

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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- Joy Livingston and Donna Reback of Flint Springs Associates, our consultants, who managed the project, facilitated the Stakeholder Advisory Group meetings, conducted research, and prepared the final report.

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**<http://dail.vermont.gov/dail-publications>**

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# Message from the Commissioner



**W**e 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%<sup>1</sup>. 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%<sup>2</sup>.
- 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

<sup>1</sup> 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](http://www.directcareclearinghouse.org/download/WY_2005_Wage.pdf)

<sup>2</sup> 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&sectionID=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:**

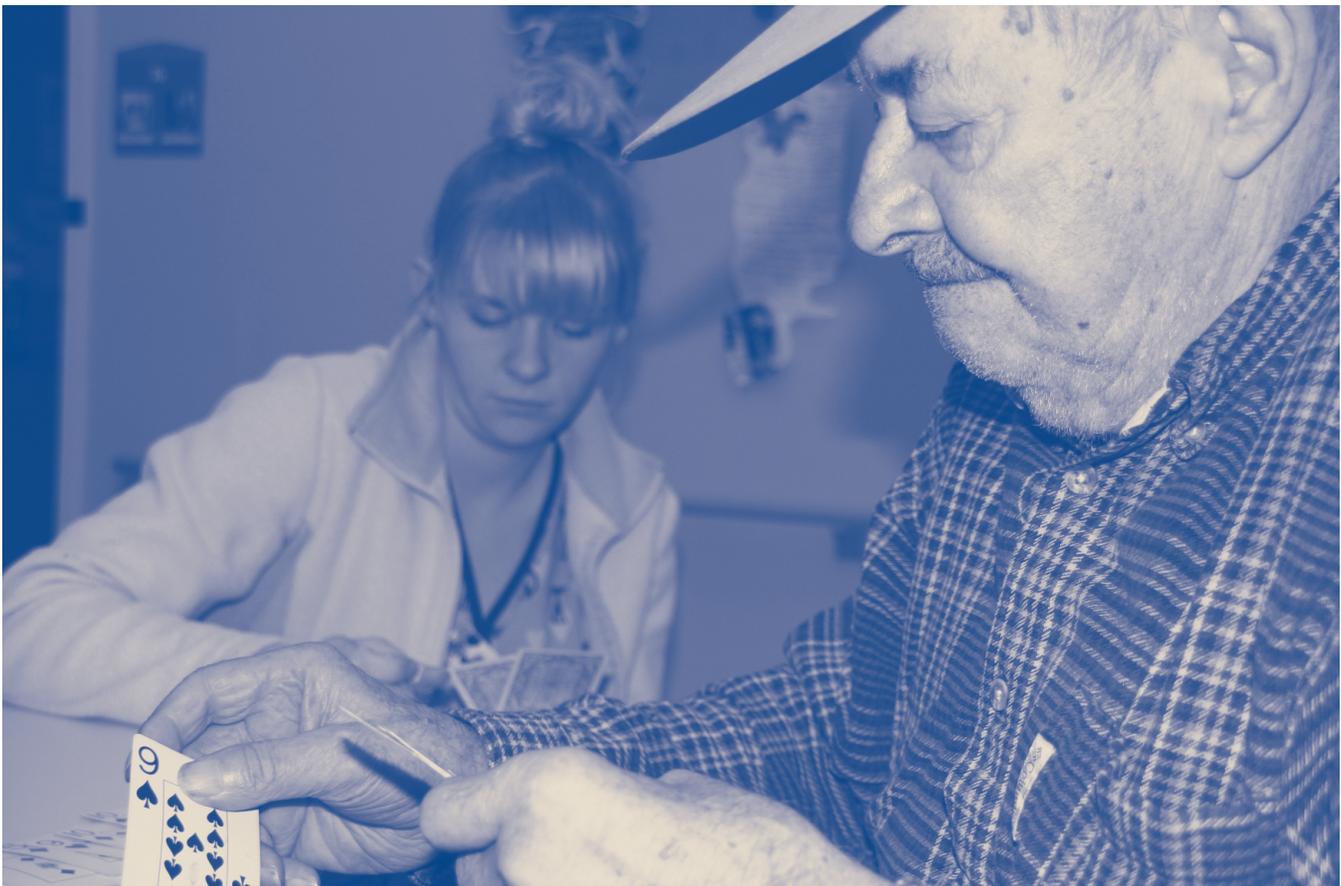
- Within Vermont, standardized data needed to accurately describe the direct care workforce in terms of retention, turnover and adequacy of supply does not exist.
- The U.S. Bureau of Labor Statistics' employment categories used by the Vermont Department of Labor (DOL) do not accurately reflect the direct 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

**M**any 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

**T**he 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 Vermont<sup>3</sup> 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

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<sup>3</sup> 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.

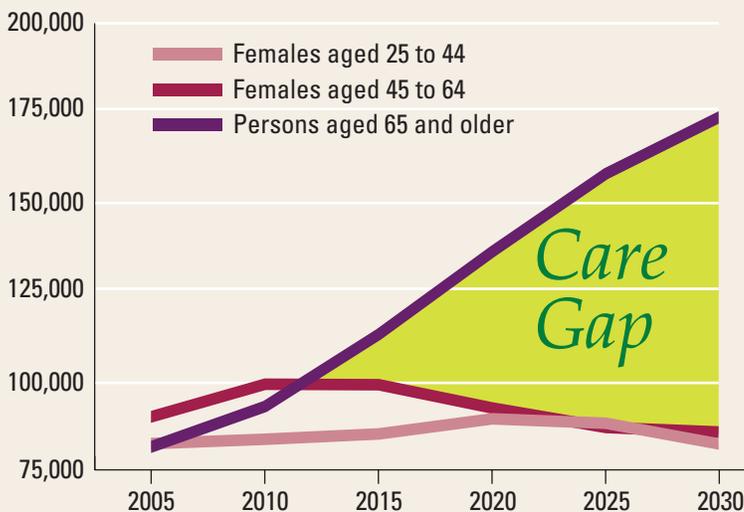
While estimating the future demand for care is as complex a task as estimating the workforce supply (see Appendix L), it is clear that demand will grow in coming years because of the aging baby boomers. Of equal concern are

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 data<sup>4</sup>, 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

<sup>4</sup> 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 registries<sup>5</sup>. Last year, our legislature provided initial support to establish a Vermont direct care workers registry.

<sup>5</sup> See PHI's *Selected State Registry Websites* ([http://www.adrc-tae.org/tiki-download\\_file.php?fileId=26953](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 history<sup>6</sup>. 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 retirement<sup>7</sup> 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 work<sup>8</sup>.

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 settings<sup>9</sup>.

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<sup>6</sup> 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)

<sup>7</sup> 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](http://assets.aarp.org/rgcenter/econ/multiwork_2003.pdf)

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

<sup>9</sup> See *Organizational Cultural Competency Assessment: An Intervention and Evaluation*. Available through Better Jobs Better Care, [www.bjbc.org](http://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.<sup>10</sup> 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
<b>In-service programs<sup>1</sup></b>			
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
<b>Courses paid by employer<sup>2</sup></b>			
DCW report paid courses not available	4.54 yrs	5.76	1585
DCW report courses paid by employer	5.75 yrs	6.09	114
<b>Conferences/workshops paid by employer<sup>3</sup></b>			
DCW report paid workshops not available	3.85 yrs	5.29	1168
DCW report paid workshops available	6.30 yrs	6.46	531

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

<sup>10</sup> 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](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](http://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*<sup>11</sup>. 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 <sup>1</sup>	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 <sup>2</sup>			
Not satisfied	\$10.75	2.21	146
Neutral	\$10.76	2.25	468
Very satisfied	\$11.11	2.07	850
Opportunities for pay raises <sup>3</sup>			
Not satisfied	\$10.76	2.15	669
Neutral	\$11.17	2.29	546
Very satisfied	\$11.14	1.81	216

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

<sup>11</sup> PHI (June 2007) Elements of a Quality Job for Caregivers: Key Research Findings. At [www.PHInational.org/clearinghouse](http://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 <sup>1</sup>	0.63	1219
Received no orientation	2.00	0.62	346
Received formal orientation	2.54 <sup>2</sup>	0.59	685
No formal orientation	2.17	0.65	880
Opportunity to shadow	2.52 <sup>3</sup>	0.62	690
No opportunity to shadow	2.20	0.64	875
In-service programs	2.49 <sup>4</sup>	0.62	820
No in-service	2.16	0.64	745
Courses paid by employer	2.52 <sup>5</sup>	0.59	108
No courses paid by employer	2.32	0.65	1457
Workshops paid by employer	2.49 <sup>6</sup>	0.61	511
No workshops paid employer	2.26	0.66	1053

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

<sup>5</sup> F(1,1563)=9.32, p<.01; <sup>6</sup> 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 residents<sup>12</sup>. 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 homes<sup>13</sup>. This program

<sup>12</sup> 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](http://www.bjbc.org)

<sup>13</sup> 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](http://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
<b>Total</b>	<b>4.6</b>	<b>5.8</b>	<b>1699</b>

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 assignments<sup>14</sup>.

**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 <sup>1</sup>	3.86 yrs	4.09 yrs	5.05 yrs	4.64 yrs
Stable work days and scheduling <sup>2</sup>	3.62 yrs	4.37 yrs	5.00 yrs	4.66 yrs
Training and preparation to provide direct care/support <sup>3</sup>	3.95 yrs	4.41 yrs	5.12 yrs	4.67 yrs

<sup>1</sup> F(2,1602)=6.1, p<.02; <sup>2</sup> F(2,1591)=4.8, p<.01; <sup>3</sup> 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**<sup>15</sup>: 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

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

<sup>15</sup> 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**<sup>16</sup>: a designated staff member, specially trained to assess retention issues, develop and implement strategies to improve retention.
- **Coaching Supervision**<sup>17</sup>: 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**<sup>18</sup>: direct care workers, across all settings, actively participate in care planning for the consumers with whom they work.
- **Peer-mentoring programs**<sup>19</sup>: 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**<sup>20</sup>: 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.

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<sup>16</sup> Pillemer, K. and Meador, R. (2006). *The Retention Specialist Project*. A Better Jobs Better Care Research Study. Available at [www.bjbc.org](http://www.bjbc.org)

<sup>17</sup> 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](http://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

<sup>18</sup> 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](http://www.abramsoncenter.org/PRI/documents/PA_LTC_workforce_report.pdf)

<sup>19</sup> 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>

<sup>20</sup> 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](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 impact<sup>21</sup>.

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

<sup>21</sup> 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](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%<sup>22</sup>. 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%<sup>23</sup>.

### 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 retention<sup>24</sup>.

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)<sup>25</sup> “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

<sup>22</sup> 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/WV\\_2005\\_WAge.pdf](http://www.directcareclearinghouse.org/download/WV_2005_WAge.pdf)

<sup>23</sup> 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&sectionID=4>

<sup>24</sup> 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&sectionID=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](http://www.hchcw.org/uploads///pdfs/hchcw_retentionfactsheet.pdf)

<sup>25</sup> *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

**T**he 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%<sup>26</sup>. 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%<sup>27</sup>.
- 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.

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<sup>26</sup> 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](http://www.directcareclearinghouse.org/download/WY_2005_Wage.pdf)

<sup>27</sup> 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&sectionID=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

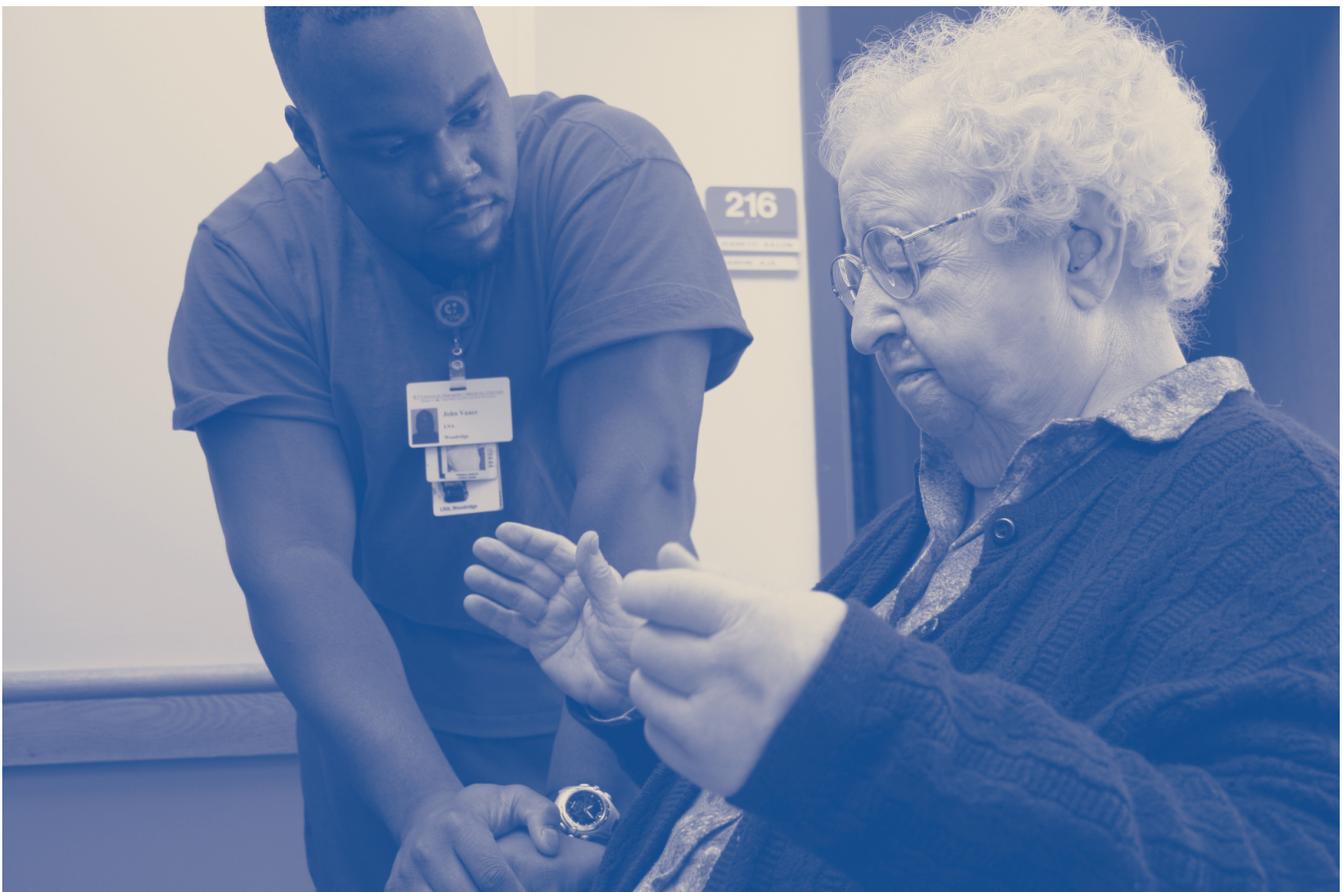
### **Research findings and rationale that support recommendation #6:**

- 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**



## **Appendix A**

**Legislation Authorizing Study of Direct Care Workforce:**

**H 881 (Section 271)**

## Appendix A

### Legislation Authorizing Study of Direct Care Workforce:

#### 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**

**Direct Care Workforce Study Advisory Group**

## Appendix B

### Direct Care Workforce Study Advisory Group

Suzanne Braunegg  
Direct Care Worker

Maria Mireault  
Department of Disabilities, Aging  
and Independent Living

Peter Cobb  
Vermont Assembly of Home Health  
Agencies

Joan Senecal  
Department of Disabilities, Aging  
and Independent Living

Dolly Fleming  
Community of Vermont Elders

Mary Shriver  
Vermont Health Care Association

Susan Gordon  
Vermont Association of Professional  
Care Providers

Margaret Trautz  
Northeastern Vermont Area Health  
Education Center

Brendan Hogan  
Department of Disabilities, Aging  
and Independent Living

Kay VanWoert  
Parent to Parent of Vermont

Denise Lamoureux  
Refugee Coordinator, Agency of  
Human Services

Greg Voorheis  
Department of Labor

Deborah Lisi-Baker  
Vermont Center for Independent  
Living

Marlys Waller  
Vermont Council of Developmental  
and Mental Health Services

Alex Olins  
Paraprofessional Healthcare Institute

Kathy West  
LEADS Project, Community of  
Vermont Elders

Jean Mankowsky-Upham  
Attendant Services Program  
Eligibility Committee

Consultants: Joy A. Livingston, PhD and Donna Reback, MSW, LICSW  
Flint Springs Associates, Hinesburg, VT

## **Appendix C**

Key Informant Response Summary Chart

**Appendix C**  
Key Informant Response Summary Chart  
September 10, 2007

<b>Research Question</b>	<b>Common Responses</b>	<b>Unique Responses</b>
<p>2. What is the <b>demand</b> for workers:</p> <p>Specifically: How have consumer needs changed over the past 10 years? What changes do you expect to see in the coming 10 years?</p>	<p>Needs and conditions of consumers more acute, complex –living longer become more frail, mental health, autism, dementia, safety risk (corrections), TBI, trauma, stress, depression (elder refugees), behavioral issues, aggression –</p> <p>Increased desire to stay in home and community settings with acute, complex needs who used to be in NH and/or hospitals</p> <p>Changing face of consumers - more knowledgeable, independent, demanding higher skill levels and demanding different kinds of services – more social, quality of life, not just medical – wanting assistance versus care – Self-advocacy movement – consumers want to be involved in system design, direct care – implications for staff training, skills</p> <p>DCW roles changing - require higher skill level, knowledge, training (on above issues), provide supervision of correctional clients, outside of NH's need 1-1 supervision with memory loss</p> <p>VAADS - MH services maxed out putting pressure on DCW's/caregivers and ADS settings to deal with cases that fall between the cracks</p> <p>PHI – consumers will want more help navigating the system</p> <p>TBI – need expansion in case management services – organizational assistance, paperwork, handling money, remembering tasks, appointments, etc</p> <p>Need support systems for families</p> <p>Financial pressures requiring family members to work, not stay at home, or to lose jobs – burnout</p> <p>Increased need for overnight care which is not reimbursed</p> <p>Need for housing options</p> <p>VT is a state that is aging more rapidly (including refugee population increasing) - reimbursements and staffing haven't kept pace with growing demand - - means many won't have family members who can care for them (don't have immigrant population that other states have to provide caregiving)</p>	<p>Consumers living at home w/ elderly parents due to funding cuts</p> <p>More people w/o benefits (not rich or poor) struggle to pay for care, often in worst shape</p> <p>DS service model change requiring more supervision</p> <p>Private – encourage people in 40/s – 50's to buy LTC insurance – over next decades willingness to pay for services at home</p> <p>DCW - Drug use among today's younger generation will have later effect on brain functioning.</p>

Research Question	Common Responses	Unique Responses
<p>4. What <b>recruitment and retention strategies</b> are currently in use?</p> <p>Specifically: What are the most effective strategies for recruiting DCWs? What is most effective for retaining DCWs? What are the barriers for improving recruitment and retention?</p>	<p>Barriers: decreasing funding/reimburse rates &gt;burnout, isolation, &gt;different needs and expectations of younger generation (pay, schedules, advancement) clash with values of older workers/supervisors &gt;medical model (old style management and supervision, hierarchy vs team – part time workers, shift moving) &gt;low pay for increasingly higher skill and educational levels – competition means can work in less emotionally demanding places for same/more \$\$, and flexibility &gt;work not valued, populations stigmatized</p> <p>Recruitment: through family (essential for refugee elders), personal and community networks, word of mouth (with other consumers or agencies), try to identify personal connection, &gt;offer higher pay, medical benefits, mileage &gt;caregiver list or registry &gt;news paper ads (mixed reviews) &gt;build public awareness about value and meaningfulness of work (make a difference) – campaign, one-on-one, instill pride in workers &gt;Older workers – easier to recruit to work with elders, more understanding of elder needs (not just babysitting), don't have to pay medical b/c have medicare</p> <p>Retention: higher pay (liveable wage), health insurance &gt;other benefits – mileage, paid vacation, retirement &gt;rotation of assignments/consistent assignments &gt;address isolation by connecting to agency (team meetings, newsletter, supervision, respectful environment) &gt;supervisors with low caseloads to provide more support &gt;Team - decision making, support &gt;Mentoring, shadowing for new workers acknowledgement &gt;Training – in-service and off-site &gt;Advancement – specialties, teaching peers, pay for conferences, continuing ed, more pay for specialty</p>	<p>Barriers: parents depending on college students need to constantly recruit and retrain Lack of professional training for LNA Few advancement opportunities HH – cars break down, reliability low, people don't call in</p> <p>Recruitment: develop coop of self-managed people to advertised more broadly Open house, paid trainings VAADS – not a problem b/c of flex schedules, hours (VAHHA) Refugee – training in materials – on program, benefits, rules, regs, policies, rights - in order to translate to consumer</p> <p>Retention: rotation, (VCDR) ability to watch 2 kids at same time, legal ability to supplement pay Job sharing Critical incident stress debriefing (VAADS) Private – assign one DCW to 2 clients – if one client leaves/dies worker still has employment and check – or DCW's are working for more than one agency to ensure paycheck</p>

Research Question	Common Responses	Unique Responses
<p>3. What are the <b>gaps</b> between supply and demand?</p> <p>Specifically: What factors influence the time it takes to fill a DCW position?</p>	<p>Funding cuts requiring more family care giving leading to parental/caretaker burnout</p> <p>Poor wages, Money and benefits (gas prices)</p> <p>Takes between 30 to 90 days to fill</p> <p>Complex, multiple consumer needs – overwhelming to potential worker</p> <p>Immediate need for care</p> <p>Rural locations – dirth of potential workers for families, difficulty of getting to home, lack of services outside of Chittenden, etc</p> <p>Advertising all the time (HH) – takes time to place ads</p>	<p>Whether there is dedicated person in agency to hire</p> <p>Flexible schedules</p> <p>Family members – interview, screen</p> <p>Overnight care</p> <p>Home settings - Demanding or non-compliant consumer – wears down DCW and agency - requires training, team approach, proper matching</p> <p>Difficulty describing in length of ads what is needed in order to find right person</p> <p>Reputation of facility</p> <p>Reputation of not re-hiring people who have left</p> <p>Needed child care for DCW's – not available</p> <p>TBI – transportation to services</p>

Research Question	Common Responses	Unique Responses
<p>3. What are the <b>gaps</b> between supply and demand?</p> <p>Specifically: How well do staffing patterns meet consumer needs?</p>	<p>In home situations - Need for overnight, evenings, weekends difficult to fill – consumer needs not just 40hr/wk, consumers end up making compromises Situations that combine 2 PT positions don't meet consumer needs, limits choice and flexibility for consumer and DCW</p> <p>NH – state mandates don't address rising acuity levels</p> <p>VAADS – levels vary but consensus there is never enough</p> <p>VAHHA – notes need to have seasoned, experienced workers for difficult cases</p> <p>All – not enough workers in any setting – leads to stress on part of workers not being able to meet needs, give enough time, address specific care issues</p> <p>New models of care (patient centered) and consumer knowledge will require more caregivers – individualized and social, vs medical models</p>	<p>Res care – generally able to meet needs – acuity of residents influences adjustment of staff</p> <p>Private – generally able to meet</p>

Research Question	Common Responses
<p>13. To what extent do <b>employers</b> experience <b>stability</b> in workforce?</p> <p>Specifically: How do you calculate retention rates? What have been your DCW retention rates over the past year? In what other ways would you assess work force stability?</p>	<p>Retention rates: Very mixed depending on the care sector, individual care setting and the consumer – some don't track at all – aggressive, assaultive clients will have lower retention – need good supervision and support to address</p> <p>Formulas – VHCA NH uses QIO, HH uses formula, RC and VAADS varies</p> <p>Private agencies – wide variation</p> <p>Stability: Satisfaction surveys of consumers and DCW's – concerns with increased COL, health insurance</p> <p>Team model</p> <p>Quality of care to consumer – worker needs to be around</p> <p>Flexibility in scheduling, responsive to worker illness</p> <p>Address worker isolation, create community of caregiver – develop specialized peer networks for supporting care to difficult clients such as consumers</p>

Research Question	Common Responses	Unique Responses
<p>13. To what extent do <b>employers</b> experience <b>stability</b> in workforce?</p> <p>Specifically: What do you think contributes to DCW turnover? What aspects are within your control?</p>	<p>Low pay/poor benefits</p> <p>Not enough guaranteed work/hours/pay</p> <p>Working conditions - Unappealing physical/home environments</p> <p>Weather/driving</p> <p>Can't get consistent schedule</p> <p><u>Aspects within control</u>: - creating respectful environment</p> <p>Team approach – involvement of DCW's in meetings and decisions</p> <p>Acknowledgement – monetary and non-monetary</p> <p>Money to programs for recognition similar to Gold star</p>	<p>DS – calculate turnover – 10 – 50%</p> <p>- notes that lower turnover not always good if there are strong unions/weak management</p> <p>Difficult clients</p> <p>Lack of respect (other staff viewing a new worker as just another warm body)</p> <p>Unappreciative attitude toward worker by consumer</p> <p>DCW personal inadequacies – feeling of intimidation</p> <p>Home-based settings – not enough work available</p> <p>BIA – finding case managers, burnout, no training, not good knowledge about BI, pay</p> <p><u>Within control</u> – training to supervisors on skills/attitudes</p> <p>Cross-training</p> <p>Licensure</p> <p>Good pay</p> <p>PHI - Pay for performance</p>

Research Question	Common Responses
<p>8. What <b>skill sets and training</b> are expected of DCWs?</p> <p>Specifically: What are job descriptions and required qualifications for DCWs?</p> <p>How does the Nurse Practice Act impact on DCW job descriptions?</p>	<p><b>Job Desrp/Quals:</b></p> <p><u>DS</u> – 18, HS diploma (can be waived) driver’s license, background check Special needs consumer – difficult to address with persons with minimum quals but who need special skills</p> <p><u>VCDR</u> – no formal job description/quals</p> <p><u>AAA</u> – don’t hire, but suggest the following quals: - flexible around meaningful tasks, can make decisions on feet vs follow flow sheet</p> <p><u>NH</u> – similar quals for LNAs, descriptions for LNA 2 Job descriptions may vary across homes in terms of responsibility. Senior aides do some supervision, assignments, etc</p> <p><u>VAADS</u> – written job descriptions, different in each setting</p> <p>HS/GED – other degrees if required by position (ex: program specialist, LNA, RN)</p> <p><u>VAHHA</u> – LNA for some</p> <p>Physical exam required by some programs – should be required as a screening tool by all, but \$\$ is issue – would prevent losses and turnover due to injury</p> <p><u>Res Care</u> – have job descriptions, 18 or more, reading comprehension required b/c administering meds under RN license</p> <p><u>Private</u> – 1)good driving record, reference, felony, abuse/neglect checks 2) – written job description - serious screening/interview – non-medical therefore don’t require prior training/ed, they provide, background checks</p> <p><u>Champoux</u> – for PCA’s there is no statute on “scope of practice” – may not be negative, viewed as the “social model” where consumer is directing – sees this as an evolving scope of practice – notes that PCA’s can do what LNA’s can’t and they can respond to consumer without the limitations of a license. VAPCP developing voluntary course for PCA’s on core skills.</p> <p><u>Refugees</u> – qualifications should require some knowledge of language and culture of consumer being assisted.</p> <p><u>TBI</u> – under contract with case mgrs</p> <p><b>Nurse Practice Act:</b></p> <p><u>DS</u> – nurses concerned about putting license at risk by delegating medication admin – skirt act by having MD delegate special procedures – need for and lack of supervision is issue</p> <p><u>VAADS</u> – NPA has no impact</p> <p><u>Res Care</u> – depends on personalities of RN and DCW as RN provider training and supervision</p> <p><u>Champoux</u> – verifies above that interpretation of NPA varies by individual and agencies (“this is on <b>my</b> license”), no consistency, lot’s of tension around this</p> <p><u>Swartz/AHEC</u> – feels LNA’s can easily exceed their level of legal care as they are often asked to give opinions/advice about meds</p>

<b>Research Questions</b>	<b>Common Responses</b>
<p>8. What <b>skill sets and training</b> are expected of DCWs?</p> <p>Specifically: How is initial and ongoing training provided? What topics are covered? What are turnover rates during/following training?</p>	<p><b>Provision of Trg</b> - see individual interviews:  <u>DS</u> – state required pre-service trg across all agencies  Annual in-service trg in each agency  Offer additional trainings, respond to staff trg requests  <u>VCDR</u> – individually determined – families provide, PT, schoos  <u>DDAS</u> – should be individualized and based on consumer/dcw situation, believes that teams are way to exchange information  <u>AAA</u>- suggested trg, safety, injury prevention, setting boundaries  <u>VHCA</u> – Voc. ctrs LNA training, all provide orientation, some mentoring, in-service, some person centered care, videos, liked BJBC on-site resources  <u>VAADS</u> – all have orientation – some do in-service - Expense of off-site travel and training, replacing staff are barriers. Professional trg offered by nursing homes make DCW's feel demeaned, doesn't apply to what's needed.  See list training wanted by staff  <u>VAHHA</u> – varies by agency – have in-services, different and specialized topics  <u>Res Care</u> – 2 week orientation, range of in-services on range of topics  <u>Private</u> – 1)80 hr training program – has house as a training ctr - how to cook, made beds, track meds, walkers will let people go. Also specialized trg on alz, other conditions  2) have 3 different programs, basic and advance guides, special conditions, alz – is required, take home materials/tests  <u>PHI</u> – provides resources for this – see notes, states with minimum requirements  <u>Champoux</u> – nothing uniform yet for PCA's  <u>Refugees</u> – see above  <u>BIA</u> – state TBI does some trg with providers  <u>Swartz, AHEC</u> – feels most are not comfortable with basic 70 – 80 hr trg  Sees mentoring as desirable way to train  <u>VAPCP</u> – everything from being thrown into job, to extensive orientation by staff  CPR, Communication Skills, Safety, LNA course  <b>Impact on turnover</b>  <u>DS</u> – satisfaction higher due to trg, but no impact on t/o b/c of low wages &amp; benefits  <u>Swartz, AHEC</u> – believes mentoring reduces turnover  <u>VAPCP</u> – would like tier advancement, ability to work towards credentials</p>

Research Question	Common Responses
<p><b>5. Can technology and equipment</b> be used to bridge gaps between supply and demand?</p> <p>Specifically: To what extent can equipment and technology reduce the need for DCW care/support? What are the barriers to using technology &amp; equipment? Might technology be helpful to reduce paperwork demands on DCWs?</p>	<p>Reduce need for DCW? Monitoring devices could reduce need for constant on-site presence Lifts, vans, etc could reduce injury which would reduce need to recruit/replace Electronic records increase shared information, better decisions, share in care planning Many low cost memory loss technologies can take stress away from DCW or allow DCW to spend more time and attention on other things if not fearing consumer will wander off</p> <p>DS – yes, through phone, computer monitoring technologies PHI - telemedicine VCDR – technologies like computers (games, interactive experiences, learning tools) may improve social existence of consumer – not sure this addresses need for DCW, suggests change in quality of interaction, lift vans provides access to community for consumer Emphasis is on how technologies would improve quality of life of consumer and need to think about how that would impact need for DCW – may change need as well as in some settings reduce it. Front loading washers/dryers would reduce need for some dcw NH fine line between observing w/o invading privacy – question how CMS would view use of different technologies in this regulatory era</p> <p>Barriers to using – expense of, lack of benefits for lifts, vans, lightweight wheelchairs etc, knowledge to use – need to train in use of computers – older workers may find this stressful Rural nature of VT may limit use of effective telecommunications as cell service, high speed lines not available everywhere.</p> <p>Reduce paperwork demands – unclear if electronic record keeping will reduce demands, mixed opinions – value, however is in easier ability to share important information would help provide better care, better decisions within and between departments (ex: recording of diets, serving food)</p>

Research Question	Common Responses
<p>9. How do care and support setting address <b>cultural issues</b></p> <p>Specifically:            What specific skill sets, attitudes and knowledge should DCWs have with regard to cultural diversity?            What are the cultural diversity issues for consumers, DCWs?            What type of training is offered?</p>	<p><b>Needed:</b></p> <p>Translators for refugee needed            Poverty – socio-economic issues require good fit between worker and consumer, want interactions to be intelligent, stimulating, not just babysitting and have same values            Address class differences, prejudices, education to build tolerance            Racial intolerance – of residents and consumers towards DCWs of different race            Communication skills to be able to relate, interact effectively with different cultures, demands knowledge of those cultures            Course on successful aging, on sexuality and aging, generational issues – know how we asexualize older people            Language barriers need to be addressed            Training for all levels of staff in agency – identify whole range of cultures            Question about importance of experience and how to teach/build cultural competence.            Listed whole range of cultures            Learn how to cook favorite food of consumers</p> <p><b>Type of training offered?</b></p> <p>Very little – responses were very extensive (see above) to what is needed            Should note Cathedral Square curricula developed through BJBC and Resource manual for health care providers from NW AHEC (see interview with Deb Emerson) – being revised and updated – chapters specific to refugee populations – do some workshops in cultural competency generally geared to refugees and their health care needs</p>

Research Question	Common Responses
<p>14. How do <b>wages</b> compare across waivers, programs and services?</p> <p>Specifically: How do you define the total compensation package for DCWs? What is included? What is the range between starting workers and those with varied years of service?</p>	<p>Comp package – got few responses</p> <p>VAADS – pay rate varied from \$8 to 14 depending on whether was LNA or no “initials after name, on experience, on specialty</p> <p>VAHHA – varies also (see notes) Some cafeteria style benefit packages</p> <p>Res Care – health insurance, retirement, earned time off/ can sell vacation time for cash) can earn up to 6 wks off – if don’t use full benefits, DCW will be given extra amount in wage, tuition reimbursement of \$1000/yr, extra for evening/overnight, weekend work. More for shift leader, cash awards for perfect attendance, worker’s comp.</p>

Research Question	Common Responses	Unique Responses
<p>16. What <b>wages (and benefits)</b> must caregivers receive to maintain a viable workforce?</p> <p>Specifically: What level of compensation is needed to retain DCWs? What are sources of competition for DCWs?</p>	<p>Rate above the liveable wage – opinions varied on exact amount, sensitivity to geographic location of programs</p> <p>VAADS – goal of \$15/hr</p> <p>Private – 1) goals of \$17/hr, prefer salary to wage and have them on-call 2) – could retain with \$10-11/hr plus health benefits</p> <p>Health and dental insurance</p> <p>Benefits for 20hr/wk</p> <p>Retirement</p> <p>Mileage</p> <p>Vacation - time off</p> <p>Tuition reimbursement</p> <p>Dedicated training days</p> <p>Family friendly environment/policies</p> <p>Guaranteed wage increase</p> <p>Child care – on-site would help welfare worker take a job</p> <p>Cafeteria style benefits</p> <p>For NH’s ability to compete with hospital packages which are higher</p>	<p><u>DS</u> – state should allow home providers to form association giving them access to health care insurance, same benefit as agency employees</p> <p>Champoux – need to stop talking about “entry level” this is hierarchical, medical model – have to pay them well</p> <p>Refugee - Gift certificates to grocery stores</p> <p>VAPCP – shoes, yoga/relaxation session, discount to gym, retirement account is a way to reward longevity, reimbursement of out of pocket expenses</p>

<b>Additional Thoughts</b>	<p>DS – system has gone from staff to contract, more difficult to monitor quality</p> <p>VCDR - \$\$ for training – would keep workforce interested Need for parent training on what it takes to be effective employer</p> <p>VCDR – need financial support to enable consumers to participate in design and monitoring of care system – mileage, per diem</p> <p>Private agencies - once trained will leave for other place, may form team, think they can do the work, but not skilled/supervised adequately</p> <p>VHCA – state should mandate that PPD is higher – leading to higher staffing levels and coverage</p> <p>Swartz – training needed on elder abuse, skin care, grooming and prevention, pharmacological issues, normal and abnormal reactions to meds, physical and emotional self-care</p>
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## **Appendix D**

Summary of Structured Group Interview Responses

## Appendix D

### Summary of Structured Group Interview Responses

Research Question	Common themes across groups	Themes particular to groups
<p>2. What is the <b>demand</b> for workers?</p> <p>Specifically:            What do consumers need to live as full a life as possible?            What type of support/care is needed?</p>	<ul style="list-style-type: none"> <li>• Consistent caregivers to provide assistance</li> <li>• Flexibility to allow for spontaneity, recreational &amp; social activities</li> <li>• Flexibility to allow use of funds to give DCW raise, mileage, or cover other needed supports/services</li> <li>• Societal/community support &amp; involvement -- including value caregiving</li> <li>• Traits/type of support/care provider needed:               <ul style="list-style-type: none"> <li>○ Safe (no criminal record)</li> <li>○ Known person (relative or friend)</li> <li>○ Reliable, trustworthy</li> <li>○ Connect with consumer &amp; family, able to establish relationship</li> <li>○ Respectful, listen to needs/desires of consumer/family, do tasks as requested</li> <li>○ Able to communicate (including speak consumer's language)</li> <li>○ Compassionate, "caring heart"</li> <li>○ Pleasant, good sense of humor, "cheery"</li> <li>○ Open-minded, tolerant, understand elders/persons with disabilities</li> <li>○ Physically able to provide care</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Residential programs for young adults with complex needs (Families of adults with developmental disabilities and parents of children receiving personal care services)</li> <li>• Opportunities to attend skill building conferences (TBI)</li> <li>• PCA's coordinate care since not one caregiver able to address all needs (TBI)</li> <li>• Provide annual budget or allotment of hours to cover situation if lose DCW and not able to find replacement quickly (parents)</li> <li>• Traits identified by specific consumer groups:               <ul style="list-style-type: none"> <li>○ Flexible (VCIL)</li> <li>○ Past experience with person with disability (families)</li> <li>○ Mellow, know how to handle aggression (parents)</li> <li>○ Motivator, empathetic (TBI)</li> <li>○ Able to maintain confidentiality (self-advocates)</li> </ul> </li> </ul>

Research Question	Common themes across groups	Themes particular to groups
<p>3. What are <b>gaps</b> between supply and demand?</p> <p>Specifically: What factors influence time to fill positions? Are allocated hours used?</p>	<ul style="list-style-type: none"> <li>• Screening, background checks take time</li> <li>• Low wages, lack of benefits</li> <li>• Travel to remote locations (without mileage reimbursement, or access to 4 wheel drive vehicle)</li> <li>• Many do not use allocated hours because: <ul style="list-style-type: none"> <li>○ Cannot find DCWs</li> <li>○ Finding, screening, training new workers is too much work</li> <li>○ Juggling schedules to match needs takes time and effort, not always successful</li> <li>○ Needed service not covered by funding source</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to find DCW willing to live-in (VCIL) or overnight care (TBI)</li> <li>• Difficult to find DCW willing to work with complicated, demanding needs (families of children, adults with developmental disabilities, and adults with Alzheimer's)</li> </ul>
<p>4. What <b>recruitment and retention strategies</b> are currently in use?</p> <p>Specifically: What are most effective strategies for recruiting DCWs? What retention strategies have been most effective? What are barriers to recruitment and retention?</p>	<ul style="list-style-type: none"> <li>• Agency recruits DCWs (varied levels of satisfaction with skills of DCW recruited by agency)</li> <li>• Consumer recruitment relies primarily on word-of-mouth; sometimes use ads, in wide variety of settings (e.g., schools, coop, church, gym)</li> <li>• Background checks and screening critical: sometimes consumers able to conduct reference checks, often say don't know how/where to conduct background checks</li> <li>• Some consumers unsure of where to look for DCWs, want a list and coordinator to screen &amp; match</li> <li>• Primary barriers: low wages, lack of health care benefits, not sick leave or time off, no mileage reimbursement</li> <li>• Additional barrier: time and energy to screen &amp; training workers</li> <li>• Establish a list (registry), match DCW with consumer</li> </ul>	<ul style="list-style-type: none"> <li>• Establish clear training requirements and certification for all DCWs to create professional standing in community and thus dignity for workers (elders)</li> <li>• Introduce specific tasks through incremental training (little by little) (parents)</li> <li>• Flexibility in hours and funding (e.g., offer room &amp; board) (parents)</li> <li>• Show appreciation for workers' lives and "really hard work" (elders)</li> <li>• Conduct thorough needs assessment to create good match (TBI)</li> </ul>

Research Question	Common themes across groups	Themes particular to groups
<p>5. Can technology and equipment be used to bridge gaps between supply and demand?</p> <p>Specifically: What types of technology and equipment are in use? What could help reduce the need for DCWs? What are barriers?</p>	<ul style="list-style-type: none"> <li>• Many consumers do or would use simple technology (e.g., tub rail, walking stick, grabber, Palm Pilot) to allow for increased independence</li> <li>• Lifts and tracks for home and cars would be useful</li> <li>• Primary barrier: cost, also waiting time to receive modifications</li> </ul>	<ul style="list-style-type: none"> <li>• Service dogs (VCIL)</li> <li>• Clearinghouse on technology &amp; equipment resources would be helpful (families)</li> <li>• Technology for cognitive assistance (e.g., alarms, wireless key boards, computers) (TBI)</li> <li>• Consistent use of technology and equipment between home &amp; school (parents)</li> </ul>
<p>8. What <b>skill sets and training</b> are expected of DCWs?</p> <p>Specifically: What are required qualifications? Initial training requirements? Ongoing training requirements?</p>	<ul style="list-style-type: none"> <li>• Understand working with consumer/family as team</li> <li>• Understand how to provide personal care, including body mechanics, with attention to consumer's dignity</li> <li>• Training must include families, parents</li> </ul>	<ul style="list-style-type: none"> <li>• Ability to follow family's instructions (families of elders)</li> <li>• Specific knowledge about disabilities (TBI, parents)</li> <li>• Basic safe care for children (parents)</li> <li>• Basic food preparation skills (VCIL)</li> </ul>
<p>9. How do care and support settings address cultural issues?</p> <p>Specifically:  What are the cultural diversities of consumers? What sort of culture differences must be addressed for DCWs, consumers?</p>	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• People with disabilities perceived as simple-minded (VCIL)</li> <li>• Speak common language, understand food (Refugees)</li> <li>• Understand gender issues, family cultural issues (build relationships, trust) (TBI, refugees)</li> <li>• Respect for choices (religion, sexual preference) (self-advocates)</li> </ul>
<p>12. To what extent do consumers experience a stable workforce?</p> <p>Specifically: Number of different DCWs providing care? Reliance on students as DCWs?</p>	<ul style="list-style-type: none"> <li>• Many different people provide care when work with agency – need for consistency to build trust, learn routine, allow for consumer's dignity (especially important for persons with Alzheimer's and autism)</li> <li>• With many different caregivers, exhausting for consumers &amp; family members to train</li> </ul>	<ul style="list-style-type: none"> <li>• TBI survivors may prefer different caregivers providing different care</li> </ul>

## **Appendix E**

Direct Care Worker Survey

## Appendix E

### Direct Care Worker Survey

Thank you for taking a few moments to complete this important survey. Results will help Vermont address the concerns of workers who provide needed care and support services. Your completed survey will be forwarded to and only opened by the independent research team conducting the study, Flint Springs Associates. They will treat your responses confidentially and report results in aggregate so that no individual will be identifiable.

***Please return completed survey by November 9, 2007.***

For more information about the study, please see the accompanying cover letter, or contact Joy Livingston, Flint Springs Associates, (802)482-5100, [joy@madriver.com](mailto:joy@madriver.com).

1. In what county do you live?
 

A. <input type="checkbox"/> Addison	F. <input type="checkbox"/> Grand Isle	K. <input type="checkbox"/> Rutland
B. <input type="checkbox"/> Bennington	G. <input type="checkbox"/> Franklin	L. <input type="checkbox"/> Washington
C. <input type="checkbox"/> Caledonia	H. <input type="checkbox"/> Lamoille	M. <input type="checkbox"/> Windham
D. <input type="checkbox"/> Chittenden	I. <input type="checkbox"/> Orange	N. <input type="checkbox"/> Windsor
E. <input type="checkbox"/> Essex	J. <input type="checkbox"/> Orleans	
  
2. Are you:
 

A. <input type="checkbox"/> Male	B. <input type="checkbox"/> Female
----------------------------------	------------------------------------
  
3. What is your age? \_\_\_\_\_ years old
  
4. What level of school have you finished?
 

A. <input type="checkbox"/> Currently attending school (what type of school? _____, level? _____)
B. <input type="checkbox"/> Less than high school
C. <input type="checkbox"/> High school diploma or GED
D. <input type="checkbox"/> Some college
E. <input type="checkbox"/> Technical school
F. <input type="checkbox"/> Bachelor's degree
G. <input type="checkbox"/> Advanced degree (Master's, Ph.D.)
  
5. How many jobs do you currently hold?
 

_____ Number of direct care worker jobs
_____ Number of jobs that are NOT direct care work (describe: _____)
  
6. Which of the following jobs or positions do you **currently** hold? *Check all that apply.*

A. <input type="checkbox"/> LNA	H. <input type="checkbox"/> Activity aide
B. <input type="checkbox"/> PCA	I. <input type="checkbox"/> Respite provider
C. <input type="checkbox"/> Direct support professional, community or employment support worker	J. <input type="checkbox"/> Hospice care
D. <input type="checkbox"/> Developmental home/foster care provider	K. <input type="checkbox"/> Privately paid caregiver
E. <input type="checkbox"/> Resident assistant/aide	L. <input type="checkbox"/> Other, please describe: _____
F. <input type="checkbox"/> Homemaker	
G. <input type="checkbox"/> Geriatric aide	

7. How many hours a week do you work as a direct care worker? \_\_\_\_\_
8. How many hours a week do you work in other jobs that are NOT direct care work?  
\_\_\_\_\_ Hours per week in non-direct care work job  
\_\_\_\_\_ Do not work a job other than as direct care worker
9. To which of the following populations do you **currently** provide care/support?  
*Check all that apply.*
- A.  Older adults
  - B.  Adults and/or children with physical disabilities
  - C.  Adults and/or children with developmental disabilities
  - D.  Adults and/or children with traumatic brain injuries
  - E.  Persons with dementia and/or Alzheimer's disease
  - F.  Other, please describe: \_\_\_\_\_
10. Which of the following best describe your **current** work setting?  
*Check all that apply.*
- A.  Client homes, hired by client
  - B.  Client homes, hired by agency
  - C.  My home
  - D.  Nursing home
  - E.  Assisted living residence
  - F.  Residential care or group home
  - G.  Adult day center
  - H.  Community or client workplace
  - I.  Other, please describe: \_\_\_\_\_
11. How many miles per day do you have travel to your direct care work? \_\_\_\_\_
12. How long have you worked as a direct care worker? \_\_\_\_\_ months or \_\_\_\_ years
13. How long have you worked with your current employer/contractor?  
\_\_\_\_ months \_\_\_\_ years
14. Do you have any plans to retire in the next five years?
- A.  Yes
  - B.  No
  - C.  Not sure
15. What is the **one most important** reason you provide direct care or support?
16. What did you receive when you first started your **current** position as a direct care worker?  
*Check all that apply.*
- A.  No orientation at all, just started to work
  - B.  A brief orientation to the work provided by \_\_\_\_\_
  - C.  Formal orientation program, including instruction & materials such as a manual
  - D.  Opportunity to shadow a more experienced worker to "learn the ropes"
  - E.  Other, please describe: \_\_\_\_\_

17. Since working in your current position, what type of training have you received?  
*Check all that apply.*
- A.  Learn "on-the-job"
  - B.  In-service programs at the job site
  - C.  Courses at school paid by my employer
  - D.  Courses that I have paid for
  - E.  Attend conferences or workshops paid for by my employer
  - F.  Attend conferences or workshops at my own expense
  - G.  Other, please describe: \_\_\_\_\_
18. What is the **one most important** area of training you feel is needed for direct care workers?
19. Do you currently work: (*check all that apply*)
- A.  Nights
  - B.  Weekend
  - C.  Weekdays
20. Would you be willing/able to work: (*check all that apply*)
- A.  Nights
  - B.  Weekend
  - C.  Weekdays
21. What do you currently earn as a direct care worker?  
\$\_\_\_\_\_/hour or \$\_\_\_\_\_ monthly stipend
22. Do you expect to receive pay raises in your current direct care worker position?
- A.  No
  - B.  Yes
  - C.  It depends, please explain: \_\_\_\_\_
23. What unreimbursed expenses do you pay for?
- A.  Travel time (how much time do you travel each week? \_\_\_\_\_ hours)
  - B.  Mileage (number of miles traveled weekly? \_\_\_\_\_ miles)
  - C.  All my expenses are reimbursed
  - D.  I do not have any unreimbursed expenses
  - E.  Other costs, describe: \_\_\_\_\_
24. What would you have to earn to continue working in direct care/support?  
\$\_\_\_\_\_/hour \$\_\_\_\_\_ monthly stipend
25. Which of the following benefits do you receive as a direct care worker? *Check all that apply*
- A.  Health insurance
  - B.  Time off (including vacation days, sick leave, personal leave, or combined time)
  - C.  Mileage reimbursement
  - D.  Reimbursement for expenses such as supplies, program fees
  - E.  Tuition reimbursement
  - F.  On-site child care or reimbursement for child care costs
  - G.  Retirement
  - H.  Do not receive any benefits
  - I.  Other benefits, please describe: \_\_\_\_\_

26. How much money do you have to pay for health care insurance?
- A.  I don't have health insurance
- B.  I don't pay anything, my employer covers the whole premium
- C.  I pay \$\_\_\_\_\_/month through my employer
- D.  I have health insurance through a job other than direct care
- E.  I have health insurance through my spouse or family

27. How satisfied are you with the following aspects of your job as a direct care worker?

*Circle the number on each item that comes closest to your feelings.*

	<b>Not at all satisfied</b>	<b>Neutral</b>	<b>Very Satisfied</b>
Training and preparation to provide direct care/support	1	2	3
Reliable number of work hours each week.	1	2	3
Stable work days and scheduling.	1	2	3
Consistent assignment to clients/consumers/residents	1	2	3
Clear communication and expectations from supervisors	1	2	3
Support and respect from supervisors	1	2	3
Team work with co-workers	1	2	3
Feeling part of a community of direct care workers	1	2	3
Specific and clear expectations of the job	1	2	3
Time to provide needed care/support	1	2	3
Time I have to build relationships with clients/consumers	1	2	3
Time I have to complete paperwork	1	2	3
Flexibility to meet clients'/consumers' social needs	1	2	3
Availability of tools to ease work demands & reduce injury	1	2	3
Workplace attention to cultural differences	1	2	3
Opportunities for pay raises	1	2	3
Opportunities for advancement	1	2	3

28. What do you like the **best** about direct care/support work?

29. What do you like the **least**?

30. What is the **one most important** factor you believe could improve recruitment and retention of direct care workers?

Thank you for your valuable input!  
**Please return by November 9, 2007**  
 in the stamped self-addressed envelope to:  
 State of Vermont; 1078 US Route 2; Montpelier VT 05602-9808

## **Appendix F**

Employer Survey

## Appendix F Employer Survey

Thank you for taking a few moments to complete this important survey. Results will inform strategies for attracting and keeping workers providing critical direct care and support services. Your responses will be forwarded to and only opened by the independent research team conducting the study, Flint Springs Associates. They will treat your responses confidentially, reporting results in aggregate form so that individual organizations will not be identifiable.

***Please return the completed survey by November 9, 2007.***

For more information about the study, please refer to the accompanying cover letter, or contact Joy Livingston, Flint Springs Associates, (802)482-5100, [joy@madriver.com](mailto:joy@madriver.com).

1. Which of the following best describes your organization? *Please check one.*
  - A.  Nursing home
  - B.  Home health agency
  - C.  Private duty agency
  - D.  Residential care home
  - E.  Assisted living
  - F.  Adult day program
  - G.  PACE program
  - H.  Developmental services provider
  - I.  Other type of organization, please describe: \_\_\_\_\_
  
2. What counties do you serve? \_\_\_\_\_
  
3. Which of the following populations do you serve? *Check all that apply.*
  - B.  Older adults
  - C.  Adults and/or children with physical disabilities
  - D.  Adults and/or children with developmental disabilities
  - E.  Adults and/or children with traumatic brain injuries
  - F.  Persons with dementia and/or Alzheimer's disease
  - G.  Other, please describe: \_\_\_\_\_
  
4. For each of the populations you serve, please estimate the number of persons served on September 1, 2007.

Population served	Estimated Number served on September 1, 2007
A. Older adults	
B. Adults and/or children with physical disabilities	
C. Adults and/or children with developmental disabilities	
D. Adults and/or children with traumatic brain injuries	
E. Persons with dementia and/or Alzheimer's	
F. Others	
G. Total number of persons receiving direct care/support (if you do not use above categories)	

5. Please estimate the number of DCWs (by type outlined below) employed by or contracted with your organization on September 1, 2007.

Type of DCW	Number Employed on 9/1/07
A. Licensed Nurse Assistant (LNA)	
B. Personal Care Attendant (PCA)	
C. Direct support professional, employment or community support worker	
D. Foster care or developmental home provider	
E. Resident assistant or aide	
F. Homemaker	
G. Geriatric aide	
H. Activity aide	
I. Other, please describe:	

6. When you seek to fill DCW positions, on average how many weeks does it take to fill the position?

Type of DCW	Average Number of Weeks to Fill Position
A. Licensed Nurse Assistant (LNA)	
B. Personal Care Attendant (PCA)	
C. Direct support professional, employment or community support worker	
D. Foster care or developmental home provider	
E. Resident assistant or aide	
F. Homemaker	
G. Geriatric aide	
H. Activity aide	
I. Other, please describe:	

7. Do you track turnover or retention rates?

A.  No

B.  Yes If yes, how do you track rates, please describe: \_\_\_\_\_

What were retention and/or turnover rates in the last year?

Type of DCW	Retention	Turnover
A. Licensed Nurse Assistant (LNA)	%	%
B. Personal Care Attendant (PCA)	%	%
C. Direct support professional, employment or community support	%	%
D. Foster care or developmental home provider	%	%
E. Resident assistant or aide	%	%
F. Homemaker	%	%
G. Geriatric aide	%	%
H. Activity aide	%	%
I. Other, please describe:	%	%

8. Whether or not you calculate retention rates, what do you estimate is the average annual retention rate for direct care workers in your organization? \_\_\_\_\_% retention
9. In your organization, on average, how many years of continuous service do direct care workers provide?

Type of DCW	Average Number of Years of Service
A. Licensed Nurse Assistant (LNA)	
B. Personal Care Attendant (PCA)	
C. Direct support professional, employment or community support worker	
D. Foster care or developmental home provider	
E. Resident assistant or aide	
F. Homemaker	
G. Geriatric aide	
H. Activity aide	
I. Other, please describe:	

10. What is the **one** most **important** training need among direct care workers employed or contracted by your organization?

11. As of September 1, 2007, what were starting and maximum hourly wages for direct care workers in your organization?

Type of DCW	Starting Hourly Wage	Maximum Hourly Wage
A. Licensed Nurse Assistant (LNA)	\$	\$
B. Personal Care Attendant (PCA)	\$	\$
C. Direct support professional, employment or community support worker	\$	\$
D. Foster care or developmental home provider	\$	\$
E. Resident assistant or aide	\$	\$
F. Homemaker	\$	\$
G. Geriatric aide	\$	\$
H. Activity aide	\$	\$
I. Other, please describe:	\$	\$

12. Does the organization provide scheduled increases in wages for direct care workers?

*Check all that apply.*

- A.  No, there are no type of scheduled wage increases
- B.  Yes, DCW's receive regular cost of living (COLA) increases
- C.  Yes, wages are increased commensurate with years of services
- D.  Yes, we have merit wage increases
- E.  It depends on the type of DCW, please describe: \_\_\_\_\_

13. Which of the following benefits does your organization provide to direct care workers?

*Check all that apply*

- A.  Health care insurance
- B.  Time off (including paid vacation days, paid sick leave, paid personal leave, or combined time off)
- C.  Mileage reimbursement
- D.  Reimbursement for DCW expenses such as supplies, program fees
- E.  Tuition reimbursement
- F.  Childcare on-site or reimbursement for child care costs
- G.  Retirement
- H.  Other benefits, please describe: \_\_\_\_\_

If benefits vary depending on type of DCW, please describe:

14. How many hours a week must DCW's work to be eligible for most benefits?

\_\_\_\_\_ hours/week

Please describe any variance by type of DCW or benefit:

15. If your organization offers health insurance, what percentage of the premium do you cover?

\_\_\_\_\_ % of health insurance premium covered by agency

\_\_\_\_\_ Agency does not provide health insurance

\_\_\_\_\_ Other, please describe: \_\_\_\_\_

16. What is the one most important factor you believe could improve recruitment and retention of direct care workers?

17. Anything else you would like to add?

Thank you for your valuable assistance!

**Please return by November 9, 2007**

in the stamped self-addressed envelope to:

State of Vermont, 1078 US Route 2, Montpelier VT 05602-9808

## **Appendix G**

Consumer/Surrogate Survey

## Appendix G

### Consumer/Surrogate Survey

Thank you for taking a few moments to complete this important survey. Results will help efforts to attract and keep workers who provide critical direct care and support services. Your completed survey will be forwarded to and only opened by the independent research team conducting the study, Flint Springs Associates. They will treat your responses confidentially, reporting results in aggregate so that individuals will not be identifiable.

For more information about the study, please refer to the accompanying cover letter, or contact Joy Livingston, Flint Springs Associates, (802)482-5100, [joy@madriver.com](mailto:joy@madriver.com).

***Please return completed survey by November 9, 2007.***

1. Which of the following best describes you? *Please check one.*
  - A.  I receive care or support from a direct care provider
  - B.  I am completing this survey for a family member or friend who receives direct care or support
  - C.  Other, please describe: \_\_\_\_\_
  
2. In what county does the person receiving care/support live?
 

A. <input type="checkbox"/> Addison	F. <input type="checkbox"/> Lamoille
B. <input type="checkbox"/> Bennington	G. <input type="checkbox"/> Orange
C. <input type="checkbox"/> Caledonia	H. <input type="checkbox"/> Orleans
D. <input type="checkbox"/> Chittenden	I. <input type="checkbox"/> Rutland
E. <input type="checkbox"/> Essex	J. <input type="checkbox"/> Washington
F. <input type="checkbox"/> Grand Isle	K. <input type="checkbox"/> Windham
G. <input type="checkbox"/> Franklin	L. <input type="checkbox"/> Windsor
  
3. The person receiving care/support is:
 

H. <input type="checkbox"/> Male	B. <input type="checkbox"/> Female
----------------------------------	------------------------------------
  
4. What is the age of the person receiving care/support? \_\_\_\_\_ years old
  
5. Does the person receiving care/support have any of the following?  
*Please check all that apply.*
  - A.  Physical disability
  - B.  Developmental disability
  - C.  Dementia or Alzheimer's disease
  - D.  Traumatic Brain Injury
  - E.  Other type of need for direct care, please describe: \_\_\_\_\_
  
6. In an average week, how many different paid caregivers provide direct care/support?  
\_\_\_\_\_ number of different people per week
  
7. On average, how long do paid caregivers stay in your employ?  
\_\_\_\_\_ months or \_\_\_ years
  
8. Generally, how long does it take to find and hire a direct care worker?  
\_\_\_\_\_ weeks or \_\_\_\_\_ months

9. Of the direct care workers you hire, how many of them attended college while working for you?  
 A.  None      B.  All      C.  Some (\_\_\_\_\_% of workers)
10. What is the **one** most **important** skill you look for when hiring a direct care worker?
11. If there were a registry listing the names and contact information of direct care workers, would you use it to hire workers?  
 A.  Yes      B.  No      C.  Don't know
12. What do you think would be **most important** for a registry to include?  
*Select the 3 top items: Mark the most important with a "1", the next most important with a "2" and the third most important with a "3".*
- H.  Type of training  
 I.  Years of experience  
 J.  Type of experience  
 K.  Only list workers that have gone through a screening process  
 L.  Other, please describe: \_\_\_\_\_
13. Do you have access to background check information for direct care workers you might hire?  
 A.  Yes, in Vermont only  
 B.  Yes, for anywhere in the country  
 C.  No  
 D.  Don't know
14. How do you cover the costs of direct care workers pay?  
*Please complete as much as possible.*

What covers the cost?	How much of the cost is covered?
Choices for Care	% of cost
Attendant Services Program	% of cost
Children's Personal Care Services	% of cost
My own money	% of cost
Other source, describe:	% of cost
I don't know	

15. If you receive money through a government program (such as Choices for Care or Children's Personal Care Services) to pay for direct care workers, about what percent of the allocated hours are you able to use?  
 \_\_\_\_\_% of allocated hours are used

16. If you cannot use all the allocated hours, why not?  
*Select the top 3 reasons: Mark the most important with a "1", the next most important with a "2" and the third most important with a "3".*
- A.  Can't find workers at all
  - B.  Can't find anyone to work at the wage available through the program
  - C.  Can't find anyone to work at needed times (such as weekends, evenings, vacations)
  - D.  The program won't pay for evening and/or weekend hours
  - E.  Other, please describe: \_\_\_\_\_
17. On average, how much of the direct care workers pay is "under the table" or "off the books" so that you can pay a high enough wage?
- A.  None
  - B.  \_\_\_\_\_%
  - C.  Don't know
18. Are you able to give direct care workers a raise in their hourly wages?
- A.  No, there is no source of funds to allow for raises
  - B.  Yes, I give workers cost of living raises using my own money
  - C.  Yes, I give workers raises for years of service using my own money
  - D.  I don't know if there are funds available for raises
  - E.  Other, please describe: \_\_\_\_\_
19. Which of the following benefits do direct care workers in your employ receive?  
*Check all that apply*
- A.  Health insurance
  - B.  Time off (including vacation days, sick leave, personal leave, or combined time)
  - C.  Mileage reimbursement
  - D.  Reimbursement for expenses such as supplies, program fees, movies
  - E.  Tuition reimbursement for training or education related to this work
  - F.  Pay for time spent training
  - G.  Reimbursement for child care costs
  - H.  Retirement
  - I.  They do not receive any benefits
  - J.  Other benefits, please describe: \_\_\_\_\_
20. What is the **one most important** factor you believe could improve your ability to recruit and retain direct care workers?
21. Right now, are the direct care workers who provide care/support for you:
- A.  Employed by me only (self-directed only)
  - B.  Some are employed by me, some are employed by an agency such as Home Health
  - C.  Don't know

22. Which of the following are the most important reasons for hiring direct care workers on your own? *Select the top 3 reasons: Mark the most important with a "1", the next most important with a "2" and the third most important with a "3".*

- A.  It was the only way I could get funding through the government program
- B.  Prefer to select my own direct care worker rather than have an agency do so
- C.  I can get the hours of the day or days of the week I want
- D.  There are more hours of care allocated when I use the self-directed program
- ~~E.~~  I can pay workers more money
- F.  Workers can do the things I want them to do, the way I want them to
- G.  More likely to have the same people providing care/support over time
- H.  I can pay a family member or friend to provide care
- I.  I like how caregivers I hire treat me and/or talk to me
- J.  I can find someone with the skills I need
- K.  I was not satisfied working with an agency
- L.  I can get care much more quickly than if I used an agency
- M.  Other reason, please describe: \_\_\_\_\_

23. Which of the following reasons might be most important for having an agency, such as Home Health, hire your direct care workers?

*Select the top 3 reasons: Mark the most important with a "1", the next most important with a "2" and the third most important with a "3".*

- A.  Easier for the agency to find people to hire
- B.  Prefer to have agency screen possible workers
- C.  Prefer to have agency provide training
- D.  We get more care hours when we use an agency
- E.  Workers receive a higher rate of pay with an agency
- F.  Prefer the type and range of care/support workers are able to provide
- G.  Agencies are better able to find people with the skills I need
- H.  More likely to have the same people providing care/support over time
- I.  I like how caregivers hired by an agency treat me and/or talk to me
- J.  I can get care much more quickly working with an agency than hiring someone myself
- K.  I do not like using the self-directed program
- L.  I don't know as I have never used an agency
- M.  Other reason, please describe: \_\_\_\_\_

24. If all things were equal, would you prefer agency or self-directed care?

- A.  Agency
- B.  Self-directed
- C.  Don't know

Please explain:

Thank you for your valuable input!

**Please return by November 9, 2007** in the stamped self-addressed envelope to:

State of Vermont

1078 US Route 2

Montpelier VT 05602-9808

## **Appendix H**

### Direct Care Worker Survey Results

## **Appendix H**

### Direct Care Worker Survey Results

The Direct Care Worker Survey was designed to gather input from direct care workers serving in a variety of settings. The survey was distributed in October 2007 using three strategies:

- Vermont Association of Professional Care Providers (VAPCP) provided mailing labels for all members
- 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)
- Survey packets were sent to employer organizations, including: nursing homes, residential care facilities, assisted living programs, home health agencies, adult day programs, and developmental service providers. Employers were asked to address and mail the survey packets to their direct care employees and/or contractors

The Department of Disability, Aging and Independent Living (DAIL) was responsible for creating distributing surveys directly and to employer organizations. Each survey included a cover letter from DAIL’s commissioner explaining the survey and a self-addressed stamped return envelope. The cover letter explained the purpose of the survey and ensured respondents that responses would be treated confidentiality, no individual identities would be revealed in reported results. Return envelopes were delivered to DAIL; FSA gathered the envelopes, opened them and sorted out the entry forms and surveys. FSA was responsible for overseeing data entry and completing data analysis.

### **Survey Respondents**

Approximately 7,850 surveys were distributed to direct care workers (DCWs). A total of 1699 DCW surveys were returned and analyzed, for a response rate of 22%.

DCW respondents represented every county in Vermont, and a few respondents worked in Vermont but lived in neighboring states.

**Table H1: DCW Survey Respondents' County of Residence**

County of residence	Frequency	Percent
Unknown	26	2%
Addison	132	8%
Bennington	116	7%
Caledonia, Essex, Orleans	223	13%
Chittenden	281	17%
Franklin/Grand Isle	154	9%
Lamoille	58	3%
Orange	74	4%
Rutland	240	14%
Washington	164	10%
Windham	96	6%
Windsor	104	6%
Outside of Vermont	31	2%
Total	1699	100%

The vast majority of respondents (n=1525, 90%) were women, averaging 44.9 years of age. Age ranged from 16 to 86 years; 64% of respondents were over 40 years of age.

**Table H2: DCW Survey Respondents' Age**

Age	Frequency	Percent
16 to 21	104	6%
22 to 29	238	14%
30 to 39	248	15%
40 to 49	365	22%
50 to 59	457	27%
60 to 69	204	12%
70 and over	58	3%
Total	1674	100%

Most all DCWs had completed high school, and half had attended at least some college. Among DCWs currently attending school, the majority of respondents were attending college; 9 respondents were currently in high school and 3 were in graduate school.

**Table H3: DCW Respondents' Educational Level**

<b>Educational Level</b>	<b>Frequency</b>	<b>Percent</b>
Currently attending school	109	6%
Less than high school	81	5%
High school diploma or GED	648	38%
Some college	450	27%
Technical school	129	8%
Bachelor's degree	220	13%
Advanced degree	53	3%
<b>Total</b>	<b>1690</b>	<b>100%</b>

The survey asked how many “direct care worker jobs” and “jobs that are NOT direct care work” respondents currently hold. Three quarters of the respondents held one DCW job. More than one-quarter of the sample (29%) held non-DCW jobs as well; nearly all of respondents who held a non-DCW job (81%) held one such position.

**Table H4: DCW Survey Respondents -- Number of Current DCW Positions**

<b>Number of DCW jobs</b>	<b>Frequency</b>	<b>Percent</b>
None	11	1%
One	1275	78%
Two	248	15%
Three	74	5%
Four or Five	13	1%
more than 5	9	1%
<b>Total</b>	<b>1630</b>	<b>100%</b>

**Table H5: DCW Survey Respondents -- Number of Non-DCW Jobs**

<b>Number of non-DCW jobs</b>	<b>Frequency</b>	<b>% of sample</b>	<b>% of DCWs with other jobs</b>
One	395	23%	81%
Two	73	4%	15%
Three	15	1%	3%
Four or more	6	0%	1%
<b>Total</b>	<b>489</b>	<b>29%</b>	<b>100%</b>

Respondents who held non-DCW jobs described an array of other positions.

**Table H6: Most Frequently Cited Non-DCW Jobs**

<b>Non-DCW jobs</b>	<b>Frequency</b>	<b>Percent</b>
Para educators and aids	54	11%
Office/clerical	44	9%
Retail & sales	36	7%
Cleaning & janitorial	36	7%
Teachers	29	6%
Food services	27	6%
Child care/pre-school	25	5%
Self-employed	20	4%
<b>Total</b>	<b>271</b>	<b>55%</b>

The survey asked respondents to identify the type of DCW position they currently held. The sample included representation from all types of positions. While 644 respondents said they held at least two different types of DCW positions, only 427 said they worked in more than one setting. Cross tabulations indicated a number of confusions, such as DCWs working in nursing homes identifying themselves as direct support professionals (a term which generally applies only to DCWs serving persons with developmental disabilities in the community).

**Table H7: Type of DCW Position Currently Held**

<b>Current DCW position</b>	<b>Frequency</b>	<b>Percent</b>
LNA	554	33%
PCA	428	25%
Direct support professional	205	12%
Developmental home/foster care provider	74	4%
Resident assistant/aide	318	19%
Homemaker	322	19%
Geriatric aide	103	6%
Activity aide	94	6%
Respite provider	340	20%
Hospice care	78	5%
Privately paid caregiver	164	10%

**Table H8: Number of Different type of DCW Positions Held**

<b>Total number of DCW positions currently held</b>	<b>Frequency</b>	<b>Percent</b>
One	946	59%
Two	381	24%
Three	149	9%
Four	69	4%
Five or more	45	3%
<b>Total</b>	<b>1590</b>	<b>100%</b>

Respondents provided care and support for persons with a range of needs, often multiple needs.

**Table H9: DCW Survey Respondents' Clients' Needs**

Care Needs	Frequency	Percent
Aging	1051	62%
Physical disabilities	505	30%
Developmental disabilities	551	32%
Traumatic brain injuries	140	8%
Dementia and/or Alzheimer's Disease	664	39%

When asked about their current work settings, 72% (n=1219) of the respondents reported that they worked in one setting; another 20% (n=332) worked in two settings; and the remainder of respondents worked in three or more settings. Most frequent settings included clients' homes, caregivers' homes, and nursing homes. Looking only at the 1219 respondents who worked in one setting, we find a similar distribution of the sample by work setting. About three-quarters of respondents working in nursing homes and adult day centers worked in only one setting; half of respondents in most other settings worked in one setting; about one-third of workers in community or client workplace settings worked in one setting.

**Table H100: DCW Respondents' Work Setting**

Work Setting	Full Sample		Work in one setting		
	Frequency	% of all respondents	Frequency	% of setting	% of work in 1 setting
Client home, hired by client	389	23%	201	52%	16%
Client home, hired by agency	415	24%	217	52%	18%
Caregiver's home	364	21%	202	55%	17%
Nursing home	350	21%	270	77%	22%
Assisted living residence	246	14%	129	52%	11%
Residential care or group home	200	12%	100	50%	8%
Adult day center	53	3%	37	70%	3%
Community or client workplace	166	10%	63	38%	5%
Total	Multiple responses		1219	72%	100%

Some survey respondents listed additional settings in which they worked, most frequently these included schools (n=27); hospitals (n=15); and, acute care/rehabilitation (n=11).

There was a significant difference in age across work settings ( $F(7,1194)=11.6, p<.001$ ): nursing home workers were the youngest (mean = 39.8) while adult day center workers the oldest (mean = 50.2).

**Table H11: DCW Survey Respondents' Age by Work Setting**

<b>Work Setting</b>	<b>Mean</b>	<b>Std. Dev.</b>	<b>N</b>
Client home, hired by client	43.8	15.2	201
Client home, hired by agency	49.2	14.1	214
Caregiver's home	49.4	13.6	200
Nursing home	39.8	14.0	261
Assisted living residence	43.3	15.1	129
Residential care or group home	42.9	14.4	98
Adult day center	50.2	16.0	37
Community or client workplace	44.2	13.0	62
<b>Total</b>	<b>44.9</b>	<b>14.8</b>	<b>1202</b>

Among respondents who work in one DCW setting, DCWs in nursing homes and residential care settings have the most work hours each week ( $F(7,1129)=17.2, p<.001$ ). DCWs working in their own homes and community settings work the most weekly hours in non-DCW positions ( $F(7,417)=4.63, p<.001$ ).

**Table H12: Weekly Work Hours by Work Setting**  
(Respondents with One DCW Setting)

<b>Work Setting</b>	<b>Hours/week as DCW</b>			<b>Hours/week in non-DCW job</b>		
	Mean	Std. Dev.	Number	Mean	Std. Dev.	Number
Client home, hired by client	25.6	16.0	184	23.5	13.9	109
Client home, hired by agency	27.9	14.4	210	21.5	15.8	70
Caregiver's home	28.5	21.7	159	28.5	14.0	110
Nursing home	37.7	12.4	265	20.4	16.7	41
Assisted living residence	34.9	13.1	125	23.2	14.1	36
Residential care or group home	36.8	7.2	95	13.3	14.5	28
Adult day center	28.2	13.0	37	14.8	15.7	8
Community or client workplace	27.1	12.6	62	25.8	16.2	23
<b>Total</b>	<b>31.4</b>	<b>15.5</b>	<b>1137</b>	<b>23.4</b>	<b>15.2</b>	<b>425</b>

### Research Question #1: Quantity and Availability Issues

DCW plans to retire in next 5 years: Within the next five years, might we see a reduction in the supply of workers due to retirement? Retirement will not have a major impact on the workforce supply as the majority of respondents do not plan to retire in the next five years.

**Table H13: DCW Respondents' Report of Plan to Retire in Next Five Years**

Plan to retire in next five years	Frequency	Percent
Yes	127	8%
No	1285	77%
Not sure	248	15%
Total	1660	100%

Not surprisingly, respondents planning to retire were significantly older ( $F(2,1635)=229.70, p<.001$ ), had worked as DCWs significantly longer ( $F(2,1657)=13.08, p<.001$ ) and had been in their current positions significantly longer ( $F(2,1657)=24.85, p<.001$ ). There were no significant differences in reported plans to retire by work setting.

**Table H14: Respondents' Plans to Retire by Age, Years as DCW, and Years in Current Position**

Plan to retire in next five years	Age			Number of years as DCW			Years in current DCW position		
	Mean	<i>std dev.</i>	N	Mean	<i>std dev.</i>	N	Mean	<i>std dev.</i>	N
Yes	58.8	11.3	125	10.2	10.0	127	7.1	8.2	127
No	41.0	13.2	1269	6.7	7.6	1285	4.1	5.2	1285
Not sure	56.5	11.6	244	8.1	9.3	248	6.1	6.7	248
Total	44.7	14.5	1638	7.2	8.1	1660	4.7	5.8	1660

DCW willingness to work evenings/weekends: Nearly all of the DCW respondents currently work during weekdays (82%, 1388); more than two-thirds of weekday workers also have weekend shifts. Of DCWs currently working weekdays, 56% report that they are willing to work weekends and 43% said they are willing to work nights.

**Table H15: Current Weekday DCW Worker's Current and Possible Work Shifts**

Among current weekday workers:	Frequency	Percent
also work weekend	964	69%
also work nights	628	45%
willing work weekend	781	56%
willing work nights	591	43%

Workers willing to work nights and weekends were significantly younger (mean = 43.3 years and 42.3, respectively) than those who did not report an interest in working nights (mean = 46.1 years,  $F(1,1672) = 68.83, p < .001$ ) or weekends (mean = 48.1 years,  $F(1,1672) = 15.43, p < .001$ ).

DCW report attractive and disagreeable aspects of job: In response to open-ended question, DCWs most often report liking relationships with people, giving help, and making a difference in the lives of clients/residents.

**Table H16: DCW Respondents: Like Best about Providing Direct Care**

Like Best about Providing Direct Care	Frequency	Percent of Total Respondents
Relationships with people	522	31%
Giving help and care	308	18%
Making a difference in consumer's and family's lives	230	14%
The work is rewarding and fulfilling	129	8%
Flexibility and independence	95	6%

Similarly, DCWs said they serve as direct care workers because they like to help others and because of their relationships with people.

**Table H17: DCW Survey Respondents: Why they Provide Direct Care**

Reasons Why Respondents Provide Direct Care	Frequency	Percent
Like to help others, give back,	505	30%
Relationships with people	198	12%
Want to make a difference in others' lives	156	9%
Like working with elders, learning from them	155	9%
Work is rewarding, fulfilling	152	9%
Caring for family members	146	9%

DCWs most often report that that what they like least are pay and benefits. Other issues are inadequate staffing and negative work environments.

**Table H18: DCW Survey Respondents: Like Least About DCW Jobs**

Like Least about Direct Care Work	Frequency	Percent
Pay, benefits, compensation	434	26%
Inadequate staffing	233	14%
Negative work environment	174	10%
Emotional stress, attachment to clients, loss	85	5%

Most important to improve recruitment and retention: The DCW 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.” Nearly all respondents (82%, 1387) provided a response to this question. Several respondents provided multiple responses.

The far and away most frequent response was financial: improve wages and provide benefits. Additional efforts should focus on supervision practices which are supportive, appreciative and respectful of workers and training/orientation that provides workers with needed skills and information. These results mirror those found in the 2001 Paraprofessional Staffing Study, when workers identified key needs for retention as higher wages, benefits, and training/educational opportunities.

**Table H19: DCW Respondents: How to Improve Recruitment/Retention**

Strategies to Improve Recruitment/Retention	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%

**Research Question #2: Quality Issues**

**Orientation and Training:** About one quarter of DCWs report they received no orientation, another quarter received only a brief orientation. Workers hired by clients or working in their own homes were least likely to receive an orientation.

**Table H20: DCW Survey Respondents' Reported Receipt of Orientation in Current Position**

<b>Orientation in Current Position</b>	<b>Frequency</b>	<b>Percent</b>
No orientation	392	23%
Brief orientation	413	24%
Formal orientation	712	42%
Shadow experienced worker	711	42%

**Table H21: Orientation Received by Work Settings**

<b>Work setting</b> (respondents work in one setting)	<b>No orientation</b>		<b>Formal orientation</b>		<b>Shadowing</b>		<b>Total</b>	
	<b>Frequenc y</b>	<b>Percen t</b>	<b>Frequenc y</b>	<b>Percen t</b>	<b>Frequenc y</b>	<b>Percen t</b>	<b>Frequenc y</b>	<b>Percen t</b>
Client home, hired by client	93	46%	22	11%	28	14%	201	100%
Client home, hired by agency	36	17%	121	56%	89	41%	217	100%
Caregiver's home	121	60%	29	14%	13	6%	202	100%
Nursing home	15	6%	151	56%	168	62%	270	100%
Assisted living residence	11	9%	61	47%	82	64%	129	100%
Residential care or group home	7	7%	52	52%	62	62%	100	100%
Adult day center	3	8%	18	49%	23	62%	37	100%
Community or client workplace	7	11%	29	46%	32	51%	63	100%
<b>Total</b>	<b>293</b>	<b>24%</b>	<b>483</b>	<b>40%</b>	<b>497</b>	<b>41%</b>	<b>1219</b>	<b>100%</b>

The vast majority of workers received their training “on-the-job,” especially DCWs hired by clients or working in residential care or adult day centers. Half of the respondents said they also had in-service training programs; generally workers employed by nursing homes, adult day centers and assisted living residences. One third of respondents attended conferences or workshops paid for by their employers; these workers most often worked in adult day centers and with clients in community or workplace settings.

**Table H22: DCW Survey Respondents' Report of Training Received in Current Position**

<b>Training in current position</b>	<b>Frequency</b>	<b>Percent</b>
Learn on the job	1241	73%
In-service programs	848	50%
Courses paid by employer	114	7%
Courses paid by DCW	162	10%
Conferences/workshops paid by employer	531	31%
Conferences/workshops paid by DCW	135	8%

**Table H23: Training in Current Position by Work Setting**

<b>Work setting (respondents work in one setting)</b>	<b>Learn on the job</b>		<b>In-service programs</b>		<b>Courses paid by employer</b>	
	<b>Frequency</b>	<b>Percent</b>	<b>Frequency</b>	<b>Percent</b>	<b>Frequency</b>	<b>Percent</b>
Client home, hired by client	173	86%	14	7%	1	0%
Client home, hired by agency	145	67%	119	55%	25	12%
Caregiver's home	143	71%	15	7%	6	3%
Nursing home	188	70%	222	82%	21	8%
Assisted living residence	98	76%	91	71%	5	4%
Residential care or group home	81	81%	67	67%	2	2%
Adult day center	31	84%	31	84%	2	5%
Community or client workplace	42	67%	30	48%	4	6%
<b>Total</b>	<b>901</b>	<b>74%</b>	<b>589</b>	<b>48%</b>	<b>66</b>	<b>5%</b>

**Table H24: Training in Current Position by Work Setting**

Work setting (respondents work in one setting)	Courses paid by DCW		Conferences/ workshops paid by employer		Conferences/ workshops paid by DCW	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Client home, hired by client	23	11%	10	5%	22	11%
Client home, hired by agency	13	6%	84	39%	13	6%
Caregiver's home	20	10%	23	11%	26	13%
Nursing home	23	9%	92	34%	6	2%
Assisted living residence	15	12%	38	29%	5	4%
Residential care or group home	11	11%	41	41%	6	6%
Adult day center	4	11%	27	73%	4	11%
Community or client workplace	0	0%	36	57%	5	8%
Total	109	9%	351	29%	87	7%

Overall, 680 (43%) respondents were very satisfied with the training and preparation they received.

Respondents who did not receive an orientation were significantly less satisfied with training and preparation (mean satisfaction = 2.00) than those who did receive orientation (mean satisfaction = 2.43). Workers were significantly more satisfied with training and orientation when they had received formal orientation, opportunities to shadow, in-service programs, and opportunities to attend courses or workshops paid by their employer.

**Table H25: Satisfaction with Training by Orientation and Training Provided**

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

<sup>1</sup> F(1,1563)=129.84, p<.001; <sup>2</sup> F(1,1563)=53.57, p<.001; <sup>3</sup> F(1,1563)=37.31,<.001;

<sup>4</sup> F(1,1563)=105.07, p<.001; <sup>5</sup> F(1,1563)=9.32, p<.01; <sup>6</sup> F(1,1563)=18.55, p<.001

**Most important area of training:** An open-ended question asked DCWs what they felt was the “one most important area of training” needed for direct care workers. Two-thirds of the respondents (1138) provided a wide array of responses ranging from “everything is important” to very specific skills. About 400 responses were so widely divergent they did not reflect any quantifiable pattern. Of the remaining responses, DCWs most frequently identified training that was specifically focused on individual client’s needs, including information about their disability or illness, and training that addressed the need for “soft skills” such as compassion, caring, patience and respect for clients.

**Table H26: Most Important Areas for DCW Training**  
DCW Survey Response to Open Ended Question

<b>Important areas for training</b>	<b>Frequency</b>	<b>Percent</b>
Individualized training about client's needs, information on particular disability	173	10%
Compassion, caring, patience, respect	161	9%
Safety issues, including CPR, first aid	97	6%
Body mechanics, lifting, transferring	68	4%
Basic care giving (e.g., ADLs, hands-on experience)	67	4%
Infection control, hygiene	57	3%
Communication with clients	50	3%
Dealing with difficult behavior	49	3%
Coping with stress	16	1%

DCW work satisfaction: DCW survey respondents were generally satisfied with most aspects of their work and workplaces; workers were least satisfied with opportunities for pay raises and advancement.

**Table H278: DCW Survey Respondents Level of Satisfaction with Work**  
(1=not at all, 3=very satisfied)

Work and Workplace Issues:	Mean	<i>St. Dev.</i>	N
Training and preparation to provide direct care	2.33	0.65	1565
Reliable number of hours each week	2.50	0.66	1605
Stable work days and scheduling	2.48	0.67	1594
Consistent assignment to clients	2.52	0.62	1553
Clear communication and expectations from supervisors	2.31	0.72	1564
Support and respect from supervisors	2.39	0.71	1562
Team work with co-workers	2.32	0.67	1504
Feeling a part of a community of DCWs	2.25	0.69	1541
Specific and clear expectations of the job	2.49	0.63	1575
Time to provide needed care/support	2.35	0.73	1578
Time to build relationships with clients	2.50	0.66	1583
Time to complete paperwork	2.37	0.67	1547
Flexibility to meet clients' social needs	2.35	0.67	1564
Tools to ease work demands & reduce injury	2.30	0.69	1556
Workplace attention to cultural differences	2.37	0.59	1524
Opportunities for pay raises	1.70	0.72	1558
Opportunities for advancement	1.83	0.71	1517

Levels of satisfaction varied significantly across work settings, for most all dimensions. Often, workers employed by adult day programs have highest satisfaction ratings, particularly in terms of training, reliable hours, stable scheduling, workplace culture, and opportunities for pay raises.

**Table H289: Work Satisfaction by Work Setting**

(1=not at all, 3=very satisfied)

Work setting (respondents work in one setting)	Training <sup>1</sup>	Reliable Hours <sup>2</sup>	Stable scheduling <sup>3</sup>	Consistent assignment <sup>4</sup>
Client home, hired by client	2.15	2.44	2.48	2.62
Client home, hired by agency	2.47	2.33	2.46	2.56
Caregiver's home	2.10	2.32	2.45	2.53
Nursing home	2.42	2.64	2.46	2.37
Assisted living residence	2.50	2.62	2.58	2.55
Residential care or group home	2.33	2.75	2.66	2.71
Adult day center	2.63	2.77	2.77	2.66
Community or client workplace	2.30	2.57	2.48	2.55
Total	2.34	2.51	2.50	2.54

<sup>1</sup> F(7,1115)=9.6, p<.001; <sup>2</sup> F(7,1148)=9.50, p<.001; <sup>3</sup> F(7,1139)=2.4, p<.05; <sup>4</sup> F(7,1106)=4.60, p<.001

**Table H30: Work Satisfaction by Work Setting**

(1=not at all, 3=very satisfied)

Work setting (respondents work in one setting)	Clear communication w/ supervisors <sup>5</sup>	Support from supervisors <sup>6</sup>	Team work with co- workers <sup>7</sup>	Community of DCWs <sup>8</sup>
Client home, hired by client	2.44	2.51	2.31	2.03
Client home, hired by agency	2.44	2.59	2.43	2.32
Caregiver's home	2.42	2.42	2.22	2.03
Nursing home	1.99	2.08	2.24	2.29
Assisted living residence	2.32	2.39	2.40	2.45
Residential care or group home	2.27	2.44	2.27	2.38
Adult day center	2.53	2.67	2.72	2.72
Community or client workplace	2.32	2.46	2.32	2.26
Total	2.30	2.40	2.32	2.26

<sup>5</sup> F(7,1114)=10.53, p<.001; <sup>6</sup> F(7,1114)=11.66, p<.001; <sup>7</sup> F(7,1067)=4.03, p<.001; <sup>8</sup> F(7,1097)=10.38, p<.001

**Table H291: Work Satisfaction by Work Setting**  
(1=not at all, 3=very satisfied)

<b>Work setting</b> (respondents work in one setting)	<b>Expectations of job</b>	<b>Time for care/support<sup>9</sup></b>	<b>Time for relationships<sup>10</sup></b>	<b>Time for paperwork<sup>11</sup></b>
Client home, hired by client	2.51	2.49	2.69	2.48
Client home, hired by agency	2.59	2.58	2.67	2.67
Caregiver's home	2.48	2.41	2.61	2.53
Nursing home	2.42	1.86	2.07	1.98
Assisted living residence	2.55	2.34	2.39	2.39
Residential care or group home	2.52	2.46	2.55	2.48
Adult day center	2.54	2.51	2.62	2.27
Community or client workplace	2.43	2.44	2.65	2.13
<b>Total</b>	<b>2.50</b>	<b>2.33</b>	<b>2.48</b>	<b>2.37</b>

<sup>9</sup> F(7,1122)=23.80, p<.001; <sup>10</sup> F(7,1125)=23.83, p<.001; <sup>11</sup> F(7,1101)=26.06, p<.001

**Table H302: Work Satisfaction by Work Setting**  
(1=not at all, 3=very satisfied)

<b>Work setting</b> (respondents work in one setting)	<b>Meet clients' social needs<sup>12</sup></b>	<b>tools to ease demands<sup>13</sup></b>	<b>Attention to cultural differences<sup>14</sup></b>
Client home, hired by client	2.51	2.23	2.35
Client home, hired by agency	2.51	2.47	2.40
Caregiver's home	2.50	2.25	2.29
Nursing home	1.98	2.18	2.25
Assisted living residence	2.30	2.35	2.43
Residential care or group home	2.41	2.30	2.47
Adult day center	2.48	2.65	2.65
Community or client workplace	2.48	2.29	2.33
<b>Total</b>	<b>2.35</b>	<b>2.30</b>	<b>2.35</b>

<sup>12</sup> F(7,1113)=17.90, p<.001; <sup>13</sup> F(7,1108)=4.77, p<.001; <sup>14</sup> F(7,1085)=3.73, p<.001

**Table H313: Work Satisfaction by Work Setting**  
(1=not at all, 3=very satisfied)

<b>Work setting</b> (respondents work in one setting)	<b>Opportunities for pay raises<sup>15</sup></b>	<b>Opportunities for advancement<sup>16</sup></b>
Client home, hired by client	1.51	1.70
Client home, hired by agency	1.91	2.03
Caregiver's home	1.61	1.82
Nursing home	1.67	1.79
Assisted living residence	1.88	1.91
Residential care or group home	1.86	1.93
Adult day center	1.91	1.97
Community or client workplace	1.71	1.83
<b>Total</b>	<b>1.72</b>	<b>1.85</b>

<sup>15</sup> F(7,1108)=3.43,p<.001; <sup>16</sup> F(7,1071)=3.52,p<.001

As DCW wages increase, DCWs express increased satisfaction with reliable hours, stable scheduling and opportunities for pay raises. There was no significant relationship between wages and satisfaction with opportunities for advancement.

**Table H324: Relationship between Work Satisfaction and Wages**

	<b>Wage in dollars</b>		
	Mean	<i>St. Dev.</i>	N
<b>Reliable number of hours each week<sup>1</sup></b>			
Not satisfied	10.63	1.88	134
Neutral	10.66	1.93	458
Very satisfied	11.15	2.27	881
<b>Stable work days and scheduling<sup>2</sup></b>			
Not satisfied	10.75	2.21	146
Neutral	10.76	2.25	468
Very satisfied	11.11	2.07	850
<b>Opportunities for pay raises<sup>3</sup></b>			
Not satisfied	10.76	2.15	669
Neutral	11.17	2.29	546
Very satisfied	11.14	1.81	216

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

### Research Question #3: Stability Issues

Years of service as DCW and for current employer: Respondents had served as DCWs for an average of 7.31 years; and in their present position for an average of 4.78 years. About one-quarter of respondents had been DCWs for less than a year and one-third for seven or more years.

**Table H335: DCW Survey Respondents Years of Service**

Time of Service	Number of years as DCW		Years in current DCW position	
	Frequency	Percent	Frequency	Percent
6 months or less	166	10%	268	16%
7 months to 1 year	238	14%	313	19%
2 to 3 years	343	21%	388	24%
4 to 6 years	301	18%	281	17%
7 to 12 years	285	17%	233	14%
13 to 20 years	152	9%	115	7%
more than 20 years	170	10%	45	3%
Total	1655	100%	1643	100%

There were significant differences across work settings in DCW's years of service: respondents working in their own homes, in clients' homes hired by clients and in community/workplace settings had the fewest number of years as DCWs, while respondents in nursing homes had served many more years. A similar pattern was found with years in current position, although much here the largest discrepancy was between DCWs working in clients' homes hired by clients and working in nursing homes; the length of service in the other settings was relatively similar.

**Table H346: Years as DCW and in Current Position by Work Setting**

Work setting (if work in one setting)	Years worked as DCW <sup>1</sup>		Years in current position <sup>2</sup>	
	Mean	<i>Std. Dev.</i>	Mean	<i>Std. Dev.</i>
Client home, hired by client	4.40	6.36	2.76	2.85
Client home, hired by agency	6.28	6.75	4.75	5.20
Caregiver's home	4.89	6.10	4.45	5.61
Nursing home	10.45	10.29	6.58	8.01
Assisted living residence	8.08	9.08	4.46	6.02
Residential care or group home	8.01	8.41	4.54	5.92
Adult day center	8.14	9.46	4.66	4.61
Community or client workplace	4.80	4.97	4.18	4.97
Total	6.98	8.22	4.69	5.96

<sup>1</sup>F(7,1211)=14.04, p<.001; <sup>2</sup>F(7,1211)=7.31, p<.001

DCW satisfaction with stability and reliability of hours: About two-thirds of DCW survey respondents were “very satisfied” with the reliability of their work hours; the stability of their work days and scheduling; and, the consistency of client assignments.

**Table H37: Number of Survey Respondents Reporting Satisfaction with Stability**

	Not satisfied		Neutral		Very satisfied		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Reliable number of hours each week	154	10%	500	31%	951	59%	1605	100%
Stable work days and scheduling	158	10%	506	32%	930	58%	1594	100%
Consistent assignment to clients	103	7%	538	35%	912	59%	1553	100%

Workers hired by agencies and providing care in their own homes were least satisfied with the reliability of their hours; residential care and adult day center workers were most satisfied with reliability of hours. Workers most satisfied with the stability of scheduling work in adult day centers and residential care or group homes. Nursing home workers are least satisfied with the consistency of assignment to clients, while residential care home, adult day center, and client hired workers are most satisfied with the consistency of assignment.

**Table H358: Work Satisfaction by Work Setting**

(1=not at all, 3=very satisfied)

Work setting (respondents work in one setting)	Reliable Hours <sup>1</sup>	Stable scheduling <sup>2</sup>	Consistent assignment <sup>3</sup>
Client home, hired by client	2.44	2.48	2.62
Client home, hired by agency	2.33	2.46	2.56
Caregiver's home	2.32	2.45	2.53
Nursing home	2.64	2.46	2.37
Assisted living residence	2.62	2.58	2.55
Residential care or group home	2.75	2.66	2.71
Adult day center	2.77	2.77	2.66
Community or client workplace	2.57	2.48	2.55
Total	2.51	2.50	2.54

<sup>1</sup> F(7,1148)=9.50, p<.001; <sup>2</sup> F(7,1139)=2.4, p<.05; <sup>3</sup> F(7,1106)=4.60, p<.001

Factors associated with retention:

DCWs worked longer in current job when satisfied with reliability of hours and stable work days and scheduling.

**Table H369: Years in Current Job by Satisfaction with Reliable Hours and Stable Scheduling**

	Not satisfied	Neutral	Very satisfied	Total
Reliable number of hours each week <sup>1</sup>	3.86	4.09	5.05	4.64
Stable work days and scheduling <sup>2</sup>	3.62	4.37	5.00	4.66

<sup>1</sup>  $F(2,1602)=6.1, p<.02$ ; <sup>2</sup>  $F(2,1591)=4.8, p<.01$

Training and satisfaction with training were associated with longer terms of service. DCWs worked longer in current position when satisfied with training and preparation ( $F(2,1562)=4.01, p<.05$ ).

**Table H40: Years in Current Job by Satisfaction with Training & Preparation**

Training and preparation to provide direct care/support	Years in current DCW position		
	Mean	Std. Dev.	N
Not satisfied	3.95	5.71	156
Neutral	4.41	5.49	729
Very satisfied	5.12	6.10	680
Total	4.67	5.80	1565

Years of service were also significantly longer with employer provided training.

**Table H371: Years in Current Job by Employer Provided Training Opportunities**

	Years in current DCW position		
	Mean	Std. Dev.	N
<b>In-service programs<sup>1</sup></b>			
No report of in-service	3.55	4.93	851
Report in-service available	5.69	6.36	848
<b>Courses paid by employer<sup>2</sup></b>			
No report	4.54	5.76	1585
Report available	5.75	6.09	114
<b>Conferences/workshops paid by employer<sup>3</sup></b>			
No report	3.85	5.29	1168
Report available	6.30	6.46	531

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

Availability of benefits was also associated with longer terms of service in present DCW position.

**Table H382: Years in Current Job by Employer Provided Benefits**

	Years in current DCW position		
	Mean	<i>Std. Dev.</i>	N
<b>Health insurance<sup>1</sup></b>			
No report	3.89	5.16	1188
Report available	6.30	6.74	511
<b>Time off<sup>2</sup></b>			
No report	3.58	4.85	954
Report available	5.94	6.57	745
<b>Mileage reimbursement<sup>3*</sup></b>			
No report	2.85	3.14	299
Report available	5.47	5.61	182
<b>Retirement<sup>4</sup></b>			
No report	4.03	5.22	1408
Report available	7.45	7.35	291
<b>Do not receive benefits<sup>5</sup></b>			
No report	5.32	6.22	993
Report available	3.63	4.96	706

<sup>1</sup> F(1,1697)=64.31, p<.001; <sup>2</sup> F(1,1697)=72.52,p<.001; <sup>3</sup> F(1,479)=43.17, p<.001;

<sup>4</sup> F(1,1697)=88.34, p<.001; <sup>5</sup> F(1,1697)=36.30, p<.001

\*Only includes DCWs working in clients' homes or community settings

**Research Question #4: Financial Issues**

DCW report of wages: DCW survey respondents report an average current hourly wage of \$10.92 (standard deviation \$2.12) with a range in wages from \$7.25 to \$40.00.

**Table H393: DCW Respondents' Report of Current Hourly Wage**

Hourly wage	Frequency	Percent
\$8.00 and under	105	7%
\$9.00 to \$9.99	209	14%
\$10.00 to \$10.99	671	44%
\$11.00 to \$11.99	203	13%
\$12.00 to \$12.99	149	10%
\$13.00 to \$13.99	82	5%
\$14.00 to \$14.99	42	3%
\$15.00 to \$19.99	64	4%
\$20.00 and over	9	1%
Total	1534	100%

DCW's working in nursing homes, adult day centers, and community/workplace settings report significantly higher wages than workers in other settings, particularly those providing care in their own homes ( $F(7,1105)=18.5, p<.001$ ).

**Table H44: DCW Hourly Wage by Care Setting**

Respondents who work in One Setting

Work setting (work in one setting)	Mean	<i>std.dev.</i>	N
Client home, hired by client	\$ 10.34	1.44	188
Client home, hired by agency	\$ 10.49	1.39	199
Caregiver's home	\$ 10.06	0.83	165
Nursing home	\$ 11.73	2.55	261
Assisted living residence	\$ 11.15	2.02	120
Residential care or group home	\$ 10.84	1.96	91
Adult day center	\$ 11.67	2.32	35
Community or client workplace	\$ 11.53	1.83	54
Total	\$ 10.88	1.94	1113

**Table H45: DCW Hourly Wage by Client Care Need**

Care Needs	Mean	std.dev.	N
Aging	\$11.06	2.35	974
Physical disabilities	\$10.88	1.82	464
Developmental disabilities	\$10.83	1.71	501
Traumatic brain injuries	\$11.40	2.29	132
Dementia and/or Alzheimer's Disease	\$11.28	2.50	619

DCW report expected raises: About half of the DCW respondents expected to receive pay raises in their current DCW position; one third did not expect to receive raises. Respondents who said “it depends” indicated several possible factors including state funding and agency budgets. Many respondents said they “hoped” they would be receiving raises and marked “it depends” as their response to the survey question.

**TableH46: DCW Survey Respondents Reported Expectation of Receiving pay Raise**

Expect raises	Frequency	Percent
No	509	33%
Yes	780	50%
It depends	262	17%
Total	1551	100%

DCWs working with persons with developmental disabilities were least likely to expect to receive pay raises.

**Table H47: Expectation of Pay Raise by Client Care Needs**

Care Needs	Expect Raises	
	Frequency	Percent
Aging	565	58%
Physical disabilities	234	50%
Developmental disabilities	210	42%
Traumatic brain injuries	72	56%
Dementia and/or Alzheimer's Disease	370	59%

DCWs working hired by clients or providing care in their own homes were significantly less likely to expect raises than workers in other settings ( $X^2_{(df=14)}=220.92$ ,  $p<.001$ )

**Table H48: Expectation of Pay Raise by Work Setting**  
DCWs with One Work Setting

Work setting (if work in one setting)	Expect raises	
	Frequency	Percent
Client home, hired by client	42	23%
Client home, hired by agency	145	58%
Caregiver's home	68	27%
Nursing home	172	61%
Assisted living residence	114	66%
Residential care or group home	113	65%
Adult day center	26	55%
Community or client workplace	82	55%
Total	762	50%

DCW report benefits received: 42% of DCW survey respondents reported that they do not receive any benefits as part of their DCW position. Of those who do report benefits, the most frequently cited benefit is “time off (including vacation days, sick leave, personal leave, or combined time.”

**Table H49: DCW Survey Respondents' Report of Benefits Received**

Benefits	Frequency	Percent of Sample
Do not receive benefits	706	42%
Time off	745	44%
Health insurance	511	30%
Mileage reimbursement	263	41%*
Retirement	291	17%
Expense reimbursement	154	9%
Tuition reimbursement	102	6%
Child care	19	1%

\*41% of 643 DCWs working in clients' homes or community/client workplace

DCWs hired by clients or providing care in their own homes were significantly more likely to report that they do not receive employment benefits ( $X^2_{(df=7)}=390.43$ ,  $p<.001$ ).

**Table H50: No Employment Benefits by Work Setting -- DCWs with One Work Setting**

Work setting (if work in one setting)	Do not receive benefits	
	Frequency	Percent
Client home, hired by client	159	79%
Client home, hired by agency	71	33%
Caregiver's home	165	82%
Nursing home	45	17%
Assisted living residence	29	22%
Residential care or group home	18	18%
Adult day center	5	14%
Community or client workplace	14	22%
Total	506	42%

DCWs working in nursing homes were most likely to receive health care benefits, time off, tuition reimbursement and retirement benefits. Workers in community settings also received health insurance, mileage reimbursement, expense reimbursement and retirement benefits more often than other workers.

**Table H51: Employee Benefits by Work Setting -- DCWs with One Work Setting**

Work setting (if work in one setting)	Health insurance <sup>1</sup>		Time off <sup>2</sup>		Mileage <sup>3</sup>	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Client home, hired by client	5	2%	12	6%	15	7%
Client home, hired by agency	46	21%	76	35%	123	57%
Caregiver's home	7	3%	13	6%	8	4%
Nursing home	158	59%	206	76%	13	5%
Assisted living residence	59	46%	87	67%	9	7%
Residential care/group home	44	44%	72	72%	29	29%
Adult day center	16	43%	30	81%	12	32%
Community/ client workplace	35	56%	43	68%	44	70%
Total	370	30%	539	44%	253	21%

<sup>1</sup>  $X^2_{(df=7)} = 297.9$ ,  $p<.001$ ; <sup>2</sup>  $X^2_{(df=7)} = 450.84$ ,  $p<.001$ ; <sup>3</sup>  $X^2_{(df=7)} = 382.63$ ,  $p<.001$

Work setting (if work in one setting)	Expense <sup>4</sup>		Tuition <sup>5</sup>		Retirement <sup>6</sup>	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Client home, hired by client	7	3%	2	1%	1	0%
Client home, hired by agency	25	12%	14	6%	48	22%
Caregiver's home	3	1%	3	1%	5	2%
Nursing home	12	4%	40	15%	74	27%
Assisted living residence	6	5%	3	2%	27	21%
Residential care/ group home	16	16%	4	4%	24	24%
Adult day center	9	24%	2	5%	7	19%
Community/client workplace	19	30%	0	0%	18	29%
Total	97	8%	68	6%	204	17%

<sup>4</sup>  $X^2_{(df=7)} = 92.05, p < .001$ ; <sup>5</sup>  $X^2_{(df=7)} = 65.28, p < .001$ ; <sup>6</sup>  $X^2_{(df=7)} = 105.97, p < .001$

DCW report of health care insurance: About one-third of DCW survey respondents report paying for their health care insurance premium; very few respondents work for employers that cover the full cost of the premium. On average, DCWs who pay for their health care insurance, pay \$142.72 each month (standard deviation = \$142.11) with workers paying up to \$810.00 monthly.

**Table H52: DCW Survey Respondents' Health Insurance Premium Costs**

Cost of Health Insurance to DCW	Frequency	Percent
Do not have health insurance	424	28%
Employer covers full premium	33	2%
Pay for health insurance premium	437	29%
Insurance through another job	161	11%
Other source (spouse, public program)	453	30%
Total	1508	100%

**Table H53: DCW Monthly Cost for Health Insurance Premium**

Monthly premium paid by DCW	Frequency	Percent
\$50 and less	85	24%
\$51 to \$100	121	34%
\$101 to \$200	83	23%
\$201 to \$300	31	9%
\$301 to \$500	25	7%
\$501 or more	11	3%
Total	356	100%

Relation between wages/benefits and retention: As DCW's reported wage increased, the number of years served in current position increased ( $r=.27$ ,  $p<.01$ ). DCWs report significantly longer length of service in positions that provide benefits than in positions that do not provide benefits ( $F_{(1,1697)}=36.02$ ,  $p<.001$ ). Mean years of service in their current position are significantly higher for DCWs receiving health insurance (mean time in current position = 6.3 years), time off (mean 5.9 years), mileage reimbursements (mean 5.2 years), and retirement benefits (mean 7.5 years) than for DCWs not receiving each of these benefits.

**Table H54: Years in Current DCW Position by Receipt of Benefits**

Receive 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

Wages caregivers must receive to maintain a viable workforce: The survey asked DCWs, “What would you have to earn to continue working in direct care/support?” Of the 1699 survey respondents, 1092 answered this question. The average wage needed was \$13.84 per hour (standard deviation \$3.32).

DCWs working in adult day centers need a significantly higher hourly wage than other settings ( $F(7,776)=5.5, p<.001$ ).

**Table H55: Needed Hourly Wage by Work Setting**  
DCWs with One Work Setting

<b>Work setting (if work in one setting)</b>	<b>Mean</b>	<i>std.dev.</i>	<b>N</b>
Client home, hired by client	\$ 13.36	3.07	145
Client home, hired by agency	\$ 13.02	3.02	139
Caregiver's home	\$ 13.03	2.97	94
Nursing home	\$ 14.48	3.09	194
Assisted living residence	\$ 13.07	2.32	81
Residential care or group home	\$ 13.56	3.24	66
Adult day center	\$ 15.81	8.43	20
Community or client workplace	\$ 14.77	3.50	45
<b>Total</b>	<b>\$ 13.67</b>	<b>3.33</b>	<b>784</b>

There was a very strong relationship ( $r=.58, p<.001$ ) between DCWs' current and desired wage. On average, there was a \$2.97 difference (std dev \$2.70) between DCWs' reported current wage and desired wage; with no significant differences among work settings.

## **Appendix I**

### Employer Survey Results

## Appendix I

### Employer Survey Results

The Employer Survey was designed to gather input from long-term care organizations that employ direct care workers. In October 2007 the survey was distributed to nursing homes, residential care facilities, assisted living programs, home health agencies, adult day programs, and developmental service providers. The Department of Disability, Aging and Independent Living (DAIL) distributed surveys. Each survey was sent with a cover letter from DAIL's commissioner explaining the survey, a copy of the survey, and a self-addressed stamped return envelope. The cover letter explained the purpose of the survey and ensured that confidentiality of responses would be respected so that no one organization would be identifiable in reported results. Return envelopes were delivered to DAIL; FSA gathered the envelopes, opened them and sorted out the entry forms and surveys. FSA was responsible for overseeing data entry and completing data analysis.

#### Survey Respondents

Employer surveys were sent to 210 organizations employing direct care workers. A total of 54 organizations responded to the survey, representing a 26% response rate. Nursing homes and developmental service agencies had the highest response rates.

**Table I40: Employer Survey Respondents by Types of Organization**

Type of organization	Frequency	Of Population
Nursing home	20	48%
Residential care home	23	21%
Assisted living	2	33%
Home health agency	3	23%
Adult day	3	20%
Developmental services	6	40%

Survey respondents were from throughout Vermont.

**Table I41: Employer Survey Respondents by Counties Served**

Counties served	Frequency	Percent
Addison	6	11%
Bennington	5	9%
Caledonia	2	4%
Chittenden	6	11%
Essex	2	4%
Franklin	6	11%
Grand Isle	3	6%
Lamoille	3	6%
Orange	2	4%
Orleans	4	7%
Rutland	9	17%
Washington	5	9%
Windham	6	11%
Windsor	6	11%

Organizations served from 4 to 750 individuals, averaging 77.4 persons served. Most organizations served multiple populations.

**Table I42: Employer Survey Respondents by Needs Organizations Serve**

Needs of Persons Served	Frequency	Percent of Survey Respondents
Elder care	47	87%
Physical disabilities	18	33%
Developmental disabilities	21	39%
Traumatic brain injuries	13	24%
Dementia &/or Alzheimer's	40	74%
Adults with mental illness	3	6%

### **Research Question #1: Quantity and Availability Issues**

For most DCW positions, employers report it takes from 2 to 4 weeks to fill the position; less time for homemakers and aides than for LNAs. Developmental services providers report that it takes an average of 9 weeks to find foster care or developmental home providers.

**Table I43: Number of Weeks Employers Report it Takes to Fill DCW Position**

<b>DCW Positions</b>	<b>Number of responses</b>	<b>Minimum number of weeks</b>	<b>Maximum number of weeks</b>	<b>Average number of weeks</b>
Foster care or developmental home	4	6	12	9.0
Direct support professional	6	3	5	4.2
Licensed Nurse Assistant (LNA)	34	2	12	3.9
Personal Care Attendant (PCA)	17	1	5	2.8
Resident assistant or aide	12	1	4	2.6
Activity aide	16	1	8	2.4
Geriatric aide	4	1	3	2.3
Homemaker	1	2	2	2.0

Employers were asked to name the “one most important factor you believe could improve recruitment and retention of direct care workers.” Employers overwhelmingly identified the need for increased wages. In addition, some employers spoke of the need to address reimbursement rates in order to allow for higher wages.

**Table I44: Most Important to Improve Ability to Recruit and Retain DCWs**

<b>Factors listed by employer survey respondents</b>	<b>Frequency</b>	<b>Percent of all Respondents</b>
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%

## Research Question #2: Quality Issues

Employer survey respondents were asked, in an open-ended question, “what is the one most important training need among direct care workers employed or contracted by your organization?” Employers identified learning how to treat residents/clients and professionalism as the two top training needs.

**Table I45: Employer Survey Respondents Identified Training Needs for DCWs**

<b>Needed Training</b>	<b>Frequency</b>
How to treat residents/customer service	9
Professionalism, showing up on time	5
Medication administration	2
Lifting, safety mechanics	2
Education regarding specific disabilities, needs	2

Examples of employer responses include:

*Dealing with challenging residents with empathy and compassion*

*How to be good to the residents they care for, each other, and themselves*

*Work ethic, professionalism, boundaries, value to an organization serving vulnerable people of staff coming to work, not calling in*

*Ongoing education programs with enough time for them to attend*

### **Research Question #3: Stability Issues**

**Retention rates and years of service:** Interviews found that calculations vary among care sectors, and individual providers. Employer survey respondents were asked if they track retention or turnover rates; 53% reported that they do track one or both. Residential care homes were least likely to report that they track turnover, while all three home health agencies reported that they tracked turnover. About two-thirds of the nursing homes reported that they tracked turnover rates; however, according to Vermont Health Care Association, all nursing homes are required to track turnover rates. We also know from the Vermont Assembly of Home Health Agencies (VAHHA) that all VAHHA member agencies also track turnover. Our survey response data, then, is not clearly reliable in providing a picture of the number of organizations that do gather turnover data.

**Table I46: Employer Survey Respondents Reporting that they Track Turnover by Type of Organization**

<b>Type of organization</b>	<b>Frequency</b>	<b>Percent</b>
Nursing home	12	63%
Home health agency	3	100%
Residential care home	6	32%
Assisted living	0	0%
Adult day	1	50%
Developmental services	4	80%
<b>Total</b>	<b>26</b>	<b>53%</b>

Employer survey respondents were asked to estimate their retention rates, whether or not they actually tracked this information. On average, respondents estimated a 66% retention rate across all categories of DCWs, ranging from 10% to 100%.

Of the 26 (43%) employer respondents that do track turnover or retention, reported rates varied across types of DCWs. Given small numbers it is difficult to generalize, but it appears that retention is lowest and turnover highest among LNAs and direct support professionals.

**Table I47: Employer Survey Respondents Report of Retention and Turnover Rates among DCWs**

<b>Retention Rates</b>	Number of responses	Minimum Rate	Maximum Rate	Average Rate
Personal Care Attendant (PCA)	1	100%	100%	100.0%
Resident assistant or aide	3	80%	100%	90.0%
Activity aide	11	1%	100%	89.5%
Licensed Nurse Assistant (LNA)	13	20%	100%	69.8%
Direct support professional	3	20%	84%	61.3%
<b>Turnover Rates</b>				
Foster care or developmental home	2	11%	11%	11.0%
Activity aide	8	0%	77%	11.8%
Personal Care Attendant (PCA)	4	0	36%	17.4%
Geriatric aide	1	23%	23%	23.0%
Licensed Nurse Assistant (LNA)	21	0	82%	34.5%
Resident assistant or aide	3	10%	100%	43.3%
Direct support professional	7	16%	100%	45.4%

Employer survey respondents reported that activity aides, developmental home and direct support professionals had the longest terms of service.

**Table 48: Employer Survey Respondents Report of Average DCW Years of Service by Type of DCW**

<b>Years of Service</b>	<b>Number of Responses</b>	<b>Minimum Number of Years</b>	<b>Maximum Number of Years</b>	<b>Average number of Years</b>
Activity aide	13	1.38	36	8.6
Foster care or developmental home	3	6.5	8	7.5
Direct support professional	8	4	9	6.1
Licensed Nurse Assistant (LNA)	31	0.5	9.57	4.4
Resident assistant or aide	13	0.5	14	4.3
Personal Care Attendant (PCA)	13	1.5	9	4.1
Geriatric aide	2	1	5.1	3.1

**Research Question #4: Financial Issues**

Employer report of DCW wages: Employer survey respondents were asked to report wages by type of DCW position. Starting wages averaged from \$7.50 to \$10.00 an hour and maximum wages averaged from \$10.50 to \$14.00 per hour.

**Table I49: Employer Survey Respondents Report of DCW Average Hourly Wages**

<b>Starting Hourly Wage</b>	<b>Number of responses</b>	<b>Mean</b>
Direct support professional	6	\$10.33
Licensed Nurse Assistant (LNA)	36	\$10.09
Activity aide	14	\$ 9.48
Personal Care Attendant (PCA)	14	\$ 9.12
Geriatric aide	4	\$ 8.69
Resident assistant or aide	13	\$ 8.49
<b>Maximum Hourly Wage</b>		
Direct support professional	3	\$14.67
Licensed Nurse Assistant (LNA)	31	\$13.47
Activity aide	12	\$12.63
Personal Care Attendant (PCA)	9	\$12.46
Resident assistant or aide	9	\$10.94
Geriatric aide	1	\$10.50

Employer report of wage increases: Employer survey respondents were asked, in a forced choice question, if they provided scheduled increases in wages for DCWs. Multiple responses to this question were possible. Only 22% of respondents said they did not provide any scheduled wage increases for DCWs.

**Table I50: Employer Survey Respondents Report of Scheduled Wage Increases**

<b>Increases in Wages for DCWs</b>	<b>Frequency</b>	<b>Percent of Respondents</b>
No scheduled wage increase	12	22%
COLA increases	21	39%
Wages increased with years of service	14	26%
Merit wage increases	26	48%

Employer report of DCW benefits: Nearly all employer survey respondents reported that they provided DCWs with time off and health insurance.

**Table I51: Employer Report of Benefits Provided to DCWs**

<b>Benefits</b>	<b>Frequency</b>	<b>Percent of Respondents</b>
Time off	52	96%
Health insurance	45	83%
Mileage reimbursement	39	72%
Retirement	32	59%
DCW expense reimbursement	23	43%
Tuition reimbursement	20	37%
Child care on site/reimbursed	7	13%

Organizations least likely to offer health care insurance were residential care homes, often the smallest organizations responding to the survey.

**Table I52: Employer Survey Respondents Offering Health Care Insurance to DCWs by Type of Organization**

<b>Organizations offering health insurance</b>	<b>Frequency</b>	<b>% of these employers</b>
Home health agency	3	100%
Assisted living	2	100%
Adult day	3	100%
Nursing home	19	95%
Developmental services	5	83%
Residential care home	13	65%
<b>Total</b>	<b>45</b>	<b>83%</b>

On average, employers covered 70% of health care insurance premiums.

**Table I53: Employer Report of Percent of Health Care Insurance Premium Covered by Organization**

Percent of health care insurance premium covered by employer	Frequency	Percent
None	1	2%
50%	10	24%
51 - 75%	13	32%
76% - 95%	12	29%
100%	5	12%
Total	41	100%

On average, employees must work 27.5 hours to be eligible for benefits.

**Table I54: Employer Report of Hours Per Week DCW Must Work to be Eligible for Benefits**

Hours per week	Frequency	Percent
<20 hrs	8	17%
20 – 30	24	50%
>30	16	33%
Total	48	100%

Relation between wages/benefits and retention: The employer survey requested data on wages and retention by specific category of DCW (e.g., LNA, PCA, etc.). Given the number of categories, and small sample size, for most categories of DCW it was not possible to conduct meaningful analyses. However, most respondents did employ LNAs, so we can examine the question in terms of this one specific category of DCW.

There was one significant relationship between wages and retention for LNAs: as maximum hourly wages increased, turnover significantly decreased ( $r=-.56$ ,  $p<.05$ ). There were no statistically significant relationships between retention or turnover and starting hourly wages.

Nearly all respondents reported that they provided benefits for DCWs so we did not have the ability to compare retention rates between employers that did and did not provide benefits.

## **Appendix J**

Consumer/Surrogate Survey Results

## Appendix J

### Consumer/Surrogate Survey Results

The Consumer/Surrogate Survey was designed to gather input from consumers, or their surrogates, who hired their own direct care workers. The survey was distributed in October 2007 to all recipients of Vermont's self-directed programs including: Choices for Care, Attendant Services Program, and Children's Personal Care Services Program. The Department of Disability, Aging and Independent Living (DAIL) was responsible for creating mailing labels, based on the data bases for each of the programs. Each recipient received a cover letter from DAIL's commissioner explaining the survey, a copy of the survey, and a self-addressed stamped return envelope. The cover letter explained the purpose of the survey and offered respondents an opportunity to enter a raffle for one of ten \$50 grocery gift certificates. Survey respondents who wanted to participate in the raffle completed a separate entry form and could choose to return the form with their survey or in a separate envelope.

Return envelopes were delivered to DAIL; FSA gathered the envelopes, opened them and sorted out the entry forms and surveys. FSA was responsible for overseeing data entry and completing data analysis.

#### Survey Respondents

A total of 655 persons responded to the survey out of 2,584 distributed, for a 25% response rate. The survey asked respondents if they were completing it for themselves or "for a family member or friend who receives direct care or support." The majority of respondents (61%, n=402) said they directly "receive care or support from a direct care provider;" while 36% (n=235) said they were completing the survey as a surrogate.

Consumer respondents ranged in age ranged from 1 to 103 years, with an average age of 38.8 years. Half of consumer/surrogate survey respondents represented consumers under age 21.

**Table J55: Consumer Age Reported by Consumer/Surrogate Survey Respondents**

Consumer Age	Frequency	Percent
21 and younger	342	53%
22 to 64	116	18%
65 and older	192	30%
Total	650	100%

Consumers were equally distributed by gender: female (49%) and male (50%) across the full sample. When examined by age and gender, about one third of consumers under 21 years of age were male while about three quarters of consumers 65 and older were female.

**Table J56: Consumer Age by Gender Reported by Consumer/Surrogate Survey Respondents**

Gender	Age of Consumer			Total
	21 or younger	22 to 64	65 or older	
Female	111	68	137	316
Male	228	48	52	328
Total	339	116	189	644

About half of the survey respondents represented consumers with developmental disabilities and the remaining half of consumers had physical disabilities, dementia or Alzheimer's disease or TBI. Note that consumers may have had multiple care or support needs.

**Table J57: Care or Support Needs as reported by Consumer/Surrogate Survey Respondents**

Care/Support Needs	Frequency	Percent of all responses
Physical disability	285	44%
Developmental disability	316	48%
Dementia and/or Alzheimer's	62	9%
Traumatic Brain Injury	37	6%
Other care needs (excluding above)	52	8%

The majority of consumers with developmental disabilities represented in the survey sample were under age 21. Since the survey was only sent to consumer/surrogates who employ their own DCWs through a self-directed option, and most adults with developmental disabilities do not use self-directed funding options, this is not surprising. Among the other care/support needs, consumers of all ages were equally represented.

**Table J58: Consumer Age by Care/Support Needs as reported by Consumer/Surrogate Survey Respondents**

Care/Support Needs	Age of Consumers			Total
	21 or younger	22 to 64	65 or older	
Physical disability	108	105	155	368
Developmental disability	279	17	18	314
Dementia or Alzheimer's	0	5	57	62
Traumatic Brain Injury	17	12	8	37

Since half of the respondents represented consumers under age 21, it is not surprising that nearly half of the survey respondents reported that Children's Personal Care Services provided funding for DCWs. Some respondents reported receiving funding from multiple sources.

**Table J59: Consumer/Surrogate Survey Respondents Report of DCW Funding Source**

Source of Funding for DCW	Frequency	Percent of all Respondents	Average % of Costs Covered
Choices for Care	181	28%	91.75
Attendant Services program	103	16%	85.27
Children's Personal Care Services	293	45%	90.61
Own money	114	17%	27.14
Other funding source	33	5%	48.98
Don't know funding source	29	4%	

Consumer/surrogate survey respondents represented all counties within Vermont.

**Table J60: Consumer/Surrogate Survey Respondents County of Residence**

County	Frequency	Percent
Unknown	3	0%
Addison	40	6%
Bennington	36	5%
Caledonia	51	8%
Chittenden	114	17%
Essex	11	2%
Franklin	57	9%
Grand Isle	10	2%
Lamoille	20	3%
Orange	39	6%
Orleans	39	6%
Rutland	88	13%
Washington	40	6%
Windham	58	9%
Windsor	49	7%
Total	655	100%

**Research Question #1: Quantity and Availability Issues**

Time to fill DCW position: On average, consumer/surrogates report that it takes 2.65 months to find a DCW – ranges from 1 week to two years.

**Table J61: Time for Consumer/Surrogate to File DCW Position**

Months to find DCW	Frequency	Percent
Less than 1 month	103	29%
One to two months	123	35%
Two to six months	107	30%
More than six months	22	6%
total	355	100%

It takes significantly longer for consumers under 21 years of age to find DCWs ( $F(2,348) = 6.28, p < .01$ ).

**Table J62: Time for Consumer to Find DCW by Age of Consumer**

Consumer Age	Months to find DCW		Number
	Mean	Std. Dev.	
21 or younger	3.02	2.99	229
22 to 64	2.52	2.92	53
65 or older	1.64	2.32	69
Total	2.67	2.90	351

Consumer/surrogate report use of allocated hours: On average, consumers use 84% of their allocated hours of DCW service. Consumers under 21 years use significantly fewer allocated hours ( $F(2, 518) = 8.11, p < .001$ ).

**Table J63: Percent of Allocated Consumer/Surrogate Directed Hours Used by Consumer Age**

Age groups	Percent of allocated hours used		Number
	Mean	Std. Dev.	
21 or younger	80.4%	29.1	312
22 to 64	89.8%	26.4	76
65 or older	90.6%	24.9	133
Total	84.3%	28.0	521

Consumers in Choices for Care use the largest proportion of allocated hours ( $F(2,472) = 10.94, p < .001$ ).

**Table J64: Percent of Allocated Consumer/Surrogated Directed Hours Used by Funding Source**

Funding Source	Percent of allocated hours used		Number
	Mean	Std. Dev.	
Choices for Care	93.0	20.9	152
Attendant Services Program	85.6	31.8	50
Children's Personal Care Services	80.5	28.0	273
Total	85.0	26.9	475

The primary reason consumers do not use allocated hours is because they cannot find DCWs to work at the times needed, such as weekend, evenings, and vacations). Secondly, consumers can't find "workers at all" and "can't find anyone to work at the wage available through the program." Other reasons for not using allocated hours include scheduling issues with DCWs (n=15); inability to find DCWs with needed skills (n=14) and limitations of funding such as not covering evening hours or two DCWs at same time (n=12). Ten respondents reported that they did not need the hours allocated.

**Table J65: Number of Consumer/Surrogate Survey Respondents Rank Why Not Use Allocated Hours**

Reasons for not using allocated hours	Rank 1	Rank 2	Rank 3	Total Frequency
Can't find workers for needed time	105	74	24	203
Can't find workers at all	68	37	34	139
Can't find workers for available wage	53	44	35	132
Program doesn't allow evening/weekend hours	16	10	11	37
Other reason don't use allocated hours	54	11	28	93

DCW Registry: About half of consumer/surrogate survey respondents report that they would be interested in using a DCW registry; a bit over one-third of respondents don't know if they would use a registry

**Table J66: Consumer/Surrogate Survey Respondents Interest in DCW Registry**

<b>Use of registry</b>	<b>Frequency</b>	<b>Percent</b>
Yes would use registry	326	51%
No, wouldn't use registry	61	10%
Don't know	249	39%
Total	636	100%

Consumer/surrogate survey respondents ranked screening as the most important element for a DCW registry, with information on the DCW's type of experience as second most important. Other important information respondents also wanted to see in a registry: references (n=13); worker's location and access to transportation (n=8); and, worker's reasons for wanting to be a DCW (n=6).

**Table J67: Number of Consumer/Surrogate Survey Respondents Ranking Registry Elements**

<b>Information to include in registry</b>	<b>Rank 1</b>	<b>Rank 2</b>	<b>Rank 3</b>	<b>Total Frequency</b>
Only list screened workers	225	53	81	359
Type of experience	106	203	127	436
Type of training	103	135	128	366
Years of experience	85	103	129	317
Other information for registry	31	16	27	74

The consumer/surrogate survey asked if respondents had “access to background check information for direct care workers you might hire.” Only 8% of respondents said they could get background check information for anywhere in the country; and, 20% said they had no access to background checks.

**Table J68: Consumer/Surrogate Survey Respondents' Reported Access to Background Checks on DCWs**

<b>Access to Background Checks:</b>	<b>Frequency</b>	<b>Percent</b>
In Vermont only	288	45%
For anywhere in country	48	8%
No access	129	20%
Don't know	175	27%
<b>Total</b>	<b>640</b>	<b>100%</b>

College Students: Consumer/surrogate survey respondents were also asked “of the direct care workers you hire, how many of them attended college while working for you?” About 27% of respondents said they had hired DCWs who were college students at the time of their employment.

**Table J69: Consumer/Surrogate Survey Respondents Employment of DCWs who are College Students**

<b>Caregivers are college students</b>	<b>Frequency</b>	<b>Percent</b>
Unknown	33	5%
None of caregivers are students	445	68%
All caregivers are students	33	5%
Some caregivers are students	144	22%
<b>Total</b>	<b>655</b>	<b>100%</b>

Of the 144 respondents that said some of their DCWs were college students, 125 provided more detail on the percentage of DCWs in their employ that were college students. Of these 125 respondents, on average they reported that 35% of their DCW employees were in college.

**Table J70: Percent of Consumer/Surrogate Directed DCW Workforce Composed of College Students**

<b>Percent college students</b>	<b>Frequency</b>	<b>Percent</b>
1 to 25%	49	39%
30% to 50%	61	49%
51% to 85%	15	12%
Total	125	100%

**Research Question #2: Quality Issues**

Consumer/surrogate survey respondents were asked, in an open-ended question, “what is the one most important skill you look for when hiring a direct care worker?”

**Table J71: Consumer/Surrogate Survey Respondent Report of Most Important DCW Skill**

<b>Skills listed by respondents</b>	<b>Frequency</b>	<b>Percent of all Respondents</b>
Compassionate, kind, caring	130	20%
Competence, knowledge, experience	128	20%
Reliable, responsible, dependable	89	14%
Compatible, able to connect/relate	63	10%
Honest, trustworthy	59	9%
Patient	52	8%
Flexible, willing to learn	24	4%
Understand, able to care for need	27	4%
Personality	20	3%
Follow directions	12	2%
Physical ability to provide care	12	2%
Respect, dignity	12	2%

### Research Question #3: Stability Issues

Length of Service: Consumer/surrogate survey respondents report that DCWs stay in their employ for an average of 2.7 years, ranging from 1 month to 37 years.

**Table J72: Average Length of DCW Service Reported by Consumer/Surrogate Survey Respondents**

Average time employed	Frequency	Percent
Less than 1 year	98	21%
One year	119	26%
Two years	88	19%
Three to five years	103	23%
More than five years	49	11%
Total	457	100%

DCWs serving consumers under 21 years of age had significantly shorter terms of service than did DCWs serving older consumers ( $F(2,450) = 9.67, p < .001$ ).

**Table J73: Average Years of DCW Service by Consumer Age, Reported by Consumer/Surrogate Survey Respondents**

Consumer Age	Average Years DCW Employed		Number
	Mean	Std. Dev.	
21 or younger	2.18	2.29	260
22 to 64	3.99	4.19	76
65 or older	3.09	4.44	117
Total	2.72	3.39	453

DCWs serving consumers through ASP have significantly longer terms of service than through other programs ( $F(2,390) = 14.55, p < .001$ ).

**Table J74: Average Years of DCW Service by Funding Source, Reported by Consumer/Surrogate Survey Respondents**

Funding Source for Consumer	Average Years DCW Employed		Number
	Mean	Std. Dev.	
Choices for Care	2.4	2.3	117
Attendant Services Program	4.7	6.2	59
Children's Personal Care Services	2.2	2.3	217
Total	2.7	3.3	393

Number of care/support providers over time: In structured group interviews, consumers discussed the difficulties they face with many different people providing care. All respondents to this survey received at least some of their care through self-directed programs, not primarily through agency or other community-based programs; and, none of the respondents received care in residential care, assisted living or nursing home settings.

Results from the survey, which should not be generalized to consumers who do not hire their own direct care workers, indicate that half of the consumers receive care from an average of one DCW each week while another quarter of respondents report receiving care from an average of two DCWs per week.

**Table J75: Consumer/Surrogate Survey Report of Average Number DCWs Providing Weekly Care/Support**

Number paid caregivers in one week	Frequency	Percent
Unknown	5	1%
Report "0"	20	3%
One	343	52%
Two	172	26%
Three	72	11%
Four	18	3%
Five to Eight	23	4%
More than eight	2	0%
Total	655	100%

There were no differences in the average number of caregivers by consumer age or type of care/support need.

**Table J76: Consumer/Surrogate Report of Average Number of DCWs Providing Care/Support by Age of Consumer**

Number paid caregivers in one week	21 or younger		22 to 64 years		65 or older	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
One	190	58%	60	53%	91	49%
Two	89	27%	27	24%	53	28%
Three	32	10%	18	16%	22	12%
Four	8	2%	2	2%	8	4%
Five or more	7	2%	6	5%	12	6%
Total	326	100%	113	100%	186	100%

**Research Question #4: Financial Issues:**

The consumer/surrogate survey asked respondents if they were “able to give direct care workers a raise in their hourly wages.” The majority of respondents said that they had no source of funds to allow for raises. Of the respondents who marked the “other” category, 34 (5% of all respondents) said that it was not up to them to provide raise, and 16 (2%) said they provided bonuses or covered DCW expenses out-of-pocket.

**Table J77: Consumer/Surrogate Survey Respondents Report of Ability to Give DCWs Pay Raises**

<b>Able to give workers raises</b>	<b>Frequency</b>	<b>Percent of all Respondents</b>
No source of funds to allow for raises	392	60%
Give workers COLA from own funds	21	3%
Give workers years of service raise from own funds	18	3%
Don't know if funds are available	129	20%
Other	63	10%

In another question, consumer/surrogate survey respondents were asked to identify “which of the following benefits direct care workers in your employ receive.” By far, the most frequent response across all types of funding programs was that DCWs do not receive any benefits. Several respondents marked the “other” category and reported that DCWs receive workman’s compensation insurance (n=18), and expense reimbursement from consumer/surrogate’s own funds (n= 12).

**Table J78: Consumer/Surrogate Survey Respondents Report of Benefits Provided to DCWs**

<b>Benefits provided to DCWs</b>	<b>CFC</b>	<b>% of CFC</b>	<b>ASP</b>	<b>% of ASP</b>	<b>CPCS</b>	<b>% of CPCS</b>
No benefits	139	77%	75	73%	211	72%
Health insurance	3	2%	1	1%	6	2%
Time off	11	6%	7	7%	16	5%
Mileage reimbursement	14	8%	6	6%	28	10%
Expense reimbursement	11	6%	5	5%	37	13%
Tuition reimbursement	0	0%	0	0%	2	1%
Training time paid	2	1%	6	6%	19	6%
Child care reimbursed	0	0%	1	1%	4	1%
Retirement	1	1%	2	2%	1	0%

## **Appendix K**

Supply of Workers

## Appendix K 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. Indeed, our Direct Care Worker Survey found that about one-quarter of workers hold more than one direct care position. 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 K1: 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	Communit y Care for Elders	Other Residentia l Care	Individu al & 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
<b>Total</b>	<b>7,584</b>	<b>1,803</b>	<b>643</b>	<b>37</b>	<b>2,474</b>	<b>23</b>	<b>4,980</b>

**Table K2: Direct Care Workers Employed in Community-Based Settings through State Funded Programs (2006)**

<b>DAIL Administered Programs</b>	<b>Number DCWs</b>
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
<b>Total of All DAIL administered programs</b>	<b>5,145</b>

Source: DAIL and ARIS

**Table K3: Other Sources of Data on Number of DCWs Employed**

<b>Additional sources of data</b>	<b>Number of DCWs</b>
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 aides"<sup>1</sup>
- "nursing aides, orderlies, and attendants"<sup>2</sup>
- "personal and home care aides"<sup>3</sup>

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.

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. .

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<sup>1</sup> 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"

<sup>2</sup> 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"

<sup>3</sup> 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)

## 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-employed<sup>4</sup>.

## 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.

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<sup>4</sup> 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

## **Appendix L**

Demand for Direct Care

## Appendix L

### Demand for Direct Care

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.

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 annual report: *Shaping the Future of Long Term Care and Independent Living 2006-2016* (Wasserman, 2007)<sup>5</sup>. Wasserman conducts a point-in-time analysis of the number of Vermonters age 18 and over with long term care (LTC) needs; that is, "requiring the help of another person to perform two or more ADLs." Based on 2000 Census and other data sources<sup>6</sup>, Wasserman reported that 4,559 Vermonters with LTC needs were living in the community in 2006. Community living included one's own home as well as residential care or other non-institutional community-based settings (e.g., assisted living, congregate housing with supports). As shown in Table L1, the majority of these Vermonters were age 65 and older.

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<sup>5</sup> Wasserman, J. (2007) *Shaping the Future of Long Term Care & Independent Living 2006-2016* Vermont Department of Aging and Disabilities

<sup>6</sup> Sources used by Wasserman (2007): Vermont-specific data on broad disability and population characteristics from the 2000 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on the Assumptions Sheet of the report.

**Table L1: Number of Vermonters Living in the Community\*  
with LTC Needs\*\* (2006)**

Age Groups	Number of Persons with LTC Needs
18 to 64	1,283
65 and older	3,276
Total	4,559

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

\*\* Long Term Care (LTC) needs defined as needing the help of another person to perform two or more ADLs, excludes persons with developmental disabilities

In addition, 3,158 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 **7,717** Vermonters in need of direct care during 2006. This total does not include persons with developmental 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

The 2001 National Survey of Children with Special Health Needs<sup>7</sup> 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 disability<sup>8</sup>. 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.

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<sup>7</sup> National Survey of Children with Special Health Care Needs (2001) Maternal and Child Health Bureau, U.S. Department of Health and Human Services

<sup>8</sup> Brain Injury Association of Vermont (2007)

## **Appendix M**

Quality of Care: Consumer Satisfaction Surveys

## Appendix M

### Quality of Care: Consumer Satisfaction Surveys

Results from several surveys conducted among consumers in Vermont's programs to provide direct care indicate high levels of satisfaction with the quality of care. Specifically:

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%).

The Vermont Health Care Association contracts with Press Ganey on an annual basis to conduct nursing home satisfaction surveys. Vermont scores, since 1999, have been consistently higher than national or even New England, averages. Most recent scores from March 2007<sup>9</sup> indicate that residents are particularly satisfied with the quality of care from "nurse's aides" (see Table M1).

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<sup>9</sup> Press Ganey Satisfaction Measurement, Spring 2007, Vermont Nursing Home Reports

**Table M1: Percent of Residents Reporting Satisfaction with Nurse's Aides**

<b>Area of satisfaction:</b>	<b>Vermont Average</b>	<b>National Average</b>	<b>New England Average</b>
Friendliness of Aides	89.1%	83.3%	84.6%
Technical Skill of Aides	85.7%	79.8%	81.8%
Adequacy of information from aides	82.1%	75.2%	76.8%
Aides responsive to ideas	82.0%	76.2%	77.6%
Aides explanation of care	83.6%	76.0%	78.0%
Aides treat resident with dignity	87.0%	80.7%	82.7%
Aides respond to call lights	76.6%	67.8%	71.0%

## **Appendix N**

Evidence Based and Promising Practices

## Appendix N Evidenced-based and Promising Practices

Several sources provide summaries of evidenced-based and promising practices linked to improving retention of direct care workers. For example:

- The American Association of Homes and Services for the Aging (AAHSA) publishes a monthly magazine focused on best practices, *FutureAge*, available at: [www.aahsa.org/pubs\\_resources/futureage/default.asp](http://www.aahsa.org/pubs_resources/futureage/default.asp)
- PHI has a National Clearinghouse on the Direct Care Workforce Best Practices with an extensive database available at: <http://www.directcareclearinghouse.org/practices/index.jsp>

We have highlighted seven specific practices in the body of the report. The following provides more detailed information about each:

### Vermont's Gold Star Employer Program

The Vermont Department of Disabilities, Aging and Independent Living (DAIL) partnered with the Vermont Health Care Association (VHCA) to develop a "Gold Star" initiative intended to recognize nursing homes that utilize recruitment and retention methods identified and accepted by the profession as "Best Practice". Through research, deliberation and discussion with members of the state's nursing home profession, a Retention Best Practices Committee identified seven categories of Best Practice:

- Staff recruitment
- Orientation and training
- Staffing levels and work hours
- Professional development and advancement
- Supervision training and practices
- Team approach
- Staff recognition and support

The Committee designed a voluntary process through which interested nursing homes could gain Gold Star recognition. The steps of the process require that nursing homes:

- Conduct a Best Practice self-assessment
- Complete a Best Practice work plan
- Document progress towards self-identified goals

The Nursing Home Gold Star Employer Program was launched in 2004. A Gold Star Council was established to provide ongoing oversight and management of the Gold Star Employer Program. Designation as a Gold Star employer serves as one criterion toward a nursing home receiving the DAIL annual Quality Award of \$25,000.

In 2006, the Vermont Assembly of Home Health Agencies (VAHHA) adapted the above model to create a Gold Star Employer program for its member agencies. The home health agency program is similar in that participation is voluntary. Again, interested agencies must:

- Conduct a Best Practice self-assessment
- Complete a Best Practice work plan
- Document progress towards self-identified goals

In 2007, Reback and Livingston<sup>10</sup> conducted an evaluation of the nursing home Gold Star Employer Program in which the experiences of 14 nursing homes that had participated in the program in 2004 and 2005 were examined. The evaluation found that the majority had built and actively involved a team of personnel from different departments and job rankings to implement the Gold Star program. Employees reported these teams made a positive impact on the workplace culture. Indeed, the evaluation found that in both years, Gold Star nursing homes experienced lower LNA turnover rates (58%, 65%) than non-Gold Star nursing homes (72%, 79%).

### Retention Specialist

The Cornell Institute for Translational Research on Aging, Cornell University, developed and tested a retention specialist model designed to improve retention of certified nursing assistants (CNAs) in nursing home settings<sup>11</sup>. Key features of the retention specialist model included:

- Participating nursing homes designated a staff person to serve as the Retention Specialist, including allocation of at least 20% of time for retention activities over one year
- Retention Specialist attended a three-day intensive training institute to review an organizational assessment (using tool provided by program); diagnose their facility's specific retention issues; review possible evidence-based intervention strategies; and, develop a site specific retention plan for their facility.
- Retention Specialist had ongoing access to technical assistance including web site, telephone contact and print material for information on retention activities

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<sup>10</sup> Reback and Livingston (2007) *Nursing Home Gold Star Employer Program: Status Report* Berlin, VT: Vermont Health Care Association Gold Star Council

<sup>11</sup> Pillemer, K. and Meador, R. (2006). *The Retention Specialist Project*. A Better Jobs Better Care Research Study. Available at [www.bjbc.org](http://www.bjbc.org)

- Retention Specialists received information about community resources such as educational materials and contact information for support on personal issues such as financial well-being, healthy lifestyles, parenting, transportation, and childcare to share with their employees.

Cornell compared 16 nursing homes using the Retention Specialist with 16 comparison nursing homes, all located in New York and Connecticut. Research results indicated that statistically significant improvements in retention among nursing homes with the Retention Specialists. Over one year, turnover rates remained constant in the comparison nursing homes, but declined from 21% to 11% in the Retention Specialist nursing homes.

### Coaching Supervision

PHI has developed a training curriculum, *Coaching Supervision*, 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. In contrast to a punitive approach, *Coaching Supervision* emphasizes the supervisor's role in working with direct care workers to develop problem-solving skills. It teaches the importance of setting clear expectations, requiring accountability, and at the same time encouraging, supporting, and guiding each worker.

This training curriculum has been used successfully in Vermont as well as elsewhere in the country. Researchers at the University of North Carolina, in testing a continuing education program for direct care workers, attribute *Coaching Supervision* as critical to the success of their training program<sup>12</sup>.

### Worker involvement in care planning

As PHI<sup>13</sup> has often demonstrated, direct care workers feel devalued and their job commitment undermined when their skills and expertise are not acknowledged and employed through organizational policies and practices. Several efforts have been made to include direct care workers, across all types of work settings, as active participants in care planning and other decision-making. In one study, for example, researchers found that increased direct care workers involvement in decision making and care planning was associated with lower retention problems and decreased turnover<sup>14</sup>.

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<sup>12</sup> 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](http://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

<sup>13</sup> PHI (2007) *Elements of a Quality Job for Caregivers: Key Research Findings* June 2007 available at: [www.PHInational.org/clearinghouse](http://www.PHInational.org/clearinghouse)

<sup>14</sup> 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](http://www.abramsoncenter.org/PRI/documents/PA_LTC_workforce_report.pdf)

## Peer-mentoring programs

Peer-mentoring training programs are offered on-site or through community colleges for experienced direct care workers across nursing home and home health settings. These programs teach leadership and foster mentoring skills. Experienced direct care workers provide mentoring to newly-hired direct care workers. Mentors provide ongoing orientation and support during the initial employment period. Moreover, mentors not only benefit from training and skills development, they also generally receive increased wages to compensate for increased responsibility. Research on peer-mentoring programs has shown them to have positive impact on both mentors and mentees and to improve retention<sup>15</sup>.

## Northern New England LEADS (Leadership, Education, and Advocacy for Direct-care and Support) Institute<sup>16</sup>

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. PHI staff worked with the Community of Vermont Elders (COVE) and with long-term care and community-based providers in Maine, New Hampshire and Vermont, beginning in 2005. Providers in Vermont included: the VNA of Chittenden/Grand Isle Counties; the Rutland Area Visiting Nurse Association and Hospice; Mt. Ascutney Nursing Home; and Woodridge Nursing Home. LEADS staff worked with these providers to implement Coaching Supervision and Peer Mentoring, and to implement more person-directed care practices, and to involve direct care workers more closely in organizational decision-making. LEADS staff also worked to advance public policy issues in Vermont (and Maine and New Hampshire) on behalf of care-givers, consumers, and employers. PHI is currently seeking funding for phase II of this project.

A final evaluation of the impact of the LEADS Institute will be available at the Directcare Clearing House, <http://www.directcareclearinghouse.org/index.jsp>, by the end of June 2008.

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<sup>15</sup> 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>

<sup>16</sup> 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](http://www.bjbc.org/content/docs/FA_FEAT_RespectfulRelationshipsHeartofBJBC_V6N2.pdf)

### 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.

## **Appendix O**

### List of Acronyms

## Appendix O

### List of Acronyms

<b>Acronym</b>	<b>Organization or Term</b>
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
CCV	Community College of Vermont
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
PHI	Formerly known as Paraprofessional Healthcare Institute
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
VCDMHS	Vermont Council of Developmental and Mental Health Services
VCIL	Vermont Center for Independent Living
VHCA	Vermont Health Care Association