The Direct Support Professional Workforce Crisis:

Challenges, State Approaches, and Opportunities for Georgia

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Executive Summary

There is a growing demand for Direct Support Professionals (DSPs) to support citizens with disabilities in home and community settings. DSPs are staff who are employed to provide a wide range of supportive services to individuals with intellectual or developmental disabilities (I/DD) on a day-to-day basis, including habilitation, health needs, personal care and hygiene, employment, transportation, recreation, housekeeping and other home management-related supports, so that these individuals can live and work in their communities and lead self-directed, community and social lives. The direct support workforce is one of the fastest growing in America due to population growth, the increased life expectancy among persons with disabilities, the aging of family caregivers, and the mandated movement from institutional to community-based services.

This demand is outpacing the supply of available workers. Vacancy rates and voluntary turnover is high. Low wages and limited benefits, minimal training, ineffective supervision, and few opportunities for career growth, combined with the growing complexity of work, are barriers to creating a stable workforce. The crisis of care in home and community-based service settings is of high concern in Georgia. The annual turnover rate of direct support professionals is 45%. Only 64% of staff stays in their positions for more than one year. The average hourly wage is $10.30 (below the national average of $11.76 and far below the living wage for Georgia for one adult and one child of $22.52). Only 16.3% receive any kind of paid time off, and health insurance is only offered to 43.9%.

The DSP crisis is extremely costly to the human service system and to the individuals who need assistance. People with disabilities were significantly less likely to have most quality of life indicators present when they experienced DSP turnover. The DSP crisis puts people with I/DD who need assistance at great risk of harm, contributes to unreasonably long waiting lists for services, and is leading many people to reconsider more expensive institutional models of segregated care outside their home.

There are a number of approaches states are taking to address this crisis. States are forming in-state partnerships to collaborate with state workforce agencies, trade associations, and educational institutions. Legislatures are advocating for a standard occupational classification for DSPs to improve workforce data collection. Wages and benefits are being evaluated and Medicaid reimbursement rate changes, including cost of living adjustments, wage pass throughs, and value based payments are being implemented. Competency-based training and affiliated credentialing has been found to positively impact staff retention and outcomes for people receiving support. Among many state-level efforts, comprehensive interventions to increase the recruitment and retention of DSPs are being undertaken by Tennessee, Ohio, and New York.

Given the quantity of current national research and innovative strategies implemented by states to address the DSP crisis, there are a number of opportunities for Georgia to consider. These include: 1. the creation of a standard occupational code for DSPs; 2. creation of a state-level task force to address systemic DSP challenges; 3. incentives to innovate recruitment; 4. expansion of nationally accredited competency-based training; 5. development of a career ladder with affiliated wage increases; 6. reassessing Medicaid reimbursement rates to include training costs and wage increases for staff; 7.creation of a public-facing DSP registry; and, 8. establishment of an HCBS Innovation Fund to support pilot studies to address the workforce shortage in Georgia.

This paper is dedicated to Dawn Alford, Policy Director for the Georgia Council on Developmental Disabilities, who advocated fiercely for improving the direct support workforce in Georgia.

I. Problem Statement

As is the case in most states, the crisis of care in home and community-based service (HCBS) settings is of high concern in Georgia. According to the 2018 National Core Indicators (NCI) Staff Stability Survey report, the annual turnover rate of direct support professionals (DSPs) is 45%. Only 64% of staff stay in their positions for more than one year. The average hourly wage is $10.30 (below the national average of $11.76 and far below the living wage for Georgia for one adult and one child of $22.52). Only 16.3% receive any kind of paid time off (NCI average = 35.2%) and health insurance is only offered to 43.9% (NCI = 66%).

To better understand the crisis in Georgia, the *House Study Committee on the Workforce Shortage and Crisis in Home and Community Based Settings* was created by House Resolution 1257 during the 2018 Legislative Session of the Georgia General Assembly (http://www.house.ga.gov/Documents/CommitteeDocuments/2018/Workforce_Shortage_and_Crisis/HR_1257_Final_Report_Signed.pdf) . HR 1257 acknowledges that tens of thousands of Georgians with physical, intellectual, and developmental disabilities receive out-of-home care and support in 24-hour, seven day a week residential settings throughout the state, participate in day programs during each weekday, and receive care from their family. All of these citizens, as a result of their disabilities, require the support of DSPs to ensure their good health is maintained and that their medical needs are promptly and properly met. The resolution also recognizes that all of these citizens require the support of well-trained personnel from a workforce that is stable and reliable and experiences only a modest turnover rate; however, there is a well-documented shortage of qualified applicants for these vital positions as well as a high turnover rate in this workforce. HR 1257 acknowledges that there are developed and effective means of workforce recruitment and retention that are vital to serving this growing population; however, providers of services to Georgians who have disabilities have found it difficult and costly to attract and retain a workforce able to implement the current laws and regulations related to care in home and community-based settings. Therefore, HR 1257 recommended that a study of the conditions, needs, issues, and problems concerning the workforce shortage for home and community settings be done in order to discover solutions to support this population. The study committee held three public meetings at the State Capitol during 2018, occurring on 9/11/18, 10/09/18, and 12/12/18. During these meetings, the committee heard testimony from multiple agencies and stakeholders involved in the home and community based services workforce in Georgia.

Testimony pointed to the growing crisis with the state's DSP shortage. Quality, retention, and turnover were all common themes identified by presenters. Furthermore, there was broad agreement that these trends are worsening due to demographics, low unemployment, and increasing demand for services. Common themes for improvement include the creation of a career ladder for advancement, reducing unnecessary regulation and policies, improving training and increasing Medicaid reimbursement rates for services. Multiple staff spoke about their desire for continued training as well as a career ladder that allows them to have attainable career goals and provides opportunity for promotion and specialization.

II. Background

There is a growing demand for Direct Support Professionals to support citizens with disabilities in community settings. DSPs are staff who are employed to "provide a wide range of

supportive services to individuals with an intellectual or developmental disabilities (I/DD) on a day-to-day basis, including habilitation, health needs, personal care and hygiene, employment, transportation, recreation, housekeeping and other home management-related supports, so that these individuals can live and work in their communities and lead self-directed, community and social lives" (Congressional Record, November 4, 2003, p. H10301). DSPs are interdisciplinary professionals. They develop and implement effective strategies to teach people new skills; dispense medications, administer treatments, document care and communicate with medical professionals; assess needs, implement specific treatment plans and document progress; connect people to community resources and benefits; and listen, reflect and offer suggestions (PCPID, 2017). DSPs, who may be full (70%) or part time (30%), work in a range of settings including family homes, people's own homes or apartments, intermediate care facilities, residential group homes, community job sites, vocational and day training programs, and others (PCPID, 2017; PHI, 2016). According to the Bureau of Labor Statistics (2016) , between 2014 and 2024 there will be a 26% increase in need for personal care aides and a 38% increase in need for home care aides with a 48% increase in total demand (which includes DSPs as well as direct care workers who support the elderly and physically disabled) because of population growth, the increased life expectancy among persons with disabilities, the aging of family caregivers, and the expansion of home and community-based services, making these among the fastest growing occupations in the United States. Normal economic pressures that would drive supply in response to increased demand may not apply, in large part because of the dominant role of Medicaid in funding HCBS, as well as the imperative to better control Medicaid spending. Further, this demand is outpacing the supply of available workers. Women ages 25 to 64, the main labor pool from which these workers are drawn, is only projected to increase by less than 2 million (ANCOR, 2017). The median age of a direct support staff is 47, 87% are women, and 60% are people of color (PHI, 2018a). Immigrants are a growing part of the direct support workforce with 28% of all health paraprofessionals, such as Certified Nursing Assistants, and Home Health Aides, having immigrated to the US from other countries (ANCOR, 2017) and 57% of immigrant direct care workers have been living in the U.S. for 10 years or longer (PHI, 2018b). The national turnover average of DSPs leaving the field is currently 45.5% (NCI 2018). Turnover is also frequent; 56% of DSPs leave their employment within a year, and roughly 35 % do so within six months (NCI, 2018). Low wages and limited benefits, minimal training, ineffective supervision, and few opportunities for career growth, combined with the growing complexity of work, are barriers to creating a stable workforce (Larson and Hewitt, 2012). This is supported by data gathered through a national survey seeking reasons why DSPs leave their positions in which inadequate pay and benefits (88.54%), stress of the work (66.88%), lack of advancement opportunities (49.68%), lack of supervisory support (42.04%), and insufficient training (28.66%) were among the highest cited reasons (Medisked, 2016).

Overview of the Issue

In August 2016, the President's Committee for People with Intellectual Disabilities (PCPID) identified possible topics for the 2017 Report to the President. The PCPID polled its members about the most pressing topic for the 2017 report with the final tally yielding overwhelming support (87%) for addressing the crisis in the DSP workforce as challenges in finding, keeping, and training this workforce persist and have reached crisis levels in the long-term services and supports (LTSS) industry. This crisis stems from the following factors:

- high staff turnover;

- growing demand for services due to the growth and aging of the U.S. population in general;
- increased survival rates for people with ID;
- demographic shifts resulting in fewer people moving into the DSP workforce;
- persistently non-competitive aspects of direct support employment, including low wages, poor access to health insurance, and lack of paid time off (PTO) and other benefits;
- high stress and demands of direct support employment, including round-the-clock, seven-days-a-week work;
- insufficient training and preparation for DSP roles; and
- lack of professional recognition and status for skilled DSPs.

Not only does the DSP crisis impact individuals and families, but it is also extremely costly to the human services system and the overall U.S. economy. Each vacancy costs agencies between $4,200 and $5,200 in direct costs (e.g. separation, training a new employee, etc.) and indirect costs (e.g. lost productivity and client revenue) (Medisked, 2016). The aggregated cost is substantial. Nationally, these costs are estimated at $2,338,716,600 (PCPID, 2017).

Fewer DSPs are entering the field. DSPs are often thought of as an uneducated workforce; however, 86% have a minimum of a high school education, 19% have an associate's degree or higher, 33% have some college, and 34% are high school graduates (PHI, 2017). Yet, median annual earnings for this workforce are at poverty levels ($17,000 national average) and workers rely on public assistance (including 40% on public health coverage) and multiple jobs to meet their needs (PHI, 2017). These are among the factors that deter workers from entering the DSP workforce. Other factors include isolation from other workers, high rates of injury, high accountability, lack of a career ladder and insufficient training and professional development (PCPID, 2017).

According to the PCPID (2017), the DSP crisis puts people with I/DD who need assistance at great risk of harm, contributes to unreasonably long waiting lists for services, and is leading many people to reconsider more expensive institutional models of segregated care outside their home. The Council on Quality and Leadership recently conducted a study (Freidman, 2018) which analyzed over 1,300 Personal Outcome Measures® interviews with people with intellectual and developmental disabilities to examine the impact DSP turnover had on different aspects of people with disabilities' quality of life. People with disabilities were significantly less likely to have almost every quality of life indicator present when they experienced DSP turnover. Compared to people with IDD who did not experience change, people who experienced DSP change in the past 2 years are less likely to experience human security including: (a) being safe,(b) having the best possible health, (c) exercising rights, (d) being treated fairly, (e) being respected, and (f) experiencing continuity and security. For example, people with disabilities were 32% less likely to be in integrated environments when they experienced DSP turnover and 17% less likely to participate in community life (Friedman, 2018). For people with I/DD to live in their communities, they must have available to them DSPs who are well trained and will provide them with individualized supports in all facets of community life: home, work, education, faith, family, friendship, activity and the responsibilities of citizenship (e.g., paying taxes and voting) (PCPID, 2017).

The direct support workforce and the service system that supports it are in a crisis that will result in catastrophic outcomes for people with ID and their families unless significant and

immediate responses are implemented (PCPID, 2017). Without this workforce, we have a public health crisis because the workforce crisis affects all members of the community, including:

- Providers who need stability to plan for the future and give their clients the standard of care they require and deserve;
- DSPs performing this emotionally rewarding but difficult work with insufficient relief;
- Consumers and families for whom services are a matter of life or death; and
- Local economies that are not benefiting from full employment because a fast-growing sector is not filling vacancies (ANCOR, 2017).

III. National and State Approaches to Address the Crisis

The National Quality Forum (2016) identified the direct support workforce as an important domain in measuring quality in home and community based settings (HCBS). Aspects of workforce quality include:

- DSPs have a person-centered approach to services;
- DSPs have demonstrated competencies;
- The organization and state ensure safety and respect for the worker;
- There are sufficient workforce numbers, dispersion and availability;
- DSPs are adequately compensated with benefits;
- DSPs are culturally competent; and
- DSPs are engaged and participate in the organization and system.

In their state plans and waiver applications, all states are required to provide assurances to the Center for Medicaid Services (CMS) that they are able to develop a provider network that is adequate to serve the anticipated number of participants. States with managed care programs establish contractual network adequacy standards for the health plans, which they regularly monitor. Failure to meet these requirements could result in the imposition of penalties, primarily financial, by the state on the health plan. For all states, the adequacy of the provider network is highly dependent on the adequacy of the workforce. In 2011, the National Association of State Directors of Developmental Disability Services (NASDDDS) estimated that at least 20 percent expansion of the current residential system would be necessary to address the demand for high quality HCBS services.

In-State Partnerships

In many states, Medicaid agencies partner or collaborate with state workforce or economic development agencies to give voice to healthcare and human service workforce needs as part of their state's overall workforce adequacy efforts. For example, directors of Indiana's state Medicaid Agency, state Unit on Aging, and state Mental Health Authority, all participated on a gubernatorial task force that was chartered to examine and address how state policies impacted healthcare workforce needs (NASUAD, 2018). In the 2018 National Association of States United for Aging and Disabilities (NASUAD) survey, over a third of states (36%) responding indicated they are forming partnerships in their state to address workforce challenges. Among those states: 75% have partnerships with their provider trade associations; 50% have partnerships with their state's workforce development agency; 42% have partnerships with educational institutions; 42% have partnerships with a sister human services agency; and 25% have partnerships that include a special commission or task force.

Standard Occupational Coding for DSPs

Data on DSPs in the I/DD field are not readily available or regularly compiled as the profession lacks a standard occupational code (SOC). The Department of Labor (DOL)'s Bureau of Labor Statistics uses three separate databases which list health paraprofessional occupations. These lists include occupations which do work akin to but not entirely similar to that of DSPs who care for individuals with I/DD, including:

- Home health aides/assistants (HHAs);
- Personal care aides (PCAs);
- Certified nursing aides (CNAs);
- Physical therapist assistants; and
- Social and human service assistants.

When surveyed, I/DD providers are not able to fill in their information accurately since the descriptions do not align with the work their employees perform, further compounding the challenge of finding accurate data for this sector (ANCOR, 2017). The lack of a SOC has many important ramifications:

- When states do not have a SOC for classifying the roles of DSPs, they struggle to appropriately set reimbursement rates for services and compensation.
- Without a SOC, there is no real measure for identifying staffing needs, gaps in services, and risks for cessation of services. Data provided through a SOC will lead to better understanding workforce shortages and developing long-lasting approaches to fixing them.
- Despite the fact that a DSP's work requires complex skills, thoughtful compassion, diverse care, and deep medical knowledge, there is a failure to identify this position on the scale it deserves.

A SOC would create a concrete understanding of both the contributions and the struggles of the workforce (Smith, Macbeth & Bailey, 2019). In 2017, the Illinois House of Representatives passed HR272, a resolution which urges the United States Department of Labor's Bureau of Labor Statistics to designate the Direct Support Professional as its own standard occupational classification so that more accurate and precise data on this workforce can be captured and analyzed on an ongoing basis.

Wages and Benefits

Wages for direct care workers have been stagnant or declining over the past 10-plus years. While low wages are not the sole factor in the challenges facing the direct care workforce, a wage that does not enable the worker to meet their basic needs is a barrier to recruiting more individuals into this workforce. Because Medicaid is the dominant payer for HCBS, rates are largely outside of providers' control. To further clarify what it means to have Medicaid as a primary source of funding, I/DD providers:

- Do not receive funding from private insurance companies;
- Do not benefit from other profit-generating sources;
- Do not benefit from private pay.

Some providers receive state or local contracts for non-Medicaid services, or fundraise through their networks, but these are not core funding streams for this sector (ANCOR, 2017). Medicaid rates for HCBS services have typically not kept pace with market costs, making it more challenging for providers to recruit and retain an adequate number of workers.

Wage and benefit increases are perhaps the most obvious step to draw more workers into the HCBS workforce, and states are responding. CMS has noted macro-level strategies that

impact the workforce at large, such as raising minimum wage requirements, linking wages to inflation, or implementing living wage laws. CMS encourages states and providers to be mindful of the relationship between wage sufficiency, workforce health, and access to care. Wages paid to individual workers are often slow to be adjusted in response to inflation and economic growth and can lag behind wage increases in other health and service sectors (CMS, 2016). As direct care workers tend to be in low-wage positions, state minimum wage limits can have a direct impact on median wages. Maine passed a bill to increase Medicaid reimbursement rates for direct care workers, helping to improve wages for workers who support older people and people with disabilities (PHI, 2018). Similarly, New York has living wage requirements, set wage and benefit minimums for certain segments of the home care workforce, passed the nation's first "Domestic Worker's Bill of Rights," and implemented paid family medical leave.

In the most recent Medicaid Budget Survey for State Fiscal Years 2018 and 2019, states identified gaps in community-based provider capacity (especially in rural areas) and/or direct support workforce shortages, reimbursement challenges (e.g., rising and/or more favorable rates paid to nursing facilities compared to HCBS providers) and the need to risk-adjust rates as patterns of utilization change as challenges they face. In the same survey, 15 states reported implementing wage increases for Medicaid-reimbursed direct support workers, while 24 states report implementing wage increases in FY 2019 (14 states in both years) (Gifford, et.al., 2018). 52% of responding states indicated they made rate changes to enhance capacity in their HCBS workforce. Of those states: 63% made a rate methodology change; 50% created a directed pass through for wages; 6% added a value-based payment related to staffing (NASUAD, 2019). Rate methodology changes that incorporate indexed cost of living increases or other regular reviews increase the likelihood that wages can remain competitive with other industries. Studies have found that frontline support workers enrolled in employer health insurance plans have more than twice the tenure of those without employee coverage and that when the wages of direct service providers doubled, the retention rates increased from 39% to 74% (Medisked, 2016).

Competency-based Training and Credentialing

DSPs and the Frontline Supervisors (FLS) who oversee their work need training to gain the knowledge, skills and attitudes required of their roles. Training that focuses on building DSP/FLS competency and the translation of those skills into ongoing performance reflects the complexity of the job, better prepares staff for their role, and improves the quality of supports provided. A recent study found that when DSPs were supported by organizations to complete a competency-based training program that included on-line training, in person group discussion, and mentoring by supervisors the workers gained knowledge and skill and felt more valued by their supervisors. This study also found that the sites within the organizations that participated in the intervention had a 16% decrease in turnover rates. More importantly, the individuals who received services from trained DSPs experienced more improvement in outcomes such as employment, social relationships, inclusion, and health and safety than their peers supported by DSPs who did not receive the comprehensive training (Bogenshutz, Nord, & Hewitt, 2015). In addition, when retention and turnover was measured independently as an outcome of a competency-based training intervention in four states (NY, NH, KS, and NC), the reduction of turnover ranged from 6.9% at its lowest to a decrease of 50% at its highest (Elsevier, 2015). The creation of advanced roles, coaching supervision, e-learning and entry-level training, as well as recruitment and retention strategies are all part of efforts in Minnesota and Wisconsin to improve home care jobs across their states, particularly in rural areas.

Many states have been able to strengthen their capacity to support relevant educational and training activities by claiming some of the costs as Medicaid related activities that are eligible for federal participation (FFP).When developing payment rates for direct support services, states should also consider business costs incurred by a provider – whether a support agency or an individually employed worker – associated with the recruitment, skills training, and retention of qualified workers. Similarly, a state may build into its payment rates the provider's cost of maintaining status as a qualified Medicaid provider, attending Medicaid-specific pre-service orientations or trainings, and post-enrollment training. A provider's costs for other benefits offered to workers, such as tuition assistance, performance-based bonus payments or higher wages for shiftwork, can also be built into the rate the state pays the provider for the service rendered. This can be accomplished by claiming related training expenditures as either administrative costs covered under the Medicaid State plan, that are identified and included within the state's Medicaid administrative cost allocation methodology, or as a component of the costs that are reimbursed through the state's payment rates for services. In order to fund professional preparation activities in this way, states will need to work with their State Medicaid Agency to review the options, select either the "administrative rate" or "services rate" approach and establish a sound basis and methodology for making claims for training and educational activities (NADSP, 2009)

The President's Committee for People with Intellectual Disabilities (2017) made the following training recommendations to address this crisis:

- Develop federal standards and implement specialized credentials and professional development opportunities for DSPs, ensuring: (a) that people with intellectual disabilities are trainers and mentors, (b) that programs are focused on competencies specifically identified for DSPs, (c) that completion of training to meet standards is voluntary and occurs post-hire, and (d) that the credentials result in increased wages and access to benefits for DSPs.
- Engage the broader American workforce system to find solutions to this crisis by using community colleges and American job centers to develop and invest in career training and credentialing for DSPs.
- Engage the business community and provide grants and other incentives to states to develop online matching registry services and other creative options to match people with intellectual disabilities and their families who need help finding available DSPs.

In *Moving from Crisis to Stabilization: The Case for Professionalizing the Direct Support Workforce Through Credentialing* , Smith, Macbeth, and Bailey (2019) assert that in the I/DD sector, it is anticipated that the adoption of a standardized credential for Direct Support Professionals would accomplish three key milestones to stabilization:

1. Implementation of competency-based credentialing to ensure that DSPs understand and are implementing competency-based training to enhance the quality of support;
2. Coordination of competency-based credentialing within state reimbursement rate structures for incentive payments based on credentialing to raise DSP wages and linked to skill enhancement and testing; and
3. Introduction of a true career ladder to the workforce, promoting employee tenure.

Credentialing models that are often cited in human service sectors include Certified Nursing Assistant/Aide (CNA) and Home Health Aide (HHA) certification programs. However, both

emphasize physical health and a "medical model of disability," and are less comprehensive than the training needed by DSPs to provide home and community-based supports. HCBS is different from medical care. Much of HCBS involves provider travel to the participant, rather than a participant going to a health care provider's office. Moreover, medical care tends to be episodic in nature, unlike HCBS where services are provided more frequently, even daily, over extended periods of time. Finally, HCBS addresses many of the social determinants of health, including housing and healthy food, rather than health itself. While DSPs need the skills required of a CNA and an HHA to support people with health, self-care and home-living needs, they require much more training focused on supporting independence, learning new skills and teaching people with an I/DD how to make informed decisions about their own lives, community living, and social participation. As such, their training and career development needs should be focused much more on a social model (full societal inclusion and civil rights) than on a medical model (treat and cure) of disability (PCPID, 2017).

IV. State Examples

A number of states have begun to think about how to address the DSP crisis. Three comprehensive state-level interventions are highlighted below.

Tennessee

Tennessee engaged with national subject matter experts in competency-based education and in workforce challenges to develop a comprehensive approach to workforce development for DSPs working in 1915(c) waiver services. Through this initiative, they are partnering with community and technical colleges to provide a consistent, competency-based training program, rooted in person-centered practices, that supports the development of career ladders for direct care workers, including the opportunity for college credits. Their objective is twofold: improve the quality of care by improving the quality of the workforce; and to change the perception of direct care work as a dead-end job. Through its work with the University of Minnesota's Institute on Community Integration, the state is establishing processes for the collection and use of workforce-related data at provider and system levels to target and measure improvement efforts over time. Over a period of years, about 45 providers will be engaged in a statewide learning collaborative and will receive training and technical assistance on using workforce data to drive improvements through the adoption of practices that have been shown to result in more effective recruitment, increased retention, and better outcomes for people served, including organizational and business model changes. They hope to use the learning collaborative group to mentor other providers to increase data and workforce capability. Value-based payment (VBP) strategies in contrast to traditional fee-for-service models will be implemented to incentivize provider adoption of practices that will lead to desired outcomes. Incentives will also be aligned at the worker level by implementing pass-through incentive payments to ensure wages are increased as workers increase their level of competency and complete the training program. VBP approaches will transition to financial incentives for specific workforce and quality of life outcomes once practices expected to result in the outcomes have been effectively adopted.

Ohio

Through the Ohio Alliance for Direct Support Professionals (OADSP), in partnership with their state DD agency and the state provider association, Ohio has implemented a number of innovations to recruit and retain DSPs.

In 2015, the Ohio Provider Resource Association and OADSP partnered to expose high school juniors and seniors to the field of developmental disabilities through the Community Connections Career Partnership in Ohio program also known as C3P (O). This is a program that

combines classroom education (through OADSP's Credentialing Program, DSPATHS) and a yearlong internship program, culminating with the students developing a portfolio that demonstrates their ability in a variety of DSP competency areas, and earning a credential upon the successful completion of the course. Upon graduation, the hope is that these students will find positions as DSPs and continue working in the I/DD field. Provider agencies have access to a new pool of trained and qualified candidates to fill currently vacant positions and students graduate with their high school diploma. The goal is to implement the program in high schools across the state.

DSPOhio is a unique statewide DSP recruitment effort that combines data-driven, targeted DSP branding and recruitment advertising with an on-line direct link that connects potential employees with provider employers. To effectively recruit DSPs on an ongoing basis, a process is required to increase awareness of, and familiarity with, the role of DSP. DSPOhio builds awareness and understanding of the term DSP, the rewarding nature inherent in the work and the potential career opportunities available. Media content will be posted on social media platforms. It focuses on provider identified employee demographics and offers interested employees a simple way to immediately connect with prospective employers through an easy to use website. The website will also offer more in-depth information on the role and responsibilities of a DSP, testimonials, and videos and will allow provider specific information. DSPOhio is a subscription-based service open to all I/DD providers. The first year of DSPOhio subscriptions is free thanks to generous support from multiple County Boards of Developmental Disabilities and the Ohio Developmental Disabilities Council. After the first year, each subscribing provider will pay an annual fee with an opportunity for advertising. Vendors will also have an opportunity to advertise. Revenues from subscriptions and advertising will be reinvested back into multi-media buys (and the cost of operations) thereby ensuring an ongoing year after year effort.

OHIO PATHS Direct Support Credentialing is one of the earliest statewide portfolio-based credentialing programs for DSPs. Over a ten-year period, approximately 1,200 DSPs have received a credential through this program. An evaluation of the OHIO PATHS Direct Support Credentialing program has also identified a positive impact on DSPs and the organizations in which they are employed. Recent surveys yielded the following results (Ohio PATHS Report, 2010 & 2013):

- The average length of service for PATHS graduates (8.1 years) was higher than non-PATHS DSPs (4.9 years).
- The crude separation rate is lower for graduates (7.6%) than non-PATHS DSPs (17.8%).
- The retention rate for PATHS graduates (91.8%) was significantly higher than the Ohio average retention rate of 42.8% reported 2010.
- PATHS graduates (43%) have increased their organizational participation when compared to non-PATHS DSPs (31%).
- Employers (69%) offer employees a monetary award after graduation;
- Employers (56%) offer employees a wage increase after graduation;
- Employers (87%) rate the benefits of DSPATHS as well worth the cost (Ohio Alliance for Direct Support Professionals (OADSP), 2012).

On July 1, 2018, the Ohio Department of Developmental Disabilities began offering a competency based wage increase incentive for experienced direct care staff who have also completed approved training. The requirements for receiving the additional wage reimbursement were designed to have minimal administrative impact while empowering direct service providers

to advance professional goals. Upon CMS approval, independent providers and agency direct support staff interested in obtaining the incremental add-on rate following specified time on the job and hours of continuous applicable training over time. The employer reviews transcripts of completed courses or course certificates and verify work experience, after which the employer can bill for that direct care provider's hours using a billing code that reimburses the provider at a higher rate. No re-certification is required to maintain the add-on rate. Once obtained, the provider remains eligible indefinitely. In the FY2020 and FY2021 budgets, $253 million was allocated to direct support wages to move average reimbursement to $13.23 from the current rate of $11.12.

The Leadership LAUNCHpad, which has been replicated in Georgia, was created as the solution to developing the leaders of today and tomorrow in the developmental disabilities field. Leadership LAUNCHpad is a unique leadership retreat experience, created especially for the I/DD field's leaders that allows participants to fully immerse themselves in the culture of leadership with like-minded people. This inspiring program is for leaders of all levels in the developmental disability field including; DSPs, Supervisors, Program Directors, Qualified Intellectual and Developmental Disabilities Professionals, Executive Directors, and other interested stakeholders. This program gives participants the opportunity to interact with, connect to, and learn from a wide variety of people so they can build their personal resources, core skills, and network of resources and supports within the field. The major outcomes identified for participants of this program include:

- Learning and understanding one's own leadership perception
- Exploring the soft skills of leadership
- Developing/improving conflict management resolution skills
- Professional development and accountability.

New York

The Regional Centers on Workforce Transformation (RCWT) in New York were created in 2013 to strengthen the professionalism of DSPs who support people with I/DD following a series of stories highlighting cases of abuse and neglect. The RCWT are regional collaborations between service providers, DSPs, people who receive services and other stakeholders in the field. The RCWT are coordinated by the New York Alliance for Inclusion & Innovation (New York Alliance) through funding provided by New York State Office for People with Developmental Disabilities (OPWDD). The RCWT work with provider agencies in the implementation of the National Alliance for Direct Support Professionals (NADSP) Code of Ethics, the New York State OPWDD DSP Core Competencies, and DSP Performance Evaluations, all of which guide the professional growth of New York State's more than 110,000 DSPs. The RCWT vision is to create a stable DSP workforce in New York State - one that is ethical, competent, professional, and effective in helping people with intellectual and developmental disabilities live the lives they want to their fullest potential.

The NY Core Competencies for Direct Support Professionals were developed through the input of multiple stakeholders in a grassroots effort to move from top-down compliance to a commitment to excellence. They were adopted by the NYS Talent Development Consortium and apply to all Direct Support Professionals across the state, working at state-operated and voluntary programs. The Competencies are broken down into seven goal areas covering all aspects of a person's life, while also including the professionalism of DSPs. A Core Competencies video series is available that demonstrates the key areas. The seven key goals are:

- Putting People First

- Building and Maintaining Positive Relationships
- Demonstrating Professionalism
- Supporting Good Health
- Supporting Safety
- Having a Home
- Being Active and Productive in Society

Within each goal, there are competency areas that are defined by specific technical and values based skills that can be demonstrated by a DSP in their work. The RCTW created a training crosswalk to illustrate how training requirements support the goal areas of the DSP competencies. Within each competency there are examples of tasks that illustrate each of the skills to allow for objective performance evaluation. These tasks are not skills; rather, they are illustrative of the skills. Performance evaluations provide standardized expectations that focus on people-first services and advance the profession of direct support and present an opportunity for portability of skill transfer for DSPs and occupational recognition by the NYS Department of Labor.

Service providers were tasked with the implementation the NADSP Code of Ethics, the Core Competencies and Performance Evaluations for DSPs as outlined through an Administrative Memorandum (#2014 -03) issued in 2014 to all OPWDD state-operated and voluntary-operated services and supports that employ DSPs. A timeline of 18 months for implementation was given. The RCWT have developed numerous tools to help agencies implement the new competencies, including a Core Competency Tool Kit. Agencies were not expected to revamp their training programs, but rather, compare their current training to the Core Competencies and crosswalk the training criteria. These documents and videos, along with many others, were available on the RCWT's Resource Library. These include a series of webinars on the NYS Direct Support Professional Core Competencies. Each webinar reviews one of the 23 core competencies through story-telling and vivid descriptions of a competent DSP supporting someone with an intellectual and/or developmental disability. Presenters of the webinars are all workforce champions, including RCWT regional leads, staff development trainers, DSPs, and self-advocates. Presenters have also designed one-page interactive activities that can be used to facilitate discussions with staff, assess understanding of the competency, and take learning further. Evaluating DSPs on their use and understanding of the DSP Core Competencies is an important part of New York State's Workforce Transformation initiative. All DSPs in New York State are now required to adhere to the Code of Ethics and Core Competencies, and it is up to their Frontline Supervisors (FLSs), the families, or the people receiving support who hire them directly to complete the annual evaluations of their work performance. The Office for People with Developmental Disabilities has implemented the NYS DSP Performance Evaluation tools to provide standardized expectations, focused on people-first services and advancing the profession of direct support.

The RCWT further developed a crosswalk between core components of OPWDD's transformation agenda and the NYS DSP Core Competencies to demonstrate an inter-relationship of purpose and practical expectations occurring in service transformation in NY and across the United States. These include the Council on Quality and Leadership's (CQL) Personal Outcome Measures, which are general validated measures for providing successful habilitation services; the NADSP Code of Ethics which outlines the standards of DSP conduct and professionalism; the federal Home and Community Based Services regulations; and Person-

Centered Planning to support a process of continuous learning to ask, listen, discover and honor the uniqueness and self-determination of the people served (NYSACRA, 2016).

In 2016, Governor Andrew M. Cuomo and the New York Legislature charged the New York Office for People with Developmental Disabilities (OPWDD) to provide recommendations for the design and implementation of a Direct Support Professional (DSP) credential pilot program. To fulfill this charge, the OPWDD funded and engaged in a comprehensive project that included four main components: 1) an environmental scan and literature review, 2) a statewide series of structured focus groups to gather input about the development, utility, design and implementation of a credentialing program for DSPs from multiple stakeholder groups, 3) a comprehensive statewide survey of New York licensed organizations that provide community services to people with intellectual and developmental disabilities (I/DD) and employ DSPs and Frontline Supervisors (FLS), and 4) recommendations for NYS DSP credentialing design. The resulting report describes a proposed competency-based New York DSP Career GEAR Up Credential Program and offers recommendations to the legislature and OPWDD on its implementation (NYSACRA, 2016).

Further in 2014, a coalition of nine associations in NY launched the #bFair2DirectCare campaign to raise awareness of the profession of Direct Support, share data on the crisis, and advocate to the state to be sure provider reimbursement rates would increase in proportion with a $15 minimum wage increase across industries. Using the MIT Living Wage calculator (http://livingwage.mit.edu/), the coalition advocated with both the Executive and Legislative branches of government to allocate funding for a living wage for DSPs. In 2017, a budget bill for $55 million was passed to support wage increases for this workforce.

V. Recommendations for Georgia

Given the quantity of current national research and innovative strategies implemented by states to address the DSP crisis, there are a number of opportunities for Georgia to consider.

1. Propose a Legislative Resolution urging the United States Department of Labor's Bureau of Labor Statistics to designate the Direct Support Professional as its own standard occupational classification modeled after the Illinois General Assembly HR272: http://www.ilga.gov/legislation/100/HR/PDF/10000HR0272lv.pdf; and consider a similar **resolution enacting the creation of a standard occupational code for DSPs in Georgia** through the Georgia Department of Labor (GDOL) to allow for more accurate data collection on this workforce within the state. Improved, consistent, regular data collection from the provider level on up will make it possible to assess the extent of any current HCBS workforce shortage, predict any anticipated shortages for the future, or determine what other issues may be impacting staffing challenges in the HCBS workforce.
2. **Create a task force** of stakeholders including the Department of Community Health, Department of Behavioral Health and Developmental Disabilities, Department of Labor, the Administrative Services Organization, support provider associations, DSPs, and people receiving supports along with other stakeholders to assess the National Quality Forum (2016) DSP domains in Georgia and propose evidence-based interventions to address deficiencies.
3. Consider **innovative recruitment incentives** for expanding the labor pool targeting younger workers ages 18 -24, older workers over age 55, and men. These may include tax credits for retirees, educational tax incentives for transitioning high school students, and debt forgiveness for college students.

Further, immigrants are a valuable part of the direct care workforce and the state may implement the evaluation of policies impacting this population, promote cultural competence in the workforce, and partner with immigrant-focused organizations.

4. **Expand competency-based training** offered through existing NADSP accredited training programs in Georgia and standardize **competency-based staff performance review** processes which may be linked to credentialing opportunities.
5. Develop a **career ladder** that provides opportunity for DSP promotion and specialization based on completion of competency-based training and tenure.
6. Continue and expand DBHDD's support for Georgia's **Leadership Launchpad**.
7. Consider setting **reimbursement rates which include DSP professional development costs** by working with the Department of Community Health using the Toolkit for State Medicaid Agencies on Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting: https://www.medicaid.gov/medicaid/ltss/downloads/workforce/dsw-training-rates-toolkit.pdf.
8. Consider increasing Medicaid reimbursement rates using a methodology that incorporates **indexed cost of living increases and a wage pass though** for DSPs. Further, Georgia should also **explore wage incentive reimbursements** for DSPs who complete accredited training/credentialing programs: https://www.nadsp.org/wp-content/uploads/2016/08/BuldingDSPTrainingIntoMedicaidBudgets.pdf
9. Create a public facing **DSP registry** that shows criminal background check results and data regarding a DSPs training, education, and credentialing to allow providers and individuals to view more details about potential frontline staff. Medicaid administrative match is available to states to help fund the development and maintenance of the registry. Guidance on administrative claiming for these functions can be found at https://www.medicaid.gov/medicaid-chip-program-information/bytopics/financing-and-reimbursement/downloads/qa-training-registry-costs-071015.pdf
10. Establish a **HCBS Innovation Fund** to support pilot projects that address recruitment and retention of DSPs. Policymakers could use the results of these pilot studies to help address the workforce shortage in Georgia.

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