

March 2008

Legislative Study of the Direct Care Workforce in Vermont



Submitted to:

**The Senate Committees
on Appropriations and
Health and Welfare**

and

**The House Committees
on Appropriations and
Human Services**

Submitted by:

Joan K. Senecal,
Commissioner
Department of Disabilities,
Aging and Independent Living
Vermont Agency of Human
Services

Prepared by:

Flint Springs Associates

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Message from the Commissioner



We have a vision for Vermont. We want to make this the best state in which to grow old or to live with a disability, with dignity and independence. State government can not and should not, try to achieve this vision alone. We work along side many consumers, family members, advocates and providers, all dedicated to the same end.

Vermont is a place where people feel they can belong, they can feel safe, they can participate in the life of their communities, but

for many people of all ages, this doesn't come easily. They depend on the assistance and support of direct care workers, the foundation of the diversity of long-term care in Vermont. No matter what direct care workers are called, Personal Care Attendant (PCA), Licensed Nursing Assistant (LNA), Support Professional or any other name, they make an invaluable contribution to a better quality of life and quality of care for thousands of our friends and neighbors.

Seven years have passed since we completed the first study on a portion of the direct care workforce. That study was a good first step, but it was incomplete because it only included PCAs) and Licensed Nursing Assistants (LNAs). Two years ago, the Vermont Legislature agreed that a broader, comprehensive study was needed. In addition to funding from the Legislature, support came from the Better Jobs/Better Care grant managed by the Community of Vermont Elders, from PHI, a national non-profit organization working on behalf of direct care workers and from the Department of Disabilities, Aging and Independent Living. Over 18 months of work, a wonderful group of people have now produced this report that will go to the Legislature and be distributed widely across Vermont.

We cannot achieve our vision for Vermont without a sufficient number of well-trained and adequately reimbursed direct care workers. As the number of older Vermonters increases and the lifespan of younger Vermonters with disabilities continues to rise, the gulf that already exists between the number of people needing care and support and the number of direct care workers available to provide that care and support, will continue to widen.

Continued on next page

There are nine recommendations in this report and all of them deserve your thought and attention. We must now carefully consider how much we can accomplish and how quickly. In these difficult financial times, implementing these recommendations will be challenging. We need to look at either creative funding for, or take an incremental approach to meeting these goals.

I want to thank the dedicated members of the Statewide Advisory Group who spent many hours engaged in spirited discussions, reworking drafts of surveys and reports, and pushing for the best work product possible.

Joan K. Senecal

Joan K. Senecal, *Commissioner*
Department of Disabilities, Aging and Independent Living
Vermont Agency of Human Services



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Executive Summary

Introduction

Many of us are able to accomplish activities of daily living on our own. We get out of bed in the morning, go to the bathroom, take a shower, dress, eat our breakfast, take care of our families, and make our way to work, school or other activities. Throughout the day, we attend to our tasks and take care of our personal needs. At day's end, we follow our night-time rituals, prepare for bed and climb in for another night's sleep.

But not all of us are able to perform these *activities of daily living*, or ADLs, on our own. Some of us need help getting out of bed, attending to our personal hygiene, eating and other personal care tasks. Some of us need help with instrumental activities of daily living, or IADLs, such as doing laundry, shopping for food or getting to work in the morning. And, some of us need support communicating with others, remembering our tasks, or engaging in meaningful activities.

Direct care is the hands-on help and support one person gives to assist another in negotiating the tasks of daily living. Sometimes this direct care is provided by a family member or friend. However, not all of us have family or friends to give us direct care and support; and families or friends cannot do it all. In these instances, we rely on direct care workers—who may come into our homes, take us into their homes, or staff our adult day centers, assisted living, residential care and nursing homes; and, they provide support in work and community settings—for the most basic human needs; without them, many of us would not be able to get out of bed in the morning, let alone make it through the day.

However, Vermont faces a growing crisis: the number of us who need direct care and support is outpacing the growth of the direct care workforce. Baby boomers are aging; the number of children diagnosed with cognitive disabilities such as autism is growing; those of us with physical disabilities seek more independence; and, medical advances continue to enable us to live longer, manifesting more complex needs.

Simply said, we do not have enough direct care workers to meet current and future needs for care and support. As a result, Vermont is challenged to identify and implement effective ways to attract (recruit) and keep (retain) a high quality and stable direct care workforce.

Legislative Study

The Legislative Study of the Direct Care Workforce was funded by the Vermont Legislature and directed the Commissioner of the Department of Disabilities, Aging and Independent Living (DAIL) to gather information and develop informed policies and practices to address the workforce shortage. The legislature, in authorizing this study, required that the Commissioner appoint an advisory group to:

- Provide advice on planning and implementing the study
- Develop recommendations based on the study's findings

The authorizing legislation (see Appendix A) identified organizations representing a wide range of stakeholders to participate in the Advisory Group which was formed and met regularly between September 2006 and January 2008.

Four questions drove the research:

1. What are workforce **quantity and availability** issues across care and support settings and consumer populations?
2. What are workforce **quality** issues across care and support settings and consumer populations?
3. What are workforce **stability** issues across care and support settings and consumer populations?
4. What are **financial** issues across care and support settings and consumer populations that will need attention?

The research design that emerged from the deliberations of the Advisory Group incorporated three strategies to address the research questions:

- Qualitative data collection—*interviews were conducted with direct care workers, individual consumers of direct care or their surrogates, employers of direct care workers, and other "key informants"*
- Quantitative data collection—*direct care workers, , individual consumers of direct care or their surrogates who employ direct care workers, and agency employers of direct care workers responded to surveys*
- Review of relevant literature—*additional research conducted within and beyond Vermont was examined*

Research Results

The Legislative Study of the Direct Care Workforce generated findings to the research questions, which are detailed in the full report. Our research data clearly tells us the following:

- Wages and benefits are central to attracting and retaining direct care workers.
- The people who do this work value their relationships with the people they care for and support, and have a deep commitment to helping and making a difference in others' lives.

Recommendations: Call to Action

The Legislative Study of the Direct Care Workforce generated findings to the four research questions that provide a strong foundation for strategic planning and action targeted at building and maintaining an adequate, quality, stable direct care workforce for Vermonters into the coming years. The members of the Stakeholder Advisory Group reviewed and considered the research findings. Nine consensus recommendations emerged from their deliberations which are presented below with their supportive findings.

I love it and I love helping other people that need help.

—Direct Care Worker

Pay them what they deserve. It is the most satisfying thing I've ever done. You just can't pay the bills doing it.

—Direct care worker

Recommendation #1: Increase direct care worker wages.

Our research indicates that if Vermont could do one thing toward insuring the desired quantity, availability, quality and stability of the direct care workforce, it would be to improve direct care worker wages.

- Ensure that direct care workers who are employed, and perform similar functions, in self-directed settings such as Choices for Care and Attendant Services Program, enjoy wage parity and receive adequate pay for their service.
- Provide direct care workers with regular cost of living adjustment (COLA) wage increases.
- Create opportunities and incentives for direct care workers to receive merit raises to recognize good quality care.
- Provide adequate reimbursement rates to organizations such as home health agencies, nursing homes, residential care facilities and other provider agencies that hire direct care workers, and earmark reimbursement increases to cover the cost of increased wages for direct care workers.

Since raising our hourly rates and the frequency of merit raises, our retention has significantly increased. Thus our hourly average pay exceeds \$11/hr. This makes us “struggling”; would need adjustment of \$20 or more per day just to catch up.

—Employer

Research findings and rationale that support recommendation #1:

To find and keep direct care workers, wages must be improved. We found that:

- Inequities exist 1) in the reimbursement rates received by agencies that hire direct care workers, and 2) in the wages paid to direct care workers who perform similar work across different work settings.
- Employers, consumers and direct care workers all agree that increased wages will, by far, have the greatest impact on attracting and keeping workers. When asked to name the most important step Vermont can take to increase recruitment and retention of direct care workers, survey respondents overwhelmingly identified increased wages.

- Vermont's direct care workers earn an average of \$11.00 per hour, not even a livable wage for a single adult.
- The research showed a strong and statistically significant correlation between length of stay in a job and wages ($r = .27, p < .01$). The higher the wage, the longer direct care workers stayed in one position.
- In Wyoming increased state funding to increase direct care workers' compensation led to a dramatic drop in turnover rates, from an average of 52% to 32%¹. San Francisco County nearly doubled the wages of home care workers over a 52-month period. In that time, annual turnover went from 70% to 35%².
- Only half of the 1700 direct care workers who responded to the survey expect to receive pay raises. Absent cost of living adjustments, inflationary pressures mean that direct care workers in Vermont will lose income by staying in their jobs at current wages.
- Employers report that they are unable to pay increased wages to direct care workers because reimbursement rates do not cover the cost of providing care.
- Merit raises represent a common mechanism for increasing wages by rewarding quality work performance. While merit raises are standard practice in many work settings, low reimbursement rates prohibit their inclusion in direct care worker compensation strategies.

I need health benefits but it is hard to make ends meet when you have to put a large chunk of your income towards health insurance.

—Direct care worker

¹ Lynch, R., Fortune, J., Mikesell, C. and Walling, T. (2005) "Wyoming demonstrates major improvements in retention by enhancing wages and training." Links, Vol. 35, No. 9. Available at: http://www.directcareclearinghouse.org/download/WY_2005_Wage.pdf

² Howes, C (2006). *Building a High-Quality Home Care Workforce: Wages, Benefits and Flexibility Matter*. A Better Jobs Better Care Research Study available at: <http://www.bjbc.org/grantpage.asp?projectID=9§ionID=4>

Recommendation #2: Increase access to health insurance through group health plans.

- Ensure that direct care workers and their advocates are included in all formal efforts to improve access to health care.
- Continue to explore the possibility of making the Vermont state employee health insurance program open to direct care worker enrollment.
- Ensure that all Green Mountain Care outreach target direct care workers.

Research findings and rationale that support recommendation #2:

- Provision of benefits, including health insurance, ranked second, only to increased wages, as important to attracting and keeping direct care workers.
- Retention rates for direct care workers who receive health insurance are higher than for those who do not. On average, workers with health insurance remain in their jobs 2.5 years longer than those without health insurance benefits.
- Only one-in-three direct care workers reported that they receive health insurance as an employment benefit.



Recommendation #3: Create accessible and affordable orientation, training, and professional development for direct care workers and their employers.

- Research and inventory effective orientation, training and professional development opportunities and programs.
- Provide funding to pay workers for their time to attend orientation, training and professional development programs.
- Fund the development and delivery of orientation and training programs, including professional development programs that support career ladders
- Utilize a variety of strategies that widen accessibility to training and orientation modes such as: class-room instruction, web-based learning, and peer-mentoring.

I like that there are always plenty of work options and I will never face unemployment.

–Direct care worker

Research findings and rationale that support recommendation #3:

- When direct care workers do not receive the formal orientation and on-going training, they are more likely to abandon their positions sooner and more frequently, leaving providers, and particularly consumers who hire them directly, without needed care.
- Direct care workers provide significantly longer years of services when employers offer:
 - In-service training (5.7 vs 3.6 years)
 - Funding for courses (5.8 vs 4.5 years)
 - Funding for conferences or workshops (6.3 vs 3.9 years)
- Direct care workers stay in their jobs longer when they are satisfied with the preparation and training they received. Workers that report satisfaction with the preparation and training provide significantly more years of service (5.1 years) than workers who are not satisfied with the preparation and training received (4.0 years)
- Only 42% of workers overall receive formal training; 11% of workers hired by consumers receive formal training. In-service training is available to only 50% of workers overall; 7% of workers hired by consumers receive in-service training.

Recommendation #4: Recruit direct care workers from new sources.

- Create public awareness about the value of direct care work.
- Develop and disseminate messages that attract people to this work.
- Target recruitment efforts at young workers, mature workers, family caregivers and new Americans.

Research findings and rationale that support recommendation #4:

- Because the population of Vermonters is aging, and both elders and persons with disabilities can choose their settings for care, the growing need for direct care workers in a range of settings renders this work “recession proof” and not vulnerable to changes in economic conditions.
- The need to engage in and expand recruitment targets is clear; the current supply of workers does not meet the demand, and the gap between supply and demand is expected to grow.
- The direct care workforce is aging along with our entire population. At present, 64% of direct care workers surveyed are over age 40. As these workers approach retirement age and begin to leave the workforce, there will not be an equal population of younger workers to replace them.
- Recent research from AARP and Operation ABLE indicate that older workers intend to work at least part-time in their retirement and would be interested in direct care.
- National research indicates that in addition to mature workers, new Americans and paid family caregivers represent potential pools of workers.

And there have to be safeguards put into place too. Sure, you can have them come to your house. You can interview them and they're going to be nice. And what happens when you're not there. She can't talk; she can't walk. She is blind in one eye. She's at their mercy.

–Consumer Surrogate
using Choices for Care

Recommendation #5: Continue support for the development and full implementation of the Direct Care Worker Registry.

- Explore changes in policy and practice that would enable background checks to be conducted prior to offers of employment so that pre-screened workers can become a feature of the Registry.

Research findings and rationale that support recommendation #5:

- Vermont law currently does not allow pre-screening of workers; background checks can only be conducted with an offer of employment.
- Consumers want the registry to include only workers on whom a background check has been done.
- In response to a survey question, 51% of consumers report they would use a registry to hire direct care workers, 39% might, and only 10% would not use it.
- Consumers who say they would use the Registry rank screening potential employee backgrounds as the feature most important to them.

(A direct care worker) is someone who will work for a minimum wage, but has the skills of a PhD and the strength and endurance of a lion.

—Consumer

Recommendation #6: Promote recruitment and retention through the use of evidence based tools and promising approaches.

- Continue and expand the Gold Star Employer Program in nursing homes and home health agencies
- Provide Coaching Supervision training for supervisors
- Involve direct care workers in care planning and organizational decision-making
- Promote the widespread use of Peer-Mentoring programs

Research findings and rationale that support recommendation #6:

- Within Vermont and nationally, evidence-based research indicates that specific evidence-based and promising practices make a positive difference in finding and keeping direct care workers.
- Vermont nursing homes that have earned Gold Star Employer awards have lower turnover rates among their direct care workforce. Gold Star nursing homes reported 49% turnover compared to 60% turnover in non-Gold Star facilities.
- Lower turnover rates are associated with adoption of Coaching Supervision programs that teach supervisors to set clear expectations, while encouraging, supporting and guiding direct care workers.
- Involving direct care workers in care planning improves retention: 51% of providers that highly involve direct care workers in care planning report that they have no job vacancies and only 10% report serious staff retention problems.
- Peer-mentoring programs provide supportive orientation and hands-on training for new workers and are associated with increased worker retention rates: up to 81% retention for mentors and 67% for mentees.

Recommendation #7: Create standardized and portable career ladders for direct care workers.

- Create a range of options through which direct care workers can assume leadership responsibilities within their current jobs.
- Encourage direct care workers to become specialists in care areas of particular interest (for example, developmental disabilities, dementia care, palliative care, nutrition, diabetes care).
- Allow direct care workers to “carry” credentials such as an LNA II that they have earned in one setting to any other setting in which they carry out the same or similar responsibilities.
- Provide recognition for direct care workers who complete professional development and continuing education programs.
- Create and deliver standardized curricula that are associated with particular career ladders such as LNA II or PCA II.

Research findings and rationale that support recommendation #7:

- In response to survey questions, direct care workers reported only one other area of dissatisfaction beyond low wages; the lack of opportunities for advancement.
- No standardized LNA II or PCA II curriculum and credentialing exists in Vermont. Each organization provides its own training curriculum and the LNA II designation is not transferable from one nursing home to another. As a result, direct care workers are consigned to limited options for advancement within their profession and those exist primarily within their current work setting.
- Career ladders provide workers with recognition and advancement while enabling them to continue within the direct care worker profession.

Recommendation #8: Establish a workgroup responsible for developing protocols and methods for collecting needed direct care workforce data.

The workgroup would be charged with:

- Developing standard definitions that delineate and describe the various types of direct care workers and the different categories of direct care provided based on actual job functions and work settings.
- Designing a method for collecting raw data that captures the number of direct care employees in the workforce (full time and part time), the number of direct care employee hires and terminations, vacancy rates, and wages and benefits provided to direct care employees.
- Gaining compliance from employers (i.e., nursing homes, home health agencies, residential care facilities, assisted living programs, adult day services, and development services) to use the data collection method.

Research findings and rationale that support recommendation #8:

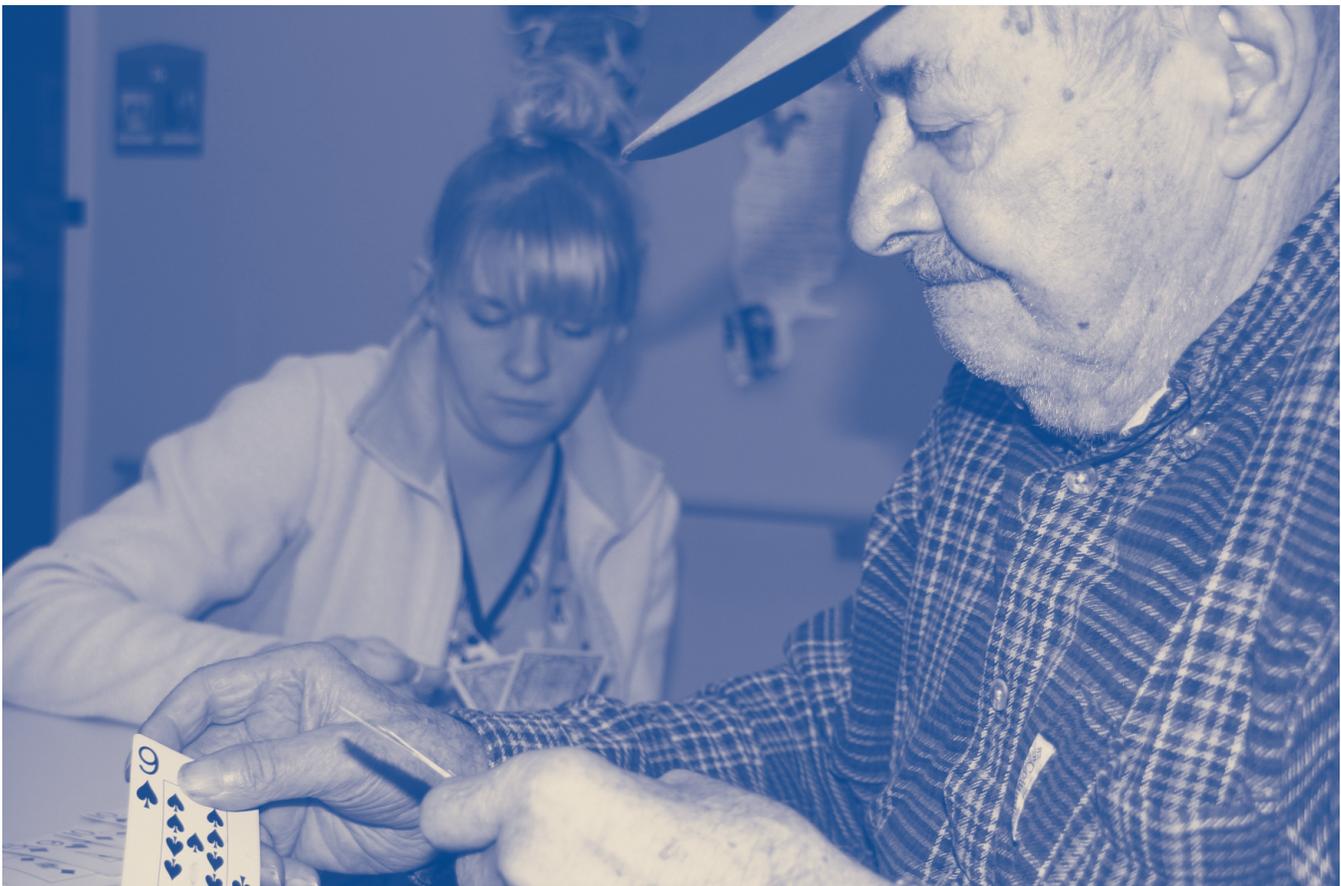
- Within Vermont, standardized data needed to accurately describe the direct care workforce in terms of retention, turnover and adequacy of supply does not exist.
- The U.S. Bureau of Labor Statistics' employment categories used by the Vermont Department of Labor (DOL) do not accurately reflect the direct care workforce. The categories do not capture all direct care work jobs, and collapse direct care work into categories that include distinctly other jobs (e.g., hospital orderlies)
- Not all direct care employers collect and report employee data. Moreover, employers that do track turnover use a variety of formulas to do so, resulting in diverse data sets that lack comparability across employers or settings.

Recommendation #9: Establish a group that is charged with directing, implementing and monitoring progress on the recommendations.

- The membership should include representation from state government (DAIL, DOL, and Department of Education (DOE)), consumers, direct care workers, advocates, and providers.
- Model the group on successful examples such as the Blue Ribbon Commission on Nursing which was convened between 2000 and 2001.

Research findings and rationale that support recommendation #9:

- Successful efforts to improve recruitment and retention of direct care workers require collaborative efforts of an organized, multi-disciplinary group that is staffed, resourced and representative in its membership of key stakeholder interests.



Conclusion

Individuals who provide direct care to help us negotiate the tasks of daily living answer a calling: they come to work each day to help others. These workers care deeply for those of us who live with developmental disabilities, physical disabilities, or the challenges brought on by aging. To insure that the growing need for direct care is met, Vermont must develop effective strategies for attracting and keeping direct care workers.

First and foremost, direct care workers must earn a livable wage. Second, workers should receive some degree of employment benefits. Beyond that, provisions such as training, quality supervision and opportunities for advancement can improve workers' satisfaction and willingness to stay in this profession. The findings from this Vermont study are supported by findings from other research initiatives conducted here and across the country. What we learned in the 2001 *Paraprofessional Workforce Study* remains constant: direct care workers engage in this profession because they want to work with, help, and make a positive difference in other's lives.

The 2001 *Paraprofessional Staffing Study* recommended the formation of a direct care worker organization or association to support workers and further the development of this vital workforce. The Vermont Association of Professional Care Providers (VAPCP) has since been established and become essential in raising awareness about the profession, providing training opportunities for all direct care workers, advocating for direct care workforce issues, and supporting opportunities for leadership development. This study is another critical step in the process of understanding and strengthening the direct care workforce in Vermont. The Vermont Association of Professional Care Providers (VAPCP), if resourced and supported, will continue to serve as a sustainable vehicle for workforce development.

Introduction

Many of us are able to accomplish activities of daily living on our own. We get out of bed in the morning, go to the bathroom, take a shower, dress, eat our breakfast, take care of our families, and make our way to work, school or other activities. Throughout the day, we attend to our tasks and take care of our personal needs. At day's end, we follow our night-time rituals, prepare for bed and climb in for another night's sleep.

But not all of us are able to perform these activities of daily living, or ADLs, on our own. Some of us need help getting out of bed, attending to our personal hygiene, eating and other personal care tasks. Some of us need help with instrumental activities of daily living, or IADLs, such as doing laundry, shopping for food or getting to work in the morning. And, some of us need support communicating with others, remembering our tasks, or engaging in meaningful activities.

Direct care is the hands-on help and support one person gives to assist another in negotiating the tasks of daily living. Sometimes this direct care is provided by a family member or friend. The husband of an elderly woman recovering from a stroke is there to help. When he needs a break, their daughters step in. The mother of a child with physical disabilities gets him dressed each morning.

Not all of us have family or friends to give us direct care and support; and families or friends cannot do it all. In these instances, we rely on direct care workers. Direct care workers come into our homes or take us into their homes; they staff our adult day centers, assisted living, residential care and nursing homes; and, they provide support in work and community settings. We rely on direct care workers for the most basic human needs; without them, many of us would not be able to get out of bed in the morning, let alone make it through the day.

Direct care workers make a critical difference in the lives of people of all ages who need support and care. Direct care workers are essential to the long-term care system that supports the physical, mental and social well-being of these Vermonters.

However, the number of us who need direct care and support is outpacing the growth of the direct care workforce. Among the many factors: baby boomers are aging; the number of children diagnosed with autism has increased; and, medical advances continue to enable us to live longer with more complex needs.

Vermont faces a growing crisis: we do not have enough direct care workers to meet the current need for care and support and that need is increasing.

Legislative Study

The direct care workforce staffing crisis was brought to the attention of Vermont's legislature by the Better Jobs/Better Care (BJ/BC) project of the Community of Vermont Elders (COVE), in partnership with the Vermont Association of Professional Care Providers (VAPCP) and the Northern New England Leadership, Education and Advocacy for Direct Care and Support (LEADS) Institute. The legislature responded by directing the Commissioner of Disabilities, Aging and Independent Living (DAIL) to conduct a study of the present and future workforce issues impacting direct care workers in Vermont. BJ/BC contributed 20% of the funding for the study.

The Legislative Study of the Direct Care Workforce in Vermont was designed to gather information needed to develop informed policies and practices intended to address the workforce shortage. Specifically, the study sought to determine what conditions and issues are related to, and/or impact the quality, quantity, availability and stability of the direct care workforce.

Context of Study

Across the country many efforts have been directed at the direct care workforce shortage described above. To date, there have been no studies as comprehensive as this one that Vermont has undertaken. The results of this study provide important information to both Vermont and the rest of the nation.



The Legislative Study of the Direct Care Workforce is one of several efforts advanced by Vermont's legislature and the long-term care community that focuses on developing a high-quality, long-term care system for older Vermonters and persons with disabilities. Included in these efforts are the:

- Long-Term Care System Sustainability Study
- Direct Care Worker Registry
- Health Care Workforce Development Partnership
- Olmstead Commission
- Nursing Facility Reimbursement Study
- Nursing Facilities for the 21st Century Study
- Sharing Staff Pilot Program
- Sustainability of Designated Provider System for Substance Abuse, Developmental and Mental Health Services Study.

Because direct care work can provide valuable, meaningful, and rewarding employment opportunities, the findings of this study provide important information to the above initiatives as well as to the workforce development efforts in the Department of Labor, vocational education and health care education. Inevitably, as the demand for direct care work grows, so do opportunities for job development and creation.

Staffing for Study

Through a competitive request for proposals (RFP) process, DAIL selected and entered into a contract with Flint Springs Associates (FSA) in September 2006 to conduct the study.

Stakeholder Advisory Group

The legislature, in authorizing this study, required that the Commissioner of DAIL appoint an advisory group to:

- Provide advice on planning and implementing the study
- Develop recommendations based on the study's findings

The authorizing legislation (see Appendix A) identified organizations representing a wide range of stakeholders to participate in the Advisory Group. In September 2006, DAIL and FSA invited representatives of all identified organizations and direct care workers to attend a first meeting of the Stakeholder Advisory Group. Organizational representatives and one direct care worker joined the group (Appendix B). The Advisory Group first convened on

September 26, and has met monthly with FSA staff who provided meeting facilitation services in addition to conducting the research and analysis for the study.

Unlike many advisory forums, the Direct Care Workforce Stakeholder Advisory Group set a high standard for active participation and meaningful project guidance. Members attended monthly meetings regularly, were well-informed, and demonstrated a strong commitment to direct care workers and the people receiving their care and support. The group was actively engaged in every step of the study. The work presented reflects their insight, knowledge, collaboration and direction.

Defining Study Parameters: Groups to include in study

In order to conduct the research, the Stakeholder Advisory Group was asked to provide guidance on the scope and parameters of the study—in other words:

- Which direct care workers would be included?
- Which direct care work settings would be included?
- What types of consumers who receive care and support would be included?

The deliberations around these questions and the decisions that emerged are discussed below.

Direct Care Workers

Direct care workers are given many different job titles, depending on:

- The specific type of professional care giving they provide
- The setting in which they provide care and support
- The particular needs or disabilities of the persons they support

In addition, their job titles continuously evolve as our long-term care system evolves. Therefore, determining exactly which direct care workers to study was not an easy task. After examining the varying and often confusing job titles used in different work settings, the Advisory Group decided that the following criteria define which workers were to be included in the study. Specifically, those direct care workers who:

- Provide the most direct care and support
- Are at the lowest end of compensation

The group acknowledged that, while Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) also provide direct care, they should not be included in this research since numerous other studies and initiatives are in place to address the nursing shortage.

Using the criteria described above, the Advisory Group chose to include the following spectrum of direct care and support workers in the study:

- *Licensed Nursing Assistants (LNA)* (licensed by the state and generally employed in nursing homes, residential care, assisted living, and home health agencies to care for older adults and persons with disabilities)
- *Personal Care Attendants (PCA)* (non-licensed, more often employed in home-based settings by agencies or privately by older adults, persons with disabilities, or families)
- *Direct support professionals and community support workers* (often providing supports to persons with developmental disabilities in home, work, and community settings)
- *Developmental home providers* (contracted with Developmental Services agencies to provide support to persons with developmental disabilities in the provider's home)
- *Resident assistants or aides* (generally employed in residential care and assisted living settings, serving older adults and persons with disabilities)
- *Homemakers* (provide help in-home with IADLs such as housework and making meals for older adults and persons with disabilities)
- *Shahbaz* (title for professional caregivers in Greenhouse model of nursing homes, an innovative approach to creating resident-centered and home-like care)
- *Geriatric aide* (generally work in nursing home settings with residents)
- *Activity aides* (help with activities such as arts, games, exercise in adult day, assisted living, residential care and assisted living settings)
- *Privately paid professional caregivers* (provide care and support in homes, hired and paid by older adults, persons with disabilities, or their family members)
- *Respite* (professional caregivers who stand-in for family caregivers or other professional caregivers)
- *Hospice* (professional caregivers, other than RNs and LPNs who assist with on-going end of life care).

Consumer populations

The Advisory Group identified the following populations who receive care and support as a focus of the study:

- Older adults in need of support
- Individuals with developmental disabilities (both children and adults)
- Children with personal care needs
- Adults with physical disabilities
- Individuals with traumatic brain injuries

Care and support settings

Direct care workers provide care and support for children and adults in many different settings. It is important to note that Vermont has taken a leadership role in encouraging the growth of community-based care and support options for consumers. As a result, the spectrum of work settings listed below, chosen by the Advisory Group for inclusion in the study, is wide and reflective of the range of choices consumers now have in this state.

- *Individuals' homes*—children or adults with a range of needs may receive care or support in their own homes. As medical technology advances, individuals with increasingly complex needs may be cared for in their homes.
- *Professional caregivers' homes*—caregivers may bring children or adults needing care or support into their own homes, often for brief periods of respite for other caregivers.
- *Developmental homes*—adults or children with developmental disabilities may live full-time in the home of an individual who is contracted to provide 24/7 support.
- *Assisted living residences*—adults needing some assistance with activities of daily living and/or instrumental activities of daily living reside in their own apartments within buildings or complexes that include direct care staff to provide needed care.
- *Residential care/group homes*—adults with more intensive needs may live in residential care or group home facilities. These are often small, home-like buildings in which individuals have their own rooms and receive care or support as needed, including medical care.
- *Nursing homes*—when care and support needs are too intensive for care in homes or residential care settings, or when diseases such as Alzheimer's require 24 hour supervision, skilled nursing facilities provide intensive care and support.
- *Adult day services*—these services offer adults with physical disabilities and/or cognitive disabilities such as dementia, opportunities to engage in social and recreational activities during the weekdays. Adult day programs provide a range of services, including basic medical care, as well as assistance with a range of activities of daily living. Adults who participate in adult day programs continue to live in their own homes or in the homes of family members.
- *Employment settings*—persons with developmental disabilities often rely on direct support workers to help them succeed in employment settings.
- *Community settings*—persons with developmental disabilities are able to participate in their communities, engaging in a range of social and recreational activities, with the help of direct support professionals.

Study Methodology

Study Questions

The authorizing legislation for the Study of the Direct Care Workforce directs DAIL to assess “potential problems regarding quantity, quality, stability and availability of workers.” In accord, the Stakeholder Advisory Group translated this mandate into four research questions that have guided the study:

1. What are workforce **quantity and availability** issues across care and support settings and consumer populations?
2. What are workforce **quality** issues across care and support settings and consumer populations?
3. What are workforce **stability** issues across care and support settings and consumer populations?
4. What are **financial** issues across care and support settings and consumer populations that will need attention?



Research Design

The research design that emerged from the deliberations of the Advisory Group incorporated three strategies to address the four questions:

- Qualitative data collection
- Quantitative data collection
- Review of relevant literature

Qualitative information was gathered through individual and group structured interviews with “key informants.” These interviews helped identify critical issues related to each of the research questions that would require further research. Interviews were conducted with:

- Direct care workers
- Consumers and/or their family members who directly employ workers
- Long term care provider organizations that employ direct care workers
- Advocates for consumers and their families.

Information gathered through interviews was analyzed and presented for review by the Stakeholder Advisory Group (see Appendices C and D). Results of the interviews provided useful information to the group and informed the development of survey instruments used to collect qualitative data.

Three survey studies were conducted to gather quantitative information:

1. **Direct Care Worker Survey** (see Appendix E)—This was distributed to approximately 7,500 direct care workers using three strategies:
 - a. Vermont Association of Professional Care Providers (VAPCP) provided mailing labels for all members
 - b. Mailing labels were produced from the list of all direct care workers employed through state programs (i.e., Choices for Care, Attendant Services Program, and Children’s Personal Care Services Program)
 - c. Survey packets were sent to every employer organization included in the care and support settings for this study (i.e., developmental services, assisted living facilities, residential care homes, nursing homes, adult day services, and home health agencies). Employers were asked to address and mail the survey packets to their direct care employees and/or contractors.
2. **Employer Survey** (see Appendix F)—This was sent to all administrators of the organizations in the study defined care and support settings (i.e., developmental services, assisted living facilities, residential care homes, nursing homes, adult day services, and home health agencies).
3. **Consumer/Surrogate Survey** (see Appendix G) was sent to all consumers, or their surrogates, who hire their own direct care workers through state funded programs (i.e., Choices for Care, Attendant Services Program, and Children’s Personal Care Services Program). DAIL identified names and addresses using data bases of consumers for each of the programs.

Each of the three surveys was mailed with a cover letter from the DAIL Commissioner explaining the purpose of the study, a copy of the appropriate survey, and a stamped self-addressed envelope. The cover letter ensured recipients that their names would not be attached to completed surveys, all responses would be treated confidentially and no individually identifying information would be reported. Completed surveys were delivered to FSA which was responsible for data entry and analysis.

Data from all three surveys were analyzed, summarized and reported to the Stakeholder Advisory Group (see Appendices H, I, and J for detailed results).

Key Findings

Preface

Before diving into the rich findings of this study, it is important to understand why people do this work. While the data tell us that wages and benefits are critical to attracting and retaining workers, the primary reason individuals choose to be, and continue to serve as direct care workers is their desire to help and make a positive difference in the lives of others. Indeed, the 1700 direct care workers who responded to open-ended survey questions, declared:

- Relationships with the people they care for and support
- Helping others
- Making a difference in others' lives

as the top three reasons for what they liked best about, and why they provide direct care (See Appendix H).

Previous research in Vermont³ confirms this finding: direct care workers choose to do this work because they like to help others. Their relationships with consumers are extremely important. Successful efforts to attract people to this work must appeal to potential workers' altruism and desire to make a difference in other's lives. Similarly, efforts to raise public awareness about the valuable role that direct care workers will ultimately play in many of our lives should stress the very special nature of this workforce.

I like making a difference in someone's life, helping with normal tasks they can't do on their own anymore.

—Direct Care worker

I enjoy working with elderly people just feel that this was what my calling was meant to be, I feel fulfillment with my job and to know I'm helping someone.

—Direct Care worker

³ Livingston, J (2001) Paraprofessional Staffing Study. Vermont Department of Aging and Disabilities, Staffing Study Steering Committee.

Introduction to the Research Findings

The Legislative Study of the Direct Care Workforce generated findings to the four research questions that provide a strong foundation for strategic planning and action to build and maintain an adequate, quality, stable direct care workforce for Vermonters into the coming years.

The following section is organized around each research question. First, a brief summary of findings is presented, followed by in-depth discussion of the findings with relevant supporting data and citations.

We can't find enough
people to provide
services.

—Consumer



Research Question #1: What are workforce quantity and availability issues?

Summary of Key Findings

- The current supply of workers is not meeting current demand. In the future, the supply will remain steady as the demand increases.
- Because the U.S. Bureau of Labor Statistics' employment categories used by the Vermont Department of Labor do not accurately reflect the specific jobs that direct care workers do, at present there is no way to count how many people are doing these jobs.
- Employers, consumers and direct care workers agree that increasing wages and providing health benefits for this workforce are the two actions that will have the greatest impact on attracting and keeping workers so that the supply will meet the demand.
- National research indicates that recruitment efforts should be extended toward mature workers, new Americans, and paid family caregivers who represent potential new pools of workers.
- No matter where workers are found, Vermont's consumers and employers want a direct care worker registry that can help them with their recruitment efforts. Inherent in that, self-directed consumers in particular want to feel confident about their hiring choices by knowing that prior to being listed in the registry potential workers have been screened for background history.

Supply and Demand

Accurately calculating the size of the direct care workforce is impossible, given the absence of standard job definitions and data collection mechanisms and so we are left to generate estimates. As outlined in Appendix K, even estimating numbers of direct care workers currently employed is a complex task. The Bureau of Labor Statistics' job categories that Vermont's Department of Labor (DOL) uses to track workforce data are not congruent with the job descriptions and titles used in the field of long-term care. This reality presents a significant barrier to providing a reliable count of direct care workers and clear sense of the workforce size, both here in Vermont and across the nation. This is further compounded by the fact that no state dollars are used to track workforce data; it is all federally funded.

With no uniform objective data to consult, the Stakeholder Advisory Group reviewed several sources of information and agreed that a reasonable estimate of persons currently serving as direct care workers in Vermont is 11,000 (see Appendix K).

Our survey provided demographic data that indicate nearly all Vermont’s direct care workers are women whose average age is 45. Indeed, 64% of the direct care workforce is over age 40.

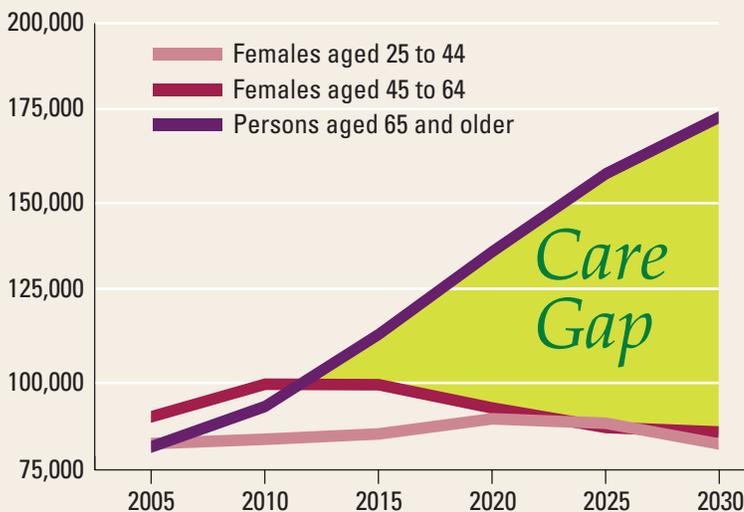
While estimating the future demand for care is as complex a task as estimating the workforce supply (see Appendix L), it is clear that demand will grow in coming years because of the aging baby boomers. Of equal concern are

claims by key informants and focus group participants that the current *supply of workers does not meet the current demand* and our survey results substantiated their experiences. For example, according to survey results, consumers who hire their own direct care workers are able to utilize, on average, only 84% of the care and support hours allocated to them through their benefits because they can’t find the number of care givers needed. Not only are they challenged to find enough workers, they also experience long waits to meet their care and support needs. On average, consumers require nearly three months to fill a direct care worker position. As one consumer’s surrogate reported, “this person is now in a group home because we couldn't find direct care workers.”

Vermont’s aging population presents another factor influencing the supply/demand gap. According to the most recent U.S. Census data⁴, Vermont ranked 26th in the nation with 12.7% of our population aged 65 or older in 2000. By 2010, 14.3% of our population will be over age 65 and we’ll have become 11th in the nation. In the year 2030, one in four Vermonters will be age 65 or over, making us the 8th oldest state in the country. While not all persons over age 65 will need direct care, as the number of older adults increases so too will the need for long-term care and support.

Finally, Vermont continues to lead the nation in our efforts to give consumers options to receive long-term care in home and community-based settings. As consumers increasingly

Figure 1: Vermont’s Care Gap: Women of Caregiving Age and Older Vermonters 2005–2030



Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005

⁴ U.S. Census Bureau, Population Division, Interim State Population Projections, 2005. Internet Release Date: April 21, 2005, <http://www.census.gov/population/www/projections/projectionsagesex.html>

exercise their choices for care, the need for the services of direct care workers will increase commensurately.

The data are irrefutable; as the number of potential consumers, that is persons over age 65, dramatically increases, the number of potential caregivers, women under 65, remains steady (see Figure 1).

Recruitment Strategies

In order to address the shortage of direct care workers, both at present and into the future, it is critical to know what factors attract and keep direct care workers in their jobs.

Wages and Benefits: We found resounding agreement among direct care workers, organizations and consumers who employ them; improved wages and benefits are central to finding and keeping direct care workers. Results from our surveys of direct care workers, employers of direct care workers and consumers/surrogates (see Appendices H, I and J for details) indicate that wages, first and foremost, followed by benefits, are far and away the most important factors to successful recruitment and retention.

Going to the data, the direct care worker survey included an open-ended question asking respondents to name the “one most important factor you believe could improve recruitment and retention of direct care workers.” Most frequently direct care workers said: improve wages and provide benefits (see Table 1). Coming in a distant second, they identified supervision practices which are supportive, appreciative and respectful of workers and training/orientation that provides workers with needed skills and information. It is notable that these results mirror those found in the 2001 Paraprofessional Staffing Study, where workers identified higher wages, benefits, and training opportunities as key to improving job retention.

The wages aren't sufficient to find people. Wages haven't increased.

–Consumer

I don't know anyone who does not live paycheck to paycheck as a direct care worker.

–Direct care worker

Real income isn't keeping up with the cost of living.

–Employer

Table 1: DCW Survey Respondents Report How to Improve Recruitment/Retention

Strategies identified by workers	Frequency	Percent
Improve wages/benefits	949	56%
Supervision practices	122	7%
Training/orientation	94	6%
Improve staffing	61	4%
Publicize rewards of job	30	2%
Advertise, increase awareness	25	1%
Improve teamwork	22	1%
Improve scheduling	13	1%
Supportive community of workers	14	1%
Opportunities for advancement	12	1%

Employers, in response to the same open-ended question, overwhelmingly identified wage increases as the best way to improve recruitment and retention outcomes (see Table 2). Additionally, 9% of responding employers spoke of the need to increase reimbursement rates in order to allow them to pay higher wages.

Table 2: Employer Survey Respondents Report How to Improve Recruitment and Retention

Strategies identified by employers	Frequency	Percent
Increase wages	27	50%
Offer benefits	12	22%
Positive image/respect for DCWs	6	11%
Increase reimbursement rate to allow higher wages	5	9%
Career ladder/opportunities for advancement	2	4%

Registries and Background Screening: Often consumers, or their surrogates, who hire their own direct care workers have the most difficulty finding potential workers. To help both individual consumers and organizations that employ direct care workers with their recruitment efforts, several states have developed direct care worker registries⁵. Last year, our legislature provided initial support to establish a Vermont direct care workers registry.

⁵ See PHI's *Selected State Registry Websites* (http://www.adrc-tae.org/tiki-download_file.php?fileId=26953).

Vermont consumers and surrogates responding to our survey said they would definitely use such a registry (51%) or might use a registry (39%); very few consumers said they would not use a registry (10%). Furthermore, consumers told us in our interviews that they want to know whether a potential worker has a criminal background, including a poor driving record.

To determine whether an individual should be listed, a number of states that operate direct care worker registries screen potential employees for background information related to circumstances including criminal history, bad driving record and undesirable employment history⁶. For example, if a background check on an individual detects a criminal record, that person will not be included in the registry. Consumers who responded to our survey ranked screening as the most important criterion for determining one's inclusion in the direct care worker registry: *"only list workers that have gone through a screening process."*

Recruiting from new sources: As our population ages, older adults may become care and support givers as well as consumers. The AARP recently conducted a study on working in retirement⁷ and found 7 out of 10 workers between 45 and 74 plan to work in some capacity in retirement. In some cases, people nearing retirement age felt financial pressures to continue working. In others, people reported wanting to remain vital and involved in activities and could not see themselves retired in the traditional sense. Respondents to the study identified "health care aide" as one of six types of work they were interested in pursuing. Corroborating data from Operation ABLE, which conducted a study of older adults in seven states, found 43% of people sampled expressed an interest in performing direct care work⁸.

New Americans should also be considered when recruiting for this workforce. As a refugee resettlement site, Vermont is experiencing growth in immigrant populations. That growth may translate into both increases in need for direct care within those populations and increases in potential workers. In reaching out to new Americans to join the direct care workforce, diligent efforts will be required to address and develop cultural competence in direct care workplace settings⁹.

⁶ See *Study of Maine's Direct Care Workforce: Wages, Health Coverage and a Worker Registry*, Maine Department of Health and Human Services (March 2007); and *Survey of Nurse Aide Registries (Direct Care Worker) in the United States*, Iowa Caregivers Association (November 2004)

⁷ Brown, S. (2003) *Staying Ahead of the Curve: 2003: The AARP Working in Retirement Study*. Washington, D.C.: AARP. Available at: http://assets.aarp.org/rgcenter/econ/multiwork_2003.pdf

⁸ Operation ABLE (June 2006) *Older Workers in Direct Care: A Labor Force Expansion Study*. Available through Better Jobs Better Care, www.bjbc.org

⁹ See *Organizational Cultural Competency Assessment: An Intervention and Evaluation*. Available through Better Jobs Better Care, www.bjbc.org

High school students and new graduates represent a third area in which to cultivate a work pool. Attracting younger workers will require thoughtful marketing and messaging that appeal to those who, like the workers in our survey, care about relationships with the people, are interested in helping others and want to make a difference in others' lives. One member of our Advisory Group aptly pointed out that unlike other professions, direct care work is "recession proof". Changing economic conditions will not reduce the demand for competent, caring individuals to do this work.



Research Question #2: What are workforce quality issues?

Summary of Key Findings

- Survey results show that when employers provide training, direct care workers stay in their jobs longer.
- Despite the link between training and retention, less than half of direct care workers surveyed receive formal orientation and ongoing training opportunities.
- Professional development opportunities or career ladders represent additional links to increased job satisfaction and improved retention.
- And, although direct care workers generally report being well satisfied with their jobs, they reported dissatisfaction with the limited opportunities open to them for pay raises and advancement.

Quality of Care: Consumer Satisfaction

Consumers, of course, want the care and support they need and receive to be more than adequate. Like any of us, consumers of direct care want certain characteristics infused in the care and support they receive.

DAIL conducts several consumer surveys in Vermont and their results are summarized in Appendix M. Overall, it is important to note that consumers served by various programs report they are well satisfied with the quality of care they receive.

Quality of Care: Direct Care Worker Skills and Training

In order for workers to provide high quality of care, they need appropriate skills and training to develop those skills. In an open-ended survey question, we asked consumers what type of skills they most wanted in their direct care workers. Compassion, competence and reliability

**Table 3: Consumer/Surrogate Survey Respondent Report
Most Important Direct Care Worker Skills**

Skills listed by respondents	Frequency	Percent
Compassionate, kind, caring	130	20%
Competent, knowledgeable, experienced	128	20%
Reliable, responsible, dependable	89	14%
Compatible, able to connect/relate	63	10%
Honest, trustworthy	59	9%
Patient	52	8%

were the terms consumers used to describe “skills” they most desired in workers (see Table 3).

Direct care workers responding to a similar open-ended question, most frequently identified needs for training that were congruent with the “skills” consumers said they wanted; specifically workers wanted training that helped them focus on individual client needs, including information about their disability or illness, and training that addressed the need for person-centered skills such as compassion, caring, patience and respect for clients.

We know from the national research that initial preparation of new workers and ongoing training not only leads to improved quality of care, it also keeps workers in their jobs.¹⁰ Similarly, our survey found *workers stayed in their jobs significantly longer when their employers provide ongoing training*. For example, as shown in Table 4, workers stayed an

Everything is important. Being in this position you have to care, have common sense and the ability to communicate and patience.

–Direct Care worker

Table 4: Years in Current Job by Employer Provided Training Opportunities

	Years in current DCW position		
	Mean	Std. Dev.	N
In-service programs¹			
DCW did not receive in-service training	3.55 yrs	4.93	851
DCW report in-service training available	5.69 yrs	6.36	848
Courses paid by employer²			
DCW report paid courses not available	4.54 yrs	5.76	1585
DCW report courses paid by employer	5.75 yrs	6.09	114
Conferences/workshops paid by employer³			
DCW report paid workshops not available	3.85 yrs	5.29	1168
DCW report paid workshops available	6.30 yrs	6.46	531

¹ F(1,1697)=59.69, p<.001; ² F(1,1697)=4.66, p<.05; ³ F(1,1697)=67.73, p<.001

¹⁰ See description and report on Kansas’ Realistic Job Preview for direct support workers serving persons with developmental disabilities at http://www.workforce.lsi.ku.edu/resources/resources5_07.shtml; Castle, N. Engberg, J. Anderson, R. and Men, A. (2007) “Job satisfaction of nurse aides in nursing homes: intent to leave and turnover,” *The Gerontologist*, 45(2): 193-204; see *STEP UP NOW for Better Jobs and Better Care: the evaluation of a workforce initiative for direct care workers* describing success of University of North Carolina training initiative at www.bjbc.org

average of 6.3 years in jobs where employers paid for conferences or workshops compared to an average of 3.9 years in jobs without such employer funded training opportunities.

Despite this evidence, we found that less than half, 42%, of direct care workers receive formal orientation; moreover, only 11% of workers hired by consumers receive formal orientation. In addition, only half of the workers (50%) receive in-service training on the job, and even fewer workers (31%) attend employer paid workshops or conferences. Finally, workers hired directly by consumers rarely attend in-service programs (7%) or employer-funded training programs (5%).

Satisfaction with Quality of Work and Workplace

Studies conducted in other states demonstrate that *when workers are satisfied in their jobs, the quality of care improves and workers stay in their jobs longer*¹¹. We found that direct care workers in Vermont were generally satisfied with most aspects of their work and workplace; they ranked most aspects of their work an average of 2.3 to 2.5 on a three point scale (with 1=not at all satisfied and 3=very satisfied). *Workers were dissatisfied with only two aspects of their jobs:*

- Opportunities for pay raises (average rank = 1.7)
- Opportunities for advancement (average rank = 1.8)

Table 5: Relationship between Work Satisfaction and Wages

Satisfaction with:	Mean	Wage in Dollars Std. Dev.	N
Reliable number of hours each week ¹	Mean	St. Dev.	N
Not satisfied	\$10.63	1.88	134
Neutral	\$10.66	1.93	458
Very satisfied	\$11.15	2.27	881
Stable work days and scheduling ²			
Not satisfied	\$10.75	2.21	146
Neutral	\$10.76	2.25	468
Very satisfied	\$11.11	2.07	850
Opportunities for pay raises ³			
Not satisfied	\$10.76	2.15	669
Neutral	\$11.17	2.29	546
Very satisfied	\$11.14	1.81	216

¹F(2,1470)=9.65, p<.001; ² F(2,1461)=4.78, p<.01; ³ F(2,1428)=6.16, p<.01

¹¹ PHI (June 2007) Elements of a Quality Job for Caregivers: Key Research Findings. At www.PHInational.org/clearinghouse

Workers who were more satisfied with the reliability of their work hours, stability of their work schedule, and the opportunity for raises also earned higher hourly wages (see Table 5).

We also found a statistically significant relationship between worker satisfaction and provision of training and orientation. As shown in Table 6, workers were significantly more satisfied with the preparation and training they received in their current job when their employers provided formal orientation, opportunities to shadow experienced workers, in-service training programs, and courses and workshops.

Table 6: Satisfaction with Training by Orientation and Training Provided

Orientation and Training Provided in Current DCW Position	Satisfaction with Training and Preparation Mean	Std. Dev.	N
Did receive orientation	2.43 ¹	0.63	1219
Received no orientation	2.00	0.62	346
Received formal orientation	2.54 ²	0.59	685
No formal orientation	2.17	0.65	880
Opportunity to shadow	2.52 ³	0.62	690
No opportunity to shadow	2.20	0.64	875
In-service programs	2.49 ⁴	0.62	820
No in-service	2.16	0.64	745
Courses paid by employer	2.52 ⁵	0.59	108
No courses paid by employer	2.32	0.65	1457
Workshops paid by employer	2.49 ⁶	0.61	511
No workshops paid employer	2.26	0.66	1053

¹ F(1,1563)=129.84, p<.001; ² F(1,1563)=53.57, p<.001; ³ F(1,1563)=37.31, p<.001; ⁴ F(1,1563)=105.07, p<.001;

⁵ F(1,1563)=9.32, p<.01; ⁶ F(1,1563)=18.55, p<.001

Beyond Vermont, research results similarly find that increasing direct care workers’ professional development opportunities leads to improved job satisfaction. One recent study of certified nurse assistants (similar to Vermont’s LNA) found that workers were more satisfied with their jobs when supervisors called upon the workers’ knowledge of residents¹². In another, the University of North Carolina tested the impact of an on-site clinical and leadership training program for nursing assistants in eight nursing homes¹³. This program

¹² Bishop, C., Weinberg, D., Dodson, L., Gittel, J., Leutz, W., Dossa, A., Pfefferle, S., Zincavage, R., and Morley, M. (2006) *Nursing Home Workers’ Job Commitment: Effect of Organizational and Individual Factors and Impact on Resident Well-being*, Better Jobs Better Care Research Report at www.bjbc.org

¹³ Ryzin, J (2007) “Workplace Interventions for Retention, Quality and Performance,” *FutureAge*, 6(2) or see *STEP UP NOW for Better Jobs and Better Care: the evaluation of a workforce initiative for direct care workers* at www.bjbc.org

provided opportunities for increased specialization and leadership, and led to improved quality of care and increased job satisfaction among participants. The Iowa Caregivers Association examined the impact of peer-mentoring programs finding that on average 81% of mentors and 67% of mentees stayed in their jobs.

With this evidence in hand, constructs known as career ladders offer promising approaches to increase job satisfaction and better retention. Career ladders enable advancement *within* the direct care profession. Programs such as Peer Mentoring and LNA II certification promote career ladders by honing specialized knowledge and leadership skills in direct care givers. While programs that promote career ladders exist in a variety of direct care work setting in Vermont, they are developed within and delivered on a work-site by work-site basis. The lack of standardized curricula and portable credentials across work settings creates barriers for worker advancement and commensurate compensation beyond the workplace in which one is trained.

In Vermont there are few training curricula for direct care workers beyond the federally mandated LNA training curricula which are delivered at technical centers and other venues and overseen by the Board of Nursing.

One program is *CareWell*, a 40 hour research-based curriculum which was developed as part of the *Better Jobs Better Care* (BJBC) grant through the Community of Vermont Elders (COVE). The Visiting Nurses Association of Chittenden and Grand Isle Counties contracted with COVE to develop a core curriculum for direct care providers in three settings: home health, residential care, and adult day programs. The goal of this program is to offer a standardized training that can be used in Vermont to provide the basic, but complex, set of tools needed to deliver competent and compassionate care. This curriculum has been piloted and delivered a number of times in different venues including the Barre Technical Center and soon will be offered by the Community College of Vermont (CCV).

Other standardized training curricula used statewide over the past two years are: *Beyond Basics: Specialized Training in Dementia* and *Beyond Basics: Specialized Training in Palliative Care*. These curricula were developed as part of the BJBC project by the Northeastern Vermont Area Health Education Center (AHEC).

Also, many employers provide their own specific training opportunities for their employees. Beyond professional development opportunities within specific work settings, there are limited opportunities. Over the past six years, continuing education programs through workshops and seminars have been offered for direct care workers by the Northeastern Vermont Area Health Education Program within its six county region.

Research Question #3: What are workforce stability issues?

Workforce stability is characterized by factors such as the reliability of workers to show up and to perform their functions well, how much time is required to find, hire and train workers, how long workers stay in a job and how often workers leave a job which in turn, requires a reiteration of activities focused on recruitment, hiring and training. Indicators of stability include worker turnover and retention rates.

Summary of Key Findings

- Employee turnover is a key measure used to understand how stable a workforce is. In Vermont it is difficult to track turnover rates within the direct care workforce.
- Two barriers obstruct our ability to 1) understand turnover and 2) determine whether and how to take action to reduce it. First, not all direct care employers collect and report employee data. Second, there are no standard accepted definitions for turnover. Therefore employers who track turnover use different definitions and collect different data which yields calculations that are not comparable across employers or work settings.
- Retention is a correlate of turnover: when job retention is high, job turnover is low. Research demonstrates that workers stay in their jobs longer when the following conditions are present :
 - Higher wages
 - Employment benefits, including health insurance
 - In-service training and employer funded courses/workshops
 - Reliable hours
 - Stable schedules
 - Satisfactory preparation and training for their jobs
- A range of evidence-based practices exist that, applied to direct care work settings, are known to improve worker retention.

Consumer Experience of Worker Stability:

The longer workers remain in their jobs, the higher the quality of care received and experienced by consumers. In structured group interviews, consumers told us that cycling through many new and different workers makes it difficult to develop the level of trust needed for the intimate types of care they require. Furthermore, each new worker must learn the routines and preferences of an individual consumer. Cycling through one new worker to

the next challenges consumers' ability to retain their dignity, and exhausts the consumer and his/her family.

Consumer satisfaction surveys regularly conducted through DAIL have found varying degrees of satisfaction with direct care worker stability among consumers who receive their care:

- The DAIL consumer satisfaction survey found that 86.6% of consumers were satisfied with the "reliability" of their professional caregivers.
- ASP survey respondents report having trouble hiring and retaining workers; 39% say this difficulty is attributable to low wages and 40% attribute difficulty recruiting and retaining attendants to lack of benefits
- The Children's Personal Care Services survey revealed that:
 - 28% of those families who said they were unable to use the entirety of their allocated service could not find workers
 - 11% said they cannot keep workers.

The Consumer/Surrogate Survey, sent to individual employers, found that that workers hired by consumers stay in their employ for an average of nearly three years (mean years of service = 2.7 years).

Employer Report of Worker Stability

The Employer Survey, sent to organizations that employ direct care workers, provided mixed results and does not provide a reliable estimate of workers' length of service. The survey asked employers (a) if they track retention and/or turnover rates, and (2) if so, what those rates were. Employers did not consistently respond to the survey question. Moreover, of those who did reply and reported that they do track retention and/or turnover rates, methods for doing tracking so differ across settings making it difficult to compare rates or draw conclusions about stability as a function of these two factors.

Workers' Report of Stability

Direct care workers responding to our survey report that they have been in their current job an average of nearly 5 years (mean = 4.8 years). The survey also found that the *number of years a worker remains in his/her job significantly increases* when:

- Wages increase (statistically significant correlation between wages and years in job, $r = .27, p < .01$)
- Employers provide benefits (see Table 7), including health insurance (mean years of service with health insurance = 6.3 years, without health insurance = 3.9 years)

- Employers provide in-service training and funded courses and workshops (see Table 4, from 1 to 2.5 more years of service with training)
- Workers are satisfied with the reliability of their hours (see Table 8)
- Workers are satisfied with the stability of their work days and scheduling (see Table 8)
- Workers are satisfied with the preparation and training for their job (see Table 8)

Table 7: DCW Reported Mean Years in Current Job by Receipt of Benefits

Benefits	Mean Years of Service	Std. Dev.	N
Do receive benefits	5.3	6.2	993
Do not receive benefits	3.6	5.0	706
Total	4.6	5.8	1699

F(1,1697)=36.02, p<.001

The broader field of research supports our survey findings (Table 8) that retention can be improved with consistent work assignments¹⁴.

Table 8: DCW Reported Mean Years in Current Job by Satisfaction with Hours, Scheduling, Preparation and Training

Satisfaction with:	Not satisfied	Neutral	Very satisfied	Total
Reliable number of hours each week ¹	3.86 yrs	4.09 yrs	5.05 yrs	4.64 yrs
Stable work days and scheduling ²	3.62 yrs	4.37 yrs	5.00 yrs	4.66 yrs
Training and preparation to provide direct care/support ³	3.95 yrs	4.41 yrs	5.12 yrs	4.67 yrs

¹ F(2,1602)=6.1, p<.02; ² F(2,1591)=4.8, p<.01; ³ F(2,1562)=4.01, p<.05

Evidence-Based and Promising Practices to Promote Retention

Below we present an array of evidence-based and promising practices that are linked with improving retention (see Appendix N for detailed descriptions):

- **Vermont’s Gold Star Employer Program**¹⁵: a voluntary program, established in Vermont, through which nursing homes and home health agencies receive recognition for implementing “Best Practice” recruitment and retention strategies. Participating

¹⁴ PHI (June 2007) *Elements of a Quality Job for Caregivers: Key Research Findings*. At www.PHInational.org/clearinghouse

¹⁵ Reback and Livingston (2007) *Nursing Home Gold Star Employer Program: Status Report* Berlin, VT: Vermont Health Care Association Gold Star Council

agencies: conduct an organizational self-assessment of their current practices; develop a work plan that incorporates Best Practices, implement the workplan, document their progress in meeting the workplan goals; and document outcomes related to changes in turnover.

- **Retention Specialist**¹⁶: a designated staff member, specially trained to assess retention issues, develop and implement strategies to improve retention.
- **Coaching Supervision**¹⁷: a PHI program that targets and trains supervisors of direct care workers to promote communication skills such as active listening, problem solving, and an environment of mutual respect within the work place.
- **Worker involvement in care planning**¹⁸: direct care workers, across all settings, actively participate in care planning for the consumers with whom they work.
- **Peer-mentoring programs**¹⁹: training programs, offered on-site or through community colleges for experienced direct care workers that foster mentoring skills. Mentors provide newly hired direct care workers with ongoing orientation and support during their initial employment period.
- **Northern New England LEADS (Leadership, Education, and Advocacy for Direct-care and Support) Institute**²⁰: This PHI sponsored project provided a range of training and activities designed to work with providers to improve supervisory relationships, implement peer mentoring programs and provide direct care workers with leadership and growth opportunities.
- **Continuing Education Programs for Professional Development**: The Northeastern Vermont Area Health Education Center offers annual series of workshops and seminars that are not site-specific. Since 2002, 26 programs have been attended by over 1,000 direct care workers in Vermont.

¹⁶ Pillemer, K. and Meador, R. (2006). *The Retention Specialist Project*. A Better Jobs Better Care Research Study. Available at www.bjbc.org

¹⁷ Konrad, T. and Morgan, J. (2006) *STEP UP NOW for Better Jobs and Better Care: The Evaluation of a Workforce Intervention for Direct Care Workers* A Better Jobs Better Care Research Study. Available at www.bjbc.org and Brannon, D. and Barry T. (2006) *A Demonstration Project to Determine the Effect of Supervisory Training of Line Supervisors on the Retention of Paraprofessional Staff in Long-Term Care Facilities*. Lancaster County Workforce Investment Board

¹⁸ Leon, J., Marainen, J. and Marcotte, J. (2001) *Pennsylvania's Frontline Workers in Long Term Care: The Provider Organization Perspective*. A Report to the Intergovernmental Council on Long Term Care. Polisher Research Institute at the Philadelphia Geriatric Center. Available at: http://www.abramsoncenter.org/PRI/documents/PA_LTC_workforce_report.pdf

¹⁹ Richardson, B and Graf, N (2002) *Evaluation of the Certified Nurse Assistant Mentor Program*. Program Evaluation Summary, Des Moines, IA: Iowa Caregivers Association. Available at: <http://www.directcareclearinghouse.org/download/CNAMentorEval.pdf>

²⁰ Barrett, J. (2007) *Leadership stories from Maine: The voices of direct-care workers in culture change*. A Project of the Paraprofessional Healthcare Institute. Available at: <http://www.directcareclearinghouse.org/download/LEADS7-07.pdf> and McDonald, I and Kahn, K. (2007) "Respectful relationships: The heart of Better Jobs Better Care." *FutureAge*, Vol. 6, No. 2 available at: http://www.bjbc.org/content/docs/FA_FEAT_RespectfulRelationshipsHeartofBJBC_V6N2.pdf

Research Question # 4: What are financial issues?

The research findings presented in this section paint a clear picture of how poorly direct care workers are compensated, and therefore valued and acknowledged, for the needed services they bring to Vermonters. While we know that the majority of workers in this profession experience levels of satisfaction and fulfillment from working with and helping others, according to our surveys, they are overwhelmingly clear that current wages need to be addressed to keep the workforce vital.

The reimbursement rate for residential care providers is very poor, how can you pay staff more when you can barely make ends meet.

—Employer

Summary of Key Findings

- Direct care workers do not receive livable wages, as defined by the Vermont Joint Fiscal Office
- Half of the 1700 direct care workers who participated in our survey do not expect raises in wages
- Only one-in-three direct care workers report that they receive health insurance as an employment benefit.
- Employers report that reimbursement rates from state and federal funding to organizations employing direct care workers are often too low to fully cover the cost of care, making it difficult for organizations to increase wages.
- Inequities exist in the reimbursement rates received by agencies that hire direct care workers, and in the wages paid to direct care workers who perform similar work across different work settings.

Wages

Results from our DCW Survey show that direct care workers across all settings in Vermont earn an average \$10.92 per hour. Workers providing care in consumers' homes earn the lowest wages (average \$10.42 per hour) while those who work in institutional settings such as skilled nursing facilities earn the highest hourly wage, which still averages only \$11.73 per hour.

The Vermont Legislature's Joint Fiscal Office produces a biennial report on Basic Needs Budgets and the Livable Wage. The basic needs budget includes estimated monthly living

expenses including food, rent and utilities, transportation, child care, clothing and household expenses, telephone charges, a personal expense allowance, health care, dental care, renter’s insurance, life insurance, and savings. After accounting for tax obligations, an hourly livable wage is calculated by dividing total annual expenses by the hours in a year of full-time work. Comparing direct care worker wages to livable wages shown below in Table 9, it is clear that *direct care worker wages fall below livable wages, even for single adults.*

Only 50% of those workers who responded to the survey expect to receive a raise in their wages. Consumers who hire their own direct care workers report they have no source of funding to give raises to their direct care workers. Furthermore, only 39% of employer organizations provide cost of living raises to direct care workers and only 48% provide merit wage increases. Given the correlation between higher wages and better job retention rates, these realities are cause for concern.

And yet, when asked how much they would need to earn to continue working in direct care, direct care workers did not make unreasonable demands. On average, they asked for \$13.84 per hour, an average \$3.00 increase from their current wage. Again, looking to the evidence, we know that increased wages can reduce turnover; indeed a raise of as little as \$1.00 an hour can make a significant impact²¹.

Evidence from other states demonstrates the link between wages and retention. For example, in 2002, the Wyoming state legislature increased funding for the Medicaid Home and Community-Based Services program by 28%, with a specific target to increase direct care workers’ compensation. An average raise in starting wages for direct care workers from \$5.15

Table 9: Vermont Livable Wages (2005)

	Single Adult	Single Parent w/1 Child	Two Wage Earners w/2 Children
Urban w/ employer funded health care	\$12.02	\$18.55	\$14.48
Urban w/out employer health care	\$13.49	\$19.96	\$15.56
Rural w/ employer funded health care	\$12.71	\$18.22	\$14.55
Rural w/out employer health care	\$14.08	\$19.61	\$15.63

Source: Basic Needs Budgets and the Livable Wage, Vermont Joint Fiscal Office, January 2007

²¹ Mickus, M., Luz, C. and Hogan, A. (2004) *Voices from the Front: Recruitment and Retention of Paraprofessional Workers in Long Term Care Across Michigan*. Michigan State University. Available at: http://www.directcareclearinghouse.org/download/MI_vocices_from_the_front.pdf ; Howes, C. (2005) "Living Wagers and Retention of Homecare Workers in San Francisco," *Industrial Relations*, 44(1): 139-163

to \$7.50 an hour led to a dramatic drop in turnover rates, from an average of 52% to 32%²². San Francisco County nearly doubled the wages of home care workers over a 52-month period. In that time, annual turnover went from 70% to 35%²³.

Benefits

While wages are clearly critical to retention of direct care workers, some studies outside Vermont have found that benefits such as health insurance and paid time off are equally, if not more, important to retention²⁴.

Nearly half of the direct care workers surveyed (42%) in this study do not receive any employment benefits; *only 30% of workers said they have employer funded health insurance*

benefits. Most consumers who hire their own direct care workers (77%) have no funding to provide benefits of any kind. Workers who do receive health insurance pay an average \$143 per month for premiums. Workers stay in the jobs longer when they receive benefits, as previously noted.

According to the *Reimbursement Practices and Issues in Vermont's Long-Term Care Programs* (2006)²⁵ “providers in all of Vermont’s care settings report that current reimbursement rates fall short of the actual cost of providing care and that the gap has been growing.” In addition, the report found: lack of reimbursement parity for the same services conducted within and across settings, and, under certain publicly funded programs, and lack of wage parity for direct care workers performing the same tasks but under different programs.

Health care, retirement,
all the stuff the
office workers get!
BENEFITS!! I had to
resign my position
contracting with XXX
for many years to
work with a hospital
to get benefits.

—Direct Care worker

²² Lynch, R., Fortune, J., Mikesell, C. and Walling, T. (2005) “Wyoming demonstrates major improvements in retention by enhancing wages and training.” *Links*, Vol. 35, No. 9. Available at: http://www.directcareclearinghouse.org/download/WY_2005_WAge.pdf

²³ Howes, C (2006). *Building a High-Quality Home Care Workforce: Wages, Benefits and Flexibility Matter*. A Better Jobs Better Care Research Study available at: <http://www.bjbc.org/grantpage.asp?projectID=9§ionID=4>

²⁴ Howes, C (2006). *Building a High-Quality Home Care Workforce: Wages, Benefits and Flexibility Matter*. A Better Jobs Better Care Research Study available at: <http://www.bjbc.org/grantpage.asp?projectID=9§ionID=4> ; and see *Health Insurance Improves Job Retention* a Paraprofessional Healthcare Institute summary of research findings available at: http://www.hchcw.org/uploads///pdfs/hchcw_retentionfactsheet.pdf

²⁵ *Reimbursement Practices and Issues in Vermont's Long-Term Care Programs* (2006). Report prepared by Paraprofessional Healthcare Institute for the Long-Term Workforce Policy Committee of the Community of Vermont Elders (COVE)

Recommendations

The members of the Legislative Study of the Direct Care Workforce Stakeholder Advisory Group have reviewed and considered the research findings presented above. Nine consensus recommendations emerged from their deliberations. The following section presents each recommendation by describing the key components of the recommendation, providing the underlying study findings leading to the recommendation, and identifying in summary form what steps are needed to implement the recommendation and who should be involved in those steps. Appendices H, I and J provide detailed descriptions of the research findings that shaped the thinking and final agreement of Advisory Group members on each recommendation.



Recommendation #1: Increase direct care worker wages.

Our research indicates that if Vermont could do one thing toward insuring the desired quantity, availability, quality and stability of the direct care workforce, it would be to improve direct care worker wages.

- Ensure that direct care workers who are employed, and perform similar functions, in self-directed settings such as Choices for Care and Attendant Services Program, enjoy wage parity and receive adequate pay for their service.
- Provide direct care workers with regular cost of living adjustment (COLA) wage increases.
- Create opportunities and incentives for direct care workers to receive merit raises to recognize good quality care.
- Provide adequate reimbursement rates to organizations such as home health agencies, nursing homes, residential care facilities and other provider agencies that hire direct care workers, and earmark reimbursement increases to cover the cost of increased wages for direct care workers.

Research findings and rationale that support recommendation #1:

To find and keep direct care workers, wages must be improved. We found that:

- Inequities exist 1) in the reimbursement rates received by agencies that hire direct care workers, and 2) in the wages paid to direct care workers who perform similar work across different work settings.
- Employers, consumers and direct care workers all agree that increased wages will, by far, have the greatest impact on attracting and keeping workers. When asked to name the most important step Vermont can take to increase recruitment and retention of direct care workers, survey respondents overwhelmingly identified increased wages.
- Vermont's direct care workers earn an average of \$11.00 per hour, not even a livable wage for a single adult.
- The research showed a strong and statistically significant correlation between length of stay in a job and wages ($r = .27, p < .01$). The higher the wage, the longer direct care workers stayed in one position.

- In Wyoming increased state funding to increase direct care workers' compensation led to a dramatic drop in turnover rates, from an average of 52% to 32%²⁶. San Francisco County nearly doubled the wages of home care workers over a 52-month period. In that time, annual turnover went from 70% to 35%²⁷.
- Only half of the 1700 direct care workers who responded to the survey expect to receive pay raises. Absent cost of living adjustments, inflationary pressures mean that direct care workers in Vermont will lose income by staying in their jobs at current wages.
- Employers report that they are unable to pay increased wages to direct care workers because reimbursement rates do not cover the cost of providing care.
- Merit raises represent a common mechanism for increasing wages by rewarding quality work performance. While merit raises are standard practice in many work settings, low reimbursement rates prohibit their inclusion in direct care worker compensation strategies.

What needs to be done and by whom to implement Recommendation #1:

- DAIL must conduct budget analyses to determine the financial impacts of implementing wage and reimbursement rate increases through strategies that include cost of living increases, livable wages, wage equity, wage increases and merit raises.
- DAIL must study what policy changes, both state and federal, are needed to ensure reimbursement and wage equity across programs.
- The support from the Legislature and Governor is needed to advance needed policy changes and funding.
- Employers must apply increases in reimbursement rates resulting from policy changes and appropriations to increases in direct care workers' compensation.

²⁶ Lynch, R., Fortune, J., Mikesell, C. and Walling, T. (2005) "Wyoming demonstrates major improvements in retention by enhancing wages and training." *Links*, Vol. 35, No. 9. Available at: http://www.directcareclearinghouse.org/download/WY_2005_Wage.pdf

²⁷ Howes, C (2006). *Building a High-Quality Home Care Workforce: Wages, Benefits and Flexibility Matter*. A Better Jobs Better Care Research Study available at: <http://www.bjbc.org/grantpage.asp?projectID=9§ionID=4>

Recommendation #2: Increase access to health insurance through group health plans.

- Ensure that direct care workers and their advocates are included in all formal efforts to improve access to health care.
- Continue to explore the possibility of making the Vermont state employee health insurance program open to direct care worker enrollment.
- Ensure that all Green Mountain Care outreach target direct care workers.

Research findings and rationale that support recommendation #2:

- Provision of benefits, including health insurance, ranked second, only to increased wages, as important to attracting and keeping direct care workers.
- Retention rates for direct care workers who receive health insurance are higher than for those who do not. On average, workers with health insurance remain in their jobs 2.5 years longer than those without health insurance benefits.
- Only one-in-three direct care workers reported that they receive health insurance as an employment benefit.

What needs to be done and by whom to implement Recommendation #2:

- Office of Vermont Health Access (OVHA) and the Vermont Campaign for Health Care Security should direct outreach activities to promote direct care workers' enrollment in Green Mountain Care.
- Vermont Association of Professional Care Providers (VAPCP), with other direct care workforce stakeholders, should be included as a key player in efforts to study, develop and advance recommended strategies to the Executive and legislature branches that provide access to health care insurance for direct care workers.

Recommendation #3: Create accessible and affordable orientation, training, and professional development for direct care workers and their employers.

- Research and inventory effective orientation, training and professional development opportunities and programs.
- Provide funding to pay workers for their time to attend orientation, training and professional development programs.
- Fund the development and delivery of orientation and training programs, including professional development programs that support career ladders
- Utilize a variety of strategies that widen accessibility to training and orientation modes such as: class-room instruction, web-based learning, and peer-mentoring.

Research findings and rationale that support recommendation #3:

- When direct care workers do not receive the formal orientation and on-going training, they are more likely to abandon their positions sooner and more frequently, leaving providers, and particularly consumers who hire them directly, without needed care.
- Direct care workers provide significantly longer years of services when employers offer:
 - In-service training (5.7 vs 3.6 years)
 - Funding for courses (5.8 vs 4.5 years)
 - Funding for conferences or workshops (6.3 vs 3.9 years)
- Direct care workers stay in their jobs longer when they are satisfied with the preparation and training they received. Workers that report satisfaction with the preparation and training provide significantly more years of service (5.1 years) than workers who are not satisfied with the preparation and training received (4.0 years)
- Only 42% of workers overall receive formal training; 11% of workers hired by consumers receive formal training. In-service training is available to only 50% of workers overall; 7% of workers hired by consumers receive in-service training.

What needs to be done and by whom to implement Recommendation #3:

- DAIL should be charged to conduct an inventory, in partnership with VAPCP, of effective orientation, training and professional development programs for direct care workers
- DAIL, DOL, and DOE should research and propose policies that enable employers

to use their reimbursements to pay workers to attend orientation, training and professional development programs

- The Legislature and the Governor should allocate funding for orientation, training and professional development programs, including use of Next Generation funding (Act 46, H433)
- VAPCP, DAIL, DOL, DOE, CCV, Technology Centers, AHEC, Vermont Assembly of Home Health Agencies (VAHHA), Vermont Health Care Association (VHCA), Vermont Council of Developmental and Mental Health Services (VCDMHS), direct care worker employers, consumers and family members should work together to expand and advance variety of training strategies.



Recommendation #4: Recruit direct care workers from new sources.

- Create public awareness about the value of direct care work.
- Develop and disseminate messages that attract people to this work.
- Target recruitment efforts at young workers, mature workers, family caregivers and new Americans.

Research findings and rationale that support recommendation #4:

- Because the population of Vermonters is aging, and both elders and persons with disabilities can choose their settings for care, the growing need for direct care workers in a range of settings renders this work “recession proof” and not vulnerable to changes in economic conditions.
- The need to engage in and expand recruitment targets is clear; the current supply of workers does not meet the demand, and the gap between supply and demand is expected to grow.
- The direct care workforce is aging along with our entire population. At present, 64% of direct care workers surveyed are over age 40. As these workers approach retirement age and begin to leave the workforce, there will not be an equal population of younger workers to replace them.
- Recent research from AARP and Operation ABLE indicate that older workers intend to work at least part-time in their retirement and would be interested in direct care.
- National research indicates that in addition to mature workers, new Americans and paid family caregivers represent potential pools of workers.

What needs to be done and by whom to implement Recommendation #4:

- Key stakeholders from the state, provider agencies, advocacy community and consumers (DAIL, DOE, DOL, VAPCP, COVE, PHI, VHCA, VAHHA, VCDMHS, AHEC, refugee resettlement network, Governor’s Commission on Healthy Aging, Healthcare Workforce Partnership) must coordinate efforts to develop messages and outreach strategies that attract young workers, mature workers, family caregivers, and new Americans.
- The Department of Economic Development should lead efforts to examine the results of PHI’s John Merck Fund-funded pilot project “Faces of Caregiving” campaign to recruit new workers; and, in partnership with PHI and key stakeholders adopt those strategies with positive impacts for state-wide replication.

- All stakeholders should partner with national public awareness campaigns to ensure inclusion of Vermont
- Extend Next Generation funding (described in Act 46, H433) to launch a campaign that raises public awareness about the value of direct care work, particularly for adults and second career job seekers.



Recommendation #5: Continue support for the development and full implementation of the Direct Care Worker Registry.

- Explore changes in policy and practice that would enable background checks to be conducted prior to offers of employment so that pre-screened workers can become a feature of the Registry.

Research findings and rationale that support recommendation #5:

- Vermont law currently does not allow pre-screening of workers; background checks can only be conducted with an offer of employment.
- Consumers want the registry to include only workers on whom a background check has been done.
- In response to a survey question, 51% of consumers report they would use a registry to hire direct care workers, 39% might, and only 10% would not use it.
- Consumers who say they would use the Registry rank screening potential employee backgrounds as the feature most important to them.

What needs to be done and by whom to implement Recommendation #5:

- The Registry Advisory Group and DAIL must consider strategies that address consumers' desire to have background checks conducted on potential direct care workers in order for their inclusion in the registry.

Recommendation #6: Promote recruitment and retention through the use of evidence based tools and promising approaches.

- Continue and expand the Gold Star Employer Program in nursing homes and home health agencies
- Provide Coaching Supervision training for supervisors
- Involve direct care workers in care planning and organizational decision-making
- Promote the widespread use of Peer-Mentoring programs

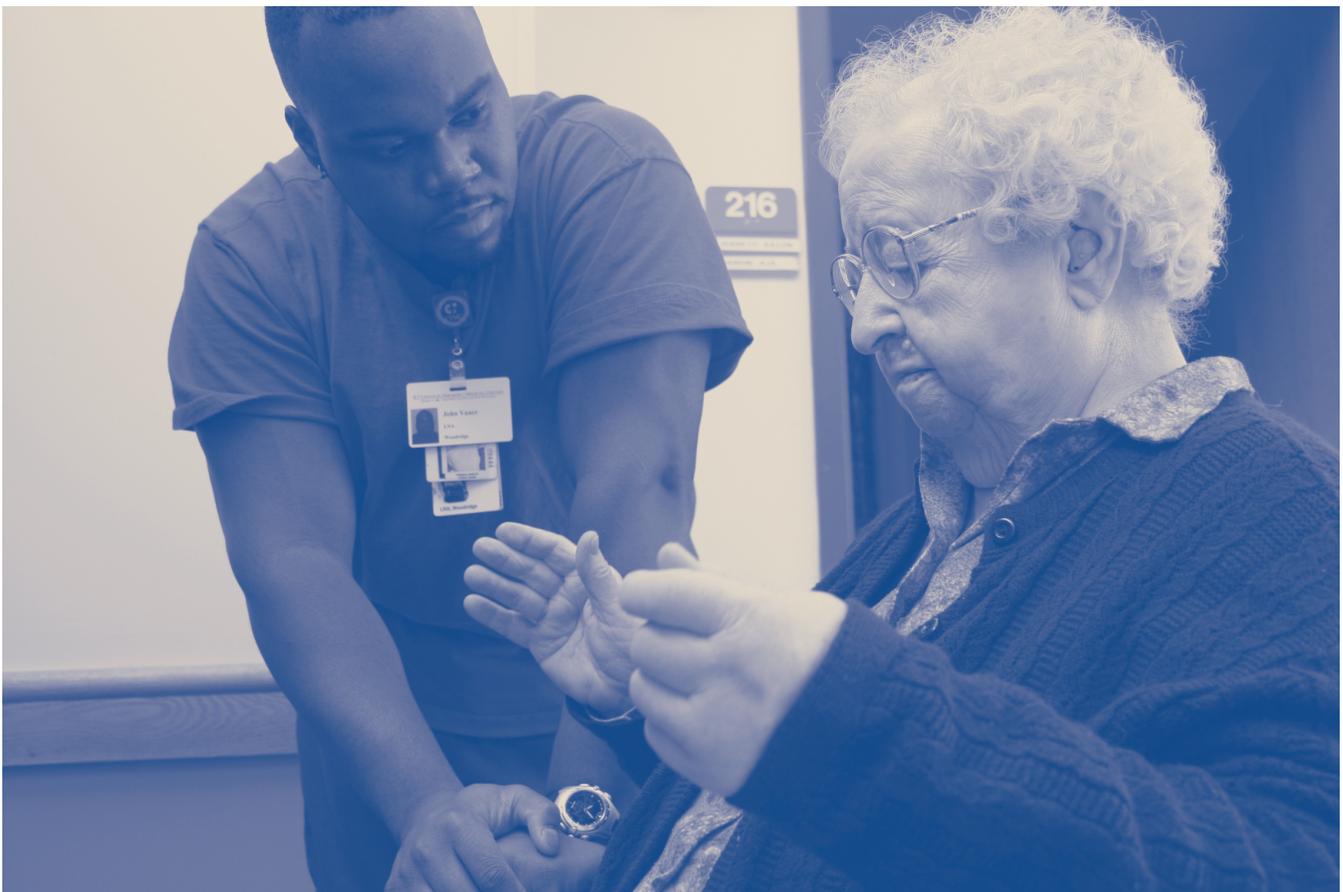
Research findings and rationale that support recommendation #6:

- Within Vermont and nationally, evidence-based research indicates that specific evidence-based and promising practices make a positive difference in finding and keeping direct care workers.
- Vermont nursing homes that have earned Gold Star Employer awards have lower turnover rates among their direct care workforce. Gold Star nursing homes reported 49% turnover compared to 60% turnover in non-Gold Star facilities.
- Lower turnover rates are associated with adoption of Coaching Supervision programs that teach supervisors to set clear expectations, while encouraging, supporting and guiding direct care workers.
- Involving direct care workers in care planning improves retention: 51% of providers that highly involve direct care workers in care planning report that they have no job vacancies and only 10% report serious staff retention problems.
- Peer-mentoring programs provide supportive orientation and hands-on training for new workers and are associated with increased worker retention rates: up to 81% retention for mentors and 67% for mentees.

What needs to be done and by whom to implement Recommendation #6:

- VAPCP, DAIL, DOL, DOE, VAHHA, VHCA, VCDMHS, and PHI should continue efforts to increase employers' awareness and knowledge of how to utilize evidence-based and promising practices and promote the use of evidence-based practices. To assist these efforts, DAIL should provide a clearinghouse of best practices in recruitment and retention.

- Employers should familiarize themselves with and utilize evidence-based practices to improve recruitment and retention.
- Continue and expand the Gold Star Employer Program and to deliver PHI's Coaching Supervision curriculum. #6
- Direct care workers should be included in all policy and planning efforts focused on implementing evidence-based recruitment and retention practices.



Recommendation #7: Create standardized and portable career ladders for direct care workers.

- Create a range of options through which direct care workers can assume leadership responsibilities within their current jobs.
- Encourage direct care workers to become specialists in care areas of particular interest (for example, developmental disabilities, dementia care, palliative care, nutrition, diabetes care).
- Allow direct care workers to “carry” credentials such as an LNA II that they have earned in one setting to any other setting in which they carry out the same or similar responsibilities.
- Provide recognition for direct care workers who complete professional development and continuing education programs.
- Create and deliver standardized curricula that are associated with particular career ladders such as LNA II or PCA II.

Research findings and rationale that support recommendation #7:

- In response to survey questions, direct care workers reported only one other area of dissatisfaction beyond low wages; the lack of opportunities for advancement.
- No standardized LNA II or PCA II curriculum and credentialing exists in Vermont. Each organization provides its own training curriculum and the LNA II designation is not transferable from one nursing home to another. As a result, direct care workers are consigned to limited options for advancement within their profession and those exist primarily within their current work setting.
- Career ladders provide workers with recognition and advancement while enabling them to continue within the direct care worker profession.

What needs to be done and by whom to implement Recommendation #7:

- DAIL, DOE, DOL, VAHHA, VHCA, VAPCP in partnership with the Vermont Board of Nursing should convene a workgroup to craft changes in current policy that result in the creation of a standardized LNA II curriculum and the acceptance of LNA II and PCA II credentials between facilities and across work sites.
- PCA Skills Assessment and CareWell training resources should provide the basis of developing a standardized curriculum that is recognized across similar work sites.
- AHEC and CCV should partner with VAHHA, VHCA, VCDMHS, VAPCP and employers to make accessible and deliver standardized training curricula and continuing education programs across direct care work settings.

Recommendation #8: Establish a workgroup responsible for developing protocols and methods for collecting needed direct care workforce data.

The workgroup would be charged with:

- Developing standard definitions that delineate and describe the various types of direct care workers and the different categories of direct care provided based on actual job functions and work settings.
- Designing a method for collecting raw data that captures the number of direct care employees in the workforce (full time and part time), the number of direct care employee hires and terminations, vacancy rates, and wages and benefits provided to direct care employees.
- Gaining compliance from employers (i.e., nursing homes, home health agencies, residential care facilities, assisted living programs, adult day services, and development services) to use the data collection method.

Research findings and rationale that support recommendation #8:

- Within Vermont, standardized data needed to accurately describe the direct care workforce in terms of retention, turnover and adequacy of supply does not exist.
- The U.S. Bureau of Labor Statistics' employment categories used by the Vermont Department of Labor (DOL) do not accurately reflect the direct care workforce. The categories do not capture all direct care work jobs, and collapse direct care work into categories that include distinctly other jobs (e.g., hospital orderlies)
- Not all direct care employers collect and report employee data. Moreover, employers that do track turnover use a variety of formulas to do so, resulting in diverse data sets that lack comparability across employers or settings.

What needs to be done and by whom to implement Recommendation #8:

- DOL should lead development efforts to create standard definitions of direct care workers and identify policy changes needed at the state and federal levels to implement the use of these definitions.
- DOL in partnership with DAAIL should convene a work group that develops methods for gathering raw data. To promote consensus around the methodology, membership should include employers from all direct care work settings.

- The assigned workgroup should explore whether funding through CMS Direct Service Worker Resource Center is available to develop standard definitions and data collection strategies.
- The Legislature should provide funding to DOL and DAIL to implement and monitor the designed data collection strategy. Currently all such efforts to track labor market trends are federally funded.



Recommendation #9: Establish a group that is charged with directing, implementing and monitoring progress on the recommendations.

- The membership should include representation from state government (DAIL, DOL, and Department of Education (DOE)), consumers, direct care workers, advocates, and providers.
- Model the group on successful examples such as the Blue Ribbon Commission on Nursing which was convened between 2000 and 2001.

Research findings and rationale that support recommendation #9:

- Successful efforts to improve recruitment and retention of direct care workers require collaborative efforts of an organized, multi-disciplinary group that is staffed, resourced and representative in its membership of key stakeholder interests.

What needs to be done and by whom to implement Recommendation #9:

- The Legislature and Governor should authorize the establishment of the group and appropriate funding to support its activities and ability to fulfill its mission.
- The Legislature and Governor should approve the allocation of funds needed to implement the above recommendations, including:
 - DAIL must conduct budget analyses to determine the financial impacts of implementing wage and reimbursement rate increases through strategies that include cost of living increases, wage equity, wage increases and merit raises.
—*Recommendation #1*
 - DAIL must study what policy changes, both state and federal, are needed to ensure reimbursement and wage equity across programs.—*Recommendation #1*
 - DAIL should be charged to conduct an inventory of effective orientation, training and professional development programs for direct care workers.—*Recommendation #3*
 - Continue and expand the Gold Star Employer Program and to deliver PHI's Coaching Supervision curriculum.—*Recommendation #6*
 - DOL should lead development efforts to create standard definitions of direct care workers and identify policy changes needed at the state and federal levels to implement the use of these definitions.—*Recommendation #8*
 - DOL in partnership with DAIL should convene a work group that develops methods for gathering raw data. To promote consensus around the methodology, membership should include employers from all direct care work settings.
—*Recommendation #8.*

Conclusion

Individuals who provide direct care to help us negotiate the tasks of daily living answer a calling: they come to work each day to help others. These workers care deeply for those of us who live with developmental disabilities, physical disabilities, or the challenges brought on by aging. To insure that the growing need for direct care is met, Vermont must develop effective strategies for attracting and keeping direct care workers.

First and foremost, direct care workers must earn a livable wage. Second, workers should receive some degree of employment benefits. Beyond that, provisions such as training, quality supervision and opportunities for advancement can improve workers' satisfaction and willingness to stay in this profession. The findings from this Vermont study are supported by findings from other research initiatives conducted here and across the country. What we learned in the 2001 Paraprofessional Workforce Study remains constant: direct care workers engage in this profession because they want to work with, help, and make a positive difference in other's lives.

The 2001 Paraprofessional Staffing Study recommended the formation of a direct care worker organization or association to support workers and further the development of this vital workforce. The Vermont Association of Professional Care Providers (VAPCP) has since been established and become essential in raising awareness about the profession, providing training opportunities for all direct care workers, advocating for direct care workforce issues, and supporting opportunities for leadership development. This study is another critical step in the process of understanding and strengthening the direct care workforce in Vermont. The Vermont Association of Professional Care Providers (VAPCP), if resourced and supported, will continue to serve as a sustainable vehicle for workforce development.



Appendices

- A. Authorizing legislation**
- B. Direct Care Workforce Study Advisory Group**
- C. Key Informant Response Summary Chart**
- D. Summary of Structured Group Interview Responses**
- E. Direct Care Worker Survey**
- F. Employer Survey**
- G. Consumer/Surrogate Survey**
- H. Direct Care Worker Survey Results**
- I. Employer Survey Results**
- J. Consumer/Surrogate Survey Results**
- K. Supply of Workers**
- L. Demand for Direct Care**
- M. Quality of Care: Consumer Satisfaction Surveys**
- N. Evidence-based and promising practices**
- O. List of Acronyms**

