



A synthesis of direct service workforce demographics and challenges across intellectual/developmental disabilities, aging, physical disabilities, and behavioral health

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Prepared by

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Introduction and purpose

The Direct Service Worker Resource Center brings together a consortium of leading workforce development experts in the areas of aging, physical disability, intellectual and developmental disabilities and behavioral health to provide technical assistance to states, organizations and individuals and to provide support in addressing workforce challenges such as recruitment, retention and training. Funded by the Centers for Medicaid and Medicare (CMS) funded the national Direct Service Workforce Resource Center has worked intensively with 23 states, provided over 1,500 hours of general and approximately 3,700 hours of intensive technical assistance to states and other interested entities. It has logged over 400,000 hits on its web site where users can access thousands of documents regarding the workforce. This paper provides an overview of direct service workforce challenges and practices across four service sectors: intellectual and developmental disabilities, aging, physical disabilities and behavioral health. Another DSW Resource Center national white paper addresses data collection regarding workforce challenges across service sectors.

The direct service workforce is highly fragmented. This fragmentation is deeply rooted and reflects the fact that each sector has its own funding, policy, service and advocacy systems. One of the objectives of the Direct Service Workforce Resource Center is to provide an opportunity for researchers, educators, practitioners, and policymakers to begin dialogue regarding the similarities and differences of the direct service workforce challenges and solutions and their implications for practice and policy across sectors.

The purpose of this paper is to provide an overview of direct service workforce challenges and practices across four sectors: intellectual and developmental disabilities, aging, physical disabilities and behavioral health. While much has been written and studied within sectors about the workforce challenges and solutions, this paper provides a synthesis of the similarities and differences of the workforce challenges and solutions across the sectors. Drawing on the literature, activities and outcomes of the Direct Service Workforce Resource Center since its inception in 2005, the paper identifies the complexities of the service sectors with respect to the workforce that provides hands-on services and supports to people who are aging, have disabilities, or experience substance abuse issues. Another Direct Service Workforce Resource Center white paper addresses data collection regarding workforce challenges across these four service sectors.

The direct service workforce

Direct service worker roles and occupational titles

Direct service workers (DSWs) are individuals who receive monetary compensation to provide support to individuals with a wide range of health and human service needs. They provide hands on support to individuals to assist them in living more fulfilling, independent, and self-directed lives. Supports provided by DSWs vary depending on the type of service setting in which they work. Identified roles for DSWs across sectors include but are not limited to activities such as —

- Assisting with personal-care and hygiene such as bathing, dressing, and grooming;
- Assisting with home skills such as meal planning and preparation, housekeeping, and budgeting;
- Ensuring health and safety;
- Monitoring health;
- Providing health-related tasks such as medication management and administration, ileostomy, colostomy, and gastrostomy care);
- Providing transportation;
- Providing employment supports;
- Implementing positive behavior support, crisis intervention;
- Implementing recreation activities and supporting community involvement;
- Conducting assessments and community referrals;
- Teaching new skills (e.g., independent living, self-advocacy);
- Supporting self-determination and self-direction of people served;
- Working with family members;
- Providing opportunities for community integration; and
- Providing companionship and support in developing, and maintaining social relationships.

There is not a single, unified occupational title for DSWs in aging, physical disability, behavioral health, or intellectual and developmental disability services. Occupational titles vary both within each sector and across sectors. Previously these workers were frequently referred to as “paraprofessionals” because many did not have a formal post-secondary education. However, in recent years this label has become increasingly less popular across sectors due to the recognized need for professionalism (e.g., training, codes of ethics, worker-related professional associations, and career paths, etc.) and in recognition that in some health and human service settings, DSWs have post-secondary education or degrees.

In behavioral health a broadly recognized occupational title to denote this work group does not exist. Titles are employer generated and there is wide variability among employers, both across and within geographic areas. As the role of people in recovery as providers has increased, the term “peer support specialist” has been more widely used. In the intellectual and developmental disability (IDD) service sector there are also many employer-derived titles used to define the direct service workforce. However, the title “Direct Support Professional” or “DSP” is increasingly used by employers, advocacy organizations, and in recent legislation passed by the U.S. Congress. In aging and physical disability services there are three commonly recognized categories of job titles: “nurse aide,” “home health aide,” and “personal care assistant.” In everyday practice, workers in the third category are known by a variety of names including “personal assistants,” “personal care attendants,” “home-care aides,” and “home attendants.”

Employment locations for DSWs

DSWs are employed in a wide variety of settings. They work in both institutional and community services. Within community services they work in residential, employment, individual and family homes, and community treatment centers. Direct support is both privately and publicly funded and provided in both private for-profit and non-profit organizations. Funding for these programs comes from a vast array of federal, state, local and private funding mechanisms, though Medicaid and Medicare are a significant funding source.

Table 1 below shows the continuum of long term care employment settings that are common to most DSWs.

Increasingly across all service sectors the employment locations of DSWs are community based

and smaller in size. Supreme Court decisions such as *Olmstead v L.C. & E.H.* as well as federal policy efforts such as the New Freedom Initiative have resulted in an increase in community services across sectors. Deinstitutionalization has led to an increase in the variety of different places in which people live and has encouraged living arrangements for smaller numbers of people.

This decentralization of home settings for people who receive services has also led to greater geographic dispersion of the workforce. This dispersion has led to direct service roles that require greater skill, judgment and accountability and that require greater autonomy, responsibility and independent problem-solving and decision-making, thus increasing the challenges faced by DSWs with respect to receiving adequate supervision and having opportunities for co-worker interaction.

Table 1. The continuum of long term care settings

Institutional settings		Home- and community-based settings		
		Community residential	Supports to individuals & families	Non-residential community supports
<ul style="list-style-type: none"> • Nursing facility & residential rehabilitation (e.g., SNFs, ICFs) 	<ul style="list-style-type: none"> • State operated institutions & large private institutions (e.g., ICF-MR, residences with 16 or more people, residential rehabilitation, psychiatric hospitals, VA hospitals, residential schools/colleges) 	<ul style="list-style-type: none"> • 24-hr residential supports & services (e.g., group home, supported living arrangement, supervised living facility, assisted living, residential treatment) • Less than 24-hr residential supports & services (e.g., semi-independent living services, home-based/family preservation) 	<ul style="list-style-type: none"> • Home health care services • Personal care services (agency-directed) • Personal care services (consumer directed) 	<ul style="list-style-type: none"> • Day programs, & rehabilitative or medical supports (e.g., day services for seniors, MH day services, adult day programs, rehabilitation for working age adults, outpatient treatment, detoxification programs, methadone treatment, homeless shelters) • Job or vocational services (e.g., supported employment, work crews, sheltered workshops, job training)

Demographics of DSWs

National data about the direct service workforce is not consistently available and reported across all sectors inclusive of all DSWs. A national study of this nature has never been completed. However, national and state estimates of employment and wages for a set of occupations containing the vast majority of DSWs are available through the Occupational Employment Statistics (OES) program, a federal-state cooperative program between the Bureau of Labor Statistics (BLS) and State Workforce Agencies that conducts a semi-annual mail survey of employers. The four occupations usually identified as being related to the direct service workforce are: nursing aides, orderlies and attendants; home health aides and personal and home care aides; and psychiatric aides. Within IDD the most recent national study of the community DSW workforce was conducted in 1990 (Braddock et al, 1990). Since then state and local studies of various sizes and levels of sophistication have been used to identify the characteristics of the workforce. The Residential Information Systems Project provides national data on wages, turnover, and full-time equivalent DSW staff ratios every two years for DSWs in publicly funded institutions for persons with IDD (Larson, Byun, Alba & Prouty, 2007).

While the OES estimates for direct-service related occupations can be useful in suggesting broad changes in state employment and wages for several key DSW occupational categories, several features of the underlying occupational and industry classification schemes are problematic or confusing, limiting the use of this data for workforce planning or development purposes.

In particular, the occupational definitions are out of date and mix DSWs with workers who provide indirect services. Some of the industry classifications such as “Residential Mental Retardation Facilities” combine institutional and community long term care services, reflecting an earlier era in which community-based settings were the exception not the norm. In addition, the reference to the range of populations receiving services and supports could usefully be made more explicit to include: older adults, people

living with intellectual, developmental, and physical disabilities, and people with chronic mental illness or addictive disorders. Finally, the OES counts of workers do not include workers who are directly employed by households or who are self-employed, leading to a serious undercount of DSWs who work in home- and community-based settings where consumer-directed arrangements are the fastest growing mode of service delivery.

While there are national data available for most of the workforce, other non-national data sources exist as well. Many states conduct studies related to this workforce and researchers have long been reporting and synthesizing the data that do exist. Table 2 provides an overview of what is known about the demographics of the workforce across all four sectors.

In addition to data obtained from ongoing national/state surveys, some states have conducted occasional studies related to this workforce. Various non-state entities such as provider trade associations and university research institutions have long been reporting the results of particular provider and worker surveys. Table 2 provides an overview of the broad demographic outlines of the workforce across all four sectors.

The demographic make up of the direct service workforce shows both similarities and differences across sectors. In general, DSWs are typically women in their 30s and 40s. The direct service workforce in the aging and physical disabilities sector is more diverse with regard to race and ethnicity. Within intellectual and developmental disabilities there is great variation across states regarding racial and ethnic diversity among DSWs. Behavioral health and IDD report higher proportions of DSWs with at least some post-secondary education than does the aging and physical disability sector. However, the available behavioral health care data captures only a small portion of DSWs in that field.

DSWs are increasingly first generation Americans and many have a first language other than English. In some situations, these DSWs worked as health care professionals (doctors, nurses and other professionals) in their countries of origin and are pursuing credentials to practice their profession in the United States while working as DSWs. Organizations employing DSWs report challenges related to the

increasing diversity of the workforce (e.g., age, gender, race, ethnicity, language, religion, and culture). As the demand for workers continues to increase and more immigrant workers are employed as DSWs, it will be important to have organizational and community supports that offer effective training and retention practices for these diverse workers.

Table 2. DSW demographics

Setting type	Age	Gender	Race/ethnicity	Foreign born	Education
Nursing care facilities	Median 36	91% F	<ul style="list-style-type: none"> • 49% white • 33% black • 11% Spanish, Hispanic or Latino 	20%	<ul style="list-style-type: none"> • 54% high school education or less • 66% high school education or less
Home health care services	Median 44	91% F	<ul style="list-style-type: none"> • 41% white • 29% black • 22% Spanish, Hispanic or Latino 	25%	<ul style="list-style-type: none"> • 58% high school education or less
Personal and home care		90% F	<ul style="list-style-type: none"> • 48% white • 23% black • 17% Spanish, Hispanic or Latino 		
Residential care facilities		75% F			
Community residential and vocational settings	32-39; Median 35	66%-99% F, Median 81% F	<ul style="list-style-type: none"> • 59% white • 22% black • 8% Spanish, Hispanic or Latino 	Increasing	<ul style="list-style-type: none"> • More than 50% some college • 35% college degree
Psychosocial rehabilitation	Average 38	65% F	<ul style="list-style-type: none"> • 70% white 	Increasing	<ul style="list-style-type: none"> • 22% high school degree • 13% some college • 38% college degree
Addictions	45-53	70% F	<ul style="list-style-type: none"> • 70-90% white 		

Duffy, Wilk, West et al., 2006; NAADAC, 2003; Knudsen, Johnson, & Roman, 2003; PHI, 2008; Larson, Hewitt & Knobloch, 2005

Evolution of support and service models along with guiding principles of direct service work

Many guiding principles and values have influenced each service sector. Except for addictions, all have historical roots in the medical model of service delivery. All, except for addictions, are at various stages of moving away from a model in which doctors and medical personnel make all of the decisions to a person-centered model in which the individual service recipient acts as the primary director of his or her own services. The extent to which each service sector has aligned with the community support model is described in the following paragraphs.

Behavioral health

The workforce models within behavioral health have had two distinct trajectories. In the field of addictions, the foundations were in self-help, most notably Alcoholics Anonymous (AA), and later Narcotics Anonymous (NA). These self-help programs were anchored by twelve action steps laid out by AA's founder Bill Wilson. For this reason the programs and their many spin-offs are referred to as "twelve step" programs. The AA tradition stressed anonymity and volunteerism.

As the field has grown and as the science base around prevention of and recovery from substance use disorders has become more robust, the workforce has changed as well. Originally heavily oriented toward self-help and peer-supports, the field has increasingly created more organized social intervention models for which training and credentialing are preferred or required. With the acknowledgement that there are genetic predispositions and physiological implications of addictions (now recognized formally as illnesses as opposed to a moral failing or negative habitual behaviors) the field has gradually moved closer to a more traditional medical or "professional" model. That said, there remains a strong social-

systems orientation, and even such interventions as detoxification are often conducted in non-medical settings.

For treatment of mental health conditions, the tradition has been strongly medical in orientation. The field of psychiatry developed primarily in state hospitals, and did not shift toward community-based practice until after World War II. With this shift away from institutions and augmented by a focus on consumer rights and direction, the field is now much more accommodating of a social-intervention model. This change involves greater recognition of the needs of the whole individual as the driving force in treatment planning, as opposed to the much more narrow focus on staff-driven efforts at symptom reduction and management. The mental health field has embraced the concept of recovery, a cornerstone of treatment for substance use conditions, in the past decade. As consumers have increasingly organized and exercised leadership, self-direction and self-advocacy have become more prevalent guiding principles.

Aging and physical disabilities

Services for older adults and people with physical disabilities increasingly focus on person-centered approaches and self-direction. These principles first appeared in relation to services for younger adults with physical disabilities who were key leaders in the civil rights movement for people with disabilities. Self-direction and person-centered support have long been an entrenched values in services to people with physical disabilities. For younger people with disabilities, the civil rights model that brought us the *Olmstead v. L.C. & E.H.* decision has settled into a self-direction approach for Home- and community-based services. Self-direction has increasingly been adopted throughout the aging services arena. While the medical model remains a dominant model

for elder services, particularly for services in large congregate care settings, progressive standards of care, as exemplified by the work of the Pioneer Network, call for person-centered delivery of care even within a medical setting. In addition, growing numbers of older Americans rely on non-medical care services delivered by independent providers who are hired and directly supervised by the individual served and/or his or her family.

Intellectual and developmental disabilities

In 2006 the President of the American Association on Intellectual and Developmental Disabilities, a physician, declared that the medical model no longer drives how supports and services for persons with IDD are delivered. Since the populations of public institutions peaked in 1968, supports and services for people with IDD have been transformed from being based on hospitals and medical services to being based in homes, jobs, communities and supports to empower people with IDD to live fulfilled lives. The number of people with IDD living in facilities with 16 or more people declined from 207,356 in 1977 to only 62,496 in 2007 (Prouty, Alba & Lakin, 2008). In 2007, 501,489 individuals with IDD received supports through the Medicaid Home- and Community-Based Waiver program compared to 96,527 living in ICF-MR settings and, 26,013 living in nursing homes.

Additional values and philosophies guiding the field of intellectual and developmental disability services include “self-determination,” “valued social roles,” “inclusion and normalization.” Self-determination is having access to opportunity and resources to make one’s own decisions about life. This is implemented through valuing the opportunity for individuals with IDD to make their own decisions in daily life from when they get out of bed, to who they live with and what they eat for dinner. The concepts of valued social roles center on the belief that people with disabilities will be included in their communities when they have valued roles in their community. DSWs assist and support people with IDD to have valued roles and to be included in activities with people with and without disabilities. Lastly,

normalization is the principle that individuals with IDD should live their lives with typical rhythms of the day, month, week and year.

Codes of ethical standards

There is no universally accepted code of ethics for DSWs across sectors. The purpose of a code of ethics is to provide support and guidelines to practitioners who are faced with decision-making and problem solving responsibilities. A code of ethics provides guidance to the worker regarding their behavior, actions and attitudes as related to their professional work. Because DSWs have been considered “paraprofessionals” and have not historically had professional affiliation and associations, it is not surprising that there is not a universally accepted code of ethics for DSWs across sectors.

Within behavioral health the National Association of Addictions Professionals, which is a membership organization and certification body for substance abuse counselors, has adopted a code of ethics comprised of nine principles addressing the following topics: 1) non-discrimination, 2) client welfare, 3) client relationship, 4) trustworthiness, 5) compliance with law, 6) rights and duties, 7) dual relationships, 8) preventing harm, and 9) duty of care. This code of ethics is required for all levels of employees in the substance abuse field and was not specifically designed for DSWs (<http://naadac.org>).

In mental health, the United States Psychiatric Rehabilitation Association (USPRA) serves as a member organization and certification body for rehabilitation practitioners. Formerly the International Association of Psychosocial Rehabilitation Services (IAPSRS), this organization maintains a code of ethics adopted in 2001 and built on core principles addressing five areas: 1) the conduct of a psychiatric practitioner, 2) psychiatric rehabilitation practitioner’s ethical responsibility to people receiving services, 3) psychiatric rehabilitation practitioner’s ethical responsibility to the profession, and 5) psychiatric practitioner’s ethical responsibility to society (<http://www.uspra.org/i4a/pages/index.cfm?pageid=3361>). This code of ethics was also not designed specifically

for DSWs but instead for all psychiatric rehabilitation professionals, irrespective of their position or work.

The National Alliance for Direct Support Professionals (NADSP) developed a code of ethics for DSWs who are employed in community human services. This code of ethics is intended for use by all DSWs who work in community settings serving people with a wide variety of human service needs. NADSP's Code of Ethics includes the following nine principles that guide DSWs through the ethical dilemmas they face daily and encourages the highest professional ideals. These principles cover the following nine areas: 1) person-centered support, 2) promoting physical and emotional well-being, 3) integrity and responsibility, 4) confidentiality, 5) justice, fairness and equity, 6) respect, 7) relationships, 8) self-determination, and 9) advocacy (<http://www.nadsp.org>).

Within the aging and physical disability sector there is no known and widely accepted code of ethics for DSWs such as nurse aides, home health aide and/or for personal and home care aides. However, considerable attention in the field has been focused on a closely related matter: defining the quality of care and identifying practical metrics to measure the quality of care. This work began in nursing facilities but has now been extended to home health care services and beyond. Standard quality-of-care measures range from indicators of care outcomes (e.g., pressure sores, urinary incontinence, mortality, and outcomes related to physical and psychosocial functions) to use-of-service measures (e.g., emergency room visits and acute-care hospitalization) to process-of-care measures (e.g., overuse of restraints, use of urinary catheters, and frequency and completeness of assessment). Analyses of quality of care also sometimes incorporate measures of patient and family satisfaction with services as well as the incidence of complaints, violations, and deficiencies. Unifying frameworks for articulating both the quality of care for consumers and the quality of jobs for DSWs recently have been proposed by PHI. See <http://phinational.org/what-we-do/advocacy/the-9-elements-of-a-quality-job/>

Direct service workforce challenges

The status and image direct service workers

There are high levels of societal stigma associated with mental illnesses, addictions, intellectual and developmental disabilities, disabilities in general, and aging, so working with such individuals is too often stigmatized as well. Together, relatively low wages and benefits, minimal training, the absence of status, clear role definition, and career pathways often create the sense that DSW positions are low skill, dead end jobs. While the significance of the DSWs' role in the provision of long-term care and community support has become more recognized by professionals and researchers, general public awareness of their role is very limited, out of date, minimized or vilified. It is not uncommon to see exposes on television or negative articles about caregivers and DSWs in the newspaper. The popular media rarely documents stories about the importance of direct support work, the contributions that DSWs make to their communities and the positive outcomes that they support people and families to achieve.

DSWs also face status and image problems within their organizations. Employers often view DSWs as interchangeable, easily replaced, entry-level workers on the lowest rung of the workforce ladder. They are rarely in decision-making roles and often carry out treatment plans, interventions, program goals and orders from medical, nursing, psychiatric, and other specialists. In addiction and mental health services, DSWs who are in recovery are almost always passionate and committed to their work, but can experience the dual stigma of having these illnesses and being entry-level workers. NADSP has identified enhancing the status, image and awareness of DSWs as a key guiding principle and a goal of the association. Related goals for how to improve the status and image of this workforce include: 1) Providing better access for all DSWs to high quality educational experiences (e.g., in-service training, continuing and higher education)

and lifelong learning which enhances competency, 2) Strengthening the working relationships and partnerships between DSWs, self-advocates, and other consumer groups and families, 3) Promoting systems reform that provides incentives for educational experiences, increased compensation, and access to career pathways for DSWs through the promotion of policy initiatives (e.g., legislation, funding, and practices) and 4) Supporting the development and implementation of a national voluntary credentialing process for DSWs.

Supply and demand conditions for DSWs

The supply-side demographic with the most substantial future implication for the direct service workforce is the fact that the growth rate of the overall workforce of working age females will continue to level off for at least the next decade. Female labor force participation rates peaked at the end of the 1990s after years of rapid growth. The potential supply of DSWs is also declining because the baby boom generation is aging and retiring. In fact, the overall national growth rate of working-age females (aged 25 to 54) over the period 2006 to 2016 is expected to be negligible at one percent (Toosi, November 2007). The direct service workforce is also aging. As demands for new employees increase and the pool from which new workers can be recruited shrinks, the age of DSWs will also likely increase. Many DSW positions require physical strength and stamina. As the workforce ages, proportionately fewer workers will be able to do physical tasks sometimes associated with providing supports for activities of daily living (especially lifting and transferring). The use of assistive technology and other strategies to reduce the physical demands of the job for older workers will become essential.

The declining growth rate of the core female labor supply contrasts with the economy's booming demand for DSWs. According to the latest 2006

employment estimate for the DSW workforce from the BLS, the current workforce surpasses the 3 million mark and projected demand calls for an additional 1 million new positions by 2016. Personal and Home Care Aides and Home Health Aides will be the second and third fastest-growing occupations in the country between 2006 and 2016, increasing by 51% and 49%, respectively. Moreover, personal and home care aides, home health aides, and nursing aides, orderlies and attendants are on the list of the top ten occupations projected to register the largest numeric job growth across the entire economy (PHI, April 2008).

A 2006 study indicated that in the field of intellectual and developmental disabilities 900,000 new full time equivalent (FTE) DSWs will be needed by the year 2020 (APSE, 2006). The demand for new DSWs in behavioral health is unknown. While direct-service work remains an occupation with relatively few barriers to entry, this fundamental

supply side reality means that meeting the demand for growing numbers of DSWs will require improving the competitive attractiveness of DSW occupations, particularly those in home- and community-based settings.

Recruitment and vacancies

Current vacancy rates across sectors in direct support positions are influenced by a number of factors, including the demographic make up of the direct service workforce, high rates of turnover in direct support positions and increased demand for community health and human services. Some research has been done to understand the breadth and depth of these challenges, although this research varies by sector with the most limited completed in behavioral health. Table 3 identifies a number of studies and their key findings. There are no national surveys of vacancy rates in home health care or home and personal care, although there is considerable

Table 3. DSW vacancy rate information by sector

Study and key findings by sector

Larson & Hewitt, 2005

DSW vacancy rates in recent reports ranged from 0% to 33% depending upon position type, with a median of 8% for all positions and 16% for part-time positions. The range for which DSW positions were vacant was an average of 2.8 to 10.5 weeks. Frontline Supervisors (FLSs) in residential settings reported that they offered positions to 53% of all applicants (an indication of having very little choice in whom to hire; Larson et al., 1998). In Kansas in 2003, 43% of administrators reported curtailing services to newcomers due to workforce challenges (Kansas Mobilizing for Workforce Change Stakeholder Advisory Group, 2004)."

PHI National survey of state initiatives, 2007

97 percent of states responding reported that direct-service worker vacancies and/or turnover constituted "a serious workforce issue." This compares to 76 percent of states reporting a serious workforce problem in the next to last survey, conducted in 2005.

AHCA nursing home study, 2003

CNA vacancy rate in 2002 was 8.5%, with state rates ranging from 3.6 to 16.7%. A vacancy rate of 8.5% in 2002 translates into 52,000 vacant nursing assistant positions.

Hoge & Paris: Behavioral health literature review 1990–present, 2006

The literature on this topic is extremely limited and is focused principally on engaging minorities in graduate-level training. There are very few published articles on the recruitment of individuals into paid positions or volunteer roles and, with few exceptions; this literature is essentially devoid of data.

There are frequent anecdotal reports of recruitment difficulties in behavioral health. Some of these are focused on the problem of finding DSWs, although the complaints regarding recruitment are more often focused on the graduate-degreed workforce.

anecdotal evidence that these rates are high enough to be of serious concern.

The biggest obstacles to successful recruitment of DSW workers in aging and physical disabilities are the low quality of these jobs and their unattractiveness relative to other jobs, many of which are less demanding. Although many DSWs enjoy their chosen field of work and find it rewarding, they experience stressful working conditions, little career mobility, and are among the lowest paid workers in the health care and human services fields and in the economy at large. In IDD, administrators report lack of qualified applicants, inadequate pay and benefits, and challenging hours as significant issues contributing to their vacancy challenge (Hewitt et al, 2000).

The economy’s booming demand for DSWs only increases the challenge of how to make direct support jobs competitive so that they attract enough workers to meet this increased demand. This is especially important at a time when the growth in the labor force is slowing significantly due to the aging and retirement of the baby boom generation and because the labor force participation rates of women have finally peaked.

Turnover of DSWs

Turnover rates

High turnover rates among DSWs are widely known and accepted by administrators, researchers and advocates as a problem and a key barrier to the delivery of quality services and supports in community health and human services. While there is a growing body of literature that explains turnover, the availability of recent national studies that quantify DSW turnover rates throughout the U.S. is scant. Table 4 provides a snapshot of what is known about the turnover rates across for DSWs across sectors. It is important to note that the only national study is AHCA, 2003. Other studies are limited in scope to specific states or regions. All studies have methodological limitations.

Challenges in measuring turnover

No comprehensive cross-sector national data on DSW turnover exist (GAO, 2001). This is in part because well-designed studies are costly and because obtaining data across sectors is difficult. What data do exist suggests that turnover, while generally high for all DSWs, varies widely both within and across various types of long-term care providers (institutions, residential care, home care, assisted living, etc.) and by geographic region. The lack of uniformity in occupational titles and the vast array of employment settings also complicate the process of obtaining accurate national data. National surveys are

Table 4. DSW turnover across sectors

Sector/setting	Source	DSW turnover
Nursing facilities	AHCA, 2003	71%
Home health	Various studies	40–60%
Assisted living	National Center for Assisted Living, 2001	40%
IDD in-home	Hewitt and Larson 2007 — Review of 13 state and 2 national studies between 2000 and 2007	65%
IDD residential		50%
IDD employment		69%
IDD multi-service		42%
Community mental health residential	Ben-Dorr, 1994	50%
Addictions (not DSW specific)	McLellan Craise & Kleber, 2003	Exceeds 50%
	Gallon, Gabriel & Knudsen, 2003	25%

sometimes conducted and reported by national trade associations within the various sectors where DSWs are employed. Recently, the federal government added new major national surveys of nursing assistants and home health aides to two pre-existing surveys. Preliminary data from the National Nursing Assistant Survey is currently available at: <http://www.cdc.gov/nchs/nnas2004.htm> and data from the home health aide survey is due out soon.

Because turnover is not calculated the same way across surveys, the use of inconsistent measures can make comparing turnover rates from different studies problematic; turnover is not calculated the same by all researchers. Barry, Kemper and Brannon (2008) conclude "while these differences may reflect differences in labor markets or state level policy, they are also likely to result in part from inconsistent methods in measuring turnover." A 2004 report from the Health Resources and Services Administration outlined the need for more uniform approaches to collecting turnover data for DSWs. In addition, a recent national white paper from the DSW Resource Center addressed state challenges concerning direct service workforce data collection across service sectors and proposed that states collect a "minimum data set" of information on these workers across settings, with turnover and vacancies being one of six suggested elements for inclusion in the data set (<http://DSWresourcecenter.org>).

Factors associated with DSW turnover

Perhaps the greatest solution to the challenges of vacancies is to solve the turnover problem. Considerable research has been done to study the factors that influence DSW turnover. Much of this research has been conducted either in the aging and physical disabilities sector or in the intellectual and developmental disabilities sector and the least has been completed in the behavioral health sector. Most turnover studies have looked at single factors associated with turnover but a few have also conducted multivariate analyses (ASPE, 2006; Dawson, 2007; Castle, 2007; Stearns & D'Arcy, 2008). There is also one study that was longitudinal in nature (Larson, 1997).

The factors associated with DSW turnover can be broken down into three basic vectors (Stearns & D'Arcy, 2008): 1) personal demographic and socioeconomic characteristics, 2) reported job characteristics, and 3) other characteristics of the facility and geographic area. In general, wages and benefits are the two factors that have been consistently identified in studies as factors associated with higher rates of turnover for DSWs across the IDD, aging, physical disability and behavioral health sectors.

Factors associated with turnover in the general human resources literature have been examined in several meta-analyses. Six factors were found to be associated with higher turnover in more than one meta-analytical study, low organizational commitment, low overall job satisfaction, intent to leave, low performance, and staff's expectations about the job not being met (Larson, Lakin & Bruininks, 1997).

Table 5. Factors associated with DSW turnover across sectors

Personal demographic and socio-economic characteristics

- Gender (A/PD)
- Race/ethnicity (A/PD)
- Age (A/PD)
- Marital status (A/PD)
- Children in household (A/PD)
- Citizenship (A/PD)
- Full-time work (A/PD)
- Commute (A/PD)
- Household income (A/PD)
- Education (A/PD)

Reported job characteristics

- Full-time hours if desired with stable work schedules, balanced workloads, and no mandatory overtime (A/PD)
- Wages (A/PD, IDD)
- Health insurance and other family-supportive benefits (BH, A/PD, IDD)
- Excellent training that helps the worker develop and hone skills (A/PD, IDD)
- Participation in decision-making (BH, A/PD, IDD)
- Non-financial incentives such as positive performance reviews and recognition (BH, IDD)
- Pleasant physical work environment (BH)
- Informal support from co-workers (IDD)
- Career advancement opportunities, professional challenge (BH, A/PD)
- Flexible work schedules (BH)

Additional facility and area characteristics

- Owners and managers willing to lead a participative, on-going “quality improvement” management system-strengthening the core support relationship between the consumer and the DSW (A/PD)
- Linkages to organizational and community services, as well as to public benefits (A/PD)
- Supervisors who set clear expectations and require accountability, and at the same time encourage, support and guide each DSW (BH, A/PD, IDD)
- Staff-to-consumer ratios (IDD, A/PD)
- Date program opened (longer the site was opened the lower the turnover) (IDD)
- Size of program site (smaller program sites had higher rates of turnover). (IDD)
- Geographic location (urban areas tended to have higher rates of turnover). (IDD, A/PD)
- Needs of people supported (organizations and sites that serve people with more intensive needs have higher rates of turnover). (IDD)
- Live-in status (settings employing live-in workers had lower turnover) (IDD)
- Union status (IDD)
- Unemployment rates (areas with lower unemployment rates tended to have higher rates of turnover) (IDD, A/PD)

* BH = Behavioral health; A/PD = Aging and physical disability; IDD = Intellectual and developmental disability

Wages and benefits

DSW wages

Wages and access to benefits are consistently identified as strong predictors of DSW turnover. Wages for this workforce are low. Table 6 identifies DSW wages based on data obtained through the U.S. Department of Labor (DOL) as well as other national and state level studies.

Careers in direct support work often do not provide livable wages. Low wages translate into low family or household incomes. In 2006, just about a quarter of DSWs employed in home health care services lived in families with incomes under the federal poverty level. This compares to 16 percent of DSWs employed in nursing care facilities. Compared to other low-wage jobs such as food preparation and janitors and cleaners, a relatively high proportion of DSWs live in families that earn under 200 percent of the federal poverty level (PHI, 2008).

Benefits: Access and utilization

Employer provided health insurance is an important factor related to finding and keeping DSWs (Ebenstein, 2006). Most organizations offer health insurance benefits to some of their DSWs but many DSWs are not eligible to receive benefits because they work part-time or on-call hours. Growing health care costs have resulted in increased co-pays and

employee contributions which make insurance less affordable to DSWs.

Research in the aging and physical disability sector describes access and utilization of benefits for DSWs in that sector. However, little is known in behavioral health specifically related to DSW benefits. Employee benefits offered to DSWs decline on the provider continuum as workers move from positions in institutional care toward community care and home care. Although most providers contribute some amount to employee health insurance for full-time DSWs, the amount paid by community-based providers is less than the amount paid by large institutional or state run programs. Similarly, paid vacation and sick leave decrease along the continuum. Across sectors there is more information and research in the aging and physical disability sector about access and utilization of benefits for DSW; little is known in behavioral health specifically related to DSW benefits.

Data from the 2007 Current Population Survey indicate that 43.1% of DSWs who were employed by home health care services did not have health insurance coverage in 2006. This compares with 25.8 percent of DSWs in nursing care facilities (PHI, 2008). Employer-sponsored insurance (ESI) varies greatly between nursing facilities and home and residential care providers. The Hospital and Healthcare Compensation Service (HCS) publishes annual salary

Table 6. DSW wages across sectors

Sector	Data source	Hourly median wage	Hourly mean wage	Hourly range 10 th percentile to 90 th percentile
Nurse aides	U.S. DOL, 2007	11.14	11.50	8.10–15.52
Home health aides		9.62	10.03	7.41–13.47
Personal and home care aides		8.89	09.11	6.34–12.01
Institutional	Polister et al, 2003; Larson et al, 2007		11.67 13.17	
Community residential and vocational	Polister et al, 2003		08.68	
Substance abuse counselors (not limited to, but inclusive of, DSWs)	Kaplan, 2003 Johnson and Roman, 2002		13.71 16.41	

and benefits reports for both nursing homes and home care, and their latest report indicates that nearly all (99.9%) nursing homes and home care agencies offer a health care benefit program (HCS, July 2007). Several state-specific studies found lower levels (e.g., Minnesota Department of Health found that only 81% of long-term care facilities surveyed offered health insurance — Minnesota Department of Health, 2002). PHI's analysis of CPS data found that 52.4% of all direct care workers have ESI, with 57% of nursing and home health facility workers receiving ESI but only 42% of personal and home care workers (PHI, 2008). Those workers employed directly by individual households clearly fare much worse.

Industry data from HCS indicates that nursing home employers pay on average 76% of the insurance premium for individual coverage, with home care agencies paying approximately 74%. Many state studies have found a lower contribution paid by the employer. National data on take-up rates for employer-supported insurance by DSWs is not available, but studies both on this sector and low wage workers overall find that if workers have to pay more than 5% of their income for health insurance, they do not take it. Even when they do, often plans have high co-pays and deductibles which create additional barriers to seeking care when needed. With average wages of under \$10 per hour, and average annual insurance premiums of \$4,500 for individuals, most direct care workers cannot afford coverage without significant subsidies or employer contributions. In Minnesota (MDH, 2002) there was a 68% take-up rate for eligible employees and a total of 36% of employees enrolled. A 2004 cross industry study showed that only 41% of employed adults earning less than \$10 an hour qualified for employer sponsored health care insurance for the entire year compared with 72% of adults earning \$10 to \$15 per hour and 88% of adults earning more than \$15 per hour (Collins et al., 2004).

After health insurance, probably the two most important benefits are paid sick days and other paid time off. The information available on these two benefits is extremely limited. One estimate comes from IWPR 2007 which found that in 2006, of full-

time DSWs, 55% of personal and home care aides and 35% of nursing, home health and psychiatric aides were not offered sick days in 2006 (IWPR, 2007).

Public assistance

A high proportion of DSW households rely on some form of public assistance in order to make ends meet. This assistance can be found in the form of food assistance, cash assistance, housing assistance, transportation and energy assistance, public health care and/or Medicaid. In 2007, 42 percent of all DSWs (as captured by the CPS occupational categories "Nursing, Psychiatric and Home Health Aides; and Personal and Home Care Aides) lived in households that relied on some kind of public assistance (PHI, 2008).

Worker injury and employee assistance

Work-related injuries are common in direct support work. According to the latest Survey of Occupational Injuries and Illnesses in 2006, the nursing aide occupation had the highest incidence rate of injuries and illnesses of any occupation. These rates exceeded those of construction laborers, tractor-trailer truck drivers, roofers, and welders. All types of nursing and residential care facilities reported injury and illness rates that are 2 to 2.5 times those for service producing industries in general (U.S. DOL, November 2007; PHI, 2007).

The Substance Abuse and Mental Health Services Administration (2007) recently reported that, among all workers in the U.S., personal care workers experience the highest rates of depression lasting two weeks or longer. Yet, most DSWs do not have access to employer funded employee assistance and health insurance benefits that include mental health services.

Training and education

While DSWs spend more time with individuals who receive long term care and human services than other degreed professionals, they receive the least amount of training and have the least education. The delivery of training and education to DSWs is an

increasing challenge across service sectors. With the exception of CNA and HHA programs, there are few state required or employer-based pre-service training programs for this group of workers. Most DSWs rely solely on employer developed and delivered training post hire. As services become more geographically dispersed, the ability to get workers to training is more difficult and costly for their employers. In many states and organizations workers are not reimbursed for mileage and some are not paid to attend training.

DSW training is also difficult because often it is driven by regulations concerning a training hour-level requirement rather than being competency based. In other words, new workers are required to have a certain amount of training on specific topics and they are told they have to get training because of regulations. Training is often a mandated minimum instead of individually focused staff development. This regulatory-driven culture of training results in DSWs who are not trained to develop the competencies they need to do the job but instead complete seat time on required topics. Additionally, most of these training regulations are outdated or are non-existent for certain groups of DSWs. Wide variation exists, with the better training programs often going beyond the minimum hours required by federal or state law and others providing only the minimum or close to the minimum number of hours.

Identified DSW competencies

Each DSW service sector has separately addressed the training needs of the DSWs that work in sector-specific settings. Varied methodologies were used to identify the training needs of DSWs within each sector. Methods have included: 1) the completion of

comprehensive national job analyses, 2) validation studies, and 3) expert review and analyses. These analytic activities assist policy makers and trainers in developing curricula designed to advance knowledge, skills and attitudes in the direct service workforce. Post-secondary educators, employer trainers, state-level policy makers and training and development professionals have used these sets of competencies to design training for DSWs in the U.S. In depth descriptions of the following specific sets of competencies are provided for review in Appendix A of this paper: 1) Community Support Skills Standards (community human services), 2) Community core residential competencies (community residential in IDD), 3) PHI competencies and skill standards for direct-care workers (aging and physical disabilities), 4) Certified psychiatric rehabilitation practitioner competencies (behavioral health), and 5) Addictions counseling competencies; Foundations and practice dimensions (behavioral health).

While each of the sets of competencies have their own evolution and are used in many ways within their respective sector, there are common competencies across the sectors in which DSWs are employed. Table 7 identifies some of these common areas of competence. The dark shaded fields are those in which there was overlap in three or more of the sets for that specific competency area. This is intended to show that there is clear overlap. However, until a thoughtful and comprehensive job analysis is completed across sectors, it is not possible

to fully understand the common core competencies. Once these are identified, career pathways that build from the core competencies could be developed and implemented.

Table 7: Common core competencies for DSWs across sectors

DSW competency sets by sector					
	Intellectual and developmental disabilities (CRCC)	Community human services (CSSS)	Substance abuse (addiction counseling competencies)	Mental health (CPRP)	Aging and physical disabilities (PHI)
Competency areas*	Household management	Community living supports and skills			
	Facilitation of services	Facilitation of services	Service coordination; Treatment planning		
	Health and wellness		Understanding addiction; Treatment knowledge		Personal care skills; Health related tasks; Infection control; In home and nutritional support; Self care
	Organizational participation	Organization participation		Diversity	Role of the direct care worker
	Documentation	Documentation	Documentation		
	Consumer empowerment	Participant empowerment	Counseling	System competency	
	Assessment	Assessment	Clinical evaluation; Applications to practice	Assessment, planning, and outcomes	Apply knowledge to the needs of the consumer
	Advocacy	Advocacy	Professional and ethical responsibilities		Consumer rights, ethics, and confidentiality
	Community and service networking	Community and service networking	Referral	Community resources; System competency	
	Building and maintaining friendships and relationships				
	Communication	Communication	Client, family, and communication education	Interpersonal competency	Communication, problem solving, and relationship skills
	Crisis intervention	Crisis intervention		Interventions	Safety and emergencies
	Professionalism	Education, training, and staff development	Professional readiness	Professional role competency	
	Vocational, education, and career supports	Vocational, education, and career supports			

* Dark shading indicates competency areas where three or more sets identified similar competencies have been identified

Federal and state training requirements for DSWs

Federal and state training regulations and requirements for DSWs vary by sector and the specific service type (and related funding) in which DSWs are employed. In general, the more restrictive and institutional the service is, the greater the requirements and regulations. Aging and physical disability services tend to have the greatest number of federal regulations. In intellectual and developmental disabilities, training requirements for services other than ICF/MR are left to the states and in behavioral health, there are no uniform mandatory training requirements for DSWs.

Aging and physical disabilities

Federal regulations require initial and ongoing training for DSWs who work as home health aides in certified home health agencies or as certified nurse assistants (CNAs) in Medicare- and/or Medicaid-certified nursing homes. These workers must demonstrate competency in specific areas and are required to have at least 75 hours of instruction, 16 of which involve practicing hands-on “clinical tasks” under the direct supervision of a nurse and prior to direct contact with a resident or patient (PHI, 2005). Federal regulations also require that both CNAs and home health aides receive a minimum of 12 hours of in-service training during each 12-month period, but the regulations offer little guidance as to what must be taught.

For CNAs, basic training must cover various subjects that address communication and interpersonal skills, infection control, safety and emergency procedures, and promoting residents’ independence and rights. Other required topics that must be included in the training curriculum include: 1) Basic nursing skills, 2) Personal care skills, 3) Mental health and social service needs, 4) Care of cognitively impaired residents, 5) Basic restorative services (e.g., training the resident in self-care or use of assistive devices) and 5) Resident rights.

CNA curricula must be state-approved, but there is no limit to how many programs a state

may approve. As of 2002, about half of states had established a single approved curriculum; others have approved more than 100. Based on state-reported information, the OIG estimated that as of 2002 there were more than 12,500 state-approved nurse aide training programs in the United States, with approximately 60% (or 7,500) facility-based nurse aide training programs, primarily sponsored by nursing homes with classroom instruction held in the nursing facility. These programs are designed to assist nursing facilities with recruitment and to facilitate training for new hires that may undergo training in the facility in which they will be employed. The remaining 40% (or 5,000) non-facility based training programs were held in high schools, vocational-technical schools, community colleges, and private schools. Some programs were sponsored by non-profit organizations such as the American Red Cross, others were sponsored by labor unions or affiliated with government welfare-to-work programs or other government entities such as the Department of Veterans Affairs (DHHS, 2002).

About half the states go beyond these minimum federal training requirements for CNAs (AARP 2006). The more rigorous training requirements reflect the concern that the 75-hour federal minimum may not be sufficient to prepare CNAs to provide good care to residents, given that the complexity of caring for nursing home residents has increased since federal training requirements were established with the passage of the 1987 Nursing Home Reform Act. In addition, many training programs provide more hours required by federal or state law, because program directors do not believe that the required topics can be adequately covered without additional time. Other training programs, however, provide only the minimum or close to the minimum required number of hours.

Federal requirements for home health care aide training indicate that participating agencies must address the following twelve subject areas: 1) Communication skills, 2) Observation, reporting, and documentation of patient status and the care or services furnished, 3) Reading and recording

vital signs, 4) Basic infection control procedures, 5) Basic elements of body functioning and changes in body function, 6) Maintenance of a clean, safe, and healthy environment, 7) Recognition of and procedures for emergencies, 8) The physical, emotional, and developmental characteristics of the patients served and patient privacy, 9) Personal hygiene and grooming, 10) Safe transfer techniques and ambulation, 11) Normal range of motion and positioning and 12) Basic nutrition and fluid intake. State laws and/or regulations generally follow the federal requirements for training certified home health aides. States that have established training requirements for home health aides may be similar to federal requirements or go beyond federal requirements. For example, states may require more training hours or require home health aides to complete CNA training and certification in order to provide home health services. According to PHI, 27 states and the District of Columbia already require additional hours for CNA training beyond the federal minimum requirement of 75 hours. In addition, 13 states and the District of Columbia require 120 hours or more, and five require 150 hours or more. Depending on the training sponsor, the actual amount of total training time can exceed the federal and/or state minimum requirements.

There are no federal requirements related to training personal care assistants (PCAs). For states that offer Medicaid-funded personal care services, the State Medicaid Manual (Chapter 4, Section 4480, paragraph E) requires them to develop provider qualifications for PCAs. The manual does not list specific qualifications, but rather offers examples of areas where states may establish requirements including: 1) Criminal background checks or screens for attendants before they are employed, 2) Training for attendants, 3) Use of case managers to monitor the competency of personal care providers, and 4) Establishment of minimum requirements related to age, health status, and/or education.

A 2006 report by the Office of the Inspector General of the U.S. Department of Health and Human Services (HHS, 2006) examined state requirements for

Medicaid-funded personal care services. The study found that the majority of states (43) had established multiple sets of requirements for Medicaid-funded PCAs. More specifically, these requirements differed across the different types of benefits within a state's Medicaid program (Medicaid state plan vs. Medicaid waiver services) and/or the delivery models within these types of Medicaid benefits (agency-directed vs. consumer-directed). Overall, these differences produced 301 sets of requirements for PCAs across Medicaid programs in all 50 states and the District of Columbia. Seven states had established uniform requirements across their state Medicaid program.

According to the OIG report, 46 states incorporated training requirements in at least one Medicaid program offering personal care services. However, variation in these requirements exist by program and state in terms of the content, duration, and time necessary to complete training. Only 45% (or 102) of the 227 requirement sets that include training specified the number of required training hours, and the median number was 28. Subjects covered in the training curricula include: 1) First aid or cardiopulmonary resuscitation (CPR), 2) Basic health (e.g., food and nutrition, hygiene), 3) Assistance with activities of daily living, 4) Basic orientation (e.g., beneficiary rights, safety, behavioral issues, patient confidentiality), 5) Specific training related to beneficiary's needs and 6) Other training included in the state-developed curriculum.

Intellectual and developmental disabilities

Training regulations and standards within the field of IDD are not articulated in federal regulations. ICF/MR standards require that a training program exists for DSWs. This program must have the following components: 1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently; 2) For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental, behavioral, and health needs; 3) Staff must be able to demonstrate the skills and techniques

necessary to administer interventions to manage the inappropriate behavior of clients, and: 4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. Many states include additional state required training for DSWs but this varies from state to state and national data regarding variation across states does not exist.

Within the IDD sector most DSWs are employed in Home- and community-based services because this is the primary service type delivered to this population. Currently CMS does not prescribe training requirements under this program. However, states must ensure provider qualifications for providers receiving Medicaid funds. The reality for DSWs is that they experience vastly different orientation and training programs depending upon the state in which they live and the organization in which they are employed. Some states require few if any training hours and others have rigorous expectations. A common experience for DSWs would be approximately 20–40 hours of initial training delivered in the classroom based on topics such as first aid, CPR, blood borne pathogens, HIPAA, introduction to developmental disabilities and medication administration. A national curriculum, College of Direct Support, is now being used for training DSWs statewide in 16 states and is used daily by approximately 114,000 DSWs. While it is predominately used in intellectual and developmental disabilities, in a few states it is being used across sectors (CDS, 2008).

Behavioral health

There are no federally mandated training requirements for DSWs in behavioral health. Standards from organizations such as the Joint Commission on the Accreditation of Healthcare Organizations (www.jcaho.org) or the Commission on the Accreditation of Rehabilitation Facilities (www.carf.org) mandate orientation and training for all employees, although participation in the accreditation process is voluntary. Workforce related requirements in accreditation standards tend to be

general in nature, focusing on the need to ensure that employees receive adequate training for their functional duties, including safety related skills such as infection control.

States typically license mental health and substance abuse treatment facilities. Licensing standards that require adequate staffing and basic orientation and training for staff typically cover DSWs who work in these settings. However, such requirements tend not to be highly prescriptive and do not target DSWs.

There is no standard curriculum used to train mental health practitioners at any level of this workforce. Many organizations have designed such curricula, but none have become nationally recognized and widely adopted. A review focused on competencies and curricula for mental health DSWs did find promising models, though not widely adopted (Stryon, Shaw, McDuffie, & Hoge, 2005).

Most training in substance use disorders treatment is linked to the Addiction Counseling Competencies (Center for Substance Abuse Treatment, 2006). However, training programs that teach the competencies (knowledge, skills, and attitudes) previously identified in this paper have not been standardized (Morris, Goplerud, & Hoge, 2004). Edmundson (2002) studied the 260 training programs listed by NAADAC, the addiction counselors' professional association. Fifty-five percent were at the community college or two-year Associate level, 13% at the bachelor's level, and 32% at the graduate level.

DSW career paths

Well-established career paths for DSWs do not exist. With only a few exceptions, those that do exist are sector specific and are built around sector specific competencies. These career paths are typically not rooted pathways that move from pre-service training to post-secondary degree programs. Instead, these usually seek to move DSWs out of the role of direct support and into supervisory or more clinical positions.

Furthermore, few systemic incentives typically are built into the career paths that do exist. Any incentives usually have to be funded by organizations that are already struggling to provide adequate wages and access to benefits. Finally, it is extremely unusual to find rate-setting mechanisms in place that provide for increased wages and other incentives for completing training tied to career paths. In sum, a lack of incentives coupled with the rigor of the required training hours and the costs associated with training result in low completion rates for DSWs with regard to career path training.

Behavioral health

Career paths for DSWs in behavioral health are most robust in the area of addictions. Individuals without prior experience or training can enter the workforce as technicians in varied programs, such as residential or methadone treatment facilities. There are diverse educational opportunities available through community and four year colleges and graduate schools that qualify an individual for increasing levels of state and national certification and state licensure. Positions that require higher levels of certification and licensure typically have higher salaries and benefits. While this career ladder in addictions has many positive features, salaries and benefits in this sector of the behavioral health workforce are often considered non-competitive, leading many individuals to leave this career path for other pursuits.

The career ladder in mental health is strong for those pursuing graduate level training, but largely absent for DSWs. Few community colleges offer relevant training that fosters advancement, salary enhancement, or certification for DSWs. The rungs of the career ladder that might lead to certification or licensure are largely missing. The Alaska Native Tribal Health Consortium is pioneering a multi-tiered career ladder for behavioral health aides that is built on the “grow your own” principle (<http://www.anthc.org/cs/chs/behavioral/>). However, such innovation in the mental health field is rare.

Aging and physical disabilities

About one-fifth of states have implemented some kind of state sanctioned or approved career ladder and/or advancement programs for DSWs. In several other states career path programs are under consideration. Examples of these programs include: state-adopted U.S. DOL apprenticeship programs for CNAs, HHAs and Health Support Specialists (HSS) and the establishment of specialty aide positions such as medication aide, geriatric aide, nutrition assistant, and, senior aide (PHI, 2008). These specialty positions generally require advanced competency training and certification.

Career paths for DSWs in aging and physical disabilities are not well established in post-secondary education programs. However, there are professions, such as LPN and RN, with established education programs in which CNAs, HHAs and HSSs could matriculate.

Intellectual and developmental disabilities

Career paths in direct support for persons with intellectual or developmental disabilities are rare and within states that do have them, they are not widely accessible and used by DSWs. Existing programs are sometimes attached to post-secondary education programs (e.g. ND, GA, IN) but often are provider driven (e.g. OH, FL, WY). The U.S. DOL has federal guidelines for the occupational title of Direct Support Specialist, however only a handful of these programs have been approved at the state level and completion rates are low. Yet, there is an increasing awareness among providers and advocacy associations that career paths are perhaps one way to improve DSW retention and justify increased wages for workers.

NADSP has developed a national credentialing program for DSWs working in community human services. This credentialing framework has been used (or is currently being developed) in a few states that have career paths for DSWs who work in services to persons with IDD (e.g., OH, KS, IN, NJ, CA, FL). The purpose of this credentialing program is to provide national recognition for the contributions and competence of DSWs who apply

for and meet the credentialing standards. NADSP's credentialing program affords DSWs the opportunity to commit to the profession of direct support through its three-tiered credential program. DSW career paths begins with the Registration Level (DSP-Registered). As a DSP-Registered, DSWs are eligible to complete expert training in the key competencies of empowerment, communication, planning, ethical practice and advocacy to become a fully certified DSW (DSP-Certified). The third level of NADSP credentialing (DSP-Specialist) recognizes DSWs who have obtained specialized training and have demonstrated competence in providing specialized support to individuals with disabilities in community human services. In order to receive a DSP-Certified or DSP-Specialist credential, DSWs must complete an approved training program that offers training on specific competencies in both related instruction hours and on the job training. Currently, NADSP has approved five existing curricula that meet the education/training requirements of NADSP's national credential. Other educational programs can be approved but an application, site review, and NADSP review of curriculum must be conducted before approval is granted.

The first accredited curriculum is the U.S. DOL certified apprenticeship program for the occupational title of Direct Support Specialist. Certified apprenticeship programs that meet the federal guidelines for Direct Support Specialist and have been reviewed by NADSP are approved curricula. Another accredited national curriculum is the College of Direct Support (CDS). CDS is a multimedia, interactive web-based curriculum. CDS curriculum is designed for use in conjunction with employer-based training. Three state or agency level programs have also been accredited in Georgia, Ohio, and Minnesota. Any employer, post-secondary program, or other entity can apply to NADSP to have their programs reviewed and accredited so their graduates can apply for the national credential.

Supervision of DSWs

Supervisor tenure and the quality of supervision are associated with DSW turnover. When DSWs leave their positions, they often cite lack of or poor supervision as one of the primary reasons they are leaving (Larson, Lakin & Bruininks, 1997). Supervisors have a powerful impact on the lives of DSWs. A DSW's relationship with his or her supervisor is often the most influential factor in determining whether or not she/he feels valued and respected in her work. It is also key to job satisfaction and ability to adequately provide support and care (Bowers et al., 2003; Kopiec, 2000; Laninga, 2001; Noelker and Ejaz, 2001; Iowa Caregivers Association 2000).

There are many reasons for the lack of effective supervisor training and effectiveness across sectors. First, most supervisors in aging/physical disabilities and behavioral health are clinical staff and in intellectual and developmental disabilities they usually are DSWs who have been promoted. Few supervisors in these sectors have received formal education or training on how to be effective supervisors. Secondly, as services become less institutionally based, supervisors do not work in close proximity with the DSWs they supervise. In IDD services, it is increasingly common for DSWs to be supervised by individuals they rarely see.

Anecdotal reports provide compelling evidence that the provision of supervision has declined significantly in both the mental health and addiction sectors of the behavioral health field (Hoge, Morris, Daniels, et al., 2007). This is due principally to increasing financial constraints in behavioral health organizations. Recognition of the need to restore supervision has been increasing over the past five years, although progress has been minimal given the absence of clear models for covering the costs involved related to supervisee and supervisor time. Evidence of the growing recognition of the importance of supervision can be found in the recent release of competency models for supervision in the addiction sector (Center for Substance Abuse Treatment, 2007) and in mental health (American Board of Examiners in Clinical Social Work, 2004).

While recognition of the importance of effective supervision has increased across sectors, planned and well-executed training programs for supervisors are not prevalent. However, key attributes of an effective supervisor have been identified and include: 1) The ability to listen attentively in order to understand the perspective of the worker when a problem arises, 2) The ability to constructively present and address problems, 3) The capacity to help workers develop problem-solving skills, and 4) The ability to build relationships with supervisees. One approach that has been gaining support among long-term care providers and nurse education programs is Coaching Supervision (PHI, 2005). Coaching Supervision is an approach to supervisory training that emphasizes the supervisor's role in working with DSWs to develop problem-solving skills (Murphey, 2005). It teaches the importance of supervisors setting clear expectations and requiring accountability, and at the same time encouraging, supporting, and guiding each DSW.

Specific competencies required of supervisors were developed in Minnesota (Hewitt, Larson, Lakin, Sauer, O'Neil, & Sedlezky, 2004) and validated in a national study (Larson, Doljanac, Nord, Salmi, Hewitt & O'Neil, 2007). From this work, fourteen broad competency areas were identified for supervisors including: enhancing staff relations, providing and modeling direct support, facilitating and supporting consumer support networks, planning and monitoring programs, managing personnel, leading training and staff development activities, promoting public relations, maintaining homes, vehicles, and property, protecting health and safety, managing finances, maintaining staff schedules and payroll, coordinating vocational supports, coordinating policies, procedures, and rule compliance, and performing general office work.

Workplace culture and respect for DSWs

Organizational culture can have a profound effect on DSWs intent to stay in their jobs and their overall job satisfaction, and therefore has an important impact on turnover and retention. When DSWs report positive views of their organizational culture—experiencing high morale, teamwork, and participation in decision-making—they report higher levels of job satisfaction and organizational commitment, and residents report greater satisfaction. Greater DSW involvement in decision-making and care planning is associated with lower retention problems, fewer job vacancies, and decreased turnover.

Specifically with regard to DSWs working in nursing facilities, management and work environment have been found to be associated with nurse assistant satisfaction, loyalty, and commitment. The satisfaction of nurse aides with involvement in decision-making and professional growth was significantly related to better overall job satisfaction and greater intent to stay in nursing home jobs. The job satisfaction, loyalty, and commitment of nursing assistants deepen when DSWs perceive that supervisors care about them as people, appreciate their work, evaluate them fairly, and communicate with them on important matters. Nurse assistant satisfaction and engagement were higher when the style of management was participative (“managers listened to and cared for their employees and helped out in times of stress”) and when there was ongoing quality improvement (“managers kept the workplace safe, did not stint on tools and supplies, and trained workers well to deal with difficult residents and families”). Finally, how DSW ratings of the quality of management and of their work environment were found to be significantly correlated with the way residents' family members rated the residents' quality of life, care, and services provided (Dawson, 2007; Sikorska-Simmons, 2005 and 2006; Leon et al., 2001; Banaszak-Holl et al., 1996; Tellis-Nayak, 2007; Parsons et al., 2003).

In a study of best practices in DSW workforce development, NADSP and the Research and Training Center on Community Living at the University of Minnesota reported that organizations that excel at DSW workforce development were ones that: 1) Were learning organizations, 2) Hired Executive Directors/CEOs that relied on advice from DSWs and knew who they were, 3) Made listening opportunities where management met with DSWs a part of their routine, 4) Had executive and management staff that made it clear by modeling that they could and would do direct service; 5) Decision-making authority was given to DSWs and site level supervisors; and 6) Were culturally competent (ANCOR, 2008)

Self-direction

Self-directed services are increasingly being offered by states in aging/physical disabilities and intellectual and developmental disabilities. This model provides the opportunity for the individual with the disability (sometimes in conjunction with family or other legal representatives) to self-direct their services using Medicaid funds. While increasingly identified as a desirable approach in behavioral health, self-direction in that sector has moved toward person-centered planning, more consumer control over treatment options and decision-making, peer support, and the employment of persons in recovery in the behavioral health workforce. Self direction is one solution to increasing the pool of potential DSWs because often persons in recovery, friends, and family can be hired as employees.

The Consumer Direction of Personal Assistance Services (CD-PAS) is one of the fastest growing programs under Medicaid Home- and Community-Based Services, although a relatively small number of Medicaid beneficiaries are currently enrolled in this type of program model. In 2006, 42 states allowed some form of self-direction. Within A/VPD and IDD there are three general models of self-direction used by states to extend varying degrees of choice and control to Medicaid beneficiaries over their personal assistance services and supports.

- **Agency with choice.** These are programs that provide services to the Medicaid beneficiary. They range from a traditional home health agency, which assumes most of the responsibilities for arranging services, to agencies that involve Medicaid beneficiaries in arranging multiple aspects of their personal assistance services.
- **Public authority.** These are programs that rely on the Medicaid beneficiary to structure and arrange who, when and how their personal assistance services will be provided. The public authority makes information regarding screened individual providers available to the Medicaid beneficiary.
- **Fiscal/employer agent.** These are programs that typically rely on the Medicaid beneficiary to assume the role of the employer and the responsibility for arranging most aspects of their personal assistance and submitting information to a fiscal agent that performs payroll functions for the Medicaid beneficiary under contract with the state. Individual budgets are typically associated with Fiscal/Employer agent models of consumer direction.

Within the public authority and fiscal/employer agent models of self-direction, the vast majority of direct care workers are considered independent providers. (In the agency with choice model, direct care workers are typically employees of the agency and not the individual). In these models, the DSW is employed or, minimally, guided and directed by the individual being served. Most self-directed programs do not require workers to undertake any formal training. However, an increasing number of states are making training available to workers.

Another growing trend is state-supported training and education provided to the service recipient, and his or her family on how to find, choose, hire and keep DSWs. While initially individuals who self-direct often rely on friends and family for staff, eventually, if they receive services for extended periods of time, these individuals may need to hire and retain more traditional employees. Without effective support, this can be a daunting task.

Promising policies and approaches

The pervasiveness of the challenges brought on by the growing need to create an adequate, stable and well-prepared direct service workforce has resulted in numerous demonstrations and a growing emergence of evidence based practices. Both states and provider organizations are showing increased interest in and responsiveness to the difficulties of finding, keeping and training DSWs.

Emerging promising policies and practices are clustered in several broad areas —

- Improving DSW wages and access to benefits
- Reforming training and credentialing systems
- Reforming long-term care payment and procurement systems
- Engaging the public workforce system to support the recruitment and training of DSWs
- Designing worker registries and other resources
- Developing statewide stakeholder coalitions to develop and implement state-level workforce development plans

These approaches are not necessarily occurring across all sectors, but rather are more likely to be tied to a single service sector or group of provider organizations. Much of the information below comes from the results of the 2007 National Survey of State Initiatives on the Long Term Care Direct Care Workforce (PHI & Direct Care Workers Association of North Carolina, 2008) and two papers which assessed the activities of the CMS DSW Demonstration grantees in the areas of marketing, recruitment and selection and in providing health coverage.

Improve DSW wages and access to benefits

States, providers and other disability stakeholders are working to find ways of improving the competitiveness of direct service jobs in the labor market. Several policy tools have been used at the state level. These include (Seavey & Salter, 2006; PHI, 2008): 1) Targeted funding for wage add-ons such as wage pass-throughs (e.g., a 60 cents per hour increase or a 2% COLA); 2) Reimbursement rate reform that changes the methods for rebasing, or updating rates for the services and supports provided by DSWs, or that provides for enhanced rates for providers meeting higher standards relating to their workforces; 3) Changes to procurement and contracting standards in order to establish minimum benchmark standards for providers to participate in public programs, such as wage floors or requirements that a minimum part of the service rate be allocated to cover direct service labor costs; and 4) Creation of public authorities to organize consumer-directed Medicaid-funded services provided by independent providers, allowing for collective bargaining on behalf of DSWs in order to improve the quality of their jobs.

There are also approaches that lift the wages of a broader group of low-wage workers, including DSWs. For example, indexing the state minimum wage to inflation can help low-wage workers receive wage increases tied to changes in the cost of living. Furthermore, a few states and several localities have passed living wage laws that ensure a base minimum wage that is substantially higher than the minimum wage set by the state or federal government. These efforts are not limited to long-term care but instead extend to a larger set of occupations and industries within these states.

Several states have created policies to encourage the provision of health care coverage to DSWs as a means of improving the quality of their jobs and stabilizing this workforce. A recent report of PHI's Health Care for Health Care Workers initiative documented five successful strategies used to

expand coverage for direct care workers. These strategies are —

- Make employer-based insurance more affordable through the use of purchasing pools to bring down the cost of insurance or by using public funds to subsidize employer or employee share of premiums.
- Expand public insurance coverage by expanding eligibility for Medicaid or other public health programs.
- Establish coverage through collective bargaining allowing workers to negotiate for employer-sponsored coverage.
- Build insurance costs into Medicaid reimbursement providing rate enhancements to cover the cost of health coverage; and
- Assist workers with health care expenses through the use of limited benefits products like prescription discount cards, mini-med plans, health savings accounts and health reimbursement accounts.

The Centers for Medicare and Medicaid Services (CMS) conducted demonstrations in this area that modeled a number of these strategies, particularly subsidizing employer based coverage and assisting workers with health care expenses. The CMS study and other research have documented the strong positive link between health coverage and retention. In addition, the CMS study offered some practical guidance to others interested in pursuing health coverage programs. First, that while subsidizing the cost of insurance premiums can reduce the cost, care must be taken to ensure they are affordable to employers and workers. Second, that limited benefits products and help with health care expenses can be useful when a comprehensive plan is not available, but they offer limited benefits and, for older workers especially, there simply may not be enough coverage. And finally, when states pursue any of these strategies, it can be helpful to provide targeted outreach to DSWs so that they understand their health coverage options and receive assistance with enrollment as needed.

Reform training and credentialing systems

Many states and providers are working to improve their existing training and credentialing programs for different groups of DSW workers, including creating opportunities for advancement through state-sanctioned career pathway and advancement programs. These efforts are motivated by the goal of providing DSWs with the knowledge and skills to excel in their roles, by a desire to improve retention, and by changes in service delivery systems, in particular the dramatic expansion in the demand for Home- and community-based services and supports that many states are experiencing.

Several strategies can be distinguished. One approach is to identify core competencies for DSWs on which training should be based in order to support the development of consistent training programs. In some states, these efforts have led to the development and implementation of a standardized curriculum to train DSWs across the state and/or to new streamlined credentialing and certification programs for these groups of workers. Many states and NADSP use Community Support Skill Standards as the foundation of their training and credentialing programs. These skill standards should be updated.

Another approach has been to adopt U.S. DOL apprenticeship programs for various types of DSWs. To date, four such apprenticeship programs have been developed: Direct Support Specialist, Certified Nurse Assistant, Home Health Aide, and Health Support Specialist. Apprenticeship programs combine work place learning and related instruction and require DSWs to complete a specified number of hours of training and on the job skill implementation. Upon the completion of training, apprenticeship standards require that DSWs receive a wage increase.

Within behavioral health, some states are developing peer support training and certificate programs that provide intensive training, testing, certification, continuing education and ongoing technical support to consumers who wish to support other persons in recovery. Certified Peer Specialists are trained in a specific skill set to role model recovery

and teach self-directed recovery tools and serve in a paid direct service role with other persons in recovery.

Reform long-term care payment and procurement systems

Several states are working to develop systems to reward provider investments to promote job quality, encourage delivery of quality services, and include workforce standards in quality assurance efforts. One strategy in this area is to modify contracting or procurement standards to establish minimum benchmark standards for providers to participate in particular programs. For example, standards related to basic staff compensation (wages and benefits), training, supervision, new worker orientation, and career development. This approach requires the employer to achieve benchmarks regarding the DSW workforce as a component of their contract.

Another strategy is to provide incentive awards or enhanced rates to providers who meet higher standards relating, for example, to improved turnover or retention rates or enhanced training practices. This provides an incentive for providers to adopt new practices and often results in a better work environment, increased wages or improved benefits for DSWs.

Engage the public workforce and education systems to support recruitment and training of DSWs

Workforce Investment Boards across the country are beginning to address the problem of health care worker shortages but many still pass over direct service employment in long-term care in their assessments of high-priority occupations for receiving workforce investment dollars. At the same time, there are notable examples of efforts underway to create strong partnerships between the workforce development system, employers of DSWs, and educational institutions such as community colleges (Seavey, 2006). These are often designed to enhance recruitment and job quality by improving training, engaging in job redesign, and creating career pathway infrastructures.

Collaboration with departments of labor can bring together health and human service providers who need to find, hire and train DSWs, using one-stop networks to create pools of available workers who have met pre-employment requirements. Finally, another approach is to engage with the workforce development system to cultivate an economic development approach to developing multi-employer industry partnerships focused on developing jobs within the health care and health assistance sector, including direct service jobs within long-term care. At the same time, engaging with state departments of education is critical to ensure that post secondary and adult education programs targeting DSWs can be developed and implemented.

Design worker registries and other supportive resources

Some states have created new approaches to support both consumers and workers in home- and community-based services. This support is especially important for workers and consumers under consumer-directed programs. These supportive activities can include developing comprehensive worker registries that help workers find people who need support and help consumers find people to provide support. Developing worker professional associations to enhance opportunities for networking, professional development activities, policy advocacy and empowerment is another strategy used in some states. These associations often affiliate with NADSP or the Direct Care Alliance.

Develop statewide stakeholder coalitions to develop and implement state level workforce development plans

In several states, efforts have been made to bring together advocates, individuals who receive services, policy makers, workforce development staff, educators, employers and other interested stakeholders to identify the DSW challenges in those states and then to develop and implement statewide plans to address these challenges. This committed focus often involves identifying strategies for funding and shared resources.

Some states have developed strategies to provide training and technical assistance to organizations that employ DSWs on effective recruitment, retention, and training programs. These programs have created train-the-trainer approaches to teach individuals within the state how to deliver training to providers on effective recruitment and retention strategies such as: realistic job previewing, targeted marketing, empowerment of workers, competency based training, peer mentoring and other strategies. Other states have developed systemic training for supervisors and other workers on leadership and effective supervision practices and have implemented statewide train-the-trainer programs to support these efforts.

Areas for planning and action

Direct service workforce development challenges warrant immediate and focused action on the part of many stakeholders. The partners of the Direct Service Workforce Resource Center present here several ideas for actions steps that could be taken in partnership across the various workforce sectors to address these challenges. These ideas are based on published research and the experiences of the Resource Center partners in providing technical support to states and organizations.

Areas of focus

Creating new partnerships and strengthening existing partnerships

Many action steps can be taken to improve collaboration across sectors in planning and taking action to address direct service workforce challenges. Creating new partnerships and strengthening existing partnerships is a first step, followed by a focus on other specific areas of action through these partnerships.

- **Develop cross-sector partnerships to create a unified voice and mutual understanding about the direct service workforce, its challenges and strategies to resolve these challenges.** Convene advisory and other collaborative groups (at the federal, state or local levels) that bring together multiple departments within government and other interested organizations across intellectual and developmental disabilities, aging, physical disabilities, and behavioral health services. These groups would be charged with: 1) gathering and using data and information to inform policy makers, advocates and service recipients about the status of the direct service workforce across these three service sectors; and 2) making recommendations about strategies to address the direct service workforce challenges. In order to encourage collaboration across government agencies and in partnership with stakeholders,

membership on these groups should include decision-making representatives from many federal, state or local departments (based on the level targeted) as well as representatives of key stakeholder groups. Partnerships should include but certainly not be limited to the following groups —

- » State, federal or local government agencies (e.g., Departments of Health and/or Human Services, U.S. DOL and Department of Education)
 - » DSWs
 - » Community providers/employers
 - » Family advocacy organizations
 - » Self-advocates/service recipients
 - » State and national policy organizations
 - » University and private Research and Training Centers with DSW workforce expertise
 - » National protection and advocacy organizations
- **Strengthen partnerships between health and human service agencies and the public workforce system (e.g. Workforce Investment Act programs and One-Stop Career Centers) at national, state and local levels.** For many states, the direct service industry will be a leading growth industry over the next 20 years, given the aging of the population and increased longevity among younger people with disabilities. In some regions, LTC employers are already among the largest employers of low-wage workers, and investing in these jobs can help community economic development. Despite their workforce and community economic development potential, DSW workforce initiatives undertaken by health and human services agencies and organizations are rarely coordinated with the workforce development system. Workforce development systems should play critical roles in responding to the increasing demand for DSWs.

Private employers and industry associations must be engaged in partnerships with the workforce system agencies to identify strategies to accurately assess the demand for DSW workers, opportunities for improving recruitment and retention practices, and the need for augmented and enhanced training that better meets the real needs of employers.

Education and training

Coordinated approaches to education and training at the national, state, and local levels to improving training for DSWs are critical to preparing greater numbers of workers for direct service work as well as ensuring the quality of supports and services provided to consumers. Education and training encompasses a wide gamut of activities including: identifying competencies by conducting job analyses, developing curricula, creating training systems infrastructure, delivering training to various targeted learners, and creating credentialing and certification programs.

- **Identify DSW core competencies and specialization competencies across sectors.**

These competencies should draw on existing job analyses and input from key stakeholders to outline common knowledge, skills and attitudes across employment sectors (intellectual and developmental disabilities, aging, physical disabilities, and behavioral health). The competencies should be based on forward thinking and current best practice so that they identify the knowledge, skills and attitudes required of exemplar DSWs today as well as future workers. Competencies should serve as the foundation for policy and practice regarding education and training for DSWs at the national, state and local levels.

- **Increase access to training, lifelong learning and career paths for DSWs across sectors.**

Identify and implement strategies that increase access to affordable training, education and lifelong learning for DSWs. These training and educational opportunities should lead to career paths and articulated credentials that

connect with recognized skills and related incentives. Training should use evidence-based practices and be integrated into K-12 and post-secondary educational programs as well as other career and workforce training options, such as apprenticeship and employer-based training partnerships. Trainees enrolled in existing educational programs should complete regular self-assessments in order to evaluate the relevance and effectiveness of their current training.

Recruitment and retention

Joint efforts and collaboration to support employers, families and individuals to find and keep good workers constitutes an essential area of collaboration. Across the sectors, poor recruitment and retention leads to high rates of worker turnover, which in turn results in poorer quality of service for consumers and increased work stress for DSWs. Across all sectors, considerable progress has been made in identifying human resource practices that are consistent with and support effective recruitment and retention.

- **Provide training and technical assistance to states and employers on effective evidence-based recruitment, retention and training interventions.** This training and technical assistance should be disseminated throughout the U.S. and target employers within the sectors of intellectual/developmental disabilities, behavioral health, physical disabilities and aging. Training should address marketing and recruitment, selection, orientation/socialization, mentoring, supervisor training, organizational cultural change, competency-based training, and motivation and recognition. Strategies should be highlighted that provide incentives to organizations that successfully reduce their turnover and vacancy rates, and improve retention using the recommended strategies.

- **Support the dissemination of effective supervisory practices for DSWs.** The presence of good basic supervision has been shown to be a vital factor effecting the intent of DSWs to stay in their jobs. In order to ensure that DSWs in each sector have competent and well-trained supervisors. Effective training programs for the frontline supervisors who guide and direct the work of DSWs need to be developed and disseminated. Training should build from existing identified supervisor competencies within and across each sector. These programs could be accompanied by recommended supervision standards that specify how often and in what format supervision should be provided across settings.
- **Keep training and worker support central to all consumer-directed service programs.** Under consumer-directed programs, self-direction takes several forms. For consumer-directed programs in the aging, physical disability and intellectual and developmental disability sector, individuals and families typically hire and direct their own DSWs. The individual served (or their family as appropriate) becomes the employer with family members, peer support workers, friends, and neighbors often delivering the services. In behavioral health models, persons in recovery and family members provide self care and peer support through voluntary and paid roles. While consumer-directed programs rely on non-traditional workers, training, supervision and support remain critical for those providing services. Individuals and families should have access to training on how to find, choose and keep their DSWs, as well as deliver effective worker support. It is also important that the DSWs who provide service under consumer-directed programs are given opportunities to find potential employers and to access training and other supports, if desired.

Wages, benefits, and rate structures

Across the sectors, wages, benefits and reimbursement rate structures have been identified as issues that must be addressed to overcome direct service workforce challenges. There is consensus agreement across the sectors that these issues are a priority. A unified voice and strong collaboration could be effective in pursuing the following action steps.

1. **Increase the wages of DSWs across sectors.** Implement strategies to increase DSW wages across sectors and settings, ensuring that this workforce earns family sustaining wages in every community throughout the U.S. Wage scales should be developed that are commensurate with competence, experience and levels of responsibility.
2. **Provide access to affordable health insurance benefits to all DSWs across sectors.** Implement effective strategies to ensure that all DSWs have access to affordable health and dental insurance.
3. **Redesign the long-term care payment and procurement policies to reward investment in the direct service workforce.** Identify and implement rate and other payment strategies that provide incentives for employers and provider organizations to invest in the workforce, improve retention, increase the competence of their workers, and encourage the delivery of high quality services and support. Include workforce standards (i.e., retention of DSWs, vacancy rates and DSW credentialing/certification) in quality monitoring activities with states and providers.

Develop federal guidance to states concerning both the monitoring of wages and benefits paid to DSWs and the rate-setting principles and standards that support an adequate and stable direct service workforce. Use federal review processes and quality assurance systems to provide guidance and technical assistance to states concerning workforce monitoring and effective payment methodologies for Medicaid long-term care services and supports.

Status and awareness

Enhancing the status and image of the direct service workforce can improve recruitment efforts and influence policymakers' understanding of the workforce development challenges facing this workforce.

- **Create a national marketing and public awareness campaign for DSWs.** In collaboration with the members of a cross-sector stakeholder work group, create a well-designed and comprehensive national, state and local marketing and public relations campaigns to inform citizens about the contributions that DSWs make to our communities and to people's lives. Develop marketing materials and resources for providers to use in recruiting DSWs through workforce centers, K-12 education and other community-based educational sites where people seek career guidance.
- **Provide opportunities to listen and empower DSWs.** Create opportunities to include DSWs in public discussions and public policy processes regarding workforce as well as the programs serving the individuals whom DSWs support. Provide financial support to workers to facilitate their participation. Provide support for national, statewide and local professional associations for DSWs.
- **Support national, state and local direct service recognition activities.** In 2008, the U.S. Senate designated the week of September 8, 2008 to be Direct Support Professional Recognition Week. States and local governments have made similar designations.

Data collection, research, and evaluation

Collaborative efforts are key to encouraging the collection of better state and national DSW workforce data, evaluating DSW workforce development practices and policies, and coordinating new research and evaluation efforts and initiatives.

- **Establish a cross-sector state and national research and evaluation agenda on direct service workforce issues.** Identify key components of a research agenda that furthers understanding of the entire direct service workforce and can be used to shape state and federal public policy. This research agenda should include rigorous evaluation methods to identify effective organizational and policy interventions.
- **Support the development of national job quality/ workforce indicators for direct service occupations, relating, for example, to turnover rate, staffing levels, and compensation.** These indicators could be useful to policy makers and industry leaders in creating incentives for adequate and safe staffing, and greater workforce stability.
- **Establish cross-sector data collection systems at the federal and state levels.** Data collection should encompass key indicators of workforce stability, size, and compensation for publicly financed health and human service programs. Regular workforce monitoring should be instituted and made publicly available. Finally, occupational and industry codes and definitions that are used by state and federal labor departments in establishment surveys should be updated in order to provide a more accurate count of DSW employment and wages.

Conclusion

Across the aging, physical disability, intellectual and developmental disability, and behavioral health sectors there are ever-present, pervasive direct service workforce challenges. While there are important differences across the sectors, many challenges each sector are experienced in similar ways. Most importantly, each sector has accumulated considerable knowledge concerning effective practices and policies for addressing these challenges. As a result, important opportunities exist for collaboration, networking and sharing of information and resources.

The key strategic areas for collaboration identified by the partners of the DSW Resource Center are compensation, training and education, recruitment and retention, reimbursement rate structures and procurement systems, status and awareness, and data collection, research and evaluation. Coordinated initiatives across these areas are needed to develop the capacity of service delivery systems to meet the needs of long-term care consumers for quality services and supports by ensuring an adequate and well-prepared direct service workforce.

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Appendix A

Community Support Skill Standards

In a focused initiative to create standards in the broad community human service field, the Community Support Skill Standards (CSSS) project conducted an in-depth study of DSWs who have the most direct responsibility and contact with human service participants and the greatest impact on the service outcomes. This project was funded by the U.S. DOL to identify skill standards across high growth occupations. The CSSS project used a structured DACUM (Development of a Curriculum) analysis process to study and validate DSW roles and to write and validate a set of skill standards. The CSSS are not designed to be a set of minimal skills for entry level workers but rather a set of “master level” skills for a more experienced worker who is viewed by peers and others as competent. The CSSS are designed around 12 broad areas of skills needed for effective direct support work. The list is prioritized —

1. *Participant empowerment* — The competent community support human service practitioner enhances the ability of the participant to lead a self-determining life by providing the support and information necessary to build self-esteem, and assertiveness; and to make decisions.
2. *Communication* — The community support human service practitioner should be knowledgeable about the range of effective communication strategies and skills necessary to establish a collaborative relationship with the participant.
3. *Assessment* — The community support human service practitioner should be knowledgeable about formal and informal assessment practices in order to respond to the needs, desires and interests of the participants.
4. *Community and service networking* — The community support human service practitioner should be knowledgeable about the formal and informal supports available in his or her community and skilled in assisting the participant to identify and gain access to such supports.
5. *Facilitation of services* — The community support human service practitioner is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner.
6. *Community living skills and supports* — The community support human service practitioner has the ability to match specific supports and interventions to the unique needs of individual participants and recognizes the importance of friends, family and community relationships.
7. *Education, training and self-development* — The community support human service practitioner should be able to identify areas for self-improvement, pursue necessary educational/training resources, and share knowledge with others.
8. *Advocacy* — The community support human service practitioner should be knowledgeable about the diverse challenges facing participants (e.g., human rights, legal, administrative and financial) and should be able to identify and use effective advocacy strategies to overcome such challenges.
9. *Vocational, educational and career support* — The community based support worker should be knowledgeable about the career and education related concerns of the participant and should be able to mobilize the resources and support necessary to assist the participant to reach his or her goals.
10. *Crisis intervention* — The community support human service practitioner should be knowledgeable about crisis prevention, intervention and resolution techniques and should match such techniques to particular circumstances and individuals.

11. *Organization participation* — The community based support worker is familiar with the mission and practices of the support organization and participates in the life of the organization.
12. *Documentation* — The community based support worker is aware of the requirements for documentation in his or her organization and is able to manage these requirements efficiently.

The Community Residential Core Competencies (CRCC) were validated in a study that replicated the DACUM process specifically with DSWs employed in a variety of residential living environments and who provide supports to people with intellectual and developmental disabilities. This validation process yielded results that indicated a strong overlap between the CSSS and the knowledge, skills, and attitudes required of DSWs in community residential services. The identified CRCC provides more specific areas of competence than the CSSS. However, the CRCC do fit into the broader CSSS competency areas. The CRCC competencies were further validated as relevant to residential DSWs in a study of DSWs, supervisors and managers from four states (Larson, Doljanac, Nord, Salmi, Hewitt, & O’Neill, 2007). They are listed in order of priority as identified in the study (Hewitt, 1998) —

1. *Household management* — Assists the individual with household management (e.g., meal preparation, laundry, cleaning and decorating) and with transportation needs to maximize his or her skills, abilities and independence.
2. *Facilitation of service* — Staff has knowledge sufficient to fulfill his or her role related to individual service plan development, implementation and review.
3. *Health and wellness* — Promotes the health and wellness of all consumers.
4. *Organizational participation* — Staff is familiar with the organizational mission.

5. *Documentation* — Staff is aware of the requirement for documentation in his or her organization and is able to manage these requirements efficiently.
6. *Consumer empowerment* — Enhance the ability of the individual to lead a self-determining life by providing the support and information necessary to build self-esteem, and assertiveness and to make decisions.
7. *Assessment* — Staff is knowledgeable about formal and informal assessment practices in order to respond to the needs, desires and interest of the individuals.
8. *Advocacy* — Staff should be knowledgeable about the diverse challenges facing individuals (i.e., human rights).
9. *Community and service networking* — Staff is knowledgeable about the formal and informal supports available in his or her community and is skilled in assisting the individual to identify and gain access to such supports.
10. *Building and maintaining friendships and Relationships* — Support the participant in the development of friendships and other relationships.
11. *Communication* — Staff is knowledgeable about the range of effective communication strategies and skills necessary to establish a collaborative relationship with the individual.
12. *Crisis intervention* — Staff is knowledgeable about crisis prevention, intervention, and resolution techniques and should match such techniques to particular circumstances and individuals.
13. *Professionalism* — Staff pursues knowledge and information necessary to perform job duties.
14. *Vocational, education, and career support* — Staff is knowledgeable about the career and education related concerns of individuals.

PHI competencies and skill standards for Direct Care Workers

In aging and physical disability services, a set of competencies and skill standards has been developed by the PHI for direct care workers (DCWs) who work in settings that provide supports for persons with long term care needs. Competency areas identified in this skill set include —

1. *Role of the direct care worker* — The DCW will understand their role within the service team and how their role is focused on the needs and issues of the consumer. The DCW will demonstrate professionalism and responsibility to their job and profession.
2. *Consumer rights, ethics and confidentiality* — The DCW will respect consumers and their personal preferences at all times. They will empower consumers and ensure they are treated with dignity and respect.
3. *Communication, problem-solving and relationship skills* — The DCW will be able to communicate professionally and effectively with consumers and others. The DCW will resolve conflicts courteously while ensuring consumer's preferences are respected.
4. *Personal care skills* — The DCW will provide quality personal care services to residents at all times and provide them in a way that is most comfortable to the consumer.
5. *Health related tasks* — The DCW will provide quality health related supports to consumers to ensure their health and well being at all times.
6. *In-home and nutritional support* — The DCW will support consumers in living independent and meaningful lives. The DSW will provide support to consumers in their homes and assist them in making their homes safe while supporting healthy nutrition.
7. *Infection control* — The DCW will follow all procedures related to infection control at all times to ensure the health and well being of consumers and themselves.
8. *Safety and emergencies* — The DCW will use proper techniques when lifting and transferring consumers. The DSW will check equipment regularly and know how to respond to emergency situations.
9. *Apply knowledge to the needs of specific consumers* — The DCW will respect and treat each consumer as an individual. The DCW will have knowledge of how aging and illness affect each consumer differently.
10. *Self care* — The DCW will have knowledge and access to organizational and community resources to assist them in reducing stress and preventing burnout.

Certified psychiatric rehabilitation practitioner competencies

The competencies for Certified Psychiatric Rehabilitation Practitioners (CPRP) were created to guide training and certification of practitioners in the field. Prior to certification, practitioners were part of a voluntary registry. These systems did not provide for accurate, standardized, and cohesive practice standards. The United States Psychiatric Rehabilitation Association (USPRA) was responsible for commissioning a consulting organization to develop, administer, and score the new certification examination for Psychiatric Rehabilitation Practitioners. A set of competencies, organized around domains, was used to create a standardized test in the field. Each learner is tested in each of the 7 Domains. Due to the depth and complexity of CPRP domains with task, knowledge, and skill statements, the full competency set cannot be listed here. For further information and detail, the reader is encouraged to review and/or download the competencies at the U.S. Psychiatric Rehabilitation Association Web site at: <http://www.uspra.org/i4a/pages/index.cfm?pageid=3924>

The following is a list and description of CPRP competency statements for each of the seven domains —

1. *Interpersonal competencies* — CPRPs are expected to engage in healthy interpersonal communication with clients, families, and other professionals. CPRP's should seek to maximize interaction between clients and families.
2. *Professional role competencies* — CPRPs will review emerging literature and seek to increase their skills and knowledge base through continuing education and training.
3. *Community resources* — CPRPs are expected to create linkages with other community resources and assist clients in creating natural supports. CPRPs will match client's needs with various community resources and assist in integrating the resource with other treatment supports.
4. *Assessment, planning, and outcomes* — CPRPs are expected to engage in mutual treatment planning, goal setting, holistic assessment, and crisis management. CPRPs will evaluate client outcomes and seek to ensure client satisfaction and success.
5. *Systems competencies* — CPRPs will fight discrimination and protect client's civil rights and liberties. CPRP's will advocate for clients at the community, local, and state levels and empower clients to become self advocates.
6. *Interventions* — CPRPs will seek to actively engage clients. CPRP's will support and teach skills, develop leaders, promote effectiveness and achievement, and instill hope in clients. CPRP will engage in outreach services.
7. *Diversity* — CPRPs will provide culturally sensitive and appropriate services to all clients. Diversity incorporates the inclusion of all populations and expects CPRPs to assist in identifying and removing institutional barriers. (USPRA, 2008)

Addiction counseling competencies

Since 1998, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT) have been actively developing and publishing addiction counseling competencies. This set of competencies was initially developed by a national curriculum committee as a technical assistance publication (TAP 21). The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice has been widely distributed and provides concrete benchmarks as well as a tool for which training and curriculum can be developed for professionals in this field. This essential tool continues to be monitored and updated by its national curriculum committee and was last updated in 2005.

The core set of Addiction Counseling Competencies has 12 competency areas and each competency area has a number of competency statements, knowledge areas, skill sets, and attitude statements. Due to the depth and complexity of the

core set of Addiction Counseling Competencies, the entire set cannot be listed here. For further information and detail, the reader is encouraged to review and/or download the entire set from the U.S. Department of Human Services and SAMHSA's Clearinghouse for Alcohol and Drug Addiction Web site at: <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=13283>

The following list identifies the 12 competency areas for the core set of Addiction Counseling Competencies (foundations and practice dimensions) —

Foundations

1. *Understanding addiction* — Counselors will have an understanding of current models of theory and treatment. Counselors will seek to understand how social, cultural, and economic factors influence addiction.
2. *Treatment knowledge* — Counselors will understand models of addiction, treatment, the importance of family and communities in recovery, and the interdisciplinary approach to treatment. Counselors will use research, literature, and outcome data to provide the best clinical treatments.
3. *Application to practice* — Counselors will use diagnostic criteria, various treatment modalities, and placement criteria to provide the most tailored treatment approach. Counselors will use helping strategies, pharmacological resources, and other insurance or entitlement programs to provide customized treatment.
4. *Professional readiness* — Counselors will provide culturally sensitive treatment and be sensitive to issues of diversity. They will adhere to responsibilities of the profession and seek to have a level of healthy self awareness. Counselors will actively participate in treatment plans and crisis management.

Practice dimensions

1. *Treatment planning* — Counselors will consider all treatment options for clients, assess client's readiness for treatment, and inform clients of their rights. Counselors are responsible for coordinating treatment activities and accessing appropriate resources.
2. *Referral* — Counselors will maintain a network of community resources and be aware of various treatment options and services in their area. Counselors will exchange information with referral sources when appropriate and know how and when to make a referral for service.
3. *Client, family, and community education* — Counselors will provide culturally sensitive and relevant information about addiction to clients, their family, and the community. Counselors will provide education and explain the addiction process and teach others about treatment, recovery, and prevention.
4. *Documentation* — Counselors will document in detail all aspects of a client's treatment while rigorously ensuring client confidentiality. Counselors will handle client records with extreme care to approved third parties.
5. *Service coordination* — Counselors will encourage an interdisciplinary team approach to treatment. The team will be informed and educated about treatment, addiction, and recovery. Team members will be encouraged to support and engage the client in order to maximize the client's resource base and success.
6. *Professional and ethical responsibilities* — Counselors will follow a professional code of conduct, as well as all state and federal regulations. The primary concern for counselors is ensuring the safety and well being of clients. Counselors will pursue continuing education and training and review emerging literature.

7. *Counseling* — Counselors will create a warm, genuine, and respectful relationships with clients while setting healthy boundaries and encouraging empowerment. Counselors will provide safe environment with supportive therapeutic techniques.
8. *Clinical evaluation* — Counselors will build rapport with clients. They will gather data, screen, assess, and apply diagnostic criteria when appropriate. Counselors will assist clients in understanding their addiction and make treatment recommendations.