

A Study of the Direct Care Workforce in Vermont:
Status Report

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and

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Services

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Introduction and Background

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 do 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 another in negotiating the tasks of daily living. Sometimes the 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. 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.

The number of us who need direct care and support is growing faster than is the direct care workforce. Among 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 is facing a direct care workforce crisis: a **care gap** in both quality and quantity of direct care workers.

The care gap 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. DAIL contracted with Flint Springs Associates to conduct the study.

Purpose of Direct Care Workforce Study

While wages and benefits are clearly important to direct care workers, we know that improved compensation alone will not close the impending care gap. As the past study of direct care workers in Vermont¹ tells us, working conditions, supervisory practices, regional economic conditions, and other issues play a significant role in attracting and keeping direct care workers. Additionally, the care gap results, in part, from an inadequate supply of workers; solutions require attention to expanding the pool of workers and/or reducing the need for direct care and support.

The Direct Care Workforce Study will gather information needed to develop informed policies and practices intended to address the care gap. Specifically, the study will seek 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

While efforts have been directed toward addressing the direct care workforce throughout the nation, to date, there have been no studies as comprehensive as the present effort. The results of this study will provide important information to both Vermont and the rest of the nation.

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

- 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
- Sharing Staff Pilot Program
- Sustainability of Designated Provider System for Substance Abuse, Developmental and Mental Health Services Study

The findings of this study will provide valuable information to these initiatives as well as to the workforce development efforts in the Department of Labor, vocational education and health care education. Direct care work can provide valuable, meaningful, and rewarding employment opportunities. As the demand for direct care work grows so too does the opportunity for job development and creation.

Staffing for Study

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

¹ *Paraprofessional Staffing Study*, Vermont Department of Aging and Disabilities, March 2001

Stakeholder Advisory Group

The legislature, in authorizing the 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. Fifteen organizations and one direct care worker (listed at the start of this report) have joined the group. The Advisory Group first convened on September 26, and has met monthly with FSA staff providing meeting facilitation services.

The four meetings of the Stakeholder Advisory Group yielded progress as follows:

- *Meeting 1* focused members on the purpose of the study, encouraging them to identify issues of concern to their constituencies. Input from the first meeting resulted in a re-organization of FSA's work plan, allowing the Group members more time to discuss and agree on the research parameters and questions.
- *Meetings 2 and 3* discussions of research questions helped this diverse group of stakeholders, with varied interests and agenda, clarify the purpose and nature of the study.
- *Meetings 3 and 4* focused on methods for collecting data, and reviewed information FSA was able to gather from existing sources.

Unlike many advisory forums, the Direct Care Workforce Stakeholder Advisory Group sets a high standard for active participation and meaningful project guidance. Members attend monthly meetings regularly; they are well-informed and strongly committed to direct care workers and the people receiving their care and support. The group has been actively engaged in every step of the study. The work presented here is a direct result of their insight, knowledge and direction.

Study Questions

The authorizing legislation for the direct care workforce study directs DAIL to assess "potential problems regarding quantity, quality, stability and availability of workers." In accord, the Stakeholder Advisory Group took on its first task of translating this mandate into a set of clear research questions to guide the study

Specifically, the Advisory Group determined that the study should seek answers to the following questions:

1. What are workforce **quantity and availability** issues across care and support settings and consumer populations? Specifically:
 - a. What is the supply of workers?
 - b. What is the demand for workers?
 - c. What are gaps between supply and demand?
 - d. What are recruitment and retention strategies currently in use?
 - e. Can technology be used to bridge gaps between supply and demand?
 - f. Can other strategies work to bridge gaps between supply and demand?
2. What are workforce **quality** issues across care and support settings and consumer populations? Specifically:
 - a. What is the level of service quality?
 - b. What skill sets and training are expected of direct care/support workers?
 - c. How do care and support settings address cultural differences?
 - d. What is the level of worker satisfaction with work and workplace?
3. What are workforce **stability** issues across care and support settings and consumer populations? Specifically:
 - a. To what extent do consumers of care/support services experience a stable workforce?
 - b. To what extent do professional caregivers and support providers experience stability in their jobs?
 - c. To what extent do employers experience stability in the direct care workforce?
4. What are **financial** issues across care and support settings and consumer populations that will need attention? Specifically:
 - a. How does compensation compare across programs and services?
 - b. What administrative policies impact on compensation for caregivers?
 - c. What compensation must professional caregivers receive to establish and maintain a viable workforce?

Defining Study Parameters: Groups to include in study

In October, 2006, at the second meeting, the Advisory Group identified three critical parameters, or sources of information to feed the study. This was not an easy task. Because each care and support setting utilizes different language, the group members first had to educate each other on use of terms and definitions. What followed was agreement within the Advisory Group that the study should focus on those workers who:

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

While Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) also provide direct care, other studies and initiatives are in place to address the nursing shortage.

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 changes. To best accommodate this “moving target,” the Advisory Group agreed 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/foster care* (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 with in-home with IADLs such as cleaning and making meals to 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 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. The Advisory Group chose the following care and support settings to include in the study:

- Individuals' homes
- Professional caregivers' home
- Developmental/foster homes
- Crisis homes
- Assisted living residences
- Residential care/group homes
- Nursing homes
- Adult day centers or programs
- Employment settings
- Community settings

Current Status of Study

Accomplishments

Over the first five months of the study period, accomplishments include:

1. Completion of the Request For Proposal (RFP) process resulting in a contract with Flint Springs Associates
2. Establishment of the Stakeholder Advisory Group
3. Clarification of the study's purpose and its specific research questions
4. Definition of the study's parameters (direct care workers, consumer populations and care/support settings)
5. Development of a comprehensive method for gathering information to address the research questions
6. Identification and collection of information from existing data sources

Revised Research Design

After a thorough review of the proposed research method, the Advisory Group recommended several enhancements to the design. First, the group said to broaden the pool of key informants to be interviewed. The original research design proposed to interview representatives from long term care settings. However, the Advisory Group maintained that to fully answer the research questions, additional qualitative information must be gathered from:

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

The Advisory Group understands that as a result of its recommendations parts of the study will be completed in a longer timeframe than originally outlined. However, it believes that expansion of the research method and activities is essential to understanding the complexities involved with the direct care workforce in long-term care.

The Advisory Group's rationale holds that the entities listed above represent the full spectrum of the long-term care system in which direct care workers play a vital role. Therefore, the Group felt it essential to address the research questions from these diverse perspectives. In response, Flint Springs Associates proposed gathering needed information through a combination of:

- Key informant interviews
- Focus groups
- Surveys

The Advisory Group spent considerable time and effort guiding FSA in developing relevant questions to use in interviews or focus groups.

Study Findings to Date

The study has addressed a number of research questions through collection of existing quantitative information. This information gives us an emerging understanding of the current status of the direct care workforce. The sources of information and findings are described below.

Legislative Study Charge – Examine the Quantity and Availability of Workers

Research Question - What is the supply of workers?

Estimating the number of individuals currently employed as direct care workers is a complex task. First, the information needed comes from multiple sources which collect information differently and analyze it through a variety of lenses and methods. Second, different care and support settings give different titles to direct care workers who may be engaged in similar work. As stated earlier, over time, titles change as the work changes. Third, direct care workers may, and often do, hold more than one job in more than one setting. In most record keeping systems, there are no mechanisms to account for this possible duplication in counting workers.

Tables 1, 2 and 3 present current data on the number of direct care workers employed. More detailed discussion of these data follows.

Table 1: Vermont Department of Labor Statistics: Job Count for Persons Employed as Direct Care Workers

DOL/BLS Job Category	2004 Data (number of jobs)	2005 Data by Setting (number of Jobs)					Total 2005
		Nursing Home	Community Care for Elders	Other Residential Care	Individual & Family Services	Voc Rehab Services	
Home Health Aides	3,372	173	295	37	1,934	13	2,452
Nursing Aides, orderlies, and attendants	2,934	1,629	348	0	5	0	1,982
Personal and Home Care Aides	1,278	1	0	0	535	10	546
Total	7,584	1,803	643	37	2,474	23	4,980

Table 2: Direct Care Workers Employed in Community-Based Settings through State Funded Programs (2006)

DAIL Administered Programs	Number DCWs
Choices for Care (consumer/surrogate directed)	956
Attendant Services Program (all funding sources)	332
Developmental services	2,521
Children's Personal Care Services – self manage	1,336
Total of All DAIL administered programs	5,145

Source: DAIL and ARIS

Table 3: Other Sources of Data on Number of DCWs Employed

Additional sources of data	Number of DCWs
VHCA -- number LNAs in nursing homes (2005)	1,433
VAHHA -- number PCAs in home health (2006)	604
Board of Nursing -- number LNAs registered (2007)	3,825*
Non-medical providers – number DCWs employed (2006)	554

*This count includes hospital-based LNAs

Department of Labor DCW Data

The Vermont Department of Labor (DOL) 2004 statistics estimate there were 7,584 direct care jobs in hospitals, home health, nursing homes, community care, and residential settings (see Table 1). DOL’s 2005 data indicate that 4,980 direct care workers were employed across settings consistent with some of the care and support settings identified on page 6.

The Vermont DOL statistics use the U.S Bureau of Labor Statistics (BLS) direct care worker categories for:

- “home health aides²”
- “nursing aides, orderlies, and attendants³”
- “personal and home care aides⁴”

It’s important to understand that the BLS/DOL job categories and definitions are not the same job descriptions and titles used in the field of long-term care. For example, orderlies are not defined as direct care workers. On the other hand, the DOL data do not track or report developmental service support workers (including contracted home providers and community support providers) as direct care workers.

² BLS definition: “Provide routine, personal healthcare, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in the home of patients or in a residential care facility. Include: Respite Workers; Exclude ‘Geriatric Aides’ for skilled nursing care facility sites”

³ BLS definition: “Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, or move patients, or change linens. Excludes ‘Home Health Aides’ Include: LNA (Licensed Nurse Assistant); Patient Transporter; Transporter; OR Assistant; Patient Support Tech/Lifter; Hospital Aide; Assistant, Operating Room; Attendant Nurse; Attendants; Baby Nurse; Birth Attendant; First Aid Attendant; First Aid Nurse; Gericare Aide; Health Aide; Health Care Aide; Helper, Ward; Hospice Entrance Attendant; Hospital Aide; Hospital Attendant; Hospital Corpsman; Hospital Orderly; Infirmary Attendant; Institutional Aide; Medical Aide; Medical Attendant; Medication Aide; [Midwife]; New Patient Escort; Nurse Sitter; Nurse’s Aide; Nursery Attendant; Nursing Aides; Nursing Aides, Orderlies, and Attendants; Orderlies; Orderly; Patient Care”

⁴ BLS definition: “Assist elderly or disabled adults with daily living activities at the person’s home or in a daytime non-residential facility. Duties performed may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. Includes: homemakers for home health agency; perform personal care and housekeeping duties at client’s home. Caregiver; Blind Escort; Geriatric Aide. Strictly NON-medical; no health care needs.” (Vermont DOL, 2006)

Therefore, BLS data becomes problematic for both Vermont and the rest of the nation, as it currently cannot provide a reliable count of direct care workers. In order to develop useful data sets that are in concert with evolution of the long-term care direct care workforce, this reality will require attention and changes at the national level. .

State Funded Programs' Data on DCWs

Another approach to estimating the number of persons employed as direct care workers is through figures generated by DAIL. A variety of programs administered through DAIL provide direct care and support services to elders and adults with disabilities in their homes and communities. These programs are outlined in Table 2.

Home and Community Based Programs

Participants in the Choices for Care Medicaid Waiver program may choose to employ their own direct care workers; other Choices for Care participants rely on nursing homes, residential care homes, or home health agencies to hire and coordinate their direct care workers. Attendant Services Program (ASP) participants hire their own direct care workers; a small portion of total 316 ASP participants are funded through Medicaid, while the remaining participants receive funding through General Funds.

An independent organization, ARIS Solutions, handles payroll for the Medicaid funded direct care workers hired by individuals, their surrogates or family members. Based on the last full employment quarter in FY2006, DAIL estimated that about 956 workers were on the ARIS payroll for Choices for Care (see Table 2). In addition, there were 332 attendants providing care through ASP; 82 under Choices for Care and 250 under General Funds.

Children and Adults with Developmental Disabilities

DAIL administers programs that employ direct care workers to provide community, work, and home supports, as well as respite, to adults and children with developmental disabilities. DAIL also contracts with developmental home providers to provide support. Across these programs, 2,521 direct care/support workers were recorded as employed or under contract in 2006.

Children's Personal Care Services

Children's Personal Care Services provide income eligible families with direct care for children under age 21 with disabilities that need assistance with activities of daily living. Very young children, regardless of whether or not they have a disability, need assistance with activities of daily living. The Children's Personal Care Services (CPCS) program assumes that pre-school age and younger children are primarily cared for by family members. Many of the families served by CPCS self-manage care, which means the family hires direct care workers. At present, DAIL reports that there are 1,336 workers providing direct care to children through self-managed CPCS (that is, on the ARIS payroll). There were 179 children that received CPCS through an agency; at a minimum of one worker per child this would add 179 more DCWs to the CPCS total, for a total of at least 1,515 workers.

Taken together, these data indicate that there were 5,145 direct care workers providing care and support through DAIL administered community-based programs during 2006.

Self-employed DCWs

At present, no resources exist to count the number of direct care workers who are self-employed and therefore provide care and support directly to, and are compensated directly by, individuals who have no formal relationship to an agency or state funded program. For example:

- A direct care worker is hired by a woman to help her mother with daily activities.
- The wife of a man with disabilities hires a friend to help out three mornings a week so the wife can take a class.

Vermont does not have any mechanisms for counting these self-employed workers, leaving us to look, for the present to national research data which indicates that 29% of home-care workers are self-employed⁵.

VAPCP Estimate of DCWs in Vermont

Table 3 outlines other data sources through which we can count DCWs currently employed in Vermont. The Vermont Association of Professional Care Providers (VAPCP) reviewed these data, along with data provided by DAIL, and estimated that between 8,000 and 13,000 direct care workers were employed in Vermont in 2006. This figure does not include developmental home providers or respite workers.

Estimating the Number of DCWs Currently Employed

So, here is the conundrum - if we total the number of reported workers from the range of information sources just described (i.e., DOL, DAIL, VHCA, VAHHA and private providers), the count reaches about 16,000 workers. We know there is duplication in this number; for example, workers counted by VHCA may also have been counted by DOL. Moreover, workers may be counted more than once if they work in multiple jobs. And we know this number does not include self-employed workers unaffiliated with any established program.

The Advisory Group grappled with these factors and agreed that a reasonable estimate to use in the short term is that **11,000** individuals currently are employed as direct care workers in Vermont.

Nevertheless, in order to effectively project what type and size of workforce will be needed, future efforts to develop reliable data must be pursued.

One promising approach to this conundrum would be the development of a Direct Care Worker Registry. In 2006, COVE and its workforce initiatives – BJBC, VAPCP and LEADS convened a task force to consider a Vermont voluntary direct-care worker registry. The task

⁵ Leon, J. and Franco, S. (1998) *Home and community based workforce, final report*. Bethesda, MD: Henry J. Kaiser Foundation Project Hope. Reported in: *Caregiving in America* (2006) International Longevity Center-USA and Schmieding Center for Senior Health and Education

force membership⁶ was diverse, including consumers, providers, representatives of state programs that depend on direct care workers and the Department of Labor. The task force agreed that a Direct Care Worker Registry is needed as it would:

- Provide consumers with better and safer access to caregivers
- Expand employment opportunities for direct-care workers and allow them to list experience and training
- Support development of the workforce and the work of this study

Importantly, a well-structured registry can provide a reliable, unduplicated count of DCWs employed and seeking work in Vermont.

DCW Demographics

The Paraprofessional Staffing Study of 2001 found that:

- The majority of direct care workers were women over age 35
- The average age for home-based workers was 47
- Workers employed in nursing homes averaged 40 years of age
- These workers were generally high school graduates
- More than 25% had at least some college education

VAPCP also surveyed direct care workers and found the vast majority were women, averaging age 43. The story that is emerging tells us that as the number of individuals needing care and support increases, the amount of direct care workers are aging, resulting in a decreased workforce

In Vermont, about 3% of the total population are persons of color. Less than 1% of aides/medical assistants in 2000 were persons of color⁷. In other parts of the nation however, direct care workers are increasingly women of color and/or new Americans. The survey of direct care workers will examine demographics, including race and ethnicity to determine if and how Vermont's direct care workforce has changed over the past seven years.

Research Question - What is the demand for workers?

Estimating the demand for workers, that is the number of individuals in need of care and support, is no less complex than estimating the supply of workers. Once again, data sources are numerous and not comprehensive leaving research to draw incomplete conclusions.

⁶ DCW Registry Task Force: Deborah Lisi-Baker (VCIL), Merle Edwards-Orr (DAIL), Dolly Fleming (COVE), Susan Gordon (COVE/VAPCP), Michelle Champoux (COVE/BJBC), Kathy West (COVE/LEADS), Michael Sirotkin (COVE lobbyist), Heidi Pfau (COVE/BJBC), Greg Voorheis (DOL), Joan Senecal (DDAIL), Kathy Webb (Transition II), Jeanne Kern (CVCOA/Family Caregiver Program), Mike Meunier (DAIL), Mary Lou Thorpe (Homeshare Vermont)

⁷ *Minority Women in the Healthcare Workforce in New England* (August 2006). The Center for Women in Politics & Public Policy

US Census Bureau data provided most of the information used to address this question. To paint as broad a picture as possible we examined the data for:

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

Persons with Disabilities and Older Adults in Need of Support

A key source of data on the number of Vermonters with disabilities is DAIL’s recent report: *Shaping the Future of Long Term Care and Independent Living* (Wasserman, 2006)⁸. Wasserman looked specifically at the number of Vermonters age 18 and over with long term care (LTC) needs; that is, “hands-on assistance with two or more ADLs”. Based on 2000 Census data, Wasserman reported that 4,406 Vermonters with LTC needs were living in the community. Community living included one’s own home as well as residential care or other non-institutional community-based setting (e.g., assisted living, congregate housing with supports). As shown in Table 4, the majority of these Vermonters were age 65 and older.

Table 4: Number of Vermonters Living in the Community* with LTC Needs** (2005)

Age Groups	Number of Persons with LTC Needs
18 to 64	1,279
65 and older	3,126
Total	4,406

* Community living includes homes, residential care, or congregate care with supports

* Long Term Care (LTC) needs defined as needing help of another person to perform two or more ADLs

In addition, 3,168 Vermonters were living in nursing facilities during the same time period. The vast majority of persons living in nursing homes (93%) were age 65 and older.

Taken together, there were a total of **7,574** Vermonters in need of direct care during 2005. This total does not include persons with developmental disabilities.

⁸ Wasserman, J. (2004) *Shaping the Future of Long Term Care & Independent Living 2003-2013* Vermont Department of Aging and Disabilities

Individuals with Developmental Disabilities

DAIL reports that an unduplicated total of **3,224** people were served through publicly funded developmental services programs in FY 2006. This number includes children and adults with developmental disabilities. Of this total number of persons, the following counts refer to the number of children and adults that received specific types of supports:

- Home supports = 1,359
- Employment support (including Vocational Rehabilitation) = 1,447
- Community support = 1,320
- Respite/in-home family supports = 1,453
- Flexible Family funds which can be used for direct support = 891

It is important to note that these data reflect the number of individuals served through publicly funded programs, not necessarily the total number of Vermonter children and adults with developmental disabilities that need and/or use supports.

Children with Personal Care Needs

DAIL's projections on the number of children with personal care needs are based on work completed by the Lewin Group⁹. The Lewin Group used trend data based on adult disability rates to project rates for children in Vermont. Based on this projection, in 2005 there were 82 children under age 18 with LTC needs.

The 2001 National Survey of Children with Special Health Needs¹⁰, on the other hand, reports that 22.9% of Vermont families say their children's special health needs consistently affect daily activities, often a great deal. Using population estimates, the CHSHN projects that there are 5,216 children with this level of need in Vermont.

In FY 2006, **1,700** children received direct care through the Children's Personal Care Services program. This Medicaid program serves income eligible children under age 21 with disabilities who need assistance with activities of daily living.

Individuals with Traumatic Brain Injury

Each year 80,000 persons nationally experience a TBI that results in a long-term disability¹¹. At present we do not have a clear sense of how many Vermonters have sustained a traumatic brain injury that requires the assistance of direct care workers. We do know that the Traumatic Brain Injury Waiver program currently serves 62 participants, with eight persons on the waiting list; however this represents a small fraction of the number of individuals with TBI. Services through the TBI Waiver are limited to individuals who meet a strict set of criteria.

⁹ Ibid.

¹⁰ National Survey of Children with Special Health Care Needs (2001) Maternal and Child Health Bureau, U.S. Department of Health and Human Services

¹¹ Brain Injury Association of Vermont (2007)

Legislative Study Charge – Examine Workforce Quality Issues

Research Question - What is the level of service quality across care/support settings and for different consumer populations?

Consumer surveys provide a useful way to assess the quality of services. Several consumer surveys are conducted in Vermont. Overall, their results, which are summarized below, indicate that consumers are satisfied with the quality of care they receive.

For example, Attendant Services Program (ASP) recipients, responding to a survey in 2005 provide these findings:

- 83% report program satisfaction with services;
- 88% say their attendant provides “high quality services;”
- 14% of respondents say their need for services could be reduced by assistive technology, adaptive equipment or home modification.

DAIL periodically conducts a client satisfaction survey, the most recent of which was completed in 2002 (an update will be available in March 2007). The study found:

- 86% of respondents over all programs were satisfied with “quality of assistance” (ASP – 88%; Homemaker – 85%; Waiver – 93%; Adult Day – 88%)
- 92% of respondents over all programs were satisfied with the respect and courtesy shown them by professional caregivers (ASP – 93%; Homemaker – 94%; Waiver – 96%; Adult Day – 94%)

The Children’s Personal Care Services Program Status Report (June 2005) includes responses to a family survey which showed that:

- 74% said personal care workers were respectful to their family and family life
- 85% said personal care services made a positive difference
- 88% said personal care services were helpful to their family’s well being

DAIL’s Division of Disability and Aging Services (DDAS) conducted a Survey of Adults Receiving Developmental Services in the summer of 2005. Results showed that nearly all persons surveyed were satisfied with the support they received in the community (94%) and at their jobs (95%).

Independent resident satisfaction assessments conducted in half of Vermont’s nursing homes indicate that about 85% of residents are satisfied with their care and service. The Centers for Medicare and Medicaid Services (CMS), Nursing Home Quality Initiative¹² found Vermont nursing homes on par with national LNA averages of 2 hours 18 minutes per resident per day. This staffing level is important to quality as the time DCWs have to work with residents directly impacts quality of care. Vermont’s nursing homes’ average performance on clinical quality measures is generally close to the national average. Specifically, Vermont nursing homes’ performance measures are:

¹² Nursing Home Compare (www.medicare.gov/NHcompare) provides summary of clinical assessment data for Medicare or Medicaid certified nursing homes. Data collected by nursing homes and reported to Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services (updated January 3, 2007).

- better than the national average on one measure¹³
- equal to the national average on four measures¹⁴
- within a few percentage points of the national average on ten measures¹⁵
- notably poorer than the national average on four measures¹⁶

The study will examine quality issues in more detail through key informant interviews, focus groups, and surveys.

¹³ This measure is: Percent of long-stay residents given flu vaccines (VT 92%, Nation 87%)

¹⁴ Vermont nursing homes' average is equal to the national average on the following four measures:

- Percent of long-stay residents with moderate to severe pain (VT 5%, Nation 5%)
- Percent of high-risk long-stay residents with pressure sores (VT 12%, Nation 12%)
- Percent of long-stay residents who spend most of their time in bed or chair (VT 4%, Nation 4%)
- Percent of short-stay residents given flu vaccine (VT 73%, Nation 73%)

¹⁵ Vermont nursing homes' average performance is close to the national average on the following 10 measures:

- Percent of long-stay residents assessed & given pneumococcal vaccines (VT 76%, Nation 75%)
- Percent of low-risk long-stay residents with pressure sores (VT 5%, Nation 3%)
- Percent of long-stay residents who were physically restrained (VT 3%; Nation 6%)
- Percent of long-stay residents with catheter inserted and left in bladder (VT 7%, Nation 8%)
- Percent of long-stay residents with urinary tract infection (VT 10%, Nation 9%)
- Percent of long-stay residents who lose too much weight (VT 10%, Nation 8%)
- Percent of short-stay residents assessed and given pneumococcal vaccines (VT 62%, Nation 66%)
- Percent of short-stay residents with delirium (VT 4%, Nation 2%)
- Percent of short-stay residents who had moderate to severe pain (VT 25%, Nation 22%)
- Percent of short-stay residents with pressure sores (VT 20%, Nation 17%)

¹⁶ Vermont nursing homes' average was notably poorer than the national average on the following four measures:

- Percent of long-stay residents whose need for help with daily activities has increased (VT 25%, Nation 16%)
- Percent of long-stay residents who are more depressed and anxious (VT 24%, Nation 14%)
- Percent of low-risk long-stay residents who lose control of their bowels or bladder (VT 56%, Nation 48%)
- Percent of long-stay residents whose ability to move about in and around their room got worse (VT 20%, Nation 12%)

Legislative Study Charge – Examine Stability of Workforce

Research Question - To what extent do consumers of care/support services experience a stable workforce?

To date, information assessing consumers' experiences of stability come from a number of satisfaction surveys whose findings are summarized below:

- 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% have had trouble hiring attendants due to low wages; 40% have had difficulty recruiting and retaining attendants due to lack of benefits
- The Children’s Personal Care Services survey revealed that:
 - 28% of families that did not use the allocated service hours did not because they couldn’t find workers
 - 11% said they cannot keep workers
- Adults receiving developmental services who have been surveyed report that “a lot of different people” provide support to them in their home (45%), on their jobs (57%), and in the community (49%). Importantly, 85% of respondents receiving services in their homes, 83% receiving services at work, and 90% receiving services in the community did not identify this as problematic.

Thus, the data indicate that currently, consumers are satisfied with the support and care they receive **if** they are able to find and keep direct care workers to provide that care and support.

As our study proceeds, further information will be gathered to address stability issues.

Stakeholder Advisory Group Charge – Examine Financial Issues

Research Question - How do wages compare across waivers, programs, and services?

At this writing, information is being gathered by Vermont DOL, VAHHA, and VHCA from home health agencies and residential care settings to assess wages for their direct care workers. Additionally, employers and direct care workers will be surveyed to fully understand the how wages differ within and across waivers, programs and services.

At present, we know that wages for direct care workers generally range from minimum wage to about \$10.00 an hour (see Table 2 for DOL statistics on wages).

Table 5: Average Wages for Direct Care Workers across Job Categories (May 2005)

Location	Home Health Aides	Nursing Aides, Orderlies & Attendants	Personal & Home Care Aides
Northwestern Vermont	\$9.68	\$10.49	\$9.19
Northeastern Vermont	\$9.46	\$10.16	\$9.20
Central Vermont	\$10.37	\$10.56	\$10.53
Southern Vermont	\$9.45	\$10.50	\$10.29

Source: Occupational Employment Statistics, Vermont Labor Market Information, U.S. Bureau of Labor Statistics May 2006

The 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. As shown in Table 3, direct care worker wages do not provide livable wages for even single adults.

Table 6: Vermont Livable Wages (2005)

	Single Adult	Single Parent with 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

Recommendations, Required Resources and Next Steps

Recommendation 1: Expand the Research Activities

In response to the thoughtful guidance of the Stakeholder Advisory Group, Flint Springs Associates has re-designed and expanded the study methodology to gather qualitative information from additional sources in order to more fully understand the complex issues that affect the current and future direct care workforce. The issues to be examined will include:

- Rules and regulations affecting the care and support of different consumer groups based on funding sources and care settings
 - The range of skills direct care workers must have depending on their clients and care settings
 - Factors which have an impact on the quality of care consumers experience
1. Through focus groups and key informant interviews we will gather important qualitative information from:
 - Direct care workers on quality, stability, and finances, including wages needed to maintain and increase the workforce
 - Consumers and other employers on quality, stability, and the gaps between supply and demand, as well as financial issues.
 2. Using the findings from the groups and interviews, FSA will design and administer a quantitative survey to employers and DCWs to verify the degree to which the qualitative findings are generalizable across Vermont.

This combined research approach delivers a more comprehensive method for addressing the four research questions than originally envisioned by DAIL and proposed by FSA, and responds to the experience, expertise and directives of the Advisory Group.

3. Finally, the study will examine the current and future status of the workforce. As originally conceived, the legislation asks the study to project 30 years into the future. However, we strongly recommend that the study project forward to 2015 in order to align its projections the Long Term Care Sustainability Study.

The Stakeholder Advisory Group will use the results of the study to shape recommendations that address the direct care gap. Recommendations will address steps:

- The legislature may take, such as policies and program initiatives
- Agencies may take to increase the pool of workers and improve education and training efforts
- Provider agencies might take to improve recruitment and retention while finding ways to reduce the need for direct care services

- DAIL can take to improve the availability and skills of workers for individuals who choose to hire their own direct care professionals.

Resources Needed - The revised study methodology will add the following tasks to our research design:

- Focus groups with consumer populations
- Group interviews with long-term care provider organizations
- Survey of employers, including individuals who hire their own direct care workers

Without a supplemental allocation, the full scope of the study as designed by the Stakeholder Advisory Group can not be completed. We estimate the addition of these critical elements to the study will require an additional \$15,000 in funding. The current legislative allocation of \$40,000 is not sufficient to gather and analyze qualitative information from consumers and survey information from employers curtailing our ability to address the full set of research questions. The Stakeholder Advisory Group strongly recommends that these additional resources be directed to the study.

Recommendation 2: Establish a Direct Care Worker Registry

The Stakeholder Advisory Group recommends that the Direct Care Worker Registry be established. The need for a registry has taken on more importance due to a number of developments:

- Choices For Care is driving the demand for caregiver lists to be available to consumers
- Organizations such as the Area Agencies on Aging, the Vermont Center for Independent Living and HomeShare Vermont (to name just a few) are frequently called upon for help in this area. These agencies are feeling more vulnerable handing out lists of caregivers, knowing very little about them since they cannot perform background checks. Many of these agencies have discontinued this practice.

As previously noted, the registry will also support the further development of the workforce and the work of the Direct Care Workforce Study.

Resources needed - After examining the needs of Vermonters and researching similar initiatives around the country, the Registry Task Force estimates that \$100,000 is required to set up a successful registry in Vermont.

Next Steps

Flint Springs will move forward to accomplish the tasks of the research design described in this report. An outline of the methods to address each of the study questions is presented in Appendix C. The data will be gathered and analyzed during 2007, with a final report completed by January 15, 2008.

Appendix A

Legislation Authorizing Direct Care Workforce Study:

H 881 (Section 271)

8) \$40,000 to department of disabilities, aging, and independent living to fund a needs assessment as follows:

(A) The commissioner of disabilities, aging, and independent living shall perform a needs assessment regarding present and future workforce issues of direct care workers in Vermont. The assessment shall focus on potential problems regarding quantity, quality, stability, and availability of workers, specifically as they apply to long-term care services and supports provided to Vermont's elderly and disabled populations. At a minimum, the assessment shall identify the potential problems and opportunities projected through 2030 and shall include recommendations for addressing these problems in the near and long term.

In preparing the assessment, the commissioner shall consult with representatives of the community of Vermont elders (COVE), AARP Vermont, Vermont association of professional care providers (VAPCP), Vermont center for independent living (VCIL), Vermont health care association (VHCA), Vermont association of adult day services (VAADS), Vermont assembly of home health agencies (VAHHA), northern New England association of homes and services for the aging Vermont (NNEAHSA), the workforce development partners (WDP), parent to parent of Vermont (P2PVT), Vermont Refugee Resettlement Program (VRRP) or a similar organization representing Vermont's refugee and immigrant workforce, the state long-term care ombudsman, developmental service providers, and the commissioner of labor.

(B) The commissioner shall submit a report on the results of the needs assessment and recommendations to the house committee on human services and the senate committee on health and welfare no later than December 30, 2007. No later than January 15, 2007, the commissioner shall submit an interim report to the committees, including an assessment of existing needs and recommendations for short-term strategies to address these needs.

Appendix B

List of Acronyms

Acronym	Organization or Term
ADL	Activities of Daily Living
AHEC	Area Health Education Center
ASP	Attendant Services Program
BJ/BC	Better Jobs/Better Care
BLS	Bureau of Labor Statistics
CMS	Centers for Medicare and Medicaid Services
COVE	Community of Vermont Elders
DAIL	Vermont Department of Disabilities, Aging and Independent Living
DCW	Direct Care Worker
DOL	Vermont Department of Labor
DS	Developmental Services
FSA	Flint Springs Associates
IADL	Instrumental Activities of Daily Living
LEADS	Leadership, Education and Advocacy for Direct Care and Support
LNA	Licensed Nursing Assistant
NNEAHSA	Northern New England Associates of Homes and Services for Aging
P2P	Parent to Parent
PCA	Personal Care Attendant
RFP	Request for Proposal
TBI	Traumatic Brain Injury
VAADS	Vermont Association of Adult Day Services
VAHHA	Vermont Assembly of Home Health Agencies
VAPCP	Vermont Association of Professional Care Providers
VCIL	Vermont Center for Independent Living
VHCA	Vermont Health Care Association

Appendix C

Direct Care Workforce Study Research Questions and Methods

Direct Care Workforce Study
Research Questions and Methods

Research Questions/Areas	Information Needed	Source of Information	Collection Strategy
What are workforce <i>quantity</i> and <i>availability</i> issues across care/support settings and consumer populations?			
1. What is the supply of workers?	1.a. Current number of persons providing home-based care/support through private pay or consumer/surrogate directed programs 1.b. Current number of persons providing care/support through agency or organization	1.a. Existing statistics, including: BLS, VDOL, State Board of Nursing, VAPCP, DAIL 1.b. Existing statistics, as above plus VAHHA, VHAC, VAADS & other employers	1.a. Request data from organizations, track data available through internet 1.b. Request data from organizations using a standard set of questions to promote uniformity
2. What is the demand for workers?	2.a. Describe complexity of needs across each consumer population and within care settings 2.b. Current population of persons needing care & support services by type of consumer & care setting	2.a. Research and key informants for each consumer population and care setting 2.b. Existing databases (e.g., Census, studies of ADL needs)	2.a. Gather research through literature review 2.a. Conduct key informant interviews and focus groups 2.b. Access databases through internet
3. What are the gaps between supply and demand?	3.a. Vacancy rates across consumer populations and care/support settings 3.b. Length of time required to fill professional caregiver/support position	3.a. Service sector or individual employer data 3.b. Individual employers, including consumers in consumer/surrogate directed & self-managed care programs	3.a. Conduct key informant interviews to identify data sources & request data 3.b. Conduct key informant interviews, focus groups and surveys to request information

Research Questions/Areas	Information Needed	Source of Information	Collection Strategy
What are workforce <i>quantity</i> and <i>availability</i> issues across care/support settings and consumer populations?			
4. What recruitment and retention strategies are currently in use?	4.a. Recruitment strategies used by each care/support setting or employer 4.b. Retention strategies used by each care/support setting or employer 4.c. What does it take to attract possible workers to become DCW?	4.a. Key informants 4.a. Research literature 4.b. Key informants 4.b. Research literature 4.c. Potential workers including high school students	4.a. Conduct key informant interviews 4.a. Conduct literature review 4.b. same as above 4.c. Focus groups
5. Can technology & equipment be used to bridge gaps between supply & demand.	5.a. Current & potential uses of technology and equipment, including assistive technology, to reduce needs for care/support	5.a. Key informants, including consumers and providers 5.a. Research literature 5.a. Consumers	5.a. Conduct key informant interviews 5.a. Conduct literature review 5.a. Focus groups across populations of consumers
6. Can other strategies work to bridge gap between supply & demand?	6.a. care/support givers responses to use of “staff sharing” model 6.b. other models in use	6.a. Staff involved in “staff sharing” pilot project 6.b. Research literature	6.a. Conduct interviews with staff 6.b. Conduct literature review

Research Questions/Areas	Information Needed	Source of Information	Collection Strategy
What are workforce <i>quality</i> issues across care/support settings and consumer populations?			
7. What is the level of service quality across care/support settings and for different consumer populations?	7.a. Consumer satisfaction ratings 7.b. Industry or care setting assessments of service quality	7.a. DAIL consumer satisfaction survey data; Nursing Home Resident Satisfaction Survey; DS Consumer Satisfaction survey 7.b. CMS Nursing Home Quality Initiatives data, and other industry service quality data	7.a. Work with DAIL to identify written summaries of results 7.a. Through key informant interviews identify sources and access to data 7.a. Consumer focus groups 7.b. Access on-line data through the internet
8. What skill sets and training are expected of care/support providers?	8.a. Job requirements, including specific areas of skill and certification 8.b. Training provided and required across care/support settings and consumer populations 8.c. Training & skills DCWs want 8.d. Preferred training models	8.a. Care settings and consumer population job descriptions and required qualifications 8.b. Training programs offered across care settings 8.c. DCWs 8.d. Consumers	8.a. Conduct key informant interviews 8.b. same as above 8.c. Self-report survey 8.d. Focus groups
9. How do care and support settings address cultural issues ?	9.a. Defined competencies (skills, attitudes, knowledge) of staff 9.b. Populations/cultures addressed	9.a. Care settings and consumer population 9.b. Census data	9.a. Include in key informant interviews a. Focus groups of consumers 9.b. Access on-line data
10. What is the level of worker satisfaction with work and workplace?	10.a. DCW satisfaction with job & workplace across settings & consumer populations: <ul style="list-style-type: none"> ▪ Workplace culture ▪ Support systems ▪ Job expectations ▪ Cultural issues ▪ Use of tools & technology to ease demands 	10.a. Direct care workers/support providers	10.a. Self-report survey

Research Questions/Areas	Information Needed	Source of Information	Collection Strategy
What are workforce <i>stability</i> issues across care/support settings and consumer populations?			
11. To what extent do consumers of care/support services experience a stable workforce?	11.a. Stability of specific care/support provider over time (number of different DCWs within week, over time) 11.b. Stability of schedule for care/support over time	11.a. Consumer satisfaction surveys across settings and consumer populations 11.b. Consumer satisfaction survey across settings and consumer populations	11.a. As above (#7), access existing data sets and summaries of results 11.a. Consumer focus groups 11.b. same as above
12. To what extent do professional caregivers & support providers experience stability?	12.a. Stable, reliable hours of work 12.b. Consistency in clients, assignments	12.a. Professional caregivers & support providers across settings and consumer populations served 12.b. Professional caregivers & support providers across settings and consumer populations served	12.a. Self-report survey (as in #10) 12.b. same as above
13. To what extent do employers experience stability in workforce?	13.a. Retention rates across settings and consumer populations, including geographic variations 13.b. Years of service among care/support providers	13.a. VHCA, VAHHA and other organizations 13.a. Nursing Home annual staff turnover report 13.b. Professional caregivers and support providers self-report	13.a. Key informant interviews 13.a. Employer survey 13.b. Include question on years of service in Self-Report Survey (see #10)

Research Questions/Areas	Information Needed	Source of Information	Collection Strategy
What are <i>financial</i> issues across care/support settings and consumer populations that will need attention?			
14. How do wages compare across waivers, programs and services?	14.a. Wages and benefits (including health, time off as well as range of supports such as transportation, paid expenses) received by direct care & support providers across different funding programs & settings (identify wages set by state, agencies, consumers); total compensation package; frequency with which wages increased; starting wages compared to wages after years of service	14.a. Professional caregivers & support providers 14.a. Consumers 14.b. Employers	14.a. include questions about current wages in DCW survey (#10) 14.a. consumer focus groups 14.a. employer survey
	14. b. Percent of workers that receive benefits	14.b. same as above	14.b. same as above
	14.c. Out-of-pocket expenses for workers	14.c. same as above	14.c. same as above
	14.d. Off-the books payments, other costs borne by consumers (including undocumented workers)	14.d. same as above, also Family Practice survey	14.d. same as above & contact Family Practice
15. What administrative policies impact on compensation for professional caregivers?	15.a. Policy changes at the administrative levels of state government that impact the level of compensation earned by professional caregivers	15.a. Key informants	15.a. Conduct key informant interviews
16. What wages must professional caregivers receive to maintain a viable workforce?	16.a. Acceptable wages from DCW perspective	16.a. DCWs	16.a. include questions about acceptable & fair wages in self-report survey (#10)
	16.b. What it will take to keep DCW on job	16b. DCWs, employers	16.b. survey & focus groups
	16.c. Competing forces vying for DCW	16.c. DCWs, employers	16.c. survey & focus groups