The New Jersey Council on Developmental Disabilities Recommendations on the Direct Support Professional Workforce

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1. I.Introduction

Direct Support Professionals (DSPs) provide personal care, social support and physical assistance to individuals with disabilities in a wide range of activities of daily living. DSPs also help individuals with intellectual and developmental disabilities (I/DD) learn independent living skills such as cooking and shopping, and make it possible for people with I/DD to participate in employment and social activities. DSPs work in a wide variety of service settings including individual and family homes, group homes, supported apartments, schools, workplaces, recreational and fitness programs, and residential institutions like developmental centers and nursing homes. These dedicated professionals facilitate connections to people, resources, and experiences that foster a full life in the community. Although DSPs play a critical role in the life of people with intellectual and developmental disabilities, nationally, there is a worsening shortage of paid caregivers:

> [A] major factor in the deficit of direct-care workers is the poor quality of these types of jobs. Direct-care workers typically receive very low salaries, garner few benefits, and work under high levels of physical and emotional stress. [T]he wages of direct-care workers are so low that they "do not appear to adequately support the recruitment and retention of these workers.' [1]

Although details may vary between states, and across research and statistical reports, certain conclusions are consistent and undisputed: (1) there is a much greater demand for direct care workers than can be filled by the current workforce; and (2) compensation and conditions of employment are directly related to turnover and vacancies.[2]

I. **II.Current Conditions: Workforce Shortages and Instability**

A. **A.Turnover and Vacancies**. States across the nation are reporting significant DSP workforce shortages and instability. In the *2007 National Survey of State Initiatives on the Direct-Care Workforce*, 97 percent of responding states reported that DSP turnover and vacancies constituted "a serious workforce issue." Just two years earlier, in the 2005 survey, only 76 percent of respondents reported a serious workforce problem.[3]

Several small scale studies have reported turnover rates for personal care assistants from 44-65%. The *2007 National Home Health Aide Survey* of 56,000 workers found 35% intended to quit their job within the next year. One review of studies reported turnover rates for DSPs caring for people with intellectual and developmental disabilities as: 65% among in-home workers, 50% among residential workers and 69% in employment services.[4]

B. Projected Need. The Department of Health and Human Services (HHS) estimates that by 2020, the nation will require approximately 1.2 million full time equivalent DSPs to meet the needs of roughly 1.4 million people with developmental disabilities for residential, vocational and other supports.[5] The United States Bureau of Labor Statistics projects that "Home Health Care" and "Personal Care Aides" will be the third- and fourth-fastest growing occupations in the country between 2010 and 2018.[6]

In 2012, New Jersey had a combined total of approximately 41,170 "home health aides" and "personal care aides." Researchers project the state will need an increase of 43 and 26 percent, respectively, of people in these job titles between 2010 and 2020. By way of contrast, all occupations in our state are expected to increase by only 8 percent during this time.[7]

These striking statistics illustrate the projected need for growth in the DSP workforce and compel stakeholders and policymakers to take immediate steps to address the recruitment and retention of skilled workers in this critically important profession.

C. Wages. Nationally, nearly half of all households that include a person who works as a DSP rely on public assistance such as: Medicaid, food assistance, cash welfare, or assistance with housing, energy, or transportation costs.[8] In 2009, 16% of individuals employed in home health care services lived in families with incomes under the federal poverty level.[9]

In New Jersey, direct care workers earn significantly less than the average wage across all occupations in the state. Forty-eight percent of direct-care worker households in New Jersey rely on some form of means-tested public assistance, particularly Medicaid or the Supplemental Nutrition Assistance Program (SNAP) (formerly known as the "food stamps program").[10] A 2009 study found that the entry level full-time salary for a DSP working for a private agency was $21,861. The federal poverty level for a family of four was $22,050. [11]

A. **D.Hours and Benefits.** To compound the impact of low wages, over half of the DSP workforce works part-time. For some this is by choice but a significant portion of DSPs would prefer to work more hours. Unfortunately for those workers, their jobs are structured as part-time employment, often with erratic or unpredictable hours, and without benefits such as paid time off for vacations, holidays or sick leave, reimbursement for travel, or eligibility for state unemployment insurance or workers' compensation. The Paraprofessional Healthcare Institute reports that, nationally, 38% of individuals providing "home health care services" lack health insurance.[12]

Home care workers have among the highest rates of injury of any occupation in the U.S, and one in three lack health insurance**.[13]** Direct care workers routinely have to lift and position individuals or handle wheelchairs and other equipment. Given these working conditions, the

struggles faced by DSPs to meet basic living expenses or raise their households out of a subsistence existence are compounded by the lack of access to workers' compensation, unemployment benefits, and health insurance. Although New Jersey requires minimum wage and paid overtime, these two important benefits do not ensure a living wage for the thousands who work part-time and irregular hours. These working conditions also undermine workforce stability and continuity of care.

A. **E.Cost of**Staff turnover raises the costs of providing care as providers incur increased expenses for recruiting and training to fill vacancies. Providers also incur the costs of higher overtime wages paid during staff shortages. It is estimated that a provider's cost of replacing one direct care worker is at least $2500 in direct expenses plus a minimum of an additional $1,000 of indirect costs. Indirect costs include lost productivity until a replacement is trained, lost revenues or reimbursement for client services, increases in worker injuries, increases in clients' physical and emotional stress, and a deterioration of working conditions that can lead to more turnover.[14] Nationally, the annual cost of DSP turnover incurred by community service organizations (and taxpayers) is approximately $784 million every year.[15]

These extra provider costs also fuel the need for higher rates from the state and federal agencies that pay for DSP services. In some states, the lack of a full workforce and the related financial burdens of this shortage can reduce provider and state capacity and can make it harder for states to meet growing demands for home- and community-based services.

I. III.System Change to Build DSP Workforce Capacity and Stability

A. **A.Increasing Wages and Benefits**. As the largest purchaser of in-home services and supports, federal and state governments play a crucial role in shaping the home care and personal assistance industry. Together, Medicaid and Medicare programs finance over 80 percent of home care and personal assistance services in the United States. DSP wages are largely influenced by the rates Medicare and Medicaid will reimburse states for services provided through state Medicaid or Medicare programs. Accordingly, changes in federal Medicaid rates and regulations are a key component of DSP wage rates in the I/DD community.

According to numerous studies, wages play a critical role in the adequacy and stability of the home care workforce. Lower wages have been consistently identified as predictors of higher turnover and vacancies for DSPs, especially in community settings.[16] However, although New Jersey and other states have taken legislative action to establish minimum wage requirements for DSPs, and although 2013 rule changes by the federal Department of Labor will require more providers to pay in-home direct care workers minimum wages and overtime benefits beginning in 2015, broader system change is needed for lasting compensation reform.

The following wage and benefit improvement strategies have been identified[17] as effective in maintaining an effective compensation system:

A. **B.Provide Comparable Wages** – Structure DSP wage rates and benefits to be comparable to what other employees in similar positions receive, and are at levels that allow community providers and individuals who are self-directing staff employment to attract and maintain qualified workers.

1. **1.Provide Living Wages** - Provide wage rates and benefit packages that, at a minimum, enable workers to afford basic living expenses such as health care, and ensure that workers generally do not have to rely on income-based public assistance programs for food and shelter.

1. **2.Provide Updated Wages** – Federal and state agencies must identify a mechanism for automatic wage increases based on economic conditions. Periodic inflation adjustments can be based on an index of health care labor costs, on the Consumer Price Index (CPI), or on the Medical Care CPI.

1. **3.Costs of Care** – Federal and state agencies, in consultation with all stakeholders, must identify procedures to regularly evaluate the adequacy of rates so they are sufficient to meet providers' actual costs of providing care and doing business, including appropriate allocations for direct care labor costs.

1. **4.Individual Budgets.** In addition, as more disability services are delivered through individual budgets, resources available for individual budgets must be at levels that allow individuals and families to pay appropriate wages. Initiatives to address the clear need for a greater investment in providing DSPs a living wage and opportunities for career and financial advancement, must include consideration of two current shifts in services delivery systems: (1) providers are modifying their business model to provide more in-home support; and (2) more individuals and families are directly hiring, training and supervising direct care professionals. These shifts require a payment structure that provides a living wage and professional career path, while also ensuring that wage and hour requirements and reimbursement rates do not make it unreasonably costly for providers to assign DSP staff to work in individual and family homes or for people and families to use self-directed support services.

A. **C.Institutional Bias**. Another needed federal Medicaid reform is to address the system's "institutional bias" in the way services are funded. Over the last four decades, supports and services for people with I/DD have been transformed from a medical model that provides "treatments" to people in hospitals and institutions, to a social justice / inclusion model that provides services designed to support people to live full, participatory lives in typical homes, jobs and communities.[18] Despite this refocusing of disability services to integrated settings, Medicaid still funds institutional care as an entitlement but provides limited and sometimes insufficient resources to people seeking and waiting for home- and community-based support.

In 2011, nearly half a million (472,334) individuals with intellectual and developmental disabilities across the country received supports in settings with 6 or less people. By way of contrast, 84,432 people were served in settings with 16 or more people.[19] The number of

people receiving residential supports in the community is more than five times the number of people receiving supports in institutions and large congregate settings. It is also estimated that more than 115,000 people across the country have chosen to be placed on waiting lists for non-institutional residential services rather than accept institutional care,[20] and that 3.5 million families in America are providing caregiving for a child or adult with I/DD at home.

Given these stark facts about the demand for caregiving and direct support in home and community settings, it is clear that there is an urgent need to reform Medicaid's funding design to eliminate the outdated preferential funding of institutional care. In order to meet current and future needs, Medicaid must convert to an equitable system that funds individual budgets, provider rates, and DSP compensation all at levels that meet the needs of people served. Medicaid must be redesigned to support feasible operational budgets for providers and generate an ample and stable workforce.

Such federal reform must include the redirection of resources from large institutions to the community in order to ensure that sufficient compensation is available for supervisors and DSPs who are transitioning from developmental centers to home and community settings. In addition, resources must also be redirected from developmental centers to training and re-training transitioning and new DSP's to develop new skills and knowledge to meet the physical, behavioral and other diverse support needs of the full range of people with disabilities in a manner consistent with person-centered and self-directed care models.

Suggestions to end the federal Medicaid bias include:

- make institutional care an optional benefit instead of an entitlement[21]
- require states to offer community services as part of their Medicaid program
- require enrollment in HCBS prior to placement in an institution
- require beneficiaries to "opt-in" to institutional care
- make eligibility determinations based on functional support needs rather than institutional level of care

A. **D.Professional Development and Career Ladders.** In 2006, the Elizabeth Boggs Center, New Jersey's University Center of Excellence in Developmental Disabilities Research and Training (Boggs Center) created The New Jersey Direct Support Professional Workforce Development Coalition (Coalition), with the overarching goal of reducing the turnover of direct support professionals. The Coalition soon identified its mission as follows:

   To promote the recruitment and retention of a professional workforce to enhance the quality of direct supports for people with disabilities and their families, by:

- *supporting the choice of direct support professional as a lifelong career;*
- *building partnerships among agencies, funding sources, educational institutions, families, and consumers; and*
- *improving the quality of the work environment for direct support professionals.*

The following year, the Boggs Center and the Coalition obtained grant funding from the New Jersey Council on Developmental Disabilities (Council), to implement a two-year pilot program that offered a career path for Direct Support Professionals through online professional development courses. The Boggs Center and the Coalition also received funding for technical assistance from the Centers for Medicare and Medicaid Services (CMS). The program uses the online courses of the College of Direct Support in combination with onsite mentors and demonstrations of skill development. Completion of each level of the career path results in a state certificate and gives DSPs the opportunity to apply for national credentialing through the National Alliance for Direct Support Professionals (NADSP). This credentialing program has three levels: DSP-Registered, DSP-Certified and DSP-Specialist.

The Boggs Center pilot program resulted in a 33% reduction in professional turnover. As a result of the success of the program, the NJ Division of Developmental Disabilities (DDD) now funds statewide access to the College of Direct Support program for employees of all DDD-licensed provider agencies. In addition, state-licensed provider agencies are required to use the College of Direct Support's Learner Management system to track the completion of state-mandated Pre-Service Training. This drives traffic to an extensive list of additional optional online courses covering autism, brain injury, depression, communicating with individuals who are non-verbal, community inclusion, supported employment, and many other competencies for direct support professionals and frontline supervisors.

In addition to its positive impact on turnover, such training and career ladder opportunities can also lead to further innovations that, nationally, have improved DSP compensation and quality of services. States have the authority to set higher Medicaid payment rates for services performed by DSPs who meet higher credentials. This trend toward rewarding professional development can include incorporating the level of care a particular DSP provides – and the higher skill and education levels needed to provide such care-- into compensation and provider rate structures. Higher payment based on training, seniority and competency milestones support a highly-skilled and stable workforce. [22] Additional areas of exploration include mentorship, acuity-based care (which considers the intensity of a care-recipient's needs when determining core competencies and compensation), and participant (care-recipient) directed training

I. **IV.Summary and Recommendations**

A. **A.Goals.** There appears to be a national consensus that in order to meet the current and future demand for a sufficient, skilled and stable workforce of direct support professionals in the developmental disabilities community, changes in federal and state practices are needed to:

- increase the availability of DSPs in home and community settings
- identify core competencies across settings and client needs and establish competency-based training
- support career advancement and professional development
- reduce turnover and vacancies
- ensure DSPs a living wage and employee benefits

- assure quality of care
- publicize the DSP field as a respected and skilled profession
- implement rate setting practices that remove cost barriers to these goals

A. **B.Recommendations of the National Commission on Long-Term Care**. On September 18, 2013, the Commission on Long-Term Care released its final report to Congress [23] with detailed recommendations for reaching the national goal of a more responsive, integrated, person-centered, and fiscally sustainable service delivery system that ensures people can access quality services in the settings they choose. Recommendations for Congressional action include:

- rebalance Medicaid so that the institutional bias is removed and eligible individuals can obtain necessary care in the least restrictive setting that meets their needs
- create federal system change in payment rates for Medicaid home and community-based services to foster greater parity of wages and benefits across long term care settings
- create a national advisory committee to continue to advance the Commission's recommendations and to explore system change in financing direct care

In addition, the following recommendations can also be implemented by individual states:

- create meaningful opportunities for direct-care workers to develop skills and advance up a career ladder
- collect workforce data including numbers employed, compensation, and training levels

Five members of the Commission filed a dissenting report, stating that the recommendations in the majority report do not go far enough to address how to finance long term care. In their separate report, the five members recommend the creation of a "public social insurance program that is easily understood and navigated." In a press release, the dissenting members stated, “We are convinced that no real improvements to the current insufficient, disjointed array of LTSS and funding can be expected without developing social insurance financing." The alternate report also calls on Congress to assure that "direct-care workers are paid a living wage, are well trained, and have opportunities for career advancement."

A. **C.Recommendations of the NJ Council on Developmental Disabilities**
Based on all of the above, the New Jersey Council on Developmental Disabilities will continue to study these issues and to advocate for state and federal actions that:

- Enhance the terms and conditions of employment for community DSPs
    - Fund DSP wage increases and expanded, continuous training
    - Raise provider rates, tied to increased salary, benefits and training
    - Advocate for the elimination of the federal Medicaid institutional bias and support NJ’s continued redirection of resources to the compensation and professional development of DSPs working in less restrictive settings
    - Maximize federal funding for DSP training and professional development

- Expand the availability of steady work hours, health benefits, paid leave, temporary disability insurance, worker's compensation, unemployment benefits and other terms and conditions of employment

a. oContinue to support New Jersey's current training and credentialing system, and expand career ladder training and mentoring for expanded competencies; identify additional training needs such as English as a second language

a. oPromote cross-training and career development that encourages DSPs and supervisors to develop a broad and diverse range of competencies across the lifespan and across populations, so that their skills and experiences qualify them to work in varied settings with people who need diverse medical, behavioral or mental health supports, supported employment services or assistance aging in place. Efforts must include encouraging government agencies and providers to embrace and support this type of cross-training and expanded competencies as integral to meeting the state's caregiving needs.

a. oAddress the cost barriers to initial training and continuing professional development and maximize Medicaid and other federal funds to support DSP career and skill enhancement

- Ensure that rates for services are sufficient to cover costs of pre-service training and continuing career development, especially in the case of DSPs who supervise or mentor other staff and who provide intensive or complex behavioral and/or medical supports.

a. oFormalize state recognition of the certification process of the National Alliance for Direct Support Professionals so that training and career milestones will be recognized with career advancement and increased compensation

- Support the recruitment of new DSPs and incorporate DSPs into relevant state and local workforce development efforts, including the work of NJ Department of Labor State Employment and Training Commission, Workforce Investment Boards, One Stop Centers, Community Colleges Vo-tech education, and other initiatives involving the healthcare and home health workforce

a. oPromote recognition of direct support care as rewarding profession and career

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[1] Caring in America page 52, citing Institute of Medicine (2008) *Retooling for an Aging America: Building the Health Care Workforce*, Prepared by the Committee on the Future Health Care Workforce for Older Americans, Board of Health Care Services, Washington, DC: The National Academies Press, p. 200.

[2] In preparing statistical reports about the DSP workforce, researchers use different definitions and parameters of workers studied. Accordingly, data gathered varies across studies with regard to the group of people being described, with respect to where work is performed, what

populations are served, and the job titles and duties of the workers included in the data collection. This leads to some numerical differences in reports of compensation, vacancies and demand.

[3] The 2007 National Survey of State Initiatives on the Direct-Care Workforce: Key Findings.

PHI National (Paraprofessional Healthcare Institute)(December 2009) pp. 2, 7. http://www.phinational.org/sites/phinational.org/files/clearinghouse/PHI-StateSweepReport%20final%2012%209%2009.pdf

[4] Seavey, D. *Caring in America: A Comprehensive Analysis of the Nation's Fastest-Growing Jobs*: *Home Health and Personal Care Aides* (December 2011) pp. 69-72. www.PHInational.org.

[5] Macbeth, J.M. *Commitment, Capacity and Culture: Solutions for the Direct Support Workforce Crisis.* (August 2011) The National Alliance for Direct Support Professionals.

www.nadsp.org; see also

http://www.ancor.org/resources/topics/dsp-workforce-development#sthash.Vk3fRuuR.dpuf

[6] http://www.bls.gov/news.release/ecopro.t06.htm; see also Seavey, *Ibid.*

[7] http://phinational.org/policy/states/new-jersey/

[8] PHI National, The Direct Care Worker at a Glance (May 2012) http://phinational.org/sites/phinational.org/files/05012012-dcwataglance.pdf

[9] PHI National, Direct Care Workers at a Glance http://phinational.org/direct-care-workers-glance (2011)

[10] PHI National, State Data Center http://www.phinational.org/policy/states/new-jersey/

[11] *ANCOR 2009 Direct Support Professionals Wage Study: A report on national wage, turnover and retention comparisons.* Prepared by the Mosaic Collaborative for Disabilities Public Policy and Practice (DSP Wage Facts - NJ) http://www.ancor.org/sites/default/files/pdf/new%20jersey_2009_dsp_onepgr.pdf

[12] PHI National, The Direct Care Worker at a Glance (May 2012) http://phinational.org/sites/phinational.org/files/05012012-dcwataglance.pdf

[13] Vladeck, B. (March 6, 2013) http://thehill.com/blogs/congress-blog/economy-a-budget/286539-act-now-on-fair-wages-for-home-care-aides#ixzz2h43YZOke)

[14] Barbarotta, L. *Direct Care Worker Retention: Strategies for Success*. Institute for the Future of Aging Services and American Association of Homes and Services for the Aging (AAHSA) (2010).

[15] Macbeth, J.M. *Commitment, Capacity and Culture: Solutions for the Direct Support Workforce Crisis.* (August 2011) The National Alliance for Direct Support Professionals.

[16] Polister, B., Lakin, K. C., and Prouty, R. (2003). Wages of Direct Support Professionals Serving Persons with Intellectual and Developmental Disabilities: A Survey of State Agencies and Private Residential Provider Trade Associations. *Policy Research Brief* (University of Minnesota: Minneapolis, Institute on Community Integration), *14*(2); *The Supply of Direct Support Professionals Serving Individuals with Intellectual and Other Developmental Disabilities*, Office of Disability, Aging, and Long-Term Care Policy, U. S. Department of Health and Human Services Report to Congress. (January 2006)

[17] Paraprofessional Healthcare Institute (PHI), Workforce Strategies, State Wage Pass-Through Legislation: An Analysis (April 2003) http://www.leadingage.org/uploadedFiles/Content/About/Center_for_Applied_Research/Publications_and_Products/Wage_Pass_Through_Brief.pdf

[18] Hewitt, A., et al. *A synthesis of direct service workforce demographics and challenges across intellectual/ developmental disabilities, aging, physical disabilities, and behavioral health.* National Direct Service Workforce Resource Center. November 2008.)

[19] (Prouty, Alba & Lakin, 2008). Braddock et al., Coleman Institute and Department of Psychiatry, University of Colorado, 2013. http://statofthestates.org

[20] Larson, Ryan, Salmi, Smith, & Wuorio, 2012) cited on p. 61 of Braddock

[21] Advocates are expected to oppose efforts to place aggregate or individual limits on state Medicaid spending as part of reform efforts to end the institutional bias, or as an overarching feature of federal budget negotiations over appropriations to states.

[22] http://phinational.org/policy/issues/payment-policy-reform#sthash.jKRnounf.dpuf

[23] http://www.ltccommission.senate.gov/Commission%20on%20Long-Term%20Care%20-%20Final%20Report%20-%209-18-13.pdf