unemployment rates. Additionally, there are few career paths within the field to hold workers once engaged. The profession of direct support has a low social status, low pay, limited access to benefits, and is often considered by educators, economists, and policy-makers to be a secondary labor market. The growing phenomenon of high staff turnover and associated vacancies have serious negative consequences. Higher staff turnover has been associated with a low morale, absenteeism and the phenomenon of "burnout" in which staff may stay on the job but without commitment to it (Pine & Maslock, 1978; Jacobson & Ackerman, 1990). When there is high DSP turnover and vacancies, existing DSPs often work overtime shifts (Larson, Lakin & Bruininks, 1998). Given the intense, stressful nature of the DSP job, when employees work large amounts of overtime they are susceptible to exhaustion, increased mistakes and decreasing quality of performance. Many agencies respond to turnover and resulting vacancies by using "temp agency employees." This often causes additional stress for DSPs and results in service quality deterioration as "temps" do not always know the routines and the needs of the people receiving services nor how to provide supports that are included in their service plans. Increasingly, however, overtime and the use of temporary employees is simply not enough to meet the need for "warm bodies" and therefore agencies are forced to let shifts go unfilled, despite the implications to peoples' safety and the content of their service plans.

Retention Challenges

High turnover of direct support staff has long been a part of community residential services. Studies have shown that community direct support staff turnover rates have consistently been between 45% and 70% (Larson, Lakin & Hewitt, in press; Braddock, et. al., 1992; and Lakin & Bruininks, 1981). No national studies have been conducted since 1992 (Braddock, et. al.), but there have been a number of more recent statewide studies conducted in recent years. Table 1 summarizes research on direct staff turnover that have attempted to identify DSP annual turnover rates. It is important to note that the turnover rate for frontline supervisors (FLS) is also high. Recently in Minnesota FLS turnover rates were found to be 27% (Hewitt, et al., 2000). Given that FLSs are responsible for guiding and directing the work of DSPs, their lack of stability only exacerbates the lack of continuity and difficulties in establishing competence and quality with high turnover. Turnover studies have identified several factors that are associated with higher turnover of DSPs. These include DSP wages, organizational socialization and training practices, the length of time that a service setting has been in existence, the characteristics of the people served in the setting, supervisor tenure and the extent to which FLSs are viewed as *"As a single mom I have lost three jobs, because I cannot find a*

PCA….or they don't show up." Parent 7 treating DSPs fairly (Hewitt, et al., 2000; Larson, et al., 1998; Bachelder, 1994; Braddock & Mitchell, 1992; Lakin & Bruininks, 1981). Direct support personnel report that the biggest reasons they have for leaving their positions are difficulty in getting along with co-workers, inadequate pay and benefits and issues with their supervisors (Lakin & Bruininks, 1981; Larson, et. al., 1998). Turnover is obviously costly to organizations that employ DSPs. In a recent study conducted in Alaska, the cost per hire for DSPs was estimated to be $2, 341 (Johnston, 1998). Considering the estimated 400,000 FTE DSP positions in community residential services alone and the estimated more than 50% turnover, the annualized cost of DSP turnover in the United States is astronomical. The human costs to people who receive services are also significant. People living in a small residential setting are routinely expected to "get used to" five or more new employees each year coming in to their home, often providing the most intimate of personal care or other supportive aspects of their private lives. Lack of continuity makes it extremely difficult to develop and sustain the trusting and familiar relationships that foster personal growth, independence, and self-direction.

Table 1. Direct Support Professional Average Annual Turnover Rates

Lakin & Bruininks	1981	54.2%	29.5%	Nat'l
Larson & Lakin	1992	57.0%	N/A	Nat'l
Braddock, et al.	1992	70.7%	34.2%	Nat'l
Bachelder, et al.	1994	55.4%	N/A	IL
Johnston	1998	166%	N/A	AK
Sjoberg	1999	50%	14%	CA
Test, et al.	1999	41%	N/A	NC
Larson, et al.	1999	N/A	20.3%	Nat'l
Colorado DHS	2000	67%	18%	CO
Hewitt, et al.	2001	44%	N/A	MN

Wages and Benefits

Community direct support wages have always been low when compared to the wages of direct support staff who work institutions and in other types of human service settings such as community mental health programs and youth programs (Larson, Lakin & Hewitt, in press; Colorado Department of Human Services, 2000; and Johnston, 1998). Table 2 provides an overview of several studies and their resulting data regarding DSP wages in community residential services as compared to wages in the public sector and/or institutional settings. A national study has not been completed to examine DSP wages in the United States since 1992, although as represented in Table 2, several individual state studies have recently been conducted. Direct support staff who work in vocational settings often earn higher wages then those who work in residential services. For example, in Minnesota the average DSP wage in residential supports is $8.81 per hour while in vocational services it is $10.49 per hour (Hewitt, Larson & Lakin, 2000). As recruitment of new personnel has become more difficult many organizations have brought up the base rate of pay at the expense of long term employee wages. This results in situations in which newly hired DSPs make as little as $1.00 - $1.50 per hour less than long-term employees. For

Table 2. Direct Support Professional Wages: A Comparison Across States and Between Public Institutions and Private Community Service Settings

Lakin & Bruininks	1981	N/A	$3.49	N/A	$4.01	Nat'l
Braddock, et al.	1992	$5.22	$5.97	$6.85	$8.72	Nat'l
Bachelder, et. al.	1994	$5.37	$5.75	N/A	N/A	IL
Start & Cook	1997	N/A	$8.41	N/A	$12.41	WA
Fullagar, et. al.	1998	N/A	$7.30	N/A	N/A	KS
Johnston	1998	N/A	$9.14	N/A	N/A	AK
Rubin, et. al.	1998	N/A	$7.36	N/A	$10.65	IL
Sjoberg	1999	N/A	$8.89	N/A	$17.50	CA
Test, et. al.	1999	$7.82	$9.13	N/A	N/A	NC
Larson, et. al.	1999	N/A	N/A	$8.68	$10.81	Nat'l
Colorado DHS	2000	N/A	$8.95	N/A	$13.10	CO
Hewitt, et. al.	2001	$8.13	$8.81	N/A	$9.27	MN

For example, in Minnesota between 1995 and 2000, the average starting wages of community DSPs grew by 15% while top level DSP wages grew by only 9.6% (Hewitt, Larson & Lakin, 2000). Many DSPs also receive limited benefits such as paid time off (PTO) and health care insurance. A study, in North Carolina found that 21% of DSPs were not eligible for health care benefits (Test, et. al., 1999), in Minnesota 31% of DSPs were not eligible for paid time off and another 33% were not eligible for health benefits (Hewitt, et. al., 2000). Reasons for the lack of paid benefits for DSPs include: 1) soaring health care costs which have made it difficult for private provider agencies to absorb the premium costs with their payment rates; and 2) growing numbers of DSPs who work part-time in agencies that provide benefits only to full-time employees (ANCOR, 2001; Colorado DHS, 2000).

Training Challenges

Training DSPs presents significant challenges to maintaining and improving the quality of community services. The geographic dispersion and the around-the-clock nature of community services make it more difficult to get training to DSPs. Extremely high employee health care costs, the ongoing need to provide cost of living rate adjustments to employees, and the cost associated with increased consumer expectations have all contributed to investments in training that are substantially less than the nature and responsibilities of the DSP role demand. Well-developed pre-service training programs for DSPs are rare. Ongoing training programs that target developing new skills rather than complying with mandatory topics are also rare. Career paths are limited for direct support professionals. Some DSPs are promoted into frontline supervisor and management positions, but there are limited numbers of these positions available. Unlike other professions such as nursing and teaching where individuals can remain as direct practitioners and advance substantially in compensation, specialization and recognition, DSPs simply do not have such options. Training opportunities for DSPs are usually regulatory-driven and include classroom training on topics such as emergency procedures, blood borne pathogens, consumer rights, introduction to developmental disabilities, CPR and first aid. Few states have developed effective training materials and programs for DSPs, leaving training responsibilities solely to the service provider organizations. Those states that have created and

continually updated statewide training curriculum and outreach training efforts including but not limited to: New Mexico, North Dakota, Oklahoma, California, and Kansas. DSP training is commonly not transportable from one employer to the next and is rarely competency-based (Larson, et al., in press). More often then not DSPs receive up front training that includes up to 40 hours of classroom training and rarely integrates effective adult learning strategies. DSPs have reported that this training is not effective because it is often repetitive and "*The biggest problem in the whole field is the low wages which lead to burnout, frustration, and high turnover." DSP "The budget situation is the worst thing. There is never enough money to train direct support staff." Supervisor* 10 boring for employees who have considerable experience in the field, is too fast and not comprehensive enough for people who come to their new jobs with no experience and it rarely is focused on the specific characteristics and needs of the people the DSP has been hired to support (Test, et al., 1999; Hewitt, 1998). Philosophies and values in community human services are frequently changing (Bradley, Asbaugh & Blaney, 1994). Training programs struggle to keep pace and many do not move beyond the care-taking, health, safety and the developmental focus of the DSP training originally developed for congregate care facilities. New efforts have been made to identify the specific skill set required of community DSPs (Hewitt, 1998; Taylor, et al., 1996). The Community Support Skill Standards were developed in 1996 and describe the specific competencies required of DSPs to support people in living self-directed and connected lives. These competencies are organized into twelve broad competency areas that include: 1) participant empowerment, 2) communication, 3) assessment, 4) community and service networking, 5) facilitation of services, 6) community living skills and supports, 7) education, training and self-development, 8) advocacy, 9) vocational, educational and career supports, 10) crisis intervention, 11) organizational participation, and 12) documentation. There remains a significant challenge in integrating these or other sets of competencies based on structured job analysis into the training provided to DSPs.

Effects of the Workforce Crisis

Sustainability and Development of Community Supports

The ability to create new services and to maintain those that already exist are made enormously more difficult by this direct support staffing crisis. Even as the U.S. Department of Human Services issues requests for proposals for "systems change" grants that will increase access to community services (Thompson, 2001), service providers, families and advocates express concern about the sustainability of currently existing services and great reluctance to expand to meet new demand (Hewitt, Larson & Lakin, 2000). Pressure to reduce waiting lists, to increase the availability of community supports for individuals that want them and to provide high quality, individually oriented supports that deliver desired outcomes make this workforce crisis even more ever present and underscore the need to find solutions. Many states still have large numbers of people living in institutionss and large congregate care settings. In fact, today as a nation an estimated 47,329 people with developmental disabilities still live in institutional settings and 81,363 live in places where 16 or more other people live (Prouty & Lakin, in press). With the 1999 Olmstead pending lawsuits that have resulted from this decision (Smith, 2001) there could not be a more pressing urgency for federal and state agencies to find solutions to the direct support workforce crisis. There is no *"We can' find people to work in the community services we have, I don't see how it is possible to think about bringing 12,000 new people onto*

the HCBS Waiver." Regional office staff 11 foreseeable way that continued efforts to provide equal access to community services can occur without finding resolutions to the problems of DSP recruitment, retention, and training. The ability of states to create any type of systems change effort designed to enhance community opportunities for people with developmental disabilities must include a specific, planned, proactive, and comprehensive effort to increase the public awareness of the direct support profession, the numbers of people who enter this line of work and serious efforts to enhance DSP wages, benefits, and incentives designed to get DSPs to remain in their positions.

Quality of Services and Supports

This workforce crisis has serious and detrimental effects on the lives of people who receive community supports. Perhaps the most detrimental effect is a revolving door of support staff, which effects the quality of support by creating a diminished ability to: 1) develop and maintain relationships of support, 2) understand and develop mutual respect between direct support staff, individuals who receive support and their family members, and 3) develop trust with every new support staff person that enters the person's life. Recruitment and retention concerns have been noted by consumers (Jaskulski & Whiteman, 1996), parents (Jaskulski & Whiteman, 1996; Larson & Lakin, 1992; Hewitt, et al., 2000), service providers (ANCOR, 2001, Rosen, 1996) and policy makers (NASDDDS, 2000). It is inconceivable to imagine that when there are a lot of vacant DSP positions, an increased use of overtime and a DSP turnover rate that averages 50% there is not a resulting negative effect on quality. Without continuity, quality, commitment, and competence the opportunity for people with mental retardation and related conditions to become full citizens and active community members is greatly diminished. The reality is that the nature of the current workforce crises makes it even difficult to provide basic care such as self-care and medical support.

Finding Solutions

The direct support workforce crisis is real and complex. It will not get better without serious attention, involving all aspects of the service system engaged in multifaceted solutions. These solutions demand immediate, comprehensive and focused intervention that includes not only service provider agencies, but also the federal and state agencies which too often view this system problem as belonging to those who provide services. Without involvement of all responsible entities, direct support staff recruitment, retention and training in community human services will be an increasingly insurmountable problem of growing significance to the opportunities of Americans with disabilities. On May 22, 2001 HHS Secretary Tommy G. Thompson announced the release of solicitations for new grants to states to develop new programs for people *"If we want direct support professionals to walk in partnership toward self-determined lives; if we want people with developmental disabilities to share their dreams and hopes; if we want excellence, then we must....promote continuity and competence of direct support professionals." (Taylor, 2001)* 12 with disabilities. Secretary Thompson commented, "these grants will help to extend new opportunities and freedom to Americans who have disabilities or long term illnesses and allow them to live and prosper in their communities." Such "new opportunities" are wholly dependent on recruiting and retaining increased numbers of committed and qualified people to provide the direct support needed by people with disabilities.

Applicants for such funds who do not attend to finding solutions to the challenges of direct support worker recruitment, retention and training are not likely to substantially "extend new opportunities" as the Secretary envisions. The potential elements of such multifaceted "solutions" are numerous. Primary focus must be given to efforts to attract people to the profession of direct support. These strategies are needed so that the direct support profession is recognized as a primary labor market that requires personnel to have a specific set of skills and competencies for which they are compensated with a living wage. Federal and state agencies must establish ways to assure substantial real dollar increases in the wages and benefits provided to direct support professionals. Substantial improvements in the public's understanding, awareness, and appreciation of the important roles that are performed by direct support professionals also need to occur. Programs must be developed and implemented which are designed to heighten the awareness of educators and workforce development specialists about this industry and the career opportunities it offers to people who are entering the labor force. School-to-work, welfare-to-work, technical college and other formal programs must be induced to incorporate direct support in the menus of occupational options. Efforts to create education and training programs that offer career paths and other incentives for people to remain in direct support positions must be implemented. For example, financially rewarding direct support professionals who obtain additional education, demonstrate new skills and remain in their positions for periods of more than a year. Distance learning and web-based training programs must be created to improve the quality, consistency and access of training information for direct support professionals. Tuition vouchers and community service benefits must be explored to assist human service agencies and families to be able to compete successfully for young adults who are working as they prepare for careers in education, nursing, law, medicine, business and other areas of importance to persons with disabilities. Direct support staff vacancy rates, retention and competence should become a serious and seriously monitored component of quality assurance. If quality assurance is to enhance the quality of services to people with disabilities it makes no sense to ignore the skills and stability of the people who provide these services. Providing recognition and other incentives for service organizations that have few vacancies and low turnover rates should be made. Higher expectations must be established for agencies and states in which people experience a revolving door of strangers to whom they must subject themselves for the most intimate interactions are essential. But this is where responsibility must be shared. Higher expectations are vacuous without providing organizations the opportunity to learn more effective workforce development practices. There are a number of organizational and management practices that have been proven to be 13 effective at reducing vacancies and increasing the retention of direct support personnel (Larson, Lakin & Bruininks, 1998; Hewitt & Larson, 1998). However, many organizations simply do not have the necessary information about these strategies to design and implement within their organizations. To the full extent possible federal and state governments should support technical assistance and training programs that assure that service providers have access to information and assistance to improve their DSP recruitment, retention and training. One other important solution to the direct support workforce crisis is the continued expansion of consumer-directed support options to people with disabilities and their families through Medicaid Home and Community Based Services and other service options. Although this option is not one that all consumers of services will likely choose, it is one that offers the greatest flexibility in who is recruited to deliver direct supports and how much these individuals are paid. But individuals and families also face many challenges in using this consumer-directed option. Many

of these are similar to those of agencies but many are more complex. Families must have supportive assistance in the recruitment and training of direct support staff. They must learn the basics of positive management techniques to assure that they support the effectiveness and retention of the valuable people they hire. They also need assistance with identifying and using strategies to enhance the wages paid to their employees while simultaneously improving service quality. Written materials, websites, town meetings and other opportunities to learn such skills must be available to people who take on this challenging role of directing their own supports. At a time when there is a limited supply of agency personnel, supporting families and friends to identify potential direct support staff or to serve in this role themselves is essential. But providing people such responsibilities without proper support will make the option attractive to an unnecessarily limited number of people and will substantially hamper the longevity in that role of many who take it on. In order to make the needed substantial improvements in direct support professional vacancies, wages, and retention it is critical that these issues are regularly measured and that effort is made to monitor progress on a systems level. The federal agencies responsible for gathering labor statistics must improve their classification system to more accurately reflect the industry. Additionally, states need to collect ongoing data about DSP wages, benefits, vacancies, and turnover in order to know whether intended solutions are effective. In many ways the development and expansion of community services for persons with developmental disabilities has been a remarkable success. It has been a success in the sense that the vast majority of people receiving services outside their family home are living in regular houses and participating in regular activities of their community. It has been a success that families have access to greater amounts of support designed to keep their family members living in their family homes. It has been a success in the sense that there are ever-growing expectations that people will enjoy greater freedom, expanded options, the full measure of citizenship, inclusion in their neighborhood and acceptance in their community. These successes, however, are fragile. Nothing has made this fragility more evident than the national crisis in providing for an adequate and well-prepared direct support workforce. A 14 workforce with the knowledge, skills and attitudes needed to maintain the previous successes, keep the promises to citizens with disabilities, and assure that increased numbers of those currently denied access to the lives they want in the homes and communities they choose will not come easily. It will take active involvement of leaders in all national, state and local aspects of the service system.

Worker Wage Hikes Pay Off for Wyoming

April 30, 2003 - A report from Wyoming finds that a state initiative to boost retention by raising the wages of direct-care workers had a "dramatic" positive effect.

In 2001, the state legislature directed the Department of Health to conduct a study of wages and salaries of direct-care staff in assisted living facilities, nursing homes, programs for people with developmental disabilities, mental health care facilities, and other settings in an effort to "attract, retain, and build a skilled workforce of direct healthcare providers." Before the initiative was implemented, annual turnover for these workers averaged more than 50 percent and hundreds of positions were left unfilled.

Based on the report's recommendations, the legislature provided $7.6 million in biennial state general funds and nearly twice that much in federal matching funds to improve wages for direct-care workers who assist people with developmental disabilities. A $7.50 an hour minimum was established for new staff, with an $8 minimum for staff with at least 12 months of experience. The rest of the money helped support improved wages and benefits for current staff and develop better career ladders for direct-care personnel.

According to the follow-up report, which was published late last year, turnover had already dropped by nearly one-third just three months after the changes were instituted. During that 90-day period, minimum wages for direct-care staff increased from $5.15 to $7.50 an hour, average wages rose from $7.38 to $10.32, and total compensation for full-time direct-care staff, including both wages and benefits, shot up from an average of $9.08 to $13.74 per hour.

The report anticipates that turnover will decline even more in the coming year. "This translates into substantially greater continuity of knowledgeable staff working directly with the individuals served, greater availability of staff to meet critical health and safety needs, and less staff burnout due to insufficient or untrained help," it notes.

The report recommends that the state continue to pay providers enough to maintain these wage increases and keep pace with cost-of-living increases. "Failure to do so," it warns, "will create the same kind of crisis that precipitated the legislative actions identified in this report."

Report Links Positive Outcomes to Massachusetts Career Ladder Initiative
April 14, 2003 -A report on a Massachusetts demonstration project to enhance recruitment and retention of direct-care workers concludes that the initiative was a success and recommends ways of expanding on it.

The Extended Care Career Ladder Initiative (ECCLI), which was introduced in the fall of 2000, funded teams of workforce training partners and long-term care providers in nursing homes, assisted living facilities, adult day centers, hospice, home care, and other areas. These partnerships created career ladders for certified nursing assistants and other direct-care staff, as well as addressing staff training, work environment, and quality of care issues. The goal was to improve the quality of care for consumers by increasing the skills of direct care workers.

The report, titled Creating Career Ladders in the Extended Care Industry, outlines the role of community colleges as ECCLI training partners. In addition, authors Rosemary Dillon and Lisa Young of the Massachusetts Community College Executive Office's Health and Human Services Programs summarize how the project affected outcomes overall at participating long-term care sites and list the key factors that led to success.

The support offered by community colleges varied depending on the project, but most provided assessment services, adult basic education, and English language classes for speakers of other languages. In addition, many provided management and supervisory training for staff who supervise direct-care workers, and some taught classes in team building, conflict resolution, diversity, or computer literacy.

One project coordinator reported that turnover appeared to have decreased after the implementation of ECCLI. Another noted that nursing assistants seemed more knowledgeable and self-confident and were more inclined to offer their contributions to resident care plans after their training, and residents interviewed at one facility said they were pleased with the nursing assistants who had received training.

The report identifies the following as key factors in creating effective career ladder programs that include a comprehensive training component:

Collaboration between the workforce training and long-term care provider partners
Involvement of all stakeholders in the initial planning and goal setting
Completion of a comprehensive needs assessment for the site and its workers, which must be shared with all partners
Ongoing process reviews and adjustments, with input from those most affected
"Buy-in" to the training program from both supervisors and direct-care workers
Creativity and flexibility in scheduling to assure coverage while workers are attending class
Holding classes at the workplace when possible
Using adult learner principles, including participatory learning, opportunities for discussion and problem solving, and content relevant to the students' work lives

The authors note that there's nothing new about community colleges working with long-term care facilities, although some of the colleges involved in ECCLI had no previous connection to

long-term care. However, even for those with prior experience, they write, this project "presented an exciting opportunity to develop and expand sustainable partnerships and models for collaboration."

As a result of their participation in ECCLI, the authors write, representatives of participating colleges have developed "a respect for the work that nursing assistants do and an appreciation of the nursing assistants' eagerness for continuing education." Furthermore, in part due to ECCLI, the state's community college executive office has formed a new committee consisting of representatives from the health care education departments at each campus, which will meet quarterly. "Certainly, the education and training needs of the long-term care industry will be an important topic," they conclude.

Paraprofessional Healthcare Institute

The research is already in[1] about what is needed to improve the quality of long-term care in this country: a more stable, experienced and trained paraprofessional healthcare workforce. Furthermore, since the long-term care services delivered by these paraprofessionals are largely paid for by public dollars, the government enjoys significant leverage to effect the changes necessary to improve this workforce.

Public Policy Actions Needed:

Investigate how our tax dollars are being spent. The government pays the private sector billions of dollars every year to deliver long-term care services. Yet the government does not require that these private agencies report on how many of those dollars actually get down to the frontlines of long-term care delivery: i.e., to the training, compensation or support of the direct-care workers who provide 80-90% of those publicly funded long-term care services. The government should collect data from all its providers on workforce turnover, training, and wages and benefits to establish greater accountability and to establish a baseline from which the government might assess how to improve more broadly the delivery of these hands-on services.

Require and support better training. The government has set some standards for paraprofessional certification within nursing homes and Medicare home health, but these have proven largely inadequate — and there are entire segments of the direct-care workforce, particularly under Medicaid, for which no training standards exist at all. The government needs to create better and more uniform training standards across a range of comparable direct-care positions. In addition, while the healthcare delivery system has taken responsibility for training its professionals (doctors, nurses, etc.), it has largely left the training of low-income paraprofessionals to public workforce development programs (JTPA/WIA, welfare-to-work, etc.) — a system that in recent years has begun to turn away from supporting pre-employment HHA/CNA training for many low-income job-seekers. The government should convene an interagency working group among agencies responsible for health care, labor, and welfare to focus on these gaps in our country’s healthcare workforce development system.

Target reimbursements to the frontlines of care. Several state Medicaid programs have used mechanisms like “wage pass-throughs” to ensure that a certain portion of the public dollars paid

to private long-term care agencies is passed on directly to the frontline workers who are delivering those services. Such initiatives have multiplied in response to current labor shortages. States should look at how they can direct more of their Medicaid dollars down to the frontlines of care, so that too many of those resources are not lost to agency overhead and profit.

Ensure health insurance for healthcare workers. Through CHIP and other initiatives, the Federal government has created vehicles to ensure health coverage for greater numbers of low-income Americans. In addition, some states have expanded coverage for adults below or near the poverty line—including workers within particular industries that rarely offer employer-paid health insurance (e.g., Massachusetts' fishing industry or Rhode Island's childcare workers). The government could likewise address the tragic irony of healthcare workers without healthcare coverage through an industry-specific "healthcare for healthcare workers" initiative, thereby significantly reducing turnover and instability within this vital American workforce.

Who would gain from such initiatives:

The Elderly and People Living with Disabilities — They would be cared for by the paraprofessional workforce that they need and deserve.

Women— They are the primary consumers of long-term care, and they are the primary deliverers of that care — whether they are paraprofessional workers or family members who need assistance with the care of their loved ones.

Providers — They would be able to count on a stable, competent, and well-trained workforce that was capable of meeting the increasing demand from consumers.

People of Color — Within our urban centers and the rural South, direct-care workers are primarily a workforce of color — composed largely of low-income African-American and Latina women caring for their neighbors.

Low-Income Workers and Their Advocates — Unionization of this workforce is less than 10-12% nationally. These "working poor" would benefit greatly from national leadership calling attention to their situation. And unions that have prioritized the future organization of this workforce would likewise enjoy the support of a national call for an improved and better supported direct-care workforce.

Welfare Recipients— Low-income women on welfare are being "set up to fail" if we continue to direct them toward paraprofessional jobs with turnover rates of up to 100% a year. Individual agencies — like those in PHI's Cooperative Healthcare Network — have shown that direct-care jobs can become long-term vehicles of employment and advancement for women on public assistance. A national strategy to expand on those lessons could mean stable and enriching employment for hundreds of thousands of TANF recipients.

Delivering on the Promise: Preliminary Report

Federal Agency Actions to Eliminate Barriers and Promote Community Integration
Personal Assistance, Direct Care Services
and Community Workers

As the President's Executive Order is implemented and more people with significant disabilities live in home and community-based settings and enter the workforce, the already critical need for personal care assistants and other direct care staff and community service workers will become even more pronounced. A chronic inability to attract and retain dedicated people in these fields can be traced to the fact that traditionally, across the country, these workers earn very low pay, work long hours, and often receive no benefits. There is an urgent need to address the areas of recruiting, training, retaining, promoting, and improving the earnings/benefits of personal assistants and other community service workers. The following activities are planned to address these barriers.

Department of Labor

DOL's Office of Disability Employment Policy (ODEP) will work to identify and propose options for increasing the availability of personal assistants for people with disabilities and providing some path of career progression for personal assistants and other direct care staff. ODEP expects to consult with DOL agencies and with other Federal agencies including the Department of Education, HHS' Assistant Secretary for Planning and Evaluation's Office for Disability, Aging and Long Term Care; and others. The overarching goal is to develop a cross-agency/cross-department plan to increase the availability and quality of personal assistants, and to identify options for the education, training, and career advancement for personal assistants and other direct care staff and community service workers.
ODEP and ETA will explore increased access to personal assistance supports through the One-Stop Center system.

ODEP will establish an online registry, similar to America's Job Bank, on DisAbilityDirect.gov where local or community-based organizations that help locate personal assistance can be identified.

ODEP will work with ESA's Wage and Hour Division to assess the impact, if any, of the Fair Labor Standards Act's minimum wage and overtime exemptions for companionship services and live-in help services on the availability of personal assistance services.

Department of Education

ED's Rehabilitation Services Administration (RSA) will seek collaboration and partnerships with appropriate federal agencies in order to explore how funds for attendant services can be more "consumer driven." RSA will also work with other Federal agencies to assess training opportunities for personal assistance service providers, consumers, family members, and consumer representatives in skill areas such as recruiting, hiring and supervision of personal assistance service providers.

Department of Health and Human Services

HHS will, together with a limited number of volunteer states, initiate a national demonstration designed to address workforce shortages of community service direct care workers. The demonstration will test the extent to which workforce shortages and instabilities might be

addressed through (a) better coordination with the Temporary Assistance for Needy Families (TANF) program; and (b) the availability of vouchers for worker health insurance or for tuition or day care credits. Participating states would be expected to develop options for workers to purchase affordable group health coverage through the state health insurance system or similar organized insurance group.

HHS components will collaborate on a joint initiative to: (a) mobilize and make available to states a coherent body of information about methods to address worker shortage issues; (b) research significant issues; and (c) partner with foundations, other private sector organizations, the Department of Labor, and other agencies to formulate a comprehensive approach to the worker issue.

HHS will work with other federal agencies to devise and implement additional strategies on workforce issues as part of the activities of the Interagency Council on Community Living.

Annotated Bibliography (listed in alphabetical order)

Bachelder, L. & Braddock, D. (1994).*Socialization practices and staff turnover in community homes for people with developmental disabilities*. Chicago, University of Illinois, Institute on Disability and Human Development, College of Associated Health Professions.
This 1994 study was one of the first specifically within the field of services to people with developmental disabilities to investigate the correlation between direct support staff turnover and organizational socialization practices for direct support employees. It was conducted in Illinois and included a random sample of 120 small community residential programs including Intermediate Care Facilities for the Mentally Retarded (ICF/MRs), Community Residential Alternatives (CRAs), and Community Integrated Living Arrangements (CILAs). Data was collected through two structured telephone interviews, one with a supervisor/manager and the second with the most recently hired direct support employee. Direct support employee turnover among sampled agencies was 55.4% per year. Of the staff who left these facilities in the past year, 56% exited prior to completing 6 months and 83% exited prior to one year. The mean starting wage for direct support employees was $5.37 and the mean wage was $5.75. The most significant finding from this study was that informal coworker support (e.g., providing opportunities to work in groups, mentoring arrangements) shows a significant negative correlation ($r=-.64$, $p<.001$) with turnover. This key finding suggests that the provision of informal support to newly hired employees is important when trying to retain employees. Providing opportunities for direct support staff to work in groups and assigning mentors to new workers are among the recommendations found in this study.

Braddock, D., & Mitchell, D. (1992). *Residential services and developmental disabilities in the United States: A national survey of staff compensation, turnover and related issues.* Washington D.C.: American Association on Mental Retardation.
This study is the most recent study of direct support staff compensation, turnover and related issues based on a national sample of residential service settings. It includes data from a modified random sample of 1,012 facilities throughout the United States (186 public institutions, 700 private community, and 126 public community). National as well as individual state profiles are presented. Data gathered on wages and turnover rates were of particular interest. Nationally, in state institutions the starting wage at the time of the study was $6.85, the average wage was $8.72 and the crude separation rate was 24.8%. In private community facilities the starting wage at the time of the study was $5.22, the average wage was $5.97 and the crude separation rate was 70.7%. In public community facilities starting wage at the time of the study was $7.00, the average wage was $8.41 and the crude separation rate was 34.2%. Wages were significantly correlated with employee turnover. Factors associated with higher starting wages were the facility type, whether the facility was unionized and the location of the facility in an urban area. Part-time workers had higher separation rates than full 15 time workers. Separation rates were lower in facilities that were unionized. Key findings of this study were: 1) mean starting wages were 3% above the poverty level in privately run community facilities; 2) the mean starting wage for direct care staff in private facilities was about 24% less than those in public facilities; 3) the disparity between private an public wages has grown over the past decade; 4) workers in private facilities receive fewer benefits then workers in public settings; 5) turnover was three times higher in private facilities then in public ones; and 6) the rate of turnover for direct care staff in private facilities grew by more than 25% in the ten years prior to this study.

Colorado Department of Human Services. (2000). ***Capacity of the community services systems for persons with developmental disabilities in Colorado: Response to Footnote 106 of the FY 2001 appropriations long bill. Denver, CO:*** **Developmental Disabilities Services, Office of Health and Rehabilitation Services, Colorado Department of Human Services.**
This report prepared by the Department of Human Services, Developmental Disabilities Services in Colorado provides an overview of the challenges faced within Colorado to provide for capacity and quality within the community service system. The major challenges in meeting the demands of capacity and quality that were identified included: the need to serve more people with more significant needs associated with their developmental disabilities, the demands for increased service for people with other types of human service needs (e.g. mental health, corrections), and limitations on the ability to increase community capacity due to restricted funding, labor shortages, and other factors. One of the primary findings of this report is that there is a direct support workforce crisis that is substantially affecting the ability of the community service system to maintain quality in current services, let alone expand and improve. This argument was supported by a wage and turnover study conducted by a contracted firm, Effective Compensation, Inc. The key findings included in this report are: 1) direct support staff turnover was 67% for community providers as compared to 18% for regional centers; 2) direct care wages in community services averaged $8.95 per hour while direct care wages in regional centers averaged $13.10, a difference of $4.16 (46%); 3) employees of community service providers are paid anywhere from 13% - 52% less than employees of other human service agencies that perform similar job functions; 4) regional center staff wages are commensurate with employees in jobs requiring similar experience and education levels in Colorado's general industry because these wages are adjusted annually; and 5) community service staff received less training than staff in other human service organizations.

Hewitt, A., Larson, S.A. (1998). ***IMPACT: Feature issue on direct support workforce development.*** **Minneapolis: Institute on Community Integration, University of Minnesota).**
This newsletter provides an overview of the issues of direct support recruitment, retention and training. It includes featured articles about best personnel practices within the field of developmental disabilities. Best practice examples include: 1) how to assess workplace recruitment and retention problems; 2) school-to- work education in community human services; 3) using the Community Support Skill Standards to guide training programs; 4) strategies to reduce turnover; 5) support and training for mid-level managers; 6) using peer mentoring; 7) self-directed work teams; 8) welfare-to-work programs; and 9) competency-based training. In addition to best practice illustrations, this issue provides the reader with a simple overview of various interventions that can be used within systems and organizations to address problems related to the recruitment, retention and training of direct support 16 personnel. Articles are also included that illustrate how workforce "problems" affect the lives of the people who receive support and services.

Hewitt, A., Larson, S.A. (1998). ***The Minnesota frontline supervisor competencies and performance indicators*****. Minneapolis: Institute on Community Integration (UAP), University of Minnesota (College of Education).**
This publication presents the results of a job analysis study that focused on identifying the necessary skills and competencies for frontline supervisors who work in community support services for people with disabilities (e.g., group homes, supported living and employment, and sheltered employment settings). One important aspect of responding to the workforce challenges is to prepare effective supervisors who can support, train and guide the work of direct support personnel. This study identified skills that are important for frontline supervisors to have in order for them to be effective at supervising direct support personnel. These skills are clustered into 14 broad competency areas: 1) staff relations, 2) direct support, 3) facilitating and supporting consumer networks, 4) program planning and

monitoring, 5) personnel management, 6) training and staff development, 7) public relations, 8) maintenance, 9) health and safety areas, 10) financial activities, 11) scheduling and payroll, 12) coordinating vocational supports, 13) coordinating policies, procedures and compliance with regulations and rules, and 14) office work. In addition to identifying the skill set, this publication provides: performance indicators for each identified skill, suggestions for how agencies can adapt and use this tool, and an assessment and planning tool that can be used to develop a professional development plan for the frontline supervisor.

Hewitt, A., Larson, S.A. & Lakin, K.C. (1997). ***Resource guide for high quality direct service training materials (2nd Edition)*****. Minneapolis: Institute on Community Integration, University of Minnesota.**
This publication is a compendium of reviews of existing high quality training materials that are designed for use by trainers of direct support personnel. It is available in both hard copy and electronic copy on the WWW (rtc.umn.edu/dsp). The training materials that are reviewed for this guide are obtained from Universities, Governor's Councils on Developmental Disabilities, state program agencies on developmental disabilities, private publishers, and other sources. Several criteria are used in reviewing each training material, including: 1) stated goals and objectives, 2) competency measures, 3) experiential components, 4) content validity, 5) comprehensiveness, 6) quality of learner instructions, 7) quality of instructor instructions, 8) adaptability for individual instruction, 9) variety of instructional modes, 10) freedom from bias, and 11) emphasis on inclusion and self-directedness. Only materials that are rated high on these criteria are included in the resource guide.

Hewitt, A., Larson, S.A., & Lakin, K.C. (2000). ***An independent evaluation of the quality of services and system performance of Minnesota's Medicaid Home and Community Based Services for persons with mental retardation and related conditions.*** **Institute on Community Integration, Minneapolis: University of Minnesota.**
This recent study provides data results and system recommendations from a comprehensive evaluation of Minnesota's Home and Community Based Services (HCBS) for people with mental retardation and related conditions in Minnesota. This evaluation used many research methodologies to gather information regarding this service option. Methodologies that were used included: 372 face-to-face interviews with 17 individuals who receive HCBS in Minnesota, six focus group interviews with stakeholder groups, telephone interviews with 21 local county HCBS administrators, 183 written surveys from family members of HCBS recipients, 468 surveys from case managers (service coordinators), 266 written surveys from provider organizations, and 288 written surveys from direct support personnel who work in provider organizations that deliver HCBS. This study collected information from a variety of perspectives on direct support workforce issues and how they affect the lives of people who receive services, their family members, provider organizations and policymakers. Key findings related to the workforce issues include: 1) 75% of all organizations reported finding qualified applicants was a problem as compared to 57% in 1995, 2) direct support staff (DSS) vacancy rates were 14% in Twin Cities metropolitan counties, 3) families reported that they did not receive the services authorized and that they often could not find in-home support staff, 4) starting residential DSS wages averaged $8.13 with the mean wage being $8.81 while starting vocational wages were $8.89 and the mean was $10.49, 5) starting wages in residential settings grew by 15% between 1995 and 2000 but the average highest wage paid by agencies rose only 9.6% during those years, 6) case managers reported that the high number of DSS in the lives of consumers was a serious problem, and 7) DSS turnover averaged 44% in residential settings and 23% in vocational settings.

Jaskulski, T. & Ebenstein, W. (Eds.). (1998). ***Opportunities for excellence: Supporting the frontline workforce*****. Washington D.C.: President's Committee on Mental Retardation.**
This report provides multiple perspectives on issues related to the direct support workforce in the United States. The history and scope of direct support workforce issues such as recruitment, retention and

training are reviewed in the context of efforts to assure full citizenship, inclusion and consumer-directed supports for people with developmental disabilities. The roles and responsibilities of direct support professionals in the context of these new and inclusive services and supports are explored and defined. Personal stories and descriptions of best practices are provided from the perspectives of direct support employees, consumers of services, family members, and agency managers. Connections between the quality of the direct support workforce, factors affecting the workforce, and the quality of services are made. The power of positive, respectful and supportive relationships between direct support employees and consumer outcomes are illustrated.

Johnston, K. (1998). ***Developmental disabilities provider direct service worker study: Results and findings*****. Anchorage, AK: Governor's Council on Disabilities and Special Education.**
This report presents the results and key findings of a study of direct service worker recruitment and retention challenges conducted by the Alaska Governor's Council on Developmental Disabilities in collaboration with the Association on Developmental Disabilities (a trade association). This was one of the most recent studies within community human services to estimate a cost per hire for the direct care position and to compare direct care wages with those of other human service positions and with the average wages in similar labor market segments. The findings represent 23 of the 28 developmental disability service providers in Alaska. Key findings were: 1) a 17% vacancy rate, 2) annualized cost of $724,542 in overtime expenditures (beyond straight time expenses), 3) the total of 570 direct support workers statewide with a turnover rate of 166% and a projected number of direct care positions to be filled each year estimated at 1,062, 4) the difference between the average direct care hourly wage compared to other comparable 18 human service positions was -$3.54, 5) when compared to other labor market segments the direct care wage on average was between $.28 and $2.84 per hour less, and 6) the estimated cost per new hire was $2,341.

Larson, S.A., Lakin, K.C., & Bruininks, R.H. (1998). ***Staff recruitment and retention: Study results and intervention strategies*****. Washington, DC: American Association on Mental Retardation.**
This monograph provides the results of a comprehensive study with two main components. The first was a survey of 110 small residential sites (fewer then 6 people) in 83 agencies in Minnesota that provided community residential supports to people with developmental disabilities. Two facility surveys were conducted, one at the beginning of the study and one 12 months later. These included information about facility characteristics, staffing patterns, general staff characteristics, recruitment and retention challenges and the characteristics of the people who lived in the home. The second component followed 124 newly hired direct support staff of these same agencies for twelve months. Participants completed several surveys that at different times over a twelvemonth time period. These surveys gathered information about: personal characteristics, education and experience, job expectations, employment context, job characteristics, organizational commitment and satisfaction, supervisor characteristics, training needs, employment context, organizational socialization practices, reasons for leaving a position and the good and bad aspects of direct support work. There were many key findings of this study. Direct support wages on average were $7.07 per hour to start and the average highest wage was $9.27 per hour. Forty-three percent of direct support workers included in the study were full-time employees; 58% were eligible for medical benefits and 72% were eligible for paid time off. Staff recruiting was found to be the most difficult problem faced by these agencies (57%), followed by turnover (44%) and staff motivation (37%). Average annual turnover for direct care staff was 46% with most people leaving within the first 6 months of employment. An annual turnover rate of 27% was found for supervisors. Supervisor tenure in the home was found to correlate with direct support staff turnover, as did the proportion of direct support staff eligible for paid time off and the number of direct support staff who had been promoted in the past year. Of the newly hired staff followed in this study, 33% stayed in their same position for 12 months, 3% were promoted, 11% moved to another home in the same agency, 38% left voluntarily and 15% were fired. The most common reasons cited by direct

support staff for leaving were: problems with co-workers (17%), inadequate pay, benefits or incentives (16%), problems with supervisors (13%) and scheduling problems (13%). Findings include strategies to address recruitment and retention of direct support personnel that were identified in the study.

O'Brien, J. & O'Brien, C.L. (1992). ***Remembering the soul of our work.*** **Madison, WI: Options in Community Living.**
This publication is a compendium of stories about direct support professionals and their the important, reciprocal relationships with the people to whom they provide direct support. The stories provide glimpses into the work of direct support staff and help to better understand the role and meaning of their work. The editors identified several themes that emerged from this collection of stories, including: ordinary moments, everyday triumphs, assistance, understanding, how people change, dreams, family, friends, money matters, fighting the system, clienthood, control, suffering and death, teachers, words of power, and why I do this work.

Sjoberg, K. (California State Auditor). (1999). ***Department of Developmental Services: Without sufficient state funding, it cannot furnish optimal services to developmentally disabled adults.*** **Sacramento, CA: Bureau of State Audits.** This study conducted by the California Bureau of Audits was requested by the Joint Legislative Committee to assess the ability of the State of California to provide optimal services to its 78,000 adults with developmental disabilities through organizations in the community and the statewide network of 21 independent, nonprofit regional centers. The report compares issues of direct support recruitment and retention in community organizations, non-profit regional centers, and the state developmental centers. Key findings are many. Community organizations pay an average of $8.89 per hour to direct support workers and fewer then 40% of these workers are eligible for health insurance and paid time off for illness. Most direct support personnel in these agencies remain on the job for less than two years and their average turnover rate is 50%. Regional center case managers earn an average of $17.50 per hour, remain on the job at least three years and have a turnover rate of 14%. This report concludes that although the State system was designed to provide optimal supports its ability to do so is limited by insufficient funding and budget cuts. This lack of adequate funding results in community providers paying low average wages to direct care staff, thus having difficulty competing for new workers. The findings of this report included data that is of significance in the arguments used in the recently filed class action lawsuit in California (Sanchez, et al. vs. Johnson, et al.) that claims that people with significant disabilities are discriminated against with respect to the availability of and access to community supports because of the low wages paid to direct care staff in community services versus the state developmental centers.

Taylor, M., Bradley, V., & Warren, R. Jr. (1996). ***The community support skill standards: Tools for managing change and achieving outcomes*****. Cambridge, MA: Human Services Research Institute.**
This document includes the results of a national job analysis regarding the role of direct support workers in progressive community human service agencies. This job analysis was funded by the U.S. Department of Education for the purpose of developing national voluntary skill standards for direct service workers, based on the assumption that identifying the complex skills needed by direct support personnel will strengthen education and training programs, improve services, create career paths, increase the marketability of workers and enhance the effectiveness and quality of services. The job analysis was conducted through focus groups of direct service workers and supervisors/managers in several states using a DACUM (developing a curriculum) process. The focus group results were then nationally validated using a technical expert panel and through a written survey. The resulting competencies for direct service workers were benchmarked to a "master worker" level. They were developed to represent the necessary skills for excellent community human service direct care practitioners. The more than 100 identified skills were clustered into 12 competency areas, including:

1) participant empowerment, 2) communication, 3) assessment, 4) community and service networking, 5) facilitation of services, 6) community living skills and supports, 7) education, training and self-development, 8) advocacy, 9) vocational, educational and career supports, 10) crisis intervention, 11) organizational participation, and 12) documentation. Although not specifically focused on developmental disabilities, this skill set is reflective of the skills needed by direct support staff to foster self-determination, inclusion and consumer-directedness of people with developmental disabilities 20

Test, D., Solow, J. & Flowers, C. (1999). ***North Carolina direct support professionals study: Final report.*** **Charlotte: University of North Carolina at Charlotte.**
This study was conducted in NC to assess the status and skills of the direct support workforce relative to the needs of people with developmental disabilities who receive personalized services and supports in the community. The study used written surveys and focus groups to gather information from administrators (164), direct support personnel (223) and individuals who receive support services or their family members (70). This study is one of a few that includes data collected from people in direct support roles and provides a lens for direct support demographic information and important issues related to these demographics. Key findings from this study included: 1) a total of 27,700 direct support workers are employed in NC; 2) most DSPs had some college education (31%) or had a Bachelor's degree (32%); 3) forty-three percent of direct support workers were the primary wage earners in their households and on average they had two children; 4) thirty-five percent of direct care staff reported that they had a second job so they could make ends meet; 5) the average turnover rates in direct support positions was 41%, consumers suffer from inconsistency in supports and services; 6) direct support staff reported over 155 total job titles that were used to describe their role; and 7) twenty-five percent of direct support staff reported that they had received fewer then eight hours of training before starting their job duties.